

# Doctors, Borders, and Life in Crisis

**Peter Redfield**

*University of North Carolina at Chapel Hill*

Our action is to help people in situations of crisis. And ours is not a contented action. Bringing medical aid to people in distress is an attempt to defend them against what is aggressive to them as human beings. Humanitarian action is more than simple generosity, simple charity. It aims to build spaces of normalcy in the midst of what is profoundly abnormal. More than offering material assistance, we aim to enable individuals to regain their rights and dignity as human beings . . . . Our action and our voice is an act of indignation, a refusal to accept an active or passive assault on the other.

—The 1999 Nobel Peace Prize acceptance speech, Dr James Orbinski, President of the Médecins sans frontières International Council<sup>1</sup>

On a beautiful fall morning in New York City, the light is clear and bright as it filters through the buildings and into Central Park. A small group of people mill about before a temporary enclosure, white shirts emblazoned with a bright red insignia. Throughout the day, they shepherd a growing stream of visitors through a circle of structures representing a simulated refugee camp: tents and prefabricated huts, a mobile clinic, and a mock latrine. A year prior to when New York itself would experience the immediacy of disaster, the image of a displaced, panicked population in this setting seems absurdly remote. Two young men join the same group that I do. Their appearance and behavior exude an air of cool indifference. However, a simple concrete block, molded to include the impressions of two feet and a hole for a wooden pole captures their attention. The purpose of this artifact begins to dawn on one of them even before our guide launches into describing the dynamics of a temporary pit latrine. “No way,” the young man says loudly, staring at it in incredulity. Absorbing the rawness of physical need that it reflects, he then steps backwards, one hand raised in emphatic rejection: “No way!”

The politics of life grows particularly acute from the perspective of “crisis,” a perceived state of rupture that invites response. Médecins sans frontières (MSF) or

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Doctors Without Borders is an organization explicitly founded to mediate crisis in terms of basic human health. With the intermittent rhythm imposed by academic labor, I have followed MSF, for the last several years, as an object of ethnographic study in the largest methodological sense of that term. In addition to interviewing present and former members of the group and visiting several of its section headquarters and field missions, I have also examined its material culture and sifted through the vast array of documents that circulate through and beyond its different forums of representation.<sup>2</sup> The refugee camp exhibit from October 2000 was my first direct encounter with MSF in its public advocacy mode. Here, I return to that event to introduce a discussion of MSF's global form of medical humanitarianism and the conditions of life in crisis to which it responds. For the reply to the youth's exclamation is, of course, graphically materialized in the camp exhibit as an "oh yes, indeed." Under certain circumstances, people's lives may indeed shrink to the immediacy of survival, shedding even the everyday trappings of customary dignity. Not only did the last century see the emergence of regimes committed to the physical destruction of populations but also of entities devoted to monitoring and assisting populations in maintaining their physical existence, even while protesting the necessity of such an action and the failure of anyone to do much more than this bare minimum. Within such contexts, the political dynamic emerging from situations of life and death contracts into an attenuated form focused on survival—a minimalist biopolitics. The rhetorical power of this possibility finds its most elementary expression in a model pit latrine, a small artifact of the larger and discomfiting threat of impersonal necessity.

My goals in this article are threefold. The first is to suggest that rupture is more central to modern order than we frequently choose to remember. The essential ethical tension of the present, in other words, derives less from exceptional failures of normative moral codes of conduct (such as the Hippocratic oath or the American Anthropological Association's code of ethics), than from the obvious systemic violation of such codes in settings where good professional behavior provides little absolution.<sup>3</sup> My second goal is to imply that the sort of medical action pursued by MSF reveals ethical complications within this field of global crisis, including dilemmas of place and capacity in the aftermath of European empire, as well as the political limits of a medical sensibility. A humanitarian response to human suffering, after all, cannot escape either the historical context of conditions to which it responds or its own categorical rejection of any justification for the sacrifice of human lives. My third goal, following the work of Michel Foucault and Giorgio Agamben, as well as related recent writing in anthropology on the topic of "biopolitics," is to underline key intersections connecting the political concern for life exemplified by MSF, its historic operating space in the shadow of disaster, and its self-proclaimed "ethic of engaged refusal." MSF defines itself around a concern for life in crisis on a global scale, in which survival in perceived settings of social rupture or political failure is put in question. Yet the group's action is not simply an analog to that of a state agency insofar as it avoids wider

governance and its inherent mobility produces only partial and limited effects of sovereignty and citizenship.

My basic argument has two parts. The first is to claim that MSF's activities around the globe collectively register a minimal line of biopolitics in world affairs, one connected less to the active presence of state actors than to their perceived failure.<sup>4</sup> Such a biopolitics extends norms of power in an effort to effect the government of health, but without any certainty of control as responsibility for rule is ever deferred by humanitarian organizations such as MSF to absent political authority. The second part of my argument explores the distinction between *zoë* (a state of being, common to all animals) and *bios* (elaborated human experience) that Agamben makes by resurrecting a moment of Greek etymology originally noted by Hannah Arendt. I use these terms to identify an inherent tension within the value of "life" that humanitarians seek to defend, between the maintenance of physical existence, on the one hand, and the defense of human dignity, on the other hand. I suggest that the significance of a survival state like *zoë* rests less in any facts of biological nature per se than it does in its threat to *bios* by demarcating a lower threshold possibility of "life." Amid worldwide zones of repeated disaster, medical humanitarian action offers the promise of preserving existence. It does so, however, at the possible expense of deferring actions that might support a mode of being more consistent with dignity. The potential stabilization of crisis in these terms, I suggest, reveals an essential ethical quandary in the haunting possibility of a form of distinction enacted within life itself that simultaneously includes and excludes different human populations at the species level.

The ambition of this work is not simply to produce a general critique of humanitarian action or an elaboration of its political limitations. Although there is certainly much to be said on that score from academic, humanitarian, and journalistic perspectives (e.g., Brauman 1996; de Waal 1997; Hancock 1989; Malkki 1996; Pandolfi 2000; Rieff 2002), the rhetorical force of critique stems from a promise to unveil and denounce untruths and violations. As such, it structurally evades the less comfortable possibilities of implication within the process in question and the problem of approaching what is already represented or already familiar (Latour 2004; Riles 2000). Along with much recent anthropological writing on topics like torture and human rights (e.g., Asad 2003; Wilson 1997), I wish to move away from treating humanitarianism as an absolute value by approaching it as an array of particular embodied, situated practices emanating from the humanitarian desire to alleviate the suffering of others. In so doing, I hope to reintroduce a measure of anthropological distance to a familiar set of contemporary phenomena, while simultaneously accepting the premise that action occurs in an untidy, thoroughly implicating, "second best world" (Terry 2002).

### Doctors Yes, Borders No

Médecins sans frontières provides aid to people in need, to victims of natural and man-made disasters, wars and civil wars, irrespective of race, religion, ideology or politics.

Médecins sans frontières observes strict neutrality and is completely independent. Based on universally recognized principles of medical ethics and the right to humanitarian aid, Médecins sans frontières demands complete freedom in the performance of its task.

The members, volunteers and staff of Médecins sans frontières observe the medical code of conduct and maintain complete freedom from any political, religious or economic power.

The members, volunteers and staff of Médecins sans frontières decide for themselves whether the risks and dangers of the work are acceptable and do not demand any compensation whatsoever for themselves or claimants aside from what the organization can give them.—charter of MSF

In 1971, distressed by ineffectual and morally compromised relief work in response to the Nigerian civil war and a devastating flood in the emerging nation of Bangladesh, a small group of French physicians in concert with journalists from a medical publication established a new humanitarian organization. Naming it Médecins sans frontières, they hoped to circumvent national bureaucracies and short-circuit international politics by providing rapid medical intervention in the face of crisis. Some of them also sought to establish an independent voice to condemn human suffering that would not avoid the media or mute itself in the face of controversy (unlike the International Committee of the Red Cross [ICRC], for which several of them had worked).<sup>5</sup> Three decades later, the movement has grown into an international assembly of 19 national sections, and it has become a transnational fixture not only in emergency relief efforts but also in a much wider array of global health concerns. It has also served as a prototype for nongovernmental organizations (NGOs) that adopt a borderless sense of space and an ethos of direct intervention and media involvement. Alongside Doctors, the world has gained Reporters, Pharmacists, Engineers, Animals, Sociologists, and even Clowns sans frontières. In 1999, MSF was awarded the Nobel Peace Prize, an honor read by many as a significant affirmation of their work. Since then, the organization has continued to extend its mission, taking up new challenges such as the administration of AIDS therapy and advocating for the provision of essential medicines on a global scale, while maintaining a commitment to independence and outspokenness.

The establishment of MSF followed the events of May 1968 in France; it also reflected the development of emergency medicine out of a military specialty, decolonization, improved systems of air transport, and the emergence of global media (Brauman 2000:60; Ross 2002; Tanguy 1999; Vallaey 2004). MSF also belongs to a lineage that includes not only the Red Cross but also a long line of colonial endeavors related to health and the activities of missionary societies. From the start, Africa would play a particularly important role in the formation of MSF. Not only had Africa been the focus of significant representation of disease within empire (Lyons 1992; Vaughn 1991), but it was also the home of a central icon of colonial claims to a civilizing mission, namely Albert Schweitzer's hospital in Lambarene. Although that project may have lost its allure for a new generation in the 1960s (Fernandez 1964), more ambitious and spatially dispersed versions of a humanitarian ideal soon emerged in the European imagination.<sup>6</sup>

Indeed, the MSF movement can be understood as an evolutionary transformation of generational experience. In a spirit of self-mockery, an article in *Dazibao*, the internal broadside of MSF–France, suggested that the real charter of the movement has dramatically shifted over time (MSF 2001a): In 1970, an original “community of friends” offered “love to Third World populations” along with residual Maoist principles and hallucinogenic substances. By 1980, “mercenaries” of a private organization offered food aid to “Ethiopians, Afghans, and other victims of the Moscow Olympics boycott.”<sup>7</sup> In 1990, a “profitable multinational company quoted on the unlisted securities market” offered assistance to populations victimized by disasters and was so overwhelmed as to “no longer know where help is needed most.” By 2000, the e-charter of MSF.com championed both the 35-hour work week and the right to “full and free on-line access for anti-retroviral drugs.” (2001a:2). Beneath this tongue-in-cheek representation lies the recognition, troubling to more than a few within the organization, that MSF has moved from being an oppositional and marginal presence to become an established institution, now entering middle age.

Generational tensions are quite explicit at the level of human resources. The young, single, “unshaven, cigarette-smoking French man,” to quote a female volunteer’s description of the stereotype, is no longer the organization’s given norm. Efforts to improve and formalize working conditions for both expatriate and local staff, as well to broaden the range of backgrounds from which international staff is drawn, have raised difficult issues for the organization. Concerns that were unthinkable in the 1970s, such as retirement benefits or the desire of dual-career couples and those with children to find appropriate placement, now affect the recruitment and retention of experienced personnel, many of whom leave for personal or financial reasons as they grow older. Also, as the group seeks to “decolonize” the makeup of its membership, a pay scale designed to provide a modest, temporary stipend for Western European personnel translates into a profitable salary in other economic contexts, a potential threat to MSF’s volunteer ethos. Indeed, a common apprehension of older MSF veterans is that the work might become “just a job” for their successors, rather than a passionate, moral endeavor. At the same time, they worry that they may never be able to pursue a more regular life beyond the organization.

An additional generational burden derives from relative organizational success, and the accompanying threat of inertia. Over the past two decades, MSF has developed considerable technical capacity, lending credence to its claim to be able to commence field operations almost anywhere in the world within 48 hours. MSF has pioneered emergency health care to populations in distress. As one public health officer noted with some pride, “we literally wrote the book on refugee health care.” At the same time, the ever shifting configuration of its membership and leadership, coupled with an ever expanding horizon of perceived needs, fosters continual reinvention. MSF has developed a number of significant semi-autonomous offshoots, such as multiple logistics supply services with standing

depots of materials and an epidemiological wing known as Epicentre. It has also established a range of operational programs to deal with issues as varied as street children, mental health, and the trauma of sexual violence. Likewise, the group has sought new forums for advocacy, such as the model refugee camp described above and the Campaign for Access to Essential Medicines (partly funded by its Nobel Prize) in an effort to address structural inequities in the global pharmaceutical supply.<sup>8</sup>

Thus MSF's history can be tracked through the evolving forms and contexts of its interventions. The early period focused solely on emergency response, beginning with the Nicaraguan earthquake of 1972 and then in war theaters in Vietnam and Lebanon. Missions at this time were haphazard in organization, largely symbolic in impact, full of romantic panache, and entirely temporary in duration. Following a schism that produced the sibling group Médecins du monde (MDM; Doctors of the World) in 1979, the movement grew better organized and became more efficient and professional in response to both criticism and growing experience with crisis situations. It also began to maintain an ongoing presence in troubled parts of the world, addressing specific diseases and more chronic conditions. In the 1990s, amid the breakdown of Cold War alliances and a rapidly expanding universe of NGOs, MSF grew alongside civil wars, the displacement of people, and renewed media attention to ethnic conflict and epidemic diseases, HIV/AIDS in particular. It also weathered a series of bitter humanitarian catastrophes in Somalia, the Balkans, and Rwanda, while its presence in settings like Afghanistan, Congo, Sudan, Thailand, or Uganda began to be measured in decades rather than years.<sup>9</sup> Issues of security for its members and the cynical manipulation of humanitarian aid by local irregular militias and powerful nation states became increasing topics of concern. "They know too much; they know our weakness," a veteran member of MSF-France lamented to me in Uganda, observing that would-be manipulators learn quickly and also benefit from global media.

Nonetheless, some aspects of MSF have remained relatively constant. At its core, the movement operates under a self-ascribed authority derived solely from its own charter. On the one hand, MSF embodies the moral insistence of a human right to health and the dignity of life that goes with it. On the other hand, MSF represents a technical apparatus designed to implement basic health care quickly over great distances and under extreme conditions. The most valued, sometimes contradictory, actions are thus both *témoignage* (witnessing or advocacy) and effective treatment. The different sections balance their collective undertaking unevenly and coordinate their actions imperfectly, amid considerable discussion, reflection, denunciation, and occasional self-recrimination. However, as Renée Fox (1995:1609) notes, the collective ethos—however transnational and variable it has become—still retains traces of a French inflection of *engagement*: action full of immediacy and speech. The self-representation of the organization suggests what she terms a "nonideological ideology" based on the Rights of Man, but directed against both abstract idealism and the state. This anti-utopian utopianism—a realist geopolitical

perspective combined with a categorical moral conscience about suffering—implies a close link between reason, affect, politics, and techniques. If MSF perceives a significant crisis in terms of health care in any setting, be it an emergency, such as a cholera outbreak among displaced people, or a policy issue, such as ineffective national malaria protocols, it responds with whatever combination of passionate speech and instrumental action it deems appropriate and can muster. Significantly, this response almost never claims to represent a comprehensive solution or to conform to conventional utilitarian rationales of public health. The majority of its operational programs justify themselves through moral legitimacy rather than through cost-effectiveness. By demonstrating what is possible, the MSF doctrine suggests, a technically efficient project can highlight the failures of political will behind inadequate health care and remove the excuse that “it can’t be done.” At the same time, members of MSF rarely suggest that their work will directly build a better social order or achieve a state of justice. The goal is to agitate, disrupt, and encourage others to alter the world by practicing humanitarian medicine “one person at a time” (MSF 2003b:8).

Finally, there are two important sociological points to emphasize about this particular humanitarian body. The first is that MSF is no longer French or simply a collectivity of doctors. Rather, it has grown into a federated movement of loosely connected, argumentative national groups, coordinating the efforts of a circulating international assembly of personnel. Of the 19 current national sections, five are fully “operational” in directing independent missions, whereas the rest largely assist with the provision of personnel and material support for the central European office with which they are affiliated.<sup>10</sup> With some 2,000 volunteer physicians, surgeons, nurses, logistics experts, and engineers, as well as 15,000 locally hired staff spread over more than 80 countries, MSF is now a highly dispersed and mobile transnational entity. Beyond doctors and support personnel, it provides aid through an assortment of nonhuman equipment: Land Cruisers, preassembled kits to control an outbreak of cholera, satellite uplinks, and generator-driven refrigerators that can deliver vaccines to any corner of the world.

A second significant social fact is that MSF not only maintains its independence as an ideal value but it also has worked over the past decade to achieve a greater measure of it in economic terms. Unlike many NGOs—both local and transnational—that rely heavily on large appropriations from a donor system of states and major foundations, MSF has dramatically expanded its fundraising base. In 2001–02, it received over 80 percent of its collective funds from private sources, largely composed of small-scale donations by individuals. Although this relative financial independence has not been uniformly realized by all sections and although it requires a continuous demand for fundraising and nonprofit marketing, MSF is in a position to operate with fewer restrictions from institutional donors. It has, in fact, grown comparatively wealthy, with a total income of more than 360 million euros.<sup>11</sup> Although its revenues are insignificant relative to those of a major state or corporation or an international body like the UN, they nonetheless permit a degree

of economic possibility unknown to smaller nonprofit organizations. Whereas an earlier generation of MSF missions skimmed and scraped, operational concerns now focus less on the availability of funds and more on logistics to address perceived needs and expanding concerns for security. In 2002, a lead administrator in Uganda noted: “Now we work for logistics and objectives first and think about money afterwards. Before we thought about budget and logistics and came up with objectives in the field. [Now] we can think what we want to do for a population, and then do it.” Although perhaps minimizing the complications of practice, this comment recognizes the core challenge at present: that of administering MSF’s very real capacity. For instance, when key elements of the organization decided with the advent of antiretroviral therapy to engage more directly with AIDS (a reversal of the organization’s earlier reluctance), they could directly establish, fund, and staff programs in poorer countries worldwide without having to wait for funds or donor authorization.<sup>12</sup>

Here, I will simplify the complicated material and rhetorical assemblage of MSF into an enacted statement in response to crisis, loosely characterized as “doctors yes, borders no.” This statement distorts even as it reveals: Nurses and logistics experts play at least as large a role as doctors in MSF’s actual operations, and the movement redefines national borders more than it simply eliminates them (the original name in French was intended to imply liberation from, not eradication of, boundaries).<sup>13</sup> However, the claim “doctors yes, borders no” also reflects a motivation frequently acknowledged by MSF volunteers: the opportunity to experience the essence of a medical career, “to feel like a real doctor” by providing basic health care in response to a clear need irrespective of political or social considerations.<sup>14</sup> Emergency missions—particularly in destitute Third World settings—define MSF’s collective image, even though emergencies constitute only part of its current practice. To understand the ethical dilemmas that this statement “doctors yes, borders no” implies, we must consider the question of what might constitute a crisis in the first place.

### **What is a Crisis? Moment and Capacity**

The English word *crisis* descends from the Greek root for discrimination or decision, designating a turning point, a moment of decisive change, or a condition of instability (OED). As Randolph Starn (1971) has noted, Greek physicians had an interesting extension of the word. “‘The crisis,’ according to the Hippocratic treatise *On Affections*, ‘occurs in diseases whenever the diseases increase in intensity or go away or change into another disease or end altogether’” (1971:4). Starn suggests that this clinical measure of observed transformation in condition was adopted by Thucydides as a model for historical explanation, whereby facts could be organized into patterns of development. In such a narration of time, “crisis situations became moments of truth where the significance of men and events was brought to light” (Starn 1971:4).<sup>15</sup>

In this regard, I apply the term *crisis* to a general sense of rupture that demands a decisive response, as most dramatically exemplified by the convergence of media coverage around episodes of conflict and disaster. War, famine, and calamities such as earthquakes (once ascribed to “acts of god” but now designated as “natural”) are thereby given narrative turning points, organizing the prose of everyday existence into more poetic, if only partly analytic, chapters. These moments fill the contemporary international media landscape, equipped with soundtracks and titles, and the size, length, and duration of these moments as media events reflect their relative rank within an order of official valuation.

For example, after receiving the Nobel Peace Prize, MSF–USA published the second edition of a bright red poster: “The Ten Most Underreported Humanitarian Crises of 1999 . . .” read the heading, followed by an admonition at the bottom: “. . . Must Not Be Neglected in The Year 2000.”<sup>16</sup> Between these lines, the organization listed ten current issues of human suffering ranging from (1) the “Forgotten War in Congo Republic” to (4) “Millions Die from Lack of Medicines” to (10) “Civilians Face the World’s Neglect in Somalia.” In its digital ranking of perceived need, the poster encapsulates MSF’s self-ascribed task of witnessing states of crisis across borders. Here is a barometer of global distress: a catalog of painful ruptures that deserve crisis status and yet remain “underreported” and insufficiently recognized by the media or a wider public. The list implies an ethical response: recognition followed by action.

For MSF, ethics are clearest in relation to crisis. In the breakdown of political failure, they locate the burden of civic responsibility that they hope to meet. To quote again from the Nobel Prize acceptance speech: “Humanitarianism is not a tool to end war or to create peace. It is a citizens’ response to political failure. It is an immediate, short term act that cannot erase the long-term necessity of political responsibility.” Their ethical position centers around an “ethic of refusal” that resists the cleansing of moral failure on any part. “For MSF, this is the humanitarian act: to seek to relieve suffering, to seek to restore autonomy, to witness the truth of injustice, and to insist on political responsibility” (MSF 1999c). The statement “doctors yes, borders no” is, therefore, a response that is deeply reactionary in the technical sense of a physician confronting a clinical patient: disorder presents symptoms, diagnosis prescribes treatment.

However, MSF must factor two additional component dilemmas into its ethical calculus: the issue of geographical location, on the one hand, and that of capacity, on the other. MSF framed itself in reaction to failings of the state-structured Red Cross, but in practice it evokes general contradictions of postcolonial expatriate life. To work “without” borders confronts the basic territorial logic of the nation-state; however, it also recalls the legacy of imperial expansion. Relations of identity and place cut two ways, depending on position and history amid empire. Eight of the ten sites listed on the poster bear the names of former colonies and colonial borderlands of the European imperial era (Congo Republic, Afghanistan, Angola,

Congo, Mozambique, Sri Lanka, Burundi, and Somalia), mostly in Africa. Of the two exceptions, Colombia represents the outgrowth of an older colonial order and the other (the essential medicine campaign) speaks more generally to the poverty of the Third World (in itself a postcolonial spatial designation). Place and identity of origin are, therefore, not neutral characteristics; a borderless world retains the ruins of earlier frontiers, across which some people move far more easily than others.

Alongside place we must also consider capacity. The ethical position implied in MSF's crisis poster is that of the global citizen, a particular variety of "moral spectator" made possible by the immediacy of electronic media (Boltanski 1999; see also Das 1999; Kleinman and Kleinman 1997; Tsing 2000). The poster speaks in English, implicating everyone with its passive voice. Yet not everyone is equally in a position to receive or respond to its imperative. Again, medicine serves as metaphorical as well as literal referent in this case. Facing a world composed of patients, those with medical skills bear a particular ethical responsibility for offering treatment. When patients are incapacitated, certain ethical norms of self-determination can be suspended in the interest of urgent care. Someone must speak and act when silence asserts passive negation and inaction threatens life. Once a state of crisis has been established, then action (especially technical, expert action) acquires self-authorizing status by virtue of circumstance. In ethical terms, if one has a capacity to act, then not acting takes on new significance. Many within MSF are deeply aware of the incongruities its mobile missions embody, but they nonetheless subscribe to a baseline humanitarian position that inaction, except in rare circumstances, is unthinkable in the face of injustice and suffering. In the end, the doctors who say "yes" must perforce say "no" to borders, even at the risk of echoing the historical inequities of empire, for the suffering other lies at the center of humanitarian reason, and recognition and action in relation to that other constitute the primary measures of ethical value.<sup>17</sup>

From this perspective, then, neither cultural difference nor economic rationality should stand in the way of action at a moment of true crisis. However, emergency, like violence, is an expansive term, and many of the situations within which humanitarian organizations find themselves operating bear little resemblance to the abstract figures of philosophy. When missions enter a potentially "post-emergency" phase, or attempt to combat long-term afflictions like HIV/AIDS, MSF must confront questions of both human difference and economy of scale. Some of the most interesting debates within and around the movement concern the complicated status of its "national" staff in field missions, cultural variations in concepts of well-being, and whether its actions are effectively "for" or "against" the realist rationality of public health.<sup>18</sup> For some members of MSF, demonstrating that medical aid for a few is possible is a way of protesting its absence for the many; by constituting an outside presence in a conflict zone, they present an extralocal conduit for those caught between warring factions. To quote an essay in one of MSF's recent annual reports:

Humanitarian action may be a small remedy given the magnitude of useless, global suffering. However, it can make a huge difference, if we can avoid pretending that we will change the destiny of entire populations . . . . Medical humanitarian action goes beyond the mere analysis and repair of physical disorders; it offers choices where there were none; it provides a human touch in an inhumane environment and it may ultimately help reestablish human dignity . . . . And this is not utopian; it's very realistic . . . and very needed. [MSF 2003b:11]

The ethical stances MSF most frequently maintains are neither naïve nor optimistic.<sup>19</sup> Because their focus rests on present suffering and the indignation it can inspire (see Boltanski 1999:182), members cannot resort to the more abstract comforts of the past (in juridical proceedings to redress injustice) or the future (in development projects to build later “capacity”). Essentially realist and skeptically minded, MSF is wary of involvements that would position its work as a substitution for what they see as responsibilities of states. For example, the same administrator for Ugandan projects who was quoted earlier observed to me, “We don’t want to put a foot in the [local] hospital, or we’ll be there ten years later.” His point was not that the work there was not valuable, but rather that it did not fall into the scope of MSF’s mission and would only result in a situation of long-term dependency.

Members of MSF commit themselves to witness injustice and thereby contribute to a larger representational struggle against inhuman conditions, but they do so always through the frame of a present decision in the field, rather than an overriding conceptual strategy of development or a political ideal. “Of course we think about change,” one person put it rhetorically to me in a phrasing echoed by many others, “but at *this moment* what do you do?” The question is a real one, when faced with a potential crisis and equipped with the wherewithal to respond. “Do you start to prepare supplies for 100,000 displaced people before anything happens,” asked an operational director for MSF–Holland regarding Macedonia in the summer of 2001, “or wait until they actually are displaced? There will be criticism either way.” Here, the Hippocratic physician monitoring potential crisis in a patient meets the Thucydidean historian anticipating a larger narrative of human events through which significance will be revealed. Capacity, place, and rupture all factor into MSF’s moment of decision and the lines of potential history emerging from it. For how else are we to evaluate action, if not through its eventual incorporation into a historical frame? And yet, by focusing continually on present imperatives, MSF foreshortens the historical scope of its action, contributing to a planetary time far narrower in temporal range than any local time.<sup>20</sup> The delimited goals of humanitarian engagement—alleviation of suffering and care of members of an afflicted population—provide only temporary measures for any form of relative “success” amid a greater cascade of failure. Assessment remains a retrospective task that is always one disaster behind. But a continuing pattern of temporary measures can itself have historical effects. Some refugee camps now have endured for decades, some populations regularly require international food aid, and an increasing number of social problems find administration through the

larger apparatus of crisis response. Here, I will turn the discussion to address the third of my concerns: biopolitics as the dynamics of government focused on facts of living.

### The Thin Line of Government

Today it is not the city but rather the camp that is the fundamental biopolitical paradigm of the West.

—Giorgio Agamben, *Homo Sacer*

Experienced aid workers will guide you through the exhibit. You will see various types of shelter used in tropical, desert, and cold climates; see how food is distributed; learn how clean water and waste disposal are essential to survival; and understand basic health care and epidemic control in a clinic, cholera treatment center, and vaccination tent. You will also learn about the scale of the world's refugee crisis and what causes and prolongs population displacements. Through interaction with your guides, you will hear personal testimonies of aid workers, some of whom are refugees themselves.

—MSF brochure, “A Refugee Camp in the Heart of the City”

A few years after MSF was founded, Michel Foucault (1990) sketched out the potential significance of the inclusion of life processes into politics. He introduced the term *biopower* to describe an emerging context in 18th- and 19th-century Europe, within which facts of existence related to bodies and populations could become the focus of specific operations of government. Birth rates, issues of public hygiene, and the regulation of sexual acts now emerged as potential affairs of state, as well as the preoccupation of new cadres of recognized experts. In keeping with his central preoccupations, Foucault positioned biopower to mark a historical break between eras and modes of power moving from sudden destructive acts and toward the promotion of productive norms. “One might say that the ancient right to take life or let live was replaced by a power to foster life or disallow it to the point of death” (Foucault 1990:138; see also Foucault 2003:240–241). The political apparatus governing physical being, in other words, should now include finer instruments than a sword.

Three decades later, biopower and biopolitics have grown into familiar concepts for many anthropologists, and an expanding literature examines the ways in which governance and citizenship intimately involves the condition of living bodies and populations (e.g., Cohen 2004; Fassin 1996; Lakoff 2004; Lock et al. 2000; Nguyen 2002; Ong 1999; Petryna 2002; Rabinow 1999; Rose 2001). Many of the phenomena now under study lie at a considerable historical or geographic remove from Foucault's original points of reference. Distinctly contemporary phenomena such as radiation sickness, HIV/AIDS, pharmaceutical marketing, assisted

reproduction, or genomic medicine and the reconfigurations they introduce to their social worlds are inherently biopolitical in the sense that the management of physical well-being is expected, if not fully achieved. This research examines not only clear centers of geopolitical influence but also postcolonial settings and marginal domains within state rule, in which distinct gaps between desires, fears, and actions are frequently visible (Das and Poole 2004). Although biopolitics may incorporate the universality of a species body, the actual politics of that body appears multiple when examined over the varying grounds of practice.

Modifying Foucault's vision with a key element from German political theorist Carl Schmitt (1985), Giorgio Agamben (1998, 1999, 2000) has returned discussions about life and politics to issues of sovereignty. Following an overarching concern with the Holocaust, Agamben suggests a genealogy for biopolitics that originates in a sovereign's power to suspend law by declaring a state of exception and ultimately expands into the deadly form of the concentration camp. First, he enlarges Hannah Arendt's (1959:85) distinction between two Ancient Greek terms for life: *zoë* (zoological life, the simple fact of living) and *bios* (biographical life, a life that is properly formed through events such that it can be narrated as a story). Agamben (1998:8–9) uses this distinction to identify a lower threshold of human possibility: "bare" life, or a form of naked existence without any benefits of social being. The key figure for him is *homo sacer*, a status under Roman law of one who may be "killed and yet not sacrificed" (Agamben 1998:8)—whose death, in other words, can occur without recognition of loss. From this obscure legal category, Agamben maps a migration of politics into an expanded state of exception, producing a "zone of irreducible indistinction" between bare life and citizenship. Second, Agamben identifies the concentration camp as a key political space of modern experience. In his vision, the camp, and the exceptional suspension of law within it, is not simply a historical referent but the "hidden matrix" at the center of our world (Agamben 1998:166). He suggests we should contemplate anew Walter Benjamin's (1969:257) dictum that "the tradition of the oppressed teaches us that the 'state of emergency' in which we live is not the exception but the rule."

Agamben's provocative recasting of biopolitics requires some translation for an anthropological discussion of humanitarian action. His perspective is decidedly European, aligning Sarajevo with classical Greece and Rome, and the camp he usually has in mind is Auschwitz. Furthermore, the image of sovereignty found in much of his writing (like that of Schmitt) is that of a powerful government, one clearly exhibiting capacity and control, rather than the less certain political conditions prevalent in many of the areas in which humanitarian organizations operate. Finally, and most generally, his concern is ultimately directed toward the mass production of death and its potential within claims to political sovereignty.<sup>21</sup> However, if we widen this history to accommodate the mutations of imperial practice, fragmenting this image of rule and adjusting his trajectory toward questions of survival, Agamben provides us with additional elements to better situate MSF and its complex negotiation of both politics and suffering.

Consider one of the key spatial contexts within which MSF and other humanitarian actors operate: a refugee camp explicitly defines biopolitics in terms of the preservation of life where it has otherwise been abandoned or put at risk—an attenuated form of government, if you will (see Biehl 2001; Pandolfi 2002). At the same time, it is important to recognize that a refugee camp is not a concentration or a death camp, although they may share certain technical traits and general strategies of control. When properly functioning, a refugee camp fosters the possibility of mass survival, not mass extermination.<sup>22</sup> Nonetheless, the troubling status of refugees plays a critical role in the efforts of Arendt (1973) and Agamben to comprehend the political trajectory of totalitarian genocide; the image of massed refugees undeniably represents an archetype of human suffering (Malkki 1996). In both kinds of camps, those designed for refuge as well as for elimination, the figure of the human emerges from behind that of the citizen, in a bodily condition exposed by crisis. Concerns for stateless persons and victims of genocide pervade international codes for human rights and humanitarian law that followed World War II. Although those documents have rarely enjoyed enforcement, an elaborate system of UN agencies, national governments, and NGOs, has established the refugee camp as the predominant mechanism of practical response to severe political and ecological instability. In exceptional conditions of displacement, an exceptional space of preservation now opens, to relieve a population, if never quite cure or fully care for it. This is where the threshold possibility of Agamben’s “bare life” again comes into view within the circumscribed existence of the involuntarily displaced.

To further clarify the point, let me return to the ethnographic example from my introduction. In the fall of 2000, MSF brought a traveling exhibit to several sites in greater New York and Los Angeles as part of a special publicity campaign on behalf of displaced people.<sup>23</sup> Entitled “A Refugee Camp in the Heart of the City,” it brought together two of Agamben’s key elements—the camp and the city—as a small circle of tents briefly appeared in the center of Central Park. MSF volunteers and staff issued identity cards to visitors and then led them through the exhibit in small groups to experience the key features of a miniature model camp. The first section of the exhibit illustrated basic needs: shelter in the form of simple tents adapted to different climates, water purification in the form of a giant bladder dispensing five gallons per person per day, food in the form of compact bars providing 2100 calories, and finally hygiene in the form of a latrine (the VIP version) equipped with both a public education folk painting about hand washing and an ingenious method of trapping flies. Here was a panorama of survival in all its measured essence. To one side hung a small poster about mental health and trauma and beyond lay the medical zone, featuring a model clinic, a weighing station, and vaccination center, and finally a cholera exclusion area. The tour closed with a depiction of landmines and a photographic testimonial to the plight of refugees.

In this model camp the spatial order is both exact and essential. It does not represent a final solution or a politics involving fully realized subjects, however,

but an endlessly temporary defense of minimal existence. In this sense, it is the precise inverse of a concentration camp, if likewise revealing a border zone between life and death. The camp arranges itself around an effective rationale of immediate concerns localized within biological necessity. There are bodies to cleanse, to shelter and protect from hunger and disease. There are children to weigh, inoculate, and categorize by the circumference of their upper arms. In the model camp, links between these different tasks are clear. Indeed, a number of volunteer guides remarked how much clearer the system appeared to them in this context than it had in the chaos of an actual emergency. Life itself is exposed beneath the language of rights invoked to defend it and the protest against conditions that produced the camp in the first place. In this setting, human zoology exceeds biography: those whose dignity and citizenship is most in question find their crucial measurements taken in calories rather than in their ability to voice individual opinions or perform acts of civic virtue. The species body, individually varied but fundamentally interchangeable, grows visible and becomes the focus of attention.

Here the context of MSF's "ethic of refusal" comes most sharply into focus. The group's insistence on a politics of witnessing combined with its abstention from taking a directly political role stems from an unwillingness to accept the extended state of emergency within which it generally operates. Simply to denounce situations would achieve no immediate humanitarian ends and to endorse political agendas would potentially sacrifice the present needs of a population for the hope of future conditions. But to maintain formal neutrality at all times without protest would mimic the classic limitations of the Red Cross movement that the founders of MSF originally rejected. Confronted with such a range of unsatisfying options while still being committed to humanitarian values, MSF's ideological strategy is to claim a position of "refusal" in the form of action taken with an outspoken, troubled conscience.

The practical application of this approach varies according to the situation. In truly exceptional circumstances MSF has found itself forced out or has chosen to withdraw. For example, during the highly televised Ethiopian famine of 1984–85, the French section was forced to leave after accusing the regime of using both famine and relief aid to effect a forced resettlement policy. During the dark Rwandan spring a decade later, MSF publicly proclaimed its helplessness with a bitter, angry refrain: "you can't stop genocide with doctors." The French section both denounced the political complicity of its national government and issued its first call for some form of military intervention to halt the slaughter. Upset at the flagrant manipulation of aid by the perpetrators of genocide in the aftermath, MSF–France subsequently pulled out of the Rwandan refugee camps in Zaire and Tanzania at the end of 1994 and then condemned the new Rwandan regime for the forcible repatriation and massacre of Hutu refugees. Although other MSF sections followed different strategic lines of action amid heated debate, they all eventually withdrew from the camps by the end of 1995, publicly protesting the continuing political situation within them. Most recently and poignantly, the

organization withdrew from Afghanistan following the murder of five members of a team from MSF–Holland in 2004. After more than two decades of continuous presence, the organization felt that the altered political circumstances of U.S.-led coalition efforts to administer a post-Taliban reconstruction had eliminated the “humanitarian space” necessary for its operations.<sup>24</sup>

Such extreme actions, however, are rare. Within more common conditions of rupture, MSF usually practices a noisier variety of humanitarian diplomacy of the Red Cross variety, intermingled with threats, denunciations, and protests. At the same time, it operates as a technical agency, alongside other NGOs, to administer a substitute for medical government amid what it identifies as political failure. Yet this action rests squarely on a central, categorical paradox: the more successful MSF is at protecting existence in the name of a politics of rights and dignity, the more this temporary response threatens to become a norm. Related lines of tension run through much of the movement. Even as MSF seeks to maintain an anti-institutional ethos, it achieves the institutional recognition of the Nobel Prize, a recognition that promises both to increase its influence and impede its reinvention. Even as the organization seeks new forms of engagement that might emphasize structural inequities (such as the Access campaign to lower pharmaceutical costs for poor countries), it remains attached to the language of urgency: for example, “Millions Die from Lack of Medicines” (crisis number four on the poster described earlier). The group’s anti-utopian utopianism requires both situational and categorical criteria of evaluation at different levels of engagement: Team reports for each local context filter through an organizational structure with global ambition. Universal techniques and expert guidelines mix with a legacy of continual improvisation. An established oppositional ethos takes shape within a definitional claim to humanitarian ethics. Therefore, in the face of continuing disaster, MSF responds with a defense of life that both recognizes and refuses 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. At the same time it maintains a critical frame of action that has undeniable political as well as social, economic, and technical effects on both local and systemic scales. Such is the dilemma of “doctors yes, borders no.”

When analyzed at a general level, the work of NGOs such as MSF and other humanitarian groups certainly contributes to the greater contemporary world order, forming part of an established apparatus for crisis response. Thus, Michael Hardt and Antonio Negri (2000:36) can identify international NGOs as pacific weapons of what they call “Empire.” More concretely, Maria Pandolfi (2002:1, 5, and see 2000; see also Appadurai 1996:45–49) includes them in an expanding military-humanitarian field she terms “migrant sovereignties,” self-legitimized through a “culture of emergency” exemplified by the massive intervention in Kosovo. At the very least, surely Akhil Gupta and James Ferguson (2002) are correct in observing that humanitarian organizations performing statelike functions contribute to

a transnational variant of governmentality, one that complicates our conceptions of national and international space. Nonetheless, MSF seeks to define itself in contrast to emerging conventions, while also participating in a larger moral economy of evaluating politics through human life and suffering. It generally opposes humanitarian operations by military forces or any standing “right of intervention” (a principle memorably championed by one of its original founders-turned-politician, Bernard Kouchner, and implicit in the group’s initial formulation). And it will occasionally withdraw from situations in which it believes external political manipulation outstrips its ability to influence conditions of suffering. Yet its actions, however agonizingly debated and qualified from within, often blur together with those of other aid actors when seen from the perspective of their intended beneficiaries as a continuing stream of white all-terrain vehicles.<sup>25</sup>

General accounts of NGO governmentality, therefore, risk slipping an older political vocabulary too quickly over contemporary forms. Although the doctors who say “yes” to humanitarian action may find themselves replicating colonial patterns and inadvertently contributing to successor global orders, their own expansion is ever conflicted and oppositional. MSF may contribute to a migrant mode of sovereignty, administered through Toyota Land Cruisers, satellite phones, and laptop computers, but we should not forget that this sovereignty is not only mobile but it is also at the same time attenuated. MSF may have achieved a measure of direct power over survival and a measure of indirect influence in bringing recognition to crisis situations. It may also reserve, like Schmitt’s sovereign, a measure of final decision over life and death by determining what constitutes a legitimate exception, although this is reactive and largely in a medical vein. However, its actual ability to govern—to care for a population—is limited both by external factors and by internal will. Moreover, MSF is, as are most contemporary NGOs, an association composed of private citizens and, therefore, operates obliquely with regard to classic legal categories of administration and sovereignty. As such it holds no particular mandate to act (unlike the legally sanctioned ICRC), nor does it seek to rule.

As the director of one MSF section observed to me: “Four people sitting in Sudan surrounded by people with guns aren’t running things.” This facile political analysis is nonetheless revealing when positioned alongside descriptions of global empire, for it reminds us that power can extend into settings where a monopoly of authority is rarely apparent.<sup>26</sup> MSF acts on particular bodies and contributes to a larger political regime of humanitarian values. However, between these two levels, its actual command over events is ever precarious and unsure. What MSF has achieved—now passionately, now reluctantly—is a temporary and restricted form of modestly productive power that is uncertainly revealed in states of crisis. This is what I mean by a “minimalist” biopolitics: the temporary administration of survival within wider circumstances that do not favor it. In foregrounding such a project, and pursuing it within the attenuated sovereignty of an independent, but self-limiting organization, MSF protests inadequate government and provides

a temporary alternative. Whether such a minimalist biopolitics can achieve the deeper humanitarian goal of reestablishing human dignity, however, remains less clear, other than publicly demonstrating an attachment to that ideal at the moment of its abnegation. As Paul Rabinow (1999:109–110) notes with regard to French concerns over their HIV blood scandal and genomic research, the bios that understands itself as a civilizing force has difficulty imagining a zoë that it could not civilize or one whose alteration might change the very conditions of dignity. In classic humanist reason, dignity is already defined and inherent to the human person. And yet the direct pursuit of such dignity, in the form of a humanitarian ideal undertaken by a medically oriented and historically French movement, may reveal the limits of life in precisely these terms.

### “The Bracelet of Life”

Another striking image renders most acutely the dilemma of life confronted by MSF. In a continuing publicity campaign partly aimed at children and entitled “The Bracelet of Life,” (see Figure 1) MSF–USA has featured one of the simplest tools used in medical responses to crises involving nutritional stress, a thin paper strip

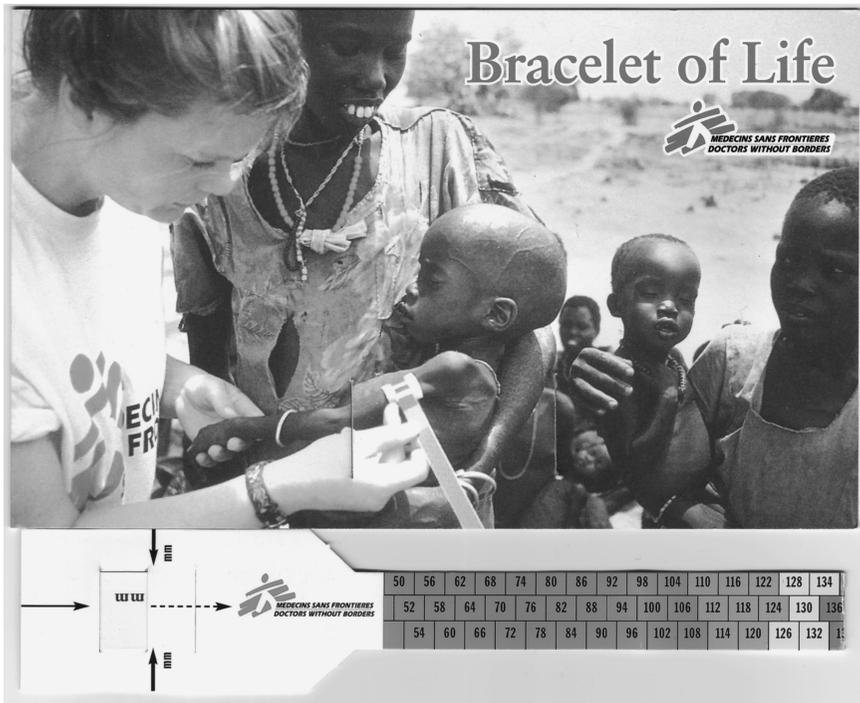


Figure 1

The “Bracelet of Life.” Doctors without Borders/Médecins sans frontières advocacy material, 1998. Courtesy of MSF–USA.

used to measure the middle upper arm circumference (MUAC) of children below the age of five. Looped and pulled tight it gives a quick indication of nutritional health, expressed both as a numerical measure and a declining gradation of colors: green, yellow, orange, and red. Inexpensive and simple to operate, this is an elegant tool for triage and assessment amid famine.<sup>27</sup> And yet the green only indicates the absence of one form of stress within a broader definition of a secure childhood. The bracelet of life cannot adequately measure the gap between general distress and happiness (as a fully realized bios). It records the extent of suffering and informs estimates of potential crises in a manner that is both exceptionally clear and clearly limited. MSF members often cite nutritional work as a rare example of humanitarian gratification, as those children who remain above a threshold of survival do recover with satisfying regularity once carefully fed. But they also describe frustration, recalling instances when recovered children would return for a second visit, their bodies withered anew by the same conditions that brought them there in the first place. Survival, after all, is a perpetually temporary outcome. Rather than a happy ending, MSF can offer only recognition and sporadic world attention to cruelly thin arms and the potential of short-term gain in the shape of specially formulated foods. It may be better than nothing for the chosen few, certainly—at least in the present—but hardly an ideal basis for a dignified life.

Where, then, shall we locate such a minimalist biopolitics amid the greater architectures of time? A crisis is both a potential historical event and historical deferment; a rupture that marks time indelibly yet stands outside it in a state of exception. Within crisis, time contracts and one inhabits the present as intimately as possible—the “immediate present” to borrow a phrase from Achille Mbembe and Janet Roitman (1996:153). In this respect, crisis is the most pure environment for a technician, where expertise can and clearly must engage in technical terms with the immanence of problems. It is also the natural habitat of a moral witness, who acquires the capacity to give testimony by virtue of presence. One can both act and know by being somewhere at just the right moment.<sup>28</sup> But if disaster becomes circumscribed through limited governance (as exemplified by the model refugee camp) then one enters another mode of time, one of incomplete history and abeyance. It is in the extension of this mode of time that crisis becomes truly a state in which humanitarian action can preserve existence while deferring the very dignity or redemption it seeks. And it is the expansion of the geographic scope of this state that threatens the emergence of a new configuration of old inequalities.<sup>29</sup>

In responding to an earlier version of this article, a member of MSF–Belgium pointed out that camps for displaced persons are not simply spaces of exception; they can also be historically productive forces that encourage the extension of less undesirable social norms and political expectations. Certainly there might be worse things than the normalization of basic health care in the form of pit latrines in the midst of a cholera epidemic. Yet the extension of public health and the Enlightenment are not the only sort of bios produced in camps, as Liisa Malkki

(1995) demonstrated in her depiction of history making among Hutu refugees in Tanzania, where camp life only further distilled ethnic resentments and nationalist sensibilities (see also Hyndman 2000; Malkki 1996). Returning to Starn's etymology of the term *crisis*, the crucial moment of transformation may indeed be found between Hippocrates and Thucydides, in the translation from medicine to history. Rony Brauman, the former head of MSF–France, noted in a public discussion associated with the camp exhibit that “as a doctor there is no emergency that lasts.”<sup>30</sup> A patient improves, expires, or enters a chronic state. But for a historian, every age has its turning points and critical decisions amid turmoil. This sense of crisis stems less from the particularities of suffering per se, than the repeated discovery of moments of truth within them and the ordering of that truth into a revelatory narrative. Thus, the problem before us is not crisis per se but the very codification of crisis into a state, a condition of action, and the subsequent limiting of emergency to within these borders.

The camp I have deployed as a central image for this article is a model camp, constructed and temporarily displayed for educational ends. Its constituent elements are all fully real, and identical versions can be found in actual use worldwide. But their assemblage into a representation of stateless survival transforms them into something more ephemeral and yet also more static: the possibility of nakedness at the level of the simple fact of living. For is not the real political horror of “bare” life found in the realization of its possibility—in the recognition of the routine indignity of an open latrine? Life in the sense of *zoë* only appears a problem from within bios, amid circumstances in which someone accustomed to defined forms of self-respect and personhood faces the potential dissolution of that personhood into a species body. This is a fantasy, of course, in that the species body is never absent, and the being who could imagine such a fear remains a person. But it is a socially real fantasy, nonetheless, enacted not only through projects of genocidal extermination but also from the opposite direction and in different ways, through projects of humanitarian survival. When elements of this very real fantasy migrate within international politics, when Agamben's European history opens outward to include a wider array of “violence prone areas” (Das et al. 2000; see also Nordstrom 2004), then a permanent state of emergency can threaten to find its own realization through the normative responses that seek to contain it. The doctors who seek human dignity continually labor over problems of human survival but their technical ability is never quite able to satisfy their ethical desire. The more they save bodies within limited conditions, the starker the contrast between minimal existence and fully formed life. The larger system within which they operate returns them repeatedly to the humanitarian point of necessary refusal and urgent action. For at this moment—yet again—what else can we do?

Such is the problem that MSF both embodies and confronts on a continual basis, acting and reacting indignantly through conjoined, disjunctive categories of techniques, ethics, and politics around minimal existence. The record of their work lies simultaneously open and closed to critique around the value of simply living

and the simultaneous rejection of its indignity. In the tension within life itself we can see why MSF has restlessly created other programs seeking alternative forms of secular redemption, and yet it has never left emergencies behind. Small victories, large defeats, continuing refusal: are not many of us familiar with these amid our uneven zones of life and history?

### **Coda: Anthropology and the Allure of Action**

In this article, I have written as if from outside and beyond the field of crisis surrounding MSF. Yet it presents anthropology with an uncomfortably familiar figure, reflecting alternative responses to shared conditions and overlapping fields of value. MSF embodies a particular form of thoughtful action, one built around a centrally significant moral claim to combat human suffering distilled in the familiar call to arms: “but people are dying!” The defense of life is a fluid and rhetorically dominant value amid contemporary secular ethics, now publicly claimed by agents of war as well as those of peace and framed by a similar justification through crisis. In denouncing the distortions introduced by such claims, humanitarians can only reaffirm their continued allegiance to the relief of suffering (Weissman 2004). Even critics of humanitarianism rarely embrace openly antihumanitarian alternatives, such as the conscious sacrifice of individuals or populations for material or political gain. Cost-benefit analyses in public health generally factor survival outcomes as well as cost, and progressive calls for social change now largely expect it to unfold without recourse to a guillotine. At this historical moment, then, it is not easy to stand completely outside the humanitarian frame of value, even amid graphic evidence of its widespread and cynical violation. When writing about MSF, both hagiography and critique grow too comfortable.

Anthropologists, at least those of the cultural variety, emphasize dignity more often than survival and even more precisely a collective right to define differing forms of dignity. Ethnographers, disciplinarily predisposed to longer-term presence and the significance of language, predictably challenge biomedical assumptions of universality and humanitarian claims to neutrality, stressing local knowledge, on the one hand, and larger patterns of political economy, on the other hand.<sup>31</sup> Even the work of Paul Farmer and his associates in Partners in Health—probably the closest corollary to MSF familiar to many anthropologists—differs strategically and ideologically in its continuing investment in place and overt attachment to ideals of social justice (see Farmer 1999, 2003; also Butt 2002; and response by Irwin et al. 2002, as well as Nguyen and Peschard 2003). Yet when facing episodes of human suffering and genocide, anthropologists confront a similar problem: measuring moral failure in physical destruction and death, worrying about survival, and finding *zoë* amid the bios.<sup>32</sup> The identification of crisis evokes an acute desire for action inside as well as outside the academy. And in professing such a desire for action, anthropologists might do well also to examine actual practices of intervention and advocacy, together with their potential

contradictions, failures, and refusals, rather than to assume them as stable goals, distanced on an ideal plane at the very moment of embrace.

Recent studies of social movements, transnational activism, and NGOs readily illustrate that action comes in a variety of forms and has varying effects, sometimes even within the same context. The greater industry of transnational virtue, however, involves not just humanitarians, human rights activists, states, and corporations, but also anthropologists, who have long trafficked in the moral representation of difference. Acknowledging a condition of implication and recognizing shared constructions of value cannot match the seductive clarity of denunciation. Such an approach yields less masterful truth claims, necessarily incomplete by virtue of subject and analysis (Rabinow 2003; Riles 2000). In recompense, however, it constitutes the ground for a form of reflexivity that opens outward into practice, finding concrete conditions for discussions of ethics, politics, and action amid the imperative present, and recognizing the involving stakes of life and care within it.

### Notes

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1. The Nobel speech was the product of fevered last-minute negotiation among the movement’s constituent sections and individual members. Here, I treat it as a unitary public statement through which to locate the contested vision of the organization. For the complete text of the speech see MSF 1999c; for more on the context of its final production and the moment of the prize reception, see MSF 1999b, as well as Vallaey (2004):744–751.

2. My strategy for research has been to follow MSF across its many sites and along selected strands of its greater network for concentrated periods lasting one or two months, while gradually working through an expanding set of collected materials related to the MSF movement’s larger trajectory (see Marcus 1998 for discussion of various methodological possibilities in approaching dispersed ethnographic objects). I have focused on the headquarters of the three largest European sections (in France, Belgium, and Holland) and on field projects in Uganda where MSF has been continuously active for over two decades in a variety of capacities. This project has also been the beneficiary of MSF’s long tradition

of encouraging debate and reflection about its activities, a legacy that has provided a range of opinion available for study and a remarkable degree of access to the group's operations.

3. I intend this point as a reminder rather than a revelation, echoing those who suggest that the category of "ethics" escapes simple containment within debates about human rights, international humanitarian law, or universal codes of clinical or research conduct, most of which presume paternalistic professional relations, formal law, and individual choice. For insightful discussions of bioethics, see the 1999 special issue of *Daedalus* on "Bioethics and Beyond," especially Das 1999 as well as Farmer 2003 and Franklin 1995; for a genealogy of "secularism," see Asad 2003.

4. MSF is obviously not alone in this endeavor but part of a much larger complex of relief agencies, media institutions, and academic consultants that Alex de Waal (1997:4) identifies as constituting the "humanitarian mode of power." The associated sections of MSF exhibit similarities not only to a number of smaller, historically related organizations such as MDM and Merlin but also the legally mandated ICRC, as well as secular NGOs concerned with food resources and advocacy such as Oxfam International and Action contre la faim (Action Against Hunger). However, given its size, financial independence, media involvement, and biomedical focus, together with its expanding purview, I suggest that MSF embodies humanitarian biopolitics in a particularly significant way.

5. The heroic origin myth commonly presented both inside and outside MSF focuses on the role played by veterans of the Biafran conflict in Nigeria, especially Bernard Kouchner, who would later rise to political prominence. However, Vallaey (2004), incorporating comprehensive oral history of the original French section, endorses a more complex history, in which the group's controversial attachment to publicity became realized only later in the decade. For further history of MSF and the related group MDM, see Fox 1995 and Tanguy 1999. Deldique and Ninin 1991 and Weber 1995 provide accounts of the organization's earlier years, Leyton and Locke 1998 a snapshot of its action amid extreme crisis, and Dauvin and Siméant 2002 a sociological study covering a sample of its adherents. Bortolotti 2004 also offers a recent and extensive treatment of the organization from a Canadian perspective.

6. For more on colonial medicine in the French empire, see Headrick 1994; for a suggestion of the complex colonial history surrounding the term civil society, see Comaroff and Comaroff 1999. According to MSF's annual activity reports (MSF 2000, 2001b, 2003a, 2003b), between 1999 and 2002 MSF expended over half its funds in Africa (annual rates varying between a low of 50 percent and a high of 63.4 percent). Asia came next in continental priorities (19.7–25 percent), followed by the Americas (7.7–11 percent), and Europe (4–16 percent). This funding breakdown underscores the degree to which Africa represents the regional epicenter of the global medical humanitarian world and suggests historical continuities with the colonial era. The 19th-century Red Cross movement focused on civilizing conflicts between recognized nation-states in metropolitan contexts, helping to transform military medicine, on the one hand, and to establish a body of international humanitarian law, on the other hand. See Finnemore 1999 and Hutchinson 1996. Other significant humanitarian predecessors also emerged during crises born of European conflict, for example Save the Children in World War I and Oxfam in World War II (Black 1992).

7. This was an era when MSF–France was involved in a series of controversial activities, such as providing clandestine medical care in Afghanistan during the Soviet occupation and denouncing resettlement policies of the Marxist regime in Ethiopia during the famine of 1984–86, not to mention establishing a short-lived think tank devoted to the topic of "liberty." This mention of the Moscow Olympics references the American boycott of the games over the Soviet invasion of Afghanistan. The wider medical humanitarian movement of MSF and related organizations encompasses strands of several political ideologies. Some of the splits between them can be read in terms of political orientation that go beyond

mere personality conflicts or operational disputes with the related groups MDM and MSF–Belgium, which were generally positioned to the “left” of MSF–France in some of their more acrimonious disputes during the 1980s. However, this reading risks foreshortening the convoluted tangle of specific biographies and issues involved and misses the militant Jacobin spirit claimed by all sides—especially for the French. See Vallaey 2004 for a narrative chronicle.

8. This campaign constitutes a sustained effort to publicize the difficulties encountered by poor people in obtaining medicines to combat conditions that particularly affect them, focusing on HIV/AIDS, leishmaniasis, malaria, sleeping sickness, tuberculosis, and meningitis. Lobbying efforts coordinated with other actors has helped produce a precipitous drop in the price of antiretroviral drugs over the last couple of years and has focused on the shortcomings of pharmaceutical corporations as well as states. MSF also helped launch a separate nonprofit entity related to the campaign known as the Drugs for Neglected Diseases Initiative (DNdi) in 2003. Operating in partnership with other nonprofit groups, governmental and intergovernmental institutions, and generic pharmaceutical manufacturers, this ambitious venture seeks to fund and coordinate the production of medicines for particularly unprofitable conditions.

9. For example, MSF has been operating in Uganda off and on for over 20 years. Beginning with brief efforts to ameliorate episodes of famine in 1980, the group has supported a long list of successive projects: providing care for displaced populations gathered in camps, an 18-year effort to combat sleeping sickness, epidemiological studies of malaria and kala azar among pastoralists along the Kenyan border, the delivery of antiretroviral drugs to AIDS patients in the town of Arua, the establishment of a garage to maintain the organization’s vehicles in use throughout the wider region, and support for a local NGO training traditional healers to provide AIDS counseling in rural areas.

10. The central operational sections are MSF–France (founded in 1971), MSF–Belgium (1980), MSF–Switzerland (1980), MSF–Holland (1984), and MSF–Spain (1986). These sections are effectively autonomous, even if linked by a charter and a loose international association. At times they have moments of extreme acrimony and near civil war, particularly among the largest three (France, Belgium, and Holland). Other sections are located in Australia, Austria, Canada, Denmark, Germany, Hong Kong, Italy, Japan, Luxembourg, Norway, Sweden, the United Kingdom, and the United States. The group also maintains several smaller offices, including one in the United Arab Emirates. A section based in Greece was expelled after a controversy over its conduct during the Kosovo conflict in 1999 and was only reinstated in 2005. As the partner sections have grown in size and influence, their status has begun to shift, and they have acquired some field responsibilities; for example, MSF–USA took over most of MSF–France’s operations in Uganda in January 2004.

11. MSF global accounting uses the monetary unit of the euro. Figures given here are drawn from MSF 2003a:96–97 and 2003b:84–85. The Belgian section has had a harder time achieving the goal of financial independence, being a large operational center in a small country, with a historical affinity for longer-term, institutionally supported projects. Both the French and Dutch sections have benefited from their affiliates in key markets: MSF–USA and MSF–UK, MSF–Germany and MSF–Canada, respectively. The international structure and alliances between sections are artifacts of history rather than coordinated planning. By way of comparison, MSF’s international budget is roughly comparable to Oxfam’s and about half of the budget of the ICRC (see Aall et al. 2000).

12. I do not mean to minimize the considerable difficulties, negotiations, and controversies involved in this larger project or its potential long-term complications but wish to emphasize that after beginning the delivery of treatment in a preexisting AIDS project in

Thailand at the end of 2000, MSF had a dozen programs open by the end of 2002 and some 10,000 patients on antiretroviral drugs in different countries around the globe by the end of 2003—all without an extensive need to conform to funding cycles, agency directives or the elaborate dance of consultation that characterizes most such projects (MSF 2002, 2003b).

13. The translation of “frontières” into “borders” remains a source of continuing controversy. The original name, born out of the happy union of two groups of activist French physicians and a few journalists under the auspices of a medical publication, is often interpreted by adherents of the movement to denote a willingness to expand and overcome barriers more than any statement about national borders. Indeed, Rony Brauman, MSF–France’s long-serving former president, noted to me that the expression “sans frontières” was apparently first used by a youth travel agency of the late 1960s (Jeunes sans frontières) before being popularized by MSF. Even when yielding to the international dominance of English as the language of world governance (the French section most grudgingly), the movement has retained its French acronym. Here I am simplifying the linguistic questions involved for the sake of a broader conceptual point about biomedical reason.

14. This comment is one I have encountered in various forms both in interviews and in written commentaries by MSF volunteers. Although particularly resonant for physicians and surgeons, I would suggest that it resonates with the broader motivational impulse of other medical and nonmedical personnel as well and probably of many among their donor base seeking a secular form of “doing good.” For recent discussion and study of roles played by NGO actors and advocacy networks, see Appadurai 2000, Bornstein 2003, Dezalay and Garth 1998, Fisher 1997, Fortun 2001, Gupta and Ferguson 2002, Keck and Sikkink 1998, Rabinow 2003, Riles 2000, and Wilson 1997; for a description of direct anthropological involvement in crisis settings, see Williams 2001.

15. For more on crisis, see Starn 2004; Calhoun n.d. addresses the related terms *emergency* and *disaster*.

16. A virtual version of the 1999 list, along with its successors, can be found on the website of MSF–USA: <http://www.doctorswithoutborders.org/publications/reports/2003/top10.html> (accessed March 15, 2005).

17. See Rackley 2002 for an extended analysis of humanitarian logic in relation to the philosophical tradition of phenomenology, including the work of Emmanuel Levinas on the ethics of the other.

18. Local employees, the bulk of MSF’s actual workforce, present a number of administrative and conceptual complications for the organization. As paid employees generally performing semiskilled tasks, their status is conceptually distinct from that of “volunteers,” and their concerns are often perceived to focus more directly on labor issues than idealism. Generally lacking the proper passports together with the capital, cultural, and linguistic resources requisite to mobility, it is harder for them to circulate through different missions and thereby achieve career advancement. Although an increasing number of individuals do expatriate from poorer contexts, the bulk of national support staff experience MSF work as a series of economic engagements in place. For a sense of the tone and depth of MSF’s reflections on issues affecting their practice, see the remarkable dialogs contained in the workshop proceedings (sponsored by MSF–Holland) on cultural difference, rights, and humanitarianism (MSF 1999a) and the collection edited by Brauman (2000) on public health.

19. MSF maintains a strong tradition of criticism and self-criticism about humanitarian action, publicly reflected in Brauman 1993, 1996; MSF 1997a, 1997b; Terry 2002; and Weissman 2004. In addition, a broader field of critical writing now surrounds contemporary humanitarian action, for example, de Waal 1997, Ignatieff 1997, and Rieff 2002, all of which are familiar to many longer-term practitioners. Thus, although individual actors

within MSF may exhibit moments of optimism or naiveté, the collective vision remains decidedly troubled and aware.

20. Pandolfi (2002), Bindé (2000), and Laïdi (2001) alert us to the dangers of overemphasizing the present at the expense of the future, and substituting a simulacrum of action in place of politics. See also Kelly 1998, and, for a reminder of the broader ordering of history, see Chakrabarty 2000.

21. As such, it arguably represents thanatopolitics (a politics of death) as much as biopolitics (see Rabinow and Rose n.d.; also Foucault 2000:416). I am leaving to one side any internal questions about Agamben's analysis of Roman law or its import, given that the distinction he notes can potentially apply to the contemporary world, whatever its historical significance.

22. This is not to suggest that all places nominally classified as refugee camps equally provide refuge or that long-standing camps do not develop additional features. See Hyndman 2000 and Malkki 1995 for critical descriptions of specific refugee camps and the general form they represent.

23. The camp exhibit was originally a project of MSF–France, and it toured Europe before reaching the United States. A virtual version of it can be found at <http://www.refugeecamp.org/> (accessed March 15, 2005). Later, MSF created an advocacy exhibit as part of their campaign promoting global access for affordable drugs that toured far more widely through U.S. cities and medical schools in 2002–03. Both featured the now-familiar technique of inviting the audience to engage in role-playing to experience the conditions under discussion.

24. The limit cases described above have been the focus of considerable internal and external controversy. In Ethiopia, MSF–France's accusations ruffled the feathers of the wider aid community amid the surge of BandAid music publicity, and it was in turn accused of incompetence (see de Waal 1997:124; Jansson et al. 1990, as well as MSF reports from the period). This episode may have contributed to the self-conscious drive to professionalize in the later 1980s. During the greater Rwandan tragedy, MSF was a much larger multinational presence, and the strategic disagreements between MSF–France, MSF–Belgium, and MSF–Holland at times grew acrimonious. The events in Rwanda left considerable scars, and a recent internal project by MSF–France to document episodes of MSF “speaking out” has devoted three early volumes to the period, itself provoking some controversy within the larger organization. For a close analysis of several controversial cases of humanitarian action by an MSF insider, see Terry 2002. Trends toward military action claiming humanitarian ends and the recent U.S.-led “War on Terror” have also altered the circumstances for humanitarian activity. For a collection of MSF's critical views on “just wars,” see Weissman 2004. A concise delineation of MSF's rationale for leaving Afghanistan can be found in a letter to the editor of the *Wall Street Journal* written by the president of MSF's International Council (Gillies 2004) charging the Afghan government for failing to investigate the murders and suggesting that the conflation of humanitarian and military objectives, together with the specific threat of future assaults by a Taliban spokesman, had created an atmosphere in which MSF could no longer responsibly risk the lives of its staff. “We refuse to choose sides,” the letter concludes, “just as we refuse to accept a vision of a future where civilians trapped in the hell of war can only receive life-saving aid from the armies that wage it” (2004: A13).

25. This has prompted Sampson (2003) to describe endemic crisis zones as “white jeep states.” For all that, MSF's very name suggests an ability to supersede state sovereignty in the name of humanitarian action. It has both engaged in occasional clandestine activities and periodically issued calls for political guarantees of security for populations. The organization has opposed the establishment of any standing *droit d'ingérence* (the right of

state intervention for so-called humanitarian purposes) as a principle of international affairs (see Kouchner 1991). Kouchner left MSF in 1979 amid considerable acrimony to found MDM and later entered French politics. The expansion of military action by powerful states claiming a humanitarian rationale has posed additional representational difficulties for humanitarian organizations above and beyond the routinization of humanitarian assistance. In a painful and graphic example, MSF found itself being identified with the U.S. presence in Afghanistan after the fall of the Taliban—a particularly galling experience for an organization with French ancestry and an extensive legacy of operations in the area, and ultimately it became a deadly association for the European and Afghan members of an assassinated MSF–Holland team (Gillies 2004; Weissman 2004). The group also withdrew from its comparatively short-lived mission in Iraq in 2004. As Didier Fassin (2004) illustrates with regard to humanitarian interventions in the Palestinian territories, MSF faces difficulties when the political stakes of the situation do not easily translate into the language of victims and lives saved.

26. For discussion of the tensions of state formations after formal empire, see Das and Poole 2004. Hansen and Stepputat (2001), Mamdani (1996), and Scott (1999) remind us of the complications of colonial rule and its legacies. Amid his general indictment of international aid agencies, de Waal (1997:217) also cautions against overestimating NGO influence relative to arms manufacturers, civil servants, and a range of other political and economic actors.

27. There are debates about the adequacy of MUAC measures to evaluate nutritional status within a population. The cutoff norm of 12.5–13 cm (4.9–5.1 in) was defined by well-nourished Polish children of the early 1960s and reference to additional factors such as height would be more sensitive to age and sex differences (see Mei et al. 1997). However, the MUAC bracelet remains in wide use as a rapid assessment tool by virtue of its speed and simplicity. It has also served as an inspirational model for an MIT group involved in an effort to apply design to nonprofit problems. See [www.designthatmatters.org/proto\\_portfolio/cholera\\_treatment/](http://www.designthatmatters.org/proto_portfolio/cholera_treatment/) (accessed March 15, 2005).

28. Luc Boltanski nicely captures this dual nature of immediacy and its importance to organizations like MSF: “Ultimately what justifies the humanitarian movement is that its members are on the spot. Presence on the ground is the only guarantee of effectiveness and even of truth” (Boltanski 1999:183). This moment of truth making partially resonates with the “modest witness” tradition of scientific observation (see Haraway 1997 for review and discussion).

29. Mbembe and Roitman (1996) provide an eloquent description of everyday life amid a landscape of crisis in urban Cameroon, including a graphic image of state rupture at its physical center:

The traffic lights no longer function. Some are still intact but no longer light up. Due to the absence of maintenance vandalism, or, most often, traffic accidents, others have either toppled over, exposing their massive cement base, or lean dangerously over the ad hoc sidewalk or over the road itself. Although they are all still there, sometimes in the very spot where they were erected, they are now masses of useless “traces,” outliers of bygone days. [Mbembe and Roitman 1996:156]

30. See also Edward Rackley’s insistence on the need for humanitarians to consider causes as well as suffering: “Emergency rescue may still exist on ski slopes and in burning buildings, but the humanitarian act in times of war is not a temporary or immediate mode of intervention. It is protracted, and requires its practitioners to live in the same environment with those populations whose lives they are there to save” (2002:13).

31. A number of situated, critical studies by anthropologists involving specific MSF projects have recently begun to appear. See Laplante 2003 and Lofving 2002 for quite

different cases involving Brazil and Guatemala; Allen (1994) addresses an earlier incarnation of MSF in Uganda, while Butt (2002) discusses a project in Indonesia. For another cogent discussion of collective behaviors by several NGOs amid conflict in northern Uganda, see Leopold 2001. Escobar (2004) makes the case for politics of place in an effort to imagine political alternatives “beyond the Third World.”

32. I do not mean to imply identity between anthropology and humanitarianism, only comparability. Significant differences obviously remain in terms of their respective orientations toward local and expert knowledges. What I wish to make visible is that few contemporary anthropologists—however politicized—would be likely to endorse an antihumanitarian politics in which life could be thought expendable. At the same time, calls to arms and denunciations within anthropology frequently find moral force in allusions to death and suffering, or a condition of poverty expressed in the suffering species body. This *zoë* is far less detailed than that of medical humanitarians, even as the depiction of a particular bios (in the tradition of thick description) is far more so. But for both a dual sense of life, not to mention crisis, appears deeply imbricated in concepts of action.

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**ABSTRACT** *The politics of life and death is explored from the perspective of Doctors Without Borders (Médecins sans frontières [MSF]), an activist nongovernmental organization explicitly founded to respond to health crises on a global scale. Following the work of Michel Foucault and Giorgio Agamben, I underline key intersections between MSF's operations that express concern for human life in the midst of humanitarian disaster and the group's self-proclaimed ethic of engaged refusal. Adopting the analytic frame of biopolitics, I suggest that the actual practice of medical humanitarian organizations in crisis settings presents a fragmentary and uncertain form of such power, extended beyond stable sovereignty and deployed within a restricted temporal horizon. [nongovernmental organizations, crisis, medical humanitarianism, biopolitics, Médecins sans frontières]*