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A cura di Marco De Biase e Stefania Ferraro

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INDICE

Editoriale: guerre per i diritti/guerre ai diritti?
Globalizzazione e crisi della democrazia
di Marco De Biase e Stefania Ferraro 9

MAPPE

Esclusione identitaria e inclusione selettiva: la marcatura biopolitica della governamentalità neoliberale
di Laura Bazzicalupo 23

For a "constituent" conception of citizenship and "hosting right"
di Tito Marci 43

Humanitarian tarzanism: the discursive tension between inequality and solidarity
di Pierluigi Musarò 63

The global governance of human rights under neoliberalism
di Diego Giannone 81

Mémoire de guerre
Lieux communs et hors champs mémoriels
di Philippe Mesnard 97

ROTTE

Potere discrezionale e politiche securitarie
Le chèque en gris dello Stato alla polizia
di Didier Fassin 119

Governing immigration through crime at the street level
The metamorphosis of an immigration detention centre in Belgium
di Andrew Crosby 145

The (local) medical worker
Understanding the act of bearing witness through a reorientation of *testis*, *superstes*
di Shubranshu Mishra 167

«I didn't cross the border, the border crossed me»
Le mobilità palestinesi attraverso il confine tra Egitto e Striscia di Gaza
di Lorenzo Navone 193

La démocratie en Irak après la guerre
Entre représentations, rhétoriques et stratégies d'ordre
di Stefania Ferraro 213

RILIEVI

L'intégration et l'Europe: quels enjeux?
di Carla Mascia 241

Caporali and *gangmasters*
A comparative study of informal labour intermediation and workforce reproduction practices in Italy and the U.K. A research in progress
di Sara Angiuoni 261

Una genealogia dei movimenti sociali latinoamericani: esperienze di resistenza e produzione di nuove pratiche
di Marta Vignola 287

Mafias et mobilité internationale
Les mafias italiennes entre stéréotypes consolidés et retour à une perspective marxienne
di Marco De Biase 307

Gli apolidi della metropoli
La povertà come frontiera del diritto alla casa. Il caso Napoli dagli anni Cinquanta a oggi
di Giuseppe Daniele De Stefano 331

WUNDERKAMMER

Per la mia eroica resistenza
Scritti per la libertà
a cura di Elena Cennini 351

TRAVELOGUES

Bisogna cambiare lessico
di Fabrizio Greco 371

The marks of capital
di Lucio Castracani 377

Shubranshu Mishra

THE (LOCAL) MEDICAL WORKER
Understanding the act of bearing witness through a reorientation of *testis*, *superstes*

Abstract:

The concept of bearing witness has acquired a paradigmatic value following the work that appeared in the twentieth century and bred a forceful discussion on the significance of a witness and its subjectivity and ethics. It also led to dogmatic positions and limitations, negations and negotiations, possibilities and impossibilities. This paper explores the act of bearing witness to exception through the conflict in Kashmir to understand the case of body and its origin in order to dehomogenise the figure of the witness. It is done to widen its scope, understand it reorienting into new forms, occasionally becoming more radical, and sometimes choosing to moderate themselves under a different logic. It offers an understanding about the local medical worker as a witness but not limiting it to the terrain of *superstes* or *testis* and other categories as suggested by Giorgio Agamben (1999) and Didier Fassin (2008, 2012). The objective is to understand the local medical worker as a witness who testifies not only in place of those he or she treats, but to his or her own condition as an actor in conflict, thereby mixing the "clinical with the political", using Fassin's phrase.

Keywords:

Witnessing, Kashmir, War, Exception, Humanitarian.

1. *Introduction*

Do you know what you're doing?
Exactly what a doctor should be doing.
Which side are you on?
I am for life.

Haider 2014

The conversation from the opening act of Vishal Bhardwaj's *Haider*[1], a film adaptation of Shakespeare's *Hamlet* set in the mid-1990s in the Indian-administered Kashmir (Kashmir hereafter), is between a surgeon, Dr. Hilal Mir, and his wife, Ghazala Mir, after he, for humanitarian reasons and/or under Hippocratic oath, brings an injured leader of the insurgency movement Commander Ikhlaq Latif, from a hide-out to his home in an ambulance under a strict curfew in the city, to conduct an appendicitis surgery on him. Following a cordon and search operation by the Indian Army in the neighbourhood and with the help of a hooded informer (*mukhbir)* the house of the doctor is bombed and gutted to kill the hiding militants. The doctor is detained for attending to a separatist leader (taken to Mama-II in the film depicting the infamous Papa-II torture cell in Srinagar) and later disappears, as several thousand civilians have since the early 1990s, leaving Ghazala a half-widow[2]. Many years later, the son of the doctor, Haider, determined to take revenge, finds his father's body in a mass grave.

The aforementioned confrontation between the doctor and his wife is significant in understanding of the subjectivity of medical worker, questions over loyalty and duty and the political economy of death in a state of conflict. It also reflects, as Basaran argues, that in order to contain the humanitarian space, liberal democracies tend to redefine the «nature and scope of humanitarianism» which has a direct bearing on the categories of

1 Haider, 2014, Vishal Bhardwaj (Director), VB Pictures/UTV Motion Pictures.

2 The term "Half-widows" is often used in a description of the conflict in Kashmir denoting those women whose husbands disappeared, whether in the custody of security forces or crossed over to the other side of the Line of Control, thereby leaving no means of knowing whether their husbands were dead or alive. Because their husbands are not declared dead, they cannot marry for four years as per Islamic laws and cannot seek monetory help from the social welfare department meant for widows. - See more at: Association of Parents of Disappeared Persons (APDP)'s Report: "Half widow, Half Wife? Responding to Gendered Violence in Kashmir" (2011) at http://www.jkccs.net/wp-content/uploads/2015/02/Half-Widow-Half-Wife-APDP-report.pdf.

the «humanitarian actor and the humanitarian subject» (Basaran 2015, p. 50). Those stepping out of line and those excluded from that humanitarian border, may then be penalised. We notice that occurring in the context of Kashmir where certain sections of the population are being subjected to techniques of control and penalisation in the form of instilling fear followed by detention, torture, disappearance and death. Duschinski writes, «Such techniques of governance maybe initially posed through legal provision as states of emergency – temporary and provisional measures for managing an urgent or exceptional problem – but linger indefinitely as infinite wars, wars without end, with crippling consequences for local people» (Duschinski 2009, p. 692). For a medical worker, more so if he or she is a local Kashmiri, is it possible to not get engrossed in the politics of violence and remain oblivious to control and occupation? What positions it has the ability to invoke and because these medical workers come from the same community on whom the violence is directed at by the agencies of the state for their association, does that mean they follow only a particular kind of response? Additionally, even if it were possible to be neutral, as expected from a doctor, would he or she not do everything to save a life, whosoever it may be, and even if secretly, knowing the danger to *the wanted man*? This aim of this paper is to offer an understanding about the medical worker as a witness and explore the various forms of witnessing. The objective is to understand this medical worker as a witness who testifies not only in place of those he or she treats offering a «humanitarian testimony», using Fassin's (2008; 2012) phrase, but to his or her own condition as an actor in conflict. Is "I am for life" only a turn of phrase to mean a neutral position and not taking any side the state or the separatist? Is it then a humanitarian response or an ideological response to the daily humiliation he or she has to endure? These doctors have grown up and were trained in an atmosphere of vicious cycle of violence, human rights violations marked by brutality against civilians, shooting on unarmed protestors, rape and torture. This paper is about those doctors and medical workers who grew up, trained and worked in Kashmir, amidst violence in the most turbulent times of the 1990s. Interviews with medical practitioners, activists and locals were carried out in Kashmir during the field research undertaken between 2013 and 2015.The argument this paper suggests proceeds through four main points. First, when the local medical workers bear witness to their own story, it does include those who did not survive but it is fundamentally about their own precarity because they are part of the victim structure in the humanitarian space they inhabit. Second, by making witnessing an act of narrating their own experience, the local medical workers formulate a

new reading of bearing witness blurring the distinction between the two archetypal figures, *testis* and *superstes*. In this reformulation of the authentic witness, these medical workers describe their own experience as aggrieved actors in a conflict rejecting any burden of neutrality. Third, the roles with which they are identified with by the forms of authority and/or by themselves are enough a justification for them to be forced out of sight to restore the honour of the patriarchal state. This completes the act of knowing who the enemy is. Fourth, this reformulation of the authentic witness disrupts the representation of a true witness, as suggested by Giorgio Agamben (1999) and thereafter by Didier Fassin's (2008; 2012) attempt to dehomogenise the figure of a witness, as both attempts do not allow the subject to be anything other than the prescribed role. Through the analysis of these four points and narratives of local medical workers in Kashmir, the paper suggests that the overlapping subjectivity of the local medical workers demonstrates a continuous reorientation of strict roles that the structure of witnessing burdens them with. It is through this reorientation they find a remedy to deal with everyday violence.

2. Witnessing

Rumana Makhdoomi, a pathologist at the Sher-e-Kashmir Institute of Medical Sciences (SKIMS) in Srinagar, has chronicled her daily struggles, weaving in and out of her experiences, and the «humiliating searches» as she completed her medical degree in Kashmir during the most violent times of the 1990s. She writes

> […] I am trying to write an account of Kashmiri doctors in turmoil, but then I just cannot dissociate myself from all that was happening around us. Some events might not have affected my working as a doctor… but yes, all that which kept happening affected me as a Kashmiri, affected me as a sufferer (Makhdoomi 2013, p. 135).

Faizan Khan (name changed), a doctor based in Srinagar, says, «It was a war – like scenario in Kashmir in the 1990s. We were scared to leave home for work and pondered whether we would return back safe. There was no rule of law and everyone was considered inhuman»[3], suggesting a certain

3 All quotations without a note are taken from field research undertaken in Kashmir between 2013-2015. Wherever necessary and requested by the person, names have been changed. Otherwise, original names are retained with their consent.

kind of "thingification" of the human, to use Césaire's (1950) term in the context of colonisation. What lends to this thinking about inhuman, destruction of the human and dignity? The incessant fear and threat to life points to a certain commodification of that body and therefore it is by making the subject go through that experience every day, the state restricts or, as Basaran writes, «narrows the boundaries of humanitarian spaces» (Basaran 2015, p. 50). The thingification works against the lives, security and dignity of people. Khan goes on to add, «I did have an opinion on what was going on around us but it did not matter to me whether I was treating a soldier or an alleged militant. I tried to do my job as a professional». The problem, however, arises with the response it spawns when he or any doctor treats the latter. The response exposes the nature of absolute certainty about one's enemy even when this enemy might not completely be committed to the other side as he or she may seem or is presented. It is this certainty that creates the basis for impunity or a lack of malintent. Historian Dilip Simeon's (1986, 1998) work on communalism in India in the context of anti-Sikh riots of 1984 and hatred directed at Indian Muslims helps to explain hardened perceptions towards the other. Simeon writes, «For every type of communal fascism, enemies lurk everywhere, whose physical destruction is the only ultimate guarantee of the safety of the *chosen*» (Simeon 1986)[4]. In explaining the majoritarian communalism in India, the internal enemies are the minorities, particularly Muslims, as Simeon (1998) notes, and as we understand through the local medical workers in Kashmir, for anyone to be associated with the adversary, the *militant*, even if it is a professional and ethical duty, is that enemy, the abnormal. Once that naturalisation is complete through regulatory mechanisms, the process opens up the body to abuse and destruction and check or normalise the rest.

We may therefore ask, is the local medical worker curing a militant and a supporter of the insurgency movement two figures of a witness while being the same person? Following Fassin's line of political subjectification, «the production of subjects and subjectivities possessed of political meanings within social interactions» (Fassin 2012, p. 202). If these are two different figures, do they witness on different registers of witnessing, *testis* and *superstes*? If not, as Fassin (2012, p. 206) suggests, «they occupy the structural place of *testis* but employ the reasoning of the *superstes*», is it still possible to distinguish the registers, particularly when the experience they narrate is their own, not just of others? What provides the certainty

4 A more recent (2012) version of this article can be found here: http://www.sacw.net/article2760.html.

with which states mark its subjects and deem fit to eliminate or force them out of sight? What the turbulence of terror and counter terror mechanisms do to the subjectivity of local medical workers as actors in conflict is what the subject of this inquiry is. In so doing, this paper attempts to dehomogenise the figure of the witness, as understood in the scholarship, particularly through Giorgio Agamben's *Remnants of Auschwitz: The Witness and the Archive* (1999) and others, including Didier Fassin (2008; 2012), that bred a forceful discussion on the significance of a witness and its subjectivity and ethics, and widen its scope to understand it acquiring new forms, sometimes becoming more radical, and often choosing to moderate under a different nuance, and when they do not see the same as sufficient motivation. Ethics and politics are the defining characteristics in the formation of that motivation within a milieu in which the subject might define himself or herself or the milieu itself that defines the subject.

Furthermore, there is a distinction between the medical worker, who is a local, trained and works in Kashmir, and a medical worker from an international agency as the international protocol and protection is hardly ever provided to the former by either the state or the non-state actor. The distinction becomes even more important because when the idea of the body is linked to its origin then an additional identity of being a medical worker does not help to attain a privilege. A certain kind of privilege of the international worker in the negotiation with the security official is not a possibility for a local Kashmiri medical worker, particularly when there is an absolute certainty about the enemy. Second, the local medical worker and his or her standpoint can make his or her family at risk as well. It is not only his or her movement which is continuously monitored by the state but the apparatus of surveillance proliferates to include the family and associates. It is however pertinent to acknowledge here that most international agencies rely on support from its local staff. These international medical agencies facilitating access to medicalcare in areas of armed conflict around the world with its staff work under dire conditions. It is well-known that health care services have been one of the most affected sectors as a result of armed violence and it is very challenging to make available an effectual and unprejudiced health care system in those zones. There have been several instances where, the medical workers, as well as patients, have been attacked, detained, tortured or killed constraining their work. This has made a strong case for building a pressure on states and non-state actors for the protection of medical workers in conflict-ridden zones. The idea behind pointing out the distinction is not to create a hierarchy of who is more vulnerable because of the huge personal risk involved in the nature of their work as crossfires do not identify

who is local and international. It is done to suggest that medical workers do not necessarily bear witness on the register of "compassion" as Fassin (2012) talks about, and explored later in the paper, but about themselves as an inmate in the camp in the context of being local. Samrat Sinha *et al* describe the nature of insecurity experienced by the local health-workers in an intra-state conflict and argue, «While there are protocols and guidelines for humanitarian organizations involved at the organizational-level in conflict areas for staff protection, there is little recognition and consequently little work done on the protection of local health services and providers at the hospital-level» (Sinha *et al*. 2013)[5]. The reason, however, why this paper focuses on the local medical worker is not to analyse the danger to the work of local medical services, although crucial, but to draw attention to the, as Bronislaw Malinowski (1935, p. 462) writes, «everyday, inconspicuous, drab and small-scale» where the exception resides and flourishes, understand the subjectivity of that medical worker and of the under, over and erroneous representations of the act of bearing witness.

It might be useful to outline the discussion on the different figures of a witness. In Latin, witness means *testis* which connotes the figure of a third party (*testis*) in a context where two persons are involved and under Roman law, the *testis* is expected to bring his or her personal observation, by virtue of his or her presence as an observer in that context, in a trial with the objective of facilitating the resolution of a dispute. The *testis* is not individually involved in a dispute and for reasons of detachment, the witness account is considered independent and impartial for the purpose of judgement. Fassin writes that *testis* «has no vested interest and it is this supposed neutrality that is the grounds for hearing and believing him, including in legal proceedings» (Fassin 2008, p. 535). Another Latin meaning for the term witness is *superstes* who is personally involved, endures and survives a torment to bear witness. Emile Benveniste, a historical linguist of Indo-European period of the twentieth century, analyses *superstes* in Latin etymology as the one bearing witness 'in the sense of surviving' (Benveniste quoted in Derrida 2005, p. 73). *Superstes* is a figure in which the witness and the survivor unifies into one and this unified figure testifies to one's own precarity, familiarity and experience. Fassin (2008; 2012) suggests that incontemporary practice the boundary between *testes* and *superstes*

5 The Geneva Conventions of 1949 and their Additional Protocols aim to protect non-combatants, prisoners of war and wounded combatants and medical and aid workers working in a zone of armed conflict. These can be accessed on the ICRC website:https://www.icrc.org/eng/war-and-law/treaties-customary-law/geneva-conventions/overview-geneva-conventions.htm.

is gradually becoming blurred. Using the example of Primo Levi, as an archetypal witness, Fassin notes that as a survivor, Levi can bear witness to something having occurred for the reason that he has lived through it. However, because Levi himself admits that since he has survived, he cannot bring to light the truth of those who perished and therefore he can only witness as a third party (Fassin 2008, pp. 535-36; 2011, p. 205). Primo Levi (1988) writes it is those who died in the concentration camps, and not the survivors, who are the real witnesses. It is this assertion of Levi, borne out of guilt, Agamben (1999) pursues further to suggest that it is the *Muselmann*, the desubjectified subject, who is the complete witness, the one who has no ability to speak or affect. Agamben writes

> we may say that to bear witness is to place oneself in one's own language in the position of those who have lost it, to establish oneself in a living language as if it were dead, or in a dead language as if it were living – in any case, outside both the archive and the corpus of what has already been said (Agamben 1999, p. 161)[6].

After understanding these distinctions between *testis* and *superstes*, one may ask, are the local medical workers, working in conflict zones, testifying as a proxy for those who did not survive, as *testis* by observing what was happening to people around them, or as *superstes* of having lived through an ordeal? This paper suggests that they bear witness to their own story which is although closely connected to those they assist or who did not survive but is fundamentally about their own precarity. The blurred distinction between the two figures, as suggested by Fassin, does not do justice to their own condition.

3. *The split in the humanitarian movement: a new formulation of witnessing*

The International Committee of the Red Cross (ICRC), founded in 1863, is a leading emergency relief agency working with the objective «to ensure

6 Other historians, literary theorists and psychoanalysts, Francois Lyotard (1988), Shoshana Felman and DauriLaub (1992), Cathy Caruth (1995) and Dominick LaCapra (2001) have suggested bearing witness to be a necessary yet an impossible task. Other writers, including Kelly Oliver (2001), Annette Wieviorka (2006) and Thomas Trezise (2013), have attempted to unpack the formulations of Agamben, so as to understand its ramifications for current and future instances of bearing witness.

protection and assistance for victims of armed conflict and strife. It does so through its direct action around the world, as well as by encouraging the development of international humanitarian law (IHL) and promoting respect for it by governments and all weapon bearers», as mentioned on its website. However, not taking an open political position has been a criterion for many of the international agencies to be able to function in conflict-ridden areas. Remaining silent or neutral appears to be a *problématique* as ICRC chose to remain silent about human rights violations on several occasions. Daniel Warner (2005) and others, including Jean Claude Favez (1999) and David P Forsythe (2005) have drawn attention to the absence of ethics of ICRC by not taking a public position against the Nazi regime despite, as written extensively by Hugo Slim (2001), having access to the victims of the holocaust and been a witness to their condition. In the backdrop of ICRC's experience, Didier Fassin's work has outlined the split in the humanitarian movement in the early 1970s which gave rise to *Medecins sans Frontieres* (MSF) «born out of the refusal to remain silent during the war in Biafra» (Didier Fassin 2008, p. 536; 2012, pp. 205-206) and the floods in Bangladesh. He underlines the formation of MSF in 1971 and *Medecins du Monde* (MDM) in 1979 as the second phase of international humanitarianism corresponding to the «advent of the witness, not the witness who has experienced the tragedy, but the one who assists the victims» (Fassin 2008, pp. 536-537).

With the founding of MSF in 1971, Fassin writes, «testimony became an integral part of humanitarian intervention, on an equal footing with aid. It was no longer enough simply to save the victims of war; one must also plead their cause» (Fassin 2012, p. 200). Peter Redfield, however, maintains

> Members of MSF commit themselves to witness injustice and thereby contribute to a larger representational struggle against inhuman conditions, but they do so always through the frame of a present decision in the field, rather than, an overriding conceptual strategy of development or a political ideal (Redfield 2005, p. 338).

The «ethic of engaged refusal» is the objective with which most agencies of humanitarianism, including MSF, as Redfield points out, operate in areas of conflict (Redfield 2005, p. 329). These agencies and its personnel tend to project a sense of distance, as a form of political limitation, for a larger concern of saving a life and take a position only on a bigger issue and not on regular, everyday issues affecting the needs of people. Peter Redfield (2005) puts forward a strong critique with respect to MSF but

subsequently also cites the exceptions in the cases of Ethiopia in 1984-85, Rwanda in 1994 and Afghanistan in 2004, and writes

> The group's insistence on a politics of witnessing combined with its abstention from taking a directly political role stems from an unwillingness to accept the extended state of emergency within which it generally operates. Simply to denounce situations would achieve no immediate humanitarian ends and to endorse political agendas would potentially sacrifice the present needs of a population for the hope of future conditions. But to maintain formal neutrality at all times without protest would mimic the classic limitations of the Red Cross movement that the founders of MSF originally rejected. Confronted with such a range of unsatisfying options while still being committed to humanitarian values, MSF's ideological strategy is to claim a position of "refusal" in the form of action taken with an outspoken, troubled conscience (Peter Redfield 2005, p. 342).

Although there are critiques from different strands of thinking that have appeared in the existing scholarship as well as the churning that happened around it, however amidst the two phases of humanitarianism, we seem to have forgotten those medical workers who do not belong to any international relief agency but are active participants in the conflict by virtue of having been bred and trained in the zone of conflict. Their act of bearing witness is not only in the name of victims but because they are part of the victim structure themselves, they bear witness to their indispensable condition within the localised humanitarian space they inhabit. The predicament within this localised humanitarian space is not how to «maintain impartiality» when speaking for one and «condemning the other», as Fassin writes about stakes of humanitarian organisations in establishing legitimacy, but maintaining an ethical space in which caring for one is not seen antithetical to the other (Fassin 2012, p. 200). Even if it were to be antithetical, it stems from an experience. It is the experience that has to be brought to the fore in order to disrupt representation.

The concern of this paper, therefore, is to shift from a collective standpoint of an international humanitarian agency to an individual one and explore the subjectivity of the personnel, i.e. a medical worker, in Kashmir, having grown up in a militarized environment, with the rationale for looking for the missing voice as well as being critical about issues of representation or suppression on how particular groups, a local medical worker here, are affected during conflicts and the contextual knowledge and perspective or lack of it with which their stories can be understood. What happens to the agency of the medical worker, who is also a state subject, in a state of conflict? Is it possible to be divorced from a political agency with what is

happening around? Is it possible for the medical worker to see oneself an actor outside of politics, particularly when the politics is a lot about his or her own identity as a subject? Not only with connection to medical action and humanitarianism, but does the medical worker bear witness to one's own destruction of being through constant crackdowns, search operations and verbal and physical abuse directed at him or her by the security personnel? Is it therefore possible to understand the medical worker as a witness, *testis* or *superstes*? The witness here is not speaking in the place of the victims or for them, he or she is testifying for himself or herself. In so doing, he or she also formulates a new reading of bearing witness blurring the distinction between the two archetypal figures, *testis* and *superstes*. He or she is sometimes one or the other and at other times, both.

Ever since violence escalated in Kashmir in the late 1980s and early 1990s, the Indian security forces have functioned with absolute impunity often disregarding the laws protecting the medical services in a state of conflict. Various laws, namely the Armed Forces Special Powers Act (AFSPA) of 1990 and the Public Safety Act (PSA) of 1978, provide the impunity from prosecution with which the security forces act in a "disturbed area", as the Government of India describes wherever AFSPA is in place. These laws not only constrict people and their freedom, they affect the humanitarian space. This permeating nature of violence in the state of affairs has affected not only the work of medical personnel working under calamitous conditions amidst regular gun battles between the two opposing sides but has had a toll on those in need of a medical service. Faizan Khan explains how the security condition in Kashmir affected the movement of doctors who could not reach hospitals at odd hours to attend to patients. He says, «People could not get the right medication. They were not attended, particularly during nights, as doctors did not dare to step outside their homes. For them, it was a matter of their own survival as well». Zahida Shah, a doctor in Srinagar, adds «it was not the distance from home to hospital but a sense insecurity of being caught in a crossfire which frightened us». She further states, «It was also traumatic for everyone working in the hospital to see the condition in which the bodies were brought after a violent incident. There was no criterion of where people can be shot at. There was blood oozing out from everywhere». These narratives depict the gruesome nature of their work inside the four walls of the hospital compound and yet there were ambulance drivers being targeted outside. Shabir Ahmed Dhar and his colleagues write

> More than any other health care workers, ambulance drivers are exposed to difficulties because they must work outside the relative safety of the hospital

> premises. This risk is magnified when the streets are the theatre of the turmoil (Dhar 2012).

Many other cases of the challenging conditions under which ambulance drivers work in Kashmir bringing patients and medical staff to hospitals at the peak of violence in the 1990s have been documented in various fact-finding reports and mentioned later in the paper.

A field research was undertaken in Kashmir by researchers of Asia Watch and Physicians for Human Rights (AW and PHR), between 1992 and 1993, documents deliberate assault on medical workers by the armed forces in their counter-insurgency measures[7]. The health professionals, it documented, were frequently «detained, assaulted and harassed» while being on duty. The report observed

> Security forces have also repeatedly raided hospitals and other medical facilities, even paediatric and obstetric hospitals. During these raids, the security personnel have forced doctors at gunpoint to identify recent trauma patients. Because of their injuries, the security forces have suspected these patients of militant activity. Injured patients have been arrested from hospitals, in some cases after being disconnected from intravenous medications or other treatments. The security forces have also discharged their weapons within hospital grounds and inside hospitals, and have entered operating theatres and destroyed or damaged medical supplies, transports and equipment (AW and PHR 1993, p. 15).

Makhdoomi narrates one such crackdown by the Indian Army in the Shri Maharaja Hari Singh (SMHS) hospital in Srinagar. She was a medical student then and all the students were brought out into the corridors and the entire hospital was sealed, all doctors, paramedics, and nurses were made to sit an awkward posture facing the wall. She writes «All were sitting and squatting in the corridors where they used to walk like kings» (Makhdoomi 2013, p. 36). The forces paraded the doctors in the same corridor with their heads held low. «One refused to bow down, one neck refused to bend» (Makhdoomi 2013, p. 36). The displeased soldier asked the professor to face towards the wall and sit. The professor refused and replied «Go and get a chair for me. I cannot sit like a criminal» (Makhdoomi 2013, p.

7 The report has documented cases of extra-judicial executions, rape and torture of detainees by the Indian forces. It also documented cases of violence committed by the armed groups in the form of rape, kidnapping and indiscriminate attacks on civilians.

36). Crackdown, as she says, was a «tool which cracked our spines and humiliated us. It told us about our weakness, about our desperations, and it reminded us about our enslavement» (Makhdoomi 2013, p. 09).The medical space, a hospital, was no different than the neighbourhoods in Kashmir where young boys and men were being dragged outside their homes, canned and kicked every night by the security personnel as a part of counter-insurgency measure.

Bringing into light the violence directed at the medical personnel and the challenges faced by them in Kashmir through the 1990s is done with the objective to understand the local medical worker as a figure not outside of a camp-based existence but an inmate and to explore how different, if at all, is his or her understanding on the experience of death, reduction of self. And therefore, it is pertinent to ask here, what do these medical workers describe? What is the condition to which they bear witness? These medical workers put before us a figure of a witness that blurs the distinction between *testes* and *superstes*. The observation of the local medical workers is so intricately linked to their own experience as the aggrieved actors in conflict that they reformulate their role as an 'authentic' witness rejecting any burden of neutrality and of a register of mere "compassion" (Fassin 2012).

4. *Exploring the scope of witnessing*

The medical worker and a humiliated civilian, both non-combatants but also possibly the same person, is similar to the *non-distinction* Fassin makes between the «bold youth throwing stone and the distressed victim of trauma in Palestine as figures used to describe individuals, and with which they are identified, whether or not they recognize themselves through them» (Fassin 2012, p. 202). Like the Palestinian teenager, following Fassin's line of argument, the medical worker might be 'presented' as a combatant by the state or he or she «may even present himself alternately» as a non-combatant (Fassin 2012, p. 202). Therefore, the doctor in the film *Haider* (2014), on being signalled by the *mukhbir*, is presented, against his will, as an unbecoming of a doctor into a collaborator with the militant. It is then, in that light, it becomes justifiable to detain and torture him. The emphasis Fassin (2011) draws on this non-distinction calls attention to the works on the Partition (India-Pakistan) and particular forms of gendered violence during that event. The humiliated local medical workers remind us of the women who were subjected to grave violence by the men of their own family. It was seen acceptable to kill women of one's own community fearing the

dishonour it would have brought if the women were to be abducted or raped by the men of the other community. Those women who were rescued or managed to escape or return were not accepted by their families and were considered "polluted". Urvashi Butalia (1998), Ritu Menon and Kamla Bhasin (2007) and others including Saadat Hasan Manto's Partition stories, have produced extensive literature on these private stories calling upon us to look at particular forms of gendered violence legitimised as "normal". The local medical worker does not have be abducted by the insurgents, he or she might offer care willingly. However, the association with the militant is enough a justification for him to be forced out of sight by the patriarchal state. The signalling of the *mukhbir* and by the act of caring for an injured militant leader are enough reasons for the security officer to justify the detention of the doctor and put his house on fire in the film *Haider*. This completes the act of knowing who the enemy is and demands no condemnation. The honour of the patriarchal state is thereby restored by having them eliminated.

Fassin (2012) goes a step further than a production of subjectivity. His probe is to delve into the «truth tests» the subject is made to undergo by the forms of authority in order to «conduct the conduct», to use Foucault's phrase *conduire la conduite*, of the subject. Our inquiry does not decentre the subject from the experience of that subject, an experience which is about his/her own condition. In so doing, it however, does not present an «essentialist conception that reduces the experience of trauma to the condition of the traumatised person», as Fassin suggests about a psychological account because whether the victim and the doctor are the same or not is a conundrum we are trying to unpack here (Fassin 2012, p. 203). This paper suggests that these two figures might be different but also the same. Because these might be the same, the attempt is to explore how does witnessing of the medical worker renders the distinction between *testis* and *superstes* inadequate to fully understand the figure of a witness and scope of witnessing. The existing understanding of these archetypal figures and Fassin's attempt to disrupt that distinction, however on a different register of compassion, does not allow the subject to be anything other than the prescribed role. Both attempts make recourse to the position of the individual in order to trap his or her possibilities. As a matter of self-identification, this paper posits and agrees with Fassin, the role and the testimony of a local medical worker blurs the distinction between *testis* and *superstes* and strengthens the scope of witnessing. The local medical worker testifies as a third-party for having seen the victim suffer closely, as Fassin points out, but also as a *superstes,* as this paper points out, for having experienced it

himself or herself as a victim. This medical worker is neither the ICRC personnel who is expected to remain silent on issues related to human rights violations in order to bring medical care to the victims nor the MSF or MDM doctor bearing witness as a third party. It is possibly both or a reorientation of those strict roles. This witness figure does provide medical intervention and it also feels necessary to speak for oneself on the basis of what one has lived through as an inmate in that environment. There were and are no protections, as international humanitarian laws demand, provided to them by the state because the state has often considered the conflict to be a law and order problem and seen many medical workers as agents of conflict because of their association and standpoint.

Writing about MSF and MDM, Fassin observes

> […] even if they attempt to analyse the political issues involved in the situations they face, the register in which they set their legitimacy is constructed in the public arena: is that of compassion. They speak of bodies, of wounds, of suffering. Through a sort of reversal of the traditional roles, they occupy the structural place of the *testis* but employ the reasoning of the *superstes*. In other words, they privilege experience over observation, but this experience is the experience of other (Fassin 2012, p. 206).

It is the concluding line of this observation, we may want to discuss further. For example, consider this narrative by Faizan Khan about the massacre that took place in 1990, «when the massacre took place. I was at the hospital. Several people had died when a procession was being carried out in Srinagar. We piled those dead bodies, one over another. Bodies were carried as cattle. It was such a dismal, horrible situation. There was a heap of bodies. One gets scared while even talking about it». On 21 May 1990, Mirwaiz Molvi Mohammad Farooq, the religious leader of Muslims in Kashmir, was assassinated in the old city at his residence by unidentified gunmen. Security personnel of the Central Reserve Police Force (CRPF) killed scores of mourners by firing upon Mirwaiz's funeral procession which started from SKIMS. Sixty-seven people, although numbers were contested, were killed in the Hawal massacre. Most Kashmiris remember it as «one of the worst massacres in Kashmir's recent history». We notice that Khan does talk about the plight of others, the dead and the injured, thereby affirming Fassin's observation, but he is also talking about his own experience as he goes on to discuss about the human condition, as a whole, and a thingification of life, «One who has no basic rights, the person is no longer human, it is inhuman. In those days, everyone was inhuman. It was not a society of humans». It is striking that Khan often uses the term inhuman to

describe a sense of degradation of the human, a sense of helplessness and as if it were «a common sense», to use Dilip Simeon's (1998) phrase in context to violence, to the state of tyranny and daily humiliation.

There have been several reports published by fact-finding commissions stating that in many instances, the security forces have responded to attacks by militants by attacking civilians. Farooq Ahmed Ashai was one such civilian, a doctor and founder of Srinagar's Bone and Joint Hospital. He was an expert in bullet injuries and a report states, «he was also frequently sought out by militants» (AW And PHR 1993, p. 66) as he often treated victims of torture. On February 18, 1993, Ashai was driving back to his home in Barzulla Hospital's residential compound with his wife, also a doctor, and his daughter when he was shot by the CRPF soldier from a bunker despite having being cleared by the previous bunker. Official statements which appeared in media after the incident held that Ashai was killed in the crossfire as there was a grenade attack on another CRPF bunker, across the bridge, but field-research undertaken by AW and PHR (1993, p. 140) found, «circumstantial evidence suggests that the shooting was deliberate, rather than a reaction to a sudden attack» and his family and many civil society organisations believed Ashai was killed because of his frequent meetings with foreign journalists and human rights workers documenting cases of torture in Kashmir. Several other doctors have fallen to guns whichever side they may have come from for the nature of their arduous task[8] and possibly their standpoint. There have also been well-documented cases when the security forces have intentionally stopped injured people seek any medical care, and have shot at ambulance drivers, arrested people admitted in the hospitals. In another incident documented by AW and PHR (1993), an ambulance driver described an incident in April 1992 in which he was used as a shield by the security forces while he was driving through an area where security officers were engaged in an encounter with militants. The ambulance was made to «be positioned in such a way as to shield a military bunker from sniper fire by militant forces», he told the researchers of Asia Watch. The ambulance driver was on duty to bring the emergency staff of a hospital. Another incident occurred with the same ambulance driver two months later when he was sent to pick up a doctor from her home:

8 Fayyaz A.A., (20 August 2013), *Top doctors in militant crosshairs*, in «The Hindu», New Delhi. Online at: http://www.thehindu.com/todays-paper/tp-national/tp-newdelhi/top-doctors-in-militant-crosshairs/article5040227.ece (Accessed August 20, 2015); Also, Kashmir: the Untold Story by humraquraishi (2005) and Kashmir in Conflictby Victoria Schofield (2003).

> He was stopped at Lal Bazar by Border Security Force (BSF) soldiers, who opened fire into the air, forcing him to back up. They ordered him to stop, then removed the keys from the vehicle, and struck him in the forehead with the butts of their rifles. He was then beaten with kicks and fists, and only then was he permitted to show his identification papers. He explained to the BSF that he was on emergency duty. At this time, A. observed that three injured persons were lying on the road in front of his vehicle. The BSF ordered him to leave the area, but before he did so, he asked if he could take the injured persons with him. The BSF told him that he could, but when he proceeded to back up, the BSF opened fire on the ambulance, shooting through the windshield. A. was shot in the abdomen and right wrist. He managed to drive himself back to the hospital where he was treated for his injuries (AW and PHR 1993, p. 109).

Here, we notice again, the testimony of the ambulance driver does entail a description of suffering of others as a *testis*, however, he is not detached from that suffering. He is the target of violence too and for that reason part of the victim structure and thereby testifying as a *superstes*. The medical personnel in the hospital too have been prevented from carrying out their duty, been subjected to humiliating searches and been arrested during crackdowns and tortured because of their own identity as a local Kashmiri. Just as it affects general civilians, it is quite reasonable to suppose that the violence and humiliation inflicted on local medical workers must have serious consequences on their subjectivity and yet, to be able to find meaning in their work, they bear witness for the suffering they have gone through. This is a renegotiation of the distinction between *testis* and *superstes* through an overlapping subjectivity.

5. *Rumana Makhdoomi: The clinical and the political*

Rumana Makhdoomi, who hails from old Srinagar city and works as a senior pathologist at the SKIMS, published a book in 2013, *White Man in Dark*, giving an account of her journey of becoming a doctor, from the year 1988 when she got admission in the Government Medical College in Srinagar. Within a year of her admission, the violent conflict began in Kashmir which changed her life and the lives of many others. In a similar manner as Levi (1996), she expresses her need to tell this story as borne out of a an «immediate» and perhaps «violent impulse», as Levi writes (Levi 1996, p. 9). She says to me

> My work is about offering a history of turmoil in Kashmir and in the way I have perceived this turmoil amidst which students became doctors and re-

> ceived training. Writing about the events, which were stacked in my heart and mind, required courage and it has provided me with an *outlet* to offer a voice to my own victimisation and also to the suffering of several others that I have been witnessing.

The *outlet* is perhaps what Levi referred to «as an interior liberation» (Levi 1996, p. 9) and in order to achieve that "outlet" she does not make herself invisible from the account she offers. As a *testis*, Makhdoomi gives a description of what people around her had to suffer but as *superstes*, she is narrating her story as a participant in that endurance. «This trauma is transgenerational and the spectrum of violence and experience develops from my grandparents to my daughters and each generation has a story to narrate», says Makhdoomi. She adds «As a doctor, I had to see the harsh reality of violence almost every other day». In her book, she writes about the conflict taking an effect on the medical students who had to put in not only more effort, given the turmoil in which they were trained, but had to spend longer years at the medical college to acquire their degrees because of depleting condition of the college and the administration. She knits her narrative through various interlocking events of crackdowns and assassinations and pulling off the ordinary and mundane events running parallel, namely «humiliating searches» by security forces in the hospital, about schools being burnt, graveyards get filled with bodies of young boys of the neighbourhood, in the last twenty-five years of conflict in Kashmir. She says, «There were these young boys I used to play with being dragged out of their homes by the security forces during crackdowns. One would only hear about their mutilated bodies being discovered later and then buried in the Malkha graveyard», one of the largest cemeteries *in* Kashmir. «It was not something happening in a remote village in Kashmir but in the heart of the city», she adds.

Makhdoomi talks about the lawlessness penetrating into the daily life of people. It did not confine itself to the most extra ordinary instances but entered into the most mundane things. We may understand this following Hannah Arendt's description of evil spreading like a «fungus on the surface», as she puts it very compellingly in her work *Eichmann in Jerusalem: A Report on the Banality of Evil* (1963). There was no application of thought, it appears through the numerous narratives of Makhdoomi, Khan and Shah, in countering-terror in Kashmir. The rationale behind security measures resulted in more suffering, and further alienation, for the people in Kashmir. «There has been a wide-ranging experience of trauma», Makhdoomi says, adding further, «There were brides who were raped while on

the way to their in-laws place after the wedding had taken place and then in the hospital, among many other wrong-doings, new-born babies were being secretly sold for money. It took seventeen years for one such baby to be reunited with his biological parents and it remains the only successful return». The fungus was growing everywhere, affecting most actors in conflict. It was not limited to the actions of the state and its agencies. In August 1994, a nurse working in the maternity ward of a hospital in Srinagar sold a child, born with his twin brother, to a childless couple for ten thousand rupees. He was reunited with his biological parents after seventeen years when his quarrelling foster parents asked him to leave and find his real parents. Although he was warmly embraced by his biological parents but the boy, Sarmad, wants his story to be told «so that no greedy nurse or doctor dare sell somebody's baby in future»[9]. It is Rumana who decides to tell this mundane tale evoking Bronislaw's 'drab and small scale' and recollects this incident, in detail, in her book,

> An error done 17 years back will never be owned and yes, will never be probed. Like all mysterious happenings in our Dark Valley, all errors will be forgotten and manipulated to be forgiven. I recollect my days in maternity posting, my days during internship at LD Hospital. Those women who counted money in evenings, were they the ones who stole Sarmad from his mother or was it some other woman in some other hospital? (Makhdoomi 2013, p. 162).

The incident, takes us back to Arendt's observation when she points to a situation where the ability to make «conscientious choices» is broken down. Arendt (1963) writes that in the camps, prisoners are forced to choose not between good and evil, but between evil and evil. Everyone makes a choice to survive but the condition in a camp weakens the ability to make a an ethical and moral decision. This is true for all inmates of a camp, no matter which side they are on and such acts, like the one by the nurse, become «incomprehensible data». Who, then, is accountable become a futile inquiry.

The narrative of Makhdoomi tends to «mix the clinical with the political», as Fassin observes in the context of field observations of psychiatrists and psychologists in Palestine (Fassin 2012, p. 212). The events in hospital, at times, are only an alibi for a portrayal of state brutality and a

9 Qayoom S., (25 September 2011), *Stolen as infant, back as teen: Kashmiri twin's tale*, «DNA», Srinagar. Online at: http://www.dnaindia.com/india/report-stolen-as-infant-back-as-teen-kashmiri-twin-s-tale-1591304, (Accessed 25 August 2015).

feeling of injustice for Makhdoomi. Therefore, her narrative as a medical professional hailing from Kashmir is different from a narrative of medical worker of an international agency operating in a conflict zone. She says «It was not a priority to protect the doctors working in Kashmir and even those doctors who were vulnerable, for example Dr. Guru, too were not provided with any security. Eventually, he was kidnapped and killed». Abdul Ahad Guru was founder-head of Cardiovascular and Thoracic Surgery Department at the SKIMS. He was also the member of the governing council of Jammu and Kashmir Liberation Front (JKLF) and therefore had a public position on Kashmir in favour of separatism. He was questioned by the security forces for treating the commander of JKLF, Yasin Malik, at his residence in 1990. In 1993, Dr. Guru was believed to have been kidnapped and assassinated by Hizbul Mujahideen militants, rival group of JKLF. In 2008, a senior bureaucrat and Divisional Commissioner of Kashmir in 1993, Wajahat Habibulah, revealed in his book, *My Kashmir: Conflict and The Prospects Of Enduring Peace*, that the Jammu and Kashmir Police had made an arrangement with a Hizbul militant in custody to kill Guru in exchange for his release. The militant was however shortly killed by the Police to keep the secret behind Dr. Guru's assassination a mystery (Habibulah 2008)[10]. We may be compelled to, therefore, believe that those protocols and conventions of international laws do not make any sense when that fungus has already trickled down and in many ways has been internalised. This nexus throws light on the political economy of terror and counter-terror and the oscillation of the marginalised subject between life and death.

«Despite carrying curfew passes», as a security measure of the state, «it was to the sweet-will of the trooper to allow the doctors into the hospital premises. Those passes made no sense when the doctors became victims during crackdowns and crossfires. The sanctity of a hospital was never respected by the security forces as they continued with their search operations even when surgeries were underway», Makhdoomi recollects. The report by AW and PHR cites several cases through witness accounts and in one incident in 1990, the report states,

> Indian army doctors ordered the medical staff at the Saura Medical Institute to transfer all patients with recent injuries to them so that their cases could be reviewed. Physicians at the Institute complied with the order, but objected to the transfer of one patient in the intensive care unit who was awaiting surgery for a liver abscess. At the time, the infection had spread to the bloodstream

10 The assassination of Dr. Guru has been document in detail by AHR Report and WajahatHabibulah makes that disclosure in his book (pp. 81-83).

> (a condition known as sepsis) and the patient required life-sustaining cardiac pressor agents to maintain his blood pressure. Despite the patient's precarious condition, the hospital staff were forced to remove him from the intensive care unit and pressor support. The patient died three hours after he was disconnected from his medication and before he was able to be returned to the intensive care unit. The crackdown reportedly lasted for seventeen days, during which time no one was allowed to enter or exit the hospital grounds. According to hospital staff, five dialysis patients who were not permitted to enter the hospital compound died as a result (AW and PHR 1993, pp. 113-114).

«The doctors were never treated in a different way, as standards demand, and in fact they were often held with suspicion», Makhdoomi says. She recounts the day when bunkers were established in hospitals and «the movement of doctors and patients was intensely monitored by the security forces. There were cases when newly-admitted or operated patients were removed from high dependence wards or intensive care units, their gauzes and bandages were removed and subjected to interrogation jeopardising their safety», Makhdoomi adds. She has not only given an outlet to pain of people as she saw wounded patients getting treated at hospitals and the howling family members wheeling out the bodies of people from hospitals killed in crossfire but she has also found meaning in her own work by discovering her ability to bear witness. Although what emerges from these narratives is «a political account of violence rather than a clinical account of trauma» (Fassin 2012, p. 214), but this narrative is not that of a «spokesperson of the victims», as Fassin insists about the nature of witnessing of medical health professionals of international agencies, but it is about the uncertainty and helplessness of a profession, amidst violence, through a description of her own trials and tribulations. «I do not hate the security person because he was working on the orders of someone. My protest is why was he not educated? He, among others, were given a training on arms and were sent to work in Kashmir without knowing anything about the context», she says trying find some reason of the evil. Makhdoomi knows that her search for reason will end in a naught because it is not reason but blind obedience without thought, as Arendt (1963) explained it, which makes the soldier to perform certain tasks. By giving recognition to the adversary as much as she puts the emphases on victimisation of people as a result of the actions of the same adversary, she brings the human condition to the fore. This is what she does by bearing witness and this takes us to Dilip Simeon's analysis of victimisation when he says «examination of instances of mass animosity will reveal that the sense of being victimized is central to an explanation of violence» (Simeon 1998, p. 3). Rumana adds

«The problem is also when there is complete indifference by brazening it out that things never happened. There can never be a closure when there is indifference. If ever there were an apology rendered by the state that wrongs have been committed, then that does open a window for reconciliation. Years and decades have passed and there is no acknowledgement which only inflates hatred». It is here she brings back the perception of victimisation to her narrative.

> Dignity is indispensable and no one should be alienated. As doctors in the hospital, we were searched over and over again and privacy of our rooms was often disturbed. Choosing to remember or forget as an option does not arise because there is no closure. I pass through the same lanes, meet the same people and a scar cannot heal if it is scratched over and over again. It is not easy to retain humanity within oneself in those circumstances and except for religion there is no relief.

She finds her remedy to deal with violence.

Medical workers working in conflict zones have often been caught in violence between the warring sides and at times have also been the deliberate target with hospitals being attacked and health workers humiliated and abducted. This has put them in a vulnerable position and has deeply affected access to medical care by the general population. Samrat Sinha, together with his colleagues, argues «in spite of being part of the setting of armed conflict for decades such violence against healthcare providers and facilities is grossly overlooked, compounded by limited reporting, lack of impact-analysis and absence of mechanisms to prevent them. Events which even do receive some attention mainly involve international humanitarian workers» and suggest that «less focus is directed towards security conditions that threaten the average working day of local healthcare workers» (Sinha *et al*. 2013). The aim of this paper was to open up issues of the missing point of view and to look at how humanitarianism can also be intricately liked with a political standpoint of the actor in conflict. Significant to our discussion was to uncover the manipulative apparatus of witnessing, in knowledge making, and to critically address the problems thrown up by homogenizing and erroneous representations of these subjectivities and act of witnessing, particularly through the strict distinction of *testis* and *superstes*, and Agamben's *Muselmann* and even a shift of perspective encouraged by Fassin from a standpoint of blurring that representation, but in the process creating another fixed position. We also attempted to understand how that standpoint comes into being by looking into instances of abuses made by state on local medical workers, their detention, torture and a design of eliminating them.

Through a diversity of sources, we have tried to understand the implicit or not so visible vulnerabilities, and even motivations, of certain actors, local medical workers in this case, emerging from deep set of injustices and how their survival was jeopardized because of the absolutist way of the exercise of state sovereignty. In understanding their act of witnessing, we have tried to highlight the problem of how the regulatory processes of the state can present a medical worker as a collaborator with the enemy, particularly when he or she attempts to contest a totalizing attack on his or her subjectivity by the state.

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