Frictionless Expectations: When Bioethics Travels to Serbia

Dragana Lassiter

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Approved By:

Dr. Margaret Wiener

Dr. Peter Redfield

Dr. Terence Evens

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Abstract

Dragana Lassiter: Frictionless Expectations: When Bioethics Travels to Serbia
(Under the direction of Margaret Wiener)

Over the last seven years, the European Union (EU) has promoted the institutionalization of bioethics in Serbia as part of EU citizenship. This paper looks at what it is about bioethics that makes it possible to take its universal application for granted and why are actors such as the Consul of Europe invested in transporting bioethics from their origins in the United States and Western Europe to Serbia. I start by examining discourse around institutionalized bioethics that makes transplanting of its ideas and practices appear unproblematic. Drawing on the concept of audit cultures and looking at bioethics as an audit mechanism, I show how promoting bioethics becomes an ethical end in itself. Finally, I consider how Westerners have historically construed Serbia as backwards, savage, and violent. I suggest that promoting bioethics as a condition of EU citizenship might be a means of making ethical subjects or of civilizing Serbia.

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Introduction

Over the last seven years, the European Union (EU) and the United Nations Educational Scientific and Cultural Organization (UNESCO) have been active in Serbia in promoting a set of ideas and practices in science and medicine known as bioethics. The United Nations and the Consul of Europe, an organization invested in fostering of democratic principles based on human rights among the EU member states, have undertaken a number of tasks. They have helped train a multidisciplinary group of scholars in bioethics, encouraged and funded the foundation of hospital ethics committees, organized conferences on bioethics, and assisted in the incorporation of bioethics into medical school curricula. Working with the University of Belgrade School of Medicine and the Serbian Ministry of Health, in 2008, these actors have assisted in establishing the Serbian Bioethics Committee. The committee was composed of an interdisciplinary group of Serbian scholars charged with deliberating and steering reflection and legislation on the effects of biotechnology upon all aspects of human life in Serbia. This new branch of expertise intended to replace the existing Serbian medical ethics with principles more attuned to issues of global health and transnational research.

In pressing Serbia to make changes to the way that science and medicine are practiced, to adapt an ethical framework for approaching issues in these two fields, and to change policy in order to standardize these practices, the Consul of Europe and UNESCO representatives have often linked bioethics to a process they call "democratization." In various documents I have reviewed, interviews given to local newspapers and conference presentations, actors involved refer to the UNESCO's Universal Declaration on Bioethics and Human Rights of 2005- a pledge to assist institutionalization of bioethics in countries undergoing democratization, linking bioethics to democracy through a discourse on human dignity and individual rights presumably neglected by the Communist regime. In the name of democracy, various organizations and the EU, along with bioethics, have been promoting economic decentralization and the movement of power and capital from the state to non-governmental and private actors.

Scholarly and legal discourse often portrays the process of translating the ideas and practices of bioethics as a simple transplantation of a universal called bioethics. Intrigued by the way people involved in the promotion of bioethics imagine its practices and ideas to travel, I interviewed a bioethics professor from the Philosophy Department at the University of Belgrade. My interlocutor was helpful but concerned about the topic of my research. Alluding to a number of scandals involving physicians who had accepted bribes from newly present international pharmaceutical companies to prescribe untested or unapproved medications, my interlocutor insisted that Serbs are "morally primitive." "There is no bioethics in Serbia," he said, "If you want to study bioethics, you should go to one of the Western countries." His comment illuminates how the Serbian transition to

democracy, which includes pressures to privatize and open its market to international pharmaceutical companies and which evokes the historical division between East and West Europe, is a fraught process. Moreover, his comment and the context discussed above raise several concerns that I will unravel in this paper. What is the abstract notion of bioethics that has come to inform the practices associated with new biotechnologies in Serbia, as well as to saturate professional and public discussions in medicine? How did the ideas and practices of bioethics come to be? What is it about bioethics as it developed in the country of its origin that makes it possible to take its universal application for granted? And importantly, why are actors such as the Consul of Europe invested in transporting them from their origins in the United States and Western Europe to Serbia? How did Serbia become a target of their investments? In this paper, I set up an interpretative framework for looking at these questions using existing scholarship.

I begin by looking at the history of bioethics as a discipline and a set of practices, and examine how it came to be linked to democratic states and a process called "democratization" through the discourse of rights. I show how we may apply insights from Science and Technology Studies (STS) scholarship to challenge the rights discourse and the link between bioethics and democracy. This insight shows how bioethics circumscribes ethics, and how bioethics is compatible with the view of scientific progress as an unquestionable good. STS scholarship can address the criticism that bioethics serves institutions and markets in which it is embedded (Petryna 2006; Churchill 1999; Farmer 2005; Scheper-Hughes 2005; Rose 2007). The modern ontology and the resulting separation of nature and culture, on which the STS analysis draws, however, is less

helpful for examining why the EU construes Serbia as in need of bioethics. To help explain why the EU is invested in making Serbia the new grounds for bioethics, I turn to Nikolas Rose's (1996; 2007) discussion of the new modes of governing that have become dominant in Western Europe and North America. Such modes of governing operate through the mechanisms of audits and standards. By treating bioethics as an audit mechanism, I show how promoting bioethics becomes an ethical end in itself. Finally, moved by the discussion of primitivism and moral hierarchy which my interlocutor evoked, I consider how Westerners have historically construed Serbia as backwards, savage, and violent. I suggest that promoting bioethics as a condition of EU citizenship might be a means of making ethical subjects or of civilizing Serbia.

The larger story that I hope to trace by engaging this scholarship is how bioethics as a presumed universal is imagined to be able to travel unimpeded and unchanged by the new context into which it is transported. I try to draw out what is particular about bioethics and Serbia as the new ground that enables such an imaginary. Drawing on Anna Tsing's (2004) work, I suggest that ethnographic research looking at bioethics in Serbia can show that the movement of ideas and practices across cultural and political boundaries does not proceed unimpeded by particular local historical conjectures.

Chapter 1

History

Bioethics is a branch of ethics. For the purpose of this paper, when I speak of ethics, I mean the responsibility and accountability of individuals and institutions for their own actions and for the world these actions produce. Bioethics emerged in the United States in 1960s as a social movement responding to a sense of change and anxiety over novel scientific interventions, a perceived dehumanization in medicine though the pervasiveness of new technologies, and the discovery of abusive research practices (Rosenberg 1999; Jonsen 1998; Rothman 2003).

In the 1960s, advances in diagnostic technology, reproductive and transplant technology, as well as a restructuring of hospitals in the United States prompted public criticism of deteriorating patient-physician relationships that increasingly were becoming mediated by impersonal machines (Jonsen 1998:11) and diagnostic technology that had become more valued than the patient's narration of illness (Rothman 2003:142). Medical technologies of the 1960s and 1970s undeniably shaped the emergence of bioethics by

bringing to public attention to debates over how to distribute the benefits of that technology and how to cope with their effects on the shifting boundaries of life and death. Dzur (2002) points out the significance of Shana Alexander's 1962 *Life* magazine article, "They Decide Who Lives, Who Dies," which described how Swedish Hospital in Seattle had developed criteria for allocating hemodialysis machines, a scare resource at the time. In 1974, Fox identified some of the emerging technologies implicated in the constitution of bioethics:

> "Actual and anticipated developments in genetic engineering and counseling, life support systems, birth technology, population control, the implantation of human, animal, and artificial organs, as well as in the modification and control of human thought and behavior are principal foci of concern. Within this framework, special attention is concentrated on the implications of amniocentesis (a procedure for detecting certain genetic disorders in utero), in vitro fertilization, the prospect of cloning (the asexual reproduction of an unlimited number of genetically identical individuals from a single parent), organ transplantation, the use of the artificial kidney machine, the development of an artificial heart, the modalities of the intensive care unit, the practice of psychosurgery, and the introduction of psychotropic drugs." (Fox 1976:230).

Technological advancements such as transplantation, reproductive technologies and hemodialysis spurred the creation of numerous national committees and legislation to grapple with issues such as when to turn off ventilators, how to distribute hemodialysis machines, and what kind of life should depend on hemodialysis machines, new pharmaceuticals, and exposure to invasive diagnostic technologies promote (Fox 1976:232). Some historians, such as Rothman (1999), argue that these technological developments arose in the context of an already deteriorated sense of intimacy in doctor-patient relationships, as medical training was re-oriented towards increasing

specialization (Rosenberg 1999:33). Medical advances, in this view, simply made manifest larger social issues. Others contend that technologies shaped social contexts and ethical sensibilities. Some scholars might argue (Jasanoff 2004, 2005; Franklin & Lock 2001) that the most appropriate perspective though which to view the emergence of bioethics and biomedical technology is the one of co-production in which biology and discourse emerge together (Franklin & Lock 2001; Lock 2002). Questions of life and particular ethical problems did not precede or follow the changes to bodies enabled by new medical technologies. New ethical concerns and a new biology developed together.

In 1966, Henry Beecher, a professor of anesthesiology at Harvard University published an article in the *New England Journal of Medicine* entitled "Ethics and Clinical Research." The article discusses some abusive practices in clinical research, such as the injection of seventeen senile hospital patients with cancerous cells in order to study immunological responses, or the insertion of catheters into the bladders of twenty four newborns followed by taking a series of x-rays in order to study the process of voiding (Rothman 2003:16). Unregulated experimentation on human beings was not a new practice, but the context had changed. Rothman argues that until World War II, medical research was almost always therapeutic in intent and executed on a small scale, as a "cottage industry" (1999:18), with a few physicians working on their own and carrying out experiments on themselves, their family members, and friends. In the 1960s, the horrors of large-scale Nazi experimentations during WWII loomed as a dangerous prospect in any larger scale research. Furthermore, a human rights movement was gaining strength in the later 1960s in response to the publication of abusive research practices and

the historical exploitation of minorities, mentally disabled, poor, and incarcerated subjects. The discovery of the Tuskegee study, in which hundreds of impoverished African Americans with syphilis were given a placebo instead of penicillin, was a galvanizing moment for the federal regulation of clinical research. These abusive research practices linked several studies to the discourse of rights (Rothman 2003:10; Jonsen 1998: xii), transferring discussion of research ethics from the intimacy of scientific institutions into media, political forums, and courtrooms.

The configuring of ethical issues in terms of patients' rights and of setting limits to experimentation in the name of science drew the attention of the US Congress, which started to call upon experts not directly engaged with biosciences, such as philosophers, ethicists, lawyers, and social scientists (Jonsen 1998: xii). Congress set up a National Commission to explore medical and research ethics. Federal regulations resulting from this commission limited the once considerable freedom of researchers (Rothman 2003:10). Investigating problems that arose from medical practice and clinical research, bioethical questions gathered together an interdisciplinary group of scholars teaching and researching ethics to serve on new bioethics committees set up nationwide in hospitals and research institutions or to work as consultants in clinical settings (Rosenberg 1999:39-40). In 1979, philosophers Tom Beauchamp and James Childress produced the first edition of *Principles of Biomedical Ethics*, a textbook charting theoretical ground for bioethics and marking in significant ways its formalization as a discipline.

Although its practitioners come from multiple disciplinary backgrounds, bioethical theory is strikingly uniform. It embraces a philosophical and legal perspective

grounded in abstract Western liberal principles of autonomy, privacy, benevolence, nonmaleficence, and social distribution of medical benefits and risks. Bioethics takes the presumed universal rights of the individual as its primary unit of analysis. These rights are balanced against the greater good of society. Treating morality as universal, this philosophical approach has been marked by the rationalization of ethical norms and prescriptive behaviors that define the standard for a good physician, including patient-physician relationship and truth telling. Bioethical principles are also supposed to guide how to protect human subjects in research, how to prioritize transplant organ recipients, and how aggressive life prolonging measures should be.

In the last three decades, bioethical principles have become embedded in technical literature, research protocols, and institutional review boards. From a once marginal social movement in the 1960's, bioethics has transformed into a bourgeoning body of professional expertise. In his account of biopower, Foucault (1990) addresses the constitution of modern states through increasing focus on the management of the biological existences of populations, which entails controlling the processes of reproduction, mortality, and life expectancy. In this view, the state's investment in promoting and legalizing bioethical principles can be viewed as an extension of biopower. More than simply being interested in "making live and letting die," the imperative Foucault (1990) ascribes to the modern state, sovereign power has become engaged in deciding how to achieve those goals ethically.

Now an established discipline with its own set of competencies, training practices, and textbooks, bioethics has become indispensible to the working of hospitals and

research centers in North America and Western Europe. Bioethicists are called to resolve ethical issues that arise in the delivery of healthcare. What this means in practice is they seem to ensure that sufficient information is provided to patients to enable them to make autonomous choices. The goal is to protect patients from becoming victims of patronizing decisions by their healthcare providers. Increasingly, bioethicists also serve as facilitators of public discussions involving controversies in science and medicine, such as the concern with human genome sequencing, as their expertise is solicited by the media and before congressional legislative committees (Churchill 1999:254). Both private and public funding for bioethics-related research abound (Churchill 1999:253). Biotech companies increasingly employ bioethicists as they try to present themselves as good citizens (Ecks 2008) to potential consumers. By setting aside five percent of its budget for the study of the ethical implications of genetic research in 1995, the National Human Genome Research Institute created the most extensive ongoing bioethics research project to date.

Chapter 2

Bioethics and Democracy

Not all scientific and medical institutions and pharmaceutical companies employ bioethicists. But those that do not, employ bioethical principles. Informed consent, a document exemplifying the bioethical principle of autonomy, has become a normative part of the clinical encounter for people undergoing any invasive medical procedure, taking part in clinical research, and donating body tissue. In recent years, use of such consent has been extended from medical practice and research, to be incorporated into regulations governing the protection of personal information and the use of human tissue and genetic information (Manson & O'Neill 2007). Informed consent takes as its fundamental principle respect for the autonomy of the individual human being to decide her own course of life. The right to choose is linked in bioethics literature to dignity and to the unique capacities of humans to reflect upon their own existence. Choice is thus perceived to be an expression of personhood.

The other side of the principle of autonomy is the demand that healthcare professionals and medical researchers, as administrators of informed consent, do not try to constrain anyone's pre-given right to choose a course of life. Informed consent, more

than any other bioethical imperative, elucidates the universal liberal notions of selfhood implicit in bioethics. The presumed universality of the autonomous and liberal individual coupled with the discourse of rights is how bioethics travels as a transnational imperative. This is evident in educational and legal documents such as UNESCO'S Universal Declaration on Bioethics and Human Rights, in professional literature, and in the "Bioethics and Genetic Research" conference presentations held in Serbia in 2010 and sponsored by The European Commission's Steering Committee for Bioethics. The UNESCO Declaration emphasizes such humanism in referring to the unique and universal human capacity for moral reflection and choice, and insists that the ethical issues arising from rapid advances in science "should be examined with the due respect to the dignity of the human person," (unesco. org).

Bioethics belongs to a group of disciplines loosely held under the name of medical humanism that are concerned with deepening and enriching the self-understanding and human perspective brought to bear when people confront new situations and choices (Belkin 2004:378). The humanization of medicine and science through bioethics, by ensuring that the unique human moral ability to reflect upon one's own experiences as just or unjust is given priority over the good inherent in scientific and medical goals, has developed through a discourse of rights. If humanization is an abstract goal of bioethics, rights are how that goal is achieved through particular forms of citizenship. The state needs to be accountable for its workings in order not to be paternalistic and make decisions for its citizens, undermining their right to choose. Thus the UNESCO Declaration reminds member states that their citizens have a right to preserve their human dignity. This discourse of rights also calls on the collective

responsibility to distribute benefits, such as the access to the life-prolonging medical technologies. In this metaphor, medical interventions concern both the individual body and the body politic.

As the news from Serbia indicates, there is an unexamined democratic value associated with bioethics, such that the United Nations and the Consul of Europe promote the bioethics as evidence of "democratization" and a condition of EU citizenship. The UNESCO Universal Declaration on Bioethics and Human Rights gives special attention to building capacities in developing countries to address ethical issues and preserve human dignity in the implementation of new medical technologies and human subject research. Jasanoff (2005) notes that in the last two decades bioethics has come to occupy a prominent position in national political discourse and has been implicated in projects of democracy building because of the tight relationship between the state and life sciences. People demand that states protect their citizens from potential abuses of medical technology. The birth of bioethics overlaps historically with states' interest in sponsoring biomedical advances at the same time as states faces the risk of offending religious sensibilities, violating racial and gender inequality (Jasanoff 2005:188). Foucault's (1990) concept of biopower addresses the close relationship between state and life sciences, as modern states rule by managing biological lives of its constituents. Both liberal and socialist regimes are modern in the Foucauldian sense, but socialist states do not merely regulate scientific research or medical practice. They also employee those same researchers and physicians and have a control over knowledge production in medicine and science. This has historically led to paternalism, whereby socialist states make decisions at their own discretion about the lives of their citizens undermining the

notion of a liberal individual that bioethical principles evoke. In order to be a new ground for bioethics, a socialist state must be accountable to the public. Demands for state accountability and transparency are linked to the origin of bioethics in the United States. Thus the Serbian state, emerging from communism, needs to be accountable to the Consul of Europe and United Nations in order to ensure transparency and the protection of human rights. As a feature of the "democratization" process, the EU expects the Serbian state to share its decision-making and economic power with the non-governmental and private sector, allowing for privatization of healthcare and the pharmaceutical industry.

Chapter 3

Science and Technology Studies Scholarship

Thus far I have examined the history of bioethics and its increasing entanglement with rights discourse. I have suggested this entanglement has led bioethics to be linked to democracy and thus "democratization" that requires the presence of bioethical practice. Yet, many have questioned this connection between democracy and bioethics, noting that bioethics can serve the interests of the very institutions from which it is supposed to protect people. (Petryna 2006; Churchill 1999; Farmer 2005; Scheper-Hughes 2005; Rose 2007). "Democratization" in Serbia embodies this contradiction precisely because it entails both instituting of bioethical practices and the opening of the market to transnational pharmaceutical companies. Many of these companies have exploited the economic insecurity of Serbian healthcare professionals in the interest of profit and competition through the use of incentives to institutions and individuals to test medications without patients' knowledge or consent or to administer therapy that had not been approved for that particular use. I turn now to scholars in Science and Technology Studies whose ontological turn might suggest what it is about bioethics that makes it at

once necessary in modern regimes and able to limit issues deemed worthy of ethical concerns (Belkin, 2004). Demonstrating how a discourse of rights and choice limits ethics in the countries where bioethics is fully developed, this scholarship challenges the assumed linkage between democracy and bioethics.

In *We Have Never Been Modern,* Latour (1993) denounces humanism as a universal concern by showing that humanism is ontologically contingent: "Modernity is often defined in terms of humanism, either as a way of saluting the birth of 'man' or as a way of announcing his death. But this habit is itself modern…" (Latour 1993:13). Thus the humanism on which theory of bioethics hinges, for Latour, is a result of the moderns' denial of the co-emergence of material and natural things with human and religious beings (things, humans and God) and their effort to purify the three spheres (things, humans and God) into either human or non-human. (Latour 1993:13). In practice, hybrids compromised of things, humans, and deities proliferate, but when moderns reflect on them, they purify them by presupposing that these three categories have immaculate boundaries. Considering things and people as belonging to different spheres of reality requires distinct epistemologies. Thus, for moderns, scientists deal with things and social scientists deal with people. Science and humanism belong to opposite poles of the modern ontology. Claims to knowing the world of the human cannot be reconciled with access to the world of material things: what is natural cannot be human.

In *The Politics of Nature*, Latour (2004) expands this argument through a critique of political ecology. While political ecology has a hybrid name and in practice mixes nature with politics, as a theory, it purifies these two spheres. This is due to the modern

tendency to separate facts (which speak for nature) from values (which reflect culturally-imbued morality and politics). "The tempting aspect of the distinction between facts and values lies in its seeming modesty, its innocence, even: scientists define facts, only facts; they leave to politicians and moralists the even more daunting task of defining values," (Latour 2004:95). The fact and value division is a symptom of the nature-culture division. Scientific facts reflect the state of nature, speak for the material and non-human, and are sometimes transcendent. Morality and politics, on the other pole of the nature-culture divide, the moderns treated as immanent.

Like the analysis of political ecology, a Latourian analysis of bioethics reveals that though it at first appears to be a hybrid, bioethics suits modern sensibilities because it thrives on the nature-culture divide called into question by scholars such as Latour (1993, 2004), Haraway (1991, 2007), and Stengers (2005). Bioethics places ethics in the realm of values, a human concern, and relegates fact-making to the sphere of the material, the concern of scientists. Instead of including the material and semiotic fact-making that science is engaged with, ethics in bioethics surfaces too late, as a humanistic endeavor which encourages reflection upon the "implications of science."

Annemarie Mol (2002) more explicitly addresses the fact and value division in the institutionalized performance of bioethics. Mol's (2002) analysis shows that the understanding of science and human values resulting from the fact and value division can be mobilized to serve the purpose of relentless scientific progress as an unquestionable social good. Mol (2002) calls the enfolding of ethical questions as matters of patient rights and patients choice the "*politics- of- who."* Ethicists and social scientists have

contributed to the configuring of moral issues in these terms because of their suspicion of the decisions made by healthcare professionals (2002:168). While the "*politics-of-who"* aims to protect patients from the interests of science and medicine, it inadvertently stabilizes the power of professionals by granting all the facts to them (Mol, 2002: 170). The "*politics-of-who"* hinges on the obligation of healthcare professionals to present information that is presumably true and neutral. In doing so it relegates concern with "technicalities" (Mol 2002:171) to scientists and healthcare professionals. Questions such as which facts might be pertinent to the diagnosis of a particular disease, what machines should be put to use, and how their used should be to paid for (Mol 2002:171) have escaped the "*politics-of-who*." Granting facts to the professionals obscures the "practicalities, power plays, traditions" which reveal the implicit values residing inside facts. (Mol 2002:171).

The distinction between fact and value informs the performance of bioethics in hospitals in the United States. In practice, bioethicists mitigate clinical problems by serving on committees or as consultants to hospital staff or administrators. For example, a bioethicist might be paged when a middle-aged woman refuses a life saving treatment. Emphasizing the principle of autonomy, bioethicists make sure that the woman is competent and has thought through the risks associated with her choice. Mediating between physicians and patients, the ethics committee member will present the medical facts to the woman. Bioethicist will explain, "if you refuse this treatment, you might die in the next month." In the face of these facts, the woman is given a choice. But inquiry into what to do will never lead behind the making of the facts presented. There will be no

discussion of biomedicine's historic tendency to align its goals with the natural characteristics of the body (Mol 2002:173) whereby improving physical health or legal responsibility trump all other concerns. There will also be no recognition of how institutional values and arrangements have stabilized the treatment as life saving, or of the practically contingent work of diagnosing, such as decisions over which tools to use to visualize a lesion.

Scientific truth falls outside the consideration of bioethics. It is a concern only when it touches the life of a "human subject." The ethical moment for bioethics is the moment in which scientific facts and personal histories meet in such a way to cause discomfort. It is a non-routine moment in which science cannot proceed as usual due to the capacity of human beings to reflect on their experiences. Ethics is invoked when the woman refuses treatment, not if, like majority of patients, she goes along with the doctor's recommendation. Issues arise when patients' morals do not align with objectives of science and medicine. Hence, standardized hospital practices do not require bioethics. Bioethicists are not called to the pathology lab where pathologists Monday through Friday make decisions on what constitutes a deadly lesion. This is a materially contingent practice that involves choices over what kind of machines to use. It may be difficult to line up the lesion of a particular patient with the picture of the standard lesion. Translations abound and are not always smooth. But bioethicists do not take this into consideration. They are only paged to come to a bedside or a conference room to discuss the implications of such non-negotiable facts (a deadly lesion) for a particular patient and her family. Bioethics thus circumscribes the space of ethics because it pre-determines the

moments of ethical concern and thus isolates when choice is made (Mol 2002:169): not in cancer clinical trials where five- year survival is taken as a fixed statistical variable and an unquestioned good, but in a patient's refusal to undergo chemotherapy.

Turning to a discussion of bioethics in research, Mol (2002) shows how clinical trials, the instrument of fact-making in medicine, require scientists to negotiate their design. Epidemiologists must choose a large enough population to sample, one with a lot of disease. They also have to establish a target population. But targets could be multiple. Besides medical information such as age and sex, researchers often use race and ethnicity when selecting target population. These are value-laden practices. Trials are translated into facts that determine the type of treatment to be used. If the population consists of women, being a woman might become a risk factor for a certain condition. Women could be getting annual screenings based on a perceived risk. Women become associated with their medical risks. But what is good for one population may confer little advantage to an individual and vice versa. The numbers that indicate success in population terms, such as a five- year survival rate, may not be indicators of success for an individual. The question of what kind of five years depends on the individual.

Scientist and physicians are well aware of these uneasy translations and the way they are laden with values. In clinical trials, cancer treatment protocols are standardized and do not include a patient's age. They are altered on the basis of someone's overall health. But there is an implicit urgency in treating younger people more aggressively. This often requires translating "overall health" into age. Doctors might also suggest a more aggressive treatment if the patient is a young mother. Mothers should be treated

more aggressively because they have children to raise. Decisions over how to achieve a longer life for a mother, given that the trials do not include mother as a category, are contingent. The value in taking a riskier approach when treating the mother of young children translates smoothly into the administration of chemotherapy. What kind of chemotherapy mothers get becomes a standard in the form of a hospital chemotherapy protocol that is presented as unproblematic. When bioethicists are called to the bedside to ensure that a young mother knows all of the potential consequences of her decision not to continue treatment, all of these contingencies and values are presented as non-negotiable facts. While in the hospital and in clinical trials the categories of "the individual" and "the population" are sometimes conflated and at other times elegantly differentiated or translated into one another, the principle of autonomy maintains that ethical decisions are only made when an individual chooses her own course of life.

An ontological approach to bioethics reveals that the fact-value dualism implicit in the theory of bioethics consolidates the power of facts as given and non-negotiable and, importantly, renders morality impotent in the face of established facts (Latour 2004:233). Bioethics relegates ethics to the aestheticization of medicine and science, an afterthought that does not threaten the transcendence of nature and its true reflection in science, the pre-human realm. In line with this logic, value is added to science when we reflect upon its otherwise non-negotiable and timeless reservoir of certainties. Due to the fact-value division, within bioethics, ethical dilemmas become merely the "implications of science and medicine," a response to the impact of scientific advances, a value-saturated human experience. This allows bioethics to expertly manage ethical issues in

hospitals and clinical research. Thus, bioethics serves as a manager of the fact-value encounters and a domain of instrumental decisions. Bioethical principles can help absolve institutions of ethical responsibility by presenting ethical dilemmas as the choice of autonomous individuals. Oriented towards managing clashes between scientists and the facts they represent and patients and the value they add, bioethics seems to have the job of resolving problems and speeding up the presumably value-free scientific and clinical agenda. Ethical issues are considered resolved when institutions are absolved of their responsibility to individuals or to the public they are supposed to serve.

Thus the ontological turn in STS scholarship illuminates how bioethics has come to serve institutions such as hospitals and pharmaceutical companies. It challenges the linking of bioethics to democracy and the promotion of bioethics in countries where public is conceived of as inadequately protected against the interest of science and medicine and the state as their patron. This insight from STS can illuminate the contradictions which my interlocutor in Serbia raised by showing why it is that bioethics can be both indispensible and undermined at once. Promoting bioethics as a set of practices and ideas in Serbia comes with new economic and political arrangements that make it possible to circumscribe ethics.

Furthermore, by insisting on a frame that does not separate nature and culture, the STS approach asks bioethics to consider what Mol (2002) calls "technicalities," the material practices in science and medicine, a concern which bioethics has relegated to the scientists and physicians. Latour's (1993, 2004) and Mol's (2002) work raise the question of how ethical concerns could be re-shaped and expanded if bioethicists would not limit

ethics to a reflection on the established practices of science. The dissolution of the fact and value divide that Latour (2004) and Mol (2002) call for would require bioethics to dispense with its traditional tools of thinking that evoke a particular notion of a human that, as my discussion on the history of bioethics and humanist discourse in Serbia shows, the universal principles in bioethics take for granted. The focus on the universal liberal human, marked by a unique capacity for reflection and ethical reasoning, has encouraged the universal application of bioethics, in which its movement to different cultural and political contexts is imagined as unproblematic. If bioethics was to concern itself with both sides of the nature-culture divide, instead of playing out at patient's bedside, the ethical drama would shift to include the pathology lab. The "*politics of who*" that enfolds between the two poles of the fact and value divide with physicians standing for science, and patients standing for human experience, would include the machines we use, images we make, and bacteria we involve in the making of medical treatment and new science. Expanding the circle of relevant actors in bioethics to non-humans would require bioethics to shift from dealing only with humanist discourse to looking at practices that bring these actors together at a particular moment. The analysis of modern ontology that STS scholarship provides thus can serve as a counter-claim to two universalisms evoked in the promotion of bioethics in Serbia: bioethics itself and the process of democratization. However, conceptualizing bioethics in terms of a modernist ontology does not address the questions of why Serbia needs bioethics in the first place, and the degree of difference that makes bioethics a legitimate tool in a transition to democracy

and in seeking EU citizenship. To help unravel this issue, on the next few pages I turn to a different theoretical framework.

Historically, Western Europe has constructed Serbia as part of the backwards and savage Balkans and Eastern Europe (Mazower 2000; Wolff 1994) whose imaginary boundaries have caused anxiety among Western intellectuals and politicians over the extent to which this area can be considered European at all, rather than Asian. But the communism of Yugoslavia was a modern project. Twentieth century socialism and capitalism shared similar utopian desires for social arrangements achieved through a particular coupling of economic and political power (Susan Buck-Morss 2002). Over the 50 years of its existence, the Yugoslav state thoroughly modernized medicine in Serbia. It thus would be difficult to claim that the nature-culture boundaries of Serbian biomedicine differ from those in the United States or Western Europe, places where bioethics is native and its practices and ideas embedded in institutions such as hospitals and research center. Hence, in what follows I evoke a different theoretical framework in order to address the question of what makes it possible to construe Serbia as in need of bioethics. Drawing on Nikolas Rose's notion of "advanced liberal democracies" and Marylin Strathern's (2000) concept of audit cultures I explain how Serbia could appear different to Western Europe. Though this difference does not neatly align with the dichotomy between modern Western Europe and backwards Eastern Europe, the politics of promoting bioethics in Serbia resonates with the centuries old ethical project of civilizing Serbia. The fall of the iron curtain, Serbia's more recent history of war in Bosnia and Kosovo, the Serbian government's resistance to acknowledge its role in the resulting genocide, have greatly

delayed the transition period and re-invigorated the moral discourse that construes Serbia as primitive, violent, and abusive to human rights. Such circumstances can explain why the issue of bioethics is particularly political in Serbia.

Chapter 4

Audit Regimes

In *The Death of The Social*, Nikolas Rose addresses how the privatization of welfare and the marketization of healthcare in Western Europe and North American have led to new forms of governing in which the social does not figure as prominently as it once did: “The social is no longer the target or objective of the strategies of the government ” (Rose 1996:327). Instead, management of public services is now built upon models from the private sector. This entails new relationships between clients and service providers as well as more emphasis on the need for individuals to take responsibility for their lives (Rose 1996:327). In the states that Rose calls “ advanced liberal democracies” the power of the state to manage health and reproduction has devolved to semi-autonomous regulatory bodies, professional groups, and private corporations (Rose 2007:3-4). By contrast, Serbian healthcare is still largely centrally controlled by the state. The EU requires that the state relinquish some of its decision-making power to independent committees, such as the Serbian Bioethics Committee and a private

healthcare sector. The founding of bioethics committees in hospitals and among professional groups, such as the Serbian Association of Geneticists, is meant to grant non-state actors some of the decisions-making power in science and healthcare.

Another side of the transformation is occurring at the level of the individual, as the EU requires Serbian government to draft a patient bill of rights and it encourages and expects various NGOs and professional organizations to empower patients to take responsibility for their own wellbeing through education and public campaigns. Corruption in healthcare that the EU perceives to stem from the paternalistic relationship between healthcare providers and patients is one of the most concerning aspects of the Serbian transition to the EU. A committee for corruption now has a hotline where citizens can anonymously report instances of, for example, being charged a fee in order to get any information from a physician about their health status. The new governing of healthcare creates new experts and forms of certification. As Rose (2007) shows, bioethical authority is indispensible to "advanced liberal democracies." It both guides patients and consumers of healthcare services through decision-making processes (Rose 2007) in the increasingly complex and parceled landscape of healthcare, at the same time as it promotes responsibility of the individuals for their own health.

The new modes of governance in "advanced liberal democracies" operate through regimes of accountability and transparency such as standards and audits (Rose 2007:4). Marilyn Strathern (2000) calls these regimes of accountability "audit cultures." Management practices derived from protocols of financial accountability, audits have acquired the force of a cultural movement, turning into patterned and ubiquitous

bureaucratic performances central to the working of all kinds of institutions (Strathern 2000: 2-4). The need to transplant practices and ideas of bioethics to Serbia and make them a common feature of the way medical and research institutions operate is part of increasing accountability, transparency, routinization and standardization of operations in medicine and science. Accountability and transparency are commonly perceived to be lacking in socialist regimes where states, at their own discretion, make healthcare decisions for their citizens. These two aspects of audit regimes are particularly salient for the post-socialist Serbian context as audits formalize practices of reflexivity giving a presentation of visibility. Using an organization's statement of value as an example, Strathern (2002) argues that an audit displaces what it stands to represent because, with the statement of values in place, no one questions the implicit institutional values. Having an audit in place becomes an ethical act in itself that is often taken as the end of responsibility: "Documented disclosure (of benefits, of risks) becomes virtuous in itself: if a project can self-style itself as transparent, it easily enters the realm of the ethical," (Pottage 1998: 759). " The most commonly used statement of disclosure in bioethics that creates a sense of accountability and transparency is informed consent. Listing all the known benefits and risks associated with a medical treatment or research protocol, informed consent demonstrates that the institution in question has not hidden any facts from patients or research participants. Beyond requiring understanding on the side of the person signing, signed and filed consent form in itself is sufficient to relinquish institutions of legal responsibility associated with the listed risks. In this way, informed consent, as a material form and a practice, rather than its content, becomes an ethical end.

Thus "institutionalizing" ethics in Serbia takes priority over the issues of what is ethical and how such ethics fits the context where it is being transplanted. The process of making routine and standard the practices of bioethics in Serbia such as the use of informed consent is ethical in itself. The EU, a major actor in this process is an ethical agent since it promotes bioethics as a way to EU citizenship. The EU, which loosely aligns with the Western European values and regimes of governance that Rose calls "advanced liberal democracies," governs through the practice of audits in an accountable and ethical manner. To understand why bioethics appears to travel as an unimpeded and unchangeable universal, we must examine the practices which actors involved call "institutionalization" rather than simply consider the transplantation of the ethical principles in themselves.

In this light, promoting practices of bioethics in Serbia that match EU bioethical standards could be examined as a way of making ethical subjects in Serbia. The need to make ethical subjects in Serbia evokes a centuries old discourse of violence and savagery that intellectuals, travelers, scholars, nobility and politicians have used to call for a need to civilize the Balkans. This discourse has revived following the fall of communism (during which a different distinction between East and West was salient) and especially following Serbia's involvement in genocide in Bosnia and ethnic cleansing in Kosovo, both of which have delayed Serbia's accession to the EU.

From the 14th -19th centuries, Serbia belonged to the Ottoman Empire, a polity that encompassed multiethnic and religiously diverse populations in Southeastern Europe. For the rest of Europe, the Ottoman Empire's expansion into Europe was perceived as a

threat to Europeanness (Mazower, 2000). From the second half of the 17th century on, Catholic Europe increasingly described the Ottoman Empire as tyrannical, illegitimate, corrupt and intolerant of religious diversity (Mazower, 2000: xxxiii). Lack of developed industry and commercial agriculture, and a large peasant population, contributed to constructions of the region as backwards in the narratives of neighboring Austro-Hungarian travelers and scholars (Mazower, 2000). Used to designate Southeastern European countries under the rule of Ottoman Empire, previously called Turkish Europe, from the start, the term "Balkans" had negative connotations associated with savagery, violence and primitivism. (Mazower, 2000). Contrary to account by intellectuals, political officials, and travelers, Mazower (2002) shows that multiethnic populations under the rule of the Ottoman Empire co-existed peacefully for many centuries until the Europe-wide rise of national consciousness at the end of the 19th and beginning of the 20th century. The Ottoman Empire was more tolerant of the variety of languages and religions in its territory than the Austro-Hungarian Empire (Mazower, 2000). The wars at the end of 19th and early 20th century liberated the small countries of Serbia, Bulgaria, Montenegro and Albania from Ottoman rule and resulted in quarrels over territorial divisions in the Second Balkan War.

Yet, as several scholars have noted, since the 1990s historians and political theorists have referred to the supposedly violent history during Ottoman rule and re-mobilized the metaphor of the violent and savage Balkan in order to explain the perceived essential cultural difference of Southeastern Europeans. The authors of *Balkan as Metaphor* explore the construction of the Balkans as Europe's Other, often refered to

as a "fracture zone," (Goldsworthy 2002: 26) of "ancient hatreds." (Goldsworthy 2002: 26). Such discourse about "natural instability" gained new currency with the 1990s wars of the Yugoslav succession and the war in Kosovo (Goldsworthy 2002: 27). Though the wars were a deliberate and orchestrated violence against civilians by army units (Mazower 2000: 148), political actors, media and Western scholars interpreted them as a spontaneous eruption of primeval hatreds. The Balkan was a particularly salient metaphor that the US media used to justify the NATO bombing of 1999. Envisioning people living on the Balkan Peninsula as bound by "ancient hatreds" endemic to the region that "extend back in time where it is impossible to look for explanation (Allcock 2000: 2-3)" (or, perhaps, not worth looking), this discourse has helped to stabilize indiscriminate violence and lack of ethnic and religion tolerance as essential Serbian characteristics.

Another overlapping framework through which Serbia's position *vis a vis* Europe is constructed is that of Eastern Europe. Wolff calls "Eastern Europe" a cultural production of Western European writers and scientists in the age of Enlightenment; it also stems from the rising orientalism and the cartographic and moral ambiguity of this region, located between East and West. (1994:7). During the Enlightenment, evolving ideas about civilization and barbarism provided terms of reference for situating Eastern Europe as backward on the scale of moral development. (Wolff 1994: 360). Such notions were somewhat suspended during the Cold War, when urbanization and industrialization changed the Balkan countries. The more active referent of difference became that of communism and capitalism. With the fall of communism Eastern European countries

were placed in a new hierarchical relationship to the West; now the relevant framework refers to development and transition to democracy (Barsegian 2000).

The speedy reorientation of Poland towards the EU and NATO, and the granting of EU membership to other post- socialist countries make these countries models of successful "democratization." But Serbia's "transition" did not start until the fall of Slobodan Milosevic's regime in 2000. From 1989-2000, the Serbian government participated in wars in Bosnia, Croatia and Kosovo. In 1995 in Bosnia, unbeknownst to the general public in Serbia, the Milosevic abetted the systemic execution of 8000 men and boys in Srebrenica. It took years before the Srebrenica genocide made Serbian news and many more years before the Serbian government acknowledged these atrocities. Numerous other crimes and the general corruption of the Milosevic regime and its leftovers have been uncovered since. For example, privatization of the Serbian pharmaceutical industry that the EU has encouraged as a requisite in the process of "democratization" has brought wealth into the hands of the political elite in Serbia who, through their connections with the socialist regime, managed to buy government-owned pharmaceutical companies for nominal amounts of money. Additionally, the Serbian government's failure to cooperate with the EU in prosecuting Serbian war criminals and to fight corruption has significantly delayed Serbian entry into the EU. Such corruption has generated more mistrust in the Serbian government both by its people and the EU. In the eyes of the EU, the lack of transparency that the Serbian government has shown makes the promotion of bioethics both more urgent and more complicated. In order to show how this recent Serbian history distinguishes Serbia from other countries in the

region and makes Serbia a unique ground for bioethics, I turn briefly to considering how bioethics in Croatia has developed.

While Croatia participated in the wars of Yugoslav succession, the media and the public have generally interpreted Croatian participation in wars in Croatia and Bosnia as an attempt to break from growing Serbian political dominance and Serbian nationalism in Yugoslavia. Unlike Serbia, Croatia was not involved in ethnic cleansing that gives the politics of life particular salience in Serbia. Though Croatia was part of Yugoslavia, until the early 20th century it belonged to the Austro-Hungarian Empire. As I discussed above, the Austro-Hungarian Empire was distinguished from the Ottoman Empire as the 'civilized' part of Europe. Historical narratives of violence and moral backwardness, as well as recent wars and corruption that have shaped the perception of Serbia in the world and the EU's political and ethical projects in Serbia, are not as relevant for the way decisions about life and death are made in Croatia.

The EU and UNESCO have been active in promoting bioethics in Croatia where it has also been linked to Croatia's "transition to democracy" and EU citizenship. Over the past two years, UNESCO has organized and funded research in bioethics in Croatia and supported the Ethics Teacher Training Course at Dubrovnik International University (unesco. org). However, the process of developing bioethical practices and ideas in Croatian medicine and science started much earlier than in Serbia, a full fifteen years before the beginning of EU and UNESCO involvement in

bioethics in Croatia (Zagorac 2008). Bioethics in Croatia has developed as a ground-up initiative, led by Croatian philosophers and physicians in the1990s and informed by their collaboration with their colleagues in research centers and universities in Germany (Zagorac 2008). As a result, Croatian bioethics has adapted a unique direction that my interlocutors in Serbia alerted me to, called "the integrative approach." Over the last decade, Croatia has been heralded as a leader in bioethics for Southeastern Europe (Zagorac 2008). The annual Lošinj Days of Bioethics conference draws scholars from all over the region. In the interviews I conducted as part of my preliminary research, members of the Serbian Bioethics Society spoke of the conference as a significant opportunity in their professional careers.

Conclusion

There is no simple way in which these social and political circumstances and the historical construction of Serbia as backwards, violent, and savage align with the EU's effort to promote bioethics in Serbia. I have suggested that the EUs work in transplanting bioethics as a set of practices and ideas to Serbia could be considered as the promotion of a system of audits and standards common to "advanced liberal democracies," (Rose 1996; 2007). Audits, as Strathern (2000) notes, become an end in themselves: the mere act of standardizing and developing audits becomes ethical. Making ethical institutions and subjects resonates with the long-standing call to civilize the Balkans, but this should in no way imply simple causality.

In this paper I have used existing scholarship to frame the movement of bioethical ideas and practices to Serbia. I have set up a framework for looking at why bioethics appears to lend itself to universal application and a process called "democratization." I have also examined the particular historical context that helps the EU construe Serbia as

in need of bioethics. The larger story of promoting ethics in Serbia is how Serbian history, the history of bioethics, and the fact and value divide implicit in bioethics facilitate the presumed unproblematic movement of bioethics across cultural and political boundaries. Anna Tsing's (2004) work has shown how ethnography is well suited to challenge the view of universals such as bioethics as moving across different grounds unimpeded by local context. Tsing shows that in practice the movement of phenomena such as bioethics does not proceed in this way: "How we run depends on what shoes we have to run in," (2004:8). For Tsing, (2004) universals, such as bioethics, make sense and are effective only thorough this process of "*friction*," the particular historical conjunctures in which bioethical practices hit new grounds such as Serbia. Thus, ethnographic research focused on practice can elicit what bioethics looks like in Serbia. Drawing on the STS scholarship, I have suggested that one way to undermine the enchanting universalism of bioethics implicit in the discussion of its principles would be to include the material and the non-human in our study of ethics. My future ethnographic research in Serbia would look at bioethics in practice by engaging particular medical technologies and the nature-culture assemblages they involve. This, I hope, will give bioethics in Serbia more "*friction.*"

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