

Chapter 6

The Perils of Scientific Obedience: Bioethics under the Spectre of Biofascism

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Introduction

This chapter invokes the research of Stanley Milgram, the Yale University social psychologist made famous by his experiments on obedience to authority in the early 1960s. I argue for the relevance of Milgram's insights in the context of modern Western healthcare, claiming that the rhetoric of healthcare demands a perilous obedience to scientific authority. This argument extends beyond medicine's proverbial paternalism; indeed, the rhetoric of healthcare has become internalized as a worldview, and has come to authorize and regulate a limited set of normative terms—a language—in and through which individuals relate to the social world, to themselves, to their bodies, and even to their own genetic material. In other words, healthcare discourses extend seamlessly beyond the medical sphere to touch every aspect of human life and death, increasingly underpinning modern subjectivity and identity—effectively spelling the end of the rational, autonomous subject in the traditional sense of the term. Taking an ethical and political perspective, this chapter draws on the implications of Milgram's eponymous experiments to support the stark claim that emerging healthcare discourses tend toward totalitarian or fascist modes of (self-)governance. I limit my analysis of healthcare rhetoric to three interrelated instances of “fascist” ideology in play: (1) biomedicalization, (2) the political economy of neoliberalism, and (3) popular biocultural discourses. The constellation of these three “fascisms” I call “biofascism,” and I turn to the phenomenon of genetic screening or “pre-diagnosis” as an illustrative example that cuts across all three. Given that we are subject to biotechnologies and healthcare discourses that clearly exceed our understanding and control, the challenge will be to imagine an ethic that is not fettered to an obsolete principle of autonomy. I conclude with a discussion on “genetic subjectivity” to suggest how we might begin to imagine subjects who are not “autonomous,” but who are nevertheless responsible to understand—and to resist—the perilous political and moral authority of healthcare rhetoric and practice.

It is no coincidence that Milgram's well-known experiments at Yale University began just a few short months after the beginning of the Adolf Eichmann trial in Jerusalem. A high-ranking Nazi officer charged with war crimes and crimes against humanity, Eichmann claimed that he was innocent because he

was merely “following orders,” obeying the authority of the *Führerprinzip*. In a nutshell, then, the Milgram experiments engaged the terms of Eichmann’s defence, and set out to test the extent to which ordinary citizens could be prompted by an authority figure to act against their own political and moral conscience. I begin here because the Eichmann case dramatizes for us, as it did for Milgram, the conflict between individual autonomy and collective responsibility. On the one hand, we demand that Eichmann be held responsible for his crimes; on the other, however, we acknowledge that he formed part of a fascist, ideological “machine,” and therefore cannot be considered to be “autonomous,” *sensu stricto*. There is no contradiction here. Indeed, I shall conclude below that ethical responsibility ought to be re-conceived in broader terms, and need not presume—or shore up the fiction of—the autonomous subject. If traditional bioethics continues to insist on founding itself in autonomy, it will grow increasingly irrelevant in the face of burgeoning biotechnologies that evacuate that autonomy, as I argue below.

It is worthwhile recalling the main experiment. Research subjects were recruited from the general public and told they would be participating in an experiment that tested the effects of punishment on learning. Two subjects drew lots to determine who would be the “teacher” and who would be the “learner”; in reality, the roles were fixed. The learner was played by an actor whose lines were scripted, while all subjects were cast in the teacher role. The learner/actor was strapped into what resembles an electric chair, and electrodes were attached to his body. The teacher/subject was then led into an adjoining room and seated in front of an elaborate machine with switches ranging from “Slight Shock” and “Moderate Shock” through to “Extreme Intensity Shock” and “Danger: Severe Shock.” Two switches beyond these bore the obscene label, “XXX.” The “shock generator” was clearly marked with a voltage output from 15 to 450 volts. The teacher/subject was asked to read simple word pairs to the learner through a microphone and then test the learner’s ability to remember and repeat the words correctly. For an incorrect answer, the teacher/subject was instructed by the experimenter to “shock” the learner, beginning at 15 volts and increasing each shock by 15 volts for each incorrect response. Despite scripted screams of pain from the learner, the outcome of the experiment was that most subjects were fully compliant, administering the maximum, lethal shock of 450 volts. Only a few participants refused to comply—but these did not refuse until reaching or surpassing the 300 volt level.

Much like Hannah Arendt (1963) had depicted Eichmann, Milgram held that his research participants were “ordinary” or even “good” people, neither monstrous nor innately sadistic:

After witnessing hundreds of ordinary persons submit to the authority in our experiments, I must conclude that Arendt’s conception of the banality of evil comes closer to the truth than one might dare imagine. The ordinary person who shocked the victim did so out of a sense of obligation and impression of his [or her] duties as a subject—and not from any peculiarly aggressive tendencies. (Milgram 1973, 75)

There is an ordinariness, then, to our obligation to authority, just as there are ordinary social pleasures that attend our sense of duty, of discipline, and loyalty to what we might call a dominant symbolic order, to fulfil socially mandated roles. “Morality does not disappear,” Milgram suggests, “it acquires a radically different focus: the subordinate person feels shame or pride depending on how adequately he [or she] has performed the actions called for by authority” (1973, 77). In this view, morality becomes reconfigured as social compliance. If Milgram’s work has had a tremendous afterlife and is invoked to help make sense of such phenomena as US torture at Abu Ghraib and Guantánamo (see, for instance: Fiske et al. 2004; Packer 2008), it is because the individual’s place in contemporary society is increasingly mediated by command hierarchies, a sociopolitical machinery of obedience. And while they might appear to be “banal,” as Arendt would say, our increasingly militarized and corporatized structures of governance divide human labour and diffuse individual responsibility. In our submission to authority, we come to displace our personal responsibility onto that authority. Again, if we consider the murders and other US crimes in Iraq, Afghanistan, and so on, we find ourselves directed toward a vague and amorphous hierarchy, to the point where one wonders if anyone at all is responsible. This was Eichmann’s defence. There is always potential displacement, (im)plausible deniability, the shadows and shadowmen of extralegal bureaucracy. Milgram concludes: “The person who assumes responsibility has evaporated. Perhaps this is the most common characteristic of socially organized evil in modern society” (1973, 77).

This chapter will reflect on the kinds of sociopolitical structures that prompted Milgram’s bleak comment on “socially organized evil.” Below, I apply Milgram’s insights to the rhetoric of healthcare, asking, what is left of personal responsibility if there is no person, no autonomous subject, in the traditional sense of the term? Milgram writes: “The most far-reaching consequence is that the person feels responsible *to* the authority directing him [or her] but feels no responsibility *for* the content of the actions that the authority prescribes” (1973, 77). But Milgram’s explicit distinction between “responsibility to ...” and “responsibility for ...” must be pushed further still. We are not just responsible for the “content” of our actions, including those prescribed by authorities, symbolic or otherwise: in a civil society we are also responsible for those structures of authority themselves, for the system of rewards, right down to the conditions of possibility by which we experience duty, loyalty, and discipline. In other words, being “responsible for ...” surpasses the question of obedience to pose the question of consent, which is often tacit. Discussing the Nazi collaborators, Arendt writes: “the question addressed to those who participated and obeyed orders should never be, ‘Why did you obey?’ but ‘Why did you *support*?’” (2003, 48). To be sure, whether or not to consent, condone, support, or otherwise authorize wider cultural systems of governance and meaning-making is much more complex outside the experimental situation where there are few clear authority figures and where social roles are less well-defined. Milgram’s more speculative statements bear this out: “when ... they are asked to carry out actions incompatible with fundamental standards of morality,

relatively few people have the resources needed to resist authority" (1973, 76; emphasis added). What would these resources look like? And what could they mean, particularly when that authority is nearly total, an immersive environment, where authority is disembodied, and social roles poorly defined or differentiated?

The work of social psychologists, such as Milgram, offers a common way to map "evil" and our ethical responses to it. In another case, Philip Zimbardo's 1971 prison experiment at Stanford University draws similar conclusions (see, most recently: Zimbardo 2007). These experiments claim to provide insight into "how good people turn evil." Such work is described as a "situationalist" ethics because it seeks recourse to the situation or social context, rather than to principles, such as autonomy or nonmaleficence. In Zimbardo's experiment, wholesome young university boys became cruel, authoritarian, and sadistic when they were cast in the role of prison guards, meting out such frightening punishment on the boys who were "prisoners" that the experiment had to be cut short. Zimbardo explains that these boys were not predisposed to adopt a "guard mentality," but that their behaviour can be explained by the social roles and expectations that encourage, condone, or authorize it. In short, the social situation turns them bad, a "Lucifer effect." Unsurprisingly, Zimbardo appears frequently in the media as an expert on "prison abuse," brought in to explain the situational "causes" of the abuse, arguably undermining the moral gravity of these crimes, exonerating the criminals. Rejecting Zimbardo's conclusion, however, need not return us to an ethics based on personal responsibility and autonomy, as I discuss below.

Three Fascisms: Socially Organized Evil in the Rhetoric of Healthcare

Here I would like to consider "socially organized evil" within the specific context of the healthcare industry. While we may not be persuaded by their conclusions, Milgram and Zimbardo lay out the problem rather well: Is ethics a matter of personal responsibility and autonomy—a "responsibility to ..."? Or must we take account of something inherently more social and political, a question of collective responsibility—a "responsibility for ..."? This conflict arrives at a crisis in all manner of "total institutions" (Goffman 1961)—whether this is in the laboratory, the prison, the medical clinic, or society at large where these institutions authorize and regulate a limited set of normative terms in and through which individuals are (self-)governed. Below I discuss the case of genetic screening or "pre-diagnosis." Before doing so, however, I would like to build on earlier work (Holmes et al. 2006) in the politics of healthcare to sketch three closely related political ideologies—or "microfascisms"—at play in the way that healthcare, increasingly, is deployed rhetorically.

Biomedicalization

The first microfascism is in the seemingly inexorable "biomedicalization" of healthcare management and delivery. As my colleagues and I have argued (Murray

et al. 2007), the healthcare industry is a mind-boggling nexus, a tangled web that includes Big Pharma, innumerable government lobbies, government agencies and public policymakers, academia and its research sponsors, the convergence of research and business with its multiple public and private "stakeholders," and the insurance industry, to name just a few. For the person who is (potentially) ill, this complex system can be barely navigable, and it is not farfetched to imagine the apparently autonomous individual disappearing into this apparatus, subject to the "disciplining" (Foucault 1977) frenzy of best-practice guidelines, evidence-based medicine (EBM), bureaucratic proceduralism, and the like. What I point to here is not simply the expansion of medical authority and practices into new realms; rather, it is the emergent paradigm by which we are coming to understand the relation between medicine, health, and life itself. I follow Adele Clarke and her colleagues who characterize biomedicalization as a number of interrelated phenomena, including the new political economic valences of biomedicine, the rise of risk factors and risk surveillance, and the emergence of biomedical or technoscientific identities, to name just a few (Clarke et al. 2003).

While it is undoubtedly a polemical position, it is nevertheless worthwhile to consider obedience to this new scientific authority in Milgram's terms and to trace how it operates as a pervasive ideology, politically, as a form of fascism. Milgram himself refers to the political writings of Arendt and considers at length the social and political implications of his findings (see Milgram 1974)—whether there could be ethics after Auschwitz, we might say. Dave Holmes and his colleagues have more recently turned to the work of Michel Foucault and Gilles Deleuze to demonstrate the *microfascism* of current medical practices, examining in particular the narrow ideologies and methodologies that govern evidence-based medicine (EBM). Following Foucault and Deleuze, they:

understand such fascist logic as a desire to order, hierarchise, control, repress, direct and impose limits. *Fascism* is one of the many faces of totalitarianism—the total subjection of humanity to the political imperatives of systems whose concerns are their own production. (Holmes et al. 2006, 184)

EBM, as one instance of biomedicalization, is a totalizing logic because it privileges the randomized controlled trial (RCT) above all else, foreclosing upon other possible ways of knowing. Holmes and his colleagues argue that evidence-based practitioners, much like Milgram's subjects, reap institutional rewards and the pleasure of "a job well done," dutifully capitulating to a scientific authority that is authoritative merely because it has the institutional imprimatur of Science. Patients, too, are interpellated into this regime through the promise of "better outcomes"; they are not told that their own narratives are ranked as "low evidence" according to the Cochrane Hierarchy. "Evidence" is arranged hierarchically: RCTs are on top, while clinician experience is typically located somewhere near the bottom, and patient narratives rarely appear at all. The hierarchy works authoritatively to pre-judge the relative value of "evidence," determining in advance what—and who—will be authoritative.

The Political Economy of Neoliberalism

What is more, the totalizing impulse of biomedicalization maps neatly onto the political economy of neoliberalism, arguably the reigning ideology of contemporary Western democracies. Here healthcare is aligned with what I am calling a second “fascism,” where neoliberal political economic discourses supplement and feed on biomedicalization. Each demands greater efficiency and greater economy in the face of dwindling financial resources and soaring healthcare costs. Biomedicalization, from EBM to self-surveillance and risk-management, is enabled by the neoliberal ideology that expresses an almost evangelical faith in free market capitalism (see, for instance: Barry et al. 1996; Bunton and Petersen 1997; Rose 1996b; Rouvroy 2008). And *vice versa*. From academe and its research granting bodies to hospital ethics review boards and the medical insurance industry, the dominant discourse is borrowed from the corporate sphere: client-based (also known as a patient-centred mantra), key performance indicators (KPIs), outcomes, best-practice guidelines (BPGs), knowledge mobilization and transfer (also known as scientific transfer), capacity building, operationalization, commercialization, and so on. “Client” patients are encouraged to conceive of themselves in “entrepreneurial” terms, which means relating to their own bodies and to their genetic material instrumentally and economically, as “biocapital” (see, for instance: Sunder Rajan 2006). The phenomenon of private “biobanking”—storing one’s umbilical cord blood, eggs, semen, or other stem cells for later use, should the need arise—is one instance where the economic relation to oneself is literalized through one’s own body (see, for instance: Waldby 2006).

In Michel Foucault’s terms, the neoliberal subject is “an entrepreneur and an entrepreneur of him- or herself” (Foucault 2004, 232; translation mine). In this form of its self-relation, the subject is not just a consumer but is doubled: “The consumer, in so far as he or she consumes, is a producer” (*ibid.*). It is a closed economy where the subject herself is imagined to produce the satisfactory health and wellbeing that she will enjoy and “consume”; she repays her own debt. It is a model of self-sufficiency, a circuit that is closed by responsabilization and the politics of risk—“technologies of the self.” Under neoliberalism, the subject’s own self-improvement is internalized as a moral duty. Many healthcare models are based on the self-care ideology (see, for instance, Orem’s nursing conceptual model). In the case of illness, she is expected herself to compensate for the deficits imposed by her disease, and this relation is marked as both a responsibility to one’s own body and to the population as a whole. Within a market economy, the person who is ill accrues a kind of social debt which must be redeemed by locating herself within compensatory discourses that are both social and corporeal—that is, they must be performed publicly and they must be done to the body, whether something is cut from or added to that body. If this sounds like “autonomy,” it is an extreme and reductive form in which the terms of self-relation must obey a narrow econometrics.

Popular Biocultural Discourses

Biomedical and bioeconomic discourses work in tandem to inform wider cultural perceptions of health and the individual’s relation to his or her body and to the healthcare system and industry in general. Here I identify a third “fascism” that is sociocultural. It has less to do with biomedical facts or with bioeconomic imperatives and their measures, but with shifting perceptions—with the dominant popular terms that circulate and with the ways that these terms shape our self-understanding in the quotidian. This is best illustrated through an example. Consider the ways that the gene has entered popular discourse and has come to inform how we understand human life and the body, the individual’s relation to history, and to health and illness more generally. In his speech on the occasion of the mapping of the Human Genome, former US President Bill Clinton typifies the kind of thinking that has entered the mainstream:

With this profound new knowledge, humankind is on the verge of gaining immense, new power to heal. Genome science will have a real impact on all our lives—and even more, on the lives of our children. It will revolutionize the diagnosis, prevention and treatment of most, if not all, human diseases. In coming years, doctors increasingly will be able to cure diseases like Alzheimer’s, Parkinson’s, diabetes and cancer by attacking their genetic roots. (Clinton 2000)

The metaphor of the “map” complements popular conceptions of genetic “blueprints” and the gene as the “book of life” (Fox Keller 2002). What emerges is a social and cultural science fiction of the gene, a popular discourse that increasingly informs our understanding of kinship relations, health, and medicine in the post-genomic age. This authority and “knowledge” is internalized. And, true to the logic of the gene, the “internalization” is both figurative and quite literal. While the gene has become a dominant rhetorical figure for individuality and identity, the “matter” of genes is of paramount importance because they are considered to be the most elementary particles of the body, the very authors of who we are, from eye colour to personality.

The “genetic” discourse is compelling. In a world of disenchantment, where transcendent truths are increasingly unfashionable, genomics fulfils a deep cultural desire for Truth. As Nelkin and Lindee argue, in popular culture DNA is not just a dominant trope for individual identity, in many respects DNA also functions as a secular equivalent of the Christian soul. Seemingly independent of the body, DNA appears to be immortal; it extends indefinitely into the past and, if one has children, it stretches indefinitely into the future. DNA has become fundamental to identity, charged with the tremendous power to explain individual differences, moral order, and human fate. Incapable of deceiving, genes seem to be the locus of the “true self” (Nelkin and Lindee 1995, 2; also see Nelkin 2001). The gene thus operates as a cultural science fiction, offering what is at times a deeply moralistic vocabulary that masquerades as Science and Truth. But the meaning of DNA is

culturally mediated, conveyed through particular social and historical contexts that are nevertheless contingent. When genes are raised to the level of Truth, the inherent danger is that cultural values become “naturalized,” no longer subject to discussion and interpretation. Bill Clinton continues:

Today’s announcement represents more than just an epic-making triumph of science and reason. After all, when Galileo discovered he could use the tools of mathematics and mechanics to understand the motion of celestial bodies, he felt, in the words of one eminent researcher, “that he had learned the language in which God created the universe.” Today, we are learning the language in which God created life. We are gaining ever more awe for the complexity, the beauty, the wonder of God’s most divine and sacred gift. (Clinton 2000)

This rhetorical excess is politically dangerous; it casts the scientist as God, and marks scientific knowledge with divine—and hence, indisputable—authority.

The Birth of “Biofascism”

I use the term “biofascism” to point to the constellation of the biomedicalized, bioeconomic, and biocultural microfascisms that I have sketched above. In other words, biofascism invites, if it does not demand, a totalitarian obedience to scientific authority, to the ideological political economic coordinates of neoliberalism, and to the cultural science fiction of genetic “truth.” These spheres overlap; they are mutually implicated in complex ways. Together, they form a totalizing ideology that governs life itself—whether “life” is located in the most microscopic biological terms, or whether it is deployed in the widest possible sense, as something sacred and inviolable. No matter; the governing structures are nimble enough to be applied across a range of social spheres in the project of biopolitical governance (Foucault 2004).

I would like to explain my use of the term “fascism” and to argue for the value of provoking an ethical and political reflection on the emerging crisis in healthcare rhetoric and practice. What kind of totalitarianism is biofascism? Slavoj Žižek argues that historically there are two totalitarianisms, the first, which is aligned with Hitler and National Socialism, and the second, which is properly Stalinist. As Žižek writes, “In the Stalinist ideological imaginary, universal reason is objectivised in the guise of the inexorable laws of historical progress, and we are all its servants, the leader included” (2005). Stalinism conceived of itself as following Enlightenment principles, hence the famous show trials where individuals “confessed” and, as so-called rational subjects, were held responsible for their “crimes.” As Žižek points out, for the Nazis there was no such pretence: a Jew was guilty by virtue of his genetic makeup alone. But what if we imagine a kind of synthesis of the Nazi and Stalinist ideologies: where, for example, the Jew is *de facto* guilty, thanks to his genes, but is now made to confess publicly, to be responsible for,

and to wholeheartedly believe and to adopt the ostensibly rational and enlightened perspective according to which he will demand his own execution in the name of hygiene, History, Science, Progress, and Nature? It is not difficult to imagine a totalitarianism, an ideology of “life,” obedient in the first instance to scientific authority. While Arendt famously writes that totalitarianism “is quite prepared to sacrifice everybody’s vital immediate interests to the execution of what it assume[s] to be the law of History or the law of Nature” (2004, 461–2), here the term “sacrifice” becomes nonsensical because the programme is implemented in the very name of “vital immediate interests,” in the name of life. We might call this a vital self-subjection, where the individual concedes to the Truth of his being, and the ideology is internalized so completely that he demands this knowledge, makes it public, and even yearns for it. Ironically, it appears that such a system preserves the liberal, rational subject—and perhaps even vouchsafes a perverse “ethics” based on the enlightened principles of “freedom” and “autonomy.” And yet, it fosters such a subjectivity only to have it delight in its own self-annihilation.

There is a distinct parallel here with the way that traditional bioethics fetishizes the liberal, autonomous subject, preserving it at the cost of that subject itself. Even mainstream bioethics tends to embrace biomedicalizing, bioeconomic, and biocultural discourses because they *appear* to shore up patient autonomy, giving individual patient-clients the tools for self-knowledge, self-surveillance, and self-regulation, so that they can become entrepreneurial managers of their own healthcare regimens. In reality, however, the subject is increasingly tied to expert advice and a cadre of medical authorities, increasingly inculcated into a regime that ultimately hijacks the liberal, autonomous subject in the guise of freeing it (Novas and Rose 2000; Rose 1996a; Rose 2001). And as the two examples below suggest, genomic medicine itself renders the notion of a unified, rational, and autonomous subject practically obsolete.

Two Examples: Genetic “Pre-Diagnosis”

The scientific authoritative constellation I call “biofascism” can be demonstrated through the phenomenon of genetic screening, or what I call genetic “pre-diagnosis.” The first case is a relatively rare condition in which an individual is genetically pre-disposed to develop stomach cancer. Hereditary Diffuse Gastric Cancer (HDGC) is associated with the *CDH1* gene and a particular encoding of the protein E-cadherin (Gayther et al. 1998). The genetic predisposition can now be detected by a blood test. Women with this genetic condition have a 70 per cent chance of developing stomach cancer; for men, the numbers are somewhat lower. With HDGC, women also carry a 50 per cent chance of developing lobular breast cancer. Because the stomach cancer is virtually undetectable with scopes or biopsies, and thus regular screening is not likely to detect it, the recommended treatment is a prophylactic gastrectomy—removing the stomach and attaching the oesophagus directly to the small intestine. The operation has a high potential for morbidity and mortality; risks and long-term complications are legion, including

extreme weight loss, infection, anastomotic leaks (where the oesophagus joins the small intestine), blood clots in the lung(s), spleen, or liver, and sometimes death. Roughly half of those who test positive opt to have the surgery—surely an unthinkable and terrifying decision.

The second case is much more well-known. By screening for the BRCA1 and BRCA2 genes, geneticists can predict the likelihood that a woman will develop breast cancer in her lifetime. Based on epidemiological statistics, she is assigned a risk factor. Perhaps she learns that she has a 29 per cent chance of developing breast cancer. She must now decide whether or not to undergo a prophylactic bilateral mastectomy. Whether or not she opts for the surgery, she will be forced to weigh her 29 per cent risk in “real” terms. The number, I would suggest, is a maddeningly unreal artefact; the discourse on risk is alien, it belongs to the insurance industry, to epidemiology, to mathematics. But it is on this terrain that she must find the normative terms by which she will be compelled to relate to herself, to her body, and to her future. The numbers are probabilities, uncertainties. While she may be cancer-free at the moment of the test, with a positive test result she will be inducted into the strange temporality of medical surveillance; she will be expected to take responsibility for a spectral disease that may or may not affect her at some indeterminate point of time. She will be expected to avail herself of expert service-providers while calculating the value of a life she has not yet lived. She will be expected to calculate and weigh the costs and the benefits of various treatment options. She will be summoned to think like a “health economist,” rationally plotting her “Quality Adjusted Life Years” (QALY)—the number of years that would be added by the medical intervention, each year ranked from 0 through 1, with 1 representing perfect health and 0 representing death. She will be railroaded into an impossible temporal and epistemological relation with herself: she must account for a future-self and must do so in terms that may have little phenomenological relevance to her bodily and psychic life.

Discussion: An Autoimmunity Response

The cases above draw on and contribute to a “genetic” worldview; however, despite the appeal to scientific authority, this world is not necessarily rendered more navigable. I suspect that for the client-patient this “geneticized” network of healthcare services and their attendant structures can invoke a kind of “autoimmunity” response—a condition where the organism fails, as it were, to recognize its own constituent parts as part of itself, and therefore attacks them in a perverse form of “self-defence.” I borrow the metaphor of “autoimmunity” from Jacques Derrida. Giovanna Borradori describes it as follows: “Autoimmune conditions consist in the spontaneous suicide of the very defensive mechanism supposed to protect the organism from external aggression” (in Habermas et al. 2003, 150). Thus, the organism succeeds in destroying its own defence mechanisms, “immunizing” itself, paradoxically, against its own immunity. “One function of the concept of autoimmunity,” Borradori continues, “is to act as a

third term between the classical opposition of friend and foe” (151). “Friend” and “foe” here must be understood metaphorically, but just barely: with genetic “pre-diagnosis,” the classic political binary between friend and foe soon breaks down. If the threat comes from my genes, are my genes then the enemy? Or are they not also “me,” my body, my self? In Milgram’s terms, are we “responsible to . . .” our genes, “responsible for . . .” them, or some strange hybrid of the two? And how are we either constituted by or free to relate to the “geneticized” network of healthcare services and their attendant structures? After all, they authorize and regulate a limited set of normative terms in which to locate oneself. Not only have I been subjectivated by these terms, the strange indefinite futurity of the “pre-diagnosis” binds me to a potentially open-ended and fluctuating set of terms and practices as I am inducted into the imaginary futures of medicine. While we are accustomed to speak of the ongoing “war” on diseases such as cancer, with genetic “pre-diagnosis” there is no certain infection, no invasion, no attack on the body. Rather, we imagine the body poised to attack itself or as leaving itself open to attack because of defective defences—both autoimmunity responses.

Borrowing his metaphor from medicine, Derrida discusses autoimmunity in relation to terrorism and the War on Terror, where the enemy is imagined as anyone who could be anywhere, and the Western coalition might properly be said to be waging war against itself, ostensibly, in its own rational self-defence. I see this as akin to the sinister combination of the two totalitarianisms from Žižek, discussed above, where the subject’s biological self-subjectivation becomes biopolitical as well, ostensibly obedient to an Enlightenment political rationality. For Derrida, autoimmunity is a deconstructive “third term,” meant to upset the problematic binary between friend and foe, us and them. With genetic “pre-diagnosis,” however, friend and foe are already unstable categories: self and other are radically uncertain when we seek to locate “genetic selfhood” and “genetic alterity.” Moreover, the “we” who “seek” in this formulation is itself without stable ground, ethically and epistemically: is it an inquiry on behalf of “me,” “my kin,” “DNA,” or some “stakeholder” in the biomedical-industrial complex? The information from a genetic “pre-diagnosis” raises the terror of the spectral disease to a new level, inscribing my potential illness in terms that can be spoken and claimed by no one. Not only are the subject and her body seemingly at odds, not only will she be at pains to locate her subjectivity and her body spatiotemporally, not only will she founder when she wonders who speaks in her name when she seeks the meaning of her genes, but all of this occurs as she navigates between the authority of and obedience to biomedicalizing, bioeconomizing, and biocultural discourses. She will now be forced—unable to refuse—to consent to these terms; she will be forced—unable to refuse—to choose whether or not to act with a pre-emptive medical strike. Once she is armed with this genetic information, she is unfree not to choose. Patients frequently describe their DNA as a “ticking bomb,” borrowing from a military vocabulary and a logic that authorizes “pre-emptive strikes” and even torture. It is this self-sacrifice that must be made, the paradoxical and impossible demand of autoimmunity, in the name of life itself.

Conclusion: The Address of the Gene

Where are genes located? No place, no physical address, inside and outside. In biomedical terms, they introduce a strange temporality into a subject's self-understanding. While they have no physical address, we are addressed by genes. We are called into being genetically, through biomedicalizing, bioeconomizing, and biocultural addresses. And we are at pains to formulate an appropriate, ethical response that would be commensurable with the new forms of subjectivity that arise in tandem with burgeoning biotechnologies. From the foregoing, it should be clear that the total situation is more complicated than any "genetic essentialism" that might characterize the materialist position. Regardless of the ontological underpinnings of the gene, however, when it faces the complexity of genetic discourses, bioethics will be forced to admit that the modern liberal principles of freedom, autonomy, and reason are rather shaky foundations, indeed. Attempting to reinstall the liberal subject through the structures of biomedicine, a political economy of neoliberalism, or through the naturalizing manipulation of our wider cultural conceptions, ultimately robs the subject of freedom, autonomy, and reason—telling a lie in order to induct the subject into a biopolitics under the spectre of biofascism, where the terms of the subject's self-understanding and the meaning of life itself are too narrowly prescribed.

If the traditional foundations of bioethics have become obsolete, does this mean that we cannot have an ethic? In reply, we might gesture toward a poststructuralist response and ask, as Judith Butler does, "which foundations have come under criticism, and how is it—through what means—did we come to understand foundations to be a kind of *sine qua non* of ethics in the first place?" (Murray and Butler 2007, 419). Butler mobilizes the terms, understands them to be in relation. This is one way to think about the address of the gene, neither as a fixed abode nor as a command that I, the subject, receive in any stable fashion, for I, too, am of no fixed address, and the command calls or entreats me, demanding a response rather than obedience. "This self is distributed in its relational, social, and historical dimensions," Butler says,

But this fact does not destroy the idea of responsibility; all it does is to relocate responsibility as a problem of my relationality, of the fact that I am constituted fundamentally in a relationship with others, and that that constitution does decenter me; it both decenters me and provides the condition of a certain kind of responsibility. (Murray and Butler 2007, 419–20)

This relocates ethics from its presumptive foundations into a "scene of address" (see Butler 2005). Thus, we might begin to understand ethics as a responsibility for the scene of address itself, for the myriad conditions in and by which an address or claim will be made, in and by which the terms of our relation to ourselves and to others will make sense and will circulate socially, politically, and biomedically.

How shall we account for the "genetic" scene of address, and to what—and whose—terms shall we be obedient? In the early pages of *The Human Condition*, Arendt claims that "speech is what makes man a political being," and she warns against biotechnological modes of relationality: "the 'truths' of the modern scientific world view, though they can be demonstrated in mathematical formulas and proved technologically, will no longer lend themselves to normal expression in speech and thought" (1998, 3). Here Arendt distinguishes technological know-how from thought and speech. She writes further:

If we would follow the advice, so frequently urged upon us, to adjust our cultural attitudes to the present status of scientific achievement, we would in all earnest adopt a way of life in which speech is no longer meaningful. (1998, 3–4)

In other words, our relations are in danger of becoming meaningless if they are obedient to a technoscientific vocabulary. Within the coordinates of biofascism, these terms have a powerful normative authority, constraining the subject and installing her within a particular discourse that limits her freedom by regulating and prescribing the available terms in which her "free choice" might be exercised. If she refuses these terms she risks appearing unrecognizable, inhuman, since the discourse has already defined the human ontologically, as genetic, and epistemically and ethically as embodying a particular normative relation to one's own genetic material. This sets out in advance what will be permissible and impermissible expressions of the human, recognizable and unrecognizable life. The word "fascism" is therefore warranted, and perhaps not even scandalous enough. It is at this basic level of signification, of meaning-making, that we might begin to intervene.

I began this chapter with Milgram and Zimbardo because they raise the problem of obedience to authority in concrete terms; however, their analyses are limited because they continue to represent the "commonsense" view that responsibility is no more than a rational self-relation, posing questions to oneself in a particular way, and of drawing on one's own personal resources to muster the courage simply to refuse or consent. This view continues to dominate popular impressions of what responsibility is: the domain of the self. But this is to bypass or to downplay the power relations—in part, political and biomedical—through which the subject came into being in the first place. And it is to deny the ethical implications of these relations both as conditions for the emergence of a meaningful subject and, equally importantly, as that for which the subject is also in part responsible by taking account of those conditions that set any scene of address.

Milgram begins his essay, "The Perils of Obedience," with the assumption that "Obedience is as basic an element in the structure of social life as one can point to" (1973, 62). He claims that "Some system of authority is a requirement of all communal living" (*ibid.*). When asked about this claim, Butler responds as follows:

It may well be that authority is necessary for social life, its regulation and control. But it may also be that the means for a critical contestation of authority in the name of justice is equally important for social life, or any number of other political matters. (Murray and Butler 2007, 441)

The task might be to resituate obedience and authority within a critique that locates justice as the basic element of communal living. Here we might begin by asking: What is community? What is life? In her discussion, Butler contests Zimbardo's work as an apologist for US murder and torture at Abu Ghraib. Were these men good soldiers and good patriots, as Zimbardo claims? Rather than ask the question of obedience—"Why did you obey?"—she takes an Arendtian tack and points to the conditions under which the prison guards supported, consented, condoned:

these experimental scenarios ... cannot actually look at the generation of political, social, and cultural norms—in particular, those that valorize lawless violence in the name of the nation, in the context of a war effort—and see how they actually enter into the individual actions of prison guards ... But what if torture has become the very sign of patriotism within the lexicon and normative culture of this war? (Murray and Butler 2007, 442)

Butler demonstrates that patriotism and goodness—terms that are ostensibly self-evident—are themselves contestable because they are part of a wider normative discourse. So too are the crimes that are committed in their name.

This critique maps onto the broader political, social, and cultural norms of healthcare rhetoric. Just because norms are operating, just because there is a command hierarchy, it does not mean that nobody is responsible. However, nor does it mean we must return to a principle of autonomy in order to ground responsibility. Responsibility opens onto the scene of address, a scene in which we are all players—each of us, whose responsibility extends beyond the limits of our skin, spatially, and out into a world beyond the immediate effects of our individual actions, temporally. This is a different view on subjectivity. Here, responsibility is not simply a "response" to the given scene in which we find ourselves: it is a creative, forward-looking endeavour. We must create possibilities to refuse the terms, to rearrange them, to set them into different scenes, to imagine counter-scenes, and to critically intervene in order to expose vested powers and interests. To say that we are responsible for the scene of address does not imply that we "know" it and hold it before our mind's eye; instead, it might mean that we feel it, that we "try on" another scene, that we are "in" it but not "of" it. Here we can begin to respond to Milgram when he claims that his subjects lacked the "resources" to refuse to obey: "there would have to be other cultural norms and other cultural resources and other legal traditions to which one could turn in order to draw upon the resources that one needs to make the claims of justice," Butler suggests.

This is because we do not have access to some Platonic idea of justice and we do not have access to a natural right. Instead, we have a set of texts, cultural traditions, various kinds of philosophical and social movements and institutions that have been articulating justice and producing it as a cultural resource precisely for these moments. (Murray and Butler 2007, 443)

It is incumbent upon us, theorists and practitioners alike, to foster these philosophical and social movements and institutions, to safeguard the texts and traditions that will serve as valuable resources when we need them. We must struggle together against the collapse of meaning, to make speech and thought possible, and to claim responsibility for those scenes of address in which life itself might emerge from under the spectre of biofascism. Here we might begin to imagine, together, the renovation of bioethics through relations that neither return us to the unreconstructed authority of personal autonomy, reason, and liberalism, nor force a capitulation to the biomedicalized, bioeconomic, and biocultural discourses that now hold us in their grip.

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