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Citation for published version:

Kelly, T, Harper, I & Khanna, A (eds) 2015, *The Clinic and the Court: Law, Medicine and Anthropology*. Cambridge Studies in Law and Society, Cambridge University Press, Cambridge.
<<http://www.cambridge.org/asia/catalogue/catalogue.asp?isbn=9781107076242>>

Link:

[Link to publication record in Edinburgh Research Explorer](#)

Document Version:

Peer reviewed version

Publisher Rights Statement:

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The clinic and the court: law, medicine and anthropology

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Introduction

Tobias Kelly, Ian Harper and Akshay Khanna

In the spring of 2013, the parents of Robbie Crane, a severely disabled thirteen year old boy, won an out of court settlement of over £7 million from the English National Health Service. When Robbie was born he was seriously ill with a congenital heart defect. He underwent an operation when he was just a few days old, which seemed to be a success.¹ However, something went wrong during the ventilation afterwards. Robbie was left with cerebral palsy, limited speech, learning difficulties, and behavioural problems. He will require round the clock care for the rest of his life. The settlement was designed to reflect compensation for any medical negligence as well as cover the cost of Robbie's future care. Such cases are far from rare. According to a report in 2012, the English NHS spent over £15 billion on medical negligence claims a year.² That is nearly one seventh of the entire NHS budget.

Ian Brady appeared before a mental health tribunal in Manchester in the summer of 2013. Brady is one of the most notorious serial killers in modern British history. In 1966, he was found guilty of the murder of three children and sentenced to life imprisonment. Nearly twenty years after first being sent to prison, Brady was diagnosed as a paranoid schizophrenic with a severe personality disorder, and sent to

¹ '£7.3m payout for brain-damaged boy from Hertfordshire', *BBC News*, 13 March 2013, available at: <http://www.bbc.co.uk/news/uk-england-beds-bucks-herts-21861568>

² 'NHS facing £15.7bn for rising number of clinical negligence claims', *Daily Telegraph*, 7 February 2012, available at: <http://www.telegraph.co.uk/news/politics/9065534/NHS-facing-15.7bn-for-rising-number-of-clinical-negligence-claims.html>

a high security psychiatric hospital. In 1999 he went on hunger strike, protesting against his incarceration. As Brady was being detained in a psychiatric hospital, doctors were permitted to continue his treatment and force feed Brady against his will. Brady was therefore appearing before the tribunal to argue that he was no longer mentally ill and should be transferred to prison, so that he could have control over the time and manner of his own death.³ His appeal was turned down.

In December 1998 Diane Blood gave birth to a baby boy. The boys' biological father had died more than four years previously.⁴ Following a protracted legal battle, Ms Blood had won the right to artificial insemination with her husband's sperm. Ms Blood and her husband had been planning to have children when he was struck down with meningitis. She persuaded the doctors to remove her partner's sperm whilst he lay on life support. However, because the sperm was not removed with Mr Blood's consent, the hospital was not legally allowed to hand it over to Ms Blood. In February 1998, Ms Blood won the right to take the sperm abroad. The court ruled that although it was illegal to use sperm taken without consent in the UK, there was nothing in the law that prevented the insemination taking place outside the country. Ms Blood would eventually have two sons, Liam and Joel, after visiting a Belgian clinic. It was not until 2002, and a change in the law, that Mr Blood's name could be put on the birth certificate, as prior to this fathers who were dead at the moment of conception could not be legally recognised as parents.

³ 'Moors Murderer Ian Brady banned from carrying pens', *BBC News*, 18 June 2013, available at: <http://www.bbc.co.uk/news/uk-22953626>

⁴ 'A baby boy for Diane Blood', *Independent*, 12 December 1998, available at: <http://www.independent.co.uk/news/a-baby-boy-for-diane-blood-1190812.html>

In 2001 Stephen Kelly was found guilty of recklessly causing injury to another by the High Court of Justiciary in Glasgow after infecting a woman to whom he had not declared his HIV status. Sentenced to five years in prison, this was the first successful case of the criminalisation of HIV transmission in Scotland (Chalmers 2002). Beyond the UK, in many parts of the world HIV transmission has been criminalised. Despite limited evidence that this has any public health benefit, a number of other countries have now added this measure as an aspect of the attempts to control the HIV epidemic.

Between 400 and 1,200 patients died ‘as a result of poor care’ at Stafford Hospital between January 2005 and March 2009⁵. These deaths were revealed through statistical analysis, which enabled comparisons of death rates to be produced between hospitals, raising alarms should these lie outside of a deemed acceptable range. In a damning indictment of audit practices, Robert Francis, QC, the barrister chairing the public enquiry that followed suggested that the ‘NHS culture’ was to blame, and that this focused ‘on doing the system's business – not that of the patients’.⁶ This stimulated an ongoing debate into the question of legal sanctions, and whether senior managers at the NHS could face criminal prosecution if they are deemed to be not open about mistakes that are made, or whether already available provision of manslaughter law that can be levelled against doctors, or a corporate version of this, could force greater accountability.

⁵ ‘Mid Staffs report calls for sweeping changes to improve patient safety’, *The Guardian*, 6 February 2013, available at: <http://www.theguardian.com/society/2013/feb/06/mid-staffordshire-report-sweeping-changes?guni=Article:in%20body%20link>

⁶ ‘NHS culture at Mid Staffs that tolerated low standards and sold patients short’, *The Guardian*, 6 February 2013, available at: <http://www.theguardian.com/society/2013/feb/06/nhs-mid-staffs>

As the above five examples attest, law and medicine can be caught in a tight embrace. Although the examples above are all taken from the UK, similar processes are at work around the world, from the US to India, from the Czech Republic to South Africa, from France to Germany, Guatemala, Brazil and beyond. Clinicians may try and heal pain and suffering, but what counts as necessary or unnecessary suffering, suffering that should be prevented or allowed to continue, can be decided by the law. Furthermore, when medicine is unable to heal, the law can be called upon to provide redress. Litigation is often seen as the answer to medical needs, and public health claims when doctors and public health physicians come up against their limits. Medical negligence cases, such as Robbie Crane's, for example, involve lawyers deciding what clinicians can and should have done when confronted by a sick patient, as well as providing financial remedy for clinically inflicted distress. In the Brady mental health tribunal, it was the judges who had to decide which clinical diagnosis was most appropriate, and therefore implicitly whether the suffering caused by force-feeding was worse than the suffering caused by lack of treatment and potential suicide. It was not doctors who would decide how Brady would end his life, but a judge. In 2001 it was a judge who made the decision that Stephen Kelly was guilty of recklessly injuring his girlfriend when he failed to tell her he had HIV and subsequently infected her. Following the Mid Staffordshire Hospital deaths, it was suggested that criminal negligence charges might also be levelled at senior managers in the NHS. As such, and at multiple levels, medicine can be said to operate in the shadow of the law, as clinical, public health and institutional decisions are shaped by their potential legal outcomes.

Yet, the movement is not all one way. Legal processes, for example, can rely on clinical evidence in order to make decisions. It is clinicians who tell the court what

particular symptoms might mean and what forms of treatment are possible. The mental health tribunal relied on psychiatric evidence to decide on whether Brady was clinically sane or not. The Robbie Crane litigation similarly needed clinical evidence in order to determine whether the staff at the hospital where he was born had exercised the required level of care. Law also has to respond to medical advances and new forms of diagnosis. Paranoid schizophrenia has been a diagnosis with shifting parameters and definitions reflected in the evolving Diagnostic and Statistical Manual (DSM) revisions, but the law is dependent on these shifting terrains of knowledge at particular moments in time. It was not proposed as a distinct clinical diagnosis when Ian Brady was originally sent to prison in the early 1960s, yet subsequent diagnoses were dependent on new categorisations of the condition. The development of IVF as a therapeutic treatment has also created new and challenging legal problems. Issues of parenthood, such as in the Diane Blood case, would simply not be legal problems if it was not for clinical developments. In another register, it has been the development of the capacity to collate and analyse complex statistical data sets that has allowed the emergence of thinking of larger institutional complexes as legal entities in relation to health outcomes.

The ways in which we acknowledge, and attach importance to pain and suffering, can be understood as a constitutive feature of modern political and social life (Brown 1995). They are deeply implicated in what it means to be human in contemporary societies. Alongside, or even instead of, a concern with equality, exploitation and fairness, claims about the nature, distribution and adequacy of the response to pain and suffering play an important part on the formation of collective identities and the distribution of resources. Pain and suffering, however, are never self-evident. Neither are the responses to pain and suffering. What counts as necessary

and unnecessary, preventable and unpreventable distress, and what counts as adequate and suitable responses are profoundly political and cultural processes. Law and medicine are key to this wider politics of harm, deciding on what counts as injury, and what are the most suitable forms of redress. But they both also claim to lay out spaces for redemption, for cure, for healing and redress.

As law and medicine respond to harm and suffering, they become entwined. Let's take the concept of injury, for example, to illustrate the close relationship. Injury is a legal term par excellence. It derives from the Latin words 'in' and 'jus', meaning 'against justice' (Jain 2006: 4). Legally speaking, injury involves a violation of rights. Yet, although injury can imply financial loss, or damage to reputation, the archetypal modern image of injury is a body (or mind) in pain. Injury is therefore widely seen as a problem that can be addressed through medical intervention. However, the very fact that we refer to physical or mental damage by a term that implies justice or its absence, despite us not being necessarily conscious of this metaphorical inheritance, speaks to the powerful place of law in our imaginations of harm.

Death too, to give another example, is simultaneously a medical and a legal category rather than the self-evident end of life. As Margaret Lock has famously shown, the category of brain death requires both clinical and legal interventions (2002). Developments in medical technology have forced a re-evaluation of the very distinction between life and death. In order for organs to be harvested for donation, bodies have to be legally dead – or a clinician could be charged with homicide – but clinically alive, as otherwise the organs would be medically useless. Anglo-American law has decided that this event takes place in the brain, rather than the heart. Medicine

had to respond by providing ways in which the exact time of brain death could be identified.

The relationship between law and medicine can, equally, be symbiotic or collaborative. In a sense, both law and medicine may be understood as practices in the management of uncertainty. In the context of law, this is not just in relation to ‘subjective’ elements such as ‘intention’ and *mens rea*⁷, but in the very processes through which ‘facts’ are assessed, produced and appreciated in a court of law. This is most obvious in adversarial systems of law, where litigating parties are typically engaged in the making of objects and chronologies intelligible. The production of ‘facts’ is thus contingent upon such things as the resources available to contesting parties, the diversity of principles in laws relating to procedure and evidence, the political milieu, and most significantly, the very ability of the court to sense, recognise and name objects. The legal process is in this sense the identification of ‘true’ facts in the face of ambiguity. The practice of medicine as well, as several papers in this volume suggest, is about the production of facts in the face of disparate possibilities. The process of diagnosis, for instance, is an inherently inter-subjective process where physicians and patients are entangled in a negotiation of their realities, and the languages and metaphors through which bodily or psychological experiences gain intelligibility. The diagnosis of a syndrome such as AIDS, i.e. the enumeration

⁷ In jurisprudence criminal responsibility is, broadly, based on the assessment of two elements – the ‘*actus reus*’ (‘guilty act’) relating to whether a given act has been done by a person or not (did X pull the trigger, for instance), and ‘*mens rea*’ (‘guilty mind’) or the ‘mental state’ that makes the act meaningful (did X ‘intend’ to kill Y by pulling the trigger? Did s/he intend to simply injure Y? Did s/he know that pulling the trigger might cause the death of Y? Ought X have known that this act might lead to the death of y? Etc.). Except where there is an explicit admission of intention, *mens rea* is typically ‘inferred’ – it cannot, strictly speaking, be ‘known’, but rather be assumed.

of, and identification of 'symptoms' and the recognition of patterns, is an obvious case in point. Here again we see the socially, economically, politically, procedurally and epistemologically contingent process of producing certainty in the face of ambiguity. What is interesting is the ways in which, often, both law and medicine project the responsibility of this management of uncertainty onto each other, thus mutually re-affirming their positivist claims, their authority in speaking objective truths.

Yet the relationship between law and medicine can also be deeply uneasy. The ways in which lawyers and clinicians try and understand the world, as well as the responses they put in place can be very different. Lawyers may understand harm through legal languages and definitions of injury, victim and perpetrator. Medical practitioners might think about harm in terms of categories of disease and pathology translated from the subjective illnesses of patients. The law courts allocate compensation and redress. Medical practitioners try to alter the course of disease processes, and thus heal and alleviate suffering, albeit within narrow medically defined parameters. As two high status forms of expert knowledge, it is not always clear which, or how, either should predominate in particular contexts. The law can marshal far greater resources, it can decide what can and should be done, and invoke legal sovereignty to do so. However, it is this political dominance of the law that medicine counters through access to levels of intimate knowledge that is simply unavailable to the law. A legal decision might provide formal redress – which in certain circumstances might assist with healing as broadly socially defined – but clinicians can, and frequently do, improve the subjective feelings of being unwell through their clinical interventions.

Anthropology, the law and medicine

Historically, legal and medical anthropology have often talked past each other. We publish in different journals and go to different conference panels. Yet, over the last ten years at least there has been an increasing convergence of analytical and ethnographic interests. Issues such as biological citizenship and its wider family of terms (Petryna 2003; Rose 2007; Nguyen 2010) have brought the importance of rights and the sovereign power of the state over bodies, life and death to the heart of medical anthropology (Das and Poole 2004; Inda 2005). Similarly, a concern with the provision of pharmaceuticals and their place within particular economies of ownership and need, has meant that legal property regimes have been a key object of analysis (Petryna, Lakoff and Kleinman 2006; Hayden 2007; Petryna 2009). Many medical anthropologists have become interested in exploring the implications of institutional and expert responses to suffering, turning to issues historically more associated with legal anthropology, such as human rights, citizenship, and bureaucracy (Farmer 2001, 2004; Fassin and Rechtman 2009; Beihl & Petryna 2013; Redfield 2013).

In this volume we acknowledge these intellectual shifts and explore the intersections of, and relationship between, law and medicine. The book asks: How do those working in law and medicine seek to understand harm and suffering, and allocate remedies? What are the points of convergence and contradiction between law, medicine and their own sub-disciplines, as they seek to understand and respond to harm and suffering? Are new spaces for political and moral action created by the intersection of law and medicine? Crucially, we do not take the central role of law and medicine in responses to harm and suffering as self-evident. As law and medicine define and categorise, options are closed down, just as new ones are opened up. What

happens, for example, to a sense of mutual obligation for the sick and unwell when they are framed in terms of legal rights? What issues arise when medical care is determined and overshadowed by the potential for criminal redress? Such questions allow us to explore the relationship between a politics of suffering, expert claims to privilege insight, and the potential for remedy and redress. Rather than reify law and medicine as two separate ways of interacting with the world abstracted from each other and their conditions of entanglement, we argue that responses to harm and suffering have to be understood in terms of their enactment and engagement within specific local contexts. Hence, the issues are ones that are fundamentally and necessarily open to ethnographic investigation.

The volume is organised into two sections. The first section deals with the different ways in which legal and medical processes understand, confront and conceptualise harm and suffering, in short, an epistemological exploration. The second section deals with the ways in which law and medicine understand and allocate remedies to harms, that is the more practical side of how interventions are managed. The distinction between understanding harm and providing remedy is of course not hard and fast. Remedy is only possible once harms have been identified, and harms are seldom categorized for abstract reasons, but often with the aim of providing some form of alleviation. While there may be a case for some of the chapters appearing in either section, we have made the division as a way of pulling out and emphasising important analytical themes and as a heuristic undertaking. Before addressing issues of pain and suffering, remedy and redress in more detail, it will be useful to examine what types of expert knowledge are represented by both law and medicine?

Expert knowledge

Law and medicine are both highly technical forms of expert knowledge. They seek to define, categorise and regulate. Indeed, they may be the archetypal form of modern expertise (Carr 2010). Law and medicine are both backed by powerful institutions and bureaucracies, such as hospitals and courts, not to mention universities. Law and medicine are high status, highly paid professions, represented by powerful lobbying bodies. They are also both learnt at university, and contain languages and forms that are only available to the initiated (Sinclair 1997; Mertz 2007). Law and medicine both fundamentally involve a claim to superior positivist knowledge by those who speak in their name. Finally, in all their technical specialisms, law and medicine can also both be seen as highly pragmatic forms of knowledge, concerned with getting things done, rather than philosophical hair-splitting or political negotiation. Doctors want to make their patients better. Lawyers want to come to a final legal decision.

However, even though law and medicine may both be pragmatic disciplines, they can produce very different relationships between means and ends. Legal processes aim to seek finality, as they look to end the debate and come to a legal decision. In doing so, they frequently turn in on themselves, referring to little else than the law. As Bruno Latour has famously argued, writing about the French Conseil D'Etat, legal decision-making is a process of trying to move beyond questions of fact as fast as possible, in order to arrive at legal debates (2004). Legal processes then become concerned fundamentally with reaching a decision that is legally justifiable, rather than making a profound statement. The law is what matters, not the outside world (Riles 2006). Law, ideologically at least, claims a self-referentiality, that gestures to other laws, and other cases. Whilst new objects and issues are constantly entering the legal realm, especially following developments in medicine and clinical

practice, legal regimes always try and articulate these new arrivals within self-referential terms, as though they already always existed in the legal realm, and are merely finding articulation through new interpretation.⁸ As far as legal actors are concerned, there is no need to look elsewhere, as in the end, it is the judge who decides what happens and the outcome of a legal case. As such, once a decision is reached, it is final. In the common law system it can be appealed, but only on matters of law, not on fact. The facts of the case are frozen in time when a judge comes to a decision. Law decides on both the means and the ends.

Medical decisions, in contrast, are often provisional and open to being revised in the light of clinical advances or as a patient's health fails or improves. As Foucault famously argued, modern medicine is marked by a concern with observation and the clinical gaze (2003). Clinical categories may shape what is seen, and the clinician may cultivate a sense of detachment from the body being observed, but the clinician always returns to that same body. Medicine has no luxury of near total self-referentiality. It must always look beyond itself to the sick patient, whose responses it can never totally control. Although medicine too is a field with a strong sense of its own traditions, canons, and principles, however diverse, any attempt to transform the world into its own terms can reach its limits when it confronts a mind or body in pain which seems to resist medical intervention. A diagnosis is only useful and clinically correct if it helps the patient's condition improve. There is relatively less space to

⁸ The enrichment of the meaning of the 'Right to Life' to cover such issues as issues of livelihood, bonded labour, child labour, housing, health, privacy, education, sexual harassment at the workplace, domestic violence, marriage, clean environment and dignity etc., for instance, is seen not as an introduction of new objects into the law, but merely the act of a more full interpretation of already existing provisions.

switch off the outside world, to say ‘clinically speaking the decision was right’.

Biographical narrative, individual history and life intervene (Bowker and Starr 1999). It is no coincidence that many General Practitioners and community health workers rapidly come up against the limits of the purer forms of disease abstraction in the everydayness of their patients’ lives, and turn to other modalities of intervention to help them in their struggles with being subjectively unwell. Medical means and ends, when compared to the law at least, are relatively more open and contingent.

A contrast between a ‘distanced’ law and an ‘engaged’ medicine can be overplayed of course. Lawyers are not always unconcerned with the outside world. Doctors too can also be, relatively satisfied with a clinical outcome, irrespective of how the patient feels about it. An asthma sufferer for example, may have a decrease in the constriction of their bronchioles – the medical outcome of an intervention – but still not feel that well in themselves. A surgical intervention might be a technical success, even in the absence of subjective improvement in wellbeing. Furthermore, to talk about law and medicine, the clinic and the court, doctors, and lawyers, as unified entities, and coherent bodies of knowledge is untenable. Whilst both law and medicine may have relative coherence as professional identities, both also have a tendency to fracture and contradict, breaking down into sub-fields. Criminal law, civil law, and administrative law can have very different assumptions and goals, as can surgery, psychiatry, public health, and palliative care, to give but a few examples. In such situations, law and medicine have been known to submit to one another, the ability to resolve internal contradictions. The recent case where the Supreme Court of India reinstated Section 377, the colonial anti-sodomy law, provides us with an instance of this. Parties on both sides of the litigation introduced medical evidence to support their cases – those that sought to get rid of the antiquated law filed evidence

that homosexuality was no longer considered a ‘disease’, that the protection of human rights of same-sex desiring people was a central tenet of public health policy, and that the continuation of the law in force had mental health implications for Gay, Lesbian, Bisexual and Transgender citizens. The parties in support of the law similarly introduced medical opinion to the contrary, claiming that homosexuality was indeed a curable affliction, one responsible for the spread of the HIV epidemic and which must thus remain criminalised. The court, in this case, was called upon to act as an arbiter of what constituted ‘good’ science, and to resolve the apparent conflict within the realm of medicine. Conversely, in the making of HIV/AIDS policy, the government’s National AIDS Control Organisation was essentially tasked with the responsibility of identifying ‘good’ law, having to decide between the fact that homosexuality was, in effect, criminalised under Indian law, and the constitutionally guaranteed Right to Life, which included the Right to Health. What we see here is a circularity, where the practices of law and medicine draw upon each other for the resolution of their own internal conflicts, and always in the context of pragmatic questions. As inherently pragmatic disciplines and sub-disciplines, law and medicine are always context specific, trying to answer very particular questions at very particular moments, and for particular ends.

There is an obvious danger in presenting law and medicine as self-enclosed, all powerful forms of knowledge, despite the sovereign forms of power invested in them. It is also important to recognise their limits, hesitations and inconsistencies. Neither law, nor medicine, even in their own eyes, are all knowing and all seeing. There are limits to their expertise. People will die for reasons that are beyond medical knowledge; indeed, death itself brings medicine abruptly up against the limits of its domain (even if defining the moment of its coming can be complicated). The law can

become confused. Clinical categories can contradict one another – as different bundles of signs and symptoms from the reading of the contours of the body are placed in different diagnostic categories as can the law. Judges are as fallible as doctors. It is in these spaces of uncertainty that innovation can take place. It is here that the space for ethnographic investigation is most needed. Law and medicine, in all their various and contradictory forms interact and contradict, producing new potentials and closing down old.

Recognising harm and suffering

The pictures from Abu-Ghraib seemed to shock most of the world. Images of Iraqi men being humiliated and punished by their smiling American captors sent out a chilling message. For many people, such photographs seemed to encapsulate all that was wrong with the Anglo-American invasion. Even those who supported the war professed to be shocked and sickened by what they were shown. The photographs of bodies in pain appeared to provide self-evident and easily recognisable evidence of wrong doing that transcended political, cultural and religious boundaries. Complex arguments about international law or military strategy paled into insignificance alongside pictures of a naked man with electrodes attached to his fingers. Whilst we might differ on issues of international politics, it was as if we could all come together to agree that the treatment of prisoners in this way was wrong.

Suffering and pain seem universal. As Miriam Ticktin has argued, there is a widespread assumption that we recognise suffering as self-evident because it seems to be universal human experience (2011: 11; see also Fassin and Rechtman 2009). But suffering and pain must be made legible, categorised, and distinguished, in order to be

given moral and social meaning. Whilst being widely thought of as universal, pain and suffering can appear inscrutable. Elaine Scarry famously argued that physical pain leads to the unmaking of the world, and can stand beyond language (1984). It is the ability of the torture, for example, to destroy our capacity for language and communication that, for Scarry, makes it so morally problematic. Yet, as Veena Das has persuasively written, pain is never simply a private experience, but has fundamentally social dimensions (1997). The statement, 'I am in pain' does not simply describe an interior state, but also voices a complaint, a call for help and assistance. The issue is both one of the person in pain communicating their experiences, and crucially of the audience to see, hear and recognise what is in front of them.

Law and medicine are two privileged sites for the recognition of pain and suffering and involve very particular ways of seeing and knowing. The reading of the mind or body for signs of pain are historically located processes, and are as much aesthetic and technical, as emotional. The result is that some forms of pain and suffering are discursively brought into view, where as others are left illegible. Harm must be made legible in order to be politically and socially salient. Marsland examines in this volume, how public health bylaws allow the Tanzanian state to make visible forms of harm, those derived from witchcraft, mourning and inheritance – forms that are deemed traditional and superstitious. In 2002, new bylaws legislating against traditions of the Nyakyusa deemed to be detrimental to public health were announced throughout Kyela District (Tanzania). In this chapter, she shows how particular articulations of 'tradition' in public health and law produce particular visions of harm. Once identified and made visible, they can become the focus of state sanctioned reform.

The clinical gaze has a very particular way of reading the body for signs of suffering, illness and disease. As Michel Foucault famously argued, there was a shift in the late eighteenth century towards inferential interpretation of outward signs (2003; Crossland 2009). Diseases came to be thought to be knowable through their observable symptoms. Otherwise hidden and unobservable processes could now be seen and heard. In her contribution to this volume, Ticktin explores how an inferential logic that attempts to read signs of suffering for hidden causes, can be applied to ever new contexts. For Ticktin, the ‘innocent victim’ is deemed the most morally legitimate recipient of humanitarian interventions. However, as more and more is revealed about victims and survivors, the more and more innocence is compromised. The attempt to reveal and make legible risks undermining the humanitarian project. In this context, after children, non-human animals can become the locus of this search for innocence. Meaningful signs of suffering previously observed in humans can be read from the bodies of non-human animals. Humanitarian psychiatry, for example, is applied to non-human animals. Elephants are diagnosed with PTSD. Veterinary forensic medicine also becomes a diagnostic tool for revealing animal suffering, as well as importantly human cruelty. Whilst a concern with animal suffering is far from new, in the early twenty-first century it is increasingly perceived through technical forms, which were previously linked to human beings. In doing so, Ticktin shows how humanitarian techniques can be spread to novel areas, revealing ever wider forms of suffering as morally urgent.

Law and medicine do not simply bring particular forms of pain and suffering into view. They also attribute moral and political meanings to that pain and suffering. Not all pain and suffering is thought to be problematic. Pain and suffering on their own have no inherent social or political implication, it engenders no ‘natural’

response (Laqueur 1989). Above all, attributing a cause to suffering can make it seem relatively legitimate or illegitimate, acceptable or unacceptable, a source of moral scandal, or a source of moral reassurance. Pain and suffering without an apparent cause, can create particular disquiet. But, as Clifford Geertz wrote, if pain and suffering can be attributed with a cause, people can ‘morosely or joyfully, grimly or cavalierly... endure it’ (Geertz 1977: 104). Objectifying back pain, for example, through x-rays that reveal lesions can bring great relief: a cause has been found and it is ‘not all in the mind’, a judgement that can be hugely stigmatising (Jackson 1989). If suffering is seen to have different causes it can engender very different moral responses. The pain from falling out of a tree, or drinking too much alcohol, produces different social and political reactions to the pain caused by child abuse, or cancer, to give but a few examples. The attribution of causes can make pain and suffering morally meaningful, and socially acceptable.

Law and medicine are two of the central devices used for distinguishing between different types of cause. Yet, as Kelly shows in this volume, both forms of expert knowledge can have very different understandings of causation. His chapter focuses on medico-legal reports written about torture survivors in the UK immigration and asylum process. Legally speaking, torture is not just pain and suffering, but pain and suffering deliberately inflicted by public agents for specific purposes. Medico-legal reports are therefore asked to attest to the apparent causes of scars and marks left on people’s bodies. Yet, medical and legal understandings of causation can come into conflict. Legal processes try and strip away all other possible causes, only to be left with those that are deemed legally relevant. They also rely on a positive and mechanistic notion of change. Medical notions of causation can be, in contrast, much more open ended, and subject to revision, depending on how a patient responds.

Medical notions of causation can also operate at several levels simultaneously with causal agents including insects, bacteria, or even lifestyles. It is the difference between these two very different ways of conceptualising pain and suffering that opens up space to deny that torture has taken place.

In her contribution to this volume, Lydie Fialová shows how psychiatric medicine and criminal law can understand harm in very different ways. Her chapter focuses on a Czech psychiatric hospital, and the particular case of a man who she calls Josef K.. Josef killed his own mother, but was found not guilty on the grounds of insanity. In this process Josef's act was reclassified from crime to illness. His family, however, interpreted the murder as an unforgiveable wrong, whilst Josef was himself unsure how to interpret the act – refusing to identify with it in any way. A diagnosis of schizophrenia was particularly significant, as schizophrenia was more likely to be perceived as external to the person, treatable but not curable – in contrast to psychopathy (redefined in the DSM as 'antisocial personality disorder'), which might be seen as an inherent trait of the person. This distinction between causes that were seen to be external and those thought to be internal to Josef, had implications for the extent to which he was thought to be culpable for the death of his mother. We see another example here of the ways in which law and medicine seek to delineate different types of causation. Ultimately, though, Fialová suggests that it is impossible to draw a neat line between insanity and crime, which is reflected in the very structure of secure psychiatric hospitals.

Anthropology has often criticised institutionalised forms of knowledge for abstracting, reifying and distorting the experience of suffering. Adriana Petryna, for example, has shown how in the aftermath of the Chernobyl Nuclear disaster, suffering was rationalised into a bureaucratic object (2003). Definitions of radiation injury were

elaborated through particular technical categories (2003: 35). Legitimate and recognised injury was limited to that which was bio-medically measurable and calculable. Suffering had to be clinically legible and knowable for it to count, even though scientific knowledge in the area was provisional at best. For Veena Das, writing in the context of the Union Carbide chemical plant disaster in Bhopal, such bureaucratic forms of knowledge result in a constant stripping away from the experience of the survivor (1997). Suffering is appropriated through technical forms of knowledge. The suffering survivor becomes an object for the exercise of power, and the moral implications of their own suffering are effectively extinguished. Such criticism of bureaucratisation effectively builds on Lyotard's notion of the *differend* (1989). For Lyotard, there are situations where wrong doing or harm can not adequately be represented. The result is an effective silencing of the victim. It is not that they cannot speak, but rather that they cannot express their experiences fully in the languages that are demanded by those who might respond. Law and medicine, for example, demand that harms be understood and expressed in very specific ways. Whether the anthropologist can reclaim these representational spaces, and better represent the experience of suffering is a moot point, and one we reflect upon below.

At one level the critique of bureaucratic forms of knowledge for failing to represent the suffering of survivors and victims is very powerful, as it reintroduces an ethnographic thickness to the experiences of survivors and the sick. At another level, though, there is a danger of failing to treat technical forms of expertise as ethnographically interesting in their own right. The suffering of the 'victim' is presented as the most authentic ground, and potentially flattens suffering itself into this particular form of ethnographic truth. It is after all another discursive translating away. Yet, when clinicians and lawyers attempt to understand the nature and

implications of very specific forms of suffering they do so with very particular ends. As fundamentally pragmatic forms of expertise, lawyers and clinicians are not in principle concerned with reproducing suffering in its full phenomenological complexity (Williams 2007). It would be perverse to reproduce an assault in a criminal trial, or for a doctor to deliberately infect themselves with the TB bacillus (as witnessed by the response to scientist and HIV denialist Peter Deusberg injecting himself with HIV infected blood). Instead, the attempt is to understand assault in order to get a criminal conviction, to diagnose TB in order to provide treatment. Profound philosophical and political questions about the nature of harm can be suspended in the name of getting something done. When clinicians and lawyers attempt to understand the nature and implications of very specific forms of suffering they can do so with very particular ends, such as allocating legal entitlements or providing relief from pain.

Lawyers can often seem somewhat distanced from suffering. This is not to say that there are not many profoundly empathetic lawyers, for whom the nature of suffering is of great importance. It is to say though, that legally speaking, for lawyers what is important is not suffering in and of itself, but a breach of a legal norm. Indeed, some forms of suffering may be deemed legal, such as that caused by the death penalty, incarceration, and therefore legally irrelevant in and of themselves. Courts do not object, necessarily, to the pain of state execution, as this is seen, in many jurisdictions as being legally justified. Harm must also take on a particular structure to be legally recognised. To be a legal violation, there must be a victim and a perpetrator. Structural harms, and those that are not the product of some sort of intentional action or negligence are hard to legally recognise. Evidential barriers must

also be met. Legally persuasive proof must be provided that a harm has taken place, and that a particular person is culpable.

Distance from suffering is not so straight-forward for all clinicians. Again this is not to say that clinicians do not comprehend suffering though distinct clinical categories. It is to point out again though, that a clinician can be forced to confront the body in front of them, in ways that lawyers are not. There are of course many forms of medicine that, in practice, abstract away from the body. Laboratory technicians, which deal with blood samples, viruses and bacilli, are an obvious example. However, there are other forms of medicine, such as General Practitioners, for example, who constantly have to deal with and respond to the person in front of them. The result is that the ethical tensions faced by such clinicians in the face of perceived suffering can be particularly acute. In her chapter in this volume Estelle d'Halluin shows the tensions between pragmatic, technical and ethical forms of action. d'Halluin's chapter examines how French doctors decide whether or not to produce medico-legal reports for immigrants and asylum seekers. These reports can play a central role in persuading the French immigration authorities whether or not to allow the migrant to stay in France or not. Some doctors follow mechanical procedures, where they simply document every clinical fact, irrespective of the potential impact of doing so for the client's asylum case. Some doctors will decide whether to produce certificates, not on the basis of clinical signs but on whether they believed the client's story. Others will refuse if they think the certificate will be harmful to the client's asylum case. For d'Halluin, clinicians can be torn between the empathetic desire to be close to their clients' and the demand to produce a formal technical document. The result is a fine-grained and context specific negotiation of what might count as justice.

Forensic medicine produced a very specific manner of making the body legible, and of bringing harm into view for particular ends. Neither entirely legal, nor entirely clinical, forensic practice can sit awkwardly at the juncture between legal and medical means and ends. In his chapter in this volume, Rees examines the tensions between the production of legal evidence and the need to provide therapeutic care when forensic nurses are confronted with rape survivors. Forensic Medical Examiners in Canada and the UK have clinical obligations to survivors of rape, yet they must also collect evidence from the body of the person before them, and maintain a critical distance from the account that the complainant is providing. Any dichotomy of objective evidence and subjective care though is partially collapsed, as a more or less compassionate approach to patient care can change the ways in which evidence is collected. Sympathetic care can produce more legally persuasive evidence. Rees's chapter also ultimately reminds us that the line between the recognition of harm and the allocation of remedy is far from absolute. Recognition can in itself be a form of remedy, and remedy cannot begin before recognition takes place. Post rape interventions therefore combine elements of the legal and the medical, creating a new space of action, a point that will be taken up in the final section of this introduction.

Understanding and allocating remedy

The second section of this collection deals with the ways in which law and medicine understand and allocate remedies to harm. Medicine can aim to heal and alleviate. The medical definition of remedy is a specific treatment for an injury or a disease condition. But legal processes can also produce relief and repair. More generally, remedy means to redress a moral wrong, or specifically legal redress when used in

law. In this process, both law and medicine can both come up against the limits of their knowledge and the capacity to shape the world, deferring to one another. The finality of law can provide ‘closure’ to clinical uncertainty, and vice versa, clinical practice can provide an attempt to intervene directly in minds and bodies that more distanced forms of legality find difficult.

Human rights legislation as applied to health has been central to the changing boundaries between medicine and the law in relation to the application of remedy. Biehl’s chapter in this volume explores this development, and examines how the Brazilian courts are intervening in deciding who gets medical treatment and in what ways. In the wake of the rise of rights based activism into access to HIV/AIDS treatment right-to-health litigation has become the key mechanism through which Brazilians are able to access healthcare. This richly ethnographic chapter reveals how the boundaries of the medical and legal are frequently blurred, where we see ‘the judiciary as a sort of pharmacy, the public defender as physician, the physician as activist, the patient association as a legal council...’. Anthropology here has to struggle with these boundaries, and the complexity and contradictions in our taken for granted understanding of the roles, functions and norms of these institutional forms. In a biopolitical context where public health has become increasingly both privatised and more and more dependent on the consumption of pharmaceuticals (or pharmaceuticalisation), the right of access to pharmaceuticals has come to predominate. Access to medical remedies here, in this fast changing public system, particularly for the poor and marginalised, is mediated through the increasing use of the courts. The judges overseeing these cases nearly always grant access to the medicines requested, seeing this as being entirely consistent with the constitution and the right to health. The law here has come to be seen as a mechanism for access where

treatment protocols and cost-effectiveness discourses limit their availability. Seen by Biehl as a ‘minimal political belonging’, it is a field of temporal imminence, a legal relief to the increasingly market driven field of health and access to services.

As Biehl points to the potential of human rights legislation in leveraging access to remedy in the context of Brazil, Harper’s chapter also points to the limits of the legal domain in the realm of public health. The rise of multi-drug resistant tuberculosis (MDRTB) across the globe has stimulated differing responses, in varied national contexts. He compares the situation of the US with South Africa, and their responses to the rise of MDRTB. In the US attempts to regulate and limit the travel of one individual diagnosed with MDRTB – Andrew Speaker – as he travelled across Europe and to Canada allowed the application of old laws, and called on the idioms of post-9/11 security concerns. The ensuing legal tussle over Andrew Speaker’s own rights to privacy, as he sued and was in turn counter sued should be read as the oscillating limits of the law applied to individual and the public’s right not to be exposed to infection. Remedy here moves beyond that of the individual to that of the broader public. When Harper presented this paper to a public health audience in South Africa, their reaction to the idea that we can respond to the epidemic by controlling the movement of individuals was met with disbelief. This made little sense given the scale of the MDR epidemic they are currently facing. The limits of legislation are realised in this context – where attempts to deal with the problem in fortified hospitals has been met with resistance and even riots – and where the current capacity to deal with the epidemic is overwhelmed by the scale of the problem. Here the social, political, economic and structural complexities become paramount, and point to the need to deal with issues more broadly than just through translation into legal and juridical debates, or as a problem of regulating the movement of individuals. Here, as

with Beihl's paper, the limits of remedy at the interface of medicine and the law are starkly highlighted.

A potentially more optimistic perspective on the ability of law to provide remedies is presented in Richards' contribution to this volume. In her chapter she describes how the terminally ill can turn to the law in order to try and bring closure to what would otherwise be ambiguous end of life decisions. She draws on the UK case of Debbie Purdy, who was living with multiple sclerosis, and who mounted a legal challenge against the potential criminal legal repercussions for her partner, Omar Puente, should he assist her in travelling abroad to a jurisdiction where she could lawfully be helped to die. The Suicide Act in the UK states that it was illegal to assist others in the act of suicide. Medically she cannot be cured of this degenerative condition, but she turned to the law to provide a remedy that would make her final days more bearable – an assisted death. Rather than a dispassionate and abstract ruling, the comfort provided by the high court's ruling in the couple's favour, provided the emotional and moral relief that they sought. Even if the terms of the ruling have since been challenged and questioned following their case, it was the law that provided a remedy, in the absence of medicine's capacity to sustain a dignified life.

The three papers in this section attest to the ways in which the law is being appropriated in order assist in anticipating future harm. Borneman, in his contribution to this volume, also demonstrates how the vagaries of the future are managed, in this case in relation to the clinical rehabilitation for child sex offenders. Drawing on fieldwork with sex offenders in Germany, the chapter shows how it is the potential risk of repetition that is important for both law and medicine here. While the law requires that there is an assurance for the public that there will be no repetition of the

act, the therapist attempts to gain access to the unconscious workings of the individual, and to articulate transformation at this deepest of psychic levels.

Ronsbo, in turn, explores how remedy is being provided for, in situations of extreme pain and grief, in a context of genocide and conflict. Guatemala emerged from decades of violent conflict, and with this, up to 200,000 individuals were killed or disappeared. A network of organisations drew on psychosocial interventions to focus on the survivors and assist in the alleviation of their suffering. These ‘platforms of recognition’ are the result of a field of interaction involving donors and NGOs (thus within the field of development), and therapists and their clientele in this particular political context. This approach to the idea of remedy as trauma moves beyond the conceptualisation of trauma as a tool of ‘empire’ (Fassin and Reichtman 2009) to the inherently relational emergence, where traditional relationships of patronage are reformed by newer claims based on a rights based framework. A new space is thus carved out where new hopes and fears are expressible in the emergent Guatemalan democracy.

The political space between law and medicine

We see through these chapters how, as law and medicine interact, potentially new forms of political action, understandings of harm and forms of redress are produced. The spaces between the clinic and the court create the possibility for new claims based on the sick or vulnerable body or the traumatised mind.

Crucially, these claims cannot simply be reduced to the claims of legal subjects. This is a much fuller notion of legal personhood that cannot be reduced to

formal citizenship or its absence. The people making them are seen to bleed, to haemorrhage and to cry in pain. Nor, though, are these claims that can be reduced to the biological substrate upon which medicine ekes out its interventions. They do not simply involve biological forms of living, and cannot be reduced to 'bare life'. Rather, they involve active and often disruptive claims and counter claims that do not fit neatly into legal categories, based as they are on the lived experience of pain, suffering and its potential alleviation. At stake here are forms of subject making that cannot simply be reduced to subjectification. If they are biological citizens, or therapeutic citizens, or pharmaceutical citizens (Rose 2007; Petryna 2003; Nguyen 2010; Ecks 2005), they are citizens in the sense of being active, entitled and often unruly, embedded into institutions of rule, but never wholly subsumed by them. They are, in this sense, subjects gaining intelligibility, simultaneously, in at least the two registers of law and medicine, but inscribed in the space between them.

The above insight has significant implications for the ways in which we understand the forms and possibilities of the subject of political action. Foucault's undeniable influence on both legal and medical anthropology has often implied an underlying concern with the question of the constitutive effects of the law and medicine respectively. The assumption here is that these discourses somehow produce subjects. In the context of law, the question is – how does engagement with law constitute us as subjects. Structurally similar is the question in the context of medicine – of how engagement with medical discourse and apparatus, in requiring us to occupy the 'patient role' for instance, generates the conditions for the relationship with the self. But as the papers in this volume suggest, innovations in and of the subject lie between these registers, in the tensions and resolutions within and between them. The

political subject, then, cannot be considered through a focus on the constitutive potential of these discourses, but rather on their failure to do so.

The theoretical implication of this argument is that the subject can no more be considered an internal conversation instigated by, or circumscribed by, the limits of the language of law, or of medicine. Rather, we might consider the subject as the effects generated in engagements with these registers, as a series of vehicles that we occupy in political contestation. The political subject might then usefully be considered as neither 'internal' (as in a relationship to the self instigated or required by an authoritative discourse), nor 'external' (as a performance of a form intelligible in the authoritative discourse), but rather, in-between. It is in this sense that the failure of law and medicine to constitute the subject generates the space for the political subject, and the potential for new, transformative forms of political action.

It is as crucial to recognise that as law and medicine interact, and as the space between them generates political action, their categories and forms are transformed. Crucially, as Ian Hacking has pointed out, clinical categories are not simply abstract disembodied forms of regulation. Instead, they have a social life of their own (1995). Clinical categories are taken up and used by the people they are applied to. A 'looping effect' can take place, where clinical categories are given flesh and bones, shot through with emotional content as lived realities. People come to live their diagnosis as victims of trauma, as autistic, or bi-polar, for example, and in this process the very meanings and implications of the applied categories are transformed. Exactly the same thing could be said about law. Legal categories are not simply cold, artificial, and distant. They can also be thick and full of meaning, being lived out in everyday life. Thus both medical and legal labelling goes to the heart of their experience of what it means to be a citizen and even a human being. Law and medicine can be, to

paraphrase Hacking, 'engines for making up people' (1995), but once these engines are started, they can have a life of their own. In the spaces between the clinic and the court, there are forms of political and social action that cannot be reduced simply to biopower, bare life or neo-liberalism. Whether this space is seen as restricting and regulatory, or liberatory, the juridical languages of rights, law and punishment, create the possibility for new claims based on the sick or vulnerable body and the traumatised mind. As the chapters in this book attest, the analysis of these news spaces is an inherently anthropological project, as the entanglement of law and medicine point to crucial deminsion of what it means to be human today.

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