

Where ethics and politics meet:

The violence of humanitarianism in France

ABSTRACT

I examine the role of humanitarianism and compassion in an emergent ethical configuration that makes illness a primary means by which undocumented immigrants obtain legal residency (“papers”) in France. I argue that the sacred place of biological integrity in this ethical discourse leads immigrants to trade in biological integrity for political recognition. I demonstrate first how humanitarianism has been transformed into a form of politics, functioning as a transnational system of governance tied to capital and labor even while purporting to be apolitical. I focus in the second half of the article on the consequences of humanitarianism as politics, which include new biopolitical practices, unexpected diseased and disabled citizens, and a limited version of what it means to be human. [*medical humanitarianism, human rights, France, anthropology of ethics, biopolitics, immigration, citizenship*]

While I was conducting fieldwork in Paris, the former president of the gay-rights activist group Act-Up Paris told me that he had received phone calls from undocumented immigrants inquiring how they could infect themselves with HIV and thereby obtain legal status in France. Although this particular account of HIV self-infection is anecdotal, the rhetoric of willed self-infection can be located in the larger reality I observed during the course of my research between 1999 and 2001: I increasingly saw undocumented immigrants, or *sans papiers* (lit. those without papers), turn to physical injury or infection to claim the basic rights supposedly granted to all “human beings.”¹ This tendency to turn to illness for papers occurred in the wake of the limited success of the social movement by and for undocumented immigrants in France to secure basic human rights. It also coincided with the introduction of a humanitarian clause in French law—what I call the “illness clause”—that gives people with serious illnesses the right to stay in France and receive treatment.²

In this article, I examine the role of humanitarianism and compassion in the development of an ethical configuration that has made illness a primary means by which to obtain papers in France. I open with the HIV anecdote to introduce the notion of the often-unintended consequences of ethical discourses such as humanitarianism or practices that claim to further social justice. More broadly, I use this example as an entryway into what I see as an incipient or emergent ethical configuration in which people end up trading in biological integrity for political recognition.

The sacred place of biological integrity in this emergent ethics became apparent to me over the course of my fieldwork with undocumented immigrants. I initially went to Paris to examine the promises and failures of human-rights discourse in the *sans papiers* movement and, more broadly, to understand transnational ethical and legal regimes. Thus, in addition to working with *sans papiers* organizations and nongovernmental organizations (NGOs), I conducted research at various hospitals, state medical offices, and clinics both within and just outside of Paris that focused on

marginalized populations (those *en situation de précarité*).³ In the clinics, social workers and doctors worked hand in hand, driven by the conviction that social and medical issues are intertwined, particularly for those designated “les exclus” by the French—society’s excluded. Early on in my observations, however, I noted that the first question many social workers asked their undocumented clients was, “Are you sick?” and if an individual answered yes, they would ask almost too eagerly, “How sick?” I gradually understood that the answer they hoped for was “Very sick,” because it provided clients with the one clear means by which to apply for papers. A woman from an immigrant-rights association confirmed this conclusion at a workshop on sans papiers and HIV/AIDS, stating, “Isn’t it terrible? We almost wish for illness when we talk to sans papiers.” This wish for illness, of course, was not born of malice but of a desire to better help the undocumented.

The illness clause is a provision of the 1998 amendment to the Ordonnance of 2nd November 1945 no. 45–2658 on Conditions of Entry and Residence of Foreigners that grants legal residency permits to those in France with pathologies of life-threatening consequence if they are declared unable to receive proper treatment in their home countries.⁴ The logic behind this provision was humanitarian and exceptional; indeed, legal permits for illness are officially given for “humanitarian reasons.” The French state felt it could not deport people if their deportation had consequences of exceptional gravity, such as their deaths.

Despite the goal to keep it exceptional, the illness clause—instituted as a humanitarian provision—has come to play an important role in the politics of immigration. In this article, therefore, I explore the consequences of a politics of immigration largely grounded in a humanitarian logic. How does humanitarianism function as politics—how does it address inequality and injustice? My main contention is that, when humanitarianism, often enacted through a moral imperative of compassion, fills in for the failure of political-rights discourses and practices, the exclusionary effects can be brutal; indeed, I argue that, rather than furthering human dignity, the result is a limited version of what it means to be human. By drawing on ethnographic examples of how humanitarianism works on the ground, in “a space of concrete problems, dangers, and hopes that are actual, emergent, and virtual” (Rabinow 2002:145), I trace its contours and its often-counterintuitive consequences.

My argument has two main theoretical points. First, I suggest that humanitarianism, although driven by the moral and ethical imperative to relieve suffering, can have discriminatory and even violent consequences in the absence of guiding political principles and practices. These consequences are all the more striking because they are unexpectedly found at the very heart of the compassion that grounds humanitarian action. Here, I engage in a debate

about the contemporary resurgence of discourses of moralism and how they blur boundaries between legal, political, and ethical–moral orders. I am particularly interested in the growing emphasis on the role of compassion, sympathy, and benevolence in political life—sentiments that play a crucial part in the discourses of what some call “global civil society.” NGOs fighting in the name of human rights, environmentalism, and cultural preservation, among many other causes, intervene on behalf of a moral order, each fighting for a role in “the global meritocracy of suffering” (Bob 2002).

One of the most prominent of these movements is humanitarianism, which grew in global importance and visibility over the course of the 1990s. The massive proliferation of humanitarian organizations, the awarding of the 1999 Nobel Peace Prize to Médecins Sans Frontières (MSF, or Doctors Without Borders), and the entry of humanitarianism into common political discourse—illustrated by British Prime Minister Tony Blair’s government calling the bombing of Kosovo a “humanitarian bombing”—are just a few examples of its growing presence.⁵ There has been a concomitant focus on suffering, in the name of which humanitarianism intervenes.⁶ As just one example, the diagnosis of posttraumatic stress disorder (PTSD) has increased exponentially in recent years, giving public prominence to the suffering and trauma endured in a variety of contexts, from military interventions to domestic disputes.⁷ Yet how does the recognition of suffering result in a political program for change? Although the question of how moral demands translate into politics has a history as long as political philosophy itself, I am interested in its current manifestation precisely because moral demands have increasingly filled the space of political action.

Whereas scholars such as Wendy Brown and Chantal Mouffe have argued that the tendency to moralize has taken the place of political action, I make my second but related point by suggesting that this moralism has created another type of politics, even while being labeled *apolitical*.⁸ I engage here in the contemporary debate about biopolitics and humanitarianism, which relies heavily on work done by philosopher Giorgio Agamben. Agamben, in turn, builds on the intersection of works by Michel Foucault and Hannah Arendt. Agamben (1998:133) suggests that humanitarian organizations can only function by grasping human life as “bare life,” the Greek *zoe*, the fact of living common to all beings—life unqualified by the political and social communities that distinguish humanity from other types of life. Bare life is life excluded from the polis, and insofar as human beings are political or social beings, the polis marks the boundary between human and nonhuman. In fact, my research suggests that humanitarianism does not simply produce or reproduce bare life as separate from political life, even if the protection of bare or biological life is its goal; rather, it allows for the recombination of bare life and

political life in new ways, such that the political dimension of human life is never lost. Political subjects can be found in the most “apolitical” of spaces. The political aspect of life, however, is radically transformed—often in undesirable ways. In other words, the political choices allotted to *sans papiers*, although still choices, are composed of undesirable options: poverty, exploitation, exclusion, or illness.

In this article, I first discuss how humanitarianism has been transformed into a form of politics, functioning as a transnational system of governance tied to capital and labor even while purporting to be apolitical. To this end, I examine the distinction between human rights and humanitarianism, or between a juridical and a humanitarian logic, grounding my argument in the context of French immigration policies. I then examine the illness clause as a practical example of the turn to a humanitarian politics.

I focus in the second half of the article on the consequences of humanitarianism as politics. I fill out my argument that the joining of ethics and politics actually limits rather than expands notions of humanity. Thus, I describe new biopolitical practices and the unexpected diseased and disabled citizens that are produced by humanitarianism as a system of governance, and I end by discussing how a limited humanity is produced on the ground by a politics of compassion. I show that the humanity protected is one of suffering bodies and biological life devoid of social and political content; yet this is a notion of humanity that, even in its minimalism, keeps intact racial and gender hierarchies. Indeed, the struggle to define citizenship and the borders of the nation-state is now also a struggle to define the threshold of humanity and of life itself.

My intention in this article is not to call into question people’s illnesses or disabilities as somehow inauthentic but, rather, to understand the effects of a new “biosocial” space, and here I draw on Paul Rabinow’s (1996) concept not only to refer to a social community created by shared illness but also to indicate the way that biology is used as a flexible social resource. For instance, once an undocumented immigrant is given papers for illness, he or she might choose to escape this biological community in favor of another political or cultural identity. Biosociality here becomes the socially framed choice to draw on one’s biology.⁹

I write, finally, with the recognition that in exposing the violence at the heart of this humanitarian practice, I may be helping to further undermine a key opening to legality that *sans papiers* have benefited from. Yet I do so because the underlying regime of which it is a part is, ultimately, inherently destructive, not only reproducing a racially stratified society built on the colonial legacy but also maintaining certain people as less than human. Moreover, the violence inherent in this particular French ethical configuration has larger global echoes. Ultimately, my underlying question concerns the notion of humanity promoted by a politics based on

humanitarianism—what is the image of the human that this politics projects?

The shift from human rights to humanitarianism

The issue of illegal immigration erupted into the French public imagination in 1996, when a powerful social movement calling for basic human rights for illegal immigrants gained world media attention through the occupation by 300 African immigrants of the Saint Bernard church in Paris. The ensuing violent eviction by French police of the immigrants, many of whom were women and children, caused an uproar. The movement organized by and for these immigrants changed their labeling from *illegal immigrants* to *sans papiers*. This was a self-conscious move away from the image of criminality and suspicion associated with clandestinity to one of people deprived of basic human rights, and the movement played on the idea of this happening in what the French themselves like to think of as the “home of human rights.”

To understand the terms chosen by the *sans papiers*, the place of both human rights and humanitarianism in the French imaginary and in French public debate is crucial to note. France is the originator of both the NGO MSF (now nearly synonymous with humanitarianism in the contemporary world) and the 1789 Declaration of the Rights of Man and Citizen, on which the 1948 UN Declaration of Human Rights is largely based.¹⁰ The French, therefore, have much invested in their identity as global moral leaders, especially in today’s climate in which geopolitics and moral codes are intimately intertwined. Perhaps even more important for my purposes is the distinction between human rights and humanitarianism—a distinction that is not always evident in the U.S. context but is more clear in the French one.¹¹ My goal here in laying out the somewhat analytical distinction between humanitarianism and human rights is to examine what happens when humanitarianism is forced to take on a primary role in government, largely subsuming a system based on rights. Without advocating for a regime of human rights at the expense of humanitarianism, I am interested in the consequences of a humanitarian logic filling in for the failure of rights discourses and practices.¹²

Although both human rights and humanitarianism are complexly constituted transnational institutions, practices, and discursive regimes, in a broad sense, human-rights institutions are largely grounded in law, constructed to further legal claims, responsibility, and accountability, whereas humanitarianism is more about the ethical and moral imperative to bring relief to those suffering and to save lives; here, the appeal to law remains opportunistic.¹³ Although both are clearly universalist discourses, they are based on different forms of action and, hence, often institute and protect different ideas of humanity. The political discourse of human

rights has its origins in the French Revolution and the Enlightenment movement away from religion and toward a secular vision of humanity, whereas humanitarianism was initially a form of religiously inflected charity.¹⁴ Even the “new” humanitarianism—which can be dated to the 1970s and the founding of MSF, followed by the development of an industry of NGOs—often perceived reason to be an “enemy of humanity” because this medical humanitarianism advocated action on the basis of emotion;¹⁵ founders such as Bernard Kouchner and Xavier Emmanuelli both identify the Catholic Church as a forerunner and inspiration (Taithe 2004).¹⁶

Human rights and humanitarianism do, of course, overlap, and humanitarianism cannot be defined accurately just in terms of religion, or emotion, or as outside the political or legal realms it necessarily engages with: Indeed, humanitarianism is legally instituted through the laws of war. Thus, although Fiona Terry of MSF states that three of the fundamental principles of humanitarian action are neutrality, impartiality, and independence, crucial to forge “a humanitarian space . . . separate from the political” (2002:19), she recognizes that such a separation is seldom possible in practice.¹⁷

The French situation reveals such a shift in emphasis from rights to the practices of humanitarianism in regulating immigration. The issue of “les sans papiers” was one of the major platforms on which the Socialists entered into power in 1997; Prime Minister Lionel Jospin’s government promised to deal with sans papiers more generously, respecting their basic human rights. Despite this rhetoric, the promised reexamination of cases of undocumented immigrants in 1997 and the new law in 1998 on entry and residence of foreigners were both much less generous than promised. The reexamination of cases on the basis of more-favorable criteria—an “amnesty” of sorts—only gave 80,000 people papers, fewer than half of those who applied, and many sans papiers still found themselves without papers, despite fulfilling the required criteria. Struggles are ongoing for the basic right to freedom of movement in the new borderless Europe, the right to housing and autonomy, and the right to be free from violence and exploitation;¹⁸ I both participated in and witnessed a continuous stream of protest marches, occupations of buildings, and hunger strikes. Despite the proliferation of human-rights NGOs, and regardless of the protests that take place at a rate and level rarely attained elsewhere, very little ground has been gained.¹⁹ These cries for human rights fall on now-deaf state ears—a reality that has only been confirmed and exaggerated with the turn to the right in France after the 2002 elections.

Indeed, the social movement seems to have come to an impasse with its appeals to human-rights principles. The larger context is one in which refugees have been increasingly viewed with suspicion by both the French state and the French public and conflated with economic migrants. This conflation has been made explicit in recent policies of

restricting asylum to control migration flows, joining two processes that should be entirely independent. As Hubert Védrine, the minister of foreign affairs stated, “The practice [of asylum] followed must maintain a just balance with our desire to control migration flows” (1997; cf. Delouvin 2000:70).²⁰ More broadly, asylum policies must be seen as part of prohibitionist, restrictive immigration policies, in which the state seeks to close all doors.²¹ In this climate of closure, many examples can be cited of human-rights violations by the state itself, not to mention by nonstate actors; for instance, immigrants are imprisoned in detention centers without trial, despite condemnations of the inhumane and insalubrious conditions in the centers.²² Similarly, immigration officials are known to be utterly arbitrary in their dealings. My interviews with both sans papiers and immigration officials, combined with my experience in accompanying sans papiers to state offices, revealed that how one is treated depends on which immigration office one goes to, the official one meets at the desk, how many that official decides to admit that day, the “look” of the immigrant, and so on. Undocumented immigrants are subject to entry on a case-by-case basis and have to prove their merit without knowing the rules being applied.

Paradoxically, this arbitrariness was exaggerated by the new law that went into effect in 1998, which added Article 12bis, the right to “private and family life,” to the two previously existing conditions for legal immigration—family reunification and asylum.²³ Drissia, a 50-year-old woman of Moroccan origin I met through an activist group for undocumented women, revealed to me the extent of this paradoxical situation. In the absence of a spouse or children in France that would allow one to enter under the family reunification clause, Article 12bis°3 gives those who have lived in France for ten consecutive years the right to papers. Residency, however, must be proven, not simply declared. Drissia had been in France for over ten years, which qualified her for papers; yet, despite what immigrants-rights’ lawyers believed was proof of her uninterrupted presence on French soil, her request had been turned down multiple times. I saw her alternate between tears and deep anger, often in one sentence, at the sheer frustration of being treated as though she did not exist. As Drissia’s case illustrates, what counts as proof of uninterrupted presence is unclear—it depends on the interpretation of each immigration official. For people who have been trying to erase any trace of their presence so as not to be deported, providing official proof of each month of residence for over ten years is a nearly impossible task—practically a contradiction in terms.

The inscription of this article in the law, thus, in many ways simply legitimized the arbitrariness practiced by the *préfectures* (local governments), working along the lines of what immigrant-rights lawyer Danielle Lochak (2001) calls a “humanitarian” logic rather than a juridical one.²⁴ Law always involves interpretation, and it is always enacted in

specific contexts that help determine its meaning; the difference here is that, because the law is so open-ended, those asking for the protection it affords are entirely dependent on eliciting the compassion or pity of those enacting it. Indeed, this open-endedness takes on even more significance in the French context, in which the civil-law tradition involves applying the law, not interpreting or building on it.

The new clause is not alone in being subject to arbitrary application; family reunification and asylum have been equally compromised. Indeed, one result of the new clause is that claims for family reunification and asylum have been increasingly redirected toward the more restricted and ambiguous private and family life clause, limiting the number of people accepted for asylum or family reunification, to which more-comprehensive rights are attached. The creation of a new type of asylum—"subsidiary asylum"—which comes with fewer attendant rights, is another example of the increasing attempt to limit people's ability to claim rights.²⁵ This is the consequence of a politics of immigration based on closure (Lochak 2001:41).

To understand the nature of this politics of closure, which has resulted in an increasingly important role for humanitarianism, it helps to take a step back here to emphasize the context in which this is all happening. At an event to support *sans papiers*, Ahmad, an ex-*sans papiers*, said to me incredulously, "It was so much easier to find work on the black market! I never had trouble. Now that I have papers, I can't find work." In France, as elsewhere in the industrialized world, a significant tension has emerged: As increasingly restrictive legislation has forced borders closed, transforming the so-called open European space into Fortress Europe, the black market and informal economies have grown, and labor conditions are otherwise changing to favor temporary, insecure forms of labor with no legal protection. In this sense, the increased demand for workers in the agricultural, garment, and construction industries in France is met by closed juridical doors: Undocumented immigrants are desired precisely because they can be denied all rights.²⁶ Ahmad exemplifies this tension between industry wanting and needing labor and the nation-state refusing to let people legally onto its territory. The French state is complicit in this process, having passed laws that produce a category of persons who are neither legalizable nor deportable. On another register, this liminal status is part of an increasing tension between regimes of circulation for capital and people—capital circulates freely, whereas people cannot—a consequence of the changed relationship between states and capital.²⁷

How does this political economy relate to the shift to humanitarianism? Both the discourse and practice of medical humanitarianism have followed this flow of exploitable labor from the South into the urban centers of the industrialized North; just as MSF started by intervening in crises of governance and economy in the South, so, too, it now intervenes in industrialized centers like Paris—cities in which it

has established offices for local concerns. Just as it protects a particular vision of life in war-torn zones, working to ease the immediacy of suffering, so, too, it now intervenes to ease suffering when the larger societal and political structures of the North fail to do their job—when they let increasingly large portions of their population fall through the cracks. Here, medical humanitarianism governs the less desirable portions of the population when the state abandons them.²⁸ In this sense, ethical systems in the form of medical humanitarianism are part of the transnational circulation of capital and labor, linking the political economy of immigration to the political economy of health and illness.²⁹

The illness clause

The illness clause emerged as an alternative to human-rights discourse and discourses of social injury for those whose appeals to rights did not easily coincide with state interests or whose positioning has not allowed their claims to be heard.³⁰ To reiterate, the 1998 amendment grants legal residency permits to those already living in France who have pathologies that entail life-threatening consequences if they are declared unable to receive proper treatment in their home countries; the goal is to permit them to receive treatment in France.³¹ Indeed, it was the lobbying of medical humanitarian groups such as MSF and Médecins du Monde (Doctors of the World) that helped turn the illness clause into law in France in response to what was perceived as arbitrary treatment of those who were sick—sometimes helping them, sometimes deporting them.

The "illness permit" was instituted formally in 1998. That is, only in 1998 did the Ministry of Health officially become involved in the immigration process, which normally falls under the rubric of the Ministry of Interior. Nevertheless, the *banlieue* (suburb) outside Paris that receives the highest number of claims for legal status began the practice of taking illness into account in claims for papers in 1990. I conducted my fieldwork primarily in this suburb and in Paris. I followed *sans papiers* through the different steps of the trajectory to papers: To access the illness clause, the *sans papiers* are referred by their own doctors to immigration authorities and then by the immigration officers at the *préfectures* to state health officials.³² It is ultimately the job of these officials to ascertain if people's conditions are of sufficient gravity to merit granting papers for treatment in France, although the permits are actually issued by the *préfectures*, with the understanding that they rely the state health officials' opinions. The state office in which I did a large part of my research is one of the few in which nurses receive the *sans papiers* in person. Other offices receive *sans papiers*' files by mail; the files are initially sorted through either by nurses or administrators and then passed to doctors. The state medical doctor can recommend that a medical certificate be granted for varying lengths of time, from a period of three months

to an indeterminate (long-term) period, depending on the illness and the doctor's interpretation of the length of treatment needed.³³ People can claim citizenship after a period of five years on the basis of their residency on French soil; thus, continual renewal of illness permits may eventually lead undocumented immigrants to citizenship.

The process is multilayered, taking different shapes and forms in different locations—very little about it is systematic. As noted, the law states that people should receive papers if they suffer from a pathology that has life-threatening consequences and they do not have access to treatment in their own country. Yet there are no lists of life-threatening pathologies and no easily accessible information on whether people can receive treatment in their home countries. The doctors are urged to contact the Direction de la Population et des Migrations (Office of Population and Migrations) for information. But no source takes into account people's substantive ability to access medical treatment: Do they live far away from city centers? Do they have the means of transport to hospitals or doctors? Do they have the money to get treatment or to continue treatment if it involves subsequent trips to medical facilities? These questions are not addressed in the guidelines. They are asked at the discretion of the medical officials receiving the case or at the préfecture beforehand. Already, one sees the discretionary power of the nurses, doctors, and immigration officials and the advantages and disadvantages that *sans papiers* derive from being able to interact face to face with state officials. Ultimately, the immigration officers at the préfecture make the decision about who will receive an illness permit and for what duration, and although, in theory, they should follow the advice of state doctors, they do not necessarily do so. Thus, although legalizing the process was an attempt to systematize the arbitrary treatment of the *sans papiers*, in practice, the illness clause has made little difference to the nature of the process. Instead, a different logic has been instituted, one based on benevolence and compassion.

With the possibility of obtaining papers effectively shut off to new immigrants and refugees—who, as I have mentioned, are seen as either criminal or economically burdensome—those already in France without papers have turned to the illness clause as a means to ease the exploitation that is a regular part of being undocumented, believing—rightly or wrongly—that papers will solve all their problems.³⁴ Statistics back up my ethnographic work, demonstrating the increasing importance of the illness clause. The local statistics from the Direction Départementale des Affaires Sanitaires et Sociales (Departmental Directorate of Social and Health Welfare; DDASS), the state medical office in which I did my research, show that applications for the illness residency permit increased seven times over the course of the 1990s and that three-quarters of applications were given positive responses. Indeed, the most recent statistics are even more striking: From 194 patients treated in 1993,

Table 1
Distribution of Recommendations for Illness Permits Given by the State Medical Doctor (MISP) in the Region Where I Observed: 1998, 1999, and 2000

Recommendation	1998	%	1999	%	2000	%
Negative	233	23	97	10	325	20.0
3 months	71	7	145	15	266	16.5
6 months	102	10	158	16	314	19.5
1 year	127	13	174	18	265	16.5
Long term	422	42	412	42	442	27.5
No opinion (lack of information)	52	5	0	0	0	0.0
Total	1,007	100	986	100	1,612	100
			889		1,287	
			accepted		accepted	

the number of those treated rose to 4,000 in 2003. Table 1 shows that the number of positive responses increased by 44 percent just in that particular *département*, from 889 in 1999 to 1,287 in 2000. Table 2 shows the types of illnesses admitted and their frequencies and the type of permit granted—top among the illnesses is HIV, but cardiovascular illnesses, cancer, diabetes, and tuberculosis are all included.

How does the French state reconcile the denial of papers to immigrants who are perceived to be economically burdensome with the decision to give papers and social services to

Table 2
Most Frequently Encountered Pathologies in the State Medical Office Where I Observed: 1998, 1999, and 2000

Pathologies	1998	%	1999	%	2000	%
HIV	113	15	124	16	156	12.6
Cardiovascular	74	10	88	11	139	11.3
Rheumatology, trauma, orthopedic	67	9	81	10	144	11.6
Cancer	49	7	50	7	57	4.6
Diabetes	44	6	41	5	89	7.2
Psychiatry	42	6	44	6	87	7
Urinary-nephrology	26	4	39	5	61	5
Otorhinolaryngology, ophthalmology	54	7	53	7	89	7.2
Tuberculosis	36	5	40	5	67	5.4
Gastroenterology	24	3	26	3	47	3.8
Pneumonic	32	4	22	3	44	3.6
Hepatitis	25	3	48	6	45	3.7
Gynecology	25	3	15	2	44	3.6
Neurology	29	4	22	3	42	3.4
Endocrine	36	5	27	4	25	2
Hematology					17	1.4
Sterility					26	2.1
Diverse (multiple pathologies)	62	8	52	7	56	4.5
Subtotal	738	100	772	100	1,235	100
In process	53		82		89	
Accompanying adults	46		85		211	
Undiagnosed					29	
Absence of pathology					48	

immigrants who are sick? Stated otherwise, why is it that illness is allowed to travel across borders, whereas poverty cannot? The framing of the illness clause helps to explain this. Although the French state instituted the illness clause out of “respect for human dignity,” it was only ratified because it was perceived as outside the political realm. That is, it was instituted in May 1998 under the right to “private and family life.” Placing this clause under the aegis of the “private” exempts it from debates about the politics of immigration, citizenship, and notions of the French nation and ignores the structural problems and economic demand that may have caused the immigration in the first place. Instead, the clause focuses attention on what is construed as an apolitical, suffering body. This clause is based on the notion of the universality of biological life—what I have already mentioned as Agamben’s “bare life.”

State officials and doctors confirmed to me that the space of pure life honored in the illness clause is conceived of in opposition to political community. In this sense, the boundaries of the political are demarcated from a purported universal and, hence, legitimate, biological realm. One such example came in a conversation I had with M. Bonnet, a member of the Conseil Constitutionnel, the highest legal body in France; M. Bonnet explained to me that one cannot intervene in the political matters of sovereign nations—except when violations of bodily integrity are at issue. Similarly, health care officials found ways to subvert politically charged immigration laws for the higher, moral cause of the suffering body. Indeed, despite increasingly restrictive legislation that has managed to alter and limit the right to health care, that right remains the most extensive of all those granted to immigrants, whatever their legal status—more comprehensive than any civil, political, or social rights (Fassin 2001a).³⁵

As proof that this clause is humanitarian and apolitical in nature and that it remains in the realm of the private, the French state does not automatically include a work permit with the illness visa—initial attempts to do so rendered the clause too politically contentious. That is to say, the work permit for those with illnesses is subject to the same arbitrary treatment as the rest of the legalization process—sometimes people are granted it, but more often they are not. The visa given for illness is thereby isolated from all other aspects of life—it is narrowly focused on the healing of suffering, injured, or disabled bodies, disqualifying its recipients from taking any economic, social, or political role in French society. Consequently, those who gain entry on the basis of chronic illness, such as those who are HIV+ and who are fully capable of sustaining a full-time job, are for the most part not given the right to work. Although their papers formally allow them to rent apartments, open bank accounts, and travel on the metro without the risk of being arrested and deported, they do not have the substantive means to rent apartments, and they have nothing to put in bank accounts and no money to buy metro tickets. Ironically, in the

name of human dignity, the French state indirectly sanctions work on the black market. In this sense, a doctor named Isabelle who worked at one of the clinics for undocumented immigrants where I observed suggested that, in her experience, the illness clause was “a curse.” It was worse than nothing because it gave people hope, and yet, because work permits were not granted with the papers, it paved the way for greater exploitation of their misery, making them work in situations of virtual slavery and prostitution. She suggested that politicians got rich on the backs of those working on the black market—“Why else are they not deported?” she asked. “It must mean that it is profitable for the state to keep them.”

Economic profitability of undocumented immigrants aside, the illness clause is also productive of a particular moral economy, in which a new hierarchy of morals takes shape and certain ethical configurations gain credence. Here, humanitarianism functions as politics and has inevitably unanticipated consequences. The threatened body associated with political asylum has been recast as suspect, conflated with that of the economic immigrant—or, in the words of former Socialist minister Michel Rocard (1996), “the misery of the earth,” which, he claimed, France cannot absorb. With humanitarianism as the driving logic, only the suffering or sick body is seen as a legitimate manifestation of a common humanity, worthy of recognition in the form of rights;³⁶ this view is based on a belief in the legitimacy, fixity, and universality of biology. As just one example of this new moral economy, Didier Fassin (2001a, 2001b) has documented that, as the number of permits for medical reasons has increased, the number granted under the title of refugee has significantly diminished.³⁷ What are considered basic human rights are themselves now circumscribed to fit the limited understanding of human life. It is in this sense that I speak of the space of the apolitical suffering body as the very center and grounding of the new politics of citizenship in France, a humanitarian space at the intersection of biopolitical modernity and global capital, in which contradictory and unexpected diseased and disabled citizens emerge.

Diseased and disabled subjects

I turn in the second half of this article to a discussion of the consequences of humanitarian governance, beginning with the counterintuitive subject positions produced by this shift to humanitarianism in the politics of immigration. Here, political subjects can be found in the most “apolitical” of spaces.

I have been arguing that this shift to seeing the suffering body as more legitimate than the threatened or deprived person reveals the desire to recognize the universality of biological life above all else: that is, to find common humanity in apolitical suffering, a universal humanity that exists beyond the specificities of political and social life. Indeed, according to Agamben, humanitarianism as a practice cannot help but

grasp human life in the figure of “bare life,” thereby reproducing the very idea of a form of life distinct from political life. Liisa Malkki has ethnographically confirmed this tendency, demonstrating how humanitarian practices make refugees into “universal man”—how they set up a “bare, naked or minimal humanity” (1996:390). Of course, humanitarianism does work to reduce people to “pure victims” (Malkki 1996), making it easier for them to be configured as objects of charity rather than of law. Yet, when one looks closely at this process, one sees that bare life and political life actually combine in new ways as a result of humanitarian practices, particularly when humanitarianism takes over the space of political action and responsibility. In other words, people elide victimhood and reduction to bare life in interesting, albeit troublesome, ways; political action is constituted as a series of biological compromises. More to the point, however, is whether this type of political action can be considered desirable or acceptable.

Part of the reason for recognizing the universality of life involves controlling, managing, and cultivating it; this is the biopolitics that Foucault (1978) speaks of, making the individual body and population part of the problem of sovereign power, in which the power/knowledge of life allows for its transformation. In other words, neither humanitarianism nor the state’s support of humanitarianism can be understood outside the context of disciplinary power—the state does not act “altruistically” in recognizing a common humanity. If life is not only the object of political struggle but also the very grounding of sovereignty, as Agamben suggests—building on Foucault—then the power to define bare life, that is, the power to draw the line and decide who and what is included and excluded from the juridical and political realms is what actually constitutes sovereign power. Paradoxically, the state’s focus on the universality of biological life is turned on its head here, given that the life the state purports to recognize (and control) through the illness clause is not familiar or “universal” at all—it is, in fact, produced as utterly foreign and unknowable in the liberal terms that constitute the French state, in which willed maiming is considered abhorrent or aberrant and the autonomous liberal subject requires bodily integrity.³⁸ In other words, these subjects call into question the sovereign power of the state by defying definition in terms familiar to the liberal French state; as a result, they also require one to probe further into the conditions under which bare life can—if ever—be isolated and excluded by the state. Political life can take shapes not immediately identified as such, recombining political and bare life in new ways; indeed, *sans papiers* demonstrate how biology is not the domain of the incontestable—biological norms are created.

Contradictory subject positions emerge from a politics based on this belief in the universality of life, but only as biological life. On one end of the spectrum is the person who infects her- or himself with HIV in an effort to be treated like

a human being, to be granted legal recognition and, hence, acknowledged as part of humanity, willfully disabling her- or himself to live more fully. If willed infection is one end of the spectrum, on the other end is the person who refuses the possibility of treatment—purposefully giving up bodily integrity to maintain human dignity in the face of the stigma of HIV/AIDS. Here, bodily integrity and human dignity are decoupled and differently reconfigured. For instance, one day as I sat with the state nurses while they attended to undocumented patients requesting papers to stay and receive treatment in France, I watched as a woman named Amina refused to even speak the name of her illness. The nurses questioned her many times: “What do you have?” they asked. “What are your symptoms?” She shook her head and said nothing. Originally from Mali, Amina had come with her baby strapped onto her back in a colorful wrap, and she spent her time unraveling herself and the baby to change his diapers, responding distractedly to the nurses’ questions. She handed over a slew of documents, both medical and legal—the telltale pile of papers that all those who are “paperless” must carry wherever they go—a cruel irony, indeed; after the nurses had thumbed through the majority of her documents, their attitude suddenly changed from mild annoyance to care and concern. And one nurse asked her again, “Do you really not know what you have?” This time, Amina responded that, yes, yes, of course, she did. She left it at that—the illness remained unnamed. The nurses promised her papers and told her to take care of herself and the baby. When she left, I was told that both Amina and her baby were HIV+.

This phenomenon was explained to the nurses and me by another woman named Fatoumata, who also opened up exceedingly hesitantly when questioned. Fatoumata had recently been released from prison. She had been arrested on drug-related charges and had been infected with HIV through needle use. She told us about the many infected African women in Paris who simply reject the opportunity to obtain a visa that would not only grant them basic rights, such as the right to housing, but would also permit and pay for their regimen of triple therapy—a visa that would literally provide them with both the right to live and life itself. The stigma of HIV/AIDS is so great in their communities that they would rather compromise their bodily integrity and pay with their lives than live ostracized and without dignity. Fatoumata had a tough exterior, but when she mentioned her inability to trust her closest family or friends with the news that she was HIV+, she began to cry softly.

In talking to Fatoumata, I became aware of the gendered nature of the stigma of HIV/AIDS among African communities in France. All pregnant women in France must, by law, be tested for HIV, whereas men are never forced to get tested. Thus, more women find out about their illness than do men, leading to an unequal gender dynamic and a particularly gendered stigma in African communities. Indeed,

this dynamic has the consequence of increasing the numbers of women granted papers through the illness clause; it also results in more women than men having to lead double lives, hiding their diagnosis from their loved ones, or leading lives that define them solely in terms of their illness, existing outside all community affiliation except for the patient groups they may belong to.³⁹ In other words, this stigma creates a subject position for women, in particular, in which their reason for living becomes their illness—it becomes their only source of social recognition—yet it is also their death sentence.

Further illuminating the various subject positions created by the structural situation that favors suffering and sick bodies, the nurses told me about cases of people purposefully not treating their illnesses, prolonging them to keep their legal status. As mentioned, legal papers are initially granted as temporary permits that can be renewed. Even something as simple as a cataract can serve the purpose of prolonging one's stay. Of course, it means that the advantages of legality are exchanged for the difficulties of living one's life partially blind. I say this with an added caveat, in that those who do not treat themselves often have good structural reasons for not doing so, such as not having sufficient money to cover the costs, or the time, or the means to get to and from the hospital. The nurses themselves agreed that a patient's reasons for not pursuing treatment were not always clear. The point here is still valid, however; one must remain diseased to remain in France and to eventually claim citizenship. Both the medical officials and *sans papiers* realize this.

Each of the cases mentioned plays on different configurations of bodily integrity and human dignity. Along this spectrum are other unanticipated subject positions. For instance, one of the doctors I worked with treated a patient who took on the identity of a person who had AIDS, including taking the person's medication—in fact, he literally stole the identity of a friend of his who died of AIDS. He did this to get French papers—to obtain legal recognition that enabled both a life free from daily violence and a modicum of human dignity. Paradoxically, his dignity was not recognized, in the sense of his unique, individual self; he preferred to give up that identity to get legal recognition as someone else, again complicating theories of the liberal individual that ground notions of French citizenship.

Finally, the case of a Senegalese woman named Aicha illustrates the results of a politics of humanitarianism that creates political subjects, albeit with limited political choices. Aicha had a thyroid tumor and a serious skin condition aggravated by heat. She left her family in Senegal, including her five children, to live in France and treat her condition. Aicha had lived in France during her first marriage and, thus, had some knowledge of the medical system. Her illnesses were chronic, however; she needed both the thyroid medication and the skin creams on a constant basis, and neither medication was readily available in Senegal. She left her life

and family, ironically, to protect what the French law calls her right to “private and family life”; not only was she not legally permitted to bring her children to France, but she was also not given papers to work, transforming her life into a monotony of shelters in which she slept at night—shelters force people out at 8 a.m.—and cafés and parks in which she sat during the day to pass the time.

The nurses and doctors at the hospital clinic for the disenfranchised where Aicha received treatment were her main source of community—and even their friendship and support were contingent. As she stood outside, they complained to me that they did not need to see her anymore and wished she would leave space for other patients. In their understandable desire to give others a chance at health and bodily integrity, the larger structural reality of which they are a part dictates that they deprive Aicha of her only source of humanity that goes beyond biological life. Occasionally, she wondered aloud to me whether her life was worth living—what kind of life was it, she asked, with no family, no work, no money, no fulfillment, and nothing to wake up to each morning except one's illnesses, the simultaneously driving and disabling force of her life? She cannot escape her state of injury, which is not only named as such but also embodied. She is just one of the new subjects produced by the French nation-state—given life by the consequences of ethical regimes such as humanitarianism that are both created and circumscribed by global capitalism.

In the face of what can be called a new space of “biosociality,” in which biology is remodeled not only on culture but also on structural need—in which biological compromises are made as a primary form of political action—the subjects that I have just described are not easily explained by liberal notions of the self, of the good life, or of human flourishing.⁴⁰ In this emergent ethics, those with cancer, HIV, polio, or tuberculosis—and even occasionally those with more explicitly socially and politically grounded injuries such as rape or disfigurement—become the most mobile, the most able to travel without hiding themselves in the cold-storage containers of trucks or making mad dashes through the English Channel tunnel or across the straits of Gibraltar.⁴¹ Such notions of the mobility of the disabled or injured—indeed, the emergence of the disabled as the modal subject of political economy—force reexamination of ideas of who is “able-bodied” and what *able-bodiedness* actually signifies, and, even more broadly, what *good health* or *well-being* signifies. The standard of able-bodiedness as the norm and the ideal is herein exposed as fictional, constructed and normativized for a certain type of economic and civic functionality. Indeed, the assumption that the normative human is able-bodied begs redefinition of who is included in the category of “human.”

How can one make sense of these subject positions? In what sense are they the result of a form of politics based on humanitarianism? Although the ill and disabled are not

entirely stripped of their political or social qualities, they exemplify the dangers of humanitarian government insofar as it limits one's political and social choices and capacities—it forces one to conceal one's political self, all the while drawing on that self. In fact, the paradox of willed infection or disability suggests that *sans papiers* can act in one of two ways: They can choose to suffer from exploitation, exclusion, and poverty, or they can suffer from illness. But what kind of choice is this, and what kind of humanity does it sustain? The question becomes, how have these two options come to be interchangeable, how can they be bartered against one another—how is it that self-inflicted violence has come to have the same value as the violence of being undocumented? How is a compromised biological life equated with a compromised political life? And how can one characterize or explain this type of ethics and its related politics? I turn now to the way the politics of humanitarianism actually works on the ground, helping to answer these questions and, ultimately, to contribute to understanding what kind of humanity a politics of humanitarianism reproduces.

The new politics of compassion: A limited humanity

Dr. Amara, who worked at the clinic for undocumented immigrants that I had been observing, suggested to me that I might be interested in a paradox he had witnessed. He explained to me that several of his HIV+ patients had stopped taking their medication once they had received their papers, despite having received papers to gain access to the medication. This seemingly incomprehensible act reveals the violence at the heart of this story: Without political recognition, undocumented immigrants exist as a form of “living dead” (Mbembe 2003; Petryna 2002:3), in a state that, in the immediacy and intensity of their struggle for survival, is indistinguishable from the threat of physical death.⁴² The difference between the type of future each remedy guarantees—papers or medication—is elided. In this sense, it is unclear to both doctors and patients which is the more virulent form of suffering: no papers or no medication. The conflation of the two reveals a new territory in which the politics of immigration and citizenship is at once a politics of life and death. In this scene, biological life and political life have taken on equal significance—life as someone sick is interchangeable with life as a politically recognized subject. Indeed, being sick is what is required to be a political subject.⁴³

How did this happen? So far, I have discussed the subject positions produced by the intersection of global capital, labor, and humanitarian ethics—but I have not addressed the actual process by which this occurs. What I have been articulating is the result of the simultaneous institution of a humanitarian illness clause and the closing of borders to immigrants and refugees. This simultaneous opening and closing suggests greater respect for the conception of hu-

manity that illness evokes. Although one might have imagined that this concept of humanity based on the universality of biological life would come closer to equality, closer to a system of inclusion that overlooks all divisive political identities and affiliations—what Richard Rorty (1993) refers to as “species-membership”—in fact, this concept has been put into play through a politics of compassion that emphasizes benevolence over justice, standards of charity over those of obligation—one that ultimately protects and encourages a limited and limiting notion of humanity.

In shifting the politics of immigration to a politics of humanitarianism, those who enact the humanitarian clauses suddenly wield great power—they become the gatekeepers. In this case, they include the state nurses and doctors as well as the medical establishment more broadly. In the state office where I observed, the medical officials went beyond seeing if a person had a disease; they explicitly joined social and medical, knowing that in the cases they treated, to cure the medical one must inevitably deal with the social—they are inextricably intertwined. Yet the medical officials also admitted to being constrained by their relationship with the *préfecture*; despite acting out of a desire to further a notion of social justice, they could not simply let everyone in, because they were being monitored. They had to provide their statistics to *préfecture* officials at meetings every few months, and as the nurses said to me, there was always a deadly serious statement couched in the language of joviality at the end of each meeting, in which medical personnel were warned to drastically reduce the numbers of sick people they let in. The nurses and doctors realized that, to be kept in the decision-making circles, they had to maintain legitimacy—and their legitimacy depended on only letting in people who suffer from pathologies that have life-threatening consequences.

Yet what qualifies as “life threatening” when life itself remains undefined? As I have already demonstrated, biological life is more malleable in its abstractness than those who insist on its universality may realize. There is room for play. Life is ultimately defined quite pragmatically, by the particular context in which requests for papers are received and by those applying the clause. As noted, this is a relatively arbitrary process, one that changes case by case, location by location, and this is precisely because of the nature of the task: How does one protect “life”—the broadest of concepts?⁴⁴ Thus, in France, differences have been documented in the understanding of what it means to be in a “life-threatening” situation, and they evidently result in different strategies by both medical officials and *sans papiers*. Of the state medical offices in three *départements*, one gives papers to immigrants for nearly every pathology—the percentage of overall positive responses is 96.7 percent. The other two give papers 90–100 percent of the time to those suffering from fatal or terminal illnesses such as HIV/AIDS and cancer, but they differ on giving papers to those suffering from chronic illnesses such as diabetes (24 percent vs. 84 percent) and heart

disorders (24 percent vs. 92 percent), and finally, they differ radically on psychiatric problems (0 percent vs. 80 percent; Delettre 1999; Fassin 2001b).

What this means, of course, is that different understandings of “life” are being played out and that the structure of the particular state medical office is a major factor in outcome. The face-to-face interaction between the nurses and *sans papiers* largely determined how “life threatening” was interpreted in the particular state office where I observed and, thus, who was granted permits for illness. The personal interaction allowed for compassion to be evoked—it allowed the *sans papiers* to appear as people, not simply as files or pathologies. It allowed for their social realities to be included in the judgment. Yet a face-to-face encounter allows for performances on both sides, and if one does not perform in the desired manner, one may be penalized and excluded.

The dilemmas and the evocation of compassion came for nurses and doctors with the more complicated cases—often chronic or psychiatric, as indicated by the above statistics. The following story, described to me by the nurses, illustrates the way that humanitarianism often depends on compassion to ground a larger politics. Although I was not present in this instance, I witnessed many similar cases, and I use the story here to reveal as much about the nurses as about the *sans papiers* they describe. In the late 1990s, a young Algerian woman named Fatima came to Paris after having been raped and disfigured by her uncle. The background to this violence was the death of her primary caretaker, her grandmother, which forced her into the care of her uncle and aunt. Both her uncle and aunt blamed her for the rape. Fatima was therefore sent to France, where her mother was living. The nurses said that she looked horrible. They decided to give her temporary papers to receive medical care. When the treatment was finished and her permit about to expire, Fatima returned to the state medical office to ask for a renewal of her papers. As they later explained to me, the nurses understood that she would return to a “pitiful” life in Algeria; she would be forever shamed because of her rape and, hence, unmarriageable. According to them, her life would be one of ostracization and loneliness. They decided that, in the face of this reality, they would rather grant her authorization to stay in France for treatment for an indeterminate period—which means, effectively, forever, if she so chooses, renewing her illness permit until she can apply for citizenship. The treatment they prescribed was psychological—she was considered to be suffering from trauma. They were very clear when talking to me that this decision crossed over into the realm of social justice; but they saw themselves inevitably implicated in moral decision making, which they believe is required at a fundamental level in caring for people’s health and well-being.

I deeply respect the medical officials for allowing their view of health to include the social and for allowing the disenfranchised to remain when all other doors were and are

increasingly closed. Clearly, however, the health officials’ decisions are not based on laws, or rules, or rights. Ultimately, they are within the discretion of the person who receives the case. The state medical officials’ decisions are, thus, based at least in part on a notion of humanitarianism and compassion or, as it may happen, the lack thereof.⁴⁵ I found that the result depended on the way the *sans papiers*’ story was told and on the emotions evoked. Indeed—perhaps unsurprisingly—I found that compassion is elicited differently according to race and gender. Some people’s stories of suffering do not strike a chord in the nurses or doctors.

Thus, for instance, I sat with the nurses as a 25-year-old Algerian man came in one day. Not long after he entered the office, he started crying. He claimed that he had had a heart attack a few days earlier, which the nurse, Felicia, pointed out was not true. He had a heart murmur, she said, looking down at his file. He said that he could not go on. If he was sent to Algeria, who would take care of his wife and his mother? “Last week I was going to commit suicide,” he said. “I’ve never done anything to anyone, I haven’t committed a crime and still they do this to us, they break up couples!” I could tell Felicia was getting impatient. Her tone of voice changed. The man told a long story about his mother, who was a healer, and his wife, who was sick, and he kept saying how unfair it was to have a heart attack at his age! He was worked up and kept repeating himself. When he left, Felicia said “*son nez est grand comme un bec*” [his nose is as large as a beak], gesturing toward her own nose, pretending it was growing, insinuating that the man was lying. She claimed his marriage was one of convenience because the wife was 39 and he was only 25. Why Felicia was immediately so suspicious is hard to say. The man certainly exaggerated, and his story did not make complete sense. But, then, he was distraught and crying. At the time, I was surprised by Felicia’s reaction because she rarely lost patience, and I concluded that the man must have elicited a negative feeling in her—nothing concrete, because to me, the message he conveyed largely rang true.

As Arendt (1990) notes, compassion is most effective in face-to-face interactions, when those who do not suffer come face to face with those who do. In the state medical offices, however, the suffering is not always immediately apparent—the immigrant has to make a case for it, either in person or in his or her file, as the emotional commitment involved in compassion is dependent on the ability of the nurses to imagine the suffering. And, yet, for imagination to play its role in the coordination of emotional commitments, people must nourish their imagination from the same referents; they must be shaped by the same ideas of what suffering is and where the threshold of the bearable is drawn (Boltanski 1999:50). Indeed, compassion is a practice that all are trained in (Berlant 2004). In Fatima’s case, compassion was clearly based on a familiar Orientalist narrative about pitiful Muslim women. In other words, compassion depends on circulating narratives, images, and histories and often on maintaining

an unequal power relation between nurse and patient and citizen and foreigner—distinctions that are already heavily gendered and racialized. To be accepted as a French subject on the basis of compassion, one must be accepted as plausible; and images of the Other inform the legitimacy of one's performance. Algerian men are depicted in the French public imaginary as violent and deceitful and as oppressive to women. These images are the colonial legacy and in some ways have become all the more intense since the bitter war of Algerian independence from French colonial rule.⁴⁶

The man described above might have had a better chance in an office in which simply his file was presented, in which he did not need to appear in person; in other words, face-to-face interactions are not the answer for everyone. As critics of the humanitarian movement have noted, for help to be extended, humanitarianism often requires the suffering person to be represented in the passivity of his or her suffering, not in the action he or she takes to confront and escape it (Boltanski 1999:190; Malkki 1996). Whether the Algerian man who claimed to have had a heart attack was indeed lying or not, his performance was not convincing because it was too active, he demonstrated too much agency—he was perceived as strategic and not as a suffering, passive body. His personality took up too much room in the narrative.

Conclusion: An anti-Enlightenment universality?

My ethnographic research demonstrates the difference between bare life as conceived and practiced: Although, in theory, bare life may be the grounding of humanitarian action and the sovereign exception, the concept is enacted differently in differing places, both creating and requiring new realms of biosociality. The politics of humanitarianism, thus, show how conceptions of bare life blend with politics and the near impossibility of getting beyond socially embedded and mediated interpretations of life. In this particular instance, humanitarianism leads to a politics of life and death, quite literally, in which one's death warrant in the form of AIDS can secure life in France, and citizenship is only given to those who remain diseased. In this sense, one must see the medical realm as an important new site of sovereign power, in which doctors, nurses, and state officials become gatekeepers not only to the nation-state but also, more importantly, to the very concept of "humanity," in the sense that humanitarianism protects individuals by virtue of their membership in humanity.⁴⁷

Although I think it crucial that there be alternatives to a rights regime for claims to social justice, particularly when rights cannot be equally harnessed—and let me reiterate that this is not about returning to a regime of rights but about exploring what lies in between the focus on law, on the one hand, and sentiment, on the other hand—I want to end by suggesting that in this emergent regime of humanitarianism, one must inquire into the consequences of its (often) arbi-

trary nature, asking what conditions evoke compassion and why and what hierarchies are reproduced by it. The ability of such a system to further a more just world must be seriously interrogated when humanitarianism acts as a form of policing, choosing exceptional individuals and excluding the rest. For instance, although compassion may abolish the distance between people, opening the hearts of sufferers to the suffering of others, thereby creating an affective public space, by its very definition, compassion is unable to generalize.⁴⁸ In joining people in the immediacy and intensity of suffering, compassion abolishes the space between people in which political matters are located, shunning the processes of persuasion, negotiation, and compromise, which are the methods of law and politics (Arendt 1990:86–87).

The citizens produced by the joining of humanitarian ethics and politics have inequality literally inscribed on their bodies. They are forever marked and interpellated as sick, as already handicapped—they can never realize equality. This politics of humanitarianism shows itself to be a politics of universality, but an anti-Enlightenment universality—one that sets biological life against explicitly rational, political beings.⁴⁹ Immigrants are stripped of their legal personas when identified solely as suffering bodies, and, as such, they cannot be protected by law; they are rendered politically irrelevant. And although they may be liberated from suffering, they are not liberated into full citizenship.

To understand the nature of their particular status, Arendt's ideas are once again instructive. She argues that being thrown out of one's national community means being thrown out of humanity altogether—being stateless deprives one of the essence of humanity—its political character (Arendt 1951). Conversely, she suggests that citizenship, as membership in a polity, conveys full belonging in the category "humanity." In what I have described, government by humanitarian discourses and practices actually does not allow undocumented immigrants to be expelled from humanity altogether, as Arendt believes, because it is now instituted and enacted in a supranational political framework (i.e., through NGOs, among other institutions); but it does create and sustain a humanity that is very limited and forced to make new forms of biological compromise. Ultimately, it sustains a more powerful distinction between citizen and human while impoverishing the idea of the human: One can be either a citizen or human but not both—once one is affirmed as part of humanity and protected by humanitarian clauses, one loses one's political and social rights.⁵⁰ Here, for instance, the people entering France through the humanitarian clause come from already marginalized backgrounds, primarily from former colonies; this process, thus, reinforces racial hierarchies while casting France as benevolent. Indeed, the postcolonial space created through this politics of humanitarianism continues in the manner of its colonial predecessors, reconfigured for ever-greater forms of exclusion.

I want to be clear here: I am not arguing that the discourse of human rights is in the past either in France or elsewhere but, rather, that an incipient or emergent discourse overlaps and coexists with it and is becoming increasingly powerful. Ethical regimes must be understood as always contextualized, now as part of larger, transnational regimes of labor, capital, and governance. Clearly, this discourse of compassion or humanitarianism is not new—compassion is embedded in the notion of “human rights” and in the concept of “democracy” itself. The balance between the two, however, has shifted; and, although I ground my argument in the French situation, I believe that it links up with more-widespread phenomena induced by the era of global capital. It is no accident that MSF won the Nobel Peace Prize in 1999 or that countries such as the United States, Canada, and the United Kingdom have humanitarian clauses for entry that are becoming increasingly significant. It is not accidental that medical humanitarianism is playing an increasingly important role in both the North and South, intervening in the name of basic human life in ways that neither human-rights organizations nor development projects are allowed to do. Rights entail a concept of justice, which includes standards of obligation and implies equality between individuals. Humanitarianism is about the exception rather than the rule, about generosity rather than entitlement. The regime of humanitarianism is based on engaging other people in relationships of empathy and in this way demonstrating one’s common humanity; this is an ethics that, when taken to the extreme, entails selling one’s suffering, bartering for membership with one’s life and body. As the political body loses legitimacy in an increasingly globalized world in which national sovereignty is at stake and borders of all kinds are zealously guarded, the supposedly apolitical suffering body is becoming the most legitimate political vehicle in the fight for a broader concept of social justice; our task is not only to understand the consequences of this shift but also to form a response to it.

Notes

Acknowledgments. Funding for the research on which this article draws was provided by the Social Sciences and Humanities Council of Canada (SSHRC), a Graduate Research Opportunity Grant from Stanford University, and Phi Beta Kappa; support for writing was provided by a Giles Whiting Fellowship in the Humanities. For comments on earlier iterations of this argument, I want to thank, in particular, Jane and George Collier, Didier Fassin, Akhil Gupta, Purnima Mankekar, and Sylvia Yanagisako. Special thanks to my two writing groups in New York City and at the University of Michigan as well as to Jonathan Metzl for insightful comments and edits. I am grateful to audiences who commented on portions of this argument at Columbia University (Society of Fellows/Anthropology); City University of New York Graduate Center (Human Rights Program); Johns Hopkins University (Political Science); University of Toronto (Anthropology); University of California, Santa

Cruz (Anthropology); and University of California, Santa Barbara (Law and Society/Human Rights symposium).

1. I am not suggesting that huge numbers of people, if any, are trying to infect themselves. And although I cannot offer statistics, I can say that the very inclusion of this phenomenon as part of the rhetoric of the politics of immigration is indicative of a certain larger qualitative political shift. Cases of people infecting themselves with HIV have been documented in other contexts: in New York City, to get housing benefits (Allen Feldman, personal communication, spring 2002), and in South Africa (Nattrass 2005).

2. I am deeply indebted to Didier Fassin, both medical doctor and anthropologist, for alerting me to the existence of the illness clause and for helping me to establish contacts in state medical offices and hospital clinics.

3. Although, in theory, the clinics I observed were for poor, homeless, or otherwise underserved people, in practice, they tended to be almost entirely for undocumented immigrants. For instance, at one hospital clinic where I conducted fieldwork, 90 percent of the patients were *étrangers* (foreigners, meaning undocumented immigrants or those with unclear or unstable legal status); another clinic gave 99 percent as its figure of foreigner patients.

4. Article 12bis of the 1998 amendment covers the right to “private and family life,” which is itself a direct reference to Article 8 of the European Convention on Human Rights (CEDH). There are 11 categories under which individuals may qualify for legal residence, of which the *Autorisation Provisoire pour Soins*, or APS (temporary authorization for medical care) is the 11th. Article 12bis was later changed to Article L. 313-11-11° (Subsection 6), part of *Ordonnance* of 24th November 2004 no. 2004-1248, “relative à la partie législative du code de l’entrée et du séjour des étrangers et du droit d’asile” [regarding the legislative part of the code of entry and residence of foreigners and the right to asylum].

5. The use of the term *humanitarian* in the Kosovo context was clearly controversial, as is the connection between humanitarianism and militarism. Humanitarianism itself is, of course, not new. Thomas Haskell traces the origins of humanitarian sentiment back to the rise of capitalism in the late 18th and 19th centuries. He argues quite persuasively that it relates to changes wrought in perception and cognitive style, made possible by market discipline (Haskell 1992).

6. The focus on suffering in public and political life has been mirrored in the discipline of anthropology. For instance, *Social Suffering*, edited by Arthur Kleinman, Veena Das, and Margaret Lock, came out in 1997 and was followed by two more volumes on the same theme (Das et al. 2000; Das et al. 2001). These volumes group together many types of hitherto differently named experiences, such as the pain and trauma of atrocity, poverty, substance abuse, street violence, domestic violence, HIV/AIDS, and so on, with the goal of drawing attention to the multiple forms of suffering in the current global political economy. That said, they also point to a tension between those suggesting that this suffering is the result of the current climate and those suggesting that suffering unifies people as human beings across time—that it is the tie that binds humanity.

7. PTSD was formally recognized in the *DSM-III* (American Psychiatric Association 1980). Nearly one-fifth of U.S. women and one-tenth of U.S. men are now estimated to have had episodes of PTSD. See Young 1995, 2001.

8. For instance, Brown (1995) argues that the role of moralizing politics is a turn away from freedom’s pursuit. Similarly, Mouffe (2000) expresses concern that the recently “fashionable” topics of ethics and morality are a retreat from the political and the expression of a lack of a credible political alternative to the dominance of neoliberalism. Elaborating on the significance of political retreat, Lauren Berlant (2002) focuses on a politics that equates the eradication of

pain with the achievement of justice, thereby risking the equation of changes in feeling with substantive social change.

9. Although I use the term *biosociality* somewhat differently than Rabinow does, I still focus on practices of life as important sites of new knowledges and powers and employ the term to indicate the ways that nature is known and remade through technique. Instead of the techniques of scientists, however, I refer to the techniques of “ordinary” lay people—such as undocumented immigrants—who manipulate their biology to the extent that they overcome the nature-culture split. In this way, what I describe is on a continuum with Adriana Petryna’s (2002) work on what she calls “biological citizenship” in Ukraine, in which the damaged biology of a post-Chernobyl population has become the grounds for social membership and the basis of staking citizenship claims. As Petryna states, in such contexts, pain and suffering are made into social instruments, which does not mean that they are any less authentic but that new values are being attached to them. I thank an anonymous reviewer for insight into the ways the situation I am describing differs from Rabinow’s original notion of “biosociality.”

10. Although MSF is derived from and owes much of its philosophy to the International Committee of the Red Cross (ICRC), founded in 1863, it has publicized the “new humanitarianism” in heretofore-unimaginable ways, helping to shape the meaning of humanitarianism and what are considered laudable public expressions of morality.

11. The distinction is also clear in the context of the United Nations, which has sponsored evaluations of humanitarian responses to complex political situations, trying to understand the relationship between humanitarian responses, human-rights attempts to prevent impunity, and political efforts to bring peace. These have been grouped under the idea of “coherence.”

12. This shift does not represent an entirely new phenomenon; it can be understood more broadly as part of a political rationality that focuses on the sphere of the social. Indeed, it can be seen as on a continuum with “government of the social”—a transformation in French democracy dating from the Revolution of 1848, which separated moral duties from legal rights, enabling government under an administrative and philanthropic framework, rather than a juridical one. In this sense, humanitarianism functions by making moral and ethical concerns central to forms of government, taking them out of the juridical sphere. It echoes French policies toward the poor in the 19th century, which were inspired by philanthropic and nonjuridical principles and which, in turn, prompted the creation of the field of social discourse (Procacci 1989). I thank an anonymous reviewer for pushing me to think about these social logics of government.

13. Jean-Hervé Bradol, the current president of the French section of MSF, states that the appeal to law “must remain purely opportunistic” (2004:7), suggesting that law can also mean violence.

14. For instance, humanitarianism was deployed in Catholic missions through colonial medicine. See Taithe 2004.

15. For a discussion of the market for humanitarianism, see DeZalay and Garth 1996, 1998 and Rabinow 2002.

16. The model pioneered by MSF involved (1) a reconceptualization of *sovereignty* by challenging the sovereignty of nation-states to intervene; (2) a moral obligation to “interfere” in the name of suffering (*le droit d’ingérence*); and (3) the use of *mass media* to break down borders and bear witness to violations of human rights. See Allen and Styan 2000, Fox 1995, and Ticktin 2002. I want to be clear that I am concerned primarily with humanitarianism less in its legal form—under the rubric of the laws of war—than in its shape as a form of urgent ethical action driven by sentiment and need, albeit broadly sanctioned by law.

17. There have been various recent attempts to examine what Terry calls “the paradox of humanitarian action”: its ability to “con-

tradict its fundamental purpose by prolonging the suffering it intends to alleviate” (2002:2). War correspondent David Rieff examines the same paradox: He observes that the apolitical goals of service and solidarity of the ICRC are being questioned by aid workers themselves as well as by outside observers because giving aid may serve to exacerbate conflict and, hence, suffering. Thus, Rieff (2002) notes with some skepticism, *some are abandoning humanitarianism-against-politics for the politics-of-humanitarianism*.

18. Among the majority of immigrants of non-European origin, particularly immigrants from former colonies, Europe is now referred to as “Fortress Europe” rather than as a space of freedom and openness.

19. As the former *sans papiers* spokeswoman Madiguène Cissé told me, the French *sans papiers* spearheaded a European-wide network for the rights of undocumented immigrants—other nascent national movements looked to them to lead the way. For example, undocumented immigrants in Italy followed the French strategy by occupying a church.

20. This shift in perception of refugees is illustrated by a radical change in the criteria needing to be met to acquire refugee status, reflecting a belief by the authorities that asylum seekers are “potentially bogus” (Delouvin 2000:61). Finally, it reflects the initial stages of the coordination of refugee policies in the European Union, which has promised to reduce asylum to the lowest common denominator among member states.

21. The one exception here is for immigrants with high-tech skills. To see how policies that restrict immigration lead to a perversion of the rule of law, see Lochak 2001.

22. *Although detention centers fall under the rubric of the administrative system, not the judiciary, the treatment of people in these centers still constitutes violations of basic human rights*. See the reports by the Association Nationale d’Assistance aux Frontières pour les Étrangers (ANAFE) and by the Groupe d’Information et de Soutien des Immigrés (GISTI). A February 10, 2003, report by ANAFE stated that the conditions in the *zones d’attente* (detention centers) were “contrary to human dignity.” They have only gotten worse in the current climate of “security” and increased racism and xenophobia. Indeed, the phenomenon of detention centers demonstrates how the move from the juridical sphere to an administrative one (which encompasses humanitarianism) allows for new forms of injustice.

23. Article 12bis was instituted partly to address sanctioning of the French state several times by both French tribunals and the European Court of Human Rights for not protecting the right to private and family life.

24. Lochak was the head of GISTI, the foremost immigrant-rights organization in France.

25. *The most significant way in which France has changed the conception of “refugee” is by adopting a severely restricted interpretation of the Geneva Convention on Refugees*. For instance, the state introduced a ruling that *restricts the granting of political asylum to victims of state persecution*. An exception to the ruling initially existed, in a “territorial asylum” clause, which was created for Algerian victims of Islamic terrorism, but this was an exceptional clause for exceptional circumstances and existed effectively in name only. Only eight refugees were allowed entry under this clause in 1998 out of 1,400 who applied. This clause has now been abolished and replaced with one *referring to asile subsidiaire (subsidiary asylum), which became effective in January 2004*. It was introduced with the reform of law 52–893 of July 1952 that created law 2003–1176 of December 10, 2003.

26. See Fassin 2001b, which describes how the immigrants are no longer wanted as legal workers because they are perceived to be taking away jobs from the French, and yet, of course, their labor is still of enormous value.

27. Saskia Sassen (1996) describes this phenomenon as a tension between denationalizing economic spaces and renationalizing political discourse. Otherwise stated, capitalism is both transterritorial and relies on territorial structures such as states to organize the forces and relations of production, requiring stable political spaces to push the boundaries of economic zones. In this sense, although there is a drive to break down national sovereignty to enable the circulation of capital, not only through transnational corporations but also through international forms of commercial arbitration, there are equally powerful drives to keep sovereignty at the nation-state level, with states controlling their borders.

28. Aihwa Ong's (1999:217) discussion of graduated sovereignty helps to explain this phenomenon. Ong describes how different populations are subject to different types of political control by state and nonstate agencies, suggesting that the state gives up control over its weaker and less desirable groups to the regulation of supranational entities such as NGOs, the United Nations, corporations, and so on.

29. For a wonderful analysis of the relationship between capitalism and human rights, drawing on Emile Durkheim, see Collier 2002.

30. For a discussion of the limits of human rights in this context, see Ticktin 2002.

31. Article 12bis-11° states that "une carte de séjour temporaire est délivrée de plein droit à l'étranger résidant habituellement en France dont l'état de santé nécessite une prise en charge médicale dont le défaut pourrait entraîner pour lui des conséquences d'une exceptionnelle gravité, sous réserve qu'il ne puisse effectivement bénéficier d'un traitement approprié dans le pays dont il est originaire" [a temporary residency permit is granted to the resident foreigner in France whose state of health requires medical treatment in the absence of which there would be consequences of extreme gravity; this is subject to the foreigner's inability to obtain appropriate treatment in his/her country of origin].

32. To get to a doctor can, in itself, be a trial for the undocumented; a whole new set of challenges are posed for those trying to find a doctor who will refer patients to the immigration office (see Ticktin 2002).

33. I am calling the permits granted under the APS provision "illness permits."

34. Fassin (2001b) argues that because illness is devoid of the suspicion associated with economic migrants, it has become a source of social recognition. Also see Ticktin 2005 for a more detailed discussion of the criminalization of immigrants and sans papiers.

Unfortunately, obtaining papers often does not end the suffering or the struggle; immigration legislation has been so volatile that one can have papers one day and none the next, without one's situation having objectively changed. See Fassin and Morice 2000.

35. I refer here to the Sarkozy laws of 2003. Interior Minister Nicolas Sarkozy proposed changes, voted in by parliament in December 2002, to the finance law of 2002 (Loi de Finances Rectificative of 30 December 2002, no. 2002-1576), which began the dismemberment of access to state-subsidized health care—Aide Médicale Etat (AME)—for those most disenfranchised in France. As of January 1, 2004, sans papiers no longer benefit from immediate and free access to health care; they have to first put together a file proving their presence in France for a period of three months. Vociferous protests met the 2004 proposal to limit free health care and to require proof of three-month residency.

36. See also Fassin 2001b and Lochak 2001 for a discussion of the role of humanitarianism in this process.

37. The decrease is the result of increased surveillance of borders and harsher treatment of refugees by administrators, and, more

broadly, it is the result of a shift from a universal conception of refugee to a restrictive juridical concept that is "independent of the reality of dangers incurred" (Legoux 1995; cf. Delouvin 2000).

38. See Breckenridge and Vogler 2001 for a discussion of how practices such as mutilation of beggar children are interpreted as the result of "native" forms of violence, barbaric cultural practices, and uncivilized ethical systems.

39. One group that attempts to bridge the gap between patient and community is Ikambere, an association for women of African origin with HIV/AIDS, which acts as both family and community for women who have been ostracized by their own families and communities.

40. This is happening in other contexts: As Petryna notes, in Ukraine, "biology, scientific knowledge and suffering have become cultural resources through which citizens stake their claims for social equity in a harsh market transition" (2002:4).

41. I am referring here to the 58 undocumented Chinese immigrants who were found dead in Dover (Britain) on June 19, 2000, in the back of a cold-storage container of a Dutch truck. This horrific event drew attention to the issue of trafficking in humans, an ever-growing transnational enterprise, and to the increasingly restrictive measures placed on asylum seekers.

Until November 2002, there was a refugee center at Sangatte, outside Calais, near the last rail stop on the French side of the English Channel tunnel (Chunnel); trains to the United Kingdom pass through here, and refugees gathered in the center to cross into the United Kingdom, where political asylum was seen to be more accessible. The various ways by which to cross were all fraught with danger and included hanging onto the bottom of the train or lying on top of it, risking electrocution or falling off. The bodies of the unsuccessful occasionally stopped traffic in the Chunnel, damaging Britain's international freight industry; freight traffic was halted for up to three days at one time to deal with the problem of refugees, who sometimes even tried to walk across (Landesman 2002). The problems eventually led to the closing of the refugee center at Sangatte.

42. Judith Butler provides another way of thinking about this phenomenon: Those excluded from legitimate social and political community are kept "on the far side of being" (2000:81), not given the type of recognition that allows the notion of human to come into being.

43. To demonstrate how this ethical configuration is not limited to France, but, rather, is a more widespread phenomenon resulting from the current intersection of ethics and political economy, I turn to Petryna, who makes a similar point in the Ukrainian context, suggesting that "Ukrainians employ knowledge of biological injury as a means of negotiating public accountability, political power, and further state protections in the form of financial compensation and medical care" (2002:7).

44. Petryna's work points to the dangers of leaving the value of a person undefined: She demonstrates that physical risks, abuses, and uncertainties escalate when the value of life is undefined (Petryna 2002:3).

45. Health officials' decisions are, of course, also based on other factors, such as their personal criteria of justice. I thank an anonymous reviewer for this insight.

46. New discourses on terrorism and security since September 11, 2001, build on these same stereotypes, albeit configuring them to fit the new context.

47. For definitions of humanitarian action and assistance, see Terry 2002 and Brauman 1996.

48. Arendt's exception to this rule is Jesus Christ, as portrayed by Fyodor Dostoevski; the sign of Jesus's divinity was his ability to have compassion for all men in their singularity, without lumping them together into one suffering mankind (Arendt 1990:85).

49. I would like to thank Nadia Abu El-Haj for helping me see this.
 50. See Agier 2004, which elaborates on the incompatibility between citizen and human in the context of refugees in Africa.

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accepted August 24, 2005
final version submitted August 24, 2005

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