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Medicine at the Border
Disease, Globalization and Security, 1850 to the Present

Edited by Alison Bashford

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Medical Humanitarianism in and Beyond France: Breaking Down or Patrolling Borders?

Miriam Ticktin

In 1998, France officially instituted a humanitarian clause in the law, granting legal permits to those in France with pathologies of life-threatening consequence, if they were declared unable to receive proper treatment in their home countries. This ‘illness clause’ was put in place to permit undocumented immigrants to receive treatment in France. The logic behind this was humanitarian; the French state felt it could not deport people if such a deportation had consequences of exceptional gravity, such as their death. It was the lobbying of medical humanitarian groups such as Médecins Sans Frontières (MSF) or ‘Doctors Without Borders’ and Médecins du Monde (MDM) or ‘Doctors of the World’ that helped institute the illness clause as law in France.

In this moment in French immigration history – and in particular, between 1997–2004 – those with cancer, HIV, polio or tuberculosis, or those who were understood as suffering from a medicalized form of trauma, became the most mobile, the most able to travel without hiding themselves in cold-storage containers or making mad dashes across the Channel Tunnel, risking their lives in the process. While I applaud the fact that those who are sick or disabled can indeed travel across borders into France, particularly when they are often prevented or discouraged from doing so in other national contexts studied in this book, the problem arises in allowing only such people to travel. In the absence of other immigration policies or means of legal access, the illness clause forces people who want papers to configure themselves as sick or suffering, and hence recognizable to humanitarian organizations, doctors or medical officials. Indeed, in this case, illness becomes the primary relationship between immigrants and the state: illness and/or suffering functions as a passport in the absence of other means of entry.

In a global political climate in which immigrants and refugees are increasingly labeled as criminal or economically burdensome, and in which the word ‘immigration’ is often paired with that of ‘security’, we must ask how the French state reconciled the denial of papers to immigrants because they were perceived to be criminal or economically burdensome, with the decision to give papers and social services to immigrants who were sick? Stated otherwise, why is it that illness is allowed to travel across borders, while poverty cannot? And in what ways is this situation specific to France?

This chapter examines the new medical humanitarianism, suggesting that it constitutes the critical underlying context for the illness clause, and for the way in which sick bodies can travel across borders in this instance. Grounded in the French republican principles of universalism, which hold that all human beings are equal regardless of political, cultural, religious or other affiliation, medical humanitarianism offers the possibility of a world where borders are less relevant, of freedom and equality for all. It is built on the belief that humanity should not be divided into those who may live and those who must die. Its goal is to save as many lives as possible. Yet is this goal, while universal in ambition, applicable across borders? In what sense is this type of humanitarianism limited to the French cultural and political conditions in which it was produced? And in what senses do these conditions determine its characteristics, even when it travels?

Elsewhere, I have analyzed the details of the illness clause itself. Here, I discuss the genesis and characteristics of the humanitarian institutions that made it possible. Indeed, by addressing the case of medical humanitarianism, my larger goal is to examine one instance of ‘universalism’ in the contemporary world, how universal ideals are linked to national and colonial cultures, and how health and medicine help turn national ideals into transnational practices. I argue that while medical humanitarianism opens borders for some, it also inherits similar blind-spots of the universalism that grounded the French colonial ‘civilizing mission’. Indeed, humanitarianism has its own tensions and exclusions, which often end up being expressed as a limited version of what it means to be human. With medical humanitarianism playing an increasingly important role in the contemporary world – recognized, for instance, by MSF’s Nobel Peace Prize in 1999 – this chapter grapples with the need to understand how medical humanitarianism, in the form of NGOs or international institutions, works to manage borders – the openings, as well as the closures.

The suffering body

The humanitarian discourse of the late eighteenth and early nineteenth century functioned by publicizing the details of cruelty inflicted in individual bodies. Indeed, as Thomas Laqueur writes in his exploration of nascent humanitarian sensibilities, ‘humanitarian narrative relies upon the personal body, not only as the locus of pain but also as the common bond between those who suffer and those who would help’. This focus on the
individual suffering body has carried through into the new medical humanitarianism, but another dimension has been added: its apolitical status. As Lisa Malkki notes in the context of Hutu refugees living in Burundi and receiving humanitarian aid, ‘wounds speak louder than words. Wounds are accepted as objective evidence, as more reliable sources of knowledge than the words of the people on whose bodies those wounds are found’. Here, the political or historical circumstances of the refugees are ignored in order to focus on the individual body of the ‘pure victim’.

The suffering body plays a critical role in the French illness clause. The clause was instituted in France when other doors to immigrants and refugees were closing. Indeed, an inverse correlation has been documented between the statistics on political asylum and permits for medical reasons: as the number of people admitted for political asylum decreased, those entering under the auspices of medical humanitarianism increased. In this context, I have suggested that the illness clause was ratified only because it was perceived as outside the political realm. That is, it was instituted in May 1998 as an amendment to the Ruling (Ordonnance) on the Conditions of Entry and Residence for foreigners, specifically, that which concerns the right to ‘private and family life’. Placing this clause under the aegis of the ‘private’ exempts it from debates about the politics of immigration, citizenship, and notions of the French nation, and ignores the structural problems and economic demand that may have caused the immigration in the first place. Instead, the clause focuses attention on what is construed as an apolitical, suffering body. This clause is based on the notion of the universality of biological life— a concept of life that overlooks all divisive political identities and affiliations— what Rorty refers to as ‘species-membership.’ In my conversations with state officials and doctors, they confirmed that the space of pure life honored in the illness clause is conceived of in opposition to political community— in this sense, the boundaries of the political are demarcated from a purported universal, and hence legitimate, biological realm.

These examples illustrate a notion of life as outside or beyond politics. Humanitarianism can be credited with legitimizing this notion of life in the contemporary world. Indeed, humanitarianism is grounded in the ethical and moral imperative to bring relief to those suffering and to save lives, regardless of political affiliation. It is precisely the ability to isolate victims in their present crisis, outside of politics and history— and to retain ‘political neutrality’— that allows humanitarian organizations to do their work, to render borders irrelevant in the name of a higher moral injunction to prevent and relieve the suffering of others. Yet, in what sense is this ability to move across borders in the name of political neutrality — and in the name of the suffering body — a French phenomenon, and in what sense does it have transnational articulations or possibilities? As chapters in this book detail, suffering in the form of HIV/AIDS does not travel across other national borders. There is a specificity to the French case, even as medical humanitarianism has contemporary transnational implications.

**The new medical humanitarianism: a brief history**

Humanitarianism has a long and sometimes ambiguous history, largely because it is not easily defined. Some call it a concern for the suffering of distant strangers; others assert that it is framed by an ethics of intervention. Religious orders dispensing charity and abolition efforts to ban slavery are early examples, but the direct precursor to the new medical humanitarianism— and an important player ever since — is the Red Cross movement, which was started in 1864 by a Swiss businessman, Henry Dunant, on the basis of the plight of suffering soldiers. The mandate of the International Committee for the Red Cross (ICRC) was the protection of, and assistance to, victims of war. During and after World War II, a number of humanitarian organizations were born, such as Oxfam (Oxford Famine Relief Committee), some of which also fell under the rubric of the United Nations, such as UNICEF. French humanitarianism, however, was conceived considerably later.

Médecins Sans Frontières (MSF) was founded in 1971 by a small group of French physicians, headed by Bernard Kouchner. In the context of the civil war in Nigeria, these physicians served as volunteers in Biafra doing medical relief work among the Ibo. The founding of MSF grew directly out of Kouchner’s reaction to the International Red Cross’ strict approach to neutrality in war zones which involved a high degree of confidentiality because the emergency work of such international organizations was both made possible and constrained by agreements between states. The Red Cross and other international organizations had been providing equal amounts of relief to all sides in the Nigerian conflict, but in the spring of 1968 the government of Nigeria withdrew support for relief in an attempt to force the rebels into negotiations. A few NGOs like Oxfam decided to break with the tradition and airlift in food without the government’s permission.

Kouchner was one of the volunteers for the Red Cross who decided to flout the ICRC’s policy on confidentiality, and talk to journalists about what they had seen. He stated: ‘By keeping silent, we doctors were accomplices in the systematic massacre of a population.’ Returning to France from Biafra in 1969, he started an International Committee against genocide in Biafra, and in 1971, this group was constituted as a new species of NGO called ‘Médecins sans Frontières’.

One of MSF’s guiding principles is the desire to bear witness to the violations of human rights and human dignity that doctors encounter in the field. This resolve grew out of the finding that the International Committee of the Red Cross did not speak out against atrocities taking
place in the camps in World War II, despite witnessing them through their deliveries of food and medicine: the Red Cross responded that their silence enabled them to continue doing relief work in the Holocaust setting. Kouchner and MSF’s real innovation came in the way that they ruptured the silence: they informed a vast world-scale public about human rights abuses, and evoked public indignation about them, making sophisticated use of the mass media. They called this a ‘duty to bear witness’.

Three defining features of MSF have fueled medical humanitariam as a movement. As I will argue, they lay the groundwork for the new type of ethics exemplified in the ‘illness clause’ and the way that French nationalism has been transformed into a form of internationalism, which diminishes the significance of national borders. Let me make clear that MSF, perhaps more than any other NGO, is self-reflexive, constantly interrogating its role, its principles and its effectiveness. The following must be seen, therefore, as historically contingent features of the movement, rather than firm principles. First, MSF challenged and reconceptualized the notion of sovereignty. Second, they created the notion of the moral obligation to interfere in the name of suffering; and third, they strategically used the mass media to break down borders and bear witness to violations of human rights.

Their name itself – Médecins Sans Frontières – indicated a desire to put aside conventional borders of nation-states, to challenge sovereignty. While MSF never purported to suggest that borders are irrelevant – the name is about overcoming barriers more than borders – they disavow any political or religious affiliation or identification, and assert their independence from political and governmental bodies. They do not agree that a nation should be free to determine its own destiny. Their vision is a global one governed by the principles of the Universal Declaration of Human Rights. Their vision of medicine is also transcendentally universalistic: they claim that because ‘illness and injury do not respect borders’, neither should medical care. Despite the extant mandate instituted in 1948 by the Universal Declaration of Human Rights to put aside the rules of sovereignty in cases of human rights abuses, this mandate was never insisted upon, let alone acted upon so clearly a way. MSF in many ways spearheaded a group of what researcher James Rosenau has called ‘sovereignty-free’ actors that include Greenpeace and Amnesty International, each positioning themselves on an international stage previously reserved for states.

This universalistic aspect of MSF has a distinctly French flavor; that is, the French have long ground their politics on a paradigm of universalism. This is what undergirds French notions of Republicanism: a belief in equality and the denial of the relevance of particularities. In this same way, MSF emphasizes a universalistic conception of human worth, and the unity of the human condition, playing down different social and cultural attrib-

utes of both the doctors and those whom they assist. This universalism was clearly evident in French politics at the time. A member of the Communist Party and as a medical student, Bernard Kouchner was a child of the May 1968 student movement in France. Indeed, the French medical sociologist Claudine Herzlich argues that medical humanitariam rose out of the context of 1968, where the School of Medicine in Paris was a place of high activism. The medical students drafted a ‘white book’ containing a radical reform of medical education, the medical practice of medicine, and the practice of ‘capitalistic medicine’. Herzlich argues that Kouchner is in many ways representative of that movement and the fight it waged against capitalism. His will to practice a different medicine resulted from the failure of May 1968, and she explains that the doctors who were involved in 1968 now practice a type of medicine linked to public campaigns and actions, and to a universal cause whose symbolic value reaches well beyond the field of medicine. Kouchner’s universalism draws on the tradition of the ‘Rights of Man’ that is conceptualized as inherent to French civilization, and linked to French nationalism. MSF works on the premise that this tradition must be upheld at all costs. In other words, wherever suffering exists, it must be alleviated: all people have an equal right to exist without violence or pain. Indeed, there have been a multitude of organizations both professional and voluntary born from this idea of ‘sans-frontièreism’; there are now groups that range from ‘reporters without borders’, and ‘engineers without borders’ to ‘chiropractors without borders’.

The second defining feature of MSF, le droit d’ingérence or the right to interfere, is based on the universal conception of the human condition; sovereignty is challenged in the name of this universal humanity. This is a particularly interesting idea, because le droit d’ingérence can be translated into English in several different ways: it can mean the ‘right to intervene’, but it can also signify the ‘right to interfere’, and the latter translation is preferred by Kouchner. In fact, the preferred translation is the ‘duty to interfere’, which again plays with the word ‘droit’. In English, ‘droit’ could signify the ‘law to interfere’ but in French, the preferred meaning has a connotation of moral obligation. In English, the idea of a ‘duty’ carries more weight than that of a ‘right’. Yet, as Allen and Styan point out, Kouchner takes the duty to interfere as a given – one is morally obligated to interfere if others are suffering. As a result, he has spent his time fighting to institute the legal right to interfere. Again, this draws from a French political and legal tradition: the French practice of international law regarded intervention as technically legal, while others interpret it as infringing on the rules of sovereignty. In this sense, MSF suggested that ‘ingérence’ be more actively developed in the wider international community.

Early in MSF’s life – 1979 – there was split between its founding members and members of the second generation over the extent of intervention or
interference, and where the line should be drawn. The split resulted from a disagreement about Vietnamese ‘boat-people’ who were dying in the sea by the thousands. Kouchner wanted MSF to invest its resources to charter a boat to rescue these refugees, and he joined with prominent French intellectuals to mobilize the media and draw support for the cause. The younger members of MSF felt that it surpassed their competence and the capacities of medical humanitarianism, and voted against him. Rony Brauman, the president of MSF from 1982-1994, was amongst this younger group, and writes that the disagreement was about whether to forge an independent organization of doctors, with specific guidelines and limits (later called private humanitarianism), or a series of symbolic actions, that ultimately remained state-affiliated (state humanitarianism). This in fact remains an ongoing tension in the notion and practice of humanitarianism. There were accusations of betrayal on both sides, but ultimately Kouchner and many of the other founders left and formed Médecins du Monde (MDM) or Doctors of the World.28 These remain the two most prominent medical humanitarian organizations, and for the most part share the same goals; nevertheless, the split highlights the ongoing debate and tension about how much ‘interference’ is enough, and how ‘moral obligation’ or ‘right’ is defined.29

Part of the debate over le droit d’ingérence involves France’s colonial history, and subsequent post-colonial political developments. French colonial policies were highly interventionist, and were involved in nearly all aspects of life, from health to education to sexuality. With the war in Algeria and the independence movements of many French colonies in the 1950s and 60s, the New Left led by student youth espoused a Marxism that identified and sympathized with the international proletariat in the Third World. This movement was called tiermondisme or ‘third-worldism’ and took a position of solidarity with revolutionary movements in the ‘Third World’, rebuking any criticism of these independence movements, and any type of interference with their regimes: this was in reaction to the previous interventionist colonial policies. In the late 1970s and 80s, however, it became more apparent that the anti-colonial revolutionary Marxist movements were not necessarily successful and intervention again became an issue. As MSF president at the time, Rony Brauman claimed, ‘Some 90 percent of refugees in the third world were fleeing this kind of regime, and we were working in camps where they had been gathered ... We were ferociously critical of third worldism and what [Raymond] Aron called the ‘lyrical illusion’ that it permitted’.30 Specifically, a division emerged between those who reaffirmed the original anti-colonialist position (the original tiermondistes), and those who wanted to promote a new mission civilatrice or ‘civilizing mission’ in the name of human rights. MSF fell into this latter category, as did the broader ‘without borders’ movement.31 In other words, a form of universalism based on rights explained the ‘moral obligation’ to once again interfere, walking in the footsteps of the colonial legacy, even as it worked to counter practices that resulted from centuries of colonialism and the struggle to decolonize. The ‘need for defense of human rights in the “Third World”’ was endorsed by President Mitterand in 1987, and his government included ‘humanitarianism of the State’ in its policies. Indeed, there was a place for the emerging humanitarianism in the French state itself: the Minister of Human Rights from 1986-1988 was Claude Malhuret, an ex-president of MSF. And in 1988, Kouchner was named French minister of health and action humanitaire – the latter being a position created especially for him by the newly-elected government.

This droit d’ingérence has been gradually institutionalized internationally: it can no longer be accurately labeled just ‘French’. Kouchner likes to claim that this relates to his influence.32 He has held political office in France and has been engaged with proposing and framing the plethora of UN resolutions that have created a new framework for international law. UN General Assembly Resolution 43/131, passed in 1988, broke new ground by stating that abandoning victims without humanitarian assistance ‘constitutes a threat to life and an offense to human dignity’, and stressed the importance of ‘intergovernmental and non-governmental organizations working with strictly humanitarian motives’. While resolutions are not binding, Allen and Styan write that this was widely taken to mean that cross-border operations in war zones were now formally acceptable; and Resolution 45/100 made this support for ‘humanitarian corridors’ more explicit.33

While acknowledging that all international movements begin in specific national contexts, it is also the case that medical humanitarianism has moved beyond being simply a French tradition. There are 19 current national MSF sections, five of which are fully operational in directing independent missions. MSF is now a mobile transnational entity.34 Yet even within the French section, not all French politicians and intellectuals support the right to interfere; Rony Brauman (former president of MSF) was highly critical of Kouchner’s attempt to institute humanitarian intervention as a legal right and duty, suggesting that international jurisprudence can be used by states when they find it convenient or in their interest to interfere. Brauman pointed to the inevitable mix between military and humanitarian aims in a ‘humanitarian invasion’ (or a legal intervention supported by United Nations or national military forces to help with transportation or supplies) and suggested that mixing medical humanitarianism with military interventions runs counter to the idea of allowing NGOs access to victims, and to medical humanitarian’s purported vocation of healing. Indeed, there is evidence that relief activities reinforce war economies.35

The third element characteristic of MSF in particular and medical humanitarianism more broadly is the use of the media, which functions as a critical part of the duty to give testimony. The mediatization of missions
was considered essential to the new humanitarianism; not only did it publicize the findings of doctors as part of moral duty to bear witness, but the publicity helped to secure funding and provide a degree of immunity from governments and other political interest groups hostile to their interventions. Media publicity crossed borders and built solidarity. MSF quickly learned that official funding as well as private donations were most effectively secured when international media covered acute suffering. Kouchner had an intuitive sense of the role of media in politics, and NGOs all over the world have since followed his lead. Early on, MSF became a key source representing the 'Third World'.

The success of medical humanitarian organizations in harnessing the media and in professionalizing NGOs is problematic. Clearly, there is a fine line between bearing witness to suffering, and sensationalizing it, turning human disaster and tragedy into a spectacle that is at once distant and close. Through television, people have witnessed death, starvation, and mass violence on an unprecedented scale. This mediatization runs the risk of dehumanizing and numbing both the victims and spectators, rather than creating a sense of empathy for a common humanity. Moreover, such mediatization of suffering can be harnessed in self-interest, to push certain causes and to compete for funds, recognition and prestige. Yet, as Tom Keenan has noted, mediatization in many ways is no longer a choice: 'one cannot understand, nor have a properly political relation to, invasions and war crimes, military operations and paramilitary atrocities — both of maximal importance for human rights campaigners — in the present and the future if we do not attend to the centrality of image production and management in them'. Thus, while the French first demonstrated the good that can come of publicizing suffering, the moral dilemma of what to do with that testimony now extends far beyond France.

Perhaps the most important tension in the debate over the duty to bear witness to publicize suffering is how this affects the purported political neutrality of humanitarian NGOs. As I suggested, a belief in political neutrality is what allowed the illness clause to come into existence in France — it was perceived to be apolitical, or above politics. As Kouchner himself states: 'If you are humanitarian...this is not politics, you must be neutral, taking care of all'. Indeed, I attended the 2005 Annual International General Assembly meeting of MSF, and the question of political neutrality as related to the duty to give testimony was foregrounded: to what end does MSF bear witness? To advocate for justice, for policy changes, for an end to the impunity of certain actors? This, the representatives realized, quickly ran into the dangerous terrain of political engagement and intervention, which MSF prides itself on avoiding. It should be noted that this is in direct contrast to the 'Anglo-Saxon' or British tradition of humanitarianism exemplified by CARE or Oxfam, who choose to combine humanitarianism with development, taking a more utilitarian approach.

To solve this problem of descending into politics through witnessing, Rony Braiman advocated for the 'description' of what one witnesses as opposed to 'qualifying' it, which entails making a judgment. However, the line between these is not always so clear. For instance, a representative from MSF-Holland suggested that bearing witness to rape in the crisis in Sudan required that one also call for justice for the victims. He cautioned about the slippery-slope between political neutrality and irresponsibility. There is an ongoing debate, then, not only in France, but transnationally, about medical humanitarianism and the moral obligations it entails — a debate in which all sides are informed by French history and political traditions, but also one to which each humanitarian worker and each crisis brings its own cultural, political and historical location. As Redfield states, 'MSF responds with a defense of life that both recognizes and reframes politics. It forcefully claims an independent right to speak out and act without regard to considerations other than conscience, yet it never quite abandons neutrality in its insistence that final responsibility for alleviating suffering lies elsewhere'. The place of témoignage itself is constantly debated, and the current MSF charter does not even mention témoignage in an attempt to avoid suspicion by local authorities that missions have an element of political intent. Instead, bearing witness is framed as a choice for members, rather than a moral duty, even as the guide suggests that the organization itself feels morally bound to speak out.

The medical humanitarian NGOs have expanded in several directions since their founding. They have moved beyond emergencies to focus on longer-term projects such as MSF's 'Campaign for Access to Essential Medicines', which is a sustained effort to attend to the difficulties of poor people in obtaining medicines for conditions such as HIV/AIDS, malaria and tuberculosis. Similarly, many new medical humanitarian organizations have sprung up in Western locales with variations on the same theme: Physicians for Human Rights, Global Lawyers and Physicians for Human Rights, Physicians for Global Survival, to name but a few. These developments pose constant challenges to the conception of medical humanitarianism, adapting and re-adapting the French tradition: for instance, while the Access to Essential Medicines campaign grows out of frustration at drug shortages in MSF's work, it borders on playing an advocacy role in the realm of policy, again, something MSF has strictly refused, acknowledging that it cannot save the world by itself. The British humanitarian organizations see fewer problems with this combined approach, and their organizations tend to be more thematically than professionally organized. Thus, for instance, Oxfam is organized in opposition to poverty and hunger, which allows both emergency and long-term responses. But in the transnational arena, we see a growing convergence between these two forms of humanitarianism.

Medical humanitarian organizations have also turned their attention to situations of socio-medical need in their own and other so-called 'developed'
countries: they have brought their concerns back home, within their borders, and in ways which draw critical attention to national borders. With the effects of severe economic recessions in the late 1980s, MSF and MDM saw the need to help those excluded from systems of social security in France. In 1993 Bernard Granjon, the president of MDM-France, asked: 'Must we accept, in this rich country which is France, in the homeland of the rights of man and of the citizen, the ineluctable spiral of poverty which results in what more and more resembles professional and social apartheid?'

In France, these medical humanitarian organizations joined with other NGOs in 'Mission Solidarité France', a network of centers across France instituted to ensure that the socially excluded received free medical and social services, and further helped to reinsert the excluded into the mainstream social security system. With this same impetus to bring humanitarianism 'home', MSF and MDM began to advocate for the 'sans papiers' (undocumented), and with the help of the larger Collective for the Rights of Sick Foreigners, the illness clause was pushed through.

**Inclusions and exclusions: reviving universalism and colonialism**

Humanitarianism has been associated with a revival of universalist discourse, with the opening of borders to compassion, but also to intervention; MSF in particular was seen to offer an alternative to increasingly tired internationalist ideals - it was part of a Left with a new vision. In some senses, it offered a fresh way to express the universalist French values of liberty, equality and fraternity. MSF and the values it embodied were - perhaps paradoxically - both a way to create a new internationalism, and also a new international role for France. The founders ultimately believed that there was no better nation to incarnate the universal dynamic.

Yet, as many have shown, a universalist ideology also grounded the colonial enterprise; in other words, a system that celebrates its universalism and tolerance can also maintain structures of racial and economic exclusion. While medical humanitarianism need not be bound to the same fate, especially given its characteristic reflexivity, as Redfield suggests, 'a borderless world retains the ruins of earlier frontiers'. This imbricated history highlights the national ideological inheritance of medical humanitarianism. I examine briefly some of the tensions within the colonial civilizing mission itself and the links with colonial humanitarianism. I then turn to the inheritance of this colonial legacy both in MSF and in the MSF-inspired 'illness clause'.

Drawing on universalist rhetoric of 1789 regarding the right of all people to basic freedoms, republican ideology inspired the French to take measures to liberate Africans from indigenous forms of oppression they believed to exist, which included not only forms of African slavery and 'feudalism', but also disease. French colonial regimes operated on the principle that the colonized had the potential not only to be emancipated, but to be assimilated as citizens of the Republic: everyone had the potential to be equal, and to be free. The goal was to make people citizens when they were ready - when they were 'evolved' enough.

Yet as early as the 1790s, principles of universal inclusion were combined with practices of racial exclusion. It was the universalist ideal of the unity and fundamental equality of all humankind and its uniform capacity for civilization that provided the justification for colonial violence and oppression: in the name of equality, imperial forces constructed knowledge of non-Western cultures as inferior, in need of intervention and civilizing. Colonial subjects were seen to be unready and immature, but the 'generosity' of the French persisted in civilizing those 'évolués' - those who were evolved. Assimilation depended on a gradual process of transformation through education, from tradition to modernity. So, universal citizenship - while held up as goal and ideal - was for the most part deferred.

As Dubois notes, the idea that people were not ready for citizenship is one that was at the heart of the contradictory regimes of French emancipation, particularly in the French Caribbean in 1794 and 1848. Victor Hugues, for example, who abolished slavery in Guadeloupe in 1794, and later oversaw the re-establishment of slavery in Guyana in 1802, argued that the continued subjugation of the newly emancipated slaves could be justified by the fact that equality was not absolute, and that citizens had to be treated differently according to their moral and intellectual capacities. To learn how to be free, they had to be forced to work. As Dubois writes: 'Only then could the moral stain of generations of slavery be removed; only then could the ex-slaves become citizens'. Dubois calls this deferral of the application of universal ideas 'Republican racism', and suggests, rightly so, that this continues to haunt contemporary discussions around immigration in France.

Humanitarianism inherits the ideological underpinnings of republican racism, as I will discuss, in that those being saved must defer their political status in order to remain apolitical suffering bodies. It also inherits the contradictions of colonial humanitarianism. Humanitarianism itself expanded with colonial settlements, and there was a cadre of 'colonial humanitarians' who specifically worked to foreground the requirements of justice and morality, placing them on a par with the motives of interest. Importantly, Lester argues that colonial humanitarianism was not simply a legitimating screen for imperialism. It was formulated explicitly to challenge colonial military discourses and settler practices through a new global ethics - one which did not work to colonize land, but to 'colonise the mind. To bring down, as it were, the ideas and principles of Heaven... and to deposit them in understandings and hearts of the inhabitants; and thus to elevate and to save them'. Interestingly, Lester also notes in the British context that the
concern for distant strangers and pursuit of collective moral action served as a form of national pride — not unlike the way humanitarianism works today, intervening to clean up the mess of military intervention, while simultaneously affording a feeling of moral superiority.\(^{53}\)

In addition to the practices of ‘Republican racism’ and colonial humanitarianism, MSF’s genealogy includes a long line of colonial endeavors related to health, especially missionary activities. Albert Schweitzer’s hospital in Lambarene figured centrally in colonial claims to a civilizing mission. Similarly, MSF inherits the special place occupied by Africa in both the French civilizing mission, and the representation of disease in empire. As Redfield points out, in 2002–2003 MSF spent over half its funds in Africa, keeping it the center of humanitarian activity.\(^{54}\) A colonially-derived racial hierarchy inadvertently underlies their missions, where the doctor is still predominantly a White male, and often a European expatriate. In the name of the protection of human dignity, he speaks for and represents non-White, non-European victims. There is, then, a colonial legacy in humanitarianism generally and for MSF specifically, which recalls the exclusions and contradictions of universalism.

The humanitarian-inspired illness clause in current French law brings with it some of the same contradictions and blindspots of universalism. While we might have imagined that a concept of humanity based on the universality of biological life would bring us closer to equality, closer to a borderless world that overlooks all divisive political identities and affiliations, in fact, it encourages a limited and limiting version of who can travel across borders. Indeed, this universalism has resulted in a structural situation that favors sick and suffering bodies above all others.

In order to illustrate the limitations and colonial legacy of humanitarianism as exemplified in the illness clause, I turn to an insightful piece by medical doctor and anthropologist Didier Fassin about the social condition of HIV+ immigrants in France.\(^{55}\) Fassin describes the case of a Nigerian man who initially found out he was HIV+ in his quest for legal documents in Germany. Unlike some other aspiring immigrants, this man neither infected himself nor deliberately configured his illness to get papers. Rather, the discovery of his positive status came as a result of the AIDS test in Germany, mandatory for his application for papers. He fled to France, and as Fassin astutely points out, his first experience of France was as an undocumented immigrant, with no home, not a sick person with HIV. He moved to France for papers, not for medical treatment. In other words, he experienced his positive status as a political condition in the sense that it expelled him from Germany. His condition was at once political, social and biological, but he understood it primarily through a political and social lens. After 4 years, however, this man did fall seriously ill. He was forced to undergo a surgical procedure, and after several months and many visits to social workers and associations, he was granted papers for ‘humanitarian reasons’, on the basis of the illness clause. Gradually, illness became the driving force of his life. It gave him legal papers, an apartment, and a minimum financial allocation, which he would not have otherwise had.\(^{56}\) His biological condition determined his social condition — that is, insofar as he proved he was suffering and life-threateningly sick, he was granted social and legal status in France. Of course, because the illness clause is dependent on life-threatening conditions, it is in fact his physical life that he trades in for social recognition — the prospect of his death is what ensures his social life.

Fassin argues that AIDS is thus a social condition in France. While in most countries, HIV/AIDS is a dangerous secret that immigrants must keep from the state at all costs, in France, HIV/AIDS can act as the primary relationship between the immigrant and the state, actually bestowing legitimacy. However, in this realm where biological life is regarded as primary, and a politics of humanitarianism and benevolence come into play, special assistance or entitlement rights serve to segregate rather than to integrate. This politics of humanitarianism requires that people remain ill, that they remain exceptional. The renewal of papers is dependent upon their continued identity as victims. Thus, if granted a 1-year residency permit, one must renew this five times before being granted a 10-year residency permit, and only then is one eligible to apply for citizenship. During this time, one must inhabit the subject position of dependency. Indeed, entitlement rights, of which the illness clause is one example, mark subjects within structures of economic stratification and cultural or ideological valuation. Their distinguishing characteristic is dependence. As the history of poor relief or the establishment of public orphanages might imply, one need not have the right to vote to receive some form of public support, and vice versa: public assistance does not necessarily open the way to political rights or citizenship.\(^{37}\) Subjects dependent on public provision for basic needs are marked as a particular type of subject, not quite equal, not quite able to take care of themselves.

This relation of dependence takes on added significance as it maintains power dynamics deriving from the colonial era: the majority of sans papiers in France come from former French colonies. In a neo-colonial relation, one is able only to be assisted or rescued, and — crucially important — this status is exceptional: one is by definition not considered ‘normal’. In this sense, the sans papiers who receive papers through the illness clause are reproduced as physically vulnerable. They are maintained as a special and extraordinary category of subjects.

Here, we can see how medical humanitarianism in the form of the illness clause works to create subjects who will never be equal; they, like the subjects of colonial regimes, are only recognized through their lack. Just as colonial subjects could never become civilized enough, the subjects of humanitarianism forever miss the jump to full citizenship. To maintain
their status as recognized subjects, they must remain either sick, suffering, or displaced - they must remain subjects of benevolence, not of full rights.

Humanitarianism and the 'anthropological minimum'

Is humanitarianism inherently flawed in its ethical goals? Uday Mehta helps to explain how these limitations might derive from the exclusions built into the notion of universalism, as embodied by liberalism, and in particular, liberal imperialism. He suggests that the base standard of universal human nature described by Locke, what he calls 'the anthropological minimum' - that humans are equal, free and rational from birth - is in fact too minimal, and too devoid of context to be substantiated. In other words, it ignores the specific cultural and psychological conditions woven in as preconditions for the actualization of these capacities. It assumes certain characteristics are common to all human beings, with which they are born - it does not leave room for their development. It takes human beings out of all sociological or historical context, again in order to fix a universal set of characteristics about human nature. This anthropological minimum therefore allows for strategies of exclusion based on implicit divisions and exclusions in the social world. If one does not exhibit the expected characteristics of human nature - for instance, if one behaves in a way that is differently rational, and hence unrecognizable in liberalism's terms - liberal universalism locates this outside of the anthropological minimum, and hence, outside the category human. For example, Mehta explains how, in the British Empire, Indians were treated as inferior, and therefore governed without freedom, because their purported 'inscrutability' led to the belief that they were like children, lacking in appropriate rationality. Without rationality, according to the British interpretation of the anthropological minimum, one could not be counted as fully equal, or, for that matter, fully human. In other words, because Locke neglected to qualify the context of his concept of universal human nature, exclusions based on the different qualifications of 'human nature' were justified.

Humanitarianism protects a similar universal, but minimal and acontexual vision of life, in this case, defined by the capacity to suffer. As such, it also allows for the differential and unequal treatment of people who are not recognized within this minimum, historically contingent standard. If undocumented immigrants - or refugees or victims of war, for that matter - have their lives saved by humanitarian action, it is not clear what notion of life this entails. Does the life saved come with cultural attributes, political inclinations, linguistic skills, skin color? This is not made clear. These attributes, these qualifications, belong to the political realm. They are not part of the humanitarian mission, which responds to suffering in its most rudimentary and often biological forms, such as hunger and disease. As Redfield suggests, 'humanitarian action can preserve existence while defer-

ring the very dignity or redemption is seeks'. Indeed, by responding only to emergencies, limiting action to a temporal frame of the present and therefore deferring political solutions, humanitarianism can only defend a minimal existence. And, when different forms of suffering are not recognized by the conceptual framework employed by humanitarian workers, they are not responded to: that suffering is placed outside the minimal conditions requiring response, as in the case of Mehta's liberal universalism. Such people are thus similarly located outside the definition of human. In this form of minimalism, too, there is room for exclusions and hierarchies. Thus, the universalism of humanitarianism only works for a very basic notion of humanity; the rest is qualified and protected or stopped from crossing borders by the political context in which each person is found - which in our contemporary world, remains the nation-state.

Conclusion

Medical humanitarian organizations have largely reconfigured how we understand borders - crossing them in the name of a transnational moral imperative - and such organizations also help individuals to survive if and once they cross borders. However, these individuals can only cross - and remain on new territory - as specific types of limited subjects: in refugee camps, and in France, for instance, as sick or suffering bodies. This said, let me be clear: to blame humanitarianism for not solving the world's political problems and creating a just world is not my goal. Humanitarianism does not act with longer-term political consequences in mind. In fact, it avoids precisely this, in the name of immediate, urgent and temporary care, and in the name of political neutrality. Its constituents are clear that it will not - and should not - save the world. My goal, rather, has been to explore the ways that medical humanitarianism embodies a universalist ethic that enables border crossings, that enacts a notion of (apparent) equality. Insofar as medical humanitarian organizations ground their action on the desire to relieve suffering, and do not qualify this notion further, they allow for differential protection, and for inequality to flourish; in this sense, humanitarianism inherits, and remains limited by the paradoxes of French universalism on which it is founded. What travels across borders is a basic understanding of what suffering entails - defined differently in each context - while the human, qualified beyond suffering by its political, social, cultural, economic and religious dimensions - remains suspended at the border.

Notes

1 The law states, 'une carte de séjour temporaire est délivrée de plein droit à l'étranger résidant habituellement en France dont l'état de santé nécessite une prise en charge médicale dont le défaut pourrait entraîner pour lui des conséquences d'une exceptionnelle gravité, sous réserve qu'il ne puisse effectivement
bénéficiar d’un traitement approprié dans le pays dont il est originaire’. Or, ‘a temporary residency permit is granted to the resident foreigner in France whose state of health requires medical treatment in the absence of which there would be consequences of extreme gravity; this is subject to the foreigner’s inability to obtain appropriate treatment in his/her country of origin’ (author’s translation).

2 MSF and MDM joined with other NGOs to form the ‘Collective for the Rights of Sick Foreigners in France’ which was comprised of 35 associations or NGOs including associations for sick people, doctors’ organizations, trade unions and associations for immigrant rights.

3 I refer here to the humanitarianism that began with Médecins Sans Frontières in the early 1970s.


10 Ticktin, ‘Between Ethics and Politics’.


13 As Didier Fassin suggests, discussing immigration in France, ‘the legitimacy of the suffering body proposed in the name of a common humanity is opposed to the illegitimacy of the racialized body, promulgated in the name of insurmountable difference’. Fassin, ‘The biopolitics of otherness’, 4.

14 This is a term I will discuss later in the essay, but it should be noted it is highly contested what this neutrality involves, and the ICRC model of neutrality is different from that of MSF.


a heroic achievement at the time, later it was recognized as ‘an act of unfortunate and profound folly’ in that it prolonged the war for a year and a half and contributed to the deaths of 180,000 people’ (I. Smillie, The Arms Bazaar (London: IT Publications, 1995); c.f. Allen and Styan, ‘A Right to Interferes’.


20 By the word Internationalism, I intend to denote that MSF is structured as a federation of national sections, a product of the organization’s history, rather than a truly transnational organization.


22 See Fox, ‘Medical Humanitarianism and Human Rights’.


24 Renée Fox writes that the United States branch of MSF pays more attention to cooperation with indigenous medical organizations and to learning about the history and cultural background of the places in which they intervene; the French branch (and the headquarters) have been less inclined to learn about cultural differences because they work with a notion of universality that they believe rises above cultural particularities (Fox, ‘Medical Humanitarianism and Human Rights’).


29 This debate is ongoing: I attended the annual 2005 international MSF General Assembly meeting in Paris, and again, this question was raised and discussed.


31 Allen and Styan, ‘A Right to Interferes’.

32 In an interview in 1999, Kouchner referred to the General Assembly Resolutions 43/131 and 45/100 and stated that ‘I was not only influential. I was writing it. They were my people, coming from my cabinet and myself’. Quoted in Ibid., 835.

33 Ibid.

34 For more on MSF’s current status as a transnational entity, see Redfield, ‘Doctors, Borders, and Life in Crisis’.


37 Fox, 'Medical Humanitarianism and Human Rights'.
39 For a particularly insightful discussion of the role of media in producing suffering as a distant spectacle upon which one feels no compunction to act, see L. Boltanski Distant Suffering: Morality, Media and Politics (Cambridge: Cambridge University Press, 1999).
40 Interview with Tim Allen, April 1999, c.f. Allen and Styan, 'A Right to Interfere'.
41 See K. Blonect and B. Martin (eds) Critique de la raison humanitaire (Paris: Le caverlier bleu, 2005) and in particular, the essay by Egbert Sondorp, comparing the different ethical approaches taken by French and Anglo-Saxon humanitarian organizations.
42 Redfield, 'Doctors, Borders, and Life in Crisis', 343.
44 For an interesting juxtaposition of French and British humanitarian traditions, see R. Braunman 'Preface' in Blanchet and Martin (eds) Critique de la raison humanitaire.
45 B. Granjon, 'Mission France existe encore' (Editorial), Les Nouvelles, 32(2) (1993); c.f. Fox, 'Medical Humanitarianism and Human Rights', 1614.
47 Redfield, 'Doctors, Borders, and Life in Crisis', 337.
48 For a discussion of how an instrumentalist approach to understanding French imperialism – one that assumes civilizing the natives was a cover for base motives of greed and power – does not take seriously enough the civilizing language which justified intervention, and the truly universal ideals on which it was based, see A. Conklin 'Colonialism and Human Rights, A Contradiction in Terms? The Case of France and West Africa, 1895–1914', American Historical Review, 103 (1998): 419–42.
49 Of course, most subjects could never be quite civilized enough – Fanny Colonna demonstrates the tension at the heart of French imperial project that kept colonial subjects at an 'appropriate' distance – the best subjects were not too distant from French cultural norms, yet nor were they too familiar with them. See F. Colonna, 'Educating Conformity in French Colonial Algeria' in F. Cooper and A. Stoler (eds) Tensions of Empire (Berkeley: University of California Press, 1997).
52 Ellis, quoted from Elbourne 1991 'To Colonize the Mind': Evangelical Missionaries in Britain and the Eastern Cape, 1790–1837, DPhil Dissertation, Oxford University, p. 311. c.f. Lester, 'Obtaining the due observance of justice'. See also Conklin, 'Colonialism and Human Rights'.
53 For a discussion of how humanitarian and peace-keeping missions feed into nationalist projects, see S. Razack's Dark Threats and White Knights: The Somalia Affair, Peacekeeping and the New Imperialism (Toronto: University of Toronto Press, 2004).
54 Redfield, 'Doctors, Borders, and Life in Crisis', 350.
55 Fassin, 'Une double peine'.
56 Ibid.
59 Redfield, 'Doctors, Borders, and Life in Crisis', 346.