GOOD INTENTIONS

Norms and Practices of Imperial Humanitarianism

The New Imperialism, Volume 4

Edited by
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ALERT PRESS
Montréal, Québec, Canada
2014

Library and Archives Canada Cataloguing in Publication

Good intentions : norms and practices of imperial humanitarianism / edited by Maximilian C. Forte.
(The new imperialism ; volume 4)
Includes bibliographical references and index.

ISBN 978-0-9868021-5-7 (bound).--ISBN 978-0-9868021-4-0 (pbk.)
1. Humanitarian intervention. 2. Imperialism. I. Forte, Maximilian C., 1967-, editor II. Series: New imperialism (Montréal, Québec) ; v. 4
JZ6369.G66 2014 341.5'84 C2014-905200-6

Front cover image: According to the official caption, this is US Navy Hospital Corpsman 2nd Class Porfirio Nino, from Maritime Civil Affairs Team 104, practices speaking Kinyarwanda, one of the official languages of Rwanda, during a civil observation mission in Bunyamanza, Rwanda, August 7, 2009. (DoD photo by Senior Chief Mass Communication Specialist Jon E. McMillan, US Navy. Public domain.) This particular photograph was also used as the lead image for 2011 presentation by AFRICOM titled, "United States Africa Command: The First Three Years". On the image the following words were superimposed: "'Umuntu Ngumuntu Ngamantu' I am a person through other people. My humanity is tied to yours.~ Zulu proverb"

Back cover image: According to the official caption, these are US Airmen assigned to the 23rd Equipment Maintenance Squadron, 75th Aircraft Maintenance Unit "downloading" an A-10C Thunderbolt II aircraft during an operational readiness exercise at Moody Air Force Base, Georgia, August 4, 2009. (DoD photo by Airman 1st Class Joshua Green, US Air Force. Public domain.)

1455 de Maisonneuve Blvd., W.,
Montreal, Quebec, Canada, H3G-1M8
www.alertpress.net

Printed in Canada

CHAPTER 1

Iatrogenic Imperialism: NGOs and CROs as Agents of Questionable Care

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Military interventions by powerful nations have increasingly occurred under the justification of humanitarian values and principles. In deploying a moral imperative to act for the benefit of the maximum number of innocent lives, the destructive aspects and politics of intervening are often overlooked. This chapter concerns a similar pattern being reproduced in healthcare worldwide. In the wake of the retreat of the state in matters of welfare provoked by the pressures of International Financial Institutions (IFIs), various actors have filtered into the daily lives of people across the world and have offered themselves up as options for providing care. I will speak here only of certain health-oriented non-governmental organizations (NGOs) and contract research organizations (CROs) as they relate to neoliberal imperialism.

A modality of empire, in this case, emerges from good intentions and the provision of care to bodies that are said to desperately need it: a humanitarian movement that constructs itself as unexploitative and outside political considerations, but dominates people therapeutically and reproduces global inequalities (Calhoun, 2010, p. 41; Fassin, 2010, p. 273; McFalls, 2010, p. 318). NGOs and CROs

have become participants in networks of decentralized and managerial care often operating through exception which ultimately does not realize health benefits equally or for all.

I will first outline how neoliberal policies starting around the 1980s shaped healthcare in states like Brazil and Mozambique and then examine the material and ideological conditions that allowed NGOs and CROs to become involved in global health. I then turn my focus to NGOs like Save the Children and CARE whose drive for efficiency in saving a maximum number of lives, especially in situations described as emergencies, makes for easier partnership with pharmaceutical companies like Merck and government organizations like USAID. Lastly, the role of CROs, as both healthcare providers and profitable subcontractors of pharmaceutical companies, is discussed in relation to the purported social good clinical trials provide.

Neoliberal Imperialism in Healthcare

Policies of privatization of healthcare and international patent regulations can perhaps be best understood as part of a US-led neoliberal imperialism that promotes a system that benefits all parties yet produces and takes advantage of asymmetries in trade and capital flows. When the IMF and World Bank open up the markets of countries, "the wealth and well-being of particular territories are augmented at the expense of others" with capitalist interests based in the US as prime beneficiaries (Harvey, 2005, pp. 31–32, 39). Though this continues to an extent today, I discuss reforms that began in the 1980s.

Healthcare was an important area affected by these reforms. Privatization was pursued as a solution to what were perceived as inefficient government services. While the extent of these measures varied, privatization or *decentralization* took hold in many countries in both the Global North and Global South. Through decentralization, the World Bank continues to believe efficiency can be achieved

locally, improving the delivery of services (Reich, 2002, pp. 1670, 1672).

In neoliberal reform, the public sector was not erased, but rather took care of the unprofitable aspects of public health. The World Bank is of the opinion, shared by many in the US government, that market principles should be placed first as they are expected to produce health benefits and prosperity in turn (Waitzkin et al., 2005, pp. 898–899). In other words, the state is only there to ensure "that the conditions are right for capital accumulation" which will improve health (Hanieh, 2006, p. 187). But asking *cui bono* here is important: who benefits in terms of health and wealth? Claims of *pharmaceutical* empire seem relevant when the US can put pressure on South Africa to prevent it from calling a state of emergency over HIV/AIDS and circumventing the WTO rules on importing generic drugs (Cooper, 2008, pp. 52–53). This resonates with Harvey's (2005) description of imperialist practices as states try to retain control of capital flows according to the strengths of the regional economy (in this case, pharmaceuticals) (p. 107).

Alongside healthcare reform, patent regulations were increasingly lobbied for by the pharmaceutical industry and indeed sought to make strong intellectual property laws a prerequisite for countries' continued access to US markets. The use of the word *piracy* to describe unsatisfactory patent protections branded the practices of Brazil and India as tantamount to theft and dangerous. Interestingly, in this instance *lack* of regulation was criminal to a neoliberal government (Harrison, 2001, p. 496).

What were the effects of all this for Brazil and India? In Brazil, just as an AIDS epidemic was making its way to the fore, the state implemented reforms leading to serious understaffing and underfunding in healthcare as it instituted a constitution in 1988 making healthcare a universal right (Biehl, 2004, p. 108). The Brazilian state also changed its philosophy of public health from one focused on prevention and clinical care to one of pharmaceuticalization at the same time as it joined the Agreement on Trade Related

Aspects of Intellectual Property Rights (an international agreement to protect patents). It also imported vast amounts of patented medication on which all taxes were abolished. This created a lucrative market for pharmaceutical companies and made access to specialized care increasingly difficult for those without the capital to purchase healthcare (Biehl, 2004, pp. 112–113). Most international and national funds were allocated to AIDS prevention through NGOs (with the number of these organizations growing from 120 in 1993 to 480 in 1999) and local programs operating like NGOs. Before a law made medicines universally available (to reduce costs on care for opportunistic diseases accompanying AIDS), citizens were represented to their own state through NGOs, who decided who got what care (Biehl, 2004, pp. 108–110).

In Africa, similar stories have unfolded as USAID and the World Bank have pushed for structural adjustment and dismantled state services. These same organizations have also pushed for NGOs to fill in the voids created by compressing the state (Pfeiffer, 2003, p. 726). For example, in Uganda, the World Bank pressured policymakers to implement user fees for healthcare and a Danish aid agency pushed for a policy change concerning essential drugs, using the promise of future benefits and the threat of cutting off aid (Reich, 2002, p. 1669).

Foreign aid itself and Public-Private Partnerships (PPPs), to eradicate disease with drugs and vaccines, became entry points for pharmaceutical companies and NGOs in the 1990s and 2000s. In both cases, the state's inefficiency or incapacity to provide medical services justified these new initiatives, especially as states could no longer turn to the USSR for support with the end of the Cold War. In Mozambique, for instance, aid from USAID and the World Bank (two of the most aggressive proponents of structural adjustment) has been increasingly funnelled through NGOs as these are thought to reach poor communities more efficiently and *compassionately* than public services (Pfeiffer, 2003, pp. 725–726). As a powerful example of what I would call *iatrogenic imperialism*, the in-

flux of compassionate NGOs fragmented the public healthcare system in Mozambique (previously touted as a model for the *developing world* by the WHO) and intensified the already growing social inequality (Pfeiffer, 2003, pp. 726–727). Not only did healthcare professionals find new possibilities for better livelihoods with NGO salaries, but the state found itself busy managing deals with and competition between NGOs rather than dealing with care (Pfeiffer, 2003, p. 732).

Public-Private Partnerships, comprised of governments, academia, international organizations and pharmaceutical companies, have also emerged out of the gaps in the state. These are geared towards improving access to or developing drugs and vaccines for diseases (such as malaria and tuberculosis) often seen as unprofitable objects of research by the pharmaceutical industry. People from the countries concerned are usually a small fraction of those on the board of these partnerships and some PPPs become independent NGOs that use portfolio management approaches, underscoring a certain managerial tendency emerging in this enterprise (Campos, Norman & Jadad, 2011, pp. 986–987, 992–993).

Non-Governmental Organizations

With the retreat of the state in many countries of the Global South, NGOs have stepped in to fulfill some of its roles. As organizations that are not elected by the people they are helping, their direct accountabilities lie elsewhere. In many respects NGOs function like modern states and corporations: they often adopt managerial practices oriented towards efficiency to maximize their objective of saving as many lives as possible. It should be clear in stating this that I am not referring to all NGOs and all their practices, but certain influential NGOs and prominent tendencies in humanitarian practice. The practices of NGOs have many effects: they fill gaps and give legitimacy to the state while also undermining state governance (as previ-

ously argued), they can inflate housing costs, and they offer opportunities for advancement for middle-class, public sector workers in the Global South which reproduces global inequalities (Schuller, 2009, pp. 85, 87, 92, 97).

However, these are only some of the externalities of the capillary forms of therapeutic domination that take place when NGOs exert the power over life and death in situations of emergency. HIV/AIDS treatment programs offer a good example of what I mean. Lack of access to treatment for HIV/AIDS became a global humanitarian emergency in 2000. Vinh-Kim Nguyen (2009) argues that it was biomedical advances in therapy and diagnosis that allowed decades of neglect to be reframed as a crisis (pp. 196, 200). The newly-constituted HIV emergency invited intervention from NGOs in the name of saving lives. Ironically, their actors and even their tasks are increasingly seen as indistinguishable from those of intervening military forces. Indeed, both are concerned with the management of populations to ensure that lives are saved (Nguyen, 2009, p. 201). In the case of HIV, massive treatment programs have involved enrolling patients, deploying unprecedented funding, drugs and technologies to better manage the well-being of populations of individuals with the most intimate detail.

PEPFAR (President's Emergency Plan for AIDS Relief) launched under George W. Bush, became the prime example for the administration of its humanitarian foreign policy (Nguyen, 2009, pp. 202–203). Its implementation was mostly left to local faith-based organizations advocating abstinence and fidelity as prevention measures, part of a set of intimate technologies deployed in order to save lives that change the way people care for and talk about their bodies and their families. Though PEPFAR differs in its singularity from assemblages of NGOs, it operates in a similar mode of therapeutic domination (Nguyen, 2009, pp. 204–205; McFalls, 2010, p. 318).

To prove the effectiveness of treatment, certain measures of efficiency like the number of lives or *years* of life saved then become the basis for experimentation and the

generation of evidence in staying accountable to funders (Nguyen, 2009, pp. 209, 211). NGOs must often attract funding from external sources like USAID, which has led to accusations of them being subcontractors for foreign powers as their projects may reflect the priorities of their funders more than grassroots demand (Landolt, 2007, p. 707).

The measures used to explain effectiveness and intervention go beyond the usual humanitarian concern for *bare life*, that is the number of lives saved (McFalls, 2010, p. 324). Other measures such as *quality-of-life* have become important for NGOs working in India in the field of HIV/AIDS, moving beyond its past as a measure of development to become a justification for intervention. Measures such as these minimize the need for political coercion as people become *empowered* to see their actions as a sort of entrepreneurial maximization of their own health. *Empowerment* has a history in biomedicine going back to the 1970s. It emerged out of concerns for efficiency of public health promotion and the limits of biomedicine, leading to a focus on making people responsible for their own health and *empowered* to change *unhealthy* habits (Lock & Nguyen, 2010, p. 295). In this case of HIV/AIDS in India, quality-of-life *empowerment* is a strategy to regulate peoples' behaviour embedded in a neoliberal program of health governance (Finn & Sarangi, 2008, pp. 1569–1570).

It is thus unsurprising that health should be advocated as important to US foreign policy. A report co-sponsored by the Council on Foreign Relations established that the US promoting global public health would be a means of preventing infectious diseases from reaching the US in a time of increased mobility. It would also improve political instability crucial to maintaining economic flows. Surveillance and treatment systems become justified in claiming strategic and *moral* benefits (Kassalow, 2001). The 2010 US National Security Strategy further emphasizes that pandemic diseases are threats to the US and its citizens, and that the US should seek to create a stable international or-

der for its own interests, but also as an end to be sought in and of itself (White House, 2010).

Interestingly, some of the most influential NGOs have significant ties to US state agencies and major corporations. The ones I allude to here are fairly widely known: Christian Action Research and Education International (CARE International) and Save the Children. CARE's areas of concern include water sanitation, economic development and emergency response. Their total assets and liabilities for 2012 amount to €500 million. Their partners include many UN agencies, such as the World Bank, as well as development agencies, including CIDA and USAID, from many governments of the Global North. Their corporate sponsors are unlisted (CARE, 2012; CARE, 2014). However, the current Chairperson of CARE, Ralph Martens, is a former vice president at Merrill Lynch (SourceWatch, 2014a) and the Chairperson before him, Lydia Marshall, had previously worked as a vice president for Citigroup (SourceWatch, 2014b).

Save the Children is another relief-oriented organization. It discloses its numerous corporate partners on its website. These include GlaxoSmithKline, the Merck Foundation, Disney, Mattel, Goldman Sachs and Johnson & Johnson (Save the Children [STC], 2014). However they also receive hundreds of millions of dollars from governments according to a 2005 financial form. Save the Children subsequently retracted the form from their website, obscuring the staggering US $149 million contribution by USAID (SourceWatch, 2014c).

GlaxoSmithKline, a multinational pharmaceutical corporation, recently partnered with CARE International and Save the Children to increase its presence in the Global South. GSK's CEO framed this move in terms of investing in a region where profits were relatively low and where they could "make a difference" (World Pharma News, 2011). Save the Children's Chief Executive called GSK's move brave and said it would help their top priority of "saving the lives of some of the poorest children of the poorest communities" (World Pharma News, 2011).

Further blurring the line between profitable investment and humanitarianism is the Partnership for Quality Medical Donations (PQMD). The executive director of this organization, in a speech entitled, "The Evolving Role of NGOs in the Pharmaceutical Industry's Product Donation Programs," claims that the Global South's markets offer not just an opportunity for future profit, but also the opportunity for "this magnificent industry to show its concern for the world community as a whole, even to the poorest among us" and ensuring some "victory for humanity" (Russo, 2004, p. 1). The mobilization of humanitarian sentiment is quite clear here.

After the WHO changed their guidelines for drug donations in 1999 in favour of the PQMD's recommendations, a 2001 WHO study conducted in *emergency* countries like Mozambique and India found that those in violation were governments and local distributors, not major pharmaceutical corporations and *experienced* NGOs (Russo, 2004, pp. 2–5). Instead of examining the pressures the pharmaceutical industry-NGO alliance itself has placed on governments and local distributors and the way it has turned the pharmacy into the primary site of healthcare after the retraction of the state in countries like India, this statement makes an appeal to efficiency and an objective humanitarian good (Kamat & Nichter, 1998, pp. 779–780). Their position could be summarized in this way: our experts are better at delivering these inherently good drugs according to the best guidelines and those local amateurs are guilty of irrational and *iatrogenic* drug donation practices (since they may harm those who consume them). I use *iatrogenic* here to illustrate its usage as a term of power in medical discourse that pathologizes local practice while obscuring the influence of the *experts* in fostering these *irrational* and *harmful* practices.

Contract Research Organizations

The extent to which neoliberal imperialism in healthcare is felt is not limited to NGOs. Indeed, pharmaceutical companies arguably have a more direct presence through the Contract Research Organizations they hire to conduct pharmaceutical research at low cost and recruit subjects. At the same time, CROs offer the possibility of treatment to local people for the illness they are researching. Since an increasing number of clinical trials are being conducted in the Global South, some claim these offer a new kind of social good that the state cannot provide (Petryna, 2005). Though global clinical trials are a new phenomenon, they have come under scrutiny through the book and film *The Constant Gardener* (Goldacre, 2012, p. 119). The original material is based on the case of a clinical trial in 1996 illegally conducted at the behest of pharmaceutical giant Pfizer in Nigeria, which caused the deaths of eleven children (Stephens, 2006/5/7). One cable shows Pfizer pressured local officials to drop the matter and accept settlement money (US Embassy, Abuja [USEA], 2009). I will return to this example, but before that it may be useful to explore the issues raised by this example through the main facilitators of pharmaceutical clinical trials today: CROs.

If I specify *today* it is because CROs are in part a product of some of the recent history of neoliberal policy I have alluded to previously. In part due to US regulatory limitations implemented in the 1970s on using prisoners as test subjects, the pharmaceutical industry began to look abroad. Interestingly, the FDA's response to the scandal around prisoner testing was to claim ignorance and reiterate its vow to protect intellectual property rights. By the 1990s, with the help of the FDA, drug development had become a booming, globalized and outsourced endeavour. The search for treatment-naive human bodies upon which to conduct cost-effective experiments abroad meant dealing with foreign bureaucracies, a service which newly-formed Contract Research Organizations are apt to provide, having ties to oversight boards in the countries they

operate in. It should be noted that CROs have increasingly made their way into situations of emergency, where needs are higher, to gather patients for trials more effectively (Petryna, 2005, p. 185–192).

Though their clients are giants like Merck and Pfizer, some of these organizations also have a significant global presence, conducting trials that can involve tens of thousands of people in dozens of countries, a practice that also precludes FDA audit efforts (Petryna, 2005, pp. 185–192; Petryna, 2007, p. 295). Large, US-based CROs like Charles River Laboratories (SourceWatch, 2014d) and Covance Laboratories (SourceWatch, 2014e) are also beginning to engage in lobbying directly. Capital not only links CROs to pharmaceutical multinationals and governments, but also links these last two together: without even getting into campaign contributions, Pfizer and Merck, for example, both received millions of dollars in contracts from the US Department of Defense in past years (US Office of Management and Budget [OMB], 2014a; OMB, 2014b).

In conducting globalized trials, CROs not only profit, but they bolster the advance of the pharmaceutical industry in health and reproduce global inequalities in various ways. Much like NGOs, CRO trials also draw away locally trained clinicians to better-paying jobs. In addition, testing a new line of drugs can help create new markets for pharmaceuticals in countries like Brazil by changing patients' expectations and exposing them to expensive, patented drugs (Goldacre, 2012). *Seeding trials* are in fact conducted as barely masked attempts to market new drugs (Psaty & Rennie, 2006, p. 2787). And by playing up the markets for patented drugs, trials play into the dominant position in US foreign policy of ensuring medicinal access through patent protection, to the benefit of the research pharmaceutical industry (Gathii, 2003). These marketing tactics have real consequences for local governments, as policy makers in the Global South trying to make healthcare delivery safe and equitable become mired by pressures and potentially unreliable data from the pharmaceutical industry (Petryna, 2010, p. 60).

Moreover, pharmacists then become consultants in a process of consuming health through drugs and encouraging self-experimentation (Kamat & Nichter, 1998, pp. 779–780). People thus engage in subject-making and self-disciplining in relationship with the research and health industry (and occasionally local governments), becoming part of therapeutic markets in an attempt to secure health benefits in a time where the state alone is not providing it. This makes populations visible and allows them to be *managed* and cared for more *efficiently* (Biehl & Petryna, 2011).

Returning to the Pfizer case, it is a useful example to understand some of the wider context embedding the practices of CROs. Pfizer claimed its researchers went purely out of the goodness of their hearts as a meningitis epidemic ravaged the country. Indeed, Pfizer's statement claimed that the drug had undoubtedly "saved lives" (Stephens, 2006/5/7). However, as the panel of Nigerian doctors reviewing the case pointed out, the Pfizer-sponsored researchers left after the trial, even as the epidemic raged on (Stephens, 2006/5/7). Even though the idea that clinical trials are a depoliticized social good may not be convincing, there is a disincentive to point out the harm resulting from a particular CRO trial because they can simply do business somewhere else (Petryna, 2010, p. 62).

Indeed, ideas of emergency and goodwill legitimated Pfizer's intervention, leading to a deadly experiment that would have been impossible under normal clinical conditions in the US (Petryna, 2005, p. 191). But the Nigerian panel's response must also be viewed critically. Borrowing the language of medical ethics, they called it a clear case of the "exploitation of the ignorant" and proposed increased regulation and oversight (Stephens, 2006/5/7). The panel reinforces the liberal ideas in biomedical ethics of people as free subjects that must become informed, emphasizing moral protections rather than addressing concerns like hunger or sickness that might have more to do with why people sought out the trial (Redfield, 2013, p. 37). This is especially salient as people internalize a neoliberal gov-

ernmentality that makes them entrepreneurs of their own health, and as states of exception are produced not by suspending the law but by CROs posing obstacles to current legal frameworks (Prasad, 2009, pp. 3, 13). These processes should be seen within the context of "neoliberal securitization," in which the erosion of the state also triggers the state to focus aggressively on social stability to attract global capital (McLoughlin & Forte, 2014, pp. 4–6). CROs and the capital their pharmaceutical sponsors are expected to bring can thus be seen as stabilizing forces, especially in periods of *emergency*.

With clinical trials there is a strange blending of the therapeutic, the commercial and indeed the humanitarian. We see this concretely in how Pfizer responded to the accusations coming from Nigeria: the lawsuit froze momentum to do clinical trials in Nigeria and a Pfizer manager "opined that *when another outbreak occurs, no company will come to Nigeria's aid*" (US Embassy, Abuja [USEA], 2009). This statement reflects the convergence of the need to provide health services in the wake of a dispossessed state, the ostensible goodwill of the pharmaceutical industry's trials and the threat to commerce that resistance poses. Though the industry and US regulators do not necessarily codify providing a social good as a justification for promoting clinical trials in poor areas, it has become a norm (Petryna, 2005, p. 187). In other words, the "politicization of bare life" in neoliberal governmentality seems to be an intrinsic part of the ethicality of drug trials (Prasad, 2009, p. 19).

Unlike security risk management, the management of clinical trials seems to proliferate risk for the subjects of the trials, as protecting patents and the rights of CROs rather than test subjects becomes the neoliberal state's agenda (Prasad, 2009, pp. 15–16). Indeed, CROs whether they are based in the US or India, for instance, rely on global inequalities of disease and access to biomedical treatment to be able to gather enough people who haven't been taking drugs beforehand and ensure untarnished data. The therapeutic and the commercial come together in the way that diseases become marketable assets that exist perhaps only

as exchange value as it is a commodity with not a result of useful or productive labour (Prasad, 2009, pp. 6–7, 17). Paradoxically, the pharmaceutical industry seeks to extend the reach of its drugs in the global market while relying on large populations of diseased people seeking treatment globally to develop new drugs.

In the film *The Constant Gardener*, the film's protagonist gets warned not to go looking in "foreign gardens" (Meirelles, 2005). As the title suggests, these *gardens* are not naturally occurring: they are produced. Much like what I have tried to bring out through the idea of iatrogenic imperialism, this idea of a constant gardener implies that though *gardens* may fail, the fundamental assumptions that everyone will become more *prosperous*, *healthy* and *free* are universally true and good. However, we might reconsider the territorialization that the metaphor of the garden implies: increasingly, any one state or region will have significant inequalities within its borders, pointing to a need to look beyond any one state or actor as *the* constant gardener. Indeed, it is problematic to see clinical trials as being created and controlled solely by Western organizations as well as seeing medical narratives within the frame of colonizer-Other or doctor-patient dichotomies (Saethre & Stadler, 2013, p. 115). As I mentioned before, *iatrogenic* is a term of power, one associated with medical discourse. While I have used it to reflect on the influence of humanitarianism and neoliberalism in healthcare, I would caution against buying into the logic that makes some people into *patients* and others into *experts* or *doctors*. Indeed, the word *iatrogenic* seems to have a dual potential through this dichotomy, whereby it can be used to criticize the harmful practices of non-experts and patients, but can also be used to show the limits of expertise.

Conclusion

In sum, NGOs and CROs have become powerful actors in global healthcare, mobilizing the idea of emergency and

humanitarian goals to justify their activities, which have undermined public healthcare systems and reproduced global inequalities. Under neoliberal empire, healthcare has become the individual's responsibility, largely absolving the retracted, managerial state from providing it directly. I have focused here on a facet, or perhaps a modality, of empire that I have called *iatrogenic* for its penetrating and far-reaching consequences, which have emerged from the level of state infrastructure down to the level of the everyday. But it is perhaps this level of the everyday which has been insufficiently explored here. It is in everyday practice that we are likely to find empire in its most minute and hegemonic expressions, but it is also perhaps where empire is most likely to be adapted and resisted.

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