

Episode: *Ethics Talk: Chronic Emergency and the Limits of Peace-Time Bioethics*

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[mellow music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff.

Many clinicians, especially those practicing in countries like the U.S., might see caregiving in conflict zones as an aberration from "normal operations" of stable hospital and clinic-based care. But stable environments are not the norm everywhere, and conflict over resource scarcity, exacerbated by climate change, will only grow. Clinical practice in these environments illuminates the need for thinking more powerfully about how to care well for people affected by conflict. Short-term vulnerabilities of a specific group of refugees displaced by genocide, for example, might be addressed by temporarily redirecting funds and resources to affected groups. But ongoing instability in some regions of the world presses us to find sustainable long-term responses to people enmeshed in protracted conflict.

On this episode of the podcast, we'll talk with Dr Thalia Arawi, the Senior Editorial Fellow who helped develop this issue, who is the founding Director of the Salim El-Hoss Bioethics and Professionalism Program at the American University of Beirut Faculty of Medicine and Medical Center in Lebanon. Dr Arawi joined us to discuss the rise of states of chronic emergency, how health care workers can be protected when working in conflict zones, and how the international community needs to move beyond declarations to support those affected by war and conflict. [music fades out]

Dr Arawi, thank you so much for being on the podcast with me today.

DR THALIA ARAWI: It's great to be here and thank you for having me.

HOFF: So, conflict over resources is obviously not a new phenomenon, but it's expected to continue to be exacerbated by the ways that climate change affects the availability and need for certain resources. So, to begin with, what are the most important and ethically relevant risks that you think deserve attention when we think about health care and ethics in places where there's war and conflicts specifically over resources?

ARAWI: So, there are several issues.

HOFF: Mmhmm.

ARAWI: Allow me to pick a few. I think the most striking ones would be the strategic disruption of supply chains, electricity, and water that significantly affects the capacity of health systems to actually provide acute preventive and routine care. So, as you said, scarcity of resources is very important, and it is another concern, particularly in areas under siege such as Gaza, or under constant threat such as Syria or Yemen, Libya, Afghanistan, South Sudan, to mention but a few, unfortunately. If I'm not mistaken, in 2016, health care workers in Syria, including technicians, nurses, drivers, and medical support personnel, have been driven actually to leave their work when they discovered that they are unable to provide care in destroyed hospitals because there is also no medical supplies. And that was, I think, in 2016. So, what we are seeing, unfortunately, is a diaspora of medical personnel, if you wish, an exodus in a way.

HOFF: Mmhmm.

ARAWI: They find themselves faced by a weak law. So, it's closed, nothing they can do.

And let me give you another scenario too. In besieged Gaza, patients are not allowed to travel for medical treatment without permit, which is a more often than not denied.

HOFF: Hmm.

ARAWI: So, in such situation, the word that comes to me, although it might sound harsh, is perhaps "murder by omission."

HOFF: Hmm.

ARAWI: And of course, we cannot ignore the fact that the ecology of war itself is affecting everything in health care.

HOFF: Mmhmm. You note that some places are in sort of a state of constant threat, and that brings to mind a phrase that you used in your From the Editor letter that opens this issue of the Journal of "chronic emergency." And to some, that might seem like a contradiction. But obviously, as you note, that is just the reality in many places in the world where there are these just repeating and compounding emergencies. So, how does the state of chronic emergency play out in health care settings that are situated in war and conflict zones?

ARAWI: So, emergency, to begin with, I would say, is attributed to a situation when something urgent occurs, and you need to address it. And ideally, it ends once it is addressed. So, for example, you have casualties from an earthquake or a tornado, a building on fire, or an explosion. But in areas of conflict, there is no end to such emergencies. They linger on and on and on. And unfortunately, they become a way of life or lack thereof, if you wish.

HOFF: Hmm.

ARAWI: So, it's one emergency after another. And sometimes it's the same emergency, it's the same victims, it's the same trauma, if you wish.

HOFF: Mmhmm. Earlier as well, you said this phrase, as you stated, was a strong one, "murder by omission." And to me, that implies that there's some kind of blame to be laid somewhere. So, in situations where this sort of murder by omission is happening, who do you see the responsibility as lying with to avoid these issues that are preventing health care workers from providing care?

ARAWI: OK....

HOFF: Obviously, that's a difficult question. [chuckles]

ARAWI: [laughs] So, to begin with—and you just said it's a difficult question—there is a feeling of despondency when we speak of responsibilities.

HOFF: Mmhmm.

ARAWI: Because it seems that this concedes that the agent is allowed the freedom not to care as he or she ought to do, which eventually entails the need for accountability precisely, precisely because you would like to see what is right and humane done intuitively, as a second nature, as it were. But it is not. So, I will try to address your question.

BOTH: [laugh]

ARAWI: We all have a duty to be humane. I don't want this to sound as if it's a duty, but we would like to believe that we are all humane, okay, moral, and dignified. And we all must admit that the other person, even the other party to the conflict, possesses these qualities as well.

HOFF: Mmhmm.

ARAWI: So, the main hindrance, I would say, is biopolitics.

HOFF: Mm.

ARAWI: Biopolitics seems to be the master puppeteer that is playing around all over areas of conflict. So, biopower is having power over our bodies or over bodies. And as Foucault, Michel Foucault, would say, it's an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations. So, we see it all over. We see it in the aforementioned countries, unfortunately. Those in power in areas of conflict are guilty of practicing what we call necropolitics, which is the relationship between sovereignty and power over life and death.

HOFF: Mmhmm.

ARAWI: And thus, they allow themselves, as it were, to choose who can live and who can die, who can eat and who can starve. Case in point is the calorie count that was once established in the OPTs (Occupied Palestinian Territories), which is to say reducing some fellow humans to the status of, to use the word of Agamben, of homo sacer.

HOFF: Hmm.

ARAWI: In camps, for example, in refugee camps in, in these areas in particular, there's something we call the state of exception where the constitutional rights can be weakened, superseded, and perhaps even vetoed in the process of demanding this extension of power by government. And this becomes the rule. So, if you want, if you look at Syria, Yemen, South Sudan, Gaza, Iraq, what have you, in many ways there are such states of exceptions, and the world observes, doing nothing. And I'm sorry to be blunt here. International powers play with conflict as if it were a chess game. It's all about power and money. And I think that if there was really a will to protect health care workers and facilities and provide care for civilians, they would have been protected. But I don't see any honest will.

HOFF: Mmhmm.

ARAWI: I only see empty speeches, or hear empty speeches, that attempts at soothing simple minds, if you wish.

HOFF: So, to jump ahead a little bit, which responsibilities and duties do you see at the local, domestic, and then international level when we are trying to respond to either health care workers who need support and resources or to respond directly to patients and refugees and asylum seekers? Can you outline a little bit of what those responsibilities are at the different levels that people might approach these conflicts?

ARAWI: Okay. So, in 2016, I think, the United Nations Security Council unanimously adopted a resolution to strengthen protection for health care workers, if I'm not mistaken, the sick and the wounded, hospitals, clinics in war zones. Now we are in 2022, and we are still witnessing worse attacks and assaults.

HOFF: Hmm.

ARAWI: So, at the risk of being too ingenuous, be it locally, internationally or regionally or nationally, if resolutions, laws, decrees, etc. remain on paper and speeches and in press conferences, they are practically useless, and all they do is numb some and unnerve others.

HOFF: Hmm.

ARAWI: So, if there is all that, if you wish, of such entities, is to issue such resolutions or decrees or what have you, then the mere existence of such entities is

a charade and an exercise in futility. They often come up with a list of musts, oughts. For example, you need to facilitate humanitarian access. You need to develop domestic legal frameworks that protect health facilities and medical workers. We have to train forces and armed forces to understand what the right is, to teach them the IHL and what have you. But—

HOFF: Can you clarify IHL for our listeners who are unfamiliar?

ARAWI: Yes, sure. So, it's the international humanitarian law that regulates, so to speak, although it's an oxymoron by itself. How can you regulate conflict?

HOFF: Right.

ARAWI: But it regulates conflict. How to prosecute responsible who do these attacks and violations. But unfortunately, these are words that ever evaporate as soon as they are uttered.

HOFF: Hmm.

ARAWI: I'd rather not dupe our listeners. Unless there's a true will to honor duties and what have you, they would have been honored. What we need is a paradigm shift and a serious one, too, I guess.

HOFF: Mmhmm. So, how are health care workers protected in conflict zones? If these sort of international statements and declarations are not as effective as we would like them to be, what are the methods for protecting people in those situations?

ARAWI: So, again, a very important question. This brings to mind the concept of medical neutrality, which basically refers to a globally accepted principle that actually derives from international human rights law and medical ethics. And this principle is based on ideas or requirements of non-interference with medical services in times of armed conflict and civil unrest. So, such, there are laws and regulations that call for the protection of health care workers, including the international humanitarian law mentioned earlier on the Geneva Conventions and its additional protocols. But unfortunately, we continue to see health care workers targeted.

It's happening in the Middle East, even while health care workers are attending to patients. I know people, physicians in Syria, physicians in Yemen and in Gaza, who have worked actually in hospitals, in operating rooms when these hospitals were bombarded and targeted. So, ambulances were ambushed, hospitals are destroyed, and medicinal supplies demolished. All of this in spite of the presence of such international laws and regulatory entities, if you wish. So, I would say that absent the collective conscience, if I may call it that way, the protection cannot come from resorting to moral scruples or integrity.

HOFF: Mmhmm.

ARAWI: What we need actually, at least, are external sanctions, but unfortunately, even those are being biased and cherry picked.

HOFF: Hmm.

ARAWI: So, for example, one of the objectives of the regulations by countries that are signatory of IHL, the Geneva Conventions and its protocol, it's not enough to say or to tell these countries, "Uh-oh. What you did is wrong," we give them a spank, and that's it. War is not a game, and parties to the conflict are not players. They are lives damaged, destroyed, and some perpetually so. So, it's the same old problem. We have regulations, but they are just ink on paper.

HOFF: Mmhmm.

ARAWI: We have very serious people who want to make a difference, but unfortunately, without accountability, practically everything is useless. And accountability is subject to biopolitics and bias. So, we go back to where we started.

HOFF: Mmhmm. So, the picture you paint of enforcement of these international declarations is pretty bleak, and it sounds like rightfully so. What I'm wondering is if there is any movement on the international stage that might give you hope that there are enforcement strategies on the way being produced, being supported in the way that they need to be in order to make sure that the people affected by conflict and the health care workers responding to those people are kept safe.

ARAWI: So, from what I know, there are provisions under the Geneva Conventions and additional protocols for this. For example, they have issued or formed, I think, a fact-finding commission, which, the role of which is actually to inspect or investigate into allegations of serious violations of the Geneva Conventions. But to my knowledge, this has really never been active. This commission has never been active, and probably because these inquiries need to be initiated by state parties and to other state parties. So, it's quite complex.

HOFF: Hmm.

ARAWI: They also have protecting powers in order to ensure that persons are protected and are treated as per the Convention and the IHL. Again, unfortunately on the ground, the system has not been effective and very rarely implemented.

HOFF: Mmhmm.

ARAWI: One resource was also penal measures, so sanctions, if you wish.

HOFF: Mmhmm.

ARAWI: And by this, we mean that state parties have an obligation to investigate persons accused of carrying out what I call, for example, murders by omission or

what have you, and war crimes, which are, of course, grave breaches of both the Geneva Conventions and the IHL. So, unfortunately, many states, even those who are signatories of the conventions and the laws, did not really implement this, did not start a national penal system. And we've seen it here, particularly in the Middle East, in Jenin, for example, and we had a big massacre in Lebanon actually a long, long time ago. And if I'm not mistaken, I was practically almost a child or a teenager then. And the United Nations, the President, Director General of the United Nations said it's a war crime.

HOFF: Just a quick point of clarification here. Dr Arawi is referring to Boutros Boutros-Ghali, who was the Secretary General of the United Nations, until his second term was vetoed unilaterally by the United States.

ARAWI: And as a result of his condemning what has happened, he has been removed from office. So, what is really needed is actually moral courage. I think his name was Boutros Boutros-Ghali, yes. So, two things here. Physicians and health care workers in war zones need to exert a lot of, if you wish, moral courage, but often they are victim of moral distress and moral scarring. And if you want to be a member of these penal measures or fact-finding commissions, or if you really want to follow up, and in a way, sentence or bring to court those who are culprits, you need to have moral courage.

Because the world, I mean, the world being what it is these days where might is right and power is the most important thing, those who speak up the truth are often sacked, if you wish. Sorry to use that term. So, if you really believe in what you are saying, you have to say it knowing that your moral courage is going to affect you, and you will be asked to leave the post you are in.

HOFF: Mmhmm. I wanted to turn away from the international stage for a moment and focus on what the conditions of working in a conflict zone are like on the ground, especially since many clinicians in the U.S. have little to no familiarity with providing care in war and conflict zones. So, could you elaborate a bit on what the conditions of war demand of health care ethics and professionalism, especially perhaps as opposed to the kind of ethics that U.S.-based clinicians are likely to learn during the course of their medical education?

ARAWI: So, the general statement would be that health care workers working in areas of armed conflict or in conflict zones are not working under what we call quote-unquote "normal" circumstances.

HOFF: Mmhmm.

ARAWI: So, they are attacked in different ways because of the ecology of the war, because of the social determinants of health. For example, you know that cholera has increased, for example, in Yemen.

HOFF: Mmhmm.

ARAWI: Okay. And this is because of the war, not, precisely, exactly because of the war. They work in situations where they don't have enough, if you want, medicine supplies that actually would help them do their job. So, I'm going to go to be a little bit more, not theoretical, but more bold again, if you wish.

HOFF: Sure.

ARAWI: Building on the theory of Thomas Kunz when he spoke about, Thomas Kuhn, when he spoke about paradigm shift, my colleague and co-editor of this same issue, Dr Ghassan Abu-Sittah, and I published an article not long time ago in which we argue for the importance of classifying war as an endemic disease.

HOFF: Mm.

ARAWI: So, not one that you can treat medically. It was not, and it's not an attempt at decontextualizing war from the political and ethical responsibility of those who wage war.

HOFF: Mmhmm.

ARAWI: But we came to realize, living in this part of the world, that the endemic nature of war in the Arab region means that local health providers must be trained to mitigate its effects, which in turn has a bearing on policies and education. And I'm sure you know that several universities these days teach biomedical engineering in courses or majors.

HOFF: Mmhmm.

ARAWI: Unless I'm mistaken, I'm not aware of any such university that addresses the biomedical engineering needs in areas of conflict. So, no one is investing in teaching students the importance of having low cost and low maintenance medical equipment, which are extremely useful in conflict zones. So, students are taught how, or instructed how, to preserve an X-ray machine, CTs, and MRI scans, but they are not told how, for example, to build external fixators, which are extremely needed in warzones for a price well below world market prices, as was done by the Cubans. Our students in this area of the world, students who are going to become health care providers, live in an atmosphere or in a world ravaged by conflict of different kinds that suffers inadequate surveillance and response systems, shattered infrastructure, crumbling health systems. And all this is in addition to an unending insecurity and poor synchronization among humanitarian agencies who are not actually taught how, if you wish, how to, for example, locally generate dialysis fluids that can supply the needs of areas in conflict.

So, the new conceptual framework that will allow to transforce or mitigate the effects of war is something that needs to be taught to students. What is needed is revised health care policies, education rules, and regulations. I would even say that this is the first lesson that we need to take away, if you wish.

The second point, I would say, or lesson, if you wish, or takeaway is to appreciate that while international regulations of research ethics are important universally—because we see humanitarian agencies and international powerful countries doing research in areas of armed conflict—it is important for researchers, and here we're talking research ethics, to appreciate that they have a moral obligation to challenge the international regulations of research ethics, as bizarre as this might sound, because of the vulnerability and contextual background of the population, which often induces trauma. False hopes might arise akin to therapeutic misconceptions, if you wish. And this necessitates the altering of someone's resource methodology to fit the few.

So, and researchers, for example, when you have someone coming from MSF or ICRC or any other organization, they are not trained as researchers. They are trained as something else. And even if they are trained as researchers, their training is an international training, which occurs if you want to do studies in normal situation, which is not the case because our population is a vulnerable one, and they cannot be used as a research tool, rather as participants in research.

The third lesson, [chuckles] I think, is something that I always tell my students of medicine. Not everything, is for us to be aware that, not everything that is legal is ethical and vice versa.

HOFF: Mm.

ARAWI: So, at the risk of sounding oxymoronic, if you wish, coming from me as an ethicist, I think it's important to realize that by being too ethical, unfortunately, even if we were doing this because we think we are good people or we would like to be good people, by being too ethical, we verge towards the unethical.

HOFF: Hmm.

ARAWI: So, it does not to end here, though. There are many situations where what is ethical is also inhumane and vice versa. And the burden—and indeed, it is a heavy burden—of proof lies on the shoulder of the person who makes the choice, often at the risk of moral distress. And we often face this law versus ethics versus humanism in areas of conflict.

HOFF: Can you give an example to illustrate that tension?

ARAWI: Sure. So, the simplest thing is, or example is, everyone, from what I know, everyone talks about medical ethics, and the four principles of Beauchamp and Childress come to mind.

HOFF: Mm, mmhmm.

ARAWI: So, they would like to ensure that they are respecting these principles, okay? However, sometimes in situations of conflict, you simply need to think of other, if you wish, prima facie obligations.

HOFF: Mmhmm.

ARAWI: And you would say that a dermatologist who is doing a surgery on a patient is actually breaching the principle of non-harm because this is not his expertise or her expertise. But when there is a dearth of surgeon, there are no surgeons but in this room at this point of time, because the other ORs are filled and it's a lifesaving surgery, the dermatologist might find himself or herself forced to do the surgery.

HOFF: Hmm.

ARAWI: And if he were to be ethical and say, "No, this is not my role," the patient would immediately die. If he tries—first, all physicians have studied some kind of surgery—if he attempts in good faith, there's at least a 50 percent chance that that child will live.

So, I truly believe that ethics in general is not contextual, but to be a good physician in war, you have to be like a good, if you want, steersman. So, when you're guiding your boat, you have to keep your eye on 101 things maybe. You need to keep your eye on the state of the water, where is the sun rising from or setting, the direction of the wind. So, you have to factor in all these things and use your moral imagination to be able to deal with the situation. So, sometimes you even use tools that are not made for this particular surgery because you don't have any other tool. Doing nothing just because you need to respect the protocol is often, perhaps, I'm ethical enough to respect the protocol, but this ethical issue of mine is inhumane and even unethical. [mellow music slowly returns]

HOFF: Yeah, that analogy, I think, really captures how complicated this issue can get and perhaps a little bit of why it's so difficult to tease apart all of the different considerations that clinicians have to make when working in these circumstances. So, Dr. Arawi, we thank you so much for you and your co-editor's work on the Journal this month. And thank you especially for spending the time to talk with me on the podcast today.

ARAWI: Oh, I say thank you for having me, really. It's an important topic, and it's not an easy topic to talk about, actually. So, thanks again, Tim.

HOFF: That's it for our episode for this month. Thanks to Dr Thalia Arawi for joining us. Music was by the Blue Dot Sessions. To read the full issue for free, head to our site, JournalofEthics.org. And for all of our latest news and updates, follow us on [Twitter](#) and [Facebook @JournalofEthics](#). We'll be back next month with an episode on arts-based research. Talk to you then.