FRACTURES: An inquiry into the figure of the medical doctor in films set in African conflict zones.

by

Kenneth Dan Kaplan

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ABSTRACT

This thesis is part of a creative arts PhD which explores the cinematic figure of the medical doctor in African conflict zones. It is presented along with a fictional feature film screenplay entitled *Across the River.*

The discursive component of this research is not intended as an explanation of the screenplay but rather as a contribution to the discourse around the representation of the medical doctor in the cinematic imagination of a filmed Africa, of which little is written about in film research. This emblematic figure appears at the centre of the selected film narratives about humanitarian intervention in the imagined African conflict zone. The research is significant beyond the locality of the films under consideration because of the pervasive nature of emergencies in our contemporary understanding of the world.

The conceptual application of the medical term 'triage'—a system used for the sorting of casualties for treatment in resource-scarce areas—offers unique insights into the authority and power vested in the doctor figure within the imagined conflict zone. A framework based on political and legal theories is also applied to an understanding of emergencies and humanitarian crises. This considers the representation of the doctor figure as part of new world order shaped by emergency and the uncomfortable overlap of military and humanitarian operations in the filmed conflict zone. In response to these new conceptions, this study approaches African film practice through less conventional theoretical perspectives. It critiques canonised texts of African film theory which define African filmmaking from the perspective of race, geography and ideology. Rather than ignoring the complexities of film production as many theorists do in favour of a purely textual reading, this study considers the system of inputs and exchanges that situates African filmmaking practice within a globalised film economy using a film services approach. A Metzian framework is applied in considering the cinematic fact—the industrial and economic conditions of the production and distribution of the film—alongside the filmic fact with its focus on the interpretation of meaning contained in the film text.

Meshing film theory with political concepts derived from the social sciences, the study investigates how emergencies operate and influence the cinematic construction of the humanitarian gaze. In choosing to focus on films that relocate the doctor from the traditional setting of the ordered institutional confines of the hospital, the study investigates how this fictional figure becomes a site of fracture and is transformed in significant ways within the conflict zone. This research finds that while this conception of the doctor at the masthead of modern humanitarian intervention in the African conflict zone might appear freed of its colonial past, certain inescapable associations endure in therapeutic actions through the exertion of power over life itself.

Finally, the study shifts the conflict zone to the interior world of the doctor character and considers the emotional and psychological dimensions of the wounded healer, which informs the main character in the feature film screenplay component of this PhD.

Keywords

Doctor; Medical; African cinema; Emergency; Schweitzer; Conflict; Iatrophobia; South African Film incentives; Film Services; Global Health; Global Hollywood; Postcolonial; Colonial medical

DECLARATION

I declare that this dissertation is my own unaided work. It is submitted towards the degree of Doctor of Philosophy by creative project and thesis at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination in any other university.

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Kenneth Dan Kaplan

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Publications and presentations emanating from this research include earlier versions of chapters two and four that were published in a special themed edition of the journal *Communicatio* entitled 'Trauma on Screen' (K. Kaplan 2018).

A week of intensive teaching based on the research was presented to Masters students at the Valand Academy at Gothenburg University in Sweden in September 2019.

Access to Bassek Ba Kobhio's film was made possible with the help of MNET's Media Archives and Gray Hofmeyr kindly provided copies of his film.

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Finally, I dedicate this project to my parents, Drs Sylvia and Cyril Kaplan, for their guidance and understanding that art and science should encounter each other as equals.

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PREAMBLE

PERSONAL MEDITATIONS

My earliest memories of film are tied to family viewings of home movies. That hermetically sealed and darkened space defined by two points of light: the projector at one end of the room, and the silver screen at the other.

This was a safe environment where our family gathered to indulge shared memories.

There were holidays and birthdays, arrivals of newborn siblings which for the boys was accompanied by tense hand-held images recording the Jewish circumcision ritual. Concern on the faces of the women and anticipation among the men crowded around the baby. A glint of a blade and then celebration as cousins and friends smiled or pulled faces for the roving camera. Self-ridicule and teasing were always endured in those unguarded moments of infantile behaviour captured in the tiny frames of 8mm film and relived over and over again.

Today the ubiquitous cell phone with its multi-function digital camera has all but swept away analogue video technology. Where once we gathered in my father's study, curtains drawn, chairs lined up facing the screen as the projector was unpacked and cleaned and then carefully threaded with reels of brittle film, these ritualised family gatherings now seem antiquated. The selfies, streamed clips and timelines of our always-on media updated instantly to mobile phones negate the need for the proximity which those film screenings demanded.

After a few hours of watching family movies, my parents would send me, the youngest, off to bed. When I pleaded to stay and watch with them, my mother gently explained that I had to be older before I could watch the "medical films". Those reels, kept separately from the home movies, were stored among my father's journals and papers. They were films of surgical procedures of my father's pioneering hip transplants and spinal tuberculosis cases filmed by my mother. There were prosthetics and joint replacements, and one particularly arduous double leg amputation.

One evening, instead of going to bed as I was told, I crept back into the darkened room and faced the unwatchable and encountered its self-inflicted consequences. The opening tableau of the film was a single wide shot of the surgical team arrayed around a human form, the patient draped in green sheets, anaesthetised and prepped for surgery. My father, hardly recognisable behind a face mask and sterile hood, was, like the others, shrouded in green scrubs. The sleeves of their surgical

gowns tucked securely into double-layered latex gloves rendered their hands like some sort of robotic extension of their bodies.

The first cut is deep and determined. The scalpel draws a fine line through the outer layer of yellow iodine-tinted skin. It's shot in close-up and there's little to connect the dark line the knife draws across the flesh with the human patient beneath the steel blade. But as deeper layers of human tissue peel away, the blood comes from nowhere, and everywhere, and my resolve falters. The blood flows and pulses with the patient's heartbeat and despite the quick and rhythmic swabbing at the site of incision, a physical disquiet rises up in me. As the surgeon's scalpel probes deeper, a sensation I haven't experienced before begins as a ringing in my ears, followed by a cold sweat and a deeper arterial throbbing sound. As is common in the early stages of vasovagal reactions, I feel the visual and aural distortions caused by the constriction of blood supply to my brain.

The smooth motion of the projected image starts to fragment. No longer a seamless illusion of movement sustained by the constant frame rate, the images appear to unravel as each frame ghosts the one preceding it. The smooth purr of the projector distorts too, into a metallic grating of whirling teeth and clattering rollers growing impossibly loud. I look away, firmly into the primal grip of the vasovagal syncope. I must escape the film, the noise and those bloodied images before the darkness closes in on me completely. A terrifying thought forms: is this what death feels like?

Struggling for breath and close to fainting, I manage to escape the cinema. Finding refuge on the cool stone floor outside my father's study, I rest as the syncope gradually passes.

Years later, as a write this, I wonder if those first encounters with films and doctors may have somehow set me on this journey to understand those "medical films" in new and unexpected ways.

Growing up in a 'medical family' I became aware at an early age that doctors held some special importance in the way people spoke to them. Similarly, in conversations when they were not around, a certain reverence seemed to accompany the way others spoke about what they did. My father was an orthopaedic surgeon in Durban, and often while out with his family, grateful patients would approach us and thank him for the outcome of some operation he had performed. My mother qualified as a pathologist so that her work was confined to the laboratory. She would describe harrowing moments in which, while examining a blood smear, it was clear that the patient was faced with a chronic disease, maybe a cancer or other terminal diagnosis.

My eldest brother followed in my parents' paths and after completing his medical studies, went on to a peripatetic career as a trauma surgeon working in various conflict areas around the world. He

chronicled his experiences in an acclaimed book, *The Dressing Station: A Surgeon's Odyssey* (J. Kaplan 2001), which was favourably received in South Africa[1] and internationally.

Ironically, as a child I developed an irrational fear of doctors which could be precipitated by the smell of hospital disinfectants, and the sight of hypodermic needles or blood. This was sometimes accompanied by a rising sense of dread similar to the vasovagal response triggered by the "medical films" which remained with me from my earliest childhood memories. Visits to hospitals where my parents worked only stoked my iatrophobia.

When I wrote, produced and directed my first feature film, *Pure Blood* (2003), I transformed these childhood experiences into creative impulses and visualised them in the opening scene where the main character attempts to hide out of fear of having his blood taken while in hospital.[2] Not explicitly about the medical encounter, the film attempted to bend the horror film genre towards a parable about the eugenics of inherited blood lines and the ideology of racial supremacy. Apartheid ideology in *Pure Blood* served also as cathartic purging of my experiences while working as a news producer and cameraman during the tumultuous period between 1989 and 1994 in South Africa, Namibia and Mozambique and witnessing the high levels of violence and blood-letting associated with those transitions.

My first morbid encounters with the 'medical films' has evolved into a fascination both creative and intellectual with the figure of the medical doctor and its cinematic representation. Writing the feature film screenplay that forms the artistic component of this research launched a deeper inquiry into cultural myths and social preconceptions that emerge around the figure of the medical doctor and, more specifically, how these representations position the doctor character in the fictional constructions of a filmed Africa.

[1] Winner of The Sunday Times Alan Paton Literary Award in 2002 (Goodreads n.d.).
[2] *Pure Blood* received the Lucio Fulci Award at the Roma Fantafestival XXI (IMDb 2001).

INTRODUCTION

In theorising around the representation of the medical doctor in films set on the African continent, this study does not intend to explain my childhood memories through reasoned argument, but rather deepens an understanding of the formations that merge around the doctor figure in this setting. The feature film screenplay, *Across the River*, accompanies this theoretical study. The screenplay is an engagement with dramatic and representational questions around the central characters of the story: young medical doctors during their year of compulsory community service in South Africa. The thematic and analytical significance attached to this figure adds to discourses around representations of the doctor character in the imaginative constructions of a filmed Africa. This scholarly work should be considered together with the creative screenwriting as two interpretations of a similar subject matter, but without the one serving to explain the other.

The title: *Fractures*, of this thesis serves as a framing device for both the artistic research and the theoretical study which set out to explore how history, geography and race shift our understanding of the medical doctor in specific films set in the African conflict zone. The surgical textbook defines the fracture as "a break in the continuity of the bone", the severity of which is compounded by the level of force applied and the quality of the bone itself (Chen, 2020:1). This metaphor is helpful when considering how the continuities constructed around the doctor figure, might themselves become fractured when subject to the force of the conflict zone. It is through these fractures that new, and often surprising, configurations and discontinuities are revealed.

In focusing on feature films centred on the portrayal of the doctor figure in African conflict zones, a subject and format shared by the screenplay component of this research, the intention is to open new areas of research not covered before in the predominance of literature focusing on television medical dramas and health-themed developmental films.

Scholarly research on television medical dramas is wide ranging and includes perspectives from medical sociology, feminism, health education, psychology, media studies and cultural studies (Turow 1989; Gesler and Kearns 2002; Seale 2002; Lupton 2003; Cotter 2011). Works by Clive Seale (2002) and Deborah Lupton (2003) offer an enquiry into the socio-cultural dimensions in Western societies of medicine, health and illness. In focusing on the representation of the medical profession and health providers in TV news programmes, newspaper stories, journal articles, advertisements, and television dramas, these sociological studies raise important questions and insights into how their peers, other medical sociologists and health educationalists, as well as audiences receive and

understand these mediated messages. I include this brief account on the literature relating to television medical dramas in the context of my later reference to Angela Cotter's (2011) work on the popular series entitled *House* (2004).

A quick online search of some of the most popular drama series originating in the United States include *Marcus Welby MD*, *St. Elsewhere*, *Doogie Howser MD*, *Chicago Hope*, *ER*, *House* and *Grey's Anatomy* (IMDb n.d.). This abundance of medical dramas is repeated on British screens with programmes such as *Dr Finlay's Casebook*, *Casualty*, *Cardiac Arrest* and *Peak Practice* (Turow 1989). This brief list should be read in comparison to the relatively low number of similar themed productions from Africa. The paucity of published academic texts on similar subjects in the African context reflects the much lower level of production of television medical dramas on the continent when compared to the industrialised nations. In South Africa the earliest example was *Dokter, Dokter* (IMDb n.d.), an Afrikaans language medical drama series aired on the state broadcaster in the 1970s. More recently, *Jozi H*, a Canadian-South African co-production ran for one season between 2006 and 2007 and was set in the trauma ward of a large public hospital where "foreign surgeons, along with a mix of local doctors and nurses, band together to form a dedicated, overworked, underpaid team of health care workers" (Morula Pictures n.d.).

Some medical-themed television productions produced in Africa might be grouped under what Oswelled Ureke, who is an academic writing about the proliferation of donor-productions in Zimbabwe, terms the "development support paradigm", whereby "[d]onors define development projects but employ local voices and images to communicate" (2016, 22). Ureke underlines the problematic way in which these developmental films construct Africans as 'problems' for the benefit of the Western developmental gaze. One such example is *Soul City*, produced with funding from the Johns Hopkins Centre for Communication based in the US.[3] *Soul City* ran for 21 years on a South African Broadcasting Corporation (SABC) channel from 1994 to 2014 over an impressive 12 seasons ('Soul City Television Series' n.d.). Similarly, the Nigerian series *Newman Street*, set in a fictional street of the same name, offered dramatic storylines where "the quest for fame, love and acceptance set in urban Nigeria" was interwoven with medical encounters to effect behavioural

[3] Set in the fictional Soul City Township, the series established a popular following amongst audiences in South Africa and in other African countries by offering a hybrid educational-drama format where health and social advocacy messaging addressing behavioural change focussed on "social norms, attitudes and practice, and [gave] power to individuals and communities to make informed healthy choices" ('Soul City Television Series' n.d.).

change around malaria ('Newman Street' 2014). In these educational TV dramas, the doctor is situated on the periphery of the central narrative as they advocate for improved public health, rather than as main characters struggling to reconcile personal and intra-personal conflicts within the dramatic setting of the story. Since this thesis intends a deeper inquiry into the central figure of the medical doctor, I have chosen to avoid this form and its decentralisation of the doctor character. While acknowledging the useful work African educational television like *Soul City* and *Newman Street* contribute to public health issues, my intention to limit this study to feature films also aligns with the format of the creative component of this research that frames the doctor as a central dramatic figure in the narrative.

Moreover, the scope of this study is broadened by varied locations, historical periods and dramatic scenarios. The films chosen depict the doctor within imagined cinematic iterations of a broadly defined 'conflict zone', far removed from the ordered setting in which the doctor is usually located within the medical dramas mentioned. In moving beyond the conventional urban setting of the clinic or hospital, the question how the figure of the doctor is fractured and (re)constituted within the conflict zone is significant. The topicality of this research is framed by the pervasive nature of emergency in the world and is amplified by the current global crisis involving the Coronavirus pandemic that emerged at the end of 2019. This public health response has elevated public awareness of doctors and other frontline health workers to new levels.

In selecting two feature films, *The Last Face* (Penn 2015) and *Beyond Borders* (Campbell 2003), this study considers the assumed moral right of the doctors depicted in these fictional narratives to undertake humanitarian intervention under the primary concern of providing medical care to those in mortal danger. It is through this lens that the study considers the conflict settings and the international response underwritten by an increasingly pervasive and influential global humanitarian order. This order positions the doctor at the centre of the emergency medical response team and, consequently, as the order's emblematic masthead. My interest in these films is in how aspects of the doctor's authority and its significance, founded in the ordered setting of the hospital, continue and transform once relocated to the conflict zone where urgent assistance to the victims of war is provided. The metaphor of the fracture and the discontinuities explored in this thesis help bolster our understanding of the doctor figure within the conflict zone and are directly relevant to the choice of these films. In substantiating the selection of these films, the study acknowledges the poor critical response that accompanied them. *The Last Face* was considered a "stunningly self-important but numbingly empty cocktail of romance and insulting refugee porn" (Rooney 2016). Roger Ebert (2003) referred to *Beyond Borders* as having "good intentions [in wanting] to call attention to the

plight of refugees," but added: "what a clueless vulgarisation it makes of its worthy motives". These important concerns are discussed later. However, it is important to note that the selection of these films, and the films based on fictional interpretations of Dr Albert Schweitzer, are not predicated on critical or box office success, but rather on the opportunities they offer beyond these obvious shortcomings, for a deeper inquiry into the doctor figure within the cinematic conflict zone reimagined in these fictional African settings. These films invite a critical discourse around the figure of the medical doctor and the exertion of biopolitical power across varied temporalities and localities. These aspect are explored in later chapters through a reading of certain scenes from the films that draw on political concepts of state sovereignty and a "state of exception"—a concept first developed by Carl Schmitt (C. Calhoun 2010) to describe a situation where conflict or natural disaster has rendered the sovereign unable to exert power and control. This does not include a complete analysis of the entire films. I am guided in my selection of scenes by thematic and analytical interests and their relevance to certain interdisciplinary approaches. These theoretical constructs are useful to the main focus of this thesis in expounding on the figure of the medical doctor to understand the power relations these cinematic narratives depict in the medical and humanitarian interventions portrayed in the selected films.

For this study productions made in Africa by African filmmakers, together with films conceived and financed by filmmakers from outside of Africa but shot on location in different countries on the continent and involving local actors and crews, are considered. Among these, *The Last Face* and *Beyond Borders*, made by non-African filmmakers are considered alongside two productions centred on the fictional representation of Dr Albert Schweitzer, a historical figure reimagined by filmmakers from Africa. Cameroonian filmmaker Bassek Ba Kobhio's *Le grand blanc de Lambaréné* (1995) and South African director Gray Hofmeyr's *Lambaréné* (1990), which was also released as *Schweitzer* (1990), offer competing interpretations of the doctor's humanitarian work as a medical missionary in the former French colony of Gabon during the first half of the 20th century. These films offer an opportunity to explore linkages between colonial imaginations and our contemporary understanding of the doctor within the modern conflict zone and to examine how long-held prejudices and imbalances in the power relationships are perpetuated between rich northern hemisphere donors and the poorer recipients of the global South.

In Chapter One: *Theorising African Film Practice*, an engagement with the homogenous view of 'African cinema' and the rigid definitions this imposes on defining the 'African film' is undertaken. The discussion problematises the settling for simplistic binaries in defining African indigenous cinema in opposition to the global North or Hollywood film. In positioning the spectrum of films

made by both African and non-African filmmakers, it is necessary to engage with debates that have for decades split film theorists and critics over the understanding of what constitutes 'African cinema'. Working from the contemporary scholarship of Frank Ukadike (2014a, 2014b), Kenneth Harrow (2007), Anthony Guneratne (2003), Robert Stam (2003), Lucia Saks (2010), Keyan Tomaselli (2013; 2017), Oswelled Ureke (2016; 2017) and others, the study hopes to offer a more nuanced understanding of current African film practice.

In critically engaging with past and current film theory, the intention is to understand how the variety of films selected for this study might fit in to African film practice, and its place within the broader international film economy. I also consider how these foundational methodologies risk limiting our reading of the evolving nature of African film practice by excluding certain films, while privileging those that conform to certain ideological positions. Rather than risk regurgitating a comprehensive overview of African film theories, which have already been reproduced in enough publications to inspire a certain dizziness, the discussion in Chapter One is limited to a mapping of key concepts accompanying the theoretical debates that influence the definitions of an 'African cinema'.

For this purpose an evaluation of early film theory and critical thinking that emerged with the postcolonial imaginations of African filmmakers in the 1960s and 1970s is necessary. In resisting colonial tropes and racial stereotypes, these filmmakers drew inspiration from the anti-colonial struggles of their times and the persistence of neo-colonial influences. As the first theoretical framework to emerge outside of an Anglo-American context, the work of Teshome Gabriel (1982) is important. Gabriel's social and political theories enunciated their anti-capitalist and anti-imperialist orientation, and picked up on the notion of a 'Third Cinema', a term borrowed from a strident manifesto by Argentine filmmakers Solanas and Gettino (1976) which proclaimed the historical moment of anti-colonial struggle as defined by "a new man born in the process of the anti-imperialist struggle demand[ing] a new, revolutionary attitude from the filmmakers of the world" (1976, 45).

The film theorists taking up these revolutionary positions sought to impose a tripartite division on filmmaking, labelling First Cinema as primarily focused on profit and entertainment, Second Cinema as being defined by *auteur* films and Third Cinema as the redoubt of militant filmmaking collectives espousing radical political messages (Solanas and Gettino 1976). The study is less interested in the semantic questions that swirl around the terminology mobilised in these theories, but seeks to engage with the contradictions and debates that accompany the slippages associated with rigid definitions (Guneratne 2003; Harrow 2007). In mapping the ideas attributed to Third Cinema

debates, I show how these concepts endure in current critical thinking and bolster claims to 'authenticity' in African cinema through the work of Frank Ukadike (2014a). Drawing on Harrow (2007) and others, I argue that rigid definitions inherited from Third Cinema that associate commercial filmmaking in African cinema with foreign influences predominantly from the Hollywood and the West, are outdated and must give way to more nuanced understandings. Rather than relying on outdated categories defining which films constitute an African cinema, new theoretical perspectives are explored that offer more inclusive parameters while responding to the changing realities of international co-productions and global cinema exchanges that contribute to new and emerging film economies in Africa. This approach includes the case studies that use African locations, local actors and depend on the technical skills of local crews.

Acknowledging the importance of Third Cinema theorists, within the specific socio-political moments and definitions shaped by anti-colonial struggles, the argument advanced in this chapter is that they could not have foreseen the disruptive influences that low-cost video and newer digital technologies pose to their theories in the form of highly profitable and commercial film economies. I extend my argument in this direction by considering the Nigerian example where a thriving sustainable film industry has emerged and found markets for its content beyond its borders through international and pan-African distribution networks. I use this point to illustrate that films made by both local and international filmmakers working in Africa, such as those represented by the selected films, constitute aspects of the same African film practice within an emerging digital and transnational landscape. In this respect, the work of Tomaselli and Ureke (Tomaselli 2013; Ureke and Tomaselli 2017) is indispensable.

These scholars in turn draw on the work of Goldsmith, O'Regan and others (2003; 2012) by applying their ideas of an extended value-chain to film production in the southern African region. The film services approach offers a more inclusive film theory that is not limited by narrow definitions construed by race, geography or ideology. In describing how film production services are understood alongside the film text, the film services approach considers the use of locations, local actors and local technicians, as part of system of inputs and exchanges between local and international filmmakers. Instead of a singular focus on film content and meaning, these insights invite questions around the availability of creative and technical skills, access to suitable locations within a film-friendly environment, the role of government incentives in attracting international productions, and how these aspects contribute increased industry capacitation and development to African film economies.

By way of transition to Chapter Two, I introduce an analogy between film services and medical services. This comparison serves to frame the meshing of different literatures introduced in Chapter Two: *Imagining the Conflict Zone* and continued in subsequent chapters. The analogy brings together ideas from different fields of study to the explanation of the fictionalised imagery of the emergency doctor in *The Last Face* (Penn 2015) and *Beyond Borders* (Campbell 2003). In bridging film theory and aspects of the social sciences in this analysis of cinematic representation of the medical doctor in the African conflict zone, I am inspired by the work of other scholars referenced in this study. Ariella Azoulay (2008) draws on much of the same political theory in making her claims about the power formations operating between subject, photographer and viewer around photographs taken in emergency situations. Pooja Rangan (2017) also connects film theory with political and legal theories of emergency and humanitarian intervention in understanding the cultural aspects of how emergencies operate in the mode of documentary filmmaking. Drawing on these literatures, I attempt to weave various intellectual traditions and approaches in building a collaborative cross-disciplinary study of the doctor figure in the films identified here.

A brief overview of Médicins Sans Frontières (MSF) provides a factual reference against which certain attributes and activities represented in the fictional doctor characters in the films might be compared and understood. MSF's response to global humanitarian emergencies, particularly where medical services are urgently required, is described as a form of 'global triage' whereby the order of need is ranked against real limitations of funding, reach and medical expertise (Packard 2016). The application of humanitarian and medical terms to the reading of these films set within the reimagined conflict zone is justified, not solely on the basis of overlapping context, but also for the usefulness they offer in opening new forms of analysis and insight. An important part of this analysis utilises the system of medical triage and applies it conceptually to a closer reading of selected scenes from the films. Where the conflict zone has severely restricted access to adequate medical services, the doctor resorts to the triage system to sort casualties by prioritising the treatment of those most likely to survive if they receive immediate medical care. The attendant professional and ethical issues are central to this deeper exploration of the construction of the doctor figure in the selected scenes.

In analysing these contemporary versions of the doctor deployed to the conflict zone it is necessary to consider how notions of authority and power attached to the doctor figure arose in modern societies of the West. For this purpose, Michel Foucault's *The Birth of The Clinic: An Archaeology of Medical Perception* (1973) and his interest in the rise of institutional medicine in 19th century France situates the doctor at the heart of an evolving web of power relations endorsed by the authority of

the State. The ideas that Foucault advances that truth is never a neutral phenomenon, but rather the product of power relations serving the interest of specific groups of individuals or the State, is important to our understanding of how these power relations transform when the doctor figure is located to the conflict zone, outside of the ordered and bureaucratic structure of the European clinic. Although this research does not conduct a systemic analysis of Foucault's work, it is also extended to subsequent chapters to question how states use modern medicine in conflicts and humanitarian emergencies in exercising power and control over these populations. Considering examples from the films, questions arise around the impact of the collapse of state scaffolding and the attendant scarcity of available medical resources, and how these impact the doctor's function within the parameters of medical ethics. Here, I turn to Valentin-Yves Mudimbe's (1988) key Foucauldian text on Africa, to consider how Africa is implicated in the construction of modernity, not as an equal partner, but as an indispensable part for the West's projection of its self-image.

In Chapter Three: *The Aesthetics of Emergency*, 'emergency' as constituting a particularly modern conception of the world is expanded on. Craig Calhoun (2010) and others' work pose the idea of the 'emergency imaginary' as a set of values shaping an understanding of contemporary society. This is further developed using aspects of Rangan's (2017) writing on the aesthetics of emergency, which he applies to documentary filmmaking and news reportage and the frequency with which these conflict zone images permeate our media landscapes while informing our cultural, social and political understanding of the world (Chun 2011; Murthy 2013). In dissecting the complex layers of mediation operating through the images of suffering that accompany these fictional narratives set around the figure of the emergency medical doctor, it is necessary to consider the role of photography and news reporting and how these influence aesthetic choice in the cinematic restaging of events depicted in the narrative films. While acknowledging the differences between the still image and cinema's moving images, this reliance on certain well known photojournalistic images for verisimilitude does, I argue, lead to a problematic blurring of fact and fiction. In making this argument, I explore the link between early photography and its use in mobilising public opinion for humanitarian causes. While discussing the complex moral and ethical dilemmas that swirl around questions of spectatorship in relation to these images of suffering, photographic and cinematographic, I resort to influential scholars like Luc Boltanski (1999), Susan Sontag (2003) and Lilie Chouliaraki (2006). Azoulay (2008:14) brings dimensions of time and movement, ideas usually synonymous with the viewing of films, to the "watching" of photographs. In mobilising political theory relevant to my argument, Azoulay argues that photographs taken within emergencies, such as those recording life under the Israeli occupation of Palestinian territories, challenge conventional ideas around those implicated in the image. Her work also challenges Sontag's views on the

limitation of judgement and responsibility on the part of the spectator for what is seen in the photograph (Azoulay 2008). I use this theoretical space for exploring the narrative tropes deployed in the case study films to interpret the fictional aesthetics of emergency centred on the doctor figure. In concluding this chapter, I propose that the doctor figure might be understood as a trusted interlocutor between the narratives of suffering that are produced around usually voiceless humanitarian subjects and the spectator, in this case, the cinema audience.

In Chapter Four: *Therapeutic Securitisations and Colonial Linkages*, common tropes associated with the representation of the doctor in the contemporary conflict zone are extended to a consideration of the biopolitical and the securitisation of medical and humanitarian intervention in the films. Using selected scenes to illustrate how seemingly opposing formations, military and humanitarian, coexist in the conflict zone, I consider how the securitisation of medical services under the guise of humanitarian action intersects with the doctor figure. Further analysis of *The Last Face* draws attention to the significance of this trope when it comes to a reading of the doctor figure in the African conflict zone. To establish certain theoretical linkages between biopolitical power in Western democratic societies and how these might be applied to a reading of the emergency medical doctors in the conflict zone, I return to Foucault's (2008) work in relation to the biopolitical. A reading of Foucault (2008) alongside Achille Mbembe (2001; 2003) in relation to race and colonial power are expanded on and applied to an understanding of the fictional representations of contemporary power exerted through humanitarian intervention. In comparing the role of the doctor in the films centred on contemporary medical securitisation with that of the colonial doctor, I explore the two films offering dramatised accounts of the life and work of Dr Schweitzer by Ba Kobhio (1995) from Cameroon and Hofmeyr (1990) from South Africa. In concluding this chapter, it is argued that these representations of the colonial European doctor are indispensable to uncovering the enduring linkages in the modern filmed construction of the emergency medical doctor in the conflict zone.

Chapter Five: *Internal Conflict Zones*, marks a shift in the line of inquiry as it is directed towards the internal manifestation of the conflict zone as embodied in the doctor figure. By choosing to work from the physical expression of the conflict zone towards an internalised conflict zone, the study is guided by the artistic research in the writing of the feature film screenplay that forms part of this work. This is not intended as an explanation of the creative component or as an elucidation of the screenwriting process, but rather as an exploration of conflict at the emotional level of dramatic characterisation of the doctor figure. Reaching into the internal conflict of the doctor characters, the study speculates on ideas that shape our modern conception of the doctor which have evolved across centuries and can be traced back to ancient Greek mythology. Drawing on scholarly work

based on the immensely popular medical TV drama, *House* (2004), I expand on this mythology and the paradoxical notion of a healer afflicted by an incurable wound, which is applied to the doctor characters in the films across both the colonial and contemporary settings. The motif of the healer who is also 'wounded' is applied to the oppositional figures of the European medical doctor and the African healer in both Ba Kobhio's and Hofmeyr's films.

In rounding off Chapter Five it is argued that colonial medical intermediaries represented in the films are a product of asymmetrical power differentials derived from ideologies of white superiority. The medical intermediary is not a detour from the main focus of this research nor is the idea advanced to undermine the central argument for the significance of the doctor figure within the conflict zone as depicted in these films. Instead, the medical intermediary is discussed as a compelling opportunity for further cinematic research into a figure that is situated, perhaps even more profoundly than even the doctor, at the junctures of the conflict zone in its many forms. It is significant that the medical intermediaries depicted in the films discussed, derive their dramatic purpose from the figure of the doctor and do not supplant their central importance in the narrative.

Acknowledging the scope of film studies and in trying to offer useful insights into these complex and seemingly entangled systems of representation relating to the figure of the medical doctor across different settings and periods, the study endeavours to focus on the main themes identified in this introduction. Instead of attempting the impossible and offering a comprehensive survey or a complete analysis of the films, the thematic and analytical view will be guided by the relevance of certain interdisciplinary approaches identified. In bridging these applications, I intend to arrive at outcomes specific to this study and the questions it raises around how discourses in the West and Africa position themselves in relation to the doctor figure in the filmic constructions of an imagined Africa.

In the following chapter, I map the contribution of earlier theorists who, in talking about African filmmaking, looked for inspiration outside of Western academies and critical thought. In charting Third Cinema and its reliance on ideas arising with the anti-colonial thinkers and revolutionaries of the 1960s and 1970s, the theoretical foundations shared by later notions of 'African film' are identified and discussed. Definitions relying on rigid distinctions separating Western cinema from an African cinema derived from categories of races, geographies and limited political positions are challenged in terms of increasingly blurred ideological and national boundaries represented by the filmmakers and films analysed in this study.

CHAPTER ONE

THEORISING AFRICAN FILM PRACTICE

Introduction

In discussing *Beyond Borders* (Campbell 2003) and *The Last Face* (Penn 2015) and the representation of the medical doctor in these films, the research intends going beneath the immediate metaphors depicted in both, of the selfless white medical/humanitarian protagonists arriving as self-appointed saviours to alleviate African suffering. In choosing to write about these films this research does not condone such practices nor does it support the perpetuation of racist stereotypes of Africans as hapless victims reliant on the West for aid. The aim of this thesis is to offer a more nuanced and complex investigation into how these films construct the figure of the doctor within the imagined conflict zone. Where harmful narrative tropes arise, whether out of ignorance or malice, this study joins the voices of other African film theorists and filmmakers who resist an uncritical reception of such dominant narrative conventions that impose on the postcolonial imagination "western images of material superiority and moral exemplarity" (Nkunzimana 2008, 85).

The range of filmmakers selected for this study raises important questions, not only around issues of representation, but also over the critical and analytical perspectives deployed in interpreting these diverse films when it comes to wider debates over what comprises 'African cinema' or what constitutes an 'African film'. These problematic categories debated by a range of scholars over the last 60 years reveal no overriding clarity on an approach to African filmmaking when considering the range of filmmakers selected for this study. Although all are men, they represent directors from South Africa to Cameroon, the United States of America and New Zealand. What the films do have in common is a reliance on African locations, actors and crews in telling stories set on the African continent. If, as Kenneth Harrow (2007:138) suggests, the intention of all film studies is to "not only see the unseeable, but see it anew" then the requirement to challenge certain limiting African film criticism advancing ideological principles with claims to 'authenticity' and a rejection of commercial filmmaking practices as 'foreign', is necessary to this thesis. I argue for a more encompassing approach to African film practice that includes the range of films made on the African continent by both African and non-African filmmakers, as represented by the films selected for this research.

Harrow (2007) criticises the limiting effects of early African film criticism for its rejection of filmmakers whose work failed to conform to certain rigid categories. He questions the ongoing relevance of these positions in understanding the work of new and emerging African filmmaking. In this chapter, I argue along the lines of Harrow, that such rigid definitions arising with early Third

Cinema theorists insisting on the primary role of African filmmaking as a response to the false histories and narratives generated by the commercial centres like Hollywood and the West, continues to limit debates around what we understand as African filmmaking practice. In challenging the dependence on notions of 'authenticity' upon which these forms of criticism frequently rely, Harrow's argument covers terrain relevant to this study but the outcomes are notably different. Harrow's intention in addressing the pioneering works of early African filmmakers and the critical scholarship that accompanied these films within the context of wider social and political struggles of the 1960s and 1970s forms the basis for his argument for alternative understanding of the relationships between ideology and fantasy, drawing on the philosophies of Slovaj Žižek.

My intention in grappling with "a framework of analysis and critical renaissance stemming from the contradiction and tensions in defining African cinema" to which Ukadike (2014a, ix) refers, is to consider their relevance in accounting for the range of films used here that tell stories set in Africa by filmmakers from different continents. In attempting to explain how these international cinematic exchanges continue to develop and shape African film practice within a broader film economy, a deeper engagement with the work of Murphy (2000), Harrow (2007), Dovey (2009), Ureke and Tomaselli (2017) and others becomes necessary. These views must also challenge the simplistic framing of ideas like 'authenticity', which in earlier methodologies sought to safeguard ownership of African cinematic storytelling, which was considered to be under threat by the participation of non-African and Hollywood-type commercial interests. While the Hollywood studio system is rooted in late-nineteenth century capitalist exchanges (Saks 2010), the argument that profit and commercial access is synonymous with shallow and ignorant filmmaking inevitably leads to the mistaken conclusion that African filmmakers who aspire to commercial success must then also forego claims to deeper insight and knowledge about their subjects.

In mapping the formative concepts of Third Cinema Theory from the late 1960s and 1970s and the anti-colonial positions which accompanied its integration into African film criticism through the work of Teshome Gabriel, I intend to trace certain linkages in later critical methodologies advancing notions of 'authenticity' which consider the lack of commercial imperative as a prerequisite for inclusion in the murky and often contradictory definitions of what might constitute an 'African film'. In drawing a connection between early Third Worldist approaches and Manthia Diawara's (1992) work around national cinema movements, aspects relevant to Ba Kobhio's film chosen for this study are discussed. This introduces the changing nature of creative relationships characterised by the former colonial power and its funding and support of Francophone African filmmakers dating back to its earliest pioneers. Conditions peculiar to the production of Hofmeyr's film in South Africa during

the period of Apartheid and the role of government funding are considered in Chapter Four in contrast to Ba Kobhio's production.

In mapping more contemporary African film criticism relevant to this study, I refer to the work of Frank Ukadike and Martin Mhondo as examples of African film theory and criticism uniformly aligned behind the idea of an African cinema defined by cultural and aesthetic specificity and distinct from Hollywood and European practices. In considering their work in the context of Nigerian commercial video production as a detractor to claims of an 'authentic' African cinema. I argue that these views not only perpetuate distinctions inherited from earlier Third Worldist positions, but fail to respond to the evolving realities of African film practice facilitated by technological innovation. To illustrate this point, I briefly extend my analysis to new cinema economies in Africa catering to digital platforms and the increasingly interconnected nature of global cinema exchanges. In advancing these arguments, I am concerned with mapping key points relevant to this thesis rather than attempting a comprehensive overview or chronological history of the evolution of African film criticism. The intention is not to discard the contributions of these earlier scholars but rather, as Harrow (2007) ventures, to go beyond the limitations they impose by exploring different ways of seeing and understanding African film practices from the past, present and possible future trajectories.

Through these arguments, the chapter introduces a separation of cinematic fact and filmic fact based on the ideas of Christian Metz (1974). The cinematic fact pertains to the industrial and economic conditions of the production and distribution, which are to be considered alongside the filmic fact with its focus on the interpretation of meaning contained in the film text (Ureke and Tomaselli 2017). This lays the groundwork for subsequent discussions of the African and international co-productions characterised by the case study films: *Lambaréné* (Hofmeyr 1990), *Le grand blanc de Lambaréné* (Ba Kobhio 1995), *Beyond Borders* (Campbell 2003), *The Last Face* (Penn 2015). A film services approach to the African context is considered through the work of Ureke and Tomaselli (2017) which adapts the pioneering work of Goldsmith and O'Regan (2003) to local conditions. In recognising film as a product of a system of inputs, economic arrangements and specialised skills involved in the development, financing and distribution of the film, the films services approach understands film industry practices as equal in importance to interpretation of the film text. Through this application, a broader reading of economic, political and social forces shaping African film practice is possible beyond the intractable ideological positions and militant revolutionary posturing defined by historical periods which shaped the early Third Cinema theorists of the 1970s.

An introduction of the film services approach also mobilises the analogy with medical services where a history of underdevelopment in Africa have resulted in limitations in medical supplies, medical personnel and health infrastructure. The disparities apparent in health systems between underdeveloped parts of the global South and those available to richer nations in the global North (Packard 2016) also characterise the uneven nature of cinematic exchanges between these groupings. This metaphor which also explains certain conditions which attract commercial productions form the global North to use locations, crews and actors in African locations segues to the discussion of cinematic representation of the medical doctor within the context of global humanitarian responses within the African conflict zone.

Third Cinema debates

This section does not attempt a comprehensive treatment of the many complexities that continue to percolate around Third Cinema. Instead it maps key concepts from the origins of Third Cinema and their relevance in defining ideas that continue to frame African film practice and theory as a distinct and autonomous entity rather than "merely an appendage of dominant cinematic discourse" (Ukadike 2014a, xii).

Teshome Gabriel's influential book, *Third Cinema in the Third World: The Aesthetics of Liberation* (1982), appeared in 1979 as the first English publication to offer a comprehensive overview of the Third Cinema movement through "the lives and struggles of the peoples of the Third World" (1982, xi). In seeking a definition for Third Cinema as "built on the rejection of the concepts and propositions of traditional cinema, as represented by Hollywood," Gabriel focuses on examples of films drawn from the tricontinental geographies of Latin America, Africa and China. These films are chosen for five major themes which he considers to be the basis for inclusion in the Third Cinema movement and are attributed to the modes of oppression he identifies as afflicting these countries.

Gabriel expands his theoretical and conceptual framework from Solanas and Gettino's Third Cinema manifesto, drawing, as they do, on the writings of Frantz Fanon. Thus the language of Third Cinema is inflected by anti-colonial struggles and, like Fanon's language, legitimises the use of violence against oppression, to become like "violent works made with the camera in one hand and a rock in the other" (Solanas and Gettino 1976, 57). The early pioneers of postcolonial filmmaking in Africa and elsewhere adopted this view in the *Resolutions of the Third World Filmmakers Meeting in Algiers*, 1973, which stated that "the role of cinema in the Third World is to promote culture through films, which are a weapon as well as a means of expression for the development of the awareness of the people" (The Third World Filmmakers meeting (1973) in Algiers 1982).

Gabriel's use of Fanon as the inspiration and guide for his theoretical framework aims to sever the practice and theorising of revolutionary cinema in the Third World from any claim to European or North American influence. Harrow (2007:24) criticises this reliance on Fanonian ideas of political revolution extending from colonial domination to liberation for its problematic Hegelian ideas of history as a linear development leading to greater social, economic and political sophistication. In comparing the domination phase to the Hollywood model and its associated forms of mass entertainment, Harrow (2007) highlights this important aspect of African film criticism which emerges with Third Cinema and its calls to mobilise filmmaking in the greater social and political struggles of the times while dismissing, as superficial, cinema that entertains based on its emotional subjectivities. Distinctions between 'superficial' and 'serious' cinema implicit in the rejection of commercial modes of filmmaking as 'foreign' or Western when compared to politically engaged African films carrying labels of authenticity are especially relevant to the diverse range of films used in this cinematic exploration of the medical doctor in films produced by filmmakers from Africa and those from outside the continent. In delving further into these questionable assumptions through a mapping of Third Cinema categories, I question to what degree these definitions are still relevant.

First, Second and Third Cinema terms relied on ideological definitions derived from Cold War divisions between the First World Capitalist West and the Second World Communist East. These were defined by Argentine filmmakers Solanas and Gettino in their manifesto of 1969 entitled *Towards a Third Cinema* (1976). In this revolutionary document, First Cinema shares the language and narrative structure of Hollywood movies, if not their actual location, and through its domination of all markets seeks to maximise its returns. Second Cinema, defined by *auteur* films, were opposed to the industrial scale manufacture that epitomised the Hollywood studio system and its reliance on easily replicable genre formulas for commercial success. Third Cinema films, by contrast, were associated with the "film-guerrilla group" which sought to demystify the production of film and challenged the *auteur*-driven notion that directors wielded a singular power over the film's creative vision (Solanas and Gettino 1976, 57). Instead, Third Cinema was dedicated to the production and distribution of revolutionary films that were accessible to the masses and reflected their struggles against the many forms of oppression they experienced (Solanas and Gettino 1976). Within these categories the Third World was characterised by the shared "collective plight of those countries which had until very recent memory suffered through the dying spasms of the grand imperial projects of Europe" (Guneratne 2003, 7).

The positions that Gabriel argues are intended to define Third Cinema as an autonomous entity and not as a branch of First or Second Cinemas, although allegiances with non-Third World filmmakers

from “progressive or Left groups in America, Italy or France” (1982, 3) are acknowledged. These clear distinctions were further complicated by the embrace of *auteur* filmmakers like Ousmane Sembène, Souleymane Cissé and Med Hondo whose work was more suited to inclusion in the Second Cinema category. As the founding fathers of African filmmaking they “proved more visibly fruitful in contesting social inequality and neo-colonialism than the more restricted activities of the militant collective” (Guneratne 2003, 10). Harrow (2007) points out that in canonising filmmakers like Sembène, Third Cinema theorists declared a prerequisite for certain politically engaged positions resulting in few filmmakers daring to make films outside of these categories. Those that did, such as Djibril Diop Mambéty with *Touki Bouki* (1973), were dismissed as “trivial entertainment or forms of overly indulgent subjectivism” (Harrow 2007, 19).

In Julianne Burton’s response to Gabriel’s book in the journal *Screen* (1985), she points out that the founding Latin American filmmakers behind the Third Cinema manifesto advocated that film practice and theory be worked out side-by-side. Burton rejected the separation of practice and theory and the way that Third Cinema theorists “dismissed the operations performed by the critic as intrusive, arbitrary, superfluous” (1985, 4). That the role of the film critic and theorist was marginalised by the very filmmakers that Third Cinema theorists had hoped to promote, contributed to the critical underdevelopment of film theory in the Third World. This, according to Burton (1985, 4), perpetuates imbalances in the cultural exchanges between universities of the global North as consumers of Third World films and the return flow of critical writing produced by specialist Western theorists to the peripheries.

Burton also attacks Gabriel for suppressing some of the inconsistencies and contradictions in the original texts and among the film movements involved in order to present Third Cinema as a “unified and unitary signifying practice” (1985, 9). This “illusion of ideological consistency” (Burton 1985, 5) among the proponents for the Third Cinema movement is attributed to the close identification with the ideals and ideological positions represented by these films and the theories they advocate.

Worse still for Burton was that this partisanship resulted in a lack of rigour in confronting the inherent ideological contradictions of Third Cinema positions and in addressing local differences, and was also based in an “impulse to win recognition for their object of study within the very institutions which serve to endorse and perpetuate dominant, colonising hierarchical cinematic discourses” (1985, 5). This attack was against Gabriel’s position in a North American university, far removed from the realities and experiences of filmmakers and theorists based in Third World countries. The view that his strident belief in the ideological principles on which these theories depended may have overshadowed a clearer reading of realities on the ground is supported by Guneratne’s (2003)

observation of Gabriel's insistence that Third Cinema be under nationalised government control. In reality the conditions encountered by many African filmmakers in postcolonial states were far from the expectation that this would entail progressive state support in Third World settings.

A collection of writings edited by Guneratne and Dissanayake and published as *Rethinking Third Cinema* (2003) re-evaluates these theories more than twenty years after Gabriel's work and the manifestos of the founding filmmakers were produced. It appreciates Third Cinema for its radical move and historic contribution in articulating a form of artistic liberation and independence by declaring a new kind of cinema. Critical engagements around its limitations, historical specificities and ideological orientation pursued the hope of its continued legitimacy because of its iconic value as "the only major branch of film theory that did not originate within a specifically Euro-American context" (Guneratne 2003, 7).

Guneratne (2003, 4) laments Third Cinema's lack of theoretical progression in response to criticism and discussion and points to this as a reason for its diminished presence in more recent books on cinemas from emerging and established non-Hollywood production centres such as Hong Kong, China and India. Guneratne reaches back to the original filmmaker/theorists like Solanas and Gettino who, in positing their ideas of resistance against colonial and systematic oppression, "suggest that a legitimate countervailing force to monolithic First Cinema was not an equally monolithic alternative but instead a constellation of cinematic forms which embraced hybridity and polyglossia" (2003, 18 - 19).

Guneratne (2003, 10) points out the shortcomings of Third Cinema theorists in accounting for the tensions and differences characterising the Third World and their failure to acknowledge national, regional and local differences while choosing to see Third Cinema themes of struggle as common to the tricontinental world of Latin America, Africa and Asia. This homogenised definition of the Third World is not incidental but central to the construction of clear distinctions between Third cinemas and those categories of the First and Second, as Burton (1985) points out in her critique of Gabriel's arguments. Guneratne (2003) highlights the failure of these rigid definitions to recognise the inconsistencies posed by China's inclusion in the Third Cinema category considering its developed state-sponsored studio production system that often rivalled and even surpassed the scale and production of many film industries in Europe.

India was another example where the Third Cinema label proved awkward and non-encompassing: popular musicals derivative of earlier Hollywood extravaganzas exist side-by-side with socially-conscious works by Third cinema-aligned directors like Shyam Benegal (Guneratne 2003). India, with

its various “amalgams of First, Second and Third Cinema” coexisting within the same national industry, confronts Third Cinema theory, with its separate and rigidly defined categories of cinema, with the “most complex range of issues that the three-cinema model fails to account for, let alone to address” (Guneratne 2003, 20). Yet, without this rigid segmentation, the fundamental rallying call of Third Cinema for rejecting Hollywood’s approach ideologically and in the organisation of its production and distribution model would not be possible.

When Gabriel writes that any cinema made in the Third World that shows “dependency on an external or alien culture cannot, therefore be characterised as Third Cinema” (1982, 2) he is re-asserting the claim by Solanas and Gettino that any imitation of capitalist industrial models and language “leads to the adoption of the ideological forms which gave rise to that language and no other” (Solanas and Gettino 1976, 50). In highlighting the consequences of these influences on other African film criticisms that exclude filmmakers whose work does not conform or aspires to commercial modes of production, Harrow (2007, 23) defends against the label of neo-conservatism. Instead he offers his analysis, not as a rejection of these ideas, but as a way of seeing beyond them to offer a break from the past in the hope of charting a new way forward. In a similar embrace, I turn to more recent African film criticism mindful of the importance of these earlier ways of thinking, while attempting to show the implications of these influences on our theoretical engagement with African filmmaking. Over the next few sections of the chapter, the changing nature of African film practice is considered through an array of theoretical positions that are traced back to earlier Third Cinema ideas.

Third Cinema in Africa

Frank Ukadike and contributors to his book, *Critical Approaches to African Cinema Discourse* (2014), attempt to define African cinema as autonomous instead of as “merely an appendage of dominant cinematic discourse” (Ukadike 2014a, xii). In the introduction, Ukadike (2014, xii) states the intention as “an indigenous means of uncovering the real meaning of, in this, a culturally circumscribed aesthetic point of reference (e.g., what makes a film an African film)”. He seeking meaning and definitions outside of Third Cinema positions resulting from its Latin American origins, Ukadike and others seek indigenous meanings that are culturally and aesthetically distinct in defining what makes a film an African film. These approaches fail to completely avoid the influences of Third Cinema’s revolutionary incitement which also resonates in Ukadike’s requirement that African filmmaking acknowledge its service to national duty in constructing an African identity based on the lost cultural heritages of the past (Harrow 2007, 26). The critical and theoretical traces of Third Cinema’s rejection of Hollywood examples in the work of African filmmakers that was produced during the

period of colonial resistance and immediately following independence from colonial rule is acknowledged in Ukadike's claim that these early films succeeded in "replacing egregious foreign storytelling technique, film style, and film appreciation with an African aesthetic/critical paradigm and orientation" (2014a, xi). The requirement that Third World films abandon the structures and thematic concerns of commercial cinema in order to be deemed 'authentic' Third Cinema is complimented by Ukadike's measure of what constituted the 'authentic' African cinema of the time where "narrative structure of the early films were deliberately political, unapologetically didactic, and ideologically dialectical" (2014a, ix). While Third Cinema assumes African filmmaking to be an agent of resistance to dominant forms of representation, claims by auspicious filmmakers such Sembène that a "truly African creativity, free of foreign influence, is a revolutionary act by itself" (Gabriel 1982, 25) demarcates a bright line between foreign or Western influences and indigenous African perspectives.

African cinemas and global exchanges

In response to the homogenising views of Third Cinema which Gabriel advanced, other theories tied to national cinema movements emerged a decade later. Key among these was Manthia Diawara's *African Cinema* (1992) with its focus on the organisational and institutional developments of individual and regional industry bodies, showing how some postcolonial countries have reshaped the conditions of production and distribution "to liberate African cinema from its colonial trappings"(1992, ix). In shifting from a Pan-Africanist to a regional view, Diawara explores the nature of postcolonial identity in cinema, particularly its use as a constructive force in the developmental project rather than as reflecting pre-existing social discourses privileged by Third Cinema. These developments did not mean that filmmakers from Africa were no longer engaged in reclaiming the screen against representations that "reinforce the dominant Hegelian vision of Africa as a continent with no history and no culture" (Murphy 2000, 239) synonymous with the early *Tarzan* movies or the frequent reworking of racist novels such as *King Solomon's Mines*. The work of Diawara and others writing about the maturity of cinema cultures in postcolonial African nations specifically addressed old prejudices steeped in colonial narratives.

Diawara's work identifies continuities between the colonial and postcolonial cinemas, pointing out the emergence of postcolonial film industries that build and develop new production and distribution infrastructure in the independent African state. Of particular relevance to this research is the funding of early African filmmakers by the former colonial masters, specifically the French Ministry of Cooperation, founded in 1963, and later the French Centre National du Cinéma (CNC). This financial and technical backing was indispensable to the production of early African films by

Sembène from Senegal, Hondo from Mauritania and Cissé from Mali (Diawara 1992). Diawara points to the fact that more than double the number of films made by black Africans by 1982 came from Francophone Africa compared to Anglophone and Lusophone Africa (1992, 21). This support for Francophone African production is relevant to Cameroonian filmmaker Bassek Ba Kobhio's *Le Grand Blanc de Lambaréné (*1995), discussed in greater detail in Chapter Five. Ba Kobhio's explores the colonial medical encounter through the eyes of the African characters in this fictionalised narrative of the real-life Dr Albert Schweitzer during his work in colonial-era Gabon. Ba Kobhio's approach invites a comparative analysis of the representation of the colonial doctor figure through its hybrid subjectivities in contrast to the one-sided Eurocentric gaze that accompanies Hofmeyr's *Lambaréné* (1990) with its fictionalised account of Schweitzer. Harrow (2007, 20) considers Ba Kobhio the "heir to the earlier generation's politics" championed by the likes of Sembène in reference to the film's didactic message conveyed through its fictional narrative. Though more than 30 years separates Sembène and Ba Kobhio, both filmmakers relied on funding from the French Ministry of Cooperation, and later the CNC, to make their films. However, by the time Ba Kobhio made *Le Grand Blanc de Lambaréné,* a shift in attitude by filmmakers of his generation is apparent when compared to the ideological positions advocated by the pioneers of Sembène's generation in the 1970s.

In speaking about Ba Kobhio, a beneficiary of the French Ministry of Cooperation and CNC like Sembène, Obed Nkunzimana (2008, 92) mentions his controversial call that "Europe is invited to come back to colonise Africa, this time without ulterior motives and for a good cause". The contrast in these sentiments to those of Sembène, who objected to the former colonial master's frequently paternalistic euro-centric views of Africa which made these relationships untenable (Diawara 1992), are clear. Ba Kobhio's comments are used by Nkunzimana (2008) in support of financial and technical exchanges which benefit African filmmakers in producing their own stories. Consider Ba Kobhio's and Nkunzimana's positions against the statements released by the *Third World Filmmakers Meeting* in Algiers in 1973 that co-production with the "imperialist" nations is "foreign to the realities of our countries" and should be rejected for its "cultural and economic exploitation of our countries" (Anon 1982, 108). Compared to the outright rejection of international co-production advanced by many earlier African filmmakers and Third Worldists, Ba Kobhio's views represent a break with the past in recognition of the benefits of international cinematic relations while still working to pull away from "western images of material superiority and moral exemplarity" (Nkunzimana 2008, 85).

Returning to African film theorists like Ukadike (2014a) and filmmakers advocating the universalist definition of 'African cinema', the requirements of self-sufficiency and a rejection of imported

commercial film codes are important. At the heart of this position is the claim to an 'authentic' African cinema. Yet, as Murphy points out, "the reality of 'Africans filming Africa' has not produced a unified, 'authentic' African cinema" but rather a "complex and often contradictory vision of the continent" (2000, 240). Ba Kobhio's comments above might be considered in light of Murphy's (2000) statement to represent African filmmakers pulling back from the more strident calls that accompanied these earlier positions with their explicit rejection of Western influences.

In arguing that there is a problematic dependence on the rejection of commercial modes of filmmaking to explain universally used terms such as 'African cinema' or an 'African film industry', this study identifies a need for an updated and revised approach to African film practice that extends beyond the limiting influences inherited from Third Cinema and national cinema paradigms. This view does not ignore the uneven relations which Diawara (1992) observed in these cultural and technological transfers between North and South. In drawing conclusions on the role of French funding for African filmmakers, Diawara (1992) sees this aid as neo-colonialist as it tries to assimilate African filmmakers, and then make these filmmakers reliant on foreign funding for production. This also extended to undue influence over script content and the controlling of access to technologies and distribution outlets, while the location of postproduction facilities in Paris meant that Africans were not trained in essential technical skills. In light of Ba Kobhio's comments promoting access to French funding, technical facilities and distribution, the importance of expanding this discussion of African film practice to offer new perspectives that also account for the diverse nature of the films selected for this study becomes necessary.

An awareness of these dependencies created in the past which are perpetuated in economic imbalances and cinema exchanges between Africa and more developed economies today is important and informs the arguments made here for an expanded understanding of contemporary African film practice within an increasingly global and interconnected film economy. Through this mapping of key Third Cinema debates and the linkages that extend from these earlier theories through the construction of an autonomous 'African cinema' as distinct from Hollywood or European influence, the study moves towards an exploration of film content as not only a vehicle for the communication of ideas and meaning. This approach sees film not as just a product, but also as a system of inputs, economic arrangements and specialised skills involved in the development, financing and distribution of the film project.

Film industry practice and critical perspectives

In acknowledging film industry practice along with film text, this approach provides a useful framework for considering how the four films selected for this study can be approached within a

broader and more inclusive understanding of African film practice. Oswelled Ureke and Keyan Tomaselli, writing in the *Journal of African Cinema* (2017), draw on the pioneering work of Goldsmith and O'Regan (2003) in developing an approach to African screen studies. This approach moves away from the purely theoretical definitions of 'African cinema' or 'African film industry' based on a preference for cultural, racial, ideological or geographic specificity or an 'authentic' African film aesthetic.

The view espoused by Ureke and Tomaselli (2017) considers terms like 'African cinema' and its implied autonomy outside of an increasingly globalising film environment as outmoded for the task of explaining films made in Africa by filmmakers both from the continent and from outside who work with local crews and actors during whatever period of production is located on the continent. In developing a more inclusive response, the idea of a "holistic value chain framework" (Ureke and Tomaselli 2017, 75) is proposed, recognising the value of co-production opportunities, access to funding, skills development and distribution outlets in wider markets.

Ureke and Tomaselli (2017) adopt the terms 'cinematic fact' and 'filmic fact', which was first articulated by Christian Metz (1974) as a proponent of film semiotics and later developed by Robert Stam in the 1990s. The cinematic fact explains the institution of cinema, its production and economic context, which "includes pre-filmic events such as the economic infrastructure of the studio system and technology, as well as the post-filmic, which includes distribution and exhibition" (Ureke and Tomaselli 2017, 75). The filmic fact signifies the cinema text with all its layers of meaning. The separation of film production and distribution from content and representation paves the way for a revision of terms like 'African cinema' and 'African film industry' which often ignore these industry qualifiers and is helpful in understanding the wide range of films selected for discussion within the broader context of African filmmaking practice. Their plea is for a re-evaluation of these terms against the industry value chain, an area that theorists have avoided in the past because of the segregation between theory and practice and the hope of theorising into existence a certain type of film that might not actually exist or might not be possible to make. Such rigid dogmas often refuse to accept that purely theoretical and ideological positions are seldom found in the real world of filmmaking. By recognising the importance of the cinematic fact, the intention is to lift a veil of theory that may obscure rather than reveal the reality of film production. This does not negate the importance of analysis of content (the filmic fact); rather, the approach sees the two as complimentary (Ureke and Tomaselli 2017).

The following section uses Nigeria's thriving homegrown film industry to highlight some of the complexities that commercial film production in Africa presents for Third Cinema theorists and later

African film scholars approaching a definition of what constitutes 'African cinema'. Although some 20 years separate the emergence of the Nigerian film industry from ideas first developed around Third Cinema in the 1970s, theorists (Guneratne 2003) have considered the challenges the Nigerian example poses to Third Worldist positions. The argument below also discusses the work of African film theorists Mhando (2014) and Ukadike (2014a, 2014b) and their views on the Nigerian industry in the face of sustained popular consumption of these films among African audiences and beyond, ensuring a uniquely self-sustaining African commercial film economy.

The next section applies a separation of the cinematic fact in analysing the production and economic context of the Nigerian example and introduces the film services approach to this discussion as a useful addition to our understanding of African film practice.

The business of Nollywood

On the basis of the cinematic fact alone, the Nigerian film industry, or 'Nollywood' as it is popularly called, is impossible to ignore for anyone interested in the evolving dynamics of filmmaking in Africa. Based on the number of titles it produces, Nollywood is ranked second largest after India's film industry and ahead of Hollywood (PwC South Africa 2017). This is a uniquely African phenomenon which commercially dominates imported films from Hollywood and elsewhere in the Nigerian market. Nollywood also exports its content through informal distribution networks to African Diasporas in the global North and widely across sub-Saharan Africa, the Middle-East, Asia and the Caribbean (Miller 2012). Financial profitability has been achieved without government support (Chowdhury et al. 2008), which is an exception to other African film economies such as South Africa.

I will return to South Africa and government support for the industry in more detail in the following section. As a potential model for the future development of African filmmaking, the Nigerian example is important considering the ongoing reliance of Francophone Africa on French government support for postcolonial filmmakers as previously noted in the case of Ba Kobhio's film. This troubled relationship with the former colonial master dates back to the earliest pioneers of African filmmaking (Gabriel 1982; Diawara 1992). Despite an "antagonistic relationships with the government over taxes, the loans and grants upon which other film industries can rely" (Miller 2012, 119), Nollywood has experienced exponential growth from almost nothing in 1992 to over 2 000 productions per annum by 2006 without international donors or forms of national government funding as in South Africa.

Guneratne highlights the complexities that Nollywood poses for Third Cinema theorists who are forced to confront "the painful dilemma of choosing either to celebrate anti-hegemonic Third World

initiatives which successfully out-compete imported First Cinema or to condemn their ostentatious capitalism" (2003, 19). These irreconcilable tensions necessitate a wider reconsideration of the polemical and pedagogical assumptions which have limited critical theories deployed in past debates around African filmmaking and continue to influence our current understanding of African filmmaking.

When applying the film services approach, discussed in greater detail in the next section, to Nollywood, Jade Miller (2012) and also Ureke and Tomaselli (2017) consider the term 'African film industry' as misleading in the traditional sense that Diawara (1992) uses it to describe organisational and institutional developments of individual and regional industry bodies. In reality, Nollywood consists of "informally constituted film services" and like most African film economies does not involve highly specialised divisions of labour in providing production support for filmmakers (Ureke and Tomaselli 2017, 83). Mhando celebrates Nollywood cinema and its informal distribution networks for contributing to African-based solutions to the problem of accessing wider markets. However, he mistakes the cinematic fact of lower production standards for an 'African' film aesthetic when he speaks of a binary struggle between "confrontation and compliance" (2014, 17). From this perspective, content constrained by technological standards, as Nollywood video productions often are, is proposed as a form of "survival and resistance" against exclusionary Western industry norms (Mhando 2014, 19). Nigerian filmmakers seeking technical compliance with higher and more expensive international standards are viewed as "extensions of western cultural imperialism and so connect less well with local audiences" (2014, 19). In elevating the limits of technical resources and skills to a choice between acceptance or rejection of existing Western paradigms he chooses to ignore current (and possibly) future trends of rising budgets and increased efforts in both script development and technical standards as more Nollywood filmmakers target theatrical releases in Nigerian cinemas. The alignment of African filmmakers with their homegrown audience requires, according to Mhando, some "attachment to their native countries, investment in cultural expressions, affiliation to black 'ethnicity', and a racial historiography that are no less important manifestations of the African personality" (2014, 17).

However, in praising the aspiration to lower technological standards as an iconic form of resistance to Western and commercial influences and standards, Mhando (2014) underestimates the aspirations of African filmmakers to strive for higher technological standards and access to local cinema releases and international markets. Instead of alienating local audiences, as Mhando contends, examples such as the internationally benchmarked popular romantic comedy *The Wedding Party*, released in 2016, produced an accumulated box office return of US$12 million,

making it the highest grossing Nigerian film (PwC South Africa 2017, 90). Contrary to Mhando's expectation, compliance with technical standard for theatrical release which also facilitated access to international markets in Canada and the USA increased the film's popularity with local and international audiences thus ensuring financial success and the sustainability of film production practices ('The Wedding Party' 2016). A sequel, produced to the same international technical standards, was released in 2017 and reaped even greater box office rewards. In reverting to technical sophistication as a measure for authenticity in Nollywood cinema, Mhando (2014) seems prepared to deny aspirant Nollywood filmmakers any current and future ambitions towards improvement of their product while still remaining relevant within the critical framework he imposes.

Ukadike (2014a) argues that the business of Nollywood, the cinematic fact of production and distribution, is a consequence of globalisation and free market manipulation aimed at entrenching dominant cinema. He advances this view by drawing a direct link between the use of cheaper video technology and the International Monetary Fund's (IMF) intervention in the Nigerian economy, which resulted in steep devaluations of the local currency, making the cost of celluloid film unaffordable (Ukadike 2014b, 243). While it is understandable that economic conditions at the time influenced the choice of home video formats, to pose a causal link to neo-colonial designs by the IMF is to ignore issues of safety and security that changed Nigerian cinema-going culture. Nigerians enjoyed a strong cinema-going culture in the 1960s and 1970s, yet by the early 1980s there wasn't a single cinema still operating in Lagos as most had been converted into churches because people had become increasingly fearful of their security and avoided going out after dark (Miller 2012). With the advent of video production and distribution Nigerian audiences were able to rent tapes from one of the half a million estimated outlets in the country and view these on home video recorders, of which there are an estimated 57 million in Nigeria, in the relative safety of their homes (Chowdhury et al. 2008).

Harrow (2007, 214) points to the success of the Nigerian industry in overcoming the limitations of "serious" African filmmaking which has failed to develop economically viable markets thus ensuring an ongoing dependence on Western production funding. In differentiating between categories of serious and commercial filmmaking in talking about Nollywood, Harrow draws our attention to another important consideration relevant to this discussion: the modernist judgement of popular culture as something "we have dismissed as cheap or meretricious or unworthy of serious analysis" (2007, 29). Ukadike applies this hierarchy of definitions to "video-films", as he refers to Nollywood films, and "celluloid films", which he reserves for an "authentic African cinema" based on the

cinematic traditions of Africa's filmmaking pioneers (2014b, 244). Ukadike laments the adoption of "alien conventions" which some Nigerian filmmakers deploy in reaching their audiences as "mimicry of the West [...] thus eroding knowledge, imagination, and direction, and the negation of the varied ways in which the artistic production of culture contends with claims of power and authenticity" (2014b, 234-235). In hoping to rebottle the elusive definition of 'authenticity' that was part of the revolutionary zeitgeist of African cinema's founding fathers and found theoretical basis in the views of early Third Cinema, Ukadike appears to hold onto moribund and outdated views that consider African film theory and criticism as uniformly aligned behind the idea of an African cinema as distinct from Hollywood or European practices.

Clearly, Nollywood's innovative approach and unashamedly commercial imperatives pose serious dilemmas for theorists seeking an 'African cinema' that rejects shallow commercial imitation which is advanced as a non-African influence. Ukadike considers the very popularity of these Nollywood films as arising from "the contradictions and tensions within the definition of African cinema" in that the audiences are drawn to the everyday drama of the popular and are "indifferent to the social responsibility agenda of contemporary African cinema" (2014b, 244). This view blames the practice of filmmaking for not conforming to theory.

In reality, Ukadike's and other film criticisms theorising around African cinema and implied authenticity fails to recognise the diversity of a new generation of African filmmakers that consider embracing rather than rejecting, as earlier generations may have done, the possibilities of international co-production and new technologies with the opportunities of an increasingly interconnected world. This outcome further underlines the importance of the cinematic fact in explaining the economic context of the productions when considering the diverse case study films chosen for this thesis. This opens our understanding to the evolving realities of production and new technologies alongside our reading of the film text itself.

Technical disruptions

Theories mentioned here such as Third Cinema, Third-World Cinema, Postcolonial Cinemas and African Cinema are rightly acknowledged for the important contribution they made in a particular historical moment, yet their insistence on binaries dividing the West from Africa around notions of 'authenticity' appear more and more out of touch with emerging African filmmakers empowered by digital technologies and aspiring to interconnected local and global markets.

As the term 'fourth industrial revolution' gains popularity in African dialogues about future development and economic stimulation, the realities of global interconnectedness and the digital

revolution which continues to reshape film practices in Africa must be acknowledged in theoretical debates about African film practice. While it is true that these advances could not have been foreseen by earlier theorists working to explain an emerging postcolonial African filmmaking, the increasing hybridity that results from current developments must be recognised. It is common knowledge that as new digital technologies evolve, professional digital cameras and editing software became more affordable. This technology not only circumvents the costly photo-chemical processes required for the origination of filmmaking on celluloid but also changes the distribution and exhibition of films as high-resolution digital projection becomes ubiquitous in cinemas. Now professional results of the highest international standards are achieved at a fraction of analogue costs with consumer-priced cameras, digital sound recording equipment and personal computers being used to achieve excellent levels of postproduction. No proof of this seismic shift speaks more loudly than the results seen in Nollywood, which has altered the landscape of film production and distribution across Africa and far beyond (Miller 2012).

This does not deny that Africa's unequal status in the world economic order is not perpetuated in cinema exchanges, yet it is also clear that emerging technologies offer filmmakers from Africa new unparalleled opportunities that could never have been foreseen even a generation ago. Filmmakers intent on accessing linkages in the global entertainment world are increasingly able to do so through the accessibility afforded by the internet and the proliferation of international film festivals providing programmes for filmmakers to pitch their ideas to co-producing partners.

Based on current metrics for internet penetration in Africa, where mobile access dwarfs fixed line broadband access in the surveyed countries of Nigeria, South African, Kenya, Ghana and Tanzania, connectivity is expected to more than double over the next five years, except for the more mature markets in South Africa which is projected to reach 78% by 2021 (PwC South Africa 2017). Falling data costs and increased internet connectivity will impact directly on the production and distribution landscape in Africa and internationally (PwC South Africa 2017). As demand for content in Africa and internationally rises accordingly, African filmmakers will be more inclined to innovate around the opportunities that international exchanges and access to globally connected markets offer them. African filmmakers, as they are already doing, will continue to embrace new media distribution opportunities such as Netflix, Amazon, Hulu, YouTube, Red and similar African platforms such as iRoko, Buni.tv and Showmax in order to gain market share and challenge for dominance of their content in local markets, as Nollywood has shown.

Film services and medical services

The films selected for their portrayal of the medical doctor in various African conflict zones represent complex economic flows and other exchanges indicative of production in African countries where access to financing, skills and infrastructure is less developed in comparison to industries in the global North. These films all include international exchanges between filmmakers from the global North working with South African, Namibian and Cameroonian cinematic resources in their locations: film crews, actors and directors.

The analogy between film services and medical services reiterates the interdisciplinary approach of this thesis. Where similarities do exist, they are offered metaphorically and not as rigid and functional comparisons intended to blur the boundaries between these operations. Medical and film services operate in distinct structures with different logistical requirements and outcomes, yet they share a response to the increasingly interconnected nature of economic, social and political exchanges which the forces of globalisation imply.

While it is true that much of the funding for major commercial English-language films has for many years flowed from outside of southern California and the USA, Hollywood continues to represent a design centre within the system of the global film economy (Goldsmith and O'Regan 2003). The term 'Hollywood' in this context refers to both a concept and a location. Goldsmith et al. (2012) use the term 'Global Hollywood' to describe the complex network of partners and interests that are not only implicated in the global dispersal of production, distribution and consumption of Hollywood films but also include the people, companies and places all over the world that participate in the production of these runaway films by offering film services. Where these film services are aggregated and organised at a level that facilitate the making of international quality productions to their full potential in a cost-effective manner, Cape Town in South Africa or the Gold Coast in Australia are established outposts of the Hollywood production machine and might be understood as representing a 'local Hollywood' (Goldsmith, Ward, and O'Regan 2012; Tomaselli 2013).

The term 'Global Health' is applied by Randall Packard (2016, 6) to name the multi-billion dollar enterprise that has developed in response to "a desire to reduce global inequalities in health; efforts to promote economic development; and the political and economic interests of donor countries". Packard's *A History of Global Health* (2016) describes the lasting colonial legacies of underdevelopment and the catastrophic effect of war and conflict on national health systems in the global South. Where these systems are strained, or even collapsed, as a result of conflict, environmental disaster or contagion, global health systems operate to deliver a mode of emergency medical service as part of the humanitarian response to alleviate human suffering.

Returning to the film aspect of this analogy between medical and film services, consider the example of *Beyond Borders* which was filmed on locations in Namibia in 2002 (Barnard 2002a) and *The Last Face*, filmed in South Africa during 2014 (Jang 2016). Both films were directed by non-African filmmakers, working alongside local crews and support casts. These films are typical of 'runaway' productions that film outside the major commercial film centres of Europe, and particularly Hollywood, in order to access less expensive production infrastructure such as locations, studios, crews and actors (Goldsmith and O'Regan 2003; Goldsmith, Ward, and O'Regan 2012; Tomaselli 2013). While the intention and outcome prompting film productions in accessing these film services can hardly be compared to the conditions that require emergency medical services to save lives, certain modalities overlap.

Where a global health response is prompted by crisis, the necessity of fast action and the rapid deployment of medical services requires maximum impact to ensure quick short-term gains. Consequently, there is little attention to the long-term development of health systems in places overwhelmed by catastrophe (Packard 2016). As described in greater detail in the next chapter, these emergency medical services are often planned and implemented by outsiders under the control of doctors from the global North volunteering their services (Fox 2014). This perspective privileges Western biomedical technologies and tends to ignore local perspectives and community participation in the planning process (Fox 2014, Packard 2016).

Similarly, Ureke (2016) observes, the non-Hollywood partners in cinematic exchanges are frequently relegated to junior status, which replicates the uneven nature of global exchanges between the global North and South. As far as control over content and decisions over what films get made goes, Ureke is correct: the controlling partner in these film service exchanges is the international producer who brings the lion's share of the capital and owns the intellectual copyright to the film. However, in South Africa, for example, government incentives offered to foreign producers also help subsidise the transformation of the industry by empowering black filmmakers with increased incentives for the production of their own films (Department of Trade & Industry (DTI), South Africa 2018a).

In applying a film services approach to African film practice, a theoretical space opens to redirect attention away from film content (the filmic fact) to include "processes or services provided to production, including tax incentives, capacity building and loan financing" (Ureke and Tomaselli 2017, 81). In applying this approach to the films chosen for the study, I make the argument that international productions filming in African countries are also contributors to the development and transformation of local film industries through skills, technology and infrastructure transfers.

However, should the foreign producer consider the terms under which the film is made too onerous they would surely choose to go elsewhere to secure the appropriate production services.

Like emergency medical services fixed on short-term gains, the primary aim of foreign producers is not to build long-term production capacity in the countries where they are filming. In accessing financial and creative opportunities through local rebates and incentives, suitable filming locations, skilled crews and actors, these runaway productions intend maximising available opportunity to complete the production before departing as soon as possible. As discussed in later chapters, the ability of states who are recipients of emergency medical services to regulate international humanitarian interventions for the benefit of local health systems, is severely curtailed by conditions of conflict or disaster which necessitated the emergency response in the first place. In contrast, an effective film services industry relies on national government to enforce effective regulatory frameworks to ensure the renewal of benefits that attract these foreign productions. A viable return to the fiscus in the form of investment, employment and taxes is usually required. Another important aspect, which I will discuss in connection with the South African film rebate, is the contribution of the film services sector to the development of local filmmakers through the extension of government funding and support.

Research from 2017 commissioned by the National Film and Video Foundation of South Africa (NFVF), a statutory body created, according to its website, to "enable the development and promotion of a transformed and thriving audio-visual industry" ('National Film and Video Foundation' n.d.), lists twelve countries that compete aggressively against South Africa to attract foreign film and TV productions. This lists South Africa in tenth position after countries like Colombia, the United Arab Emirates, Malaysia, Canada and France (National Film and Video Foundation 2017, 25-26). As Goldsmith, Ward and O'Regan point out, these local Hollywoods are in a "global competition to host Hollywood and other productions" (2012, 3).

International producers looking to service the production of their films in South Africa would ostensibly avoid working in the country if they were required to make only certain African-themed content or back only local filmmakers. But African filmmakers, who historically sought Third Cinema options to counter the hegemony of Hollywood, would regard this approach which seeks minimal interference in the content of the films produced by international producers working in African countries with suspicion. This tension in the production value chain has contributed to the dual nature of the South African film industry, one formed around the internationally-regarded film service sector and the other around the less known local film and television industry (Tomaselli 2013). Aware of the need to incentivise the development of local filmmakers interested in telling

stories that reflect local aspirations, and to redress the imbalances of colonialism and apartheid, the South African government initially introduced two film incentive schemes in 2012 to promote both sectors of the film industry (Department of Trade & Industry (DTI), South Africa 2018b).

The first incentive was aimed at promoting South African films that were produced and owned by citizens of the country and the second incentive focused on attracting foreign films to the service industry "to encourage and attract large budget films and television productions and post-production work that will contribute towards employment creation, enhancement of the international profile, and increase the country's creative and technical skills base" (Department of Trade and Industry (DTI), South Africa 2018b, 3). The NFVF (2017) report argues that foreign service films coming to South Africa contribute to advancing the developmental and transformation agendas of the local film incentive scheme, as the Minister of Trade and Industry announced that it would "ensure that the incentives support the development of sustainable value chains and inclusive ecosystems" (Department of Trade & Industry (DTI), South Africa 2018a).

In 2014, the South African Black Emerging Filmmakers Incentive, seen "as particularly important for achieving transformation in the film industry", was announced (Department of Trade & Industry (DTI), South Africa 2018a). As a form of equitable redress, black filmmakers who were historically marginalised by the policies of racial discrimination receive increased incentives that are made available to majority black-owned film companies. This and additional incentives intended to address historical imbalances were introduced in the latest guidelines aimed at transforming the film industry to become more representative of the country's demographic. An important aspect in the dual nature of the South African film industry is that the service industry, with its higher international film production budgets, has remained "mostly dominated by the white demographic in the country" (National Film and Video Foundation 2017, 27).

The film incentives offer a tax-free cash rebate calculated on the total Qualifying South African Production Expenditure (QSAPE). Fees paid to non-South African actors, directors, writers and other key creative participants do not qualify as QSAPE. While exceptions are made for foreign crew working on films recognised as official co-productions under international treaties between South Africa and signatory countries, definitions of QSAPE generally exclude capital acquisitions of land and buildings, deferred payments, marketing and publicity expenses and the purchase of certain production equipment. However, in July 2018, under the Emerging Black Filmmaker Incentive, a

once-off allowance was made for the purchase of key production equipment to a maximum cost-sharing incentive of R2 million. [1]

Between 2013 and 2017 a total of 530 productions were supported with a total QSAPE valued at R14.175 billion (National Film and Video Foundation 2017, 41). QSAPE includes all expenditure incurred in South Africa or paid to South African entities and crew directly related to the production of the films that are pre-approved under the scheme. From these figures over the first four years of the rebate it is notable that QSAPE for local films remains quite stable between R630 million and R700 million (Independent Producers Organisation 2015). The introduction of the Black Emerging Filmmaker scheme accounts for an additional R93.3 million in QSAPE in the 2014/2015 reporting period, while QSAPE for the Foreign Film Incentive shows a clear increase over the same period. In the first reporting period of 2012/2013 the service industry QSAPE was less than that for local films at R530 million, but in the 2014/2015 period the service sector accounts for just over R2.9 billion (Independent Producers Organisation 2015). When official co-production films (those made with partner countries that have official treaties with South Africa[2]) are added to the service industry numbers the total QSAPE increases to just over R3 billion (Independent Producers Organisation 2015). These metrics indicate a positive accrual to the South African economy and recognise the combined impact of foreign film productions alongside local films in developing the South African film industry while also contributing to fiscal growth through tax revenue, foreign investment and job creation (National Film and Video Foundation 2017).

The producer of *The Last Face*, Bill Gerber, acknowledged the attractiveness of the incentives in luring the shoot to South Africa (Jang 2016). The success of the Foreign Film Incentive has had regional benefits too. Namibia, sharing a border with the north-west of South Africa, has benefited from productions lured to South Africa. Notable examples are large budget productions like *Mad Max: Fury Road* (Miller 2015) and *The Mummy* (Kurtzman 2017), which were shot partly on location in Namibia under the production management of South African service companies (Moonlighting n.d.). Although *Beyond Borders* was filmed in Namibia in 2002, ten years before these incentives were introduced in South Africa, the production utilised the services of Moonlighting, a company that also provided film services for *The Last Face* (Moonlighting n.d.).

[1] The Film Rebate Incentive Guidelines are available on the Department of Trade & Industry website: http://www.thedtic.gov.za/financial-and-non-financial-support/incentives/film-incentive/

[2] The National Film & Video Foundation of South Africa (NFVF) lists Canada, Germany, Italy, United Kingdom, France, New Zealand, Australia, and Ireland as having official co-production status with South Africa (National Film and Video Foundation n.d.)

Gerber refers to the use of locations in South Africa that could "double" for the story locations in Zurich, South Sudan and Liberia (Jang 2016). The decision to film the Liberian jungle scenes on the KwaZulu-Natal coast was informed by the Ebola outbreak in 2014 which made filming there too risky (Jang 2016). *Beyond Borders* was filmed over five months in three different countries, all 'doubling' for locations elsewhere (*Behind the Lines* 2003). In *Beyond Borders*, Montreal doubles for Grozny, the capital of Chechnya during the war there in 1995. In the same film, Thailand stands in for Cambodia and Namibia was chosen for the setting of the Ethiopian famine of 1985 (*Behind the Lines* 2003). The bankable star power of Angelina Jolie and Clive Owen no doubt helped secure the financing for *Beyond Borders* - raised through a German film investment incentive in the form of tax credits (*Behind the Lines* 2003). Filming began in March 2002 and continued for five weeks in a desert area located behind the Roessing Mountains about 30 kilometres outside the coastal town of Swakopmund (Barnard 2002b). Lloyd Phillips, the producer responsible for bringing the production to Namibia, was one of the first international filmmakers to see the potential that Namibia and South Africa offered as a film services location (Barnard 2002b).

At a press conference, covered by *The Namibian* newspaper and held on 7 March 2002 in Swakopmund, Phillips announced that "Hollywood knows about Namibia" and indicated the possibility of further productions because of the geography, stable climate and the safety of filming in this "relaxed and peaceful country" (Barnard 2002b). He also acknowledged the Namibian government's willingness to foster a 'film-friendly' environment and that it had "bent over backwards to make the movie happen" (Barnard 2002b). Co-operation between local film production and government departments is important in creating "[f]ilm-friendly locations [which are] spaces that have a disposition towards production, which is evident in their people, companies and governments" (Ureke and Tomaselli 2017, 82).

Guided by theorists working within a film services framework, I use aspects of their analysis in "assess[ing] the cinematic fact for economic and creative value, even when complemented by an analysis of content (filmic fact)" (Ureke and Tomaselli 2017, 81). In describing the commercial arrangements, distribution and production services that characterise the films selected, I intend to illustrate how the cinematic fact, when considered alongside filmic fact, opens this analysis to a consideration of cinematic exchanges and their place within African filmmaking practice. Instead of rigid definitions of African cinema or the siloed categories of Third Cinema, this approach seeks to widen our understanding of African film practice by avoiding definitions that are exclusionary on the basis of kinship, geography or national identity. Harrow (2007, 37) reminds us that with an insistence on these rigid definitions African cinema risks continuing the incomplete project of colonialism in

issues regarding race, domination of certain values over others relying on “eurocentric definitions of self and other along lines of modern and primitive, or modern and traditional”.

Arguing for a thorough recognition of context and its impact on filmmaking, which the film services approaches allows, does not ignore the ideological issues confronting African cinema or the importance of Third Cinema as a theoretical proposition arising outside of Western paradigms. However, rejecting international exchanges as ‘foreign’ and undesirable will only perpetuate the marginalisation of filmmakers working in Africa and deny them access to a growing audience, higher revenues and consequently greater capital accumulation to fund sustainable film production.

This chapter has already argued the value of unfixed definitions in considering African film theory that signal an increasing tolerance for interdisciplinary studies more suited to post-nationalist discourses that accord with the flow of information in the digital age. Underpinning the analogy between medical and film services is the fluidity my argument applies in bridging film studies and other literatures to arrive at an understanding of how the cinematically constructed figure of the medical doctor is represented in the imagined African conflict zone.

In Chapter Two: *Imagining the Conflict Zone*, the study considers the mode of emergency response and how this shapes medical response to humanitarian disaster. These occurrences significantly infuse the narrative setting of the films discussed. The chapter also introduces political and legal theory related to international law and state sovereignty. These have important implications for the function and authority of the doctor figure and informs our understanding of the films. I mesh these diverse literatures through my reading of the film text configured around the central doctor figure within the imagined African conflict zone.

CHAPTER TWO

IMAGINING THE CONFLICT ZONE

Introduction

The Last Face (Penn 2015) and *Beyond Borders* (Campbell 2003) are of particular interest to this research in that their stories are told outside the more conventional locations of the clinic or hospital. The doctor in these films is located at the centre of a medical response team, providing emergency medical services within the imagined conflict zone. These conflict zones are restaged for cinema, revealing scenes unfolding against a variety of catastrophic events including the Ethiopian famine in 1985, the Liberian Civil War in 2003 and conflict in South Sudan in 2014. The doctor-characters that drive these narratives display qualities of the selfless volunteer-hero romanticised in the media as they act in the name of humanitarianism. Yet these constructed fictional characters are not without their contradictions and shortcomings as they confront the practical difficulties of rendering medical care under difficult and often dangerous situations, just like their real-life counterparts. In confronting these dilemmas, questions of ethical complexity frequently arise in the practice of medical humanitarianism. Where medical resources are scarce, these doctors must often make stark choices in triage situations which require the selective treatment of certain patients over others based on their best chances of survival considering the severity of their wounds. Difficult decisions must also be faced in balancing personal risk in the conflict zone where withdrawal from the field may be necessary, versus the continuation of the medical mission where lives are at stake. In approaching these dilemmas, I have turned to the work of real-life medical response organisations like Médecins Sans Frontières (Doctors Without Borders) and Médicins du Monde (Doctors of the World). The work of Renée Fox (2014), Elliott Leyton (2007), Randall Packard (2016), Peter Redfield (2010) and a host of other scholars encompassing sociology, anthropology and medical history, is invaluable in understanding these organisations in the context of this study and its focus on the fictional doctors represented in the narrative films.

This understanding of real-life medical response organisations is necessary in teasing out the tensions arising around the doctor figure depicted in the films relying on fictionalised recreations of similar events. Later, this chapter moves to Michel Foucault's (1973) institutional history of the hospital and its implications for reading the imaginary figure of the modern doctor subject to the fracturing of the conflict zone. In describing the nature of these emergency medical services, this section also lays an important foundation for the next chapter which considers how film services are utilised within the filmed aesthetic of the conflict zone.

Emergency medical response

Instead of the emergency ward of the city hospital or the family clinic which has customarily been the setting for many medical television dramas, these films position the doctor at the centre of an emergency medical response team that is deployed to the field and provides services in the unstable environment of a conflict zone. Whether arising from human confrontation or natural disaster, the outcomes in a conflict zone, medically speaking, are very similar. Both scenarios frequently produce casualties in large numbers that strain local health services that may still function or may have collapsed completely as a result of the disruption.

In furthering this account of the cinematically-constructed figure, I bring ideas from the social sciences that explain emergency as a new global phenomenon and consider the responses these generate. I am inspired by the example of scholars like Azoulay (2008) and Rangan (2017), discussed later, for their weaving of the same political and legal theory into explanations of cultural aspects of how emergencies effect our social and political life. My application requires an understanding of how 'emergency' is conceived of and integrated into modern life and how the doctor's power and special significance is to a large extent derived from the global humanitarian order that serves as a response to crisis and disaster. Craig Calhoun (2010, 30) speaks of the "emergency imaginary", evoking the sociological term for a common set of values and perceptions shared by a social group through a culturally-constructed understanding of what constitutes events typical of the conflict zone.

This reading of the emergency implies a shift in our treatment of time. Luc Boltanski observes that the temporal recalibration *"*isolates the *present* [author's emphasis] from the past and the future" (1999, 182). The temporality of emergency focuses attention on the immediate conditions of the conflict zone rather than searching for the root causes of current conditions and potential outcomes in the future. For C. Calhoun (2010), this conditions our perception of emergency as a sudden eruption, unpredictable and short-lived, which looms out of conditions of apparent predictability and normality. The eliding of deeper contemplation to prioritise immediate action is supported by medical ethics that justify the rush to help those in need of urgent medical attention (Boltanski 1999). As I will show later, *The Last Face* and *Beyond Borders* frame fictional medical-humanitarian responses within a particularly modern conception of the doctor arising in the 1960s and 1970s.

Médicins Sans Frontières

Of the many health organisations working outside of traditional global-health systems and government-run organisation, the best known is Médicins Sans Frontières (MSF), claiming some 42 000 staff in its ranks with operations in over 60 countries in 2018 ('Doctors Without Borders'

n.d.). Among the many highly-skilled support staff and humanitarian workers helping to ensure MSF's success in the field, the doctor is from the start elevated within the organisation as a figure of power. The translation of the organisation's name into the language of each of its national subgroups, as in the English translation of *Doctors without Borders,* places the doctor at the centre of these operations. Elliot Leyton (2007), an anthropologist writing about MSF's work in Rwanda during the genocide, considers this idealisation of the doctor as "an unfortunate linguistic capitulation to the prestige of physicians in the modern world" (2007, 547). Whether this prestige is warranted is not the focus of the argument made in this chapter. What is of importance here is the ways in which the doctor appears at the nexus of a complicated web of power relations and humanitarian beliefs that converge around the provision of emergency aid in the conflict zone. The positioning of the doctor on the masthead of MSF's mission seems entirely intentional given that its founding members were doctors driven by the need for action in response to what they perceived as institutional shortcomings at the time.

MSF was founded in 1971 out of moral outrage by a group of mostly French doctors following the Biafran War in Nigeria (Leyton 2007; R. C. Fox 2014). In protesting against the International Committee of the Red Cross's (ICRC) preference for silence in the face of the systematic withholding of food aid from Igbo inhabitants of Biafra, these doctors drafted a charter of principles upon which MSF was started. Fiercely independent from the start, the organisation still considers itself a collective today, with each of its independent chapters sharing the same principles and objectives while ensuring a level of autonomy in fund raising and in the missions they select to undertake (R. C. Fox 2014). Ninety percent of its funding comes from private, nongovernmental sources, which allows MSF to claim that it is free to "act independently," without regard to "political, military, or religious agendas" (R. C. Fox 2014, 2).

The founding doctors drew their inspiration from the "New Left" intellectual movement with its embrace of Maoist ideals grounded in the same tricontinental movement that inspired Third Cinema theory and practice (R. C. Fox 2014, 44). As Fox explains, following the massive sacrifices the Soviet Union suffered in helping liberate Western Europe from fascism during World War II, the intellectual Left embraced Marxism and its analytical understanding of history. When the horrors of Stalinism were denounced by Khrushchev in the mid-1950s, the move away from European Communism led instead to identification with anti-colonial struggles raging at the time in Africa, Asia and Latin America (R. C. Fox 2014). These influences were wide-ranging, permeating countless social movements and political responses the world over. Students of cinema will recognise these influences in the response of the *Nouvelle Vague* or French New Wave. Jean-Luc Godard's work with

Maoist elements after 1967 through the Marxist-Leninist organisation of the French Union of Young Communists is well known (Colin MacCabe 1980). As a prominent New Wave filmmaker, Godard's collaborations with Maoist militants through the Dziga-Vertov group influenced other French filmmakers at the time (MacCabe 1980). While no direct connection can be made between the response of MSF's founding doctors and those of the French filmmakers "radicalised by the experience of strikes and demonstrations [who] wished to find new methods of distribution for the films that they now wanted to make" (1980, 19), responses to these ideological positions and the current political climate were felt by young filmmakers and doctors alike. Many French filmmakers responded by advancing an anti-establishment, anti-capitalist cinema while MSF sought to rewrite established norms of international medical intervention in response to humanitarian crises.

Since its founding in the 1970s, international aid organisations like MSF have evolved into the multi-billion dollar industry described by Packard (2016, 6) under the title of "Global Health". The analogy between medical services and film services was expanded to incorporate a discussion of Global Health and Global Hollywood at the end of the last chapter. *The Last Face* producer, Bill Gerber, refers to suitable film services and favourable incentives in choosing to film in South Africa (Jang 2016). As many countries offer incentives, Goldsmith, Ward and O'Regan (2012, 3) describe the "global competition to host Hollywood and other productions". Both these globalised networks are, in their own ways, a response to the interconnectedness of the world's populations. This response to humanitarian disaster requires that "MSF is continually engaged in a process of triage on a global scale, deciding who is most in need of help" (Packard 2016, 334).

Global triage

The term 'triage' has been applied to the sorting of casualties in battle situations since the Napoleonic Wars (circa 1812) when wounded soldiers were categorised based on the priority of their treatment (Giannou and Baldan 2010). In the context of 'global triage' the term refers to the difficult choices required between those worth helping over those that may be considered 'less worthy'. This approach suggests that in allocating resources to humanitarian responses, some level of ordering of suffering on a global scale is required. Boltanski (1999) does not specifically mention global triage; however, his point that any selection by the humanitarian movement must also consider the political view is relevant to our understanding of how global triage operates in ordering global suffering on a scale of worthiness. Boltanski suggests a political view is required "to rank unfortunates, to choose those who are worth the effort required to help them and those who are not" (1999, 191). He distinguishes between the past and the future in weighing the cause of peoples in need through this political view. Looking back, an assessment of past actions and suffering is

necessary, while a political view orientated towards the future contemplates misfortunes to come and the suffering of future victims.

Boltanski (1999) and C. Calhoun (2010) refer to a delinking of past and future considerations within the temporality of emergency. Yet, for organisations like MSF, where the moral imperative of saving lives is paramount, past and future political considerations may be overridden in favour of medical ethics justifying the rush to help those in need of emergency medical services (Boltanski 1999). The eruption of the emergency event might diminish the need of ranking situations on the basis of cause or effect as C. Calhoun (2010) suggests. However, the decision to intervene in one crisis zone rather than another can also be seen as a form of triage in which difficult choices must be made between different moral imperatives.

In *Beyond Borders*, Callahan expresses the need for medical response in the Ethiopian camp at a gala event in London. His grim description of caring for "30 000 people dying at 40 a day" (Campbell 2003) in a camp beset by typhoid, measles and cholera makes clear the pressing medical needs. To support his appeal for help, Callahan has brought a malnourished African boy named Jojo with him from the camp. Jojo's presence in the scene is the subject of discussion later. At this point, my focus in the scene is international response to humanitarian crisis and the selective application of available resources as a form of global triage. In real-life situations, MSF correlates its "proportionality of assistance [...] to the degree of needs" (Médicins Sans Frontières 1995, 3), based on the medical assessment of those requiring urgent help.

The first recipients of global triage in Campbell's (2003) film are the victims of the Ethiopian famine of 1984-1985. These fictional scenes convey elements of resistance which initially accompanied President Mengistu Haile Mariam's government response to MSF and other aid organisations entering the country following media attention created by events like Live Aid (R. C. Fox 2014). The Live Aid musical concerts raised public awareness and funding, while bolstering calls for something to be done for the victims of the famine conditions in Ethiopia.[3]

In *Beyond Borders* the Ethiopian scenes are set in and around a feeding centre and refugee camp recreated for the film (*Behind the Lines* 2003). Jolie's character, Sarah Jordan, having responded to Dr Callahan's plea for help at a London fundraising event, brings emergency food aid to the refugee

[3] Drought and harvest failure precipitated the famine in northern and southern Ethiopia but the response of the Marxist-Leninist Workers' Party of Ethiopia only compounded the human suffering as the worst affected groups were forcefully relocated into new areas under control of the "Dergue", the Amharic name for the military leaders who had removed Emperor Haile Selassie from power ten years earlier (Kapuściński 1984).

camp. South African actors Nambitha Mpumlwana, as the strong-willed truck driver Tula, and Tumisho Masha, as the medical assistant Hamadi, are featured alongside the international cast. En route to the camp, Jordan sees a starving child and its wounded mother lying beside the road, and brings the convoy of trucks to a halt. Fearful of attack from armed militia groups waging a counterinsurgency against the government at the time, Tula insists that Jordan leave the child and mother behind, telling her that it's a waste of time trying to save them. But Jordan's need to help is greater and she insists that the mother and child be brought to the camp where Dr Callahan runs his clinic.

The Triage Sieve

'The Triage Sieve' provides operational guidelines in under-resourced environments where triage is necessary, such as conflict zones or conditions arising from natural disasters and other crises, when it is impossible to treat all casualties optimally. The International Committee of the Red Cross (ICRC) outlines procedures for doctors in treating victims in violent conflicts where limited resources are available in its manual entitled *War Surgery* (Giannou and Baldan 2010). While there are distinctions between natural disaster triage and war triage, the authors point out that "many of the fundamental concepts underlying war triage apply to the disaster scenario" (2010, 191). Triage prioritises casualties on the basis of key indicators, such as the ability to walk, respiratory function and pulse, and on the available resources, such as surgeons, operating rooms and resuscitation equipment. Based on these variables, Giannou and Baldan describe a trimodal distribution of casualties based on "what can be done under various operational scenarios in the field" (2010, 112). The first priority for treatment is those who have suffered moderate to minor wounds and have the highest chance of survival. Those with severe but survivable wounds are treated in the next category. The third category is expectant cases: those for whom nothing can be done as they are expected to die of their wounds. Under these conditions, the role of the doctor is to provide the most effective emergency medical treatment in order to maximise survival for the greatest possible number of casualties (Giannou and Baldan 2010).

When the severely wounded mother and starving child are brought to Callahan, he insists that they be triaged and denied medical care because "they're too weak to survive" (Campbell 2003). When Jordan challenges the doctor's decision, effectively questioning his authority in withholding treatment, Callahan responds angrily that his responsibility is to care for the other 30 000 people in the camp who depend on the very limited medical resources available. Jordan tries to appeal to his emotions, but this only provokes an angry response when he accuses her of manipulating him in order to "indulge some fucking white girl's idea of heroism" (Campbell 2003).

This crucial scene invites deeper examination with its confrontation between the diagnostic response of triage and Jordan's immediate humanitarian impulse which contradicts the doctor as she exerts the need to help save the mother and child. The insights drawn from this scene are that the doctor's objective detachment reproduces factual truths about the external reality of the body in keeping with the key diagnostic requirements of the Triage Sieve. Although the doctor's decision is based on the humanitarian principle of saving lives, it is of a different and more detached kind. This risks the doctor's objective observation being received as heartless by Jordan and the audience. That Jordan's concern for the victims resonates with the audience is based in the deeply rooted ideals that remind us of the ancient parable of the Good Samaritan. This biblical story of the Good Samaritan informs a wider public response to help those in need (Chouliaraki 2006). Thus when Callahan refuses to help in his detached, yet precise medical assessment, Jordan appears to fulfil the audience's expectation of social responsibility and moral duty.

In this reading of the scene, the audience's response to Callahan's triage of the victims is complicated by the professional role this figure is understood to perform at the confluence of medical care and emergency aid in the conflict zone. The factual explanation Callahan offers in describing the state of the wounded bodies would be described as repugnant according to the "rule of common humanity" (Boltanski 1999, 43). However, according to Boltanski, certain exceptions are made for the doctor's role as actively intervening in the action on the side of those who are suffering. Thus in the triage scene, we overlook the moral ban which Boltanski casts over insensitive factual reporting of human suffering, and accept this mode of address as appropriate for the doctor figure while trying to save lives. Sharing Boltanski's understanding in expanding the reading of the scene, it is possible to infer that the audience is less inclined to condemn Callahan's judgement as cruel and unacceptably detached, even though they also identify with Jordan's challenge to his authority and her insistence that he do something to help the mother and child. When Callahan finally relents, Jordan's persistence pays off as she miraculously nurses the child back to health. The child's mother also survives after Callahan reluctantly agrees to operate and close her wounds. With this resolution, the triage scene validates the doctor's prioritising of certain casualties over others, as well as rewards the audience's emotional investment in Jordan's instinct to help in the face of what appears as an overwhelmingly hopeless situation.

A triage scene from *The Last Face* (Penn 2015) depicts similar stark choices and decisions that doctors are forced to make. The narrative is centred on the character of Dr Wren Petersen, played by South African actor Charlize Theron, who heads up an emergency medical response team based

on the real-life Médicins du Monde (MDM) or 'Doctors of the World' in its English translation.[4] The story opens with scenes inspired by real events during the Second Liberian Civil War in 2003 when Charles Taylor's government of Liberia, controlling only a third of the country at the time, is forced to abandon Monrovia after it was besieged by Guinean and Ivorian-backed rebel forces. Concerned that it has become too dangerous to remain in the capital, Dr Petersen and her team make for the border as the rebels close in. Amid torrential downpour, their convoy is attacked by rebel soldiers who kill their driver and take their vehicles along with most of their supplies, forcing the doctors and their party to make the perilous crossing to Sierra Leone on foot.

The triage scene comes after a fictional massacre in a local village as Dr Petersen and her romantic interest, Dr Miguel León, played by Spanish actor Javier Bardem, argue over which survivors should receive transfusions from the very limited supply of available blood. In this reading of the scene the argument is made that triage is not simply a diagnostic exercise but ventilates some of the moral dilemmas that doctors face in the field over their function and effectiveness. Instead of impartial agents prone to factual accounts in sorting trauma causalities which triage requires, the doctors in this scene are shown as conflicted at both the internal and external level. They must weigh their individual roles in the chaotic violence of the conflict zone against wider implications for the emergency medical intervention. Petersen's doubts over the effectiveness of the humanitarian mission in the face of very real constraints is contrasted by León's view that the medical limitations, such as the shortage of blood transfusion, does not prevent them from continuing their work in the field in order to provide whatever help they can to those in need. This conflicts with Petersen's view that they might be more effective by withdrawing from the field in order to communicate the dire situation on the ground to a wider audience, so that the West is compelled to intervene to stop the sort of atrocities witnessed in the film.

In real situations where MSF personnel are considered to be in direct risk of danger and are withdrawn from the field, they have engaged the media to extend this ethos of *témoignage* or "witnessing" (R. C. Fox 2014, 46). Bernard Kouchner[5] laments sometimes uncomfortable relationship with the media and its sensational use of shocking images, yet he also recognises its power and

[4] Médicins du Monde (MDM) was formed by Bernard Kouchner following a break over his very public appeal to the media which contradicted MSF's founding charter in drawing attention to the suffering of the Vietnam Boat People Crisis in 1979 (R. C. Fox 2014).

[5] Kouchner's influence in humanitarian politics was bolstered by the various political posts he held in France as Minister of Health and as Minister of Humanitarian Affairs. He also served as the UN Special Representative to Kosovo in 2001 (Boltanski 1999).

influence in bringing attention to important humanitarian causes which might otherwise go unnoticed or unreported (Boltanski 1999).

Resisting the idea of *témoignage* in the film, León believes that the media would be ineffectual in this situation and questions Jordan's idealistic belief that "they [the West] will give up on Middle Eastern oil and come rushing into west Africa" (Penn 2015). Petersen reacts to León's doubts about her idealism when she points out that, unlike him, she is "not going to fool herself out here, playing god to a lucky few" (Penn 2015).

León's concern over abandoning their mission in the hope of revealing the nature of the Liberian Civil War carries with it the very real concern for those left behind and still in need of medical attention. This reading of the triage scenes highlights the stark choices doctors must confront in the conflict zone, which position the doctor, not as an impartial agent, but as a figure torn by personal doubts and contradictions at the very centre of emergency aid.

The metaphor of the doctor "playing god" (Penn 2015) to which Petersen refers, evokes a common view that it is deities alone who have the power over who lives or dies. In relation to the doctor figure, this study argues that this power is based in an unquestioning regard for the authority of scientific knowledge, allowing the doctor to diagnose especially 'hidden' ailments afflicting the human body. In brandishing this knowledge, the authority of the doctor is elevated to a 'god-like' status which can be traced back to the emergence of the modern western state.

The clinical gaze

The work of Michel Foucault in *The Birth of The Clinic: An Archaeology of Medical Perception* (1973) offers an explanation of how new forms which accrue power to the doctor result from shifting perceptions that changed the course of modern medicine in the 18th century.

Foucault uses the French word *clinique* (translated as 'clinic' in English texts) to refer to both clinical medicine and the hospital. The institution of the clinic is central to Foucault's explanation of the evolving nature of medical knowledge which positions the doctor within a system of power relations endorsed by the authority of the state. In his deconstruction of these myths, he argues that the political and social re-organisation following the French Revolution (1789-1798) transformed not only our idea of disease but also the perception of the doctor figure itself. Where once illness was managed at home by family caregivers and involved the individual's experience of disease, the move to treating patients in government clinics shifted the responsibility for illness to the state and prioritised the doctor's reading of disease over that of the patient's (Foucault 1973).

Social restructuring around the time of the revolution introduced the myth of a "nationalised medical profession" which was reflected in a "strict, militant, dogmatic medicalisation of society, by way of a quasi-religious conversion, and the establishment of a therapeutic clergy" (Foucault 1973, 32). By drawing an analogy between the clergy and the medical professionals Foucault highlights the powers and systems deployed by both in their respective areas of focus, in service to the health of the individual or consideration of the soul. Where once the priestly classes held domain over the soul which was considered inseparable from the body, now doctors would become "priests of the body" and responsible for the health of the populace (1973, 32). Foucault's interest in these events is that they represent a major reorientation in our thinking about modern medicine. The doctor emerges as centrally responsible for the cure and prevention of disease and for the overall well-being of the human body within the institution of the hospital, implying a shift in our understanding of medicine as a modern clinical science. This modernist turn also announces medicine as founded on rational systems in contrast to 'irrational' systems based on superstition. The latter were excluded from the clinical framework because they were not based on evidence and therefore dismissed as "unscientific" (Foucault 1973, 19-20). As responsibility for treating the sick moved from the family and the home environment to the clinic and the doctor, so the newly anointed health professional no longer received payment for their services from the individual patient, but received a salary from the state and thus became "no more than an instrument of that service" (1973, 32).

With the doctor's power and authority being derived from the legal protections he or she enjoys as an agent of the state, the construction of knowledge backed by the institutionalised structures of the clinic extends to our understanding of the modern figure of the doctor. Foucault proposes that the "clinic was probably the first attempt to order a science on the exercise and decision of the gaze" (1973, 89). The "clinical gaze", which Foucault (1973) uses interchangeably with the term "medical gaze", is understood as an act of perception bound up with encoded knowledge. While the rigour of scientific inquiry suggests that the gaze re-orientated the doctor to a new awareness of the absolute empirical value of what they saw, this was only partially the case since advancements in technology at the cellular and molecular level was still beyond reach. Instead the gaze recalibrated the perceptual lens and transformed the way knowledge itself was received and dispersed.

With this perceptual shift, Foucault announces a new gaze and new language based in scientific ideas which supplanted the imaginary powers of superstition and religion: "after over-indulging in speculation, they [doctors] had begun to perceive once again, or they listened to reason rather than to imagination" (1973, xii). The doctor emerged with the ability to penetrate the hidden reality concealed beneath the veil of the patient's body. In this environment the doctor is empowered to

see what others cannot about the hidden workings of the body. Neither is the doctor's perception of the patient limited to a singular clinical encounter but is supported by "a collective consciousness, with all the information that intersects in it, growing in a complex, ever-proliferating way until it achieves the dimensions of a history, a geography, a state" (1973, 29). Here Foucault extends the singular medical encounter between doctor and patient to a generalised presence where a network of interconnected gazes merges across time and space and is held under the constant and mobile supervision of medical knowledge.

Returning to the fictional conflict zone of *Beyond Borders* in the Ethiopian famine, it is interesting to consider how aspects of the god-like ability associated with the surgeon persists even when removed from the more stable jurisdiction of the clinic or hospital. Having consented to help the mother and child that Jordan rescued against Tula's advice, Callahan operates on the wounded mother in order to stop her bleeding. When Jordan enters the make-shift operating room, she faces the grim reality of surgery without the necessary anaesthetic. She asks if the patient can be given something for the pain and Dr Callahan—in his patronising way—asks one of the nurses to call down to the pharmacy and order additional morphine. Within the context of the scene and its setting in an under-resourced environment, we understand there is neither a pharmacy nor morphine in the camp, nor is there any other medication for pain relief. Pausing for effect, Callahan directs one of the local medical staff to fetch a bottle of Fanta which is offered to the woman in the hope that the sweet fizzy drink might provide some distraction. Callahan then directs Hamadi, another local staff member, to ask the woman if she is able to endure the pain. Hamadi translates her whispered response into English: "She says she feels the pain of hunger, but knows that death [is] more hungry than pain, so she gives thanks, she gives thanks to you, she calls you by your name, 'the one who steals from death'"(Campbell 2003).

This scene might be read on multiple levels. A surface reading reveals the selfless volunteer doctor figure from the global North working in the conflict zone alongside local support staff to help those in mortal danger. There is the reliance on simple technologies and medicines designed for use in resource-poor settings where modern surgical technologies and drugs are not always available and might hamper rapid deployment. At a deeper level, the god-like power of the surgeon in cheating death alludes to an important shift in our perception of the doctor from a figure associated more with morbidity and death to one configured in the role of saving lives.

Foucault (1973) contends that the union of surgery and medicine represents a pivotal point for modern medicine and our understanding of the doctor figure. This point he patiently advances by correcting a misconstrued reading of medical history from the mid-1700s, in which pathology and

the dissection of the dead body was considered an outlawed and taboo topic for medicine (1973, 124-146). The real reason he advances for this cover-up was the need to dispel any damaging associations between the emerging knowledge of clinical medicine and earlier anatomical studies of the dead. Since surgical knowledge relies on an understanding of anatomy and the internal functioning of organs which is accrued through dissection, clinical medicine was required to first turn away from the idea of the doctor as orientated towards death which was associated with anatomical dissection. In this moment, "the medical gaze pivots on itself and demands of death an account of life and disease" (Foucault 1973, 146). Without this paradoxical and difficult reorientation medicine would not have escaped its fear of death in order to allow a more positive association with the cure and elimination of disease in the promotion of life. Reading the scene from this perspective, the honorific 'the one who steals from death' describes the surgeon's escape from the existential dilemma of being seen on the side of death; instead, he is cast as standing against its dominion.

This study now looks at how aspects of the doctor's authority, when subjected to stress within the chaotic forces of the conflict zone, becomes fractured in these distant locales depicted in the films where an idealistic belief in medical-humanitarian intervention takes precedence over all other considerations.

Neutrality of the medical intervention

The narrative in *Beyond Borders* begins in London in 1984, the same year that MSF deployed its doctors to Ethiopia to assist in the crisis there (R. C. Fox 2014). Dr Callahan's arrival in London coincides with the 25th anniversary ball for Aid Relief International, a fictional humanitarian organisation that has been funding his work. An irate Callahan storms into the formal dinner with the African boy named Jojo. He has brought the boy with him as proof of the conditions persisting in the camp which Callahan oversees in Ethiopia and to protest against the termination of his funding. The reasons for this are made clear in a letter he reads which has been sent by the evening's host, the head of Aid Relief International, informing him that "due to the repressive political climate we can no longer sustain a relief presence in Communist-supported Ethiopia" (Campbell 2003). When Callahan and the boy are physically removed from the premises, a Mr Steiger approaches him and offers to meet his funding needs in return for Callahan helping Steiger's people get into Ethiopia. Guessing that Steiger is actually working for the CIA, Callahan refuses his offer, asserting his independence and refusing to become involved on the side of any political interests in the Cold War dynamics playing out in Ethiopia. In this reading of the scene, Callahan's claim to independence from political influence mirrors the humanitarian logic that the provision of medical care to those in need takes precedence over all other considerations. In furthering my analysis of the filmic representation

of the doctor, it is necessary to briefly explain the political and legal concepts that underpin international law and state sovereignty. These aspects not only govern international humanitarian interventions, but also impact the function and authority of the doctor as a central figure in these undertakings.

As a founding members of MSF, Kouchner stridently supports meaningful action in response to actual disasters as the only form of direct intervention and dismisses talk as ineffective and unable to change reality on the ground (Boltanski 1999). For Kouchner, even action from a long way off is doubtful as it "also belongs to the order of the useless, of illusion and even mystification" (1999, 183). MSF insists that its independence from state actors and government funding allows action without regard for political considerations. Paradoxically, the organisation also recognises that its choice to remain non-aligned has political dimensions to it. Dr James Orbinski of the MSF International Council made the point in his Nobel Peace Prize acceptance speech on behalf of MSF when he stated that, "the humanitarian act is the most apolitical of acts, but if its actions and its morality are taken seriously, it has the most profound of political implications" ('The Nobel Peace Prize 1999' n.d.). Humanitarian interventions may not prevent war or suffering, but as Orbinski noted, the political implications of this intervention function on many levels including the ways in which it might limit the impunity of perpetrators.

From the launch of MSF in the 1970s it was clear that this group of radically independent-minded doctors was turning its back on orthodoxy by speaking out against the ICRC's handling of the crisis caused by Biafra's attempt to secede from Nigeria (Leyton 2007). A similar observance of the principles of state sovereignty had also accompanied the ICRC's response to the Holocaust and its failure to denounce the German government at the time (Weiss 2011).

The construction of modern sovereignty dates back to the Treaties of Westphalia of 1648 that ended the Thirty Years' War and set out the rights of states "to make treaties, declare war, legislate, levy armies, and impose taxation" (Teschke 2009, 241). These tenets were later expanded to include a respect for human rights whereby the definitions of sovereignty also required that the state assume responsibility for protecting its citizens and their property (Weiss 2011).

Limitations of unfettered sovereignty gained momentum following World War II and the international recognition of legal concepts like 'crimes against humanity' and 'genocide' which were

presented at the Nuremberg Trials of Nazi war criminals in 1945 (Sands 2017).[6] These legal and political concepts exposed the perpetrators to accountability by the international community and countered any defence that claimed impunity on the basis of legality within the jurisdiction of the sovereign state. Under international law it is currently understood that where the state refuses or is powerless to honour its obligations to protect the human rights of its citizens, "the residual responsibility to protect victims of mass atrocity crimes shifts upwards to the international community of states" (Weiss 2011, 18). Whatever justification the international community used to intervene by means of humanitarian action, MSF has always insisted on the primacy of its own values in maintaining independence from the machinations of state players (R. C. Fox 2014). In *Beyond Borders*, a similar response is echoed by Callahan's rejection of Steiger's funding offer in return for assistance with his political cause. Callahan's response is justified by the real political and ethical concerns that confront aid organisations and doctors involved in the delivery of emergency medical services.

In order to help those injured and in mortal danger inside the conflict zone, medical ethics and international humanitarian law require that assistance is rendered to assist the sufferers and to save as many lives as possible. Indeed, Callahan's actions in the scenes set in London and his return to Ethiopia uphold the ideal separation between state and humanitarian actors and express similar ideas to Kouchner's call for urgent and direct action based on a belief that the need for medical intervention overrides all other considerations (Boltanski 1999). Redfield's (2010, 191) claim that "ethics take definition through action" supports Kouchner's views on the prioritisation of direct action for groups like MSF, focused on the outcome of saving lives. This requires that doctors undertake their work "in the name of universal medical ethics and the right to humanitarian assistance" in order to provide help to victims of conflict or natural disaster without regard to their political, gender, race or religion ('Doctors Without Borders - Principles' n.d.). With these views in mind and in the face of media awareness focused on events such as Live Aid, MSF-France put aside further debates over the causes of the crisis in Ethiopia or assessment about future outcomes and elected for "clarity of action" (Redfield 2010, 177). As discussed in the triage scene from *The Last Face,* the neatly defined moral principles and theoretical ideas that justify medical intervention are limited when confronted by the realities on the ground. The moral and ethical debate informing the

[6] Philippe Sands (2017) traces the introduction the legal concept of 'crimes against humanity' at Nuremberg to Hersch Lauterpacht's argument that the 'community of nations' is justified to intervene in sovereign affairs to protect the rights of individuals who are endangered by the State. Sands credits Rafael Lemkin for the term 'genocide' as a more realistic application of the law because the concept includes individuals who are targeted based on their membership of particular groups rather than their individual qualities.

dramatic confrontation in the film's scene can also be read into MSF's real-life lesson in Ethiopia where it became apparent that in certain situations, medical and humanitarian intervention might actually do more harm than good (R. C. Fox 2014).

In *Beyond Borders*, the reluctance with which foreign aid workers shown in the film are received in Ethiopia by government forces is depicted in scenes where Callahan's presence is barely tolerated in the tense standoff with the army and other state officials. Real events offered much harsher lessons for MSF-France volunteers when they witnessed the death of an estimated six thousand children who were denied access to available aid by the government officials because "a sufficient number of them had not agreed to be resettled" (R. C. Fox 2014, 56).[7] Realising the uncomfortable reality that their presence had provided a degree of international legitimacy to the government's actions, MSF denounced the Ethiopian government and withdrew their medical services, after which they were expelled from the country (R. C. Fox 2014).

Neutrality within the conflict zone and the right not to take sides in such conditions was stated in the revised Chantilly Principles (Médicins Sans Frontières 1995). In reference to events such as those witnessed ten year earlier in Ethiopia, the phrasing conceded that in extreme circumstances where mass violations are witnessed the members may resort to denunciation in trying to assist those under threat. In situations where the doctor, while performing their duties in accordance with professional ethics, may render assistance to a patient from the opposing side in a conflict, whether civilian or military, protection from punishment was also upheld by claims to neutrality. This provision ensured that no doctor was forced to carry out a medical act which contradicts their professional code of ethics for the benefit or disadvantage of one side over another (Médicins Sans Frontières 1995).

The view of this study is that the intrinsic logic of neutrality and impartiality asserted under the practice of medical ethics by organisations like MSF, is made manifest in the representation of the doctor figures in both films. Subjected to various stresses in the film narrative, the character of Dr Wren Petersen in *The Last Face* becomes a site of fracture and opens this exploration to a consideration of the discontinuities represented by the imagined conflict zone. The limitations of

[7] Realising the value that the presence of international aid groups, like MSF, lent to the legitimacy of the government's collectivisation policy in northern and south-eastern Ethiopia, President Mengistu ordered the military to forcibly recruit members and sign up others from among the destitute gathered at the feeding centres for relocation according to government resettlement quotas (R. C. Fox 2014).

medical ethics as a justification for neutrality in humanitarian action will frame this study's approach in the next section to a climactic scene from *The Last Face*.

Crisis of medical ethics and the humanitarian mission

Viewing of *The Last Face* for the study reinforces the observation that the doctor/god myth is conspicuously absent in the film. However, in its place the contemporary figure of the 'heroic' selfless volunteer, willing to work in dangerous conflict situations while placing their lives at risk in order to save those less fortunate, evokes a similar register of the saviour figure. In expanding on the main characters in the film, this section interrogates the film's treatment of the doctor as a flawed individual, weighed down by medical ethics and philosophical concerns as they struggle with the lack of adequate medical resources for providing the help that is needed.

The idea of the emergency response to suffering on an international scale has been characterised as a particularly modern conception of the world (C. Calhoun 2010). This view, shared by C. Calhoun and Packard (2016), emerges out of modern liberal democracies and the industrialised and wealthier countries of the global North and considers the interconnected nature of the world as important in respect to their dealing with the poorer states of the global South. In reaction to chaotic eruptions, whether by human action or natural disaster, the humanitarian response embraces a liberal view of equality between all people. This view imagines "humanity in the abstract, as it were, in their mere humanity, disembedded from kinship, religion, nationality, and other webs of identity and relationship" (C. Calhoun 2010, 35) but also acknowledges that these values might not be universally held, and, would be actively contested in certain quarters. The idea that this liberal view of the world, backed by a willingness to provide financial and material support, is a uniquely Western perspective is questioned in this research. South Africa's Gift of the Givers Foundation, which is motivated by Islamic notions of charity and service and provides medical support and aid in many African countries, the Middle East, Asia and Eastern Europe, challenges easy assumptions that humanitarian work is confined to the wealthier countries of the global North (Gift of the Givers Foundation n.d.). The point to be made from this is that attempts to identify any form of ethical "universalism" are closely aligned with the practice of medical ethics and its assumed right to treat those in need without regard to political considerations as MSF's "without borders" vision suggests (R. C. Fox 2014, 6). These principles are helpful when approaching the following scene from *The Last Face* where the dramatic situation tests the carefully constructed figure of the doctor operating under MSF principles.

My reading of the scene, questions the reliance on medical ethics to steer the doctor through stressful situations within the conflict zone. The events play out when the doctors are surrounded by

the bloodied survivors of a massacre set in a hospital located somewhere near the Sierra Leone border.[8]

Here the team of doctors from Petersen's group work alongside others wearing MSF insignia who are also trying to save what casualties they can without the necessary resources to deal with the severity of the medical trauma. A severely injured woman, one of the survivors of the attack, begs Petersen to find her daughter. When Petersen is unable to locate her among the survivors, the woman begs her to help her die (Penn 2015). Upon viewing the scene, the woman's cry for help seems impossible for the doctor to entertain within our understanding that doctors are devoted to the saving of lives. Yet within this chaotic and violent configuration of the conflict zone it becomes apparent, as the scene develops, that moral certainty does not adhere to clear-cut principles and tidy theoretical positions. Overwhelmed by the brutality of the scene and without the necessary medical supplies to save the suffering woman, we are witness to Petersen's transgression as she oversteps the basic medical principle that the doctor shall do no harm to her patient and administers a fatal dosage to end the woman's suffering. The other doctors condemn her actions but none actively intervene to stop her as they work on the patients in front of them (Penn 2015).

These findings suggest that two opposing views might be formed around Petersen's actions: while the terrible suffering of the woman and the loss of her daughter mitigates Petersen's merciful killing, the doctor—sworn to uphold certain principles—has no justification for taking a life. Whichever position one takes, the outcome of the scene obscures medical ethics and its boundaries within the conflict zone, and also reveals the limitations of the humanitarian mission. Viewed in this way, the scene fractures the viewer's faith in the carefully-constructed central figure of the selfless volunteer-doctor, a saviour figure able to function under extreme conditions. Realising the limitations imposed on the team by the scarce resources and her lapse in medical judgement, we see Petersen's decision to withdraw the team because, in her assessment, they are no longer able make a difference.

Dr León chooses to remain in the conflict zone and work alongside the other medics as the others withdraw. His actions restore some legitimacy to an organisation committed to providing medical assistance and mitigate the dire consequences its withdrawal might have for those dependent on it

[8] The choice of setting is not without historical reference. During the Bentiu Massacre in 2014, the South Sudanese Government claimed that over 400 non-Nuer people and Sudanese were killed by anti-government Nuer-led rebels, and many of those reported to have lost their lives were killed in the town's main hospital (Copnall 2014).

for help. For narrative purposes, León's decision to return drives the romantic arc of the film as the audience is left wondering if the two lovers will ever overcome the physical barriers of the conflict zone which keeps them apart. At a sub-textual level, León's decision to remain functions to redeem the doctor figure following Petersen's transgression of medical ethics in assisting her patient to die. His actions remind us that the doctor, no matter their spatial or geographic location, depends for their legitimacy and power on the hospital, even when it is reduced to a rudimentary emergency dressing post.

The clinic and the conflict zone

The doctor's response to suffering in the African conflict zone, which relocates this figure outside the European clinic or hospital, invites speculation on how this distancing from the institution that Foucault sees as the source of the doctor's powers, should be read in the scene described above. Even as events lead to Dr Petersen to overstepping the boundaries of medical ethics and the team withdrawing their medical services, the authority of the doctor is not diminished. As explained earlier, the clinic, as a site of modernity for Foucault (1973), implies a system of knowledge and power associated with medicine and its emergence as a modern clinical science. Within the 'ruin' of the clinic these power formations persist around the doctor figure, even as the legitimacy of the humanitarian intervention is called into doubt.

How might we understand this configuration of knowledge and power where the once ordered space associated with Foucault's institutional setting of the 18th century European clinic, is rendered as a ruin? In this version, the remnants of the old hospital are repurposed as an emergency dressing post for "vital emergency measures including the beginning of resuscitation" (Giannou and Baldan 2010, 22) where the doctors struggle to save the casualties. To analyse the layers of meaning that arise with these images of the ruined clinic within the African conflict zone, Mudimbe's important work in *The Invention of Africa* (1988) is necessary.

Drawing on Foucault's understanding of knowledge as a form of power, Mudimbe (1988, 71) considers 19th century Eurocentric influence on the social studies, anthropology in particular, and how these writings "depict the essential paradigm of the European invention of Africa: Us/Them". In his careful dissection of Western epistemology he not only demonstrates its enduring influence over knowledge and power in Africa, but advances a dialogical interpretation of these theoretical perspectives. He demonstrates how the "conceptual framework of African thinking has been both a mirror and a consequence of the experience of European hegemony" (1988, 185). Within his analysis, European Enlightenment relies on the invention of Africa to justify and define its philosophical modernism as everything that Africa is not. Similarly, the dressing post scene in the

film, staged within the 'ruin' of the clinic, might also be read as functioning in this way. If, as I argued, the intention of the scene, within the narrative logic of the story, is to depict the doctor and the humanitarian response on the verge of crisis, then the ruined hospital can also be read in opposition to the 'ideal' represented by the ordered institutional clinic of which Foucault (1973) writes. From this perspective, the cinematic performance of the uniquely chaotic force of the African conflict zone capable of visiting destruction on hospitals and innocents alike, also implicates the West and the emergency medical doctor, as an agent of its operations.

Harrow (2007) extends this theoretical lens in criticising assumptions that tend to forget the reliance on the 'other' in constructing the European self-image when discussing how these differences are reproduced in early *Tarzan* films or in *King Solomon's Mines*. In rejecting an overly simplistic binary analysis of these cinematic representations intent on reproducing ideas of Western superiority, Harrow advances his intention for "a study of African cinema from within the zone, and especially from within the contact zone," for this he states: "A new space and time are required for the terms of modernism and globalization to be understood as the property of that zone" (2007, 20).

In contemplating ideas of modernism and globalisation together within the contact zone, not only does Harrow propose enclosing a period extending from the 19th century to the present, but his words also encompass an earlier analogy in this thesis. In mobilising the comparison between medical and film services, I referred to the globalised response of these two very different operations to explain the integration of political and legal concepts into my analysis of the film text configured around the central doctor figure within the imagined African conflict zone. This analogy is extended into the next chapter which considers how film services are utilised within the filmed aesthetic of the conflict zone.

The next chapter considers the representation of emergency medical services within the conflict zone and the aesthetic and narrative choices which commodify the humanitarian subjects of suffering. These morally complex arguments are examined in relation to the films' construction of the 'humanitarian gaze'.

CHAPTER THREE

THE AESTHETICS OF EMERGENCY

Introduction

The previous chapter concluded within the filmed setting of a shattered clinic set in an imagined conflict zone somewhere near the border between Liberia and Sierra Leone. Supposedly set during the Liberian Civil War in 2003, these scenes were staged in South Africa in 2014 for the narrative film *The Last Face* (Penn 2015). Building on ideas introduced from Mudimbe (1988) and Foucault (1973), this chapter draws on Achille Mbembe's (2001) explanation of how Africa and the West encounter each other through the theoretical and practical consequences of violence. I engage with the 'aesthetic of emergency' in the opening scenes of *The Last Face* and develop a critical framework to analyse the imagined conflict zone and the fictional narratives produced in these distant locations. The discussion also considers scenes from *Beyond Borders* (Campbell 2003) which was filmed in Namibia in 2003. My exploration of this aesthetic of emergency turns to the analogy between film services and medical services and how these very different operations overlap in sometimes unexpected ways. Applying a Metzian framework involves a parallel assessment of the cinematic fact and film services (locations, crew and background actors) and their contribution to the aesthetic construction of the filmic fact, examined in the interpretation of meaning represented by the film text. For this, I rely on ideas derived from other fields of study to deepen our understanding of how the mode of emergency is represented in the films to construct the fictional doctor figure. In reading this aesthetic of emergency in key scenes from *Beyond Borders,* I trouble the blurring of boundaries between fact and fiction. I do not attempt a complete analysis of the films, rather I am guided in my thematic and analytical selection of certain scenes that are relevant within the interdisciplinary approach already identified. Beginning from a historical perspective, I trace the emergence of photography and its importance in humanitarian causes before moving to certain scholarly works on contemporary photojournalism and the images of real suffering they depict. This approach invites a deeper critical reading of the fictional performance of humanity's suffering within the cinematic imagination and explores the positionality of the doctor figure within the complexities of the humanitarian gaze.

The humanitarian gaze, within the fictional setting of the conflict zone, depends on the artificial reproduction of humanity in all its suffering. In reading this construction, a deeper insight into the political and aesthetic choices is required.

Imagining the African conflict zone

Without discounting the widespread violence, coercion and oppression of the postcolonial state, Mbembe (2001) seeks a more nuanced reading of Africa's current condition, well aware of the historical antecedents, and the systems that have replaced it. Whether through a reliance on patronage, transfers and coercion, he considers the implications of state violence in ensuring continuity of statehood and political power where these are under threat (Mbembe 2001). In identifying the persistence of violence in Africa, Mbembe points out that it was through colonialism and slavery that Africa first really encountered modernity, resulting in "a lingering doubt of the very possibility of self-government, and with the risk, which has never disappeared, of the continent and Africans being again consigned for a long time to a degrading condition" (2001, 13). These insights are helpful in contextualising the fictional scenes that open *The Last Face* (Penn 2015) which are discussed next.

Dr Petersen's opening voice-over in *The Last Face,* which can be heard as the doctors and support staff rush to escape Monrovia ahead of the rebel attack, reads:

> God and colonialism had visited upon Liberia a particular ugliness in the nature of their war. Heroic adults assassinated and forced to flee and children stolen from their families compelled into battle provided with a myth of their own invincibility. Those not convinced of their own invincibility bravely plead for the help we could no longer offer.
>
> (Penn 2015)

A closer examination of its phrasing reveals how it delinks the past with its mention of colonialism from any causal connection to the description of the unique horrors of the current war. This distancing of history from the present conflict achieves the desired narrative outcome of raising the dramatic stakes in the film for the medical team. In this description of the quickly deteriorating conflict, the voice-over plays out over visuals depicting a fictional reimagining of the rebel attack on Monrovia. The Liberian people are described as trapped in a conflict for which the only explanation is one based in the myth of invincibility in battle. This reading shares problematic associations with colonial stories that promoted generalised views about the inevitability of an Africa gripped by "a pre-ordained madness" where the worst of human excesses and the terrible consequences of living outside rationality and restraint are constantly on display (Mbembe 2001, 176). When an overriding temporality of the present is conflated with thinking about emergency as C. Calhoun (2010) expresses in the thematic of emergency, these media-hyped images of conflict and collapse result in discourses that delink politics from cause and effect. A failure to understand the cause of these

eruptions reproduces colonial discourses that confirm Hegel's view of Africa as a place that "never attains to immanent differentiation or the clarity of self-knowledge" (Mbembe 2001, 173).

Mbembe (2001), like Mudimbe (1988), points to the futility of trying to define Africa as separated from the West by some vast insurmountable gap, asserting that there is a persistent denial of African humanity due to a Western self-image which negates everything that does not match up to itself. These ideas are understood in the context of this research as founded upon notions of racial superiority and used to justify slavery and colonisation. The misguided beliefs over inequalities between Africa and the West were strongly underpinned by a belief in the superiority of European scientific rationalism over other forms of knowledge (Mbembe 2001; Kramer 1993).

When this thinking is applied to the scene unfolding during Petersen's voice-over, the doctor figure, and by extension the humanitarian mission itself, is relocated to the madness that enthrals both victim and perpetrator in the violence and bloodshed of the conflict zone. Discursively, the presentation functions to depict Africa as everything that Europe or the West is not. As shells explode around them, Petersen's words call into doubt the viability of the state, and insinuate that Liberians are suffering by their own hand. It is under such situations that international humanitarian law dictates that intervention override sovereign concerns in order that citizens be protected from the brutality of their own governments (Weiss 2011). In expanding on the cinematic representation of what Petersen refers to in her voice-over as "a particular ugliness" it is necessary to consider debates around the representation of violence in films within the African setting.

Sontag (2003) points out how photographic images contribute to expectations of postcolonial collapse and promote the notion of Africa as perpetually gripped by inexplicable violence. Sontag's views are helpful to this research in understanding how factual and fictional images of suffering feed harmful expectations of postcolonial collapse and the sense of such incidents being inevitable in African countries. Within the context of the cinematic imagination, Sontag (2003, 69) refers to the way iconic war photographs of D-Day in World War II were restaged in *Saving Private Ryan* (Spielberg 1998). This muddling of fact and fiction is important to our understanding of how real events are restaged in the narrative films under discussion and will be developed across this chapter.

The spectacle of violence

In approaching the difference between films made in Africa for predominantly non-African audiences and those produced by filmmakers from Africa targeted at African audiences, we must first understand the term 'runaway productions' in regard to those films emanating from the commercial hub of Hollywood. As already explained, both films analysed here are runaway

productions that travelled to South Africa and Namibia to make use of the film services available in those film-friendly locations. Dave Calhoun (2007) points to a dominance of certain modes of commercial filmmaking which can be traced through these and other recent films set in Africa but aimed at non-African audiences. He considers films like *Blood Diamonds* (Zwick 2006), *Hotel Rwanda* (George 2004), *The Constant Gardener* (Meirelles 2005), *The Last King of Scotland* (MacDonald 2006) and *Catch a Fire* (Noyce 2007) to be "white conscience films" (2007, 32). This subjectivity, he explains, is derived from a reliance on white protagonists who, for commercial reasons, are deployed to guide the viewer through the suffering which is experienced overwhelmingly by the black characters in the stories.

The Last Face and *Beyond Borders* share many of these characteristics in their reliance on white doctor protagonists while offering the black African characters as mostly voiceless recipients of humanitarian help. Rather than dismissing these films on the basis that they are overly simplistic representations symptomatic of ignorance and commercial pressure, this study argues that when the films are viewed through the thematic of emergency, the opportunity arises to probe beneath these obvious shortcomings. Through constant exposure to images from African countries depicting violence and suffering (Sontag 2003), Western audiences have come to expect the formulaic storylines that fall back on these media-hyped representations. Whether in *The Last King of Scotland* (MacDonald 2006) depicting Amin's Uganda, or *Blood Diamonds* (Zwick 2006) regarding Sierra Leone's civil war, the films contrive various cinematic stylisations of violence that "desensitises [the viewer] to the associated traumas as they focus on the surface and superficial fun representation of violence embedded in style" (Dokotum 2014).

When violence is harnessed within narrative tropes set in the conflict zone, the result is that problematic stereotypes of collapsed states may be exploited to perpetuate Hegelian ideas of Africa as a continent outside of history which is fixed in the Western mind as in a state of constant strife and inexplicable violence (Mbembe 2001). The enduring nature of these colonial ideas is illustrated by French President Nicholas Sarkozy's July 2007 speech at Dakar's main university when he said: "The tragedy of Africa is that the African has not fully entered history [...] They have never really launched themselves into the future" (Ba 2007).

In turning to the representation of violence in *The Last Face,* it is worth remembering Calhoun's (2007) concerns about how mainstream media images of famine, internecine violence and postcolonial collapse are frequently reproduced in the fictional imagery of Africa. I am interested here in the ways that photojournalism and other documentary sources influence cinematic narratives and blur the boundaries between fiction and reality. Sontag's (2003) caution over the use

of documentary images of war to bolster the fictional restaging of such events, focuses attention on the requirement for heightened verisimilitude in these portrayals of violence. The ways in which these journalistic images influence cinematic recreations is the subject of a scene from *Beyond Borders*, which I return to later. It is this realistic portrayal of fictional violence which Dovey (2009) also laments for its horrific delight. Dovey's interest in the portrayal of violence in films set in Africa rejects the Afro-pessimists who choose to view the continent as precariously poised on the verge of destruction (2009, 26). According to her, this racist view is based on the mistaken belief that Africans are unable to rule themselves. Dovey advocates the need for a deeper analysis which would also avoid another convenient view: that all postcolonial problems can be traced to historic events like colonialism, slavery and apartheid. Dovey worries that simplistic explanations for all contemporary problems as rooted in the past only "patronises Africans by assuming that they have no agency" (2009, 26). Nyasha Mboti (2014) draws attention to the importance of reading representations of violence in cinema with a constant vigilance towards context and history and within analytical frameworks that also advance a critical understanding of these depictions. Like Dovey, Mboti is interested in the forms of violence represented by African filmmakers and how these might be read for a deeper understanding of Africa's cinematic imagination because these interpretations might offer insights beyond the international filmmakers' shallow focus and avoidance of the complexities of African reality.

In tackling the treatment of film violence it is important to consider that the problematic representations of conflict and violence in Africa do not exist only in the imagination of the mainstream media of the global North. As Nigerian writer and Africa's first Nobel Literature laureate, Wole Soyinka, reminds us, the loss of life that feeds wide-scale dehumanisation has become emblematic for many parts of Africa which seem locked in "a permanence of violence" (Saks 2010, 31). While Dovey (2009) acknowledges that violence is central to the African filmmaker's imagining of the postcolonial state, she rejects the notion that violence is central to African filmmaking. Mboti considers depictions of violence as a symptom of the normalisation of violence which has become "endemic to our socio-economic-order," warning that "these violences are neither things of the past nor things that only abnormal people do. Rather, *they are us* [author's italics]" (Mboti 2014, 130).

In questioning the treatment of violence by African filmmakers, Dovey (2009) considers the very act of representing violence as potentially a powerful critique of how Africa is represented by dominant Western media as inherently violent. In accepting that the medium of film is complicit in the manufacture and representation of violence for the primary purpose of appealing "to the fantasies of the viewer as voyeur", Dovey argues that cinema can "achieve a critique of violence in a way that

is not available to the verbal, concept-bound, rational critique of the traditional disciplines" (2009, 32). She takes this argument further by enlisting African filmmakers in a healing process of the traumatised individual fractured in the colonial aftermath.

How does violence operate in *The Last Face* and *Beyond Borders* and within the aesthetics of emergency? The violence in the films is integral to the narrative centred on the doctor figure within the humanitarian emergency; it justifies the immediate need for therapeutic intervention to save the 'imagined' sufferers in mortal danger. The films substitute the need for an explanation for the causes of medical trauma depicted with a ready-made response that these wounds are received as a consequence of violence and that it is the doctor figure who offers resolution by treating the suffering. The insertion of the doctor into these scenes alters the audiences' relationship and dispels the voyeuristic attraction often associated with looking at images of violence which Sontag describes in terms of our "morbid fascination of looking at images of dead human bodies which might grow from the gruesome spectacle which both attracts and repulses at the same time" (2003, 88). Within the medical context, the violence represented in these narratives appears to fit neither the category of the sensational or superficial, nor does it set out to re-historicise violence in order to offer a rational critique or liberatory outcome. In trying to understand how these images of suffering construct the humanitarian gaze within the filmic texts, this study turns to the thematic of emergency in order to focus on the narrative choices expressed in these films.

Filmmaking and the humanitarian impulse

The desire to intervene where humanity is perceived to be in trouble is one of the defining aspects of the modern age (McFalls 2010). The therapeutic intervention in particular arises from this. The justification for humanitarian intervention is that state sovereignty can be superseded, if only on a temporary basis, to protect citizens from atrocities committed by their own governments or by the incapacity of the sovereign (C. Calhoun 2010).

The images of suffering from far-flung emergencies which accompany these responses have become an important public catalyst for action from those societies that are willing and able to offer help and assistance (Chouliaraki 2006, Chun 2011). However, the great distances and costs associated with action means that these interventions are restricted to governments and large organisations capable of mobilising the resources and skills necessary for an effective emergency response (Packard 2016). A saturated media landscape with various causes clamouring for attention means that celebrity actors are useful in media campaigns intended to create awareness of specific conflicts and emergencies. Stars like George Clooney, Sean Penn, Angelina Jolie and Oprah Winfrey (CNN 2006; B. Fox and Daniel 2012; Sims 2014; Starr 2005) are just a few of the more prominent

personalities who appear on our media screens as they use their public profiles to draw attention to a range of humanitarian issues in Darfur, Haiti, South East Asia, and in their support for victims of Hurricane Katrina in the USA.

Jolie's research into the character of Sarah Jordan began years before *Beyond Borders* was made and brought her in contact with the United Nations High Commission for Refugees (UNHCR) (Sims 2014). Jolie's desire to tell a story about the UNHCR's work, which had become a significant part of her life, is frequently referred to by the filmmakers of *Beyond Borders* as one of the main reasons that financing for this production was possible (*Behind the Lines* 2003). The humanitarian impulse behind the film is clearly enunciated in the closing captions: *This film is dedicated to all relief workers and the millions of people who are victims of war and persecution. They continue to inspire us all with their courage and will to survive* (Campbell 2003).

Sean Penn's encounter with a wider-range of qualities among relief workers, including those which he describes as "akin to the worst of Hollywood ambitions" (B. Fox and Daniel 2012) during his two-year stint helping some 40 000 survivors of the devastating earthquake in Haiti in 2010, offers another perspective. In the same interview, Penn makes it clear that his impulse to act is expressed in different forms, through direct action in Haiti or by making a film such as *The Last Face*. This study assumes that the more nuanced treatment of doctors and the paradoxes of humanitarian work which surface in his film are likely to have been informed by his real-life field experience. Such complexities appear in the triage scene and in the hospital massacre scene, which is resolved in a crisis of medical ethics and the partial withdrawal of the humanitarian mission. The sometimes uncomfortable portrayal of doctors in the film is missed in *The Hollywood Reporter* review of the film (Rooney 2016). Ten years later, in an overview of Jolie's filmmaking career, *Beyond Borders* was identified as a low point among other generally unsuccessful attempts on her part to use cinema to convey messages she felt strongly about (Sims 2014). Jolie and Penn have acted on their humanitarian impulses in real-life situations and through the production of fictional narratives such as the films discussed. In lending their names and popularity to these films, they hope to bring attention to the humanitarian suffering and the importance of medical intervention to a wide audience.

In defending the need to entertain while making a narrative fictional film rather than a documentary, both Penn and the producers of *Beyond Borders* acknowledged the very real commercial challenges they faced in trying to reach a wide audience with a film set against the backdrop of human suffering and conflict (*Behind the Lines* 2003; Ford 2016). Calhoun (2007, 34) blames international market pressures for enforcing narrative conventions which insist on white

American or European protagonists telling the stories of black African suffering. It seems the overall poor box-office performance of both films (Box Office Prophets 2003; Box Office Mojo 2016) condemns the logic of these narrative choices, based as they are on the misguided racial assumptions by some filmmakers and distributors concerning the viewing preferences of non-African audiences. Although a racial bias may have influenced the casting choices of the narrative protagonists in *Beyond Borders* and *The Last Face,* the need to headline well-known film stars was also a likely consideration in reassuring investors of the potential financial returns. Whatever the reasoning behind the casting of white actors in the main roles, it is the large number of background actors depicting the scale of black African humanitarian suffering that I want to focus on next.

The Hollywood Reporter points out the overriding lack of individual identity among the African characters in *The Last Face* and criticises the treatment of these voiceless subjects as "just being bleeding wallpaper" (Rooney 2016). Repeated viewings of both films substantiate the criticism that shallow depictions of the African characters juxtaposed by the foregrounding of their suffering within the conflict zone characterise these films. Having considered the individual humanitarian impulse of the filmmakers and the ways in which violence is configured within the conflict zone, it is important to consider how these audio-visual tropes are mobilised in the aesthetics of emergency.

The humanitarian gaze

While engaging critically with the themes of the doctor figure in the films, it is necessary to ask how certain aesthetic and narrative choices utilise the film services available to the filmmakers to produce the temporal and spatial urgency associated with the delivery of emergency medical services. In proceeding with this line of inquiry, this study considers how the representation of Africans positions these subjects within the humanitarian gaze.

Pooja Rangan, in probing the documentary form of filmmaking, is interested in how "disenfranchised humanity is repeatedly enlisted and commodified to corroborate documentary's privileged connection to the real" (Rangan 2017, 2). Rangan also draws on Craig Calhoun's writing around the idea of "emergency thinking" (C. Calhoun 2010, 31) to resolve questions around "aesthetic, formal, and narrative tropes" (Rangan 2017, 4) linked to the idea of emergency within the documentary film. My application of similar ideas derived from political theory to explain humanitarian aid are distinct from Rangan's focus on documentary filmmaking. I argue for their use in reading fictional narrative strategies and how these are deployed in the cinematic imagination around the central figure of the doctor within the emergency humanitarian setting within an imagined African conflict.

The fiction films discussed here make no such claims to the 'real' as Rangan's documentary film examples do, but instead to a certain verisimilitude in the portrayal of setting and the medical encounter within the violence of the conflict zone. So important is the suspension of disbelief in the restaging of the narratives, that huge effort is expended by the production in approximating the 'real' in the various scenes that are imagined in the films.

Consider the requirements in the making of *Beyond Borders* for the setting of the refugee camp and feeding centre to portray the dramatic events of the Ethiopian famine of 1984. The set, which was constructed in Namibia in 2002, is central to the African portion of the narrative. In the film, Dr Callahan describes the camp as holding 30 000 displaced Ethiopians in desperate need of help, which required that the location convey a scale commensurate with this fact. An account of the construction challenges involved in making the set is provided in the documentary film *Behind the Lines* (2003). The construction crew under designer Wolf Kroeger, first had to build an eight kilometre road to access the remote site before building the massive set sprawled across the Namibian landscape. The camp needed to include a school, clinic, feeding centre, living quarters and various other infrastructure to approximate the real-life setting (*Behind the Lines* 2003). Integral to the plan was the provision of water, sewerage and generators for electricity to support the construction crew during the building period. Voicing his satisfaction with the final results, Lloyd Phillips, one of the producers, noted that "the set is very authentic. It is a mixture of a number of camps" (*Behind the Lines* 2003). This verisimilitude creates a compelling backdrop for the audience and the narrative tropes operating in the film.

Popular interest in the country at the time of the film's production near Swakopmund prompted frequent national press coverage by *The Namibian* newspaper (Barnard 2002a; 2002b). Certainly the presence of international stars like Angelina Jolie and Clive Owen contributed to the media attention, but much of the public interest seems to have been on the work opportunities the production offered to Namibians and South Africans. Over 100 South African and Namibian crew were utilised in the production and over 2 000 thousands extras were recruited as refugees for the large scenes that depicted the scale of the humanitarian crisis in and around the camp (Barnard 2002b). To provide for the narrative demands of the story, the life-threatening risks faced by the doctors in supplying their fictional medical services are only justified by the levels of mass suffering on screen. The film services described here are a direct consequence of the scale of the humanitarian disaster envisaged by the filmmakers. On 7 March 2002 *The Namibian* ran a story about the number of local jobs created and the lengths the production had gone to meet the needs of the extras cast in the film. Quoting Phillips, the article stated that the production paid

“competitive” salaries to the extras while also “employ[ing] a separate caterer to look after any special dietary requests, as well as a medical team dedicated to the extras" (Barnard 2002b). Interestingly, the analogy between medical and film services is not limited to the film aesthetic and the suspension of disbelief required for the imagined conflict zone, but also extends to the provision of actual medical services to care for the large number of background actors required for the filming. When asked about rumours that Ethiopians would be flown in as extras, Phillips stressed that it made more sense to cast local people. He went on to explain that one of the main concerns about the production going to Namibia to shoot the Ethiopian famine scenes was that they would be able to cast extras who would be believable in having the "look of people in need of help of a relief agency” (Barnard 2002b).

Similar concerns for verisimilitude drove the recreation of the conflict zones in *The Last Face*, which were restaged in South Africa thousands of miles from where events in the film originally played out in Liberia and Sudan. Producer Bill Gerber explained that, prior to finding the locations in South Africa, the director, Sean Penn, and the cinematographer had undertaken a trip to West Africa in order to see the original settings in Monrovia and Liberia (Jang 2016). After seeing the available locations in South Africa, “everyone was satisfied that we could double the landscape accurately and that it would make for great filming” (Jang 2016).

Despite all the attempts by these productions to approximate the real-life settings and people within the conflict zones, critical reception of the films was swayed against the representation of images of suffering deployed in these fictional narratives (Ebert 2003, Rooney 2016). *Beyond Borders* was met with a generally unfavourable response by the non-African audience for which it was intended. Ebert (2003) singled out one scene in particular to illustrate the problematic way in which the film uses images of suffering. This is the moment when Jolie’s character, Sarah Jordan, stops the convoy of food aid in order to rescue the starving Ethiopian child and the mother (Campbell 2003). He laments the lack of decency in the way “the suffering of real children is used to enhance the image of movie stars who fall in love against the backdrop of their suffering” (Ebert 2003). By highlighting this moment, Ebert’s concern for the how the figure of the child is enlisted in the narrative film also recalls Rangan’s (2017, 5) observations on the “production of humanitarian commodities” in the documentary film. The fictional construction of the humanitarian gaze around the figure of the suffering child and mother draws on a long tradition extending back to the emergence of photography as a documentary form.

In framing the discussion of this scene it is necessary to first consider how the visual trope of the non-Western mother and child have been employed as emblematic of the humanitarian cause.

These ideas have found consistent use in humanitarian imagery dating back to the earliest use of photography in the 1800s. At the start of the 20th century, images galvanised public opinion to act against the enslavement and mutilation perpetuated on Africans in the rubber trade in the Belgian Congo (Fehrenbach and Rodogno 2015). Chouliaraki (2006) points out how hard it is to conceive of the exponential growth of the humanitarian sector since the 1970s without considering the impact of images of human suffering, which were circulated with increasing frequency through print and electronic media from the 1980s. Supporting this view are the many cases, from Africa to Russia, the Middle East to central and southern Asia, where the figure of the child became emblematic of the human desire to help and marshalled assistance and aid to be dispatched to places where humanity was perceived to be in trouble.

During the floods in Mozambique in 2000, South African and international media devoted airtime to the story of Carolina Chirindza: the birth of her baby Rosita and their rescue by a South African Air Force helicopter. Months after these mediatised images of a mother in childbirth had gripped the imagination of a global audience, Carolina and her daughter travelled to Washington D.C. on behalf of the victims to lobby the US government to provide more aid to help the tens of thousands caught up in the devastating cyclone (Agence France-Presse 2017). In the subsequent ten years, images of the 2004 Indian Ocean tsunami which claimed hundreds of thousands of lives reached international screens with the shocking impact of countless dead. Dhiraj Murthy (2013), writing about media coverage of the disaster, describes how different mediatised depictions presented the dehumanised mass of nameless Asian victims as 'others' while offering individual stories of missing babies, such as the rescue of 'Baby 81' in Sri Lanka. This story was picked up by BBC, CNN and carried by most major international newspapers. It turned the as yet unclaimed and unnamed infant into a global media icon of the tsunami and resulted in increased support and donations for the reconstruction efforts (Murthy 2013). In 2015 the images of Alan Kurdi, a three-year-old Syrian refugee lying face down in the water on a Turkish beach in Bodrum, went viral on social media before being carried by newspapers and television channels around the world. Pictures of the lifeless boy became a powerful symbol of the human cost of the war in Syria and highlighted the plight of Syrian refugees (Fehrenbach and Rodogno 2015).

This study is less interested in whether these images may have shifted public opinion in the West or influenced Germany to accept larger number of refugees while other countries turned them away. Instead, what is relevant to my argument is the ways in which these and similar images deployed by modern media technologies have been used to win over public opinion about humanitarian causes by utilising powerful tropes and narratives centred on ideas of the suffering of the 'mother and child'

or the ‘child alone’. One of the most famous of these images is the Pulitzer Prize-winning press photograph taken in 1993 by the South African Kevin Carter, who captured the image of a vulture stalking an unnamed infant during a famine in Sudan (Geurts 2015).

The picture was quickly picked up by multiple news outlets and became an iconic reminder of Africa's anguish as hundreds of people contacted the newspaper to find out what had happened to the malnourished child (Geurts 2015). Carter’s vagueness about the fate of the child and his lack of assistance only compounded questions and public debate around the ethical dimensions of such photographic practices (Fehrenbach and Rodogno 2015). As mentioned earlier, fictional representation of actual events in narrative films have used documentary news images to inform the aesthetic choices by making these scenes appear more realistic (Sontag 2003).

A closer viewing highlights certain elements of Carter’s image that are also present in this scene from *Beyond Borders*. These compositional similarities seem to inform Ebert’s (2003) consternation over the vulgar use of the suffering of real children within the narrative of the film. It is likely that Ebert and the filmmakers were familiar with Carter’s image, which *The New York Times* ran on 26 March 1993 in its coverage of the suffering and famine in Sudan (Geurts 2015). Re-imagined in the film, the foreshortening effect seen in Carter’s use of a telephoto lens is dispensed with but the key elements of the vulnerable child and the looming vulture are maintained in the frame until the moment Jordan intervenes and chases the scavenging bird away in order to rescue the child. In this reimagining of the Ethiopian conflict zone, it is possible to see how the conflation of Carter’s photojournalist lens with the cine camera’s narrative subjectivity results in what Sontag (2003) identifies as a slippage of reality towards fiction.

Sontag (2003, 69) refers to the way iconic war photographs of D-Day in World War II were restaged in *Saving Private Ryan* (Spielberg 1998), resulting in a blurring of fact and fiction. Similarly, the adaptation and restaging of Carter’s famous press image taken in South Sudan to the cinematic representation of the Ethiopian famine of 1984 alters the meaning of the authentic press image. As a record of real events, where nothing is staged, it becomes like a still from the movie, where everything is fiction. Sontag does not imply that the proliferation of these images renders them ineffectual. Instead, she directs her criticism at those who claim that over-exposure to such images of suffering result in a reduced response, attributing these views to “cynics who have never been near war and the war-weary who are tired of being photographed” (Sontag 2003, 99).

Ebert’s (2003) rightfully judges the use of the image of the starving African child within the fictional narrative as a backdrop to bolster the romantic narrative of the Western lovers. In commodifying

this fictional setting of suffering, the humanitarian gaze draws on a long tradition of images depicting mother and child to reinforce the idealism of the West's humanitarianism (Rangan 2017; Fehrenbach and Rodogno 2015). Understandably, Ebert's criticism and that of others are restricted to the films under review. However, a deeper analysis requires a sensitivity towards the overlay of multiple modes of representation where "the reality of emergency is more and more difficult to tell apart from its perception" (Rangan 2017, 10). In objecting to these images, Rangan (2017) suggests, it is necessary to consider the commodification of suffering through the depiction of voiceless subjects. In this approach, it is important to also see how the real and the fictionalised aesthetics of the conflict zone that accompany mediatised images of suffering become harder and harder to tell apart.

The spectacle of suffering

We now turn to a deeper inquiry into the positioning of voiceless figures within the fictional narrative of the films discussed here. In proceeding to offer an understanding of how these figures of suffering are positioned as humanitarian subjects in the fictional setting, it is necessary to delve further into the tensions surfacing between those suffering and the distant observer, in what Chouliaraki terms a "spectacle of suffering" (2006, 2).

Before considering the implications of the fictional use of these images of suffering, it is helpful to first look at journalistic accounts. Reports from around the world proliferate through broadcast television and ever more personalised and connected media platforms, and are accompanied by often shocking images of suffering caused by violence and natural disasters (Chouliaraki 2006; C. Calhoun 2010). Engaging with these images, and the ways in which they are received by spectators far away from these disasters, the study is less concerned with the subjectivity of individual spectators but rather with society at large and how media impacts on ethical and social norms, which in turn shape contemporary responses to these images (Chouliaraki 2006).

Chouliaraki (2006, 2) cites the familiar example of the archetypal 'Good Samaritan' to illustrate how an encounter with the suffering of others arouses compassion and a desire for action to help those in need. Yet, when confronted with these images from far-off places, Chouliaraki points out that a direct response is all but impossible for the vast majority of viewers. In theorising the representational aesthetics and morality of the emergency encountered in news and documentary media, Boltanski (1999) and Chouliaraki (2006) identify the increasing distance, enabled by technology that confronts spectators in one part of the world with images of suffering from a distant place. The effect of these great distances, cultural variables and economic conditions only compound the effect of separation between the spectators, often located in the West, and the

sufferers, who are usually situated in less-developed economies. Even where humanitarian intervention by well-resourced organisations might serve as a proxy for public response, social anxiety persists around these images because, Sontag notes, "[c]ompassion is an unstable emotion. It needs to be translated into action, or it withers" (2003, 90). Returning to Kouchner's views on what constitutes "meaningful action" and his dismissal of talk as ineffective because it is unable to change reality on the ground, it becomes clearer that the anxieties arising over these vast distances are exacerbated by the realisation that individual action in bringing about an end to suffering is unrealistic (Boltanski 1999, 183). Kouchner, an influential figure in French politics,[1] insists that even action from a long way off is dubious as it "also belongs to the order of the useless, of illusion and even mystification" (Boltanski 1999, 183). If meaningful action is so precarious this precipitates uncomfortable questions about the need for mediatised spectacles of suffering.

While Sontag dismisses the existence of any link between distant sufferers and the "privileged viewer" (2003, 91), Ariella Azoulay (2008) shifts the focus away from the ethics of seeing and viewing which Sontag cynically dismisses as voyeurism or morbid fascination on the part of the spectator of images of suffering of others. Azoulay (2008, 14) uses the term "to watch" a photograph which, she points out, is usually associated with the viewing of films and moving images. To this act of watching, Azoulay applies dimensions of time and movement in her interpretation of photographs to reconstruct and understand the situation in which the photograph was taken. Spatial and temporal elements are more familiar to discussions of cinema with its dimension as a moving image and the ability to manipulate time with an array of film editing techniques.

In locating an ethical responsibility towards what is visible, Azoulay challenges Sontag's passive viewer and argues for a more active one. This relationship assumes the form of a "contract" in which the photographed subject addresses the viewer directly in staking a claim within "the citizenship of photography" (2008, 17). Relying on concepts about state sovereignty derived from political theory, Azoulay extends these rights of citizens of photography to all contributors involved in the creation of the photograph: the apparatus, the photographer, the subjects within the frame, and the spectator. This departs from what Sontag (2003) says about the spectator's judgement being limited to the visible contents of the photographic image without any assumption of responsibility for what is depicted. In Azoulay's postulation, the viewer is enlisted as an active participant in the struggle to overcome the asymmetrical power relations that traditionally shape the relationship between the photographer, who claims ownership, and the subject, who usually has no control over the image or

[1] Regarding Bernard Kouchner, see footnote 3 in Chapter Two.

its eventual use. Azoulay extends this challenge over ownership, and the power relations it confers, to her analysis of pictures of women and Palestinians in the occupied territories, on the "verge of catastrophe" (2008, 85). Azoulay identifies the presence of international humanitarian organisations in the occupied territories as a sign of emergency and relevant to her interpretation of these photographs. She enlists ideas about emergency and the limits it imposes on sovereignty to argue for a form of equality extended to all who are addressed through these kinds of photographs. Azoulay includes the addressee (even if they are the most vulnerable victims of disaster or stateless persons) as members within "the civil contract of photography" (2008, 85). This use of political theory to interpret photography supports the meshing of similar ideas with film studies, in this thesis, to explain the figure of the medical doctor in the imagined conflict zone.

When applying ideas from a discussion of photographic images, it is necessary to consider the implication of such terms as 'spectator' and 'viewer' when considering specific differences between the still image and the moving image. These terms are also commonly associated with the watching of films on movie screens. Azoulay (2008, 168) points out that terms such as "look at" or "contemplate" are frequently used in discussions of photography where the object represented in the photograph is stationary and immediately accessible in its entirety. This is an important distinction with cinema's rapid projection of individual still images to create the illusion of a picture in motion. I am not suggesting that the use of these terms across both fields of study indicates a theoretical merging of photography and cinema. I point out these differences to draw attention to certain qualities which distinguish these forms, while still considering the ways in which they influence one another, within the context of this discussion.

Boltanski attempts to demystify these relations between the viewer/spectator and the subject of the image by approaching these complex and multi-sited mediations through a "politics of pity" (1999, 33). This "takes hold over suffering in order to make of it a political argument par excellence" (Boltanski 1999, 33-34). Working from these ideas, Chouliaraki (2006) critiques examples of television news images from conflicts and natural disasters. He identifies certain embedded values in these journalistic reports that influence the choices by the way the 'others' are shown and how the viewer can relate to them. Chouliaraki's conclusion that the language of news and its use of images convey ethical values about how the spectator should relate to the sufferer is important for this research. These strategies, constituted by television news discourse, render "the spectacle of suffering not only comprehensible but also ethically acceptable for the spectator" (Chouliaraki 2006, 3).

That this mediated exchange has become indispensable to Western public life is not surprising if we consider the extent to which forms of mass communication are inextricably bound to our experience of modern democratic societies. Within this space, where direct physical action across large distance remains unlikely, the politics of pity substitutes for action in attempting to bridge the mediatised distance and leads, not to common emotions like love or care, but to a socially-constructed disposition towards the subjects of suffering (Boltanski 1999, Chouliaraki 2006). The emotional interest that these images elicit in the viewer are, according to Sontag (2003), only sustained by the realisation that little can be done to resolve the issues that the images portray. Boltanski (1999, 151) warns that this lack of trust in 'real emotions' associated with the spectacle of violence results in an "unacceptable drift of emotions towards the fictional". This argument does not dismiss individual emotions arising from fictional images such as the reconfiguration of Carter's image in *Beyond Borders* as 'not real'. It is important to point out that these scholars are not describing emotions as individual feelings but as a sociological construct that influences social responsibility and the ethics of public life.

This explanation of how suffering is conveyed to a distant and sheltered spectator highlights the risk of the spectacle of suffering being apprehended in a fictional mode, and this happens the more the horizon of action recedes into the distance. With this blurring of real and fictional emotions is "[t]he distinction between reality and fiction loses its relevance for the utterly powerless spectator forever separated from what he views (Boltanski 1999, 23).

Boltanski talks here of the distance between spectators and sufferers and proposes that the denial of agency on the part of the spectator, which can be available only through meaningful action, leads to a questioning of the existence of suffering itself. Arriving at a similar conclusion, Sontag considers that spectatorship of "other people's suffering" by those privileged enough to "patronise reality" results in the perverse and misguided assumption that everyone is a spectator and thus "there is no real suffering in the world" (2003, 99). In making claims for a more active and responsible relationship in organising the gaze of the spectator, Azoulay (2008) argues against Sontag's sense of apathy in the viewer, avoiding a slide towards fiction in this encounter within the citizenship of photography whereby the photographed subject addresses the viewer directly, on a more equal basis.

When the cinema screen becomes the form of address, the audience is invited to empathise and engage with the sufferer's misfortunes, while the suspension of disbelief operates without question. The audience is compelled by the *mise-en-scène,* made all the more 'real' by the use of familiar tropes such as those derived from news photographs (for example the child and the vulture) that

enhance verisimilitude in the onscreen narrative. Certainly the producer's concern that, for the scenes filmed in Namibia, the extras must have the "look of people in need of help of a relief agency" only bolsters this illusion (Barnard 2002b). Considering these elements within the aesthetic of emergency, this chapter is concerned with how such creative choices are mobilised within the narrative to heighten the perception of suffering, even as we know that the performers are not *really* [my emphasis] suffering and that the extras cast in the scenes of famine are acting.

Like the real images of suffering and disaster that convey news about the world, narrative cinema has become a way of viewing the world. Sontag's (2003) distrust in the spectator's inability to distinguish between fact and fiction which results in questions about the actual existence of suffering, judges the viewer naïve and patronises their ability to interpret what they see. The argument that Boltanski (1999) and Chouliaraki (2006) make that suffering placed at an insurmountable distance results in the blurring of fact and fiction, seem tenable but should not be misunderstood. It does not mean that the emotions evoked by the fictional images of suffering, such as those in the films discussed, are not real feelings or that the events on which these scenes are based, never occurred. In challenging Sontag's explanation of the spectator as someone who takes no part in the event occurring before them, Azoulay (2008, 169) recognises the viewer's agency in addressing images of humanitarian disaster by "turning them into signals of an emergency, signals of danger or warning—transforming them into emergency claims". Within this complex and layered mediatised landscape, the role of the doctor as a trusted mediator between sufferer and spectator assumes a critical significance.

The doctor as interlocutor

The doctor is deployed in these films as a dependable and trusted interlocutor in mediating the spectacle of suffering for the viewer. If, as argued above, Boltanski (1999) and Chouliaraki (2006) observe the movement towards action becoming increasingly out of reach for most spectators, the justification for viewing spectacles of suffering is reduced. Faced with such uncertainty, the viewer pins their hopes on a trusted interlocutor who might, with some authority, mediate between themselves and the sufferers they encounter in this ecology of the hyper-mediated.

It is reasonable to assume that the exponential growth in private funding for organisations like MSF since the early 1970s (C. Calhoun 2010; Packard 2016) indicates a tangible response driven by public desire for action in response to the very real human and environmental emergencies which appear on our screens with regularity. In the previous chapter, we have seen how the doctor constitutes a central role as first responder and figurehead for organisations like MSF.

Following this line of argument around the doctor as interlocutor, the politics of pity which Boltanski (1999) mobilises in his engagement with the discourse of mediatised images of suffering and how these become acceptable to the viewer is salient. Boltanski identifies the need for a decency of symmetry in the relationship between the spectator and those suffering. He notes that where the spectator is offered only a report of the object with a detached precision that may be suitable for describing something technical, this becomes repellent. As discussed in the previous chapter, the film's viewer may only forgive Callahan's dismissal of the wounded mother and starving child in *Beyond Borders* because, in his clinical assessment, they are expectant cases (one of the categories in the triage system), and therefore beyond help in the resource-scarce environment imagined in this version of the Ethiopian crisis. Any understanding of or forgiveness of Callahan's decision is based on the film's portrayal of the doctor as working for the survival of the greatest number of casualties in the conflict zone.

What Boltanski (1999) is flagging in the descriptions of events or victims of disaster is that technical reports that claim to produce an objective reality based on fact alone, although truthful, are morally unacceptable. Examples of this would be "the execution of condemned persons, or the bodies of dead children during a famine" (1999, 43). Where an emotional or moral point of view is absent, he offers a discursive solution in the form of an "introspector" who can enter the report by providing a description of the suffering while also considering the effects these images may have on a spectator (1999, 43). Here the person who reports and the spectator are no longer one and the same, with the result that "[t]he spectator looks on the suffering of the patient; the introspector observes the effects of this observation on the spectator and blends these different accounts together in a composite report" (Boltanski 1999, 44). This triangular structure is common whenever the reporter is positioned to embrace those suffering and the spectator in a single gaze.

In viewing the opening of *Beyond Borders*, as Callahan crashes the gala event with Jojo, it is possible to see how these scenes bring the distant spectacle of suffering into direct proximity with the privileged world of the guests at the event. In the film, the party-goers are made more and more uncomfortable by Jojo's malnourished frame amidst the opulence of the celebration. Their discomfort is mediated by Callahan's dialogue which serves as a form of reportage as he explains the urgent medical needs of those in the camp facing disease and starvation. Here the scene's focus shifts to a series of shots combining Callahan's account with a closer framing of Jordan's mounting sense of despair. The image of wealthy revellers partying it up as one of the malnourished recipients of their humanitarian outreach watches them, highlights the seemingly irresolvable injustice of the power differential at work in the scene. But when we view the scene through Boltanski's idea of the

"introspector" the triangular relationship at play in Callahan's description of Jojo's situation becomes clear. Callahan's consideration for the effect on the spectators, particularly Jordan on whom the camera continues to focus, becomes part of his report on the state of the distant unfortunates who remain in the Ethiopian camp without the funding for food and medical supplies which they so desperately need in order to survive. Within this politics of mediation Boltanski notes that the spectator (Jordan and the revellers) becomes an object of description along with the unfortunates, embodied by Jojo's emaciated frame.

When an unseen audience member, among the predominantly white crowd, throws a banana for Jojo to eat, Callahan vilifies the anonymous racist for their stereotypical attitudes towards Africans. Ultimately the scene is resolved by Jordan taking a step towards action and moving the narrative forward. This response to the situation Callahan has described in the camp overcomes the sense of helplessness which the viewer shares over the possibility of meaningful action and goes some way towards reducing the asymmetry in power relations which emerges through the media discourse around the spectacle of suffering.

This scene, and others such as the triage scenes discussed in the previous chapter, makes it possible to see how the doctor functions, like the journalist might do when reporting on a catastrophe, to address asymmetry by implicating both the spectator and the sufferer as objects of description. In the triage scene from *Beyond Borders* and the scene where Callahan operates on the infant's mother without the availability of anaesthetic, the doctor observes the effect of the trauma witnessed by Jordan, who also represents the audience's humanitarian desire to help. While Callahan at first resists this role as mediator, offering only harsh criticism of Jordan's humanitarian desire to help, he later relents and offers his advice in saving the malnourished child. The result is a rebalancing of the extreme asymmetry between the suffering depicted and the viewer situated, in all probability, in the much more privileged position of "well-off countries" who share the "dubious privilege of being a spectator of other people's pain" (Sontag 2003, 99).

The political and aesthetic choices deployed in the scene from *Beyond Borders* implicate Jojo's emaciated body in the construction of the humanitarian gaze. The troubling ways in which the humanist aesthetic form is performed in this scene recalls aspects of the child/vulture scene, discussed earlier, where the vulnerable child and mother are enlisted to reinforce the idealism of the West's humanitarianism. Here, Jojo's emaciated form becomes emblematic of Africa's suffering and proof of the need for Western humanitarian intervention.

The next chapter extends this investigation of the doctor figure in the films through the increasingly intertwined roles of humanitarian action backed by military support. The chapter explores ways in which the medical and military dimensions merge in unexpected forms of violence which are comparable to the violent therapeutic interventions of the colonial state.

CHAPTER FOUR

THERAPEUTIC SECURITISATIONS AND COLONIAL LINKAGES

Introduction

The claim that no higher cause exists than the sanctity of human life where this might be found to be in mortal danger is one of the first-order principles justifying humanitarian operations (Fassin 2010; R.C. Fox 2014). This argument has in the last half-century or so established itself as the "secular religion of the new millennium", according to which the act of "doing good" is increasingly measured by intention and not the outcome (McFalls 2010, 317). This chapter does not intend to compile a list of humanitarian actions backed by military force, but offers these examples to highlight the complex issues that inform the analysis of the narratives of both films.

Increasingly the right to intervention has seen the participation and backing of military force to assert control across national boundaries (Fassin and Pandolfi 2010). The international coalition that backed the US-led intervention in the first Iraq war in 1991 was prompted by calls in Washington for humanitarian intervention and assistance from a public relations firm funded by Kuwaiti exiles (Lee 1990). Reports by MSF on Serbian atrocities are also known to have provided credibility to the NATO air strikes in Kosovo (Fassin and Pandolfi 2010). These operations were conducted by the United States and Western European countries with Security Council support (Kennedy 2006). The Nigerian-led intervention in Sierra Leone in 1997 received UN approval as did subsequent actions conducted with African Union (AU) backing such as South Africa's deployment of peacekeeping troops in Angola, Liberia, the Democratic Republic of Congo, Darfur and Burundi (Kennedy 2006). More recently, the Zimbabwean Army has worked closely with Gift of the Givers in providing humanitarian assistance to the victims of Cyclone Idai in Mozambique (Gift of the Givers 2019).

This chapter explores the coexistence of seemingly oppositional formations (military and humanitarian) within the frame of the emergency in a variety of scenes which depict the securitisation of therapeutic intervention in the conflict zone. Expanding on the doctor figure within the imagined conflict zone, the study argues that these seemingly paradoxical actors share many commonalities within the emergency setting. It is not merely the co-presence of military and medical actors that warrants attention, but also the securitisation of humanitarian action itself and the implications this has for understanding aspects of *The Last Face.* The political theory developed in the study of humanitarian and medical action is applied to the filmic fact as an interpretive framework to understand the way the cinematic narrative reveals these interventions as a modern form of power and control over others.

Later in the chapter, I continue with this Metzian framework in analysing the cinematic fact and the industrial conditions of production and distribution of two fictional films based on the real-life figure of Dr Albert Schweitzer. A reading of representation and meaning in the film text considers the filmic fact and extends the concept of contemporary therapeutic securitisations to the colonial medical encounter in both films set around Schweitzer's medical and humanitarian work in Gabon's colonial past. I do not attempt a complete analysis of these films. I am guided in my thematic and analytical selection of certain scenes that are relevant within the interdisciplinary framework already explained.

The securitisation of medical intervention

The opening sequence of *The Last Face* (Penn 2015) is constructed around a series of flashback scenes introducing the relationship between the romantic leads, Dr Wren Petersen and Dr Miguel León, and revealing the circumstances leading up to their reconciliation in Cape Town, South Africa. The scene in Cape Town occurs on the night of a fundraising dinner for the medical organisation founded by Petersen's father and unfolds as Petersen prepares herself for the evening. The scene feels heavy with the unspoken realisation that their romance is doomed as León makes clear his intention to return to the conflict zone where he has been working as an emergency trauma surgeon. We are jolted from their melancholia by a flashback to the chaos of the conflict zone ten days earlier.

Filmed in South Africa (Jang 2016), these scenes immerse the viewer in the conflict zone as people scramble for cover while heavy automatic gunfire erupts around them, with two groups firing at each other amidst some ruined buildings. Civilians are caught up in the crossfire and some of them are shown to be killed and wounded. León is inside a fortified compound where civilians are protected from the fighting taking place outside. Taking advantage of a lull in the fighting, he orders the huge gates to be opened just long enough to admit the wounded waiting outside the compound for emergency medical attention. An on-screen title identifies the setting of these restaged events as the United Nations Base in Malakal, South Sudan, in 2014.

Malakal is the second largest city in South Sudan after the national capital Juba and the compound depicted in the film offers a fictional representation of the Protection of Civilian (PoC) site. Actual events necessitated its establishment under the United Nations Mission in South Sudan (UNMISS) to house and protect internally displaced persons (Médicins Sans Frontières 2016). UNMISS oversaw the deployment of over 14 000 troops, with the largest contingents coming from Rwanda and Ethiopia, while other countries from Africa, Asia and Europe also contributed 'blue helmet' uniformed personnel ('UNMISS Fact Sheet' n.d.). In the film, these forces are represented by actors

wearing the characteristic UN blue helmets and guarding the perimeters of the camp while vehicles painted to represent UN armoured vehicles are shown patrolling a film set designed to approximate the real-life PoC site.

During these scenes, the restaging of events within the imagined conflict zone sees León and the other actors playing medical staff wear MSF insignia. This accurately depicts the organisation's real activities within the PoC as confirmed in an MSF report detailing its presence in the Malakal hospital and its maintenance of an emergency room in the PoC site (Médicins Sans Frontières 2016). The report describes an attack on the PoC site and the town of Malakal in February 2014—the same year as the events portrayed in the film—in which "the town was attacked and patients were executed in their hospital beds and the hospital was vandalised and partially destroyed" (Médicins Sans Frontières 2016). The film's fictional recreation does not depict these atrocities or explain the reasons for the attack that unfolds on screen. Consequently, the historical factors which led to the violence before and after South Sudan's independence from the North on 9 July, 2011, is less relevant to this study. Instead, I will use ideas developed to explain humanitarian aid and its role in the assertion of global political and military power, to understand the cinematic representation of the medical doctor as part of the humanitarian mission in the imagined conflict zone.

Political theorists Didier Fassin and Mariella Pandolfi (2010, 10) refer to "the political and moral registers manifested in the realisation of operations which are at once military and humanitarian". In charting this morally complicated topography, where life and politics converge within an emerging global humanitarian order, I return to Foucault's (2008) insights in order to draw our attention to the important biopolitical implications of the increased securitisation of humanitarian care. These ideas are useful in reading the ways in which emergency medical services are represented in the fictional setting of the filmed conflict zone. The research draws on these ideas to further the understanding of how the doctor is configured in the imagined space of a securitised humanitarian mission within the narrative of the film. Of particular interest is how the valorising of presupposed universal notions of equivalency between all peoples, which might be more idealistic than real, results in extremes when it is used as "an alibi for discriminatory and violent acts—all performed in the name of humanity" (Rangan 2017, 6).

Biopolitics and the humanitarian order

In a series of lectures delivered at the Collége de France in 1978 and 1979, Foucault (2008) tracks the development of human life as central to our understanding of political power. He speaks of the "biopolitical" and how formations of power exercise control over human life not as an aspect of contemporary politics, but as a necessary and transformative event which shapes our conception of

political sovereignty and the knowledge thereby produced (Foucault 2008; Lemke 2011). Thus our understanding of political sovereignty must include ways in which the autonomous state exercises power over the domain of life itself. This view is not limited to the sovereign state's jurisdiction over death, but rather, as Foucault argues, includes how biopolitics is elevated to the protection and management of life so that "[w]hat is at stake is no longer the juridical existence of a sovereign but rather the biological survival of the population" (Lemke 2011, 39).

Following the sequence of scenes in *The Last Face* set in the film location designed to represent the PoC site at Malakal, the narrative moves to Geneva, Switzerland. Here, Dr Petersen is seen attending a meeting of the UN High Commission on Human Rights (UNHCHR). An official reads through a press statement for the committee's approval but Petersen cynically interjects, pointing out that the statement is only a report of child mortality rates, HIV infections, the availability of anti-retroviral treatments, and the fact that malaria deaths have been reduced by 75% in sub-Saharan countries (the latter just being positive media spin). She pleads with Ivan, the committee chair, to be more "serious" about the information they put out to the media. Ivan defends the committee's position, reminding Petersen: "We are in a debt crisis and under attack by a world of impatient non-solution orientated critics. Let's just get a few good news stories out there" (Penn 2015). But Petersen persists: "Saving lives is a serious mission. For that matter, every single human interaction that changes things is" (Penn 2015).

From Foucault's perspective on biopolitics, this scene may be read as an illustration of how the control of the population is enacted through measurements and statistics about health, hygiene, birth rates, life expectancy and race (Lemke 2011). These reflected new ways of governance during the eighteenth and nineteenth centuries. Such analytic practices are, for Foucault (2008), inseparable from the political structure—European liberal democracy—in which they emerged. In the film we see that statistics measuring infant mortality, the epidemiology of HIV and AIDS, as well as matters relating to population demographics and biology, are not reported by the sovereign state regarding their national population, but by a supranational humanitarian government in the form of the UNHCHR. From this perspective, it becomes clearer how the organisations portrayed in the film analyse and order life at the level of populations across geographic and national boundaries.

McFalls identifies this shift in biopolitical power informed by a "contemporary post postmodern ethical sensibility" (2010, 318) as underlying a more sinister capitulation to forms of humanitarian therapeutic domination. This begs the question: what are the implications of these new social-political systems for the authority of the sovereign state? In approaching this problem from the perspective of the films, it is necessary to return to the filmed scenes set in and around the PoC

location in the South Sudan sequences from *The Last Face.* In revisiting these scenes, I intend to show how these contestations between the military and medical presence play out around the fictionally-constructed character of Dr León. In furthering this analysis, it is worth picturing the idea of contested sovereignties as comprising two aspects. One of these is the conventional form based on fixed national boundaries and spaces emanating from the Treaties of Westphalia (Teschke 2009), as described in Chapter Two. The other is based on ideas of sovereign mobility for groups such as the emergency medical teams that exert different forms of control and care over the lives under their influence in situations where the sovereign power has "shrunk or collapsed altogether" (Ophir 2010, 72).

In the film sequences the sense of a powerful humanitarian order established in a fortified camp within the fledgling state of South Sudan is created by means of the large exterior film set. As already observed, this presence is underwritten in the film by supranational organisations with the military backing of African and other countries suggested by the actors in military wardrobe wearing UN blue helmets as they man the armed positions around the camp. This creates the impression that the state structures have collapsed, resulting in a liminal and ungoverned zone. This is vividly depicted in the chaotic violence staged for the cameras outside the PoC site as the South Sudan military forces are no longer able to exert sovereign control and must rely on the UN-backed forces to defend the site against rebel attack. In real-conflict situations, humanitarian organisations are called upon to fulfil the functions of the failed state through substitutes for state power and control (Packard 2016). These scenes in the film might then be understood as depicting a "state of exception"—a concept developed by Carl Schmitt (C. Calhoun 2010) to describe a situation where conflict or natural disaster has rendered the sovereign unable to exert power and control. From this position, the filmed scenes set around the recreated PoC site take on a new significance, expressing a form of control and governance replacing the authority of the state which is no longer capable of providing the services and laws which its citizens rely on for their well-being and safety.

The Italian philosopher Giorgio Agamben extends Schmitt's idea to an understanding of the violent extremes of sovereignty (Redfield 2010; Lemke 2011). Agamben locates his exploration of exception within the Nazi concentration camp which produces "bare life" in the form of people without any legal claim to life through the juridical apparatus of the state (Lemke 2011, 54). Similarly, I extend this definition based on the Nazi concentration camps to include other locations, as Mbembe (2003, 34) does with his use of the term in characterising the mass relocation of peoples in African conflicts displaced by war and the extraction of natural resources into "a horrific exodus, [of people who] are confined in camps and zones of exception". Azoulay (2008, 35-56) goes further in applying

Agamben's idea of bare life to her claims for a citizenship of photography in considering the images taken within the Palestinian occupied territories. She uses the term to identify the ways in which individuals within vulnerable populations may have their civil rights stripped from them by the sovereign choosing to enforce a state of exception.

The use of these political terms in my analysis of the doctor figure portrayed in *The Last Face* may, at first, appear to be a theoretical overreach. However, in light of the points already made around the factual and fictional overlaps between photojournalism and narrative cinema I consider this application appropriate to further my analysis of the doctor figure. The fictional conflicts represented in *The Last Face* invite further consideration of the narrative implications where the state of exception becomes a permanent presence in the scenes contrived around the setting of the relocation camp based on the actual PoC at Marakal.

Mbembe explores ways in which power is exerted over life through conditions of emergency precipitated by "the collapse of formal political institutions under the strain of violence" (2003, 34). The physical form of the exception might find expression in the concentration camp, as Agamben postulates (Lemke 2011), or it might be read in the PoC setting of *The Last Face* where internally displaced persons enjoy little or no protection from the failed state. In actual PoC sites there are competing claims to governance and control over the lives held within its perimeters as the recently constituted humanitarian intervention substitutes for the failed state (Redfield 2010). This intervention assumes a "mobile sovereignty"—a term which McFalls (2010, 321) attributes to Mariella Pandolfi while Packard (2016, 333) uses it in reference to anthropologist Peter Redfield's study of MSF deployments in actual conflict situations. The provenance of the term is less important to this study. What is relevant is the ways in which this mobile power asserts control through the extension of critical medical services (Packard 2016). Where conflict and the associated effects persist, and the state's capacity continues to degrade to the point where its return to control becomes less and less likely, a state of permanent exception comes into being (McFalls 2010). As Lemke (2011, 56) observes, a state of permanent exception arises specifically within spaces where contested sovereignties are centred on formations like the camp, be it under the authority of a supranational organisation like the UN or AU or a humanitarian NGO.

The immense scale of the film location revealed in the aerial photography suggests a vast and immovable presence for the PoC setting recreated for *The Last Face* sequences. In viewing these sweeping aerial shots, the idea of the state of permanent exception comes to mind. The cinematic vista encompassing the whole design of the camp with its military and humanitarian controls under the auspices of supranational networks, begins to take shape. Although its stability is shown to be

precarious, with attacks on its periphery depicted in the narrative, the fortifications hold strong and so confirm the aspect of permanence. With nowhere else to seek shelter or essential services such as medical help, the displaced civilians portrayed by background actors recruited in South Africa, are shown within the refuge of the PoC site. The fictional performance of this humanitarian suffering can never fully represent the "brutal attempts to immobilize and spatially fix whole categories of people [within] camps and zones of exception" (Mbembe 2003, 34).

It is in these overlapping and shifting layers of representation, where fictional imaginings merge with factual images and where violence and instability are embedded in the spectacle of human suffering, that this study views the figure of the doctor as assuming a great significance. In making this argument, we see that the doctor's presence functions on a number of levels. Not only does the doctor answer societal demands for action in responding to the needs of the sufferers, but through Dr León's actions, a sense of shared humanity is reconfirmed. This redemptive interpretation is bolstered by the presence of the doctor at the victim's bedside as the conflict zone erupts around them. And so, as we see him operating behind the flimsy walls of the emergency tent, the exploding shells we imagine just outside the perimeter of the PoC camp reminds us of the doctor's vulnerability while, at the same time, reinforcing the importance of the figure as a dependable interlocutor between the viewer and the victims themselves. An aura of invincibility might be felt in this therapeutic presence which seems at odds with the militarised presence that surrounds the doctor and his patients caught up in the chaos and violence.

The military-medical paradox

It is precisely within these zones of exclusion formed around camps or relocation centres that the emergency medical station is usually located. Within these zones of exclusion, a clear asymmetry of power is apparent in the reciprocal relationship between the military and medical actors (Fassin 2010). When viewing the scenes in *The Last Face*, these power relations appear to be configured concentrically. At the outermost circumference are the supranational sovereigns backed by the blue helmets charged with securing the perimeter of the camp. This ensures protection and power for the doctor and his medical staff who are shown operating within the compound so that they might provide medical care for the displaced civilians occupying its centre. The point to be made is that from the onscreen depiction of these relationships a clear asymmetry persists. We see that the doctors, who lend the military credibility by their presence, are like the humanitarian personnel and the civilians they care for: completely reliant on the soldiers for their protection and safety. Finally, what emerges in this analysis of the cinematic restaging is a securitised medical-humanitarian order where the medical actors are forced to operate under the same state of exception as the victims and

the military protectors. Encompassed by this wider emergency thematic, the seemingly irreconcilable differences between the medical doctor, working towards saving and protecting life, and the military, defined by its primary role of taking lives, appear much smaller than at first thought (Fassin 2010).

Whether medical or military in aspect, the case for emergency humanitarian intervention is that all other considerations be deemed secondary when it comes to the primary moral objective of saving lives (Fassin 2010). This new order, underwritten by international law and the right to intervention championed by the likes of Bernard Kouchner, results in increasingly forceful outcomes where military operations are backed by therapeutic missions (Boltanski 1999; Fassin 2010). In the many attributes that these seemingly paradoxical forces share, it is important to distinguish ways in which they remain very different in practice and objective. While the military doctrine advocates the killing of some in order to save the lives of others, the medical response is predicated on the doctor's willingness to sacrifice their own life in order to assert the value of the life of others. These notable differences should not be overlooked when comparing the selfless and noble sentiments portrayed by the doctor figure in the films with those represented by the armed forces.

The argument advanced here is that these sometimes contradictory representations find expression through the central characters in both films as they aspire to act outside of political contestations but are compelled to intervene as central figures in the power formations and relationships of the conflict zone. This comes into focus in the PoC camp scenes where León works under the military protection afforded by the UN and AU forces.

In a scene from *Beyond Borders*, Callahan intervenes as the food trucks travel through a corridor where power is contested between the humanitarian and military presence. When government soldiers halt the convoy of trucks, the doctor must make a deal which involves sacrificing a few bags of food-aid, a case of whiskey and cigarettes to ensure the emergency aid gets through to the feeding centre.

In another scene from *The Last Face*, set away from the PoC fortifications at Malakal and beyond the protective reach of the UN's mobile sovereignty, León visits a remote first-aid station somewhere near Juba which is run by local medical staff. That night, attackers kill some of the local people and set fire to the medical tents before burning the helicopter that has transported León there. As the survivors mourn their dead in the aftermath, León, accompanied by a local staffer, is seen walking through the smouldering embers of the medical tent where several patients have also been killed in the attack. This shot, rendered in slow-motion, emphasises the emotional devastation of the attack

while emblematically positioning the medical figures among the flames, the dead and the dying. The closing image works to redeem the doctor from the muddied representations of the PoC camp with its uncomfortable juxtaposition of the military and medical presence. Here, the filmmaker is proclaiming the doctor figure as clearly on the side of the sufferers and standing against the violence of the armed attackers and their killing of defenceless civilians. Scenes like these make it morally simpler to criticise those pursuing political objectives through force, instead of the doctors who are seen on the side of the victims and as protectors of life.

While this image intends to reinforce claims to independence and freedom from political interference, it does not absolve the doctors from acting within other biopolitical power formations. Rather than staking a claim to impartiality, this scene specifically locates the doctor figure on the side of the sufferers, illustrating Fassin's point that "[i]n order for humanitarian agents to claim they are on the side of life, they have to place political actors on the side of death" (2010, 276). While acknowledging the difficulty of engaging critically around humanitarian work and doctors who risk their own lives in order to save others in mitigating violence and injustice, Fassin (2010, 286) argues that holding them to account is valid. This, he cautions, is not only in the interest of the societies who fund them and whose values they claim to represent but, more importantly, in the interest of those on whose side they intervene and help.

Almost uniformly, in all the film scenes constructed around the medical encounter between doctor and patient, there appears a certain reverence extended by the latter towards the former. As discussed in this study, the recipient's appreciation is usually rendered in non-verbal gestures and reactions. One of the rare moments where the humanitarian subject is given a voice is during the scene where Dr Callahan operates on the wounded mother of the starving child which Jolie's character has rescued beside the road. In this scene, discussed in Chapter Two, the mother's words are spoken with a particular reverence for the god-like qualities of the doctor's healing hands and his ability to cheat death. In a scene from *The Last Face* a sense of trepidation is observed in the way León's surgical intervention is received by those in need of care. In one such moment a surgical patient dies on the operating table as León tries unsuccessfully to help. This disquieting moment is visible through a gap in the tent as a waiting patient watches and León meets his glance. The doctor seems to shift uncomfortably as a fleeting sense of doubt appears on his face over his failure to help these victims. This is one of the only scenes in both films where a discernible ambivalence on the part of the recipient towards the doctor is communicated. Although the sentiment is unspoken, the camera's close observation of the action and reaction makes the emotional intention of the scene

quite clear. Underlying this moment, it may be argued, is a profound inequality between the dependency on the part of the recipient of humanitarian care and the provider of therapeutic aid.

Rangan draws attention to this asymmetry in his examination of the humanitarian gaze in documentary films framed by the thematic of emergency, where "humanitarian agents reassert the worth of human lives that have been stripped of their political value in their willingness to sacrifice their own (politically significant) lives" (2017, 13). Although he is speaking about documentary filmmaking, Rangan's (2017) observations are also relevant to this study and its focus on the representation of the voiceless humanitarian subjects in the narrative films discussed.

Whether the intention is to reach a wider audience in order to increase awareness of the world's suffering people as the producers of *Beyond Borders* claim in the documentary *Behind the Lines* (2003), or to promote the role played by medical doctors in providing emergency care in remote conflicts, the point made here is that these commercial feature films intentionally commodify suffering through an aesthetic of emergency. As this research has shown, the perception of the selfless actions of the doctor confronting risks and making sacrifices on behalf of the sufferers is amplified where this figure is relocated away from the conventional setting of the hospital and clinic to the conflict zone. It is important to consider how Rangan's ideas around these humanitarian figures in documentary films influence our understanding of the doctor in the narrative films. The doctor, in risking their own lives, also elevates the insignificant status of the voiceless sufferers. This raises important questions around the image that humanitarians have of themselves and how these representations are communicated to the public through the press.

The LA Times (Simmons 2018) noted that over 100 humanitarian workers were killed each year between 2006 and 2016. Internal reviews by MSF also include accounts of violent attacks against medical doctors and humanitarian workers in the various conflict zones where they work (Médicins Sans Frontières 2016). The frequency of attacks in places like Afghanistan, Syria, Somalia, the Democratic Republic of Congo, South Sudan and Nigeria (Simmons 2018) paint a different picture to that promoted through films such as those discussed here. In viewing these films, the argument is made that the overwhelmingly popular narrative of the humanitarian workers as universal saviours appears incongruent with real-life assessments detailing an increased frequency in attacks (Simmons 2018). This result suggests that not all local populations receive these doctors and the medical-humanitarian intervention uniformly.

In continuing this line of inquiry into the filmed representation of the contemporary doctor and the often ambiguous ways in which the figure is received in certain African conflict zones, it is necessary

to turn the focus towards two fictional film narratives based on real events in order to explore certain linkages that persist in the cinematic construction of Dr Albert Schweitzer, the colonial medical figure.

Cinema's curiosity about Dr Schweitzer

These films are amongst many that portray aspects of Dr Schweitzer's work during the time he spent in French Equatorial Africa (now Gabon) from 1913 up until his death there in 1965. A search of the Internet Movie Data Base (IMDb.com) reveals at least six television and feature film productions based on Schweitzer's life ('Results for "Albert Schweitzer"' n.d.). The reason for choosing these two productions is that they are the only ones amongst the search results made by African-based filmmakers. *Lambaréné* (1990) (aka: *Schweitzer*) was made by the South African director Gray Hofmeyr and *Le grand blanc de Lambaréné* (1995) by Cameroonian director Bassek Ba Kobhio. Broadly speaking, both narratives are centred on the fictional representation of Schweitzer during Gabon's colonial history, and in the case of Ba Kobhio's film, the storyline extends to Schweitzer's later years during the anti-colonial struggle and the period immediately after independence. These films are analysed in the following sections for their compelling and sometimes contrasting interpretation of the colonial doctor figure. Schweitzer's depiction will be considered in relation to his contribution as one of the pioneers of medical humanitarian work in Africa.

Ba Kobhio's film was made with funding from the French Ministry of Cooperation, Centre National de la Cinématographie (CNC) and the French pay-TV channel Canal+ (IMDbPro 1995). Written and directed by Ba Kobhio, the French producer Hugues Nonn is credited on screen with its creative conception (*idée originale*), indicating that the production involved a close collaboration encompassing more than just financial and technical requirements. The same credits indicate that *The film was made where Dr Schweitzer lived and worked* (Ba Kobhio 1995).

The discussion of these two films cannot overlook the economic and political reality of South Africa in the context of the 1980s, before the end of apartheid, when Hofmeyr's film was made. Political realities imposed on productions made in South Africa at the time are distinct from any encountered in Ba Kobhio's film with its official support from the French government. While Ba Kobhio's film announces the use of its film locations as Schweitzer's original hospital in Gabon (Koplik n.d.), a closer inspection of the screen credits in Hofmeyr's production indicate a more circumspect approach in divulging its South African film locations. The onscreen credits list Abidjan in the Ivory Coast and Strasbourg in France but make no mention of the South African locations. Hofmeyr confirmed to me that the set for Schweitzer's hospital was constructed near Port Edward in South Africa (Hofmeyr 2019), with the same tropical vegetation that doubled for Liberia in *The Last Face*

(Jang 2016) standing in for the jungles of Gabon. Interestingly, no mention is made of Port Edward in the end credits of the film alongside the other locations cited. This omission and the lack of any reference to South Africa in the end credits are not surprising since many films made in the country during the turbulent political times of apartheid preferred to avoid any such references because of negative associations with the country (Mann 2014). Intense international condemnation of apartheid had led the usually conservative American Motion Picture Association of America to support the cultural boycott of South Africa and resistance to films produced in the country was also felt through Filmmakers United Against Apartheid, an organisation started by American directors Martin Scorsese and Jonathan Demme (Mann 2014).

During 1989-90, the years that Hofmeyr shot his film about Schweitzer, 113 films were produced in South Africa by a variety of production companies (Lamont 1996). That part of financing for this "mass-scale film production" came from mostly wealthy white South Africans eager to get their money out of the country was revealed by Associated Press in December 1987 (Mann 2014, 130). This exposé named well-known actors Gary Busey, Dolph Lundgren and Peter Fonda as contravening the boycott, although there were many others who worked in South Africa at the time (Mann 2014, 130). Considering the prevailing politics, it is very likely that the involvement of Malcolm McDowell and Susan Strasberg in Hofmeyr's film would have carried a similar reputational risk back in the US if the South African connection was made known. Filmmakers inside South Africa, opposed to apartheid, organised themselves under progressive organisations like the Film and Allied Workers Organisation (FAWO). Through the organisation's newsletter, they expressed their views about international actors working in South Africa, referring to them as "boycott busters" (Markowitz 1988, 2). However, for international filmmakers and actors working in South Africa in defiance of public opinion, the risks seemed worth taking considering the generous tax incentives and subsidies that guaranteed a return of 125% for investors on completion of the film (*Business Day* 1989).

Toron Screen Corporation, which is listed in the end credits of Hofmeyr's film as supplying production services and facilities, was the largest beneficiary of the Apartheid Government's film subsidy scheme between March 1990 and March 1992, with the company claiming eight of the eleven films subsidies awarded in this period (Pearce 1996). It is very likely that Hofmeyr's film would have been among these productions since its May 1990 Cannes Film Market debut for international buyers and its South African release in August of the same year would have placed it within the same reporting period (IMDbPro 1990). How these political concerns may have influenced the outcome of the film, beyond the attempts to conceal any association with South Africa, is

unclear, yet the differences in representation of the Schweitzer character by Ba Kobhio and Hofmeyr become increasingly apparent in the next section.

Colonial linkages

C. Calhoun makes the point that "[h]umanitarian action is sometimes described as the nice face of a new colonialism" (2010, 41). McFalls (2010, 321) dismisses this comparison between modern international intervention and traditionally understood forms of conquest and colonialism, pointing out that contemporary humanitarian actions are sanctioned by international law with the approval of credible local and international organisations such as the AU and the UN. C. Calhoun qualifies his colonial comparison as one usually levelled by those outside the humanitarian movement. However, as this study argues, there are various and uncomfortable ways in which modern humanitarian action might be viewed in relation to this troubled past.

Histories of colonial medicine have usually been kept distinct from the machinations of later 20th century international health organisations (Packard 2016). In tracing these linkages through the two fictional narratives based on the historical figure of Dr Albert Schweitzer, it is worth noting Randall Packard's (2016) work on how knowledge developed for the administration and control of colonised people, and continues to be applied to the containment of infectious diseases, such as Ebola and Swine Flu, across modern national borders. In his work, Packard charts a sequence of events that illustrate how colonial medical knowledge was adapted to solve the problems that modern humanitarian medicine encounters in the developing world. In his own writings, Schweitzer describes the upheaval of large native populations for public health imperatives, as in the isolating of infectious diseases which had been introduced *to Africa* [my emphasis] for the first time by European colonisation (Schweitzer 1951). His accounts of the costs visited on the local population in matters of health and lifestyle by the logging concessions given to European businesses by the colonial powers describe how entire populations were uprooted and forced into labour in the Upper Ogowe region of French Equatorial Africa (Schweitzer 1951, 150). In rejecting this practice of enforced labour to feed the colonial desire for extractive wealth, Schweitzer provides a stark overview, illustrating how medical knowledge is deployed in controlling large populations affected by diseases, such as sleeping sickness and malaria, because of the effect these have on their productivity. These accounts are helpful for current purposes in establishing how the medical encounter rooted in the colonial conflict zone impacts on our understanding of the contemporary humanitarian and medical interventions depicted in the films.

C. Calhoun (2010) traces early humanitarianism to the social and religious movements emerging in the West around the abolitionist movements during the 19th century aimed at creating awareness of

the evils of legal slavery. During that century, humanitarians made successful use of new photographic technologies for the double purpose of authenticating and publicising previously unseen suffering and hidden abuses (Fehrenbach and Rodogno 2015; Rangan 2017). Photographs such as those from Belgian-owned Congo quickly became an essential tool in building public awareness that demanded attention and response (Fehrenbach and Rodogno 2015). In magazines, newspapers and through illustrated public lectures, these early humanitarian campaigns "gave form and meaning to human suffering, rendering the latter comprehensible, urgent and actionable for European and American audiences" (Fehrenbach and Rodogno 2015, 1125). Given the barbarity and violence that accompanied the racist and extractive industries that plundered Africa under colonial rule, it is not surprising that this period also saw Christian missionaries and other humanitarians raising awareness of the excesses of colonial power and the abusive effect it had on its subjects (C. Calhoun 2010). Certainly for Schweitzer (1951, 116) these concerns accompanied his "works of mercy" which he described as acts of "atonement" to assuage the guilt of colonial complicity. These objectives were not anti-colonial in the sense that they sought the defeat and removal of colonial control. Rather, as was the current thinking of the times, Schweitzer held views similar to other colonialists who believed in the civilising project of Western education and medical care to "convert 'wild' natives into better people and the prisoners of unfortunate traditions and superstitions into modern, rational human beings" (C. Calhoun 2010, 39).

Ba Kobhio's interest in Schweitzer stems from his long-time fascination with "this character caught between two continents and who founded, for better or for worse, what we now call 'relief work'" ('Grand Blanc de Lambaréné (Le)' 1995). The unprecedented scale and sophistication of MSF's work on a global scale is a relatively recent development, but it draws inspiration from "altruism, reverence for life, and the idea [that] brotherhood can become living realities in the hearts of men" (Jahn 1952). These words were uttered by the Nobel Prize Committee in recognition of Schweitzer's work just less than 50 years prior to MSF receiving the same award in 1999.

While MSF might wish to avoid direct and uncomfortable comparison with the colonial context of Schweitzer's medical humanitarian work, MSF's belief in speaking out against injustice (R.C. Fox 2014) has some connection to Schweitzer's (1951) willingness to declare his views. Schweitzer publicised his work to raise funds while also criticising the French colonial administration of Gabon for the suffering "brought to these children of nature [African colonial subjects] by Europeans" (Schweitzer 1951, 61).

The usually reverential way in which Schweitzer was seen by European and American humanitarians is made all the more complex by the contradictory ways in which African scholars receive him. The

first African and Muslim to occupy the Albert Schweitzer Chair in the Humanities at the State University of New York, Kenyan-born scholar Ali Mazrui, is particularly critical of Schweitzer's engagement with the Africans with whom he worked, particularly because of his restricted "interest in their bodies as patients and not their minds as thinkers" (Mazrui 1991, 99). These sentiments are borne out in repeated viewings of Hofmeyr's film where the character of Schweitzer remains overwhelmingly focused on the corporeal, making little attempt to understand the beliefs of a traditional African healer who threatens the care of his patients at the clinic. In Ba Kobhio's film, Schweitzer, now frail and close to death, exclaims his love for the land while Bissa, a fictional Gabonese woman played by Magaly Bertly who comforts him through his long stay in Gabon, laments that during his time he "should have loved the men and women here" (Ba Kobhio 1995).

In his book *On the Edge of the Primeval Forest* (1951), Schweitzer blames the colonial administration for its exploitation of the local population in order to maximise the extraction of natural resources, and for the deprivation and suffering this caused. Yet, at the same time, the paternalism he directed towards African patients and medical orderlies at his hospital contradicts his ideas of humanitarianism born of a desire for equality between all humanity. Chinua Achebe, the Nigerian writer and academic, states that "a saint like [Albert] Schweitzer can give one a lot more trouble than King Leopold II, villain of unmitigated guilt, because along with doing good and saving African lives Schweitzer also managed to announce that the African was indeed his brother, but only his junior brother" (Achebe 2009, 191). In Ba Kobhio's film, these deep contradictions are jarringly depicted in Schweitzer's continued reference to Africans as "primitives" and "savage" (Ba Kobhio 1995). In another scene in the film Schweitzer strikes Mikendi, a black worker at the clinic, who vows that "the blow the white man struck will be repaid" (Ba Kobhio 1995). This triggers a sequence of narrative events surfacing the racial tensions between the white doctor and Mikendi which runs through the rest of the film.

Race and biopolitical power

That race should feature so significantly in the narrative is also a reflection of colonial power in Africa where "race has been the ever present shadow in Western political thought and practice, especially when it comes to imagining the inhumanity of, or rule over, foreign peoples" (Mbembe 2003, 17). Colonial rulers categorised those under their control as inferior and where interventions were made in their territories to quell conflicts or disruptions, it was usually attributed to the backwardness of the local populations (C. Calhoun 2010). Where these views held a medical dimension, racist views usually extended to the assertion that indigenous subjects could not be left to account for their own health care (Packard 2016, 14).

That the colonial state is racially selective in how it applies these systems of control is amplified by Mbembe's views of race as a prominent "calculus of biopower" under colonialism (2003, 17). He extends Foucault's ideas of race as a technology operating as a biological and discursive category in the exercise of biopower by the Nazis, with its "final solution" focused on the destruction of European Jewish populations, to help define the modern racist and murderous terror-state (Mbembe 2003, 17). Mbembe (2003, 18) draws historical connections between the rise of the modern terror-state and the Transatlantic slave trade and refers to the colonial systems which also carried out genocides against their subjects as a precedent for the mass genocide of the Nazi-era.[1] Through this work, Mbembe (2003) introduces the dual ideas of "necropolitics" and "necropower". Mbembe (2003, 40) describes how the biopolitical control inherent in slavery and colonialism depend on racist rationales to improve the life of a dominant group through the neglect of marginal groups.

In explaining necropolitics as an "efficacy of the colony as a formation of terror" Mbembe (2003, 23) identifies sovereignty and states of exception, discussed earlier in this chapter, as intrinsic to the operation of these power formations. That the state of exception associated with contemporary disasters, such as the medical interventions depicted in *The Last Face* and *Beyond Borders,* should find precedents in colonial spaces is not unexpected considering that colonial administrations not only caused disasters but also developed the earliest systems of response (C. Calhoun 2010). Additionally, it is argued that the temporary nature of the emergency intervention, with its aims of

[1] *Letters of Stone* by Steven Robins (2016) offers a compelling account of Dr Eugen Fischer's first eugenics study on the Baster people in German South West Africa (Namibia) in 1908, following the genocide perpetrated during the Herero and Nama rebellion, and describes Fischer's influence on the Nazi regime's ideologies of racial science.

managing rather than governing, resonates with the colonial health administrations and their management of local populations for its extractive industries.

Hofmeyr's film avoids the moments of overt racism depicted in Ba Kobhio's narrative and instead focuses on Schweitzer's reluctance to accept new developments in medical technology and modern methods which might improve the level of care provided to his patients. When some visiting American donors raise concerns over the squalor around the hospital and the spoilage of medicine caused by the tropical heat, which might be avoided through electrification and refrigeration, Schweitzer defends his resistance to modernisation, insisting that "simple people need simple medicine" (Hofmeyr 1990). In a later scene, Schweitzer explains to Curtis, an American surgeon working with the American donors, that he intends to reject their offer to modernise the hospital because he has "learnt to treat the African people in the environment they know" and that "to do anything else would not be to cure them but to change them" (Hofmeyr 1990). Here Schweitzer's beliefs about Africa are better understood in relation to 19th century European views of the continent as an idyllic Eden that required the preservation of its people in a state of innocence, best served by protecting them from modernity and progress (Pratt 1992; Mbembe 2001).

In explaining his motivation for the missionary hospital he founded at Lambaréné in 1913, Schweitzer writes about the lack of concern amongst Europeans for the "great humanitarian task which is left to us in far-off lands" (1951, 1). His repeated references to Africans as "children of nature" who are seen as suffering "the physical miseries of the native in the virgin forests" (1951, 1) evoke the colonial imagination of Africa and its peoples as existing outside of history and progress. Similar ideas are expressed in a scene from Ba Kobhio's film in an imagined exchange between Schweitzer and Altemeyer, also a Western doctor working at the clinic. When Altemeyer criticises the unhygienic conditions from fires being lit in the clinic, in preference to the use of the electrical generators, Schweitzer questions whether modernism should be allowed to govern the lives of the Africans. He states that: "Modernism has its limits. Primitives will never give up fire" (Ba Kobhio 1995). Schweitzer's statement perpetuates the conception of Africa as outside the European notion of history as a linear process of continual development resulting in ever more sophisticated societies. Mbembe (2001, 176) characterises this colonial mode as one that perceives Africa as "a vast tumultuous world of drives and sensations, so tumultuous and opaque as to be practically impossible to represent, but which words must nevertheless grasp and anchor in pre-set certainty". As the scene continues, the Schweitzer character encapsulates his understanding of European modernity and how this sets it apart from Africa: "Our age is dazzled by science. We forget that only the spiritual truly dazzles. Let us not disturb our primitives' habits" (Ba Kobhio 1995).

Similar ideas were expressed by other colonial and imperial powers, in a colonial imagination that regarded Africa as fundamentally different from other localities (C. Calhoun 2010). While Japan and Britain may have recognised China and India as having complex civilisations that were nevertheless inferior to their own, the view Europe held of Africa was dominated by the Hegelian one of a place and people lost to history (C. Calhoun 2010). This civilising attitude continues to feature amongst some international aid organisations and "remains an uncomfortable feature of humanitarian action" (C. Calhoun 2010, 41). Where such paternalistic sentiments endure in the current humanitarian order they are frequently linked to a general sense of indebtedness to the global North and its willingness to help based on its financial means (Packard 2016).

As already explained, the object of this research is not to chart a medical history of colonial medicine and its linkages to contemporary humanitarian intervention, but rather to understand the construction of the doctor figure across these cinematic themes and modalities. To judge these films on the basis of historical accuracy is not critical to this research. But through the readings of Schweitzer's works and other commentaries about his life, it is clear that the films do not stray too far into the imaginary world while relying on fictional characters in dramatising real events. As narrative works they cannot be considered historical records or treated factually, but, as Dovey suggests, the film texts are open to interpretation for the "kinds of meanings that are made out of the source texts and their historical moments in [...] new contexts" (Dovey 2009, 10). This approach opens the study to comparisons between the contemporary state of exception shaped by the modern humanitarian response and the cinematic representation of therapeutic intervention in its colonial form.

Iatrophobia and distrust

In her book *Medical Apartheid* (2006), Harriet Washington develops the idea of fear and distrust of doctors and medicine in relation to the African-American experience. She investigates the long histories of abusive medical treatment and research conducted along unethical racial lines and coins the phrase "black iatrophobia" to describe a particular racial dimension to the fear of Western medicine associated with the Transatlantic slave trade and the antebellum period (2006, 21). While Washington's focus is on African Americans, she points to a similar tendency in the way the medical encounter may be perceived through the "long and rich history of medical abuse in African and other Third World countries" (2006, 18). The term 'iatrophobia', formed from the Greek words *iatros* for healer and *phobia* meaning fear, is used in this context to describe a fear and distrust of Western medical institutions and its doctors.

Rose-Hunt (2011) traces biomedical research and public health in the Congo during the 1890s and early 1900s, a period that partly overlaps with Schweitzer's arrival in neighbouring French Equatorial Africa (Gabon). In this text, Rose-Hunt explores the conflict and confrontation that characterised how Congolese subjects encountered various dimensions of colonising Europe such as colonial doctors, hospitals, and the diseases they diagnosed and treated. These encounters involving both "violence and negotiation" (Rose-Hunt 1999, 11) also display aspects of iatrophobic behaviour in the sinister metaphors and the warlike qualities of African therapeutics that accompanied indigenous responses to colonial European medical intervention.

The opening scene from Ba Kobhio's film, set at Schweitzer's hospital on the Ogawe River at Lambaréné, is analysed here for its fictional portrayal of the medical encounter. Compared to scenes of medical trauma and triage in *The Last Face* and *Beyond Borders*, the scene stands out for the unfiltered brutality of its portrayal and situates the doctor and medical intervention within the realm of colonial violence. The way Ba Kobhio films the excruciating tooth extraction performed on one of the patients does not allow us to look away but rather frames the shot on the patient as he screams "doctor, doctor....", imploring the unseen figure to stop the pain (Ba Kobhio 1995). The scene forces us to consider the very nature of the medical encounter by keeping the doctor's face out of shot and focusing only on the patient. In this way, the doctor's empathy for the patient's pain is impossible to gauge as we see only the hand working the forceps while prising the stubborn tooth loose. Overcome by the torment, the patient eventually loses consciousness and the scene ends as he is revived by a bucket of water thrown over him. These events convey the iatrophobia of the colonial subject even as the reason for the painful extraction is explained later in the film, not as an act of choice, but rather a necessity born of a shortage of anaesthetic and painkiller drugs at the hospital. Despite this, the unsettling impression of the violence associated with the portrayal of the medical encounter endures, raising important questions for the film's representation of the colonial doctor figure in later sequences.

Earlier in this chapter, the coexistence of military and medical actors within the zone of exception, where national sovereignty is overridden and the emergency of the conflict prevails, was discussed. In extending this biopolitical-security nexus to colonial interventions, it is necessary to consider what Rose-Hunt (2011) describes as the "nervous state". This term refers to a colonial state operating in two guises of power—"a nervous, security-orientated guise and a biopolitical one" (Rose-Hunt 2011, 20-21). For Rose-Hunt the duplicitous nature of the colonial medical administration in the Congo is evident in how it "orientated [itself] towards promoting life and health" while also remaining

focused on the securitisation of healthcare "aimed at arresting and containing public healing, sorcery-laced rumours and therapeutic forms of rebellion" (2011, 21).

While these specifics may be unique to the equatorial region of the Congo, the securitisation of medical care in advancing control over colonial subjects is not, and has received wide attention from a number of the scholars (Noble 2001; Mbembe 2003; Rose-Hunt 2011; Packard 2016). Ba Kobhio explores this aspect in the closing act of his film leading to Gabon's independence from France. As colonial power gives way to African independence, the legacy of Schweitzer's medical work and his humanitarian views are contested by an array of characters in the film. Ba Kobhio develops his critique by depicting the colonial doctor and the hospital as a conduit for the biopolitical within the colonial formation. For this purpose he mobilises the characters of Schweitzer and Koumba, the son of Mikendi, who is first introduced in the film as a boy. Having qualified as a doctor in France, the adult Koumba, played by the French-born actor Alex Descas, returns to Gabon in 1960, taking up a government position in the newly-formed state, which brings him back into contact with Schweitzer (Koplik n.d.). It is at this juncture that we see the anger of the African characters being directed against the doctor and the hospital. They resent Schweitzer's interference and his sense of superiority and soon rally under Mikendi who has a long-standing conflict with Schweitzer. Embittered by the racism he experienced in Europe while fighting Nazis on the side of France during World War II, Mikendi's determination to get rid of Schweitzer plays out as he leads the angry crowd demanding equitable redress for those who have worked at the hospital. When Schweitzer dismisses them, insisting that it all belongs to him, given by his donors for his work, the response is violent and a portion of the hospital is burnt down.

McFalls applies the term "iatrogenic violence" (2010, 318) to describe the inadvertent consequences of contemporary medical humanitarianism when the act of therapeutic intervention assumes the structure of exception and becomes a violent act in itself. Iatrogenic violence is related to the overlapping presence of the medical and security aspects in the contemporary military-humanitarian mission (McFalls 2010). When the scene above is considered in this light, it takes the performative aspect of a response to iatrogenic violence within the imagined conflict zone of the colonial setting. Rose-Hunt's (2011) characterisation of the colonial nervous state operating through the biopolitical-security nexus, also comes to mind. Following McFalls's logic, once sovereignty is replaced by these new forms of control and domination, which may be considered therapeutic domination, biopolitical power is exercised not only in the pursuit of geographic or ideological gains, as might be the case in conventional forms of violent conflict or imperialism, but in the pursuit of power over life itself.

When Koumba intervenes and claims the hospital as a resource for the people of Gabon, Ba Kobhio appears to step back from a complete condemnation of Schweitzer and his work. By claiming the clinic for the postcolonial dispensation, Dr Schweitzer's contribution is acknowledged by the filmmaker. Koumba's acceptance of Schweitzer's contribution to medical care in Gabon brings to mind the ambivalence Chinua Achebe (2009) expressed about how this humanitarian and racist paternalism is received by Africans. That such humanitarian actions can be easily categorised and judged is further complicated by Fanon's views in *The Wretched of the Earth* (1968) on the subject of aid received from former European colonisers. Fanon (1968, 102) considers aid as reparation owed by the capitalist powers to the colonised people for the extracted wealth that accompanied the slave trade and colonial expropriation of raw materials. Such sentiments seem strangely in line with Schweitzer's own description of his work in Gabon as a form of "atonement" (1951, 116) for the guilt of colonial complicity.

As narrative fiction, neither film attempts a definitive response to the question of Schweitzer's legacy. It is worth noting that whatever doubts remain about Schweitzer's work and his opinions of Africa and its people, the centenary of his arrival in Gabon was celebrated in July 2013 with the inauguration of a new building at the site of his original clinic ('Cermel - Centre de Recherches Médicales de Lambaréné - History' n.d.). That the Gabonese government continues to maintain a hospital and a tuberculosis research facility in his name is also worth noting ('Cermel - Centre de Recherches Médicales de Lambaréné - History' n.d.). This is not unique to Gabon: Rose-Hunt (1999, 11) points out that in the neighbouring Congo, where uneven and often coercive colonial interactions were imposed by Western medical systems on local populations, this history does not prevent these systems from being rebuilt in the postcolonial state. From these examples, it is possible to conclude that where the benefits of Western medicine do accrue to the local populations, these systems endure into the postcolonial African state even as the individual actions of some doctors in the past are seen as problematic.

In making the transition from the emergency medical doctor in the films depicting modern humanitarian interventions to the colonial doctor, I argue that both figures are subject to differing forms of resistance from the recipients of these medical services. I have relied on political concepts of biopower and the state of exception to prise these linkages from the cinematic constructions of the African conflict zones encompassing the contemporary and the colonial. Through the analysis of scenes from Ba Kobhio's film and Hofmeyr's narrative, I attempt to offer a comparison between the emergency medical doctor portrayed in recent conflict zones and the colonial medical doctor,

embodied in the fictional characterisations of Dr Albert Schweitzer, to understand the forces of fracture configured within this imaginary zone of exception.

Mbembe makes this transition in extending his idea of necropower from the colonial state to "contemporary forms of subjugation of life to the power of death" (2003, 39-40) which persist in the collapsed postcolonial state under the strain of violence. And it is precisely here, where formal political institutions succumb to uncontrollable violence and sovereignty gives way to the state of exception, that the medical emergency doctor is usually found providing assistance (Fassin 2010). That the contemporary state of exception and emergency intervention is not explicitly configured on the same basis as the colonial territory where the right to life may be suspended or overruled through the matrix of race does not negate the points made here or the persistence of these similarities. For example, it is possible to see how notions embedded in European colonial thinking that native populations are unable to rule themselves and take responsibility for their own health (Packard 2016), also "[underpin] the idea of humanitarian intervention—particularly the idea that one might use military force abroad to achieve humanitarian objectives" (C. Calhoun 2010, 40). In this regard, the claim is made in this study that medical interventions within the state of exception will, to some degree, mirror colonial medical systems with their need for control and subjugation to maximise profitability for its extractive programs. The idea of the nervous state advanced by Rose-Hunt (1999) and Mbembe's (2003) notion of the terror-state are shown to be particularly useful to this inquiry into the cinematic representation of the doctor figure. This reading of the films reveals how the colonial doctor is positioned in these narratives at the intersection of therapeutic and security orientated forms of biopolitical power.

In analysing the cinematic restaging of real events such as the Malakal scenes from *The Last Face* the study has described how paradoxical forces (medical and military) combine and connect within the contemporary state of exception. In forming this argument, the fictional scenes depicting violent attacks at both remote medical outpost and the Malakal PoC site were analysed for the different ways in which they represent the humanitarian and military presence. Likewise, the iatrogenic violence associated with the colonial medical intervention, described in the tooth-extraction scene, is discussed as triggering the response of the colonised subjects as they attack the clinic when their demands for equality and claims to ownership are rejected by Schweitzer.

In both films, the doctor figure is imposed on the situation in ways that connect the coloniser to the modern emergency medical response backed by military, national or supranational forces. In such form, both interventions are crisis-driven and short term with narrow outcomes in mind. Although guided by narrative and dramatic outcomes, selected scenes from these films clearly express a

confluence of these power formations centred on the doctor figure where, in all scenarios, the coloniser and the emergency medical occupier is met by violence in some form or another.

Chapter Five: *Internal Conflict Zones* turns the study inwards, relocating the emergency setting of the conflict zone within the internal dynamics of the doctor character.

CHAPTER FIVE

INTERNAL CONFLICT ZONES

Introduction

This chapter extends the analogy of conflict from the physical terrain of war and colonialism to the emotional realm. This turn is partly guided by my artistic research and the exploration of certain themes useful to the writing of the feature film screenplay that forms part of this study. In this section I must depart from already established theoretical and conceptual paradigms used in the rest of the thesis. This is necessary considering the shift in this inquiry to the emotional and psychological conflict that is internalised in the idea of the healer's wound.

In exploring the idea of the 'wounded' healer, the figure from Greek mythology that I used in developing the internal dynamics of character in my screenwriting, is valuable. I apply these to expand on the construction of the doctor in the films discussed and to argue that the healer who carries an incurable wound should be seen as unique in the configuration of the *dramatis persona* of the doctor. This approach is also applied to the character's physical and emotional journey across the film narratives. In deploying these devices from the creative research to the theoretical arguments that follow, I make no attempt to explain the screenplay.

Where the Western medical doctor's work overlaps and interacts with other healer figures in these films, a critical look at the superimposition of Western mythical and literary traditions is appropriate. This reading of the cinematic characters, European and African, from seemingly irreconcilable backgrounds, cultures and knowledge systems, proceeds on the understanding that the complexities of African healing knowledge and its cosmology and philosophy, cannot be adequately addressed through Western-constructed paradigms and theories. In her exploration of black African medical intermediaries in South Africa, Vanessa Noble (2001, 2) considers the terms "Western" and "traditional" as problematic labels which are often imposed from a particular perspective that confer meanings which do not adequately represent the diversity of experiences encountered by people accessing these healing systems. Acknowledging the Western origins of these terms, Noble (2001) resorts to quotation marks to highlight that these terms do not designate homogenous categories but diverse healing traditions. While accepting her explanation for this approach within the field of anthropology and history, this work relies on the filmed imagination and not the anthro-historical record with its problematic reliance on colonial sources as a credible voice for oppressed and disenfranchised subjects. This section is concerned with indigenous knowledge and Western biomedical systems and how they are represented through the cinematic imagination. In exploring

these themes across the internal or subjective storyline of the doctor characters, these terms are used without quotation marks while acknowledging their inherent epistemological limitations.

The incurable wound

My awareness of the dichotomies in the filmic representations of two different healing systems, Western biomedical and African traditional, and the figures embodying them, expanded while writing the screenplay about a white South African medical doctor during his compulsory community service. Stationed at a rural South African hospital, the doctor encounters an African medical practitioner or *inyanga.* Harriet Ngubane (1977, 101) describes the *inyanga* within Zulu culture as a male doctor who has specialist knowledge of herbal medicines which he prepares for and administers to his patients. In the screenplay, the white doctor is finally convinced by the *inyanga* to work alongside him in a symbiotic rather than conflicted relationship, which usually characterises interactions between Western biomedicine and traditional African healing. Considering the cinematic focus of this research and ever mindful of the limitations of my knowledge and understanding of medical anthropologies and traditional healing practices, the discussion will be limited to healer figures, their character aspects and their interactions in the selected films.

Starting with the doctor figure and the enduring popularity of the character in medically-themed films and television dramas, it is necessary to turn to the origins of these ideas in European culture and their first recorded examples. Jouanna and Allies (2012) describe the influence of ancient Egyptian medicine on Greek medicine extending as far back as the 1800s BCE[1] and through to the Ptolemaic age through a close reading of Homer's *Odyssey* and *Iliad* and the later writings of Hippocrates and Herodotus. The influence of these ancient myths on current representations of the doctor figure will now be developed further.

The immensely popular medical series *House* (2004), for example, attracted an impressive 81.8 million global viewers during its fifth season, earning its status as "the most-watched program on television for 2008" (Waddell 2011, 72). Writing about its eponymous character Dr Gregory House, Angela Cotter (2011) differentiates four manifestations of the healer derived from Greek mythology. The first of these is the "healer who both wounds and heals", another is the healer "who has walked close to death", while the third and fourth categories refer to "the healer who bears a permanent

[1] 1800s BCE is numerically equivalent to 1800s BC but instead refers to 'Before the Common Era' and has become popularised in scientific and academic texts as a culturally neutral term which avoids references to Christianity.

wound" and "the healer who heals through their wounds" (2011, 106). A character may embody all four or only some of these frequently overlapping characteristics.

In ancient Greek mythology, centaurs are savage creatures assuming a half-man half-horse form and are considered to be more beastlike than human. Among them is Chiron, who is also a healer and serves as a surrogate parent for abandoned and unwanted children. Chiron's nurturing ways earn him the reputation as one "learned in the ways of herbs and gentle incantations and cooling potions" (Hamilton 1969, 280). Upon being wounded accidentally by a poisoned arrow shot by Hercules, Chiron's wound remains incurable and his name is immortalised as the healer who endures everlasting pain as he is unable to cure himself (Hamilton 1969). This paradoxical figure of the great healer unable to cure his own wounds stands out in Greek mythology as a wounded god and lays the foundation for many subsequent embellishments that endure in Western thought and contemporary popular culture.

Before returning to the scenes of the wounded healer in the films, it is worth considering Cristancho and Fenwick's article, "Mapping a surgeon's becoming with Deleuze" (2015). Using French philosopher Gilles Deleuze's ideas to map the experience of surgery as a pedagogic tool in medical education, the researchers highlight certain findings on the surgeon's emotional wounding as a consequence of their professional practice. For Deleuze, the idea of 'becoming' is an act in and of itself and offers a break with linear representations and causal outcomes (Cristancho and Fenwick 2015). By subjects drawing maps to visualise their experiences, the emotional impact of surgery on the doctor is opened to an interpretation which "identifie[s] a number of visual archetypes that […] describe their emotional experiences, such as 'the outcast', 'the unhealable wound' and 'battles of light and dark'" (Cristancho and Fenwick 2015, 2).

These actual experiences related by working surgeons are helpful to this analysis of the internal conflicts shaping the fictional doctors in the films. In *Beyond Borders* (2003), Callahan operates on the injured mother as she stoically bears the pain of surgery without anaesthetic. While the patient's pain is significant, the audience's attention is focused instead on the surgeon and their healing hands as the patient idealises their ability to cheat death. This reveals the paradox which Cotter (2011, 106) describes as the "healer who both wounds and heals". A closely observed moment which passes between León and a waiting patient as a surgical case dies under the doctor's care on the operating table, has been highlighted in this research. For León, the flicker of self-doubt that underlies this exchange resonates with the themes revealed through the mapping exercise which describe the excessive expectations placed upon the surgeons, where this burden prevents them from "displaying weakness or uncertainty [and as] alienated from their own experiences" (Cristancho and Fenwick

2015, 1). Similarly, in *Beyond Borders*, Callahan's patronising dismissal of Jordan's concerns for the wounded victim he is required to operate on without anaesthetic, appears now as less a display of his irritating callousness than a defence against his own wounding and vulnerability.

The idea of the healer with an incurable wound who heals through the wounding process resonates with multiple figures in Greek cosmology and endures in doctors trained in Western biomedicine (Cotter 2011). These doctors swear an allegiance to The Hippocratic Oath with its ties to the deities of Apollo, Asclepius and his daughters (Waddell 2011). It is from Chiron that Asclepius learns his art and emerges as the archetypal doctor figure, the ancient physician and demigod of healing (Waddell 2011). These references carry powerful symbolic meanings associated with Western biomedical work such as the Asclepiad Staff, a recognisable symbol of contemporary Western medical culture, with its singular sacred snake representative of ancient healing qualities (Waddell 2011). This becomes a progenitor for the caduceus, the staff entwined with the double snake which is adopted by Hermes, the messenger god, which is sometimes mistakenly used as a symbol of medicine in the modern context (Waddell 2011). Within this pantheon, Apollo is also understood to be a wounded healer and serves as an analogy for the surgeon who yields the "knife that wounds [and] also heals" (Cotter 2011, 106).

This notion of the doctor with a wound that also heals resonates in many Western literary forms, such as this vivid stanza from the second poem of T.S. Eliot's *Four Quartets*:

> The wounded surgeon plies the steel
> That questions the distempered part;
> Beneath the bleeding hands we feel
> The sharp compassion of the healer's art
> Resolving the enigma of the fever chart.
>
> (Eliot 1959, 29)

These examples illustrate the essential importance of such themes to the enduring qualities of the doctor character which have carried across centuries and continue to be felt in popular depictions of Dr Gregory House (Cotter 2011, Waddell 2011) in the TV series and in the films discussed here. From the earliest television versions depicting the doctor as a faultless saviour-hero in *Dr Kildare* from the 1950s (Turow 1989), the wounded doctor inspired by mythology has emerged in its current form in series like *House* (2004) as an insecure figure with contradictions and character flaws, "capable of making mistakes or lapses in judgement under pressure and coping with complicated private lives which sometimes affected their work" (Lupton 2003, 57). As a creative tool for screenwriting and as a conceptual approach to understanding the characters in the films, the humanising quality derived

from the internal wound reveals the doctor as someone whom the audience can identify with even as they carry out the secular work of saving lives.

The contact zone

That this mythical aspect in discourses peculiar to the West should be carried into the colonies of Empire is unsurprising. Mary Louise Pratt's (1992) work around the construction of colonial identities through travel writing from the period of colonial and imperial expansion reveals how layers of representation and identity formation evolved in the zone of colonial contact. This is a space in which seemingly irreconcilable dualities encounter each other and "establish ongoing relations, usually involving conditions of coercion, radical inequality, and intractable conflict" (Pratt 1992, 7). In previous chapters, these qualities were discussed in relation to the medical encounter in both the contemporary conflict zone and its colonial form. Pratt's understanding of the two-way flow between the colonies and the metropolis invites new ways of considering the rigid binaries separating the Western doctor and the practitioner of traditional African healing as they encounter one another in both Ba Kobhio's and Hofmeyr's films.

Pratt's more nuanced approach sees the coloniser and colonised as intertwined by their "copresence, interaction, interlocking understandings and practices, often within radically asymmetrical relations of power" (1992, 7). These colonial encounters Taussig characterises as "spaces of death" (1987, 5) where jumbled signifiers for deciphering the power relations so meticulously imagined by the colonisers of the New World are subverted by the colonised. The study finds resonances of this fraying of European desire for total control in one of the canonical texts of Western colonial literature.

In *Heart of Darkness* (Conrad 1981) Kurtz's mental disintegration stems from the extreme measures he has employed to procure vast ivory stores for the company he works for. As his power over the local inhabitants becomes increasingly precarious, culminating in Marlowe's arrival, so Kurtz's physical symptoms, his emaciated body and convulsive state to which he finally succumbs on the steamboat, serve as a metaphor for his loss of control (Servitje 2016). The description of "the whole sorrowful land, the immense wilderness, the colossal body of the fecund and mysterious life" (Conrad 1981, 87) is compared to Kurtz's fevered mind and the measure of his deteriorating medical condition.

That these imaginary discourses perpetuated colonial stereotypes about Africa is not in question. What is of interest here is the fluidity of colonial exchanges and how they are expressed in sometimes surprising and unexpected places. Kramer (1993) offers the example of the European

doctor, represented in totemic figures wearing a stethoscope and drinking beer, and how this figurine is initiated into zar-cult rituals in Sudan. She also offers several examples of the European outsider being appropriated into African myths, cosmologies and possession rituals as a framework for understanding African expressions of the "other" extending back to pre-colonial times. Here, Kramer is interested in the incongruence between Europeans' ideas of uniqueness which they bestowed on themselves in their first encounters with Africans and the way they were in fact received by the indigenous inhabitants. He repositions Europe as "no longer the centre of the world or the crowning point of history" (1993, x) and so tries to understand the European as the observed, thus inverting the traditional power dynamic which views the "other" from the position of the coloniser. From this perspective, the symbolic assimilation of the outsider into African ritual practice attempts to turn the mirror back on the Western gaze and questions the scientific desire for observation (Kramer 1993).

The concluding idea of Ba Kobhio's film is expressed on screen: *Tous ce que nous poupons, c'est laisser les autres nous diviner comme nous les deri nous* [All we can do is to allow others to discover us as we discover them] (Ba Kobhio 1995). It is attributed to Dr Schweitzer and challenges us to rethink our understanding of the encounter between Schweitzer and the African healer figure by questioning the perception of European uniqueness from the colonial gaze. Drawing on established African systems extending back to pre-colonial times, Kramer offers an inverted explanation for these first encounters in which "Europeans were for Africans as Africans were for Europeans: primarily one further sort of savage among other savages" (1993, x).

In challenging the beliefs which arose in the European Enlightenment that understood itself as the observant intellect, Kramer's reading of African ritual and cults foreshadows a confrontation between traditional healing systems and what Foucault (1973) describes as the clinical gaze with its reliance on scientific observation as the basis for medical knowledge. It is important that this theoretical repositioning on Kramer's part is not misunderstood as an equalising of the uneven power relations which characterised these encounters. Rose-Hunt (2011) reminds us of this in her work on the neighbouring Congo, where the subjugation of African medicines by the colonial powers was in reaction to the fear of rebellion associated with the supposed warlike qualities of African therapeutics. In applying these ideas to the films set around the Schweitzer character, rivalries between the colonial doctor and the African healer may be seen playing out in different ways. They are given considerably more nuance in Ba Kobhio's telling than they are in Hofmeyr's version, which derives from well-worn colonial tropes "where the intrepid District Commissioner, representing

civilization and the forces of light, is opposed by the sinister figure of the witch-doctor, the epitome of evil, primeval cunning and the dark forces of barbarism" (Hammond-Tooke 1989, 103).

In Hofmeyr's version the scenes at Lambaréné begin with the Sorcerer, the Oganga—played by the imposing South African actor Henry Cele—making an unexpected visit to the hospital. The Oganga's attempt to free a mental patient restrained at the hospital forces a standoff with Schweitzer and sets their adversarial relationship in motion. As the story unfolds, the Oganga agitates to discredit Schweitzer and all he represents in order to regain the loyalty of his tribesmen, which has been diluted by imported Christian values and medical cures brought by the European interlopers. In highlighting these aspects of Hofmeyr's narrative progression, the analysis that follows intends to show how these colonial tropes seek to position the African healer as cruel and unfathomable to Western rationality and modernity. In marginalising and suppressing African customs and beliefs, the film presents European practices of healing and the treatment of disease as uniquely superior. In reality, Schweitzer's responses to local healing practices were less antagonistic than Hofmeyr's dramatic choices suggest. In his accounts, Schweitzer is surprisingly non-judgemental in his acceptance of the honorific "Oganga" given to him by Africans in their language of Galoa: "they have no other name for a doctor, as those of their own tribesmen who practice the healing art are all fetishmen" (Schweitzer 1951, 23).

In trying to decentralise the Western gaze and offer a view of the contact zone which "foreground[s] the interactive, improvisational dimensions of colonial encounters" (Pratt 1992, 7) Ba Kobhio's more nuanced interpretation explores a reluctant cooperation born of necessity between Schweitzer and the traditional African healer. In an early meeting with the Sorcerer character, played by Philippe Maury, Schweitzer suggests a brotherhood based on their shared knowledge of healing. But the Sorcerer insists that their knowledge is different because "our science isn't just written down, it's alive" and that he belongs only to the "brotherhood of the panther" (Ba Kobhio 1995). Schweitzer's rapprochement with the Sorcerer is intended to gain access to the herbal medicine called *iboga*, claimed by the locals as a powerful analgesic. With the hospital's anaesthetic depleted, he must enlist the Sorcerer's help. However, the traditional healer insists that the knowledge of this medicine is not his alone to give, but instead belongs to his people. And so Schweitzer is seen engaging the community through its established systems to plead his case that the medicine be used to help others.

While Ba Kobhio's retelling explores the contact zone as a two-way interaction (Pratt 1992) that blurs the boundary between the worlds of these different healers, Hofmeyr's version sees Western science pitted against African healing systems. In offering this approach, Ba Kobhio is mindful of the

persistent asymmetrical power relations in these exchanges when he shows Schweitzer's innate sense of superiority which relegates the traditional knowledge to an inferior position. Not surprisingly, once he receives the *iboga*, the European doctor must resort to assaying its active ingredients, subjecting the compound to scientific scrutiny to determine its efficacy so that he might provide a "native African medicine" to his "primitives" (Ba Kobhio 1995).

It is important to acknowledge the real ways in which colonial authorities sought to restrict and eradicate a reliance on traditional healing beliefs, as Masondo (2011) does in his account of the long-lasting and devastating effects this repression has had on African knowledge systems and religious beliefs. A more comprehensive account of this troubling history falls outside of the scope of this research, limited as this section is to the filmic representation of the exchanges between the colonial doctor and the African healer. With these limitations in mind, the research offers only fragmented explorations of the different healing systems represented in the films.

By avoiding any encounter with African traditional healing, the films set in the contemporary iterations of the conflict zone fail to countenance the many documented ways in which "Africans routinely negotiate therapeutic economies within postcolonial Africa, as they move with their kin among healing possibilities" (Rose-Hunt 1999, 7). Yet by this absence, these films concede to the same overwhelming faith shared by international NGOs and the medical interventions they depict in deferring to the superiority of Western medical knowledge and technology while devaluing local knowledge and abilities (Packard 2016).

The next section posits the underlying 'calling to become a healer' as shaping the journey of the healer and as a way of framing the narrative considerations important to this research and creative work.

The healer's calling

In writing about medicine among the Nyuswa-Zulu, Ngubane (1977) contrasts the choice to become a diviner, or *isangoma*, who is usually female and shares a comprehensive knowledge of medicine, with the choice to become a traditional doctor or *inyanga,* who is usually male. In the case of the *isangoma* the calling is not a voluntary one but is initiated by the ancestors who bestow upon the chosen the clairvoyant powers necessary to become a healer (Ngubane 1977). For the *inyanga* the decision is left to individual choice and unlike the *isangoma,* to whom knowledge is revealed by the ancestors, the traditional doctor acquires the necessary knowledge of herbal medicines and their preparations through study (Ngubane 1977).

In his writings about power and magic in the New World, Taussig (1987) considers that the calling to become a healer is vastly different in the worlds of the coloniser and the colonised. While the Western doctor makes professional and occupational choices that require certification by institutional authorities in order for them to practice, the "folk healers and shamans embark on their careers as a way of healing themselves" (Taussig 1987, 447). In describing the calling of the Western doctor, David Cumes (1999), himself a medical doctor, suggests that a wound exists in both healers but points to an important difference in the way the healer responds in each case to the wounding process. He describes the wounded shaman healer archetype as inflicted with a primal wound that "is often a 'wound' or crisis, physical or psychological, that is required to force a medicine man or woman on a journey of transformation" (1999, 24). Taussig expands on the idea of a journey which he describes as a shared one between healer and patient whereby the "healer relives this journey on the brink of death" (1987, 448).

Cotter also describes the wounded healer as one "who has walked close to death and recovered" (2011, 109). The myth of Asclepius illustrates this archetype of a wounded healer who is rescued from death's door by his father Apollo who killed his mother, the mortal Coronis, in order to save the child by Caesarean section at the moment that Coronis was on the funeral pyre (Hamilton 1969, Cotter 2011).

This close experience of death is also related to shamanic[2] initiation where the individual troubled by continued illness "is marked out as the one with the vocation to be a healer" (Cotter 2011, 110). Ngubane (1977) writes that the *isangoma*'s refusal to accept the ancestral calling may result in sickness and even death. The Xhosa people of South Africa refer to the ancestral calling as *ukuthwasa* which is translated to mean "come out" (Booi 2004, 3). Booi (2004, 3) describes this calling as a "healing sickness" which may present in a variety of psychological and physical ailments for the recipient. Where the initiate is unable to recover from this sickness, the *ukuthwasa* may be revised to a diagnosis of "*ukuphambana*[3] and a person may also be referred to a psychiatric hospital for treatment" (2004, 5). This pattern supports Taussig's (1987) claim that the shaman's journey in becoming a healer is, in part, motivated by the need to heal themselves. Cecil Helman (2006), another medical doctor and anthropologist, develops the idea of a wounding process in both healers

[2] It should be noted that the use of 'shaman' as a catch-all term for traditional healers in the African context is problematic given its original use by Avvakum, a 17th Century Russian Orthodox priest, in describing non-Christian beliefs and practices arising in Central Siberia.

[3] *Ukuphambana* is a Xhosa word for insanity (Booi 2004, 5).

at the centre of these different healing systems. Unlike the physical or psychological wounding which Taussig (1987) and Cumes (1999) describe as inciting the shaman's healing journey, or the forms of ancestral calling which Ngubane (1977) identifies in Zulu culture, and Booi (2004) describes among the Xhosa, Helman suggests that the Western doctor "become[s] wounded as part of their education" (2006, 162).

This learning by practice is integral to the education of medical doctors at universities and the emotional experience of surgical interns is also charted in the study using Deleuze's approach (Cristancho and Fenwick 2015). In reading the visual themes encountered in the mapping exercise, the authors identify the recurrence of "the unhealable wound" as a common visual archetype amongst the participating surgeons (2015, 2). The unhealable wound attributed to the surgeons participating in Cristancho and Fenwick's study bears direct comparison with Cotter's description of "the healer who bears a permanent wound" (2011, 106) under the four manifestations of the wounded healer in Greek mythology. In another account a surgeon relates to their morbid feelings associated with a patient dying during surgery: "you often think inside yourself that you actually killed someone despite the fact you're trying to help them" (2015, 5). This sort of secondary wound caused by the physician's professional training is not the reason why the physician embarks on his or her career as is the case with the primal wound associated with the shaman's calling to become a healer (Cumes 1999).

An understanding of this secondary wound was indispensable in developing the internal journey of the young doctor in the screenplay submitted as part of this research. His internal conflicts chart a subjective struggle that reverberates with the external conflicts he encounters during his year of community service in a rural hospital. Faced with severe shortages and the remote location of the hospital, he is forced to perform an emergency surgical procedure in order to save a dying patient. This secondary wounding inflicted in the process of becoming a doctor and surgeon gradually reveals the character's life-lesson: that in order to heal others he must first heal himself.

In previous chapters, the characters of Doctors Callahan, Léon and Petersen are shown struggling with professional and moral dilemmas as they are forced to make difficult choices using the triage system in selecting between those they can save and those who are beyond their help and should be left to die. In other scenes, dramatic conflict and crisis situations force them to question their role as neutral actors in the conflict zone. In *The Last Face* (2015), these doubts pre-empt Petersen's decision to withdraw from the field. Such screenwriting forces characters to make difficult choices under pressure in order to reveal their inner turmoil to the audience. In relocating the external conflict zone to the emotional conflict within the doctor figure, this chapter argues that the

wounded healer motif is useful in understanding the Western and African healers encountered in the films.

In applying these ideas to the filmed representation of the traditional African healers and the Western doctors in the colonial setting, the intention is not to plaster over their distinct differences but to point out certain underlying similarities. Whatever distinctions separate these types of healers, and there are many, the notion of an internal wounding associated with the healer's journey, arising from whatever cause, primary or secondary, is indispensable to a broader reading of the doctor figure. While the study has shown that the notion of a wounded healer is relevant to the reading of all healers from very different backgrounds, the main focus of this research is on the central figure of the Western medical doctor.

The external (physical) obstacles such as medical shortages and risk of attack have been prioritised for their importance to the narrative of the doctor figure in the conflict zone. In this section, the dynamics of internal conflict are offered as an important aspect of the doctor's journey as one of "first master[ing] their own inner demons, whether personal or professional, before trying to master those of others" (Helman 2006, 162). Both these conflict zones are mobilised in deepening this research and its insights. Considering the nature of these internal conflicts and the foundational myths of the wounding process, I argue that these aggregates coalesce in unique ways around the Western doctor and are important to a more holistic grasp of this narrative figure as a dramatic character in the films.

In rounding off this chapter, a brief consideration of the medical intermediary, a figure that is only glimpsed in the films within the in-between spaces of the conflict zone, is necessary. The medical intermediary is not a mere detour from the main focus of this research. I intend the next section of this chapter as an invitation offering intriguing possibilities for future cinematic research. The study raises the idea that the medical intermediary is placed, in profoundly different ways to the doctor figure, at the divide that characterises the conflict zone.

Medical intermediaries

The opening of *Schweitzer* (1990) is accompanied by a voice-over by Dr Curtis, who arrives at the hospital with visiting American philanthropists. He describes the hospital as situated at the juncture of two worlds and serving as "more than just a health facility, it is a membrane between cultures" (Hofmeyr 1990). This observation of the hospital at Lambaréné is also appropriate in describing the role of the medical intermediary figure in his or her function at the interface of a multi-level range of exchanges in both colonial and contemporary medical encounters.

Rose-Hunt (1999) and Noble (2001) explore the complex ways in which these intermediaries intercede between various groups in bridging the divide between the different types and experiences of healing systems in the colonial administration. Rose-Hunt avoids the complicated hierarchy conferred by the term "subaltern" (1999, 8) within systems of colonial power where such claims to rank also require the naming of those lower on the ladder. Instead, she prefers the term "low" (1999, 8) in referring to intermediaries rather than internalising colonial civilising hierarchies. Noble, in her study *Black Community Health Intermediaries in South Africa, 1920-1959*, uses the term "health intermediary", which she defines as a "place-marker to flesh out a range of social and hierarchical relationships that were 'middle' in one sense or another" (2001, 1). While acknowledging the racial and colonial implications of these hierarchies, this study refers to the medical intermediary in expanding on how this figure is depicted in the films.

In Hofmeyr's film Schweitzer is shown sharing tea with his wife Helen during a short break from his hospital chores, she enquires after the well-being of one of the clinic's local helpers, Joseph, played by South African actor Patrick Shai. Joseph's predicament is described by Schweitzer as being "caught between two worlds" (Hofmeyr 1990) as he is struggling with the social taboo of his wife having born a set of twins. As Hofmeyr's story unfolds, Joseph becomes increasingly embroiled in the conflict between Oganga and Schweitzer. In mobilising this figure in the narrative, Hofmeyr makes use of the medical intermediary in order to show the dramatic conflict between the two worlds of the missionary doctor and the traditional healer. Joseph's character is deployed against the practice of local beliefs, which are depicted as harmful and barbaric superstitions, and in defence of Western medicine. Used in this way, Joseph's character portrays how missionary doctors working in rural African communities in the 19th and early 20th centuries relied on trained health intermediaries in order to "halt what they saw as the harmful 'witchcraft practices' of indigenous healers, and to spread Christianity" (Noble 2001, 3).

Although only a minor aspect of Ba Kobhio's film, the role of the intermediary is alluded to when we first meet the young Koumba in a part of the story set in 1944. Still enthralled by the great white saviour, the boy wants to become a doctor like him. Schweitzer corrects the boy, explaining that Africa does not need doctors, but nurses. Beside the apparent separateness which the scene exerts over the control of medical knowledge as something reserved for white doctors, it also acknowledges the possibility of African people becoming skilled health professionals. In French West Africa, which incorporated French colonies bordering Gabon where Schweitzer had built his hospital, the training of indigenous Africans stopped short of providing them full medical training on the same level as Europeans, ensuring that African health workers were limited to the professional role of the

intermediary while the stature of the medical doctor was reserved for Europeans (Noble 2001). Avoiding this outcome in the story, Koumba leaves Gabon and studies as a doctor in France before returning to the country as it gains independence in 1960. As described in the previous chapter, this results in a series of confrontations where Koumba and his father, Mikendi, are pitted against Schweitzer over the white doctor's contribution and questions of his legacy.

In Ba Kobhio's telling, the limitations imposed on people like Koumba by the racial and professional system that restricted them to an intermediary role are only overcome by the end of colonial administration in French Equatorial Africa and the birth of independent Gabon. This milestone is pictured in Ba Kobhio's staging of a scene in which representatives of the new government of Gabon are introduced at a public rally. The events depict Schweitzer as an isolated figure on the periphery, as Mikendi and Koumba are now centre stage. This overturns the carefully imagined hierarchy that Schweitzer imposes on the young Koumba when he suggests he become a nurse rather than a doctor. Where the role of this 'middle' figure was once limited to mediating between white doctors and the black community, Koumba emerges in its place: an African doctor trained in Western biomedicine who is able to finally supplant the colonial doctor. Here Ba Kobhio inaugurates the figure of the African revolutionary and doctor to symbolise the potential of the African medical intermediary which is denied under colonial rule.

Returning to the films set in the contemporary postcolonial conflict zone, we see medical emergency teams deploy for fast action in response to the crisis at hand. These interventions measure results in short-term success at the expense of longer-term gains such as sustainable socio-economic development and local health systems (Packard 2016). In *The Last Face* we meet Moussa, played by Liberian actor Zubin Cooper, who works for the medical NGO in the story. In modern parlance, these "national staff' working in the countries where they reside are employed as drivers, cooks or medical assistants by NGOs like MSF (R.C. Fox 2014). One clear difference here is that while national staff are compensated financially for their work, the doctors, who are usually from countries in the global North and head up these medical teams, serve under an ethos of volunteerism, which is an important founding principle of organisations like MSF (R.C. Fox 2014).

In the triage scene in *The Last Face* Petersen and Léon argue over the choice between withdrawing their services from the field in order to speak out about what they have witnessed, or remaining and providing whatever limited medical help they can under difficult conditions. Moussa, dressed in a white doctor's coat and scrubs, overhears the altercation before interrupting them. After first thanking them for their work, he points out that which separates the expatriate doctors from himself as a Liberian national. The foreign doctors can leave at any time, while "It is not until you

can't leave, that you can know..." (Penn 2015). His sentence trails off, but its meaning is felt by Petersen, the white South African doctor. The implication is that while the doctors are witness to the pain inflicted by the war while trying to help the victims, somehow the path to a deeper understanding of the suffering that endures within the conflict zone is open only to those who live in Africa without an easy escape to Europe or other places. In this sense, the intermediary's experience of the conflict zone is by implication understood to be different to that of the doctors in the film. The dramatic conflict surfaced in this scene find some parallel in reality through the tensions expressed between local staff and medical doctors in organisations like MSF.

Beneath these uneven relations lies the sharp disparity in the movement of international humanitarian aid which originates from predominantly richer Western societies and flows to poorer nations in response to humanitarian emergencies caused by conflict, contagion or natural disaster (Fassin 2010; Packard 2016). While submerged in the film narratives, these tensions surfaced as real-life considerations for MSF during the La Mancha conference of 2006 (R.C. Fox 2014). Gathered to assess the progress and growth of the organisation since its previous conference in 1995, which had resulted in the Chantilly Principles (Médicins Sans Frontières 1995), the organisation had to confront an important change in its demographic. Over the intervening 10 years, the staff numbers had doubled to over 24 000, but most striking was the fact that 92% of all MSF staff working in the field were national staff who lived in the countries where the project was located, while only eight percent was made up of expatriate volunteers (R.C. Fox 2014). Uncomfortable debates over perceived racism, colonialism and neo-colonialism followed as it was acknowledged that local staff were often marginalised in favour of medical doctors who were prioritised and became the centre of media attention for their contributions (R.C. Fox 2014). Similar power imbalances arise in the cinematic imagination through the representation of the local health workers and the predicaments they confront in the films discussed.

Earlier in this section the point was made that as a product of colonial power relations, the medical intermediary straddles the divide between the colonial doctor and local African communities. Here, the argument is extended to the contemporary configuration of the NGO working in the conflict zone and the depiction of national staff such as Moussa in *The Last Face*. It is not to say that both figures assume the same functions across time, but that certain tensions linger in the representation of the local staff in the contemporary conflict zone with the intermediary figure depicted in the colonial setting.

In furthering the comparison it is necessary to return to Hofmeyr's film and its depiction of Joseph's character as caught between competing interests. While he is negotiating these contradictory

spaces, Joseph's situation is shown to be even more perilous than that which the doctor must confront since he is also subject to judgment by his own people for choosing to side with the European doctor. In various conflict zones across the world, fatalities are higher among local staff in intermediary functions working for NGOs than they are for expatriates (Simmons n.d.). One of the reasons for this is the tendency to identify aid organisations as "Western before they are recognized as humanitarian" which often has consequences which are "more serious for local employees [...] than for the expatriate workers" (Fassin 2010, 285).

These tensions are expressed in *The Last Face* with devastating consequences for Moussa. As the doctors prepare to pull out of the field following the massacre at the hospital, they are confronted by intoxicated rebel soldiers dressed in a variety of garish outfits. Their leader, The Bride, a soldier in a wedding dress, threateningly confronts each of them about what they do. When The Bride asks Moussa what he does, one of the expatriate doctors vouches that he is also a doctor. But The Bride is not impressed by this response and, finding little of value among their possessions, she turns on Moussa, doubting he is a Liberian doctor, because he has no items of material wealth on him. The harsh reality dividing national staff and the expatriate doctors is brought into stark relief as Moussa suffers the indignation of being stripped in front of his son, Sam, while the white doctors can only watch. In a violent conclusion, the rebels force the boy to shoot his father, but Sam cannot go through with it and turns the gun on himself. Moussa survives at the cost of his son's life and as the rebels drive off, The Bride turns accusingly towards Petersen shouting, "you snap [shot] the bullet!" (Penn 2015), laying the blame for the outcome with her and all she represents as the leader of the medical team. It should be noted that the intermediary figure is configured by the conflict zone, be it in the contemporary or colonial setting, alongside the doctor. It is also significant that the medical intermediaries depicted in the films discussed, derive their dramatic purpose from the central figure of the doctor.

This section argues that in straddling this divide, the medical intermediary, whether framed by colonial administrations or the contemporary conflict zone, is an important figure implicated in profoundly different ways to the doctor. The point made is that while the doctor figure might access a path to escape from the conflict zone, either through their authority or perceived neutrality, the intermediary appears fixed between competing formations. Within this dynamic the intermediary must endure the perils of the conflict zone trapped within liminal spaces between opposing sides, anchored at one end by the medical doctor while, on the other, stands an array of formations that test their allegiances based on kinship and nationality.

This shift in contemplating the medical intermediary expands the thesis to a consideration of a plurality of healing. I have already described how in Ba Kobhio's film, the doctor figure of Schweitzer is shown negotiating access to the traditional pain medicine with the Sorcerer. The destabilising of the rigid binary between Western and traditional medicine described here is also open to the medical intermediary. In Hofmeyr's film, it is Joseph who straddles this divide and serves the colonial intention of subjugating traditional African beliefs of healing for the benefit of Western science and Christian thinking.

This chapter and the following conclusion draw together the major arguments that have been advanced through this thesis. With this, a summary of the chapters is not attempted, but rather a more holistic assessment of the relevance and implications of the key points.

CONCLUSION

This research has explored the construction of the doctor figure in films set in African conflict zones. The study focuses on these stories because they relocate the doctor away from the conventional setting of an ordered urban hospital to the precarious environment of emergency. For the overwhelming majority of people living in more affluent countries, it is plausible that their encounters with emergencies and the people who suffer the effects have for a long time been primarily experienced through popular filmed entertainment and the news media. However, events unfolding at the time of writing this conclusion have changed this experience in profound and very real ways. While the ongoing global response to the COVID-19 pandemic is not a consideration of this thesis, the scale of the devastation and the burden it caused for medical services internationally should be acknowledged considering the themes explored in this study. With these events unfolding so close to home, the sense of inaction and distance that accompanied factual reports of humanitarian crises and medical emergencies occurring in far off lands in the past, may require a fundamental reconsideration of public perceptions and responses to emergency. The reality of this recalibration is apparent in the report made by CNN's Chief Medical Correspondent, Dr Sanjay Gupta, who commented that "this pandemic unfold[ing] in the United States, I now count amongst the worst disasters I've covered" (CNN 2020). His observation is all the more profound when considering that his comparison is based on personal experiences covering the aftermath of the 2004 tsunami in the Indian Ocean, the 2010 earthquake in Haiti, and the 2011 famine in Somalia. Whether as a result of natural disaster, contagion or as a result of human conflict, this research contends that the doctor is of significance because of the prominence this figure assumes in responses to emergency by providing medical care to those in need.

In identifying the limited scholarly work available on medical television dramas that are produced in African countries, the research found these to be almost exclusively occupied with productions funded by international donors. These were focused on the sociological aspects of behavioural change messaging produced in relation to health and the treatment of disease. Published work on the subject of feature films and the representation of the medical doctor where this figure assumes a central role in stories set on the African continent appear to be non-existent or beyond the reach of my research. Consequently, I have framed my research in order to fill existing gaps in knowledge and to explore new territory and themes in the feature films representing the doctor in these conflict zones.

The films discussed encompass a diverse range of African film practice. These tell stories that unfold in African localities in the recent past and also during the colonial era. Some are by filmmakers from outside Africa made with the participation of local crews and actors, while others are creatively driven by filmmakers from African countries, such as Ba Kobhio and Hofmeyr. The application of a Metzian framework separates the filmic fact, with its reading of representation and meaning in the film text, from the cinematic fact, a consideration of the industrial and economic conditions of production and distribution, granting both equal value. In describing the cinematic fact and its various inputs into the filmmaking process, I draw on a film services approach acknowledging the importance of industry practice in its various configurations and exchanges (Goldsmith, Ward, and O'Regan 2012b; Tomaselli 2013; Ureke and Tomaselli 2017). This position is adopted because it offers a broader and more useful understanding of African film practice which positions filmmaking on the continent within a wider socio-economic context.

The study finds this approach to be successful in avoiding the theoretical limitations encountered in the work of earlier theorists of African cinema that relies on concepts and ideologies derived from anti-colonial struggles of the time. I utilise aspects of Harrow's (2008) work in constructing my critique of rigid definitions arising with early Third Cinema theorists (Solanas and Gettino 1976; Gabriel 1982) and their insistence that the primary function of African filmmaking is in response to the false histories and narratives generated by the commercial centres like Hollywood and the West. The study critically engages with these theories and their inflexible definitions and contradictory notions of 'authenticity' in order to assess the ongoing relevance of these ideas to filmmakers working in African now. I challenge these claims to 'authenticity' as a definition of African cinema along with a rejection of commercial filmmaking practices as 'foreign'. I argue in this thesis for a more encompassing approach to African film practice that includes the range of films made on the African continent by both African and non-African filmmakers, as represented by the films selected. In failing to adapt to the increasingly interconnected world that filmmakers now face and which is changing the filmmaking landscape in Africa, I find that current African film analysis which is influenced by these earlier theorists, needs to be updated and new paradigms applied. In addressing these limitations, I have relied on Ureke and Tomaselli (2017) and others who advocate an approach that considers filmmaking on the African continent as consisting of international cinematic exchanges as well as productions made and owned by filmmakers based in Africa.

A more inclusive paradigm in approaching African filmmaking also acknowledges the unequal status conferred on Africa is often repeated in cinema exchanges. This underscores the importance of developing new theoretical frameworks that are able to respond to developments such as those

behind the vibrant local film economies that emerged in Nigeria and elsewhere. We see that where governments incentivise and support film production such as in South Africa and Namibia, international exchanges are encouraged and local film economies benefit through infrastructure investment and skills development while filmmakers located in these countries are encouraged to tell their own stories. This is important in empowering previously marginalised voices to produce content and access new markets so that they might take advantage of the possibilities offered by an increasingly interconnected and digitised world.

In transitioning this study to the representation of the medical doctor in certain narrative fiction films set in the imagined conflict zone, I mobilise the analogy of film services and medical services. I apply this comparison in meshing the literatures from different fields while explaining the fictional emergency doctor in *The Last Face* (Penn 2015) and *Beyond Borders* (Campbell 2003) who appears at the centre of a complex web of power relations at the forefront of the humanitarian response. This analogy also opens concepts like 'Global Hollywood' (Goldsmith et al. 2012) and 'Global Health' (Packard 2016) to further analysis and responses they offer in the face of globalisation. The analysis of the cinematic fact in respect of both films considers this global response in the form of Hollywood productions seeking financial incentives and cost effective film services in suitable distant locations such as South Africa and Namibia. The industrial and economic conditions are discussed within the context of values accruing to the host nation in the form of skills transfer, employment opportunity and tax revenues through the provision of film services. Where relevant, I also show how film services are utilised within the filmed aesthetic of the conflict zone.

With the filmic fact, the interpretation of meaning and representation in the film text turns to aspects of the social sciences for analysis. I am inspired by the work of Rangan (2017) who connects political and legal theories of emergency and humanitarian intervention in understanding the cultural aspects of how emergencies operate in the mode of documentary filmmaking. Azoulay (2008) also draws on much of the same political theory in making her claims about the power formations operating between subject, photographer and viewer around photographs taken in emergency situations. My application of political and legal theory formulated in response to a new global order defined by emergency and international humanitarian response has different outcomes to those produced by other scholars. Moving fluidly between these fields of study, I formulate my approach to understanding how the power and authority of the doctor figure is represented within the cinematic construction of a humanitarian gaze. The meshing of these different fields of study introduces new perspectives to the reading of the films. This composite view reveals how the power

and authority of the doctor figure is transformed and fractured by the conflict zone depicted in the films.

My prior understanding of doctors in films was limited to a surface appreciation of the way the significance and authority attached to this figure was represented. In researching the cinematic imagination of the conflict zone, a more complex figure emerged. One positioned at the nexus of a complicated web of power relations and humanitarian beliefs converging around the provision of emergency medical care to those in mortal danger. Engaging with these multi-layered representations leads to a more nuanced understanding of the various functions that the doctor serves in the film narratives told against this backdrop of human suffering.

While the distance between spectator and sufferer looms large in many factual accounts of these events (Chouliaraki 2006), the reimagining of real events and their deployment as aesthetic and narrative devices within the fictional setting raises important questions about the imbalance of power operating through these images of suffering (Sontag 2003; Azoulay 2008; Rangan 2017). In my reading of the fictional restaging of these events, the doctor assumes a special status as a trusted interlocutor between the distant observer and those unfortunates shown to be suffering. In accounting for both the suffering of the patient and the effect this has on the observer, the doctor plays a unique role in reconciling these divergent accounts of traumatic situations (Boltanski 1999). In mediating this cinematic discourse, I have shown that the doctor serves an important function in addressing the power differentials associated with the narrative of suffering which emerge through the portrayal of the unfortunates and the observer, represented, in this case, by both the audience and characters within the film who witness events.

My interest in the relocation of the doctor figure away from the conventional setting of the hospital to the chaotic conditions of the conflict zone stems from Foucault's (1973) understanding of how the doctor's authority is derived from the state and its institutional structures. Where the systems and structures of the state are compromised or have collapsed entirely, the doctor, operating at the head of the humanitarian intervention, is frequently required to assume functions that were previously regarded as the responsibility of the sovereign. I consider how these forces question the carefully constructed cinematic figure of the doctor situated in the imagined conflict zone. As points of fracture, these fictional scenes are examined in light of operational principles and medical ethics governing real NGOs in the field (Médicins Sans Frontières 1995). In the extreme conditions of the conflict zone where these professional medical ethics are strained to the limit, the doctors in the films must resort to their personal beliefs and practice. In these desperate situations, the doctor stills draw their authority and acts from the location of the hospital even reduced to its most

rudimentary configuration as an emergency dressing post. Mudimbe (1988) describes how Africa is implicated in the construction of European modernity, not as an equal partner, but as an essential aspect of the West's projection of its self-image. From this perspective, the ruined clinic pictured in the cinematic conflict zone does negate claims to modernity, but can be read alongside, and in opposition to, the ordered clinic of the modern European state which Foucault (1973) identifies as the source of the doctor's knowledge and power.

In tracing how military and medical actions intersect and re-emerge across different cinematic expressions extending back to the figure of the colonial doctor, linkages with the contemporary securitisation of humanitarian action and its cinematic representation are revealed. Where the temporary nature of medical and humanitarian response is extended indefinitely and backed by military forces, the therapeutic intervention exhibits a kind of permanence that assumes similarities to the administrative power exercised by the colonial authority over the health of its local populations (C. Calhoun 2010; McFalls 2010). My observation is that when the humanitarian order assumes control under a state of exception as a result of international intervention, the outcome has inescapable colonial connotations for the role of the doctor that are frequently in conflict with their professional values and individual beliefs.

A persistence of misguided colonial thinking which saw indigenous Africans as unable to care for their own health bears comparison with current emergency medical intervention which is predicated on the need to help those in mortal danger because they are unable to help themselves (Packard 2016). This right to intervention emanates predominantly from the wealthier nations able and willing to fund such actions (Fassin 2010; Packard 2016). In their urgent rush to assist, a form of emergency thinking takes hold which prioritises the immediate present over considerations about the historical causes of violence or the longer-term consequences of intervention (Boltanski 1999; C. Calhoun 2010).

Linkages between modern humanitarian interventions and colonial forms of power and control are examined through the complex and contradictory cinematic representations of Dr Schweitzer as a pioneer of medical humanitarianism in Africa. The cinematic facts pertinent to these productions are discussed before moving to an interpretation of filmic fact in the meaning and representation of the film text. *Lambaréné* (1990) (aka: *Schweitzer*) by the South African director Gray Hofmeyr is distinguished on the basis of economic and political considerations from *Le grand blanc de Lambaréné* (1995) by Cameroonian director Bassek Ba Kobhio.

While Ba Kobhio's film was made with the open support of the French Government, Hofmeyr's production concealed the fact that it was produced in South Africa while the country was still under apartheid rule. The aesthetic implications of these different cinematic facts might be read in the end credits of both films. The credits on Ba Kobhio's film indicate that many of the locations used in the film where the actual places where Dr Schweitzer lived and worked while in Gabon. For Hofmeyr's version a set was constructed near the coastal town of Port Edward in South Africa for the scenes set in Schweitzer's jungle clinic (Hofmeyr 2019). Furthermore, no mention is made of the South African location in the end credits of the film. This omission is not surprising given the international condemnation of international productions and actors working in South Africa who took advantage of the generous government tax rebates offered to investors.

The interpretation of the filmic fact expands on themes central to this research around the representation of the doctor and how this figure is received today. In critically analysing the contemporary setting, the doctor is shown to be a powerful and emblematic figure of Western rationality and humanitarian instincts relying on enduring colonial stereotypes of patient and healer in these imaginary discourses of present-day Africa. Standing against the superstitions of African therapeutics and its rebellious forms in the colonial setting (Rose-Hunt 1999), the same figure persists as a beacon of moral and humanitarian hope in the present when depicted against the chaotic backdrop of postcolonial collapse. The research troubles this construction of the selfless hero and questions how they might be implicated, knowingly or unknowingly, in the exertion of influence and power. Even as these findings focus on the cinematic interpretation of the new global order which is defined by emergency and its humanitarian response, they also provide insight into the way these begin to mirror colonial forms of power and control asserted through the medical encounter.

By shifting focusing away from the external conflicts exerted in colonial and contemporary therapeutic interventions to the emotional and psychological conflict of the doctor figure, I turn to the television medical drama series *House* (2004). Scholarly interpretations of the series rely on a unique set of themes reaching back millennia and first arose in Western myths in relation to the healer figure (Cotter 2011). I apply this mythical idea of an incurable wound from my artistic research to an understanding of the doctor at the subconscious level. A departure from already established theoretical and conceptual paradigms used in the thesis is necessary considering the emotional and psychological conflict that is internalised with the healer's wound. The outcome is to identify an unattainable striving to be remade as whole as the driving force peculiar to the internal dynamics of the doctor character in the films.

In applying the metaphor of the wound in the figure of the traditional African healer, ideas derived from Western studies of shamanism and anthropological perspectives on this discourse are not superimposed, but are intended to question the different choices made in Ba Kobhio's and Hofmeyr's films in the conflicted relationship between the two healer figures. In approaching this subject, there is no attempt at a comprehensive or authoritative comparison of Western and African traditional healing and knowledge systems. The study's interest is in the narrative choices in the films when comparing the journey of the healer figures where one might be sparked by an earlier wound in the form of a calling or is incurred in the later process of becoming a doctor. The outcome of this line of inquiry challenges the often simplistic binary representations of these healers in the films as separated by some unbridgeable gulf and representing irreconcilable backgrounds.

I expand the consideration of a plurality of healing by venturing into a brief discussion of the medical intermediary as an important yet underrepresented figure in the films. Precisely because of the unfixed definitions and the in-between spaces the intermediary inhabits, this figure straddles the divide of the conflict zone and its many iterations. This subject offers opportunities for further cinematic research into a character often overlooked because of the overshadowing authority and assumed status of the doctor figure. This reinforces the importance of the doctor in the filmic imagination through the central role in determining the dramatic purpose of the medical intermediary.

The outcome of this thesis is less surprising for the realisation that a complex layer of mediation operates around the representation of the doctor in the films, nor is it profoundly original to claim that the doctor serves a critical role in the increasingly powerful humanitarian order where the therapeutic intervention transcends traditional ideas of power and sovereignty. Yet, in relocating this study away from the ordered and institutionalised setting of the hospital and focusing on the films characterised by the African conflict zone, colonial and contemporary, this work contributes new knowledge and fills a gap in the existing body of work by identifying themes specific to the portrayal of the doctor figure. It also contributes to our ways of seeing and understanding the cinematic imagination through its exploration of the enduring nature of colonial medical themes in the filmed construction of the contemporary emergency doctor.

The relevance of this research is brought into stark relief by the looming sense of crisis and emergency which shapes our perception of the world. That climate change and contagion have now assumed the status as the defining emergencies of our times is due to the existential threat they pose not only to humanity but also to the diversity of all life on our planet, no matter its geographic location, class, race or religion. Fixed as we are in this escalating emergency and its mediatised cycle

of disaster, understanding the images and narratives produced by these discourses looms larger than ever in our perception of the world around us. It is within this *mise-en-scène* that the doctor figure warrants a closer reading and a deeper understanding of their vital role within the cinematic conflict zone.

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