Materializing Ethical Matters of Concern:
Practicing Ethics in a Refugee Camp

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This article explores the collective practices through which ethics is handled at the humanitarian aid organization Doctors Without Borders. As an international nongovernmental organization operating in 72 countries, many times facing extreme contexts and yet able to uphold its ethical standards, we consider that studying the practical achievement of ethics at Doctors Without Borders is an occasion to learn how workers themselves deal with it. Our analysis of ethnographic data suggests that the question of what is right or wrong is materialized through what we call *ethical matters of concern*. We focus on the communicative practices through which apparent individual ethical decisions are in fact collaborative in the sense that they imply people, principles, and other artifacts that substantiate organizational ethics in everyday work.

Keywords: matters of concern, ethics, materiality, communicative constitution of organizations, extreme contexts

My role as a head of mission is to defend our position, well, to express it in order to defend it. And to do that, you have to insist by using all sorts of stratagems: phone calls, visits, and follow up. It takes lots of time. (Interview with a Doctors Without Frontiers worker, Dadaab refugee camp, Kenya)

Working for an international humanitarian aid organization is a rewarding but demanding experience. The extreme contexts in which some organizations operate add layers of complexity to organizing (Barton, Sutcliffe, Vogus, & DeWitt, 2015; Weick, 1993) and questions of what is right or wrong tend to be far from obvious (Hunt, 2008; Nilsson, Sjoberg, Kallenberg, & Larsson, 2011). Usual approaches prove to be inadequate, making humanitarian aid situations "extreme contexts" for

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organizational ethics (de Rond, 2012; Hällgren, Rouleau, & de Rond, 2017). The first author has participated in several emergency medical relief missions throughout the world and has directly witnessed how humanitarian workers carry out their work despite many challenges. One crucial aspect he has observed is that workers in such uncertain situations have to stand up for the values, standards, ideals, morals, and principles that propel their missions even as they appear contradictory at times (Gotowiec & Cantor-Graae, 2017).

With this article, we highlight how humanitarian workers can uphold what we call *ethical matters of concern* (EMCs). We coin this term to include all values, beliefs, standards, ideals, principles, or any moral preoccupations that guide humanitarian organizations and to which workers are attached. EMCs materialize in speech, text, body, or otherwise, as people jointly co-orient to them, assess them, and debate them. The materiality of EMCs is what allows them to resist more or less durably in the face of adversity when humanitarian workers must collaborate with people or organizations that do not share their ethical preoccupations.

With this in mind, we explore how humanitarian workers collectively materialize ethics by playing on the double meaning of *mattering*, and observe how it is dealt with by looking at how values, standards, ideals, morals, and principles are made to count in a situation by being materialized through discourse, writing, or embodied action (Cooren, 2016). We thus consider ethics as both a mediated and materialized phenomenon: It does not exist merely as an abstract notion, but through other things that materialize it and allow it to matter in each situation. The more these things materialize and matter, the more they "scale up" to constitute the organization (Cooren & Fairhurst, 2008). This materialization in speech, text, body, or otherwise is what allows ethical matters of concern to be attended to, negotiated, or confronted in practical situations. The mediated nature of ethics also means that apparently individual ethical decisions are in fact collaborative and interactional accomplishments that involve both human beings and the many things they deal with as part of their daily work and life.

To understand how organizational actors materialize ethical matters of concern and how these materializations relate to organizing, we turn our attention to the humanitarian aid organization Doctors Without Borders/Médecins Sans Frontières (MSF). We draw from data gathered during a longitudinal ethnographic study that spanned over 10 years from 2005 to 2015. We focus on a mission in Dadaab, Kenya,[2] one of the biggest refugee camps in the world, where upholding ethical and medical standards is a daily challenge when faced with scarce resources and safety concerns. This unique context offers a rich and powerful opportunity to look at how organizational members deal with the many contradictions that confront most organizations (Putnam, Fairhurst, & Banghart, 2016).

Indeed, MSF and its humanitarian workers constantly modulate their action to adjudicate between, on the one hand, strict medical ethics demanding high standards of care and, on the other hand, possibly competing ethical considerations such as neutrality with respect to ongoing conflicts, impartiality in caring for people irrespective of their allegiance, independence from government authorities, and, most

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[2] http://www.unhcr.org/ke/dadaab-refugee-complex. According to the United Nation Refugee Agency, as of January 2018, 235,269 people were registered as refugees or asylum seekers in Dadaab.

important, openness to local customs that requires being mindful of possible postcolonial bias, including differing ideas about health care. As Redfield (2005) explains, "The sort of medical action pursued by MSF reveals ethical complications within this field of global crisis" (p. 329). As part of their everyday business of providing medical care, MSF workers are also discursively and practically handling EMCs and, in doing so, effectuating a configuration of opposing demands "one interaction at the time." By looking closely at the example of the 1999 Nobel Peace Prize recipient organization, we can learn from the vast experience of its humanitarian workers as they uphold principles in inherently unstable contexts that precipitate and magnify ethical dilemmas (Derrida, 1995).

Practicing Ethics in Humanitarian Aid: Toward a Communicative Perspective

As Seeger and Kuhn (2011) suggest, quoting Peter Singer (1986), "Most contemporary ethical dilemmas have organizational issues at their core" (p. 173). This means that ethics cannot be abstracted from the concrete and mundane situations in which collective action takes place. Against an idealistic and normative view of ethics, Clegg, Kornberger, and Rhodes (2007) contend that "ethics will be enacted in situations of ambiguity where dilemmas and problems will be dealt with without the comfort of consensus or certitude" (p. 109). Literature also recognizes that, in a time of value pluralism, there is a need to study how people reconcile the variety of stances that coexist (Dempsey, 2011). This calls for a pragmatist posture anchored in the concrete way different people deal with ethical decisions (ten Bos, 2002). Indeed, when confronted with the standards of others, one encounters conflicting ethical beliefs, as when physicians discursively confront their moral responsibilities by sharing stories of mistakes (Carmack, 2010). The question of what is right or wrong in a given situation or within an organizational setting is thus an open one, as alterity and difference are core characteristics of reality (Kenny & Fotaki, 2015) and prevent any before-the-fact decision on what ought to be (McMurray, Pullen, & Rhodes, 2011).

Ethics in Humanitarian Aid

The need to deal with ethics in each situation is even more salient in the extreme context of humanitarian aid organizations. They have to deal with ethical dilemmas exacerbated by scarcity of resources, extent of needs, and institutional constraints (Nilsson et al., 2011), as well as with the different standards that local medical staff and even patients may be accustomed to and that may challenge foreign humanitarian workers' professional identities (Hunt, 2008). In addition, social and political ambiguity, less defined roles and hierarchies, and the absence of usual support structures, combined with the need to improvise and push one's set of skills to the limits, contribute to ethical distress (Nilsson et al., 2011).

To reconcile their ethical expectations and the field's reality, humanitarian workers resort to at least four broad strategies: tolerating the situation, challenging it, revisiting their own beliefs, or bearing the burden of choices (Bell & Carens, 2004). Indeed, although efforts are being made to formulate new codes of conduct specifically for humanitarian contexts, they may be too rigid to be applicable to each local context (Black, 2003). Alternatively, some prescriptions, such as the advice to critically examine values, identify options, weigh on them, and then apply them (Clarinval & Biller-Andorno, 2014), are, in fact, too general to offer clear guidance.

Toward a Communicative Perspective to Ethics

Instead of attempting to formulate more or less practicable advice, it may be more fruitful to consider humanitarian encounters with varying ethical standards as communicative events. Indeed, "when we find ourselves shocked over what another considers important, we are face-to-face with differences in what matters, witnessing contrasting communications ethics" (Arnett & Arneson, 2016, p. xi). This means, as Cheney, May, and Munshi (2011) point out, that ethics operates at the interface of the particular and the universal, with communication mediating between them, thus allowing the mobilization of a constitutive approach to communication.

To suggest that ethics is (also) a material practice, we borrow from literature suggesting that communication constitutes organizations thanks to its material aspect (Cooren, 2016; Taylor & Van Every, 2000). The argument that organizations are constituted through communication and interaction is indeed increasingly familiar among communication scholars (see Boivin, Brummans, & Barker, 2017). In this line of thinking, communication is never abstract: It takes the form of texts and documents (Brummans, 2007), computer presentation slides (Bourgoin & Muniesa, 2016; Schoeneborn, 2013), or specific utterances in a given tongue (Bencherki, Matte, & Pelletier, 2016). As people justify their behavior or opinion as aligning with rules, a code of conduct, or some imperative, they are therefore also organizing different material entities, including their bodies, into a specific collective ordering.

In other words, practice is the hybridization of discursive, embodied, and material constituents of organizing to constitute enduring organizational configurations (Ashcraft, Kuhn, & Cooren, 2009; Pullen & Rhodes, 2015; Putnam, 2015). In the same way, the study of how organizational actors manage EMCs should not be limited to analyzing conversations, but also extended to material artifacts and other situated actions. Materialization includes bodies, as in the example of Sørensen and Villadsen (2015), who show that ethics is also incarnate in managers' bodies. Whereas artifacts can impose ethics on human beings (Verbeek, 2006) and new technology demands heightened ethical precaution (Sandvig, Hamilton, Karahalios, & Langbort, 2016), arguably the material inscription of ethics may also relieve people from the responsibility of making difficult choices. It may do so by attributing the daunting task to the organization and its nonhuman representatives, as when a measuring stick determines, from their height, which children may receive the help of a nutrition center (Cooren & Matte, 2010). Therefore, the practices of ethics and those of organizing may not be distinct.

As people invoke principles or values and lend them their voice and their bodies, they also offer them a substance; that is, they materialize them (Cooren, Fairhurst, & Huët, 2012)*.* Reciprocally, as they point to documents or measuring instruments, for instance, they position these as substantiating their opinion or decision. By empirically observing the communicative achievement of this reciprocal sharing of agency, including the negotiations or confrontations it supposes, we can therefore observe how people position themselves as animated by the EMCs they materialize. In that sense, studying how ethics is being materialized consists of observing the way people communicatively deal with matters of concern.

In short, through the notion of EMCs, we suggest that the power of an ethical principle, ideal, or standard does not lie in its intrinsic characteristics, but rather in the tangible work deployed by those who

believe in it to materialize it and make it relevant and active in each situation (Arnett & Arneson, 2016; Maras, 2007; Slim, 2015). Ethics is thus a coconstructed social achievement that at once takes place in each local situation in which questions of what is right or wrong surface and scale up as conversations and texts are woven together.

Method: Being Embedded With MSF

Our analysis of how MSF workers practice ethics consists of observing how people position themselves as being animated by the ethical values or standards they materialize. MSF is "an international, independent medical organization that provides medical assistance to people affected by conflicts, epidemics, disasters, or exclusion from healthcare" and that "observes neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance" (Doctors Without Borders, 2019, para. 1). Around one third of MSF's projects are devoted to delivering assistance to people living in war and armed conflict areas such as South Sudan, the Central African Republic, Iraq, and the Democratic Republic of Congo, among many others (MSF website, 2019). The organization operates 450 missions in 72 countries with approximately 8,000 health professionals, logistics specialists, and administrative staff assisted by more than 37,900 locally hired staff members. In 2017, the organization carried out more than 10,648,300 outpatient consultations, including 2,520,600 malaria cases and the vaccination of 2,095,000 people against measles (MSF website, 2019). These numbers illustrate the ability of this humanitarian organization to get the required resources out in the field while also upholding its ethical and medical principles and standards.

From 2005 to 2015, the first author was able to complete a series of fieldworks, both as a volunteer and as a researcher, which allowed him to observe MSF workers. He participated in activities during several missions around the world, in the Democratic Republic of Congo, Djibouti, Haiti, Jordan, Kenya, Mozambique, Niger, South Sudan, Sri Lanka, and Swaziland. He followed health workers in charge of missions in their daily (inter)actions, trying to describe "what is happening here" (Snow, Morrill, & Anderson, 2003). This longitudinal research project loosely followed an "embedded ethnographic" approach (Atkinson, 2015) as it implied an active presence from the first author in the field.

More specifically, the first author collected data by using a video-shadowing method, which consists of following someone, a project, or a group of people, and recording their activities with a video camera (Meunier & Vásquez, 2008). The use of video shadowing allowed him to capture "natural" conversations, but was also an opportunity to keep a record of physical actions and the use of tools, documents, and other artifacts. If a meeting appeared contentious over a particular (ethical) issue, we were therefore able to consider not only what people said, but also what they did, what they were looking at, or what tools they used. The use of video in ethnography has been amply discussed in the literature (see Hassard, Burns, Hyde, & Burns, 2017; Wilhoit, 2017).

Concretely, the first author attended MSF weekly operational meetings, as well as meetings of the logistics and medical departments or with partners and collaborators. He also followed nurses, patients, doctors, and logisticians in their daily activities. Each of these persons signed a written consent form. He orally informed any other patients, family members, and unanticipated individuals about the

research, and recorded their verbal consent on the camera. The first author's institutional review board approved this procedure. Because the first author spent considerable time in the field, many workers, but also some patients and their families, became acquainted with him and his research project. Once each fieldwork was completed, the first author transcribed his recordings, which totaled approximately 70 hours of footage. He also wrote 300 pages of field notes, took more than 250 photographs, and collected various MSF documents. He held numerous data analysis sessions with colleagues, including the second author. These sessions helped us understand how MSF workers did their work and what challenges they faced.

For this study, some of these sessions allowed us to identify, within the "raw" data recorded during fieldwork, a few episodes—scenes, moments, or situations—in which ethical values, principles, standards, or guidelines were talked about, negotiated, and sometimes questioned. Specifically, for the Dadaab fieldwork, we ended up with 15 hours of video data and approximately 30 pages of ethnographic notes. Focusing on moments when we felt that some form of dilemma was playing out, we attentively reviewed the data, looking for any implicit or explicit reference to medical imperatives, protocols, or values related to ideals such as neutrality or impartiality. We were particularly attentive for moments when we could witness a collective recognition that ethical issues were at stake, and when standards of care were being defended against alternative possibilities. In other words, each time, something else could have happened in regard to ethical decision making. Once these segments of data were identified, we transcribed in more detail these "key" moments or situations, loosely following Jefferson's (2004) transcription convention. In analyzing theses data, we noted all potential ethical matters of concerns that MSF representatives and collaborators materialized, discursively or otherwise.

From these data, we selected two specific vignettes on the basis of their representative characters with respect to what usually happens for health care workers on MSF missions around the world, that is, the mundane occurrences when interactions are allowed to stand for (and negotiate) what counts toward ethical matters. The first consists of a meeting between a physician and the local staff she works with. The second exemplifies the work of a physician with patients and their families. In each case, the physicians made assessments and dealt with various ethical stances. Instead of including more data or coding for recurring themes across all of it, we opted for an in-depth examination that gives us the necessary space to unfold a detailed interactional analysis and show its usefulness when it comes to studying how people deal with ethical matters, in agreement with what the first author witnessed over the years. Indeed, he participated in many meetings and medical rounds in which MSF staff discussed apparently uneventful issues, such as the importance of eating together or the inclusion of family members in treatment decisions. These questions are also important in the two vignettes we selected, and it turns out they are crucial for the organization's operations as they are culturally central in Kenya (Holtzman, 2007; Maina, 2017).

As communication scholars, we focused on language and discourse, but also on bodies and materiality as we looked for their participation in agency, action, and relations. More specifically, we followed the principles of interaction analysis (Cooren, 2007) to analyze the data. In broad agreement with ethnomethodology (Garfinkel, 1967), we consider that what people do during each turn of talk or move in the interaction is relevant to better understand how social and organizational phenomena, including membership and authority, are being shaped and "brought into being" by actors themselves

(Bencherki, Matte, & Cooren, 2019; Bencherki & Snack, 2016). The originality of our approach consists of considering that action is always hybrid and therefore looking for the way people attribute what they say or do to matters that they stage as motivating or animating them.

Analysis: Materializing Ethical Matters of Concern

In the next analytical vignettes, we highlight two key situations that exemplify many similar ones at MSF, in which ethical matters appeared particularity salient and became of concern for the organizational actors involved. In the first one, we witness an MSF physician trying to reconcile her belief in medical standards, which demand that a health care professional remain with patients even during lunchtime, with a democratic decision-making process that requires her to ask local staff for their opinion on this question. Indeed, both medicals standards and democratic decision making represent core values at MSF, although they are not always easy to conciliate (Ahmad, Smith, & Slim, 2018). In the second one, we follow another physician who again has to negotiate between her conviction in the necessity of a feeding tube to ensure a young patient's survival and the need to respect the request of a family member who wishes to feed the patient herself and to take out the tube that is causing discomfort to her niece. This apparent willingness to adapt to local manners without compromising medical needs represents a constant preoccupation at MSF, albeit not without its limitations (Redfield, 2013).

Medical Ethics and Participatory Decision Making

This morning in Dadaab (Kenya), a refugee camp of approximately 450,000 people, 50 miles from the Somalia border, the heat has already shrouded the MSF hospital on the outskirts of the camp. Before workers begin their respective shifts, a meeting is taking place between Dr. Smith and the national medical staff (hired locally by MSF) mainly composed of Kenyans of Somali descent. Dr. Smith is a female pediatrician who has just arrived in Dadaab. Everybody is seated at a table, as Dr. Smith, who is chairing the meeting, begins to talk. She wants to discuss and remedy a situation that is problematic for her and for her vision of "best" medical practice (see Jefferson, 2004, for a glossary of transcript symbols):

0	Dr. Smith	Hum, right. Couple of things. One is that, hum, we need to (0.5) assign somebody hum (0.5) who (.) has lunch at a different time. Becau::se (1) it's a bit of a problem if everybody leaves the hospital at the same time and then there is nobody here to cover (.) you know (.) the emergency department or something on the wards. So:: (0.5) if nobody has a better suggestion (.) shall we try for now the person who's covering the emergency clinic goes to lunch a bit later? O::r, what do you think? Or the person who's doing the outpatient clinic stays in until it's finish and covered? What does everybody think? ((Looks around her for a response)) (5)
1	Dr. Smith	Hum? (3)
2	Dr. Smith	ok if=
3	Clinical officer	=the person doing emergency

4	Dr. Smith	the person doing emergency, yeah it makes sense. Yeah. And and we'd have to hum (2) radio. You know let let somebody knows to keep you some lunch or something like that but. I think that's:: (.) probably a good idea. Yep?
5	Clinical officer	the person who goes for lunch, has to start one hour less=
6	Dr. Smith	=yeah
7	Clinical officer	then he goes for lunch at two
8	Dr. Smith	=yeah
9	Clinical officer	and he comes back. He goes for lunch and he come back at three
0	Dr. Smith	Yeah. Yeah
11	Clinical officer	(inaudible)
12	Dr. Smith	Hum (.) yes (3)
13	Dr. Smith	Okay and if if it seems hum cause I know that we tend to put the same people kind of in this ward, this ward, this ward ((indicating different places with her hand)). So, if it seems that it's the same person every day (.) having a late lunch and you don't like it, plea::se say and we'll do a we'll do a rotate. Okay?

Dr. Smith begins her intervention by voicing what she thinks everyone needs to do: "One is th::at, hum, we need to (0.5) assign somebody hum (0.5) who has lunch at a different time" (Lines 1–2). Although she is the one who is speaking, she is explicitly positioning herself as speaking for the medical staff (the "we" in question) and what they need to do, thus materializing the collective and attributing to it the "need" to do something. She then explains why this new assignment should take place, following a prolonged "because" follow by a long one-second pause that seems to indicate that she had not thought of providing a reason before that moment: As she says in Lines 3–4, "Becau::se (1.0) it's a bit of a problem if everybody leaves the hospital at the same time and then there is nobody here to cover (.) you know (.) the emergency department or something on the wards." By voicing this concern in this particular way—for instance, by stressing the *everybody*—Dr. Smith materializes what counts for her and what she thinks is right for the situation, that is, the medical imperative of always having someone present for patients, even at lunchtime.

Having presented what they all need to do and having defined the problem that motivates this action, Dr. Smith proposes, after a brief pause, how the new system should be tried out. Note that her proposal is presented as a question ("Shall we try for now the person who's covering the emergency clinic goes to lunch a bit later?" Lines 6–8), quickly preceded by the implication that "nobody has a better suggestion" (Line 5). This passage is interesting because Dr. Smith invokes her conception of a patient's care (first by providing a solution, then defining the problem it answers to) before "inviting" input from the staff. So, whereas the first part of Dr. Smith's intervention (Lines 1–5) is marked by some assertiveness about what needs to be done, the second part uses a more interrogative form, thus weakening her invitation to provide input (especially Lines 8–10).

The concern that transpires from Dr. Smith's intervention is the apparent contradiction between two ethical matters: On the one hand, she positions herself as being animated by the necessity to have people monitor patients without interruption, an imperative that corresponds with MSF's medical protocol (and, probably, that of most Western health organizations). On the other hand, she also appears to be animated by the principle of collaborative decision making, a principle that the organization publicly puts forward as a core value (Fox, 2014; MSF website, 2019). Although the protocol is, by definition, nonnegotiable, the principle of participatory decision making implies a form of openness that contradicts it. The manner in which she sequentially utters her apparent concern for a participatory decision-making process—after having made the decision herself, in fact—materializes the fact that she seems to prioritize MSF's medical imperative of presence for patients at all times over genuine participation.

It comes as no surprise, then, that her invitation to contribute is first met by silence on the part of the national staff (see the five-second silence at Line 11, and the three-second silence at Line 13), which is finally broken by the local clinical officer. The latter reacts by simply saying, "The person doing emergency" (Line 15), which can be interpreted to confirm his understanding of Dr. Smith's proposal (i.e., that it is this person—the person doing emergency—who stays in the clinic while the others are out for lunch). Interestingly, Dr. Smith responds by implicitly identifying what the clinical officer just said as being an original contribution ("The person doing emergency, yep it makes sense. Yep"; Line 16), as if she wanted to cast what is happening as a form of participation. The rest of the episode shows Dr. Smith reacting to her own suggestion, while briefly asking for confirmation (Lines 16–19). As for the clinical officer, his series of statements confirm that he is trying to understand precisely what Dr. Smith is proposing by repeatedly translating what this means to them (Lines 20–27). Arguably, the way this interaction evolves seems miles away from the collaborative mode Dr. Smith is trying to establish.

This excerpt shows the concern between what animates the two parties: Dr. Smith is moved by a desire to improve the way things are done—a strong ethics of care—while trying to create a collaborative atmosphere and a more democratic decision-making process. However, the way she formulates those two contradicting principles—by stating a course of action first, hesitantly defining a problem then, and finally awkwardly asking for input when it is too late—materializes a clear priority for medical standards and the apparently nonnegotiable character of the MSF protocol. We can only conjecture the national staff members' perspective, as they do not fully participate in the exchange, and their silence may appear from our viewpoint as a form of deference to the physician's authority, a situation the first author witnessed frequently over the years. More so and given the fact that, as we learned from our experience there, eating together as a group is an important tradition, and therefore agreeing so easily to single out a person who eats alone appears suspicious. Of course, Dr. Smith is White and has a marked British accent, which materializes a clear socioeconomic privilege, as well as an obvious colonial stake, that locals cannot ignore (Shevchenko & Fox, 2008). Also, we are in Dadaab, one of the most dangerous regions of the world, where the notion of always having at least one medical staff member present with the patients may seem a futile matter given the surrounding chaos. Relatedly, in this region, and as we see next, parents traditionally play the role of caregivers and remain at the patient's bedside, a presence that materializes de facto the ethics of care everyone seems to be looking for, albeit in a different matter.

A Medical Plastic Tube

We follow another European physician, Dr. Lane, who is heading toward a young girl's bed. On the way, she explains how they had to intubate the juvenile patient to make sure that she receives enough liquid for her to survive. But once we arrive at the girl's bed—and to Dr. Lane's surprise—the little patient does not have the tube inserted into her nostril. With the help of a national medical staff member, a clinical officer who also acts as a translator, Dr. Lane asks the girl's aunt, who is at her bedside, why the feeding tube has been taken out. All the while, she is examining the little patient, as shown in Figure 1. The aunt replies that it was not comfortable for the girl and that, anyway, she is there herself to give the girl water and food if necessary. This apparent discomfort highlights the tube's ambiguity with respect to two ethical imperatives: the girl's immediate well-being and her long-term health. Reconciling both poses an ethical dilemma in the sense that they can both be sound medical objectives but cannot be pursued at once as far as the tube is concerned.

During the conversation, Dr. Lane politely acknowledges the aunt's answer, but insists that if the tube is not reinstalled, the girl will probably not survive. The aunt does not understand Dr. Lane's prognosis and repeats that she is at the girl's bedside all the time. What logic is there to inflict such discomfort to her niece? Dr. Lane explains her point once again, which the aunt seems to understand as casting doubt on her sincerity in caring for her niece. At that point, Dr. Lane turns toward the clinical officer to explain again that without the tube, the girl will die, as she needs constant feeding and is too weak to ask for food or even process it if it is given to her orally.

The clinical officer, initially acting only as a translator for Dr. Lane, then adds his own voice to the conversation about the medical necessity for the plastic tube. We do not understand right away what is said between him and the aunt as the conversation occurs in Somali, but the clinical officer's tone is clearly assertive, and his body language appears to be more authoritative this time around. Later, he confirms to the researcher that he had strongly reiterated the consequences of not having the tube to save the girl's life. With this combination of various materializations (Dr. Lane's physical examination, her demand combined with the clinical officer's stern request, the tube's presence that stands in for medical procedure, etc.), the aunt accepts letting Dr. Lane put the tube back in the girl's nostril.

As we can see, Dr. Lane and the aunt do not agree on what the feeding tube means with respect to the little patient. For Dr. Lane, the girl's survival is the sole goal to pursue at this stage, and she cannot compromise with what she feels is rational medical practice. For her, the tube is instrumental to the girl's survival. This is apparent in Dr. Lane's insistence that the tube remain in place despite the girl's discomfort and the aunt's lack of consent. Dr. Lane appears so zealous in pursuing that goal that she remains mostly deaf to the aunt's alternative moral position: that she is family, and that as such she will provide everything the girl needs, will not let her die, and wants to make sure she is comfortable. Indeed, for the aunt, the tube materializes as distrust in her sincerity and a mechanical replacement for the efforts she would be putting in feeding her niece. How—the aunt seems to ask as she repeatedly reminds everyone that she is there constantly to feed her niece—could an intrusive tube be any better than the love and care of an aunt? The tube, in a sense, "robs" her of her identity as a family member and her role as a caregiver that she is resolute to play. For Dr. Lane, and this is also what the clinical officer explains to

the aunt, the tube is not an end to itself but rather the materialization of her desire to ensure that the little girl's survival is a goal the doctor and the aunt certainly share.

Figure 1. Dr. Lane, with the help of the clinical officer, putting the tube back in the little patient's nostril as her aunt comforts her. (Photograph modified to preserve anonymity.)

We see that Dr. Lane is faced with ethical matters that are posed by the tube's materiality (i.e., the fact that it both feeds and causes discomfort), either applying rational procedures to ensure the patient's survival, or respecting the family's traditional role and concern for their child's immediate comfort. In fact, however, she has already chosen a side. Had she agreed to consider the aunt's point of view, she would have betrayed the principles that guide MSF and her own identity as a physician. To the possible detriment of more considerate bedside manners, Dr. Lane and the clinical officer are reproducing MSF's ethical standards by insisting adamantly that the tube be reinserted, an insistence that also materializes the hierarchy between saving the patient's life through proven scientific means and being accommodating of local customs and issues of comfort. In this case, as in the previous one, an apparent ethical dilemma was decided on as EMCs were materialized through practice.

Materializing Ethics Through Practice

The presented vignettes show that ethical talk and action are not necessarily a special instance: It happens in ordinary, everyday work. It is through the same practices that people constitute their organization and go about their business—for instance, deciding how to coordinate lunch and who oversees feeding patients—and through which they make present and relevant ethical matters of concern. This is done in two ways: first, in multiplying the materializations of those EMCs, and second in presenting these materializations in a particular sequence. Indeed, Dr. Smith and the staff are deciding whether someone should stay with patients over lunch, but this decision is made not only in what is said, but also in how it is said. Through the sequential unfolding of the conversation, some EMCs are prioritized over others. Similarly, the second case reveals how MSF's ethical standards concerning the nutrition of patients is concretely made relevant in a local situation through a plastic tube and the joint request of two health care professionals. Again, these materializations position some EMCs above other possibly legitimate concerns, such as family consent or local customs, to the point that the physician may appear brusque in her attempt to impose her solution.

Ethical conversations, therefore, do not only debate the merits of keeping someone by a patient's side during lunchtime or the process of intubation. Materialization at times "causes" the ethical situation, as when the feeding tube both allows the little patient to survive but also causes her discomfort, thus leading the aunt and the physician to offer alternative ways of dealing with the tube. Most often, however, materialization allows confronting and configuring matters of concern, as when Dr. Smith lays out a "solution" before defining the problem and consulting her colleagues. Materializing ethical stances means that workers do not have to manipulate abstract concepts—for instance, is patient safety more important than employee participation?—but rather tend to their immediate situation: Should I ask them their opinion? Should I put the tube back? Principles and values (and contradictory ones) are made present and active in the situation as they are invoked through the many materialities of the here-and-now interaction. In other words, ethics is not reducible to intentional and rational dialogue among men and women (Arnett, 2016; Habermas, 1984), but also brings together a heterogeneous assemblage through which ethics passes, in the same way as it passes through human beings (Cooren, 2016; Latour, 2010).

Discussion

Current literature recognizes that humanitarian aid organizations and their members are strongly motivated by ethical principles (Rothschild & Milofsky, 2006) and that those preoccupations are on trial when confronted with day-to-day work in the extreme contexts in which they operate (Bell & Carens, 2004). Compromises must be made that are often felt as corrupting the principles that motivate humanitarian workers' engagement (Feldman, 2007). Rare resources, political ambiguity, and variable local ethical standards challenge foreign humanitarian workers' principles and their professional identities (Nilsson et al., 2011). However, besides broadly defined strategies to cope with dilemmas or suggestions for codes of ethics (Bell & Carens, 2004; Black, 2003; Clarinval & Biller-Andorno, 2014), few attempts have been made to concretely understand how workers practically handle ethics in the field. This study shows that when attention is turned to what humanitarian workers concretely do to deal with ethical situations, they can in fact offer valuable lessons to researchers and to workers in other contexts. In

particular, three important contributions can be spelled out in terms of adopting an ethnographic approach, considering ethics as materialization, and on the relationship between individual and organizational ethics.

Our first contribution is methodological. The empirical material of much current research on ethics typically consists of after-the-fact interviews that preclude on-site observation of how people tangibly deal with ethics. We adopted, instead, an ethnographic approach to study an organizational setting with which the first author was familiar (Alvesson, 2009; Anteby, 2013; Eriksson, 2010). By choosing such an approach to study humanitarian work, we were able to access ethical concerns as they presented themselves in humanitarian workers' daily life. We were therefore able to observe how they routinely dealt with those concerns, thus offering a window to the practices and processes through which people concretely handle ethically sensitive situations, rather than deductively prescribe lines of conduct that are abstracted from any real-life context or having people reflect after-the-fact on long-past situations. Our study shows that it is possible to see ethics at work while it unfolds in local situations in which it is an issue to members. We can thus avoid assuming that we, as Western academics, are on some moral high ground from which we can offer guiding principles that should be relevant to members. In this sense, to the field's usual normative attitude, we stress the possibility and fruitfulness of an analytical perspective to the study of ethics.

Our second contribution is that ethics proceeds from the multiplication and sequence of materializations. It was already suggested that the material dimension of artifacts imposes ethical choices on people (Verbeek, 2006). Our findings suggest that materiality and human behavior do not contradict each other, but rather that materiality participates in ethical decision making along with people. In this sense, we concur with current research on the role of materiality in providing endurance to organizational practice and in constituting organizations (Ashcraft et al., 2009; Cooren et al., 2012). Our ethnographic data show how organizational ethical standards are materialized through mundane conversations and through objects and bodies. Different ethical stances thus correspond to practical engagement with different material elements of the current situation, from people to objects to conversation structure.

Relatedly, the analysis of our ethnographic data also reveals how the "plenum of agencies" (Cooren, 2006)—the intertwining of human and nonhuman actants—that make up organizational reality participates in defining ethical standards by materializing them. Of course, many contextual elements may not be directly observable in the interactions we study, such as colonial history. However, we show that we can already learn a lot from what we can actually observe. Indeed, if we list the different elements that help MSF enact its ethics in each local situation, we find that people, their discourse, but also silence, an uncomfortable plastic tube, translators, a loving aunt, agreements reached at prior meetings, all contribute both to making MSF present here and now in a particular way (what has been called "presentification"; see Benoit-Barné & Cooren, 2009) and to upholding its ethical standards far away from the Western context from which many of these standards emerged in the first place.

This leads us to the third contribution, which is that thinking of ethics in terms of its many materializations also elucidates the relationship between individual and organizational ethics. Indeed, it is not enough to assume that the individual ethical principles of the majority of members correspond to

organizational ethics, not the least because who is a member or not may be ambiguous, especially in volunteer-based organizations. The process of "scaling up" must be observed in its own right (Cooren & Fairhurst, 2008). It is through material practices that decisions, procedures, routines, and other organizing practices are moved through time and space to become "organizational," for instance, as people refer to minutes (Cooren, 2004), share their PowerPoint documents with colleagues (Schoeneborn, 2013), or work together using a blackboard (Cooren & Bencherki, 2010). It is therefore through material artifacts that matters of concern of all kinds can be moved from individuals to their organization. However, even within one single setting, the multiplication of materializations that substantiate the same position may end up being authoritative in the situation and therefore suggest a course of action that is not reducible to the preference of any single individual. In the same way, Dr. Lane's preference for keeping the feeding tube is, precisely, not only individual but also "organizational" because of the clinical officer's intervention, because it is expressed as part of a medical examination, as well as because the tube itself, in the context of Dadaab, is an MSF technology. In other words, in each case, looking at the materializations of ethics reveals that ethical decisions are collective performances, and not merely cognitive or disincarnate reasoning that takes place within a single person's brain, heart, or spirituality.

Conclusion

Humanitarian aid organizations are in the business of negotiating ethical matters daily. Whereas much writing about ethics continues to consider the notion as a philosopher's problem, and mostly adopts a normative attitude, our analysis of ethnographic data shows that, in their own way, workers routinely balance principles, values, cultural norms, and situational contingencies against each other. They do not do so by mulling over concepts or applying categorical imperatives, but by orienting to practical problems and mobilizing the resources available to them. MSF positions the patient's health as its main concern (Brauman, 2009), but other EMCs regularly put this commitment to test because what is right or wrong is far from obvious. What our ethnographic data show is that MSF's principles, for the most part, do prevail in the end, even though the organization is active in multiple countries and faces cultural, linguistic, and other practical challenges in extreme contexts such as wars and health emergencies. The strength of an ethical principle, however, does not lie in its intrinsic features, but rather in the concrete efforts deployed by those who believe in it to materialize it and make it relevant and active in each situation.

As is the case in many organizations, MSF's values and mission must be defended every single day. They are questioned by government officials and other partners, but also negotiated among workers and patients themselves. Defending them implies a constant process of materialization of the values, principles, and norms of action that MSF cultivates. The kind of detailed analysis we have offered helps us better understand how MSF can uphold the standards that make it praiseworthy while dealing with the contingencies of emergency relief missions. It may also help us understand the organization's capacity for intervention in spite of the extreme contexts and hard choices it is faced with. In that sense, MSF's practices may serve an extreme example, or a magnifying glass, for other kinds of organizations operating in a variety of settings but nonetheless facing similar ethical matters of concern.

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