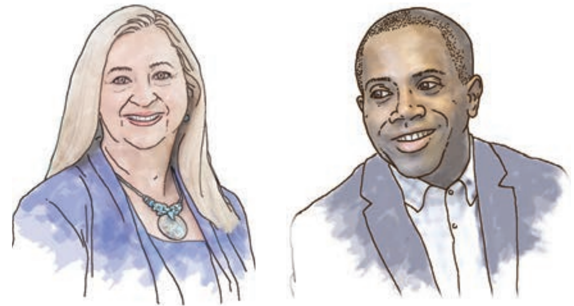
Editorial

Human Suffering and Armed Conflict

By Cindy L. Munro, PhD, RN, ANP, and Aluko A. Hope, MD, MSCE



The advent of the new year provides an opportunity to reflect on the past and to express our hopes for the future. Unfortunately, our reflections about 2023 have been marred by multiple armed conflicts that have caused intense human suffering. Examples abound, including the ongoing war following Russia's invasion of Ukraine, the large-scale terrorism by Hamas that triggered a conflict with Israel, and continuing conflicts in the Sudan and elsewhere. It can be difficult for us to fathom the targeting of vulnerable civilians based on their nationality, personal identities, or place of residence. Such targeting is at odds with the expressed ethical obligations of both nursing and medicine. The American Nurses Association (ANA) states in its scope and standards of nursing that the registered nurse should "practice with compassion and respect of the inherent dignity, worth, and unique attributes of all people,"[1(p67)] and the American Medical Association's code of ethics says that physician obligations include "providing competent medical care, with compassion and respect for human dignity and rights."[2]

Nurses, physicians, and other members of the critical care team are well acquainted with human suffering, as they experience patient and family suffering daily. Human suffering is not limited to physical suffering but also encompasses mental, emotional, and spiritual aspects. As providers, we seek to prevent, relieve, or ameliorate suffering. The ANA definition of nursing includes alleviation of suffering as a central role for nursing care.[1] Bearing witness to patient and family suffering can cause or exacerbate moral distress and moral suffering among the members of the critical care team and has been associated with burnout and posttraumatic stress disorder.[3] Nurses who spend the most time at the bedside in the intensive care unit (ICU) may be particularly at risk; before the COVID-19 pandemic, levels of moral distress, burnout, and posttraumatic stress disorder symptoms were reported to be higher among ICU nurses than other health care workers.[4]

Recent research has focused on the effects that patient and family suffering had on the well-being of clinicians involved in their care during the COVID-19 pandemic. In a qualitative study of acute care clinicians providing end-of-life care for COVID-19 patients, Bandini and colleagues[3] found that nurses and physicians experienced effects related to clinical duties (including guilt related to end-of-life decisions and challenges of conversations with patients' families) and emotional challenges (being present at death when patients' family members were not permitted to be present, having vivid memories, and "blocking out" distressing experiences). They

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concluded that their study highlighted "the sustained and cumulative emotional challenges and burden clinicians still shoulder more than 2 years after the start of the pandemic."[3(p374)] Guttormson and colleagues[4] conducted a national survey of the COVID-19 experiences of ICU nurses who were members of the American Association of Critical-Care Nurses. In responses to open-ended questions, a distinct subtheme of witnessing suffering of patients and families was identified as an important component of the burden of ICU nursing during the pandemic and a source of significant moral distress. As the COVID-19 pandemic illustrated, witnessing suffering as a result of natural events takes a heavy toll on frontline health care workers. Coming to grips with suffering caused by armed groups who harm vulnerable civilians poses similar challenges. To witness cruelty to women, children, and elders inflicted by armed groups can leave us feeling powerless, hopeless, and questioning the nature of humankind.

In the immediate vicinity of armed conflict, both emergency and intensive care services may experience surges that can overwhelm those systems of care.[5] Civilian institutions, including hospitals, may be directly affected by armed conflict. In some instances, hospitals are treated as targets of opportunity for those who intend to inflict civilian casualties and deaths, although this is a violation of international law. In other instances, hospitals are not targeted but sustain collateral damage because of their location in an area of conflict. Research by Abbara and colleagues[6] brought attention to the plight of health care workers in Syria, where health care facilities have been subjected to intentional and unremitting attacks during the ongoing armed conflict.In addition to the challenges of providing care in dire, austere, and understaffed conditions, Syrian clinicians experienced deaths and injuries of fellow health care workers, psychological distress, anticipatory stress regarding repeated attacks, and ethical dilemmas (including balancing personal safety with caring for patients and balancing personal distress with a sense of duty).

Disruptions of ongoing routine health care resulting from armed conflict can jeopardize vulnerable patients with chronic illness, and their immediate needs can further strain health care resources. As an example, shortly after the start of the Ukraine-Russia war, the European Renal Association created a Renal Disaster Relief Task Force (RDRTF) to support people with kidney disease and the clinicians caring for them.[7] Addressing issues of dialysis access for people who required life-sustaining treatment was crucial for those who remained in the conflict area and for those who were internally or externally displaced; this is an ongoing concern. No matter the combatants, armed conflict introduces disruptions of food, water, and sanitation that complicate efforts to provide care.

Nurses continue to grapple with making meaning of human suffering arising from armed conflict.[8,9] An interactive panel discussion at the October 2022 American Academy of Nursing's Health Policy Conference, Armed Conflict from Onset to Recovery: Nursing's Impact in Healing, focused on nursing's impact during and after armed conflict. Dr Donatilla Mukamana spoke about her work helping women who were victims of sexual violence in Rwanda during the genocide against the Tutsi. Her model of care for survivors of genocidal rape has benefited Tutsi women and serves as a blueprint for victims of sexual violence in other armed conflicts.[10,11] Dr Candy Wilson, a retired US Air Force colonel and women's health nurse practitioner, spoke about providing health care to women and children in Afghanistan during Operation Enduring Freedom.[12] Both Dr Mukamana and Dr Wilson highlighted the need for compassionate care for those who suffer as a result of armed conflict.

What can we do in the face of human suffering and, in particular, suffering that is systematically and intentionally caused by other humans in armed conflict? Lindberg and Brinchmann[13] wrote that while peace building is imperative, and while we have responsibilities as humans and as clinicians, it is

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not always clear how we as individuals can contribute to peace. We would argue that, as trusted health professionals, we have an imperative to act as individuals and as professionals.

We can rely on and model our professional ethical standards, viewing each person holistically, with compassion, and as a fellow human worthy of respect. Dehumanization feeds cruelty and permits rationalization of abhorrent behavior toward others. We can help others to see the connectedness of all people. Suffering is a shared human experience that does not know political or ideological boundaries.

We can, as we always have, continue to serve individuals who are suffering as a result of armed conflict and its aftermath. Some will have opportunities to provide direct care to victims of armed conflict, either through serving in the conflict area or by caring for those who have been externally displaced. For those who choose to volunteer to provide direct care, it is best to do so through an established entity (for example, The International Committee of the Red Cross[14]) that has experience with service delivery during armed conflicts and has arrangements in place for logistical support. The RDRTF suggests that volunteers should not act as individuals; safety of travel, language barriers, legislative barriers to practice, and other considerations make volunteering as part of an organization preferable and more useful. In lieu of service in the conflict zone, individuals might volunteer to care for displaced victims in neighboring countries, provide remote support (such as telehealth services, consultation, or chat discussions), and donate funds to reputable organizations.[7,15] In their usual work environments, clinicians may encounter displaced people. Compassion, respect, and awareness of their situation will promote the best care for those who have suffered as a result of armed conflict.

We can shine our own light on the darkness that surrounds us. In 2024, we wish you—and our world—peace and safety.

The statements and opinions contained in this editorial are solely those of the coeditors in chief.

FINANCIAL DISCLOSURES
None reported.

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