

A SURGEON'S CASE FOR HUMAN SOLIDARITY

The Global Burden of Human Catastrophe

Following Wars
and Revolutions

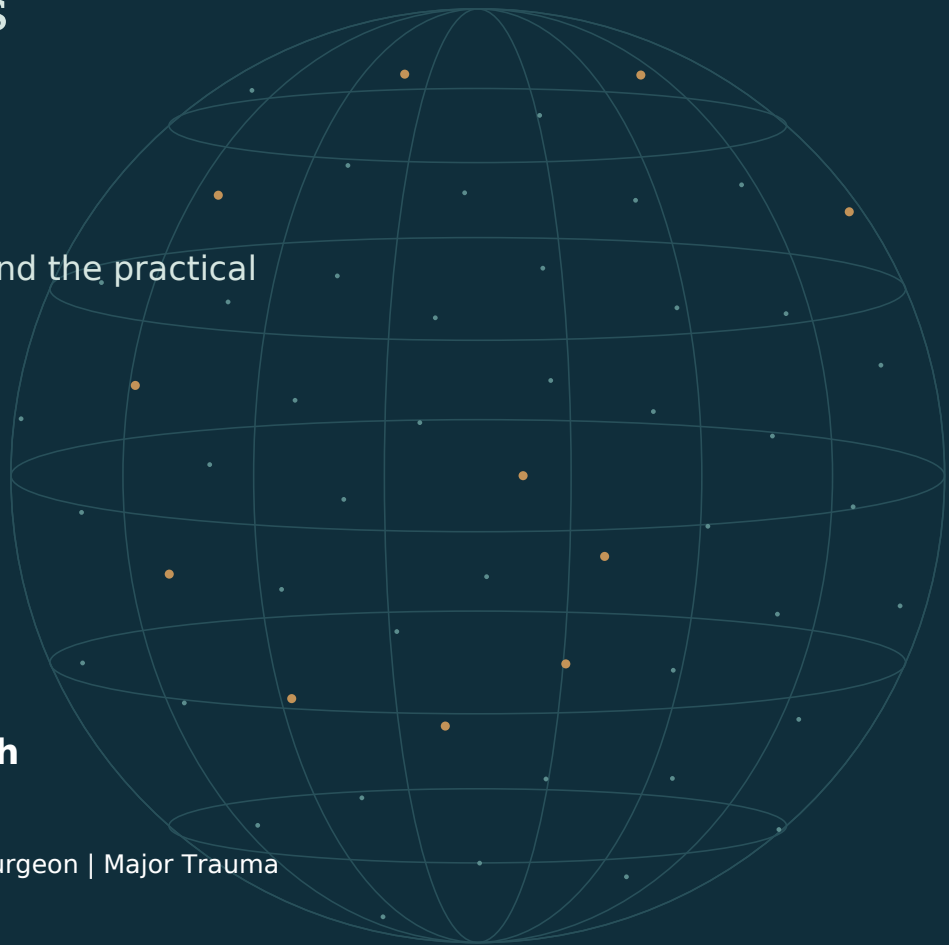
Injury, pain, displacement and the practical
work of charity

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A reference book for humanitarian action, with particular attention to Iran.

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A surgeon's introduction

I was seven years old when the Iranian revolution transformed the country in which I was growing up. I was nine when the war between Iran and Iraq began. Revolution and war were therefore part of my childhood before I possessed the language, education or experience with which to understand them. I later experienced displacement within Iran, and then exile and refuge outside it. These experiences widened my horizons, but they also left a question that has followed me into my working life: what happens to the people whose suffering continues after the world has turned its attention elsewhere?

I have not been alone on this journey. Along the way I have met people whose histories echo my own, although their countries, beliefs and political conclusions differ. Some have left a war. Others have left a prison, a revolution, persecution or the destruction of an ordinary livelihood. What connects them is not a common party or nationality. It is the experience of discovering how quickly the familiar protections of life can disappear.

I write as Mr Peyman Bakhshayesh, MD, PhD, MBA, a Consultant Trauma and Orthopaedic Surgeon with a major trauma practice. My starting point is the injured human being. A bullet passing through a body becomes a clinical problem that can last long after the political event that produced it. An injured eye may mean the loss of a profession. A damaged face may affect eating, speaking and confidence. Multiple shotgun pellets, fractures, nerve injuries, burns and the consequences of torture may change the course of an entire family's life.

This book asks us to look beyond the immediate death toll. It joins a review of published evidence to a philosophy of charitable work and a practical argument for organisation. Its central proposition is simple: human solidarity becomes meaningful when it improves somebody's prospects of treatment, recovery, dignity and participation in life.

My childhood recollections are personal testimony supplied for this book. They are not an independently investigated biography or a determination of immigration status.

Displacement within one's country is described here as internal displacement; crossing a border introduces different legal questions. The wider statistical discussion rests on identified sources rather than on personal memory.

This is an English educational book and a narrative review, not a systematic review or an original casualty investigation. It examines five completed calendar years, 2021-2025, and includes dated updates available by 21 October 2026. No complete worldwide registry of people living with war-related wounds, torture-related pain or permanent disability was identified. The absence of such a registry is one of the problems this book seeks to make visible.

How to read this book

The four chapters follow a progression: understanding the burden; understanding why statistics matter; building a practical response; and establishing a respectful dialogue with the public. A conclusion brings these responsibilities together. The appendices provide working tools that a developing humanitarian organisation can adapt.

Numbers in square brackets identify the linked references at the end. Every table states what is being counted and the relevant period. A count of injured people is different from a count of injuries, treatment visits, operations or people requiring rehabilitation. A death toll is different from an execution count. A displacement estimate describes a population at a particular time; it is not a count of bodily injuries.

The humanitarian edition contains the common evidence and charitable framework. The author's edition also contains a separately labelled political afterword. Its personal positions are not conditions for receiving assistance and are not presented as the Foundation's charitable purposes. Programme models in this book are proposals, not announcements that services, grants or overseas partnerships are already operating.

To relieve suffering, we must first recognise it; to relieve it reliably, we must organise.

Chapter 1 | Introduction: the burden that survives the event

1.1 Progress has not made civilians safe

Human beings have developed remarkable institutions: modern states, public health systems, courts, international treaties, the European Union, the United Nations and its humanitarian agencies. These achievements matter. They have created ways to negotiate, investigate abuses and organise assistance. Yet their existence does not guarantee that a civilian will be protected when violence reaches a town, a neighbourhood, a prison or a hospital.

The experience of Iran, Iraq, Afghanistan and the former Yugoslavia reminds us that war and political upheaval can enter the lives of entire societies. Their histories differ, and revolution is not synonymous with armed conflict. Some political transitions are peaceful; others involve repression, civil war or international intervention. We lose understanding when we place every episode under one undifferentiated label.

Civilian suffering is recurrent, but it should never be accepted as an unavoidable moral entitlement of those conducting a war. The people outside the military contest retain their dignity. The wounded do not become less human because their injuries occur during a politically controversial event. The child with a damaged eye and the adult unable to walk require a response before distant observers settle every disagreement about the conflict.

Nor is humanitarian assistance available only after an event has been legally classified as genocide. Existing agencies and local organisations work across many kinds of crisis. The difficulty is that access, funding, security and service capacity can be profoundly unequal. An organisation should identify those practical failures precisely, rather than imply that no humanitarian system exists.

Ukraine illustrates the value of organised public institutions and international support under extreme pressure. It also demonstrates the limits of that support: civilians continue to be killed and injured. Other societies may have less organised protection, fewer reliable referral systems or less international attention. The ethical task is to address need without ranking the worth of people by the strength of the institutions available to them.

1.2 A worldwide picture in numbers

Published figures describe different parts of the catastrophe. They cannot be combined into a single total of victims. The following evidence gives scale while preserving those differences.

Table 1. Selected global measures

Measure	Figure and period	What the figure means
Forcibly displaced people worldwide	117.8 million at the end of 2025 ^[5]	UNHCR population estimate covering persecution, conflict, violence and related causes; not all have physical injuries.
Children among forcibly displaced people	About 45 million; 38% at the end of 2025 ^[5]	Estimated children under 18; a subgroup of the total above.
Documented civilian conflict deaths	37,163 in 2025, compared with 48,011 in 2024 ^[6]	Recorded deaths in the UN indicator; incomplete coverage and later verification affect comparison.
Deaths with unresolved civilian status	13,165 in 2025 ^[6]	Victim status could not be determined; these are not an additional verified civilian total.
Landmines and explosive remnants of war	At least 6,279 killed or injured in 2024 ^[9]	Device-specific casualties; not all explosive-weapon casualties.
Mental disorders in conflict-affected populations	About 22% in WHO's evidence summary ^[10]	Prevalence estimate relating to populations exposed to conflict in the preceding 10 years; not a new annual caseload.

The UN's 2026 account explains that part of the apparent increase in its 2024 civilian death series followed access to records in Syria, including deaths likely to have occurred earlier. Thus, the reported fall in 2025 cannot simply be read as a comparable fall in violence everywhere. Definitions, access and verification are part of the result. ^[6]

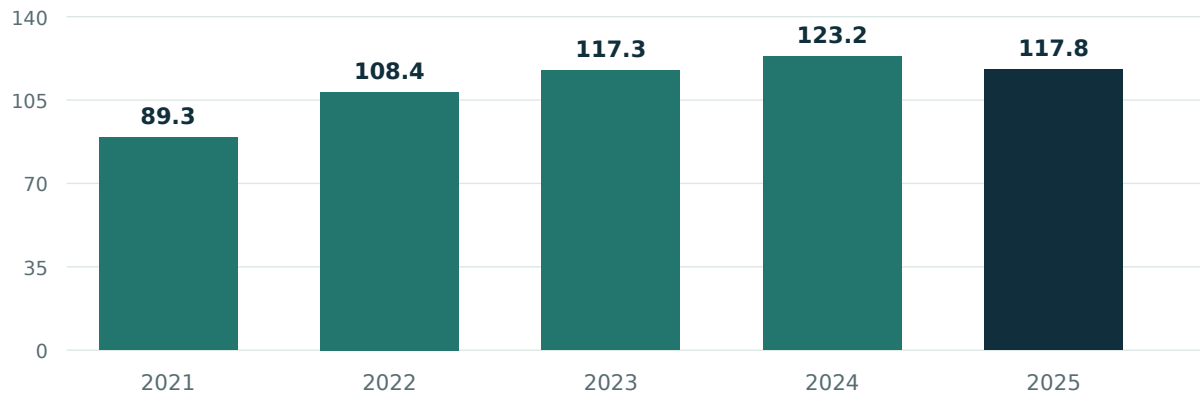
For landmine and explosive-remnant casualties in 2024, the Monitor's detailed report gives a civilian share of 90% among casualties whose status was known. It is essential to retain that denominator. A percentage calculated after excluding unknown status does not mean that every person in the entire dataset has been classified. ^[9]

The mental health figure is also easily misused. It concerns a group of conditions, including depression, anxiety and post-traumatic stress disorder, as well as bipolar disorder and schizophrenia. It should not be called a worldwide percentage of people with PTSD, or multiplied by a displacement total to manufacture a global diagnosis count. ^[10]

Table 2. Five year-end snapshots of forced displacement

Year-end	People forcibly displaced worldwide	Source
2021	89.3 million	UNHCR Global Trends 2021 ^[1]
2022	108.4 million	UNHCR Global Trends 2022 ^[2]
2023	117.3 million	UNHCR Global Trends 2023 ^[3]
2024	123.2 million	UNHCR Global Trends 2024 ^[4]
2025	117.8 million	UNHCR Global Trends 2025 ^[5]

Forcibly displaced people worldwide (millions)



Source: UNHCR annual reports [1-5]. Year-end stocks; do not add the years.

These are published year-end stocks, not the number of new people displaced each year. The same individual may appear in several successive years. Annual reports can revise earlier estimates. A lower stock may reflect returns and other changes; it does not establish that return was safe, voluntary or medically sustainable. Adding the five rows would count many people repeatedly.

1.3 Different regions, related responsibilities

A global book must resist the tendency to make the best-publicised war stand for every war. Attention is uneven, while need is widespread. The next table offers selected examples across regions, including a separately identified example of severe organised violence in the Americas.

Table 3. Selected country and regional evidence

Setting	Dated evidence	Main interpretation
Ukraine	OHCHR verified at least 2,514 civilians killed and 12,142 injured in 2025; the corresponding 2024 figures were 2,088 and 9,138. ^[7]	A documented minimum of direct civilian harm; inaccessible areas limit completeness.
Gaza	WHO estimated 43,011 people with potentially life-changing injuries, from 172,043 reported injured as of 1 April 2026. ^[8]	A model of rehabilitation need, not an individually examined registry of every person.
Sudan	UNICEF's 2026 appeal identifies 33.7 million people needing humanitarian assistance, including 17.3 million children. ^[11]	A planning estimate covering multiple needs, not a death or injury count.
Myanmar	UNICEF reported 16.2 million people in need in 2026, including 4.9 million children; nearly 3.8 million internally displaced by end-June. ^[12]	Conflict interacts with disasters and economic decline.
Democratic Republic of the Congo	UNICEF's 2026 appeal estimates 14.9 million people in need, including 8 million children. ^[13]	Needs include protection, health, nutrition and other essential services.
Afghanistan	UNICEF's 2026 appeal estimates 21.9 million people needing assistance, including 11.6 million children. ^[14]	A prolonged humanitarian crisis cannot be reduced to current gunshot injuries.
Yemen	UNHCR reports an estimated 22.3 million people needing assistance in 2026, including 5.2 million internally displaced people. ^[15]	Continuing and accumulated needs extend beyond an immediate battlefield.
Haiti	BINUH's January 2026 summary describes nearly 6,000 people killed and more than 2,700 injured during 2025. ^[16]	Severe gang and security-related violence; included as a related protection crisis, not automatically classified here as a war.

The rows use different measures and should not be used as a league table. A needs estimate for Sudan cannot be compared numerically with a verified injury count for Ukraine to decide which population has suffered more. The useful comparison concerns the kinds of support required, the quality of information and the ability to reach people.

Gaza provides a particularly clear illustration of the gap between surviving and recovering. WHO's May 2026 update estimated more than 5,000 limb amputations and

reported over 400 patients waiting for specialist rehabilitation beds. Its detailed injury ranges allow for people sustaining multiple injuries. Those ranges must not be added and presented as unique patients. ^[8]

The practical implication extends across countries. When emergency surgery succeeds but rehabilitation, an appropriate prosthesis or safe follow-up is unavailable, the care pathway remains incomplete. A charity interested in long-term recovery should therefore ask what happens after discharge, not merely how many procedures have been paid for.

1.4 Iran: separate the mechanisms of harm

For Iran, this book distinguishes lethal repression of protests, injuries to survivors, torture and ill-treatment, judicial executions, and harm arising from international hostilities. These mechanisms can affect the same families. They nevertheless require different documentation and cannot safely be merged into one headline number.

The death of Jina Mahsa Amini in custody in September 2022 was followed by the Woman, Life, Freedom uprising. The UN Fact-Finding Mission subsequently described credible figures of 551 protesters killed, including 49 women and 68 children. Its findings included serious violations amounting to crimes against humanity. This is an investigative finding, not a criminal conviction of every person alleged to be responsible. ^[17]

Iran Human Rights documented 138 eye-injury cases in its 2023 report, including 38 women and 100 men. Eight children were among those described as blinded. This is a documented sample, not a national prevalence estimate. Threats, fear and restricted access prevent a complete picture. The report also records individual experiences of multiple pellets and damage to both vision and surrounding facial structures. ^[18]

The next nationwide protest wave began in late December 2025. Iran Human Rights' report of 17 September 2026 published more than 4,200 documented deaths, including at least 420 women and 281 children. It identified at least 3,356 deaths on 8-9 January among cases with an established date. These are source-specific documented minimums, not an independently reconciled national census. ^[19]

Table 4. Iranian protest deaths and injuries: selected evidence

Episode or measure	Figure	Source and limit
Woman, Life, Freedom deaths	Credible figure of 551; including 49 women and 68 children	UN mission, reported in March 2024; the subgroups are included in the total. ^[17]
Documented eye injuries in the 2022 protests	138 cases; including 38 women, 100 men and 8 children among those blinded	IHRNGO, September 2023; a documented sample. ^[18]
January 2026 protest deaths	More than 4,200 documented; at least 420 women and 281 children	IHRNGO, 17 September 2026; minimum, not final toll. ^[19]
Concentration of January deaths	At least 3,356 on 8-9 January	IHRNGO; subset with known date, included in the overall report. ^[19]
Injured during the recent protests	Reports of 25,000 injured; more than half reportedly requiring surgery	UN mission chair's 21 September 2026 statement; reported figures, not a clinical registry verified by this book. ^[20]

The reported 25,000 injuries must be handled particularly carefully. It does not provide a national count of permanent disability, a breakdown of gunshot versus shotgun wounds, or the number of operations eventually performed. An indication that surgery was required is different from evidence that treatment was delivered. ^[20]

Public discussion also uses the name Lion and Sun movement or revolution for mobilisation associated with Crown Prince Reza Pahlavi. His own January 2026 statement called for participation, while his September address used that name and set out his political principles. These primary sources establish his stated role and programme; they do not establish that every protester followed him or that every victim had the same political allegiance. ^[40,41]

For a medical humanitarian organisation, this distinction is decisive. The person wounded while protesting has a claim to concern whether they favour constitutional monarchy, a republic or no particular constitutional model. The survivor should not be required to adopt a movement's vocabulary to receive assistance.

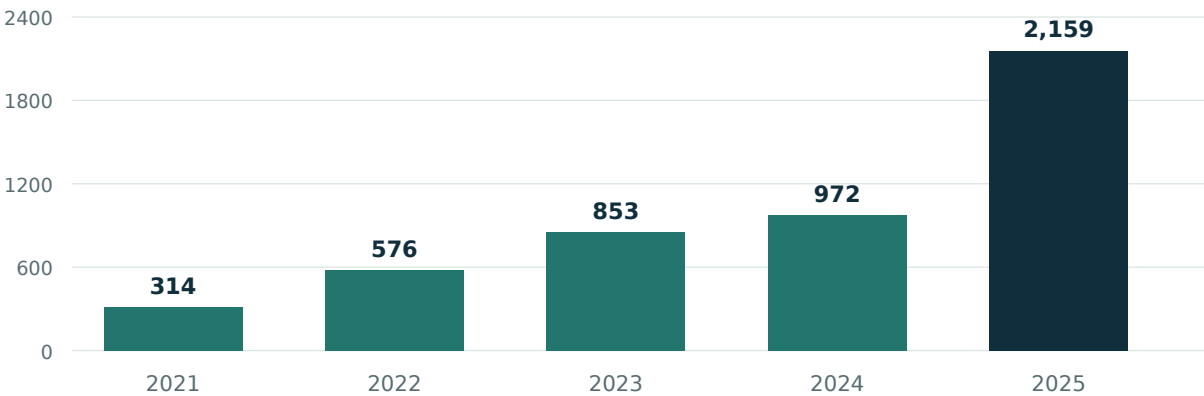
1.5 Executions: a five-year series and a current update

An execution count measures a particular form of state killing. It is not interchangeable with deaths in street protests, bombardment or custody. Nor should all people executed across criminal categories be described as political protesters. The evidence is grave enough without changing its meaning.

Table 5. Executions recorded in Iran by Amnesty International

Calendar year	Recorded minimum	Reference
2021	At least 314	Amnesty's 2021 reporting ^[21]
2022	At least 576	Amnesty's comparative reporting ^[22]
2023	At least 853	Amnesty's 2023 reporting ^[22]
2024	At least 972	Amnesty's 2024 reporting ^[23]
2025	At least 2,159	Amnesty's 2025 reporting, published 18 May 2026 ^[24]

Iran: annual recorded execution minimums



Sources: Amnesty International [21-24]. Full calendar years; 2026 excluded.

The arithmetic sum of these five published annual minimums is 4,874 executions. This is a calculation from the cited series, not a separately investigated total and not a protest-only figure. It does not include 2026. Using one organisation's series avoids quietly switching between different documentation systems. ^[21-24]

For a more recent update, Iran Human Rights recorded at least 604 executions between 1 January and 30 September 2026. It included 33 protesters: 31 connected with the January protests and two with Woman, Life, Freedom. It also reported more than 500 additional allegations that it had not verified and therefore excluded. The unverified allegations must remain outside the verified count. ^[25]

The 604 figure is a partial-year minimum from a different organisation. It must not be placed on the annual Amnesty chart as though it were a comparable full year. Differences between organisations' totals should prompt review of dates and case lists, not averaging, selective use of the largest number, or an assumption that a smaller documented minimum proves improvement.

The consequences reach beyond the person killed. Families face bereavement, financial hardship, fear and sometimes uncertainty about the final days of their relative's life. Relief organisations can support lawful access to care and related hardship within their purposes while independent legal and human-rights bodies undertake the appropriate work on accountability.

1.6 Iran: civilian harm during war

The June 2025 war and the hostilities beginning on 28 February 2026 must be treated as different periods. Later waves of attacks require further dated reporting. A number published in March or April cannot honestly be described as the final toll through October.

Table 6. Selected Iranian wartime evidence

Period and source	Reported figures	Interpretation
13-24 June 2025; HRANA report of 28 June ^[26]	1,190 killed and 4,475 injured in total; civilian breakdown: 436 killed and 2,071 injured	Includes civilian, military and unclassified cases; use the report's detailed breakdown.
28 February-7 April 2026; HRANA day-39 report ^[27]	At least 1,701 civilians killed, including at least 254 children	Period-specific documented minimum; children are included in the civilian figure.
WHO, 11 March 2026 ^[28]	Iranian health authorities reported more than 1,300 deaths and 9,000 injuries	Authority-reported total relayed by WHO; not a WHO-verified civilian-only count.
WHO, 11 March 2026 ^[28]	WHO verified 18 attacks on health care in Iran since 28 February, resulting in 8 health-worker deaths	Attacks on health care are incidents; this is not a count of all damaged hospitals.
UNHCR, 12 March 2026 ^[29]	Up to 3.2 million temporarily displaced inside Iran	Preliminary upper estimate, derived from estimated households; not refugees abroad.
8-17 July 2026; HRANA report of 18 July ^[30]	At least 48 people killed and 68 injured; including 20 civilians killed and 46 civilians injured	A later ten-day reporting window; not the entire war.

The June 2025 HRANA article contains a small inconsistency: its concluding narrative gives 431 civilian deaths, while its detailed breakdown gives 436. Table 6 uses the explicit breakdown and makes the discrepancy visible. This book has not reconciled the underlying cases. That is preferable to silently presenting an internally inconsistent source as exact. ^[26]

On 11 March 2026, WHO also relayed authority-reported figures of at least 570 deaths and more than 1,400 injuries in Lebanon, and 15 deaths and 2,142 injuries in Israel.

These figures illustrate the regional reach of the escalation; they have the same limitation concerning source attribution and civilian classification. ^[28]

The UN Fact-Finding Mission's September 2026 findings addressed both Iranian state repression and alleged violations during foreign military strikes. Its press release described reasonable grounds to believe that US forces committed war crimes in two airstrikes killing at least 178 civilians. The finding is attributed to the investigative mission, not presented as a judicial conviction or as the complete wartime civilian toll. ^[31]

The ethical principle is consistent: condemning the Islamic Republic's repression does not remove the obligation to examine civilian harm caused by another state. Equally, documenting harm from a foreign strike does not erase torture, executions or mass shootings by Iranian authorities. The patient should not disappear between these competing arguments.

The risk of further escalation is a reason to prepare, not a numerical forecast. This edition cannot establish a probability or timetable for another war. It can argue for maintaining treatment capacity, medicine continuity, safe referrals and rehabilitation under several possible futures, including renewed attacks, fragile ceasefires and prolonged insecurity.

1.7 The injuries that headlines do not describe

An injury count can conceal as much as it reveals. Two people counted in the same row may face entirely different futures. One may recover with short-term care; another may need repeated reconstruction, support with daily living or lifelong adaptation. Clinical priorities require individual assessment.

Table 7. From mechanism of harm to recovery needs

Injury or exposure	Needs that a programme should be able to assess
Gunshot wounds and major limb trauma	Pain, function, infection risk, reconstruction and rehabilitation.
Shotgun pellets and other retained fragments	Specialist assessment of symptoms, location and appropriate imaging.
Eye and facial injury	Vision, eating, speech, appearance and specialist rehabilitation.
Burns and scarring	Function, pain, mobility and longer-term support.
Brain, spinal cord and nerve injury	Independence, cognition, mobility, communication and caregiver needs.
Amputation	Rehabilitation, suitable prosthetic provision, maintenance and review.
Torture and ill-treatment	Confidential physical and psychological assessment, safety and consent.
Displacement and interrupted care	Medicines, follow-up, transport, accessibility and safe accommodation.

This is an assessment framework, informed by WHO rehabilitation guidance and the Istanbul Protocol, not instructions for treating an individual patient. Decisions about retained fragments, surgery or imaging belong to appropriately qualified treating teams. The presence of a fragment alone does not tell a remote organisation what intervention is required. ^[35,36]

Pain deserves attention in its own right. It can prevent sleep, work, walking and participation in family life even when the original wound is no longer visible. A programme that records only whether a person is alive misses an essential part of the burden. Rehabilitation should be connected to the person's goals, not reduced to a photograph of equipment being handed over.

Torture also requires a different approach from an ordinary injury survey. A survivor may face continuing fear, shame, threats or difficulty giving an account. A lack of visible scars cannot by itself settle whether torture occurred. Competent documentation considers the history, physical and psychological findings and their relationship, while respecting consent and security. ^[36]

There is no defensible single number in this book for all people worldwide who have chronic pain after war, all Iranians with shotgun pellets, or all survivors of torture requiring reconstructive surgery. Naming these gaps is part of an honest burden assessment. It should lead to better confidential service data, not the invention of a total.

Chapter 2 | Why statistics are important

2.1 The person and the population

One person in pain is enough to justify compassion. Statistics are needed for a different reason: they help us turn compassion into an organised response. They help determine where services are missing, what capacity is required, how resources should be distributed and whether a programme is improving people's lives.

A surgeon needs to understand the individual patient. An organisation also needs to understand the group waiting outside the clinic. Without that second perspective, the most visible or best-connected applicant may receive help while people with greater need remain unheard. Evidence should widen attention beyond the person who is easiest to reach.

Statistics can also protect the cause from its own enthusiasm. A moving appeal may generate many requests that a small organisation cannot meet. Before promising treatment, the organisation needs to know its budget, provider capacity and ability to support follow-up. A promise that cannot be honoured can deepen the disappointment of people who already have little reason to trust institutions.

2.2 Saadi and the shared human body

The Persian ethical tradition offers a language for this responsibility. I return to Saadi's famous lines, commonly recited in the variant: Bani Adam a'za-ye yek peykarand; ke dar afarinesh ze yek goharand. Human beings are members of one body, sharing one essence in creation. The Ganjoor text reads yekdigarand, or members of one another, in the first line. The shared ethical meaning is clear. ^[32]

For a surgeon, the image has particular force. The suffering of one part asks a response from the whole. A person does not become an irrelevant organ because they live beyond a border or speak another language. Our distance from their pain changes what we can practically do; it does not make the pain unreal.

This is an invitation to responsible participation, not a demand that every person abandon their own family or give beyond their means. People carry burdens that a fundraiser cannot see. A humane cause should help people find a sustainable contribution: time, skill, careful introductions, translation, small gifts or larger support when affordable.

The philosophy becomes practical when we ask a manageable question: what can I do, with the knowledge, resources and relationships available to me, that makes another person's recovery more possible? The answer may be modest. Modesty is compatible with usefulness. Repeated, dependable contributions can sustain work that a single moment of public emotion cannot.

2.3 Count the right thing

The first discipline is to define the unit. A charity might report 100 consultations, but these could involve 100 people or 20 people seen five times. It might fund several procedures for one person. Both forms of work can be valuable, but they answer different questions.

Similarly, a person can have a gunshot injury, an eye injury and psychological distress at the same time. If the programme totals those categories, it must say whether it is counting people or conditions. Otherwise, the same survivor can become three apparent beneficiaries. Honest reporting begins with a clear identifier and consistent definitions.

Table 8. Questions that improve a statistic

Question	Why it matters
Who is included?	Civilians, combatants, unknown status, children and adults may be mixed.
What is counted?	People, injuries, incidents, consultations and operations differ.
When and where?	Calendar years, rolling periods and selected locations are not interchangeable.
How was it obtained?	Verified cases, reports, estimates and models have different strengths.
What is missing?	Unknown status, inaccessible areas and fear of disclosure affect completeness.
Could records overlap?	Repeated visits and multiple sources can duplicate a person.
Has it changed?	Later verification can revise earlier totals.
What decision follows?	A statistic should inform care, planning, accountability or learning.

The words at least, estimated and reported are part of the information. Removing them can change a source's meaning. A documented minimum tells us what an organisation could establish by a date. It does not automatically reveal the true total, and it does not justify applying an arbitrary multiplier.

2.4 Missing people are not people without needs

The people absent from a database may be those at greatest risk: survivors afraid to identify themselves, people in inaccessible places, people without money for transport, people who cannot use the available language, or people with disabilities that make registration difficult. A programme should examine who is missing from its own applications.

However, missing information is not permission to make unsupported claims. We can say that barriers plausibly cause undercounting while acknowledging that the size of the missing population is unknown. Advocacy becomes stronger when it explains the limitation and asks for the means to investigate it.

There is also a difference between a humanitarian database and a forensic investigation. A person may need help even when they cannot safely provide evidence suitable for a criminal case. A charity should obtain enough proportionate information to assess eligibility and need without demanding an unsafe or unnecessarily detailed political narrative.

2.5 Measure recovery, not publicity

For charitable work, expenditure and activity are starting points. They do not establish recovery. An organisation should ask whether the person can reach care, whether treatment occurred, whether pain and function improved, and whether further needs remain.

An outcome system should be proportionate to the programme. At an initial assessment, a person might identify a goal such as returning to school, walking to a local shop or sleeping with less pain. Later review can ask whether progress occurred and whether the support was acceptable. Qualified clinicians can select validated measures where appropriate; an invented score should not be presented as validated research.

Not every result will be positive. Some conditions will remain severe. Some treatments will fail or require further care. A trustworthy organisation explains these limits rather than selecting only the most successful stories. Loss to follow-up must also be recorded, because an absent response cannot be assumed to mean a good outcome.

2.6 Protect the record and the person

An injured person's identity is not a fundraising asset. Clinical records, photographs, detention history and family details can expose someone to serious consequences. Access should be restricted to those who need it for a legitimate role. Public reporting should normally use aggregates with small groups suppressed where identification could become possible.

Consent to receive care is different from consent to publish a story, use a photograph, share information internationally or contribute to forensic documentation. Each decision needs its own explanation. Refusal of publicity should not reduce a person's prospects of assistance.

The aim is an evidence system that makes suffering visible at population level while protecting the individual. More information is not always better. The right information is what enables a justified decision and safe follow-up with the least unnecessary exposure.

Chapter 3 | Practical approaches to relieving the global burden

3.1 Find people who will do the work

Humanitarian institutions often begin with people who feel another person's suffering intensely. That energy matters. Yet sustained work also requires reliability, humility and the ability to complete unglamorous tasks. Someone must check an invoice, arrange an interpreter, answer an applicant and follow up a missed appointment.

The first group should therefore be selected for conduct as well as conviction. Can its members listen to people with different beliefs? Can they accept a clinical decision that does not suit a preferred story? Can they acknowledge an error? Can they protect a survivor's privacy when publicity might benefit the organisation?

Doctors are important, but doctors alone do not make an institution. Nurses, therapists, psychologists, social workers, finance professionals, administrators, translators, lawyers and people with lived experience bring different forms of knowledge. A small team should recognise its limits and establish referral relationships rather than pretending to possess every competence internally.

3.2 Agree a shared minimum purpose

People from different faiths, ethnicities, nationalities and political traditions can work together when the immediate purpose is clear. They need not agree on the explanation of every war. They do need to agree about the conditions under which help will be given.

A useful proposed purpose is to support people facing illness, injury, pain, disability and related hardship, including those affected by war, repression and displacement, within the organisation's governing purposes and available resources. The exact wording for a particular charity must follow its constitution and actual authority.

The Red Cross and Red Crescent Movement's principles provide an important reference: humanity, impartiality, neutrality, independence, voluntary service, unity and universality. A separate organisation should not claim affiliation merely because it adopts related values. Nor should a politically committed individual claim that every part of their activity is neutral. What matters is that care decisions are impartial and clinically independent. ^[33]

Medical ethics provide a corresponding professional standard. The World Medical Association's Declaration of Geneva excludes political affiliation and other personal characteristics from interfering with the physician's duty to the patient. An organisation of doctors should make this commitment operational, rather than leave it as a statement on a website. ^[34]

3.3 Build trust through clear responsibilities

In a developing organisation, friendship can create momentum but also blur accountability. A colleague's good intentions do not replace an agreed role. A trusted partner still needs a clear scope, appropriate competence and an explanation of how funds and information will be handled.

Table 9. A proposed small-team structure

Function	Core responsibility
Trustees or governing board	Purpose, eligibility policy, budget, conflicts and recorded decisions.
Clinical lead and reviewers	Assess clinical proposals within competence and advise on referrals.
Case coordination	Communicate safely, arrange practical steps and maintain follow-up.
Finance lead and independent checker	Verify payees, reconcile spending and report exceptions.
Safeguarding and information lead	Manage concerns, confidentiality, consent and secure records.
Survivor and community advisers	Identify barriers, test communication and inform programme design.

One person may perform more than one function in a small organisation, but a conflicted individual should not approve their own transaction. A clinician recommending a provider in which they have a financial interest must declare that interest and leave the appropriate decision to an independent process.

Charity Commission guidance emphasises proportionate due diligence and verification of how funds are used. For international work, this involves understanding the partner and activity, managing relevant risks and monitoring delivery. The practical arrangements should be appropriate to the transaction and setting, rather than assuming that a personal introduction settles every question. ^[38]

3.4 Design a complete pathway

The proposed pathway begins before an operation and continues after it. First, the organisation receives an application or professional referral. It establishes an appropriate contact method, understands immediate safety concerns and obtains enough information to assess the request. It should not invite applicants to send detailed medical or political histories through a public comment box.

Next comes proportionate review. What is the person's condition and functional difficulty? What help is being requested? Is there a credible treating professional or assessment? Are the proposed provider, costs and follow-up suitable? What practical barriers might prevent treatment even if its invoice is paid?

The decision should identify the assistance approved, its limit, the reason and any conditions needed for safe delivery. It should be recorded under the governing document's quorum, voting and conflicts rules. The applicant should receive a clear explanation, including what the organisation can realistically support.

Payment and delivery then require appropriate independent verification. Where feasible and justified, a provider payment with a documented invoice may be easier to monitor than an unrestricted transfer. Other circumstances may require a different arrangement. The organisation should use a lawful, suitable route with its bank and relevant advisers, rather than improvise around a blocked transaction.

Finally, somebody must check whether the person reached care and what happened afterwards. A pathway without follow-up can leave complications, continuing pain or inaccessible rehabilitation unaddressed. The objective is a practical improvement in the person's life, not completion of an administrative file.

3.5 Support recovery beyond the operating theatre

A medical charity can be tempted to prefer highly visible interventions. An operation offers an identifiable date and a clear payment. Recovery can be less visible: transport, therapy, mobility equipment, wound review, medication access or the time of a family caregiver. Those needs may determine whether the intervention achieves its purpose.

WHO's rehabilitation guidance identifies recovery of functioning, prevention of complications and participation in community life as central concerns during conflict. It covers people with new injuries and people whose existing disabilities or health conditions are made harder to manage by the emergency. This supports planning for continuity rather than treating rehabilitation as an optional final addition. ^[35]

Programme design should also recognise that needs change. A child may require repeated review as they grow. A displaced person may move to a place where the first referral is no longer usable. A survivor of torture may only feel able to discuss psychological difficulties after trust has developed. Flexibility should be budgeted and governed, rather than left to personal favours.

3.6 Work with local capacity

People already working near affected communities often understand access, language and continuity better than an overseas supporter. Collaboration should begin with listening to that expertise. Overseas professionals can contribute specialist advice, education, funding and connections while respecting the responsibilities of the treating team.

Remote advice has limits. Images and messages can support a discussion, but they cannot always replace examination, investigation and local knowledge. A charity should avoid suggesting that a distant volunteer has taken over clinical responsibility merely because they have seen a photograph.

Training and reliable follow-up systems may benefit more people than a short visit, although the right choice depends on the setting. The proposal should explain the problem it addresses and how it will continue when the initial enthusiasm or visiting team has gone.

3.7 Keep charitable work distinct from personal politics

People do not enter humanitarian work without histories or opinions. They may be refugees, campaigners, religious believers or supporters of a particular political future. Cooperation does not require erasing those identities. It requires an institution whose assistance is governed by its charitable purposes and the needs of its beneficiaries.

The Charity Commission's CC9 guidance allows campaigning and political activity that furthers a charity's purposes within the applicable rules, but a charity cannot have a political purpose. It also says trustees must not allow it to become a vehicle for an individual's personal or party-political views. This is a practical reason to distinguish humanitarian education and service delivery from a separate personal political platform. [37]

For Patriotic Doctors UK Foundation, this book proposes a needs-based model of assistance and education. It does not declare that the Foundation has adopted a party, a transition leader or a position on military intervention. Nor does it claim registration status, a charity number or operating services that have not been established in the evidence reviewed for this publication.

A patient should never be asked to donate to a political movement, sign a political declaration, display a flag or appear in campaign material in exchange for help. This protects the patient and the credibility of the doctors. It also makes collaboration possible with people who share the medical purpose while disagreeing about politics.

3.8 Prepare for uncertainty without predicting catastrophe

Preparation should be based on needs that are plausible under more than one scenario. Renewed attacks may interrupt supplies. A ceasefire may permit referrals but leave infrastructure damaged. Prolonged repression may deter people from attending hospitals. A political transition may open opportunities while creating further uncertainty.

The organisation can prepare a verified provider network, appropriate reserves, safe communications and alternative referral arrangements. It should know what it can pause, what it must continue and what would require a new board decision. These are practical capacities, not a claim to operate an ambulance, rescue or medical-evacuation service.

Table 10. A proposed first 90 days

Period	Work to complete	Evidence of readiness
Days 1-30	Agree purpose, roles, eligibility, conflicts, secure contact and referral criteria.	Approved policies, named responsibilities and a realistic budget.
Days 31-60	Verify a small provider network, test a few applications and establish payment checks.	Reviewed cases, verified payees and documented decisions.
Days 61-90	Review delivery and follow-up, examine barriers and publish aggregate learning.	Reconciled expenditure, outcome information and a correction process.

The timetable is illustrative, not a promise that a new organisation can safely begin all activity within three months. The scale should follow actual competence, resources and authority. A small, reliable programme can earn the trust required for responsible growth.

Chapter 4 | The art of dialogue

4.1 Begin with respect

A charitable cause can be urgent without treating the listener as an enemy. People may not know the facts. They may be overwhelmed by competing requests, distrustful after a bad experience, or unable to contribute financially. Calling them ignorant or uncaring will rarely create the relationship needed for useful cooperation.

The first task is to establish a language that connects the activist's knowledge with the listener's understanding. The speaker has lived with the issue; the listener may be encountering it for the first time. Information must be explained rather than merely announced. A medical term, an unfamiliar place name or a large number can otherwise become a barrier.

Respect also means accepting that a conversation may end without a donation. A person is entitled to decline. The quality of a humanitarian organisation is visible in how it treats the person who gives nothing as well as the person who gives generously.

4.2 Translate suffering into a comprehensible purpose

An effective explanation connects three things: the harm, the gap and the proposed response. The harm might be a disabling injury. The gap might be inability to reach specialist assessment or rehabilitation. The response might be a governed grant for a verified care plan. The listener should be able to understand that connection without needing a medical degree or detailed knowledge of international politics.

It is tempting to begin with the largest possible number. Sometimes a small number with a clear meaning is more useful. Saying that a report documented 138 eye-injury cases, while explaining that this is an incomplete sample, communicates a specific kind of harm. It is more informative than claiming without evidence that an entire generation has been blinded. ^[18]

Descriptions of individual experience require consent and care. Where a real story cannot safely be told, explain the care pathway in general terms. A hypothetical example must be labelled as such. An invented history should never be presented as a real beneficiary merely because it would make an appeal more moving.

4.3 A simple conversation structure

The following is a proposed structure, not a validated persuasion formula. Begin by stating the purpose in one sentence. Explain one verified problem and its date. Describe the assistance being considered and the checks that govern it. Offer a manageable way to participate, then allow the listener space to decide.

An educational introduction might read: We are developing practical support for people facing injury, illness, pain and related hardship. Conflict and repression can leave survivors with lasting disabilities and barriers to treatment. Our aim is to assess requests responsibly and support suitable care within available funds. We welcome professional help, introductions and affordable donations where a properly authorised appeal is in place.

This language is deliberately modest about operations. If the programme is still being developed, say so. If it is operating, report what it actually does. If a particular treatment is not yet available, do not imply that a gift guarantees access to it.

4.4 Answer questions without resentment

Questions about money, governance or politics are not an insult. They are an opportunity to show that the organisation has thought beyond its slogan. A donor who asks how funds are used is helping establish the standard that a trusted cause should meet.

Table 11. Questions and constructive answers

Question	A useful response
Why focus on this population?	Explain the documented need, the organisation's relevant skills and the scope of the programme.
Is help conditional on politics or religion?	State clearly that eligibility follows need and charitable purposes, not agreement with a political position.
How will money reach useful care?	Describe the actual review, approval, payment and monitoring arrangements.
What can a small contribution achieve?	Explain that affordable gifts can contribute to a pooled programme; avoid an unsupported fixed treatment promise.
What if a treatment fails?	Explain follow-up, review and honest outcome reporting; do not guarantee recovery.
I cannot afford to donate.	Thank the person and, if welcome, describe non-financial ways to help.

An organisation should be willing to say that it needs to check an answer. Improvising certainty may win a moment and lose the relationship. A clear response delivered later is more useful than a confident statement that proves wrong.

4.5 Small gifts and broad participation

I attach great importance to the number of people who choose to participate. Many affordable contributions can create a sense of shared responsibility and reduce dependence on a few supporters. Participation also creates relationships through which knowledge, skills and further cooperation may develop.

However, there is no general rule established here that the number of donations is more important than the amount raised. Both matter. A programme needs enough money to deliver its purpose, and a wide base of supporters can improve its resilience. One person making twelve gifts is also different from twelve unique donors. A transparent organisation records both transactions and people where lawful and appropriate.

Table 12. Illustrative giving models, before costs

Model	Calculation	What it demonstrates
Broad monthly participation	1,000 people giving £5 each = £5,000 a month	Small affordable gifts can collectively support a substantial budget.
A smaller group of larger gifts	10 people giving £500 each = £5,000	The same gross sum can depend on far fewer people.
A blended model	500 people giving £5 plus 5 giving £500 = £5,000	Broad participation and larger gifts can complement each other.
Sustained first model for a year	£5,000 x 12 = £60,000	A projection assuming every planned payment arrives; not guaranteed income.

These are arithmetic examples, not fundraising forecasts or treatment prices. Fees, fundraising expenses, cancellations, restricted uses and delivery costs affect what is available. Gift Aid is not included; it must not be assumed before eligibility and the necessary arrangements are confirmed.

A large donation count is evidence of participation in a particular appeal. It is not, by itself, proof of public acceptance across an entire society, endorsement of a political leader, or success in improving health. These are different questions requiring different evidence.

4.6 The heart and the reasoning mind

I understand the instinct to say that the heart ultimately gives while the brain calculates the household bills. Emotion can bring a distant person's suffering into view. But people make decisions in different ways, and this book does not claim a scientific rule that feeling always overrides reason.

The better aim is to bring compassion and judgement together. The heart recognises that another person matters. The reasoning mind asks whether the proposed help is credible, affordable and likely to be useful. A mature charitable organisation should be able to answer both.

An appeal can be warm without being manipulative. It can describe suffering without exposing a naked, distressed or identifiable patient. It can communicate urgency without inventing a deadline. It can invite a regular gift while making the commitment, amount and ability to stop clear.

The current UK Code of Fundraising Practice prohibits undue pressure and sets standards for honest and respectful fundraising. Its 2025 edition took effect on 1 November 2025. The practical lesson is that the dignity and choice of the donor belong beside the dignity and choice of the beneficiary. ^[39]

4.7 Slogans should lead somewhere

A slogan can create recognition, but it cannot replace a programme. I favour language that points towards an identifiable human purpose: Help a survivor rebuild daily life; Support care, recovery and dignity; or Many hands can make recovery possible. These are proposed phrases, not claims that a particular service is already available.

The organisation should be able to explain what happens after the slogan has done its work. Where does an enquiry go? Who assesses a request? How is a payment approved? What information does the donor receive? Who responds when something goes wrong?

Marketing should therefore be understood as truthful public explanation, not merely visibility. A clear website, accessible language, a dated evidence summary and a reliable contact route may do more for trust than an emotionally overwhelming message. Repetition should strengthen understanding rather than increase pressure.

4.8 Dialogue inside the organisation

The public conversation will reflect the internal culture. If volunteers cannot raise a concern without being accused of disloyalty, mistakes will be hidden. If clinical advice is overridden to preserve a preferred narrative, the programme will drift away from its purpose.

Meetings should distinguish disagreement about goals from disagreement about methods. People can share the aim of relieving suffering while debating the best provider, the scale of a grant or the usefulness of a campaign. A decision should explain why one option was selected, and what evidence might justify changing it.

Care for the team also matters. People who repeatedly hear accounts of torture and bereavement can become exhausted. Reasonable workloads, supervision, confidential support and permission to step back help maintain the capacity to work responsibly. An organisation should not make self-destruction the measure of commitment.

The art of dialogue is ultimately the art of making cooperation possible. It begins with listening, continues through honest explanation and becomes credible through action that can be checked.

Conclusion | A clear purpose, a credible organisation, a human response

War, repression and violent upheaval create burdens that continue in bodies, families and communities long after the event has left the news. Death counts are essential, but they do not describe everyone who lives with damaged sight, lost limbs, pain, psychological injury or interrupted treatment.

The published numbers in this book establish scale. They also establish the limits of what is known. A population displaced from home is not the same measure as a person wounded; a documented minimum is not a final census; a reported injury is not a completed operation. Respecting these distinctions is part of respecting the people concerned.

For me, the response begins with the philosophy expressed in Saadi's shared human body. Another person's suffering belongs within our field of responsibility. Our contribution will differ with our circumstances, but indifference should not be the organising principle of a modern society.

Good intentions need an institutional form. People who care must find one another, agree a practical purpose, work across differences and accept accountability. They must understand the needs they seek to address, the limits of their competence and the responsibilities that come with another person's trust.

Activists should therefore be clear about their agenda. A humanitarian organisation should state whom it aims to help, what it can provide, how it decides and how it reports results. The purpose should be understandable to a patient, a donor, a volunteer and a potential partner.

Dialogue is central to that work. We should inform people without humiliating them, invite participation without coercion and answer reasonable questions without resentment. Broad participation can give a cause stability and social meaning, while sufficient funding enables it to act. Neither should be confused with proof that the promised benefit has been delivered.

The heart can bring us to another person's pain. Clear thinking, competent care and honest organisation can help us respond. The achievement worth seeking is a person better able to live: to see, move, work, learn, sleep, belong and make choices about the future.

This is the spirit of charitable work I wish to encourage. It does not ask that everyone agree on every political question. It asks that we recognise the human being before us, and build something reliable enough to help.

Appendix A | A minimum confidential programme record

The following is a proposed service record, not a requirement to collect every field from every applicant. Collect the minimum justified by the decision and applicable information rules. Keep identity and contact details separate from an analytical dataset where feasible.

Table A1. Proposed record domains

Domain	Suggested content
Identity and safe contact	Internal identifier; appropriate identity verification; safe communication preferences.
Consent and information access	What was explained; agreed uses; authorised access; review or withdrawal requests.
Need and referral	Broad age group; clinical and functional needs; referring professional where available.
Barriers and vulnerability	Practical access, finances, disability, safeguarding and language needs.
Proposed assistance	Provider, purpose, estimated costs, alternatives and follow-up.
Decision	Eligibility rationale, conflicts handled, decision-makers, date and approved limit.
Delivery	Verified payee, payments, care accessed, delays and exceptions.
Review	Patient-defined goal, relevant clinical outcome, continuing needs, feedback and closure.

Do not add political affiliation merely because the organisation's founders are politically active. Where the circumstances of an injury matter to eligibility, record only what is necessary and safe. Public reports should not expose an individual through a combination of location, age, rare injury and event date.

Appendix B | An illustrative programme dashboard

An internal dashboard can help the governing team understand whether the programme is meeting its purpose. The figures below are categories to measure, not invented operational results.

Table B1. Measures worth reviewing

Area	Suggested measures
Access	Unique applicants; referral routes; response times; accessibility and language barriers.
Decisions	Approved, declined and pending cases; reasons; conflicts managed; review requests.
Delivery	Unique people assisted; care episodes; time to care; unmet and continuing needs.
Outcomes	Follow-up rate; progress towards individual goals; adverse events and unresolved problems.
Finance	Gross receipts; net available funds; committed grants; paid costs; reserves and restrictions.
Participation	Unique donors where known; transactions; regular commitments; volunteer retention.
Trust	Complaints, corrections, safeguarding concerns and actions taken.

Publish enough aggregate information for accountability without exposing beneficiaries. Explain missing data and use consistent periods. A smaller transparent dataset is more useful than an impressive dashboard whose numbers cannot be traced to records.

Appendix C | Publication and evidence notes

This publication is a rapid narrative synthesis and an ethical argument. Sources were selected for direct relevance, identifiable responsibility and usable dates, with priority given to UN agencies and human-rights mechanisms, the investigating organisations, professional guidance and official political statements for their authors' declared positions. It is not an exhaustive inventory of all countries or every report available by the review date.

Five complete calendar years, 2021-2025, provide the principal annual comparisons. Dated 2026 updates are included separately. No October 2026 whole-year figures are implied. Dynamic pages were consulted on 21 October 2026; the underlying reference dates remain important because publication and reporting periods differ.

Some agency pages were searchable but intermittently inaccessible in full. For the September 2026 UN mission findings, this edition also uses the accessible UN Geneva statement record and an identified reproduction of the OHCHR press release. The UN Geneva spoken record is automatically transcribed; its reported injury figure is attributed cautiously, and changing incident-specific school casualty figures are not reconciled here.

Sources may revise their records. The book does not merge casualty lists, estimate an undercount multiplier, adjudicate disputed individual cases or claim an original nationwide injury registry. Its calculated five-year execution sum is explicitly identified. Source-specific minimums and classifications are retained.

The author supplied the autobiographical account and the book's central charitable philosophy. His relevant earlier writings were consulted for continuity of voice and argument. They are references for his perspective, not substitutes for independent verification of casualty statistics. ^[42,43]

No identifiable beneficiary histories, clinical photographs or private medical records are reproduced. No institution employing the author, international agency or cited organisation is represented as endorsing the book. Educational discussion of medical needs does not replace individual clinical assessment.

The humanitarian edition ends with these notes and references. The author's edition adds the following personal afterword. Assistance proposed in either edition remains governed by need, competence, lawful delivery and the organisation's actual charitable purposes.

Author's afterword | Iran, political conviction and the duty to protect

This afterword states my personal political judgement. It is included in the author's edition for my political homepage. It is separate from the humanitarian edition prepared for Patriotic Doctors UK Foundation and is not a declaration of the Foundation's charitable purposes.

I support a free, sovereign and secular democratic Iran, equal citizenship, the rule of law and constitutional government. I support Crown Prince Reza Pahlavi's role in bringing Iranians together during transition. I see the Lion and Sun movement, under his guidance, as an expression of a national wish to recover dignity and build a different future. This is my political commitment and interpretation; it is not a statistical finding about every Iranian's preferred leader.

His published January 2026 statement called for participation in demonstrations. His September 2026 Toronto address set out four principles: territorial integrity, separation of religion from government, individual freedom and equality, and the people's right to choose their future system through a free and fair vote. He described the Lion and Sun movement as open to republicans and monarchists and to people of the left and right who accept those principles. These are his declared positions, to be judged by implementation and accountable conduct. ^[40,41]

The medical implications must remain distinct from the political choice. The people injured during Woman, Life, Freedom and the later protests include people with different beliefs. I do not need to know whether a wounded person agrees with me before recognising their claim to care. A future worth supporting must protect the dissenter as well as the supporter.

The record of mass shootings, torture and executions has left me profoundly sceptical of the Islamic Republic's willingness to become an accountable partner in a durable settlement. I believe repeated bargains can leave the underlying machinery of repression intact. These are political judgements grounded in the record of conduct; the casualty statistics do not prove that negotiation is literally impossible.

As I have argued in War for Peace, the system is capable of negotiating and signing agreements in the ordinary meaning of those words. The question is whether commitments are honoured, verifiable and capable of protecting people. Channels for humanitarian access, prisoner protection and the prevention of unintended escalation can remain necessary even between determined adversaries. ^[43]

I consider further war a serious risk. I will not convert that concern into a false certainty about what must happen next. The hostilities of June 2025 and those beginning in February 2026 already demonstrate the need for preparation. A ceasefire may fail, a new attack may occur, or a diplomatic arrangement may reduce immediate danger. A humanitarian programme should remain useful across these possibilities.

My opposition to the Islamic Republic does not exempt the United States, Israel or any other state from scrutiny when civilians are harmed. The law and ethical duty to protect patients do not change with the identity of the weapon's operator. We cannot ask the world to recognise the humanity of Iranian protesters while overlooking Iranian families killed or injured by foreign strikes.

The democratic future I support must also be practical. It must preserve and rebuild hospitals, train and retain healthcare workers, reconnect supply chains, provide rehabilitation and create conditions in which people can earn a living. A promise of freedom should be judged partly by whether a person with an injured limb can reach competent care without fear or destitution.

My earlier argument in *Humanity Before Geopolitics* was that Iranian lives should not become bargaining chips between political camps. That remains my position. The Iranian people deserve agency over their political future, while injured people deserve assistance that does not depend on endorsing a leader or an overseas alliance. ^[42]

National feeling can motivate generosity. It should also widen our understanding of others. Having seen the consequences of revolution, war, displacement and exile in my own life, I recognise something of that burden in the lives of Ukrainians, Palestinians, Israelis, Sudanese, Afghans, Congolese, people from Myanmar and many others. Their histories are not identical. Their humanity is not conditional.

I want the political cause I support to be associated with responsibility: freedom constrained by law, leadership accountable to the people, and solidarity made concrete through useful work. For doctors, the test is especially clear. Whatever our hopes for a nation's future, our patient must remain a person in the present.

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