

PENNSYLVANIA STUDIES IN HUMAN RIGHTS

Bert B. Lockwood, Jr., Series Editor

Medical Humanitarianism

Ethnographies of Practice

Edited by

Sharon Abramowitz
and Catherine Panter-Brick

Foreword by

Peter Piot

PENN

UNIVERSITY OF PENNSYLVANIA PRESS

PHILADELPHIA

2015

Conclusion

A Measured Good

Peter Redfield

Medical Humanitarianism

To begin an ending, I return to this volume's title: *medical humanitarianism*. By now it appears an innocuous phrase, common enough to forget its relative novelty on the historical stage.¹ Moreover, the term serves as a category within the taxonomy of international aid, one embraced and embodied by a generation of practitioners and encountered by populations worldwide. From the slower perspective of anthropology, however, such a compound designation itself raises a number of questions. What to make of this dual term? Given that humanitarian action generally describes a relation of care and the practice of medicine generally addresses human suffering, one might reasonably see their union as a natural one. But even if the component parts fit like fingers in a glove, why stitch them together? Is there something at stake in the juncture between healthcare and the urgent end of aid that merits analytic attention? What might focusing on an explicitly *medical* form of humanitarianism reveal?

Rather than quarreling over definitions, this collection wisely takes up these questions as an ethnographic challenge. Its contributors follow a varied set of contemporary actors engaging aspects of health and human wellbeing, not all of which neatly align. Together, though, they clarify the extent to which medicine—particularly expert biomedicine—now plays a preeminent role in defining humanitarian action. However historically variable a term, “humanitarianism” has increasingly stabilized around the figure of

emergency, as exemplified in conflict and disaster settings (Barnett 2011, Calhoun 2008). Within this conceptual terrain, medical attention has come to define not just the appropriate form of care but action itself. Whereas the Italian women aiding the Red Cross visionary Henry Dunant soothed a church full of wounded soldiers with pure water and a compassionate gaze (Dunant 1862 [1986]: 63), their successors deploy a much larger apparatus in an attempt to save lives and psyches, often with cursory regard for cultures, beliefs, and political interests. One might suggest that humanitarianism has not just grown professionalized but also effectively medicalized. At the same time, the expanding field of emergency response increasingly confers moral standing within medical endeavors. As several of the chapters demonstrate, even nonemergency projects may present themselves through a language of suffering and urgent action. Thus if humanitarianism appears caught in the sway of medicine, medicine, too, has acquired new humanitarian aspirations of the heroic mode.

Here I would like to suggest yet another sense in which an explicit appeal to medicine might prove valuable with regard to examining humanitarian practice as well as humanitarian reason (Fassin 2011). When considered abstractly as principle or policy, humanitarian action too often appears a matter of moral purity, whether cast as absolute virtue or abject failure. By contrast, medical action implies clinical practice, grounding an impassioned impulse such as *care* in a gray world of routines, procedures, and lingering uncertainty. When approached at the level of individual bodies and specific cases, medical knowledge appears resolutely imperfect. Even in the best-equipped hospital, diagnosis remains a fluid art, full of trial and error, not to mention periodic impasses. Treatment likewise exhibits an experimental edge; even wonder drugs rarely elicit precisely the same response across a population. The vast apparatus of science and technology now devoted to human health has stumbled across occasional magic bullets like penicillin. Its statistical record keeping attests to the general success of public health sanitation on a mass scale. But as any experienced patient knows, the medical encounter frequently offers more in the way of odyssey than panacea.

Medicine, then, might be good to think with when considering humanitarianism. Shifting the title of this collection from a static, descriptive term into an active analogy not only reveals the extent to which *medical humanitarianism* describes a space of cultural inquiry but also underscores its critical relation to practice. As the editors of this volume emphasize in their

introduction, a serious ethnographic engagement with the topic requires attention to specific dynamics of encounter and material effects. By acknowledging the complexity of practice at the outset and extending its study through a wider comparative frame, collaborative work such as this provides a valuable counterweight to more general pronouncements. If taken seriously, the medical analogy moves discussion beyond both the heroic melodrama of aid as compassion and its simple condemnation as a soft form of power. Just like medicine, humanitarian assistance may well involve both. But it does not always do so equally or in precisely the same way; effects as well as motivations vary. The different parties in any given encounter share a common ground of interaction, and may even have overlapping interests or desires, but they do not all read from a single script (Abu-Sada 2012). Nor do they always agree on the same definition of the problem at hand, let alone on what might constitute a positive resolution.

Framed by a comparative sensibility and focused on the details of specific conditions, the research contained in this collection recognizes diversity and plurality of form. It also presents a range of critical perspectives, if transposed into a minor key. Although its findings may at times prove disconcerting to practitioners, the discomfort is more likely to stem from recognition than any sense of shock or surprise. Many of the themes that emerge are all too familiar: programs that either collapse into a vacuum or build self-perpetuating institutions, tensions between national and international personnel, a potent mix of naiveté and moral energy, unintended consequences of well-intended action. Yet their combined presentation does not lend itself to sweeping denunciation or a general, alternative prescription. Rather, an ethnographic focus mirrors the clinical scale in exploring small truths. If hard to generalize into sweeping theory or policy, its findings nonetheless offer a reminder of the fluid, relational sense in which people experience aid in action. They are in that sense radically empirical and situated, and therefore immediately real.

The Humanitarian Pharmakon

To push the medical analogy further, I will add another reference within it: the polyvalent, irreducibly ambiguous Greek term *pharmakon*, which can translate as both remedy and poison (Derrida 1981). Beyond gesturing to the intriguing linguistic complex connecting ancient sacrifice and modern pharmaceuticals, the *pharmakon* literally recalls the vital importance of

practice. A substance can save you or kill you, depending on the amount and manner consumed. In medical terms the thin line between help and harm finds its measure in dosage and the careful calibration of a compound to particular bodies, as understood through concepts of population and history. When taken in tandem multiple additives can interact, further complicating any sense of balance and requiring a trade-off between desirable and undesirable states. At its very core, the practice of medicine involves compromises, adjustments, and imperfect goods.

Approaching humanitarianism in these terms alters the field of expectations around it. Even elemental concerns of basic human survival—food, water, shelter—appear less as timeless matters of sheer presence and absence and more as evolving problems of calibration. What sort of food? How much? For how long? When viewed through the shifting prism of the *pharmakon*, these are not simply technical questions, however much they might call deeply and repeatedly on instrumental knowledge. The moral stakes of humanitarian action stretch beyond any certain code of conduct into the lived ethics of relations, where political judgment remains unsettled. The focus shifts away from pure intentions and principles and toward contingent actions and effects. One worries less about evil and more about mistakes and malpractice. At the same time an appeal to the *pharmakon* works against the unbridled hubris of expertise and technical responses. Medical treatment can help alleviate maladies, but it also can have little impact or even cause iatrogenic harm. The magic bullet that misses its target might fall flat or wreak havoc through a population as well as a single body. Similarly a humanitarian program that appears successful in one context might stall or fail in another. Rather than an ever-growing store of sure remedies, dispensed with effective measures for impact, we are left with a partly contradictory set of “lessons learned” as well as altered lives and expectations. Under such scrutiny, humanitarian practice—like any form of practice—grows less clear or simple.

Taken together, the chapters in this volume paint a varied and complex tableau of humanitarianism in action. They insert the ambivalence of experience into more general accounts, adding cautions, nuance, and the uncertainty of specific dilemmas. As the editors note in their introduction, however, this emphasis on context includes common threads, such as a dynamic understanding of human relations and a material conception of practice. It thus does not entail a simple rejection of the humanitarian enterprise or its relevance—indeed, quite the opposite. This ethnographic

approach recalls how medical humanitarianism involves supplies and instruments as well as projects, situated persons and their interactions as well as organizations. Those dispensing and receiving aid may be acutely aware of this when engaging in their respective roles, but such details rarely feature in either public representation or formal analysis. Nonetheless they do matter acutely in practice. As the chapters included here demonstrate, there is no final solution to the continual cascade of humanitarian dilemmas. Instead the challenge appears to be one of adjustment and ceaseless recalibration, recognizing effects and missteps with appropriate humility.

Widening the focus on humanitarian actors to include national staff and national medical professionals brings other questions to the fore. As Patricia Omidian and Catherine Panter-Brick remind us, in many settings the delivery of humanitarian aid involves large numbers of people working in the context in which they also reside. Relying on national staff for the provision of healthcare might mitigate some problems, reducing the exposure of expatriates to kidnapping and damping anticolonial anxieties about occupation, but it also increases the level of risk and stress these local humanitarians experience. The program the authors describe in Pakistan responds to a need created by the practice of aid itself. They also recognize the significance of dignity, often the poor cousin to health in humanitarian initiatives. Rather than a rhetorical, floating conception of human worth, here dignity appears an intimate matter of daily work and its purpose. Laura Wagner addresses related tensions in Haiti, where an influx of foreign professionals, particularly following the 2010 earthquake, affects the status and livelihoods of Haitian doctors and even émigrés. While aid projects may seek to foster a transition to sustainability and development at a policy level, at an experiential level their presence evokes a complex range of emotions and expectations. How to be a self-respecting Haitian professional, provide for a family, and *not* work for an international nongovernmental organization (NGO)? Personal feelings and relations offer opportunities as well as dangers. From a perspective in Ethiopia, Lauren Carruth observes how peacebuilding might depend as much or more on a delicate fabric of trust woven across ethnic lines by skilled national staff as on any formal agreements. Working slowly, and relying on situational judgment, patience, and charisma, a tiny mobile medical team might accomplish as much as a phalanx of diplomats armed with official protocols.

Attending to details can also reveal the illusions hidden in larger humanitarian stories, along with the powerful current of sentiment that

sustains them. Alex de Waal introduces simple accounting into the moral clamor surrounding Darfur, demonstrating how the actual pattern of deadly violence has followed a different distribution and timeline than international commentary about genocide would indicate. Perception may prove the most intractable component of any emergency, just as a diagnosis may have its own, complicated afterlife independent of particular symptoms. On the basis of his long engagement in northern Uganda, Tim Allen finds a parallel confluence that produced inverse results. Operating within a highly circumscribed understanding of the context and its problems, international organizations focused on HIV/AIDS and abducted children while ignoring their own *de facto* participation in a vast internment program of civilians in displacement camps. The camp, that emblematic figure of both humanitarianism and genocide, can offer either remedy or poison. Once inscribed in a self-reinforcing emergency narrative, however, such ambiguity vanishes in the face of moral certainty. Questions about who constitutes a worthy recipient of aid, and who feels an obligation to provide it, soon recall the porous frontier between ethics and politics. Jean-Hervé Jézéquel further complicates this border zone by describing how an NGO might at times resemble a wandering leviathan. Recounting MSF's efforts to respond to famine in Niger with a massive infusion of therapeutic food, he underscores the contingency of decision making and the uncertainty of authority, including his own position as expert analyst. Although the intervention might appear like a coup of sorts, it proved a limited and temporary one. The immediate focus on saving lives did not address the more general problem of governing the country or ensuring longer-term food security.

Humanitarian intervention thus disrupts the logic of state sovereignty, but not always fully or in the same way. Focusing on the legacy of Médecins Sans Frontières (MSF) in Liberia, Sharon Abramowitz documents the vacuum that can appear when large projects close following the formal end of conflict. The very scale and efficiency of an NGO medical intervention can undermine faith in state capacity, even as organizations reserve the right to withdraw and deploy resources elsewhere. If the humanitarian apparatus does not achieve its own form of sovereignty, it certainly remains resolutely mobile and invested in the exceptional logic of emergency. A stronger state, however, quickly curbs such exceptions to its rule, as Byron Good, Jesse Grayman, and Mary Jo DelVecchio Good illustrate in their chapter on post-tsunami Aceh, Indonesia. Here humanitarian mobility runs aground on

bureaucratic regulation and the imposition of military curfews. To operate, NGOs must cooperate with established authority to a far greater degree, and their projects remain in the shadow of the state rather than the other way around. Whether or not such conditions are more desirable for the civilian population in a long-running insurgency, however, remains an open question. The sword of state sovereignty can cut both ways. If non-state actors sometimes appear to claim the crown, robust agents of state power can also pursue humanitarian ends. Stuart Gordon reminds us that the terrain of medical humanitarianism includes military doctors and that they play an inherently conflicted role, caught between dual dictates of medical and military priorities. Healthcare conducted by forces of war, openly aligned with state interests and equally equipped to pursue violence, epitomizes the ambiguities of intervention. It is precisely in such conditions that civilian humanitarians rediscover their claims to neutrality, however positioned or compromised such principles might become in application.

The fulcrum of practice humbles even the clearest precepts and the most triumphal results. Who could argue against the need for medicine to attend to evidence? And yet what if the norms of “evidence-based medicine” cut into the actual distribution of healthcare delivery? Peter Locke explores this quandary in Sierra Leone, where a small, well-intentioned, transnational clinical venture seeks legitimacy and sustainability and yet simultaneously raises questions about its ethics and accountability. On a different scale, Amy Moran-Thomas tells a similarly discomfiting story, showing how a great triumph of global health—the near eradication of guinea worm—looks less certain when facing a cup of unclean water and an inadequate diabetes clinic in Ghana. Whether large or small, projects reflect choices about priorities. In settings with a surplus of suffering, the diversion of funds and attention in one direction reveals gaps in another. Ilil Benjamin describes a similar balancing act with regard to nongovernmental medicine and the treatment of non-citizen immigrants in Israel. Poised between offering humanitarian assistance and advocating human rights, volunteers for an Israeli NGO balance the well-being of individual patients against the assertion of a more general claim for justice. They also engage in a complex dance with government hospitals over payment, while recognizing limits and guarding the public profile of their cause.

In sum, the volume charts a complex and uncertain terrain, offering more in the way of aporia (Fassin 2011) than denunciation. Once down in

the dust and the details we see lots of disturbing effects and few clear strategies, let alone recipes for success. Following another analogy introduced by Moran-Thomas, perhaps humanitarian efforts resemble the fog of war more than formal politics. At the very least we should begin to recognize such healthcare as a shifting and plural endeavor.

Pluralism and the Limits of Medicine

If medicine may be good to think with regard to humanitarianism, the inverse is just as true. Anthropologists have long recognized medical pluralism in terms of competing healthcare systems. Alongside biomedicine, other inherited practices have acquired the designation of “traditional” medicine, even as some have experienced their own reinvention and globalization (e.g., Langford 2002, Zhan 2009). From the perspective of many patients in the world, healthcare is field of options, not a single form. In these moments of comparison, however, it grows easy to overemphasize the unity of biomedicine itself. The actual diversity of biomedical practice—not only its own understanding of human variation and bodily forms but also the divergent traditions, engagements, and assumptions it encompasses—fades from view (Berg and Mol 1998, Good 1994, Lock and Nguyen 2010). In achieving hegemonic primacy, the vast, sprawling endeavor of modernist healthcare projects a false sense of unity.

Once turned to humanitarian ends, however, biomedicine reveals its diversity in action. The medical sense of emergency itself provides a pivotal point of intersection and divergence. Although now so conceptually linked with medicine that it is hard to imagine one without the other, emergency in the lifesaving sense of resuscitation only took shape about a century ago (Nurok 2003). The emergency room of contemporary hospitals and the specialty of emergency medicine are even younger, roughly paralleling the rise of a new aid regime following World War II. In this space biomedical specialties meet: the emergency room functions as a heterogeneous intake filter, in which all manner of maladies present themselves. A broken leg, a gunshot wound, a burst appendix, heart palpitations, a strange rash, dementia, accidents, rising fevers—the emergency physician deals with ailments across a spectrum of specialties (Sklar 2010). This convergence, however, remains strictly temporary. When the critical moment passes, a bed opens, a surgical slot appears, then the course of treatment returns to an established track of

specialization. And here the diversity of biomedicine quickly grows apparent. The sensibilities of surgery are hardly those of psychiatry; their sense of intervention and engagement, of patient history and medical relationship diverge starkly in practice. Internal medicine operates at a different scale than does public health, one focusing on individual bodies where the other engages populations. In humanitarian aid settings, with porous boundaries and limited opportunities for referral, this diversity emerges starkly into view.

Like emergency medicine, medical humanitarianism has its roots in war. However, a large organization like MSF may now sponsor projects drawing on all manner of traditions and extending well beyond conflict settings. These entail different personnel and technical infrastructure and operate with different spatial and temporal expectations. Diseases, moreover, have their own specificities: where cholera is quick, HIV/AIDS is slow. In endeavoring to treat the latter as well as the former, MSF also changed itself (Redfield 2013). At the level of practice medical humanitarianism appears increasingly plural. Indeed, the actors described in the pages of this book undertake a wide variety of activities in the name of care: operating rural clinics and urban hospitals, offering malnourished children therapeutic food, providing mental health services, conducting an international campaign to eradicate a parasitic disease, and even training aid workers to relieve their own stress. As Foucault (2000) once noted, health operates as an inflationary concern, having no internal principle of limitation.

Here we come to a final point: the worn observation that humanitarianism, like medicine, has limits. As innumerable critics have noted—academic and practitioner alike—humanitarian aid cannot escape politics. Indeed, humanitarianism may reflect a contemporary mode of government, one that invokes a discourse of suffering and yet cannot evade the violence and inequality to which it responds (Fassin 2011, Ticktin 2011). However much a clinical analogy may prove helpful for returning our analytic focus to practice, it never implies an antiseptic remove. Medical care is ever partial, even when delivered impartially, and often contested. Its form of resuscitation, moreover, proves ultimately temporary. In the ethnographic frame of this volume, humanitarianism likewise seems at once crucial and dangerous, sometimes unsettling, often unsatisfying, and ever uncertain. It appears, in short, a measured good.

Note

1. According to the radar of Google's amassed book data, the phrase appears as a blip following World War II and then takes off precipitously near the end of the

twentieth century (Google Ngram viewer. http://books.google.com/ngrams/graph?content=medical+humanitarianism&year_start=1800&year_end=2008&corpus=15&smoothing=3&share=Feb+1,+2015).

References

- Abu-Sada, Caroline, ed. (2012) *In the Eyes of Others: How People in Crises Perceive Humanitarian Aid*. New York: MSF-USA.
- Barnett, Michael. (2011) *Empire of Humanity: A History of Humanitarianism*. Ithaca, NY: Cornell University Press.
- Berg, Marc and Annemarie Mol, eds. (1998) *Differences in Medicine: Unraveling Practices, Techniques and Bodies*. Durham, NC: Duke University Press.
- Calhoun, Craig. (2008) "The Imperative to Reduce Suffering: Charity, Progress and Emergencies in the Field of Humanitarian Action." In *Humanitarianism in Question: Power, Politics, Ethics*, edited by M. Barnett and T. Weiss, 73–97. Ithaca, NY: Cornell University Press.
- Derrida, Jacques. (1981) "The Pharmakon." In *Dissemination*, edited by B. Johnson, 95–117. Chicago: University of Chicago Press.
- Dunant, Henry. (1862 [1986]) *A Memory of Solferino*. Translated by T. b. A. R. C. 1939. Geneva: International Committee of the Red Cross.
- Fassin, Didier. (2011) *Humanitarian Reason: A Moral History of the Present Times*. Berkeley: University of California Press.
- Foucault, Michel. (2000) "The Risks of Security." In *Power: Essential Works of Foucault, 1954–1984*, edited by J. Faubion, 365–382. New York: The New Press.
- Good, Byron J. (1994) *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.
- Langford, Jean. (2002) *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*. Durham, NC: Duke University Press.
- Lock, Margaret and Vinh-Kim Nguyen. (2010) *An Anthropology of Biomedicine*. Boston: Wiley-Blackwell.
- Mol, Annemarie. (2002) *The Body Multiple: Ontology in Medical Practice, Science and Cultural Theory*. Durham, NC: Duke University Press.
- Nurok, Michael. (2003) "Elements of the Medical Emergency's Epistemological Alignment: 18th to 20th Century Perspectives." *Social Studies of Science* 33 (4): 563–579.
- Redfield, Peter. (2013) *Life in Crisis: The Ethical Journey of Doctors Without Borders*. Berkeley: University of California Press.
- Sklar, David. (2010) *La Clinica: A Doctor's Journey Across Borders*. Albuquerque: University of New Mexico Press.
- Ticktin, Miriam. (2011) *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.
- Zhan, Mei. (2009) *Other-Worldly: Making Chinese Medicine Through Transnational Frames*. Durham, NC: Duke University Press.