Part I

Introduction

A Companion to Bioethics: Second Edition Edited by Helga Kuhse and Peter Singer
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What Is Bioethics? A Historical Introduction

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Since the 1960s ethical problems in health care and the biomedical sciences have gripped the public consciousness in unprecedented ways. In part, this is the result of new and sometimes revolutionary developments in the biomedical sciences and in clinical medicine. Dialysis machines, artificial ventilators, and organ transplants offer the possibility of keeping alive patients who otherwise would have died. *In vitro* fertilization and related reproduction techniques allow a range of new relationships between parents and children, including the birth of children who are not genetically related to the women who bear them. The development of modern contraceptives, prenatal testing, and the availability of safe abortions have given women and couples increased choices about the number and kinds of children they are going to have. Groundbreaking developments in genetics and the possibility of genetic enhancement add a further dimension to these choices. Technological breakthroughs, however, have not been the only factor in the increasing interest in ethical problems in this area. Another factor has been a growing concern about the power exercised by doctors and scientists, which shows itself in issues about "patients' rights" and the rights of the community as a whole to be involved in decisions that affect them. This has meant greater public awareness of the value-laden nature of medical decision-making, and a critical questioning of the basis on which such decisions are made. It has become patently obvious during the past three or four decades that, to give just one example, someone has to decide whether to continue life-support for patients who will never regain consciousness. This is not a technical decision that only doctors are capable of making, but an ethical decision, on which patients and others may have views no less defensible than those of doctors.

It was in the climate of such new ethical issues and choices that the field of inquiry now known as "bioethics" was born. The word was not originally used in this sense. Van Rensselaer Potter first proposed the term for a "science of survival" in the ecological sense – that is, an interdisciplinary study aimed at ensuring the preservation of the biosphere (Potter 1970). This terminology never became widely established, however, and instead "bioethics" came to refer to the growing interest in the ethical issues arising from health care and the biomedical sciences. It is to bioethics in this latter sense that the present volume forms a *Companion*.

Although the term itself is new, and the prominence of bioethics owes much to recent developments in the biomedical sciences, bioethics can also be seen as a modern

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version of a much older field of thought, namely medical ethics. Undoubtedly, bioethics claims medical ethics as part of its province, but in many ways it takes a distinctly different approach. Traditionally, medical ethics has focused primarily on the doctor–patient relationship and on the virtues possessed by the good doctor. It has also been very much concerned with relations between colleagues within the profession, to the extent that it has sometimes seemed to exemplify George Bernard Shaw's remark that "all professions are conspiracies against the laity." Bioethics, on the other hand, is a more overtly critical and reflective enterprise. Not limited to questioning the ethical dimensions of doctor–patient and doctor–doctor relationships, it goes well beyond the scope of traditional medical ethics in several ways. First, its goal is not the development of, or adherence to, a code or set of precepts, but a better understanding of the issues. Second, it is prepared to ask deep philosophical questions about the nature of ethics, the value of life, what it is to be a person, the significance of being human. Third, it embraces issues of public policy and the direction and control of science. In all these senses, bioethics is a novel and distinct field of inquiry. Nevertheless, its history must begin with the history of medical ethics.

Medical Ethics

Medical ethics has a long and varied history (Reich 1995: 1439–646). While it is often thought that it had its beginning in the days of Hippocrates, in ancient Greece, it is in fact much older. Even tribal societies, without a written language, already had more or less well-articulated values that directed the provision of health care by shamans, exorcists, witches, sorcerers, and priests, as well as by midwives, bonesetters, and herbalists. One of the earliest written provisions relating to the practice of medicine is from the Code of Hammurabi, written in Babylon in about 1750 BC. It stipulates that if a doctor uses a bronze lancet to perform a major operation on a member of the nobility that results in death or leads to the loss of an eye, the doctor's hand will be cut off (Pritchard 1969). Other early provisions of medical ethics were embedded in a religious tradition. A monument in the sanctuary of Asclepius, for example, tells doctors to be "like God: savior equally of slaves, of paupers, of rich men, of princes, and to all a brother, such help he would give" (Etziony 1973); and the Daily Prayer of a Physician, often attributed to the twelfth-century Jewish doctor Moses Maimonides (but now thought to date from the eighteenth century), condemns not only "thirst for profit" but also "ambition for renown and admiration" (Veatch 1989: 14).

The ancient ethical codes were often expressed in the form of oaths. The best-known medical oath in the Western tradition is the Oath of Hippocrates, commonly assumed to be from the fifth century BC, and often regarded as the very foundation of Western medical ethics. Despite the oath's continuing appeal, its origins are clouded in mystery. Around 500 BC many different schools of medical practice coexisted, each of them reflecting somewhat different medical, philosophical, and religious beliefs. One of these medical schools, on the island of Cos, was headed by the physician Hippocrates. The Hippocratic School produced a large body of writings on medicine, science, and ethics. The date of the oath, however, is unknown, with estimates ranging from the sixth century BC to the beginning of the Christian era (Edelstein 1967). The oath's significance

in the history of Western medical ethics is twofold. In affirming that "I will use dietetic measures to the use and profit of the sick according to my capacity and understanding. If any danger and hurt threatens, I will endeavor to avert it," the oath establishes the principles of beneficence and nonmaleficence, that is, that doctors must act so as to benefit their patients and seek to prevent harm. In addition, the oath's prohibition on giving a potion to produce an abortion, or giving any poison to end the life of a patient, is consonant with the view of the sanctity of human life that has dominated medical ethics under Christendom. Other aspects of the oath – like the injunction to honor one's teacher like a parent, "to share his fate and if occasion arise supply him with the necessaries of life" – are less frequently referred to in modern discussions of medical ethics.

While some scholars hold that the increasing importance of the Hippocratic Oath is linked to the rise of Christianity, this is disputed by others who believe that there are significant differences and tensions in the ethical precepts on which Hippocratic and Christian medicine were built. One obvious difference lies in the two traditions' religious commitment. At different times, various modifications were thus introduced to make the Hippocratic Oath acceptable to Christians. One of the earliest of these dates from the tenth or eleventh century. It is entitled "From the Oath According to Hippocrates Insofar as a Christian May Swear it." This oath no longer required Christian doctors to swear to Greek gods and goddesses; rather, those taking the oath addressed themselves to "God the Father of our Lord Jesus Christ" (Jones 1924: 23).

Perhaps one of the most significant moral influences of Christianity relates to its emphasis on love for one's neighbor and compassion for the ill. Religious institutions, such as monasteries, began to set up "hospitals" for the ill and destitute, and Christian teaching emphasized that doctors must cultivate the virtues of compassion and charity. A treatise, probably dating from the early twelfth century, exhorts doctors not to heal "for the sake of gain, nor to give more consideration to the wealthy than to the poor, or to the noble than the ignoble" (MacKinney 1952: 27), and in the thirteenth century Thomas Aquinas considered it a sin if a doctor demanded an excessive fee, or if he refused to give gratuitous treatment to a patient who would die for want of it.

If greed and lack of charity were regarded as sins, so were other practices as well. Navarrus, a leading sixteenth-century canonist, provided a clear statement that condemned euthanasia as sinful, even if motivated by pity. In this, he followed St Augustine's earlier pronouncement, in *The City of God*, that Christians must not choose suicide to escape illness; and Thomas Aquinas' condemnation of the practice on the grounds that it was unnatural and a usurpation of God's prerogative to give and take life.

When it came to another topic still central to contemporary bioethical debate – that of abortion – the historical position of the Church has been somewhat ambiguous. While the practice was standardly condemned in the early Christian literature, its wrongness was often regarded as a matter of degree. Following Aristotle, various thinkers – including Thomas Aquinas – thought that only the abortion of an animated fetus constituted homicide. Animation was presumed to occur at 40 days for male fetuses, and 90 days for female fetuses. By and large, this view remained dominant until 1869, when Pius IX declared all direct abortions homicide, regardless of the fetal stage of development.

Over the millennia, many different religious groups have attempted to formulate the central virtues and duties of doctors in various ways, and to articulate their particular responses to issues within medical ethics. The Roman Catholic Church is thus not the only Christian Church to have well-developed views on a range of issues in medical ethics; there are a number of Protestant Churches with distinct positions as well. In addition, there are of course extensive non-Christian religious teachings. Jewish and Islamic medical ethics, for example, articulate the duties and responsibilities of Jewish or Islamic doctors, and in East Asia and the Indian subcontinent, traditions of medical ethics are intertwined with Taoism, Confucianism, Buddhism, Shintoism, and Hinduism.

Over the centuries, medical practitioners themselves continued to reflect on the qualities that the virtuous doctor should possess, in particular in his relationship with patients. While these reflections were typically intertwined with prevailing religious trends and teachings, the seventeenth and eighteenth centuries brought some changes. John Gregory, a prominent eighteenth-century Scottish doctor-philosopher, drew on prevailing Enlightenment philosophies to articulate his view that doctors must be "sympathetic," in the sense developed by the great Scottish philosopher David Hume. In other words, the doctor was to develop "that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which, of consequence, incites us in the most powerful manner to relieve them" (Gregory 1817: 22).

Gregory's reflections on the role of doctors and the doctor–patient relationship are still highly relevant today. Not only was he possibly the first doctor who sought to develop a universal moral basis for medical ethics – one that was free from narrow religious and parochial concerns – but his view of the central role played by care and sympathy in the doctor–patient relationship may also be read as one of the first articulations of an "ethics of care." In recent times, care approaches to ethics have played an important role in feminist and nursing approaches to ethics.

Nursing Ethics

Medical ethics has not been the only source of ethics relating to health care. Professional nursing had its beginning in nineteenth-century England, where Florence Nightingale established the first school of nursing and laid down some of the ethical precepts that would shape the practice of nursing for a long time. Emphasis was placed on the character of the nurse. Above all else, a good nurse must be a good woman, as Florence Nightingale put it.

By the early 1890s nurses had begun seriously to discuss ethical issues in nursing. In 1899 the International Council of Nurses was established, professional journals, such as *The American Journal of Nursing*, sprang up and in 1901 Isabel Hampton Robb, a leader of nursing at the time, wrote one of the first books on nursing ethics, entitled *Nursing Ethics for Hospitals and Private Use* (Robb 1901). The vast majority of nurses are women and, until fairly recently, the vast majority of doctors have been men. Not surprisingly, the relationship between doctors and nurses reflected the different roles of women and men, and their relative status in society. One of the manifestations of this was the assumption that the primary responsibility of nurses was to doctors rather

than to patients, and that nurses had to show absolute obedience to their medical colleagues. As one American nursing leader put it in 1917: "The first and most helpful criticism I ever received from a doctor was when he told me that I was supposed to be simply an intelligent machine for the purpose of carrying out his order" (Dock 1917: 394).

The view that the nurse's primary responsibility was to the doctor prevailed until the 1960s, and was still reflected in the 1965 version of the *International Code of Nursing Ethics*. Item 7 of the *Code* states: "The nurse is under an obligation to carry out the physician's orders intelligently and loyally." The revival of feminist thinking in the late 1960s paralleled the developing self-consciousness and self-assertiveness of nurses, and in the 1973 *International Council of Nurses' Code for Nurses*, the nurse's "primary responsibility" is no longer seen to be to doctors but to patients – "to those people who require nursing care."

This questioning by nurses of their traditional role and their relationship with doctors and patients eventually converged with a movement by feminist philosophers that challenged the traditional (and therefore male-dominated) view of ethics as a matter of abstract, impartial, and universal principles or rules. Instead of this conception of ethics, feminist philosophers like Nel Noddings (1984) conceived of ethics as a fabric of care and responsibility arising out of personal relationships. Building on this "female" approach to ethics, both philosophers and nurses sought to construct a new ethics for nurses based on the concept of care. Jean Watson, a nurse and a prominent proponent of a nursing ethics of care, applies to the nursing situation Noddings's view that an ethics of care "ties us to the people we serve and not to the rules through which we serve them" (Watson 1988: 2).

Bioethics

Perhaps the first "modern" work of bioethics was Joseph Fletcher's *Morals and Medicine*, published in 1954. Fletcher was an American Episcopalian theologian whose controversial "situation ethics" approach to ethical questions had more in common with consequentialist ethics than with traditional Christian views. In keeping with this, he later abandoned his religious belief. Although Fletcher did much to stimulate early discussions of ethical issues in medicine, it was only in the 1960s that bioethics really began to take shape as a field of study. This period was one of important cultural and social changes. The civil rights movement focused attention on issues of justice and inequality; the Cuban missile crisis and the Vietnam War led to a renewed questioning of war and nuclear weapons; and the resurgence of feminism, coupled with the availability of safe abortions and modern contraceptives, raised questions about women's reproductive rights. For much of the late 1960s and early 1970s, university authorities were besieged by students, initially in opposition to the Vietnam War, but later also demanding that their courses be relevant to the larger social issues of the day. These changes had their effect on the practice of philosophy too, sparking a renewed interest in normative and applied ethics. While the prevailing orthodoxy among English-speaking moral philosophers throughout the 1960s was that philosophy deals with the analysis of moral terms rather than with practical issues, this

attitude began to shift in the 1970s. Increasingly, moral philosophers began to address themselves to such practical ethical issues as abortion and euthanasia, the ethics of war and of capital punishment, the allocation of scarce medical resources, animal rights, and so on. They frequently dared to question what had not been questioned before. Since some of these issues related to practices in health care and the biological sciences, this movement in philosophy helped to establish bioethics as a critical discipline.

The other major impetus to the growth of the field was the development of new medical technology that threw up questions no one had needed to answer before. One of the first high-profile bioethics issues in the United States shows this clearly. The first machines that could dialyze patients who had suffered kidney failure dramatically saved the lives of patients who would otherwise have been dead in a matter of days; but the machines were very expensive, and there were many more patients who were suffering from renal disease than there were machines. In 1962 the artificial kidney centre in Seattle, Washington, set up a committee to select patients for treatment. Its life-and-death decisions earned it the name of "the God committee," and focused attention on the criteria it used. A study that showed a bias toward people of the same social class and ethnic background as the committee itself eventually led to further discussion about the best way to solve such problems.

Of all the medical breakthroughs of this period, the most widely publicized was the first heart transplant, performed by the South African surgeon Christiaan Barnard in 1967. The patient's death 18 days later did not dampen the spirits of those who hailed a new era of medicine – with its attendant ethical dilemmas. The ability to perform heart transplants was linked to the development of respirators, which had been introduced to hospitals in the 1950s. Respirators could save many lives, but not all those whose hearts kept beating ever recovered any other significant functions. In some cases, their brains had ceased to function altogether. The realization that such patients could be a source of organs for transplantation led to the setting up of the Harvard Brain Death Committee, and to its subsequent recommendation that the absence of all "discernible central nervous system activity" should be "a new criterion for death" (Rothman 1991). The recommendation has subsequently been adopted, with some modifications, almost everywhere.

If the availability of respirators and other powerful life-extending technology raised questions about the time when a patient should be declared dead, it also brought to the forefront questions about the proper limits of employing this technology in attempts to save or prolong a patient's life. While it had generally been accepted that competent patients must not be treated against their will, the situation of incompetent patients was far less clear. This was true not only with regard to patients who had been rendered incompetent by illness, accident, or disease, but also the treatment of seriously disabled or premature newborn infants. The question was simply this: if a patient is unable to say "no," does this mean that his or her life must always be prolonged for as long as possible, even if the patient's prospects are very poor?

In 1973 a leading US medical journal, the *New England Journal of Medicine*, published a study by two pediatricians on the ethical dilemmas they encountered in the special care nursery (Duff and Campbell 1973). The doctors, Raymond Duff and A. G. M. Campbell, did not think that all severely ill or disabled infants should receive life-prolonging treatment. They thought it important to break down "the public and

professional silence on a major taboo," and indicated that out of 299 infants in the special-care nursery, 43 had died as a consequence of a non-treatment decision. A central question was whether these non-treatment decisions were morally and legally sound.

Questions about the limits of treatment for those who are unable to decide for themselves were raised not only in the United States but in other countries as well. Australian and British doctors, for example, had begun publishing their views on the selective non-treatment of infants born with spina bifida, and thereby contributed to an ongoing debate about the appropriateness of a "quality of life" or a "sanctity of life" approach in the practice of medicine (Kuhse and Singer 1985).

It was not until 1976 that a landmark US case – that of Karen Ann Quinlan – lent support to the view that doctors had no legal duty to prolong life in all circumstances. Karen Ann Quinlan, who had become comatose in 1975, was attached to a respirator to assist her breathing. Her condition was described as "chronic persistent vegetative state." When the treating doctor refused to honor the family's wishes that Karen be removed from the respirator, the case eventually came before the New Jersey Supreme Court, which decided that life-support could be discontinued without the treating doctor being deemed to have committed an act of unlawful homicide. The case had implications for future thinking about various issues relating to medical end-of-life decisions, such as the moral and legal relevance of the distinction between so-called ordinary and extraordinary means of treatment, the role of parents or guardians in medical end-of-life decisions, the validity or otherwise of a now incompetent patient's previously expressed wishes regarding life-sustaining treatment, and so on.

Important ethical issues had already been raised in the United States with regard to the ethics of human experimentation by writers such as Henry K. Beecher (1966). It had become known that patients at the Jewish Chronic Disease Hospital in Brooklyn had been injected with live cancer cells, without their consent; that, from 1965 to 1971, mentally retarded children at Willowbrook State Hospital in New York had been inoculated with the hepatitis virus; and that a 1930 study aimed at determining the "natural history" of syphilis in untreated black men continued in Tuskegee, Alabama, until the early 1970s.

The public attention directed at these cases led to important changes in the scrutiny that US agencies henceforth directed at medical research. In 1973 the US Congress established the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, whose members were charged with the task of drawing up regulations that would protect the rights and interests of subjects of research. While the Commission's role was only temporary, its influence was not. Most of the Commission's recommendations became regulatory law, and one of its reports – the Belmont Report – clearly articulated the ethical principles that should, in the Commission's view, govern research: respect for persons, beneficence, and justice. Subsequently, principles such as these have been influential in bioethics through their incorporation into a widely used bioethics text, now in its sixth edition – *Principles of Biomedical Ethics* (Beauchamp and Childress 2009).

By the end of the 1960s, mounting ethical problems in medicine, research, and the health-care sciences had already led to the establishment in the United States of the first institutions and centers for bioethics. One of the best known of these centers – the Institute of Society, Ethics and the Life Sciences (the Hastings Center) – was founded

by Daniel Callahan and Willard Gaylin in 1969, and its publication, the *Hastings Center Report*, was one of the first publications exclusively directed toward the newly emerging discipline of bioethics.

Almost from the beginning, bioethics was an interdisciplinary enterprise. While ethics had been the near-exclusive domain of moral philosophers and religious thinkers, bioethics crossed the boundaries not only of medicine, nursing, and the biomedical sciences, but of law, economics, and public policy as well. Bioethics in this broad, interdisciplinary sense has since become firmly established as a field of inquiry and of learning – first in the United States, and since then in many other countries as well. It is now taught at universities at both undergraduate and postgraduate levels, and many nursing and medical schools regard bioethics as an integral part of their curriculum. Today there are many bioethics research centers throughout the world, and bioethicists are often consulted by government commissions, law reform bodies, and professional organizations. Many countries have their own national bioethics associations and the International Association of Bioethics (IAB) links bioethicists from all parts of the world. A number of highly regarded scholarly bioethics journals emanate from different continents, and international congresses on bioethics are now a frequent phenomenon. In short, while bioethics had its beginning in the United States, it is now a global field of inquiry.

Bioethics is now also becoming more global in its focus. As Michael Selgelid points out in his contribution to this volume (chapter 36), 90 percent of medical research resources are spent on diseases that account for only 10 percent of the global burden of disease – the diseases that people in rich countries are likely to suffer from. This is in part because pharmaceutical corporations have no incentive to develop drugs to treat people who will not be able to afford to buy them, and in part because the government research funds of rich nations are also mostly directed toward finding treatments for the diseases that afflict the citizens of those nations. There is, therefore, comparatively little research into finding treatments for the diseases from which people in poorer nations are likely to suffer. That fact itself, of course, poses an ethical question – do the people of the rich nations, through their governments or through private philanthropy, have an obligation to reverse this imbalance? Bill and Melinda Gates clearly believe there is. The website of the Gates Foundation says that one of their key values is "All lives – no matter where they are being led – have equal value" and the research they are funding is directed against diseases like malaria, which kill millions of people every year, virtually all in developing countries.

But there has also been a 10/90 problem in bioethics itself – in fact, until the 1990s, probably much less than 10 percent of the work of bioethicists was focused on bioethical issues raised by 90 percent of the global burden of disease. This is now changing. *Developing World Bioethics*, a journal devoted to bioethical issues relating to the developing world, is one example of this change. The IAB has made a deliberate effort to encourage bioethics in developing countries. As discussed elsewhere in this volume, much more attention is being paid to bioethical issues raised by infectious diseases, including, but not limited to, HIV/AIDS. In this revised edition, we have also increased the number of articles dealing with global bioethical issues and issues that particularly face developing countries. It remains true, unfortunately, that the majority of articles dealing with specific issues focus on bioethical issues in affluent countries. That

reflects the state of the field today – although it is moving in the right direction, as far as increasing its focus on problems outside affluent nations is concerned, it is moving slowly and there are still very few people working in bioethics in developing countries, and writing about the issues those countries face.

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Global Health Ethics

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Introduction

Since the middle of the twentieth century, people have experienced remarkable gains in health. Life expectancy has almost doubled (World Health Organization 2003: 3) and child mortality rates have decreased by 60 percent (Moser et al. 2005: 203). Despite these positive trends, health disparities between those who are financially well off and those who are not continue to widen. In developing world countries these disparities are particularly pronounced. For example, an estimated nine million children under the age of 5 die globally each year, 50 percent of which are easily preventable (World Health Organization 2009). Many of these deaths can be attributed to the health resource gap between the developed and the developing world. At the same time, global wealth has increased to such an extent that it is now feasible to significantly reduce health-related illness, suffering, and premature death. Many of the world's health problems that result in the large-scale avoidable loss of quality-adjusted life-years are the foreseeable consequence of poverty caused by the world economic order. High drug prices protected by the international patent regime put medicines out of the reach of many of the world's citizens, and a paucity of health research funding, for diseases that primarily affect citizens living in poorer countries, results in unnecessary illness and premature death. These are two of the many factors that contribute to poor living conditions for the majority of the world's citizens that are not just tragic but unjust. A growing body of literature addresses our moral obligations to improve health globally in light of our material capacity to do so. This essay draws on this emerging ethics literature to describe two contending accounts of global health obligations. We then highlight four prominent ethical issues in global health ethics that include (1) sharing the benefits of research carried out through developing country collaborations, (2) the growing trend of patients traveling across national borders in pursuit of healthcare, (3) the migration of healthcare workers to wealthier from poorer communities, and (4) international infectious disease control.

Two Accounts of Global Health Obligations

The political case for global health obligations

Two influential approaches that aim to justify moral obligations to improve global health can be found in the global ethics literature: a political approach and a humanitarian approach (Lowry and Schuklenk 2009). The political approach, which is

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most closely associated with Thomas Pogge, adopts a Rawlsian criterion of domestic justice and applies it more broadly to international institutional arrangements. According to the political model, moral obligations that extend beyond national borders are contingent on the nature of the social, economic, and political relationships that exist between states (Pogge 2008). In today's global economic order, the lives of the world's rich and poor are inextricably linked by interactions between countries. These interactions are largely mediated by transnational institutional frameworks (*see* GLOBALIZATION). In many cases, these global institutional arrangements secure the high standard of living of more affluent people while simultaneously reinforcing the continued deprivation of many of the world's poor. To the extent that foreseeable and preventable harms to health are caused by features of these international arrangements, moral obligations to reduce these inequities are owed by those countries that derive benefits from these arrangements (*see* GLOBAL DISTRIBUTIVE JUSTICE). On this account, it is primarily states that are the actors in these relationships and who therefore bear any resulting moral responsibilities. However, this analysis could easily be extended to include multinational corporations benefiting unjustly from the criticized status quo.

Unjust interactions between states that generate moral obligations to take measures to improve health can be more or less direct. Examples of direct actions include military aggression and economic sanctions. Less direct harmful effects that give rise to a duty to aid can be generated by membership in organizations whose policies play a causal role in the production and maintenance of global health inequities or by economic practices that contribute to outcomes like climate change, which promises to leave many poor countries vulnerable to environmental harms (*see* WORLD TRADE ORGANIZATION). To ameliorate deprivations caused by both direct and indirect state actions, advocates of the political model usually endorse a combination of global health aid, in order to address immediate health needs, and international institutional reform over the longer term to prevent similar harms to health from occurring in future.

The humanitarian case for global health obligations

According to the political model, it is unjust relationships between states that give rise to compensatory moral obligations to improve health in other countries; one country's health obligations to another depend on the extent to which the former is responsible for causing the latter's poor conditions for health. What is determinative, on this view, is whether there is causal responsibility for harms created: when such a causal relationship is present, a moral obligation is created; when it is not, no obligation to improve health exists. The need to demonstrate causal responsibility and the need to quantify harms for compensatory purposes makes this model difficult to operationalize.

By contrast, the humanitarian model suggests that our shared interests as humans serve as the moral basis of global health obligations. The roots of the humanitarian model can be traced back to the early work of Peter Singer (2009). Building on Singer, the humanitarian model holds the view that all humans are equal and that

our interests carry equal weight. Which features of human nature are considered morally salient varies by school of thought. The capacity to experience pleasure and pain, the possession of physical, psychological, and emotional needs, and the ability to shape and direct one's own life are most frequently mentioned (*see* CONSEQUENTIALISM; UTILITARIANISM; NEEDS; KANTIAN PRACTICAL ETHICS). These accounts of moral status share the core commitment that human beings with equal interests should be treated equally with regard to those interests. An important implication of this view is that equal interests in health and well-being trigger obligations to assist those in need, regardless of their global location, or the types of institutional arrangements they find themselves living under. Unlike the political model which recognizes moral obligations arising from harms generated by one state's or a multinational corporation's actions in relation to the people of another state, the humanitarian model also recognizes moral obligations to improve health conditions that are the result of such factors as poor internal governance, and events like natural disasters that involve no human agency. Like the political model, the humanitarian model maintains that this collective obligation is best carried out through national governments acting on behalf of their citizens. This is the case because it is typically countries, rather than individuals, who have command over the substantial resources that need to be mobilized, and access to the global institutional channels that will make possible the biggest impact on poor global health conditions. Furthermore, the obligation to aid increases in proportion to an agent's capacity to assist. In practice, this means that affluent states generally have a strong positive moral obligation to come to the aid of people who are less fortunate.

While each account of global health obligations has different philosophical origins and offers a different description of the nature and justification of moral obligations to improve health, proponents of both accounts agree on many of the specific actions needed to discharge these obligations, including the need for significant increases in health aid and institutional reform. There is also substantial agreement about where responsibility for addressing health-related deprivations at the policy level should be assigned, namely with the countries of the developed world as well as wealthy residents of developing countries.

Important Topics in Global Health Ethics

Sharing the benefits of health research

Research ethics has featured prominently on the global health ethics agenda since the field's inception. One of the newer areas of concern is benefit-sharing arrangements in international research collaborations between developed and developing countries. The idea of benefit sharing is discussed in a variety of global health contexts. In the past, benefit sharing in the context of multi-center trials sponsored by developed countries who recruit research participants from underdeveloped countries was the main focus of attention. Here the key ethical questions are whether research participants – or the country hosting the research – are owed access to medicines and other

benefits after a trial has concluded, and what standards of clinical care are owed to trial participants (*see* INTERNATIONAL RESEARCH ETHICS). This essay focuses on two newer benefit-sharing concerns that have appeared in the literature. The first of the new ethical issues arose as a result of the commercial utilization of certain types of traditional knowledge. The second new ethical issue stems from the ownership of nonhuman biological materials that are taken from one country to another country for commercial gain. Both ethical issues share a common feature: a good that originates in a developing country is used by a developed country for research and development, eventually resulting in a profitable product, but the communities or the country from which the knowledge or biological material originated do not share in the benefits (Gehl-Sampath 2005). The ethical debate on this matter is best understood against the background of the perceived need to justify the transfer of health aid from developed to developing countries. It is doubtful that these debates – given that they rarely take place in the context of interactions between developed countries – would occur if it were not imperative that we address urgent health needs in poorer countries.

The ethical rationale for benefit sharing is built on the recognition that some profit-generating products could not have been developed without the initial contribution of developing countries in these types of collaborations. For example, without community members who were in possession of traditional knowledge about the appetite suppressing capacity of the *Hoodia* plant and who were willing to share that knowledge with others, the final commercial product would not have been possible. Similarly, without a biological sample like the *Hoodia* plant, the appetite suppressing chemicals the plant harbored may never have been artificially synthesized (Wynberg et al. 2009). At the same time, it is important to note that these commercial products would not have been created without the research and development investment by a for-profit operator. This joint contribution provides a *prima facie* ethical rationale for a fair sharing of the benefits derived from this kind of collaboration.

Even if an ethical argument for fair benefit sharing can be made, practical problems can arise when attempts are made to distribute actual benefits, such as profit shares from a licensed product, for example. In the case of traditional knowledge, the contributors of the knowledge are not necessarily formally delegated by their communities to share the knowledge in question. Often the original source of the knowledge is not known and the knowledge itself is now widely available to many community members, including, in some instances, people outside the community. For example, in the case of the *Hoodia* plant, the Khoisan bushmen and -women who use this plant live in more than one country and have no agreed governance structures. It is unclear how benefit-sharing arrangements could be implemented in informally organized communities like this one.

Furthermore, in the absence of a clearly identifiable source of knowledge, in situations where this knowledge has become widely available to people who did not help create it in the first place, it is not clear that benefits are actually owed (Schuklenk and Kleinsmidt 2006).

The issues surrounding biological nonhuman materials are interrelated but importantly different from the issues that arise from knowledge transfer. One

important difference is that with regard to some biological materials that exist only in certain parts of the world, the originating country can be clearly identified. In these cases, international conventions dictate that such countries own the material in question and, as a consequence, negotiations over benefits must take place between the commercial organization interested in utilizing biological materials and the identifiable source country. It could be argued that this could serve as a template for the benefit sharing of traditional knowledge, too, given that knowledge without the biological source material is useless. It would also resolve the question of how to distribute the resource, and to whom, because the government, as the legitimate representative of the citizens of the state, could fulfill that role, and be held accountable for it. One problem with this approach is that it assumes that these countries have legitimate governments with reasonable claims to represent their people, a state of affairs that cannot always be assumed.

On a regulatory level, the international community has agreed on the UN Convention on Biological Diversity. Its Nagoya Protocol on Access and Benefit Sharing regulates how states and other actors interact with each other in this arena. The Nagoya Protocol aims to ensure that the benefits that are derived from the utilization of genetic materials are shared in a just manner (Secretariat of the Convention on Biological Diversity 2011).

An ethical analysis keeping the two global health ethics frameworks in mind would see the attempt aimed at deriving compensation for biological materials or knowledge provided as being informed by the political model. Humanitarians would not object to this, provided well-being is improved, particularly among impoverished populations most vulnerable to disease. They would remain concerned about those developing world peoples unable to barter away raw materials or knowledge in return for access to life-preserving health services.

Crossing borders to access healthcare

Like health research, the delivery of healthcare is also undergoing a process of globalization. The term "medical tourism" describes this movement of patients across national borders to receive healthcare services. Medical tourism is a worldwide industry that is rapidly growing (*see* MEDICAL TOURISM). Historically, patients tended to travel from underdeveloped countries to medical centers in more highly developed countries in order to obtain services that were not available in their own communities. Recently this trend has begun to reverse itself, with patients traveling in greater numbers from more economically developed countries to less developed ones. This reversal is due in part to the fact that, in some developed countries, patients often now wait months to get appointments with specialists, undergo diagnostic tests and receive treatment. Reproductive outsourcing from developed to developing countries is another specialized form of medical tourism (Smith et al. 2010: 60).

While travel across borders to receive healthcare is not new, a rapid expansion in this type of activity has fueled the emergence of new medical tourism companies that promote travel to medical facilities in other countries. India, Thailand, and

Indonesia are three of the more popular medical tourism destinations with dozens more countries joining (Turner 2007: 1639). In response to this surge in cross-border care, professional medical associations have introduced official medical and surgical tourism policies to educate patients, employers, insurers, and other third-party groups responsible for coordinating such travel out of country. According to its proponents, medical tourism enhances patient choice, gives patients access to treatment options not available in their own communities, ensures more timely access to care for patients able to pay for treatment, and shortens wait lists at home for people who cannot afford to travel abroad (2007: 1639). In the United States, some advocates also defend medical tourism as a safety net for Americans who are under- or uninsured and who cannot afford expensive medical treatments locally. Other proponents maintain that international health-related travel encourages global competition in the healthcare sector, thereby driving down prices and promoting economic and social development where it is most needed by building healthcare economies in developing countries. Critics of medical tourism have raised concerns about the health inequities generated between wealthy patients who can afford to buy quicker access to care while their poorer counterparts have to wait in line. Another troubling feature of this emerging industry is that it threatens to undermine what should be a public good by creating economic incentives for poorer countries that may opt to use their healthcare systems to generate wealth by meeting foreign demand for healthcare rather than building up local medical infrastructure. There are also concerns about the increased risk of foreign patients receiving substandard care, difficulties involved in ensuring continuity of care across different national jurisdictions; and divergent ethical and legal obligations for healthcare providers who are typically governed by legislation, professional codes, and institutional policies at the local level (2007: 1640). A humanitarian mode of ethical analysis would look at the question of whether or not anyone is demonstrably worse off as a result of medical tourism. If, on balance, more quality- or disability-adjusted life-years are generated because of the existence of medical tourism, humanitarians would be supportive of it. As above, humanitarians would not accept linking access to essential medicines in an impoverished country to its ability to attract medical tourism income. Proponents of the political model would likely analyze the kinds of agreements that are struck between developed and developing countries with a view to ensuring that the peoples living in developing countries are not being treated unfairly or harmed as a result of medical-tourism-related service contracts.

Migration of healthcare workers

It is not only users of healthcare but also healthcare providers themselves who are moving across national borders in greater numbers. The lack of access to even the most basic healthcare for about 1.3 billion people globally is often attributed, in part, to large-scale migration of health professionals from poorer to wealthier countries (*see* HEALTHCARE RESOURCES, DISTRIBUTION OF). This migration is particularly problematic in countries where certain types of health professionals are in critically low supply. Wealthy nations such as Canada and Australia have been recruiting skilled

medical labor from these regions at rates that have surged in the last decade and their recruitment efforts have expanded to include a greater number of countries. These recruitment efforts are as successful as they are because these countries offer better working conditions and higher salaries than the recruits' home countries could possibly afford. For some professionals, migration provides an opportunity to move away from a situation of domestic political instability, war, or violent crime (World Health Organization 2010a). By recruiting from poorer nations to meet their own local health needs, developed countries are effectively free-riding on the investment developing countries make in educating and training health professionals at home. This scenario would seem to be an ideal case for the application of the political model. These workforce transfers from poorer to wealthier nations contribute to developing world populations becoming the worst off globally in the distribution of medical resources and, in particular, in access to healthcare professionals. The resulting scarcity of healthcare professionals needed to operate local healthcare delivery systems threatens to render other efforts to improve access to healthcare inconsequential.

One response to critical human resource shortages in developing countries has been a call for a recruitment ban. In developing countries where health professionals may be more abundant, it has been argued that an appropriate strategy would involve the strictly regulated, targeted recruitment of only those healthcare professionals that are in more than sufficient supply to meet local needs. Another suggestion, in line with the thinking underlying the political model, is to establish an international healthcare workers' migration regime that balances the right of free movement of workers and the protection of countries with insufficient numbers of local healthcare providers. This balance could be achieved by a variety of means that include compensation schemes requiring developed countries to financially compensate developing countries from which the professional originated. This compensation could take many forms including educational support, materials, and training, as well as the building of local healthcare delivery infrastructure. Mitigating the effects of medical migration may also require developing countries to make domestic improvements for their workforce in order to make leaving less attractive. In addition to the obligations of the countries involved in the migration, medical professionals themselves may have some limited responsibility to offer services to their communities for an appropriate period in return for the subsidized training they receive. It has also been argued that recruiting countries should address their own labor shortages by implementing workforce planning policies designed to increase local self-sufficiency by, for example, increasing the number of domestic educational opportunities in health professional fields where there are shortages (O'Brien and Gostin 2009: 16). Recognizing that recruiting trained health professionals from poorer countries can be unethical, some governments, professional associations, and health organizations have issued guidelines to regulate international recruitment so that harmful effects to the recruits' home healthcare systems are minimized. For example, the United Kingdom became the first country to enact a policy that bans recruitment of health professionals from developing countries

to staff its National Health Service (in 2006). The World Health Organization (2008) has also developed a code of practice to govern the recruitment of health personnel internationally. The policy propositions requiring action from wealthy countries are ethically justifiable from the perspectives of both the humanitarian and the political approaches to global justice.

Infectious disease control: the case of tuberculosis

Global health ethics is by necessity concerned with public health threats such as infectious diseases that have the potential to evolve rapidly into pandemics. AIDS and tuberculosis have long been seen as paradigmatic infectious diseases. Though it was believed to be close to eradication in wealthy countries just a few decades ago, tuberculosis (TB) is now the second leading lethal infectious disease worldwide, killing nearly as many people as AIDS does each year (*see* AIDS; INFECTIOUS DISEASES). Throughout this time TB has remained a major public health threat in many underdeveloped countries, with most incidents and deaths occurring there. The recent resurgence in TB infection rates globally has been driven, in part, by the spread of multi-drug-resistant strains and by the combined effects of TB and HIV/AIDS in people infected with both (World Health Organization 2010b: 3). No new TB drugs have been developed since the 1960s, largely because pharmaceutical companies have little financial incentive to develop products to treat diseases that primarily affect people who are poor (Selgelid 2008: 12; *see* RESEARCH ETHICS).

Because of TB's highly contagious nature, response efforts need to take into account both individual rights and liberties as well as the societal interest in achieving public health objectives. These are the two social goals that can come into conflict in this context (*see* PUBLIC HEALTH ETHICS). Like other medical interventions, TB diagnosis and treatment should be provided only with the patient's first-person voluntary informed consent. However, where there is serious risk to third parties, and persistent non-adherence to treatment or unwillingness to comply with infection control measures, it can be ethically defensible for patients to be isolated or detained (Singh et al. 2007).

TB raises ethical questions not only about the rights and obligations of patients but also about those of healthcare workers. It is generally recognized that healthcare workers have an ethical obligation to provide care to patients, even when doing so involves some degree of personal risk. In determining whether particular healthcare workers have a duty to care for TB patients, important considerations include whether appropriate infection control measures are in place that provide adequate protection from TB exposure; whether reasonable training, supplies, and infrastructure are provided; whether there is some likelihood of curative or palliative benefit for patients who require care; and what the health status is of the healthcare worker him or herself. The risk of acquiring TB, the progress of the disease, and access to effective care are causally linked to poverty and low socioeconomic status. Controlling the spread of TB therefore raises issues of international distributive justice. The World Health Organization (2010b) states that all governments have an ethical obligation to ensure

universal free access to high quality TB diagnosis and treatment for their citizens, and to provide this care in a manner that is sensitive to the dangers of stigmatization. It also maintains that governments must simultaneously address the social determinants of health that are largely responsible for the spread of the disease. Where individual governments do not have the resources to fulfill these commitments, the obligation falls to the larger international community to provide the necessary financial and technical assistance. As in the case of health workers' migration, both accounts of global health ethics obligations discussed in this essay provide a plausible ethical rationale in support of this demand. However, the political model faces a serious challenge. Poverty being a significant contributor to the spread of TB in impoverished communities makes this model applicable. It also demonstrates its weakness. This model would fail impoverished nations with high levels of TB that are unable to demonstrate that its economic problems are causally linked to the world economic order. By contrast, the humanitarian model would not invest time in finding out whose fault it is. It would offer action guidance in line with WHO prescriptions.

***See also*:** AIDS; CONSEQUENTIALISM; GLOBAL DISTRIBUTIVE JUSTICE; GLOBALIZATION; HEALTHCARE RESOURCES, DISTRIBUTION OF; INFECTIOUS DISEASES; INTERNATIONAL RESEARCH ETHICS; KANTIAN PRACTICAL ETHICS; MEDICAL TOURISM; NEEDS; PUBLIC HEALTH ETHICS; RESEARCH ETHICS; UTILITARIANISM; WORLD TRADE ORGANIZATION

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Biopolitics

Catherine Mills

In the past 15 years or so, the term "biopolitics" has emerged as one of the defining concepts of our present era. Scholarly debates currently rage between competing theories, while the term is deployed broadly outside academia. It is used to discuss phenomena as diverse as the way that biological knowledge has come to guide our sense of who we are, various aspects of global capital, governmental policies worldwide that intervene in different ways in the constitution of populations and their well-being, as well as military interventions and modes of warfare. Biopolitics, it seems, is invoked everywhere and is perhaps nowhere the same. Given this diversity of uses, in this essay I focus on two key attempts to theorize the term, by Michel Foucault and Giorgio Agamben (*see* FOUCAULT, MICHEL). While their accounts by no means exhaust the field, they have been instrumental in defining recent scholarly debates. I also consider several responses to their work, including Roberto Esposito's account in terms of immunity, and the more empirical approaches of Nikolas Rose and Paul Rabinow. Following this, I consider the implications of the concept of biopolitics for ethics. I do so initially through a discussion of the relationship between biopolitics and bioethics, and then outline the approaches to ethics proposed by Foucault and Agamben.

Theorizing Biopolitics

The current interest in the concepts of biopower and biopolitics can be traced back to the work of Michel Foucault, in the book published in English as *The History of Sexuality, volume 1*, and in published versions of lectures presented at the Collège de France in the late 1970s. Foucault's most influential statement of what he meant by these terms appears in a few pages in *History of Sexuality* under the subtitle "Right of Death and Power over Life." He argues that the eighteenth century witnessed an event nothing short of the engagement of life in history, that is, "the entry of phenomena peculiar to the life of the human species into the order of knowledge and power, into the spheres of political techniques" (1990: 141–2). Consequently, "for the first time in history, no doubt, biological existence was reflected in political existence" (1990: 142). Thus, the administration of life became the central characteristic and defining rationale of political power (*see* POWER).

Foucault begins his account of the emergence of biopower by contrasting it sharply with the sovereign right of death, which, he argues, characterized political power up until the nineteenth century. Sovereign power, he argues, operated deductively, as a "subtraction mechanism," such that it was "essentially a right of seizure: of things, time, bodies, and ultimately life itself: it culminated in the privilege to seize hold of life in order to suppress it" (1990: 136). He argues that at the end of the Classical

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period this form of power underwent a profound demotion, such that deduction was no longer the predominant form of power but merely "one element amongst others" that collectively worked to "incite, reinforce, control, monitor, optimize and organize the forces under it." The right of death of the sovereign underwent a correlative transfiguration to "align itself with the exigencies of a life-administering power" (1990: 136). Thus, Foucault writes, "the ancient right to *take* life or *let* live was replaced by a power to *foster* life or *disallow* it to the point of death" (1990: 138).

Foucault argues that this new life-administering power emerged in two basic forms, beginning from the late seventeenth century and extending through to the nineteenth. The first of these forms to emerge at the end of the seventeenth century was that of the disciplines, which treated the human body as a machine in order to optimize and control its capacities through the "parallel increase of its usefulness and its docility" (1990: 139). In the eighteenth century this came to be complemented by the second form, a "biopolitics of the population," which focused on the species body and its biological characteristics of mortality, birth rates, morbidity, longevity, etc., in order to subject them to measurement and regulatory control. These two forms of power thus operate as the two poles of biopower, where one focuses on the body in order to individualize and manipulate the forces of it and the other is "centred not on the body but upon life" – that is, in which "bodies are replaced by general biological processes" (2003: 249). These two poles, Foucault insists, are tied together through a "whole intermediary cluster of relations" at the level not of speculative discourse but of "concrete arrangements that would go to make up the great technology of power in the nineteenth century" (1990: 140).

Foucault argues that the principal mechanism of this new form of power is not law, but the norm, and the mark of power is no longer interdiction but normalization: not licit and illicit, but normal and abnormal. Foucault thus gives a central role to norms with normalization appearing as the principal form of social and political regulation, suggesting at one point that "[a] normalizing society is the historical outcome of a technology of power centred on life" (1990: 144). Biopower operates simultaneously at the level of both individual bodies and the concurrently emergent political subject of the population; it is concerned both with anatomical singularity and the vagaries of the group. Normalization ties the poles of discipline and biopolitics together, and norms provide the central axis through which the individual and the group relate to each other. As a technique of biopower, normalization is irreducible to the institutions and force of the law, though fundamentally intertwined with them. Within a normalizing society legal apparatuses are increasingly incorporated into a continuum of institutions the function of which are "for the most part" regulatory, such that the mode by which the law operates is increasingly that of the norm. This clearly does not mean that law itself is superseded; rather, the law continues to operate within the regime of biopower as a regulatory apparatus, but in a different mode than previously. Norms allow the law to operate in conjunction with apparatuses such as medicine, and, in doing so, give the law access to the body in an unprecedented way, that is, as a continuous regulatory force rather than as a repressive and constraining instrument of sovereignty.

Whereas Foucault saw the emergence of biopower as a particularly modern phenomenon, claiming that the "threshold of modernity" had been reached with the advent of biopower, Giorgio Agamben's account challenges this periodization. He argues instead that Western politics have been biopolitical from their inception: he states, "Western politics is a biopolitics from the very beginning" (1998: 181). Further, while Foucault downplayed the role of sovereignty in biopower, Agamben argues that sovereignty is itself biopolitical, such that "the production of a biopolitical body is the original activity of sovereign power" (1998: 6). Agamben's development of these claims is complex to say the least, and ranges in reference from Ancient Greece, through Roman law to modern political institutions. He begins with Aristotle, whom he claims founds Western politics on the exclusion of natural life from the political sphere, in the idea, for instance, that the city-state "comes to be for the sake of living, but it remains in existence for the sake of living well" (Aristotle 1998: 3). To explain this apparent exclusion of natural life from politics, and its implications for modern politics, Agamben draws on the work of the controversial German jurist Carl Schmitt, who proposed a strongly decisionistic account of sovereignty. Schmitt argued that "sovereign is he who decides on the exception" (1985: 5), wherein what is at stake in the exception is the very possibility of juridical rule and the meaning of state authority. Agamben interprets this to mean that sovereign power is constituted through exceptionality, or the identification of the normal and exceptional order. Further, he argues that the exception that founds sovereign power has today become the rule (1998: 9); he writes: "the state of exception tends increasingly to appear as the dominant paradigm of government in contemporary politics" (2005: 2).

According to Agamben, the sovereign exception captures within itself what he calls "bare life." Although influential, this notion of bare life is notoriously obscure. Agamben derives it from the Ancient Greek distinction between natural life (*zoē*) on the one hand, and particular forms of life (*bios*) on the other. In short, bare life is neither *zoē* nor *bios,* but the politicized form of natural life. Further, the politicization that he identifies occurs through the "abandonment to an unconditional power of death" (1998: 90), that is, to sovereignty. Hence, bare life is "life exposed to death" (1998: 88). In his book *Homo Sacer*, Agamben goes on to point to a range of examples that the notion is supposed to illuminate, from the French notion of the "overcomatose" and persistent vegetative state (PVS) cases such as that of Karen Quinlan, the systematic use of rape as a weapon of war, and the history of self-experimentation in science. Whether these clarify the concept or confuse it further is debatable, but perhaps the most thorough – and controversial – discussion that Agamben provides of bare life is in his analysis of concentration camps, especially the Nazi concentration camps of World War II.

Agamben proposes that the concentration camp is paradigmatic of the logic of sovereignty and exceptionality that lies at the foundation of Western biopolitics. He maintains that the camps were "born out of the state of exception and martial law" such that the camp is the "materialization of the state of exception" (2000: 38, 41);

and insofar as the exception has become the rule, the camp is the "hidden matrix" of Western biopolitics. This logic, of course, extends from the Nazi concentration camps to the refugee camps that have arisen around the globe. Even more controversially, he goes on to claim that apparently innocuous spaces such as airport lounges, gated communities, and soccer stadiums are or can become zones of indeterminacy that are politically and logically equivalent to concentration camps (2000: 42). For many, this stretches Agamben's thesis beyond the bounds of credibility. But setting aside the question of whether this extension of the logic of the camp is valid, what is important to note about the centrality of this logic in his account of biopolitics is that it means that the supposed politics of life is in fact a politics of death – not *biopolitics*, but *thanato-politics*.

Responses to this characterization have been significant and varied. Achille Mbembe (2003) has argued that the concept of biopower is inadequate for understanding the politics of death, especially in colonial contexts, and has instead coined the term "necropolitics." Alternatively, a number of theorists have turned to the project of developing an *affirmative* biopolitics beyond its modern thanato-political manifestation. In this vein, the work of Roberto Esposito is increasingly influential. The central concept in Esposito's analysis of modern biopolitics is that of immunization. He argues that this concept provides the nexus between the two poles of biopolitics – politics and life – because the term immunity itself has both a biological and a political valence. It refers to both a "natural or induced refractoriness on the part of a living organism when faced with a given disease" and a "temporary or definitive exemption on the part of the subject with regard to concrete obligations or responsibilities that under normal circumstances would bind one to another" (Esposito 2006: 24). Beyond this semantic value, the notion of immunization also highlights the way in which biopolitics consists in the protection of life through the contradiction of it: the protection of life requires a dose of the evil that threatens it, precisely in order to generate the protection required against that evil. In this sense, immunity is a kind of negative protection: "it can prolong life, but only by continuously giving it a taste of death" (Esposito 2011: 9). For Esposito, the critical question is then whether life can be preserved in a way that does not pursue this negative protection, a possibility that he argues emerges through pushing the internal contradictions of immunization to their breaking points.

Another influential approach to biopolitics has been that of anthropologist Paul Rabinow and sociologist Nikolas Rose, who reject the association that Agamben makes between biopolitics and thanato-politics. For them, biopower is not about "making die" but "making live"; they write, "central to the configuration of contemporary biopower are all those endeavours that have life, not death, as their *telos*" (2006: 203). Rabinow and Rose oppose any association of contemporary biopower with Nazism and the Holocaust (*see* HOLOCAUST). Further, they reject Agamben's "totalization" of sovereign power to everyday life, arguing that a more "nuanced" understanding of power is required to "analyse contemporary rationalities and technologies of biopolitics" (Rabinow and Rose 2006: 202). According to these

scholars of medicine and the life sciences, Agamben and others fall into an abyss of overarching theories that "describe everything but analyse nothing" (2006: 199). Thus, they eschew theories that claim to capture the logic of biopower in its entirety and instead favor empirically detailed, but nevertheless conceptually rich, analyses of particular apparatuses of biopower.

Accordingly, Rabinow and Rose's work seeks to diagnose what they have called the "near future," in the sense given to this term by Gilles Deleuze (1992: 164) – that is, "what we are in the process of becoming." Rabinow and Rose write:

> [T]he concept of biopower seeks to individuate strategies and configurations that combine three dimensions or planes – a form of truth discourse about living beings and an array of authorities considered competent to speak that truth; strategies for intervention upon collective existence in the name of life and health; and modes of subjectification, in which individuals can be brought to work on themselves … in the name of individual or collective life or health. (2006: 203–4)

In particular, they see the fundamental aspects of contemporary biopower manifest in biotechnologies and biosciences that manufacture our understanding of life itself. In different ways, each has argued that biotechnologies allow for a novel view of life, one which Rose (2007) depicts as an "emergent form of life" characterized by trends such as viewing life at the level of the molecular rather than the organic, optimizing life through treating susceptibility rather than disease, and enhancing capacities rather than simply restoring health.

Biopolitics and Ethics

These differing conceptions of biopolitics have been widely influential in disciplines such as sociology, anthropology, legal studies, and cultural studies, to name but a few; however, their implications for ethics, including more specific areas such as bioethics, remain underexamined (*see* BIOETHICS). Given their shared concern with matters biological and technological, one might be led to think that scholars in the fields of biopolitics and bioethics have much to discuss, that the fields are compatible and indeed complementary. Interestingly, this has not been borne out, and the relationship between the two fields has been more marked by either non-engagement or critique. For instance, Rabinow has remarked that bioethics constitutes a "para-national phenomenon" deeply embedded within the regulation of medical practice and scientific experimentation. He writes:

> [T]he main mode of regulation is now "ethical." In principle, and by principle, ethical regulation operates now at the scale of living beings (*le vivant*) and takes as its task the protection of life – life and living beings that are presumed to be threatened and endangered. (2003: 115)

The implication of this is that while bioethicists position themselves as adjudicators of moral questions that arise in medicine, science, and related spheres of human

life, they are in fact operating as a particular node within the biopolitical management of life. This point that bioethics is actually biopolitics is made even more explicitly by Jeffrey Bishop and Fabrice Jotterand (2006: 211), who claim that the biopolitical aspects of bioethics are increasingly apparent, and imply that there is a "stench of totalitarianism" in contemporary bioethics. While there are numerous crossovers in topics between the two fields, the areas of bioethics that reveal this complicity especially well are the debates around the historical and contemporary efforts to improve humanity through means such as the regulation of reproduction, and biomedical enhancement of humans (*see* ENHANCEMENT, BIOMEDICAL; EUGENICS; REPRODUCTIVE TECHNOLOGY).

Nineteenth- and twentieth-century efforts to improve the human "stock," either through the regulation of reproduction or through the killing of those persons deemed unfit, provide a particularly clear example of biopower in operation. Foucault did not discuss eugenics in any detail (though he did plan a genealogy of the concept of heredity), but he did identify the "socialization of procreative behavior" as a central axis of biopower (1990: 105). Arguably, today, procreative behavior is subject to even greater management and regulation than it was in the nineteenth century, and bioethicists may be instrumental in this regulation. From arguments about the obligation of prospective parents to have the best possible child (using pre-implantation genetic diagnosis), to widespread approval of the use of reproductive technologies to select against embryos and fetuses with diagnoses of malformation, and parallel moral condemnation of choices not to terminate such pregnancies (or to use similar technologies to select *for* traits often considered disabling), bioethicists lend intellectual weight to policies and practices that influence who comes into the world. Of course, individual choice and liberty are central to the contemporary use of reproductive technologies, and thus appear to distinguish modern efforts to influence the type of people who come into the world from older eugenic projects. This is also true of arguments for biomedical enhancements of humans, in efforts to extend life expectancy for instance. This might challenge the claim that there is a kind of totalitarianism at the heart of bioethics. Even so, Foucault makes it clear that the direct intervention of the state is not necessarily required for the efficacy of biopolitical measures.

The question remains, though, of whether there can be a more positive engagement between scholars of biopolitics and those of bioethics. There has been notable recent work in this direction. For instance, Jonathon Moreno defines biopolitics broadly as "the ways that society attempts to gain control over the power of the life sciences" (2011: 18) and uses the notion to examine the political machinations in bioethical debates over stem cell science, end of life decision-making, and reproductive technologies, among other things. While Moreno takes the term biopolitics from Foucault, he argues that the latter's account is outdated and we are moving into a new biopolitics that deals not with bodies and populations, but with "tissues, systems and information" (2011: 20). This resonates with Rose's "molecularization" thesis mentioned earlier. Catherine Mills (2011) has also used Foucault's work extensively in bioethical discussions. Her work focuses on the idea of normalization proposed

by Foucault and its implications for decision-making processes in reproduction. This work points to one of the key theoretical difficulties to confront in a *rapprochement* of biopolitics and bioethics, the recognition of which also helps to illuminate the implications of the concept of biopolitics for ethics more generally.

This is the question of the particular philosophical meaning and weight of normativity (*see* NORMATIVITY). As can be surmised from the preceding discussion, none of the key contemporary theorists of biopolitics engages in or is especially sympathetic toward normative philosophy. Foucault is well known for disavowing normative approaches in philosophy, and often refused to spell out the normative implications or aspirations of his work. Similarly, the empirical focus of Rabinow and Rose, and of the multitude of scholars who adopt a similar approach to biopolitics, seems to preclude – or at least set aside – normative reflections. In contrast, bioethicists are centrally engaged in normative discussions, and typically show little reticence to articulate what is right or what ought to be done. Indeed, it is in part this enthusiasm for pronouncing on the right and wrong that ensures that bioethics operates as the kind of regulatory apparatus in the manner identified by Rabinow. However, this apparent opposition is somewhat spurious, for theorists such as Foucault and Agamben do not simply reject normative philosophy, but attempt to develop a different way of doing it, or a different ethical vocabulary. Thus, while their ethical reflections remain somewhat underdeveloped, both theorists nevertheless saw promise in new ways of thinking about ethics.

Foucault's work in later volumes of *The History of Sexuality* project and related texts is often viewed as one of the most significant contributions to Continental philosophy of ethics in the generation of thinkers of the 1960s and 1970s (*see* TWENTIETH-CENTURY CONTINENTAL ETHICS). In these works, he initiated a genealogy of the ways in which individuals act upon themselves as ethical subjects, that is, the self-work that they do in order to enact certain principles and modes of ethical being into their own lives. These "arts of existence" or "techniques of the self" (1985: 11) involve establishing a particular relation to oneself, in which the adoption of certain ethical principles entails acting upon one's body, thoughts, and conduct in order to attain a particular state of morality, happiness, wisdom, or health and so on. This reflexive and transformative relation entails that one effectively makes oneself into a certain kind of ethical subject. Foucault's approach to ethics thus strongly emphasized the practical aspect of attempting to integrate a moral principle or precept into one's life. Further, from the study of Ancient Greek ethics of the self in *The Use of Pleasure* (1985), he emphasized the centrality of freedom in ethics, claiming at times that an ethics of the self was a "practice of liberty." This centrality of freedom is also evinced in the claim that "[f]reedom is an ontological condition of ethics. But ethics is the considered form that freedom takes when it is informed by reflection" (1984: 285). Even so, Foucault's concern is not with theorizing about freedom and its moral and political value (though he clearly thought it had such value); rather, his interest was in how people practiced freedom in their everyday lives. In short, then, Foucault was not interested in elaborating principles of freedom, duty, or moral right, but he did provide a method for examining how such principles might be adopted by and embedded within the lives of ethical subjects.

Whereas Foucault's work on ethics thus allows for a new way of approaching contemporary principles of morality as practice, Agamben proposes a stronger critique of such principles and the typical terminology of modern Western ethics. Enlarging on his identification of concentration camps as the hidden paradigm of biopolitics, Agamben proposes, in a manner similar to Theodor Adorno (see ADORNO, THEODOR W.), that the Holocaust necessitates a radical revision of ethical concepts. In particular, Agamben rejects reliance on concepts of guilt and responsibility in ethics (*see* GUILT; RESPONSIBILITY), claiming that "ethics is the sphere that recognizes neither guilt nor responsibility … To assume guilt and responsibility … is to leave the territory of ethics and enter that of law" (1999: 24). Instead of responsibility, he then goes on to propose the rather inscrutable notion of an "unassumable nonresponsibility" as the guiding idea of a future ethics. In a more recent book, Agamben (2013) has extended his critique of modern ethics through a genealogy of the concept of duty (*see* DUTY AND OBLIGATION) from its origins in Christian liturgy through to Kantian ethics (*see* KANT, IMMANUEL). In a forthright statement of his opposition to the form that ethics currently takes, he concludes this study with the claim that any philosophy that aims to escape the conceptual apparatuses of biopolitics must formulate an "ethics and a politics entirely liberated from the concepts of duty and will" (2013: 129). Whether this is ultimately compelling or not, Agamben certainly offers a provocative critique of modern ethics. It remains to be seen, however, whether his work so far can generate a significant positive contribution to an ethics beyond biopolitics.

***See also*:** ADORNO, THEODOR W.; BIOETHICS; DUTY AND OBLIGATION; ENHANCEMENT, BIOMEDICAL; EUGENICS; FOUCAULT, MICHEL; GUILT; HOLOCAUST; KANT, IMMANUEL; NORMATIVITY; POWER; REPRODUCTIVE TECHNOLOGY; RESPONSIBILITY; TWENTIETH-CENTURY CONTINENTAL ETHICS

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