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See **Online** for appendix

Naming palliative care in conflict and forced displacement

The Johns Hopkins Center for Humanitarian Health–*Lancet* Commission by Paul Spiegel and colleagues offers a compelling account of humanitarian system failure and its consequences for people affected by conflict and forced displacement.[1] The Commission calls for systems to uphold dignity, continuity, equity, accountability, and health for all. Perhaps most striking is that palliative care remains entirely unnamed in the Commission. A reform agenda that speaks of death, suffering, and abandonment would be strengthened by making explicit how people with serious illness are cared for when conflict obstructs access to physical, psychosocial, and spiritual support.

This omission is striking because the WHO high-priority health services package for humanitarian response already includes palliative care among interventions intended to reinforce accountability and link humanitarian services to national service packages.[2] WHO guidance sets out the case for integrating palliative care and symptom relief into emergencies and crises.[3] Palliative care is therefore neither marginal to crisis response nor merely an aspiration of the palliative care community. It is an established, evidence-based approach to relieving health-related suffering and an essential element of humanitarian health care.[4–6]

Palliative care integration formalises an intrinsic dimension of care that humanitarian teams are mandated to provide: an organised response to suffering when illness, injury, frailty, displacement, and family caregiving converge under conditions of scarcity.[4–6] It brings specialised input where available, as well as giving health workers and local service providers a framework for pain and symptom relief, communication, psychosocial and spiritual intervention, family caregiver support, and bereavement care. Its holistic and multidisciplinary model strengthens care around people, families, and communities whose needs rarely fit within a single programme or sectoral response.

Naming palliative care matters because recognition shapes planning, financing, service delivery, accountability, and access to essential palliative medicines in conflict settings.[7] Without inclusion in budgets, service packages, preparedness plans, and recovery strategies, palliative care remains vulnerable to exclusion when aid contracts or visible emergency priorities intensify.[8] Need is not limited to surviving acute shocks; people also live with serious illness, care for relatives, make constrained decisions, die, and grieve within disrupted systems.[9] Needs-based financing must recognise these realities within essential service planning.

Crucially, where disease-directed treatments are scarce, interrupted, or selectively funded, palliative care must not become a rationale for withholding curative treatment or lowering expectations of care. Its role is to make prioritisation decisions ethically explicit, prevent abandonment, and keep relief of suffering central to humanitarian health systems. The practical challenge is to give existing WHO guidance the policy visibility and operational support needed to make palliative care workable in crisis settings, so that symptom relief, communication, family support, medicines access, and referral can be delivered amid insecurity, disrupted services, workforce shortages, and caregiving realities.[10]

As the Commission continues its dissemination, implementation, and policy outreach, we hope palliative care will be included in the frameworks and priorities shaping humanitarian health policy and practice. We outline six operational points for making palliative care visible within humanitarian health reform (appendix). Capturing these issues would clarify how the Commission's core principles apply to people living and dying with serious health-related suffering, and to families and communities who sustain care when systems fracture.

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Inverting power must begin with authorship

The Johns Hopkins Centre for Humanitarian Health–*Lancet* Commission by Paul Spiegel and colleagues[1] makes a claim that is both correct and overdue: the humanitarian system requires structural transformation, not incremental reform, and that transformation is fundamentally about power—who decides and on whose behalf. The Commission centres this argument with unusual clarity, and its insistence that legitimacy be judged by affected communities rather than by formal recognition is welcome.

It is precisely because the Commission takes power and knowledge as its central categories that those categories invite application to the Commission itself. The document examines authorship as a source of power and even quantifies the under-representation of the country of study authors in the humanitarian health literature. Yet it does not turn this analysis on its own structure, in which lead and senior authorship, and the designation of contributors as Next Generation Scholars, reproduce the very hierarchy the text critiques. This ordering and tiering of contributors, which is how relative contribution comes to be read, is the one site over which the Commission held complete authority. Donor behaviour and multilateral architecture are areas that the Commission could only recommend changing, but for its own masthead it could have simply arranged it differently.

Illegitimate power evaporates in light; legitimate power solidifies in it. The Commission turns its considerable light outward—naming states, donors, and impunity—to powerful effect. The omission is reflexive: the same light is not directed inward, where it would have tested whether the call to invert power begins at home.

The cost of this is visible in the framework itself. Family and kinship networks and religious institutions are largely absent from the analysis of how displaced people actually survive, appearing chiefly as humanitarianism's history rather than its present infrastructure. Yet these are among the first responders in most displacement, and among the most locally legitimate forms of authority and care the Commission says it wishes to centre. The near absence of these networks and institutions is not incidental. The Commission's actor map—states, de facto authorities, non-governmental organisations, UN agencies, and donors—is an institutional artifact, and it screens out precisely the local, non-institutional structures the Commission claims to seek. The lens reproduces itself in what it can see.

I do not write from outside this problem. The trajectory that carries a researcher out of the places where displacement is concentrated and into the institutions in high-income countries that lead its study is the same centripetal pull the Commission diagnoses, and I am its product, not its exception. That is the point: reflexivity is uncomfortable because it implicates the author, which is why it is so easily deferred.

The Commission's diagnosis deserves the transformation it demands. The test of whether it means what it says does not begin with donors or the UN. It begins with the page the authors controlled completely.

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During the preparation of this Correspondence, I used Claude (Anthropic Sonnet 5) in order to check grammar and punctuation and to reword author-drafted sentences for clarity and readability. After using this tool, I reviewed and edited the content as needed and take full responsibility for the content of the publication.

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Authors' reply

We thank Qusai Khraisha for a critique that is at once generous and exacting. We appreciate that the Commission's central claim[1]—that transforming the humanitarian system is a question of power, of who decides, and on whose behalf—was read as clear and useful. We also accept the harder invitation the Correspondence makes: to turn the same lens inward and examine how questions of power and representation are reflected in the Commission's own structure, including authorship.