**University of Durham**

# The transformation of the medical ethos and the birth of bioethics in Colombia

## A Foucauldian approach

By

Eduardo Díaz Amado

A thesis submitted to University of Durham for the degree of PhD in Philosophy

Department of Philosophy – Centre for the History of Medicine and Disease

2013

**Content**

**Abstract**

In the late 1960s and early 1970s bioethics was born in the USA and rapidly spread across the world. Bioethicists have traditionally argued that their discipline was the answer to the ethical challenges posed by the scientific and technological progress in biomedicine, although others have emphasised the abuses committed in biomedical human research and the dehumanisation of medicine. Notwithstanding the great excitement produced by the rise of the new field, its foundations, scope, and official historical accounts have been criticised. Calls to give bioethics better philosophical foundations –beyond the American principlism- and to broaden the field, particularly to include problems typical of the developing world such as poverty, exploitation and inequality have grown in the last twenty years. In Colombia, the idea that bioethics is an advocate of life, a discipline to protect life on earth from the dangers of an irresponsible scientific and technological advance as well as from a wrong model of development has been promoted by the Colombian bioethical establishment.

Drawing on the Foucauldian view on power and knowledge, this thesis analyses the connections between the flourishing of bioethics in Colombia and the implementation of a neoliberal healthcare system in the 1990s. The historiographies and hagiographies that have dominated the official history of bioethics in Colombia are criticised and, instead, a historical approach is offered. The central argument is that bioethics, and other discourses of surveillance of medical practice such as medical liability are part of the governmentalization of the Colombian medical ethos, and that bioethics has become a totalising, all-embracing field, constituting a form of power exercise over the biomedical scenario. Complementing the analysis, information from 27 semi-structured interviews is provided. Chapter one, the introductory chapter, discusses medicine as a contemporary cultural phenomenon and the birth of bioethics in the USA, while chapter two describes the elements of the Foucauldian toolkit that I use in the analysis. Chapters three and four critically approach the arrival and development of bioethics in Latin America and Colombia. Chapter five discusses the transformation of the Colombian medical ethos, describing the political transformation of the country in the 1990s and the healthcare reform. Chapters six and seven examine the discourses and practices around medical ethics in Colombia as well as how bioethics, medical practice, medical liability and biopolitically relevant legal decisions in the context of the new constitutional reality of the country became intertwined discourses.

## Declaration

This thesis is the result of my own work. Material from the work of others has been acknowledged and quotations and paraphrases suitably indicated. Some parts related to the transformation of the medical ethos in Colombia after the healthcare reform of 1993, which were included in my final dissertation in the MA in History and Philosophy of Science and Medicine, which I completed in 2008 at Durham University, were utilised. In chapter seven I also utilised material from two articles published about abortion: Díaz Amado, E. (2009a). Abortion: ethically inconclusive, legally and politically feasible. *Revista Latinoamericana de Bioética, 9*(1), 114-123; Díaz Amado, E., Calderón, M. C., Romero, K., Prada, E. & Barreto, E. (2010). Obstacles and challenges following the partial decriminalisation of abortion in Colombia. *Reproductive Health Matters, 18*(36), 118-126.

## Statement of copyright

**Acknowledgements**

The opportunity to study for my PhD in the UK is a dream that would have been impossible to fulfil without the support of many people. First and foremost, I am grateful to my wife Mildred for the great support and patience as she showed when she had to stay in Colombia while I was studying in Durham. The birth of my son Eduardo, who we affectionately call Eduardito, during the first year of my PhD was the most powerful motivation to go forward amid many moments of weakness and tiredness. Although thousands of kilometres far from where I was, Mildred, Eduardito, and Shania, my wife's daughter, gave me a special energy every day that kept me carrying on. I should also mention my mother, Magdalena, and my aunt Zoraida, who have given me the necessary material and spiritual support during my entire student life. Without their support I would not have been able to come to the UK. I want also to thank my brothers, Fernando, Germán and Alberto who looked after my family in my absence.

A special thanks to Colciencias, the Colombian governmental agency for academic research and postgraduate studies, and to my own university, the Pontificia Universidad Javeriana. Both granted me the scholarship that made it possible to study in Durham. I am so happy to have come to Durham. From the first moment, when I visited it just for a few hours in 2005, I fell in love with this beautiful and magical city. When I returned to Colombia, I was determined to come back and study here. Luckily I was able to realise that dream. In this city I met very interesting people. I received very valuable support from the colleges to which I belonged, St. John's and specially Ustinov. Thanks to my mates of flat E, where I lived during three years and met fabulous people. I learnt a lot about other cultures, customs, and international cuisine. Also, thanks to my mates of Wakenshaw Road, where I spent my last year in Durham, learning more about life in the UK, and to Hector Rios, who made me feel at home in Durham.

I want to particularly thank my supervisors Prof. Holger Maehle and Dr. Tiago Moreira, who believed in me and always had a word of encouragement for me. All these years were a great opportunity to learn, particularly in my own department, Philosophy, and the Centre for the History of Medicine and Disease in Stockton. I am especially grateful to my German friends, Sebastian, Daniel, Stephanie and Anita (although she is Austrian) for their great support. I had the funniest and nicest moments in Durham with them. Also I want to mention

friends like Gladys López, Victor de Currea-Lugo, and my former mentor, Fr. Alfonso Llano, whose help came just when I was in crisis.

Finally, special thanks to Sebastian Pranghofer and James Kennaway for their patient work as proof readers. Their comments on all the sections of this thesis were detailed, pertinent and very useful.

## Abbreviations

ANALBE: National Association for Bioethics

ASCOFAME: Colombian Association of Medical Faculties

CMF: Colombian Medical Federation

CENALBE: National Centre for Bioethics

CC: Constitutional Court

DPR: Doctor-Patient Relationship

EBM: Evidence-Based Medicine

FELAIBE: Latin American Federation of Bioethics

GSHSS: General System of Health and Social Security

IADB: Inter-American Development Bank

IBPUJ: Bioethics Institute at Pontificia Universidad Javeriana

IMF: International Monetary Fund

ICEB: Colombian Institute for Bioethical Studies

ICBS: Interdisciplinary Centre for Bioethical Studies at University of Chile

ICU: Intensive Care Unit

IRB: Institutional Review Board

PAHO: Pan American Health Organisation

PBUEB: Bioethics Program of El Bosque University

PC: Political Constitution of 1991

RedBioetica: UNESCO's bioethics program

RPB: PAHO's Regional Program on Bioethics for Latin America and the Caribbean

USAIDS: United States Agency for International Development

WB: World Bank

WMA: World Medical Association

Chapter one

# Introduction: The bioethicalisation of medical ethics

It is striking that while discussions about the means of medicine and healthcare have often been the subject of debate between various social actors and institutions, the debate about their goals and ends has been largely neglected. For this reason, in an interesting project launched in 1993, the Hastings Center[1] examined the goals of medicine "in light of its contemporary possibilities and problems" (Hastings Center, 1999, p. 1). The premise of the project was that although issues related to healthcare services, medical practice and biomedical research have become problematic, "[t]he most common response to these problems has been essentially technical or mechanistic" (Hastings Center, 1999, p. 3). This situation is by no means limited to the United States. In the last few decades a wave of healthcare reforms has spread across the world. But these reforms have by and large exhibited an inability to integrate 'substantive' issues such as the definition of the goals and ends of medicine and healthcare. Instead "matters of economics, organisation, politics, and efficiency" have monopolised the attention of the public, political institutions, and relevant social actors in this debate (Hanson & Callahan, 1999, p. ix). This might be seen as surprising and indeed paradoxical when one considers that ethical issues in healthcare have never been discussed so intensely as today.

In the last fifty years non-medical professionals, scholars, and thinkers have turned their eyes to medicine. In fact, a new academic and professional field concerned with 'the ethical' in biomedicine has emerged: bioethics. Born at the end of the 1960s in the USA, bioethics quickly expanded across the world, becoming, along with the discourse on medical liability, one of two fundamental regulatory discourses for medicine. In this sense, it should be acknowledged that bioethics has a profound relationship with the law (van Der Burg, 1998). Usually promoted by bioethicists themselves as an answer to the ethical challenges brought by the biomedical progress, bioethics has gone further as to become *de facto* the 'natural location' for the discussion of ethical issues related to healthcare and biomedicine. Indeed, bioethics is now determining what kind of ethical issues 'legitimately' deserve to be discussed and/or analysed in the biomedical field. Since its beginnings, bioethicists have also insisted that this new discipline was necessary to 'humanize' the biomedicine and to protect

[1] One of the most important institutions for bioethics in the world, located in Garrison, New York, USA.

individuals from exploitation and abuses, particularly the weak and most vulnerable. In the last few years, however, the history of bioethics, as it has been presented by bioethicists themselves, has begun to be challenged by various scholars, particularly social scientists, philosophers and historians. What kind of phenomenon is bioethics? Why bioethics? Is all about bioethics exactly as bioethicists have said? Having its origins in the USA, how has bioethics developed in other contexts, for example in a country like Colombia? And, finally, why in the bioethics era, during the first period in history when there is so much emphasis on the 'the ethical' in the biomedical field, do healthcare and medical practice remain so 'unethical' in the majority of Western societies?

Distancing myself from the explanations offered by bioethicists themselves about the history of their own field, in this introductory chapter I will make a case for a critical approach to the history of bioethics, with special reference to Colombia. I will start by pointing out that medicine is again a 'cultural phenomenon' in our day, similarly to what Hippocratic medicine was in the Greece of the fourth century BC. Then I will review the main contemporary perspectives, particularly from social sciences, philosophy and history, on what medicine is. After that, I will focus on the idea that present day is experiencing a growing process of 'ethicalisation'; a process of which, I will argue, bioethics is seemingly the latest expression. Against the self-legitimizing explanations used by bioethicists when talking about the origins of their own field, I will suggest that the 'bio-ethicalisation' of medicine should be examined in terms of a 'power effect'. This perspective makes sense as long as one considers how much bioethics contributes to make the biomedical scenario 'governable' in accordance with fashionable neo-liberal economic and political ideologies. Finally, to close this introductory chapter, I will outline briefly the content of each chapter.

## 1. Medicine and culture

According to the historian of medicine P. Unschuld, in ancient Greece medicine and science were linked for the first time in the Western world (Unschuld, 2009, p. 19). Around the fifth century BC, associated with the Hippocratic School of Cos, medicine not only became 'scientific', as a result of its relation with natural philosophy, but also a 'cultural phenomenon', i.e. *paideia*.[2] Greek medicine of the 4th and 5th centuries BC was indeed highly appreciated and constituted a powerful cultural force. This can be seen in the long-lasting

[2] This Greek word is usually translated as 'education' or 'culture'. About the Greek *paideia*, which embodies the idea of excellence in all the aspects of human life, see the classic work of W. Jaeger (1939) *Paidea: The Ideals of Greek Culture*. Oxford: Blackwell.

effect that this medicine has had for throughout Western history. Modern medicine has not regained such the high position and prestige of medicine of the fifth century BC (Jaeger, 1939, p. 3). But medicine has become a plurisemantic concept, particularly in the current complex, globalised, technology-driven world. It is related to so many objects, institutions, disciplines, subjects, practices and discourses that trying to fit it in one single phrase is difficult. However, although contemporary medicine is amazing and successful, this does not mean that it has the same cultural value as Hippocratic medicine in its own time. Yet, in the same way that Hippocratic medicine drew the attention of professional thinkers of its time (philosophers), modern medicine has become an 'interesting' object for the social sciences, humanities, and philosophy.

A fruitful relation between medicine and philosophy was an important aspect of Hippocratic medicine. The famous Hippocratic Oath included some important precepts on how to practise medicine that are still invoked, e.g. do no harm, the ban of abortion, and the duty of upholding the identity and reputation of the medical profession. In ancient Greece, medicine "showed a progressive tendency to give life a technical change and to create a special and specialized profession that required high spiritual and ethical demands only achievable by a few" (Jaeger, 1939). But the most remarkable aspect of ancient Greek medicine is that in itself it was a 'perfect' model for philosophers to illustrate what ethics was and how it worked. In building up their ethical theories, philosophers like Plato and Aristotle appealed to medical examples, not to mathematics or natural sciences. In *Gorgias* and *Phaedrus*, for instance, Plato examines the parallels between the doctors' activity on bodies and the philosophers' on souls. The concept of *arête* (virtue or moral excellence) was also explained by showing what Hippocratic physicians actually did (Carrick, 2001, pp. 21-27), and Aristotle mentioned the clinical method in his *Ethics* (Aristotle, 2000).

It seems that twenty four centuries later medicine is back and doctors and philosophers are interacting deeply and energetically again, but in a different way. If Hippocratic doctors 'taught' philosophers important aspects about ethics through the way they founded and practised their profession, in contrast their contemporary colleagues seem to be in the opposite position. It seems that nowadays doctors need philosophers to learn what ethics is, what makes an ethical profession, and what being a good doctor is about. Furthermore, not only philosophers, but also other professional thinkers of our time, such as social scientists (particularly sociologists and anthropologists), theologians, historians, lawyers, and

economists have their own say on medicine. In short, medicine is again a cultural phenomenon (Lupton, 2003).

As I have argued elsewhere, although the Hippocratic tradition remains in our collective memory the very basis of our own Western medicine, since the eighteenth century medicine has evolved as *clinical medicine* under the paradigm of the anatomo-pathological gaze (Díaz Amado, 2002a).[3] Currently, though without abandoning this anatomo-clinical paradigm, biomedicine is becoming 'molecular' (Rose, 2007) and has been fully colonized by the dynamics of capitalism to end up being a *medical industrial complex* (Relman, 1990, p. 209). Contemporary medicine is powerful, highly effective, pervasive, and in constant transformation. However, as E. Pellegrino and D. Thomasma (1981, p. viii) have argued, "Medicine suffers from abundance of means and a poverty of ends". This assertion is at the heart of a fundamental problem of contemporary medicine: its crisis of identity. To say that medicine is an art of healing based on a rational and scientific method does not properly reflect the complexity of contemporary medicine. Neither would it be enough to appeal to intuitive definitions. Thus, *'what is medicine?'* is a question that justifiably deserves much more attention, particularly to better understand the new relations of medicine and society. For instance, contemporary doctors, unlike their ancient Greek colleagues, have seen their moral authority diminished. In the last 30 years, however, doctors have increasingly become engaged in an attempt to recover their lost moral authority by turning to bioethics, a new discipline and profession seeking to make medicine *'more ethical'*.

## 2. Social sciences and contemporary medicine as a cultural phenomenon

Social scientists, particularly anthropologists and sociologists, have highlighted important aspects of medicine such as how it is deeply related to the ways we talk about and define 'the human'. For instance, N. Rose has shown how a myriad of psy-experts,[4] biotechnology, and medicine are ways of defining ourselves (Rose, 1996, 1999, 2007). The capacity of medicine to intervene in our lives and its ability to be entrenched with other disciplines, professions, and activities, e.g. legal medicine, counselling services, genetic engineering, etc. is immense and pervasive nowadays.

The encounter between sociology and medicine has led to a vast amount of literature and perspectives. D. Lupton has listed five "major fields of scholarship and research in the

[3] Following Foucault's arguments in *The Birth of the Clinic* (1973).
[4] Psychologists, psychiatrists, psychotherapists, and so on.

humanities and social sciences that have examined the social role of medicine in Western societies [and] its theoretical developments […] over the past fifty years or so" (Lupton, 2003, p. 3). Similarly, R. Purtilo mentions a variety of approaches to the study of the professional-patient relationship in healthcare including those of authors like Talcott Parsons, Thomas Szasz, Michael Balint, and Kenneth Arrow in the *functionalist approach*; the *structural conflict theory* with Eliot Freidson; and *Neomarxism*, *bureaucracy* and the *politics of health*, which includes authors like Howard Waitzkin, Barbara Waterman and Vicente Navarro (Purtilo, 2004, pp. 2143-2144). I will follow D. Lupton's approach to outline the mainstream of the sociological view on medicine. This approach includes: functionalism, political economy, social constructionism, cultural studies, and the post-structural/linguistic turn. Notably, in her approach 'power' deserves a whole chapter.

In the functionalist view, which was dominant during the 1950s and 60s, as a pathological condition has taken over the patient's life, he should be exempted from social obligations[5]. Accordingly, the doctor's role should be to help the patient to regain the capacity to fulfil those obligations. In this view, medicine is a practice beneficial to society, and although the doctor-patient relationship (DPR) is asymmetrical in terms of power, such a relation is understood as "harmonious and consensual" (Lupton, 2003, p. 8). For this reason, a major criticism against this approach is that it tends to neglect the conflict-prone nature of the DPR.

The political economy perspective (also called critical structuralism) has its roots in a Marxist critique of capitalist economy. It had great acceptance in the 1970s and early 1980s. This perspective is highly critical of how healthcare and medical practice have become part of capitalism. Supporters of this position emphasise "the cultural crisis of modern medicine [that is deemed as] ineffective, overly expensive, under-regulated and vastly inequitable" (Lupton, 2003, p. 9). Socio-economic factors affecting people's health and access to health services are underlined. The *medicalisation thesis* in the 1970s, exemplifying this perspective, stressed the bad influence of medicine on society: "The essence of medicalisation became the definitional issue: defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it" (Conrad, 2005, p. 3). Authors like I. K. Zola (1972) accused medicine of being an exploitative and alienating profession, while I. Illich (1975) argued that medicine "has become a major threat to health."

[5] In general statements the use of the male pronoun and possessive is meant to include male and female persons.

It is not a surprise then that liberating society from doctors' influence and the 'medical dictatorship' had become a political programme as well as a moral imperative in the 1970s.

But the political economy perspective does not consider some important issues. On the one hand, it neglects micro-social aspects of the DPR, which is taken as one version of the capitalist-worker relationship. On the other hand, its calls for "a mass social movement to change dependency upon medical technology, decommodify medicine, challenge the vested interests of drug companies, insurance companies and the medical profession" were unrealistic, as medicine/capitalism constitute nowadays a solid unit, a strong marriage (Lupton, 2003, p. 11).

In the case of social constructionism, the aim is to demystify what is taken for granted in the social world. It has long been assumed that knowledge is 'external' to reality. However, a social constructionist would say that not only knowledge is part of our reality, but also that 'reality' is a construction of *knowledge*. This approach has been in vogue since the mid-1980s and is mainly informed by the historical/philosophical work of Michel Foucault and those who have continued his project. As Foucault has insisted, knowledge and 'truth' are the result of social relations shaped by power, and that knowledge, truth, and power are inextricably intertwined (Foucault, 1984c, p. 70). Thus medical knowledge is not the result of a linear, endless process towards more and better knowledge, but "a series of relative constructions which are dependent upon the socio-historical settings in which they occur and are constantly negotiated" (Lupton, 2003, p. 12). However, social constructionism is too much focused on medical discourse at the macro-level, leading sometimes to overgeneralizations and it might "descend into relativism and nihilism that all knowledge are social products" (Lupton, 2003, p. 13). Finally, there is the field of cultural studies, which is a relatively recent interdisciplinary academic field. The term was coined by Richard Hoggart in the 1960s and since then it has been a growing field, particularly in the USA and the UK.[6] It analyses the production and circulation of meanings in a particular culture. Applied to medicine, cultural studies can help to understand health/illness and medical practice as 'cultural products' or at least as culturally shaped (Lupton, 2003, p. 19).

[6] See: Centre for Medical Humanities, Durham University in: http://www.dur.ac.uk/cmh/medicalhumanities/

## 3. Philosophy and medicine

Another way to theoretically approach medicine is through philosophy. Medicine and philosophy can be linked in various ways: philosophy *and* medicine, philosophy *in* medicine or philosophy *of* medicine (Marcum, 2008). E. Pellegrino (1998) adds a fourth possibility: *medical philosophy*, examining how philosophy of medicine can be understood in a negative, expansive, or specific way. In the latter sense, philosophy would ask questions about medicine itself. Until the nineteenth century, medicine was practised by various kinds of healers, who used to earn a low income and were considered of poor status. But once medicine was professionalised, and its status and self-image were transformed, doctors were pushed to reflect on the nature and specific characteristics of their own profession. In this way the philosophy of medicine emerged in this time (ten Have, 2000, p. 21). But although philosophy of medicine is a well-established field nowadays, it still requires justification in terms of its scope, methods, and boundaries. Some scholars, for example from the philosophy of science, have even denied that the philosophy of medicine is a specific field (Pellegrino, 1998; Stempsey, 2005).

E. Pellegrino and D. Thomasma (1981) have argued that it is necessary to set clearly the legitimate goals of medicine in order to give it proper philosophical –particularly ethical- foundations. By showing that ancient Greek medicine combined *logos* and *techné* in order to achieve particular ends, i.e. that medicine is a *practice*, and by integrating Aristotelian concepts, these authors have promoted a *teleologically based* philosophy of medicine (Pellegrino & Thomasma, 1981, p. 60). Pellegrino considers that if the goals of medicine are to be defined today, they should be based on permanent values arising from the nature of medicine (Pellegrino, 1999, p. 60). However, H. ten Have has argued that a philosophy of medicine that seeks to examine the foundations of medicine "has declined with the general and rapid growth of interest in moral issues over the last three decades" (ten Have, 2000, p. 20). Linked to this trend, he describes a process of *ethicalisation* of medicine that has paved the road to the advent of bioethics (ten Have, 1997). W. Stempsey, surveying the philosophy of medicine's literature in a ten-year period, found that "[o]f the 625 articles surveyed for the years 1997–2006, nearly three-quarters dealt with matters of ethics, and of the 36 books surveyed, nearly 60% were primarily on ethics" (Stempsey, 2008).

Other social scientists have also spotted the growing ethicalisation of medicine. R. DeVries and J. Subedi (1998, p. xiii), for instance, have said that as sociologists they were

interested in exploring why and how medicine has 'gotten ethical'. Concomitantly, R. Cooter (2000) has argued that in our day the ethical discourse on medicine engages a disparate set of people, including philosophers, economists, lawyers, doctors themselves and lay people. Even business people are interested in medical ethics and the field itself has become a "burgeoning ethics industry" (Cooter, 2000, p. 452). In the same way and more recently D. Wilson, analysing the history and impact of the *Warnock Report* in the UK, has illustrated how in the last few years an *ethics industry* has developed around what might be typically seen nowadays as *bioethical issues* (Wilson, 2011). If Relman is right that modern medicine has become a *medical industry complex* (Relman, 1990), then the 'ethics industry' is a perfect counterpart. Is bioethics therefore the latest and most sophisticated version of such an 'ethics industry', or more generally speaking, is it the last wave of the contemporary 'ethicalisation' of medicine?

In 1974 the *Institute for the Medical Humanities* at the University of Texas Medical Branch co-sponsored the first *Trans-Disciplinary Symposium on Philosophy and Medicine*, which resulted in a book series to debate various issues in the field.[7] In the first volume medicine is portrayed as full of "social concerns [although yet it remains] underexamined by philosophy" (Quoted in Carson & Burns, 2002, p. ix). Twenty years later a similar symposium was organised, this time re-named as *Philosophy of Medicine and Bioethics*. In this second symposium the first question for participants was in "what ways and to what ends have academic humanists and medical scientists and practitioners become serious conversation partners in recent decades?" (Carson & Burns, 2002, p. ix). This question prefigures the idea of bioethics: a dialogue between sciences and humanities. Thus, and given the issues, topics, and approaches that were discussed during this second symposium, it would be difficult to classify the speakers who attended it: were they philosophers [of medicine] or bioethicists? It seems then that in just twenty years the philosophy of medicine had been taken over by bioethics, but what is the history of this new field?

**4. History of bioethics: "Into the whale", or a fish unable to see the water?**

In recent years historians have become increasingly interested in bioethics. Some have suggested that as a discipline, history can strengthen medical ethics and bioethics. For Pernick (2009), history might help bioethics to discover those "unnoticed value issues at

[7] *Philosophy and Medicine* was first edited by H. T. Engelhardt and published by Kluwer Academic in the Netherlands.

stake in the non-dramatic daily events of modern health care. [As bioethicists do not care about] uncontroversial, routine medicine […] the values that require history to make them visible are hard to see precisely because they are presently so uncontroversial" (pp. 16-17). In this sense, history would to a certain extent share with critical structuralists and social constructionists the goal of revealing hidden rationalities, mechanisms, and agendas in the way contemporary medicine works. In the case of bioethics, a critical historical perspective will have a similar role.

In the history of medical ethics, (including bioethics), according to R. Cooter, three important points should be considered: first, the current interest in medical ethics should be seen as a "problem demanding contextual explanation" (Cooter, 2000, p. 453); second, the "rise of medical ethical consciousness since the 1960s [is related to a] political and cultural context"; and, third, this fact should not be "comprehended only in terms of legal reflexes to abuses of professional power, or to new medical technologies and procedures. [Instead, it is necessary] to take cognizance not only of events in medicine, but the operation of social and political forces outside it" (Cooter, 2000, p. 460). In this sense, surveillance and the current challenges to medical authority that have become part of the contemporary *medical ethos*,[8] do not represent just a 'reaction' to medical abuses or medical power or reflect only a 'moral progress' in medicine. Instead, they correspond to the exercise of power over the biomedical scenario in our contemporary society. I will expand on this point later.

R. Cooter has convincingly argued that bioethicists have invented their own history (Cooter, 2000, p. 454), and that the job of historians is to contribute to the understanding of ourselves by properly analysing the bioethics phenomenon (Cooter, 2010, p. 669). However, his claim that the contemporary rhetoric of medical ethics reflects a kind of 'counter-reformation' in order that the medical establishment can keep its own power and position (Cooter, 2000, p. 457) seems to me unsatisfactory, particularly after considering that as a result of this rhetoric medical autonomy has been successfully 'put under control'. If this is the case, I would say that contemporary medical ethics and bioethics are not providing a good service to doctors' longing for power. Quoting M. Stevens (2000), Cooter argues that bioethics not only saved the life of ethics,[9] but that of medicine too, since "problems perceived to be generated by exotic technologies were transformed into problems manageable

[8] By using the term 'medical ethos' I am not only referring to discourses about medical ethics (deontology or based on any particular ethical system), but also to the institutions, practices, subjects, and other elements that contribute to outline a particular way of being in the medical arena.
[9] Echoing S. Toulmin's famous article *How Medicine Saved the Life of Ethics* (Toulmin, 1999).

by bioethicists who, unsurprisingly, tended to treat the technologies as inherently value-neutral, as well as disconnect them from the politico-economics of private enterprise biotechnology and the soaring costs of medical care and health insurance" (Cooter, 2010, p. 666). It might be the case, but it is not the whole story.

For Cooter, "[b]y the 1990s bioethics had taken up its residence in the belly of the whale of biomedicine […]"[10] (Cooter, 2010, p. 663). But within this metaphor, I would say that the problem of bioethics is not living "inside a whale" (namely biomedicine). Rather, bioethics is like a fish that is unable to see the water in which it lives. This water is made of the rationalities and discourses of our time, the *episteme*, a Foucauldian term that refers to the 'conditions of possibility' for certain objects, problems, practices, and truths to appear within a particular historical period (Foucault, 1972; Revel, 2008, p. 45). In my view, bioethics has been welcomed by both physicians and patients principally for two reasons. First, it represents a non-threatening movement for doctors, as suggested by M. Stevens (2000), and for patients bioethics embodies a just and powerful advocate. Second, we are all –doctors, bioethicists, historians, and lay people- immersed in the same ocean of rationalities. In our day the liberal/neoliberal governmentality is shaping the way we think of and define multiple elements that populate our social and existential scenarios. As M. Epstein has argued, although the success of bioethics has been officially attributed to its service to the patient, the truth is that such a success "should be attributed to the service it has done for the neoliberal agenda" (Epstein, 2010, p. 226).

In this thesis I shall argue that bioethics and other new normative discourses about medicine such as medical liability should be analysed as *new configurations* of power relations taking place in the biomedical field in contemporary neoliberal societies. Up until now the emphasis has mostly been on how medicine and doctors exercise power, e.g. with the medicalisation thesis, but it is time to analyse more seriously another hypothesis: that power is not only exercised *by* doctors, but also *on* them, and that in contemporary, neoliberal societies bioethics has had a highly effective *power effect*. If R. Cooter is right and bioethics has lost its impetus and critical eye that allegedly characterised it at the beginning and has become a "hegemonic [discourse] and its practices routinized" (Cooter, 2010, p. 663), then a critique of bioethics is justified. But although the critical literature on bioethics has grown rapidly in the last fifteen years, it is necessary to reconsider its history from a perspective that

[10] Using Charles Rosenberg 1999's expression, in which he saw bioethics as lubricating the gears of bureaucratic medicine.

reveals its deep and strong relation to power. This kind of analysis can be carried out by adapting and using the analytical tools of Michel Foucault.

From a Foucauldian perspective, it will be possible to see that bioethics is located at "the encounter between the technologies of domination of others and those of the self [that Foucault calls] 'governmentality'" (Foucault, 1997c, p. 225). Also, from this perspective, we will see that bioethics is embedded in a power-knowledge dynamic and also part of neoliberal governmentality that has pervaded the biomedical field in the last quarter of a century. Additionally, we would be in a better position to understand why the 'neutrality' that Cooter denounces in bioethicists' agenda is neither an expression of their *false consciousness* nor of their eagerness for power, but just one of the new *strategies to govern* the *medical territory* in our present.[11]

**5. The bio-ethicalisation of medicine**

The aforementioned 'ethicalisation' of medicine has meant an increase of the literature on the 'humanization' of medicine and on the necessary steps that doctors and healthcare professionals should follow to be 'good' professionals.[12] It seems that in our day medical ethics is experiencing a 'boom', particularly with the rise of bioethics as its 'natural' heir. M. Epstein has argued that our time has witnessed "the fall of the old medico-ethical systems, the rise of a global medical ethics, and the success of academic bioethics" (Epstein, 2010, p. 226). For R. Baker and L. McCullough (2009), medical ethics scholarship has been dominated by three positions. First, *presentism* or *anachronism*, which is the assumption that if a set of medical ethics issues have drawn our attention, then other people in other places and in other times should also have considered such issues in a similar way. Second, there is *traditionalism*, which is a non-critical appeal to the past in order to hold a current position. Sometimes we hear in philosophical debates that X or Y issues have been 'traditionally' addressed in this or another way. Thus, the history of medical ethics before the twentieth century is usually seen as a line of traditionalist authors talking about each other (Baker & McCullough, 2009, p. 4-6).

The third scenario is *bioethics*, which Baker and McCullough depict as if the whole history of medical ethics pre-figured its birth (Baker & McCullough, 2009, p. 10). This

[11] I will expand on this argument in chapters two and five, which are devoted to explain how the Foucauldian approach can be used to analyse the history of bioethics.
[12] See chapter six.

position has been contested by R. Cooter in a recent critical review. For him, Baker and McCullough's history of medical ethics fails in three aspects. First, their narrative remains bound to the typical view that bioethics emerged as a challenge to the monopoly of doctors in the field of medical ethics. Second, by considering bioethics as the latest stage in the history of medical ethics "bioethics remains attached to medical scenario [and the opportunity to examine the] more systemic shift involved in creating the possibility *for* bioethics [is missed]" (Cooter, 2010, p. 668). For Cooter it is also clear that concepts like informed consent or autonomy must be analysed within a particular politico-economic context and not simply as a 'moral progress' in the biomedical field (Cooter, 2010, p. 668).

But beyond Cooter's critique, the fact remains that bioethics has become the customary way of talking about 'the ethical' in biomedicine. For this reason, it would be better to say 'bio-ethicalisation' instead of 'ethicalisation' of medicine. The reduction of medical ethics to a legitimately and officially recognised discipline such as bioethics entails undesirable effects. On the one hand, there is a tendency to consider that any other form of ethical reflection about medicine is assumed to be valueless. On the other hand, there is a risk that doctors are compelled to attend bioethics courses to gain the 'permission' to participate in the discussion of different ethical issues happening nowadays in their own field. Therefore in order to understand what is happening to the contemporary medical ethos, it seems necessary to examine more carefully the rise of bioethics.

## 6. The origin myths of bioethics

In the last few years the definition, scope, and history of medical ethics as well as of bioethics have been 'problematized'.[13] Various historical events have been seen as the beginning of medical ethics, e.g. the Hammurabi Code (c1772 BC) or the Hippocratic Oath (late fifth century BC). However, for R. Baker and L. McCullough (2009, p. 3) it is difficult, or at least anachronistic, to accept the existence of *medical ethics* before 1803, when the English physician Thomas Percival famously used this term for the first time. In the case of bioethics "it is striking that despite its relatively short life span, a number of differing versions exist of when and why bioethics developed in the United States, the great majority of which have been written by persons deeply involved in the field" (Fox & Swazey, 2008, p. 21). According to these authors, depending on how such historical accounts are 'interpreted', bioethics can be seen as a *reactive* outcome (against the biomedical technological explosion

[13] About the Foucaultian term 'problematization', see chapter two.

and radical cultural pluralism), as *proactive* (acting as a social movement within the healthcare scenario as well as a social attempt to 'anticipate' the future), or as a *continuation* (bioethics would be the latest stage of medical ethics) (Fox & Swazey, 2008, p. 29).

R. Fox and J. Swazey (2008, p. 22) have methodically summarised the historical accounts, or 'origin myths', that bioethicists have proposed about the birth of their own field in the USA, the cradle of bioethics. The first account sees bioethics' origins as *technologically driven*. For instance, the *Harvard Ad Hoc Committee*'s re-definition of death in 1968 associated to the development of cardiopulmonary life support systems, organ transplants, and chronic dialysis motivated a wide social debate. However, this 'technological determinism', i.e. the syllogism *new technology = new questions = bioethics* is too simplistic and has been considered 'empirically false' by sociologists (DeVries & Conrad, 1998, p. 240). Moreover, questions generated by new technologies are not necessarily new (Emanuel, 1991) and as D. Cooper (2002) has underlined, commenting on M. Shelley's 1818 novel *Frankenstein* (Shelley, 1993), new devices and technologies in medicine have always drawn the attention of society. Yet bioethicists are used to deeming "ethical problems of current therapeutic relationships [as] driven mainly by technical imperatives [and to see] bioethics [as] determined by the value context in which medical technology must be managed, not by the intrinsic qualities of the technology" (Purtilo, 2004, p. 2145). Also, as A. Hedgecoe has suggested, bioethicists tend "to avoid fundamental debates about the construction of technologies" and devote their attention mainly to problems related to technology's *application* instead (Hedgecoe, 2010, pp. 177-178).

The second account sees bioethics as derived from the interest that theologians, philosophers, lawyers and others began to have in particular issues around the mid-twentieth century. Death/dying and fertility control started to be highly debated, particularly by scholars close to the Catholic Church. The idea that dilemmas arising in biomedicine could not be solved by the 'traditional' medical ethics and that they required a 'new' approach began to be promoted.[14] The theological position was that "the new powers of medicine raised some novel moral questions in the sixties, questions beyond the considerable expertise of scientists and technicians. They were not just medical problems but moral problems" (Verhey, 1996, p. 2). However, as theologians themselves have recognised, "[…] Christian ethicists rushed into medical ethics for many reasons, not the least of which was and is

[14] See, for example, Jonsen, A. (1998). *The Birth of Bioethics*. New York: Oxford University Press.

money and power […] So medical ethicists, being the good priests they are, went to where the power is in liberal societies –medical schools" (Hauerwas, 1996, p. 64). Influential theologians like Paul Ramsey managed to introduce personalism in this pre-bioethics period and helped to the formation of the field by transforming Christian ethics into medical ethics (Hauerwas, 1996, p. 80).

Third, the birth of bioethics has been related to shocking *events*: the Nazi experiments with the subsequent doctors' trial in Nuremberg contributed to the idea that controlling biomedical investigation was necessary. However, as R. Cooter has argued, bioethicists forget that "Nuremberg was a show trial concerned with creating an image of medicine as ideologically pristine and uniquely orientated to the defense of humanitarianism" (Cooter, 2000, p. 459). The Nuremberg Code was basically ignored, particularly because the American medical establishment considered themselves as sufficiently shielded from the possibility of committing Nazi-like atrocities; doctors trusted their ability to be self-governing (Fox & Swazey, 2008, p. 26). But, as history has proved, many abuses have been committed by those who consider themselves as 'the good guys' (Díaz Amado, 2010a). Moreover, the necessity of surveillance in the biomedical research field ended up being a movement seeking to control the whole medical profession (Rothman, D. J., 1991).

Fourth, bioethics arose when the neologism appeared: the *linguistic* explanation. The Kennedy Institute of Ethics at Georgetown University claims to have been first in combining ethics and science in the new discipline of bioethics. W. T. Reich, editor of the 1978 *Encyclopaedia of Bioethics*, considers nonetheless a "bi-located" origin: Van Rensselaer Potter, on the one hand, and Andre Hellegers and Sargent Shriver in Georgetown, on the other. Although Reich recognises that the former invented the term, he argues that it was the Kennedy Institute of Ethics' use of the term that made of bioethics a new academic and professional field (Reich, 1996). However, in my view, R. Fox and J. Swazey do not consider properly the linguistic effect of T. Beauchamp and J. Childress' *Principles of Biomedical Ethics* (first published in 1979), which marks perhaps the real moment when bioethics became a unified field as principlism gave the *lingua franca* to this area. Contentions about who was 'the pioneer' are not rare in bioethics. For example, while V. R. Potter claimed to have coined the term (Potter, 1988, p. 3), a circumstance that would make of him the 'founder' for many bioethicists, a meeting that was convened by A. Jonsen in 1992 to celebrate the birth of bioethics was a way to validate and enhance "Jonsen's own standing as a pioneer bioethicist" (Fox & Swazey, 2008, p. 128).

Finally, there are *multiyear/multicausal* accounts of the birth of bioethics: in different ways authors like LeRoy Walters, David Rothman and Albert Jonsen see bioethics coming out of a 'process' happening in a particular period of time, generally around the middle of twentieth century. Fox and Swazey's position can be placed here since they also see bioethics as evolving throughout three overlapping phases between the 1950s and 1970s (Fox & Swazey, 2008, p. 32). The issues, events and people that I have mentioned so far regarding the history of bioethics are also included in these phases. It is not rare that some histories of how bioethics originated conceal 'non-bioethical' motives. For instance, R. Cooter has suggested that Rothman's book *Strangers at the Bedside* (Rothman, D. J., 1991), considered a 'classic' book on the history of bioethics, was motivated by Rothman's own eagerness to be appointed as professor at Columbia (Cooter, 2010, p. 664). A. Jonsen has admitted that he convened the meeting to celebrate the thirtieth anniversary of bioethics in 1992 in order to claim the birthright to bioethics for the University of Washington, where he was working at that time[15] (Fox & Swazey, 2008, p. 125). Cooter has also underlined that in telling these histories of bioethics, History, as a discipline, is being utilized for "shamelessly self-serving historical stories of origin produced by bioethical practitioners" (Cooter, 2010, p. 664f).

## 7. The debates about the foundations of bioethics

Although controversies have always been frequent *in* bioethics, more and more such controversies are *about* bioethics. These can be of three types. First, debates about the answer to the question *what is bioethics*. For example, bioethics might be considered either as part of medical ethics or constituting a new independent discipline. The second type is on *how bioethics operates*, both internally and externally. Thus bioethicists and people engaged in bioethical discussions also debate what ethical theory or perspective should be the foundations of the field, what methods are most suitable, what issues, problems, or scenarios should be included, and so on. And, third, there are the controversies about the *origins* of bioethics, i.e. its history, which, as I have already discussed, has been 'problematized' in recent years. Those narratives and accounts, including pioneers, cornerstone facts, key issues, and mechanisms of legitimisation as well as of institutionalisation, have drawn the attention of social scientists and self-critical bioethicists, particularly in the last 15 years.

[15] For Jonsen and other bioethicists 'They Decide Who Lives, Who Dies: Medical Miracle Puts Moral Burden on Small Committee', an article written by S. Alexander and published in *Life* (53, p. 102-125) in 1962 (9 November), marks the birth of bioethics.

Some scholars regard bioethics as the new version of medical ethics and therefore as only suitable for medical-related scenarios. Others see it as a broad movement committed to protecting the planet's life. These two different approaches reflect the two main positions at the beginning of the American bioethics: the former is the A. Hellegers' narrow medical perspective, and the latter, the V.R. Potter's broader or ecological view.[16] Bioethics also can operate at a macro-level and/or a micro-level. In the former we find issues like fair allocation of resources in healthcare, national and international policies for ethical human research, and national commissions of bioethics, while in the latter the issues related to the DPR, ethics committees, institutional review boards, and informed consent. J. Evans, for example, sees bioethics working at three different levels: foundational, clinical, and public (Evans, 2006, p. 214). D. Callahan mentions a variety of scenarios where bioethics 'happens': theoretical bioethics, concerned with intellectual foundations; clinical ethics; regulatory and policy bioethics, becoming law generally, but also policies, rules, guidelines, etc; and cultural bioethics, which "refers to the effort systematically to relate bioethics to the historical, ideological, cultural, and social context in which it is expressed" (Callahan, 2004, p. 281).

From an internal point of view, bioethicists have always debated what ethical theory or intellectual system should constitute the 'foundations'. All bioethics textbooks customarily start with a section on this. Thus there are bioethicists who take stances on one or another position, e.g. communitarianism, pragmatism, casuistry, communicative ethics, and utilitarianism, to name but a few. T.H. Engelhardt, acknowledging such ethical diversity, has concluded that in the current secular, plural society in which we have to deal with 'moral strangers', it is impossible to find "a secular, canonical, concrete ethics to ground bioethics, […] authority is not derived from reason, not from God, nor from a will to power (i.e. force), but from the bare will to have the one authority moral strangers can share: permission" (Engelhardt, 1996, p. 72). He argues that although ethics and bioethics can derive standards from different sources like intuitions, exemplary cases, consequences, impartial observers, principles, impartial reasoning, and so forth, it is still impossible to decide about which one is best (Engelhardt, 1996, p. 41f). In bioethical debates, the discussion about what ethical theory or argument should be applied or prevail very often ends up in an endless 'give and take' of arguments that depends on the political views of the participants. This happens, for example, with the abortion debate as I have shown elsewhere (Díaz Amado, 2009a), an issue that will be analysed in chapter seven. In bioethics, divergent political positions have recently become

[16] I will expand on these two perspectives in chapter three.

the root of heated debates about what the role of bioethics should be (Caplan, 2005; Macklin, 2006).

As I suggested before, American *principlism* deserves a special place in the history of bioethics. Because of the way it was introduced by T. Beauchamp and J. Childress in their 1979 book, now in its fifth edition (Beauchamp & Childress, 2009), principlism became simply synonymous with bioethics. Its specification/balance methodology that is based on four *prima facie* principles, the 'Georgetown Mantra' (Fox & Swazey, 2008, p. 170), can be seen as a *philosophical technological device* to solve ethical dilemmas in biomedicine.[17] But criticisms against this perspective have mounted throughout the years. Principlism, the model and not the principles themselves, has been assessed as representing a *theoretical hegemony* and as an American product that only takes into account American values and its particular healthcare system.[18] Philosophical contentions have also been made, showing the weaknesses and main problems of principlism in bioethics.[19] But the fact remains that principlism is deeply entrenched in bioethics. R. Fox et al. have argued that while it might be easy to explain the successful institutionalisation of bioethics in the USA, it is not the same when trying to explain the influence of principlism in other countries. However, in some countries this American principlism-based bioethics has been regarded as something not to be emulated (Fox & Swazey, 2008, pp. 172, 215). According to Cooter, autonomy, the most cited principle in bioethics, has not been understood historically. Thus bioethics has failed to examine how autonomy "relates to notions of 'being human', and how these in turn relate to wider political economic formations which then get mediated through medical ethics" (Cooter, 2010, p. 669). Others have also been critical about how autonomy is used in bioethics, denouncing excesses committed in its name or the "moral vacuum" to which we are thrown after a 'superficial' understanding of it, particularly in the US (Gaylin, 2003; McCormick, 1999).

[17] They put forward four moral principles, *respect for autonomy, beneficence, non maleficence,* and *justice*, as moral columns to support what would be today a good medical practice. This *principlism* works like this:

1. The four principles should be considered equally important (they are *prima facie*).
2. Two steps should be taken when applying these principles:
    - ✓ Specification: It is to account for each principle and what does each one mean in a specific situation.
    - ✓ Balancing: when two principles conflict, the decision has to be made by considering consequences (Beauchamp & Childress, 2009).

[18] In the UK medical ethicists have preferred to remain within the boundaries of established disciplines such as philosophy or theology, seeing bioethics as an 'Americanism' (Cooter, 2000, p. 455).

[19] See, for example, the critique by Clouser and Gert (1999).

In the last few years scholars from different backgrounds have suggested that bioethics should incorporate social and cultural analyses. Bioethics is seen as a field dominated by the individualistic, universal [self-centred] perspective of the Anglo-American tradition and putting the emphasis mainly on issues related to biomedical research (Fox & Swazey, 2008, pp. 153, 155). According to DeVries and Conrad bioethicists lack the "sociological imagination" necessary to see "how social structures, cultural settings, and social interaction influence their work" (DeVries & Conrad, 1998, p. 233f). From a philosophical and anthropological perspective, H. ten Have has argued that "bioethics should become more appreciative of the actual experiences of practitioners and more attentive to the context in which physicians, nurses, patients, and others experience their moral lives, e.g. the roles they play, the relationships in which they participate, the expectations they have, and the expectations they cherish" (ten Have, 2000, p. 30).

Bioethicists, perhaps as a reaction to these criticisms, have in recent years made an 'empirical turn' (Hurst, 2010). The motto of the *5th Postgraduate Bioethics Conference*, which took place at The Wellcome Trust, London in January 2011, exemplifies this point: *Social Scientific Approaches to Bioethics: Methods and Methodologies*.[20] However, this empirical turn has raised many questions about both the possibilities and limits that this turn represents for bioethics. Other questions would be if the empirical approach was just to *inform* bioethics, or to explain how a code is constituted, or to characterise the world in which bioethics operates. Moreover, what kind of empirical techniques or methodologies are to be used? Finally, with the empirical studies in bioethics we cannot avoid facing the problematic distinction between descriptive and normative: the world 'as it is' in contrast to the world as 'ought to' (Fox & Swazey, 2008, pp. 176, 178).

Sometimes the sociological, empirical perspective goes so far so as to say that bioethics would be valuable only if it fully adopted the methods of the social sciences. Some authors, for instance, have proposed *social bioethics* and *bioethnography*[21]. Moreover, and paradoxically, the 'empiricist turn' in bioethics might have facilitated its institutionalisation, having given it a 'practical' face, and having produced a bioethics which is "free of ideology and idealism – in effect, an ethics free of ethics!" (Cooter, 2010, p. 663). In the case of my

[20] See: Paton, A., Jenkins, S., Morlock, G. & McKeown, A. (2011, 10 February) *Joint Review of the 2011 UK and Ireland Postgraduate Conference in Bioethics.* Retrieved from http://pfgs.wordpress.com/2011/02/10/postgrad-bioethics-conference-review/, retrieved on 20th February 2011.
[21] Hoffmaster proposed that ethnography can save the life of medical ethics from the "sterility of… 'top-down' analyses based on abstract, general, universal moral principles" (Fox & Swazey, 2008, p. 180).

doctoral research, an empirical approach was incorporated in order to illustrate perceptions, ideas, effects, and functioning of bioethics in the particular scenario this thesis is about (see below).

**8. Bioethics as a subject of study**

From its very beginnings bioethics was considered a strange phenomenon. DeVries and Subedi (1998) are "*curious*[22] about the who, what, where, and when of bioethics: Who are bioethicists? What are they saying? Where are they working? When are they called upon?" (p. xiii). R. Fox and J. Swazey have reviewed not only the history of the field, particularly in the US as aforementioned, but also have outlined 'the bioethicist' as a particular subject and analysed why bioethicists celebrate so much their own field. It seems that bioethicists are "noticeably preoccupied with explaining, chronicling, and commemorating its beginnings" (Fox & Swazey, 2008, p. 123).

Also, why bioethicists become interested in some topics while disregarding others is a quite interesting question. DeVries and Conrad have found that notwithstanding the strong bioethical presence in hospitals, places undoubtedly full of ethical issues, "not all spheres of activity attract bioethical attention" (DeVries & Conrad, 1998, p. 235). Commenting on fair allocation of resources to healthcare and on the political tactics of the American medical establishment to keep its power, DeVries and Subedi argue that the "clinical bent of bioethicists [prevents them from looking into] the most profound ethical problems of medicine" (DeVries & Subedi, 1998, p. xv). For example, in reference to the (bio)ethical issues related to intersex states, J. Nelson has argued that it is paradoxical that while bioethicists have all the time been so interested in different kinds of artificiality like artificial hearts or artificial tube feeding, they do not express the same interest in other 'artificialities' such as sex and subjectivity[23] (Nelson, 1998). A. Hedgecoe has also pointed out that bioethicists, contrary to their self-perception, tend to remain uncritical regarding the socio-technical expectations brought by scientists and the industry [doctors included], limiting their work for the most part to "reviews of possible ethical issues"[24] (Hedgecoe, 2010, p. 163).

[22] My italics.
[23] See chapter seven.
[24] Hedgecoe considers that in the debate on pharmacogenetics, five types of analysis regarding ethical aspects can be seen. The scale goes up starting with the simplest approaches: papers "mentioning" the topic, "overviews", "reviews", papers offerering real "arguments", and finally those that are able to offer "recommendations" (Hedgecoe, 2010, pp. 166-168).

Thus some of the questions that this thesis seeks to address, following DeVries and Conrad, are: "(1) How does an issue get defined as 'bioethical'? (2) Who speaks for bioethics?" (DeVries & Conrad, 1998, p. 235). In short, it is necessary to study bioethics bearing in mind "disciplinary habits, professional relationships, cultural 'ways of seeing', institutional needs, economic demands, and arrangements of power and prestige" (DeVries & Conrad, 1998, p. 233f). In this way, we will be in a better position to define what bioethics is, what bioethicists are, what they talk about, and how it is that everyone nowadays speaks about 'the ethical' in the biomedical scenario.

## 9. Governmentality and bioethics

So far I have emphasised the cultural salience of contemporary medicine, a phenomenon that resembles to some extent the Hippocratic School of medicine's relevance in the Ancient World. I have shown that contemporary medicine, its elements, dynamics, problems, effects, and interrelations have also gained the attention not only of philosophers (like in ancient Greece), but also of a myriad of modern 'professional thinkers', including theologians, historians, and social scientists. As a result, several approaches, theories, and criticisms of what medicine is (or should be) have developed and shed light on the contemporary interrelation of medicine and society. In this way, interesting aspects on how medicine works, what it represents, and where it is taking us to have become more visible. For example, how medicine is defining 'the human' in contemporary society, and how at the same time medicine is being subjected to a increasing 'bio-ethicalisation'. However, in shaping the contemporary medical ethos, bioethics is not working alone. Bioethics goes hand in hand with law and economics in a wave that seems to seek its complete **'**normativisation'. Accordingly, we better should consider bio-ethics, bio-law and bio-economics not only as *strategies* to govern "life itself", but also as important elements of the "'advanced liberal' governmental technologies" (Rose, 2007, p. 3).

In this thesis I will make a case for explaining the bio-ethicalisation and juridification of the Colombian medical ethos, as part of liberal/neoliberal governmentality strategies (Foucault, 2007). Why Colombia? Let me give at least two reasons. First, as a Colombian physician who graduated in 1994, just three years after a new political constitution was enacted (July 1991) and one year after Law 100 of 1993, which led to the most radical healthcare reform ever carried in Colombia, was passed in the Congress, I belong to a

'transitional generation' of Colombian physicians. This led me to experience myself, in 'my own body', how the Colombian medical ethos has radically changed in the last 17 years and to feel the necessity of making sense of these changes. Pursuing that end, I studied philosophy and ended up engaging in bioethics. My argument is that among the ways that neoliberal societies[25] have had available to 'govern' the complex but profitable 'land' of medicine, bioethics and medical law are part of the 'truth regimes' required to successfully govern in our time. Colombia is my own universe, although it is intended that my 'local' analysis, also contributes to the general understanding of how bioethics was born and developed.

Second, as I have shown, many scholars, but particularly social scientists and historians of medicine, have contested the assumption of many bioethicists who see bioethics as a pristine, disinterested and natural answer to the challenges 'brought' by the biotechnological developments. In the field of clinical bioethics, for instance, "nearly all bioethicists would agree that the purpose of bioethics is *to provide an* ***independent*** *and* ***reasoned***[26] *voice in medical decision making*" (DeVries & Conrad, 1998, p. 234). Is this true? This is one of the questions this thesis wants to address. R. Cooter has argued that the growing interest in medical ethics is a "problem demanding contextual explanation [and says that] 'at best' [scholars] acknowledge 'strong outside forces' and the importance of 'the entire social context'" (Cooter, 2000, p. 453). Also he has suggested that different models of healthcare systems shape the discussion: "Typically, British medical ethicists frown upon the priest-like role assumed by American bioethicists" (Cooter, 2000, p. 455). In a US American, private, marketized healthcare system (which is also the case of Colombia) Cooter argues that "managers, not bioethicists, changed the ethical face of medicine by routinizing, if not alienating clinicians" (Cooter, 2000, p. 458). Other questions I want to answer include: What has been the role of bioethicists in the private, marketized, Colombian healthcare system? Is bioethics responding to D. Callahan's question about the way we are confronting "the moral puzzles, perplexities, and challenges posed by the confluence of the great scientific and cultural changes?" (Callahan, 2004, p. 280). And is bioethics contributing to the philosophical reflection of everyday realities of medical practice, as ten Have has asked? In short, and following N. Rose, Why are the regulatory apparatuses of advanced liberal societies so eagerly seeking to integrate bioethics in their ranks? (Rose, 2007, p. 30).

[25] I do not believe that Colombia is an 'advanced liberal society', but a developing country where drastic neoliberal reforms have been implemented.
[26] Authors' highlight and italics.

In order to get some answers to these questions, in particular for case of Colombia, I have chosen a perspective that has proved to be fruitful in the analysis of various issues, problems, and objects of contemporary society. This perspective is the Foucauldian approach, which has been largely neglected in the analysis of the 'his/stories' of bioethics, particularly in Latin America, although social scientists and historians have long been familiar with it. I have so far deliberatively avoided examining the 'power perspective' in depth since I will do this in chapter two of this thesis.

**10. Content outline**

In chapter two, I will review concepts from the Foucauldian toolkit that will help me to illuminate important aspects regarding the recent changes that the Colombian medical ethos has experienced.[27] Amongst these concepts are practice, discourse, rationality, episteme, problematisation, discipline, biopolitics, governmentality, and biopower. Following R. Cooter, I argue that power should have a central place in the analysis of modern medical ethics (Cooter, 2000, p. 455). How else can one better understand the historical jump from medical paternalism to personal autonomy in contemporary medical ethics, i.e. as the problematisation of authority in medical decision making?

In chapter three, I will discuss the 'histories' of bioethics, the 'origin myths', in Latin America. I will analyse the sources, issues, and strategies that pioneer Latin American bioethicists used to build the field. In so doing, I will try to characterise the Latin American bioethics and how the field has evolved in recent years. In so doing, I will examine the main historical accounts of bioethics in Latin America, trying to see them through a Foucauldian lens. My intention will also be to explore whether bioethics has come to constitute a 'truth regime' in Latin America and/or whether bioethics might be considered a *dispositif*.[28]

In chapter four, following on from what I have previously discussed in chapter one, two and three, I will examine Colombian bioethics, its 'his/stories', main issues and protagonists. Also I will characterise the discourses of bioethics in Colombia in order to find an answer to the question, is there a Colombian bioethics? To this end I will review the main Colombian bioethical journals and textbooks. Other sources like newspapers, speeches, bioethics postgraduate programs' curricula, and so on will be also utilized. By using information from

[27] Although I must say that this thesis is not about Foucault; it is just an attempt to make use of the Foucauldian scholarship.
[28] For a definition, see chapter two. Also: Revel, J. (2008) *Dictionaire Foucault*, p. 41.

27 interviews that I carried out in 2008,[29] I offer a picture of how Colombian physicians, bioethicists, and other professionals think of bioethics. Finally, I will describe two phenomena that characterise the Colombian bioethics: first, a growing *bioethicalisation* of the medical ethos; and, second, the tendency of the Colombian bioethical establishment to see everywhere 'bioethical implications', transforming in this way a wide array of issues, problems, and objects into a scenario amenable to 'bioethical intervention', a trend that I would call *bioethicism*.

In chapter five, I will describe the process and key features of the 1993 Colombian healthcare reform, which followed the new Constitution of 1991. I will show how the Colombian medical ethos was deeply affected by these socio-politico-juridico-economic transformations that meant, in the end, the 'neo-liberalisation' of the country. My intention will be to show how bioethics has 'fitted' well into this new environment, providing the required language to a shift of focus from power exercised *by* the medical profession to power exercised *over* the medical profession. In other words, as the medical profession was asked to operate under the new rationality of neoliberalism, a new language for the new medical ethos was necessary, and bioethics has proven to be successful and functional in this way. Using the information from the aforementioned interviews, I will show that the new healthcare system fosters the coexistence of different types of physicians. A central concept here will be 'the good doctor'. I want to show how the neoliberal governmentalities shape new medical subjectivities.

In chapter six, I show how medical law, doctors' insurance, medical lawsuits, codes of ethics, legal regulations, clinical guidelines, administrative rules, and so on, can be seen as expressions of a sovereign/disciplinary power over the medical profession. New forms of power brought by neoliberalism, which represent new ways of governing that are based on

[29] I intervieweed doctors, nurses, lawyers and philosophers mainly, although other professionals were also included. These interviews were fundamental to characterise different positions in Colombia regarding the history, scope and methods of bioethics. J. D'Achiardi (2004), a former postgraduate student at the Bioethics Institute, Javeriana University, tried to offer a comprehensive historical picture of bioethics in Colombia by obtaining first-hand information using interviews. However, in his unpublished work, D'Achiardi did not challenge the self-legitimasing historical accounts and origin myths held by the Colombian bioethicists he interviewed, particularly those called 'pioneers'. Rather, in those interviews such accounts and myths were reinforced. Different authors and institutions have acknowledged the importance of interviews for historical research. The American Historical Association, for example, has offered some key points to take into account in this kind of research. See: Statement on Interviewing for Historical Documentation, http://www.historians.org/perspectives/issues/1989/8910/8910AHA1.cfm, accessed 15 March 2013. Authors like Donald, Shurman, Kirkendall, et al (1991), have also underlined that "[i]nterviews are pieces of evidence which historians create and produce" (p. 227). Then, the information provided by my interviews seeks to contribute to a better understanding of the transformation of the medical ethos in Colombia in recent times. To see more details on how my interviews were planned, carried out, and analysed, go to the appendices (p. 225).

'freedom', have also become intertwined with bioethics. I want therefore to show the 'how' of bioethics and medical liability/malpractice that, as normative discourses on medical practice, are governing the "milieu"[30] of medicine.

In chapter seven, I show how in the new politico-legal environment of Colombia the bioethical language has informed important legal decisions. Also, I will show that principlism, informed consent and other relevant bioethical concepts are now the *lingua franca* in bio-legal decisions. I analyse three legal decisions of the Colombian Constitutional Court in particular: Decision C-257 of 1997 that decriminalised mercy killing (euthanasia), Decision SU-037 of 1999 about intersexual states, and Decision C-355 of 2006 that decriminalised abortion in three types of circumstance. In the end, I argue that in Colombia bioethics has become part of biopolitics.

I conclude by challenging the idea that bioethics came into being as a response to grievances about medicine. Instead, I argue that bioethics and medical law are nothing but new ways of governing the medical profession. Bioethics is just functional to a neoliberal understanding of medical practice. As there is an increasing feeling that somehow current medical practice and healthcare entail many 'wrong', 'unethical' assumptions (and in Colombia the general unhappiness with medical practice grows day by day, not only amongst lay people, but amongst healthcare professionals themselves), I also suggest that it is necessary to 'de-bioethicalise' the discussion and not merely to broaden the scope of bioethics, as some social scientists and bioethicists have proposed both in Latin America and in other developing countries. Also I will argue that the Foucauldian perspective on ethics might contribute to transform bioethics. In this way, the 'de-bioethicalisation' of medical ethos will contribute, paradoxically, to return to bioethics its emancipatory potentiality for biomedicine.

[30] A term used by Foucault to describe how neoliberal governmentality operate (Foucault, 2007).

Chapter two

# ‘Medical practice must be governed’: A Foucauldian approach to the transformation of the contemporary medical ethos

## 1. Introduction

This chapter explains why and how the Foucauldian toolkit is useful in creating an alternative critical assessment of the history of bioethics and medical law, particularly in relation to Colombia. As already mentioned in the introductory chapter, the status quo history and nature of bioethics have become unsatisfactory for social scientists, historians, and even for some perspicacious bioethicists who do not believe things are so simple. As bioethics has turned to be a ‘field’ to be studied, critical accounts of its history have started to appear. Some critics such as R. Cooter denounce bioethics for being an extension of biomedical power. My view is that bioethics is the ultimate expression of the ethicalisation of contemporary medicine and from a Foucauldian perspective it should be understood basically as a ‘power effect’. Traditionally, power analyses have emphasised how medicine and doctors exercise power over society (e.g. via medicalisation)[31] as well as over individuals (e.g. via paternalism in the DPR). However, I want to go beyond this one-sided view by adopting a Foucauldian approach. This will allow me to show that medicine and doctors, and not only patients or society, are subjected to power in contemporary societies, and that bioethics and medical liability are discourses through which such a power is exercised. Bioethics entails new discursive practices, new systems of thought and truth, new subjectivities, and represents a new stage in the relationship between medicine and society, especially in what N. Rose has called “advanced liberal societies”, or what Latin Americans would simply call *neoliberalism*. With the new rationalities established under neoliberalism, new relations between truth, health, and capitalism have been formed. Thus, the bio-ethicalisation of medicine should not be comprehended only as a reaction against medical professional power, or to new medical technologies and procedures, as R. Cooter (2000, p. 460) has suggested, but as a strategy that contributes to the smooth operation of the *medical-industrial complex* (Relman, 1990).

[31] The ‘medicalisation thesis’ refers to a phenomenon happening in contemporary societies that consists in transforming non-medical problems and different aspects of human life into illnesses and diseases. See: Conrad, P. (2007) *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders.*

The Foucauldian approach has largely been neglected by bioethicists when examining the history of their own field, although it has already been used to discuss particular bioethical issues.[32] In the case of Latin America and Colombia, there are only very few references to Foucault in the analyses of bioethical issues as well as the history of bioethics. I want to show in this chapter that using the Foucauldian concept of governmentality in the analysis of the history of bioethics will demonstrate that the rise of bioethics in Colombia has to do more with a power displacement than with moral progress in the biomedical field. This perspective emphasises the power/knowledge/subjectivity relationship out of which disciplines, institutions and experts have been created in the modern world. It can thus help us to understand the 'mushroom-like' phenomenon of bioethics (Lindemann & Nelson, 1999, p. xi). I want to use the Foucauldian perspective as a 'key' to read particular 'notes' on the history of bioethics and the transformation of the contemporary medical ethos, which have remained superimposed by the bioethicists' narratives about the history, nature, goals, methods and elements of their own field.

As the German historian of medicine P. Unschuld argues, for medical theories to flourish in a particular historical period, the socio-political, cultural, and economic structures of such a period provide *plausibility* to these theories (Díaz Amado, 2010b). This is true about our time as well. By considering the case of AIDS, the emblematic disease of the late twentieth century, Unschuld illustrates his argument by imagining, in a thought experiment that in the future scholars, maybe historians of medicine, will refer to our present-day medical explanations of this disease in this way:

> The disease model of HIV/AIDS that emerged in the late twentieth and early twenty-first century –and found broad acceptance in teaching, research, and therapy- was clearly marked by the social and economic circumstances of the time. It had plausibility, but as we know today, it did not correspond with reality. This plausibility gains its persuasiveness through several factors. At its center was systems thinking in economics, criminal law, and many other domains, which had been emerging since the mid-twentieth century. (Unschuld, 2009, p. 187)

[32] See, for example, Juritzen, T.; Grimen, H. and Heggen, K, et al. (2011) Protecting Vulnerable Research Participants: A Foucault-inspired Analysis of Ethics Committees. *Nursing Ethics*, 6, June, 640-649. Also see the articles in volume 31, issue 3, 2006 and volume 34, issue 4, 2009 of the *Journal of Medicine and Philosophy*.

Thus, molecular biology, genetics, infectology, do not simply provide facts or represent scientific advances, but are models that explain the malfunctioning of our bodies that we all experience at some point during our lives. These models reflect not only a particular state of scientific knowledge but also social structures and culture. The explanatory model for AIDS, for example, is related to neoliberalism, market economy and globalization, which are elements that characterise our present. For Unschuld, a cynic in the scientific academia would say something like this: "if AIDS hadn't come by itself, it would have been invented" (Unschuld, 2009, pp. 186). Being medical theories socio-politically, economically and culturally determined, no matter how much scientific they are, there is no reason to think it is different with regard to the available "theories" that explain and rule the medical ethos. The ethical, political, legal and economic approaches to medicine need to be also plausible to be accepted. So the question is, what elements of our societies (cultural values, rationalities, political structures, and so forth) have given bioethics and medical liability their plausibility to and become widely accepted as the suitable regulatory discourses on biomedicine and medical practice today?

It is, therefore, necessary to analyse what factors of the current socio-political, economic, and cultural environment have been so propitious for the rise of bioethics. In doing so, different questions need to be examined: how the bioethical discourse has become a set of 'indisputable truths'; why bioethics has been enthusiastically embraced; why and how the concept of medical paternalism, as a historical truth and a despicable image of what medicine 'used to be', is opposed to the advent of the 'new kingdom' of patients' autonomy announced by bioethicists the; the rise of a rhetoric that justifies limitations to individuals' medical care in the name of fair allocation of resources, while at the same time big private corporations investing in healthcare business make huge profits, is a contradiction that should be explained;[33] and why we became convinced that increasing legal intervention in the medical scenario truly guarantees better medical attention. In short, why is there so much concern about the power doctors exercise, when the 'real' power is exercised elsewhere? Excessive medical professional autonomy and abuses in biomedical research do not completely explain the boom of bioethics or the burgeoning industry of legal insurance of our day either. What is necessary to recognise is that bioethics, medical liability, and health economics are not simply new normative discourses and/or mechanisms to solve ethico-legal dilemmas, but also new and powerful ways to redefine the whole biomedical scenario: what being a doctor

[33] I will analyse this in detail for the case of Colombia in chapter five.

means, what being a 'good doctor' implies, what medicine is about, who decides in medical matters, and so on. Bioethics, medical liability, and health economics have indeed reshaped the very nature of medicine, and the history of medicine in the twentieth century cannot be written without taking into account these developments (Cooter, 2000, p. 452).

In this chapter I want to provide the necessary elements that will let me explain why, in a similar thought experiment as Unschuld's about AIDS, I foresee future historians of medicine referring to the phenomenon of bioethics at the turn of the twentieth century in this way:

> Regulatory discourses like bioethics, medical liability, and health economics that emerged as seemingly *natural* and *necessary* answers to biomedical progress in the second half of the twentieth century quickly became the customary ways to understand the nature of medicine, the goals and structure of healthcare services, and the roles healthcare professionals should play. Widely publicized scandals about malpractice and abuses in biomedical research contributed to reinforce the idea that through bioethics and medical liability medicine would be 're-humanized' and patients' rights properly guaranteed. But as we know today, the pervasiveness and persuasiveness of such new regulatory discourses had to do more with new power mechanisms operating in the biomedical arena, as in this time medicine became a new 'territory' to be governed according to liberal/neoliberal rationalities. By then, medical practice was rendered to the service of the transnational capital and from being a 'sovereign profession', medicine ended up being basically a trade controlled mainly by powerful private corporations and much less by doctors themselves who were subjected to new rules in the name of a new and necessary medical ethics.

In what follows, I shall describe the main elements of the Foucauldian toolkit that will be the basis of an analysis of the history of bioethics and medical liability in the particular case of Colombia. To start with, I will discuss how Foucault understood power. After that, I will show that in order to be governed, medicine would first be mapped as a particular territory, while doctors' actions became one aspect of a particular human relation that gained prominence in twentieth-century medical ethics: the DPR. Then I will show how some scholars have started to use the Foucauldian perspective in the analysis of bioethical issues, but that this perspective has not yet been used to explain the process of ethicalisation of

medicine. In my conclusions, I will show why the Foucauldian approach can be useful in the analysis of the history of bioethics and medical liability, outlining some points that are developed in the following chapters.

## 2. The Foucauldian toolkit

The importance of M. Foucault's contribution to the discussion and use of theory and methodology in history, philosophy, and social sciences is well established. He carried out a particular kind of social critique in which power relations are essential in explaining how knowledge, practices and subjectivities are formed. His work reflects various intellectual influences and are worthwhile highlighting. On the one hand, Nietzsche inspired Foucault's analyses of the relations power-truth-knowledge and the genealogical method. In the Nietzschean perspective, history is mostly about revealing the contingency of our present, and how historical accounts become 'truths' about ourselves as a result of power action.[34] History is mostly about revealing the past of our truths rather than the truth of our past (Morey, 1983, p. 23). Foucault expanded on these ideas in his essay Nietzsche, Genealogy, History (1984b), in which he distinguished between *Ursprung* (myths of origin) and *Entstehung* (constructions of historical truths). On the other hand, the Kantian concept of 'critique' inspired Foucault's "investigation into what we are (how we think, what we value, how we understand ourselves, how to treat others) [and also] what else we might be – how we could be different from ourselves" (Danaher, et al., 2000, p. 11). Working on the same question that Kant answered in 1784, in another essay, What is Enlightenment?, Foucault (1984d) held that we should see modernity "rather as an attitude than as a period of history" (p. 39).

However, Foucault does not provide a new master-narrative for my project, nor am I considering his theoretical perspective as the ultimate approach to analyse the transformation of contemporary medical ethos and the birth of bioethics and other normative discourses on medicine. In a preface to Deleuze's book, *Foucault,* P. Bové (1988), the renowned American professor of English literature, said that in the last few years "the academic effort to appropriate, correct, or dismiss Foucault has gone on even more intensely –sometimes brilliantly, sometimes stupidly, and sometimes with troubling seriousness" (p. viii). It is necessary then 'to be on the alert' to avoid either considering the Foucauldian perspective as

[34] See, for instance, Nietzsche, F. (1980) *On the Advantage and Disadvantage of History for Life*. (P. Preuss Trans.) Indianapolis: Hackett.

a set of fixed, immutable, and permanent categories or adopting them in an inaccurate or inappropriate way, or to make of Foucault the object of a cult of personality, invoking him as an indisputable authority.

Concomitantly, it is necessary to take into account the criticisms that Foucault has received. During his lifetime he was involved in many polemics such as the well known debate with Noam Chomsky, aired on Dutch television in 1971, about human nature, justice, power, and political action.[35] In 1977 Jean Baudrillard published *Forget Foucault* in which he criticised Foucault's conception of power (Baudrillard, 1978). Later on, other authors came forward with similar criticisms, like Mark Poster (1984), from a Marxist point of view and Nancy Fraser (1989), from a feminist point of view, criticising Foucault's conclusions on modernity, power, and humanism. Most famous among these controversies is the polemic exchange between Habermas and Foucault, which was in some sense a version of the clash between modernism and post-modernism, representing different views about rationality, progress, knowledge, subjects and the meanings of modernity (Ashenden & Owen, 1999). Often, Foucault's work was received by the Anglo-American academic world with hostility, indifference, and scepticism, when he was accused of inventing a 'fantasy' and creating a kind of inverse version of Whiggish history (Jones & Porter, 1994, p. 3).[36]

### 2.1. Archaeology, genealogy, and ethics

Foucault's intellectual work has traditionally been considered as encompassing three overlapping perspectives or methods: *archaeology*, *genealogy*, and *ethics*. The Foucauldian archaeology is an inquiry into knowledge formations, and is focused on the analysis of discourses.[37] Genealogy is an investigation into power and focused on the analysis of practices. Ethics, finally, follows the question of how to lead a good life, which, for Foucault, is related to the possibility of self-knowledge, self-creation, and self-care, i.e. about what he calls "technologies of the self" and "practices of freedom" (Díaz Amado, 2007a, p. 18). It is important to underline, however, that all these forms of inquiry entail to a lesser or greater

[35] Excerpts from this debate can be watched on Youtube, online at: http://www.youtube.com/watch?v=WveI_vgmPz8, accessed 1 December 2011.

[36] Clifford Geertz and Richard Rorty are also among the well-known scholars who criticised Foucault. There is a complete summary of the main criticisms against Foucault's ideas in the introduction of *Foucault. A Critical Reader*, edited by D. C. Hoy (1986). Additionally, in order to understand the academic and existential struggling of Foucault, two biographical works are worth consulting: *Michel Foucault*, by D. Eribon (1989) and *The Lives of Michel Foucault*, by D. Macey (1993).

[37] Foucault also used the term 'archivistic' to refer to his archaeological method. For a proper definition of the term 'archive', see Foucault (1972) *The Archaeology of Knowledge*.

extent the question of power. In a Foucauldian sense, an archaeologist is interested "in discovering the rules which enable [certain] questions *to be posed* at one time, *not to be posed* at another, and always within the same discourse" (Soper, 1986, p. 134). The archaeological research should include an analysis of first, the relation between the 'sayable' and the visible; second, the relation between statements, between subjects and statements; third, the rules of the repeatability of statements; fourth, the surfaces of emergence of objects of knowledge and the institutions that determine discursive objects; and fifth, the forms of specification of discursive objects (Foucault, 1972; Kendall & Wickham, 1999, p. 26).

But while archaeology is about revealing the underlying structures of our present, i.e. the past of our truths rather than the truth of our past (Morey, 1983, p. 23), genealogy is a history of the present,[38] or a glimpse of our past from the perspective of our current time in relation to complex causal antecedents of the socio-intellectual reality (Gutting, 2005, p. 12f). *Genealogy*, or the *history of the present*, therefore can be understood as "an analysis of the power relations which have constituted our interpretative horizon […] showing how the crutches of legitimacy of modern truth and impartial judgment are simply a reflection of social relations saturated with power" (Haugaard, 2002, p. 182). From a Nietzschean perspective, the history of the present "[…] involved investigating the historical origins [Entstehung] of powerful institutions and discourses which claimed to be universal and eternal" (Danaher, et al., 2000, p. 24), a perspective that allowed Foucault to reveal "how it is that we have come to understand (and be in) the world the way we do (are)" (Haugaard, 2002, 182). Thus, central to the Foucauldian genealogical approach is the analysis of institutions, practices, and names which have been taken for granted (McGowen, 1994, p. 96). In short, the genealogical perspective aims at examining the 'origins' –of us, of our institutions, of the disciplines, and of any object populating our world –to show their contingency as well as the mechanisms through which power has contributed to make us what we are (Díaz Amado, 2007a, p. 27).

N. Rose has argued that, in the biomedical scenario, a historian of the present has to *decompose* the "medical complex" in terms of its constitutive practices, apparatuses, expertises, technologies, and strategies (Rose, 1994, p. 50). For J. Bishop (2009a), "[t]he task of the historian of the present is […] to find the historical and political conditions for the possibility of what we find interesting about our time and about ourselves" (p. 333), which in

[38] Foucault coined this term in *Discipline and Punish* (Foucault, 1979, p. 31).

the case of the contemporary transformation of medical ethos means to explain how, for example, the DPR or the principle of respect for autonomy became relevant 'objects' for medical ethics. In Foucault's work the old assumption that knowledge can only develop when power relations are suspended is rejected, giving way to a new understanding that indeed is the opposite: there is no knowledge without power. For Foucault (1979) "[w]e should admit […] that power produces knowledge […] that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (p. 27). Although the history of the present perspective has been useful to carry out interesting historical/sociological analyses, N. Rose has recently suggested that, as challenging our present is not a novel project anymore, it is time to go beyond "the familiar tropes of genealogy and 'histories of the present'"[39] and try what he calls a "cartography of the present" (Rose, 2007, pp. 4-5). The difference is that while in the *history of the present* we see the contingencies of what we have taken for granted, in the *cartography of the present* we reshape our present by considering the 'openness' of the future.

In his last works Foucault's intellectual efforts were devoted to the question of ethics, which for him was about the relationship we have with ourselves. It is worth bearing in mind that "by 'ethics' Foucault means a self's work on itself, the way it makes itself a moral agent as it finds the kind of relation it ought to have with itself" (Scott, C. E., 2009, p. 353). Also it is important to underline that the concept of governmentality (which I will address below) is fundamental to understand the Foucauldian view of ethics, as for him governmentality is about the relationship "of the self to itself, [covering] the whole range of practices that constitute, define, organise, and instrumentalize the strategies that individuals in their freedom can use in dealing with each other" (Foucault, 1997a, p. 300). It is necessary, according to Foucault, to take distance from those analyses that mainly stress our nature as 'subjects of law'. Instead, by using the concept of governmentality we will be able to explain how 'free' individuals use different instruments "to control, determine, and limit the freedom of others" (Foucault, 1997a, p. 300). It is the government of freedom by freedom. One important conclusion from Foucault's work on power and ethics is that a new relationship to ourselves is necessary for our time (Castro-Gómez, 2010, p. 227).

[39] I would say, however, that in Latin America a history of the present is still a task to be carried out. Yet, a cartography of the present is also a useful perspective that should not be disregarded.

## 2.2. The Foucauldian toolkit to undertake an archaeological analysis

Foucauldian terminology is extensive and Foucault himself uses his own concepts in different ways. As my interest is to carry out a critical analysis of the history of the new normative discourses on medical practice, namely bioethics and medical liability, in terms of their links with power dynamics, I shall describe in the next lines six basic Foucauldian concepts –taken mainly from his first period when he was devoted to archaeological investigations- that will help me fulfil my goal of revealing the links between the history of bioethics, particularly in Latin America and Colombia, and power. With the concept of *episteme* I will show the conditions of possibility for the rise of bioethics, also I will analyse to what extent bioethics is a *discourse*, a *dispositif*, and a *truth regime*, how it has grown up in the context of particular *institutions*, and what kinds of *problematizations* are linked to its birth and rapid development. I take archaeological perspective and I analyse the formation of bioethics as an independent field of knowledge, profession, and expertise. This analysis is necessary if we are to see how much bioethics owes to power mechanisms and power relations.

In the preface of *The Order of Things* Foucault mentions a Chinese encyclopaedia that, according to J. L. Borges, includes a particular taxonomy of animals (Foucault, 1971, p. xvi). Foucault stresses how weird and nonsensical this taxonomy might appear to us. This is not because Borges is working simply with 'fiction'. Foucault argues that the shared system of meaning that would let us make sense of this classification is not available to us. This 'shared system of meaning' is constituted by, in Foucauldian terms, the *epistemes* or *discursive formations*, which provide the *conditions of possibility* for certain events, objects, statements, institutions, and ideas to be meaningfully 'conceivable' and 'sayable' (Foucault, 1971; McGowen, 1994, p. 96).[40] In his archaeological analysis Foucault mentions two great discontinuities in the episteme of the Western culture, which gives way to three differentiated epistemological periods: *Renaissance, Classical,* and *Modern* (Foucault, 1971). These are "periods of history […] that were organised round their own specific world-views [and which are] the product of certain organising principles which relate things to one another" (Danaher, et al., 2000, pp. 15-17). However, an episteme does not follow another in a linear manner nor are they part of continuous historical progress. They are merely "shared systems of

[40] P. Bourdieu's concept of *habitus* and A. Giddens' *practical consciousness knowledge* are concepts related to the Foucaultian *episteme* (Haugaard, 2002, p. 225). T. Kuhn's concept of *paradigm* is certainly very near to episteme, too.

knowledge, which are relationally self-constituting layers of historical thought […] marked by discontinuities" (Haugaard, 2002, p. 183). Our perception of history as a solid, linear, meaningful and necessary set of events, periods, subjects and ideas is indeed a sort of 'historical artefact' created by power. In *The Order of Things* Foucault highlights the transition between Classical and Modern epistemes, asserting that it is a shift in the 'truth regime' that parallels changes in the way Western societies are governed (Castro-Gómez, 2010, p. 163). Later, according to Haugaard, Foucault replaced the concept of episteme by that of discourse, which works in the Foucauldian genealogical project "as the technical term for the tacit knowledge which informs particular ways of making sense of the world" (Haugaard, 2002, p. 185).

The analysis of *discourses* is fundamental to understand the mechanisms of power, and in *The Archaeology of Knowledge* (1972) Foucault described in detail the formation and functioning of discourses. For Foucault a discourse "can be both an instrument and an effect of power" (Foucault, 1998, p. 101). Kimsma and Van Leewen (2005) define a discourse as "a consistent system of thought, speech, and actions, in short a particular way of dealing with issues that combines the significance of different aspects of human behaviour into an ordered social practice" (p. 566). They argue that in the contemporary biomedical scenario three practical discourses are in conflict: medicine, law, and economy. By taking the case of the AIDS pandemic they argued that legal and economic discourses have come to predominate over the medical, a situation that is evident in how language has changed in the medical scenario where new subjectivities such as the 'consumer' and the 'legal rights holder' have replaced the traditional 'patient' (Kimsma & Van Leewen, 2005, p. 571). These categories reflect particular discourses about the body that become visible when the experts (physicians, lawyers, economists) 'speak'. The relation between discourses and power can be seen in the construction and action of these 'experts'. They are constituted and legitimized through a particular knowledge that gives them the ability to fulfil the function of 'disciplining' subjects at different levels and in different spaces (Scott, J., 2001, p. 11). For Foucault discourses were just "elements or blocks operating in the field of force relations" (Foucault, 1998, p. 101). Moreover, a discourse is not only a linguistic phenomenon as some discourse analyses seem to suggest (Kendall & Wickham, 1999, p. 35). A discourse is 'language in action'. For this reason it is better to talk about *discursive practices*, which "[…] are not purely and simply modes of manufacture of discourse. They take shape in technical ensembles, in institutions, in behavioral schemes, in types of transmission and dissemination,

in pedagogical forms that both impose and maintain them" (Foucault, 1997d, p. 16). These discursive practices "occurred at a particular time, and are like events in that they create effects within a discursive field" (Danaher, et al., 2000, pp. 31,33).

Another Foucauldian concept that is deeply related to discourses in the constitution of disciplinary practices is *institution*, "a relatively enduring and stable set of relationships between different people, and between people and objects" (Danaher, et al., 2000, p. 36). In our societies institutions are engaged in the production of truth, and they can be of different kinds, e.g. public/private, and operate in different fields, e.g. culture, politics, etc. The quest for truth has become a fundamental task at different levels in contemporary western societies (Danaher, et al., 2000, p. 42). But we should bear in mind that, as Foucault stresses, "truth is not outside power [and that] each society has its regime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true" (Foucault, 1984c, p. 73). As Rose (1994, p. 58) has argued, we cannot talk about 'truth' outside "institutional and organisational conditions". What Foucault calls a *truth regime*[41] is "a set of procedures that lead to a certain result, which, on the basis of its principles and rules of procedures, may be considered valid or invalid" (Danaher, et al., 2000, p. 40). A truth regime is the relation between 'truth' "as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements [and] systems of power which produce and sustain it" (Foucault, 1984c, p. 74). These truth regimes are also related to the mechanics of power in our societies. As Haugaard underlines, when particular kinds of knowledge become and are imposed as 'truth', they usually operate as a strategy to govern (Haugaard, 2002, p. 185f).[42]

*Problematization* is another essential Foucauldian concept that lets us understand how certain objects, which were previously non-existent, ignored or disregarded become legitimate objects of thought. For Foucault a history of thought should elucidate the problematizations behind all kinds of 'solutions' we have found (Foucault, 1997b, p. 118). For him "there was one element that was capable of describing the history of thought - this was what one could call the element of problems or, more exactly, problematizations" (Foucault, 1997b, p. 117). For J. Bishop, what Foucault calls "problematizations of thought" corresponds to what A. MacIntyre calls "epistemological crises", the set of 'problems' acting

[41] Foucault sometimes also talks about "games of truth" (Foucault, 1997a, p. 297).
[42] The Chilean biologist and philosopher H. Maturana has shown how, for example, 'objectivity' is sometimes used as an argument to impose certain 'truths' (Watkins, 2004).

as the 'fuel' for thought (Bishop, 2009a, p. 335). For P. Miller and N. Rose the term 'problematization' is better than 'problem' as the aim in a Foucauldian analysis is to understand how certain issues are 'problematized', e.g. by 'experts', resulting in particular kinds of interventions. In terms of governing this is important since "the activity of problematizing is intrinsically linked to devising ways to seek to remedy [the problem]." Thus, there is no sharp separation between 'problems' and 'solutions[43] (Miller & Rose, 2008, p. 15).

We also have the concept of *dispositif,* which is usually translated into English as 'apparatus'. Although this is another plurisemantic Foucauldian term that has been understood in different ways (Bussolini, 2010; Deleuze, 1992), in an interview Foucault himself defined a 'dispositif' as "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, and philosophical, moral and philanthropic statements. In short, the spoken as well as the unspoken […] The dispositif is the network that can be established between these elements" (Revel, 2008, p. 42). According to Castro-Gómez, a dispositif is just a practical operator working in the context of *relations* – between objects, discourses, subjects, etc (Castro-Gómez, 2010, p. 65). By thinking of bioethics in terms of a *dispositif*, one can better understand two things: first, how bioethics has successfully created relations with other fields, a trend that has greatly contributed to its rapid institutionalisation, and second, how bioethics has been able to put in the same space old discussions that have returned in our day (e.g. abortion) with a set of disparate social problems and concerns (e.g. the reduction of poverty and strengthening of democracy) and the new anxieties brought by the biomedical advance (e.g. cloning and critical medicine).

Finally, for S. Castro-Gómez three fundamental concepts are necessary for any Foucauldian analysis: practices, rationality, and technologies. First, practices refer to what people actually do. Practices emerge in the context of particular historical conditions and they should be analysed as being part of a *dispositif* (Castro-Gómez, 2010, p. 29). Second, for Foucault rationalities explain the way practices take place and how they work in different

[43] In *Governing the Soul*, N. Rose (1999) offers a comprehensive definition of *problematizations*: "the emergence of problems in relation to particular moral, political, economic, military, geopolitical or juridical concerns, or within the operations of particular practices or institutional sites (courts, armies, schools, prisons…); the authorities who define phenomena as problems (educational, legal, religious, political…); the criteria in relation to which certain persons, things or forms of conduct come to be seen as problematic (institutional norms, military requirements, legal regulations…); the kinds of dividing practices involved (sickness from health; madness from criminality, normality from pathology…)" (p. xi).

networks of power. In contrast to Weber's and Habermas's approaches, Foucault is not interested in the 'individual's actions', but in the rationalities that constitute the conditions of possibility of such actions (Castro-Gómez, 2010, p. 31). And third, when Foucault mentions a *technology*, he is referring to the strategic dimension of power and how technologies work within a particular framework of power relations. Foucault examined different kinds of technologies, mainly technologies of the self (Foucault, 1997c) and technologies of government. In both cases we are confronted with two possibilities: either to accept to live under *states of domination*[44] or to choose to live 'ethically', i.e. according to *practices of freedom* (Castro-Gómez, 2010, p. 39), "[…] for what is ethics, if not the practice of freedom, the conscious [*réfléchie*] practice of freedom?" (Foucault, 1997a, p. 284). I will expand on this point in the conclusions of my thesis where I will suggest possible ways for bioethics to become part of practices of freedom in the field of medical practice that has been taken over by different forms of domination.

### 2.3. Foucault and power: From sovereignty to governmentality

Although Foucault is perhaps more famous for his analyses of power relations, it is necessary to avoid making the Foucauldian perspective a way to reduce every issue to a problem of power. Nor should we imagine that power is an inexorable force on us, that people are "completely dominated by and subjected to power, [and that] we are merely the dupes of dominant social groups, never knowing what we do, and therefore unable to resist power – whether it is employed by governments, the ruling classes, capitalism or the ordinary institutions that regulate and control our day-to-day lives" (Danaher, et al., 2000, p. 4). This view of power might be related to a Manichean view of the world. But in the Foucauldian perspective power is not necessarily negative and repressive. Instead, power is also a productive force. Additionally, it is important to underline that for Foucault power relations entail 'resistances'. According to Foucault (1998), "[w]here there is power, there is resistance, and yet, or rather consequently, this resistance is never in a position of exteriority in relation to power" (p. 95). Power and resistance can be seen just as the two sides of the same coin. Resistance is not merely a 'reaction' against power,[45] but also an opportunity to self-creation through the "practices of freedom", as Foucault suggests in *The Ethics of the*

[44] Foucault distinguishes between "power relations", which he defines as "strategic games of liberties", and "states of domination", in which the exercise of power is absolute and 'resistance' is not possible (Foucault, 1997a, p. 299).

[45] See: Hartmann, J. (2003) Power and Resistance in Later Foucault. Paper presented at the 3rd Annual Meeting of the Foucault Circle, John Carroll University, Cleveland, OH, February 28th – March 2nd, 2003. Available at http://mypage.siu.edu/hartmajr/pdf/jh_fouccirc_03.pdf. Retrieved 3 March 2011, p. 4.

*Concern for Self as a Practice of Freedom* (1997a). It is necessary to bear in mind then that power does not exist alone. Instead, one always finds the couple 'power exercise/resistance'. In this scenario, freedom should be seen as a necessary pre-requisite rather than as a possibility.

If power can be resisted, it is because there are subjects who are able to recognise it (Haugaard, 2002, p. 209).[46] But power is not set in stone nor does it come from a particular person. Instead "power […] functions in terms of the relations between different fields, institutions, bureaucracies, and other groups […] within the state" (Danaher, et. al., 2000). It outlines new objects of knowledge, shapes new subjectivities, and, most importantly, founds *practices*. In doing a *history of the present*, by analysing contemporary social practices, such as medical practice or legal expertise, we should point to the effects of power. I need to clarify here that I am not suggesting a *theory of conspiracy,* where "power is always something hidden in the background doing dirty work" (Kendall & Wickham, 1999), nor am I on the path towards a critique of the power of the state like that Marxists put forward. In a history of the present, which includes an analytical and a historical account of power, the question is how different forms of knowledge, practices and subjectivities are produced and relate to strategies of control and domination, parallel to different forms of resistance.

Against 'power determinism' it is possible to argue that people do indeed have chances to choose what to believe and what to accept (Danaher, et al., 2000, p. 79). Power is not only about producing "docile bodies", to use the Foucauldian expression in *Discipline and Punish* (Foucault, 1984a, p. 182), but also about active, self-creating individuals. According to J. Bishop (2009a), "[t]hrough the internalization and habituation of dispersed power/knowledges, the subject is created [and] it is this self-creating that defines authentic subjectivity for Foucault" (pp. 338f). Resistance can be a very effective force, even causing opposite effects to those that were originally intended by power. For example, prisons are created as a 'power effect' seeking to produce "compliant bodies and behaviour". Yet paradoxically, prisons are in reality "criminal factories". This means that although prisons are successful disciplinary spaces in terms of the transformation of people into 'prisoners', i.e. creating a new category of subjectivity, the purpose for which prisons were created – allegedly rehabilitation – is not necessarily achieved (Danaher, et al., 2000, p. 79f).

[46] The possibility of resistance proves that the subject is not 'dead', as Foucault himself announced, but still "alive and well" (Haugaard, 2002, p. 209).

Five other concepts are central in understanding how Foucault used power as an analytical concept in his analyses: *sovereignty* (sovereign power), *pastorate* (pastoral power), *discipline* (disciplinary power), *biopolitics*[47] and *governmentality*. Particularly in *Security, Territory, Population* (a compilation of his Lectures at the College de France 1977/78 (Foucault, 2007), and in *The Birth of Biopolitics* (his Lectures in 1978/79) (Foucault, 2010a), Foucault reshaped all his previous ideas about power, first, by analysing different modern technologies of government; second, by linking biopolitics to contemporary political rationalities such as liberalism and neoliberalism; and third, by highlighting the role of the practices of freedom, an issue on which he expanded in his last lecture, *The Government of Self and Others* 1982/83.[48] (Foucault, 2010b) In fact, it seems that the real interest of Foucault was not power in itself, but power in the context of explaining the process of subjectification through different historical periods. Thus, in 1982, two years before his death, Foucault declared that what he wanted with his work was to "create a history of the different modes by which, in our culture, human beings are made subjects" (Foucault, 2000, p. 326). The way we become subjects entails, paradoxically, a process of objectification, which happens as a result of, first, the production of *scientific knowledge* about us (linguistics, history, biology, and so on) that will constitute the 'truth' about us; second, the creation of *dividing practices* to classify and place individuals within the social space;[49] and, third, the *use/application of self-knowledge* in the creation of ourselves, for instance, in the context of the sexuality *dispositif* (Foucault, 2000, p. 327).

*Sovereign power* refers to the feudal monarch's privilege to kill or let live. In modern times, however, as the king's head has been cut off, instead of disappearing, sovereign power has spread across disparate social scenarios like schools, hospitals, family, factories, etc. (Foucault, 1998, pp. 136, 141). In this context, sovereign power has come to work "in terms of the relations between different fields, institutions, bureaucracies, and other groups (such as the private media and other businesses) within the state [as power is] not set in stone, [but] mobile and contingent" (Danaher, et al., 2000, p. 71). Sovereign power has become embodied particularly in "the juridical and executive arms of the state" (Nadesan, 2008, p. 7), although its function is now different: *fostering* or *disallowing* life instead of *suppressing* it (Foucault, 1998, p. 138). Therefore, sovereign power did not disappear with the bourgeois revolutions of

[47] In Foucault's work *biopower*, *disciplinary power*, and *biopolitics* are terms that very often overlap.
[48] Foucault died in 1984.
[49] Foucault says that through these practices people are classified, e.g. as "the mad and the sane, sick and the healthy, the criminals and 'the good boys'" (Foucault, 2000, p. 326).

the eighteenth century, but has remained an important technology of government, based on authoritarian and centralised rules (Nadesan, 2008, p. 10), which in Foucault's words means that "in political thought and analysis, we still have not cut off the head of the king" (Foucault, 1998, p. 88f).

In the seventeenth and eighteenth centuries new power mechanisms operating not "by right but by technique, not by law but by normalization, not by punishment but by control […] took charge of men's existence, men as living bodies" (Foucault, 1998, p. 89). Foucault called this kind of new power *biopower*, power over life that evolved in two ways. First, as a kind of power

> centred on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls […]: an *anatomo-politics of the human body*. The second, formed somewhat later, focused on the species body, the body imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity […]*: a biopolitics of the population*. (Foucault, 1998, p. 139)

By the seventeenth century pastoral and territorial rationalities of governing assembled into what Foucault called *security apparatuses*. In contrast to the traditional problem of sovereignty related mainly to possessing and ruling a territory, security apparatuses are concerned with how to manage populations. And this shift affected all social structures. For instance, from being a model for the state's administration, the traditional nuclear family was converted into an instrument of political intervention (Foucault, 1991, p. 100). The process of *securitization* entailed the dissemination of new disciplinary spaces like hospitals and schools, the production of particular knowledge like biostatistics to categorize population, the institutionalisation of certain practices like hygiene, generating not only "everyday panopticons of surveillance and social control, but also […] *technologies of the self* premised in the idea of individuals as self-governing agents" (Nadesan, 2008, p. 22). What is more important is that, as Foucault himself explained, we are not in the presence of three consecutive and exclusionary forms or mechanisms of power exercise, i.e. sovereign power, disciplinary power, and government. Rather, they constitute a kind of triangle of power acting

together over populations through securitizing apparatuses (Castro-Gómez, 2010, p. 79; Foucault, 2007).

### 2.4. Liberalism, neoliberalism and governmentality

With the emergence of population as an independent and identifiable domain by the eighteenth century,[50] the art of government based on the sovereign power model was 'problematized', leading to a new form of power in western societies, biopower or biopolitics. In the Foucauldian terminology biopower is usually taken as synonymous with biopolitics since it is a synchronised combination between political aims and medical knowledge,[51] operating over populations through the use of different types of knowledge and the action of a wide array of experts (Nadesan, 2008, p. 8). Biopolitics is then related to a new "control over life […] aimed at producing subjective actions that are more attuned to the post-industrial way of life. For such life, it is no longer of interest to 'cause to live or die' but, fundamentally, 'to cause to survive', thus producing what Giorgio Agamben called 'bare life'" (Agamben, 1998; Aran & Peixoto, 2007, p. 2).[52] Biopolitics is also linked to pastoral power. While sovereign power is about possessing and governing a 'territory' as well as repressing, the pastorate is a non-territorial power inherited from the Christian ideal of the priest looking after his people as a shepherd with his flock. Pastoral power was integrated within the rationality of the modern state, e.g. through welfare institutions like state schools and hospitals, making it possible to govern at the same time the population and the individual (Castro-Gómez, 2010, p. 110). In short, biopolitics is a social strategy of policing and controlling populations by "increasingly ordering all realms under the guise of improving the welfare of the individual and the population for the purpose of reproducing and furthering the social order" (Towes, 2001, p. xxvi).

Biopolitics was fundamental in the institutionalisation of new forms of governing, i.e. the formation of modern governmentality associated to the birth of classical liberalism. Until the eighteenth century the art of governing was based on police strategies and pastoral technologies aimed at increasing the power of the state. Under the sovereign rationality maintaining order was the main goal of government, and disciplinary technologies were

[50] It is important to stress that population does not mean "people", but a "set of processes" (Castro-Gómez, 2010, p. 61), which will constitute the *raison d'etre* of the new art of government in the Modern era, i.e. governmentality.
[51] Although the term *biopolitics* is usually linked to Foucault, R. Esposito has carried out a genealogy of the term *biopolitics*, showing that other authors and in other times have also used this term (Esposito, 2008, p. 16). According to Esposito, for Foucault 'life', as a concept, has been insufficiently analysed (Esposito, 2008, p. 44).
[52] I will expand on this idea in chapter seven when analysing the issue of euthanasia in Colombia.

conceived to assure people's wellbeing. With mercantilism, the art of governing was seen as the regulation of economy, and later on, physiocrats challenged this assumption and inverted the equation: the state should leave economy alone since economic processes are 'natural'. For physiocrats the problem was not the "abuse of sovereignty" but the "excess of government" (Castro-Gómez, 2010, pp. 138,139). Thus a liberal art of government, operating through "*a biopolitics of the population* [and enframing] the population within *apparatuses of security*", was born. These forces operate today at a transnational level and are not limited to one state (Nadesan, 2008, p. 9). Moreover, from the late nineteenth century onwards to produce "the rational, autonomous agents presupposed by liberal, democratic capitalism" has been the main goal within the state, and in the twentieth century freedom became the ultimate *telos* of government (Nadesan, 2008, p. 26).

Liberalism only works if individuals have freedom both to make choices and to act. However, as G. Burchell (1996, quoted in Castro-Gómez, 2010, p. 169) has underlined, for Foucault freedom is not merely a human faculty, as many philosophers would say, but a *technical condition* for a 'rational' performance under the rationality of liberal governmentality. Freedom, Foucault (2010a) says, "is never anything other – but this is already a great deal- than an actual relation between governors and governed, a relation in which the measure of the 'too little' existing freedom is given by the 'even more' freedom demanded" (p. 63). The great innovation of liberalism was the invention of the *government over actions* rather than over individuals, which meant that instead of seeking either to constrain or to control people's behaviour directly, the aim would be to create favourable conditions for freedom to be consumed and the non-intervention of the sovereign in the private lives of individual; a true political programme that neoliberalism has fully carried out across the twentieth century and first years of the twenty-first (Castro-Gómez, 2010, p. 170).

From "the advice to the prince" (in Machiavelli) to the "art of government" (in modern times) we see the rationalisation of government in which economists, not philosophers or lawyers, will decide what governing means. According to Foucault, between the sixteenth and eighteenth centuries governing was problematized at different levels: self-government, the government of family, and the government of the souls and lives. Out of this historical process "the state of justice became […] an administrative state that gradually becomes 'governmentalized'" (Foucault, 1991, p. 103). It is a 'history of governmentality' that Foucault wanted to address in his Lectures of 1978/79, which would include, first, "[t]he ensemble formed by institutions, procedures, analyses and reflections, the calculations and

tactics" to exercise power over populations, using *political economy* as its principal form of knowledge and *apparatuses of security* as its technical means, and second, the analysis of "[t]he tendency over a long period of time in the West of this form of power (over sovereignty, discipline, etc.), which includes particular governmental apparatuses and *savoirs"* (Foucault, 1991, pp. 102-103).

In short, *governmentality* is about "the conduct of conduct" and with this expression Foucault redefined the term "government" (its mentalities, arts, and regimes) in the way it began to exist from the sixteenth century onwards (Dean, 1999, p. 2). When I use the term *governmentality* I am referring to a characteristic ethico-political and economic trend that has been developed in Western modern societies since the sixteenth-seventeenth centuries. By using the concept of governmentality we can explore "how individuals are privileged as autonomous self-regulating agents or are marginalized, disciplined, or subordinated as invisible or dangerous" (Nadesan, 2008, p. 1). However, in Foucauldian terms to consider individuals as "autonomous and self-regulating agents" is not a recognition of certain properties of individuals, but a revolutionary shift on how different issues related to governing should be analysed in modernity.

**3. Biomedicine: A new 'territory' to be 'securitized'**

In the last 40 years a variety of discourses and strategies have been developed in order to limit medical power. As I have shown, bioethics and medical liability are depicted as promoters of the interests of patients and society. Their discourse is about autonomy, individual rights and protection against medical malpractice. In fact, the official history of bioethics has become "the history of the emancipation of the patient from medical paternalism" (Epstein, 2010, p. 228), which in other words means the challenge of medical authority. The rationality of these discourses fits perfectly into the current environment dominated by neoliberal ideas, e.g. primacy of individuals' autonomy and decisions based on free choice. According to Foucault, there is an anti-authority movement against "power effects as such", which in the case of the medical profession has to do less with its profit-making orientation than with its "uncontrolled" exercise of power "over people's bodies, their health and their life and death." The attack is not against a particular institution, group or elite, but against "a technique, a form of power" (Foucault, 2000, p. 330). That medical power should be controlled might be a very valid argument, but what I want to show is that other power dynamics remain hidden behind the calls for limiting medical power in the name

of people's rights. In other words, bioethical discourses constitute a way to make medicine fit into neoliberal forms of governmentality. We are currently embedded in a *neoliberal episteme*, in which human beings are considered as rational and autonomous agents who are responsible for themselves while the state would just play the role of a 'guarantor of rules', and if we want to understand why certain discourses, practices, and rationalities, such as bioethics or medical liability make sense, we need first to recognise what this episteme is and how it works.

In the last fifty years medicine has been fully integrated into capitalism, becoming an 'economy within the economy', the "medical industrial complex" (Relman, 1990), as medicine is now an important field for investment and business opportunities. Moreover, as I argued in the introductory chapter, medicine is in our day an important cultural phenomenon and doctors still hold a great deal of power despite the criticism of medical paternalism. However, doctors were not always powerful people. According to Stephen Watkins (2004), in the Britain of the nineteenth century, doctors "were of higher status than the other groups, but the rich still saw them as a high-grade domestic servant [and by 1932] the average medical practitioner was a man of little culture or general education" (p. 37). For the USA, P. Starr (1982), quoting an American professional journal of 1869, observes that "medicine was despicable as a profession. The worst election for a liberally educated man" (p. 7). But at least in the USA and other western countries, medicine entered a "Golden Age" in the first part of the twentieth century and became a kind of "special market"[53] (Towes, 2001, p. 525), where doctors were 'sovereigns', i.e. doctors had the prerogative in deciding how the medical field should be governed. Referring to American medicine, P. Starr (1982) argued that "from a relatively weak, traditional profession of minor economic significance, medicine has become a sprawling system of hospitals, clinics, health plans, insurance companies, and myriad other organisations employing a vast labor force" (p. 4). In other words, capitalism discovered how profitable medical practice might be. For Starr, the Golden Age of medicine meant not only amazing outcomes in terms of technical achievements, but also full recognition and respect for the autonomy of the profession.

[53] Although medical practice has always been an economic activity, traditionally it had not been considered of the same nature like, for instance, trading goods or commerce. The take-over of medicine and other professions by capitalism was even foreseen by K. Marx and F. Engels who in 1861 observed that "the bourgeoisie has […] converted the physician, the lawyer, the priest, the poet, the man of science into its paid wage-labourers" (Marx & Engels, 2008, p. 37). By the late-twentieth century medical practice was indeed fully integrated into capitalism.

However, the special market of medicine from the beginning of the twentieth century has ended up being absorbed by the global market, in which patients have become consumers and consumers have become patients (Towes, 2001, p. 523). Moreover, doctors have been transformed from independent professionals into employees of powerful corporations in the Post-Fordist era. In this environment, "there is a general consensus amongst social scientists that the challenges to medical autonomy […] are real and that declining medical autonomy is more widely evident across a range of liberal democratic states […]" (Harrison, 2004b, p. 57). Concomitantly, as medicine has been 'neoliberalized', it has passed through a process of *deprofessionalisation* and *proletarianisation*. The former refers to the fact "that there has been a decline in public trust of medicine and the threat this poses to the principle of professional self-regulation" (Elston, 1991, quoted in Chamberlain, 2010, p. 7). The latter refers to how medicine has "become subject to rationalisation and routinisation [rendering medical work], subject to managerial bureaucratic control in the name of controlling costs and promoting consumer choice" (Elston, 2004, quoted in Chamberlain, 2010, p. 7).

The new form of governmentality in the medical scenario of the twenty-first century consists of regulatory bodies, the cost-effectiveness calculus, clinical guidelines, and a wide range of mechanisms to control doctors 'at distance' and limit patients' options. Moreover, as is happening in Britain and many Western countries, in the new bureaucratic environment of medical practice, governance/government discourses and rationalities are used to contrast "a mode of coordination based on networks rather than on hierarchy" (Harrison, 2004a, p. 180). In the new bureaucratized model, medical professionalism (and good doctoring) emphasises formal rules, scientific evidence, use of protocols, and clinical guidelines (in connection with EBM), cost-effectiveness, external regulation, and a stratified approach to the medical profession in which there is "explicit recognition of elites based on medical research and medically qualified management" (Harrison, 2004a, p. 185). The problem is, as Harrison points out, that "[t]he golden age of medicine as a profession may be gone… but its replacement by bureaucracy does not constitute unalloyed progress" (Harrison, 2004b, p. 59). Regarding EBM, it is necessary to take into account that

> the politics of standards should not be located solely in the regulatory-political environment from which standards emerge but in the standards themselves. Standards [including clinical guidelines] are inherently political because their construction and application transform the practices in which they become embedded. They change positions of actors: altering relations of accountability,

> emphasising or desemphasising pre-existing hierarchies, changing expectations of patients. (Timmermans, 2003, p. 22)

Since the 1970s the political project to demedicalize society, promoted particularly by social scientists, has been on the rise and it constitutes a particular form of resistance against medical power. Although Kimsma and Van Leewen (2005, p. 560) have argued that this project is being carried out via the 'juridification' and 'economization' of medicine, I would add that the aforementioned 'bioethicalisation' of medicine is part of that process, too. These phenomena reflect a shift in power relations in the biomedical field. In Foucauldian terms, the biomedical field has passed from being a 'sovereign territory' to being a 'governed population', which would explain the flourishing of pastoral discourses such as bioethics, medical liability and medical economics in the last few years. Medicine might rightly be seen as a 'territory' where doctors used to exercise sovereign power. However, beginning with the problematization of the DPR in the mid-twentieth century, medicine has since become a 'population' to be governed. In this process, bioethics, with the help of law and economics, has provided the necessary pastoral discourse to 'securitize' medicine. In this context bioethics is arguably part of clinical strategies which are being used to govern the biomedical field. In the UK, for instance, during the early 2000s, the application of a technology of governmentality to professional expertise went hand in hand with regulation and new forms of self-surveillance in the medical arena (Flynn, 2004, p. 20). In this environment, the principle of regulated autonomy has become an important tool to govern healthcare organisations; with autonomy and regulation it is possible to control at distance (Flynn, 2004, p. 21). In this context, 'good doctors' are those who practise with 'responsible autonomy', using the expression of Degeling, Maxwell, and Iedema (2004, p. 163), i.e. doctors, who are still considered 'free professionals', although in reality they are subjected to certain neoliberal principles operating through strategies of self-surveillance.

In order to make the entire medical-industrial complex work properly as well as to minimize resistance and avoid rebellions, it is necessary that discourses, rationalities, institutions, subjects, and strategies are attuned. Recall that in Foucauldian terms, the question is not 'why', but 'how'. The 'how'-perspective is related to 'governance', which also should include an appropriate 'truth regime' and an apparatus (*dispositif*) in order to "keep things going".[54] In other words, a 'power regime' is usually attached to a 'truth

[54] Using the expression of Hunk and Wickham, quoted in: Kendall & Wickham, 1999, p. 49.

regimen' (Kendall & Wickham, 1999, p. 49). According to A. Gray (2004) "[t]he **communion mode of governance** is a relationship based on an appeal to common values and creeds" (p. 5). My argument is that bioethics operates within this set of "common values and creeds", 'lubricating' the cogwheels of the medical-industrial complex. In the case of Colombia, as I will show in chapter four, bioethics flourished in the 1990s, parallel to a radical neoliberal health care reform. Under the umbrella of the neoliberal rationality, a new medical ethics was indeed necessary. Thus, as N. Rose (2007) has argued, "the **apparatus** of bioethics has achieved the salience that it has, in contemporary biopolitics, because of the problems of governing biomedicine in an age of choice and self-maximization in which the body and its capacities have become central to technologies of selfhood" (p. 8).

Furthermore, as Miller and Rose (2008) have argued, "[i]n any event, economic power could only maintain itself, could only reproduce itself, on the basis of a particular legal system, a set of ideas about the organisation of work and the definition of profit, a set of institutional arrangements for shaping and moulding the hopes, aspirations and capacities of individuals and collectivities, and much more" (p. 2). Hence, not only the discourse of bioethics but also the juridification of medicine provides a central element of the power relationships which govern healthcare today. Law and economics have also played an important role in sustaining neoliberal forms of government in various areas, including medicine. Foucault (2010a) himself suggested that in modern neoliberal societies, "[t]he economy is a game and the legal institution which frames the economy should be thought of as the rules of the game" (p. 173). However, while in classical liberalism there was a separation between law and morality, since the nineteenth century law has become more and more normative and not merely prohibitive, giving way to the birth of "social law" in which individuals are responsible not only before the state, but before others (Castro-Gómez, 2010, p. 233). Ewald, a former student of Foucault, has shown that in the nineteenth century the idea of health insurance to manage risks was born as liberalism wanted to manage the social, a category that had become problematic with the development of capitalism. The rise of 'the social' in the nineteenth century, as it had happened with 'population' in the eighteenth century, became a technology of government. Yet the term 'risk', "which one finds being used nowadays apropos of everything has no precise meaning other than as a category of this technology. [In fact] there is no risk in reality. But on the other hand, anything *can* be a risk" (Ewald, 1991, p. 199).

## 4. The Foucauldian approach *in* Bioethics

In 1987 a whole issue of the *Journal of Medicine and Philosophy* was devoted to "Michel Foucault and the philosophy of medicine" (Rawlinson, 1987). Twenty five years later, in 2009, the same journal devoted a special issue to "revisit Foucault" (Bishop, 2009b). Although the Foucauldian approach has already been used in the analysis of particular bioethical issues, it has been neglected in the analysis of the 'ethicalisation of medicine' in the second half of the twentieth century. In the opening article of the 2009 special issue of the *Journal of Medicine and Philosophy*, Bishop argues that Foucault's work is an "interpretative analytics". It is analytic in a Kantian sense "as he searches out the conditions for the possibility of unreason in *Madness and Civilisation* […]; of medicine in *The Birth of the Clinic* […]; and of life, language, and labor in *The Order of Things* (1994) [and it is interpretative in] that it seeks a pragmatic reading of the coherence of our practices – practices in which our knowledge are instantiated" (Bishop, 2009a, p. 331).

In another article in the special issue mentioned above, C. Scott argues that, although Foucault was not particularly interested in medical ethics, his work can illuminate not only those debates currently taking place in this field, but also "the knowledge and practice of biomedical ethicists" (Scott, C. E., 2009, p. 351). Scott also argues that in order to make ethical studies effective, they must go beyond than just clarifying terminology and revising other philosophical texts. This means "to interrupt dominant rationalities, […] to show the wide range of impact by knowledge and practices in many dimensions of society, and to develop vocabularies and concepts that form in experiences of concrete, highly problematic situations" (Scott, C. E., 2009, p. 360). This could be achieved by adopting the Foucaultian genealogical analysis of institutions, practices, and names that have been taken for granted (McGowen, 1994, p. 96). However, for a critical history of discourses such as bioethics and medical law it is necessary to remember that the "genealogical thought is at times difficult because it is counterintuitive [and] Foucault's genealogical thinking includes major confrontations with many established and authoritative values and truths" (Scott, C. E., 2009, p. 353). Therefore, arguing against many bioethicists' taken-for-granted "values and truths", might not be an easy task at all.

To take a critical perspective on bioethics it is necessary to ask, "[w]hat is the function of bioethics? What is the role of bioethics in the new political economy of medicine? Is the discipline honest about its relationship to individual freedom and its neutrality regarding the good?" (Lysaught, 2009, p. 387). For Lysaught, doctors and patients have become 'docile

bodies' for pharmaceutical companies and big healthcare corporations. As such, this is a power effect that can neither be unveiled by analytical philosophy approaches nor principlism. Only a biopolitical approach might explain how the "political economy of biomedicine and transnational research" have evolved at the turn of the twenty first century. In short, for Lysaught,

> [t]o see bioethics as a mode of biopolitics is to illuminate the myriad of ways that behind the rhetoric of freedom, empowerment, and improving the welfare of the individual and the population, bioethics functions to produce, organise, and manage the bodies of real, human persons –to police and control populations- towards the ends of larger institutional agents such as the state or, more recently, the biotech industry. To see bioethics as a mode of biopolitics is to raise questions about bioethics' role in the political economy of biomedicine, particularly when that political economy impinges on human bodies. (Lysaught, 2009, p. 387)

To examine bioethics in terms of biopolitics can be a fruitful way to reveal the power relations working behind the curtains in the history of bioethics. Inspired by Foucault, J. Bishop and F. Jotterand stressed the "political turn" of bioethics in recent years and claimed that bioethics has always had a deep relation with biopolitics. For them, to consider bioethics as biopolitics is to consider the relationship between medicine and politics (Bishop & Jotterand, 2006, p. 206). This does not come as a surprise, since medicine has been a fundamental component of biopolitics since the eighteenth century (Lysaught, 2009, p. 387). However, when bioethics and biopolitics are linked, authors can be referring to different things. For J. Bishop and F. Jotterand (2006) "bioethics has always been a biopolitics and the political dimension is only now coming into relief for bioethicists" (p. 205). For N. Rose contemporary biopolitics is at the intersection of medical and political perceptions and practices (Rose, 2007, p. 5). In this context, bioethics is related to *somatic expertise*: the rise of experts of the soma, and around them "[…] a whole variety of new pastoral experts [like genetics counsellors] –whose role is to advise and guide, to care and support […]" But, according to Rose (2007), "perhaps most remarkable has been the rise of a novel expertise of 'bioethics' claiming the capacity to evaluate and adjudicate on these activities, which has been enrolled in the government and legitimation of biomedical practices from bench to clinic and marketplace" (p. 6) In the same way, the rise of *Economies of vitality,* i.e. bioeconomy and biocapital are born: "Life itself has been made amenable to […] new

economic relations [and] in the process, a novel geopolitical field has taken shape, and biopolitics has become inextricably intertwined with bioeconomics" (Rose, 2007, pp. 6f).

T. Koch (2006) has criticised the narrowness and poverty that characterises the current bioethical debate. For him bioethics operates as an *ideology* whose 'axioms' are "arbitrary and exclusive rather than necessary and inclusive" (Koch, 2006, p. 251). From another angle, L. Hall argues that bioethics has become a mere "procedure", a formality to make up "ethical decisions" in biomedicine, while it remains complacent of the "imperative of progress" that characterises western societies. For this reason, she argues, is it necessary to ask: "How might Western bioethicists be more aware of the ways that our language depends upon a set of assumptions about progress, rationality, and development? [H]ow might Western bioethicists' intent to be useful in countries classified as within the two-thirds world be cognizant of the ways that we enforce through our language a set of 'rules that govern what can count as knowledge'? How might our very efforts to be of use deal in deadly ways, reinforcing 'rules that determine which human lives can be lived?'" (Hall, 2006, p. 289).

More recently, T. Juritzen, H. Grimen and K. Heggen (2011), with their analysis of power "in the exercise of guiding and monitoring procedures related to research ethics", have illustrated how a Foucauldian approach is fruitful *in* bioethics. After reviewing the interrelation between power and knowledge and the concept of pastoral power, they warn about the exercise of power that might entail a risk of abuse in the biomedical field (e.g. domination, exploitation, coercion, and so on) not only on the part of sponsors (e.g. pharmaceuticals) and researchers, but also on the part of the guiding and monitoring bodies (e.g. ethics committees). Based on the Foucauldian insight that power and knowledge coexist in an intrinsic relation, these authors criticised the "administrators of research ethics [for positioning themselves] as external to the power that is being wielded in the field of research ethics" (Juritzen et al., 2011, p. 646). Juritzen et al. argue that by holding a view according to which research ethics committees are intrinsically exempt from power effects and merely devoted to "regulate the obviously asymmetric relationship between the researcher and the participant, […] other essential positions and relationships of power [remain] invisible" (Juritzen et al., 2011, p. 647). This criticism might well apply to bioethics in general, as bioethics can be characterised for its 'will' to regulate different relationships in the biomedical scenario, e.g. doctors-patients, doctors-health care professionals, doctors-health corporations and medicine-society relationships, to name but a few, while remaining blind to the way power shapes such relations.

## 5. Conclusion: Towards a Foucauldian approach *to* Bioethics in Colombia

Bioethicists have hitherto systematically neglected and/or disregarded the role power relations have played in the creation of their field. To fill this gap, in this chapter I have made a case for a Foucauldian approach to the history of bioethics and its relation to power. Three main reasons explain why the Foucauldian approach should be included in any historical analysis of bioethics. First of all, such an approach does not consider power as such, but situates it in the context of practices, rationalities, discourses and knowledge. Today, bioethics and medical liability are regarded as new disciplines that claim to possess new knowledge necessary to make contemporary biomedicine ethical. Indeed, they represent a 'truth regime' in biomedicine as they define subjectivities and prescribe courses of action, e.g. what being a doctor and a patient is and how they ought to act. In contrast to Whiggish or naïve accounts, the Foucauldian perspective reminds us that there is not "a potential for knowledge which is undistorted by power" (Haugaard, 2002, p. 229). We must bear in mind that "the various types of knowledge of man and the historical forms of power entertain a necessary connection in which the two terms are indissociable" (Han, 2002, p. 115). Hence, a history of bioethics should not only include an analysis of power-knowledge relations, but also of the production of subjectivities and how different forms of power, i.e. sovereign power, disciplinary power, biopolitics and governmentality operate in the field of bioethics and medical liability.

Second, the Foucauldian approach is mainly focused on the 'how' rather than on the 'why'. For neo-Foucauldians like P. Miller and N. Rose the passage "from why to how" was a fundamental move for their research programme. They wanted to avoid "why-type" questions (the kind of question many political scientists like to ask), "naturalized" answers, or falling for the temptation of considering the current state of things as "necessary" (Miller & Rose, 2008, p. 6). Thus, the Foucauldian perspective focused on 'how' rather than 'why' will let me show that the process of *bioethicalisation* of medicine in Colombia is a strategy to govern the biomedical field in accordance to the dominant rationalities in advanced liberal societies.

Third, by adopting a Foucauldian approach, one is neither limited to analyse power relations by reference to the State nor is power necessarily seen a negative or repressive force. This approach will therefore let me show the productive effects of power and how it

operates at different levels in the case of the history of bioethics and medical liability. Thereby, it will be possible to understand how neoliberal practices and rationalities have caused a profound transformation of the Colombian medical ethos.

The history of bioethics in Latin America, and particularly in Colombia, both in terms of a *history of the present* and a *history of governmentality*, should then include questions such as: how did this new academic and professional field come to be? How did new experts, the 'bioethicist' and the 'medical lawyer' emerge and how were they integrated at different levels, e.g. universities, hospitals, ethics committees, etc? What do 'bioethical problems', 'bioethical knowledge' or 'bioethical aspects' mean? What is 'the bioethical'? How do categories such as 'autonomy', 'human dignity', 'interdisiciplinarity', or 'medical liability' work? What forces, actors, structures, and mechanisms constitute the "conditions of possibility" for ethics committees, a national bioethics commission and academic programs in bioethics to appear? And, how have bioethics and medical liability come to affect, shape, and be part of other discourses and practices like in the legal scenario– e.g. medical malpractice and judicial decisions on 'bioethical matters' -, managed care, governmental policies on environment, and biomedical research? Why bioethics and why medical liability? Are they a 'natural' answer to the advance of biomedical sciences? Are they as beneficial as their advocates eagerly suggest? How, when, where, under what circumstances, and with what kind of institutions do these new 'discourses of expertise' work? What are the historical 'forces' and 'conditions of possibility' that led to the rise of the new normative framework for medical practice? Which objects, scenarios, problems, and subjects do bioethics and medical law talk a lot about and about which do they remain silent?

We must think in terms of the fertile conditions that have promoted the formation of new normative discourses in the field of medical practice –bioethics and medical liability-, the characteristics of this new knowledge about 'good' and 'right', the new subjects of expertise which have arrived and stayed in a net of new institutional relationships, in sum, the new foci of control and discipline which determine the medical ethos today. We are in the presence of new relations between truth, health and capitalization which have led to new forms of administering individuals' lives. The new controls over medical practice should not be simply thought of as mechanisms to protect people from doctors' abuses. They are one element of the medical-industrial complex and its governmentalization. In this context, the Foucauldian approach also offers an interesting and fruitful alternative, which is to understand ethics in terms of the possibility of creating a new relationship with oneself. If bioethics and medical

liability have to help liberating people from domination, exploitation and abuse in the biomedical scenario, they should be scenarios where practices of freedom and self-creation are promoted, not only among patients or research subjects, but also among doctors and health care professionals. In the next chapters I will apply the Foucauldian approach I have described here. I will start with the analysis of the history of bioethics in Latin America.

Chapter three

# Bioethics in Latin America: The American bioethics meets the South

## 1. Introduction

Latin America refers to a vast region that includes Central and South America as well as the Caribbean islands. It is made up of 27 countries and Spanish and Portuguese are the main languages, although French and English are also spoken, not to mention the many indigenous languages and dialects which are still in use in the region. But more than this, Latin America is the outcome of a complex process of cultural amalgamation of European –particularly Spanish and Portuguese–, Indigenous, and African traditions. After the independence wars of the nineteenth century, the construction of the Latin American identity was a process deeply linked to the USA. By the late nineteenth century the term 'Latin America' was coined to differentiate the Anglo-Saxon America, mainly represented by the USA, from the region that was conquered and colonized by Spain and Portugal, which represented a 'Latin' tradition (Tealdi, 2008a, p. 1).[55] In this complex, multifaceted, contradictory and vast region, bioethics has been evolving since the late 1970s. But, as in many other fields, there are contesting views about what the role of bioethics should be in this setting. Since bioethics is an American product, how have Latin American bioethicists understood their own history and what role has the North/South tension played in the development of bioethics in Latin America? Have the Latin American bioethicists been aware of such power relations in the development of their own discipline, and, if yes, how have they responded to them?

At present bioethics is a well established academic, professional, and social community in Latin America. In the past fifteen years the number of people and institutions working in this field as well as of events organised to discuss bioethical issues has substantially increased. Several journals, books, bulletins and documents are published now, offering an interesting picture of how bioethics is thought and done across the region.[56] Some bioethicists have even argued that bioethics both in the Iberian peninsula and Latin America has developed a distinct identity (Pessini & de Barchifontaine, 2010, p. xvii), but in this sense the idea of 'Latin

[55] France promoted 'Latin America' as the best term since other terms like 'Hispanic America' or 'Ibero-America' would only evoke the Spanish and Portuguese influences (Tealdi, 2008a, p. 1).

[56] For an overview of Latin American bibliographic production, see: León, F. J. (2008) *La bioética latinoamericana en sus textos* [*The Latin American Bioethics Through its Texts*]. Santiago de Chile: Universidad de Chile.

American bioethics is mainly a geographical reference. In regard to this, A. Salles and M. Bertomeu (2002, p. 2) have justifiably asked: "Is there a Latin American bioethics, with peculiar touches?" In order to answer this question it would be necessary to ask if there are particular 'realities' of bioethics in Latin America, how they were formed, and what they mean within the complex net of power and knowledge relations in which biomedical practices are embedded. In order to get some answers, a genealogical approach to the history of bioethics in Latin America is useful, and provides the basis for understanding how bioethics developed in Colombia. This genealogical approach is the consideration of how power dynamics have shaped the field in this region.

Although power has already been used as a pivotal concept by Latin American bioethicists to denounce dominant models of bioethics that gloss over socio-political and economic inequalities in the region, it has nevertheless barely been used to analyse the internal dynamics of the bioethics community itself. In this sense, the use of power as an analytical category not only helps to reveal oppressive and exploitative constellations in the biomedical scenario in the region, but also helps to understand better how bioethics has evolved as a discipline in Latin America. As elsewhere, Latin American bioethicists talk about bioethical issues and stress the importance of their own field. However, when it comes to the conflicts within the field, those 'non-bioethical issues' that have shaped the ethos of bioethics in the region such as power struggles, they tend to turn a blind eye. Hence the central aim of this chapter will be to show this aspect in order to understand how power is behind the development of bioethics in Colombia.

As one of the aims of this thesis is to carry out a philosophical and historical analysis of bioethics in Colombia, I begin this chapter by offering a comprehensive view of the history of bioethics in Latin America to outline the context in which bioethics in Colombia has developed. In so doing, I will start by introducing Iberian and Latin American bioethicists and discuss the historical accounts they have offered about the birth and development of their own field. Such accounts are dispersed in the bioethical literature published in the region in Spanish and Portuguese, and to a lesser extent in international journals and textbooks in English. What interests me about these historical accounts is the role they have played in the construction of the 'origin myths' that Latin American bioethicists, like their American colleagues, have created to legitimize the way their own field has evolved.

## 2. The three-stage history of bioethics in Latin America

Some Latin American bioethicists have divided the history of bioethics in their region into three periods, and this understanding has become almost canonical for the Latin American bioethics community. Two pioneers of Latin American bioethics have shaped this view: José A. Mainetti[57] (2009, p. 501) and Alfonso Llano[58] (2010, p. 45).[59] According to them, the three periods were, first, the "reception" or "transplant", second, the "assimilation" or "development", and third, the "consolidation" or "recreation" of bioethics. Although for A. Llano (2010, p. 46) bioethics remained unknown in Latin America during the 1970s, starting its history in this region in the 1980s, Mainetti has argued that it arrived in the early 1970s via the Institute for Medical Humanities[60] that had been founded in Argentina by his father, José María Mainetti, in 1972. According to J.A. Mainetti, this Institute promoted bioethical studies following the Spanish historian and philosopher of medicine Pedro Laín Entralgo, "the patriarch of Ibero-American medical humanism" (Mainetti, 2009, p. 502).

The "assimilation" of bioethics took place between 1985 and 1995 when the first institutions for bioethics in the region were created and the first specialized publications in the field appeared. By the mid-1980s American bioethicists, mainly from the Kennedy Institute of Ethics, at Georgetown University, were going to Argentina as speakers on the courses and the first Ibero-American programme on bioethics organised by the Latin American School for Bioethics[61] (Figueroa & Fuenzalida, 1996, p. 613; Llano, 2010, p. 47). According to Mainetti, in this period bioethics in Latin America showed its "radical nature [by going] beyond a philosophy of medicine to become a philosophy of culture and technology […]" (Mainetti, 2009, p. 503). But I differ from Mainetti in this point as such a conception of bioethics, it is my contention, is still a *potentiality* rather than a *realisation* of bioethics in this region. As in Latin America bioethics encompasses a disparate set of discourses, practices, institutions, and subjects that are organised around social aspirations, anxieties, and hopes related to biomedicine, it would be better to understand bioethics in Latin America as a *dispositif*, in Foucauldian terms, rather than "a philosophy of culture and technology".

[57] Argentinean physician, bioethicist and philosopher of medicine.
[58] Colombian Jesuit priest, medical ethicist, and bioethicist.
[59] This historical categorization has been amplified by other Latin American bioethicists, for example, the Venezuelan bioethicist L. Schmidt (Schmidt, Mainetti, León, F.J. & Pessini, 2008, p. 5). In Colombia J. Escobar has divided the history of bioethics in this country following a similar periodization (PBUEB & Escobar, J., 2002, p. 11).
[60] Instituto de Humanidades Médicas.
[61] Escuela Latinoamericana de Bioética.

The third period, the 'consolidation' and 'recreation' of bioethics, would stretch from the mid-1990s until today. In this period, Latin American bioethicists became more visible on the international stage, and the concept of a *Latin American bioethics* received its own place in the international bioethics literature. For the first edition of the *Encyclopaedia of Bioethics*, the Venezuelan physician A. León (1978) wrote the article *Latin America in the Twentieth Century*. Although for Mainetti (2009, p. 503) this was an article on bioethics in Latin America, it is not difficult to see that instead of examining bioethics in the region, A. León just summarised a few points about medical ethics in Latin America and hardly mentioned bioethics. Yet, in this period it is possible to identify the first debates about the nature, scope, and methods of bioethics that have divided the Latin American bioethicists. But, before going on with the characterisation of Latin American bioethics, I will examine how powerful institutions sponsored bioethics in the region and then supported the process of its 'implementation'.

### 3. Powerful sponsors: PAHO and UNESCO

In the early 1990s, the *Pan American Health Organisation* (PAHO) began to promote bioethics in Latin America, allegedly to make biomedical research initiatives in the region more 'ethical' (Drane, 2010, p. 32). James Drane[62] was commissioned by this organisation "to take leave from Edinburgh University to become PAHO's first resident bioethicist, and in that capacity to develop some foundational medical ethics projects in Latin America" (Drane & Fuenzalida, 1991, p. 325). In Drane's view, Latin America required bioethics as an answer to the ethical violations of pharmaceutical companies in the region and the creation of Institutional Review Boards had to be promoted (Drane, 2010, pp. 32, 41). Eventually Drane travelled across Latin America, visiting five countries[63] and speaking with influential people – professionals, academics, and government officials. On his trip Drane argued that American bioethicists could contribute to the expansion of bioethics in Latin America, particularly as there were medical professionals eager to adopt the new discipline in this region. However, he acknowledged that cultural and socio-political differences between Latin America and the

[62] American Catholic ex-priest and bioethicist. In the 1970s he distanced himself from the Roman Catholic Church official stance on issues like contraception. His influence was crucial in the development of bioethics in Latin America (Lolas, 2005b, p. 164).
[63] Colombia, Argentina, Chile, Bolivia, and Brazil.

USA should be taken into account in the process of adopting American bioethics (Drane & Fuenzalida, 1991, pp. 325, 336f).

In 1990 the *Bulletin* of PAHO published a special issue on bioethics (PAHO, 1990). For A. Llano this issue "formally introduced Latin America to bioethics" (Llano, 2010, p. 49). It opens by quoting the *Encyclopaedia of Bioethics*' definition of bioethics and goes on to describe bioethics as an inclusive field in four respects: first, by embracing value-related problems in healthcare professions; second, by including biomedical and behavioural research issues; third, by giving room to a broad range of social issues; and fourth, by taking into account not only human life, but animal and plant life as well (Connor & Fuenzalida Puelma, 1990, p. vi). In 1994 PAHO, in agreement with the government of Chile and the University of Chile created the *Regional Program on Bioethics for Latin America and the Caribbean*[64] (RPB), which initially operated from Santiago. According to F. Lolas, former RPB director, PAHO wanted to have a "technical office" to carry out an "ethical supervision" and also work on legal issues related to biomedical research projects in the region (Lolas, 2005b, p. 163). In retrospect, Lolas described RPB's purpose as "to serve the needs of the countries and territories of the Americas and the Caribbean by providing the necessary assistance to stimulate reform in their health care systems, to improve their scientific infrastructure, and to provide essential medical and sanitary services for their population" (Lolas, 2010b, p. 55f). RPB became an important catalyst for bioethics in Latin America, offering courses and channelling international initiatives as well as important debates in the region. The programme indeed fulfilled J. Drane's dream of making more bioethical literature available in Spanish to disseminate bioethics across the region. Since 2000 RPB supported *Acta Bioethica*,[65] perhaps the most important bioethics journal in Latin America (Lolas, 2010a, p. 116), which is now published solely by the *Interdisciplinary Centre for Bioethical Studies*[66] (ICBS) at the University of Chile.

In 1996 RPB, in alliance with the University of Chile, offered the first MA in bioethics in Latin America.[67] As its first director was the renowned Spanish historian of medicine and bioethicist Diego Gracia (Lolas, 2010b, p. 56), whose views on bioethics have strongly

[64] Programa Regional de Bioética para América Latina y el Caribe.
[65] All the issues of this journal are available at: http://www.scielo.cl/scielo.php?script=sci_serial&pid=1726-569X&lng=es&nrm=iso, accessed 5 Oct 11.
[66] Centro Interdisciplinario de Estudios Bioéticos.
[67] Also in 2002 a training program on human research ethics was launched thanks to a grant of the National Institutes of Health in the USA, through the International Fogarty Center (Lolas, 2005a, p. 8).

influenced many Latin American bioethicists. Consistent with its vocation of spreading bioethics across the region, this postgraduate programme moved to other countries, for example the Dominican Republic, Peru, and Argentina. Since its creation, RPB promoted national commissions on bioethics and ethics committees in the region. In recent years, as RPB moved to PAHO's office in Washington,[68] part of its staff have continued working at ICBS, which was designated as a *collaborating centre* of WHO/PAHO for bioethics.[69] In short, "[t]he Pan American Health Organisation demonstrated by its pioneering effort to develop bioethics that it had identified a real need and responded to it in an appropriate form" (Lolas, 2006, p. 118).

UNESCO has also been deeply involved with the development of bioethics in Latin America, particularly after the creation of RedBioetica in 2003, a net of institutions and individuals working on bioethics in the region. RedBioetica has particularly been committed to *social bioethics*, a perspective that many Latin American bioethicists have promoted and according to which *politics* are considered of fundamental importance for bioethics in Latin America. Instead of privileging ethical implications linked to the latest biotechnological device, Latin American bioethics should promote discussions about justice in healthcare, poverty and the social determinants of health. Alya Saada has argued that Latin America initiated the so-called *social bioethics*, which for him meant a move from a bioethics centred on the individual to a holistic perspective, with a focus on social justice, equality and human rights (Saada, 2008, p. xxi).

The aim of RedBioetica is "to provide the countries and peoples of Latin America and the Caribbean with an additional new instrument for improving democracy, citizenship and human rights in the region, from constructing an expanded and more politicised concept of Bioethics and promoting wholesome transdisciplinary interchange (regional and worldwide) on this theme" (Garrafa, N.D., p. 24). RedBioetica has been very active in the region since its beginnings in 2000, promoting the creation of ethical committees and national commissions of bioethics, organising conferences, supporting academic initiatives on bioethics, and making bioethical relevant bibliography available through their webpage.[70] Regarding the role that bioethics should play in the region, it is worth mentioning that in 2004 RedBioetica rejected a draft of UNESCO's Declaration on Bioethics in which only biomedical issues

[68] About bioethics in PAHO, see PAHO's webpage at: http://www.paho.org/english/bio/about.htm, accessed 22 April 2011.
[69] See: http://www.bioetica.uchile.cl/acerca/centroc.htm, accessed 22 July 2011.
[70] See: http://www.unesco.org.uy/shs/es/areas-de-trabajo/ciencias-sociales/eventos.html, accessed 4 may 2012.

concerned with individual rights were addressed. Instead, RedBioetica called for a broader understanding of bioethics and the inclusion of health, social and environmental questions in a new agenda.

It is clear then that powerful institutions such as PAHO and UNESCO were profoundly related to the institutionalisation of bioethics in Latin America. These organisations contributed resources and political support for bioethics to develop in the region. This institutional development went hand in hand with the rise of particular discourses that characterise Latin American bioethics.

## 4. The discourses of bioethics in Latin America

### 4.1. 'Origin myths', pioneers, and genealogies

Latin American bioethical literature has reproduced, by and large, the same 'myths of origin' that R. Fox et al. (2008) described in their book on American bioethics. The most widely accepted myth among Latin American bioethicists is that bioethics is the natural and necessary answer to the ethical dilemmas posed by biomedical progress. However, a set of disparate issues, facts, circumstances and events are usually invoked to explain why bioethics emerged in Latin America. For A. Llano some of them are "negative"[71] while others are "positive"[72] (Llano, 2002, pp. 11-12). Similarly, Ludwig Schmidt[73] mentioned "20 hits" or particular events in the history of the second half of the twentieth century that would justify the birth of bioethics, including issues such as the allocation of haemodialysis in Seattle in 1962, the liberalization of abortion, genetic engineering, and Vatican documents such as *Donum Vitae* in 1987, to name but a few (Schmidt & Cecchetto, 2008, p. 19).

Another way to talk about the origin of bioethics in Latin America is by referring to V. R. Potter as the founder of the field. Unlike the American bioethicists who usually quote Potter's work just when discussing the origin of the term,[74] Latin American bioethicists have made him almost a figure of veneration. Potter is presented as a man who excelled in science,

[71] He mentions, among others, the technification of death/dying, the existence of guerrillas, and precocious puberty, to name but a few.
[72] Here he includes the rise of a global awareness of the importance of human dignity, the encyclical Humane Vitae on reproductive matters, and the Belmont Report, to name but a few.
[73] Venezuelan bioethicist.
[74] See, for example, Reich, W. T. (1994). The Word 'Bioethics': Its Birth and the Legacies of Those Who Shaped It. *Kennedy Institute of Ethics Journal*, *4*(4), 319-335 and Reich, W. T. (1995). The Word 'Bioethics': The Struggle over its Earliest Meanings. *Kennedy Institute of Ethics Journal*, *5*(1), 19-34.

successfully engaged with the humanities and lived an exemplary life.[75] For many Latin American bioethicists the Potterian bioethics is the true bioethics, because they advocate life 'in general' and not only in the biomedical scenario. Potter's ideas about *bridge bioethics* (bioethics as a 'bridge' between sciences and humanities, and between the present and the future), *global bioethics* (bioethics as concerned with life in general), and *deep bioethics* (bioethics in relation to different fields of knowledge) have strongly influenced the way bioethics have been understood in Latin America. From the Latin American perspective Potter's great achievement was not only to have coined the term 'bioethics',[76] but also to have created a system of harmony between science and ethics (Llano, 1998, p. ix). However, as many Latin American bioethicists have lamented, the kind of bioethics that prevailed in the USA was not the 'Potterian' one, which was committed with the defense and promotion of life, but that of the Kennedy Institute of Ethics, which was focused on the morality of the individual's decisions in the context of biomedicine.

Much of the historical literature available about bioethics in Latin America corresponds to first-person narratives. For instance, the section on "the discourses of bioethics in Latin America" written by J. A. Mainetti (2009) in *The Cambridge World History of Medical Ethics* is more about his 'personal' contribution to Latin American bioethics than a proper examination of such discourses. Mainetti's article is, arguably, incomplete, biased, and lacking a critical approach to what the discourses of bioethics have been in Latin America. Moreover, F. Lolas has claimed that although Mainetti's influence was very important in the development of bioethics in Latin America, it was not the only one (Lolas, 2005b, p. 163). Although for the renowned American bioethicist T.H. Engelhardt (2010) these personal accounts are important because "the voices of the founders will soon be silent [as] dead men write no autobiographies" (p. 6). This, however, raises the question as to why the idea of 'pioneering' has become such an important issue for bioethicists in Latin America? One of the difficulties with the current historical accounts of bioethics in Latin America is that they are full of self-praising and cult-of-personality narratives, as Latin American bioethicists seem to have developed special taste honouring 'pioneers'. With regard to this, F. Lolas has argued that "within each country some people have taken upon themselves the status of

[75] A. Llano claims that "[Potter] stands out as a whole symbol of bioethics for his personality, his marriage (64 years with the same wife Vivian Christensen, and three children) […] and his message. [He] initiates the dialogue between Life and Ethics" (My translation. Translations into English are, if not stated otherwise, by me) (Llano, 2002, p. 14).

[76] The first publications in which the word 'bioethics' allegedly appeared are: Potter, V.R. (1970) Bioethics: The Science of Survival. *Perspectives in Biology and Medicine*, v. 14, autumn, 127-153 and Potter, V.R. (1971) *Bioethics: Bridge to the Future*. Englewood Cliffs Hemel Hempstead: Prentice-Hall, 1971.

pioneers of irrefutable word, whereas others have worked in an honest and diligent manner and, even more so, some others have gone forth to search for connections and ties with more mature traditions" (Lolas, 2004, p. 18). This is perhaps because being a pioneer means to occupy a privileged position in the bioethical field. Even some bioethicists want to be recognised as such. For instance, J.A. Mainetti has claimed more than once that Argentina and he himself "pioneered the reception of bioethics in Latin America" (Mainetti, 1996, p. 676; 2009, p. 502).[77] But depending on how the word is defined, many other people might also be considered 'pioneers'.

By and large a characteristic of bioethicists is their special desire for talking about their 'origins'. In the case of Latin America, in the last few years bioethicists have been curiously searching for the earliest antecedent of bioethics. F. Lolas, for instance, suggested that psychoanalysis and bioethics had their German origins in common. According to him, "a few years ago it was discovered that the word 'bioethics' was not a creation of Van Renssealer Potter […] but an invention of the German Protestant theologian Fritz Jahr" in an article published in 1927 (Lolas, 2008b, p. 3). Lolas goes on to say that Jahr suggested, echoing Kant, a "bioethics imperative", according to which every living being ought to be considered an end in itself and not only as a means to an end. This approach anticipated, according to Lolas, Potter's idea of bioethics and the ethics of animal experimentation. Ironically, bioethics would return to Europe as an American invention in the 1970s (Lolas, 2008b, p. 3).[78] However, Lolas himself acknowledges the futility of such discussions about the origins of bioethics. Instead, he argues, Latin American bioethicists should better spend their time debating more fundamental questions such as the role that bioethics has to play in a region historically plagued by a wide range of problems (Lolas, 2009, p. 7).

The claim that Jahr is the 'true father' of bioethics has received much attention from Latin American bioethicists.[79] Far from challenging the official history of bioethics, this has instead

[77] Baker and McCullough have argued that with the publication of 'La crisis de la razón médica. Introducción a la filosofía de la medicina' in 1988, Jose A. Mainetti "introduces the bioethical paradigm to Latin America" (Baker & McCullough, 2009, p. 91) However, I would challenge this view, since other people had already initiated activities and published articles on bioethics in Latin America before, for instance, F. Lolas, quoted by Baker and McCullough themselves, published also in 1988 "a guide to bioethics for Latin American readers" (2009, p. 90), which at least has the name 'bioethics' in its title. Furthermore, in Colombia, from the early 1980s, articles on bioethics were published and groups working in the new field were created (see chapter four).

[78] See also: Lolas, F. (2008b) El 'imperativo bioético' de Fritz Jahr y la neobioética estadounidense [Fritz Jahr's 'Bioethics Imperative' and the American Neo-Bioethics]. *JANO* (Barcelona); 1710, pp. 10-16.

[79] See, for instance, Garzón, F. (2009) Fritz Jahr, ¿el padre de la bioetica? [Fritz Jahr, the Father of Bioethics?]. *Revista Latinoamericana de Bioética*, 9(2), 6-7.

reinforced the idea, held by the Latin American bioethical establishment, that the genuine bioethics is the Potterian variety, representing a new ethical approach to life in which science, humanities and social sciences go hand in hand, in contrast to the American 'deformation' of bioethics, which remains within the scope of biomedicine and is identified with the 'Georgetown mantra'. For some Latin American bioethicists F. Jahr is the new 'patron saint' of bioethics. L. Schmidt, for instance, referring to Jahr and Potter, argues that these "people, from theology and health sciences, sought to strengthen an ethics of life in contemporary societies in which conflicts with reason, truth, and right conscience take place. [Thus, Latin American] bioethics promotes life based on an anthropological-ethical paradigm" (Schmidt, 2008, p. 5). Others have gone even further by suggesting that F. Jahr, notwithstanding the fact that he was a Protestant theologian, presented "Saint Francis of Assisi, the Catholic saint of ecologists and pacifists, as the true discoverer of Bioethics" (Roa & Bauer, 2009, p. 158). On this account, it would not be a surprise if one day a committed bioethicist claimed that the Pre-Socratic philosophers were the real fathers of bioethics because of their love and interest in natural philosophy.

### 4.2. Bioethics, the medical establishment and religion

Debora Diniz,[80] has offered an interesting view on the history that might help to illuminate the discourses of bioethics in Latin America. Speaking from a feminist perspective, she argues that, at least in Brazil, "the initial impulse came from two masculine fields: medical politics and Catholic theology" (Diniz & Guilhem, 2010, p. 298). On the one hand, theologians contributed with three aspects to Latin American bioethics: first, a return to the humanities in healthcare; second, a thematic agenda that emphasised issues like peace or justice compatible with Catholic doctrine, but disregarded others like reproductive issues; and third, an alternative point of view that destroyed the "hegemony of the representatives of the medical class institutions as a legitimizing discourse in bioethics." On the other hand, the fact that bioethics was strongly identified with the biomedical scenario helped to catalyse its legitimization. This deep and strong relationship between bioethics and biomedicine also gave Latin American bioethics three characteristics it still displays today: first, a strong emphasis on *ethical reasoning*, "which explains the fascination with checklists theories, as was the case of principlism"; second, bioethics as a 'subject of interest' for medical education and practice; and third, a bioethics agenda driven by a medical perspective. In the end,

[80] Brazilian anthropologist and bioethicist

bioethics quickly became in Latin America an "elite intellectual enterprise"[81] (Diniz & Guilhem, 2010, p. 299).

The role of the Roman Catholic Church has been of particular importance for the development of bioethics in Latin America, a continent that has not experienced the religious pluralism of countries like the USA (Pessini, 2008, p. 9). C. Campbell (1990, p. 388) has argued that to better understand bioethics in Latin America it is necessary to take into account the religious roots of bioethical debates as well as the secularisation in the West. Indeed, religious beliefs do influence bioethical discussions, but in modern societies this influence has a secular facade. For Campbell, secularisation leads to the "[…] removal of central institutions (medicine) or values (health) from the influence of religious thought and practice." But religion's effects endure even within a secular environment: "values and beliefs once explicitly affirmed as religious may command widespread acceptance, even if their religious grounds do not". This has happened, for instance, with the concept of *sanctity of life* in bioethics or, particularly in the case of Latin America, when the Theology of Liberation claims that "justice is informed by a 'preferential option' for the poor" (Campbell, 1990, pp. 387-389).[82] Campbell's most insightful idea is perhaps that bioethics narratives could be better understood if we took a look at their religious links, for example, in some frequently used metaphors such as 'playing God'[83], the 'good Samaritan'. A. Llano, for example, criticises contemporary physicians because they are wrongly 'playing God', concluding that God must continue being God while man should accept to be "a tool in the hands of God" (Llano, 1990, p. 451).

In Latin America the content and the structure of many bioethical debates have to do with conflicts between the Roman Catholic Church's official doctrine on the one hand, and legal decisions, state policies, medical decisions and/or social movements on the other hand. In the last few years, there have been heated debates, for instance, about euthanasia, abortion, conscientious objection and so forth.[84] F. Luna and R. Macklin have stressed that links

[81] As I will illustrate with the case of Colombia in the next chapter, medical ethics discourses have always been dominated by the medical elite.
[82] According to M. dos Anjos, (2008b, p. 12) the *Liberation Theology*, with its methodology of *seeing-assessing-acting*, became emblematic of the Latin American thought and was 'exported' to other parts of the world.
[83] However, this metaphor carries positive as well as negative meanings.
[84] In chapter seven I will outline the debate on the decriminalisation of both euthanasia and abortion in Colombia.

between religion and state are still strong in Latin America. As religion still plays an important role in society, "there is an identification of ethics with the view of morality propounded by the Catholic Church and virtually no awareness that there exists a secular approach to ethics" (Luna & Macklin, 1996, p. 146) They note that at the *World Conference on Population and Development*, Cairo 1994, and at the *World Conference on Women*, Beijing 1995, Carlos Menem's government in Argentina, for example, backed the Vatican's position. Also, in Argentina, in October 1995, a bill to guarantee free distribution of contraceptives was blocked in the Congress by an alliance between the government and the Catholic Church. This Argentinian case might rightly be extrapolated to other countries in the region.

M. F. dos Anjos,[85] has argued that "the polarization between a lay bioethics and a religious bioethics deserves particular attention" especially in Latin America, particularly because in this context "the autonomy of reason" is used against "religious authoritarianism" (dos Anjos, 2010, pp. 293, 294). Elsewhere dos Anjos has also argued that Liberation Theology has made important contributions to Latin American bioethics in two particular ways: first, by seeking to reveal social injustice and states of domination, and second, by balancing the strong individualism of American bioethics with an emphasis on macro-environmental as well as social issues (dos Anjos, 2008b, p. 14). E. Rodriguez[86] has argued that if religion is neglected in bioethics, three undesirable effects might occur: first, morality would be reduced to law; second, the accumulated wisdom of religions would be wasted; and third, the discourse of pluralism paradoxically would become oppressive (Rodríguez, E., 2010, p. 7). In this sense, V. Bellver has argued that contemporary bioethics discourse is hegemonic because it ignores the social roots of the ethical issues in the biomedical scenario and tends to exclude religious perspectives. For him, this situation is related to the fact that bioethics was born in an Anglo-American environment in which individual autonomy supersedes questions related to social justice (Bellver, 2007, p. 24). A critical stance against the American principlism is part of the discourses of the Latin American bioethics.

[85] Brazilian theologian and bioethicist.
[86] A Roman Catholic priest, former researcher at RPB and currently working at the ICBS in Chile.

### 4.3. Overcoming principlism, a Latin American dream

As has been the case almost everywhere outside the USA, in Latin America principlism has been so pervasive that it has shaped the field since T. Beauchamp and J. Childress introduced this theoretical framework in the 1970s. Nevertheless, Latin American bioethicists have tried to 'resist' this dominant model. Critics have pointed out three issues with principlism: its problematic philosophical foundations, its 'alien' nature to Latin America (culturally, philosophically and politically), and its narrowness. J. J. Ferrer,[87] following K. W. Wildes,[88] has summarised the three main philosophical criticisms against American principlism: first, it lacks a convincing justification as to why these four principles and not others should be adopted; second, there is no satisfactory explanation of the principles' relationship between each other; and third, their definition and meaning is not sufficiently explained (Ferrer, J., 1998, p. 10). According to A. Llano, "medical, principlist, and utilitarian" American bioethics was not easily accepted by a medical community more familiar with a Catholic and paternalistic style. For him, principlist bioethics was 'transplanted' "without questioning whether […] this new 'medicine' was apt to cure the diverse problems of evils of these various populations" (Llano, 2010, pp. 45,47).

K. Finkler, analysing the case of Mexico, has argued that the four principles "reflect an American cultural emphasis on individualism, as well as on Christian, specifically Calvinist, theology" (Finkler, 2003, p. 38). For her, instead of a "universal bioethics"[89] that has proved to be problematic, a "contextualized ethics" should be promoted. Moreover, the understanding and practice of personal autonomy in the USA is not necessarily the same as in other cultures. In Latin American medical culture, *trust* and *solidarity* are as important as autonomy is for the Anglo-American medical culture. Yet, Finkler observed that in Mexico, after the arrival of bioethics, "trust is being supplanted by routinised procedure of informed consent" (Finkler, 2003, p. 45). In contrast, other Latin American authors like D. Lavertu and A. Linares have supported the 'universality' of bioethical principles, although emphasising that important differences need to be considered for them to be applied in non-American cultural contexts. For these authors "[…] what constitutes a basic unmet need in our countries is often a concrete achievement in developed countries" (Serrano & Linares, 1990, p. 473).

[87] Puerto Rican Jesuit and bioethicist.
[88] See: Wildes K. W. (1992) Principles, Rules, Duties, and Babel: Bioethics in the Face of Postmodernity. *Journal of Medicine and Philosophy*, (77) 483.
[89] Which usually means 'American bioethics'.

To distance themselves from the American principlism, many Latin American bioethicists have adopted the model of D. Gracia (León, F. J., 2009, p. 74; Rodríguez, E., 2009, p. 90). For Gracia bioethics is, first, the "ethics of the twenty-first century", concerned with the protection of life and the rights of future generations. Second, its method is the same as that of ethics: deliberation (Gracia, 2002, p. 38). Third, he hierarchically orders the four principles: a private level which includes the principles of respect for autonomy and beneficence, and a public level with the principles of justice and non-maleficence (Gracia, 1995, p. 192).Ontologically speaking, the public level would precede the private one (Gracia, 1999).[90] Fourth, in the biomedical scenario he says that patients are guided by autonomy, physicians by beneficence, and society by justice (Gracia, 1990, p. 359). J. J. Ferrer, for instance, has argued that Gracia´s classification of the four principles overcomes the Beauchamp and Childress model (Ferrer & Alvarez, 2004, p. 68). But this model has also been criticised.[91] In Latin America, Guillermo Hoyos[92] has disagreed with D. Gracia`s assertion that the ethics of our time "will be bioethics or nothing". Hoyos argues that two extremes should be avoided. Ethics – as a philosophical discipline on its own – should never be reduced to bioethics and bioethics should not be taken as a fashionable ideological inspiration. Instead, it would be better to assimilate bioethics to *civil ethics*, promoting a public debate about techno-scientific progress and the realisation of democracy (Hoyos, G., 1998, p. 89).[93] The Spanish philosopher Adela Cortina has also considered that bioethics can be seen as an *applied ethics* instead of a contemporary substitute for ethics. Moreover, bioethics would be important for the construction of a democratic society following the postulates of a civil ethics[94] (Cortina, 2000). Similarly, when J. J. Ferrer criticised Baker and McCullough's stance on bioethics supports the idea that bioethics is an applied ethics and

[90] Non-maleficence and justice "oblige with independence from the opinion and the will of those people implicated and, therefore, have a superior rank than the other two" (Ferrer & Alvarez, 2004, p. 64).

[91] For a summary of these criticisms, see: Ramos, Sergio. (2008). El Principialismo de Diego Gracia: crítica y alternativas [The Principlism of Diego Gracia: Critic and Alternatives]. *Bioètica & Debat*. Accessed from http://www.bioetica-debat.org/modules/news/article.php?storyid=232, accessed 1 Oct 11

[92] Director, Instituto de Bioética, Pontificia Universidad Javeriana, Bogotá.

[93] This position is informed by Habermas' comunicative ethics. Following Habermas' position in *The Future of Human Nature. Towards a Liberal Eugencis*, published in 2001, G. Hoyos argued that freedom and morality are not founded on scientific knowledge. Instead, their definition and scope belong to philosophy and the public sphere, inhabited by citizens (Hoyos, G., 2003, p. 23).

[94] Thus, an "'*ethics of minima*' for civic ethics and an '*ethics of maxima*' for ethics which make proposals for a happy life [and] there is indeed a sort of 'intersection' between the different conceptions of a good life, of a happy life, which cohabit in a pluralist society. [I]t is fitting to use the term '*ethics of maxima*' for these proposals which attempt to show how to be happy and what the meanings of life and death are, while the '*ethics of minima*' would not make statements on questions of happiness and the meaning of life and death, but on questions of justice, morally demandable of all citizens" (Cortina, 2003, p. 105).

also supports D. Gracia's view that bioethics is indeed something 'new' and not a mere 'application' of ethical systems (Ferrer, J., 2009, p. 37).

Human dignity can be also seen as a concept or category that has been utilised to counterbalance the influence of the four principles. It has been proposed as the quintessential guiding principle of bioethics in Latin America, particularly by those who hold a religious position, although this is not say that secular bioethicists ignore it. In Latin American bioethics the concept of human dignity is deeply linked to the sacredness of life, in a religious sense. Some authors have used human dignity as the central category to ground certain perspectives in bioethics, for instance, a *philosophical anthropology* (Schmidt, et. al, 2008, p. 8) or *personalism* (León, F. J., 2009, p. 74; Martínez, 2007, p. 127)[95], which are concepts that reveal nostalgia for a metaphysical approach to human nature. However, there is no more vague concept in bioethics than human dignity. Very often human dignity is invoked either as an argument, or a principle, or a criterion to legitimate a particular stance in bioethics, but the concept itself usually remains unclear (Cuéllar, J., 2006). Given this difficulty, some bioethicists like R. Macklin (2003) think that "dignity is a useless concept" (2003). Still some Latin American authors like Pyrrho, et al. (2009, p. 68) have argued nonetheless that human dignity cannot be replaced by the "aseptic concept of autonomy". Rather, they suggest, Latin American bioethicists should infuse the general, open concept of human dignity with appropriate content and meaning, taking into account the particular historical, cultural and political contexts of the region. In this respect, far from being a "useless concept" as R. Macklin argues, human dignity –like other bioethical categories– has a political function that has neither been properly acknowledged nor sufficiently analysed. As I have argued regarding the abortion debate, for instance, how a concept is used in bioethics "depends less on the rightness or wrongness of a theory than on the purposes, intentions or beliefs of the people involved in the discussion" (Díaz Amado, 2009a, p. 118).

Much of the debate about the appropriateness of the American principlist model for Latin America has happened in relation to questions about the 'epistemological status of bioethics' (Garrafa, Kottow & Saada, 2005; Schmidt & Garzón, 2006, p. 66). There are three elements that have characterised this debate in Latin America. First, Latin American bioethics is 'a field in construction', making it difficult to properly delineate its contours. However, this

[95] In *The Universal Declaration on the Human Genome and on Bioethics*, in 2005, human dignity was taken as a foundational principle. See: http://unesdoc.unesco.org/images/0014/001461/146180e.pdf, accessed 20 October 2011.

kind of 'incompleteness' of the field has become a licence for Latin American bioethicists to include in the scope of bioethics any issue or problem using the strategy of seeking the 'the bioethical aspect of'. Second, bioethics is proclaimed as a non-religious discipline, although in Latin America it is easy to see how bioethics is full of hidden religious agendas. Third, bioethics is presented as an *interdisciplinary* and *transdisciplinary* field in which decisions are made by *consensus*.[96] For Schmidt and Garzón (2006) the epistemological status of bioethics derives from Ethics and it is characterised as "human, techno-scientific, rational, reasonable, dialogal and consensual, pluralist, interdisciplinary / transdisciplinary / plulidisciplinary, and in continued improvement" (p. 69). Regarding the debate on empirical studies in bioethics, Kottow has argued that although empirical data can be useful for revealing gaps between theory and practice as well as for acknowledging failures in the application of bioethical norms, such data should not be taken as the central criterion to decide on modifications of 'the theory'. He argues that it is necessary to be careful about how some bioethicists make use of empirical bioethics' conclusions since they can be a way to facilitate the imposition of alien ethical theories on Latin America (Kottow, 2009, pp. 65, 68).

### 4.4. Towards a 'political bioethics' for Latin America

In 1994 C. Olweny, a Canadian author, suggested a bioethics agenda for the developing world. For him, in the industrialised world bioethicists usually discuss issues like gene therapy, organ transplantation, surrogate motherhood and euthanasia. These issues, however, should be put in a second line in the developing world since "the ethics of scarcity, sacrifice, cross-cultural research, as well as the activities of multinational companies, are germane." (Olweny, 1994, p. 164). The Chilean bioethicist M. Kottow suggested it would be bizarre for a bioethicist not from a developing country to define the bioethics agenda for Latin America. For Kottow, such an agenda should include a reassessment of the role of autonomy and techno-science in economically fragile environments as well as a review of the role that academia and legislative bodies are playing in channelling public opinion regarding bioethical issues (Kottow, 1995, p. 56). The bioethical discourse is often focused on biotechnological advances and futuristic scenarios while the reality proves that basic

[96] Some bioethicists, e.g. P. Hooft (2000), have talked about a "rational and interdisciplinary debate". For J. A. Mainetti, "[t]he most revolutionary achievement of the current medical ethics is the 'introduction of the moral subject in medicine' and the promotion of a rational and free agent in the doctor patient relationship" (Mainetti, 1990, p. 56).

questions including poverty, inequalities and corruption remain unsolved. The contradiction between the appalling social reality in Latin America and what is said by the dominant discourse of bioethics has led some bioethicists like V. Garrafa to initiate a movement against "imported ethical packages" in bioethics (Garrafa, 2000, p. 169).

The *Latin American Dictionary of Bioethics* (Tealdi, 2008b) opens by outlining the characteristics of the *Latin American Critical School of Thought* according to which problems like dependency, poverty, exploitation and subjection to 'imperialist' influences should constitute the front line of a genuine Latin American intellectual endeavour (Salas, 2008, p. 3). As bioethical problems are inseparable from the culture and geographical place (Neira, 2008, p. 156), it seems that for some Latin American bioethicists the socio-economic and political conditions of subjection and exploitation that have characterised Latin American history should constitute the departing-point for bioethics. They talked of a 'libertarian' bioethics, although I would prefer the term 'emancipatory'. This bioethical approach is linked to so-called *Latin American Philosophy* whose existence is nevertheless a matter of debate and which, according to C. Lértora (2008, p. 5), might mean either a philosophy originating in the region or a philosophy taking Latin America as its object of analysis.

Some Latin American bioethicists have seen in the ethical double standard used in biomedical research[97] an expression of the imperialism that allegedly characterises the dominant bioethical discourse. V. Garrafa, for instance, has argued that powerful actors, such as pharmaceutical companies and other interested parties, have callously tried to "accommodate" the content of the Declaration of Helsinki to American interests (Garrafa, 2008b, p. 535). Along similar lines, M. Kottow claimed that "international bioethicists" have appealed to different strategies to circumvent international norms. He cites the renowned American bioethicist Robert Levine as an example when arguing that Helsinki was just a declaration, that is, that it is mere rhetoric. According to Kottow, (2004) "international bioethics" is more interested in protecting the interests of researchers, institutions and sponsors from the First World than in helping to meet the necessities of the Third World.

By and large, bioethicists in Latin America have promoted a broader understanding of bioethics. In contrast to Anglo-American bioethics, which seems to have clearer boundaries,

[97] About the discussion about the double standard in biomedical research, see: Levine, R. (1998) The 'Best Proven Therapeutic Method' Standard in Clinical Trials in Technologically Developing Countries. *Journal of Clinical Ethics*, *9*(2), 167 – 172.

and usually focus on the ethical issues raised by the techno-scientific advance in biomedicine, Latin American bioethics seeks to save life from the dangers of techno-scientific progress, and from the moral degradation of modern life at different levels, including politics, environment, family relations, economics, etc. Many Latin American bioethicists, no matter what their political orientation, emphasise the social and the principle of justice. For example, F. Leon,[98] argues that is necessary to widen "the field of bioethics in Latin America from clinical ethics to a social bioethics, in order to deal with ethical dilemmas in institutions, public health, healthcare policies and reforms, and legislation" (León, F. J., 2009, p. 70). Similarly, for E. Rodríguez, social inequalities threaten human dignity in Latin America. For this reason, bioethics in this region should be focused on the social, and bioethicists should be familiar with research in the social sciences (Rodríguez, E., 2009, p. 90f). Other Latin American bioethicists, such as M. Ferrer (2003), have tried to offer a solid philosophical ground to make of justice a central principle as "bioethics should be focused on populations' health rather than individuals" (p. 115).

For V. Garrafa and D. Porto, (2003, p. 400) Latin America is part of a group of peripheral countries where certain problems such as social exclusion, concentration of power, poverty, misery, and delinquency are a daily reality. These are, in their view, *persistent problems* as they are endemic in such countries. But there are also *emerging problems* arising out of biotechnological advances, which seem to receive much attention in developed countries. This situation has led to two distinguishable kinds of bioethics. Thus, a *bioethics of emerging situations* was created to deal with "issues arising from the hasty scientific and technological development of the last fifty years, among which are the new reproductive techniques – including reproductive and therapeutic cloning – the Human Genome Project, and the advances in the field of genetic engineering, human organ and tissue transplantation, [while a *bioethics of persistent situations* is] related to those conditions that have persisted among human societies since ancient times, such as gender discrimination, social exclusion, racism, inequity in the allocation and distribution of sanitary resources, child and elderly abandonment, abortion, and euthanasia, among others" (Garrafa & Porto, 2003, p. 401).

According to Garrafa and Porto, the *bioethics of emerging situations* has been pervasive in the developing world and led people in these regions to discuss alien or for them inexistent

[98] Chilean bioethicist close to the Roman Catholic Church's bioethical positions.

situations. Sometimes, Garrafa and Porto argue, bioethical issues that are relevant for the developed world look just ridiculous compared to the persistent problems in the developing world. For example, "Peter Singer's fair preoccupations with animal defence sound anachronistic, out of place" compared to the terrible problems of poverty and injustice in developing countries (Garrafa & Porto, 2003, p. 403).[99] They insist that the dominant bioethical discourse fails to properly address practical and factual situations by diverting attention to fashionable issues like the environment or the discourse on tolerance. They say that "[…] for not having yet found the minimum patterns to establish a universal ethics that we need, we try to soften the conflicts through palliatives like the idea of tolerance in relations and inter-relations. Even though tolerance may be the obvious minimum for the production of a dialogue in the conflicts of differences, it is incapable of suppressing inequalities" (Garrafa & Porto, 2003, p. 409). For Garrafa and Porto, bioethics has privileged a market approach, particularly in regions like Latin America, which means that the current capitalist logic has transformed societies just in big markets and is driving science and technology. In this way, they argue, "the idea of equality, seeded randomly in a soil parched by injustice, has become another tool used to maximise profits and to justify domination" (Garrafa & Porto, 2003, p. 408).

In this approach, the socio-political and economic struggles of the developing world should be the first concern for bioethics. Furthermore, it raises a radical criticism of the dominant model in bioethics since "[…] even being numerically the minority, dominant societies tried to annul, ideologically and morally, the legitimacy of the others, trying to impose themselves as the only pattern. In practice, the different moralities were subjugated in the process of economic expansion and domination" (Garrafa & Porto, 2003, p. 406).[100] Thus, apart from discussing the typical ethical dilemmas arising from the biotechnological advance, bioethicists should be critical about the dominant models that characterise global bioethics today. Moreover, for Garrafa and Porto (2003, p. 410) the developing world should be more determined to condemn the permanent aggression of developed and rich countries towards nature. As long as this situation remains, a sense of 'injustice' can be even reinforced by the

[99] Salles and Bertomeu (2002), insisting on a similar point, have said that the existence of *bioethical problems* "should not be allowed to obscure most Latin American concerns with democracy, the rule of law, and the autonomy of citizens that requires the effective realization of the rights and liberties sanctioned by the constitutions of their own countries" (p. 1).

[100] B. Azerrad and D. Viegas (1998) have argued, based on the critical philosophy of the Frankfurt School, that bioethics might have what I would call "an emancipatory role" in Latin America. It is interesting to see how the conditions of subjugation have become naturalised in Latin America in a context of a process of exploitation.

dominant model of bioethics in which "[…] we consume pain as merchandise, seated in our armchairs" (Garrafa & Porto, 2003, p. 413).

### 4.5 Organisations, populism and identities

In 1991 the *Latin American Federation for Bioethics*[101] (FELAIBE) was created in Caracas following an agreement between Pablo Pulido, a Venezuelan physician for the *Pan American Federation of Medical Schools* [102], José A. Mainetti for the *Centre for Bioethics* of the *José María Mainetti Foundation*[103] and Alfonso Llano for the *Centre for Medical Ethics*[104] of the *Colombian Association of Faculties of Medicine* [105] (ASCOFAME).[106] FELAIBE embodies the ethos of the Latin American bioethics establishment: its role has been reduced to organising regional congresses,[107] and power struggles over what group or ideology should be adopted in this federation are frequent. Moreover, a lack of clear policies to control the quality of academic work submitted to its congresses have contributed to turning FELAIBE into a bureaucratic apparatus that helps little to improve the quality of Latin American bioethics. In its beginnings FELAIBE was important for the socialisation of bioethics in the region. For example, more than 1500 people attended its second congress that took place in Bogota in 1998, which, according to its organiser A. Llano, helped to spread bioethics in the region, underlined the role of human dignity in ethical debates, and facilitated a dialogue between science and ethics, particularly at the level of those in charge of making decisions in society (Llano, 1998, p. x). But it seems that while attendance has decreased since then, mediocrity has increased and, moreover, right-wing groups have now taken over the federation, imposing a particular ideological agenda and restricting certain debates, e.g. on abortion, as was manifest in FELAIBE's latest congress, at Viña del Mar, Chile, in June 2011.[108]

Latin American bioethicists have a special predilection for a language full of neologisms, metaphors and baroque language. This linguistic 'excess' sometimes complicates and obscures discussions. For this reason some bioethicists, e.g. G. Calderón (2010, p. 364), have called for avoiding the 'pamphletism' and the 'tropicalism' that has sometimes characterised

[101] Federación Latinoamericana de Bioética. Its current president is F. Leon Correa.
[102] Federación Panamericana de Facultades y Escuelas de Medicina.
[103] Centro de Bioética de la Fundación José María Mainetti.
[104] Centro para la Ética Médica.
[105] Asociación Colombiana de Facultades de Medicina.
[106] See: http://www.bioeticachile.cl/felaibe/quienes.html
[107] Sao Paulo 1995, Bogotá 1998, Panamá 2000, Puerto Rico 2003, Argentina 2007 and 2009, and Chile 2011.
[108] This was a qualified opinion given to me during a visit to Colombia in June 2011 by one of its attendants.

the bioethical discussions in the region. Moreover, for him, the sharp distinction that is usually made between American and Latin American bioethics should be avoided. Although issues like poverty and injustice are usually linked to the Third World, it is worthwhile bearing in mind that the First World also has "its own underdeveloped world within its borders." However, it was Latin American bioethicists who promoted the inclusion of social problems, giving Latin American bioethics "a distinct openness not found in other bioethics" (Calderón, 2010, p. 360). Unfortunately, this understanding of bioethics has ended up facilitating in Latin America a 'totalising' conception of bioethics: bioethics is about everything. This position causes serious issues. As I will show in the particular case of Colombia, bioethicists are able to demonstrate the 'bioethical angle' of everything and therefore make virtually any situation or problem amenable to a 'bioethical solution'. Most importantly, I argue that this totalising nature of bioethics hides a 'will to power', because this allows bioethicists to intervene at all levels, something of which even bioethicists themselves have remained unaware. Furthermore, what bioethicists see as a 'bioethical solution' is just a renaming of social problems by using 'bioethical labels' instead of properly addressing them in order to find a suitable solution.

F. Lolas urged bioethics to avoid being ideologically compromised and militant political activism. For him, some bioethicists in Latin America have flooded bioethics with outdated discourses like that about 'imperialisms'. He argues that "[t]here is, as has always been the case in Latin American initiatives, a picturesque group of pro-natives and another […] one of defenders of a third-world marginality, who purport to know and appreciate, and on behalf of which they disown, European or USA academic work, taking upon themselves the germs of irreversible alienation" (Lolas, 2004, p. 18). Lolas has warned of different dangers for bioethics in Latin America. He argues that there is a bioethics that can be characterised by its "superficiality, intellectual villainy, and academic banditry" (Lolas, 2008a, p. 133). Also for him, beyond "nominal questions", in Latin America it is necessary to know what actually do those who suppose "do bioethics", how they spend their time, what they want to achieve, and what their motivations are (Lolas, 2005b, p. 162). In short, for him there is a chapter yet to be written on the history of bioethics in Latin America: a chapter about the ethics that those who have called themselves bioethicists actually practise (Lolas, 2009, p. 8).

Lolas' critical stance is against the belligerent positions that some bioethicists, particularly in RedBioetica and the so-called Brazilian group, led by V. Garrafa, have adopted. When V.

Garrafa claimed in a recent publication that some conservative bioethicists in Latin America have used an alien mentality –Anglo-Saxon or Spanish – to analyse our conflicts, a trend that is expressed in academic meetings and publications (Garrafa, 2008c, p. xvii), the members of the Latin American bioethics community knew whom he was referring to: F. Lolas and his group in Chile. Against what he considers an undesirable 'alien' approach in bioethics, Garrafa has promoted RedBioetica's approach that, according to him, seeks to analyse "bioethical problems [with] our own mentality and perspective" (Garrafa, 2008c, p. xviii).

### 4.6. Clinical bioethics, committees, and national commissions

According to D. Gracia (1990), medical practice was for centuries a sort of dictatorship and the "pluralism, democracy, and civil and political human rights, [which can be seen as the] leading achievements of the modern era […] only reached medicine very recently" (p. 357). For him, bioethics and the rise of autonomy are parallel phenomena, representing the advent of 'true ethics' in medicine. Accordingly, bioethics is promoted in Latin America as a way out of medical paternalism. In 1996 R. Macklin and F. Luna (1996) argued that in Latin America "medicine is still practiced in a paternalistic way. Patients rarely ask for information and physicians are not in the habit of providing it" (p. 140). For these authors, medical paternalism is reinforced by "the myth of illiteracy", i.e. that patients are in principle uneducated, which is not only false, but also unjustifiably associated with mental incompetence (Luna, 2007, p. 282). For J. C. Tealdi (2009, p. 588) although Latin American medical ethics expressed the values of domination in its paternalism, it "has turned from deontology to bioethics" and according to him, bioethics is an opportunity to transform the field of medical ethics in this region through the inclusion of the language of human values.

Also in 1990, J. Drane contrasted the formalistic, theory-driven, and rule-dominated American clinical bioethics with the more humanistic European and Latin American approaches. He argues that while American medicine, culture, and society have led to a "technologized, secular and pluralistic" approach in bioethics, medical traditions in Europe and Latin America "are more humanistic [and] not so tied to deontological and utilitarian theories" (Drane, 1990, p. 401f). Drane furthermore emphasises the difference between the cultural backgrounds of the USA and Latin America (Drane, 1996). Drane argues that the bioethical issues linked to poverty in Latin America have been largely ignored by bioethicists in the USA and Europe. For him, a dialogue between different cultural approaches to

bioethics is not only possible, but also necessary since there are "common problems" in the field (Drane, 1996, pp. 559f).

Although ethical issues in clinical settings are widely discussed in the Latin American bioethics literature, issues related to public health and healthcare systems have received much less attention. In the last twenty years there has been a wave of neoliberal healthcare reform in Latin America, but there has been little space to analyse this phenomenon in the regional bioethical literature. Critical voices have attacked this silent complicity. A lack of opportunities and an effective social protection, particularly for the poor, are still common in the region, as is illustrated by the case of Chile (Olavarría, 2005, p. 47). Yet, as S. Litewka (2010, p. 149) has argued, Latin American bioethicists have been passive and even negligent in discussing the ethical issues raised by the neoliberal healthcare reforms in the region. For him, justice remains an abstraction among bioethicists, and the dominant bioethical discourse in Latin America, with its common phrases, e.g. that bioethics is the defence of life and repetition of the same rhetoric again and again, e.g. respect for human dignity and personal autonomy, has led to an "ethical atonia" (Litewka, 2010, p. 152).

At the same time, some bioethicists have talked of the necessity of implementing an 'ethics culture' in the field of human research, i.e. the adherence to international norms such as the Council for International Organisations of Medical Sciences (CIOMS) guidelines and the Declaration of Helsinki (Rodríguez, E., 2005, p. 11). In this sense, the role of bioethical commissions and committees goes beyond the protection of research subjects. They are political bodies that can have enormous influence in institutions and channel different kinds of debates, for example, as Ulloa and Barrantes (2008, p. 204) have shown in the case of Nicaragua with the discussion on abortion. In a paper at the VI International Bioethics Association's Congress in Brasilia, 2002, I argued that clinical bioethics committees might play an important role in the positive transformation of healthcare institutions. Ethical committees are not only privileged to 'approve research protocols' or 'solve ethical dilemmas arisen in clinical practice', but also to 'facilitate' self-reflection among healthcare professionals (Díaz Amado, 2002b). Unfortunately, the growing institutionalisation of ethical committees and bioethics in general has also meant a loss, to a certain extent, of their ability to criticise and/or denounce negative aspects, elements or circumstances in or around the biomedical field.

Bioethics commissions and committees are part of the 'ethicalisation' of biomedical research in Latin America. The number, performance and quality of bioethics committees have been taken as an indicator of the development of bioethics (Zwareva, 2010, p. 90). In the last 20 years national commissions for bioethics and bioethics committees have spread across Latin America, where they have been enthusiastically welcomed as a mechanism to firmly establish bioethics in the region. They are seen as guarantors of ethical standards in biomedical research and clinical practice. However, it is important to recognise the power mechanisms which were involved in their creation and functioning. The literature on bioethics committees has mainly focused on the application of human research ethics norms, decision-making methods and the role of national commissions to provide guidelines (ethical and legal) on sensitive issues like embryo research, abortion, euthanasia and so on.

Moreover, as A. Bota (2003, p. 33) has argued, while bioethics promotes sophisticated mechanisms such as informed consent, basic problems (e.g. poverty, healthcare access, exploitation and the like) remain unsolved in Latin America. This paradox reveals that some issues are privileged while others are neglected. To deal with this situation, some bioethicists have suggested that the scope of bioethics should be expanded. Perhaps, but nevertheless it would be necessary to examine other possibilities, for example, that bioethics is in itself a kind of *truth regime* that determines what is ethically, politically and legally relevant to be discussed in and about the biomedical field. In order to see this dynamics, considering the Foucauldian approach in the analysis, as I explained in the previous chapters, might be a promising path. For instance, from a Foucauldian perspective, bioethics committees and national commissions embody a pastoral discourse as they are set up to protect patients and research subjects (Juritzen, et al., 2011, p. 644). This characteristic might partially explain why they have been so welcomed in contemporary societies in which the language of threats and risks has also had a great impact.

## 5. Bioethics, biopolitics, and power

Some Latin American bioethicists have used the concept of 'power' mainly in connection with the oppressive military, political, cultural and economic conditions that characterises this region. For F. dos Anjos (2008a, p. 534), an explicit enquiry about power began in Latin American bioethics with the International Bioethics Association's Sixth World Congress in

Brasilia in 2002, with the motto *Bioethics: Power and Injustice*.[109] For V. Garrafa, who was the organiser of this congress, power should be analysed in three spheres: economic, political and ideological. He argues that as an effect of bioethics socially problematic situations become "aseptic and neutral" categories. For this reason, he calls for a 'politicization' of bioethics that would make a contribution to truly overcome exploitative social practices. Therefore, bioethics would have an emancipatory role in Latin America and liberate people by means of decisive 'political' intervention. According to Garrafa, this would be possible if bioethical discourses and practices promoted *empowerment, liberation,* and *emancipation* (Garrafa, 2008a, p. 532). From this point of view, "[t]he politization of bioethics is a concrete contribution to the construction of social justice […] of true democracy" (Garrafa, 2008a, p. 533). Hence, what V. Garrafa terms "intervention bioethics" seems to be a particular contribution of Latin American bioethics to the global theoretical framework of the field.

Latin American bioethicists have also used the term *biopolitics*, although with different meanings depending on who speaks and in what context it appears. For instance, G. Cely[110] has argued that V. R. Potter's global and deep bioethics should "biopolitically illuminate the macro-decisions that will determine the future of the world" (Cely, 2007, p. 444). What 'biopolitically' means here is not clear. When Cely quotes Potter, saying that "for the next 100 years a political bioethics is required… Global bioethics or anarchism!" (Cely, 2007, p. 445), it seems that in Latin America bioethics represents a kind of salvation. It is worth remembering that V.R. Potter argued that the survival of humankind depended on a kind of ethics anchored in biological knowledge. For Potter the leaders of the world should be taught social sciences and humanities (Potter, 1971, pp. 1, 69). For C. Maldonado, biopolitics and bioethics are neighbouring fields, as they share similar questions and horizons, resulting in the emergence of new phenomena like biolaw and bioeconomics (Maldonado, 2005, p. 9). Stressing this view, F. Garzón argues that bioethics and biopolitics are linked at the level of the human rights discourse. According to him, bioethics should enrich the biopolitics and biolaw by bringing in "fundamental human values and ethical principles in order to make scientific and human progress compatible" (Garzón, 2007, p. 7f).

According to L. Schmidt and S. Cecchetto (2008) bioethics is leading to biopolitics. However, their attempt to link bioethics and biopolitics is highly rhetorical and unclear. For instance, the link they try to create between biopolitics and bioethics is problematic. They

[109] See: Benatar, S. (2003) Bioethics: Power and Injustice: IAB Presidential Address. *Bioethics*, 17, issue 5-6.
[110] Colombian Jesuit and bioethicist.

suggest that in both fields a rational and dialogical discussion takes place on particular situations created by socio-political and techno-scientific developments entailing negative consequences for humankind, nature and science. However, they argue, while bioethics happens between persons, biopolitics is between citizens (Schmidt & Cecchetto, 2008). Similarly, the Colombian bioethicist S. Osorio mentions a "biopolitical imaginary"[111] that would constitute a political horizon to carry out a process of healing of the social fabric which has been broken by several conflicts in Latin America. For Osorio the neoliberal reforms carried out in the region are linked to such conflicts (Osorio, 2008, p. 106). With this in mind, M. dos Anjos has stressed that in Latin America neoliberalism has left the individual 'alone' and 'the technical' has become 'ethical' (dos Anjos, 2008b, p. 13). As de Carvalho has argued, at the same time that the state guarantees that individuals make decisions, it avoids intervening in people's lives, a typical neoliberal feature. Although de Carvalho´s view echoes the Foucauldian idea about how neoliberal rationalities and governmentality go hand in hand, he does not mention Foucault (Carvalho, 2008, p. 540).

M. Kottow's view is that bioethics and biopolitics are incompatible. While bioethics is concerned with *bios*, biopolitics reduces life to mere *zôì*.[112] Thus bioethics "has precisely the task of protecting the *bíos* of not being treated only as a *zôì* […]" (Kottow, 2005, p. 110)[113] Drawing on G. Agamben's recasting of the Foucauldian concept of biopolitics, particularly by including those biopolitical spaces that Foucault did not considered such as the concentration camps and the totalitarian states of the twentieth century (Agamben, 1998), M. Kottow has pointed to the "artificial dichotomy" that in Western societies is frequently presented in terms of freedom vs. life. For Kottow, instead of trying to convert bioethics into biopolitics, bioethics should inform politics, remaining focused on biomedical and ecological issues (Kottow, 2005, pp. 119-120). However, although Kottow uses the term *biopolitics*, he does not mention Foucault either. Although bioethicists have indeed used the term biopolitics and carried out reflections on power, they barely consider in depth the Foucauldian scholarship. There are a few exemptions. In 1998, for instance, B. Azerrad and D. Viegas (1998) addressed specifically the question of how the Foucauldian approach might be useful in bioethics. They emphasised that power is basically a relation of forces; that the question is not who possesses power, but how it is exercised; that it is necessary to 'denaturalise' the

[111] Although with a different meaning, this term has also been used by M. Dillon and L. Lobo-Guerrero (2009) The Biopolitical Imaginary of Species-Being. *Theory, Culture & Society*, 26(1), 1-23.
[112] While *bíos* refers to the human life in the polis, *zôì* refers to a kind of animal life.
[113] See chapter seven on the euthanasia debate.

taken-for-granted daily experience; that fragmentation facilitates the exercise of power; and that power contributes to forming identity. Yet, they only offered two examples, discussed in a narrow way, of how the Foucauldian perspective could be applied to/in bioethics. First, they argued that the idea of autonomy should be placed in a context of power relations, particularly regarding complex issues like euthanasia or abortion. Second, they argued that although the legal (penal) discourse is generally about remedying rather than punishing, the penal system is essentially punitive (Azerrad & Viegas, 1998, pp. 41-44).

## 6. Conclusion

Latin American bioethicists have told the history of bioethics in their region in heroic terms, the rebirth of humanistic values and the victory against destructive and life-threatening forces promoted by irresponsible techno-scientific endeavours in the twentieth century. By and large, Latin American bioethicists shared with their American colleagues the same 'origin myths' of the field, i.e. bioethics is an answer to the ethical challenges posed by the biomedical progress as well as a reaction to the abuses committed in the name of science. Additionally, Latin American bioethicists developed the idea of a three stages history, which has let them make sense of how bioethics was born and developed on the region. This approach privileges the work of a few people who, having learned of the new field in the USA, were tenacious and committed to transplant bioethics to Latin America. Hence, the history of bioethics has been told in terms of the achievements made by the so-called 'pioneers'. These pioneers promoted an understanding of bioethics linked to a progressive, growing 'process of awareness' about the dangers behind many scientific and technological advances, particularly in biomedicine. Bioethics would then be a new conscience, a new kind of relationship between human beings, and between human beings and nature. Bioethics was announced as the 'new ethics', a kind of 'awakening' of human civilisation.

It is clear that bioethics arrived in Latin America as an import from the USA. After its birth and expansion in the USA, bioethics went out to spread the word and Latin America was one of the first destinations of American bioethics in the early 1980s. In Latin America bioethicists have presented bioethics as a 'way-out' from medical paternalism and as a movement of 'defence of life'. In its beginnings it was a discourse strongly linked to medical associations and the Roman Catholic Church. Moreover, international powerful organisations played a big role in creation of bioethics in Latin America. In the 1990s, both PAHO and

UNESCO greatly contributed to framing the bureaucratic organisation of the field, promoting centres for research and for training bioethicists.

However, resistance against the hegemonic American discourse formed very soon, against the content, the methodology and the effects of bioethics in Latin America. A group of Latin American bioethicists began in the 1990s to criticise the dominant model of bioethics, which privileged the discussion of issues important for the First World, while those relevant to Latin America were neglected. The methodology, mainly based on the American principlism, reinforced an analytic, formalistic approach to bioethics, cast in terms of 'dilemmas' between two or more principles, while concealing the real causes of the bioethical problems, which in Latin America have socio-political and economic roots linked to an inveterate history of subjugation, poverty, dependency and exploitation. Although many bioethicists have emphasised that in bioethics it is necessary to take into account differences between the North and the South, between the developed and the developing world, bioethics has still worked as an ideological compass: pointing to the North and neglecting the South. Against the background of this kind of bioethics, a group of Latin American bioethicists developed a more politicised bioethics. Instead of being focused on the First-World's problems, their bioethics would take into account regional problems and their real causes. Thus some Latin American bioethics then developed a line that can be seen as countering the effects of American bioethics. But not all bioethicists in Latin America shared this position. For some Latin American bioethicists, who would prefer an 'academic' approach to the field, politicizing bioethics was dangerously near to 'populism' and 'tropicalism'. Differences between Latin American bioethicists have shown that they were not only concerned with healthcare justice, human research ethics, respect for autonomy or for human dignity, but also with who controls the bioethical discourse, who decides what to discuss in bioethics, who has the power to organise conferences and attract more people, etc., i.e. who holds power within the field.

From a Foucauldian point of view, the birth and development of bioethics in Latin America is by no means simply the result of moral progress or an answer to the ethical challenges brought by biotechnological advances. In fact, it was the result of a fervent activity of a few people who took the idea and inspiration from American bioethics. As bioethics in Latin America has become a 'heterogeneous ensemble' of discourses, institutions, experts, rules and practices that conveys not only the typical dilemmas related to biomedical progress, but also the socio-political and economic problems affecting this part of

the world, it is possible to assimilate it to what M. Foucault called a *dispositif*. This is also true because apart from being a 'heterogeneous ensemble', the development of bioethics as a new field in Latin America reveals a power dynamics. On the one hand, bioethics was very welcomed as it represented a kind of solution for a disparate array of problems, e.g. abuses in biomedical research, medical paternalism, poverty, corruption, inequalities and so on. In this sense, bioethics was clearly introduced in Latin America as a pastoral discourse. On the other hand, bioethicists in Latin America represent the new experts who know about the rights and wrongs in the biomedical field. Even with the idea that bioethics should be politicised and take into account more resolutely 'the social', the Latin American bioethicists have expanded the 'truth regime' of bioethics beyond the biomedical field. It is possible to think that there is a 'Latin American bioethics', which would be characterised by three aspects: first, a reframing of the principlist, biotechnology-driven American bioethics in terms of discourse of defence of life in general; second, a strong Catholic Church's and medical establishment's influence; and third, an emphasis on 'the social' that seeks to make of bioethics a 'politicised' field. In short, what is called 'Latin American bioethics' is then a mixture of American bioethics and a whole array of discourses and institutions that reflect Latin America: Catholic influence, professional dominance and thirst for freedom.

Chapter four

# Bioethics in Colombia

## 1. Introduction

Having defined the contours and distinctive elements of Latin American bioethics, I now want to offer a critical analysis of the history of bioethics in Colombia, a country which has played a key role in the development of bioethics in Latin America. It was one of the first countries in the region where bioethics was established through the creation of institutions and academic programmes. The dissemination of bioethics across Latin America owes much to the work of passionate Colombian bioethicists who promoted it not only on a national but also on a regional level. For example, when FELAIBE was created, Colombian bioethicists were important in the organisation of several events –e.g. conferences, courses, workshops, etc.–, and in the production of bioethical literature. Also Colombian bioethicists have made significant contributions to the formation of the discourses and practices that characterise bioethics in Latin America, as I have shown in the previous chapter. As is the case for Latin America as a whole, not much has been published on the history of bioethics in Colombia. Most of the existing historical accounts are personal accounts of people who are still active scholars or professionals and are considered 'pioneers' by the Colombian bioethics community.[114]

My analysis of the historical narratives that Colombian bioethicists have used to explain the birth and development of their own field, is an attempt to 'de-mythologise' the origins of bioethics, to reveal the particular forces that have led to its 'naturalisation', and, most importantly, to show how much these narratives are saturated with power in a Foucauldian sense. It is a genealogical approach to the already accepted history of bioethics in Colombia. The aim is not to discover the 'essence' of bioethics, but to point out how particular discourses, e. g. about the nature and scope of the field, have become 'truths', and how these truths have shaped bioethicists' practices and identity. Colombian bioethicists have long neglected such an angle. Thus, my task is to go beyond the Whiggish narratives in the bioethical historical literature in Colombia and make a first step towards a comprehensive history of the field. I have argued elsewhere that instead of appealing to self-indulgent, self-legitimising, and 'messianic' accounts of why bioethics emerged, it is necessary to analyse

[114] Some of them were interviewed as part of my research. See end of the chapter.

how this process in a particular historical time and space, digging deep enough to reveal the *conditions of possibility* for and the power dynamics involved in the birth of bioethics in Colombia (Díaz Amado, 2011).

As I have shown in the introductory chapter, bioethicists have a special propensity to talk about their own origins and their *raison d'être*. They devote time and energy to discuss what moment, event, person, and/or circumstance marks their 'birth', and the Colombian bioethicists are no exception. But 'birth' is a polysemantic concept, not a simple and unique fact. Therefore, the question about the birth of Colombian bioethics entails several answers. Which is the correct one? All and none. Whatever answer is given, it will be necessary to consider contexts and who is speaking. Particular answers are linked to particular contingencies and myths of origin. In Colombia, bioethics might have been born in the 1960s, mid-1970s, or the 1990s. It depends on the chosen perspective. However, I am not seeking to date Colombian bioethics as an archaeologist would do with an unearthed object, but to show that in writing its history, the process of recalling and recording names and dates, there is a power effect that has been underestimated. Therefore, instead of identifying the 'first year', 'singular event', or 'true pioneer' in this chapter, I want to make visible the rationale behind the official historiographies of bioethics in Colombia and the role it plays in keeping things going, to use Hunk and Wickham's expression (quoted in Kendall & Wickham, 1999, p. 49). My aim is to shed light on how certain bioethical discourses, rationalities and truths were formed in relation to particular people, institutions and politico-economic agendas. The two questions that summarise my inquiry about Colombian bioethics are: What were the 'conditions of possibility' for the rise of bioethics in Colombia? And, is there a 'Colombian bioethics' as such? To answer them, I will start by examining the narratives of Colombian bioethicists about the beginnings of their own field. Then, I will show how the institutionalisation of bioethics in Colombia was carried out; a process of which the production of the new expert called 'bioethicist' was an important part. After that, I will summarise the main ideas and discourses of the Colombian bioethics. Finally, I will present relevant information about the history of bioethics in Colombia obtained from the interviews I conducted as part of my research.[115]

[115] See Appendix 1.

## 2. The beginnings: pioneers, death/dying and biomedical advance

Colombian bioethicists have referred to a period called the 'pre-history of bioethics', which would be between the late-1970s and mid-1980s, when some academics started to discuss bioethical issues without having adopted bioethics as their discipline yet (PBUEB & Escobar, J., 2002). Are Colombian bioethicists referring to the 'conditions of possibility' for bioethics to emerge in Colombia? To some extent, the answer is 'yes'. But, disappointingly, bioethicists have used the expression 'prehistory of bioethics' mainly as a way to extol those who are called in Colombian bioethics the 'pioneers'; the ones who supposedly did bioethics even at a time when the word was still unknown in their region. For *El Bosque University's Program of Bioethics*, PBUEB[116] and J. Escobar (2002), the central figure in this period was Jaime Escobar,[117] who allegedly was first to introduce in Colombia the interest in 'bioethical issues' through the seminars he organised in the mid-1970s when he was head of the San Juan de Dios hospital ICU.[118] These seminars were on death and dying, patients' rights and ethical dilemmas in intensive care. They conclude that "in one word, undoubtedly, Jaime Escobar was the pioneer of bioethics in Colombia" (PBUEB & Escobar, J., 2002, p. 17). It should be noted that this quotation comes from a book co-authored by J. Escobar. It seems that the idea of 'pioneering' in the history of bioethics in Colombia is as relevant as in Latin America in general and that it should be analysed carefully.

Within the bioethics community[119] in Colombia, a 'pioneer' is not only a 'title' through which those who founded the field are acknowledged, but also a 'position' that empowers a particular group of bioethicists. Pioneers are usually invested with authority, and when they speak, for example, about the history of bioethics in Colombia, their statements constitute a kind of 'true' indisputable a-priori for understanding such a history. Thus, they are not only authoritative voices on the past of bioethics in Colombia, but also on its nature, scope and aims in the present. However, a careful analysis of what these pioneers said shows that what they call 'history' is by and large a record of particular facts (e.g. when a certain group for the

[116] Programa de Bioética de la Universidad El Bosque.
[117] General surgeon and former professor at the Faculty of Medicine, National University of Colombia. He is co-founder of El Bosque University, where he organised, together with A. Llano the first postgraduate program on bioethics in 1995.
[118] The university hospital of the National University of Colombia, one of the most important university hospitals at the time.
[119] I distinguish the *Colombian bioethics community* from the *Colombian bioethics establishment*. The former is constituted by all the people who, directly or indirectly, are working on bioethics or bioethics-related issues, while the latter is made up of those who control the means of production of bioethics, e.g. associations, publications, postgraduate programs, and so on and, therefore, exercise power on the whole bioethics community.

study of bioethics was formed or when the first postgraduate program in bioethics was created), people and institutions involved in the building of the field in Colombia, selected according to their personal criteria but chronologically ordered, thus giving the impression of an 'objective' account. In other words, what dominated so far in the history of bioethics in Colombia is really hagiography. For this reason, I argue that the history of bioethics in Colombia so far lacks a critical perspective of how it emerged and flourished as an academic and professional field.

Some authors have pointed out that death and dying boosted an ethical reflection on the new relations between medicine and society in Colombia during the 'pre-history of bioethics.' According to J. Mendoza,[120] by 1975-78 some physicians, particularly in Bogotá, promoted an academic discussion through workshops on dignified death in university hospitals (Mendoza, 2006, p. 34). In 1979 Beatriz Kopp, "a highly prestigious lady, an intellectual and a lover of classical ballet" (Mendoza, 2006, p. 40), created in Bogotá the *Fundación pro-derecho a morir dignamente*,[121] a private non-profit organisation. Mendoza argues that, "the issue through which bioethics reflections were introduced in [Colombia] – the death of the human being and the respect for the rights of the persons who reach the end of their life –, had a rather unique development [with the creation of this organisation]" (Mendoza, 2006, p. 40).

In 1988 A. Llano published in The Hastings Center Report, *In Colombia, Dealing with Death and Technology*, in which he discussed the negative effects of the biotechnological advance on the otherwise 'natural' process of dying as well as the "deplorable loss of ethical values in the practice of the medical profession" in the last few decades (Llano, 1988, p. 23). In a further article, he argued that dying had become a prolonged, passive, profane and isolated experience in contemporary society. "The hospital, and to some extent family members, take charge of the death of the patient, who is no longer allowed to die his own death [and now] people die 'scientifically' in hospital and clinics" (Llano, 1990, p. 448f). This phenomenon was linked to the 'dehumanisation' and 'detachment' from traditional moral values in the clinical setting. But for Llano, "[…] the response, when it came, assumed a name: bioethics, [which] is not a discipline that is cold, calculating, abstract, defined, and

[120] Neurosurgeon and university lecturer. Renowned medical ethicist and bioethicist in Colombia. Member of the National Academy of Medicine. Current director of The World Federation of Right to Die Societies.
[121] Foundation for the Right to Die with Dignity.

precise in its methods and content. It is rather a movement, an interdisciplinary effort, a growing process of searching out moral values […]" (Llano, 1990, p. 450). Thus, bioethics was presented since its beginnings as a solution for the growing dehumanisation of medicine and a true advocate of patients and anyone who suffered because of the techno-scientific take-over of our lives.

The beginnings of bioethics in Colombia were also linked to the idea that biomedical progress entailed *new ethical dilemmas* for which traditional (Hippocratic) medical ethics was deemed insufficient or inadequate. F. Sánchez[122] has argued that the ethical consequences of new medical technologies began to be widely discussed in Colombia by the early 1980s (Sánchez, 1990a, p. 510). By this time, euthanasia was considered a crime and there was a lack of legal regulation regarding transplants, although brain death was legally defined.[123] Reproductive technologies were also a big concern and abortion was illegal in all circumstances, although "virtually everyone, including the health authorities and police, know that the large cities harbour abortion clinics staffed by physicians and nurses, and no corrective action is taken"[124] (Sánchez, 1990a, p. 512). According to Sánchez (1990a, p. 511), there was little bioethics literature available in Colombia in the 1980s, basically just the Code of Medical Ethics of 1981[125] and three textbooks: first, *General Medical Deontology*,[126] by Gerardo Paz, first published in 1955; second, *Medical Ethics*,[127] by Luis A. Vélez, first published in 1988; and, third, the Spanish translation of *Main Issues in Bioethics*,[128] by A.C. Varga, originally published in the USA in 1984.

### 3. Institutionalisation of bioethics

Between the mid-1980s and early 2000s there was a period that the bioethical establishment has called "the normalization of bioethics", characterised by the creation of the first professional associations and groups working in the field, the first journals and book series, and the first postgraduate programmes (PBUEB & Escobar, J., 2002, p. 19). In the

[122] Gynaecologist and obstetrician, Emeritus professor of medicine at the National University of Colombia, and renowned medical ethicist and bioethicist. He has been member of Courts of Ethics and is currently member of the National Academy of Medicine.
[123] According to Decree 2363 of 1986.
[124] Abortion and euthanasia will be discussed in chapter seven.
[125] See chapter six.
[126] *Deontología Médica General*.
[127] *Ética Médica*.
[128] *Bioética. Principales Problemas*. The translation was made by A. Llano in 1988.

1980s, according to A. Llano (1988), "three developments in Colombia [gave] hope that responsibility will be renewed in the practice of professional medicine" (p. 23f): the Code of Medical Ethics of 1981, the Medical Ethics Program of ASCOFAME, and the *Colombian Institute for Bioethical Studies* [129] hereafter *ICEB*. I want to expand a little on the latter. ICEB was founded in 1985 by F. Sánchez and Alfonso Tamayo[130] and adopted the definition of bioethics provided by the *Encyclopaedia of Bioethics*[131] (PBUEB & Escobar, J., 2002, p. 20; Sánchez, 2008). ICEB is currently attached to the *Colombian National Academy of Medicine* [132] (hereafter 'the Academy') as a "consultative body" for bioethical issues. With the support of the Academy, ICEB has organised conferences and published books on different bioethical issues like euthanasia, abortion and health care reform. Although its president, F. Sánchez, has insisted that bioethics is a new interdisciplinary, plural and secular field that is committed to the protection of life 'in general' and that has overcome the old Hippocratic ethics (Sánchez, 2006, p. 182), for other bioethicists ICEB has remained too close to the Hippocratic tradition (PBUEB & Escobar, 2002, p. 20). This aspect is worth mentioning because, by and large, for bioethics groups in Colombia it is important to clearly state that they have embraced the 'new paradigm' of bioethics in which there is no room for the paternalism of the old Hippocratic tradition.

In the historiography of bioethics in Colombia ICEB appears as a 'fact' for the development of the field, but neither its creation nor the role it has played has ever been discussed. My contention is nevertheless that its existence should be problematized and not simply taken as a fact. ICEB is theoretically an independent group, but it is practically speaking part of the Academy. Not only are its headquarters located in the Academy's building, but the ICEB also shares the same ethos with the Academy: an environment of conservative values and elitism. The National Academy of Medicine was founded in 1887 and ever since it has been a body of 'selected' Colombian physicians and healthcare-related professionals. At present it does not have more than 250 members,[133] an astonishingly small number in a country with more than 58,000 physicians. Moreover, the Academy is mainly

[129] Instituto Colombiano de Estudios Bioéticos.
[130] A legal expert in medical ethics and law. He participated in writing the Code of Medical Ethics of 1981.
[131] "The systematic study of human behaviour in the field of biomedical sciences and health care insofar as this behaviour is examined in the light of moral principles and values." See: http://anmdecolombia.net/web2/component/content/article/100.html.
[132] *Academia Nacional de Medicina de Colombia*. See: http://anmdecolombia.net/web2/
[133] See: http://anmdecolombia.net/web2/acerca-de-anm/listados-de-miembros.html, retrieved 20 September 2011.

constituted and controlled by specialists,[134] despite the fact that around 70% of Colombian physicians are general practitioners (GPs).[135] By and large, the vast majority of Colombian physicians, particularly the GPs either do not know or do not care about the Academy's activities, while others would not meet the necessary requirements to be admitted.[136] According to one of its members, E. Otero (2004), the Academy should be regarded as the Colombian equivalent to the American College of Physicians. In practical terms, the Academy is an epicentre of power over the medical profession in Colombia. It might be assimilated to an exclusive club of doctors; however, it is by law an authorized consultant body for the Colombian government regarding public health and other medical issues, assuming *de facto* the representation of the whole Colombian medical professionals.[137]

Also in 1985 the *Centre for Medical Ethics*[138] was created in ASCOFAME by "the Jesuit priest Alfonso Llano Escobar, who was interested in the rise of bioethics in the international arena and the hard task that its introduction in Colombia represented" (Mendoza, 2006, p. 34). Although ASCOFAME had been a powerful medical association,[139] and its Centre for Medical Ethics played an important role in the development of bioethics in the field of medical education in the 1980s, its importance declined after the healthcare reform of 1993. Through this centre, A. Llano offered courses and seminars on medical ethics, mainly to lecturers in faculties of medicine and nursing as well as other healthcare professionals. According to J. Mendoza (2006), the attendants "were taken for three or four days, and were held in a quiet place, almost always a house of spiritual retreat like the ones some religious communities have in warm weather localities close to tourist cities" (p. 35). This is not a simple or innocent description. Rather, it reflects the environment in which the academic discussion about medical ethics has characteristically taken place in Colombia: in private, elitist, conservative, religion-related circles. In the case of bioethics, this has not been different. On the one hand, its origins and development as an academic and professional field

[134] 'Consultants' in the UK.
[135] See: http://www.medicosgeneralescolombianos.com/index.htm, accessed 27 September 2011. In the power dynamics of the Colombian medical establishment, general practitioners are usually considered and treated as 'lower rank' medics.
[136] E.g. a recommendation letter issued by two 'academics' and/or academic work.
[137] Recently, amid the most serious crisis experienced by the health care system since its creation in 1993, the Ministry of Social Protection twitted that: 'today we got a historical agreement with doctors, they back the government's healthcare roadmap' (El Espectador, 2011a) According to the news, "the government" and "the doctors" made an agreement on the necessary changes for the health care system. But, who were "the doctors" here? The answer is: the representatives of the Academy, acting on behalf of the whole medical profession. I would content that such an agreement represented the will of the majority of medical professionals in Colombia.
[138] *Centro para la Ética Médica.*
[139] At present it associates 53 faculties of medicine.

were deeply linked to a professional/social elite related to private universities, medical professional bodies and the Roman Catholic Church. On the other hand, it is interesting that bioethics was announced and promoted as a 'new ethics' as well as a 'movement' to which everyone, no matter their professional background or work, not only was invited to, but actually encouraged to join. For example, A. Llano wrote in a newspaper column: "[…] you will feel guilty if you do not know about bioethics" (Llano, 1993), "everyone no matter their profession or condition should assume the bioethical challenge" (Llano, 1996), "bioethics is the international language of those who fight for the humanization of human life" (quoted in Nieto, L., 1995), and bioethics was described as "the sun" that will get us out of problems such as "guerrillas, paramilitaries, political corruption which have kept Colombia in an endless and dark winter" (Llano, 2004). In this way bioethics became a 'land of experts', powerful people and institutions, but at the same time a field where everyone was welcomed if they wanted to join 'the movement'.

In 1993 A. Llano created the, *National Centre for Bioethics,*[140] hereafter CENALBE, an interdisciplinary group for the study and diffusion of bioethics in Colombia, which helped him to spread his own ideas about bioethics. In 1995 CENALBE in alliance with El Bosque University offered the first postgraduate programme in bioethics in the country (see below). In 1998 CENALBE hosted the 2nd Latin American Congress of Bioethics that took place in Bogotá and signed an agreement with the newly created the *Bioethics Institute at the Javeriana University,*[141] hereafter IBPUJ, where another postgraduate programme in bioethics was offered –a one year program that it is called in Colombia *Specialization*-. Since the end of the alliance with the IBPUJ in 2009, CENALBE has continued working as an independent organisation still headed by A. Llano. Meanwhile, the IBPUJ has also continued its research and educational activities, launching an MA programme in bioethics in 2008. It is worth mentioning that CENALBE created the first and most complete bioethics library in Colombia, currently attached to the Universidad Javeriana's main library.

In 2002 the *National Association for Bioethics,*[142] hereafter ANALBE, was announced as an organisation to promote research and discussion in bioethics. Its creation, directives, and policies have been largely controlled by the bioethics establishment. So far its activities have

[140] Centro Nacional de Bioética.
[141] Instituto de Bioética de la Pontificia Universidad Javeriana.
[142] Asociación Nacional de Bioética.

comprised a few conferences and workshops, but its academic impact has been modest. ANALBE reflects, to a greater extent, the politics and dynamics of bioethics in Colombia. Inasmuch as internal bureaucratic and ideological disputes are insidious and pervasive practices within the Colombian bioethics circles, there has been little room to really promote a systematic and critical approach to the field. The bioethical establishment dominates the production of discourses, delineates the practices and controls the mechanisms and institutions related to bioethics in Colombia. If one looks at the content, organisation, speakers and debates of the workshops, congresses and forums organised by ANALBE, one will see by and large the same people with variations of the same discourse and conclusions. My view is that there is still much to do to guarantee an acceptable minimum of academic quality in these congresses, conferences and forums of bioethics in Colombia, where alternative or challenging positions for the bioethical establishment's views remain marginal.

In 2005 with the support of a bioethics group based at the National University of Colombia, the Colombian branch of Redbioetica was created. Like other organisations, it was established to analyse bioethical issues, and it is mainly oriented to issues related to human research ethics, promoting a more politicised view of bioethics. It has organised several events like workshops and conferences. It is worth mentioning that in 2007, sponsored by the Ministry of Social Protection, Redbioetica held workshops and produced publications aimed at increasing the public appropriation of the Constitutional Court's 2006 legal decision that decriminalised abortion (M.P.S. & U.N., 2007).[143] In partnership with the National University of Colombia it also published the *Diccionario Latinoamericano de Bioética*[144] in 2008, which comprises different perspectives and authors on bioethics in Latin America. More recently, on 23 – 26 November 2010, Redbioetica organised in partnership with El Bosque University and the National University its 3rd International Congress for Latin America and the Caribbean with the motto 'Bioethics in a continent of exclusion: from reflection to action'. Although it was indeed an extensive congress that covered a wide arrange of issues, like many other congresses on bioethics in the region it lacked a section to discuss in depth historical and philosophical issues related to the field itself in Latin America.[145] Regarding this issue I have argued elsewhere that bioethicists in Latin America still continue working

[143] See chapter seven.
[144] Latin American Dictionary of Bioethics
[145] The proceedings of this congress are available at www.bioeticaunbosque.edu.co. Accessed 23 April 2011.

with too many taken-for-granted truths about their own field, and proper historical reflection is still a pending task for Latin American bioethics (Díaz Amado, 2011).

In the so-called 'pre-history' of bioethics some publications were considered as 'announcing' the coming of bioethics. J. Mendoza has claimed that his article *Considerations on Brain Death in Colombia*, published in 1977, was the first article addressing end of life ethical issues in Colombia (PBUEB & Escobar, J., 2002, p. 15). Meanwhile *Bioethics, or Defeating the Fear?*, published by J. Bernal in 1981,[146] is considered by others to be the first bioethical article in Colombia (PBUEB & Escobar, 2002, J., p. 17; Sánchez, 2008). By the mid-1980s, A. Llano published several articles on the field and translated *Main Issues in Bioethics*, by A. C. Varga. This book represented bioethics as the answer to the problems created by scientific progress and included Pontifical documents related to bioethics. To illustrate the 'transcendence' of the new field of bioethics, Llano mentioned in its introduction that J. Testard had decided to devote his entire life to the study of ethics after having created the first test tube baby in France in 1982 (Varga, 1988, p. 9). However, the first book in Colombia with the word 'bioethics' in its title and written by a Colombian author was, according to J. Mendoza (2006, p. 34), *The Bioethical Horizon of Sciences*,[147] edited by G. Cely in 1994. As I have shown in the previous chapter, Cely has also been one of the Colombian bioethicists who hold that bioethics is a 'new ethics', and like A. Llano, he has been a tireless proselytizer of bioethics in Colombia. However, it was not until 1990s when the word *bioethics* really entered the Colombian mainstream. At the end of this decade the emergence of postgraduate courses, ethics committees, public events, the rise of a corpus of specialised literature and the impact of highly contentious decisions made by the Constitutional Court contributed to create the demand for bioethics.[148]

One of the most successful forms of institutionalisation of bioethics in Colombia has been the ethics committees, both clinical and on human research, in healthcare and academic institutions.[149] Since bioethics was primarily related to the biomedical scenario, ethics

[146] In: *Universitas Medica*, Vol 23, No. 3. Universidad Javeriana, Bogotá. Bernal is a geneticist.
[147] Original in Spanish: El Horizonte bioético de las ciencias.
[148] See chapters six and seven.
[149] According to Drane there are three kinds of committees: *clinical ethics committees* (to solve ethical dilemmas in daily clinical practice, also called in Colombia *bioethics clinical committees*), *institutional review board*, the so-called IRBs (for the ethical analysis of biomedical protocols and trials, also called in Colombia *bioethics research committees*), and *professional review committees* (to decide in cases of professional misconduct, generally seen as breaches of the code of ethics) (Drane & Fuenzalida, 1991). This classification has been followed in Colombia. See: Hackspiel, M. M. (Ed.) (1998) and Díaz Amado, E. (2003).

committees were thought to be the best way to promote the new discipline among health care institutions (PBUEB & Escobar, J., 2002, p. 26f). In fact, in Colombia a way to distinguish bioethics from the 'traditional' medical ethics was the distinction between 'bioethics committees' and 'ethics committees'. In the Colombian healthcare scenario, 'traditional' ethics committees mean 'professional ethics committees'. These committees analyse cases of professional misconduct, which are generally put in terms of breaches of a code of ethics. However, with the healthcare reform of 1993 and the rise of bioethics in the 1990s, professional ethics committees have become just one type of ethics committee, co-existing with the newly created 'bioethics committees', which in some sense became fashionable in the Colombian healthcare system. Yet by 2002 the number of health institutions in the five biggest cities of the country with an institutional review board and/or a clinical ethics committee was still low and no information was available about how these committees actually worked (Alterio, et al., 2008, p. 113). According to some authors, these committees in Colombia are mostly dysfunctional and it is likely that they cannot provide the 'ethical control' they are supposed to exercise (Suárez, 2008).

In 1991 the Ministry of Health, following international recommendations related to human rights and ethics committees, decided to create Hospital Ethics Committees in Colombia (Sánchez, 2008).[150] However, these committees were conceived more as a mechanism to promote the participation of the local community in healthcare decisions, rather than as advisory committees in the clinical decision-making process. In other words, their role was more related to politics than to the ethics of medical decisions. In fact, according to the Decree 1797 of 1994, and in the context of the new healthcare system created by Law 100 of 1993, it was stated that 4 out of 7 of the members of these committees should be members of the lay community.[151]

In 1998 the Ministry of Health sponsored a manual on clinical committees and in its foreword the minister Maria T. Forero argued that "within the new social security system scenario clinical ethics committees are fundamental to make decisions, defend life, and carry out an ethical assessment of biotechnology" (Hackspiel, 1998). The perspective and methodology proposed in this book followed the Spanish bioethicist D. Gracia's approach as

[150] Resolution 13437 of 1991 of the Ministry of Health.
[151] See: http://www.encolombia.com/medicina/enfermeria/Enfermevol130310/Comitedeetica.htm, accessed 5 July 2011.

well as American principlism. At present, although there are still no clear regulations, many healthcare institutions, depending on their level of complexity, have some type of ethics committee. In the last few years the number of institutional review boards (IRB) has increased, both at private and public institutions. But, I argue, their institutional affiliation remains an issue to be discussed in Colombia. The independence of these committees is fundamental to guarantee possible 'conflicts of interests' and to keep them focused on their primary role: the ethical assessment of research protocols. The problem is that 'independent' IRBs, in a context of a lack of regulation and eagerness for profit in the age of biocapital (see introduction), might be working as 'legitimising' bodies of clinical trials sponsored by pharmaceutical companies. Thus, these committees have ended up being another 'business sector', as the members of these committees can earn money by carrying out the ethical assessment of clinical protocols that require 'ethical' approval.

After years of lobbying by the bioethical establishment, in 2001 the[152] was created by the presidential Decree 1101 of 2001 as a body attached to the Ministry of Health. This commission had four ministerial delegates (the ministries of Internal Affairs, Health, Education, and Environment) and seventeen permanent members. These permanent members were supposed to be distinguished scientists, scholars or professionals. However, who could actually become a permanent member also depended on the kind of relationship the person had with the Colombian bioethical establishment. Some of the people who became members of this commission had no idea what bioethics is about *Intersectoral Commission for Bioethics*,[153] as the Colombian bioethical establishment had been keen to include in their ranks influential people, no matter their academic background or experience or work in bioethics. Sometimes it seems that for the Colombian medical ethics and bioethics establishment grey hair, old age, social position, fame or professional expertise in any area guarantee *ipso facto* enough knowledge and ability to deal with 'bioethical issues'. According to F. Sánchez, who was one of those permanent members, the Comisión Intersectorial was conceived as a governmental advisory board to "analyse and design public policies aimed at protecting human beings in the context of science and technology research, development, and application" (Sánchez, 2008). However, F. Sánchez himself recognised that, no matter the good intentions, this commission never fulfilled this aim and was dysfunctional from its very

[152] Comisión Intersectorial de Bioética.
[153] It is a matter of discussion whether having a basic knowledge about bioethics should be a pre-requisite for a person to be a suitable candidate for a commission like this.

beginnings. According to him, this was because the commission was just another bureaucratic body, stripped of real powers to influence the government's decisions, and whose members never shared similar views on its purposes and modus operandi (Sánchez, 2008).

More recently, the Colombian bioethical establishment swapped this Comisión Intersectorial for a Comisión Nacional de Bioética,[154] "following the example of the most developed countries" as F. Sánchez said (2008). Then, after meetings and political lobbying, in a process full of intrigues and manoeuvrings as each bioethical group of interest wanted to get control over how to organise such a commission, the Comisión Nacional de Bioética was created by Law 1374 of 2010,[155] although the process to officially install such a commission has not yet ended. The Colombian bioethics establishment announced the creation of this commission as a 'triumph' of bioethics, but it will be necessary to see if it passes the test of time. How, for example, will this commission effectively influence national policies on human research, deal with ethical-legal-political-economic problems related to healthcare, and so on?

**4. The production of a new expert: 'The bioethicist'**

Since the late 1990s the number of academic programmes in bioethics has multiplied in Colombia.[156] The first postgraduate programme in bioethics in Latin America was offered in Colombia in 1995 by El Bosque University in alliance with CENALBE as a Specialisation (a one-year programme) in bioethics (Garzón, 2000, p. 35; PBUEB & Escobar, J., 2002, p. 22),[157] or, in other words, it was created by J. Escobar and A. Llano. The content and structure of this programme laid the foundations for future academic programmes in bioethics in Colombia. In this programme students attended seminars and lectures on scientific and philosophical issues, aimed at outlining the 'new paradigm' of bioethics: the defence of life in a technologicised, scientificised, dehumanised and anti-ecological world. Bioethics was presented in a Potterian way, as a 'bridge' between the sciences and humanities. Bioethics was on the one hand understood as an interdisciplinary dialogue, and a holistic approach to

[154] National Commission for Bioethics
[155] The main difference, apart from changes in the number of members, is that the National Commission has a higher rank in the legal/administrative hierarchy as it was created by a Law, i.e. by the Congress, while the former Intersectoral Commission was created by a presidential Decree.
[156] J. D'Achiardi (2004) mentions at least 20 bioethical programs offered in the biggest Colombian cities. However, at present the number is probably even higher.
[157] A one-year postgraduate program.

knowledge and science in general, On the other hand, bioethics was also regarded as "a bridge to the future" (Potter, 1971). Accordingly, bioethics was presented as a new ethical perspective, committed to the protection of life on the planet, and particularly concerned with the survival of the human species under threat because of irresponsible biotechnological advances. The alliance between El Bosque and CENALBE lasted less than a year as personal disagreements and disputes between J. Escobar and A. Llano led to a premature end.[158] After that, El Bosque University eventually continued to offer postgraduate studies in bioethics under the direction of Escobar, while Llano moved to the Universidad Javeriana where he later, in 1998, also organised an option in bioethics in a postgraduate programme.

In the history of the academic institutionalisation and professionalization of bioethics in Colombia, El Bosque University has undoubtedly played a major role. Apart from a Specialisation, this university started a MA programme in bioethics in 2000 and in 2005 a PhD programme. Besides, since its beginnings, PBUEB has championed the organisation of events such as conferences, workshops, forums and courses in bioethics. It is the major publisher of bioethics literature in Colombia, and in the ranking of the Colombian research groups made by Colciencias[159], it ranks first among the research groups in bioethics. However, from a Foucauldian perspective the question is how bioethics in Colombia came to be almost synonymous with El Bosque University. I would suggest three factors that might provide an answer. First, as a co-founder of this university and having been its Chancellor for three consecutive periods, from 1996 to 2002, J. Escobar was in a privileged position to create an academic programme in bioethics according to his own ideas about the field (PBUEB & Escobar, 2002, p. 27). Second, from the very beginning the PBUEB developed strategic national and international relationships, for example, with the RPB in Chile and collaborations with bioethicists like Gilbert Hottois in Belgium or Mahal Da Costa in Chile. Also, from the very beginning the PBUEB adopted a proactive policy of publications and organised several events on bioethics. In this way the PBUEB built up its prestige as a leading institution in the field of bioethics. Finally, the discourse about the institutional identity of El Bosque University matched the bioethical discourse, since at its foundation in 1978 this university adopted a *bio-psycho-social* and *interdisciplinary* approach in all its

[158] I was one of the students attending this first postgraduate course in bioethics. This episode between these two 'pioneers' of Colombian bioethics showed me very early that the development of the field was not simply a unselfish and philanthropic effort to solve urgent ethical dilemmas brought by the biomedical progress, but also a 'power struggle' between interest groups and particular individuals.

[159] Colciencias is the Colombian governmental agency that supports and regulates academic research in different fields. See: http://www.colciencias.gov.co/, accessed 24 July 2011

programmes (El Tiempo, 1997a).[160] It is not a surprise then that bioethics had found a fertile soil to grow.

For the PBUEB itself this institutional identity, 'bio-psycho-sociality' and 'interdisciplinarity', explains its own creation and successful development (PBUEB & Escobar, 2002, pp. 15, 33). According to J. Escobar, since the very moment of its foundation, El Bosque University brought 'bioethical issues' to the centre of its academic life and the promotion of bioethics became an "institutional policy".[161] In 1995, for instance, bioethics was included as one of the modules of the faculty of education with the argument that school teachers might promote "bioethics thinking" in their host institutions (De Zubiría, S., 2008, p. 8). Bringing bioethics into school education was justified as "[t]he teaching of general bioethics [is] an input and a tool for the building of a civil ethics [and] bioethics should be taught from primary to high school […] as a separate subject [for] learning respect, responsibility and love" (Escobar, Sarmiento & Gordillo, 2008, pp. 83, 128). PBUEB has emphasised that it holds a "pluralist and civil" approach to bioethics, instead of a "clerical or religious" one (PBUEB & Escobar, 2002, p. 34). This emphasis is intended, among other things, to clearly set a contrast with widely known bioethical approaches in Colombia of the 1990s like that of A. Llano, whose column in the main newspaper in Colombia gave him the opportunity to 'announce' the 'advent' of bioethics, which at the same time contributed to his reputation as a bioethicist. Once his alliance with El Bosque University was dissolved in 1996, he went to the Universidad Javeriana, a Jesuit university, where he formed a new alliance, this time with the Bioethics Institute recently created in this university in 1997. Thus, the *Bioethics Institute at the Pontificia Universidad Javeriana*[162] was born. This institute was initially attached to the faculty of science where another bioethicist, the Jesuit priest G. Cely, had already introduced bioethics. He started to teach bioethics courses for postgraduate students in this faculty in 1988, and in 1993 initiated a weekly research seminar on bioethics with an 'interdisciplinary' group that later formed the basis for the creation of the IBPUJ[163] (D'Achiardi, 2004). In 1998 A. Llano was appointed as the director of this Institute, which

[160] See also the university's webpage: http://www.uelbosque.edu.co/institucional/enfoque, accessed 24 July 2011.
[161] See: http://www.bioeticaunbosque.edu.co/presentacion.htm, accessed 20 September 2011. However, slogans and/or the inclusion of certain modules in the curricula, e.g. bioethics, is not enough to counterbalance the effects of extended institutional practices in Colombia. In short, I contend that despite the discourse of El Bosque University about 'bio-psycho-sociality' and 'interdisciplinarity', this university is very similar to any other private university in Colombia.
[162] *Instituto de Bioética* de la *Pontificia Universidad Javeriana*.
[163] See: http://www.javeriana.edu.co/bioetica/

had been removed from the faculty of sciences to become an independent institute administratively attached to the Academic Vice-Chancellor's office. It was said that this move was "to be consistent with the interdisciplinary work [in bioethics] and to guarantee that no particular discipline would predominate"[164] (IBPUJ, n.d.).

In contrast to PBUEB, which emphasised *civil ethics* as foundational discourse for bioethics, under the direction of A. Llano the IBPUJ would emphasise *human dignity* as the quintessential criterion in bioethics (IBPUJ, n.d.). Also appealing to human dignity, La Sabana University, an Opus Dei university, has promoted a personhood-centred approach to bioethics (personalism). For authors who hold this position such as I. M. Hoyos, Colombian bioethics and jurisprudence should recognise personhood as the foundational concept in which human being, human life, and person are concurrent terms (Hoyos, I. M., 2000, p. 3). People with religious commitments (certainly Roman Catholics, the predominant religion in Colombia, but also Protestants, Muslims and others) have found in human dignity a 'meeting point' between bioethics' secular demands and religion-oriented values. It is a concept deeply rooted in the Christian tradition and has recast as a semi-secular version of the sacredness of life (Cuéllar, J., 2010). The Vatican promulgated a directive, according to which Catholic universities should become engaged in bioethics (IBPUJ, n.d.). But, of course, the bioethics promoted by these universities is supposed to go hand in hand with official Catholic doctrine, although, as in other fields, there are dissident voices.[165] Human dignity also appears in the Preface of the Colombian Constitution and it has been used in important declarations pronounced by international organisations like UNESCO.[166] Yet some Colombian bioethicists have pointed to the lack of clarity surrounding this concept, making it difficult to use properly as guidance in practical situations (Cuéllar, J., 2006).

[164] Since its creation in 1998 there has been an endless debate as to a bioethics institute should be attached to a faculty of philosophy or theology or medicine or sciences. Bioethicists like A. Llano and others have held that owing to its nature, bioethics should not be identified with any particular discipline and its presence in the university is to be metaphorically seen as an 'umbrella', i.e. given its interdisciplinary nature, bioethics has to inform all fields of knowledge without belonging to any in particular. If the institute went to the Faculty of Philosophy, bioethics would probably become a 'practical or applied ethics', in the Faculty of Medicine a 'biomedical ethics', or in Theology a "moral perspective". Bioethicists have argued that only in their hands bioethics can really develop as a new field.

[165] See chapter seven about the abortion debate.

[166] E.g. *The Universal Declaration on the Human Genome and Human Rights*, 1997, by UNESCO. See: http://portal.unesco.org/shs/en/ev.php-URL_ID=1881&URL_DO=DO_TOPIC&URL_SECTION=201.html, accessed 20 August 2010.

By taking the Specialisation programme in bioethics of the Universidad Javeriana as a case-example, it will be possible to see what producing a bioethicist is for the Colombian bioethical establishment. First of all, this programme was virtually open to anyone with a university degree, thus reinforcing the idea that bioethics was suitable for any discipline, profession or field of knowledge. The programme was divided in four modules. Three were about the scientific, philosophical (mainly ethics), and anthropological 'foundations' of bioethics, while the fourth was devoted to analysing particular issues in bioethics (genetic engineering, euthanasia, etc.). A seminar on the history of bioethics was also included. In my view, in this seminar the 'myths of origin' of bioethics and the idea that bioethics was a necessary answer to the ethical dilemmas posed by the biomedical progress were reinforced. The rationale behind this programme was to provide the student with the 'right' angle so that he/she would be able to 'see' the necessity of a 'new approach' to deal with the 'new problems' posed by techno-scientific advances.

Although it was at El Bosque and Javeriana Universities where bioethics first consolidated in postgraduate programmes in Colombia, other universities have also played an important role in the academic institutionalisation of the field. For instance, La Sabana University in Bogotá offered a Specialization in bioethics in 1998, but it lasted only two years (PBUEB & Escobar, 2002, p. 23). Since La Sabana is an *Opus Dei* university, it is not a surprise that its ideological orientation is aligned with the official doctrine of the Roman Catholic Church. Three other universities have made also a significant contribution to the institutionalisation of bioethics in Colombia. In the Military University Nueva Granada had in the philosopher Gustavo García another 'pioneer' of bioethics in Colombia, and the *Revista Latinoamericana de Bioética*[167] was created here in 2001. In the faculty of medicine of El Rosario University, bioethics has been promoted as a 'transcurricular' field, which means that bioethics is not taught in a particular year or level, but throughout the whole curriculum from the first to the final year. In 2002 the *Centro Interinstitucional de Estudios en Bioética y Derecho Médico*[168] was created in that university with the important support of Juan Mendoza (Rubiano, 2010). There J. Mendoza also promoted the creation of a module called 'Ethics, Holoethics and Legislation', in which bioethical issues would be addressed. Mendoza said that with this name he wanted to emphasize the idea that bioethics is not an 'enlarged medical ethics'. Finally, the Externado de Colombia University, where bioethics has developed in the context

[167] Latin American Journal of Bioethics.
[168] Inter-institutional Centre for Bioethical and Medical Law Studies.

of a law school. Under the direction of Emilssen González, a lawyer and expert in bioethics, this university created in the 1990s the *Centro de Estudios sobre Genética y Derecho*[169] that has offered since 1999 an option called Law and New Life Technologies, focused mainly on the legal challenge that new biotechnologies represent for Colombian law. In 2003, this Centre organised the First French-Andean Seminar on Bioethics, which showed important ties between the Colombian and European understanding of bioethics (González, E. 2003).

Although I have so far only mentioned institutions located in Bogotá, it is worth mentioning that, particularly from the 1990s onwards, in other big regional cities there were people and institutions also promoting bioethics,[170] but their impact and influence at a local or regional level has not yet been properly studied. It would be tedious and unnecessary to list here the names of all the people and institutions working in bioethics in other regions and cities in Colombia other than Bogotá. Rather, I will just stress that since the late 1990s and the beginnings of the 2000s, as a kind of 'domino effect', bioethics has appeared more and more as an independent field of knowledge and professional field, and was very often linked to biomedical sciences departments or institutions.

Although altruistic motives, love of knowledge, and social necessities are invoked in the creation of new academic programmes, very often political and economic factors as well as power dynamics are deeply implicated. In the case of the PBUEB, it is clear that the powerful position of J. Escobar and in the case of the IBPUJ the social relevance of A. Llano played an important role. Bioethics has been a successful academic and professional field in Colombia not only because it is a relevant field in our day, but because powerful people have been behind its development. A critical history of bioethics in Colombia should consider this aspect, i.e. how the arguments have very often followed the big names, and not the other way round. In Foucauldian terms, it is important to determine the role of the author in Colombian bioethics, otherwise its history will continue being told as if bioethics simply and spontaneously flourished and came to be what it is in the present. The development of bioethics in Colombia has remained deeply linked to 'pioneers' and particular powerful people, those who belong to what I have called the *Colombian bioethics establishment*. The content, methodologies, ideological orientation and issues that are usually included in an

[169] Centre for Genetic and Law Studies.
[170] The unpublished work of D'Achiardy (2004) is a complete list of the main bioethics institutions, centres, and scholars working on the field up to 2004. An updated census is still an awaiting task.

academic programme in bioethics, workshop and/or association, as well as the scope, nature, and dynamics of the field, have often been capriciously determined by this establishment.

In 1998, the Second Congress of FELAIBE was held in Bogotá organised by A. Llano. This congress was widely covered by the Colombian media and had approximately 1,500 delegates (Llano, 1998, p. ix). This high attendance was not only because bioethics was a 'novelty' for Colombian academia, but also because the enormous charisma of A. Llano in Colombia. This mass event and its resonance in Colombian society were proudly taken by the Colombian bioethics establishment as a proof of the health and importance of the new field. Moreover, it was an opportunity for the Colombian bioethics establishment to show how broad, interesting and 'necessary' the new field was. One of the most interesting debates during this congress was on euthanasia, which had recently been decriminalised (in 1997).[171] By the late-1990s bioethics was clearly linked in Colombia to biomedical achievements widely commented on in the mass media like cloning, in-vitro fertilization and so on. When biotechnological breakthroughs were publicised in the news, e.g. Dolly the sheep in 1996 or the Human Genome Project in 2000, bioethicists would be consulted along with renowned Colombian scientists and lawyers (Nieto, 1995). Furthermore, once the Constitutional Court[172] began to make decisions on highly debatable social issues related to medical practice, e.g. the aforementioned decriminalisation of euthanasia, the Colombian bioethics community also had the chance of becoming more visible in Colombian society. By the early 2000s bioethics had already entered the Colombian mainstream as the right and appropriate setting for discussing important issues related to 'the survival of humankind' at the same time as bioethicists were indirectly announced as 'necessary' for our society.

**5. Ideas and discourses on bioethics**

In the 1990s the idea that bioethics encompassed much more than biomedical ethical issues had gained momentum within the bioethics community. This position was, moreover, a form of resistance against American bioethics which was regarded as being too much focused on the biomedical scenario and a medical product itself. In Colombia bioethics was promoted as the 'ethics of life' in general. J. Mendoza's illustrates this point: "some voices, however, started pinpointing the inconvenience of such limitation [of considering bioethics mainly

[171] See chapter seven.
[172] The highest court in the Colombian legal system. See chapters six and seven.

related to biomedical issues] and asking for an ampler field of action for bioethics, one of general ethics geared towards the regulation of the human beings' behavior in their relations towards themselves as well as with everything surrounding them, be this living or inanimate" (Mendoza, 2006, p. 36). In some universities and professional associations bioethics was introduced as the 'modern way' of humanising medical practice. J.F. Patiño,[173] for instance, argued that bioethics was the "new ethics" for medicine under the new economic conditions ruling this profession in our day (Patiño, 1993, p. 199f).

In general, bioethics is seen as the 'life advocate' in the contemporary world. Much of the promotion of bioethics by the Colombian bioethics establishment has to do with amplifying V.R. Potter's warnings about the future of the planet and his proposal to create 'the new science of bioethics.' Thus, in a biotechnologically-driven and dehumanized world, bioethics has to promote and protect life (Cely, 2007, p. 28). This is the mantra of many Colombian bioethicists. At present, although the Colombian bioethics literature remains mainly focused on biomedical issues, it includes more and more a disparate array of issues and problems, e.g. political violence, armed conflict, professional ethics, environmental crisis, poverty, to name but a few. Furthermore, nowadays 'bioethics' has become a word that gives particular prestige to debates, conferences, workshops and courses addressing dissimilar subjects. The idea that a wide variety of social concerns, political problems, scientific issues, etc. have a 'bioethical implication' has become paradigmatic in Colombia. Today, there is virtually no issue that does not deserve or require a bioethical reflection (Díaz Amado, 2007b, p. 92). I have called this 'totalising' and all-encompassing vocation the *bioethicism* of the Colombian bioethics.

Another extended discourse within the Colombian bioethics community is that bioethics is a discipline still in the making. This has resulted in turning bioethics into a 'grey zone' where it is very often difficult to distinguish which topics/issues belong to its scope and which ones not. This might explain why the so-called *epistemology of bioethics*, a field of study that has been promoted also in Latin America (Garrafa, et al., 2005),[174] has become a prominent research area in Colombia.[175] As F. Lolas has warned, bioethics in Latin America is under risk of becoming a commercial brand that guarantees many things: respect for the sacredness

[173] Renowned general surgeon in Colombia, university lecturer, member of different medical associations, among them the National Academy of Medicine.
[174] See chapter three.
[175] The 'foundations of bioethics' is an important issue to be studied in postgraduate programs in bioethics.

of life, love for nature, and respect for human dignity.[176] By using the word 'bioethics' many institutions, e.g. universities, hospitals, governmental offices and even particular individuals are sending a message of 'moral excellence' that sometimes contrasts with the reality.

A sort of axiom of Colombian bioethical discourse is interdisciplinarity. Interdisciplinarity is to bioethics what democracy is to modern politics: an *a priori*, but also an ideal. It is not only an intrinsic epistemological characteristic of bioethics, as many Colombian bioethicists like to point out, but also a political strategy. It is worth mentioning that, according to J. Moran (2002), "interdisciplinary study within the humanities is often an attempt to challenge the pre-eminence of the sciences as a model for disciplinary development, based on the belief that they can obtain neutral, objective forms of knowledge within their own areas of enquiry" (p.8). Therefore, interdisciplinarity is an important way of social, academic and professional legitimation for bioethical discourses. By identifying bioethics with interdisciplinarity, bioethics has achieved a powerful position, as bioethical debates, analyses and statements are seen as comprehensive, holistic and inclusive. As a result, resistances against bioethics are undermined and, concomitantly, its intervention in any field is seen as 'natural'. For this reason, any group working on bioethics nowadays wants to stress its 'interdisciplinarity', particularly if there is a particular but hidden ideological agenda that otherwise would be immediately rejected.

In 1990 A. Llano outlined the main characteristics of bioethics (Llano, 1990, p. 452) in a way that would set the foundations for the understanding of bioethics in Colombia which 20 years later has not changed (Llano, 2002, 2010). This has also been reproduced by many Colombian bioethicists. Summarising his main points, A. Llano argued that bioethics,

1. originated to protect human life and the environment.
2. is interdisciplinary.
3. offers new solutions for new problems, not 'prefabricated' ethical formulas.
4. appeals to reason and good moral judgment instead of the authority of any school of philosophy or religion.
5. entails the 'practical' aim of guiding the decision making process rather than a discussion of elaborated theories.
6. seeks to humanise the clinical scenario as well as to promote patients' rights.

[176] See chapter three.

7. regulates biomedical research, but not medical practice as this is the task of medical ethics.
8. integrates ethics and biomedical sciences to humanise healthcare professions.
9. is embodied mainly in academic centres for bioethics and national commissions of bioethics.
10. is concerned with new problems arising from biomedical developments and approaches 'traditional' issues, e.g. euthanasia or abortion, with new perspectives.

These ideas and characteristics attributed to bioethics were disseminated and amplified through the first journals and serials that also emerged in the 1990s. By the end of this decade, the number of publications about bioethics had significantly increased and the first journals in the field had been set up. In these journals not only were typical bioethical issues discussed, but diverse ideological positions regarding bioethics became visible. There are four main bioethical journals have been published in Colombia. The oldest one is *Persona y Bioética*[177] which was launched in 1998 by La Sabana University, an Opus Dei-run university. This journal stands for a philosophical anthropology-based position that takes on *personhood* as the unifying principle for bioethics (Arango, P., 1997; Santos, 1998, p. 61).

In 2002 *Bioethics Selections*, a magazine published by the IBPUJ in alliance with CENALBE at Universidad Javeriana, was first published. According to its director, A. Llano, this journal was aimed at making classical or foundational works in bioethics available for the greatest number of Colombians (Llano, 2002). In 2007 the research group on clinical bioethics and philosophy of medicine, which I founded in 2005, initiated the publication of *Anamnesis*, a bulletin focused on ethical and philosophical issues arising in the biomedical scenario. This publication was originally conceived to promote an in-depth debate on a largely neglected issue in Colombian academia, particularly after the take-over of the medical ethics academic field by bioethics, the philosophy of medicine.[178] After a re-launch in 2010, *Anamnesis* has become the official journal of the IBPUJ and now accepts articles addressing any bioethical issue, although it is not yet indexed (Díaz Amado, 2011, p. 5).[179] In 2000 the Military University New Granada launched the *Revista Latinoamericana de Bioética*.[180] This

[177] *Person and Bioethics.*
[178] See Anamnesis webpage at: http://puj-portal.javeriana.edu.co/portal/page/portal/Bioetica/publicaciones/anamnesis, accessed 5 June 2012.
[179] See: http://www.javeriana.edu.co/bioetica/publicaciones_Anamnesis.htm, accessed 23 September 2011.
[180] Latin American Bioethics Journal.

colourful and glossy journal includes articles addressing bioethics from a variety of perspectives. As any other bioethical journal it also states its pluralist, interdisciplinary, and non-confessional character. Finally, PBUEB launched in 2008 the *Revista Colombiana de Bioética*,[181] a peer reviewed journal. PBUEB is the largest academic centre for bioethics in Colombia and concomitantly the major Colombian publisher of bioethics literature, which includes important collections such as *Bios & Ethos*, with 28 issues from 1997 to 2007, and *Bios & Oikos* with nine issues, several translations, special issues, and books.[182]

But bioethics also encounters 'resistances'. In the institutionalised, ordered and hierarchical academic arena, for example, bioethics is now competing and conflicting with traditional, well-established disciplines, such as philosophy, theology or social sciences. In various circles, particularly philosophical ones, the epistemological status of bioethics has been questioned. There are unresolved internal disputes and disagreements on the status and place that the 'new field' should have in the university.[183] Sometimes there is a gap between the rhetoric that praises bioethics as a new and necessary kind of knowledge, and a daily reality that takes it as something 'secondary' or even useless. This is the case in hospitals and medical schools, which have now introduced modules in bioethics and where bioethics has received 'official' support, but where students frequently experience a gap between the 'official' curriculum and the 'hidden' one. For example, in an article I co-authored in 2005 we illustrated how the informed consent carried out in a private university hospital in Bogotá was just an administrative requisite, which lacked the characteristics of needed to be valid (voluntariness, disclosure, and competence) that were taught in the bioethics module (Suárez & Díaz Amado, 2005). In Colombia, an elaborate rhetoric about interdisciplinarity, respect for autonomy, human dignity, health equality, justice[184] and the necessity of promoting the so-called 'culture of life' has gone hand in hand with the request for 'implementing' bioethics at different levels. However, it is not clear if this has meant a real transformation of practices and a solution of problems at different levels. This is not a mere disjunction of theory/practice or incoherence. Rather, it is part of the 'nature' of bioethics in a world governed by neoliberal rationalities: bioethics is a 'buffer-discursive formation', particularly in the healthcare

[181] Colombian Journal of Bioethics
[182] See: http://www.bioeticaunbosque.edu.co/publicaciones/Biosyoikos/biosyoikos.html, accessed 20 August 2011.
[183] See above about the creation of the Institute of Bioethics in the Javeriana University.
[184] For G. Calderón, a Colombian bioethicist, in the case of Colombia "[o]ne's understanding of justice must go beyond its distributive nature to recognise its abilities as a reparative or restorative means, particularly in regions where citizens have been the victims of violence related to armed conflict" (Calderón, 2010, p. 363).

scenario. This aspect is illustrated with the opinions and experiences related by the individuals I have interviewed in Colombia as part of my research.

## 6. Bioethics in Colombia: some views (from interviews)

According to FAS,[185] a physician expert in public health, by the late-1970s different groups, unrelated to the medicine, became interested in medical ethics in some Colombian universities, some of them with a clear Christian identity. According to STF, an expert in medical ethics and bioethics, during the late 1970s and early 1980s, discussions about the 'ethicality' of the pill, Pomeroy tubal ligation, in-vitro fertilization, abortion, and human research, to name but a few issues, led to ethical debates, drawing the attention of mass media and other important social agents like the Roman Catholic Church, which has traditionally influenced many and shaped the country's socio-political life. He added that during the 1980s, some doctors, particularly those working in academia, considered this ethical debate 'too medicalised', when the first groups interested in bioethics appeared.

For ETJ, physician and bioethicist, bioethics evolved when "medical ethics was challenged by biotechnology, although he underlined that bioethics should not be reduced to medical issues. According to him, while medical ethics is medical profession-oriented, narrow, aimed at 'controlling', and deontological in character (including courts of medical ethics that are little more than 'para-judicial' bodies), bioethics instead is deliberative, non-normative, non-prescriptive, open to other professionals like lawyers, economists, etc., and oriented to debating rather than to control. It should be noted that Colombian bioethicists very often emphasise that bioethics is not –and should not be– confined to the biomedical scenario. In fact, the Colombian bioethics establishment has promoted a very wide, sometimes grandiloquent idea about what bioethics is, for instance, as MVJ, a physician and medical ethicist, claims: "bioethics is the ethics of everything."

In the same way, as the opinion of a Catholic priest and bioethicist, LEA, illustrates, bioethics in Colombia is usually seen as the 'overcoming' of traditional ethics and not merely as a sort of applied ethics or practical philosophy: "if someone thinks bioethics is 'applied

[185] The interviewees authorised to use quotations as long as they were anonymised. Therefore, each one is identified with three letters. To see how the interviews were planned, general information about the interviewees, and the informed consent form as well as the cover letter, see the appendices. Furthermore, as the answers were originally given in Spanish, all the quotations from interviews in this thesis are my own translation.

ethics', as usually philosophers do, it is because he/she is ignorant about what bioethics really is… Bioethics is a new discipline!" In his view, "while applied ethics means that a given particular ethics is 'applied' in the analysis of a case/problem, in bioethics ethics is to be made; while ethics is about teaching, bioethics is about a method." Moreover, LEA added, "traditional medical ethics is not suitable for modern day medicine. It is better bioethics, which is an *interdisciplinary* field, based on *dialogue* that facilitates the ethical debate on biomedical issues." Similar to its origins in the USA, bioethics in Colombia has been closely linked to religious groups and debates. Yet, for some bioethicists religion is influencing bioethics too much. In HVG's view, a philosopher and bioethicist, "in Colombia bioethics was born surrounded by soutanes", and for ETJ, a physician and bioethicist, "the influence of religion has led bioethics to be sometimes 'biomoral'." In this regard, I would say that a major problem is extremist and dogmatic positions in bioethics. For instance, in the debates about abortion, euthanasia, same-sex marriages and reproductive medicine, to name but a few, people with religious commitments in powerful positions have used their power to constraint, threaten, and manipulate in order to impose their own view of the world. But, as HVG pointed out, bioethics in Colombia must avoid "the dogmatism and moralism that characterise some bioethicists, particularly those linked to the Opus Dei… Dogmatic positions represent a perversion of bioethics". For him, bioethics should promote a public debate around ethico-political issues related to biomedicine and the protection of life.

For the lawyer BPA, Colombian bioethics has remained as "a kind of sophisticated knowledge, an intellectual exercise, which is neither an important part of medical education nor does it take into account particular and contextual situations." In contrast, HVG argued that "bioethics has meant a way to criticize the Roman Catholic Church's power regarding the regulation of medical issues as well as to demystify medical ethics as a field of knowledge only available for experts." For UTC, a medical anthropologist, "the special interest of the Colombian Roman Catholic Church in bioethics is not casual; it is comprehensible, since bioethics is about issues related to Catholic dogmas." UTC stressed that unlike public universities in Colombia, private Catholic universities, such as Javeriana and La Sabana, have shown great interest in bioethics. The perception that bioethics is something related to religion has prevented bioethics developing at public universities as an independent and relevant field because of their secularist tradition.

Bioethics has also been taken up in Colombia as a way to 'humanise' medical practice as well as to improve doctors' behaviour. For example, for LBG, a physician and medical

educator, "bioethics should help to, first, re-define the new relationships between users and providers in healthcare; second, help medical practice to be based on *lex artis*;[186] and third, update the Code of Medical Ethics of 1981 to take into account the necessities of the new times." For other medical teachers, such as VRR, "bioethics is not about teaching or increasing the number of ethics or bioethics modules in the faculty of medicine, but about making visible the power relations in which doctors are nowadays embedded." Moreover, for him, although bioethics is a 'heterogeneous' field, the dominant bioethical discourse in Colombia "misses the link between the ethics of a medical decision and the economic determinations of it." Furthermore, he added, differences on how bioethics is taught reflect the personal views of those who are in charge. ETJ stressed that a 'secular' approach to bioethics was necessary, particularly in postgraduate bioethics programs. For GCA, another medical teacher, medical students should be taught fundamentally on how to recognise, disclose and deal with conflicts of interest, while for LEA, as for many bioethicists holding a religious, particularly Roman Catholic, perspective, "bioethics should be anthropologically grounded, appealing to human dignity as the fundamental principle to make decisions." In contrast, physicians without formal bioethical training tend to be more pragmatic regarding medical education. LCM, for instance, argues that "regardless the definition of bioethics, the crucial point is the protection of people and the guarantee of their rights."

By and large many doctors in the clinical setting, if asked about bioethics, would agree that medical ethics and bioethics are an important part of medical education and practice today. However, in reality, clinicians are satisfied with only a basic knowledge on these matters or, more frequently, are not really interested in them. Some circumstances, in my view, contribute to seeing medical ethics and bioethics as useless for doctors' daily practice. First, the structure of the healthcare system that imposes its own 'way of practising' and does not give doctors much room to make political, ethical, legal or economic reflections about what they do. Second, the abstract and 'overgeneralising' way in which bioethicists often address biomedical issues, reinforcing the notion that medical ethics and bioethics are 'disconnected' or 'inaccurate' discourses in relation to doctors' real life. And third, the juridification of medicine, i.e. the reduction of doctor/patient and medicine/society relationships to merely legal contracts, making medical ethics and bioethics appear as useless in practical terms. As a result, although clinicians are keen to back ethical regulations, in

[186] *The law of the skill*. Colombian physicians frequently use this Latin expression to refer to generally accepted standards in medical practice. See chapter six.

reality they are most concerned with demonstrating that they have been bound to the law rather than committed to important values and/or principles. Of course, this poses the question of what "good doctoring" is, which I will address in chapter six. It is worth noting that keeping oneself bound to the law does not necessarily guarantee good doctoring. Sometimes the irony is that good doctoring entails acts or decisions which might actually break the law.

Finally, according to LMR, a physician and bioethicist working in a governmental office, the Intersectoral Commission of Bioethics had a poor performance. First of all, it lacked adequate funding and, secondly, it was a politicised body in which some issues would be discussed while others were considered taboo. For instance, this commission did not really participate in important national debates such as the decriminalisation of abortion in 2006, and many issues related to medical practice were never discussed. He mentioned that one of its members once suggested discussing the official policy on illegal drugs, which Colombia has kept unmodified over years, particularly in relation to the deleterious environmental side effects of spraying glyphosate to control coca and poppy, a policy that has been backed by the USA. This proposal was, according to LMR, immediately rejected by the Ministry of Social Protection on the grounds that such an issue was beyond any discussion. For LMR, this episode illustrated the weakness of this commission and the 'Realpolitik' behind many bioethical discussions that it made.

## 7. Conclusion

As for Latin America as a whole, not much has been published on the history of bioethics in Colombia. Most of the existing historical accounts are personal accounts of people who are still active scholars or professionals and are considered 'pioneers' by the Colombian bioethics community. As any history, this history is also made up of images, tales, subjects and places that have become 'emblematic', entailing a particular point of view, a rationality that provides a meaningful sense of what happened and why we are where we are. The history that Colombian bioethicists tell about themselves and about the development of their own field provides a rationale that legitimises the current state of Colombian bioethics. Bioethics in Colombia was established and is still managed by powerful medical organisations, private universities and 'pioneers'. The Roman Catholic Church and conservative groups exert great influence on how bioethics is actually understood and practised. Given that bioethics was conceptualised in Colombia as a pluralist, secular, interdisciplinary, and 'in formation' field,

it seems that for Colombian bioethicists there is virtually nothing without a 'bioethical side'. In this way, Colombian bioethicists, particularly those who belong to the 'bioethical establishment', have been able to claim their authority about almost any contentious issue. The eagerness of Colombian bioethicists to seek the 'bioethical side' of anything has led to what I have called the 'bioethicism' of Colombian bioethics. Bioethics in Colombia is then a totalising discourse, which is available to most of the public, but which is produced, managed, and controlled, by a minority (the bioethical establishment).

According to the historical literature, which has been produced by the Colombian bioethics establishment to explain the birth of their own field, bioethics was already 'prefigured' in the academic activities carried out by certain people at the end of the 1970s, later on known as 'the pioneers', who organised in that time seminars in university hospitals and/or published articles on the transformation of death/dying and the impact of biotechnological progress in medicine. These 'pioneers' were renowned medical lecturers and Catholic priests linked to elite medical associations and private universities. In the 1980s the new discourse of bioethics appeared in the medical scenario in Colombia. While global media coverage of biotechnological advances increased, and the clinical setting had allegedly become inhumane, impersonal, technology-centred, and socialised, some medical lecturers and Catholic priests introduced the idea that a new ethical approach to medical practice was necessary. In the 1990s, this new discipline made its breakthrough, and a wave of intense academic and social activities related to bioethics spread across the country. This breakthrough coincided with the implementation of a new political constitution and a radical healthcare reform, which took place also in the 1990s. I will expand on this 'historical coincidence' in chapter five. By the 2000s there were university postgraduate programmes and courses, institutes, associations and journals devoted to the new field, and bioethicists were already a recognisable new type of expert.

At the beginning, American bioethics brought bioethics to Colombia. This meant a focus on principlism, an emphasis on autonomy, an analytical philosophical approach to ethical discussions in medical practice, and technology-driven ethical discussions. However, scholars who introduced bioethics to Colombia very soon transformed bioethics into a '*holo-ethics*', a word used by some Colombian bioethicists, meaning an ethics with a dominion over virtually any issue or discussion, with 'power' to intervene in any field or debate. Bioethics then became an 'ethics of life', a 'salvific' discourse, or in Foucauldian terms, a 'pastoral discourse'. V. R. Potter's totalising understanding of bioethics has been a fertile soil for such

a view. There are two main consequences of taking bioethics as a pastoral, totalising discourse. First, a lack of definition of the field, which has contributed to the theoretical weakness of Colombian bioethics and, at the same time, has facilitated the ideological uses of it. In short, the scope and aims of bioethics seem to have no limits in Colombia and then anything can be said in the name of bioethics. Second, bioethics has become a field in which social hopes and fears of different kinds have been reconceptualised in terms of life-related issues. Thus, problems such as poverty, violence, inequalities, exploitation and corruption, which have been widespread in the country, have been reconfigured by bioethicists in terms of violations of human dignity, limitations to personal autonomy and disrespect for life on earth. As a result, such conditions are striped of their particular socio-political and economic roots. Instead, they are seen as abstract and universal problems to be solved in the individual sphere by the 'interiorisation' of right attitudes and behaviour, e.g. love for nature, recognition of human dignity, respect for personal autonom, and protection of life in general.

My interviews revealed coincidences as well as discrepancies with the historical literature about bioethics in Colombia. Some interviewees recalled that at the end of the 1970s, medical bioethics emerged in the aftermath of public debates about death/dying, biomedical advances and issues related to DPR, which were no longer considered issues to be discussed exclusively by doctors. The influence of elite medical associations and the Roman Catholic Church in the development of the field is obvious, and conflicting views about the nature and scope of bioethics remain until today. While some bioethicists argue for bioethics as a 'new discipline' and an ethics of everything (holo-ethics), others have tried to find a narrower definition of bioethics. Those with a philosophical background have tended to see bioethics as applied ethics or practical philosophy. For those with a medical background, bioethics represented a way to 'humanise' the biomedical field, to promote a medical practice based on the *lex artis*, and a way to update the discourse of medical ethics. However, some interviewees mentioned that bioethics should be more critical about the power relations and economic constraints that determine medical practice in Colombia today, and that bioethics should avoid becoming an abstract and discourse disconnected from the Colombian reality.

Finally, it is important to underline that, from a Foucauldian point of view, the institutionalisation of bioethics in Colombia owes much to the fact that the so-called 'pioneers' were powerful and influential people, mainly related to the medical establishment and the Catholic Church, who were able to introduce the new field at different levels: private

universities, mass media and medical associations. Also, it should be noted that the flourishing of bioethics in the 1990s coincided with the implementation of a new political constitution and a radical healthcare reform. This ‘coincidence’ will be analysed in the next chapter.

Chapter five

# The wave of neoliberal reforms in the 1990s and the transformation of the medical ethos in Colombia

## 1. Introduction

In the preceding two chapters I summarised the main accounts that bioethicists have offered to explain the history of bioethics in Latin America and Colombia, outlined the discourses, rationalities and debates that constitute the field, and analysed the contribution of particular people as well as different organisations to the successful institutionalisation of bioethics in the region. I also examined how power relations and the interaction between power and knowledge can help to understand the myths of origin, the importance of pioneers and the conflicting views on bioethics co-existing in this part of the globe. By using a Foucauldian lens, I made a case for a view in which bioethics is seen as a kind of pastoral discourse and also a *dispositif*. In the particular case of Colombia I argued that the bioethical establishment has promoted an understanding of bioethics as an *all-embracing* field that has led to the *bioethicism* that characterises the Colombian bioethics, i.e., the tendency to see bioethical problems everywhere. Having done this, I want now to examine two circumstances: first, what the coincidence between the flourishing of bioethics in Colombia and a wave of neoliberal reforms happening in the country in the 1990s and, second, in what way the transformation of the milieu, and in particular of the *medical ethos*, has made the biomedical scenario governable, i.e. how bioethics can be seen as part of contemporary governmentality in the biomedical field. In short, I intend to show how the biomedical scenario is being governed nowadays in Colombia and how bioethics is part of it.

This chapter is structured as follows: I will first review the political evolution of Colombia in order to better understand the importance and significance of the constitutional change that occurred in 1991. Then I will describe the healthcare reform of 1993. A description of the antecedents in terms of 'conditions of possibility', content, rationalities and impact of this reform is provided. After that, I will discuss to what extent the rationalities of bioethics and those of the healthcare reform overlap. In so doing, I will argue, from a Foucauldian point of view, that the emphasis that both bioethics and the healthcare reform have made on personal autonomy, far from being an expression of emancipation, can be seen as part of a new strategy to govern the biomedical scenario. At the end of the chapter I will add information

from the interviews I carried out as part of my doctoral research, seeking to complement and/or contrast what was said previously.

## 2. The way towards the Constitution of 1991

Although the historical process through which Colombia has come to be what it is has been long and complex, it is necessary here to consider some elements to better understand the current socio-political, legal, cultural and economic conditions in which a conflictive but productive relationship between the medical profession, healthcare services, and bioethical/ethical discourses has been evolving since the early 1990s. The history of modern Colombia can be traced back to the early nineteenth century when many Latin American countries were born as a result of the wars of independence. In 1823 the former Viceroyalty of New Granada seceded from Spain. These territories included current Colombia, Venezuela, Ecuador, and Panamá, which together became the Republic of La Gran Colombia. Following internal political and military struggles, Venezuela and Ecuador seceded in 1830, and Panamá in 1903.[187] The war of independence was basically a bourgeois revolt against Spanish rule, taking the advantage of the Napoleonic invasion of Spain and, moreover, the realisation of the dream of *Liberté, Egalité, Fraternité* that inspired this war did not come automatically. In fact, following the war of independence the country entered a long period of chaos for almost the whole of the nineteenth century. For some authors, independence was just a 'name changing' while an oppressive regime continued in the former Spanish colonies. As L. Eslava has argued, "[…] the historical revolutionary process in Colombia came to be seen as transference of power from a foreign monarchic elite to the local Creole elite" (Eslava, 2009, p. 193).

Throughout the nineteenth century Colombia had a variety of political constitutions and experienced several civil wars. Some of these constitutions included revolutionary ideas ahead of their time, such as the recognition of citizen's rights for indigenous people in 1812 or universal suffrage in 1853, earlier than in many European countries (Posada, 2011). In 1863, the radical liberal government in office introduced a new constitution that turned Colombia into a federal state, The United States of Colombia. However, when the conservatives were victorious in another civil war in 1886 they gave Colombia yet another constitution to counterbalance the previous influence of radical liberalism. With the

[187] This time instigated by the US government that wanted to control the planned Panama Canal.

constitution of 1886 the now re-named Republic of Colombia became a paternalistic, protectionist and centralised state with a strong presidential system. The country adopted a clear confessional identity when Roman Catholicism was recognised as the official religion. This constitution was so anti-liberal that some have argued it prevented Colombia taking part in the first wave of globalisation (Mejía, ND, p. 5). Yet two constitutional reforms (carried out by Liberal governments in 1910 and 1936) softened this authoritarianism and made the constitution more inclusive, something that according to R. Uprimny (2011) allowed the constitution of 1886 to have a long life.

In 1948, when the liberal leader Jorge E. Gaitán was assassinated, the country went into a period known as 'La Violencia' [The Violence], which has had strong and lasting effects on Colombian society until the present day. The origins of Colombia's current guerrillas can be traced to this period, when many liberals had to flee to the countryside to escape the persecution of the conservatives. The only period in which Colombia was under a military dictatorship in the twentieth century was 1953-1957, and when it finished, the ruling classes made an agreement to share power during the following years. Thus, until the early 1980s, conservatives and liberals would each have their opportunity to be in office.[188] But violence never ceased. In the last 50 years, Colombia has experienced an irregular and complex armed conflict. Moreover, in the last 30 years it has developed a global reputation for drug production and trafficking. Hence, apart from suffering internal violence in different forms (armed conflict, state repression, inequalities, corruption and so on), additionally Colombians had to tolerate the international stigma of being considered drug-traffickers. Nonetheless, Colombia is the oldest democracy in Latin America, and its economy is one of the most stable of the region. Violence, however, is so pervasive in Colombia that some consider it an 'epidemic' (Franco, 1997; Quevedo, Hernández & Miranda, 1993, p. 233) in which different factors converged: leftist guerrillas, ultra-right paramilitaries, drug-dealers, criminal gangs and even state military forces. Yet, as L. Eslava (2009) has argued, "[c]ynically, Colombia is still considered a model of democratic stability and economic growth in Latin America, [a situation that some have called] the *Colombian paradox* […] the country's resilient capacity to remain in a painful state of stability" (pp. 192, 195f). This irrational, paradoxical, painful and endless way of living of Colombians was masterly depicted by the Colombian Nobel laureate writer G. García Márquez in his celebrated novel *One Hundred Years of Solitude.*

[188] This period was called *El Frente Nacional* [The National Front].

At the end of the 1980s the country seemed to have reached the absolute low point. Four presidential candidates were killed, many people massacred or displaced, bombs rattled the cities and corruption was endemic in the country. It was the time of Pablo Escobar Gaviria, the infamous and most powerful drug baron. Against this backdrop, a political student movement, embodying a wide societal desire for change, succeeded in promoting a process that led to the creation of a National Constituent Assembly in 1991 (Dugas, 2001; Murillo & Gómez, 2005, p. 2f). Thus, the new constitution of 1991 was enacted, marking the most fundamental break in the more recent history of Colombia (Uprimny, 2011). The intention behind this constitution was to pull the country out of a profound institutional and ethico-political crisis that had been manifest since the late 1980s (Cardona, J., 2011).

Under the new constitution Colombia defined itself as a "social rule-of-law state[189] [which is] democratic, participatory and pluralistic, founded on respect for human dignity, work, and solidarity between all citizens […]"(PC, 1991) Also, a "truly effective system for the protection and promotion of a new, generous bill of rights" was introduced, following the Universal Declaration of Human Rights, Articles 11 to 95 (Cepeda, 2004, p. 575f). The 1991 Constitution also introduced the *acción de tutela* [tutelage action or demand of custody], popularly known as *tutela*, "a writ of protection of fundamental rights [that] enables any person whose fundamental rights are being threatened or violated to request that a judge with territorial jurisdiction protect that person's fundamental rights" (Cepeda, 2004, p. 552). This innovative legal tool has given Colombians the possibility of demanding from the state that their fundamental rights are guaranteed and protected. As L. Eslava has argued, without *tutela* the *status quo* in Colombia would have remained untouched (Eslava, 2009, p. 209). Moreover, the Constitutional Court, the highest court in the Colombian legal system, was designated the ultimate "guardian of the constitution".[190]

Twenty years after the impact is still a matter of debate. By and large, Colombian citizens think positively of the Political Constitution of 1991 (hereafter PC of 1991), particularly because it guarantees fundamental human rights, promotes the idea of a secular society based on pluralism and human dignity, and gives citizens legal security before the state (Cajiao,

[189] The idea of adding 'social' to the concept of 'rule of law' was inspired by the 1948's German as well as 1978's Spanish constitutions (Eslava, 2009, p. 185).
[190] Under the Constitution of 1886, the Constitutional Chamber of the Supreme Court of Justice carried out this function.

2011; R. p. El Tiempo, 2011a, 2011b). However, the PC of 1991 did not mean the end of problems for Colombian society. According to the renowned constitutionalist R. Uprimny (2006), "[t]he constitution of 1991 came into being amid the crisis of 1989-1991, but it did not solve it. The war has not finished, corruption is pervasive, and the political establishment continues as if nothing had happened. On the contrary, even positive aspects of the Charter have been reversed" (p. 81). Although it was introduced only fairly recently, the original text of the PC of 1991 has already been modified 34 times (El Tiempo, 2011b). Some have argued that the PC of 1991 was too idealistic that it was "best suited for Switzerland", while others repeated what Victor Hugo said of the Colombian constitution of 1863: "it is a constitution fit for angels" (Cepeda, 2004, pp. 532, footnote 1). Yet the more ferocious criticism of the PC of 1991 and the laws which derived from it, for instance, the healthcare reform of 1993, has been against its supposedly 'neoliberal inspiration' (Cruz, 2010, p. 274; Vega, 1999).

### 3. The neoliberal inspiration of the constitution of 1991

At the end of the 1980s important changes were happening in the world like the fall of the Berlin Wall and the end of the Soviet Union when the polarization of the Cold War began to fade. Concomitantly, neoliberalism had been on the rise since the late 1970s and finally came to dominate globally as the new economic paradigm. According to D. Harvey (2005), neoliberalism is

> a theory of political economic practices that proposes that human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets, and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. (p. 2)

By the late 1980s, neoliberal ideas and rationality had already spread across Latin America. The Reagan/Thatcher era had prompted the rise of neoliberal thought which entailed four main aspects: economic individualism, elimination of legal obstacles to flexible labour markets, restructuring of the service sector according to market criteria and the promotion of national as well as international competition. The neoliberal approach also criticised the welfare state by relating it to bureaucracy, trade unionism, patronage, state corruption and inefficiency (Estrada, J., 2004, pp. 25-30).

At the turn of the 1980s, the economic crisis was getting worse and external debt was dangerously growing in Latin America, when "all the Latin American countries became involved in the programs of stabilisation and structural adjustment prescribed by the International Monetary Fund" (Ahumada, 1998; Vega, 1999, p. 62). By the beginning of the 1990s, the Washington Consensus (Williamson, 2004) was launched.[191] This has been seen as an economic agenda imposed by powerful institutions like the World Bank (WB) and the International Monetary Fund (IMF) on developing countries and promoted by the USA (Cruz, 2010, p. 7). The aim of the Washington Consensus in Latin America was to protect private property and to promote trade liberation, privatization and deregulation. These policies imposed from the outside became legitimate state policies through the ratification of treatises and the introduction of new laws (Estrada, J., 2004, pp. 31, 50). In the new neoliberal logic, everything had to be commodified, including health. Interestingly, international investors widened their scope to embrace 'social' issues. The World Bank, for instance, initiated a series of reports in areas like education, health and environment as a strategy of this institution to take on a 'human face' (Estrada, J., 2004, p. 51).

Then, it seems that the PC of 1991 embodied two antagonistic models of statehood as it set the foundations for a social rule-of-law state and also the juridical basis for a neoliberal state (Alvarez, J.R., 2007, p. 126; Cruz, 2010, p. 12; Murillo & Gómez, 2005, p. 1). This situation has been at the bottom of the permanent tension between 'social responsibility' and 'economic growth' during these twenty years (Murillo & Gómez, 2005, p. 15). It has also led to a polarization of the debate around the constitution of 1991 since it seems that one can be either state-centred or market-oriented regarding the conception of the state (Álvarez, 2007, p. 132). It seems, however, that during the last twenty years the Colombian government has gone for the market-oriented, neoliberal model (Arango, R., 2011). This dichotomy, even schizoid situation, is reflected in the transformation of healthcare after Law 100.

### 4. Law 100 of 1993, the 'neoliberal' healthcare reform

The wave of neoliberal healthcare reforms that spread across Latin America in the late 1980s started in Chile and was soon followed by Colombia, Argentina and Brazil. In the case of Colombia, where neoliberal ideas and international financial institutions' policies were

[191] See also: http://www.cid.harvard.edu/cidtrade/issues/washington.html, accessed 1 April 2010.

adopted most closely, the reforms took place in the 1990s (Homedes & Ugalde, 2005, p. 84). Between 1986 and 1994 Colombian governments introduced neoliberal policies in healthcare that "resulted in the emergence of a new way of governing Colombian health care services and the population's health, [thus governmental intervention was based on] different domains of knowledge and technologies of power such as public health, public administration, hygiene, health economics, and social security, among others" (Vega, 1999, pp. 35f, 54f). Law 10 of 1990 was a first big step towards deregulation at different levels. This law aimed "to diminish the cost of health care by promoting a cheap primary medical care for the poor, by enhancing community participation and self-care, and by increasing efficiency in the performance of the system" (Vega, 1999, p. 40). Article 1 of this law declared the Colombian healthcare system as a public service, "that is to say, a set of institutions regulated by the central state but not necessarily under its direct administration and ownership" (Vega, 1999, p. 41) which paved the way towards a stronger market orientation in healthcare.

In the period from 1992 to 1998, during the third liberal government in office in a row, deregulation was aimed at facilitating the creation of 'new markets' (Estrada, J., 2004, p. 85). During the 1990s one policy was "to create conditions for making private profit. In the future, the modernising ideals of progress, efficiency, and equity would take the form of state-regulated market relationships, private initiative, and individual choice" (Vega, 1999, p. 62). There were important legal-political reforms during this time inspired by a neoliberal rationality, e.g. Law 50 of 1990, which introduced labour flexibilisation; Law 30 of 1992, which deregulated the education system; Law 142 of 1994, which introduced market rules in the provision of public services; and Law 226 of 1995, which allowed the privatisation of state assets.

The arrival of a new generation of technocrats, managers, consultants, advisers and experts of all kinds boosted neoliberal ideas in Colombia. Most of them came from the social elites, had studied in leading American universities and shared with international financial organisations similar cultural and economic interests (Estrada, J., 2004, p. 51; Vega, 1999, p. 63). Some authors have argued that the neoliberal wave of reforms in Latin America "was not based on people's needs, but strongly inflamed by the needs of foreign – especially North American – corporations" (De Vos, et al., 2006, p. 1604). Latin America was indeed a promising market, but it was necessary to create adequate political and legal conditions in order to implement the neoliberal project without causing trauma. During the economic crisis

of the 1980s, the IMF and the WB "took advantage […] and pressed for health reforms as a condition for borrowing." Thus, a market-oriented model for healthcare was promoted as the right thing to do in Latin America, with the participation of USAIDS,[192] IADB,[193] and even PAHO (Bertranou, 1999, p. 1; De Vos, et al., 2006, p. 1604; Homedes & Ugalde, 2005, p. 83).

In 1993, the year when Law 100 was implemented, the World Development Report of the WB stated the "need to improve equity and allocative efficiency through guaranteeing universal access to a basic package of services" (Homedes & Ugalde, 2005, p. 84). In Colombia, the PC of 1991 established "the principles and the rules for the operation of a minimum state, and defined the conditions for the wide operation of private market relations" (Vega, 1999, p. 43), then providing the foundations for a new social order based on the market. The implementation of different measures to reduce public spending as well as to reduce poverty was the strategy of the WB and the IMF to introduce this ideology in Latin America. According to the new policies, state involvement in healthcare should be limited to the provision of essential clinical, public health services and the correction of the "deficiencies of the market". These deficiencies were "[…] problems of adverse selection, moral risk, and others such as externalities and imperfect competence between providers of health services" (Vega, 1999, p. 55). Then, the WB's recommendation was to implement universal insurance in a context of *regulated competence*, i.e., healthcare services would be ruled by a market rationality while the state would guarantee the correct functioning of the system (Rodríguez-Monguió & Infante, 2004, p. 137f). In short, Law 100 was a turning point from "a unified, integrated, and regulated system [to] a regulated market based on the separation of functions" (Rodríguez-Monguió & Infante Campos, 2004, p. 131), a separation between the purchaser and the provider, between financing and provision in the name of efficiency (De Vos, et al., 2006, p. 1605). As Juan Luis Londoño, the Colombian mastermind of the healthcare reform, who would later become Minister of Health, put it: Law 100 sought to implement a "structured pluralism and managed performance" in healthcare (Londoño & Frenk, 1997, p. 17; Rodríguez-Monguió & Infante, 2004, p. 132), which in practical terms entailed a process of deregulation, decentralisation and privatisation of healthcare (Homedes & Ugalde, 2005, p. 84).

[192] United States Agency for International Development.
[193] Inter-American Development Bank.

Based on Law 100 international financial organisations demanded from the government to cut spending for public services and to act only as regulator but no longer as provider (Homedes & Ugalde, 2005, p. 83f). In the name of democracy and community participation, with the decentralisation technical responsibility and financial resources returned to municipalities (Kalk, 03, p67). However, this meant that an increasing financial burden of public services was transferred from the central government to the provinces. Yet, "[t]he policy of decentralization was wrapped under the hard-to-oppose principle of transferring power from unconcerned and inefficient central bureaucrats to the people" (Homedes & Ugalde, 2005, p. 84). In 1995 the PAHO, the WB, and the IADB "agreed on concrete strategies for health sector reform in the continent" (De Vos, et al., 2006, p. 1604) and PAHO became one of the main supporters of the Colombian reform (Coronell, 2011). For many critics of the reform it was ironic that in 2000 the WHO ranked the Colombian healthcare system first in the world despite of its tremendous deficiencies. It was clear that there was an ideological overlap between the ideologues of the reform and the staff of international organisations such as WHO/PAHO (Homedes & Ugalde, 2005, p. 89).

In the National Assembly that was responsible for the new political constitution of 1991, a Transitory Commission discussed issues related to social security and health. However, its recommendation to include in the constitutional text issues like the creation of a national healthcare service similar to the NHS in the UK, and a national policy on prescription drugs were never considered properly (de Currea-Lugo, 2003, p. 91). In the end, only two articles about health were included: Article 48, which stated the right to health, although not a fundamental right,[194] and Article 49, which decentralised health services (PC, 1991), leaving the organisation of a healthcare system in the hands of the Congress. Unfortunately, the Colombian Congress is a place full of hidden agendas, where many interests are at stake and powerful lobbyist groups influence the decision making process. The bill 34 of 1992 illustrates how much the neoliberal rationality had penetrated the legislative by then. According to this bill, the state would only have a regulatory and normative role in the economy and therefore private companies should be allowed to participate in any area. Concomitantly, non-profitable areas considered of 'social importance' would remain in the state's hands (Estrada, J., 2004, p. 98). In the end, Law 100 of 1993, the most radical healthcare reform ever carried out in Colombia was adopted, creating the General System of

[194] 'Health' was understood as part of 'social security', which was defined by the Constitutional Court's Decision T-116 of 1993.

Health and Social Security,[195] hereafter GSHSS, a mixed private/public system in contrast to a tax-financed systems like in Portugal or the UK and social insurance systems like in France and Spain.

## 5. The new healthcare structure

The text of Law 100 begins by setting out its ethical foundations embodied in six principles: proficiency, quality, effectiveness, universality, social solidarity and participation (Jaramillo, I, 1999). Moreover, Law 100 states that, first, healthcare is a public service administered by the state; second, the private sector can participate in the GSHSS; third, local governmental bodies should play an active role in the organisation and funding of healthcare services; and fourth, the affiliation to the GSHSS is compulsory for everyone in Colombia. In the new GSHSS new actors, institutions, and concepts were created, which include:[196]

1. **National Council of Social Security for Health**[197], which is responsible for standardizing, regulating, controlling and directing the system together with the Ministry of Health and local authorities.
2. **Compulsory Plan of Health**[198], which is the basic health package including procedures, treatments and prescription drugs that health insurance companies should provide to their affiliates.
3. **Health Insurance Companies**, which can be either *Health-Promoting Entities*[199] or *Subsidised Health-Promoting Entities*[200]. These two kinds of entities should guarantee, through *Health Service Providers*[201], the delivery of the Compulsory Plan of Health to their affiliates. In turn, Subsidised Health-Promoting Entities are responsible for the delivery of services included in a different package,

[195] Spanish: Sistema General de Seguridad Social en Salud. This includes health, pensions, and labour risk management. As *pension funds* were created, not only health, but the whole field of social security was commodified (Estrada, J., 2004, p. 97).
[196] For a complete description of the GSHSS and how it works, see: Arroyave, I. D. (2009). *La organización de la salud en Colombia [The healthcare structure in Colombia]*. Medellín: Hospital Universitario San Vicente de Paúl. Also see: United Nations Development Program. Colombia. Available at http://tcdc2.undp.org/GSSDAcademy/SIE/Docs/Vol18/SIE_v18_ch9.pdf, accessed 1 June 2012.
[197] Consejo Nacional de Seguridad Social en Salud.
[198] Plan Obligatorio de Salud.
[199] Empresas Promotoras de Salud.
[200] Administradoras del Régimen Subsidiado.
[201] Instituciones Prestadoras de Servicios, which include hospitals, clinics, laboratories, and the like.

the Subsidised Compulsory Plan of Health, a smaller version of the Compulsory Plan of Health for the poor (Rodríguez-Monguió & Infante, 2004, p. 131).

4. **Solidarity and Guarantee Fund**,[202] which guarantees the financing the system. Employees and the self-employed are required to support the system with contributions, while the poor and the unemployed are subsidised. This Fund delegates in the Health-Promoting Entities the collection of the compulsory premiums of their members. Of the total collected, the Health-Promoting Entities reduce the value of the **Capitation Payment Unit**[203] and transfer the difference to the Fund (Article 220, Law 100/93). It is important to stress that when difference is negative the Fund should compensate the Health-Promoting Entities for the difference (Rodríguez-Monguió & Infante, 2004, p. 132).

The new healthcare system led to the creation of a sophisticated bureaucratic structure grounded on a discourse about justice in healthcare in which private health insurance companies would have an important participation. However, as early as the mid-1990s, the first signs of failures, problems and inconveniences related to the system came up, a situation that has increasingly worsened since. To paraphrase the celebrated Colombian writer and Nobel Prize winner G. García Márquez's book, this was a 'chronicle of a crisis foretold'[204]

## 6. Chronicle of a crisis foretold

Under the new healthcare system, the number of public complaints about the poor service delivered by healthcare companies grew exponentially. The Colombian mass media coined the term "the way of death" to metaphorically describe the 'bumpy road' that patients in Colombia sadly must walk in searching of adequate medical attention. Many of them die on the way. There is a huge gap between the rhetoric of the reform and reality since, paradoxically, the healthcare system has become an 'obstacle race' for Colombian citizens because of the "bureaucratic itineraries" that characterise it:

> the Colombian health care system has created new kinds of itineraries in which health care does not depend on people's needs or medical

[202] Fondo de Solidaridad y Garantía.
[203] The value of Capitation Payment Unit is defined by the National Council of Social Security for Health.
[204] In his famous novel *Chronicle of a Death Foretold* (1982) G. García Márquez told us a tragedy: the death of an innocent and how the people of his community could have stopped it.

> assessment, but on meeting successfully the system's administrative norms and financial costs (new access and quality barriers). When it is impossible to receive the necessary care, access depends on knowing and performing legal processes, the results of which are based not only on the judges' interpretations, but also on the institutions' compliance with the ruling. These itineraries have a profound effect on the person's health, quality of life, and even life expectancy. (Abadia & Oviedo, 2009, p. 1156)

As early as 1997 the GSHSS was already in crisis, in 2001 some financial and administrative adjustments were necessary and, in fact, every year there were some news about the looming crisis in the sector. In 2008 the Constitutional Court ruled that the system required through the Case Decision T-760/08 a profound transformation in order to offer good healthcare service (González, L. E., 2011). However, little has changed (Huertas, 1998). What Rodríguez-Monguió and Infante argued in 2004 still adequately describes the current situation: "although total expenditure and public spending in health have increased, Colombia is still far from achieving the universal coverage and equitable provision of compulsory health plans foreseen by Law 100." Not to mention that the public health deficit is growing, people have neither real access nor good medical service and healthcare professionals have been downgraded (Homedes & Ugalde, 2005, p. 91; Waitzkin, 2011, p. 73).

At the end of 2009 the government declared a state of social emergency when the GSHSS became financially untenable; the deepest and most serious crisis of the healthcare system since the reform was implemented through Law 100 in 1993. For some authors linked to the government and private health organisations, "[w]hile the reform substantially increased health insurance coverage, progress was slower than forecast and entailed a substantial increase in expenditure […] Additionally, competition has not resulted in the exit of seemingly inefficient public providers" (Gaviria, Medina, Mejía, et al., 2006, p. 29). After this crisis, while some private healthcare institutions have entered administration others are under criminal and civil investigation for corruption, embezzlement monopolistic acts and so on. It would not be an exaggeration to say that the crisis of healthcare embodies the worst case of corruption that the Colombian society has seen in the last twenty years.

It became clear for the Colombian society what had been all these years an open secret: that the alleged improvement in the access and quality of healthcare had been inflated, as many of the goals of the reform stayed on paper. Moreover, while the healthcare system implemented by the reform of 1993 went to bankruptcy, private healthcare insurance companies have showed a permanent and huge economic growth all these years (Coronell, 2011; Fernández & Perilla, 2011; Robledo, 2011; Semana, 2001). For instance, *SaludCoop*, a Health-Promoting Entity that was set up in 1994, one year after the healthcare reform, was able to increase its initial capital 176 times in just 15 years (from $2,500 to $439,391 million Colombian pesos), coming to rank eighteenth amongst the biggest companies in the country. This Health-Promoting Entity was accused of misusing the money destined to cover healthcare costs when its investments in real estates, golf camps, pharmaceutical industries, and even the creation of its own buffet of lawyers became public (Coronell, 2010). It became even public that ACEMI,[205] the association of healthcare companies, had promoted a 'a pact' to systematically and subtly deny medical services to which their affiliates were legally entitled in order for them to increase their profit (González, L. E., 2011). Despite this, the government and private healthcare institutions still backed the system. Why? The answer comes easier if the question is rephrased: who are the winners within the current state of affairs? As many authors have pointed out, the winners are transnational corporations, consultant firms, the WB staff, private investors and even universities (de Currea-Lugo, 2003, p. 253; De Vos, et al., 2006, p. 1605; Homedes & Ugalde, 2005, p. 83; Jasso-Aguilar, et al., 2008, p. 158).

In this environment, ethical discourses about healthcare and medical practice have increased. This situation is exemplified by bioethics, a field that gained relevance at the end of 1990s, at the moment when the healthcare reform was being fully implemented. The question is therefore, how do bioethics, medical practice and the healthcare reform relate to each other?

## 7. Bioethics, medical practice and healthcare

Considering how bioethicists address bioethical issues in Colombia, F. Suárez, a lecturer in genetics and bioethics, ironically asked in 2007: "Where is bioethics?" (Suárez, 2007).

[205] Spanish acronym for *Asociación Colombiana de Empresas de Medicina Integral* [Colombian Association of Health Companies].

From the start Colombian bioethicists have discussed the same classical issues as their colleagues in the US, i.e. mainly the ethical implications of new biotechnologies. Accordingly Colombian bioethical literature mostly discusses informed consent, embryo research, genetic engineering, principlism and so on. Some bioethicists who have tried to enhance the scope of the field have added issues particularly relevant to Colombia such as violence, human rights abuse, armed conflict, illegal drugs and multiculturalism. After a critical review of this literature, particularly what it has been published by the most important journals in the field in Colombia such as the Colombian Journal of Bioethics[206] and the Latin American Journal of Bioethics,[207] I would like to make two observations. First, although the American principlist model is constantly criticised, it is nevertheless the 'lingua franca' spoken by the vast majority of Colombian bioethicists. The attempts to create alternatives to such a model remain generally too theoretical, ideology-laden and bureaucracy-driven. Second, the analyses of the Colombian bioethics regarding the transformation of the healthcare system and the medical ethos in relation to neoliberal rationalities have largely remained limited to truisms. This trend has shown the detachedness from the actual socio-political, cultural and economic conditions of Colombia that mirror the Colombian bioethical establishment.

In 2007, for example, in the panel Violence and Bioethics at the Third International Congress of Scientific Research Ethics in Bogotá, I presented a paper where I criticised the pseudo-scientific and pseudo-philosophical language used by many bioethicists to address ethical issues that have arisen in the biomedical scenario. Such a language has contributed to camouflage forms of social injustice and structural problems as 'ethical dilemmas'. In this paper I argued that it was necessary to revise the role that the so-called *clinical bioethics* is playing in the current clinical scenario (Díaz Amado, 2007b). Unfortunately, in Colombia clinical bioethics is frequently reduced to a set of 'technicalities' to solve 'ethical dilemmas' and doctors are misled to believe that by dealing with such technicalities they have done their duty towards a 'good medicine'. But in this way fundamental reflections, for instance, about the nature of their own profession and the new relationships between medicine and society in the context of the medical industrial complex and neoliberal rationalities are not possible. In other words, in the way the bioethical discourse has taken over the biomedical scenario, the possibility of emancipatory and critical discourses has been drastically reduced.

[206] Revista Colombiana de Bioética.
[207] Revista Latinoamericana de Bioética.

Another example is the first 'designer baby' in Colombia in 2006. After a *tutela* (writ) one judge ruled that a healthcare insurance company should provide the assisted reproductive technology required to guarantee a couple a healthy embryo as the bone marrow donor to their first child who suffered from Fanconi anaemia. Apart from a laconic headline in a Colombian newspaper,[208] this case passed unnoticed by bioethicists. The Colombian bioethics establishment remained virtually silent about this. The ethical assessment of reproductive technologies,[209] as it happens with many other issues like genetics, availability of prescription drugs and policies on science and technology is discussed in an abstract way or with little reference to actual medical practice. Moreover, empirical research in bioethics remains largely undeveloped, with only a few exceptions. In contrast, issues highly moralised or deeply linked to religious beliefs have traditionally drawn the attention of bioethicists, such as abortion or euthanasia. But regarding the healthcare reform and its recent crisis, no one in the Colombian bioethics community has yet offered a comprehensive analysis. To carry out this analysis I consider two perspectives. On the one hand the question of how bioethics has been used by healthcare professionals, particularly by doctors, as a theoretical and conceptual tool in their daily practice. On the other hand the question whether bioethics has been able to critically examine both the healthcare reform and the simultaneous transformation of the medical ethos. The same detachedness of the Colombian bioethical establishment from the particular conditions of the country occurs in relation to other issues: embryo research, reproductive medicine, medical tourism, commodification of health and medical education, healthcare system corruption, bad quality medical attention, doctors exploitation, healthcare insurance companies abuses, pharmaceutical companies' influence on health policies and so on. All of these issues remained largely unanalysed from a bioethical perspective and the few analyses that have been carried out by Colombian bioethicists are, to a large extent, incomplete, inadequate and full of commonplaces.

In 1999, the Colombian physician and expert in health economics R. A. Castaño published *Medicine, Ethics and Health Care Reform*, a book in which the language of principlism is combined with the language of economy in order to 'demonstrate' that the Colombian healthcare reform was 'morally' necessary. He argued that medical practice had so far been

[208] "A Woman Is Undergoing In-vitro Fertilisation Treatment to Save the Life of his Oldest Son." *El Tiempo*, 24 March 2006.
[209] This is a flourishing industry in Colombia, with several fertility centres, but so far bioethicists have given it virtually no attention.

guided by the principle of beneficence that advocates patients' welfare, but that this principle neglects issues of distributive justice. For Castaño, the basic conflicts between the medical profession and society nowadays can be reduced to two dilemmas: first, *doctors' beneficence v. social justice*, and second, *doctors' beneficence v. patients' autonomy*. Then, for him, a new 'social contract' with the medical profession was necessary. In this contract the medical profession should embrace new duties, particularly related to justice. Unfortunately, this argument has been used to justify the current model of healthcare and in the name of justice health insurance companies have implemented practices of intermediation, labour flexibilisation and health commodification. The approach of this author illustrates well how the principlist model has served to reinforce a truth regime facilitated by the rise of bioethics. According to this regime 'ethics' in healthcare has ended up meaning an abstract conflict between principles called 'a dilemma'. This model has become canonical in talking about ethics within the medical scenario in Colombia. The Beauchamp and Childress principlist method became synonymous with ethical analysis in medicine. As a result, only what can be presented in terms of a dilemma is seen as an ethical problem. Then, there is a power effect of bioethics that should be recognised. On the one hand, the reduction of ethics in medicine to principlist dilemmas to be solved by a bioethics committee or by a bioethicist reveals a truth regime determining the morality of contemporary medical practice. On the other hand, with the help of bioethics certain contingencies have been transformed in natural and necessary scenarios or outcomes, for instance, the current model of healthcare and the current way of being a doctor remain taken for granted truths at the same time as bioethicists permanently invoke human dignity or individual autonomy in their 'analyses'.

By and large, the aforementioned journals of bioethics have published only a few articles that address ethical issues related to the healthcare reform.[210] These articles show three main characteristics. First, they do not analyse in depth the relationship between healthcare system, socio-political conditions and the transformation of the Colombian medical ethos. Second, what is called in these articles a 'bioethical perspective' is merely a set of additional paragraphs where the four principles are mentioned. In other words, they do not offer any

[210] For example in the series *Bios & Ethos*, published by El Bosque University over almost ten years, between 1997 and 2007, there are only two articles (in the issue No. 25) that examine the healthcare reform, but from a bioethical perspective neither of them is a comprehensive and critical analysis of such a reform nor do they address properly the impact of it on medical practice. Thus, while the first article is just a list of common places about administrative, political, and economic aspects of the reform summarised (Rodríguez, C. E., 2006), the second one is an attempt to demonstrate that the healthcare reform failed to realise the concept of sanitary justice (Galvis, 2006).

original, innovative or critical perspective. And, third, when these articles seem to discuss the crisis of the Colombian medical ethos, they mainly express 'a professional point of view', i.e. a medical ethics approach but using the language of American principlism. Hence, in Colombia it seems that any discourse is 'bioethical' as long as it cites or appeals to the four principles. The approach of the Colombian bioethics establishment to the crisis of the medical ethos, in the context of the healthcare reform of 1993, first, has not been consistent with the dimensions of this crisis, second, has contributed to leave some structural problems unnoticed, and third, has reduced the philosophical reflection on medical practice to a game of balancing the four principles. In fact, the grandiloquent discourse of bioethics about personal autonomy and free choice fits well in the new neoliberal environment that characterises the current socio-political and economic life of the country. In this point, however, it is necessary to take into account the counterintuitive aspect of Foucault's position: freedom is not just a precious good or right that should have guaranteed to every human being in a modern liberal and democratic society, but rather a strategy to govern.

**8. Freedom as a strategy to govern**

One question remaining is why a healthcare system like the one in Colombia was accepted at all? A possible answer is that these systems offer something that is attractive, fashionable and much valued by people: the promise of free choice. Although the affiliation to the GSHSS in Colombia is mandatory, i.e. even against their will, individuals are told all the time that they have options, i.e. they can choose. This is true, but it only refers to the possibility of choosing between one health care insurance company and another. That's it. This is obviously a very poor concept of what a right to free choice means in healthcare. According to R. Vega (1999, p. 45), in Colombia there is a monopoly of healthcare insurance companies, although I would say 'cartel' since there is more than one company involved, which have previously agreed on the range of products and prices, according to their own interests, even though they talk about 'options' for customers. Not to mention that in this new market-oriented environment, which is deeply linked to the discourse of free choice, the individual has ended up being responsible for his/her own health, while the social determinants of health such as style of life, public services and labour conditions, to name but a few, are usually disregarded (de Currea-Lugo, 2003, p. 56; Huertas, 1998).

De Currea-Lugo, a Colombian physician and expert in health policy and international humanitarian law has argued that there are two different levels in the debate about healthcare

in Colombia. On the one hand, there is the debate about the 'theoretical foundations' of the right to health, healthcare ethics and medical ethics. This level, he says, admits a 'philosophical' discussion and solution. However, on another level, there is the debate about the provision of healthcare services. This level is presented in terms of practical matters to be solved administratively (de Currea-Lugo, 2003, p. 48). This view has facilitated the rise of new practices like management with a market approach and new technologies to govern healthcare, such as ethics committees or clinical guidelines, which not necessarily reflect or follow the 'theory'. For example, 'health economics' is a new academic and professional field that has quickly developed in the last few years in Colombia and which is now the way to know the 'truth' about how to spend the money in healthcare. In fact, as de Currea-Lugo observes, "when one searches for the word 'health' in a library, one discovers that it is now deeply associated with the word 'economy'" (de Currea-Lugo, 2003, p. 15). Today it is undeniable that healthcare has become an important economic activity, the medical-industrial complex mentioned above (Relman, 1990).

Other examples of technologies to govern medical practice include medical audit, clinical protocols and bioethics committees. In this sense, it is worth mentioning that the Colombian healthcare reform sought to increase the efficiency through, first, a macro-administrative process to allocate resources at primary level via administrative decentralisation, and second, "a micro-administrative procedure based on the containment of costs and the control of performance by using specific managerial techniques" (Vega, 1999, p. 59). However, the distinction between 'philosophical' and 'administrative' problems of the healthcare reform should be read in terms of a power effect. By labelling different issues and discussions as 'philosophical', they are confined to the undifferentiated space of the 'theoretical' where they are seen as abstract, 'inoffensive' questions that have nothing to do with reality. Then, this strategy allows that particular issues and discussions are stripped of their structural, socio-political and economic origins. Moreover, when these issues and discussions are examined in the bioethical field, particularly in the case of 'clinical bioethics', they usually are transformed in 'ethical dilemmas', i.e. a conflict between two or more bioethical principles which solution is provided through the specification/balancing process of Beauchamp and Childress (see introductory chapter). As a result, the healthcare structure, healthcare institutions and medical subjectivities usually remain untouched. Concomitantly, when the issues and discussions represent problems related to the 'administrative' level, the solutions offered have usually to do with new managerial strategies and the implementation of

additional strategies of control and surveillance. How the Colombian medical ethos was transformed by the healthcare reform is also illustrated in the answers I gathered during the interviews I made in 2008-09 as part of my doctoral research.

## 9. Interviews: The impact of healthcare reform

The impact of the healthcare reform of 1993 on the Colombian medical ethos can be illustrated by the different views that doctors and non-doctors expressed in my interviews.[211]

### 9.1. Market rationality and the commodification of health

Many interviewees agreed that the healthcare reform came into being mainly as the outcome of a political and economic program promoted by international organisations like the IMF. For ETJ, a physician and bioethicist, the real origin of the reform was the Washington consensus. Others, like VRR, a physician and lecturer in healthcare administration said that "Law 100 was passed by the Colombian Congress following a global policy to transform healthcare systems into scenarios ruled by a market-oriented rationality." For a lawyer like PAG, Law 100 was a direct consequence of the Constitution of 1991 and it meant the 'demonopolisation' of social security in Colombia. However, the demonopolisation of social security did not mean a fairer healthcare system and, ironically, it led to the implementation of another monopoly, that which healthcare insurance companies have created in Colombia. For ABC, a dentist and lecturer in social sciences, many people in Colombia are convinced that although the content of Law 100 was good its implementation was the problem. However, this was a naïve position for ABC since Law 100 of 1993 meant the arrival of managed care to Colombia and, according to him, "the nature of managed care requires a permanent search for strategies to expand the portfolio of healthcare business. Thus, in Colombia powerful healthcare insurance companies have formed a monopoly that controls the whole healthcare market." Therefore, the 1993 healthcare reform was not a way to guarantee a fair allocation of resources for health, but the best opportunity for transnationals to invest in healthcare business in Colombia.

Yet the discourse about limited resources for healthcare was an important part of the rhetoric in support of the implementation of the 1993 healthcare reform. Regarding this, VRR, a physician and expert in health administration, argued that it was necessary to consider certain questions, for instance, how the notion of limited resources became a 'truth',

[211] For more information about the interviews, see the annexes at the end of the thesis.

how resources were actually distributed in society, how priorities were set, and who made these decisions. According to him, "not only there are different ethical systems, but also different economic theories. So, how the problem of limited resources has been set out in healthcare and what solutions have been adopted in Colombia reveals that a particular economic point of view has predominated: neoliberalism." Nowadays public institutions are frequently accused of inefficiency and corruption and neoliberal discourses promote the idea that 'private administration' is synonymous with efficiency, rational use of resources and a better cost/efficiency ratio. Thus, as VRR stressed, "a rhetorical strategy to gain support for the reform was accusing public administration of inefficiency, whereupon it was concluded that the healthcare system should be in private hands… the people who know how to administer it."

But although the 1993 healthcare reform has shown serious inconveniences, those backing the reform have argued that it led to an increase in healthcare coverage. In this regard, LCM said that according to the statistics Colombia ranked well if compared to its neighbours. However, she stressed, there were huge internal asymmetries: "In some regions healthcare standards were similar to those of Western Europe, but in others they were similar to those of a poor African country." Additionally, regarding public health, the healthcare reform of 1993 has been a disaster. PRB stressed that Law 100 ignored public health. For her, the interest of healthcare companies in health promotion and disease prevention is just to meet all the requirements 'on the paper' to be certified,[212] but not because they really want to improve the population's health. Moreover, ABC pointed out that a major problem was that the Colombian public healthcare service was progressively and drastically reduced. For instance, public hospitals were transformed in 'state social companies',[213] i.e. public organisations operating with a market-oriented logic. This proved, he said, that in Colombia the healthcare system was privatised.

According to SHJ, patients have become consumers and then they are increasingly requesting procedures, treatments or medicines to fulfill their particular wishes. Hence, doctors are now subjected to fulfill patients' wishes, even against the *lex artis*. In Colombia, for example, he said, it became a common practice that teenage girls received as a gift from their parents for their fifteenth birthday, an enlargement mammoplasty or other kinds of plastic surgery. As a result, SHJ continued, many doctors in Colombia supported the

[212] That is, to receive from governmental regulatory bodies a legal permission to operate.
[213] Empresas Sociales del Estado. This was the name with which Law 100 renamed public hospitals.

healthcare reform as it represented a niche business since the cost of many procedures, like plastic surgeries, should be covered by patients directly. For LBG, a physician and university lecturer, doctors became 'sales executives' of pharmaceutical companies, using their own practice's space and time to sell new prescription drugs, vaccines, medical devices and so on.

In ETJ's words, "the problem of the Colombian healthcare reform is that all the standards and activities (medical, professional, and social, etc.) are now dominated by a commercial approach, something that is deleterious not only for medical practice, but also for the whole society." AQJ, an emergency room doctor, puts it in one phrase: "the 'principle of profitability' is nowadays driving medical practice". As a matter of fact, the commodification of health is one of the most prominent effects of the reform. For EGR, "Law 100 created a new institutional structure, which is efficiency- and profit-orientated, and which introduced intermediaries between doctors and patients." In the words of TME, a physician and university lecturer, "healthcare companies are the winners of this reform because they are the ones who are accumulating capital." The commodification of health is expressed in other aspects as well. For example, for VRR, "when a healthcare company needs to appoint the director general of a hospital, it usually seeks for anyone with a business mentality rather than a public health expert or an experienced clinician." The reason is simply that "healthcare companies are investors who expect profit, not philanthropic entities".

In the experience of JNM, a philosopher working in a health administration department, discussing ethical issues with doctors who are attending health administration and managed care postgraduate programmes was complex for two reasons. First, ethical problems arising in the clinical setting differ from those at the administrative level. Second, postgraduate programmes in managed care include professionals other than doctors, such as engineers, accountants and lawyers. These people have never taken the Hippocratic Oath nor do they have the same ethical background as doctors. This lack of knowledge and first-hand experience in medical ethics makes difficult for them to understand the genesis of and possible solutions for ethical problems arising in clinical practice. According to JNM, the people who attend managed care postgraduate programmes usually are not interested in discussing medical ethical issues. Instead, what interests them is increasing their knowledge and skills to improve the performance of their healthcare-related businesses. In fact, she said, the ethical discussion has traditionally been given little room in managed care postgraduate programmes. This shows that the clinical rationality, which is usually patient-centred, is

different, even opposite to, the managed care rationality that is commercial-centred and seeks for profit in healthcare institutions.

Law 100 stated that in Colombia health-promoting entities would provide healthcare to their affiliates by hiring the services of health providers and/or individual healthcare professionals.[214] However, according to LMG, an expert in health administration, when a health-promoting entity (i.e. a health insurance company) hires the services of a health provider (i.e. an individual doctor or a hospital), the former usually takes advantage of its powerful position to impose the contractual conditions on the latter. Then, health providers such as hospitals, clinics and independent health professionals have no option other than to accept health-promoting entities' conditions in order to survive.[215] Moreover, "there is huge difference between private and public hospitals. Usually public ones are in bankruptcy, resources are insufficient and, most notably, nobody cares about them".

Affiliates' complaints about the bad quality of health-promoting entities service and the obstacles people constantly have to face to get adequate medical service are daily news in Colombia. Thus, the abuses of health-promoting entities led the Constitutional Court, through the landmark Case Decision C-768/08, to rule that the healthcare system should provide equal and good medical service to all Colombians. The court requested from the government and healthcare companies to make the necessary measures to fulfil this aim. However, for LCM, a physician working for a NGO that supervises the performance of the healthcare system, as for FAS, a physician and expert in public health, the core of the court's ruling was the guarantee of a universal and good quality healthcare service in Colombia. However, LCM said that the court decision was yet to be fully implemented and as healthcare companies were powerful lobbyists the situation of health services in Colombia would not change much.[216]

[214] A Health-Promoting Entity can attend its affiliates through its own Health Service Providers. However, by law no more than 30% of the attention that an Health-Promoting Entity provides to its affiliates can be rendered this way. Hence an Health-Promoting Entity must hire the services of external or independent Health Service Provider. This is to avoid the so-called 'vertical integration' that in Colombia has been another way for Health-Promoting Entity to monopolize the healthcare market. However, there are many indirect ways to carry out such a 'vertical integration' that are beyond legal control and with which governments have been so 'flexible'.

[215] As health-promoting entities implemented different strategies to avoid paying or delaying payments to health providers (both in the fee-for-service and capitation models), for example, through medical audit, many independent health providers and health care professionals have simply gone bankrupt.

[216] In 2010 Norman Daniels, Thomas Bossert and William Hsiao, three internationally renowned experts who knew the Colombian healthcare system well, met in Bogota. They acknowledged good things like the increase in healthcare coverage and the subsidies for poorer patients. However, they also criticised the system as the competition between health-promoting entities had not really worked, letting them to form a monopoly, and, moreover, so powerful that they had become difficult to control. Finally, for them, Law 100 "democratised the

### 9.2. Negative impact on the medical ethos and new types of doctors

For STF, a physician and bioethicist, the Colombian medical ethos was severely damaged by the presence of healthcare insurance companies, which act as 'intermediaries' exploiting doctors. For him, doctors lost job security and many are now employed without legal labour guarantees. According to PRB, a nurse and bioethicist, the International Labour Organisation confirmed that the work conditions of healthcare professionals have deteriorated: they work long hours despite the stressful and demanding hospital environment and many healthcare workers are paid neither overtime nor for weekend shifts. Contracts of employment contracts are managed by intermediaries with exploitative practices and, as a general effect healthcare workers' wages are dramatically low. According to LMG, a physician and member of the administrative board of a public hospital, "doctors are recruited via associated work cooperatives because that is the law." These co-operatives are in reality commercial outsourcings, profit-oriented and managed by people with a business mentality. This intermediation, she said, has destroyed the sense of belonging that the medical staff should have for the proper operation of a hospital.

In contrast, GCA's view, a physician and bioethicist, was that "the healthcare reform did not destroy the Colombian medical practice; it just exacerbated existing problems". For her many problems that are now linked to the healthcare reform existed before. For example, a frequent complaint of doctors is that healthcare companies have imposed tight schedules, limiting the time doctors have to appropriately see their patients.[217] However, GCA said that before Law 100 many doctors did not spend enough time with their patients either. For SHJ, a physician and medical lecturer, doctors' behaviour before the reform allowed healthcare companies to conclude that a doctor could see a patient in just a few minutes. Then, there is no reason for doctors to complain about unfair schedules imposed by healthcare companies, SHJ said, since ironically they themselves had already proved with their wrong behaviour how quickly they were able to see patients. Similarly, STF recalled that when he was director of a hospital in the 1980s, "doctors used to skip work" and also LCM said that before the

---

opportunities to carry out acts of corruption. [Although] in highly centralised systems corruption also exists, [in the Colombian case] it is just that the money goes to fewer hands" (Ronderos, 2009).

[217]The imposition of timetables is perhaps one of the clearest expressions of the 'proletarisation' of medical practice. Different newspaper articles have illustrated this issue, for instance, 'the jet-doctor' (Alvarez, C.G., 1993), 'doctors with taximeters' (Escobar, A., 1995). In another newspaper article, a doctor compared medical practice to bus drivers' work: the more passengers (patients) a driver picks up, the bigger the salary he (the doctor) earns (Rubio, 1995). According to the law, doctors have up to 20 minutes to see one patient. However, sometimes healthcare companies subtly forced them to see one patient every 5 minutes. To more information about this, see: www.medicosgeneralesdecolombia.com, a webpage of general doctors, accessed 20 July 2011.

reform of 1993 doctors "would go barely to work, particularly in public hospitals, where moreover doctors used to be well paid. However, they did not spend enough time with their patients. Then, it is unfair when doctors say that healthcare companies have cut the medical consultation time."

For JEO, an emergency room doctor, "the income and status of GPs used to be much better. In 1982/83 a GP earned about 15 to 20 times the minimum legal wage, but nowadays it is less than 10 times even for those who earn very well."[218] For him, "unfortunately the reform was implemented at the expense of doctors' wages since the first strategy that healthcare companies implemented to reduce their spending was to cut down doctors' honorariums." For SHJ, a physician and university lecturer, under Law 100 healthcare companies are eager only to profit and also more interested in offering medical treatment than prevention. These companies have limited doctors' autonomy as a 'cost containment' strategy and do not devote resources to prevention which is regarded as a 'bad business'. According to him, as hospitals are permanently forced to reduce costs, the first measure they usually implement is to cut healthcare professionals' wages. According to BPA, a lawyer and expert in medical liability, GPs have seen their incomes rise, but in the case of specialists a decrease has been the case. In contrast, for PMJ, a former emergency room doctor and medical activist, GPs are in the worst position. He claimed that although 75% of physicians in Colombia are GPs, the medical ethos was dominated by specialists. Moreover, he added, current medical associations in Colombia do not represent properly the interests of GPs. The National Academy of Medicine, for instance, is an elitist association that neither represents the Colombian medicine nor Colombian doctors, while the Colombian Medical Federation represents the interests of a few.

Some of the interviewees said that doctors were not consulted when the reform was planned and implemented. However, according to ROE, the Academy did organise workshops to discuss the bill before it was passed by the Congress. In these meetings, he

[218] In 1973 a GP used to earn 19.8 times the statutory minimum wage and in 1990, before the healthcare reform, it was between 7.22 and 9.42 times. In 1998 it was 4 times. Healthcare companies frequently claim that they spend a lot of money to pay doctors' services, but doctors have disagreed: "That medical salaries are high is false. In 1994 medical wages were only 14.9% of the operational costs of healthcare companies" (Redondo & Guzmán, 2000, p. 85) Moreover, by 1997, 42% of doctors did not have a legal contract, which means a violation of labour laws. For this reason it is almost customary in Colombia that doctors work in different healthcare institutions to make a comfortable living. In 1997 a business magazine stressed that high school students still chose medicine when going to the university, but doctors were the lowest paid professionals in Colombia (El Tiempo, 1997b). In sum, "doctors, unaware of how macroeconomics works, have been transformed into the technical branch of a big business sector" (Redondo & Guzmán, 2000, p. 87).

recalled, doctors were told by the promoters of the reform about a promising future in which the 'good doctors' would have a large clientele. But the reality was different, he lamented, because in the end "healthcare companies imposed their will and policies and doctors did not receive what they were promised" and a good doctor became the doctor who followed healthcare companies' policies. For VRR, a physician and expert in health administration, the kind of physician that Colombian medical schools are producing is 'functional' to the system and incompetent to critically approach current healthcare policies in the country. In his view, medical schools are power structures that prepare medical students to work in hospitals, which are also power structures. Therefore, doctors enter the healthcare system well trained as rule-followers, making it easy for healthcare corporations to subject them to their own rationalities, normative discourses and practices. Thus, in medical schools doctors learn not only medicine but also obedience. In VRR's opinion, healthcare companies control the medical market place, while doctors have lost their autonomy and the ability to determine their professional life. Moreover, the Colombian healthcare system has developed for functioning smoothly not only doctors and healthcare professionals, but also managers, auditors and other specialised workers. As a result university programmes related to managed care, health economics, health administration and others related to 'control' doctors have multiplied in the last few years in Colombia. These new experts are essential as they guarantee the continuity of the system.

For LBG, a medical lecturer, "it can be true that the healthcare reform implemented more controls on doctors' practice, making them more efficient, but at the same time it downgraded the medical profession and imposed a 'new order' in the clinical decision making process. Thus, in the new system, economic and legal criteria became more important than medical criteria." Moreover, doctors became subjected to a new 'system of punishment' that is excessive and asymmetric. For instance, "if a patient in an emergency service considers he has been in the waiting room too long and then decides to seek for medical attention in another hospital, the doctor who was in charge of the emergency service will be fined or admonished, not because a delayed medical attention may damage the patient, but because this episode is a loss of a customer." The problem is, according to LBG, that "sometimes emergency room services are just crowded and there is not enough medical staff – as a result of the administrative policies of healthcare companies – to guarantee on time medical

attention." LBG complained: "how is it that doctors are made accountable for a situation beyond their control?"[219]

In the current healthcare system, according to some of the interviewees, different types of doctors coexist, suggesting that there are different attitudes to what being a doctor is and how medicine should be practised. For LBG, there were three types. First, the "orthodox", who is engaged in a patient-centred clinical practice and has remained attached to a traditional way of understanding the DPR, i.e. a fiduciary DPR in contrast to the current one which is based on a contract with a healthcare company. Second, the "technician", for whom practising medicine entails only two activities: complying with working time as stated in his contract with the healthcare company and prescribing medicines. For the "technician", healthcare companies and not doctors are responsible for patients. And third, the "merchant", who has taken the new healthcare system as an "opportunity for business" and therefore has a profit-oriented practice. Another medical lecturer, TME, identified four types of doctors. A few doctors do not practise within the healthcare system, i.e. they only have a private practice and do not accept contracts with healthcare companies. These doctors characteristically prefer a patient-centred practice, highly value their independence, and even fight against what they consider intrusions of healthcare companies in the clinic. Second, doctors with prepaid contracts with healthcare companies, who try to do their best while following the rules of the system. Third, younger doctors, who were born into the system, were shaped by it, and who unreservedly follow the rules imposed by healthcare companies. According to TME, these doctors are "like machines". They talk too little to their patients and have a poor decision-making ability.[220] For EGR, "doctors have lost ability to resolve clinical situations since they are constrained by the rules of the system; the system is in the end the decision-maker." And, finally, says TME, there are doctors who have adopted a middle position, those who accept the new healthcare system and within it they try to practise good medicine.

### 9.3. An inveterate Colombian problem: Violence

For FAS, a physician and public health expert, the effects of two phenomena should be included in the analysis of the current Colombian healthcare system: the violence that has

[219] The current medical ethos might be characterised by fragmentation, low morale, demotivation, indifference, and feelings of humiliation under the new laws and norms that govern the medical scenario.

[220] In Colombia GPs are too limited to make clinical decisions and people tend to see them as the ones who authorise a referral to a consultant rather than medics who have the ability and knowledge to adequately solve health problems. At a primary level it is sometimes not possible to distinguish between a GP and a nurse (Ruiz, F., et al., 2001, p. 56).

plagued the country for decades and the radical healthcare reform of 1993. For him, these two circumstances "entail conditions, determinations, dynamics, and important consequences" for health in Colombia. For him, the socio-economic and cultural determinants of health are important factors in this context. In FAS's view the violence that has persistently affected Colombian society was just an expression of the contradictions and limitations related to the socio-cultural, political and economic project of Colombia as a nation. He mentioned three factors that have contributed to prolong violence in Colombia: First, Colombia is a highly and increasingly unequal society (monopolies, concentration of capital, political exclusion). Second, Colombian society is intolerant. And third, high levels of impunity, not only related to failures of the judicial system, but to cultural issues. Thus, there is a lack of self-awareness about wrongdoing and misconduct. For example, criminals are celebrated as heroes in TV shows. Additionally, FAS said, the rise of drug cartels, the internal armed conflict, and the weakness of the state have contributed to a worsening of the situation in Colombia.

This situation, FAS underlined, has contributed to the degradation of medical practice, and in the last years there have been systematic attacks to the 'medical mission'.[221] Very often people are prevented from reaching a health centre or access medical services because of the internal armed conflict.[222] Violence has limited the possibility of practising good medicine or carrying out biomedical research. Also, he said, violence is related to delays in medical attention, which is particularly problematic for the treatment of chronic disease and scheduled procedures, when surgeries are constantly postponed as 'unexpected' emergencies resulting from violence alter the timetables in hospitals.

## 10. Conclusion

Inveterate problems like poverty, inequality and corruption, the assassinations of political leaders, the action of guerrillas, the emergence of paramilitaries and the pernicious influence of drug dealers led Colombia to a serious institutional crisis at the end of the 1980s. Against this backdrop the Constitution of 1991 emerged as a solution. This constitution has had a profound impact on Colombian society, although what kinds of benefits and consequences it brought remains a highly debatable issue. On the one hand, as Colombia became a *social rule-of-law state* some have stressed the positive aspects such as the protection of the

[221] A term coined in Colombia to describe medical personnel, healthcare facilities, ambulances, and the like.
[222] See, for instance, the report of *Doctors Without Borders* about Colombia at: http://www.doctorswithoutborders.org/publications/ar/report.cfm?id=5343&cat=activity-report, accessed 29 October 2011.

constitutional fundamental rights (based on human rights), the adoption of the *acción de tutela* (writ or demand of custody) as an innovative legal tool to guarantee such fundamental rights, the strengthening of personal autonomy and pluralism as foundational principles of Colombian society, and the creation of the Constitutional Court, a new high court, which has since played a decisive role in the ethical, political and legal transformation of Colombian society. On the other hand, some authors argued that the Constitution of 1991 was the result of the neoliberal policies that the governments at the time had adopted and which were promoted by international economic organisations such as the WB and the IMF. Neoliberalism meant deregulation, labour flexibility and the adoption of market-criteria to assess almost every aspect of social life, with a negative impact at different levels, particularly in terms of increasing the gap between rich and poor.

Based on two articles of the Constitution of 1991, the most radical healthcare reform in the history of Colombia was approved when Law 100 of 1993 was passed by the Congress, marking a turning point for the Colombian medical ethos. So far this healthcare reform has kept Colombian society divided. While its supporters have argued that the inequality, inefficiency and low coverage of the former system justified Law 100, its critics have insisted that in the name of universal coverage, equality and freedom, a US-like, managed care-oriented, healthcare system was implemented with disastrous effects and, ironically, without really solving health inequalities. With the new healthcare system doctors were transformed into employees of health insurance companies, the commodification of health was accelerated, and university hospitals were negatively affected. Additionally, given inefficient state control and corruption, healthcare companies have subtly constituted a powerful monopoly, exploitatively subjecting healthcare professionals to their rules and unjustifiably denying medical services which their members or policyholders were entitled to. In recent years it was revealed that these companies individually have grown exponentially, multiplying their capital, while the system as a whole paradoxically has gone bankrupt.

The implementation of a neoliberal-oriented healthcare system and the flourishing of bioethics in Colombia were paralleling phenomena in the 1990s. Moreover, there was a big coincidence between the rationalities of the reform and bioethics. Although the first individuals and groups working on bioethics appeared in the late 1970s, as I showed in chapter four, it was not until the 1990s when the institutionalisation of bioethics in Colombia really happened. By the end of the 1990s, American principlism had become the lingua

franca in discussions of ethical issues in biomedicine and bioethics was seen as the necessary and suitable ethical perspective. My interviews revealed disparate views on how the healthcare reform after 1993 actually affected the medical ethos and what role bioethics has played in this context. For practising clinicians and nurses the reform meant the destruction of the ethical foundations of the healthcare professions. At the same time, bioethics was seen as a way to save medical practice from dehumanisation. For others the decline of the Colombian medical ethos had already begun even before the healthcare reform of 1993, suggesting that the healthcare reform of 1993 did not cause, just deepened the decadence of the Colombian medical ethos that had already begun years before. My interviews also revealed new medical subjectivities, with different styles of practice co-existing within the new healthcare system, suggesting that not all doctors are practising according to the rules of the system, a circumstance that can be seen as a sort of 'resistance' against such rules. For Foucault power relations admit resistances, and then the possibility of changing the present and even ourselves. This is something that cannot happen when people live under "states of domination" (Foucault, 1997a, p. 299). Thus, different categories of doctors were described: old clinicians, orthodox, technicians, employees and merchants. New academic fields flourished, too, such as managed care, health economics, medical auditory, as well as bioethics and medical liability.

The rise of different types of doctors and the creation of new areas of expertise around the biomedical field suggests a productive effect of power. Again, it is worth remembering that for Foucault power is not only repressive but also productive. Then a myriad of professionals and experts such as economists, managers, lawyers, accountants, auditors, and so on has accessed the biomedical scenario and are influencing the medical decision making process at both a micro-level (e.g. within the DPR) and a macro-level (e.g. through health policies). Concomitantly, new institutions became the new space, the new milieu, in which medical practice would take place. New institutions and subjectivities were created. Thus *Health-Promoting Entities* became the 'entities' that are responsible for the Colombians' health, doctors and hospitals became *Health Providers*, and patients became the *clients* of the healthcare industry created by a law in Colombia. These changes came hand in hand with new discourses and rationalities such as cost/effectiveness, solidarity and free choice. As a result, in the ontology of the present of medical practice in Colombia, it would be possible to say that Law 100 of 1993 transformed the nature of medical practice in Colombia and stated new rules for its regulation. In this context, the Colombian bioethical establishment has

contributed to reinforce the current state of affairs in the biomedical scenario as its discussion and analyses remain too abstract and detached from the real conditions of practice. In other words, bioethics has become also a 'truth regime', privileging some issues while disregarding others. Additionally, the Colombian bioethical establishment has shown little interest in the genealogy of its own field, blindly promoting bioethics as 'the way' to analyse and solve the ethical problems arising in the healthcare scenario, but neither challenging the system itself nor revealing the political and legal origins of such ethical problems.

Finally, it should be underlined that the transformation of Colombian healthcare into a very profitable economic sector and the subjection of doctors and patients to neoliberal rationalities and practices were in the name of justice and freedom. Foucault explained how in areas like sexuality, education or criminal law we have mistakenly concluded that we have been liberated, giving us the feeling of a moral progress as we are supposedly freer. However, which I have tried to show in this chapter is that the neoliberal healthcare reform carried out through Law 100 of 1993 has meant the transformation of the biomedical milieu in order to make it governable. Thus, based on a discourse about free choice and personal autonomy, the healthcare reform has meant a way to, using the Foucauldian definition of governmentality, "conduct the conduct" of both patients and healthcare professionals. From a Foucauldian point of view, the healthcare reform of 1993 led to the conversion of the Colombian biomedical scenario in a 'securitised territory'. This means that the biomedical scenario has passed from being a 'territory' ruled almost exclusively by doctors, to be a complex 'population' that includes patients, doctors, other healthcare professionals, public officers, private investors, pharmaceutical company representatives and others who are now governed at distance. This means that the biomedical scenario in Colombia was, in Foucauldian terms, *governmentalized*. However, there are other forms of power working on the biomedical scenario. As I will show in the next two chapters, sovereign power and disciplinary power are also exercised nowadays not only over patients, but also over doctors.

Chapter six

# Good doctoring in Colombia after the healthcare reform of 1993: Medical ethics, bioethics and medical liability

## 1. Introduction

In 2002 the British Medical Journal published the answers of 102 people, including doctors, nurses, medical students and patients from 24 countries to two questions: What makes a good doctor? And, how can we make a good doctor? (Benn, 2002; Rizo, Jadad, Enkin, et al., 2002, p. 711; West, 2002). Amazingly, 70 different characteristics of a good doctor were listed. Among the most cited characteristics were compassion, understanding, empathy, honesty, competence, commitment and humanity, while courage, creativity, a sense of justice, respect, optimism and grace were mentioned less frequently. In general, being a good person, strongly wishing to help people, and going beyond the average were seen as basic requirements for being a good doctor. People also describe a good doctor as someone who has a holistic view of the patient, and not only sees his anatomical or physiological failures. In other words, scientific knowledge and technical skills have to go hand in hand with a satisfactory human relationship. According to this survey, doctors themselves also thought that good medical practice requires excellent teamwork, a high adherence to protocols, putting patient's needs first and always ahead of administrative ones, personal virtues like honesty, benevolence and competence and a strong concept of goodness (Benn, 2002; Rizo, Jadad & Enkin, 2002; West, 2002).

There is no reason to say that in Colombia people would think otherwise about what a good doctor is or should be. However, given the serious problems of unfairness, bad quality, corruption and exploitation that characterise the current healthcare system in Colombia, the concept of good doctoring should be not only taken more seriously, but also be adapted in a way that is more appropriate and applicable to the particular conditions of the country. Following an Aristotelian point of view, achieving a good life goes hand in hand with the correct administration of the polis (Reeve, 1992), which means that ethics and politics are closely and indissolubly linked (Fernández, 2002). Thus in the particular case of the medical scenario, it is not possible to conceive a good doctor *in abstract*. Rather, it is necessary to consider the particular socio-political and economic conditions in which medical practice

takes place. This means that any discourse or approach to good doctoring in Colombia will be biased and incomplete if it only takes into account ideals or taken-for-granted truths.

In the previous chapter I analysed how the conditions for medical practice radically changed in Colombia after the healthcare reform of 1993. I showed that such a reform meant a transformation of the milieu in which medical practice takes place, leading to the governmentalization of the biomedical scenario. In this context, doctors became subjected to the practices and rationalities imposed by healthcare companies that were created after the implementation of a neoliberal reform. In this chapter I will continue the analysis of the transformation of the Colombian medical ethos, but this time pointing to the transformation of medical ethics as a discourse about good doctoring into the new normative discourses of bioethics and medical law. In Colombia, bioethics and medical law dominate the current intellectual horizon where important issues are taken for granted, for instance, what being a doctor means or how becoming a doctor occurs. Meanwhile, medical ethics seems more and more a kind of 'historical remnant' to analyse current ethically debatable situations and, furthermore, it is usually identified with 'medical deontology', i.e. the codification of ethics. What this chapter seeks to demonstrate is that the rationalities of medical ethics, bioethics and medical law about how medicine should be practised, on the one hand, and how doctors should act under the rules of the new healthcare system on the other hand, currently overlap, producing a complex and conflicting scenario for the medical ethos in Colombia.

The key questions addressed in this chapter are: How are medical ethics, bioethics and medical liability understood in Colombia? What role have they played in re-shaping the Colombian medical ethos? How do the rationalities both of bioethics and medical law overlap with the rationality of the healthcare reform? And was it just a coincidence that bioethics and medical liability developed quickly once the healthcare reform was introduced? In order to answer these questions, I will first present an overview of the Colombian medical ethos before the reform of 1993. In this part the aim will be to examine how categories such as medicine, healthcare, being a doctor and medical ethics have been understood in Colombia. Then I will show relevant aspects in the shift from medical ethics to bioethics. After that, I will describe the contemporary medical ethos in relation to law and economics, two powerful forces that are influencing the definition of good doctoring in our time. Finally, I will analyse how medical law and liability is a field that has flourished in Colombia hand in hand with bioethics. Finally, as in the two previous chapters, and before the conclusions, I will complement the information with the interviews I carried out as part of my doctoral research.

## 2. The Colombian medical ethos before Law 100 of 1993

Colombian scientific medicine began with José Celestino Mutis, a Spanish botanist, mathematician, physician, and professor of anatomy who arrived in Bogota in 1761 as the viceroy's personal physician. In 1802 medical teaching started in the Our Lady of the Rosary Major College[223] (Rosselli, H., 1960) and later the Central Faculty of Medicine was created in 1826 by Francisco de Paula Santander, the Colombian War of Independence hero who laid the political, administrative and legal foundations of the young republic. However, the political instability of the time affected the continuity of this faculty. By the 1840s anyone who wanted to be a physician could either become a student of a qualified doctor in a system of 'free teaching' or go abroad to study, for instance, in Europe and particularly in France (Miranda, 1993, p. 20).

In 1873 a group of a few doctors in Bogota created the National Academy of Medicine that later would be officially recognised by Law 71 of 1891 and, as ratified by Law 02 of 1979, was made the national government's consultant and advisor regarding public health and medical education (Miranda, 1993, p. 110). This Academy played an important role in the creation of Law 23 of 1981, best known in Colombia as the 'medical ethics law' (Otero, 2003, p. 81). In 1935 the *Colombian Medical Federation*[224] hereafter CMF was created. This association was "interested in promoting the progress of Colombian medicine and in safeguarding the profession's moral principles" (A. Jaramillo, 1968). In 1962 the CMF promoted the legal regulation of the medical profession through Law 14 of 1962 and previously was also involved in the promulgation of a "magnificent code of medical morality"[225] (A. Jaramillo, 1968).

In the early 1900s, Colombia experienced a first wave of modernisation which went hand in hand with an increase of foreign investment, particularly from American companies. The industrialised world wanted to 'open the tropics'. In this new economic environment philanthropic organisations like the Rockefeller Foundation played an important role in improving social conditions that affected the new [American] economic projects (Quevedo, et al., 1993, p. 213). In 1931 a French medical mission visited the country emphasised that

[223] Colegio Mayor de Nuestra Señora del Rosario.
[224] Federación Médica Colombiana.
[225] This code was not very well received by many Colombian doctors and it discriminated those who were not practicing Catholics.

medical schools should be a source of professionalism, with high standards in teaching and research, and an early contact of students with patients was advised. By the 1940s the concept of social security came into being as a result of new insights into health and social welfare. Then the first institutions to provide healthcare to workers were created, for instance, the *Institute for Social Security* in 1946 (Redondo & Guzmán, 2000, p. 69). At the end of the 1940s and early 1950s two American missions visited the country to promote structural and ideological shifts in healthcare and medical education: The *Unitary (or Humphrey) Mission* in 1948, and the *Tulaine (or Lapham) Mission*, in 1953.

According to the Unitary Mission it was necessary to strengthen basic pre-clinical sciences, cut the number of students, increase the number of full-time teachers and spend more time on students' supervision. In short, this mission "recommended a reorganisation of training following the Flexner[226] programme, consisting of two years of basic sciences and four years of clinical studies, followed by one year of internship" (Marston & Ospina, 2004). In 1949 a compulsory social service year was introduced. Thus newly graduated doctors were to go to a remote area or part of the country with high demand for medical services where they would work for one year while being paid by the state (Quevedo, et al., 1993, p. 263). With the Tulaine Mission, internal medicine became the model for medical education and the length of the programme increased to six years. At the beginning of the 1950s, Colombia had four faculties of medicine, three public[227] and one private.[228] In the following ten years, three more were created. It has been argued that these new medical schools would provide cheap medical labour for the US (Miranda, 1993, p. 146) and during the 1960s the exodus of Colombian doctors to the US was a public concern (Calibán, 1967; Galindo, 1968). The Tulaine Mission also suggested the creation of an association of medical schools. In 1959 the National Association of Faculties of Medicine, ASCOFAME was created.[229]

The mid-twentieth century thus marked a turning point for the Colombian medical ethos from the 'classic' French style of practice to the 'pragmatic' American one. Since the second half of the nineteenth century, France had been a favourite destination for Colombians to

[226] For a whole picture of the impact of A. Flexner's medical education reform in the USA at the beginning of the twentieth century, see: Cooke, M., Irby, D. M., Sullivan, W. & Ludmerer, K. M. (2006). American Medical Education 100 Years after the Flexner Report. *New England Journal of Medicine, 355*(13), 1339-1344.
[227] National University, University of Antioquia, and University of Cartagena.
[228] Javeriana University.
[229] See ASCOFAME's webpage:
http://www.ascofame.org.co/index.php?option=com_content&view=article&id=1&Itemid=2, accessed 28 August 2011.

study medicine. However, throughout the first half of the twentieth century more and more doctors would travel to the US for two reasons. First, because of the leading role of American medicine, and second the Second World War prevented people from going to Europe (Otero, 1994). By the 1950s there were clashes between junior doctors who had recently returned from the US and senior teachers who had remained bound to the style of French medical practice. It became clear that "the poetic inspiration of French medicine [had given way to the] one hundred per cent positivist [American] mentality" (Miranda, 1993, p. 133).

In the 1960s doctors were concerned about becoming salaried workers of socialised medicine institutions and the bad effects of this change on their profession as they would be subjected to external rules. Doctors feared the end of medicine as a liberal profession (Redondo & Guzmán, 2000, pp. 63, 86), i.e. the end of medical autonomy. As a result, medical unions became relevant,[230] which were seen as necessary to defend medics' rights and promote the welfare of the new 'medical proletariat' (Galindo, 1968; A. Jaramillo, 1968). Medical strikes had a great impact in the 1970s, and they became a 'daily bread' for Colombian society (El Tiempo, 1970, 1973b, 1976a, 1976b). During these medical strikes some accused doctors of careless and selfish behaviour (El Tiempo, 1963a, 1966, 1973a). Although doctors were still described as "respectable, worthy […] educated and patriotic people" in the newspapers (El Tiempo, 1963a) and were honoured and greatly appreciated (El Tiempo, 1963b), their behaviour and various aspects related to their profession were now under scrutiny in the mass media. By the mid-1970s doctors would be condemned for forgetting their profession's "humanist side, deontology, and apostolate" (Castelblanco, 1973), depicted as "bad managers" (El Tiempo, 1974b), and, along with lawyers, seen as "morally deficient" (Lerner, 1975). Some non-medical voices started to become louder, arguing that medical unions should be more committed to renovating society rather than with doctors' salaries (Escribano, 1974), that citizens' opinion should be taken into account and not only doctors' requests for privileges (El Tiempo, 1974a), and that the medical profession should be legally regulated, similarly to how it was in the US (Mora, 1976).

How many and what kind of physicians the country required also became an issue that doctors and non-doctors would discuss more and more. Critical medical lecturers argued that Colombia conformed to American demands of medical education too much, for example, by

[230] For instance, the *Colombian Medical Union* [Asociación Médica Sindical de Colombia, ASMEDAS) that was created in 1958 (Calibán, 1967).

promoting among doctors 'super-specialisation', but failed to train GPs fit to practise within the country's particular socio-political and economic conditions (El Tiempo, 1971; Fergusson, 1964). Even tropical diseases were removed from the medical curriculum in a tropical country like Colombia and doctors became better trained to treat people in France or US than in Colombia (De Zubiría, R., 1972). By the early 1960s a minister of health said that "it was necessary to inundate the country with doctors" (El Tiempo, 1963c) as in many areas there was none. By the mid-1970s it was said that half a country lacked a doctor, with a worse situation in rural areas (Castelblanco, 1975; Turbay, 1974). New medical faculties were opened to deal with this problem (El Tiempo, 1978). By the early 1980s the debate about suitable medical education for the country had not ceased, but the focus shifted as some began to warn about a surplus of physicians and that it was therefore not advisable to create more faculties of medicine (Campo, 1981; El Tiempo, 1983).[231] Moreover, there were concerns about a decrease in the quality of medical education as a phenomenon linked to the creation of new medical schools and also about the geographical distribution of doctors since they tended to remain in the major cities of the country, while the number of health professionals in small cities and rural areas remained insufficient (Moanack, 1983; Sánchez, 1981).

In the 1970s private healthcare insurance companies started to manage a significant part of the Colombian healthcare market. Many doctors deplored the price competition imposed by these companies and their detrimental influence on doctors' private practice. Nevertheless, many doctors ended up working for them (Redondo & Guzmán, 2000, pp. 63, 86). In 1975 a National Health System was created (Vega, 1999, p. 36), but this system was by no means similar to the UK's NHS. Rather, it was a non-unitary system that included many autonomous institutions, and although in 1975 the government had embraced the World Health Organisation's campaign *Health for All by the Year 2000*, its commitment was limited to simple actions regarding health promotion, prevention and the improvement of very basic medical services (de Currea-Lugo, 2003, pp. 77, 79). By the end of the 1970s the impact of socialised/corporative medicine and the increase in medical lawsuits led to a discussion about the nature of medicine and doctors' legal and ethical duties. By the end of this decade a group of doctors in the Academy organised workshops to discuss the creation of a code of medical

[231] By 1983 there were 21 medical faculties.

ethics. In 1981 the Congress passed a bill that became *Law 23 of 1981*, or the national Code of Medical Ethics.

### 3. Medical ethics in Colombia

In the nineteenth century there was no formal codification of medical ethics. In the first half of the twentieth century the laws regulating medical practice included some ethical precepts for doctors.[232] In 1954, when the country was under a military dictatorship, the *National Association of Colombian Catholic Physicians* promoted the *Code of Medical Morality*,[233] which was promulgated as Decree 2831 of 1954 (Lozano, 1989, p. 89). Although the 1954 code was based on the WMA's code of ethics, it was practically ignored by the Colombian medical profession because it was imposed by a dictatorship and its content was too biased towards Roman Catholic beliefs. After the end of the dictatorship in 1956, the code was virtually forgotten. Later, medical practice was legally regulated by a new law, *Law 14 of 1962*, and a new system of penalties for doctors' ethical misconduct was introduced (Casas, 1982, p. 9).

In the period 1950-1980 the most important textbook about medical ethics was *Medical Deontology*,[234] published in 1955 by Gerardo Paz Otero, a Colombian physician and medical ethicist. This book showed the influence of the Roman Catholic Church on medical ethics. The foreword, written by a renowned Colombian physician of the time, began by praising Pius XI's encyclical in which moral and economic aspects of marriage were discussed, while "modernism" was condemned (Uribe, 1955, p. 22). The book discussed a wide range of medico-ethical issues, including chapters that might probably be considered as weird, or at least curious today, on topics such as the "pre-nuptial medical certificate" (a eugenic measure), the "conjugal onanism", and the "periodic marital continence". Condoms were forbidden as they opposed God's plan, while the Ogino-Knaus method[235] to avoid pregnancy was supported. Passive euthanasia, a topic that had been debated in a medical congress in Paris at the time, was rejected (Paz, 1955, pp. 127-130).

During the 1970s the idea that the medical profession required better ethical and legal regulation began to be openly discussed (Gómez, 1976). In 1978 the Academy and other

[232] Law 20 of 1925
[233] Código de Moral Médica.
[234] Deontología Médica General.
[235] A calendar-based contraceptive method, the only one accepted by the Catholic Church.

medical associations like CMF and ASCOFAME started to work on a draft for the code of medical ethics, which was finally approved and turned into law, *Law 23 of 1981*(Socarrás, 1991). This legal codification of medical ethics has been criticised ever since it was first discussed in the Congress at the end of the 1970s. While for some scholars, and particularly for medical associations like the Academy, CMF and ASCOFAME, this 'law of medical ethics' was seen as a 'protection' against medical lawsuits because the standards of practice were clearly defined, others argued that such a law was unconstitutional because it created courts of ethics in which doctors would be substituting judges in the administration of justice. Moreover, this code was seen as "a statute that would allow a privileged medical cast to monopolize as some doctors would be given advantages while the vast majority would be marginalized" (Cardona, A. 1985, pp. 73, 102). Some doctors argued that if the code of ethics was also a law, Colombian doctors would not practise because of an ethical commitment, but because of their fear of a legal punishment. Even for some lawyers the oath included in the code was useless because, for them, "the Hippocratic Oath was not a legally binding rule" (Socarrás, 1991).

The president of the CMF by that time presented the new code and law describing them as "a set of norms aimed at preserving a responsible, correct, and honest practice within the profession, while giving to society guiding principles for an adequate doctor-patient relationship" (Casas, 1982, p. 10). It consists of 94 articles grouped under three headings. 1. general dispositions, 2. professional practice, and 3. disciplinary issues and courts of ethics. The code opens with a definition of medicine as

> a profession that aims to take care of human health and the prevention of diseases, the refinement of the human species as well as the improvement of the living standards of the community, without distinction of nationality, or socioeconomic, racial, religious, or political aspects [...] (Code of Medical Ethics, 1981).

Following a Hippocratic tradition, chapter two includes the oath that medical students had to take at their graduation ceremony, which required from Colombian doctors the same duties that the WMA defined in its 1968 version of the Geneva Declaration.[236] Courts of Medical Ethics[237] were created to investigate violations of the code. Through a disciplinary process,

[236] See: http://ethics.iit.edu/codes/coe/world.med.assoc.geneva.1968.html, accessed 30 July 2008
[237] Tribunales de Ética Médica.

which was copied from the Code of Criminal Procedure, doctors accused of misconduct could be found guilty or not guilty (Yepes, 1995, p. 36). Although these courts of ethics consist only of physicians, any doctor involved in disciplinary proceedings necessarily requires a lawyer in the same way that any defendant in a legal court. Many experts of medical ethics in Colombia, like F. Sánchez, think that it is preferable that doctors are tried by their peers in cases of ethical misconduct and not by, for example, lawyers (Sánchez, 1990b). During the 1980s and 1990s talking about medical ethics became synonymous with talking about the code of medical ethics of 1981. However, two circumstances have transformed the discourse and practice of medical ethics in Colombia: the healthcare reform of 1993 and flourishing of bioethics in the 1990s.

**4. The impact of the healthcare reform on medical ethics**

One of the most frequent criticisms of Law 100 of 1993 has been its power to destroy the Hippocratic ethical foundations of clinical practice. Doctors frequently write about this situation in rather plaintive terms. For instance, a former president of the Academy observed that:

> We are experiencing a growing conflict between 'corporate ethics' of health care institutions […], created based on Law 100 of 1993 […] and Hippocratic ethics or medical ethics […]. Healthcare based mainly on profit making deeply affects notions of social commitment by replacing the essential Hippocratic aim to benefit the patient by an economic framework that submits medical practice to commercial management of the profession and to the consequences of an ill-conceived market […]. (Patiño, 2002, p. 6)

In this quote 'Hippocratic ethics' and 'medical ethics' are synonymous. Here the term Hippocratic seems to have at least four connotations. First, a complete and unconditional commitment to the welfare and needs of the patient. Therefore, a Hippocratic doctor is basically a patient's advocate. Second, the term refers to a profession that is dealing with human life and bodies and which requires a vocation to help others. To some Colombian doctors and bioethicists a true physician should love humankind in order to be a 'true' physician (Gaviria Neira, C., 1998). Third, Hippocratic means to be reliable, i.e. that the patient, as a vulnerable person, can trust the physician. However, the new healthcare system has proven to be a very profitable industry that uses doctors' labour to make money (Rosselli & Guzmán, 1997), and this economic priority appears to be incompatible with fulfilling

patients' needs. Finally, Hippocratic also means good quality medical care. But, with the priority given to economic goals over quality of care, Colombian doctors feel that clinical medicine is now subjected to an assessment using foreign quality criteria.

For renowned Colombian physicians like D. Rosselli,[238] medical ethics in Colombia was "fatally wounded" by neoliberalism, which emphasises cost-effectiveness, productivity, profit and the market. Rosselli invited his colleagues in Colombia to "accept with resignation the neoliberalism that permeates the healthcare system and is making doctors practise a savage capitalism similar to that of the [healthcare] intermediaries […] We doctors remain bound to the tradition, but we must accept to play with the rules of globalization: in Rome do what the Romans do […] Learn the new precept: *primum pecuniae*, profit first" (Rosselli, D., 2006).

In 2004, ten years after the healthcare reform, ASCOFAME invited another medical mission, this time from the United Kingdom. In its final report it said that the quality of medical graduates in Colombia had deteriorated over the previous ten years as a result of the applied reforms, a proliferation of medical programmes,[239] and the deterioration and disappearance of qualified centres of medical practice (Marston & Ospina, 2004, p. 12). This British Mission concluded that: First, although the UK spends some 6.8% of GDP on health and Colombia nearer to 10%, yet the UK provides a better overall service. Second, the UK has 30 medical schools of fairly uniform standard for a 60m population; Colombia has 51 of widely different standard, for a 43m population. As a consequence, the number of Colombian schools should either be reduced or at least prevented from increasing. Third, the NHS in the UK is mainly based on primary care, which is cost-effective. In Colombia, however, the introduction of such a system would require a cultural change. The mission recommended that all doctors should hold a postgraduate degree, i.e. that all physicians should be 'specialists', leading to the end of the figure of the generalist doctor. Fourth, it is necessary for Colombia to have a strong regulatory body equivalent to the British GMC in order to guarantee high standards in medicine (Marston & Ospina, 2004, pp. 59-61).

[238] Neurologist, expert on public health and epidemiology, and university lecturer.

[239] Law 30 of 1992 allowed universities freely creating academic programs and opened the door to the commodification of medical education. In 1992 there were 21 medical schools, by 1999 Colombia had 43 (El Tiempo, 1999), and at present there are 57. Even healthcare companies have created their own medical schools, like the Spanish multinational Sanitas Internacional, which opened a medical university program in 2005 (El Tiempo, 1995).

Doctors in Colombia have also argued that with Law 100 of 1993 medicine began a process of deprofessionalisation. Medicine is considered a profession as it is practised by a group or 'professional body' that possesses a set of particular skills and knowledge, it meets a social necessity and it is self-regulated (Hoogland & Jochemsen, 2000, p. 458). Since medical self-regulation has been limited by the healthcare reform, some doctors in Colombia have argued that physicians are no longer professionals but 'technicians'. For J. F. Patiño, a renowned Colombian surgeon and former president of the Academy, the economic success of the healthcare companies has been achieved at expense of the deterioration of the medical ethos (Patiño, 2001; 1998). In the new environment, Patiño lamented, if a doctor challenges the rules imposed by the system, he/she will be accused of 'non-adherence' to the 'new contract' between medical profession and society.

Others, like the renowned internist and bioethicist R. Esguerra, have argued that the deprofessionalisation of medicine is not the result of external factors such as the healthcare reform, but of internal problems of the profession, such as a poor quality medical education and a surplus of doctors (Esguerra, 1999). In 1994 Esguerra had already suggested that the fundamental principles of the medical profession should be preserved in the new environment of the healthcare reform (Esguerra, 1994). For C. Gaviria, an intensive care doctor and bioethicist, although everything had changed, the love of doctors for their own profession should be everlasting and doctors should be committed mainly to learning medicine, not laws and to making of their own professional practice "a bioethical reflection" (Gaviria Neira, C., 1998, pp. 100, 141).

**5. From medical ethics to bioethics**

By the end of the 1990s, to talk about medical ethics had become synonymous with discussing bioethical principles. The words of a president of the Academy are telling in this regard: "medical ethics are taught founded on three basic principles: beneficence, autonomy and justice" (Patiño, 2002, p. 6). However, already in 1993 he said that bioethics was a 'new ethics' for medicine (Patiño, 1993, p. 199). For the members of the Court of Medical Ethics of Bogota it seems that bioethics is nothing but medical ethics using the language of the four principles. They said that even the first Hippocratic aphorism[240] 'prefigured' such principles (Tribunal de Ética Médica de Bogotá, 2004).

[240] "Life is short, the art is long, opportunity fleeting, experiment dangerous, and judgment difficult".

F. Sánchez, president of ICEB, proposed a new code of ethics also based on the four principles, as for him bioethics is the new approach to medical ethics (Sánchez, 2010; 2006). He supports the idea that bioethics is the spearhead of progress in medical ethics. Following his position, in Colombia many bioethicists and medical ethicists consider three eras in the history of medical ethics:

| **HIPPOCRATIC ETHICS** | **MODERN CODES** | **BIOETHICS** |
|---|---|---|
| Pythagorean basis | Deontological | Consensus (Political?) |
| Physician looks for reputation | Physician looks for personal/professional satisfaction | Physician looks for fulfilling social aims |
| Based on physician's authority | Based on philanthropy | Based on patients' choices |
| Focus on individual needs and physician's values | Focus on individual needs and professional values | Focus on group's needs and social values |
| Emphasis on physician's wisdom | Emphasis on physician's duties | Emphasis on physician's legal responsibilities |
| Physician was a traveller and had variable social status | Physician reaches high social status | Physician becomes a worker for a corporation |

But this alleged 'progression' from a Hippocratic ethics to bioethics has not necessarily meant the end of doctors' ethical misbehaviour. After analysing different cases in the period 1994 – 2002, the Court of Medical Ethics of Bogotá, for instance, revealed that there was a significant number of doctors who were accused of awful, reckless and inattentive behaviour (Tribunal de Ética Médica de Bogotá, 2004). The most common cases of ethical misconduct

included: disclosure of private information, disregard of patient's own values and autonomy, and failures to correctly fill out the clinical record. The specialists who were most often sued were gynaecologists and GPs, and the most frequent type of ethical/legal misconduct was negligence.

Unfortunately doctors' ethical misbehaviour is not limited to GPs and consultants. According to an observational study carried out in a private medical school, the proportion of medical students that engaged in misconduct was very high (Vengoechea, Moreno, & Ruiz, 2008). Many medical lecturers in Colombia think teaching bioethics might help. However, as I showed in an article published in 2005, the 'hidden curriculum', i.e. the actual practices in the hospitals, is more powerful than the 'formal curriculum' (bioethics modules) in shaping medical students' characters (Suárez & Díaz Amado, 2005). In fact, as also I showed in other two articles, medical students in Colombia might be experiencing difficulties in developing the ability to adequately make moral judgments in their clinical work and the right attitudes, for instance, when they are exposed to cases of biomedical research involving human subjects (Escobar, H. & Díaz Amado, 2008, p. 73; Escobar, H., Díaz Amado, Páramo, et al, 2010, p. 35).

In this conflictive environment in which medical practice takes place nowadays in Colombia another regulatory discourse has flourished hand in hand with bioethics: medical law and liability.

## 6. Surveillance and medical liability in Colombia

In our day, bioethics and medical law are two powerful ways to regulate medical practice, although in the Anglo-American and German contexts 'medical law' has been an established discipline since the nineteenth century (Faden & Beauchamp, 1986; Maehle & Geyer-Kordesch, 2002). Today, appealing to law to solve contentious medical situations seems natural and obvious. What a lawyer wrote in the *New England Journal of Medicine* regarding Karen Anne Quinlan's case[241] at the end of the 1970s depicts very well the new times for the medical ethos in Western societies: "whoever the physicians were[, the] lawyers would have 'the last word'" (Rothman, D. J., 1991, p. 231). It has been argued, amid the emergence of

[241] She was declared in persistent vegetative state in 1975 and died in 1985 in a nursing home. He became a symbol of the right-to-die movement.

medico–legal issues during the second half of the twentieth century, that "changing perceptions of how medicine could, or should, be practised gave rise to novel legal doctrines" (Teff, 2001, p. xv). The increasing tendency to control medical practice through a legal discourse has threatened clinical autonomy and changed the ethical framework of clinical practice (Morreim, 1995). In short, the influence of law over medicine has become a pervasive phenomenon (Bal & Brenner, 2009, p. 323).

Various authors (Areen, 1988, p. 39; Brazier & Cave, 2007, p. 7; Erin & Ost, 2007, p. 4) have explained why doctors are now constantly supervised. Their reasons can be summarised as follows: First, more accountability is expected in cases of bad results, which are frequently amplified by the mass media. Second, doctors' actions have to do with sensitive moral and religious issues. Third, new technologies have been associated with abuses and there is a social imperative to make an efficient use of resources. Fourth, medical decisions now belong to the public sphere and patients have been 'empowered'. And fifth, we live in a 'blame culture'. For C. Erin and S. Ost (2007) "[t]he trend to prosecute in the medical arena is pervasive [and] there is little evidence that this has been a reflective, carefully measured development" (p. 3).

According to D. Ozar (2001, p. 4) doctors are frequently blamed "for failures that are beyond anyone's control" as a result of two wrong assumptions: that doctors are in possession of complete knowledge about patients' conditions (expertise), and that doctors have total power to restore body and life. Moreover, many medical scandals caused by doctors' misbehaviour have been publicized by the mass media in recent years and have transmitted the idea that doctors are a 'threat' to society, being "often reviled in the media as pariahs" (Brazier & Cave, 2007, p. 3). As D. Rothman has noted, already in the mid-twentieth century, doctors had become "evil actors" because of several factors (Rothman, D. J., 1991, pp. 15-29, 70-84). First, abuses in biomedical research, such as those carried out not only by the Nazis, but also by those who I called the 'good guys', as in the infamous Tuskegee experiment (Reverby, 2009; Díaz Amado, 2010a, p. 432). Second, the way doctors dealt with ethical and legal issues arising from biomedical progress. And third, the turn of doctors into strangers at the bedside,[242] leading in contemporary societies to setting a political, ethical and legal agenda of control and supervision over them.

[242] Rothman gives at least four arguments to explain the process through which doctors became strangers. First, the trend towards specialisation and the disappearance of the family doctor. Second, the little importance given

In the US many physicians will have to deal with a medical malpractice lawsuit at least once during their professional lives (Bal & Brenner, 2009, p. 323). In legal systems like those of the US and UK, medical malpractice usually falls within the scope of tort law, which is part of private law and includes negligence, nuisance, trespass and defamation. In these legal systems, medical malpractice cases are usually solved based on case law, i.e. decisions made by the courts, which constitutes the common law, but also by appealing to legislative norms (e.g. Acts of Parliament or Statutes, which constitutes the statutory law) (Bal, 2009, p. 340). While public law is largely related to criminal matters, although it also includes constitutional law and administrative law, private law is mainly about civil cases (Hope, et al., 2008, p. 47). A major concern and a matter of professional as well as academic debate is the tendency in recent years to criminalise medical practice. According to M. Brazier and E. Cave (2007, p. 8), only in medicine might an ethical and professional dispute result in a criminal prosecution.

Discourses about medical malpractice and the rise of medical liability as a differentiated and independent academic and professional field have a relatively short history in Colombia. The first known medical lawsuit in Colombia was in the 1950s, but it was not until the 1990s when these cases became common. By the early 1990s the number of scholars and academic or professional groups working on issues of medical malpractice started to increase. In this respect, the Colombian Association of Anaesthesiology has promoted among healthcare professionals in Colombia a culture of legal insurance. In 1995, this association launched a specialised journal for medico-legal issues that has contributed to building up the corpus of literature in Colombia on medical malpractice and medical liability, disseminating legal decisions relevant for medical practice and helping to shape the 'legal mind' of Colombian doctors.

In the last few years the term 'juridification of medicine' has become a topos in the field of medical ethics in Colombia. According to E. Otero, this term was formally introduced in Colombia by Eduardo Rey, a professor of internal medicine, who has strongly criticised the current healthcare system for its negative effects on the medical ethos. For him the term referred to "those legal actions that interfere with a responsible and regulated autonomy that

to talk to the doctor as being informed about new technologies became more important. Third, hospitals and other places related to healthcare became more and more a 'strange' environment for lay people –e.g. the environment of an ICU or an operation theatre. And, finally, the typical "self-segregation" of doctors encouraged by medical school (Rothman, D. J., 1991, pp. 122-147).

doctors should be granted in their practice" (Otero, 2004, p. 11). The strong emphasis on the legal side of the code of medical ethics of 1981 might have contributed to the process of juridification since the 1980s of the Colombian medical ethos. By the mid-1990s, F. Sánchez claimed that due to this juridification, medical practice was no longer a question of 'moral commitment' (Sánchez, 1997a).

Two main factors might be behind the 'necessity' that doctors in Colombia feel for devoting substantial amounts of their time, effort and money to reduce the influence of law on their professional lives. First, the medical field is depicted by a variety of actors[243] as a hostile environment in which doctors must be well prepared to deal with criticisms and attacks from different flanks. In order to be protected, experts working on medical malpractice, like the surgeon and lawyer F. Guzman, have warned about the signs of an imminent lawsuit: "medical complications or death, evidence of family/patient dissatisfaction, formal complaint to hospital board, request for a copy of the clinical record, missing medical appointments or checks, rejection to pay the hospital/honorariums, and warnings from colleagues" (Guzmán, et al., 1996, p. 47f). F. Guzmán (1998) has also described types of "problematic patients": the flatterer, the one who speaks ill of another doctor, the "owner" of the doctor, "the medical expert", the hater of the medical profession, the "gold digger", and the sociopaths (Guzmán, 1998, p. 53). It is important to stress that the number of doctors entering law schools in the last twenty years is a noticeable phenomenon in Colombia. The physician-lawyer is, alongside the bioethicist, a new expert in the field of medical ethics/law in Colombia. The emergence of this new expert, is it a sort of doctors' response to the increasing legal challenges they have to face in the new environment of medical practice? To answer this question, it will be necessary to carry out additional research outside the scope of this thesis, but according to what I have informally learned from these lawyer-physicians when they reflect on their professional choice, there is a growing feeling that the only way for doctors to deal with lawyers is to become lawyers themselves.

Second, the growing body of literature and development of academic programmes on medical liability have shaped this new academic and professional field in Colombia. Moreover, lawyers have tried to justify their intervention in the medical setting by arguing

[243] E.g. mass media, social scientists, bioethicists, and, of course, lawyers.

that, first, they considered themselves as patients' advocates,[244] and, second, that doctors should not be treated as if they had 'legal immunity' (Sarmiento, 1994). In Latin America as a whole, medical liability has developed quickly over the last twenty years. The Venezuelan physician-lawyer Rafael Aguiar has defined medical law in his extensive *Treatise of Medical Law* (2001)[245] as a set of legal norms and ethico-moral precepts, public and private, which regulate medical practice and the doctor-patient relationship; a definition which has been adopted by Colombian lawyers working in the field (Manrique, J. E., 2008, p. 29). Although in this perspective social and structural considerations are taken into account, medical liability is fundamentally regarded as a matter of 'individual liability'. As L. Meerabeau (2006) has argued "the legal system encourages the individualization of blame" (p. 130). This is the way medical liability is taught in Colombia, for example, in a programme for the specialisation in medical law at Javeriana University, which began in 2005. In El Rosario University the term 'sanitary law' is used in a broader sense than medical law as it includes not only laws relating medical liability, but also those regulating the whole healthcare system.

In Latin America there have been critical voices against the growing tendency to sue doctors. G. Russo, an Argentinian author, has called it the "new industry of medical lawsuits" (Russo, 1994). In Colombia, some authors have argued that the growing industry of medical malpractice has transformed medicine in a 'risky' activity (Ramírez, 1995), others have commented ironically that filing a legal claim against a doctor is nowadays "as common and easy as giving a glass of water" (Morales, 1996). Unfortunately, medical lawsuits in Colombia are focused on doctors' mistakes, while neglecting patients' and healthcare companies' responsibilities; not to mention that doctors' rights are frequently neglected (Otero, 1995, p. 2; 2004, p. 11). Among doctors, statistics showing the increase in the number of medical lawsuits in Colombia (López, 2003; Manrique, J. I., 2000), have reinforced the idea that it is necessary to be particularly careful about the 'legal risk' of practising medicine, promoting what L. Peña, a lawyer working in the field of medical liability, calls "the conscience of risk of medical liability" (Peña, 1995). It is now common that medical malpractice literature includes 'tips' on how doctors can avoid or cope with medical lawsuits. Such tips include strictly following the code of medical ethics of 1981, practising according to the *lex artis*, correctly applying informed consent, exercising sometimes defensive

[244] It is a paradox that in the medical ethics literature, doctors, and not lawyers, have traditionally been considered the patients' advocates (Pellegrino, 1999; Morreim, 2001).
[245] Tratado de Derecho Médico.

medicine, and avoiding promising positive outcomes (Peña, 1997, p. 45; Ramírez, 1995, p. 32; Sánchez, 1993). Once a doctor is involved in a lawsuit, the advice is that he/she should try "to look like a compassionate, competent physician, and never plead guilty" (Guzmán, 1997).

## 7. From the medicalisation of society to the juridification of medicine: A power displacement in the biomedical scenario

Although Foucault was not particularly concerned with the medicalisation of society, his work has indirectly contributed to understanding this phenomenon through his analyses of how power operates in particular areas of medical practice like, for instance, psychiatry (Foucault, 2006). Here, it is also Foucault who can help us to find an answer to Kimsma and Van Leewen's question regarding current medical practice: "why the subject of medicalisation and demedicalisation, important issues in the seventies and eighties of the last century, has disappeared from the mainstream debates in health care" (Kimsma & Van Leewen, 2005, p. 559). The preponderance that legal and economic considerations has had in contemporary medical practice has to do with a new way of exercising power in this field. It is no longer a power exercised *by* doctors (as medicalisation discourses emphasised), but *over* doctors.[246] It seems that as a reaction against medical power, demedicalising society became a political programme, widely promoted particularly by critical social scientists in the 1970s (Zola, 1972; Illich, 1975; Kimsma & Van Leewen, 2005, p. 561). However, and this is the interesting hypothesis of Kimsma and Van Leewen, the demedicalisation programme was in the end carried out at the expense of a process of juridification and economization of medicine. For them, as the HIV/AIDS case illustrates, "[a] shift from the humane goals of medical support to dominance of legal and economic discursive strategies has taken place, resulting in a replacement of medical strategies in understanding and controlling deviant behaviour by economic and political ways of thinking and doing, fuelled by issues of discrimination and stigmatisation" (Kimsma & Van Leewen, 2005, p. 560).

[246] From a Foucualdian point of view it is necessary to be careful about 'moralising' the discussion. Here, for instance, by saying that now it is about power over doctors, and not by doctors, I am not making a moral judgment, but giving an analytical description. In other words, it is about a *power displacement*, which is not bad or good in itself; it just determines a different way of practising medicine in the context of advanced liberal/neoliberal societies.

It appears that in contemporary societies the medical discourse is no longer the 'natural' space to define standards, rules and roles in medical practice. There is a contentious relationship at least between medical, legal and economic discourses that defines the scope and provision of medicine. However, what should be recognised is that conflicts arising in this environment are very often expressed as 'ethical/legal dilemmas'. Their origins and true nature, related to a power struggle over who controls medicine, remain hidden. The defining questions in this struggle are: Who defines what medicine is? Who decides about what being a good doctor is? In the past the intuitive answer would have been: doctors themselves. But such an answer is untenable nowadays. Medicine is expected to preserve what is supposed to be its ethical core: "to care for suffering and to heal the afflicted, [although doctors have started] to fight the unsolicited influences of legal and economical discourse" (Kimsma & Van Leewen, 2005, p. 563). If this is to be realised, society cannot continue assuming that doctors' reaction to recent healthcare reforms is just an expression of their 'resistance' to accept new responsibilities. It is also a 'resistance' against a power exercise coming from the legal and economic spheres, but done in the name of the *greater good* (the utilitarian motto). There is a contemporary attempt to 'control' or, better, to 'govern' medicine as well as to redistribute power in the medical scenario, and bioethics and medical law/liability contribute to this dynamics through the implementation of new practices related to surveillance, committees, subjection to principles and rules, lay experts, and so on. Moreover, as M. Dennis has argued, "[t]he lay experts' strategy often consists in drawing attention to the fateful consequences which may follow from the reforms proposed by the doctors, who, for their part, are liable to present their case badly by tending to err on each occasion in the mistaken belief that the opinion of the lay experts is that of the public" (Dennis, 1994, p. 72).

As I already suggested in chapter five, in Foucauldian terms we can say that doctors used to be 'sovereigns' of their own profession, but since "the head of the king was cut off" (Foucault, 1998, p. 89) power has been spread throughout the clinical sphere. This redistribution of power in the clinical scenario has been interpreted as a shift "from paternalism to autonomy" (González, N., et al., 1997, p. 17; Maehle & Geyer-Kordesch, 2002). At the same time the new power relationships have helped to introduce economic

arguments in clinical decision making and turned doctors into double agents.[247] Yet, this power effect remains hidden. First of all, as L. McCullough (2011, p. 73) has argued, the new regulatory discourses of medicine, such as bioethics and medical liability, have gone too far in arguing that paternalism was a norm in Western medical practice, contributing to its deprofessionalisation. Secondly, as already suggested, the clinical scenario might be assimilated to a 'territory' where doctors used to 'reign'. However, having been 'invaded' by outsiders, the power embodied in the 'monarch' [doctors] has been disseminated throughout the entire medical field. But, who exactly then controls the medical scenario, who decides about life and death? 'Sovereignty', i.e. paternalism, is gone and the medical field is now being re-founded as a 'democratic territory' whose inhabitants understand themselves as free, autonomous and rational agents. Medical practice is no longer governed by doctors; medical practice is now governed by bioethics and medical liability as discourses that talk about freedom, autonomy, and free choice. Neither doctors nor bioethicists nor lawyers nor patients monopolize power in the medical scenario. All of them are subjects of the free choice, governed *through* a discourse on freedom. Nonetheless, this does not mean that sovereign power has entirely disappeared from the medical scenario. Doctors still exercise a lot of power over patients, but now doctors are also subjected to the 'sovereign power' of bioethics and law.

## 8. Interviews: How the surveillance environment of contemporary medical practice is felt and narrated

### 8.1. Regarding medical ethics

The senior doctors interviewed said that before the Code of Medical Ethics of 1981, self-government was the most important way of regulation of the medical profession. For MGD, a senior internist, although fifty years ago there was no code of medical ethics, there was a bundle of implicit rules that every doctor was supposed to know which referred to issues such as honorariums, patients privacy and inter-professional relationships. However, he said, ethical misconduct used to be discussed only privately by doctors. If a doctor was involved in

[247] It is not difficult to see that in market-driven healthcare systems "doctors are increasingly being asked, in one way or another, to save money for a third party –and sometimes for themselves- by scrimping on the medical care they deliver. But the pressure is seldom described in these terms. Instead, it is described as practicing 'cost-effective' medicine" (Angell, 1998, p. 147). The double agency is a new kind of subjectivity, a Frankensteinian expression of how neoliberal rationalities understand the clinical set and its regulation.

a despicable action, he would lose his good reputation and his colleagues would isolate him professionally. ROE, a clinic director, stressed that good reputation and prestige constituted the most important assets for a doctor in a time when, if one wanted to secure a large clientele, it was necessary to have a good name. As PRG, a retired nurse and bioethicist, remembered, "the modules on professional ethics were given with a strong religious [Roman Catholic] influence. At the time [in the 1950s-60s] personal self-care and dressing were important. Teachers emphasised good habits, good manners, and an impeccable uniform. The nurse cap should be correctly placed."

The code of medical ethics of 1981 is a landmark document in the history of the Colombian medical ethos. MVJ said that some reasons that in the 1970s led to the creation of a code of medical ethics included "problems linked to doctors' work in private clinics, abusive contracts between doctors and healthcare companies, and relationships between doctors and drugstores". Moreover, as STF said, in the 1970s any problematic situation related to healthcare or medical practice was reduced to a problem of medical ethics. The consequence was according to STF that doctors frequently ended up in trouble, being constantly accused of ethical misconduct since there was a lack of clear norms and rules to guide medical practice. Therefore, a code of ethics was seen by doctors in the late 1970s as a mechanism to cope with these situations and as a self-protection strategy against the threats brought by the socialised medical practice. Additionally, MVJ argued that "the code of medical ethics has been very useful to inform doctors about the right way to practice and it has also provided the content to teach medical ethics in medical schools".

However it seems that, according to ETJ, only a small group of doctors and some professional associations were involved in writing the code. For ROE, who was a medical student at the end of the 1970s, the National Academy of Medicine was the medical association behind this code. It is interesting that many Colombian doctors feel that the code of ethics of 1981 is an 'alien' document. For instance, as SHJ, a physician and university lecturer, said: "the code of ethics of 1981 is simply a set of rules that a doctor has to accept, although such rules were written by people he does not know". Moreover, the double nature of this code, i.e. its deontological as well as legal nature, was controversial among doctors when it was introduced. According to STF "many doctors disagreed about creating a code of medical ethics that was at the same time a law since ethics was, in their opinion, a matter of 'personal' views and then it was not possible to legislate about that." Following the case of doctors, other healthcare professionals such as nurses had to create their own 'laws' of

professional ethics. PRG, a retired nurse and ethicist, said that nurses were advised by lawyers to transform their code of ethics also into a 'law' because this was the only way to guarantee that the decisions of the Nursing Court of Ethics were valid and binding. As a result, the nurses' code of ethics also became law through Law 911 of 2004.

Despite its evidently being outdated, the code is still regarded as an important document of the Colombian medical ethos. For BPA, a lawyer, "the code of 1981 helped to preserve the spirit of the medical profession, although it needs to be updated." In relation to the same issue, PAG, another lawyer, said that "its articles are not only ethical commands, but also legal duties. However, the code was written for doctors who practised individually, which is a problem as today doctors are tied by legal contracts and there are third parties [healthcare companies] making medical decisions." For GCA, a physician and bioethicist, the code "was ahead of its time because it included, years before bioethics was known in Colombia, the duty of informing patients." However, in the GCA's opinion there were new problems in the healthcare system that must be legitimately considered as problems of medical ethics, for instance, the problem of double agency, conflicts of interest and moral risk. For ETJ, "the code of 1981 required reforms as well as updates because the world was now more complex, and bioethical as well as legal issues should be considered in such a code." In this regard, MVJ mentioned that the draft of a new code that was being discussed by various medical associations included, first, a reformulation of the goals of medicine; second, the acknowledgement that in many situations it is not a doctor but healthcare companies that make the decisions, and that these companies should be accountable in terms of medical ethics; and third, an adequate and clear procedure to file complaints of medical misconduct.

Some of the interviewees remembered that when they were at the medical school, 'medical ethics' was seen very often as an unimportant, useless and boring part of the medical curriculum. Still, practitioners see medical ethics and bioethics as an important part of medical education. But doctors' professional life contradicts the importance verbally given to medical ethics and bioethics. This contradiction is because good comments about medical ethics and bioethics are a matter of political correctness. As LCM, a physician, has argued, the problem of medical ethics in Colombia has to do with its 'academic', disconnected character, distant field from daily practice. An emergency room doctor, JEO, said that the code was barely mentioned in his service; it was "dead letter". According to AQJ, another emergency room doctor, the code of ethics was considered as an unimportant document by

clinicians, although as many other clinicians in Colombia, AQJ thought that following the code might protect doctors from being involved in medical lawsuits.

According to LBG, a physician who was also a member of a court of ethics, the analysis of the most common cases known by its tribunal showed that: First, in the new healthcare system doctors were pressurised to accept unfair labour contracts with healthcare companies. Second, medical confidentiality was not possible within the bureaucratic style of the new healthcare system. Third, medical students were learning how to engage in the bureaucracy of the system, instead of developing the ability to make right medical decisions. Fourth, doctors were no longer committed to the patient as a whole, only to the tasks or activities they were hired for according to their own speciality or function in the system.[248] Fifth, the new healthcare system worked as a 'production chain' in which accountability was dissolved and medical attention deteriorated. One doctor sees a patient for the first time, other doctor orders some tests, another one carries out the required surgery, a different one is in charge of postoperative care, and so on.

Some of the interviewees, like FAS, a physician and expert in public health, strongly criticised what I would call the blameworthy sides of the Colombian bioethics. He said that "if anyone wants to assess the role that ethics and bioethics [as disciplines] are truly playing in the current healthcare scenario, it would be necessary to ask whom or what interests is bioethics working for". He also said that bioethicists in Colombia, particularly the renowned ones, probably were honestly doing great and interesting work, but the fact remains that their work had no intention of any social transformation. On the contrary, "bioethics is mainly about *reinforcing* the *status quo* and the discourses of some Colombian bioethicists are really *regressive*… It is not a surprise since in Colombia bioethics has never been in *progressive* hands. This is the problem!" For SHJ, a physician and university lecturer, "medical ethics and bioethics are 'visible' only in complex cases that exemplify the so-called 'ethical dilemmas'". However, for him, daily medical practice was full of ethical aspects that unfortunately were underestimated or disregarded because they were not 'spectacular'.

[248] LBG provided this example, which was a real case: a radiologist saw a malformation during an echography session, but because his contract was just to inform about the foetus' age and some data such as its weight and height, he did not write in his report anything about the finding because 'it was not his business'.

### 8.2. The emergence of medical liability

For BPA, a lawyer, medical malpractice and medical liability were terms that, in the context of the broader field of medical law, described the legal accountability of individuals and institutions within the healthcare system. As PQP, another lawyer specialising in medical liability, explained, medical liability arises from medical error. In medical malpractice cases it is necessary to prove that a bad outcome was because of reasons other than patient's disease. For BPA, medical liability was just a particular case of liability in general; all professionals are legally liable, not only doctors. However, as an emerging field medical liability has been gradually growing because, she said, it was clear that the more educated people were, the more likely they were to claim compensation for damages they suffered. Therefore the academic and professional field of medical liability had grown so much in the last few years as "a natural outcome of society's progress". This opinion was shared by some of the interviewed doctors like GCA, who thought that because today people were much more informed about medical issues as well as their rights, they tended to claim more. For ABC, the presence of lawyers in the clinical scenario meant a crisis of accountability in the healthcare sector. According to STF, thirty years ago a doctor would not have been compelled to appear before a judge unless he had done something really horrible. But today, as MGD argued, the growing legal regulation of medical practice was unavoidable as the scenario for practicing medicine had been radically transformed.

Within the medical malpractice discourse, bad medical outcomes tend to be regarded as a consequence of one individual's failure. However, the structure of the system itself can also harm patients. BPA, a lawyer, argued that "in the new healthcare system the likelihood for a doctor to be sued has increased and is linked to the presence of 'risk factors' such as the short time a doctor is given in a healthcare company to see a patient and the tendency of doctors to overwork to compensate the drastic fall in their earnings". In BPA's opinion the increase in medical lawsuits was not a consequence of the healthcare reform of 1993, but merely two coincidental phenomena. MVJ, a physician and medical ethicist, agreed and argued that "the health system is a 'professional misconduct maker' since sometimes doctors cannot do anything other than obey the rules imposed by the system. Unfortunately, lay people do not know about this reality. Therefore, people have ended up blaming doctors without considering the role that the system itself is playing in the production of bad medical results".

However, according to PAG, a lawyer, the way medical liability is understood was changing. He said that "the practice of medicine in corporative, managed care contexts is challenging the traditional concept of medical liability. At present, Colombian high courts' jurisprudence is that individuals and institutions share accountability and, therefore, liability. In 2008, for instance, there were some high court rulings against healthcare insurance companies instead of individual doctors. This illustrates a shift in the jurisprudence regarding medical lawsuits in Colombia because so far health providers and individual doctors had been the only ones targeted by lawyers when filing a medical lawsuit, while healthcare companies had remained untouched."

According to BPA, the medical malpractice discourse was aiming at preserving the ethical standards of the medical profession as well as compensating patients when they were harmed as a result of a medical act[249]. "When things went wrong in the clinical setting, medical ethics means nothing for patients". From the perspective of a 'victim', the disciplinary penalties that a doctor is given are not a compensation. For BPA, "while bioethics remains in the realm of the hypothetical, the law does actually regulate practices, interventions, actions, etc."

However, as FAS pointed out, "many people take for granted that law is neutral and good *per se*, but actually the law is just the expression of a balance between different social forces in conflict". Many lawyers like BPA thought that judges in courts of law were truly impartial, as "they know their decisions might be reviewed at a higher level, i.e. superior court, leading them to seek 'objectiveness' in all their decisions."[250] VRR, a physician and expert in managed care, pointed out that "different discourses, such as technical, scientific and others are articulated and expressed in the laws and norms regulating the healthcare system". The idea of neutrality of the law was also criticised by ABC. He said that taking up the law as neutral "is an ideological effect that allows certain groups to impose their will, but from a

[249] The concept of 'medical act' is central both for medical ethics and medical malpractice/liability discourses in Colombia, and should be differentiated from the term 'medical practice'. Medical accountability only exists as long as a medical act has taken place. From the perspective of the *European Union of Medical Specialists*, a medical act "encompasses all the professional action, e.g. scientific, teaching, training and educational, clinical and medico-technical steps, performed to promote health, prevent diseases, provide diagnostic or therapeutic care to patients, individuals, groups or communities and is the responsibility of, and must always be performed by a registered medical doctor/physician or under his or her direct supervision and/or prescription." Retrieved from: http://admin.uems.net/uploadedfiles/754.pdf, accessed 28 August 2011.

[250] The idea that lawyers, judges, and juries are *impartial* is very widespread, and nowadays reinforced by TV dramas and news. However, legal proceedings are full of subjective and ideological biases. See, for instance, Kerruish, V. (1991). *Jurisprudence as Ideology*. London: Routledge. In Latin America also some jurists have analysed this problem. See: Cuéllar, A. (2007) *Las sentencias judiciales en América Latina* [Legal Decisions in Latin America]. Retrieved from www4.jfrj.jus.br/seer/index.php/revista_sjrj/article/view/151/163, accessed 20 September 2011.

sociological perspective laws are just part of the social structure." Moreover, PAG claimed that, "lawyers are able to make-up a case from nothing". In his opinion, to file a medical malpractice case before a court was not a problem because finding weaknesses, failures and misconduct in the current healthcare scenario was too easy.

According to GCA, a physician and bioethicist, the first postgraduate programme in the field of medical liability was opened by the Bolivarian University in Medellin, in 2005, after which three universities in Bogota also opened similar programmes (El Rosario in 2006, Javeriana and Externado in 2007). GCA emphasised that these reflected a variety of approaches to the field. While at Javeriana University medical law was synonymous with medical malpractice/liability, El Rosario adopted a broader approach. GCA's view was that medical law encompassed "any problematic issue regarding life", which included not only medical liability, but also legal regulations to guarantee access to medicines, the administrative structure of the healthcare system, biotechnology and laws to regulate reproductive issues.

But not all doctors considered the presence of lawyers in the clinical scenario as negative. STF, for instance, said that his experience in a court of medical ethics of more than eleven years taught him that medical self-regulation did not work as "guild brotherhood" made impartiality a goal hard to achieve. He thought the intervention of law was necessary. LCM suggested a perspective not centred on lawsuits to consider the influence of lawyers on medical practice. For her it was also important to acknowledge that lawyers helped people to obtain from either state or healthcare companies medical services, which they were entitled to receive. For ETJ, the presence of lawyers in the medical scenario could help to guarantee patients' autonomy as well as justice. For him, "there is no such thing as an undue interference of law into medical practice. The law is there for protecting [individual's] rights". Yet, in his view "the increase of medical lawsuits in the USA might have contributed to the rise of bioethics as a successful new discipline". For STF, "lawyers are necessary, for instance, in ethics committees and also courts of medical ethics because ethical misconduct proceedings might end up in civil, criminal, or administrative lawsuits." Thus, as PQP clarified, medical misconduct usually led to malpractice lawsuits, although misconduct was not the main source of medical malpractice cases.

In contrast, for MVJ "if doctors' accountability is going to be assessed based on civil laws about compensations, the conflict between doctors and lawyers will be a war-like situation."

According to him, the medical malpractice discourse should replace neither medical ethics nor bioethics, as doctors should be taught how to be committed to doing their work well rather than to blindly obey a legal norm. The code of ethics was pointless, he insisted, if doctors did not have the intention to behave correctly. For MVJ, the increase in medical lawsuits was owed to the loss of respect for doctors. In MGD's view, patients did not trust doctors in the same way they used to in the past. According to PAG, a lawyer, the problem was that "people used to accept passively bad medical outcomes since they were an expression of God's will or just bad luck. But now people are prone to claim and – according to his professional experience – they claim whatever the outcome is". Thus reasons to sue a doctor in Colombia include: the idea of 'guaranteed rights', the weaknesses of the medical profession's self-regulation, the idea of having a mechanism of compensation whenever patients are injured by a medical intervention, and the loss of respect for doctors.

According to BPA, Colombian doctors had reacted against the medical malpractice phenomenon in two ways. Some implemented a kind of "safe practice", i.e. their practice was guided by both the *lex artis* and the code of medical ethics. But others preferred to implement a "defensive practice". At the moment the clinical scenario in Colombia is impregnated with fear. As AQJ noticed, "we doctors are constantly under risk of getting into legal trouble." Unfortunately, he said, "defensive medical practice has led to an increase of unnecessary laboratory tests and referrals to specialists. In the emergency room some doctors even avoid attending seriously ill patients since they represent a higher risk of being sued". Similarly, JEO thought that "at present doctors prefer to adopt a 'low-profile' style at their work, doing just the minimum required as the best way to avoid legal risks". Of course, as SHJ observed, doctors should record every medical intervention to have evidence that he/she has followed best practice, although "instead of hoping to be declared 'not guilty' in court, it is better for doctors to avoid legal confrontations. Then, doctors should request as many tests as possible in order to shield themselves against lawyers". However, in PAG's opinion, "Colombia is far from the 'witch-hunt' situation that characterises the US, where an increase of medical lawsuits with high premiums has occurred in the last few years."

In EGR's words, "although in Colombian law 'everyone is innocent until proven guilty', in the case of doctors it was otherwise, as they were treated as 'guilty until proven innocent'". Moreover, as VRR said, doctors were subjected to a bundle of rules that were often out of their control. For him, the discourse of ethics presupposed freedom. Hence medical ethics was not viable in the current healthcare system since it imposed severe limitations on doctors'

autonomy. As PRB said, "there is an overabundance of legal norms in Colombia that makes the healthcare sector too complex." Paradoxically, many legal and administrative norms ruling the clinical scenario can restraint doctors of doing their clinical work properly, i.e. focus on the individual's needs.[251]

## 10. Conclusion

The discourse of medical ethics in Colombia can be characterised by three aspects. First, it is a discourse that appeals to the mythical figure of Hippocrates to support the idea that the medical profession has a fundamental and unchangeable 'ethical core' now threatened by the new conditions of practice. Second, it is usually taken as synonymous with a code of ethics (medical deontology). And third, it has traditionally been a discourse related to elite medical associations, such as the National Academy of Medicine, conservative groups, the Roman Catholic Church and 'experts' in medical ethics/bioethics. It was interesting to observe that in order to face the advent of corporate medicine, with the creation of the first private healthcare insurance companies, the use of new technologies, and a growing influence of lawyers over the biomedical field, the Colombian medical establishment promoted the creation of the code of ethics of 1981. Medical ethics in Colombia has been a discourse used to saying what medicine is and what not. Moreover, as medical ethics became synonymous with this code, the discourse of medical ethics in Colombia was impoverished as it was reduced to mere medical deontology. Additionally, I would also argue that by making this code a law, *Law 23 of 1981*, the road was paved to the juridification of medicine about which many talk nowadays in Colombia. The historical concurrence of an American-style healthcare system, the values brought by the constitution of 1991, the arrival of discourses about bioethics and malpractice coming from the US, and the healthcare reform of 1993 might explain the 'conditions of possibility' for medical law, as a discourse and professional field, to have rapidly developed in Colombia since the 1990s.

During the last fifty years, accompanying the techno-scientific advance that has revolutionised the practice of medicine and led to the rise of corporate healthcare, discourses and practices of surveillance have gained importance in the biomedical scenario. This is the case for the discourses about bioethics and medical liability, which are reshaping the biomedical ethos and have also created new disciplinary and professional fields. Then,

[251] The clinical method is about individuals, not groups, which are the target of public health, epidemiology and health economics.

keeping an eye on doctors has, according to the American bioethicist A. Jonsen, become a profession. He has argued that "some people have arranged to watch from afar [the DPR]. Our culture has transformed the fascinating pastime of doctor-watching into a science [and] we have orchestrated the ooh's and ah's into a critical literature" (Jonsen, 1992, p. 1). Bioethics and medical liability constitute discourses about highly appreciated social values such as individual autonomy, freedom to choice, fair distribution of resources and protection from doctors' abuses and exploitation.

Once medical practice and healthcare services were transformed into a powerful and huge economic sector, the so-called *medical industrial complex*, new regulations were required, too, in order to keep such a sector working properly. Bioethics and medical law are part of these new regulations by providing necessary elements. First, they provide a rhetorical discourse about moral values, ethical principles, individual's rights and protection. They coloured healthcare and medical practice of humanism, respect for persons, and freedom in such a way that structural and socio-political aspects related to them remain hidden. Second, they constitute a particular way of disciplining not only healthcare professionals, and doctors in particular, but also all the inhabitants of the biomedical scenario, i.e. patients, healthcare providers, managers and so on.

From a Foucauldian point of view, bioethics has contributed, with its emphasis on personal autonomy and free choice, to the governmentalization of biomedicine, helping in 'conducting the conduct' of healthcare professionals, patients, and research subjects in a way that is functional to the rationalities and practices of neoliberal healthcare systems. However, the governmentalization of medicine does not mean that other forms of power have disappeared from the biomedical field and, most importantly, that talking about power in medicine only means the power exercised by doctors over patients (i.e. paternalism) and/or the power exercised by medicine over society (i.e. medicalisation). In this chapter I have particularly illustrated how bioethics and medical law are current ways of exercising sovereign and disciplinary power over the biomedical field. In the next chapter I will examine how bioethics has also become part of contemporary biopolitics in Colombia in the context of the new constitution of 1991 and the healthcare reform of 1993. The Foucauldian perspective allows us see that different kinds of power are operating simultaneously and in different ways in the biomedical field. Thus, in Colombia the contemporary shift from a Hippocratic/deontological view of medical practice, which was focused on self-regulation, trust and medical authority, to a practice oriented towards individuals' choices and regulated

not only by doctors, but also by bioethicists, lawyers, and economists, can be seen as a power effect.

In the way bioethics and medical liability discourses have worked over the biomedical scenario in Colombia, one can also see the productive effects of power and the inextricably relationship between power and knowledge. On the one hand, a new concept of good doctoring has evolved in Colombia as a result of changes brought by the new constitution of 1991, the healthcare reform of 1993 and the arrival of discourses of surveillance such as bioethics and medical liability. Today, being a good doctor not only means the possession of certain personal qualities and virtues, but also to be bound to administrative, legal, and economic norms of healthcare. On the other hand, medical law has become a new specialised area in which expert knowledge, expert subjects, and particular forms of judging the reality have been created. It is a practical discourse that has transformed the medical ethos by introducing new values, new accountabilities, new rationalities, and it is embodied in different institutions related to healthcare, the judiciary, schools of medicine, insurance companies and so on.

Although the law is necessary to protect the vulnerable, guarantee individual rights and compensate those who have been injured after a medical intervention, it is undeniable that the development of discourses and practices around medical malpractice has also represented a lucrative business for several actors: lawyers, legal insurance and healthcare companies. This has been another productive effect of power in liberal contemporary societies with American-style healthcare systems, such as Colombia. Following F. Ewald (1991), it can be argued that the creation of a 'legal risk' in medical practice is a power effect, which has meant that doctors are having to pay insurance policies and are practising defensive medicine, having the counterproductive effect of growing distrust between doctors and patients, and the exploitation of healthcare professionals by healthcare companies. While Law 100 of 1993 transformed the milieu in which medical practice has to take place in Colombia, making it governable, as I showed in the preceding chapter, by individualising accountabilities, using a pastoral discourse, and also the force of law to punish (sovereign power), bioethics and medical liability represent a particular way of subjection of the bodies of healthcare professionals, particularly doctors, to the particular practices and institutions imposed by the neoliberal healthcare reform of 1993 (disciplinary power). A good doctor in Colombia nowadays seems to be the 'disciplined doctor'; one who fears the law instead of respecting it and remains completely bound to the rules, practices and rationalities imposed by the system.

Chapter seven

# The Colombian Constitutional Court and its 'bioethical' decisions

## 1. Introduction

According to T. Hope, J. Savulescu, and J. Hendrick (2008, p. 35), from a legal perspective there are three main concepts to take into account in medical ethics: the patient's best interests, autonomy and rights. A medical decision based on patients' best interests is intended to guarantee that account is taken of their wellbeing, which is particularly important when patients "lack the capacity to take part in their own medical decisions" (Hope, et al., 2008, p. 35). Although there is no unanimous view on what a patient's wellbeing means, the concept of best interest is basically linked to respect for autonomy. This principle is key not only to medical practice, but also for the whole socio-political life of Western societies. Its impact on how to understand the DPR has been enormous in the last 30 years (Hope, et al., 2008, p. 40). The discourse on individual autonomy has two roots in the Western political philosophy. From a Kantian point of view, human beings are supposed to have a special dignity and should be considered ends in themselves, while from J.S. Mill's point of view, people's freedom should not be limited unless they harm others. Within the liberal paradigm, moral authority is derived from the individual, which means that in a medical context any decision or intervention requires the patient's consent. In fact, T. H. Engelhardt (1996, p. 72) renamed the principle of respect for autonomy as "principle of permission". The legal and economic counterpart of this ethical position in the medical context is that patients are seen as consumers (Díaz Amado, 2009b, p. 23). The preponderance of the individual is nevertheless a source of conflicts since his "[r]ights impose moral (and legal) constraints on collective social goals" (Hope, 2008, p. 43). Thus, finding the equilibrium between 'the individual' and 'the social' is of political importance. However, as I have shown in chapter two, from a Foucauldian point of view the pre-eminence of individual autonomy in liberal societies should not naïvely be understood merely as a proof of 'moral progress', but also as an effective and dynamic strategy of governmentality. After the PC of 1991, and with the particular role played by the Constitutional Court (CC), concepts such as best interest, respect for autonomy, and individual rights have gained momentum in the ethical discourse of biomedicine.

In this new political and legal environment, the Colombian people could obviously have celebrated that they got more freedom but, to which extent? Does 'more individual

autonomy' mean 'more freedom'? Is the current legal regulation of human life and body emancipating the individual or is it just a very effective extension of biopower? And, as P. Miller and N. Rose have asked: "how, and to what ends, did so many socially legitimated authorities seek to interfere in the lives of individuals in sites as diverse as the school, the home, the work-place, the courtroom and the dole queue?" (Miller & Rose, 2008, p. 1) The answer, as I have also argued in previous chapters, might be *governmentality*, a concept used by M. Foucault that embraces "the tactics of government that make possible the continual definition and redefinition of what is within the competence of the state and what is not, the public versus the private, and so on" (Foucault, 1991, p. 221). As part of the ongoing task to analyse how and why regulating every aspect of human life might be a strategy to govern individuals, I will therefore characterise the Colombian case as a paradigmatic example of these contemporary power dynamics in the biomedical scenario by analysing three CC decisions, the highest court, created by the PC of 1991.

The CC's decisions have introduced case law into Colombian law, leading to a gradual abandonment of

> the formalist legal approach, which disregarded the importance of preserving constitutional mandates in real-life situations. [Also the CC's role] has substantially altered imbalances of power in the Colombian social, political, and economic spheres [as its] decisions are highly sensitive to social inequalities and to the needs of the vulnerable, weak, and marginalized. [Moreover, the CC] has become a forum where the most difficult, pressing, complex, and sensitive national problems have found increasingly legitimate responses. (Cepeda, 2004, p. 536)

The role played by this court marks a turning point in Colombian political, legal and ethical life. The CC's activity since its creation has been remarkable in terms of promoting the realisation of the pluralistic, inclusive and rights-oriented values of the PC of 1991. As I mentioned in chapter five, this Constitution tried to embrace two conflicting models of the state: on the one hand, the social rule-of-law state oriented to provide welfare and, on the other hand, a neoliberal state driven by the market (Alvarez, J. R. 2007, p. 126), the latter being the model privileged by governments of the last 20 years. However, through its decisions the CC has counterbalanced the latter trend by, for example, considering rights widely, taking into account international treatises when making decisions, and guaranteeing

the Colombian citizens their fundamental rights (Eslava, 09, p204). These dynamics can be seen in several landmark CC decisions, e.g. when guaranteeing religious pluralism, an important decision in a country that has been traditionally been dominated by Roman Catholicism (case C-027/93); the decriminalisation of the personal consumption of certain psychotropic substances (case C-221/94); the decriminalisation of active euthanasia (case C-239/97), the unconstitutionality of discriminating homosexuality (case C-481/98); and more recently the decriminalisation of abortion (case C-355/06).

However, the role of the CC has not been easy and it has often met resistance. During the 20 years when governments have tended to push neo-liberal economic policies, the CC has always been a powerful voice emphasising that rights cannot be ignored and this has meant 'a stone in the shoe' for the political establishment. The economic consequences of the CC's decisions in the field of healthcare have resulted in disagreements and tensions between the government and the CC.[252] In the debate accusations of "judicial activism" by the CC have been made and the problem of a lack of clear legislation on collective rights has been pointed out (Murillo & Gómez, 2005, p. 8). The CC has even been accused of "sentimental populism" (Cepeda, 2004, p. 536). Moreover, some legal scholars have argued that in Colombia judges are having too much prominence, leading to the 'judiridification of politics' when, for example, the fundamental rights should be explained via legal decisions rather than via political agreements (Uprimny, 2006, p. 97f). Others have described this development as the "constitutionalization of daily life" in Colombia, since one of the effects of the PC of 1991 has been to channel accumulated frustrations of the Colombian people, infusing them with the optimism of having in the constitution a set of fundamental rights. Overall, the PC of 1991 has shown that the law might have an emancipatory role and not only serve as a tool to domination. Nevertheless, to change complex social realities by simply introducing new laws is difficult (Eslava, 2009, pp. 191, 215).

In this chapter I will examine in particular the CC case decisions on euthanasia (case C-239/97), medical treatment of intersexual states (case SU-037/99) and abortion (case C-355/06). Through the analysis of these decisions I want to show how the bioethical language, e.g. the concept of informed consent, has entered and is currently used in the Colombian constitutional discourse. In this way, I want to illustrate how Colombian jurisprudence

[252] In the US the situation seems to be similar. E. Morreim (2001, p. 18) has pointed out that "courts' judge-made insurance rulings that look not at the actual contract language, so much as at patients' expectations" have given the public the idea that everyone is entitled to receive anything as part of their medical treatment.

regarding biomedical issues has been bioethicalised and, concomitantly, how the juridification of the Colombian medical ethos has been reinforced. In the conclusion, I will argue that to better understand the complex relationships between medicine, law and economics in contemporary medical practice in the case of Colombia the use of concepts like biopolitics and governmentality as analytical tools is necessary.

## 2. The Colombian Constitutional Court and the language of bioethics

In the Colombian political-legal system the Constitution is the supreme law and has to prevail in conflicts between legal norms. The duty of the CC is to preserve the integrity and supremacy of the Constitution. For M.J. Cepeda, a former justice of this court, the creation of the CC meant "(i) the creation of a specialized tribunal at the head of a new 'constitutional jurisdiction' to which all Colombian judges belong; (ii) the application of constitutional judicial review to concrete situations through the writ of protection of fundamental rights (*acción de tutela*); (iii) the expansion of abstract review of laws, whether *ex officio* or through *actio popularis*; and (iv) the adoption of a means to contextualize decisions adopted in abstract review" (Cepeda, 2004, p. 537). The CC can make three kinds of decisions. First, through a judicial review process, the CC makes decisions about the 'constitutionality' of norms, laws, decrees and administrative decisions (Cepeda, 2004, p. 536) These decisions are identified with a letter 'C', e.g. the case decision C-355/06 that decriminalised abortion. Second, sometimes the Court makes decisions to provide criteria on how to analyse future cases related to a particular issue through the so-called 'unification judgments'. These decisions are identified by the letters 'SU', e.g. SU-037/99, a guideline to decide on intersexual states. And finally, decisions of *tutela* when citizens or social organisations demand from the state that their fundamental rights are protected. Although the majority of *tutelas* are solved by judges in lower courts, some reach the CC for review. In these cases the CC not only resolves a case, but also provides important elements of jurisprudence. These decisions are identified with a letter 'T', e.g. T-209/08 in which a 13 years old teenager, who had been raped, was guaranteed the right to a legal abortion which her healthcare insurance company had initially refused to cover. In this ruling, for instance, the Court not only resolved the case of this teenager, but also provided a guideline on the correct use of the *conscience objection*.

As of 23rd of February 2009 there were 1863 case decisions of the Constitutional Court related to the right to health. In many of these decisions the language of bioethics, particularly principlism, was visible. By the end of 1990s the CC had a well-developed doctrine about *informed consent*, which focused on protecting patients' autonomy (Cabal, 1999, p. 35). The CC decisions related to bioethics are based on various articles of the Constitution. For example, Articles 1, 12, and 16 are related to human dignity, the inviolability of life and the autonomy of the individual; Article 49 talks about protection of life and people's integrity, which in the case of minors is referred to in Article 44; Articles 70 and 71 promote scientific progress and the improvement of techniques; Articles 13 and 49 are related to the principle of justice (Cabal, 1999, pp. 39-40).

The CC's function can be framed within a context of the judiciary's growing influence and judges' power in Colombia after the PC of 1991 (Murillo & Gómez, 2005, p. 7). The increase in the power of judges in Colombia has had important consequences in the field of health care since, as Eslava (2009) has argued "when the law offers a dignity that the state cannot provide, legal technologies have catapulted individual and social aspirations" (p. 191). The CC has sometimes been praised for protecting individual's rights and adequately balancing [doctors'] beneficence against [patients'] autonomy (Sánchez, 1996), i.e. limiting doctors' discretion to make medical decisions and protecting the right of patients to decide on issues related to their own body and health. But other times it has been accused of deciding on medical treatments and being contradictory on how the bioethical principles should be understood (El Tiempo, 1994; Galán, 1995).

## 3. The decriminalisation of euthanasia

### 3.1. Brief history of euthanasia

Although the Hippocratic Oath forbids to provide patients with deadly substances, "[s]uicide and euthanasia were common acts in classical antiquity because fundamentally they did not conflict with the moral beliefs of the time […] When faced with hopeless circumstances, the ancient Greeks and Romans suffered little social disapproval if they chose to end their lives, commit infanticide, or perform abortions" (Dowbiggin, 2005, p. 8). In the Middle Age, Crusaders carried a special knife called *Misericorde*, a "long, narrow knife [to deliver] the death stroke […] to a seriously wounded knight" (Bradbury, 2004). For

Suetonius in the first century and still for Francis Bacon in the seventeenth century, euthanasia was understood etymologically, "that is, to signify an easy death through the mitigation of pain rather than a death hastened by a physician through the administration of poison." However by the eighteenth century, in the context of the Enlightenment, euthanasia and suicide were seen as an expression of autonomy (Dowbiggin, 2005, pp. 23, 27).

In the twentieth century, particularly after the experience of racist and Social Darwinist eugenic programmes during the Nazi period in Germany, the word euthanasia was associated with killing people whose life was considered not worthwhile to live. But it was with the medicalisation of death that euthanasia re-entered the medical and political discourse. Thus, the history of euthanasia is "a story that is influenced by technological and behavioural changes in the practice of medicine. Today, when modern medicine can do so much to prolong lives, it is no coincidence that a right-to-die movement flourishes in many countries around the world" (Dowbiggin, 2005, p. 6). Euthanasia is then a reaction against the 'excesses' of contemporary medical intervention and an attempt to exercise free will –a long-lasting effect of the Enlightenment- in this case to decide when and how to die. However, it is necessary to bear in mind that euthanasia has different meanings depending on the socio-political, cultural, and economic context. Today the debate about euthanasia takes place in the field of bioethics. In this field, legal, economic, ethical, religious and political aspects are discussed as bioethics is constituted as an interdisciplinary and pluralistic discipline. Once euthanasia becomes a 'bioethical issue', it is then managed, recast and outlined in a particular manner.

Any bioethics textbook includes a chapter about euthanasia and by and large these chapters follow a similar rationality. To illustrate this, I read the chapter on euthanasia in a book of bioethics that I randomly pick up from the bioethics shelf in the library of Durham University, W. Glannon's book *Biomedical Ethics* (2005). The debate about euthanasia is usually placed in the broader context of end-of-life issues and closely linked to the question of the definition of death,[253] physician-assisted suicide, the doctrine of double effect, the withdrawing of treatment, ordinary/extraordinary means, and futility (Glannon, 2005, pp. 120-137). During the last 30 years the euthanasia debate has increasingly taken the appearance of a 'technical issue', philosophically and medically. For instance, in their edited book *Bioethics: An Anthology* P. Singer and H. Kuhse (2006) present the issue in terms of a

[253] Cardiopulmonary, whole brain and higher brain death.

discussion between active and passive euthanasia[254] and its philosophical consequences. J. Rachels (2006, p. 288) opens by providing four reasons to argue that such a distinction should be avoided. These arguments are: first, active euthanasia is in many cases more humane than passive euthanasia; second, sometimes decisions are made on irrelevant grounds; third, the distinction itself has no moral importance; fourth, arguments backing the argument are invalid. For him, doctors are mainly concerned with the legal consequences of their acts, tend just to follow guidelines and therefore the function of the distinction between active and passive euthanasia is merely to conform to the law and not the result of a moral reasoning. In contrast, using interesting thought experiments W. Nesbitt (2006, p. 295) tries to demonstrate that "killing is indeed morally worse than letting die", although this is a claim that does not follow from the premises offered by Nesbitt, says H. Kuhse (2006, p. 297) for whom killing and letting die are interchangeable terms. But, apart from a certain familiarity with utilitarian and/or principlist theories, anyone who wanted to enter the debate would also need to have basic medical knowledge as well. Or, is it possible to debate euthanasia without having a basic knowledge about what and how permanent vegetative state, ventilators, intensive care units and gastrostomy tube feedings are and work? Instead of analysing the bio-ethical debate on euthanasia in an analytical Anglo-American philosophy, as if it was a problem of "consistency of the premises", a inductive-deductive logical exercise, or a linguistic puzzle, and as if euthanasia was a universal, clear concept, I would rather like to make a case for an approach that considers the historical, socio-political, cultural, and, most importantly, biopolitical dimension of euthanasia.

### 3.2. Biopolitics and euthanasia

In the last 40 years, euthanasia has been at the centre of a 'global debate' about life and death. After the Nazis' euthanasia programmes in the 1930s and 1940s, the first case that drew public attention was Karen Anne Quinlan in 1978, a young woman who was left in permanent vegetative state after consuming alcohol and drugs in 1975. She died in 1985 from pneumonia. This case illustrated how the courts became the location where decisions about life and death would be made in our time (Rothman, D. J., 1991, p. 3). More recently the story of Terri Schiavo was widely covered in the media, a woman in a permanent vegetative state who was kept alive until a court gave her husband permission to remove the feeding

[254] This differentiation has also a historical dimension that has not been properly analysed by bioethicists.

tube in 2005 ‘to let her die’. This case generated much attention and was so politicised that the US president personally intervened. In his analysis of Schiavo’s case, J. Bishop has shown that “bioethics is complicit in the totalising effects of contemporary medicine [and that] life and law have always been indistinguishable” (Bishop, 2008, pp. 538, 539). Bishop’s analysis can be useful to illustrate also a characteristic aspect of many current bioethical debates: the ‘*dilemma-framework model’* in which bioethics is depicted as a ‘field of dilemmas’, logical contentions between A and B, or as in the Shiavo case, between conservatives and liberals, which notwithstanding depicting a political discussion is translated in bioethics into the aseptic language of ‘dilemmas’. Something similar happens with abortion, embryo research, and so on. All the while an inability of the participants in the debate to ‘see’ its power-related roots is really evident. In order to be able to ‘see’, as Bishop suggests, the analysis should focus on the discourses that fuel certain practices and not only on logical arguments stripped of content (Bishop, 2008, p. 539).

In the Schiavo case, we saw a ‘spectacle’ in which conservatives and liberals each sought to present their perspective as the right one. In this debate, conservatives wanted to protect life, so they promoted governmental interventions whenever it was necessary to do so. For social conservatives the good life could be reduced to bare life (*zoe*). For Bishop, from a Foucauldian perspective, “[…] social conservatives wish to politicize bare life, mere life of each body within the body politic. Thus, in modern conservative politics, bare life has become the good life” (Bishop, 2008, p. 545). Meanwhile, liberals were focused on “quality of life, notions of good life, and notions of a *bios politikos.* In other words, for social liberals the good life became the foundational justification for possession of bare life. That is to say, social liberals tend to focus on liberty” (ibid., p. 546). Instead of closing the gap between bare life and bios-politikos, as conservatives did, liberals made it bigger, “for there are many kinds of life that would be worse than death because there is no liberty to pursue the good life” (ibid.). For liberals only those forms of life that were already enjoying the good life (bios) deserved legal protection (ibid.).

Following G. Agamben, Bishop said that in her situation Schiavo was in a no man’s land, somewhere between bare life and bios politikos. This state was reflected in a judge’s decision in which Schiavo was declared a being in a “state between life and death” (Bishop, 2008, p. 547). Thus, bare life has become indistinguishable from the decision, that is, that biological life has become indistinguishable from law, and *zoe* has become equivalent to *bios*. Conservatives as well as liberals are convinced they are ‘protecting life’ and ‘doing the right

thing', but they do not see that by politicizing bare life and drawing the dividing line between life and liberty, they have precisely linked bare life to good life and, paradoxically, hooked them together, no matter how irreconcilable they pretend their positions are. The same could be said of bioethicists who debate what ethical theories to use or what principles to apply.

The position of Schiavo once she became an object of bioethical debate can be seen as biopolitically determined. Once we distance ourselves from the dry, formalistic view of analytical philosophy, we can agree with Bishop that the boundaries between life and death are today not metaphysical but biopolitical: "[…] our belief in brain death, or our beliefs in notions of personhood are little more than *post hoc* metaphysical justifications for decisions already taken by the biopolitics of medicine" (Bishop, 2008, p. 554). However, when bioethicists address a particular issue such as euthanasia, the discussion is usually outlined in terms of abstract concepts or ethical theories. But how the discussion itself came into being is rarely discussed. The 'conditions of possibility' for a bioethical issue to emerge depend on how an issue is previously framed in particular areas like, for instance, medicine, law and economics, but this aspect is never part of the bioethical discussion itself. Thus, bioethics is blind about its own role in the biopolitization of life and the administration of the body politics, which not only includes patients but doctors as well. Inspired by Agamben, Bishop thinks that it is not about *zoe/bios*, but about *inclusion/exclusion*. The aporia of Western politics is where to draw the line between inclusion and exclusion and how to avoid those who fall in the no man's land being exploited, harmed or denigrated.

Bishop argued that medicine had become "one of the more subtle forms of totalitarianism in the modern biopolitics" (Bishop, 2008, p. 552). But this would not have been possible without legitimising discourses such as bioethics and medical law. Yet bioethicists, philosophers of medicine, ethicists, lawyers and theologians hardly ever put the general framework of these discourses under scrutiny. They assume that they are just freely debating, refining arguments, building interdisciplinarity and founding pluralism. However, with this naïve approach they are indeed contributing to keeping the power effects of biopolitics hidden behind good intentions and fine arguments.

In modern times, as Marx noted, "all that is solid melts into air" (Berman, 1982) and everything is moveable, loose, changeable, light, even frivolous. We live in "liquid times" (Bauman, 2007) and this situation might, misleadingly make us feel as if we have more freedom. However, as happens many times in our day, the promise of freedom' might

actually entail a sophisticated power mechanism acting upon human life. Paradoxically, we are subjected to restraining and enabling powers since freedom is at the same time a strategy to be externally governed, but also to be autonomous, i.e. to be self-governed. In fact, power creates us. Against the liberal dogma according to which human beings are free agents who behave rationally to fulfil their wishes, a belief particularly promoted by economists (Bishop, 2008, p. 541), we are instead subjected to power relations. There is a deep relation between power and the constitution of our own subjectivity. Although we believe that the individual is a monarch, a sovereign subject of himself, in reality "we are subjects of the social and political power structures that come to shape the form of our lives" (Bishop, 2008, p. 549).

Because the new regimes of power in the biomedical scenario such as bioethics and medical law "are more subtle, and because they promise new freedoms, and new possibilities for the good life, they are more seductive than the horrors betrayed by the old totalising regimes" (J. P. Bishop, 2008, p. 552). Biopsychosocial medicine, for example, which has become so fashionable in the last thirty years, is a 'totalising' strategy. There is virtually nothing beyond the scope of 'the bio-psycho-social' as "[i]t covers the totality of human being […] It is totalising, it is […] an internalized totalitarianism" (J. P. Bishop, 2008, p. 553). Mutatis mutandis, is it not the same with bioethics in a country like Colombia where this 'new discipline' has been described as 'useful and necessary' for 'everything' in the name of human dignity, defence of life, protection of nature and so on? Don't bioethics and legal discourses like medical liability promise the protection of bare life, of the vulnerable, of those without a voice? The answer is 'yes'. However, we cannot forget that these discourses are indeed "constituted power" administering life in the name of protecting it. This dynamics remains nonetheless unknown for bioethicists, who are not aware of how these discourses came into being, how they were constituted as legitimate and how the spaces of 'exception' are configured. Bioethicists are convinced that legal and ethical norms are the product of consensus (J. Rawls), mutual deliberation (J. Habermas), a sophisticated logical operation of analytical philosophy, or any other rational paradigm widely accepted today in a department of philosophy. With such ideas bioethicists want to 'guide' the biomedical enterprise, the medical-industrial complex, a land of neoliberal rationalities linked to the contemporary mutation in the way power operates now through individual 'freedom'.

A common view is that power emanates from law as well as from ethical principles, and that as a consequence power is not a cause but an effect. If one carefully examines the *modus operandi* of bioethicists and lawyers in the biomedical field, one can see the same rationality

behind it. Legal norms and bioethical principles constitute the *a priori*, the *taken-for-granted truths* that are used to build arguments and give legitimacy to decisions about life and death. However, the influence of power on the constitution of bioethics and medical liability, as disciplinary and professional fields, is considered neither by bioethicists nor by lawyers. Yet, it is necessary to acknowledge the extent to which power constitutes law and bioethics and how doctors' and patients' behaviour is not merely a question of legal norms and ethical principles, but of practices, discourses, institutional policies and truth regimes - in short, of a power effect. For instance, a patient can try to make autonomous decisions, but this possibility is limited by the structure and stated practices of the particular healthcare system in which he is precisely a patient. Even those discourses we regard as 'sacred', such as the discourse about human rights, are deeply interconnected with power mechanisms. In this case, for example, Bishop has argued that in modern biopolitics "constituting power" is hidden beneath the language of human rights that conflates bare life and the good life (Bishop, 2008, p. 548). For this reason, neither conservatives nor liberals are aware of their own role in cases like Schiavo's, in which the politicization of bare life is clear. By trying to keep her 'alive', conservatives were convinced they were proudly preserving bare life (zoe). However, they did not see that they had kept 'alive' someone who had no possibilities of living a good life (bios). In contrast, for liberals it was the possibility of having a good life what really counted, and because of this, they missed the point that someone like Schiavo, although in a permanent vegetative state, was alive. However, according to Bishop, liberals did not see that their rationale could have opened the door for intuitively wrong actions like harvesting her organs or carrying out with/in her any kind of biomedical research. Nevertheless, both conservatives and liberals appealed to the law and bioethics, to back their position. Yet, by completely subjecting life and death to law "what rears its ugly face is the unceremonious violence of constituting power, of the sovereign decision of life and death" (Bishop, 2008, p. 553).

### 3.3. The Case Decision C-257/97: The decriminalisation of euthanasia in Colombia

Although "mercy killing" was decriminalised by the CC in 1997, Colombia is hardly mentioned in the extensive bioethical literature about assisted suicide and euthanasia. This might suggest that global bioethics literature is biased, giving much room to the developed world's issues and privileging articles published in English, while issues of the developing

world and articles in other languages are ignored or treated only in the context of a kind of 'anthropological' interest for the exotic. Hence it is no surprise that the most cited cases are Australia, where euthanasia was legalised for the first time worldwide in May 1995, Oregon, where it was effectively decriminalised in 1997, and the Netherlands, where euthanasia was also effectively legalised in November 2001, although in this country the practice had been tolerated for many years. In this context, the Colombian case is relevant since it became in 1997 the only country with a Roman Catholic Church predominance where providing medical help to die on the grounds of mercy became legally possible. Moreover, it was the second country in the world to legalise euthanasia (after Australia) and the first one in the Americas (Ogilvie, 1997, p. 1849). Not to mention that Colombia "is the only country in the world where active euthanasia was, to some extent, decriminalised by a Constitutional Court decision, based on human rights arguments" (Michalowski, 2009, p. 183).

According to article 326 of the 1981 Colombian Criminal Code, a person "who killed someone else for mercy, to end the acute suffering caused by a bodily injury or serious and/or incurable disease, will be sentenced to imprisonment between six months and three years" (C. P., 1981). In 1996 a lawyer considered this punishment too lenient and that this article discriminated against those who, as a result of a disease, were severely suffering or terminally ill. Subsequently, through a *tutela*, he asked the Court to declare this article 'unconstitutional' and to impose harder punishment on mercy killing. Paradoxically, in the highly contested Decision C-239/97 the CC not only considered the article as constitutional, but also ensured doctors would not be charged in cases of mercy killings. In its decision, the court also ruled that active euthanasia could only be legal if it complied with certain requirements: First, that the subject of the procedure is a patient who is terminally ill; second, that the subject is suffering severely, for example, by experiencing intense pain; third, that the subject has freely and in full possession of his/her mental capacities requested such a procedure; and fourth, that the procedure is carried out by a qualified doctor[255] (CC, 1997). In its ruling, the court had to analyse in depth the topic of mercy killing under the new PC of 1991, as the challenged Article 326 belonged to the earlier Penal Code of 1981.

The arguments that the CC took into account to decriminalise mercy killing were based on three constitutional principles:

[255] This point generated criticisms as to why physicians should be the ones who perform the procedure, although it was clear that they are necessary to make the diagnosis and provide information, in short, to comply with the informed consent procedure (Michalowski, 2009, p. 210).

1. According to Article 1 of the Constitution, "Colombia is a social rule-of-law state […] based on respect for human dignity" (PC, 1991). From a secular point of view, human dignity is expressed in the freedom that an individual has to decide about his/her own body and life. Moreover, such dignity implies considering human life as not reducible to mere biological existence. Hence anyone suffering from a serious, painful, incurable and/or disabling disease would have the right to request medical help to die if they thought that their life lacking in meaning and dignity because of their suffering.

2. According to Article 16, "all persons are entitled to their free personal development without limitations other than those imposed by the rights of others and those which are prescribed by the legal system" (PC, 1991). This article is the constitutional mandate of respect for autonomy in Colombia, which guarantees citizens a right to live according to their own personal convictions. This right would not exclude end of life decisions.

3. The Constitutional Court also considered the *principle of solidarity* in Article 95 of the Political Constitution, which states that Colombian citizens have the duty "to strive in accordance with the principle of social solidarity [and] to defend and foster human rights as a basis of peaceful coexistence" (PC, 1991). Based on this article, the Court argued that "it is not difficult to discover a motivation of altruism and solidarity in the person whose act is prompted by the impulse to suppress the suffering of another, overcoming, probably, his own inhibition and repugnance of an act aimed at terminating an existence" (CC, 1997 quoted in: Michalowski, 2009, p. 191f). Accordingly, based on the principle of solidarity, the intervention of third parties, in this case the physician performing euthanasia, would not be threatened by possible charges of murder.

The constitutional consideration of human dignity, respect for autonomy and solidarity made it possible and comprehensible to hold such a favourable position regarding active euthanasia in Colombia. The judge who made the decision, summarised the arguments on which the court based its decision: First, Colombia is a plural society; second, Colombians have a right to a dignified death; third, not only atheists would opt for euthanasia as even some religious people might choose this path; fourth, the difference between active and

passive euthanasia is 'artificial'; and fifth, Article 326 of the Penal Code of 1981 should be reinterpreted under the new perspective of the Constitution of 1991 (Gaviria Díaz, C., 1998).

However, the decriminalisation of euthanasia had a big impact and drew much public attention to important questions regarding quality of life, body-ownership, the nature of the medical profession and the limits of state intrusion in citizens' private lives (ASCOFAME, 1997; Cepeda, 2004, p. 581). Criticisms of the decision came from a variety of sides:

1. Some argued that a 'right to die' would contradict the right to life that is guaranteed by Article 11 of the Constitution. However, the justice who formulated the Court's majority ruling replied that the right to life should not be read as if the Constitution had imposed "a duty to live". For him, to choose to die does not contravene the life in the same way that an individual can choose to remain even if he/she has the right to move (Gavíria D., 1998).
2. Fundamental rights are inviolable, so if an exception is allowed, any fundamental right might be regarded as disputable and contingent (Michalowski, 2009, p. 199). However, for the Court fundamental rights should be considered according to a *principle of proportionality*,[256] i.e. they "need to be harmonised with other constitutional rights and interests of the individual him/herself and others" (Michalowski, 2009, p. 193).
3. For a dissenting judge, every human being has dignity regardless of his/her physical or mental condition, and quality of life arguments cannot outweigh it. (Michalowski, 2009, p. 202) However, in the Court's view the offender helps someone to die precisely because he/she wants to protect the human dignity of the person who requested assisted suicide that is being eroded due to his/her deplorable health conditions. Thus, "the tribunal stated that the person who helps people in these circumstances die, would be acting out of humanitarian feelings, rather than a desire to kill" (Cepeda, 2004, p. 580).
4. Some argued that accepting euthanasia would set a very bad precedent in a country like Colombia with serious problems of violence and that it might serve as "license to kill" (Coronado, 1997; Michalowski, 2009, pp. 186, 202). The judges who opposed the ruling would refer to totalitarian regimes such as Nazi Germany or Communist states, "where the weakest and sickest are led to gas chambers […] surely

[256] This argument was also used in the decision about abortion. See below

in order to 'help them to a better death'" (Quoted in Michalowski, 2009, p. 186). Some bioethicists took sides against euthanasia based on the slippery slope argument (Garzón, 2000, p. 238).

5. The petitioner stressed in the *tutela* that accepting a lesser punishment in cases of mercy killing would violate the *principle of equality* (Article 13 of the Constitution). Also, the elderly, terminal patients and other vulnerable groups might be victimized. For a dissenting judge and others mercy killing might be avoided if palliative care was available (Ogilvie, 1997; Zea, 1997). However, in Law 100 "the expression palliative care [was] not even mentioned, and the only concept more or less closely related to it [was] a form of precarious and very limited domiciliary care provided by people with no specialized training" (Moyano & Zambrano, 2008).

6. Some argued that in cases of 'intense suffering or pain' and with patients who are terminally ill, informed consent might not be valid, since under hopeless and despair conditions the individual might only have limited mental capacity. A dissenting judge compared the consent of a terminal ill person with a confession obtained under torture (Michalowski, 2009, p. 203). However, others argued that if patients are allowed to reject medical treatment or palliative care, why would they not be allowed to opt for assisted suicide? For the Court one thing was the "capacity to make a decision [and other thing was the] evaluation of the content of the decision, however harmful or otherwise undesirable it might seem from the outside" (Michalowski, 2009).

7. Some argued that the Court overstepped its powers because its duty was to declare if article 326 of the 1981 Criminal Code was constitutional, but not to legislate on the matter and to introduce changes to the Criminal Code. The Court had concluded unanimously that article 326 of the Penal Code was unconstitutional, but five out of the nine judges went further since, according to them, "it was necessary to consider broader constitutional questions arising in this context" (Quoted in Michalowski, 2009, p. 190).

### 3.4. The debate about the decriminalisation of euthanasia in Colombia

After the decriminalisation of euthanasia, the Colombian bioethical establishment organised forums to discuss the issue and also made its position public in newspapers. With the decision, the language to address death and dying as it has been promoted by bioethics during the last thirty years was reinforced in Colombia. In the early 1990s, however,

newspapers in Colombia began to talk about ortho-thanasia, dying with dignity and therapeutic obstinacy (Moanack, 1991). F. Sánchez, a renowned medical ethicist, proposed the term 'iatrothanasia' since according to the Court's decision, only doctors would be allowed to perform euthanasia (Sánchez, 2001). His view was that the doctor's conscience, his "wisdom and prudence", should guide him to "silently do" what is necessary to do regarding end-of-life decisions in the context of the DPR (Sánchez, 2005, 1997b). For another doctor, C. Solórzano (1999), this decision was now possible, since with the PC of 1991 the right to live and the right to personal autonomy were made equal. In general, it is possible to say that the decriminalisation of euthanasia was backed by people who held a liberal, non-religious view of medical practice (Mendoza, 2005; Trías, 1997).

Others, however, openly opposed the decision on various grounds. The Catholic Church intensely opposed it and even excommunicated the judges who made the decision. The Vatican called them "notaries of death" and demanded a revision of the decision (El Tiempo, 1997b). A. Llano (1997a, 1997b), a Jesuit and renowned bioethicist in Colombia, condemned the decision and suggested that the patient should simply be allowed to die. At the 2nd Congress of FELAIBE that was held in Bogotá in 1998, three speakers debated the CC decision: the judge who made the decision (Carlos Gavíria Díaz), another judge who held an opposite view, and a Roman Catholic bishop. During the debate it became clear that the decision was solidly rooted in the liberal rights guaranteed by the PC of 1991 (CENALBE, 1998). Interestingly, some lay Catholics seemed to be more passionately opposed to the Decision than the bishops. For the president of the Latin American Association of Catholic Physicians, who was also a member of the Colombian National Academy of Medicine, after this CC Decision doctors would be called 'killers' (Cuéllar, Z., 1997). According to a member of *Blue Physicians*, a professional non-governmental association, as life belongs to God, nobody should be allowed to take their own. For him, euthanasia was an act of killing, not a therapeutic medical intervention, since it neither re-established patient's health nor did it preserve life. He suggested that relatives should be allowed to perform euthanasia so that they would be morally and legally accountable and not physicians (Merchán, 2006; 2008, p. 42). Some asked to create a 'culture of life' as the right thing in this "convulsed and violent country" (Nieto, G. I., 1998). Although for Catholics personal autonomy must not override the right to life, the CC considered that in these cases the state was at the same time not allowed to protect life "in disregard of the autonomy and dignity of the person involved" (Michalowski, 2009, p. 193). In 2009, Isa Fonnegra, the founder of the *Omega Foundation*, a

non-governmental organisation that campaigns for dignified death, published *Facing Death*, a book in which the discourse of the four principles was linked to the Catechism of the Roman Catholic Church, which was quoted to explain how to make ethical decisions regarding dying with dignity (Fonnegra, 2009, p. 91).

A survey carried out a few months after the CC Decision amongst the lecturers of 23 medical schools affiliated to ASCOFAME found that doctors were fearful of publicly giving their opinion on this issue. Almost half of them agreed with the legalisation on active euthanasia, although only 35.6% would practise it. The majority, 95.8%, disagreed with the idea that paramedics should be given licence to practice euthanasia and 49.2% would request assisted suicide should they be in a state as described by the CC in its decision (ASCOFAME, 1997, pp. 183, 196). In 2002, the ICEB published a set of ethical and medical guidelines on attending to terminally ill patients, encouraging informed consent, recommending doctors to follow their conscience and reminding them of their right to conscientious objection (Sánchez, 2002, pp. 88-90). Unfortunately, guidelines like these remain confined to closed circles like the ICEB itself, or to the academic sphere of bioethicists, because in practical terms mass media and legislators have much more impact on doctors' practices than what bioethicists or medical ethicists say.

In its ruling the CC asked the Congress to introduce a law to regulate euthanasia, but at present the moral debate has not abated nor has any bill been passed (El Tiempo, 2008b). Hence "[t]he current legal situation is characterised by the provisions of the Criminal Code penalising mercy killings, side by side with the Constitutional Court decision legalising them under certain circumstances" (Michalowski, 2009, p. 16). This means that euthanasia is still a criminal offence in Colombia, even included in the new Criminal Code of 2000, and a doctor might be prosecuted for practising it. Neveretheless, one doctor publicly claimed in 2007 to have carried out euthanasia on more than 37 patients without ever being prosecuted (El Tiempo, 2007). In August 2006, senator Armando Benedetti presented to the Senate Bill 200/2006 to regulate euthanasia based on the CC Decision, but it was withdrawn because of a lack the necessary political support (Michalowski, 2009, p. 16). This bill was controversial for several reasons. It embodied an elitist medicine since only people with resources would have met the procedural requirements (many people, for instance, do not have even access to good quality healthcare services), it opened the door for relatives to make the decision when the patient was unconscious or he/she was a minor, it stated the possibility of requesting euthanasia as an advance directive, there was confusion between 'active euthanasia' and

physician-assisted suicide, and it included some imprecise terms and opened the door for euthanasia to be carried out based on economic grounds (Díaz Amado, 2007c; Michalowski, 2009, p. 17f). In 2007 another bill was presented, the Senate Bill 05/2007, which did not conform with what the CC had ruled in C-239/1997 (Merchán, 2008) and was also rejected. In short, despite its decriminalisation in 1997, euthanasia has remained as a grey area in Colombia. But it seems that grey areas in bioethical discussions are the rule and not the exception, as the Schiavo's case showed us all.

**4. The case decision about intersexual states**

Today transsexuals undergo sex reassignment surgery because they feel they are living in the 'wrong body' on a fairly regular basis. They are adults able to express their own wishes and feelings. However, the case of newborns with intersex states[257] is a big challenge, for they are unable to express any opinion yet. The media therefore occasionally bring stories about people who were damaged, both physically and morally, by corrective surgery performed during their childhood and without their consent. As E. Morris has argued "since treatment is irreversible and permanent, discerning what is important to the child is essential for the parents or physicians who wish to do no harm. How can we ascertain what is best for the child when they are still too young to speak?" (Morris, 2004). This uncertainty has brought to light a conflict between the medical approach to this condition and the new ideas about autonomy in biomedicine. In 1999 the Colombian CC made a unifying decision[258] on the issue. In the Case Decision SU-037, the Court considered that a 3-year-old infant, who was declared by a midwife as a girl, should not undergo the sex reassignment surgery suggested by her doctors when a medical examination found she had ambiguous genitals (CC, 1999).

Some of the key points made by the Court in this case were:

1. Sexual identity is a fundamental element of the individual's subjectivity and it is highly dependent on anatomical characteristics. However, this identity is not merely 'natural', but the result of the interplay between biological facts and historical circumstances.

[257] An intersexual state is a condition "where a newborn's sex organs (genitals) look unusual, making it impossible to identify the gender of the baby from its outward appearance." In: Fallow, L. (2006) *Gale Encyclopedia of Children's Health: Infancy through Adolescence*. Retrieved from http://www.encyclopedia.com/doc/1G2-3447200316.html, accessed on 4 August 2009.
[258] Decisions in which the Court states the criteria to be followed in future decisions related to the same issue.

2. In the case of children, it seems to be more adequate to postpone any radical and irreversible surgical modification of the genitals. In the Court's view, it would be wrong to allow doctors to impose their own criteria to determine the sexual identity anyone should have, particularly when an individual is unable to express his/her wishes. Only an autonomous and fully responsible individual should decide on this matter.

3. The individual/patient is the only one entitled to decide about his/her own body. Accordingly, any kind of surgical procedure cannot be carried out without his/her permission.

**Power and intersexual states**

In the case of medical treatment for children with intersexual states, the Court has confirmed once more that personal autonomy is an essential precondition to make decisions on medical treatment. In the last ten years the constitutional discourse on personal autonomy has led to a discussion of many sensitive and even taboo issues in the public. From the restricted and reductionist view that sees sexuality in terms of only two categories, male and female, decisions like SU-037/99 have opened a door to a pluralistic idea according to which gender, although deeply rooted in anatomical characteristics, is indeed socially constructed and depends on individual preferences. Based on the right to free development of personality, the Colombian constitutional equivalent to the principle of respect for autonomy,[259] citizens have been given the opportunity to freely express their individual identities. For example, most recently the Court ruled that homosexual couples should be legally recognised, asking the Congress to legislate on the matter within a period of two years. Another a big issue to be discussed in the near future will be the right of these couples to adopt children (Amat, 2011).

In many decisions the CC has integrated bioethical principles into its decisions. For instance, in T-551/99, a decision about intersex states following the SU-037/99, a judge argued that in the medical treatment of intersex children "the tension between the principle of beneficence and the principle of autonomy [was] evident" (CC, T-551/99). Once again, the 'dilemma model' of bioethics is reinforced as the issue is presented in terms of two opposed ethical principles, attributed to the doctor and the patient respectively. Moreover, an implicit idea is that, regarding medical decisions for intersex children, biomedicine is an area where

[259] Article 16 of the Constitution.

doctors are permanently trying to impose their power and that patients should therefore be permanently on guard to avoid losing their autonomy. In her analysis of the SU-037/99, a Colombian lawyer and bioethicist concluded that decisions on sex reassignment surgery "require a bioethical approach through an interdisciplinary committee […] rather than the surgery in itself, it is medical evidence about the individual's sense of belonging to the opposite sex that is important for law" (Rojas, 2004, p. 59). Bioethics then becomes the advocate of individual autonomy and a tool to resist medical power, although in this case it is possible to observe how medicine and law go hand in hand. As I have argued elsewhere, the dominant hybrid medical/legal discourse about intersex conditions has meant that it is the individual who has to decide whether or not to accept medical treatment. However, if an individual rejects what medicine has to offer, he/she might face multiple forms of 'veiled punishment', e.g. discrimination, condemnation, humiliation. Western societies are still reluctant to a different degree to accept 'grey zones' in the sexual sphere (Díaz Amado, 2008). The problem is that sex reassignment surgery reinforces the idea of a dismorphous understanding of biological sex as well as a dichotomous understanding of gender (Kaivola, 1997). This is a power effect that bioethicists barely seem to recognise.

It is not difficult to understand why the advice states that sex reassignment surgeries in intersex children should be avoided. They are invasive and irreversible interventions on the body. Such interventions should be postponed until the patient is able to give informed consent, as stated by the CC in SU-037/99. All of this is done in the name of promoting autonomy and restraining medical power, although other issues should be considered, too. In the last thirty years or so there has been an explosion of terms related to intersex states. From the single term 'transvestite', commonly used before the 1980s, we moved on to an overwhelming myriad of terms such as LGTB,[260] transgender, gender-bender, gender-outlaws, gender-trash, gender-queer, to name but a few (Carroll, et al., 2002, p. 131). As Foucault argued, we talk today more about sex, but this is not say we have been liberated from it nor have we escaped from power influence either (Foucault, 1998). Yet, with their insistence on principles and the 'dilemma model', bioethicists have obscured important aspects of the discussion. This is perhaps because, as J. Nelson argued, bioethics is mainly engaged in "discourses of value", which emphasise moral notions such as duties, obligations, rights and virtues. Discourses of value are useful to orientate and legitimise policies, guidelines, decisions, etc. However, on this path 'discourses of power' are disregarded and

[260] Acronym for Lesbians, Gays, Transvestites, and Bisexuals.

then any analysis intended to reveal relations of force, domination or subjugation (Nelson, 1998, p. 215). In this sense, it is worth mentioning here that "the legal system is a governing, ordering, normative discourse [and] one effect of this system is that it constructs identity […]" (Bell, 2004, p. 1713). This power of law to shape indentities should not be underestimated. However, as Nelson has noted, bioethicists tend to ignore not only the power that is incarnated in law, but also the ethical and cultural implications of medicalised sex-reassignment procedures (Nelson, 1998, p. 214). For him, although

> there are at least as many transsexuals as there are 'surrogate mothers' […] bioethics is interested in many types of artifactuality –artificial hearts, artificial feeding- but not in the artifactuality of our sex or our subjectivities [and this is because bioethics] focuses too much on patients and providers as autonomous, individual moral agents and too little on the social and political structures that form, nourish, and distort that agency. (Nelson, 1998, p. 226)

Some have argued that sex reassignment surgeries are intended to make intersex children 'more normal', as they "are performed in order to regulate normative gender and sex by ruling out the possibility of alternatively sexed individuals […] silencing […] intersexed people who are usually not told about their physical condition nor the reasons for their extensive surgeries in childhood" (Hausman, 2001, p. 482f). As mentioned above, Decision SU-037/99 solved this by ruling that such surgeries should be postponed until the person decides what identity to choose. However, even when the decision is made by a completely autonomous and competent person, it does not mean that the power dynamics have disappeared. Still, "[t]he rhetoric of choice in current transgender theory, while echoing the rhetoric of the abortion rights movement [should make us think of] the vehement expansion of consumer culture in the 1980s – buy a new body, new face, 'you're worth it'- is an indispensable backdrop to this new theoretical field and continually emerging cultural phenomenon" (Hausman, 2001, p. 486). It is clear that the approach to intersex conditions has changed from a medical-centred paradigm to a [rational and free] individual-centred paradigm, or better, to a client-centred paradigm (Bockting, 2005, p. 269; Carroll, et al., 2002, p. 131). In this way, surgeons who perform sex reassignment surgeries are similar to cosmetic surgeons, i.e. they transform bodies because it is requested paid for by the patients (Hausman, 2001, p. 486). The problem is that this kind of surgery "holds out the illusory promise that the acquisition of a simulated vagina or penis will lead to wholeness and happiness" (Kaivola, 1997, p. 202). Thus, instead of liberating individuals, medical

interventions ‘on demand’ end up being another way of subjecting such individuals to particular modes of understanding human nature, medical practice and society. In Colombian society as it is today these particular modes are nothing but the neoliberal rationalities and ideas in vogue (Díaz Amado, 2009b).

For the Colombian lawyer and bioethicist J. Gaitán, in the relationship bioethics/law, the former would have three main functions: first, to contribute to the creation of positive legal norms; second, to clarify bioethical issues included in laws; and third, to help in the legal decision-making process (Gaitán, 2004). In the case of intersex states, bioethics has helped to integrate different aspects of the discussion. B. Espinosa, a lawyer, has argued that the body, as a positive legal concept, is very recent in Colombian jurisprudence and particularly related to the PC of 1991 (Espinosa, 2008, p. 69). J. Gaitán has also claimed that bioethics is necessary for the law in cases of sex reassignment surgeries, because bioethics provides an interdisciplinary perspective (Gaitán, 2008, p. 80). In this regard, I have argued that bioethics has three main functions in discussions like these about transsexualism and sex reassignment surgeries: first, a *political function* by contributing to creating a pluralist, non-confessional and interdisciplinary discussion; second, an *epistemic and ethical function* by stressing the role of *deliberation* as the best mechanism to reach agreements; and third, a *strategic function* by building a friendly, respectful and open setting for the discussion (Díaz Amado, 2008, p. 54)

## 5. The decriminalisation of abortion

### 5.1. A brief history of abortion

The history of abortion is as old as human civilisation. There are reports of induced abortions in China dating back 5000 years and in the Hippocratic Oath, from the fourth century BC, physicians were forbidden to give abortive to women who wanted to terminate their pregnancy prematurely. However, back then physicians were “free to employ contraceptives, oral abortifacients, and the various surgical and manipulative procedures available” to produce an abortion (Riddle, 1997, p. 9). Once Christianity expanded across Europe, the Augustinian doctrine provided a guideline to decide when an abortion might be

allowed. Before the 'quickening'[261], which determined the *ensoulment*, abortion was not banned. By the sixteenth century abortion had become a crime in the eyes of the Roman Catholic Church (Rothman, B. K., 1997, p. 104f), and in 1869 Pope Pius IX declared that abortion was always a *mortal sin.* An important aspect of the contemporary approach to abortion is its medicalisation. Today, doctors are seen as the natural and indisputable advocates of pregnancy, and high-tech procedures are used to conceive (e.g. IVF[262], ICSI[263]), manage the pregnancy itself (e.g. sonographies, prenatal tests, foetal surgery), and the delivery (e.g. caesareans, surrogate wombs). As pregnancy became medicalised, so too was abortion, opening the door to justify an abortion on medical grounds and, in this way, skipping the necessity of appealing to ethical theories. It seems that medical arguments are able to replace sometimes ethical arguments (Hull & Hoffer, 2001, p. 57).

Yet, the abortion debate might be characterised as one of the fiercest debates in contemporary societies, with extensive biomedical, legal, political, religious and ethical consequences. For R. Reagan it is "the prime contemporary problem of public morals" (Reagan, 1986, p. 100) and for R. Dworkin, it is the US new version of the seventeenth-century European religious wars (quoted in Boyle, 1997, p. 1). Almost all religions disapprove of abortion and many also of contraception.[264] For many Christians and Muslims, for instance, abortion is a crime against the human person (Hedayat, 2006; John Paul II, 1995). Although forbidden since the nineteenth century, abortion has become legal in many countries. Since the 1960s a wave of abortion legalisation has spread across the globe.[265] However, the degree to which it is permitted can widely vary.[266]

The ethical debate about abortion in bioethical textbooks is mainly focused on the intrinsic logic of the contended arguments. Thus, each side usually departs from particular ontological a-prioris. Personhood, for example, is usually cited by pro-lifers, while practical implications and socio-political and economic roots of abortions are put in second place. For instance, poverty and illiteracy are deeply linked to unwanted pregnancies. Traditionally there were

[261] The moment when foetal movements are felt by the woman, usually between 20 and 22 weeks in a primipara and around 16 weeks in a multipara.
[262] In-Vitro Fertilisation.
[263] Intra-Cytoplasmic Sperm Injection
[264] For a brief summary of the attitudes and beliefs of the leading religious groups in the United Kingdom to contraception see: 'Religion, Contraception and Abortion'. Pp. 1 – 3 in *The abortion Debate,* vol. 126, edited by Craig Donellan. Cambridge: Independence, 2006.
[265] In the UK abortion was legalised in 1967, and in the US in 1973 with the famous case *Roe* v. *Wade.*
[266] See: Center for Reproductive Rights (2007) *The World's Abortions Laws.* Available at: http://www.reproductiverights.org/pub_fac_abortion_laws.html, accessed 4 May 2008.

two opposed extreme positions. On the one hand, the *pro-life* view, according to which abortion is nothing but murder as the embryo/foetus has full moral status (Warren, 1997). On the other hand, the *pro-choice* position which emphasises that it is up to women to decide on their bodies. These two positions are so antagonistic that the debate looks more like a war than a discussion (Solinger, 1998).[267] In its current form this debate remains an unsolvable ethical dilemma, since it is largely shaped by an analytical philosophy model in bioethical textbooks (Díaz Amado, 2009a, p. 118).[268] For T.H. Engelhardt (1996), "[t]he stridency of the abortion debate marks the strength of such disagreements […] The abortion debate is only one of a number of issues where the controversies are both impassioned and reflect well-entrenched and conflicting moral visions, [but] physicians, after all, must apply abstract concepts of being alive or being dead to actual situations" (pp. 8, 240).

Yet, while bioethicists and philosophers continue in search for the perfect ethical argument, either to support or to condemn abortion, its unsafe practice continues to kill thousands of women around the world, particularly in poor countries. In Latin America, for instance, the number of clandestine and unsafe abortion remains high despite restrictive abortion laws, or even because of that, with serious consequences for women's health and life, particularly among the poor (Guttmacher Institute, 1996; Human Rights Watch, 2005b; Kane, 2008; Rance, 2008; Yam, et al., 2006). Illegal and unsafe abortion usually leads to high rates of maternal morbidity and mortality (Guttmacher Institute, 1996; Human Rights Watch, 2005a; Rance, 2008), so the absolute criminalisation of abortion leads to a serious public health problem and social inequality (González, A. C., 2005). But in recent years abortion has increasingly become an openly and publicly discussed issue, with different social organisations demanding from governments to provide adequate medical attention for those women seeking to terminate a pregnancy (Boland, 1993; Estrada, D., 2010). In Colombia in 2006 the CC partially decriminalised abortion, a decision that has been even more controversial than that of euthanasia, although it has also illustrated that a suitable 'solution' to the contemporary abortion debate can be found when the ethical discussion moves onto politics and law (Díaz Amado, 2009a, p. 114).

[267] For a good overview of the different positions in the debate about abortion see: Sommerville, A. (1993) *Medical Ethics Today: Its Practice and Philosophy.* Plymouth: British Medical Association, p. 103 – 109.
[268] An example of how the abortion debate is shaped in an analytical framework, see: LaFollete, H (ed.) 1997 *Ethics in Practice. An anthology*. Cambridge, MA: Blackwell, which includes: Thomson, J. *A Defense of Abortion*; Warren, M. *On the Moral and Legal Status of Abortion*; Marquis, D. *An Argument that Abortion Is Wrong*; and, Rothman, B. K. *Redefining Abortion.*

### 5.2. The Case Decision C-355/2006 that decriminalised abortion in Colombia

For many years in Colombia the abortion issue has been 'the elephant in the room' regarding women's health and sexual and reproductive rights. Despite of a lack of reliable statistics, the number of abortions in Colombia has always been considered high. In the 1980s, based on the number of hospital admissions for abortion-related complications, an estimated 250,000 to 350,000 abortions were performed per year (Singh, 2006). In the 1990s, while abortion was more frequent among young and poor women, one third of urban women would undergo the procedure (Zamudio, et al., 1999). As F. Sánchez (1990a) argued, the practice of abortion has always been tolerated in Colombia despite being absolutely banned by the Criminal Code. Everyone knew where to go if one required such a service. Far from preventing the occurrence of abortions, this repressive policy created a flourishing underground abortion industry where women would receive poor medical care and risked their lives (Ceaser, 2006). The most recent study showed that in 2008 there were an estimated 400,400 abortions, and 93,300 women were treated for complications related to abortion, while only 322 had a legal abortion (Prada, Singh, Remez & Villarreal, et al., 2011).

However, with abortion being a serious public health problem, legislative initiatives challenging the restrictive law in the Colombian Congress have failed. Five bills were presented but rejected between 1975 and 2006 (M.P.S. & U.N., 2007). It was not until May 2006, as the result of a petition filed by a female lawyer challenging the constitutionality of the Criminal Code's articles that penalised any kind of abortion,[269] that the CC partially decriminalised abortion through the Case Decision C-355/06 (CC, 2006; Women's Link Worldwide, 2007). It is also true that the constant work of several social organisations advocating women's rights for years and the presence of progressive justices in the Court also crucially contributed to this decision (Díaz Amado, et al., 2010, p. 119). The lawyer argued that, in the light of the PC of 1991 that, first, women had the right to decide on their own bodies, including pregnancy; second, abortion was basically a women's issue therefore its prohibition would violate the right to equality; and third, to impose a 'duty to continue with a pregnancy' would be cruel and violate women's human dignity.[270] The Court concluded that in three cases women's fundamental rights were indeed violated when they were denied a legal abortion: first, when the woman's life or health is threatened as a result of a pregnancy;

[269] Articles 122, 123 and 124 of the Penal Code in force since 2000.
[270] E.g. when the woman's life is in danger, to ask her to continue with her pregnancy would be against constitutional right to life.

second, when the foetus has severe malformations incompatible with life; and third, in cases of rape, incest or non-consensual insemination (M.P.S. & U.N., 2007, p. 47).

In its ruling the CC took into account that international human rights law was part of the Colombian constitutional jurisprudence[271] and that the legal protection of the unborn should be balanced against other rights, principles and values included in the Constitution. Moreover, women's rights and gender equality are constitutionally protected and the *principle of proportionality*, developed by the CC in previous decisions, imposed limits on the legislature regarding the criminalisation of abortion (Undurraga & Cook, 2009). Although for the Court the foetus was a 'human life' and therefore should be protected by the Constitution, such a right was not absolute and should be balanced against the rights of the woman. The total ban on abortion, argued the Court, imposes a disproportionate burden on women since they are forced to accept the pregnancy. Furthermore, the Court took into account international treaties signed by Colombia that advocate safe abortion services as are part of women's sexual and reproductive rights. Finally, the CC also admitted that there are limits for the jurisprudence to decide on moral matters. Individuals can have different ethical viewpoints and then it would be inadmissible for any of these particular ethical positions to be imposed by the state (Díaz Amado, 2009a, p. 121).

Yet, despite the decriminalisation of abortion, in practice for Colombian women to access a legal abortion is still an ideal (El Tiempo, 2008a; Moloney, 2009). In 2010, along with three independent consultants and a representative of a non-governmental and women rights' advocate organisation, I analysed 46 cases of women who were denied a legal termination of pregnancy during the first two years after the decriminalisation. Through these cases, we illustrated how Colombian women still experience serious difficulties to access a legal abortion, even when they are entitled to it (Díaz Amado, et al., 2010). The barriers to access legal abortion have to do with two circumstances: "first, the basic failure of Colombian society to understand what the Court ruling means, and second, the unrecognised and unresolved ethical, medical and legal differences over abortion that have continued to exist, which have made the implementation and fulfilment of the ruling a complex and difficult task" (Díaz Amado, et al., 2010, p. 121). There are difficulties in Colombian society to distinguish between the ethical and the politico-juridical level of the debate, (Díaz Amado,

[271] For example, the *Convention on the Elimination of All Forms of Discrimination* of 1979 (no discrimination against women); the *World Conference on Women*, Cairo, 1995 (sexual and reproductive rights as human rights); and the *Inter-American Convention of Human Rights*, 1969.

2009a, p. 122) and "[c]onfusion between ethical beliefs and legal obligations regarding the Court's decision is at the bottom of profound disputes and contention in relation to medical autonomy vs. women's autonomy, protection of fetal life vs. protection of women's lives, and ignorance or abuse of the law" (Díaz Amado, et al., 2010, p. 121).

Although at present healthcare providers and women are better informed about the content of the Decision C-355/06 many abortions are still clandestine. Moreover, right wing groups have not ceased in their efforts to reverse the decision (Dalén, 2011). A case that is worth mentioning is that of the current Inspector General who came into office in January 2009. Being an ultraconservative Roman Catholic, this inspector has publicly opposed the decision, although paradoxically his duty is to protect citizen's rights and to enforce the law and not the opposite (Díaz Amado, et al., 2010, p. 124). More recently, the Conservative Party, with the support of some religious organisations, presented a bill to include a new article in the Constitution, according to which life should be protected since its very beginnings, making abortion, euthanasia and even assisted procreation services unconstitutional practices (El Espectador, 2011b; 2011c). Two issues seem to be key in the present polarized discussion about abortion. There are profound disagreements and difficulties to accept the *health exception*, which "refers to the possibility of terminating a pregnancy when the pregnancy puts the woman's health at risk" (González, A. C., 2010, p. 13). Pro-lifers have argued that the *health exception* argument might open the door to abortion on demand. They have also suggested that the right to conscientious objection should also cover healthcare institutions, such as Catholic hospitals, which then would not be legally obliged to provide abortion services. But the supporters of the Court's decision have argued that in this way conscientious objection may be used as an argument to avoid the legal obligation that healthcare professionals and institutions have to comply with the law.

## 6. Conclusion

One of the most important creations of the political constitution of 1991 was the Constitutional Court (CC) as the highest court in the Colombian political and legal system. This court has played a central role in the implementation of the norms and values guaranteed by the constitution of 1991. Thus, case law, the pre-eminence of fundamental individuals' rights, and the promotion of ethical pluralism entered the Colombian mainstream. In this chapter, through the analysis of three landmark decisions, I have shown that that the language of bioethics and the language introduced by the new political constitution of 1991 are

sometimes indistinguishable. The approach of the CC to controversial issues like euthanasia, sex reassignment surgery and abortion suggests that the bioethical language, particularly American principlism, frames the public debate and the legal analysis.

In this new political environment the Colombian people obviously have felt they have got more freedom but, to what extent have they actually done so? Following J. Bishop I have shown that although it is led in the name of personal autonomy and freedom, the contemporary debate on euthanasia takes place within the boundaries defined by the bioethical discourse and embodies a power exercise to frame the discussion and its practice in a particular way. Bioethics and law not only protect the vulnerable or promote individuals' autonomy, they are 'constituted power' defining what, how, when, under what circumstances and who can decide on life and death. Moreover, the contemporary debate about euthanasia originates from and is modelled by a medical practice driven by hi-tech- as well as the discourse on autonomy, which is a fashionable discourse in our globalised world. The question about whether to withhold or withdraw medical treatment only makes sense within the contemporary intensive care unit-like scenario. Only in a world where the individual believes he/she is the 'sovereign' of himself/herself, could euthanasia be considered an 'individual right'. Yet, what bioethicists call 'autonomous decisions' take place in a biopolitically determined scenario. We often do not realise that categories like 'brain-dead person', 'terminally ill individual', 'patient in a permanent vegetative state' or 'deeply handicapped individual' do not just create special moral obligations or are related to the origins of bioethics. They are indeed biopolitical constructions, i.e. the result of particular expertise 'in action' trying to realise the modern dream of administering and governing human life.

The debate about euthanasia has often been on newspapers' front pages in Colombia. However, this does not mean that euthanasia is frequently practised in Colombia or that Colombians are frequently in a situation in which high medical technology intervenes in their lives. As Michalowski has argued, this decision "had a very limited impact both on medical practice and on the criminal law discussion of active euthanasia […] a court decision alone is unlikely to bring about fundamental changes in practice unless it finds acceptance by the main players […], in particular the medical profession, but also lawyers and politicians" (Michalowski, 2009, p. 19). Beyond the typical arguments in the bioethical debate on euthanasia that emphasise the rightness or wrongness of practising it (e.g. respect for autonomy vs. sacredness of life), it is important to underline how the debate is framed: while

dying with dignity is perhaps a fundamental issue for bioethicists and academics in the developed world, in a country like Colombia, 'how to live with dignity' surely should come first.

The CC decision on sex reassignment also shows that patients' autonomy and their choices are essential for any legitimate medical decision-making. It is interesting to see that, as this decision illustrates, it is the power of law, not medicine, which now decides what is right and wrong regarding sex reassignment. This shift of power from medicine to law has not only occurred in terms of sex reassignment, but probably across the entire biomedical field. Thus, in Colombia not only has medicine been bioethicalised and juridified, but the law has similarly been bioethicalised. These displacements do not just reflect the setting of new boundaries between disciplines or professions, but also mean power displacements. How subjects and discourses are formed, the strategies of authorities to gain legitimacy, and the construction of truths regimes reflect processes and dynamics that are necessarily transformed.

The decriminalisation of abortion in Colombia, in the three circumstances described by the CC, has also revealed the intimate relationship between bioethics and law. Taking the Colombian case, it is possible to conclude that although the ethical discussion about issues like abortion seems to have no end, in the legal and political sphere important agreements can be reached to overcome ethical disagreements. The Colombian case suggests that ethical disagreements, which are common in plural societies, cannot be resolved by appealing to ethical theories only. In these cases, the power of both law and politics to solve such ethical disagreements should be acknowledged, particularly by bioethicists. However, at the same time, political, legal, cultural and economic issues might represent an obstacle to the exercise of individual freedom. In Colombia the decriminalisation of abortion in three situations did not mean the end of the abuse and exploitation of women. "The Court ruling was not the end of the debate about abortion in Colombia. However, the partial decriminalisation of abortion has created a huge challenge for Colombian society, as legal abortion services become part of essential health care provision" (Díaz Amado, et al., 2010, p. 124).

According to Foucault, law and medicine create a particular order by classifying, governing and shaping subjects and mentalities. Beyond the endless ethical discussion about the right or wrong of medical interventions on the body (the endless dispute between conservatives and liberals or between dissimilar ethical theories), we must bear in mind that

today life is much more regulated and controlled than ever before. The bioethical discussion is usually framed by forces and tensions which are not properly recognised, e.g. powerful subjects with particular interests (healthcare insurers, religious groups, governmental agencies and so on) and discourses that legitimise the current state of affairs (law driving medical practice, economics driving legal regulations and so on).

Biopolitics creates new medico-legal categories which are deeply related to the control and discipline of the body. Medical knowledge and expertise do not decide alone when, how and by whom medical procedures like euthanasia, abortion or genital surgeries will be performed. The law today empowers people to obtain the medical services they want to receive. This happens in a particular socio-cultural and historical context. In contemporary liberal societies there is a tension between individual's autonomy to decide personal issues and the legitimacy of the state to govern people's lives. In the case of medicine this tension is actually expressed in the body, which is taken as a 'field' of conflict between different discourses, as Kimsma and Van Leewen (2005) have noted. Bioethics is now informing legal decisions, as I have shown in the case of three landmark decisions of the Colombian Constitutional Court. Regarding life and death, sex and body and the reproduction bioethics seems to be a part of biopolitics, i.e. a part of the contemporary way of administering populations as well as individual lives.

## General conclusion

According to Foucault (1973), modern medicine was born in the late eighteenth century when, due to a reconfiguration between 'the visible' and 'the sayable', ideas about what was a disease turned into the problem of what could be localized in the body. Thus, the rise of an anatomo-clinical-pathological gaze and the birth of the clinician, in the context of a particular socio-political and institutional framework at the end of the eighteenth century, constituted a reconfiguration of the whole medical scenario from which modern medicine emerged. But the brilliant and enlightened analysis that Foucault gave of the birth of modern medicine would be insufficient to explain why and how medicine has taken on a different appearance today. If Foucault had lived longer, he would surely have acknowledged that present-day medicine is a different medicine. In the early 1960s, when *The Birth of the Clinic* (1973) was first published in 1963, Foucault could not have foreseen how deeply and radically medicine was going to change at the turn of the twentieth century.

According to A. Relman (1980), contemporary medicine has become a *medical-industrial complex*. However, this process has not been exactly the same in all countries. In the case of Colombia, for instance, the influence of neoliberal forces and the dependency on the centres of power in the globalised world are especially visible. Additionally, the Colombian case illustrates the profound link between a neoliberal transformation of the medical ethos and a flourishing of new normative discourses on medicine such as bioethics and medical liability. These discourses represent not only a new regulatory framework for medicine in terms of a new set of rules and norms, but also a complete reconfiguration of the whole biomedical scenario, encompassing new practices (e.g. the DPR as a matter of public inquiry or the practice of informed consent) and new subjectivities (e.g. different ways of being a doctor and a patient).

Bioethics has been criticised since its very beginnings in the USA in the 1960s and 70s. These criticisms have been mainly of three kinds: philosophical, sociological, and political. Philosophical criticisms have pointed to the shortcomings of American principlism for its inability to solve the complex moral problems arising in the biomedical field; mostly because there is no clear rule to decide how to rank and/or apply these principles. Sociological criticisms have stressed that bioethics might be an expression of cultural imperialism since it embodies the particular values of US American society such as individualism, pragmatism

and legalism. In developing countries political criticisms have been raised against another trend of the dominant model of bioethics: its almost exclusive concern with ethical dilemmas related to biotechnological progress. It has been argued that the scope of bioethics should be widened to include issues such as poverty, health inequality, corruption, sustainable development and exploitation of human subjects in the context of biomedical research, to name but a few. In this way, it has been argued that a bioethics moulded by the dry, cold and analytical style of Anglo-American philosophy, which is too focused on biotechnological progress, but blind to acknowledging cultural and socio-political differences, should be overcome. Latin American bioethicists are perhaps among the first and fiercest critics of this narrowness of the US American bioethics. It has even been argued that an emphasis on 'the social' and the idea of making bioethics 'more political' was the Latin American contribution to the field.

Similarities and differences were found between the US American and Latin American approaches to bioethics regarding historical accounts, scope and methods. In the USA the formation of the new field was fundamentally related to the problematization of the DPR, the role of biotechnology in medical practice, and biomedical research. This led to a migration of academics of different backgrounds to constitute the new field, particularly from theology and law, and later from biomedical sciences and philosophy. In Latin America, the voice of the so-called 'pioneers', members of elite medical associations, private universities and the Roman Catholic Church promoted the idea that it was necessary to be aware and concerned about the dangers of biomedical progress. Having learnt about the new field in the USA, these 'pioneers' managed to introduce bioethics in the mass media, governmental institutions, private universities and professional medical-related associations as an important field for the region. In this process a similar rhetoric to that which had been used by the first US bioethicists to legitimise the new field was adopted. These pioneers also spoke a new language when they talked about the necessity of overcoming medical paternalism and adopting the principle of respect for autonomy and of controlling doctors' activity in both clinical and research scenarios. It was argued that traditional medical ethics was inadequate to solve a set of supposedly new ethical dilemmas brought by biomedical progress; in short, that doctors lacked the necessary moral wisdom to correctly do their work as medical ethics had traditionally been a field exclusively for doctors.

The role played by powerful organisations, such as PAHO and UNESCO was fundamental, not only to the successful institutionalisation of the field in Latin America, but

also to the formation of the two ideological and political poles of the Latin American bioethics. On the one hand, those who are identified as followers of the PAHO's bioethics unit, which was seen as too bound to the issues and methods of the US American bioethics. On the other hand, those who are close to UNESCO's RedBioetica and the so-called "Brazilian group", and deemed to be inclined to a more political bioethics, critical of the US model, and committed to the solution of the inveterate problems affecting the region. Additionally, the role played by the Roman Catholic Church in the way bioethics is understood and practised in Latin America should be underlined. Although the Catholic Church is involved in ethical debates in other countries like the USA or in Europe, its influence in Latin America, for historical reasons, is bigger than in any other region.

The 'politization' of bioethics in Latin America has led to radical divisions and has even sown discord among Latin American bioethicists. In this environment, some have warned that Latin American bioethics should avoid 'tropicalisms' and 'populisms', while others have called for strengthening it academically. These struggles are not only about 'the best argument', 'the appropriate ethical theory to apply', or 'the wellbeing of patients in the region'. They reflect what only few bioethicists are willing to openly acknowledge: that at the core of the Latin American bioethical establishment there are ferocious disputes about power, i.e. about who produces the official bioethical discourse, who controls the bioethical establishment, and who has access to resources. It is not a surprise then that many people are interested in 'owning' bioethics in Latin America since from this field it is possible to exercise great power. Who would doubt of a field that has been seen as the land of the 'good guys', the bioethicists, who look after society's important values and protect people, particularly the vulnerable, from the abuses and exploitation of doctors and biomedical researchers? By holding this pastoral discourse, in Foucauldian terms, bioethics is invested with social power, a power to 'conduct the conduct', or what Foucault called *governmentality*.

Latin American bioethics was the result of an amalgamation of the promises brought by US bioethics with the anxieties and hopes of Latin American people. American bioethics, with its emphasis on principlism, personal autonomy, analytical philosophy, and legal contracts, fitted well in the Latin American environment that might be characterised by its hope to one day solve inveterate problems such as poverty, inequality, exploitation, dependence, violence, and corruption. It also reflects the action of medical associations and groups related to the Catholic Church and people who have found in bioethics a new way to

talk about medical humanism and morality in the biomedical scenario. However, bioethics has not meant a real transformation of the medical establishment at all, and it remains blind to the challenges and necessities of the region. Given the influence of the Roman Catholic Church, certain conservative groups have used the bioethical discourse to promote doctrinal positions. However, some members of the Church's hierarchy are critical of such official ecclesiastical and conservative positions. This regional scenario configured, to some extent, the 'conditions of possibility' for the emergence of bioethics in Colombia. There are, however, some aspects that make the history of bioethics in Colombia distinctive.

In Colombia, comprehensive and critical work on the history of bioethics has not yet been carried out. So far, the historical literature about bioethics in Colombia has been produced by bioethicists themselves and basically provides a whiggish history of progress and success. By and large, Colombian bioethicists have explained the beginnings of the field by borrowing the same rhetoric that characterises the myths of origin of American bioethics. Because in the case of Colombia the official history of bioethics has been written by its 'pioneers', it is no surprise that this history is more about their own achievements than a truly historical analysis of, for instance, the institutionalisation of bioethics or the characterisation of the bioethical discourses and practices in the country. In this regard, this thesis is a critical revision of these narratives, inspired by Foucault and those who have continued his critical work. It is also a critical assessment of the official historical accounts produced by the Colombian bioethical establishment. Thus, I have shown that the historical literature about bioethics in Colombia has been written by members of the bioethical establishment, i.e. the owners of the bioethical discourse for the sake of their social, economic and academic position. They have built a historical explanation of bioethics that depicts it as a necessary and optimal answer of contemporary society to the threats of biomedical progress and the current model of medical development. Also, they have reinforced the idea that bioethicists, as individual experts or in bioethical committees and a national commission, are the ones who know best how to make ethical decisions in the biomedical field and other instances.

The Colombian bioethical establishment has awarded great relevance to V. R. Potter, who became something like the 'patron saint' of bioethics in this country. This is neither a capricious nor an innocent choice. Drawing on Potter's work, the Colombian bioethical establishment has promoted a supposedly ecological and broad understanding of the field, in opposition to the narrow American approach that sees bioethics as fundamentally a biomedicine-related field. The official discourse of bioethics in Colombia embodies two main

ideas: that neither medical ethics nor bioethics is the 'property' of doctors and that bioethics is the advocate of life in general. But the eagerness of the Colombian bioethical establishment to gain followers for their own cause, distances itself from the American bioethics model and recycle discourses formerly tainted by religious associations (e.g. the sacredness of life and the dignity of the human person) has ended up making of bioethics a totalising, even totalitarian, all-embracing field. By using the expression 'the bioethical aspects of', the Colombian bioethical establishment have managed to make of virtually any object, problem, field or issue something amenable to a bioethical enquiry. In this context, allusions to interdisciplinarity, transdisciplinarity, consensus, and dialogue are frequent. The interviews I carried out in 2008-09 revealed that philosophers saw bioethics as a kind of 'applied ethics'. This appreciation can be seen as a form of resistance against the totalitarian way of understanding bioethics. On their part, doctors were inclined to identify bioethics as a sort of new medical humanism. But this invocation of medical humanism has not meant the possibility of self-awareness among doctors about the current challenges for their own profession in Colombia. Rather, it has meant the defence of old values related to medical professionalism and privileges.

Additionally, my critical assessment of the history of bioethics in Colombia has provided useful and original information on two issues. First, I have shown that the healthcare reform of 1993 and the flourishing of bioethics in the 1990s was not a mere historical coincidence. Second, in so far as the analysis of the medical ethos has received little attention from medical historians in Colombia, the critical history of bioethics that I have offered in this thesis makes a contribution to the history of medicine in Colombia. In this point I followed R. Cooter (2000) who argued that no history of medicine in the twentieth century would be complete without examining "the social pervasiveness of the ethical contemplation of bio-medical practices" (p. 452).

In this thesis, the birth and rapid development of bioethics in Colombia has been put in a broader context, as bioethics is part of the emergence in the biomedical scenario of certain discourses, a wide array of objects, new practices and subjectivities, and new experts and authorities related to a new form of governing medicine in the contemporary world. I have shown that there are important coincidences between the rhetoric frequently used by bioethicists and the rhetoric brought by the arrival of a neoliberal rationality to the country in the 1990s. Both bioethics and neoliberal discourses emphasise the pre-eminence of the individual and 'free choice'. While in bioethics paternalism is condemned, in political life the

intervention of the state is rejected. In bioethics as well as in politics the responsibility of the individual is underlined. Thus, instead of having becoming an emancipatory force in the biomedical scenario, the bioethisation of the Colombian medical ethos has meant the reinforcement of categories, rationalities, structures and subjectivities that are functional to a neoliberal understanding of social and individual life. It also became evident that among Colombian bioethicists the technology-driven explanation was the most common account of the origins of bioethics. Regarding the unexplored facets of the history of bioethics in Colombia, there were only a few critical voices pointing to, for example, the links between bioethics and the elite and most conservative academic and political circles of Colombia.

Having graduated as a physician in 1994 and having worked for almost ten years as an emergency room doctor in Bogotá, I have first-hand experience of the transformation of the Colombian medical ethos, which is linked to the socio-political and legal changes brought by a new political constitution (1991) and a radical reform of healthcare (1993). In this new environment, the clinician about whom Foucault spoke in his *Birth of the Clinic* (1973) has been co-opted by neoliberal rationalities and practices that inspired and guided such socio-political and legal changes. Clinicians have been subjected to a process of deprofessionalisation and proletarisation. Although social scientists, particularly since the 1970s, had criticised the exercise of power by doctors and the medical establishment over patients and society (the medicalisation thesis), and argued that health had been expropriated by doctors, the current Colombian scenario constitutes a different situation. In the case of Colombia, doctors do not exercise as much power as the theorists of the medicalisation thesis in other latitudes have assumed.

However, the role that bioethics has played in the governmentalization of the biomedical field in Colombia has been an unacknowledged phenomenon. In this thesis I have made a case for an understanding of bioethics as a kind of 'power struggle' in the contemporary biomedical field, paralleling other phenomena like the commodification of health and the contemporary challenge to medical authority. Bioethics has re-shaped old medico-legal discussions, for instance, about life and death, uses of the body and sex, as the legal decisions of the Colombian Constitutional Court illustrate. Beyond what bioethicists claim as the originality and essence of bioethics, i.e. interdisciplinarity, transdisciplinarity, consensus and dialogue, it is necessary to recognise that the totalising, all-embracing nature that is ascribed to bioethics might instead be an expression of a will to power and to define truth. The Colombian case clearly shows the power dynamics behind the rise of bioethics in

contemporary, liberal societies under the influence of neoliberalism. As I have argued elsewhere, there is a link between consumerism in the biomedical scenario and the discourses of respect for autonomy and free choice promoted in bioethics (Díaz Amado, 2009b).

The truth is that in Colombia medicine has been expropriated by the overwhelming forces of the market and doctors have become subjected to these forces. This economic and political reality has been accompanied by a new ethical and legal framework for medicine. Thus, in the 1990s new normative discourses on medicine, such as bioethics and medical law flourished. From a Foucauldian point of view, the medical ethos was transformed by a power effect and in the last twenty years new practices, truths, subjects, rationalities, authorities, discourses and institutions have emerged, constituting the present of the medical profession in Colombia. Bioethics was not an isolated phenomenon regarding the transformation of the medical ethos. It came into being hand in hand with the rise of surveillance discourses and practices such as medical liability, medical audit, managed care, health economics and evidence based medicine. It was argued that the new regulations and discourses of surveillance are part of the necessary measures to make the medical-industrial complex work.

The flourishing of bioethics occurred in a particular moment of the history of Colombia. The institutional crisis and violence at the end of the 1980s had led to a new political constitution in 1991, which was seen by the Colombian people as the 'remedy for all ills'. However, although this constitution emphasised that Colombia was a social rule-of-law state, this constitution did not solve the inveterate problems of Colombia such as violence, inequality, corruption, and poverty. To have proclaimed that the foundations of the nation were the respect for human dignity and personal autonomy, and give greater preponderance to individual rights was insufficient. Moreover, a neoliberal rationality had strongly permeated Colombian society, paving the way to carry out a wave of neoliberal reforms in the 1990s, similar to those in other Latin American countries such as Chile, Brazil and Argentina. These reforms followed an agenda promoted by international financial organisations like the IMF, WB, and BID, and the American government. For many academic, professional and political sectors in Colombia the healthcare reform of 1993, which was implemented through Law 100 of 1993, was in reality an outcome of the neoliberalization of the country. Although this reform was carried out in the name of justice to guarantee universal access to healthcare services, it brought deregulation, labour flexibilisation and privatisation to healthcare services and medical practice. Almost 20 years after Law 100, the roots and impact of the healthcare reform in terms of its economic, legal

and political aspects have been largely studied. However, the nature and role of pastoral and new regulatory discourses that have flourished paralleling the healthcare reform, such as bioethics, medial liability, medical audit, health administration, health economics, managed care, and evidence based medicine, has received little attention.

Since the healthcare reform of 1993, economists, lawyers, managers and bioethicists have formed an interesting symbiotic relationship in Colombia. For instance, all of them talk about ethical dilemmas in the biomedical arena, ethical committees, fair distribution of resources, respect for autonomy and human dignity; all of them discuss what being a good doctor is, what the legitimate goals of medicine are, how a fair distribution of resources in health care should be achieved and so on. The power effect of bioethics and medical liability consists in keeping the discussion within the limits of the discourses, rationalities, institutions and practices imposed by a neoliberal understanding of healthcare and medical practice. Thus, doctors do learn how to solve ethical dilemmas 'within' the system, but not that such ethical dilemmas are very often produced by the system itself, that there are better ways to practise medicine, and that a different healthcare system is possible in Colombia. Thus, while the healthcare reform in Colombia meant the governmentalization of the biomedical scenario, bioethics and medical liability have played the role of pastoral discourses that are necessary to effectively 'conduct the conduct' of both patients and healthcare professionals within the new system. From a Foucauldian point of view, it would be possible to assimilate these discourses to a truth regime since they impose an 'order' in the clinical world, and they decide, for instance, what issues, problems and objects are worthy of discussion.

Also, from a Foucauldian point of view it is necessary to recognise that power has productive effects. The transformation of the Colombian medical ethos has entailed, first, the development of new academic and professional fields that represent new forms of 'know-how', including bioethics, health economics, managed care and medical law, and second, new subjectivities have proliferated in the biomedical scenario. During the interviews it became clear that various models of being a doctor coexist within the current healthcare system. The old clinician, the doctor-employee, the technician, and the merchant were mentioned. These models do not simply represent personal options to exercise the profession or different tastes among doctors. Rather, they reflect differences between generations and modes of being a doctor that are determined by socio-political and historical conditions. Thus, while senior doctors were identified with the old clinicians, who were strongly influenced by the French school of medicine that dominated the Colombian medical ethos

until the second third of the twentieth century, the youngest generations were seen as the 'product' of neoliberal rationalities and influence. Under this influence some doctors have become business people and others have adopted the role of a doctor-employee, a kind of doctor who is completely subsumed into the policies and regulations stated by healthcare companies.

The existence of these types of doctors suggests different mechanisms of the exercise of power and resistance to it. Although doctors seem to live in a Benthamite Panopticon as a result of the rise of new discourses and practices of surveillance within the new healthcare system, it does not mean that doctors are completely constrained. They have learned to play with the norms now governing the medical ethos. In addition to the exercise of power over the biomedical scenario that seeks to influence 'the milieu' in which medical practice takes place (governmentalization), the implementation of strict regulations and a system of punishment (sovereign and disciplinary powers), particularly through law, are characteristic of the current Colombian medical scenario. Healthcare companies have developed subtle mechanisms to punish doctors when they 'disobey' the norms, for instance, no renewal of labour contracts, internal admonitions, memos and threats about losing the job. An interesting phenomenon that has become apparent in the last few years in Colombia is the growing number of doctors entering law schools. Although this phenomenon has not been appropriately studied yet, it might be seen as a form of resistance against the asphyxiating action of lawyers in the biomedical scenario, at least for doctors, resembling what has happened also in the USA in the last three decades.

With the arrival of medical liability/medical malpractice discourses as an independent academic and professional field in Colombia, the concept of good doctoring has shifted. Although the action of law in medicine has been beneficial to guarantee patients' rights and to obtain compensation when things went wrong, this has also been part of a disciplining process useful to subject doctors to the goals of the medical-industrial complex. Nowadays doctors are not only 'controlled', but even 'threatened' by legal mechanisms. The more governmentalized and disciplined doctors are, the easier it becomes to manage the healthcare system and for the investors to achieve their economic goals. The aforementioned deprofessionalisation and proletarisation of medicine are two phenomena linked to this disempowerment of doctors in Colombia. Moreover, this medical disempowerment occurs via clinical audit, health policies, administrative rules, clinical guideline, and so on. What it means to be a good doctor within the new healthcare system is no longer exclusively

dependant on internal dynamics of the medical profession. External forces are now even more important to decide what being a good doctor is, for instance, compliance with administrative rules, being subject to the economic policies of healthcare companies, and satisfying legal requirements even though they not necessarily mean the best medical diagnostic or therapeutic procedure.

The good doctor is nowadays the one who remains bound to the policies of healthcare companies. Although bioethics and medical liability are supposedly interested in patients' well-being, and have been publicly announced as patients' advocates, too little has been said about the self-interests of bioethicists and lawyers in Colombia. Here I am not making a moral judgment, i.e. doctors are good and lawyers are evil, but just emphasising that bioethicists and lawyers exercise much power over the biomedical scenario and that this should be recognised. From a Foucauldian perspective, the question is not about the good and the bad, but about acknowledging the strategic relations that are now determining the creation of new subjectivities as well as ideas about justice and freedom, i.e. free vs. dominant relationships in the biomedical scenario, and beyond the medicalisation thesis of the 1970s, the self-legitimatising discourses and lawyers, and the naïve invitations to broaden the field of bioethics.

Regarding Colombian jurisprudence I have been able to show how the bioethical discourse influenced legal decisions in an interplay between the new values brought by the Constitution of 1991, the framework of Law 100 of 1993, and bioethics. In the analysis that I carried out of three key decisions of the Colombian Constitutional Court, I argued that both bioethics and law could be seen as *constituted power* (Agamben, 1998). This means that bioethics and medical law now define how, when, for whom and where medical care is made available. Similar to what has happened globally, the decriminalisation of euthanasia, the guarantee of sex reassignment surgeries, and the decriminalisation of abortion in Colombia have been made in the name of personal autonomy and free choice. Such decisions have been celebrated as a triumph of individual rights and pluralism. However, it is important to underline that all decisions have to do with categories that are biopolitically delineated, such as brain death, permanent vegetative state, sexual identity and the embryo/foetus. Bioethics is then helping to administer life, not only seeking to advocate or protect it.

Despite everything said so far, a Foucauldian perspective does contribute to a critical assessment of the history of bioethics. Unlike other approaches that are primarily interested in

the truthfulness or falsehood of such a history, criticising the ideological American bias of bioethics, denouncing the lack of ability of bioethics to deal with the typical problems of the developing world or lamenting that bioethics has been too focused on biotechnology and biomedical issues, the Foucauldian approach provides the necessary inspiration, the analytical tools and the right theoretical framework to analyse the rise of bioethics as the result of a new balance of forces in the biomedical scenario, revealing hidden aspects of this history.

In my analysis I have shown that it is possible to characterise bioethics as a *discursive formation*. Through its invocation of interdisciplinarity, bioethics includes statements of different kinds, e.g. ethical, sociological, political, scientific, economic, legal and so on, which are referred to a particular object: the medical ethos. Bioethics targets doctors, healthcare professionals, medical researchers, patients, hospitals, labs, administrative boards and the like. As a discourse, bioethics is much more than the words, signs or texts that are found in it. In Foucauldian terms, it is a *practical discourse*, which is able to create its own objects: the DPR as a territory subjected to surveillance and administration or the ethical dilemmas that constitute the basic categories of contemporary medical ethics. Inspired by how Foucault explained the formation of the psychiatric field (in which madness took on its modern medico-juridical appearance) and of the anatomo-clinical medicine (that meant a new correlation between the sayable and the visible), I have argued in this thesis that the birth of bioethics was an expression of a new relationship between discourse, truth, and subjectivity in a biomedical field.

In Foucauldian terms the birth of bioethics can also be characterised as an 'historical event'. For Foucault, following Nietzsche, "[a historical event] is not a decision, a treaty, a reign, or a battle, but the reversal of a relationship of forces, the usurpation of power, […] the forces operating in history are not controlled by destiny or regulative mechanisms, but respond to haphazard conflicts" (Foucault, 1984b, p. 88). It was thus neither merely a set of ethical challenges posed by biomedical progress, nor medical abuses in human research, nor the coming up of the neologism 'bioethics', nor the rise of new ethical dilemmas in medicine that explains the birth and rapid development of bioethics. From a genealogical point of view, it was a rearrangement of forces, a displacement of power *in* and *around* the biomedical scenario that would explain the rise of bioethics and other regulatory and normative discourses around medical practice in advanced liberal or, as in the case of Colombia, neoliberal societies.

Being a cultural phenomenon of our time and with the rise of the medical-industrial complex, medicine became a territory to be conquered, where doctors should not rule any more as sovereigns. In the same way that America, as a new continent, meant an unimaginable source of richness and profit to the Europeans of the sixteenth century, contemporary medicine was discovered as a rich land that had to be conquered. America was exploited and looted in the name of Christian and Medieval European values, while economic and political motivations were not talked about. In the case of the biomedical scenario, the conquest is being done in the name of respect for autonomy, beneficence, non-maleficence, justice and human dignity, while at the same time big corporations, professional associations, pharmaceutical companies, governmental agencies, banks, multinationals and medical technology manufacturers are having their golden age. The medical industrial complex represents a rich mine that the financial capital has discovered. No surprise then that healthcare has been then subjected to a process of *neoliberalization* and *financiarization* (Waitzkin & Jasso-Aguilar, 2011, p. 64).

Although bioethics was announced in Colombia as a kind of 'ethical revolution', in biomedical practice it has not meant anything other but the ethical oil that helps to lubricate the gears of the system. The implemented model, according to which healthcare services should be managed by big private corporations, the reinforcement of the idea that doctors are dangerous and have expropriated health, the myth that patients are free agents making rational decisions, the reduction of medical ethics to a limited number of ethical dilemmas, and the idea that medical ethics is independent from the political and economic realities of the country configure the current panorama of a medical ethos in which discourses such as bioethics and medical liability fit perfectly. In this sense, the argument of R. Cooter (2000) is painfully true in Colombia: "Managers, not bioethicists, […] changed the ethical face of medicine by routinizing, if not alienating clinicians [in a context in which medical ethics is] a form of politics by other means" (p. 458-59).

The Foucauldian approach is not only particularly useful to delineate new trajectories of inquiry, to challenge truths taken for granted, or to reveal hidden or neglected aspects in any field, but also to provide insights and guidance about how to understand ethics. In order to consider possible exits to the crisis of the Colombian medical ethos as well as to open new perspectives on the nature, scope, methods and role that fields like bioethics and medical liability should have in the particular context of Colombia, the Foucauldian scholarship offers interesting insights and promising paths to go forward. For Foucault (1985), the "'ethical

subject' [is formed in] a process in which the individual delimits that part of himself that will form the object of his moral practice, defines his position relative to the precept he will follow, and decides on a certain mode of being that will serve as his moral goal" (p. 28). To do this, first, it is necessary to problematize what we do, what we are, and the world in which we live. Then, we should make "the decision to submit to certain rules, precepts, truths or convictions" (Huijer, 1999, p. 74), i.e. to decide about the modes of subjection. For Foucault, following Nietzsche, ethics entails neither acting as a 'universal legislator' (as Kant would expect from us) nor accepting rules just because they were 'new' or made by a certain 'authority'. Instead, what Foucault proposes is an *aesthetic of existence* (Foucault, 1997e, p. 255).

It is possible to imagine an ethics as aesthetics. This is not a superficial, relativist, or simply 'postmodern' claim. It entails the possibility of making of one's life a work of art. In this way, Foucault derived from the ethics in the Ancient World the idea that it was necessary to become engaged in a process of self-formation (Bernauer & Mahon, 1994, p. 151), which included not only knowing oneself, but also the caring for the self. The cultivation of the self (*heautou epimeleisthai*) is the central argument in volume three of the history of sexuality (Foucault, 1986, p. 43). Thus, problematization, mode of subjection, working on oneself, and a focus on an aesthetics of existence characterise a Foucauldian-based ethics (Huijer, 1999, p. 70). For A. Davidson (1994), "ethics, or the self's relation to itself, is therefore part of both the history of subjectivity and the history of governmentality" (p. 119). Then, from a Foucauldian point of view ethics is fundamentally about what we are and how we govern ourselves, a project that the Colombian medical and bioethical community should seriously consider. If such an ethics is adopted, a process of de-bioethicalisation and de-juridification of the Colombian medical ethos might begin, i.e. the possibility of living differently. The question of how to carry out this process nevertheless falls outside of the scope of this thesis, although it outlines the basis of an ethico-political project to be examined in Colombia.

Appendix 1

## The interviewees

As part of my doctoral research, I carried out 27 interviews in Bogotá in 2009.[272] The aim was to illustrate how the transformation of the Colombian medical ethos in the last 20 years has been reconfigured, particularly in relation to the new political constitution of 1991 and the radical healthcare reform of 1993.

My hypothesis was that listening to the stories that bioethicists and non-bioethicists related directly or indirectly to the changes in healthcare could provide important clues that would help me to better understand the roots and dynamics of the current crisis of the Colombian medical ethos. At the same time, these interviews would complement the history of bioethics that has become 'canonical' in the literature. These interviews were not thought of as a statistically viable survey but of an empirical qualitative nature. The information obtained from the interviews complements the literary sources reviewed for my thesis. In this way, both personal narratives and literature on medical ethics, bioethics, and medical law in Colombia contribute to the understanding of how the conditions in which medical practice takes place in Colombia have been reshaped in recent history. The interviews also allow a better understanding of the role that new normative discourses such as bioethics and medical liability have played in this change. In this sense, the interviews provided qualitative information to complement the historical/philosophical analysis of contemporary medical practice in Colombia in this thesis.

The interviews included 27 individuals of different backgrounds and age:

**Gender**

| | **Number** |
|---|---|
| **Male** | 19 |
| **Female** | 8 |

[272] Although the approval of an ethics committee was considered unnecessary because of the nature of the survey, an informed consent form was designed and filled by all the interviewees. See appendices 2 and 3.

**Profession**

| | Number |
|---|---|
| **Physicians** | 17 |
| **Nurses** | 2 |
| **Philosophers** | 2 |
| **Lawyers** | 3 |
| **Others** | 3 |

**Year of graduation**

| | Number |
|---|---|
| **Before 1980s** | 11 |
| **1980s – 1990s** | 13 |
| **After 1990s** | 3 |

**Physicians**

| | Gender / year of graduation | Current work | Additional activities | Other | Date of interview |
|---|---|---|---|---|---|
| **STF** | Male, 1953 | Physician, medical ethicist, and bioethicist | Member of medical associations | Author of publications in medical ethics and bioethics | 24 March 2009 |
| **ETJ** | Male, 1957 | Physician and bioethicist | Lecturer in bioethics | Author of publications in bioethics | 8 May 2009 |
| **MGD** | Male, 1959 | Physician | Private practice, medical lecturer | | 26 March 2009 |
| **MVJ** | Male, 1960 | Physician, medical ethicist | Member of medical associations | Author of publications in medical ethics | 30 March 2009 |

| | | | | | |
|---|---|---|---|---|---|
| **ROE** | Male, 1975 | Physician and director of a clinic | Administrative work | | 11 May 2009 |
| **FAS** | Male, 1975 | Physician | Former lecturer in public health. Social activist | Public health & social sciences | 2 April 2009 |
| **VRR** | Male, 1981 | Physician | Lecturer in health administration. Social activist | Social sciences | 30 April 2009 |
| **LMR** | Male, 1983 | Physician | Worker in a government office related to public health | Public health and bioethics | 11 May 2009 |
| **PMJ** | Male, 1984 | Physician | Member of a medical association | Politics. Former emergency room doctor | 2 April 2009 |
| **AQJ** | Male, 1985 | Physician | Emergency room doctor | | 22 April 2009 |
| **LCM** | Female, 1986 | Physician | Non-governmental organisation assessing the healthcare system | Health administration | 5 June 2009 |
| **LBG** | Male, 1986 | Physician | Medical lecturer, private practice | Work in medical ethics | 26 March 2009 |
| **SHJ** | Male, 1987 | Physician | Lecturer in medicine, private practice | | 20 April 2009 |
| **JEO** | Male, 1987 | Physician | Emergency room doctor, administrative work in a hospital | Health administration | 4 May 2009 |

| | | | | | |
|---|---|---|---|---|---|
| **EGR** | Male, 1988 | Physician | Member of a medical association | Epidemiology and medical education | 30 March 2009 |
| **GCA** | Female, 1989 | Physician and bioethicist | Medical lecturer | Bioethics, medical law and medical education | 7 May 2009 |
| **TME** | Female, 1991 | Physician | Medical lecturer, private practice | Medical education | 14 May 2009 |

**Nurses**

| | | | | | |
|---|---|---|---|---|---|
| **PRG** | Female, 1964 | Professional nurse | Former university lecturer | Nursing professional ethics | 25 March 2009 |
| **PRB** | Female, 1975 | Professional nurse and bioethicist | Clinical practice and university lecturer | Nursing professional ethics and bioethics | 16 April 2009 |

**Philosophers**

| | | | | | |
|---|---|---|---|---|---|
| **HVG** | Male, 1965 | Philosopher | University lecturer and member of different associations | Author of publications in philosophy, ethics, and bioethics | 8 May 2009 |
| **JNM** | Female, 1983 | Philosopher | University lecturer | Working in bioethics and health administration | 7 May 2009 |

**Lawyers**

| | | | | | |
|---|---|---|---|---|---|
| **BPA** | Female, 1988 | Lawyer | University lecturer, private practice | Expert in medical liability | 21 April 2009 |
| **PAG** | Male, 1985 | Lawyer | Working for a legal insurance company | Expert in medical liability | 1 June 2009 |
| **QPP** | Female, 2002 | Lawyer | Working for a health organisation | Expert in medical liability | 28 April 2009 |

**Others**

| | | | | | |
|---|---|---|---|---|---|
| **ABC** | Male, 1993 | Dentist | University lecturer | Working in a non-governmental organisation | 16 April 2009 |
| **LEA** | Male, 1965 | Catholic priest | Lecturer in bioethics | Medical ethics and bioethics | 18 June 2009 |
| **UTC** | Male, 1974 | Anthropologist | Lecturer in anthropology | Medical anthropology | 10 June 2009 |

All of the interviewees had a direct or indirect relation to medical practice. While some were clinicians with different medical specializations, other doctors and non-doctors were at the time of the interviews working in bioethics, social sciences and/or medical law. Some of them were people who I knew directly because of my work as physician and bioethicist; others were contacted after someone else suggested them to me or because I thought his/her opinion could be important for my research. I included doctors who graduated in different decades, from the 1950s until the 1990s.

Appendix 2

## The interviews: Aims, questions, and the analysis

The aims of the interviews and a basic set of questions were previously discussed with my supervisors.

**Aims:**

**1.** To get first hand opinions from professionals and some scholars about the Colombian healthcare reform of 1993 and its influence on the medical ethos.

**2.** To hear opinions and gain some insights about the influence, ways of working, concepts and criticisms regarding three contemporary normative discourses of clinical practice: medical ethics, bioethics and medical liability/malpractice.

**3.** To catch up some key concepts, objects, ideas and problems which would be crucial to analyse in the context of my research

**Basic questions guideline:**

After explaining the main points of my project and once the informed consent form was filled in, signed, and in particular permission given to record, I held a semi-open interview following this guide-questionnaire:

1. Ideas, concepts, perceptions, and criticisms regarding medical ethics and medical practice before and after Law 100 of 1993. Question examples: What is, in your personal opinion, medical ethics? How did you learn medical ethics? What is the importance of medical ethics in the context of the Law 100 of 1993? How should medical ethics be taught today? What do you think about the Code of Ethics of 1981? What do you think of the role of ethics tribunals?

2. Ideas, concepts, perceptions and criticisms regarding bioethics and medical law. What is for you an "ethical dilemma" in the context of clinical practice? Can you give me some example? How do you deal with such ethical dilemmas? Do you know what bioethics is? Do you know what respect for autonomy, beneficence, non-maleficence, justice, virtue, informed consent, and a good doctor is? Do you know or have you participated in an ethic committee? What is your opinion of such committees? Have you received formal training in

bioethics? What is your opinion about the formal bioethics training you have received? What is the importance of the law for your practice? Which are the most important laws you know regarding your professional practice? What is the difference, importance and place of both bioethics and medical liability in your practice? Do you know some legal cases (Constitutional Court) or laws regarding bioethics or bioethical issues? What do you think about these cases and laws? Have you been sued or do you know some colleague who has been sued for malpractice? What is your opinion about his/these case/s? Do you have legal insurance? What do you think about having legal insurance?

3. Ideas, concepts, perceptions and role of the Law 100 of 1993 and the NSSSH. Question examples: How does medical practice change with the Law 100 of 1993? Why do you think medical practice changed in this way? What do you think about the role of Law 100 of 1993 for Colombian medical practice (new actors, hospital structure, medical autonomy, salary, legal responsibility, doctor-patient relationship, etc.)? How was your own practice affected by the Law 100 of 1993?

The answers were recorded and then transcribed in the original Spanish. After that, I wrote summaries and translated relevant parts of the interviews into English that contained the main points of each interview. The quotations from the interviews, which I included in different chapters, are from this English version.

Appendix 3

**Covering letter and consent form for the interviews (English and Spanish)**

**English version**

Mr/Mrs/Mss/Dr
XXXXXXXXXXX

Ref: *Juridification and Biopolitics. The Practice of Medicine in Colombia in the Context of the New Health Care System of 1993*. (Doctoral Research Project)

In many western societies the medical ethos has experienced deep changes, particularly since the second half of the twentieth century. Some circumstances frequently associated with the origins of these changes are: a huge development of biomedical technology, the crumbling of trust in the doctor-patient relationship, the commodification of health, and the presence of non-medical agents in the clinical field, such as managers, lawyers, and philosophers. In this context, bioethics and medical law are the two main normative discourses regulating contemporary medical practice.

In the case of Colombia, the rise of bioethics and medical law has paralleled the new socio-political environment which followed the new political constitution of 1991 and the health care reform of the Law 100 of 1993. Thereafter the medical profession has been experiencing a crisis, since it is not clear anymore what its nature is and which standards should drive its practice. The impact of the Law 100/93 on the medical ethos has only been assessed in part, since almost all analyses regarding the new health care system have been focused on the managerial, economical and legal aspects. Beyond this, it is necessary to assess the role that bioethics and medical law have played in shaping the Colombian medical ethos after the 1993 health care reform. The purpose of my doctoral research is to contribute to carrying out this task. In doing so, I have planned to interview some professionals, whose work, knowledge, and experience might be useful and relevant to bring to light different aspects of this process.

My purpose in writing to you is to ask if you would accept to be interviewed and, thus, contribute to our thinking around this important matter for the medical profession in Colombia. I would really like to hear about your views. If you agree to the interview, I can come to your office or the most convenient place for you. The interview will take no more than one hour and a half. To ensure an

accurate representation of your views, I will audio-tape the interview and transcribe it. To do so, I will first request your permission by using an informed consent form.

Because I know that you have many pressing calls upon your time, I will contact you in a couple of days after you have received this letter to hear about your decision. However, if you would like to let me know about it before, please contact me by phone or by e-mail (see below).

Yours sincerely,

**Eduardo Díaz Amado, MD, MA**
PhD Student
Department of Philosophy &
Centre for the History of Medicine and Disease
Durham University
E-mail: eduardo.diaz-amado@durham.ac.uk

Contact in Colombia:
Mobile: (+57) 311 5926118
Office: (+57 1) 3208320 Ext 4537, 4538, Fax 4539
Bioethics Institute,
Javeriana University
Bogotá, D.C.

Should you have any further queries or complaints, you can also contact the supervisors of this research in the UK using their e-mail:

**Prof. Holger Maehle**
Department of Philosophy and
Centre for the History of Medicine and Disease
a.h.maehle@durham.ac.uk

**Dr. Tiago Moreira**
School of Applied Social
Sciences
tiago.moreira@durham.ac.uk

UNIVERSITY OF DURHAM
DEPARTMENT OF PHILOSOPHY &
CENTRE FOR THE HISTORY OF MEDICINE AND DISEASE

CONSENT FORM

**JURIDIFICATION AND BIOPOLITICS. THE PRACTICE OF MEDICINE IN COLOMBIA IN THE CONTEXT OF THE NEW HEALTH CARE SYSTEM OF 1993**

(Doctoral Research Project)

Please, tick the box if you agree

I have received clear and wide information on what this study is about and had an opportunity to ask questions related to it……... ☐

I agree to take part in the one-to-one interview for the *Juridification and Biopolitics. The Practice of Medicine in Colombia in the Context of the New Health Care System of 1993* research……..... ☐

I agree to the interview being tape recorded and transcribed. I understand that the recordings and transcripts will be treated as confidential and securely stored at all times and that only members of the research team will have access to them…….. ☐

I agree to having direct or indirect quotations of the interview used in publications of the research, on the understanding that they will be anonymised…… ☐

Name_____ Date_____

Signature_____

**Spanish version (the version the interviewees signed)**

Bogotá, DC, DD/MM/AÑO

Sr/Sra/Dr
XXXXXXXXXXXXXXX

Ref: *Juridificación y biopolítica. La práctica de la medicina en Colombia en el contexto del nuevo sistema de salud de 1993* (Proyecto de investigación doctoral)

Cordial saludo.

En la mayoría de sociedades occidentales el é*thos* de la medicina ha experimentado cambios profundos, en especial desde la segunda mitad del siglo XX. Algunas circunstancias frecuentemente asociadas al origen de dichos cambios son: el enorme desarrollo de la tecnología biomédica, el desmoronamiento de la confianza en la relación médico-paciente, la mercantilización de la salud y la presencia de actores no-médicos en el escenario clínico, tales como administradores, abogados, filósofos, entre otros. En este contexto, la bioética y el derecho médico constituyen los dos discursos normativos más importantes en la regulación de la práctica médica contemporánea.

En el caso de Colombia, la aparición de la bioética y el derecho médico han coincidido con el nuevo ambiente socio-político que siguió a la nueva Constitución Política de 1991 y la reforma de la salud por cuenta de la Ley 100 de 1993. Después de esto la profesión médica ha estado experimentando una crisis por cuanto ya no es claro cuál es su naturaleza y cuáles han de ser los estándares que guíen su práctica. El impacto de la Ley 100/93 en el *éthos* de la medicina ha sido parcialmente valorado por cuanto casi todos los análisis en relación con el nuevo sistema de salud han estado sólo enfocados en sus aspectos administrativos, económicos y legales. Además, es necesario valorar el rol que la bioética y el derecho médico han jugado en el moldeamiento del *éthos* de la medicina en Colombia luego de la reforma de la salud de 1993. El propósito de mi investigación doctoral es contribuir en dicha tarea. Para esto, he planeado entrevistar algunos profesionales cuyo trabajo, conocimiento y experiencia podrían ser útiles y relevantes para revelar diversos aspectos de este proceso.

Le estoy haciendo llegar esta carta con el objeto de preguntarle si Ud. aceptaría ser entrevistado y, de este modo, contribuir en la reflexión alrededor de este importante tema para la profesión médica en

Colombia. De verdad estoy muy interesado en conocer sus puntos de vista y si Ud. accede a entrevistarse conmigo, lo podría visitar en su oficina o en el lugar más conveniente para Ud. La entrevista no durará más de una hora y media. Con el fin de que sus opiniones sean correctamente tomadas grabaré la entrevista que posteriormente será transcrita. Para hacer esto, le solicitaré previamente su permiso mediante un formato de consentimiento informado.

Como sé que Ud. es una persona muy ocupada, lo estaré contactando un par de días luego de haber recibido esta carta para saber sobre su decisión. Sin embargo, si desea hacerme saber antes su decisión, por favor contácteme ya sea telefónicamente o por e-mail (ver abajo).

Cordialmente,

**Eduardo Díaz Amado, MD, MA**
Estudiante de doctorado
Departamento de filosofía
Centro para la historia de la medicina y la enfermedad
Universidad de Durham
E-mail: eduardo.diaz-amado@durham.ac.uk

Contacto en Colombia:
Celular: (+57) 311 5926118
Oficina: (+57 1) 3208320 Ext 4537, 4538, Fax 4539
Instituto de Bioética
Universidad Javeriana
Bogotá, D.C.

En caso de que Ud. tenga preguntas adicionales o quejas, Ud. también puede contactar a los supervisores de esta investigación en el Reino Unido a través de correo electrónico:

**Prof. Holger Maehle**
Department of Philosophy and
Centre for the History of Medicine and Disease
a.h.maehle@durham.ac.uk

**Dr. Tiago Moreira**
School of Applied Social
Sciences
tiago.moreira@durham.ac.uk

UNIVERSIDAD DE DURHAM
DEPARTAMENTO DE FILOSOFÍA
CENTRO PARA LA HISTORIA DE LA MEDICINA Y LA ENFERMEDAD

FORMATO DE CONSENTIMIENTO

**JURIDIFICACIÓN Y BIOPOLÍTICA. LA PRÁCTICA DE LA MEDICINA EN COLOMBIA EN EL CONTEXTO DEL NUEVO SISTEMA DE SALUD DE 1993**

(Proyecto de investigación doctoral)

Por favor marque en la casilla si está de acuerdo

He recibido información amplia y clara sobre este estudio y tuve la oportunidad de hacer preguntas relacionadas con él…… ☐

Estoy de acuerdo en tomar parte en una entrevista personal para el proyecto *Juridificación y biopolítica. La práctica de la medicina en Colombia en el contexto del nuevo sistema de salud de 1993*…… ☐

Estoy de acuerdo en que dicha entrevista sea grabada y transcrita. Entiendo que las grabaciones y transcripciones serán manejadas con confidencialidad y serán convenientemente guardadas y sólo los miembros del grupo investigador tendrán acceso a ellas…… ☐

Estoy de acuerdo en que partes de esta entrevista sean citadas, directa o indirectamente, bajo el entendimiento de que tales citas se harán sin nombrar al autor…….. ☐

Nombre_____ Fecha_____

Firma_____

## Bibliography[273]


Abadia, C. E. & Oviedo, D. G. (2009). Bureaucratic Itineraries in Colombia. A Theoretical and Methodological Tool to Assess Managed-Care Health Care Systems. *Social Science & Medicine, 68*(6), 1153-1160.

Agamben, G. (1998) Homo Sacer. Sovereign Power and Bare Life. Stanford, Ca: Stanford University Press

Aguiar, R. (2001). *Tratado de derecho médico [Treatise of Medical Law]*. Caracas: Legislec.

Ahumada, M. C. (1998). *El modelo neoliberal y su impacto en la sociedad colombiana [The Impact of the Neoliberal Model in the Colombian Society]*. Bogotá: El Áncora Editores.

Guttmacher Institute. (1996). Aborto clandestino en América Latina. [Clandestine Abortion in Latin America]. Retrieved from www.guttmacher.org/pubs/ib12sp.pdf, accessed 20 March 2008

Alterio, M. G., Alvarado, R., Cifuentes, E., Garzón, F. & Ortegón, M. (2008). Estructura y organización de los comités de la investigación en Colombia (2001-2002) [Structure and Organisation of Research Ethics Committees in Colombia (2001-2002)]. *Revista Latinoamericana de Bioética, 8*(1), January-July, 96-115.

Alvarez, C. G. (1993, 11 April). El médico jet [The jet-doctor], *El Tiempo*. Retrieved from www.eltiempo.com/archivo, accessed 22 July 2008

Alvarez, J. R. (2007). Contradicciones entre el modelo de desarrollo neoliberal vigente en Colombia y la Constitución Política benefactora de 1991 [Contradictions between the Current Neoliberal Model in Colombia and the Welfare Political Constitution of 1991]. *Revista de la Facultad de Trabajo Social UPB, 23*, 119-135.


[273] In brackets I have added my own translation into English of the original titles in Spanish.

Amat, Y. (2011, 14 August). "El Congreso no puede legislar contra union gay": Presidente de Corte ["The Congress Cannot Legislate against Gay Marriage": President of the Court], *El Tiempo*. Retrieved from http://www.eltiempo.com/justicia/el-congreso-no-puede-legislar-contra-_10155544-4, accessed 16 August 2011.

Angell, M. (1998). The Doctor as Double Agent. In H. Kuhse & P. Singer (Eds.), *A Companion to Bioethics* (pp. 144-149). Malden, Mass.: Blackwell.

Aran, M. & Peixoto, C. A. (2007). Vulnerability and Bare Life: Bioethics and Biopolitics Today. *Revista De Saude Publica, 41*, 849-857.

Arango, P. (1997). Presentación [Presentation]. *Persona y Bioética,* 1.

Arango, R. (2011, 6 July). La Constitución de 1991: ¿neoliberal? [The Constitution of 1991: Neoliberal?], *El Espectador*. Retrieved from http://www.elespectador.com/impreso/opinion/columna-282460-constitucion-de-1991-neoliberal, accessed 8 August 2011.

Areen, J. (1988). Legal Intrusions on Physician Independence. In H. T. Engelhardt & S. F. Spicker (Eds.), *The Physician as Captain of the Ship* (Vol. 29, pp. 39-65): Springer Netherlands.

Aristotle (2000). *Nicomachean Ethics*. Edited by R. Crisp. Cambridge: Cambridge University Press.

ASCOFAME. (1997). Eutanasia [Euthanasia]. In Academia Nacional de Medicina / ICEB (Ed.), *La Eutanasia* (pp. 183 - 196). Bogotá: Academia Nacional de Medicina.

Ashenden, S. & Owen, D. (Eds.). (1999). *Foucault contra Habermas: Recasting the Dialogue between Genealogy and critical theory*. London: SAGE.

Azerrad, B. G. & Viegas, D. R. (1998). Filosofía crítica, bioética y bioderecho [Critical Philosophy, Bioethics, and Biolaw]. *Bioética y Bioderecho*, 3, 33-44.

Baker, R. & McCullough, L. B. (2009). A Chronology of Medical Ethics. In R. Baker & L. B. McCullough (Eds.), *The Cambridge World History of Medical Ethics* (pp. 21-97). New York: Cambridge University Press.

Bal, S. B. (2009). An Introduction to Medical Malpractice in the United States. *Clinical Orthopaedics and Related Research, 467*(2), 339-347.

Bal, S. B. & Brenner, L. (2009). Clinical Risk and Judicial Reasoning: Editorial Comment. *Clinical Orthopaedics and Related Research, 467*(2), 323-324.

Baudrillard, J. (1978) *Olvidar a Foucault* [*Forget Foucault*]. Valencia: PreTextos

Bauman, Z. (2007). *Liquid Times: Living in an Age of Uncertainty*. Cambridge: Polity.

Beauchamp, T. L. & Childress, J. F. (2009). *Principles of Biomedical Ethics* (6th ed.). New York: Oxford University Press.

Bell, M. (2004). Transsexuals and the Law. *Northwestern University Law Review, 98*(4), 1709 - 1752.

Bellver, V. (2007). Algunas deficiencias del discurso bioético contemporáneo [Some deficiencies of the contemporary bioethical discourse]. *Revista Latinoamericana de Bioética, 8*(13), 12-27.

Benn, P. (2002). Goodness and the Good Doctor. *BMJ, 325*(7366), 696.

Berman, M. (1982). *All that Is Solid Melts into Air: The Experience of Modernity*. New York: Simon and Schuster.

Bernauer, J. & Mahon, M. (1994) The Ethics of Michel Foucault. In G. Gutting (Ed.) *The Cambridge Companion to Foucault* (pp. 141-158). New York: Cambridge University Press

Bertranou, F. M. (1999). Are Market-Oriented Health Insurance Reforms Possible in Latin America? The Cases of Argentina, Chile and Colombia. *Health Policy, 47*, 19-36.

Bishop, J. P. (2008). Biopolitics, Terri Schiavo, and the Sovereign Subject of Death. *Journal of Medicine and Philosophy, 33*(6), 538-557.

Bishop, J. P. (2009a). Foucauldian Diagnostics: Space, Time, and the Metaphysics of Medicine. *Journal of Medicine and Philosophy, 34*(4), 328-349.

Bishop, J. P. (2009b). Revisiting Foucault. *Journal of Medicine and Philosophy, 34*(4), 323-327.

Bishop, J. P. & Jotterand, F. (2006). Bioethics as Biopolitics. *Journal of Medicine and Philosophy, 31*(3), 205-212.

Bockting, W. O. (2005). Biological Reductionism Meets Gender Diversity in Human Sexuality. *The Journal of Sex Research, 42*(3), 267-270.

Boland, R. (1993). The Current Status of Abortion Laws in Latin America: Prospects and Strategies for Change. *Journal of Law, Medicine & Ethics, 21*(1), 67-71.

Bota, A. (2003). El Impacto de la Biotecnología en América Latina espacios de Participación Social [The impact of biotechnology in Latin America. Social engagement]. *Acta Bioethica 9*(1), 21-38.

Bové, P. (1988) Foreword: The Foucault Phenomenon: The Problematics of Style. In G. Deleuze. *Foucault* (Trans. S. Hard) (pp. vii-x). Minneapolis: University of Minessota Press.

Boyle, M. (1997). *Re-Thinking Abortion: Psychology, Gender, Power, and the Law*. London: Routledge.

Bradbury, J. (2004). *The Routledge Companion to Medieval Warfare*. London: Routledge.

Brazier, M. & Cave, E. (2007). *Medicine, Patients and the Law* (4th ed.). London: Penguin.

Bussolini, J. (2010). What is a Dispositive? *Foucault Studies*, 10, 85-107.

C. P. (1981). *Código Penal de 1981 [Penal Code of 1981]*. Colombia

Cabal, V. (1999). El consentimiento informado en la jurisprudencia de la Corte Constitucional [The informed consent in the Constitutional Court's jurisprudence]. *Médico-Legal, 5* (3), 35-44.

Cajiao, F. (2011, 5 July). Derechos, garantías y deberes [Rights, guarantees, and duties], Editorial, *El Tiempo*. Retrieved from http://www.eltiempo.com/archivo/documento/CMS-9802868, accessed 18 August 2011.

Calderón, G. (2010). A Critical Reading of Latin American Bioethics. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. 359-368). Dordrecht: Springer.

Calibán. (1967, 2 July). Danza de las horas [Dance of hours], *El Tiempo*, p. 4.

Callahan, D. (2004). Bioethics. In S. G. Post (Ed.), *Encyclopedia of Bioethics* (3rd ed., pp. 279-287). New York: Macmillan.

Campbell, C. S. (1990). The Moral Meaning of Religion for Bioethics. *Bulletin of Pan American Health Organisation, 24*(4), 386-393.

Campo, A. (1981, 24 November). Educación médica [Medical education], *El Tiempo*, p. 5A.

Caplan, A. (2005). Policy & Politics: "Who lost China?" A Foreshadowing of Today's Ideological Disputes in Bioethics. *The Hastings Center Report, 35* (3), 12-13.

Cardona, J. (2011, 3 July). El arduo camino de la Constituyente de 1991 [The arduous path of the Constituent of 1991], *El Espectador*. Retrieved from http://www.elespectador.com/impreso/temadeldia/articulo-281784-el-arduo-camino-de-constituyente-de-1991, accessed 18 August 2011.

Cardona, A. (1985). *La responsabilidad médica ante la ley [Medical liability]* (3rd ed. Vol. II). Medellín: Copiyepes.

Carrick, P. (2001). *Medical Ethics in the Ancient World*. Washington, D.C.: Georgetown University Press.

Carroll, L., Gilroy, P. J. & Ryan, J. (2002). Counseling Transgendered, Transsexual, and Gender-Variant Clients. *Journal of Counseling and Development, 80*(2), 131-139.

Carson, R. & Burns, C. (Eds.). (2002). *Philosophy of Medicine and Bioethics* (Vol. 50): Kluwer Academic Pubishers.

Carvalho, P. A. (2008). Control Social [Social control]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 538-540). Bogotá: RedBioetica, UNESCO, Universidad Nacional de Colombia.

Casas, C. (1982). Normas sobre ética médica [Medical Ethics Norms]. In FMC (Ed.), *Código de Ética Médica*. Bogota: FMC.

Castaño, R. A. (1999). *Medicina, ética y reformas a la salud: hacia un nuevo contrato social con la profesión médica [Medicine, Ethics and Healthcare Reform: Towards a New Social Contract with Medical Profession]*. Bogotá: Fundación Creer.

Castelblanco, R. (1973, 10 April). Ante un paro médico [In a medical strike], *El Tiempo,* p. 5A.

Castelblanco, R. (1975, 20 January). Nuestra seguridad social [Our social security], *El Tiempo,* p. 5A.

Castro-Gómez, S. (2010). *Historia de la gubernamentalidad. Razón de Estado, liberalismo y neoliberalismo en Michel Foucault [History of Governmentality. Reason of State, Liberalism and Neoliberalism in Michel Foucault]* Bogotá: Siglo del Hombre - U. Javeriana - U. Santo Tomás.

CC, Corte Constitucional. (1997). *Sentencia C-239 de 1997 [Constitutional Court. Decision C-239 of 1997]*. Bogotá.

CC, Corte Constitucional. (1999). *Sentencia SU-039 de 1999 [Constitutional Court. Decision SU-039 of 1999]*. Bogotá.

CC, Corte Constitucional. (2006). *Sentencia C-355 de 2006 [Constitutional Court. Decision C-355 of 2006]*. Bogotá.

Ceaser, M. (2006). Court Ends Colombia's Abortion Ban. *Lancet, 367* (9523), 1645-1646.

Cely, G. (1994) El horizonte bioético de las ciencias [The Bioethical Horizon of Sciences]. Bogotá: CEJA

Cely, G. (2007). *Bioética Global. Homenaje a Van Rensselaer Potter [Global Bioethics. Homage to Van Rensselaer Potter]*. Bogotá: Javeriana.

CENALBE. (1998). La eutanasia en Colombia [Euthanasia in Colombia]. *Congreso de bioética de América Latina y del Caribe* [Video]. Bogotá: Universidad Javeriana.

Cepeda, M. J. (2004). Judicial Activism in a Violent Context: The Origin, Role, and Impact of the Colombian Constitutional Court. *Washington University Global Studies Law Review, 3* (Special issue), 529-700.

Clouser, K. D. & Gert, B. (1999). A Critique of Principlism. In J. E. Lindemann & H. L. Nelson (Eds.), *Meaning and Medicine: A Reader in the Philosophy of Health Care* (pp. 156-166). London: Routledge.

Code of Medical Ethics of 1981 (Law 23 of 1981).

Connor, S. S. & Fuenzalida, H. (1990). Bioethics: Introduction to the Special Issue. *Bulletin of Pan American Health Organisation, 24*(4), vi-x.

Conrad, P. (2005). The Shifting Engines of Medicalization. *Journal of Health and Social Behavior, 46*(1), 3-14.

Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*. Baltimore: Johns Hopkins University Press.

Cooper, D. E. (2002). The 'Frankensteinian' Nature of Biotechnology. In A.-H. Maehle & J. Geyer-Kordesch (Eds.), *Historical and Philosophical Perspectives on Biomedical Ethics: From Paternalism to Autonomy?* (pp. 139-149). Burlington, VT: Ashgate.

Cooter, R. (2000). The Ethical Body. In R. Cooter & J. V. Pickstone (Eds.), *Medicine in the Twentieth Century* (pp. 451-458). Singapore: OPA.

Cooter, R. (2010). Inside the Whale: Bioethics in History and Discourse. *Social History of Medicine, 23*(3), 662-672.

Coronado, T. (1997). Eutanasia [Euthanasia]. *Médico-Legal, 3*(2), 71 -72.

Coronell, D. (2010, 30 January). ¿Dónde está la bolita? [Where Is the Ball?], *Semana.com*.

Coronell, D. (2011, 1 May). Salud, dinero y... [Health, Money, and...]. *Semana.com* Retrieved from http://www.semana.com/opinion/salud-dinero/155892-3.aspx, accessed 5 June 2011.

Cortina, A. (2000). *Bioética y sociedad civil [Bioethics and Civil Society]*. Paper presented at the III Congreso de bioética de América Latina y el Caribe [3rd Congress of Bioethics of Latin America and the Caribbean] [Video], Panamá.

Cortina, A. (2003). *Covenant and Contract: Politics, Ethics, and Religion*. Leuven: Peeters.

Cruz, L. E. (2010). Political Constitution of Colombia of 1991 and Economic Opening. *Revista Facultad de Ciencias Económicas, 18*(1), 269-280.

Cuéllar, A. (2007) Las sentencias judiciales en América Latina [Legal Decisions in Latin America]. Retrieved from www4.jfrj.jus.br/seer/index.php/revista_sjrj/article/view/151/163, accessed 20 September 2011.

Cuéllar, Z. (1997, 27 May). No matarás [Do not Kill], *El Tiempo*.

Cuéllar, J. E. (2006). Dignidad humana. Una reflexión crítica sobre antropocentrismo a favor de la responsabilidad solidaria [Human dignity. A Critical Reflection on Anthropocentrism towards a Joint Responsability]. *Avances en Enfermería, XXIV* (1), 8-16.

Cuéllar, J. E. (2010). Alcances y límites de la dignidad humana en el contexto de la bioética: una reflexión crítico-antropológica [Scope and boundaries of human dignity in the context of bioethics: An anthropological critical approach]. *Universitas Humanística, 69* (enero-junio), 259-280.

Chamberlain, J. (2010). Governing Medicine: Medical Autonomy in The United Kingdom and the Restratification Thesis. *EA -Revista de Humanidades Médicas & Estudios Sociales de la Ciencia y la Tecnología, 1*(3), 1-16. Retrieved from http://www.ea-journal.com/en/archive/59-vol-1-n-3-abril2010/212-governing-medicine-medical-autonomy-in-the-united-kingdom-and-the-restratification-thesis.

D'Achiardi, J. (2004). *Directorio de organizaciones nacionales de bioética en Colombia [Directory of Bioethics Organisations in Colombia]*. Instituto de Bioética, Universidad Javeriana, Bogotá [Final dissertation in the specialization in bioethics] [Unpublished].

Dalén, A. (2011, 2 June ). Aborto: cinco años después de la sentencia [Abortion: Five Years after the Case Decision], *El Espectador*. Retrieved from http://www.elespectador.com/impreso/nacional/articulo-274766-aborto-cinco-anos-despues-de-sentencia, accessed 10 August 2011.

Danaher, G., Schirato, T. & Webb, J. (2000). *Understanding Foucault*. London: SAGE.

Davison, A. (1994) Ethics as Ascetics: Foucault, the History of Ethics, and Ancient Thought. In In G. Gutting (Ed.) *The Cambridge Companion to Foucault* (pp. 115-140). New York: Cambridge University Press

de Currea-Lugo, V. (2003). *El derecho a la salud en Colombia. Diez años de frustraciones [The Right to Health in Colombia. Ten Years of Frustrations]*. Bogotá: ILSA.

De Vos, P.; De Ceukelaire, W. & Van der Stuyft, P. (2006). Colombia and Cuba, Contrasting Models in Latin America's Health Sector Reform. *Tropical Medicine and International Health, 11*(10), 1604-1612.

De Zubiría, R. (1972, 17 August). Ignoramos problemas médicos [We ignored medical problems], *El Tiempo* p. 11A.

De Zubiría, S. (2008). Editorial. *Revista Colombiana de Bioética, 3* (Edición especial), 5-9.

Dean, M. (1999). *Governmentality: Power and Rule in Modern Society*. London: SAGE.

Degeling, P.; Maxwell, S. & Iedema, R. (2004). Restructuring Clinical Governance to Maximize its Developmental Potential. In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 163-179). Maidenhead: Open University Press.

Deleuze, G. (1992). What is a *Dispositif*? In T. J. Armstrong (Ed.), *Michel Foucault, Philosopher: Essays* (pp. 159-168). New York: Harvester Wheatsheaf.

Dennis, J. M. (1994). Surgeons under Surveillance: Dialysis and Transplantation in the USA. In J. Elster & N. Herpin (Eds.), *The Ethics of Medical Choice* (pp. 70-83). London: Pinter.

DeVries, R. G. & Conrad, P. (1998). Why Bioethics Needs Sociology. In R. G. DeVries & J. Subedi (Eds.), *Bioethics and Society. Constructing the Ethical Enterprise*. Upper Saddle River, N.J.: Prentice Hall.

DeVries, R. G. & Subedi, J. (1998). *Bioethics and Society: Constructing the Ethical Enterprise*. Upper Saddle River, N.J.: Prentice Hall.

Díaz Amado, E. (2002a). La crisis del paradigma anatomo-clínico: de las metáforas de la enfermedad [The Crisis of the Anatomo-Clinic Paradigm: On Illness and its Metaphors]. In G. Cely Galindo (Ed.), *Dilemas bioéticos contemporáneos* Bogotá: 3R.

Díaz Amado, E. (2002b). *La función política de los comités clínicos de bioética. El caso del Hospital Clínica San Rafael de Bogotá [The Political Function of Clinical Bioethics Committees. The Case of the San Rafael Clinic Hospital in Bogotá]*. Paper presented at the VI World Congress of Bioethics, IAB, Brazilia.

Díaz Amado, E. (2003). Comités clínicos de bioética: La confluencia de la ética y la clínica [Clinical Bioethics Committees: The Confluence Between Ethics and Clinics]. *Repertorio de Medicina y Cirugía, 12* (3), 109-115.

Díaz Amado, E. (2007a). *Conversación en torno a Michel Foucault clínica, medicina y literatura [Talking about Michel Foucault. Clinic, Medicine and Literature]* (1a ed.). Bogotá: Universidad Nacional de Colombia.

Díaz Amado, E. (2007b). Crítica a la bioética si ha de ser instrumento para la construcción de paz en Colombia [Bioethics as a Tool to Create Peace in Colombia. A Critique]. *Revista Latinoamericana de Bioética, 7* (12), 92 - 101.

Díaz Amado, E. (2007c). Elementos para el debate del proyecto de Ley sobre la eutanasia en Colombia [The Bill on Euthanasia in Colombia. Elements for the Debate]. *Espacioeducativo, No. 2,* 46 - 47.

Díaz Amado, E. (2008). ¿Tiene la bioética un lado rosa? [Does Bioethics Have a Pink Side?]. In B. Espinosa (Ed.), *Cuerpos y diversidad sexual [Bodies and Sexual Diversity]* (pp. 40-56). Bogotá: Universidad Javeriana.

Díaz Amado, E. (2009a). Abortion: Ethically Inconclusive, Legally and Politically Feasible. *Revista Latinoamericana de Bioética, 9*(1), 114-123.

Díaz Amado, E. (2009b). Medicina, biotecnopolítica y bioética: de la anatomía a la autonomía [Medicine, Biotechnopolitics, and Bioethics: From Anatomy to Autonomy]. *EÄ -Revista de Humanidades Médicas & Estudios Sociales de la Ciencia y la Tecnología, 1*(2), 1-35. Retrieved from http://www.ea-journal.com/en/archive/58-vol-1-n-2/164-medicina-biotecnopolitica-y-bioetica-de-la-anatomia-a-la-autonomia, accessed 20 August 2011.

Díaz Amado, E. (2010a). Susan M. Reverby, Examining Tuskegee: The infamous Syphilis Study and its Legacy. *Social History of Medicine, 23*(2), 432-433.

Díaz Amado, E. (2010b). Paul Uschuld, What is medicine? *Metapsychology. Online reviews, 14*(34), Review. Retrieved from http://metapsychology.mentalhelp.net/poc/view_doc.php?type=book&id=5713&cn=394, accessed 10 April 2011.

Díaz Amado, E. (2011). Bioética en Latinoamérica ¿Avanzamos? [Bioethics in Latin America, Are We Moving Forward?]. *Anamnesis. Revista de Bioética*, 4, 2-5.

Díaz Amado, E., Calderón, M. C., Romero, K., Prada, E. & Barreto, E. (2010). Obstacles and Challenges Following the Partial Decriminalization of Abortion in Colombia. *Reproductive Health Matters, 18*(36), 118-126.

Dillon, M & Lobo-Guerrero, L. (2009) The Biopolitical Imaginary of Species-Being. *Theory, Culture & Society*, 26(1), 1-23.

Diniz, D. & Guilhem, D. (2010). Bioethics and Women in Latin America: A Biographical and Genealogical Essay. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. 297-307). Dordrecht; London: Springer.

dos Anjos, M. F. (2008a). Poder e injusticia [Power and Injustice]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 533-535). Bogotá: UNESCO, Universidad Nacional de Colombia.

dos Anjos, M. F. (2008b). Teología de la Liberación [Liberation Theology]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 12-14). Bogotá: UNESCO, Universidad Nacional de Colombia.

dos Anjos, M. F. (2010). Bioethics and Religion in Latin America. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. 285-296). Dordrecht; London: Springer.

Dowbiggin, I. R. (2005). *A Concise History of Euthanasia: Life, Death, God, and Medicine*. Lanham, MD: Rowman & Littlefield.

Drane, J. F. (1990). Methodologies for Clinical Ethics. *Bulletin of Pan American Health Organisation, 24*(4), 394-404.

Drane, J. F. (1996). Bioethical Perspectives from Ibero-America. *Journal of Medicine and Philosophy, 21*(6), 557-569.

Drane, J. F. (2010). A Personal History of Bioethics in Latin America: The Current Challenge to the Medical Profession and the Influence of Pharmaceutical Companies. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American bioethics: history and perspectives* (pp. 29-41). Dordrecht; London: Springer.

Drane, J. F. & Fuenzalida, H. (1991). Medical Ethics in Latin America: A New Interest and Commitment. *Kennedy Institute of Ethics Journal, 1*(4), 325-338.

Dugas, J. C. (2001). The Origin, Impact and Demise of the 1989-1990 Colombian Student Movement: Insights from Social Movement Theory. *Journal of Latin American Studies, 33*(4), 807-837.

El Espectador. (2011a, 12 August). Así será la nueva reforma a la salud [The New Healthcare Reform], *El Espectador*. Retrieved from http://www.elespectador.com/impreso/temadeldia/articulo-291623-asi-sera-nueva-reforma-salud, accessed 10 October 2011.

El Espectador. (2011b, 21 September). Conservadores exigen priorizar discusión de penalización del aborto [Conservatives Say that Discussion on Abortion Ban Should Be First], *El Espectador*. Retrieved from http://www.elespectador.com/noticias/politica/articulo-300915-conservadores-exigen-priorizar-discusion-de-penalizacion-del-abo, accessed 10 October 2011.

El Espectador. (2011c, 25 October). No cesa lucha conservadora por prohibir el aborto [Conservatives' Efforts to Ban Abortion do not Abate], *El Espectador*. Retrieved from http://www.elespectador.com/noticias/politica/articulo-307560-no-cesa-lucha-conservadora-prohibir-el-aborto, accessed 2 November 2011.

El Tiempo. (1963a, 11 December). El paro de los doctores [Medical Strike], *El Tiempo,* p. 4.

El Tiempo. (1963b, 29 January). Extraordinario homenaje a la Federación Médica Colombiana [Extraordinay Tribute to the Colombian Medical Federation], *El Tiempo,* p. 11.

El Tiempo. (1963c, 9 June). Hay que inundar de médicos el país [It Is Necessary to Flood the Country with more Doctors] *El Tiempo,* p. 16.

El Tiempo. (1966, 15 February). El paro médico: ilegal e inhumano [Medical Strike: Ilegal and Inhumane], *El Tiempo,* p. 4.

El Tiempo. (1970, 11 February). Se extiende el paro médico [Medical Strike Prolongued], *El Tiempo,* p. 1.

El Tiempo. (1971, 8 October). Médicos generales critican al gobierno [GPs Criticize the Government], *El Tiempo,* p. 3A.

El Tiempo. (1973a, 11 April). Muertes por deficiente atención de los médicos [Doctors' Poor Atention Causes Deaths], *El Tiempo,* p. 7A.

El Tiempo. (1973b, 26 April). Serios disturbios en paro de los médicos [Serious Disorders in Doctors' Strike], *El Tiempo,* p. 6A.

El Tiempo. (1974a, 13 October). "En el ICSS las reformas se harán con los usuarios" dice la ministra de trabajo ["Reforms in the ICSS will Be Carried Out with Affiliates Participation" says Ministry of Labour], *El Tiempo,* p. 1.

El Tiempo. (1974b, 5 May). La crisis del seguro [The Crisis of the ISS], *El Tiempo,* p. 4A.

El Tiempo. (1976a, 10 September). Al paro profesores de medicina [Medical Teachers Vote to Strike], *El Tiempo,* p. 6A.

El Tiempo. (1976b, 10 September). No habrá estado de sitio [The State of Siege will not Be Declared], *El Tiempo,* p. 6A.

El Tiempo. (1978, 25 April). Abren primera escuela militar de medicina [The First Militar Medical School Opened], *El Tiempo,* p. 6A.

El Tiempo. (1983, 20 March). Superproducción de galenos [Excess of Physicians], *El Tiempo,* p. 11A.

El Tiempo. (1994, 16 September). Enfermos pueden rechazar tratamiento médico [Patients Are Allowed to Refuse Medical Treatment], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

El Tiempo. (1995, 6 March). Colsanitas abre universidad en Bogotá [Colsanitas Opens a University in Bogotá], *El Tiempo.* Retrieved from www.eltiempo.com/archivo

El Tiempo. (1997a, 7 March). Bioética: una prioridad en la enseñanza [Bioethics: A Priority for Education], *El Tiempo*. Retrieved from www.eltiempo.com/archivo, *El Tiempo*. Retrieved from www.eltiempo.com/archivo.

El Tiempo. (1997b, 30 May). Iglesia pide anular fallo de eutanasia [Church Says Legal Decision on Abortion Must Be Reversed], *El Tiempo.* Retrieved from www.eltiempo.com/archivo.

El Tiempo. (1999, 1 February). Los médicos de espaldas al cambio [Doctors, Turning their Back on Change], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

El Tiempo. (2007, 30 Sep). "Les he aplicado la eutanasia a más de 35 personas y no me arrepiento", dice Gustavo Alfonso Quintana ["I Have Euthanasied more than 35 People and I do not Regret It", says Gustavo Alfonso Quintana], *El Tiempo*.

El Tiempo. (2008a, 21 de mayo). Aborto, dos años después [Abortion, Two Years Later], *El Tiempo*. Retrieved from http://www.eltiempo.com/archivo/documento/CMS-4183863

El Tiempo. (2008b, 22 May). La eutanasia en el limbo [Euthanasia in Limbo], Editorial, *El Tiempo*. Retrieved from El Tiempo.com/Archivo, accessed 1 August 2009

El Tiempo, Redacción política. (2011a, 4 July). La constitución de los derechos fundamentales [The Constitution of Fundamental Rights], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

El Tiempo, Redacción política. (2011b, 4 July). Lo que las reformas le cambiaron a la Carta [How the Reforms Changed the Constitution], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Emanuel, E. J. (1991). *The Ends of Human Life: Medical Ethics in a Liberal Polity*. Cambridge, Mass.: Harvard University Press.

Engelhardt, H. T. (1996). *The Foundations of Bioethics* (2nd ed.). Oxford: Oxford University Press.

Engelhardt, H. T. (2010). Foreword. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. v-vi). Dordrecht; London: Springer.

Epstein, M. (2010) How will the Economic Downturn Affect Academic Bioethics? *Bioethics*, 24(5), 226 - 233.

Eribon, D. (1989) *Michel Foucault*. Paris: Flammarion

Erin, C. A. & Ost, S. (2007). *The Criminal Justice System and Health Care*. Oxford: Oxford University Press.

Escobar, A. (1995, 19 March). Llegan los médicos con taxímetro [Doctors with a Taximeter Have Arrived], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Escobar, H. & Díaz Amado, E. (2008). Evolución de las actitudes en el campo de la ética de la investigación con seres humanos [Attitudes Evolution in Human Research Ethics]. *Universitas Psychologica, 7*(1), 73 - 96.

Escobar, H. & Díaz Amado, E. (2010). *Dilemas morales y práctica clínica reflexiones a partir de un estudio de campo [Moral Dilemmas and Clinical Practice. Reflections from a Field Study]*. Bogotá: Corporación Universitaria Iberoamericana.

Escobar, J., Sarmiento, Y. & Gordillo, M. d P. (2008). General Bioethics Education as a Contribution of a Bioethical Thinking on Educators. *Revista Colombiana de Bioética, 3* (Edición especial), 81-144.

Escribano, T. (1974, 13 May). Más allá de los salarios [Beyond Wages], *El Tiempo,* p. 4A.

Esguerra, R. (1994). Ante los cambios en la práctica médica, reafirmemos los principios [As Medical Practice Has Changed, Principles Should Be Reaffirmed]. *Acta Médica Colombiana, 19* (3), 113-115.

Esguerra, R. (1999). El médico para el nuevo milenio [The Physician for the New Millennium]. *Acta Médica Colombiana, 24*(1).

Eslava, L. (2009). Constitutionalization of Rights in Colombia: Establishing a Ground for Meaningful Comparisons. *Revista de Derecho del Estado, 22*, 183-229.

Espinosa, B. (2008). Cuerpos e identidades. El transexualismo reta al derecho [Bodies and Identities. Transexualism Is Challenging the Law]. In B. Espinosa Pérez (Ed.), *Cuerpos y diversidad sexual [Bodies and Sexual Diversity]* (pp. 68-79). Bogotá: Universidad Javeriana.

Esposito, R. (2008) *Bios: Biopolitics and Philosophy*. (T. Campbell Trans.) Minneapolis: University of Minnesota Press.

Estrada, J. (2004). *Construcción del modelo neoliberal en Colombia, 1970 – 2004 [Implementation of the Neoliberal Model in Colombia, 1970 – 2004]*. Bogotá: Aurora.

Estrada, D. (2010). Majority Favours Legalising Abortion -but not for all cases. *IPS News*. Retrieved from http://ipsnews.net/news.asp?idnews=51928, accessed 10 February 2011.

Evans, J. H. (2006). Between Technocracy and Democratic Legitimation: A Proposed Compromise Position for Common Morality Public Bioethics. *Journal of Medicine and Philosophy, 31*(3), 213-234.

Ewald, F. (1991). Insurance and Risk. In G. Burchell; C. Gordon & P. M. Miller (Eds.), *The Foucault effect. Studies in Governmentality. With Two Lectures by and an Interview with Michel Foucault* (pp. 197-210). London: Harvester Wheatsheaf.

Faden, R. & Beauchamp, T. (1986) *A History and Theory of Informed Consent*. New York : Oxford University Press

Fergusson, G. (1964, 1 May). La asociación de facultades y los hospitales [The Association of Medical Schools and Hospitals], *El Tiempo*, p. 5.

Fernández, F. (2002) Reivindación de la Ética como Política [Considering Ethics as Politics] La Fogata. Retrieved from http://www.lafogata.org/opiniones/colectivo1.htm, accessed 20 August 2012

Fernández, C. F. & Perilla, S. (2011, 12 July). EPS niegan hasta las aspirinas, revela informe de la defensoria [Health-Promoting Entities Deny even Aspirins, Says the Ombudsman's Office], *El Tiempo*. Retrieved from www.eltiempo.com/archivo, accessed 20 August 2011.

Ferrer, M. (2003). Equidad y Justicia en salud, implicaciones para la bioética [Equity and Justice in Health, Implications for Bioethics]. *Acta Bioethica,* 9(1), 113-126.

Ferrer, J. J. (1998). Los principios de la bioética [The Principles of Bioethics]. *Cuadernos del Programa Regional de Bioética OPS/OMS*, 7, 1-17.

Ferrer, J. J. (2009). La bioética como quehacer filosófico [Bioethics as a Philosophical Activity]. *Acta Bioethica, 15* (1), 35-41.

Ferrer, J. J. & Alvarez, J. C. (2004). Anglo-American Bioethics and Mediterranean Ethics: Preliminary Considerations in the Face of a Future Comparative Study. *Revista Latinoamericana de Bioética, 6*, 32-71.

Figueroa, P. R. & Fuenzalida, H. (1996). Bioethics in Ibero-America and the Caribbean. *Journal of Medicine and Philosophy, 21*(6), 611-627.

Finkler, K. (2003). *Bioethical Practices in Developing Countries: The Case of Mexico.* Paper Presented at the Decennial Meeting of the Association of Social Antrhopologists of the Commonwealth, University of Manchester.

Flynn, R. (2004). 'Soft Bureaucracy', Governmentality and Clinical Governance: Theoretical Approaches to Emergent Policy. In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 11-26). Maidenhead: Open University Press.

Fonnegra, I. (2009). *De cara a la muerte* [Facing Death]. Bogotá: Intermedio editores.

Foucault, M. (1971). *The Order of Things.* New York: Pantheon Books.

Foucault, M. (1972). *The Archaeology of Knowledge*. London: Tavistock.

Foucault, M. (1973) *The Birth of the Clinic*. New York: Vintage Books

Foucault, M. (1979). *Discipline and Punish: The Birth of the Prison*. Harmondsworth: Penguin.

Foucault, M. (1984a). Docile Bodies [from Discipline and Punish]. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 179-187). New York: Pantheon Books.

Foucault, M. (1984b). Nietzsche, Genealogy, History. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 76-100). New York: Pantheon Books.

Foucault, M. (1984c). Truth and Power. In P. Rabinow (Ed.), *The Foucault Reader* (pp. 51-75). New York: Pantheon Books.

Foucault, M. (1984d). What is Enlightenment? In P. Rabinow (Ed.), *The Foucault Reader* (pp. 32-50). New York: Pantheon Books.

Foucault, M. (1991). Governmentality. In B. Burchell; C. Gordon & P. Miller (Eds.), *The Foucault Effect. Studies in Governmentality* (pp. 87-104). Chicago: The University of Chicago Press.

Foucault, M. (1997a). The Ethics of the Concern of the Self as a Practice of Freedom. In P. Rabinow (Ed.), *The Essential Works of Michel Foucault, 1954-1984. Vol. 1, Ethics* (pp. 281-301). New York: The New Press.

Foucault, M. (1997b). Polemics, Politics, and Problematizations: An Interview with Michel Foucault. In P. Rabinow (Ed.), *The Essential Works of Michel Foucault, 1954-1984. Vol. 1, Ethics* (pp. 111-119). New York: The New Press.

Foucault, M. (1997c). Technologies of the Self. In P. Rabinow (Ed.), *The Essential Works of Michel Foucault, 1954-1984. Vol. 1, Ethics* (pp. 223-251). New York: The New Press.

Foucault, M. (1997d). The Will to Knowledge. In P. Rabinow (Ed.), *The Essential Works of Michel Foucault, 1954-1984. Vol. 1, Ethics* (pp. 11-16). New York: The New Press.

Foucault, M. (1997e). On the Genealogy of Ethics: An Overview of Work in Progress. In P. Rabinow (Ed.), *The Essential Works of Michel Foucault, 1954-1984. Vol. 1, Ethics* (pp. 253-280). New York: The New Press

Foucault, M. (1998). *The Will to Knowledge. The History of Sexuality: 1*. London: Penguin.

Foucault, M. (2000). The Subject and Power. In J. D. Faubion (Ed.), *Michel Foucault. Power* (Vol. 3, pp. 326-348). London: Penguin.

Foucault, M. (2006). *Madness and Civilisation. A History of Insanity in the Age of Reason*. London; New York: Taylor & Francis.

Foucault, M. (2007). *Security, Territory, Population: Lectures at the College de France, 1977-78*. Edited by M. Senellart & A. I. Davidson. Basingstoke: Palgrave Macmillan.

Foucault, M. (2010a). *The Birth of Biopolitics: Lectures at the College de France, 1978-79*. Edited by M. Senellart. Basingstoke: Palgrave Macmillan.

Foucault, M. (2010b). *The Government of Self and Others: Lectures at the College de France, 1982-83*. Edited by F. Gros. Basingstoke: Palgrave Macmillan.

Fox, R. & Swazey, J. P. (2008). *Observing Bioethics*. New York: Oxford University Press.

Franco, S. (1997). Violencia y salud en Colombia [Health and Violence in Colombia]. *Revista Panamericana de Salud Pública, 2*.

Fraser, N. (1989) *Unruly Practices. Power, Discourse and Agenda in Contemporary Social Theory*. Cambridge: Polity Press

Gaitán, J. (2004). Alcances de la discusión bioética. Un ensayo acerca de las relaciones entre la bioética y el derecho [Scope of the Bioethical Discussion. An Essay on Bioethics / Law Relations]. *Universitas 35,* 29-43.

Gaitán, J. (2008). La racionalidad jurídica en la discusión bioética del transexualismo [The Legal Rationality in the Bioethical Discussion about Transexualism]. In B. Espinosa Pérez (Ed.), *Cuerpos y diversidad sexual [Bodies and Sexual Diversity]* (pp. 80-87). Bogotá: Universidad Javeriana.

Galán, A. (1995, 2 July). ¿Quién tuela mis riñones? [Who Advocates my Kidneys?], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Galindo, A. (1968, 12 February). Los profesionales [The Professionals], *El Tiempo*, p. 4.

Galvis, C. (2006) La justicia sanitaria en Colombia, un proyecto inconcluso [Health Justice in Colombia, an Unfinished Project]. In Escobar, J. (Ed.) *Bioética, justicia y salud* [Bioethics, Justice and Health]. Colección Bios y Ethos, No. 25 (pp. 123-193). Bogotá: Universidad El Bosque

Garrafa, V. (2000). Radiografía Bioética de Brasil [Bioethics Radiography of Brazil]. *Acta Bioethica, 6*(1), 165-181.

Garrafa, V. (2008a). Ética y política [Ethics and Politics]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]*. Bogotá: UNESCO, Universidad Nacional de Colombia.

Garrafa, V. (2008b). Imperialismo moral [Moral Imperialism]. In J. C. Tealdi (Ed.), Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics] (pp. 535-536). Bogotá: UNESCO, Universidad Nacional de Colombia.

Garrafa, V. (2008c). Presentación [Presentation]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. xvii-xviii). Bogotá: UNESCO, Universidad Nacional de Colombia.

Garrafa, V. (N.D.). A Unesco Initiative for Latin America and Caribbean [Power Point] Retrieved from http://portal.unesco.org/shs/en/files/12988/12611524161garrafa_redbioetica.pdf/garrafa_redbioetica.pdf, accessed 22 August 2010.

Garrafa, V., Kottow, M. & Saada, A. (Eds.). (2005). *Estatuto epistemológico de la bioética [Epistemological Status of Bioethics]*. México, D.F.: UNESCO, UNAM.

Garrafa, V. & Porto, D. (2003). Intervention Bioethics: A Proposal for Peripheral Countries in a Context of Power and Injustice. *Bioethics, 17*(5-6), 399-416.

Garzón, F. (2000). *Bioética. Manual interactivo [Bioethics. Interactive Manual]*. Bogotá: 3R.

Garzón, F. (2007). De la bioética, a la biopolítica y al bioderecho [From Bioethics, to Biopolitics and Biolaw]. *Revista Latinoamericana de Bioética, 7*(12), 6-9.

Garzón, F. (2009) Fritz Jahr, ¿el padre de la bioetica? [Fritz Jahr, the Father of Bioethics?]. *Revista Latinoamericana de Bioética, 9*(2), 6-7.

Gaviria, A., Medina, C. & Mejía, C. (2006). Evaluating the Impact of Health Care Reform in Colombia: From Theory to Practice. pp. 1-57. Retrieved from http://ideas.repec.org/p/col/000089/002647.html, accessed 22 August 2011.

Gaviria, A., Medina, C., Mejía, C., McKenzie, D. & Soares, R. R. (2006). Assessing Health Reform in Colombia: From Theory to Practice [with Comments]. *Economía, 7* (1), 29-72.

Gaviria Díaz, C. (1998). La eutanasia en Colombia [Euthanasia in Colombia] *Congreso de bioética de América Latina y del Caribe* [Video]. Bogotá: Universidad Javeriana.

Gaviria Neira, C. (1998). *Práctica médica en Colombia. Paradigma bioético por excelencia [Medical Practice in Colombia: Bioethical Paradigm Per Excellence]*. Bogotá: Página Maestra.

Gaylin, W. (2003). *The Perversion of Autonomy: Coercion and Constraints in a Liberal Society*. Washington, D.C.: Georgetown University Press.

Glannon, W. (2005). *Biomedical Ethics*. New York: Oxford University Press.

Gómez, N. (1976, 23 August). Responsabilidad de clínicas y médicos [Accountability of Clinics and Doctors], *El Tiempo,* p. 5A.

González, A. C. (2005). Current Situation with Abortion in Colombia: Between Illegality and Reality. *Cad Saude Publica, 21*(2), 624-628.

González, A. C. (Ed.). (2010). *Health Exception. Lawful Termination of Pregnancy*. Bogotá: La Mesa por la Vida y la Salud de las Mujeres - Alianza Nacional por el Derecho a Decidir.

González, E. (2003). *Derecho y bioética. Seminario franco-andino de derecho y bioética.* Memorias *[Law and Bioethics. French-Andean Seminar on Law and Bioethics.* Proceedings] Bogotá: Universidad Externado de Colombia.

González, L. E. (2011, 23 April). Catorce EPS serían multadas por hacer "pacto" para negar servicios [Fourtheen Health-Promoting Entities Would Be Fined on a "Pact" to Deny Medical Services], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

González, N., Arjona, J. P., Correa, A. & Forero, A. (1997). Ejercicio de los principios de autonomía y beneficencia en el acto médico [The Principles of Autonomy and Beneficence in Medical Practice]. *Médico-Legal, 3* (1), 17-22.

Gracia, D. (1990). Introduction: Medical Bioethics. *Bulletin of the Pan American Health Organisation, 24*(4), 351-360.

Gracia, D. (1995). Hard Times, Hard Choices: Founding Bioethics Today. *Bioethics*, *9*(3), 192-206.

Gracia, D. (1999). Prólogo [Foreword]. In T. L. Beauchamp & J. Childress (Eds.), *Principios de ética biomédica [Principles of Biomedical Ethics]* (5a ed.). Barcelona: Masson.

Gracia, D. (2002). De la bioética clínica a la bioética global: treinta años de evolución [From Clinical Bioethics to Global Bioethics: Thirty Years of Evolution]. *Acta Bioethica, 8*(1), 27-39.

Gray, A. (2004). Governing Medicine: An Introduction. In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 1-7). Maidenhead: Open University Press.

Gutting, G. (2005). Michel Foucault: A User's Manual. In G. Gutting (Ed.), *The Cambridge Companion to Foucault: 2nd Edition*. Cambridge: Cambridge University Press.

Guzmán, F. (1997). Cómo rendir un testimonio médico al ser acusado [Tips for a Doctor to Testify in a Lawsuit]. *Acta Médica Colombiana, 22*(3), 140-147.

Guzmán, F. (1998). Pacientes que representan algo riesgo de demanda [High-Risk Patients and Medical Malpractice Lawsuits]. *Médico-Legal, 5*(3), 53-59.

Guzmán, F., Delgadillo, F. & Cadena, M. (1996). ¿Por qué se demanda a los médicos? [Why Doctors Are Sued?]. *Médico-Legal, 2*(2), 42-48.

Hackspiel, M. M. (Ed.). (1998). *Comités bioéticos clínicos [Clinical Bioethical Committees]*. Bogotá: Ministerio de Salud.

Hall, A. L. (2006). Whose Progress? The Language of Global Health. *Journal of Medicine and Philosophy, 31*(3), 285-304.

Han, B. (2002). *Foucault's Critical Project: Between the Transcendental and the Historical* (E. Pyle, Trans.). Stanford, Calif.: Stanford University Press.

Hanson, M. J. & Callahan, D. (Eds.) (1999) Introduction. In M. J. Hanson & D. Callahan (Eds.), *The Goals of Medicine: The Forgotten Issues in Health Care Reform* (pp. ix-xiv). Washington, D.C.: Georgetown University Press.

Harrison, S. (2004a). Governing Medicine: Governance, Science and Practice. In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 180-187). Maidenhead: Open University Press.

Harrison, S. (2004b). Medicine and Management: Autonomy and Authority in the National Health Service. In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 51-59). Maidenhead: Open University Press.

Harvey, D. (2005). *A Brief History of Neoliberalism*. Oxford: Oxford University Press.

Hastings Center (1999) The Goals of Medicine: Setting New Priorities. In In M. J. Hanson & D. Callahan (Eds.), *The Goals of Medicine: The Forgotten Issues in Health Care Reform* (pp. 1-54). Washington, D.C.: Georgetown University Press.

Hauerwas, S. (1996). How Christian Ethics became Medical Ethics: The Case of Paul Ramsey. In A. Verhey (Ed.), *Religion and Medical Ethics: Looking Back, Looking Forward* (pp. 61-80). Grand Rapids, Mich: W.B. Eerdmans Pub. Co.

Haugaard, M. (2002). *Power: A Reader*. Manchester: Manchester University Press.

Hausman, B. L. (2001). Recent Transgender Theory. *Feminist Studies, 27*(2), 465-490.

Hedayat, K. (2006). Therapeutic Abortion in Islam: Contemporary Views of Muslim Shiite Scholars and Effect of Recent Iranian Legislation. *Journal of Medical Ethics, 32*, 652-657.

Hedgecoe, A. (2010). Bioethics and the Reinforcement of Socio-Technical Expectations. *Social Studies of Science, 40*(2), 163-186.

Homedes, N. & Ugalde, A. (2005). Why Neoliberal Health Reforms Have Failed in Latin America. *Health Policy, 71*, 83-96.

Hooft, P. F. (2000). Anencefalia: consideraciones bioéticas y jurídicas [Anencephalia. Bioethical and Legal Considerations]. *Acta Bioethica, 6*(2), 265-282.

Hoogland, J & Jochemsen, H. (2000). Professional Autonomy and the Normative Structure of Medical Practice. *Theoretical Medicine and Bioethics, 21*(5), 457-475.

Hope, T., Savulescu, J. & Hendrick, J. (2008). *Medical Ethics and Law: The Core Curriculum* (2nd ed.). Edinburgh: Churchill Livingstone Elsevier.

Hoy, D. C. (1986). Introduction. In D. C. Hoy (Ed.), *Foucault: A Critical Reader* (pp. 1-25). Oxford: Basil Blackwell.

Hoyos, I. M. (2000). *La persona y sus derechos. Consideraciones bioético-jurídicas [The Person and its Rights. Bioethical and Legal Considerations]*. Bogotá: Temis.

Hoyos, G. (1998). Ética y sociedad civil [Ethics and Civil Society]. In A. Llano Escobar (Ed.), *Congreso de Bioética de America Latina y el Caribe. VI encuentro.* Memorias *[VI Bioethics Congress of Latin America and the Caribbean.* Proceedings*]* (pp. 76-88). Bogotá: Javeriana.

Hoyos, G. (2003). Communicative Morality and Bioethics. *Revista Latinoamericana de Bioética, 5(July)*, 18-35.

Huertas, R. (1998). *Neoliberalismo y políticas de salud [Neoliberalism and Health Policies]*. Madrid: El Viejo Topo.

Huijer, M. (1999) The Aesthetics of Existence in the Work of Michel Foucault. Philosophy Social Criticism, 25(2), 61-85

Hull, N. E. H. & Hoffer, P. C. (2001). *Roe v. Wade: The abortion Rights Controversy in American History*. Lawrence, KS: University of Kansas.

Human Rights Watch. (2005a). Colombia: Mujeres enfrentan prisión por abortos. Human Rights Watch cuestiona las leyes restrictivas sobre el aborto. [Women Face Jail for Abortion. Human Rights Watch Criticises Restrictive Laws on Abortion]. Retrieved from http://www.hrw.org/legacy/spanish/docs/2005/06/22/colomb11205.htm, accessed 18 July 2011.

Human Rights Watch. (2005b). Derecho Internacional de los derechos humanos y aborto en America Latina. [Human Rights International Law and Abortion in Latin America]. Retrieved from www.hrw.org/spanish/informes/2006/wrd0106/wrd0106sp.pdf, accessed 20 October 2010, accessed 18 July 2011.

Hurst, S. (2010). What 'Empirical Turn in Bioethics'? *Bioethics, 24*(8), 439-444.

IBPUJ, Instituto de Bioética de la Pontificia Universidad Javeriana. (n.d.). Reseña histórica [Brief History of Bioethics at the Pontificia Universidad Javeriana] Retrieved from http://www.javeriana.edu.co/bioetica/inst_resena.htm, accessed 1 October 2011.

Illich, I. (1975). *Medical Nemesis: The Expropriation of Health*. London: Calder & Boyars.

Jaeger, W. W. (1939). Medicine as Paideia. In W. W. Jaeger (Ed.), *Paideia: The Ideals of Greek Culture* (Vol. III. The conflict of cultural ideals in the age of Plato, pp. 3-45). Oxford: Blackwell.

Jaramillo, A. (1968, 3 December). Qué es la Federación Médica Colombiana [The Colombian Medical Federation], *El Tiempo*, p. 19.

Jaramillo, I (1999) *El futuro de la salud en Colombia. Ley 100 de 1993 cinco años después* [*The Future of Healthcare in Colombia. Law 100 of 1993 five years later*] Bogotá: Fundación Corona

Jasso-Aguilar, R., Waitzkin, H. & Landwehr, A. (2008). Healthcare and Multinational Corporations in the United States and Latin America. *Harvard Health Policy Review, 9*(1), 158-172.

John Paul II. (1995). Evangelium Vitae. Retrieved from http://www.vatican.va/holy_father/john_paul_ii/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae_en.html, accessed 10 November 2010.

Jones, C. & Porter, R. (1994). Introduction. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine, and the Body* (pp. 1-16). London: Routledge.

Jonsen, A. (1992) *The New Medicine and the Old Ethics*. Cambridge, Mass.: Harvard University Press

Jonsen, A. (1998). *The Birth of Bioethics*. New York: Oxford University Press.

Juritzen, T., Grimen, H. & Heggen, K. (2011) Protecting the Vulnerable Research. Participants: A Foucault-Inspired Analysis of Ethics Committees. *Nursing Ethics*, 6, June, 640-649

Kaivola, K. (1997). The Ethics of Difference in an Age of Technological Gender B(l)ending *Mosaic: a Journal for the Interdisciplinary Study of Literature, 30*(3), 197-210.

Kane, G. (2008). Abortion Law Reform in Latin America: Lessons for Advocacy. *Gender & Development, 16*(2), 361-375.

Kendall, G. & Wickham, G. (1999). *Using Foucault's Methods*. London: Sage.

Kimsma, G. K. & Van Leewen, E. (2005). The Human Body as Field of Conflict Between Discourses. *Theoretical Medicine and Bioethics, 26*, 559-574.

Koch, T. (2006). Bioethics as Ideology: Conditional and Unconditional Values. *Journal of Medicine and Philosophy, 31*(3), 251-267.

Kottow, M. H. (1995). Developing Countries: Whose Views? *Journal of Medical Ethics, 21*(1), 56.

Kottow, M. H. (2004). Estrategias para justificar el doble estándar [Strategies to Justify a Double Standard]. In M. L. Pfeiffer (Ed.), *Bioética ¿Estrategia de dominación para América Latina?* Mar del Plata: Ediciones Suárez.

Kottow, M. H. (2005). Bioética y biopolítica [Bioethics and Biopolitics]. *Revista Brasileira de Bioética, 1*(2), 110-121.

Kottow, M. H. (2009). Bioética empírica. Una mirada crítica [Empirical Bioethics. A Critical View]. *Revista Latinoamericana de Bioética, 9*(1), edición 16, 64-69.

Kuhse, H. (2006). Why Killing Is not Always Worse -and Sometimes Better than Letting Die? In H. Kuhse & P. Singer (Eds.). *Bioethics: An Anthology* (2nd ed., pp. 297 - 300). Oxford: Blackwell.

Kuhse, H. & Singer, P. (2006). *Bioethics: An Anthology* (2nd ed.). Oxford: Blackwell.

León, A. (1978) Medical Ethics, History of: Latin America in the Twentieth Century. In Reich, W.T. *Encyclopaedia of Bioethics* (pp. 1005-1007). New York: Free Press

León, F. J. (2009). Fundamentos y principios de bioetica clinica, institucional y social [Foundations and Principles of Clinical, Institutional and Social Bioethics]. *Acta Bioethica, 15*(1), 70-78.

Lerner, M. (1975, 18 June). Disputa sobre la inmoralidad profesional [Dispute on Professional Inmorality], *El Tiempo,* p. 5A.

Lértora, C. (2008). Filosofía Latinoamericana [Latin American Philosophy]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 5-8). Bogotá: UNESCO, Universidad Nacional de Colombia.

Lindemann, J. E. & Nelson, H. L. (1999). *Meaning and Medicine: A Reader in the Philosophy of Health Care*. London: Routledge.

Litewka, S. G. (2010). Calidad, sistema de salud y governanza. El caso argentino [Quality, Health System and Governance. The Argentinean Case]. *Acta Bioethica, 16*(2), 148-154.

Lolas, F. (2004). Impressions on Bioethics in Latin America. *Revista Latinoamericana de Bioética, 6*, 14-31.

Lolas, F. (2005a). Presentación [Presentation]. *Acta Bioethica, 11*(1), 7-9.

Lolas, F. (2005b). Rehistoriar la bioética en Latinoamérica, la contribución de James Drane [Remaking Bioethics' History in Latin America, the James Drane's Contribution]. *Acta Bioethica, 11*(2), 161-167.

Lolas, F. (2006). Bioethics at the Pan American Health Organisation. Origins, Development, and Challenges. *Acta Bioethica, 12*(1), 113-119.

Lolas, F. (2008a). Bioética: un discurso intersticial [Bioethics: An Interstitial Discourse]. *Acta Bioethica 14*(2), 133.

Lolas, F. (2008b). Fritz Jahr, el "imperativo bioetico" y el origen de la palabra "bioetica" [Fritz Jahr, the "Bioethics Imperative" and the Origin of the Word "Bioethics"] *Bioetica Informa* XIII, 45, abril, pp. 3.

Lolas, F. (2009). Quo Vadis Bioética? *Acta Bioethica, 15*(1), 7-9.

Lolas, F. (2010a). Acta Bioethica: Una década de historia [Acta Bioethica: A Decade of History]. *Acta Bioethica, 16*(2), 115-118.

Lolas, F. (2010b). The Pan American Health Organisation and Latin American Bioethics. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. 55-60). Dordrecht; London: Springer.

Londoño, J. L. & Frenk, J. (1997). Structured Pluralism: Towards an Innovative Model for Health System Reform in Latin America. *Health Policy, 41*, 1-36.

López, M. A. (2003). Demandas a profesionales de la salud [Lawsuits Against Healthcare Professionals]. *Médico-Legal, 9*(1), 30-35.

Lozano, G. (1989). Comentarios generales sobre ética médica [General Comments About Medical Ethics]. *Acta Médica Colombiana, 14*(2), 87-91.

Luna, F. & Macklin, R. (1996) Bioethics in Argentina: A Country Report. *Bioethics*, *10*(2), 140-153

Luna, F. (2007). Bioethics in the Developing World. National Responsibilities and International Collaboration. In B. Steinbock (Ed.), *The Oxford Handbook of Bioethics.* (pp. 285-296). New York: Oxford University Press.

Lupton, D. (2003). *Medicine as Culture: Illness, Disease and the Body in Western Societies*. London: SAGE.

Lysaught, M. T. (2009). Docile Bodies: Transnational Research Ethics as Biopolitics. *Journal of Medicine and Philosophy, 34*(4), 384-408.

Llano, A. (1988). In Colombia, Dealing With Death and Technology. *The Hastings Center Report, 18*(4), 23-24.

Llano, A. (1990). Human Dying Has Changed. *Bulletin of Pan American Health Organisation, 24*(4), 446-453.

Llano, A. (1993, 12 September). ¿Qué es bioética? [What Is Bioethics?], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Llano, A. (1996, 25 August). La revolución bioética en el mundo [The Bioethical Revolution in the World], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Llano, A. (1997a, 8 June). Doctor, déjeme morir [Doctor, Let Me Die], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Llano, A. (1997b, 25 May). ¡Inaudito! [Outrageous!], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Llano, A. (1998). Presentación In A. Llano (Ed.), *II Congreso de bioética de America Latina y el Caribe.* Memorias *[II Bioethics Congress of Latin America and the Caribbean.* Proceedings*]* (pp. ix-xiii). Bogotá: Javeriana.

Llano, A. (2002). Apuntes para una historia de la bioética [Notes for a History of Bioethics]. *Selecciones de Bioética,* 1, 8-21.

Llano, A. (2004, 15 November). La bioética prosigue su marcha [Bioethics Goes On], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Llano, A. (2010). Bioethics in Latin America and Colombia. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. 43-53). Dordrecht; London: Springer.

M.P.S., Ministerio de la Protección Social & U.N., Universidad Nacional de Colombia. (2007). *Implicaciones éticas, jurídicas y médicas de la Sentencia C-355 de la Corte Constitucional. Un avance para el ejercicio de los derechos humanos, sexuales y reproductivos de las colombianas [Ethical, Legal, and Medical Implications of the Constitutional Court's Decision C-355. A Step Forward Towards the Exercise of Human, Sexual, and Reproductive Rights]*. Bogotá: Convenio 405 de 2006 Ministerio de la Protección Social & Universidad Nacional de Colombia.

Macey, D. (1993) The Lives of Michel Foucault. London: Hutchinson

Macklin, R. (2003). Dignity Is a Useless Concept. *British Medical Journal, 327*(7429), 1419-1420.

Macklin, R. (2006). The New Conservatives in Bioethics: Who Are They and What do They Seek? *The Hastings Center Report, 36*(1), 34-43.

Macklin, R. & Luna, F. (1996). Bioethics in Argentina: A Country Report. *Bioethics, 10*(2), 140-153.

Maehle, A. H. & Geyer-Kordesch, J. (Eds.) (2002). *Historical and Philosophical Perspectives on Biomedical Ethics: From Paternalism to Autonomy?* Burlington, VT: Ashgate.

Mainetti, J. A. (1990). *Bioética fundamental. La crisis bio-ética [Fundamental Bioethics. The Bio-Ethical Crisis]*. La Plata, Arg.: Quirón.

Mainetti, J. A. (1996). In Search of Bioethics: A Personal Postscript. *Journal of Medicine and Philosophy*, *21*(6), 671-679.

Mainetti, J. A. (2009). The Discourses of Bioethics in Latin America. In R. Baker & L. B. McCullough (Eds.), *The Cambridge World History of Medical Ethics* (pp. 501-504). Cambridge: Cambridge University Press.

Maldonado, C. E. (2005). Acerca del estatuto epistemológico de la bioética [On the Epistemological Status of Bioethics] *Derecho y Vida. Ius et Vita*, Vol 52, 53, pp. 1-4. Retrieved from www.carlosmaldonado.org/publicaciones, accessed 12 Oct 11 2011.

Manrique, J. I. (2000). Aspectos característicos de responsabilidad médico-legal. Revisión de 100 casos. Junio 1999 - Julio 2000 [Characterisation of Medical Liability. Review of 100 cases. June 1999 - July 2000]. *Médico-Legal*, 22-47.

Manrique, J. E. (2008). Profesionales de la salud en el contexto de la seguridad social y la responsabilidad médica [Healthcare Professionals in the Context of Social Security and Medical Liability]. *Médico-Legal, 14*(1), 28-35.

Marcum, J. A. (2008). *An Introductory Philosophy of Medicine*. Dordrecht: Springer.

Marston, A. & Ospina, J. (2004). British-Colombian Health Care Mission. Final Report. Bogotá: ASCOFAME.

Martínez, O. (2007). El modelo de investigación en bioética [Research Model in Bioethics]. *Acta Bioethica, 13*(1), 127-128.

Marx, K & Engels, F. (2008). *The Communist Manifesto*. London, UK: Pluto Press.

McCormick, R. (1999). Bioethics, A Moral Vacuum. *America, 180,* 21-25.

McCullough, L. B. (2011). Was Bioethics Founded on Historical and Conceptual Mistakes about Medical Paternalism? *Bioethics, 25*(2), 66-74.

McGowen, R. (1994). Power and Humanity, or Foucault Among the Historians. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine, and the Body* (pp. 91-112). London: Routledge.

Meerabeau, L. (2006). Mulcahy, L. Disputing doctors: the socio-legal dynamics of complaints about medical care. Review. *Sociology of Health & Illness, 28*(1), 129-130.

Mejía, A. (ND, 18 March 2010). Colombia: A Country Trapped under its Institutions. Colombian Constitution as an Obstacle for Development. Retrieved from www.freetheworld.com/papers/Andres_Vergnaud.pdf, accessed 20 November 2010.

Mendoza, J. (2005, 12 February). Vivir: obligación o derecho [Living: A Duty or A Right], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Mendoza, J. (2006). Caminos de la bioética en Colombia [Bioethics Paths in Colombia]. *Revista Latinoamericana de Bioética, 6*(11), July, 30-45.

Merchán, J. (2006). Eutanasia activa vs. suicidio asistido ¡No son lo mismo! [Active Euthanasia vs. Assisted Suicide. They Are not the Same!] *Médico-Legal, 12*(2), 26 - 29.

Merchán, J. (2008). La eutanasia no es un acto médico [Euthanasia is not part of Medical Practice]. *Persona y Bioética, 12*(1), 42 - 52.

Michalowski, S. (2009). Legalising Active Voluntary Euthanasia through the Courts: Some Lessons from Colombia. *Medical Law Review, 17*(2), 183 - 218.

Miller, P. & Rose, N. S. (2008). *Governing the Present: Administering Economic, Social and Personal Life*. Cambridge: Polity.

Miranda, N. (1993). La medicina colombiana de 1867 and 1946 [The Colombian Medicine from 1867 to 1946]. In N. Miranda; E. Quevedo & M. Hernández (Eds.), *Medicina, 2. La institucionalización de la medicina en Colombia [Medicine, 2. The Institutionalisation of Medicine in Colombia]*. Bogotá: Colciencias.

Moanack, G. (1983, 21 March). No a nuevas escuelas [No to New Schools], *El Tiempo*, p. 8A.

Moanack, G. (1991, 15 September). El Derecho a Morir [The Right to Die], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Moloney, A. (2009). Unsafe Abortions Common in Colombia despite Law Change. *Lancet 373*, 534.

Mora, N. (1976, 23 August). Responsabilidad de clínicas y médicos [Accountability of Clinics and Doctors], *El Tiempo,* p. 5A.

Morales, R. (1996). El médico en la mira de las denuncias temerarias [Doctors, Cornered by Reckless Lawsuits]. *Médico-Legal, 2*(2), 68-71.

Moran, J. (2002) *Interdisciplinarity*. London: Routledge

Morey, M. (1983) Lectura de Foucault [Reading Foucault]. Madrid: Taurus

Morreim, E. H. (1995). *Balancing Act. The New Medical Ethics of the New Medicine's Economics*. Washington, D.C.: Georgetown Universtiy Press.

Morreim, E. H. (2001). *Holding Health Care Accountable: Law and the New Medical Marketplace*. Oxford: Oxford University Press.

Morris, E. (2004). The Self I will Never Know: Esther Morris, Born with an Intersex Condition, Writes About the Scandal of 'Corrective Surgery' Whereby Thousands of Children Are Mutilated Without Consent. *New Internationalist*. Retrieved from http://www.articlearchives.com/medicine-health/medical-treatments-procedures/1530620-1.html, accessed 1 July 2009.

Moyano, J. & Zambrano, S. (2008). Ten Years Later, Colombia is still Confused about Euthanasia. *British Medical Journal,* (18 January). Retrieved from http://www.bmj.com/content/314/7098/1849.9/reply, accessed 20 November 2010.

Murillo, G. & Gómez, V. (2005). Institutions and Citizens in Colombia: The Changing Nature of a Difficult Relationship. *Social Forces*. Retrieved from https://muse.jhu.edu/journals/social_forces/v084/84.1murillo-castano.pdf, accesssed 10 September 2011.

Nadesan, M. H. (2008). *Governmentality, Biopower, and Everyday Life*. London: Routledge.

Neira, H. (2008). América Latina y Bioética [Latin America and Bioethics]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 156-159). Bogotá: UNESCO, Universidad Nacional de Colombia.

Nelson, J. L. (1998). The Silence of Bioethicists. Ethical and Political Aspects of Managing Gender Dysphoria. *Journal of Lesbian and Gay Studies, 4*(2), 213-230.

Nesbitt, W. (2006). Is Killing no Worse than Letting Die? In H. Kuhse & P. Singer (Eds.), *Bioethics: An Anthology* (pp. 292-296). Oxford: Blackwell.

Nieto, L. (1995, 9 July ). Está cerca la deshumanización [Dehumanisation is Coming], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Nieto, G. I. (1998, 15 December). Tiempo de vivir [Time to Live], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Ogilvie, A. D. (1997). Colombia Is Confused over Legalisation of Euthanasia. *BMJ, 314*(7098), 1849.

Olavarría, M. (2005). Acceso a la salud en Chile [Access to Healthcare in Chile] *Acta Bioethica 11*(1), 47-64.

Olweny, C. (1994). Bioethics in Developing Countries: Ethics of Scarcity and Sacrifice. *Journal of Medical Ethics, 20*(3), 169-174.

Osorio, N. (2008). De la pro-vocación bioética a la provocación biopolítica [From a Bioethical Pro-Vocation to a Biopolitical Provocation]. In N. Osorio García (Ed.), *Estrategias para enfrentar el desafío planetario* [Stragegies to Face the Planetary Challegne] (pp. 106-116). Bogotá: Universidad Militar.

Otero, E. (1994). El médico general: presente y futuro [The GP: Present and Future]. *Acta Médica Colombiana, 13*(6).

Otero, E. (1995). *La autonomía del médico [Medical Autonomy]*. Paper presented at the Foro nacional del Consejo Superior de Instituciones Médicas, Cartagena de Indias.

Otero, E. (2003). 130 años. Presencia de la academia [130 Years. Presence of the Academy]. *Medicina, 25*, 2 (62), 81-82.

Otero Ruiz, Efraím. (2004). Palabras del Dr. Efraím Otero Ruiz, presidente del Tribunal Nacional de Ética Médica, durante la celebración de los diez años del Tribunal de Ética Médica de Risaralda y Quindío [Speech of Dr. Efraím Otero Ruiz, President of the National Court of Medical Ethics, During the 10th Anniversary of the Court of Medical Ethics of Risaralda and Quindío]. *Gaceta del Tribunal Nacional de Ética Médica, 8*(1), 7-11.

Ozar, D. (2001). Malpractice and the presupositions of medical practice. In H. Teff (Ed.), *Medical Practice and Malpractice*. Aldershot: Ashgate.

PAHO. (1990). Special Issue on Bioethics. *Bulletin of the Pan American Health Organisation, 24*(4).

Patiño, J. F. (1993). Ética, moral y deontología en la práctica médica [Ethics, Morality, and Deontology in Medical Practice]. *Tribuna Médica, 87*(5), 199-200.

Patiño, J. F. (1998) Discurso de posesión del Académico José Félix Patiño como Presidente de la Academia Nacional de Medicina [José Félix Patiño's speech as President of the National Academy of Medicine]. *Revista Colombiana de Cirugía*, 13, 61 – 64.

Patiño, J. F. (2001). La desprofesionalización de la medicina en Colombia [The Deprofessinalization of Medicine in Colombia]. *Acta Médica Colombiana, 26*(2).

Patiño, J. F. (2002). La ética en la atención médica [Ethics in Medical Attention]. *Persona y Bioética, 6*(17), 6-11.

Paz, G. (1955). *Deontología médica general [Medical Deontology]*. Popayán: NI.

PBUEB, Programa de Bioética de la Universidad El Bosque & Escobar, J. (2002). *Historia de la Bioética en Colombia [History of Bioethics in Colombia]*. Bogotá: Universidad El Bosque.

PC. (1991). *Constitución Política de Colombia de 1991 [Political Constitution of 1991]*.

Pellegrino, E. D. (1998). What the Philosophy of Medicine Is. *Theoretical Medicine and Bioethics, 19*(4), 315-336.

Pellegrino, E. D. (1999). The Goals and Ends of Medicine: How Are They to Be Defined? In M. J. Hanson & D. Callahan (Eds.), *The Goals of Medicine: The Forgotten Issues in Health Care Reform* (pp. 55-68). Washington, D.C.: Georgetown University Press.

Pellegrino, E. D. & Thomasma, D. C. (1981). *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*. New York: Oxford University Press.

Peña, L. G. (1995). La conciencia del riesgo de responsabilidad médico-legal [The Conscience of Risk in Medical Liability]. *Médico-Legal 1*(1), 29-31.

Peña, L. G. (1997). Cómo exonerarse de responsabilidad [How to Avoid Medical Liability]. *Médico-Legal 3*(2), 45-47.

Pernick, M. S. (2009). Bioethics and History. In R. Baker & L. B. McCullough (Eds.), *The Cambridge World History of Medical Ethics* (pp. 16-20). Cambridge: Cambridge University Press.

Pessini, L. (2008). Bioética na America-Latina: Algumas questioes desafiantes para o presente e futuro [Bioethics in Latin America: Challenges for the Present and Future]. In L. Schmidt H (Ed.), *Datos históricos de la bioética en Latinoamérica [Historical Data About Bioethics in Latin America]* (pp. 49-58). Venezuela: San Pablo.

Pessini, L. & de Barchifontaine, C. de P. (2010). Introduction. In L. Pessini; C. d. P. de Barchifontaine & F. Lolas (Eds.), *Ibero-American Bioethics: History and Perspectives* (pp. xvii-xx). Dordrecht; London: Springer.

Posada, E. (2011, 7 July). Una pobre defensa de la constitución [A Poor Defense of the Constitution], *El Tiempo*. Retrieved from http://www.eltiempo.com/archivo/documento/CMS-9833830, accessed 25 July 2011.

Poster, M. (1984) *Foucault, Marxism and History: Mode of Production versus Mode of Information*. Cambridge: Polity Press

Potter, V.R. (1970) Bioethics: the Science of survival. Perspectives in Biology and Medicine, *14*, autumn, 127-153

Potter, V. R. (1971). *Bioethics: Bridge to the Future*. Englewood Cliffs: Prentice-Hall.

Potter, V. R. (1988). *Global Bioethics: Building on the Leopold Legacy*. East Lansing, Mich.: Michigan State University Press.

Prada, E., Singh, S., Remez, L. & Villarreal, C. (2011). Unintended Pregnancy and Induced Abortion in Colombia. Causes and Consequences. Bogotá: Guttmacher Institute, Fundación Oriéntáme.

Purtilo, R. (2004). Professional-Patient Relationship. In S. G. Post (Ed.), *Encyclopedia of Bioethics* (3rd edition ed., pp. 2132-2158). New York: Macmillan.

Pyrrho, M., Cornelli, G. & Garrafa, V. (2009). Dignidad Humana. Reconocimiento y operacionalización del concepto [Human Dignity. Acknowledging the **C**oncept and its Operationalization]. *Acta Bioethica 15*(1), 65-69.

Quevedo, E., Hernández, M. & Miranda, N. (1993). Ciencias médicas, estado y salud en Colombia: 1886 – 1957. Difusión de la medicina europea y norteamericana a Colombia y su influencia en las políticas de salud y de formación de personal de salud [Dissemination of the European and North American Medicine in Colombia and their Influence in Health Policies as well as Personnel Training] In N. Miranda, E. Quevedo & M. Hernández (Eds.), *Medicina, 2. La institucionalización de la medicina en Colombia [Medicine, 2. The Institutionalisation of Medicine in Colombia]* (Vol. VIII). Bogotá: Colciencias.

Rachels, J. (2006). Active and Passive Euthanasia. In H. Kuhse & P. Singer (Eds.), *Bioethics: An Anthology* (2nd ed., pp. 288-291). Oxford: Blackwell.

Ramírez, J. M. (1995). La responsabilidad legal originada en la practica medica [Liability in Medical Practice]. *Médico-Legal, 1*(2), 29-33.

Rance, S. (2008). Aborto Inseguro. In J. C. Tealdi (Ed.), *Diccionario Latinoamericano de Bioética* (pp. 555 - 558). Bogotá: Universidad Nacional.

Rawlinson, M. C. (1987). Introduction. *Journal of Medicine and Philosophy, 12*(4), 309-310.

Redondo, H. & Guzmán, F. (2000). *La reforma de la salud y la seguridad social en Colombia. El desastre de un modelo económico [Healthcare and the Social Security Reform in Colombia. The Disaster of an Economic Model]*. Bogotá: Biblioteca Jurídica.

Reeve, C. D. (1992) Practices of Reason: Aristotle's Nichomachean Ethics. Oxford: Clarendon

Reich, W. T. (1996). Revisiting the Launching of the Kennedy Institute: Re-visioning the Origins of Bioethics. *Kennedy Institute of Ethics Journal, 6*(4), 323-327.

Relman, A. (1990). The new Medical-Industrial Complex. In P. Conrad & R. Kern (Eds.), *The Sociology of Health and Illness: Critical Perspectives* (3rd ed., pp. 209-217). New York: St. Martin's Press.

Revel, J. (2008). *Dictionnaire Foucault*. Paris: Ellipses Marketing.

Reverby, S. (2009) *Examining Tuskegee: The Infamous Syphilis Study and its Legacy*, Chapel Hill, NC: University of North Carolina Press

Riddle, J. M. (1997). *Eve's Herbs: A History of Contraception and Abortion in the West*. Cambridge, Mass.: Harvard University Press.

Ritchie, D. A., Shulman, H. C., Kirkendall, R. S. & Terry, L. B. (1991) Interviews as Historical Evidence: A Discussion of New Standards of Documentation and Access. *The History Teacher*, 24(2), February, pp. 223-238.

Rizo, C. A., Jadad, A. R. & Enkin, M. (2002). Doctors Should Be Good Companions for People. *BMJ, 325*(7366), 711.

Rizo, C. A., Jadad, A. R., Enkin, M., Parmar, M. S., Sotelo, J., Rosenbaum, G. S. Gorin, . . . Alison, T. (2002). What's Good Doctor and How do You Make One? *British Medical Journal, 325*(7366), 711-715.

Roa, R. A. & Bauer, C. (2009). Presentación de la palabra bioética, del imperativo bioético y de la noción de biopsicología por Fritz Jahr en 1929. [Introduction of the Word Bioethics, of the Bioethical Imperative and the Notion of Biopsychology by Fritz Jahr in 1929]. *Bioethikos, 3*(2), 158-170.

Robledo, J. E. (2011, 25 April). EPS ¿Salud o negocio? [Health-Promoting Entities, Health or Business?], *El Espectador*. Retrieved from www.elespectador.com, accessed 20 May 2011.

Rodríguez-Monguió, R. & Infante, A. (2004). Universal Health Care for Colombians 10 Years After Law 100: Challenges and Opportunities. *Health Policy, 68*, 129-142.

Rodríguez, C. E. (2006) Aportes a la evaluación de la reforma de la salud en Colombia [Contribution to the Assessment of the Colombian Healthcare Reform]. In Escobar, J. (Ed.) *Bioética, justicia y salud* [Bioethics, Justice and Health]. Colección Bios y Ethos, No. 25 (pp. 41-12). Bogotá: Universidad El Bosque

Rodríguez, E. (2005). Cultura ética e investigación en salud [Ethical Culture and Health Research]. *Acta Bioethica 11*(1), 11-21.

Rodríguez, E. (2009). Temas para una bioética latinoamericana [Themes for a Latin American Bioethics]. *Acta Bioethica, 15*(1), 87-93.

Rodríguez, E. (2010). Religion y bioética [Religion and Bioethics]. *Acta Bioethica, 16*(1), 7-8.

Rojas, M. C. (2004). *Bioética y derecho. Implicaciones jurídicas de la transexualidad [Bioethics and Law. Legal Implications of Transexualism]*. Monograph, Specialization in Bioethics, Universidad Javeriana, Bogotá.

Ronderos, M. T. (2009, 6 July). Lo mejor y lo más débil del sistema de salud colombiano [The Best and the Worst of the Colombian Healthcare System], *Semana.com*. Retrieved from http://www.semana.com/salud--seguridad-social/mejor-debil-del-sistema-salud-colombiano/125943-3.aspx, accessed 20 June 2010.

Rose, N. S. (1994). Medicine, History and the Present. In C. Jones & R. Porter (Eds.), *Reassessing Foucault: Power, Medicine, and the Body* (pp. 48-72). London: Routledge.

Rose, N. S. (1996). *Inventing Ourselves: Psychology, Power, and Personhood*. Cambridge: Cambridge University Press.

Rose, N. S. (1999). *Governing the Soul: the Shaping of the Private Self* (2nd ed. ed.). London: Free Association Books.

Rose, N. S. (2007). *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century*. Princeton, NJ: Princeton University Press.

Rosselli, H. (1960, 21 August). Papel de los médicos en la independencia colombiana [The Role of Doctors in the Colombian Inependence War], *El Tiempo*, pp. Lecturas Dominicales, pag. 1.

Rosselli, D. (2006, 5 April). No más ética médica [No More Medical Ethics], *El Tiempo, Portafolio*. Retrieved from http://www.portafolio.com.co/hist_imp/porta_secc/porta_opin/2006-0..., accessed 20 April 2006.

Rosselli, D. & Guzmán, F. (1997, 21 July). Deterioro progresivo [Progressive Deterioration], *El Tiempo*. Retrieved from www.eltiempo.com/archivo.

Rothman, B. K. (1997). Redefining Abortion. In H. LaFollette (Ed.), *Ethics in Practice. An Anthology* (pp. 103 - 112). Cambridge, Mass.: Blackwell.

Rothman, D. J. (1991). *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*. New York, NY: BasicBooks.

Rubiano, L. (2010). *Una experiencia didáctica sobre la enseñanza de la bioética en programas de educación superior [A Learning Experience about Teaching Bioethics in University's Academic Programs]*. MA in Education, Universidad Tecnológica de Pereira. Retrieved from http://recursosbiblioteca.utp.edu.co/tesisdigitales/texto/174957R896.pdf, accessed 25 July 2011.

Rubio, I. (1995, 29 Jun). La guerra del centavo [The War of Pennies], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Ruiz, F., Matallana, M. A., Moore, F., Felknor, S., Cañón, H. M., Cortés, R., . . . Pardo, J. (2001). Análisis calidad de recursos humanos [Analysis of Human Resources] *Documento técnico ASS/848.01*. Bogotá: CENDEX - Universidad Javeriana.

Russo, G. (1994). Mala praxis medica. La nueva industria del juicio [Medical Malpractice. The New Industry of Lawsuits]. *Fundación Médica Jurídica*, 4-6. Retrieved from www.fundacionmedica.org.ar, accessed 22 August 2011.

Saada, A. (2008). Prólogo [Foreword]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dicctionary of Bioethics]* (pp. xix-xxii). Bogotá: UNESCO, Universidad Nacional de Colombia.

Salas, R. (2008). Pensamiento Crítico Latinoamericano [Critical Latin American Thought]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 3-5). Bogotá: UNESCO, Universidad Nacional de Colombia.

Salles, A. L. & Bertomeu, M. J. (2002) *Bioethics. Latin American Perspectives*. Amsterdam: Rodopi

Sánchez, F. (1981, 28 June). Educación Médica en Colombia [Medical Education in Colombia], p. 5A.

Sánchez, F. (1990a). Background and Current Status of Bioethics in Colombia. *Bulletin of Pan American Health Organisation, 24*(4), 510-514.

Sánchez, F. (1990b, 13 November). Responsabilidad médica. Un fallo saludable [Medical Liability. A Right Legal Decision], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Sánchez, F. (1993, 17 March). La ley de ética médica [The Law of Medical Ethics], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Sánchez, F. (1996, 1 October). Autonomía y beneficencia [Autonomy and Beneficence], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Sánchez, F. (1997a, 8 August). Un ejercicio defensivo [A Defensive Practice], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Sánchez, F. (2001, 11 February). Dilema médico [Medical Dilemma], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Sánchez, F. (2002). Recomendación para la atención ético-médica del paciente terminal [Recomendations to Ethico-Medical Attention of Terminally-ill Patients]. *Medicina, 24*(2), 87 - 90.

Sánchez, F. (2005, 21 February ). De nuevo, la eutanasia [Euthanasia, Again], *El Tiempo*. Retrieved from ElTiempo.com/Archivo, accessed 31 August 2009

Sánchez, F. (2006). Bioética Médica o Sanitaria [Medical or Sanitary Bioethics] *Medicina, 28*(4), 180 - 183.

Sánchez, F. (2008). *Desarrollo de la bioética en Colombia [Development of Bioethics in Colombia]*. Paper presented at the Taller de Bioética [Workshop on Bioethics], Universidad Javeriana, Bogotá.

Sánchez, F. (2010). *Normas bioéticas y disciplinarias para el ejercicio profesional de la medicina [Bioethical and Disciplinary Rules for a Professional Exercise of Medicine]*. Second draft to be internally discussed in the ICEB, Academia Nacional de Medicina. Bogotá.

Sánchez, F. (Ed.). (1997b). *La eutanasia en Colombia [Euthanasia in Colombia]*. Bogotá: Academia Nacional de Medicina, ICEB.

Santos, M. (1998). La bioética y el catecismo de la Iglesia Católica [Bioethics and the Cathecism of the Catholic Church]. *Persona y Bioética, 2*.

Sarmiento, M. G. (1994, 2 October). Beneficio para la profesion y el paciente [A Benefit for the Profession and Patient], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Scott, C. E. (2009). Foucault, Genealogy, Ethics. *Journal of Medicine and Philosophy, 34*(4), 350-367.

Scott, J. (2001). *Power*. Cambridge: Polity.

Schmidt, L. & Cecchetto, S. (2008). Introducción [Introduction]. In L. Schmidt H & S. Cecchetto (Eds.), *El por-venir bioético y biopolítico [The Bioethical and Biopolitical Time-to-Come]* (pp. 13-23). Venezuela: San Pablo.

Schmidt, L. (2008). *Bioética y sus Hitos en la Historia [Bioethics and its Hits in History]* (1a ed.). Venezuela: San Pablo.

Schmidt, L. & Garzón, F. (2006). Bioethics: A 35 year Old History. *Revista Latinoamericana de Bioética, 11*(July), 46-75.

Schmidt, L., Mainetti, J. A., León, F. J. & Pessini, L. (2008). *Datos históricos de la bioética en Latinoamérica [Historical Data about Bioethics in Latin America]*. Venezuela: San Pablo.

Semana. (2001). Las 100 empresas más grandes de Colombia [The 100 Biggest Colombian Companies]. *Semana, 988,* 98-107.

Serrano, D. & Linares, A. M. (1990). Ethical Principles of Biomedical Research on Human Subjects: Their Application and Limitations in Latin America and the Caribbean. *Bulletin of Pan American Health Organisation, 24*(4), 469-479.

Shelley, M. W. (1993). *Frankenstein, or The Modern Prometheus*. London William Pickering.

Singh, S. (2006). Hospital Admissions Resulting from Unsafe Abortion: Estimates from 13 Developing Countries. *Lancet, 368*(9550), 1887-1892.

Socarrás, J. F. (1991, 30 October). La ética médica [Medical Ethics], *El Tiempo*. Retrieved from www.eltiempo.com/archivo

Solinger, R. (1998). *Abortion Wars: A Half Century of Struggle, 1950-2000*. Berkeley, Calif.: University of California Press.

Solórzano, C. R. (1999). La eutanasia a la luz de la constitución política vigente [Euthanasia under the Political Constitutuion]. *Médico-Legal, 5*(2), 57 - 64.

Soper, K. (1986). *Humanism and Anti-Humanism*. London: Hutchinson.

Starr, P. (1982). *The Social Transformation of American Medicine*. New York: Basic Books.

Stempsey, W. (2005). The Philosophy of Medicine: Development of a Discipline. *Medicine, Health Care and Philosophy, 7*(3), 243-251.

Stempsey, W. (2008). Philosophy of Medicine Is What Philosophers of Medicine Do. *Perspectives in Biology and Medicine, 51*(3), 379-391.

Stevens, M. (2000). *Bioethics in America: Origins and Cultural Politics*. Baltimore, MD: Johns Hopkins University Press.

Suárez, F. (2007). ¿Dónde esta la bioetica? [Where is Bioethics?]. *Anamnesis. Boletín de Bioética Clínica y Filosofía de la Medicina, 1*, 9-10.

Suárez, F. (2008, 8-10 September). *Asistencia hospitalaria vs. investigación clínica. El paciente como sujeto de investigación [Healthcare vs. Clinical Research. The Patient as a Research Subject]*. Paper presented at the Congreso Internacional de Bioética, Bogotá.

Suárez, F. & Díaz Amado, E. (2005). La formación ética de los estudiantes de medicina: la brecha entre el currículo formal y el currículo oculto [Ethical Training for Medical Students: The Gap Between the Formal Curriculum and Hidden Hurriculum]. *Acta Bioethica, 13*(1), 107-113.

Tealdi, J. C. (2008a). América Latina. Pensamiento Latinoamericano [Latin America. Latin American Thought]. In J. C. Tealdi (Ed.), *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (pp. 1-2). Bogotá: UNESCO, Universidad Nacional de Colombia.

Tealdi, J. C. (2008b). *Diccionario latinoamericano de bioética [Latin American Dictionary of Bioethics]* (1a ed.). Bogotá: UNESCO, Universidad Nacional de Colombia.

Tealdi, J. C. (2009). Colonialism, Imperialism, and the History of Latin American Medical Ethics. In R. Baker & L. B. McCullough (Eds.), *The Cambridge World History of Medical Ethics* (pp. 583-588). Cambridge: Cambridge University Press.

Teff, H. (Ed.). (2001). *Medical Practice and Malpractice*. Aldeshot: Ashgate.

Tribunal de Ética Médica de Bogotá. (2004). *Doctores: ¿por qué se quejan sus pacientes? [Doctors, Why do Your Patients Complain?]*. Bogotá: Tribunal de Ética Médica de Bogotá.

ten Have, H. (1997). From Synthesis and System to Morals and Procedure: The Development of Philosophy of Medicine. In R. A. Carson & C. R. Burn (Eds.), *Philosophy of Medicine and Bioethics: A Twenty-year Retrospective and Critical Appraisal* (pp. 105-123). Dordrecht: Kluwer Academic.

ten Have, Henk (2000). Bodies of Knowledge, Philosophical Anthropology, and Philosophy of Medicine. In H. T. Engelhardt (Ed.), *Philosophy and Medicine* (Vol. 64, pp. 19-36). Dordrecht: Kluwer Academic.

Timmermans, S. (2003). *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Healthcare / Stefan Timmermans and Marc Berg*. Philadelphia, PA: Temple University Press.

Toulmin, S. E. (1999). How Medicine Saved the Life of Ethics. In J. E. Lindemann & H. L. Nelson (Eds.), *Meaning and Medicine. A Reader in the Philosophy of Health Care* (pp. 121-132). New York: Routledge.

Towes, N. (2001). Merchants of Health and Consumer Culture in the United States, 1900 - 1940. *The Journal of American History, 88*(2), 519-547.

Trías, M. (1997, 25 May). Bienvenida la eutanasia [Welcome to Euthanasia], *El Tiempo*. Retrieved from www.eltiempo.com/archivo.

Turbay, C. (1974, 1 September). Medio país sin médico [Half a Country Without a Doctor], *El Tiempo,* p. 1. Retrieved from www.eltiempo.com/archivo.

Ulloa, A. & Barrantes, M. (2008). Bioética en Nicaragua [Bioethics in Nicaragua]. *Acta Bioethica 14*(2), 200-205.

Undurraga, V. & Cook, R. (2009). Constitutional Incorporation of International and Comparative Human Rights Law: The Colombian Constitutional Court Decision C-355/2006. In S. H. Williams (Ed.), *Constituing Equality, Gender Equality and Comparative Constitutional Law* (pp. 215-247). Cambridge, MA: Cambridge University Press.

Unschuld, P. (2009). *What Is Medicine? Western and Eastern Approaches to Healing* (K. Reimers, Trans.). Los Angeles, CA: University of California Press.

Uprimny, R. (2006). Entre el protagonismo, la precariedad y las amenazas: las paradojas de la judicatura [Between Protagonism, Precariousness, and Threats: The Paradoxes of the Judiciary]. In F. Leal Buitrago (Ed.), *En la encrucijada.Colombia en el siglo XXI [At the Ccrossroads. Colombia in the 21st Century]* (pp. 81-112). Bogotá: Universidad de Los Andes, Norma.

Uprimny, R. (2011, 4 July). La constitucion en perspectiva [The Constitution in Perspective], *El Espectador*. Retrieved from http://www.elespectador.com/impreso/opinion/columna-281910-constitucion-perspectiva-i, accessed 20 July 2011.

Uribe, G. (1955). Proemio [Foreword]. In G. Paz Otero (Ed.), *Deontología médica general [Medical Deontology]* (pp. 10-23). Popayan: NI.

van Der Burg, W. (1998). Law and Bioethics. In H. Kuhse & P. Singer (Eds.), *A Companion to Bioethics* (pp. 49-57). Malden, Mass.: Blackwell

Varga, A. (1988). *Bioética. Principales problemas* [Bioethics. Main Problems]. (A. Llano Escobar, Trans.). Bogotá: Ediciones Paulinas.

Vega, R. (1999). *Health Care and Social Justice Evaluation: A Critical and Pluralist Approach.* Thesis, PhD in Philosophy, University of Hull.

Vengoechea, J., Moreno, S. & Ruíz, A. (2008). Misconduct in Medical Students. *Developing World Bioethics, 8*(3), 219-225.

Verhey, A. (1996). *Religion and Medical Ethics: Looking Back, Looking Forward*. Grand Rapids, Mich: W.B. Eerdmans Pub. Co.

Waitzkin, H. (2011). International Trade Agreements. In H. Waitzkin (Ed.) *Medicine and Public Health at the End of Empire* (pp. 72-85) Boulder, Co.: Paradigm.

Waitzkin, H. & Jasso-Aguilar, R. (2011) Neoliberalism and Health. In H. Waitzkin (Ed.) *Medicine and Public Health at the End of Empire* (pp. 64-71) Boulder, Co.: Paradigm

Warren, M. A. (1997). *Moral Status: Obligations to Persons and other Living Things*. Oxford: Oxford University Press.

Watkins, S. (2004). Medicine and Government: Partnership Spurned? In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 37-50). Maidenhead: Open University Press.

West, M. (2002). How Can Good Performance among Doctors Be Maintained? *BMJ, 325*(7366), 669-670.

Wilson, D. (2011). Creating the 'Ethics Industry': Mary Warnock, In Vitro Fertilization and the History of Bioethics in Britain. *BioSocieties 6*(2), 121-141.

Williamson, J. (2004, 24-25 September). *A Short History of the Washington Consensus.* Paper presented at the conference: From the Washington Consensus towards a new Global Governance, Barcelona.

Women's Link Worldwide. (2007). *Excerpts of the Court's Ruling that Liberalized Abortion in Colombia*. Spain: VYB Editores.

Yam, E. A.; Dries-Daffner, I. & Garcia, S. G. (2006). Abortion Opinion Research in Latin America and the Caribbean: A Review of the Literature. *Studies in Family Planning, 37*(4), 225-240.

Yepes, G. (1995). Responsabilidad ético-disciplinaria [Ethical and Disciplinary Liability]. *Médico-Legal, 1*(2), 35-41.

Zamudio, L., Rubiano, N. & Wartenberg, L. (1999). The Incidence and Social and Demographic Characteristics of Abortion in Colombia. In A. I. Mundigo & C. Indriso (Eds.), *Abortion in the Developing World* (pp. 498p.). London: Zed.

Zea, J. M. (1997, 21 October). Homicidio piadoso frente a cuidados paliativos [Mercy Killing vs. Palliative Care], *El Tiempo*. Retrieved from www.eltiempo.com/archivo.

Zola, I. K. (1972). Medicine as an Institution of Social Control. *Sociological Review, 20*(4), 487-504.

Zwareva, E. C. (2010). Los comités de ética de investigación biomédica y psicosocial en Bolivia [Biomedical and Psychosocial Ethical Review Committees in Bolivia]. *Acta Bioethica, 16*(1), 87-91.