The Global Politics of Medicine: Beyond global health, against securitisation theory

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Abstract. This article makes the case for a new field in International Relations (IR): the Global Politics of Medicine. It argues that significant avenues of research can be opened up by focusing on medicine and the life sciences, in order to both challenge current IR theories, and develop new theoretical and empirical insights in IR. In particular, the article challenges the validity of securitisation theory, and specifically the argument that health has been securitised. Showing instead that medicine and warfare have been imbricated from the nineteenth century as strategies of population, it challenges securitisation theory's ahistoricism and its assumption that social security and international security (and the norm/exception) are analytically divisible. Bringing this into the present through the examples of triage, psychological resilience, and genetic intelligence in counterinsurgency, it traces how warfare and medicine now ambitiously seek to treat populations as sets of individual bodies. Arguing that we cannot retreat to some mythical state of politics 'prior' to securitisation, it draws out how the fields of war, health, and medicine are nonetheless highly contested. The article concludes by challenging the fields of Global Health, war, and security studies, but also suggests novel routes for pursuing the study of the Global Politics of Medicine.

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This article proposes that the study of medicine in International Relations (IR) could significantly advance our understanding of the nature and history of global politics. Arguing that the Global Health literature has too often assumed that health is a natural 'good' (and that medicine is the unquestioned mechanism for delivering this good), this article advocates an alternative starting point: the investigation of the role of medicine in global politics. Rather than follow from the disciplines of economics or public health, which have placed health at the centre of analysis, this article suggests novel routes for the study of IR through an interdisciplinary focus on medicine. It illustrates how an engagement with the disciplines that place medicine as a major area of study, including History, Sociology, Anthropology as well as in Science and Technology Studies (STS) and feminist and postcolonial thought, can reorient our

attention to the politics of medicine in IR. In doing so, a Global Politics of Medicine could not only open up new areas for research, but also challenge core concepts in IR.

The article focuses on one highly influential concept in particular: 'securitisation'. In the field of Global Health studies in IR, constructivist (and to some extent post-structuralist) approaches to security based on the concept of securitisation are the most prominent lens through which Global Health Security (GHS) is analysed. This article challenges the securitisation approach not only in order to rethink global health security, but moreover to rebuke securitisation theory wholesale on both conceptual and empirical grounds.

In order to do so, this article presents a historical account of the role of medicine in global politics from the nineteenth century onwards. Showing that it is not possible to speak of a recent 'securitisation of health', the article instead traces the imbrication of modern warfare and modern medicine, of killing and curing, and of national, international, and social security. It traces the historical symbiosis of both modern warfare and modern medicine, illustrating how they grew together as means for securing the population. It further argues that, in their growth together, modern warfare and modern medicine are homologous: that is, in their imbrication, they have both come to express a *strategic* logic in the defence of the population. It is this strategic element of medicine, as the science and profession for providing health, that makes any analysis based on a supposed (recent) securitisation of health both conceptually and empirically impoverished.

To argue that warfare and medicine are co-constituted or co-generative is not, however, to argue that the precise nature of their symbiosis has remained static from the nineteenth century. Far from it. Yet it is by apprehending this general principle that modern warfare and medicine are symbiotic and homologous that we can begin to assess the specificities of this relationship. As such, the article illustrates how twenty-first-century warfare (which is here taken to include both counterterrorism and counterinsurgency strategy) has drawn on and transformed several fields of medicine, including emergency medicine, neurology, psychiatry, psychology, and the science of genetics, amongst others, while at the same time practices of intelligence gathering, interrogation, detention, winning hearts and minds, and of force multiplication and human resource management have all called upon medical practice. I argue that both medicine and warfare are now turning on the population as a mass of bodies that must be individuated in order to root out susceptibilities (to disease, to terrorist/insurgent indoctrination) and enhance the population. I trace this recent development through an analysis of the uses of triage, psychological resilience, and genetics in post-9/11 warfare.

The article is structured in three sections. The first establishes that there are some problems with the way that IR has understood Global Health as a domain that has recently been or is currently being 'securitised'. Instead, I argue that a focus on medicine can fundamentally challenge securitisation theory, and especially its foundational assumptions of a stark divide between social/national security, and the norm/exception. Here I draw out how a focus on medicine can challenge what I describe as securitisation theory's Austinian, Schmittian, and Clausewitzian problems.

The second section gives an empirical account of the historical imbrication of modern medicine and modern warfare, and of social and inter/national security. It argues that warfare and medicine have a shared history that has made them not

only symbiotic, but also homologous. By symbiotic, I mean that warfare has produced medicine and medicine has produced warfare in their historical relation. By homologous I mean that, through their historical imbrication, modern warfare and modern medicine (that is, from the nineteenth century) have symbiotically developed a common logic and position: both have been developed as strategic sciences for doing things to and with populations.

The third section brings matters up to date, drawing out some of the precise ways in which contemporary warfare and medicine – in their imbrication as symbiotic and homologous strategies for doing things to and with populations – are currently expressing novel modes of strategy in relation to the population as a set of individual bodies, centred especially on: triage, psychological resilience, and genetic intelligence. Here I demonstrate that while there is a through-line from the nineteenth century turn in both warfare and medicine to the population, the precise modes of their operation have remained far from static, and that IR, with its traditional focus on matters of strategy, presents unique opportunities as a vantage-point from which to analyse these developments.

The conclusion draws out some of the normative consequences of the article, arguing that while we cannot retreat to some mythical state of politics 'prior' to securitisation, we can nonetheless see the imbricated fields of warfare, health, and medicine as highly contested. It further stakes out what impact a Global Politics of Medicine could have on the fields of Global Health, securitisation theory, and IR more generally.

Before proceeding, it makes sense to clarify the use of the term 'medicine'. Three things are of note. First, I treat medicine to include not only clinical interactions, but as a broad disciplinary and scientific set of practices directed at the management and health of the body and the population.[1] I analyse not only those fields historically associated with warfare or security (emergency medicine, epidemiology, psychology, psychiatry, public health, nursing, eugenics) but also emergent or transformational fields (prosthetics, cybernetic and forensic technologies), as well as the ways in which medicine draws on and contributes to allied fields such as law, police, or administration. I do not make a significant distinction between the medical or life sciences and medical practice: medical science and research are practices unto themselves.

Second, while I advocate for a broad understanding of 'medicine', I do not treat it as an undifferentiated mass. Medicine is certainly not 'bad', but neither is it 'good' – such a pervasive endeavour can never be one thing. At the same time, when doctors and other medical professionals are involved in troubling actions, for instance in administering torture at Guantánamo Bay, or in the recent fake vaccination campaign during the hunt for Osama bin Laden, these events are typically understood to be anomalous, the actions of 'bad apples'. Describing these cases as anomalies limits our attention by positioning the strategic uses of health or medicine as 'misuses' of medical authority. Medicine is highly contentious not only in terms of disputes over medical knowledge itself, but also concerning the proper role of medicine in society – something expressed, for example, in the fields of medical and bioethics. Methodologically, this article moves from the more general to the more particular,

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[1] Nikolas Rose, 'Medicine, history and the present', in Jones and Porter (eds), *Reassessing Foucault: Power, Medicine and the Body* (London: Routledge, 1994).

showing how we must treat medicine in the specificities of its expressions and practices in any given space at any given time.

For this reason, a third qualification is needed: my interest is in modern medicine from about the nineteenth century onwards. This is not because this is when medicine 'improves' (although this could be argued), but because this is when medicine does two things in earnest: it links up to warfare in new ways, and it becomes a science of population (not just patients) through the invention of public health, hygiene, and social medicine. As we will see, these two developments are far from unrelated. Drawing out the relations between warfare and medicine, and social and national security will allow us to see how little it makes sense to think of health or medicine in terms of securitisation.

Securitisation theory and the politics of Global Health

IR approaches to Global Health Security (GHS) have been dominated by a focus on infectious diseases and a concern with securitisation. Briefly, securitisation theory seeks to understand the process by which threats are constructed. It studies how an issue gets elevated from 'normal politics' to a matter of security through the process of 'securitisation', or, the construction of an existential threat to a state or other referent object through securitising speech acts in a number of sectors. The theorisation of these 'sectors' originally included the military, environmental, economic, societal, and political sectors, but the securitisation framework has now been applied to a number of other issues, including global health. Securitisation theory has been used to explore responses to SARS,[2] HIV/AIDS,[3] and pandemic influenza,[4] and in understanding the military role in health interventions,[5] as well as health and human security.[6]

This literature has developed securitisation theory in relation to the empirical case of health in several ways. First, securitisation theory has been amended to take into consideration the ways in which securitisation is a multilevel process, its status as a continuum rather than a binary, and about the role of evidence in securitisations.[7] Secondly, because of a strong tradition of concern for the normative dimensions of health, the literature on health securitisations has produced conceptual innovation and empirical specification of the *effects* of 'securitisations' of health and

[2] Sara Davies, 'Securitizing infectious disease', *International Affairs*, 84:2 (2008), pp. 295–313.
[3] Stefan Elbe, 'Should HIV/AIDS be securitized? The ethical dilemmas of linking HIV/AIDS and security', *International Studies Quarterly*, 50 (2006), pp. 119–44; Colin McInnes and Simon Rushton, 'HIV/AIDS and securitization theory', *European Journal of International Relations*, 19:1 (2011), pp. 115–38; Colin McInnes and Simon Rushton, 'HIV, AIDS and security: Where are we now?', *International Affairs*, 86:1 (2010), pp. 225–45.
[4] Adam Kamradt-Scott and Colin McInnes, 'The securitisation of pandemic influenza: Framing, security and public policy', *Global Public Health*, 7:s2 (2012), pp. s95–s110; Thomas Abraham, 'The chronicle of a disease foretold: Pandemic H1N1 and the construction of a global health security threat', *Political Studies*, 59 (2011), pp. 797–812; Melissa G. Curley and Jonathan Herington, 'The securitization of avian influenza: International discourses and domestic politics in Asia', *Review of International Studies*, 37 (2010), pp. 141–66.
[5] Stuart Gordon, 'Health, stabilization and securitization: Towards understanding the drivers of the military role in health interventions', *Medicine, Conflict and Survival*, 27:1 (2011), pp. 43–66.
[6] Sandra Maclean, 'Microbes, mad cows and militaries: Exploring the links between health and security', *Security Dialogue*, 39:5 (2008), pp. 475–94.
[7] McInnes and Rushton, 'HIV/AIDS and securitization theory'. On securitisation as a continuum, see also Rita Abrahamsen, 'Blair's Africa: The politics of securitization and fear', *Alternatives*, 30 (2005), p. 59.

disease by arguing that they call forth emergency measures that can, for instance, sideline human rights, channel funds into health problems that have relatively lower global morbidity and mortality rates,[8] or otherwise warp public policy.[9] Thirdly, Stefan Elbe's work has drawn attention to the ways in which the securitisation of health may be a two-way street, thus involving the medicalisation of security – a point discussed in more detail in the following section.

Yet the adoption of securitisation theory into the study of GHS has some serious pitfalls. In order to grasp the ways in which securitisation theory has informed much of the literature on GHS, and to carve out the argument that refocusing on the global politics of medicine can mount a substantial challenge to securitisation theory, this section provides a discussion of some foundational ideas upon which securitisation theory rests. Throughout I demonstrate how these foundations have been adopted into studies of the securitisation of health. I focus particularly on the conceptual division between the norm and the exception, and by extension, social and national or international security.

The assumption that social and national or international security are entirely divisible is so axiomatic to the concept of 'securitisation' that an assertion of it takes up the very first paragraph of the 'conceptual apparatus' of Buzan, Wæver, and de Wilde's classic 1998 formulation of securitisation theory, *Security: A New Framework for Analysis*. In fact, the conceptual excision of social security sits under the subheading 'What is Security?'[10] Asking what quality makes something a security issue in international relations, they state (it is mainly Wæver writing this section, and the formulation echoes his 1995 chapter in *On Security*) that security in international relations must be treated separately because:

the character of security in that context [international relations] is not identical to the use of the term in everyday language. Although it shares some qualities with 'social security', or security as applied to various civilian guard or police functions, international security has its own distinctive, more extreme meaning.[11]

Does it? Feminist theorists in IR have been telling us for some time that we cannot assume that the state is a guarantor of security for all equally.[12] The passage continues: 'Unlike social security, which has strong links to matters of entitlement and social justice, international security is more firmly rooted in the tradition of power politics.'[13] Social security is here defined away in a brief paragraph and a footnote[14] – a separation that is also maintained in later works.[15]

The problem with this is threefold, as the remainder of this section illustrates. First, this limits the theory to national or international security speech acts, which only emerged after World War II. This is the theory's Austinian problem. Second, the excision of social security shores up a binary division between the norm and the

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[8] Elbe, 'Should HIV/AIDS be securitized?'
[9] Kamradt-Scott and McInnes, 'The securitization of pandemic influenza'.
[10] Barry Buzan, Ole Wæver, and Jaap de Wilde, *Security: A New Framework for Analysis* (Boulder: Lynne Reiner: 1998), p. 21.
[11] Ibid.
[12] Lene Hansen, 'The Little Mermaid's silent security dilemma and the absence of gender in the Copenhagen School', *Millennium*, 29:2 (2000), pp. 285–306.
[13] Buzan, Wæver, and de Wilde, *Security*, p. 21.
[14] Ibid., fn. 1 on p. 46, on p.131 the distinction between 'social' and 'societal' security is reaffirmed.
[15] Barry Buzan, 'A reductionist, idealistic notion that adds little analytical value', *Security Dialogue*, 35:3 (2004) p. 370. For a discussion see MacLean, 'Microbes, mad cows and militaries', pp. 487–8.

exception, and elides the strategic operations of social security. This is the theory's Schmittian problem. Third, the excision of social security reduces politics to 'power politics'. This is the theory's Clausewitzian problem. I deal with each of these in turn, illustrating how a focus on histories of the global politics of medicine can reveal, and potentially overcome these problems. Securitisation theory has already been amended and critiqued from a variety of angles.[16] But the study of the global politics of medicine can mount a novel – perhaps even fatal – critique.

First, the conceptual excision of social security truncates possibilities for historical analysis of relations of war or defence prior to World War II. Because, following from Austin,[17] securitising speech acts are placed at the centre of the conceptualisation of the construction of threats, I argue that securitisation theory has a problem of history. It is not only that 'national security' is a relatively recent phenomenon,[18] but also that national security was preceded by social security, which dates from the mid-1930s New Deal era. In fact, national security grew out of social security in the post-World War II era.[19] By focusing only on national or international securitising speech acts, then securitisation theory by definition has little to say about such practices prior to World War II when they were constructed in terms of war or later defence, except that, through a conceptual sleight of hand, a securitising move does not, as the theory goes, necessarily need to use the word 'security', but instead must construct an existential threat. This begs the question, however, about whether threat constructions prior to World War II (or the New Deal if we include social security) can rightly even be called 'securitisations', given a historical context wherein 'security' did not have this valence.

This problem in securitisation theory plays out in the health securitisation literature. Because of the acceptance of securitisation theory's emphasis on the role of elite speech acts in converting a political issue into an exceptional security issue, the 'securitisation' of health is often traced to the year 2000, when the UN Security Council adopted Resolution 1308 on HIV testing for peacekeeping troops, after which SARS and influenza also hit the international security agenda.[20] The work of Adam Kamradt-Scott and Colin McInnes is an interesting exception. They draw a history dating from 1918 (during the devastating influenza pandemic) of the treatment of influenza as a threat to human health, though they argue that it was only successfully securitised at the turn of the millennium. Alternatively, Lorna Weir and Eric Mykhalovskiy suggest that the critical shift around the turn of the millennium was in the conceptual, technical, and juridico-political transformation of international communicable disease control into global public health vigilance.[21]

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[16] See Thierry Balzacq, *Securitization Theory: How Security Problems Emerge and Dissolve* (London: Routledge, 2010). See also Claudia Aradau, 'Security and the democratic scene: Desecuritization and emancipation', *Journal of International Relations and Development*, 7:4 (2004), pp. 388–413; and Hudson's brief discussion of the way in which gender is relegated to social security in securitisation theory: Heidi Hudson, '"Doing" security as though humans matter: A feminist perspective on gender and the politics of human security', *Security Dialogue*, 36:2 (2005), pp. 155–74.

[17] See J. L. Austin, *How to do Things with Words* (Oxford: Oxford University Press, 1975).

[18] Tarak Barkawi, 'From war to security: Security studies, the wider agenda, and the fate of the study of war', *Millennium-Journal of International Studies*, 39:3 (2011), p. 702; Tarak Barkawi, 'Of camps and critiques: A reply to "security, war, violence"', *Millennium-Journal of International Studies*, 41:1 (2012), p. 125.

[19] Mark Neocleous, 'From social to national security: On the fabrication of economic order', *Security Dialogue*, 37:3 (2006), pp. 363–84.

[20] Kamradt-Scott and McInnes, 'The securitization of pandemic influenza'.

[21] Lorna Weir and Eric Mykhalovskiy, *Global Public Health Vigilance: Creating a World on Alert* (New York: Routledge, 2010).

These accounts suggest that a much longer history must be brought to bear in thinking through the international relations of health than the concept of 'securitisation' can traditionally capture, and further, that in tracing these histories, what is most relevant is not shifts in speech acts, but in the technical and legal administration of global health security. Apart from these exceptions, however, the GHS literature has generally followed from securitisation theory's focus on securitising speech acts, and thus also suffers from an Austinian ahistoricism. Yet this is just the first of three problems.

Secondly, social security is defined away in securitisation theory precisely as a function of its conceptual distinction between the norm and the exception. This Schmittian[22] aspect of securitisation theory has been the subject of critique by others, particularly Foucauldian scholars of IR. One critique of this conceptualisation of the norm (politics, the rule of law, social security) versus the exception (the suspension of law, national security) which has also been expressed in the GHS literature has been to suggest that the division between the norm and the exception should not be seen as a binary, but as a continuum.[23] Others, however, have launched more wholesale critiques. Andrew Neal has argued that while securitisation theory moves away from a Schmittian treatment of the exception as a 'real possibility' by treating security as a process, it nonetheless reifies the state and retains an account of security as 'urgency, extraordinary circumstances, and exceptional measures' based on a stark division between the norm and the exception, and security and politics.[24] Such critiques emphasise how securitisation theory's focus on the exceptional misses the plethora of mundane administrative and bureaucratic practices that security entails.[25] My argument is sympathetic to these critiques, but argues something adjacent: that securitisation theory not only misses mundane or routinised practices, but that it moreover misses all of the many empirically specifiable relations between the supposedly separate but actually imbricated domains of social security and national or international security.

I make this argument precisely as a function of my empirical focus on medicine. To the extent that I would press upon Foucauldian critiques of securitisation theory, it is that although these approaches have been strongly theoretically driven, they have also tended to be somewhat empirically underspecified, especially in regard to the relations between social and inter/national security. To the extent that empirical analyses have been brought to bear on challenging the norm/exception distinction, the focus has tended to be on *law*. This makes sense, given not only that the suspension of law is seen as a core feature of exceptionalism, but also more practically because critical studies in criminology and socio-legal studies serve as a resource in rethinking this apparent norm/exception division. So, for instance, a density of routinised legal practices has been traced even in that space which came to seen as

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[22] See Carl Schmitt, *Political Theology: Four Chapters on the Concept of Sovereignty* (London: MIT Press, 1985).

[23] Abrahamsen, 'Blair's Africa', p. 59.

[24] Andrew Neal, 'Foucault in Guantánamo: Towards an archaeology of the exception', *Security Dialogue*, 37:1 (2006), pp. 31–46.

[25] Didier Bigo, 'Security and immigration: Towards a critique of the governmentality of unease', *Alternatives*, 27 (2002), pp. 63–92. For a discussion of the wider problem of security constructions, see Matt McDonald, 'Securitization and the construction of security', *European Journal of International Relations*, 14:4 (2008), pp. 563–87.

emblematic of War on Terror exceptionalism: Guantánamo.[26] This focus on law has been tied to a theorisation of liberalism and its relations to authoritarian or illiberal measures. Yet law is not the only professional domain that can be treated as an empirical site from which to assess the limits of the norm/exception divide. Medicine provides a useful footing from which to reassess war and security precisely because it is not solely or characteristically a liberal technology of governance. By focusing on medicine, we can conceptually refocus on modernity.

Surprisingly, Foucauldian scholars in IR have not taken much of an interest in medicine, despite its centrality to Foucault's œuvre, and despite the range of uses to which medicine was put in the War on Terror (not least of which at Guantánamo)[27] and in counterinsurgency strategy (as McInnes and Rushton illustrate, from a different perspective, in this Special Issue). I address this empirically in the following two sections of this article. Here I want to focus on how the 'securitisation of health' argument adopts securitisation theory's Schmittian problem by assuming that there is a distinction between the norm and the exceptionality of security, resulting in an impoverished theorisation of 'politics'. Because of the assumption that health must become 'exceptional' to be securitised, and because securitisation excises social security, violent practices made in the name of health or through the authority of medicine are cast as anomalous – literally 'exceptional' – rather than as a regular and routinised part of politics as the governance of the population. As such, little stock can be taken of how deeply and historically entangled the fields of health and medicine are with warfare, defence, and security. For these reasons, I argue that there is a need to refocus our attention on the workings of medicine, and that doing so will cast serious doubt on the viability of securitisation theory.

Additionally, though there is much value in unravelling the norm/exception binary which undergirds securitisation theory, more could be said specifically about what this means for a theorisation of *politics*. Some have argued, for instance, that securitisation theory should be more normatively driven, and thus, that it should advocate 'desecuritisation' and a return to 'politics'.[28] This formulation, however, assumes a before-and-after of securitisation, that politics and security are fully distinct, and that there can be some kind of return from security. More traction can be gained, I argue, from excavating how 'politics', and relatedly 'power' is formulated in securitisation theory in order to unravel not only the Schmittian, but also the Clausewitzian underpinnings of securitisation theory – which brings me to the third problem of securitisation theory drawn out here.

In Wæver's earlier 1995 discussion of securitisation and desecuritisation it becomes apparent that the origins of this formulation of power and politics lie in Clausewitz's description of war as the continuation of politics by other means.[29] Wæver reads Clausewitz as assuming that politics is prior to war. Therefore, it is possible to posit 'securitisation' as something that happens to 'politics' in domains other than war (health, for instance). Thus: 'the logic of war – of challenge-resistance(defence)-escalation-recognition/defeat – could be replayed metaphorically and extended to other sectors. When this happens, however, the structure of the game is still derived

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[26] Fleur Johns, 'Guantánamo Bay and the annihilation of the exception', *The European Journal of International Law*, 16:4 (2005), pp. 613–35.
[27] Alison Howell, 'Victims or madmen? The diagnostic competition over ''terrorist'' detainees at Guantánamo Bay', International Political Sociology, 1:1 (2007), pp. 29–47.
[28] Aradau, 'Security and the democratic scene'.
[29] Carl von Clausewitz, *On War* (Princeton: Princeton University Press, 1984).

from the most classical of cases: war.'[30] This is, essentially, the process of securitisation. But what if there is no innocent domain of politics or social security prior to war?

Here Foucault's inversion of Clausewitz in his lectures outlining the history of the logic that *Society Must Be Defended* provides a useful starting point.[31] Foucault carves out an alternative to the notion of power as solely repressive (that is, 'power politics' in Wæver), by tracing the history of normalisation and biopower. He inverts Clausewitz's proposition in order to posit that 'politics is the continuation of war by other means'.[32] What Foucault suggests here is that the domain of 'politics' is marked by relations of force that have been 'established in and through war at a given historical moment'.[33] Foucault's inversion of Clausewitz does not mean that we simply see this as a 'two-way street' (politics to war, and war to politics, or, health to securitisation and medicalisation to security). Rather, it serves as a provocation, which Foucault develops in order to suggest that war permeates the social body through the injunctions that 'society must be defended' and that the population must be improved. Crucial here is the way in which relations of force are directed at bodies in a kind of 'social warfare'[34] that is expressed from the nineteenth century in terms of the purity and strength of the race, and increasingly through the twentieth century in terms of the life and health of the population. Public hygiene and public health became strategies for this kind of social warfare. These strategies constitute 'normal' politics – which are marked by normalising forces that work to improve the population through a range of activities, from excising those who weaken the race (eugenics) to the monitoring and immunisation of the population from disease (epidemiology/public health).

From this perspective, to speak of 'securitisation' is to mistakenly assume that there is something pure, merely, or normally political prior to security that is not permeated with relations of force. In this sense, those in IR who have asserted that 'the exception has trickled down'[35] to the mundane sphere of politics or the law, or that security policies 'feed back'[36] into society are identifying an important dynamic: that there is a relation between supposedly external security and 'society'. However, such formulations of this dynamic are too IR-centric and unidirectional (from national security into society). They fail to see how social and national security imperatives aimed at the population have been co-constituted. This is important not only for theoretical or conceptual reasons, but because it opens up new avenues for exploring empirically specifiable relations between ostensibly separate domains. What happens if we see the functioning of modern medicine within the supposedly unexceptional, unsecuritised domain of social security as a kind of normalising and

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[30] Ole Wæver, 'Securitization and desecuritization', in Ronnie Lipshutz (ed.), *On Security* (Columbia University Press, 1995), p. 54.

[31] Michel Foucault, *Society Must Be Defended: Lectures at the Collège de France 1875–1976*, trans. David Macey (New York: Picador, 2003). For a discussion see Andrew Neal, 'Cutting off the king's head: Foucault's *Society Must be Defended* and the problem of sovereignty', *Alternatives*, 29 (2004), pp. 378–98.

[32] Foucault, *Society*, p. 15.

[33] Ibid.

[34] Ibid., p. 60.

[35] Claudia Aradau and Rens Van Munster, 'Exceptionalism and the "War on Terror"', *British Journal of Criminology*, 49 (2009), pp. 686–701.

[36] Jef Huysmans, 'Minding exceptions: The politics of insecurity and liberal democracy', *Contemporary Political Theory*, 3 (2004), pp. 321–41.

biopolitical 'social warfare'? What if public health, and indeed medicine itself, is constantly productive of relations of force?

To effectively answer these questions, we need to move beyond notions that medicine has straightforwardly 'progressed' through history. A common misperception is that medical ethics vastly improved after World War II, when the enthusiastic participation of medical authorities in Nazi experimentation on Jews and others in concentration camps came to light, leading to the Nuremberg Code and the Helsinki Code governing the ethics of biomedical research. While World War II made clear that there was an all too easy alliance between fascism and medical science, medical experimentation on racialised or otherwise marginalised people is not limited only to fascist settings, and is not a relic of the past. In fact, it has frequently occurred in post-World War II Western liberal settings: the supposed domain of 'normal politics'.[37] The Tuskegee experiment is a famous case in point. The United States Public Health Service study, which ran from 1932–72 in Alabama, conducted experiments on 600 poor black men to determine the effects of untreated syphilis. The study promised its subjects free physical examinations, free transportation, meals, and the promise of a free burial – but denied them available syphilis treatments (such as penicillin), and was carried out without informed consent.[38] Similarly, in the 1940s and 1950s, doctors with the federal department of Indian Affairs ran experiments on aboriginal children in Canada, including ones involving their systematic starvation.[39] Medical experiments to gain advantage in the Cold War were often funded by the US Department of Defense. Radiological experiments to test human tolerance for radiation exposure, for example, were conducted on orphans, pregnant women, disabled and African-American children, prisoners, and others.[40] The US ban on the common practice of running clinical trials on prisoners spawned the current global clinical trial industry based on the 'experimental labour' of those living in poverty (in both the Global South and in the US), who are valued for their status as 'treatment naïve' (that is, lacking healthcare).[41] Attention to these facts challenges the construction of the domain of 'politics' or 'social security' as the 'norm'.

Yet it is not just medical experimentation that is relevant here, but all the myriad ways in which medicine is implicated in the politics of normalisation and governance. Think, for instance, of medicine's role in the management of 'abnormals' – a form of 'social warfare' aimed at improving the population. It was not until the 1973 edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-II) that 'homosexuality' was removed from psychiatry's list of disorders, and it was not until the 1986 edition (DSM-III) that 'hysterical neurosis' and 'ego-dystonic homosexuality' were deleted. After much activism, the newly-released 2013 DSM-V replaced 'Gender Identity Disorder' with the still highly problematic term 'Gender Dysphoria' but still includes the diagnosis 'Transvestic Disorder' (previously 'Transvestic Fetishism' in

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[37] Jordan Goodman, Anthony McElligott, and Lara Marks (eds), *Useful Bodies: Humans in the Service of Medical Science in the 20th Century* (Baltimore, Johns Hopkins University Press, 2003).
[38] James H. Jones, *Bad Blood: The Tuskegee Syphilis Experiment* (New York: Free Press, 1981).
[39] Ian Mosby, 'Administering colonial science: Nutrition research and human biomedical experimentation in aboriginal communities and residential schools, 1942–1952', *Histoire Sociale/Social History*, 46:1 (2013), pp. 145–72.
[40] Eileen Welsome, *The Plutonium Files: America's Secret Medical Experiments in the Cold War* (New York: Dial Press, 1999).
[41] Melinda Cooper and Catherine Waldby, *Clinical Labor: Tissue Donors and Research Subjects in the Global Bioeconomy* (Durham: Duke University Press, 2014).

DSM-IV) which essentially figures trans women as perverts.[42] These categories have real consequences for people, from lack of access to adequate healthcare, to forced sterilisation (a policy actively applied in many countries and repealed only in 2013 in Sweden, for instance). New modes of 'public safety' entail techniques such as community treatment orders for those diagnosed with psychiatric disorders, a practice equated to 'chemical incarceration'.[43] Viewed in this light, the security role of medicine is not just a relic of the past, of colonialism, or of fascism. It is also a matter of liberal modernity, entailing normalising or biopolitical expressions of power, precisely in the field defined away in securitisation theory as that of 'normal politics', 'social security', or the zone of 'entitlements'.

The excision and 'improvement' of those who are deemed (biologically) deficient is not an exception to medicine's purported altruism, but an expression of its strategic logic across the population. Violence in the domestic realm, including the strategic violence of medicine that addresses itself to the population, cannot rightly be thought of as exceptional, or as a result of national security imperatives trickling down or feeding back. Nor can these dynamics be captured by the terms 'militarisation' or 'securitisation'. Rather, it is more accurate to observe that the features that make medicine so apt a tool for working on populations in the domestic realm are also the features that make it useful in matters of national or international security.

The following section will recount the history of how modern medicine and warfare have grown together as strategies for the defence of society and the improvement of the population, revealing the co-constitutive relations between peace and war, or social security and inter/national security. It seems easy to assume that curing and killing are at opposite ends of the spectrum of human activity. However, as I will argue, the 'threat-defence' logic does not get imported into 'society', health, or medicine through the so-called process of 'securitisation'. Rather, modern medicine at least from the nineteenth century has always already functioned through this logic, precisely because it has been a science of social security and public safety at the level of the population. This is certainly not to say that medicine and warfare, or social security and inter/national security, have remained unchanged. Rather it is to say that they have been continuously imbricated as they changed. As such, we need to move beyond Global Health, and beyond securitisation theory, with its Austinian, Schmittian, and Clausewitzian problems, in order to look more closely at the history and contemporary development of the global politics of medicine and war.

Towards a Global Politics of Medicine

How might we start to forge a Global Politics of Medicine? The literature on Global Health in IR seems to be an obvious resource. Yet while the field of Global Health has not been totally silent on the question of the role of medicine, it has generally subsumed questions of medicine under the analytical rubric of health. There are two main strands of research in the Global Health literature that are pertinent here, and serve as illustrative examples.

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[42] Kelley Winters, *Gender Madness in American Psychiatry: Essays from the Struggle for Dignity* (Colorado: GID Reform Advocates, 2008).

[43] Erick Fabris, *Tranquil Prisons: Chemical Incarceration under Community Treatment Orders* (Toronto: University of Toronto Press, 2011).

First, there are several studies of Global Health that question how medicine or medical authority has been 'misappropriated'. Kamradt-Scott's research, for instance, has traced the effects of the rise of Evidence-Based Medicine (EBM), which has shaped influenza policy toward pharmaceutical-based solutions over potentially more effective and equitable ones.[44] Elsewhere, he has also argued that prominent medical authorities have been influential or complicit in the securitisation of influenza, reifying the authority of biomedicine and the associated medical community.[45] As a further example, in this Special Issue, McInnes and Rushton assess whether 'humanitarian' medical interventions (whether 'tailgate medicine' or health infrastructure projects) can successfully be used by military actors for strategic ends in counterinsurgency warfare as a form of 'smart power'. Alongside strategy or smart power, their study takes 'health' (rather than 'medicine') as its referent. The result is that they understand these activities primary as health activities, rather than as a novel turn in the ways in which emergency medicine is being generated by contemporary forms of warfare, and how contemporary warfare is being shaped by emergency medicine.

In each of these cases, the strategic use of medicine is implicitly viewed as an exception that could be restored to a norm (of medicine being nonstrategic) – that medical or health interventions could be *unstrategic*. Where I depart from this approach is in challenging the assumption that when medicine comes to be used for 'less salubrious purposes to further specific goals or objectives'[46] then medical science has been 'distorted', 'manipulated', or subject to 'bias' – an assumption common in the Global Health literature. I argue will otherwise: medicine has been thoroughly strategic since the development of modern medicine from the nineteenth century onwards. Before turning to this argument, I discuss a second strand of Global Health research that addresses questions of medicine.

The second strand of Global Health research that has touched on the study of medicine includes studies which use the concept of 'medicalisation'. Stefan Elbe, who introduced the concept to the field,[47] argues that if health issues have been securitised, then surely security, or more precisely insecurity, has also been medicalised. From this perspective, Elbe has illustrated how the rise of global health is transforming – medicalising – practices of security. Yet to note that health has been securitised and insecurity has been medicalised suffers from a 'chicken and the egg' problem: which came first? Neither did. Both modern medicine and modern warfare have, from the nineteenth century, always already entailed shared logics of defence, strategy, and later security because in many important ways they have come into being through each other. *Contra* Elbe, attention to the global politics of medicine reveals (here I

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44 Adam Kamradt-Scott, 'The politics of medicine and the global governance of pandemic influenza', *International Journal of Health Services*, 43:1 (2013), pp. 105–21. For another critique of EBM, see Colin McInnes and Kelley Lee, *Global Health & International Relations* (Cambridge: Polity, 2012), pp. 112–15.

45 Adam Kamradt-Scott, 'Evidence-based medicine and the governance of pandemic influenza', *Global Public Health*, 7:S2 (December 2012), pp. 111–26. See also Adam Kamradt-Scott, 'The politics of medicine', pp. 112–13.

46 Adam Kamradt-Scott, 'The politics of medicine', p. 113.

47 Stefan Elbe, *Global Health Security* (Cambridge: Polity, 2010); Stefan Elbe, 'Pandemic on the radar screen: Health security, infectious disease and the medicalisation of insecurity', *Political Studies*, 59 (2011), pp. 848–66.

am reversing a position which I also previously expressed)[48] that it is impossible to speak of health or medicine as things that can be 'securitised', or of the medicalisation of security. Modern medicine, like all technologies of social security, has never been pure. It has always expressed a strategic logic at the level of the defence and optimisation of the health of populations. The result is that the 'medicalisation' approach not only fails to see how a focus on medicine (rather than health) can challenge the conceptual and empirical validity of securitisation theory, but moreover that it suffers from some of the same problems, including most pointedly, the problem of ahistoricism. Is the 'medicalisation' of security really a twenty-first-century phenomenon? Or is it that modern medicine and warfare are two expressions of a broader effort to defend and optimise the population that have grown together from at least the nineteenth century?

It is precisely these shortcomings that a 'Global Politics of Medicine' could redress by shifting the focus of our attention from health to medicine. My argument is that attention to the history and sociology of medicine, and its imbrication with warfare, reveals that practices of warfare and medicine are strategic technologies, which are and have been both symbiotic and homologous. In a similar vein, Antoine Bousquet has illustrated how science and warfare are symbiotic, showing that warfare has been underpinned by a series of scientific rationalities. From the seventeenth century onwards, the history of warfare and of science has been one of mutuality, with, for example, the invention of the clock, the engine, and the computer influencing how wars are waged, while several scientific developments have been stimulated or conditioned by the experience of war.[49] Yet, to this author's knowledge, there has never been a serious and sustained study in IR of how medicine and war are similarly symbiotic. The balance of this article seeks to set out what might be accomplished through a field of study focused on the Global Politics of Medicine by focusing on the discipline's ostensible core subject matter: war.

A vast historical literature traces the relationship between warfare and medicine as, especially from the nineteenth century forward, warfare and medicine both came to be scientific, industrialised, and professionalised endeavours. With the industrialisation of conflict, new weapons meant that war less frequently involved face-to-face combat, and more often killing at a distance, making medicine and public health important tools in maintaining the human resources necessary for mass mobilisations. War has thus generated a number of forms of medical innovation, while medicine has propelled innovations in warfare.

In, and as a result of, the Crimean War, social sanitation and the administrative organisation of medical provision (through war hospitals) were developed. At the same time, new confidence in medicine gave rise to increased public concern for the lives and wellbeing of servicemen. Innovations such as preventive medicine and techniques of evacuation evolved through the Franco-Prussian war. The American Civil War propelled the development of the new medical specialty of neurology, as a medical science for increasing manpower in the face of the prevalence of nervous disorders, including 'nostalgia', amongst soldiers. In the Russo-Japanese War at the beginning of the twentieth century, the development of bacteriology and immunology

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[48] Alison Howell, *Madness in International Relations: Psychology, Security and the Global Governance of Mental Health* (London: Routledge, 2011).

[49] Antoine Bousquet, *The Scientific Way of War: Order and Chaos on the Battlefields of Modernity* (New York: University of Columbia Press, 2009).

resulted in fewer casualties from disease than battle deaths for the first time in history. By World War I, the use of medicine in warfare (especially public health systems of sanitation) was not just a matter of morale or bowing to public concern over the lives of soldiers, but of strategic advantage. Pharmaceuticals are also weapons of war: in World War II, the Allies' possession of quantities of penicillin, which was used to treat not only infected wounds but also venereal disease, proved an important strategic advantage over the Germans.[50]

Joanna Bourke's work on the role of the medical sciences in rooting out 'malingering' is instructive here. As she argues, '[m]edicine did not simply serve the military, but was crucial in actually defining and expanding military power so that the armed forces could control and direct the emotional as well as the material lives of its recruits with greater effectiveness.'[51] From this perspective, we can see that it is not just that medicine comes to be used in warfare, nor that medicine develops in relation to warfare, but rather that modern warfare and modern medicine are symbiotic.

I extend this argument by suggesting that warfare and medicine, and national and social security, are also *homologous*. They share, through their imbricated history, a common logic. They both become, from the nineteenth century onwards, strategic technologies of defence as defence refers to populations (and no longer mainly the sovereign or patient) with a common strategic aim: defending the population. As it modernised in the nineteenth century, medicine took on several roles: of improving the population, of defending society from enemies without and degenerates within, and of shoring up 'manpower' in both military and colonial spaces. Thus, it came to be a science of population through expressions of race war, not only against external 'enemies' but also in the domestic realm (as illustrated above), and in the space of the colony as well.

Clearly, colonial spaces were carved out and maintained through the use of technologies of warfare in directly violent ways. Medicine was also an important tool in conquering and maintaining colonies in numerous ways. For instance, the development and distribution of the antimalarial quinine was critical in the colonisation of the African continent beyond coastal regions. Medicine also emerged as a means for managing colonised populations. In the early nineteenth century, phrenology, craniometry, and physiognomy ascended as authoritative sciences in both Europe and North America. Based on related ideas that a person's character, personality, and brain function could be ascertained by measuring their skulls and analysing their facial features, these medical sciences cast African men in particular as primitive and degenerate, and played a major role in colonisation, the Atlantic slave trade, and the institution of systems of apartheid, for example in South Africa. Both European cooperation and contemporary global public health governance grew out of colonial attempts to contain diseases through international standardised quarantine regulations, gaining momentum after France's hosting of the International Sanitary Conferences starting in 1851 as an effort to insulate Europe from the 'exotic' diseases of the 'uncivilised world'.[52]

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[50] This fact suggests that it may be possible to further historicise the position advanced by Elbe in this Special Issue that there has been a recent 'pharmaceuticalisation' of security. See Stefan Elbe, 'The pharmaceuticalisation of cecurity: Molecular biomedicine, antiviral stockpiles, and global health security', this Special Issue.

[51] Joanna Bourke, 'Suffering and the healing profession', *War and Medicine* (London: Black Dog Publishing, 2008), p. 125.

[52] Obijiofor Aginam, 'The nineteenth century colonial fingerprints on public health diplomacy: A post-colonial view', *Law, Social Justice & Global Development Journal*, 1 (2003), pp. 2–12.

The role of medicine in colonisation was not just a matter of ensuring the health of colonisers, but of working upon colonised populations, as in the military sphere, in order to shore up 'manpower'. In response to resistance, vaccination campaigns were one of the earliest and most extensive public health initiatives that Europeans propogandised as evidence of the advantages of colonial rule.[53] They were also crucial for ensuring a healthy population from which to extract labour, in ways that relied on and propelled epidemiological activity on military populations. It should be clear here that the treatment of diseases as security issues on a global scale, and the use of medicine as a strategic technology to respond to them, is by no means a new phenomenon. These facts are empirically irrelevant to securitisation theory: worse, they are rendered invisible not only through the theory's ahistoricism, but through the assumption that 'securitisation' is something that happens to 'disease'. Rather, what we may trace is the co-constitution of medicine and practices of imperialism and warfare as symbiotic strategies aimed at diverse populations in ways that are highly connected from the outset.

Nineteenth and twentieth-century wars moulded vast swaths of medical expertise, from neurology to immunology, epidemiology, and public health, to surgical procedures, emergency medicine, triage and prosthetics, not to mention psychiatry and especially, in the twentieth century, psychology. Yet these medical tools and techniques did not remain solely on the warfront, but were developed cooperatively (and applied) in the civilian sphere. The establishment of medical sciences as strategic technologies for the management and improvement of the population were not contained merely in one domain (the military, the colony, the warzone, the homefront), but developed out of the establishment of the 'problem' of the population in each of these spaces. It is as we see how medicine was able to work on the same level and in concert with warfare, that we can see how the two technologies are homologous. Both aim at the population, both are strategic, both claim to produce security. This shared history between warfare, medicine, and society also entailed shaping modern medicine as a strategic science of public health and social security – as sciences not only for curing the patient, but also administering (to) the population, whether that population is of soldiers, citizens, or colonised subjects. The management of bodies from the front, through casualty-clearing stations, to hospitals and so forth, not to mention the management of bodies within hospitals relied on and gave rise to administrative technologies that were also used in civilian and colonial administration. This linked together bodies, warfare, and medicine in ways that permeate modes of governance that we tend to think of as 'civilian', such as the welfare state.[54] It is not simply that medical innovations born out of warfare were 'imported' into the domestic sphere. Both modern warfare and modern medicine grew together, from the nineteenth century forward, as professions for the activation and improvement of the population. Returning to the Crimean War, the figure of Florence Nightingale is illustrative here.

As the 'mother' of nursing, 'passionate statistician', and social reformer, Nightingale's expertise and influence in the development of public health grew out of her

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[53] William H. Schneider, 'Smallpox in Africa during colonial rule', *Medical History*, 53:2 (2009), pp. 193–227.

[54] Deborah Cowen, 'Welfare warriors: Towards a genealogy of the soldier citizen in Canada', *Antipode*, 37 (2005), pp. 655–78.

work in two spaces: the war hospital (in the Crimean War), and the workhouse (in Victorian London). Public health grew out of its utility in these two domains – of waging war (national security) and governing the poor (social security) – in a manner that can best be described as symbiotic. Modern medicine developed as a result of its uses in the waging of both welfare and warfare as means for the defence of society and the improvement of the population. To describe modern warfare and modern medicine as simply interacting or influencing each other is insufficient. Despite their apparently different spheres of operation – killing and curing – they share practitioners, resources, techniques, and language. They have not only been symbiotic in their repeated interactions with each other, they are also homologous in their strategic focus on the defence and optimisation of populations.

Once we recognise this symbiosis and homology through an examination of the Global Politics of Medicine, it becomes impossible to conceptualise a 'securitisation' of health. There is no process of 'becoming' securitised (or, for that matter, 'medicalised'): both modern warfare and modern medicine, as soon as they refer to the population (whether of soldiers, citizens, or colonial subjects) and not primarily the individual (the patient, the monarch) are always already thoroughly technologies of defence in which the health of the population is part of an arsenal of 'manpower'. This is not to say that the precise nature of this symbiosis or homology remain unchanged, but it is to say that this change cannot be captured by reference to 'securitisation'.

Indeed, these relations have not remained static since the nineteenth century, or even throughout the twentieth and into the twenty-first century. Rather, they are undergoing constant transformation, which must be specified *empirically.* My argument in the following section is that twenty-first-century warfare and medicine are now turning to the population in a novel way, treating the population as a set of knowable individual bodies in order to more ambitiously reach within both populations and bodies. As homologous strategies of population, medicine and warfare are doing this symbiotically.

Warfare and medicine in the twenty-first century

While the above historical evidence demonstrates the ways in which the imbricated fields of warfare and medicine have become symbiotic and homologous in their mutual modernisation, there are specificities to the twenty-first century that suggest the development of new relations between warfare and medicine in what has been called 'late modernity', and which demonstrate the power of a global politics of medicine framework to analyse our present moment. The wars in Afghanistan and Iraq (and Pakistan, Yemen, and Somalia, if we include drone strikes) have drawn on prior models of warfare, while also developing new techniques. Though the infamous 2006 US Army/Marine counterinsurgency (COIN) manual approvingly cites the colonial experience of the British military in Malaya and Kenya, and the French in Algeria, as models for the development of US COIN strategy, it is also certainly true that these wars have involved transformations not only in warfare, but also in medicine, and in the relation between the two.

The contemporary affinities between warfare and medicine are immediately discernable in their shared language. Twenty-first-century counterinsurgency strategy

involves the deployment of medical and health metaphors which position the population of the host nation (Afghanistan, Iraq) as suffering from an infectious disease, and thus in need of immune protection.[55] I argue that the frequency and evident utility of such metaphors is important not primarily because it frames our understanding of war as a health-giving exercise (which is ultimately an argument about representation), but because it points toward something more deeply-rooted: the ongoing shared strategic logic of warfare and medicine. Discourses of health and medicine are not simply being imported and abused in the service of violence. Rather, discursive similarities point us toward their common logic. There is a significant shared vocabulary of elimination, defence, containment, and frontlines, not to mention battling disease, wars on various diseases, magic bullets, doctor's orders, and so on. This shared language does not so much express a recent militarisation of medicine (or a securitisation of health) as an affinity between their strategic logics.

Of course, the precise nature of this affinity is not static, but subject to continual change, and must, therefore, be empirically specified at any given point. As examples, I briefly consider three points at which these relations between warfare and medicine have recently become visible: in the use of medical logic of triage and medico-humanitarian practices in US counterinsurgency (COIN) strategy; in the development of 'enhanced' soldiers, and in particular in the use of psychological resilience; and finally, in the use of genetics in intelligence gathering. In each of these cases, both warfare *and* medicine are now treating the populations they target as composed of individual bodies, suggesting a symbiotic innovation in both warfare and medicine. These examples show how attention to the global politics of medicine (rather than the securitisation of health) can be revealing as we attempt to understand and challenge the operations of power in the contemporary world.

Triage

COIN strategy sees the field of battle in terms not of the territory so much as the population. This population or social body is divided up between an active minority supporting the insurgency, an active minority opposing the insurgency, and a neutral or passive majority. The main objective of contemporary counterinsurgency is to win the hearts and minds of the passive majority. Hearts and minds activities, then, are figured as a kind of 'inoculation' of the passive majority from the active minority of insurgents, who are figured as an infectious disease. COIN strategy, then, involves targeting the infection (killing the insurgents) but also inoculating the population against the infection through hearts and minds, or, as the influential military strategist and consultant David Kilcullen put it: 'armed social work'.

A number of scholars have argued that COIN strategy is delivered in medicalised terms. As Derek Gregory excerpts from the COIN manual, this medical metaphor is threefold:

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[55] Colleen Bell, 'Hybrid warfare and its metaphors', *Humanity*, 3:2 (2012), pp. 225–47. See also Markus Kienscherf, 'A programme of global pacification: US counterinsurgency doctrine and the biopolitics of human (in)security', *Security Dialogue*, 42:6 (2011), pp. 517–35.

'Stop the bleeding': similar to emergency first aid for the patient. The goal is to protect the population, break the insurgents' initiative and set the conditions for further engagement.

'Inpatient care – recovery': Efforts aimed at assisting the patient through long-term recovery or restoration of health – which in this case means achieving stability ... through providing security, expanding effective governance, providing essential services and achieving incremental success in meeting public expectations.

'Outpatient care – movement to self-sufficiency': expansion of stability operations across contexts regions, ideally using HN [host nation] forces.[56]

Gregory describes this as a form of medicalised language, which pitches war 'falsely' or ideologically as a form of health intervention. This is true, but it is not the whole story.

COIN warfare has been conducted not only under the cover of medical language, but precisely through emergency medical strategy – and specifically, through the medical strategy of *triage*. Triage involves the sorting of patient bodies in order to maximise the efficiency of emergency medical provision. Because the field of the battle does not entail an undifferentiated mass of bodies (as in trench warfare), but instead a wily agent circulating in the population, the social body must be differentiated, identified, and treated according to the state of their health: if they are healthy (allied to the counterinsurgents) they can be let to live, if they are part of the susceptible majority whose allegiance must be won then they must be inoculated (through hearts and minds), and if they are insurgents then they are not only suffering from infection – they are the infection – and must therefore be eliminated. This is not just a question of language, it is a question of technique.

Others scholars have recognised this. Michael Dillon and Julian Reid have argued that COIN imports the techniques of humanitarianism learned in the 1990s.[57] But they do not sufficiently account for how the development of (medical) humanitarian activity was itself derived from wartime experience. Many humanitarian techniques are derived precisely from military techniques, such as systems of administration or logistics including food delivery (for the front or the disaster), and, of course, public health (sanitation, hygiene, food aid, disposing of dead bodies, and so on) and emergency medicine. The invention of triage as a technique of emergency medicine was born precisely out of the need to organise the provision of medical care in war. Triage emerged from the Napoleonic Wars (triage is from the French: *trier*), and was developed especially in World War I as an organisational structure necessary to handle the growing number of casualties associated with modern warfare.[58]

Triage, then, has always belonged as much to war as to civilian medicine. From this perspective, the COIN strategy of triage – a technique of emergency medicine – is simply another instance of the ongoing mutuality between medicine and warfare, and their logistics, logics, and strategies. When we see COIN making use of the model of triage, what we are witnessing is not best described as a misuse of language, or even as an importation of technique. Rather, by taking stock of the long history of the imbrication of war and emergency medicine (including triage) we can apprehend

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[56] Derek Gregory, 'The rush to the intimate: Counterinsurgency and the cultural turn', *Radical Philosophy*, 150 (2008), p. 19.
[57] Michael Dillon and Julian Reid, *The Liberal Way of War: Killing to Make Life Live* (London: Routledge, 2009).
[58] Iain Robertson-Steel, 'Evolution of triage systems', *Emergency Medicine Journal*, 23:2 (2006), pp. 154–5.

the specificities of twenty-first-century developments in both medicine and warfare, and the ways in which these fields are again evolving symbiotically, and in ways that suggest their homology.

This mutuality has some unexpected results. It has also been noted that as war becomes purportedly humanitarian, it comes to value life.[59] Indeed, there is a much lower tolerance for casualties amongst soldiers and civilians expressed both in military strategy and public concern. Bodies, in twenty-first-century warfare, have value in their individuality. Contrary to the position espoused by Judith Butler,[60] and others in IR who have followed from her, that some bodies have value while others do not due to a cultural economy of grievable and ungrievable lives, I take the position here that *all* bodies have value in twenty-first-century warfare: it is just that some have value in their life (civilians, Western soldiers), and others have value in their death (terrorists, insurgents). Bodies are now valued not in their mass, as in World War I trench warfare, but, strikingly, in their individuation and identification through triage as insurgents, civilians, or allies. The use of emergency medicine and triage are not best conceived as being 'misused' or an example of 'securitisation' since triage has always had, as a strategic technology for doing things to and with populations, a logic which is not only useful in warfare but indeed developed out of it. What is notable is not that this logic is new (on the contrary it is old) but that it is again being put to novel uses in the conduct of both warfare and medicine.

Enhancement/resilience

Contemporary warfare has entailed all kinds of new developments in medicine, directing it and being directed by it simultaneously. While soldier mortality has dropped significantly, in part as a result of body armour and the improvement of trauma care such as improved haemorrhage-control techniques, soldiers are now returning from war with catastrophic injuries that would have once been fatal. The use of improvised explosive devices (IEDs) as part of irregular warfare, and the way in which COIN military strategy takes soldiers 'far from the flagpole' and into the population, has meant that increasing numbers of soldiers have suffered brain injuries, burns, wounds to or loss of limbs, and infections, as well as high diagnosis rates of post-traumatic stress disorder (particularly in the US, though less so in the UK).[61] These developments have propelled research and new techniques in neurology, preventive medicine, prosthetics and cybernetics, emergency medicine, rehabilitation, mental health, protective technologies, medical imaging, as well as new research into regenerative medicine, including stem-cell therapies and the recently successful efforts at engineering organs and other tissue (for example, for limbs), as well as spinal cord, nerve, muscle and skin regeneration.[62] Of note here is that soldiers are generally young and generally male, and so, the wars have not propelled significant research in, for example, cardiovascular disease, diabetes or maternal health, to name a few.

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59 Dillon and Reid, *The Liberal Way*.
60 Judith Butler, *Frames of War: When is Life Grievable?* (London: Verso, 2009); Judith Butler, *Precarious Life: The Power of Mourning and Violence* (London: Verso, 2004).
61 Jennifer Terry, 'Significant injury: War, medicine, and empire in Claudia's Case', *WSQ: Women's Studies Quarterly*, 37:1–2 (2009), pp. 200–25.
62 William Wiesmann, Nicole Draghic, and John Parish, 'Advances in modern combat casualty care with a vision to the future', *War and Medicine* (London: Black Dog Publishing, 2008).

Yet perhaps the most expansive use of medicine and its allied fields in contemporary warfare is in the move from the management to the *maximisation* of force. When war involved a mass of bodies on a defined frontline, then forms of medicine aimed at maintaining this overall mass of bodies were developed and made useful in the war effort. Here, we can think of epidemiology and public health measures – vaccines, hygiene, and sanitation, for example. To be sure, these measures are still important in maintaining the overall health of the military population. But the contemporary strategic aims of both warfare and medicine are developing in new ways through their attention to the body as an individuated entity. It is in this context, I argue, that the body is coming to be something that is not only worked on or cured – but increasingly, *enhanced* – and enhanced so as to maximise the effectiveness of the population.

The scope of research and development activities related to enhancement is enormous. DARPA[63] projects for example, include attempts to improve cognition so that pilots can fly multiple robotic planes, biological interventions to help soldiers tolerate extreme conditions such as high or low temperatures or sleep deprivation, the development of exoskeletons to improve strength, and improvements to prosthetics, including the prosthetic-brain interface, amongst numerous others. The imperative of enhancement is having a major impact on multiple fields of medicine, from neurology to haematology to prosthetics. While we may be tempted to focus on the spectacular and technological aspects of human enhancement, some of the most influential methods of enhancement are less cinematic. Indeed, perhaps no field has become so thoroughly involved in military enhancement as psychology.

COIN does not only expose soldiers to new kinds of injury – it also requires new kinds of work from them. When the aim of warfare shifts to require winning the 'hearts and minds' of the population, soldiers must exercise restraint and carry out strategic triage on the spot: the use of force must be measured so as to convince the population of the value of the mission. COIN requires a new kind of soldier: the 'strategic corporal' in military-speak,[64] who operates 'far from the flagpole', making strategic decisions in the lower ranks, and all under the glare of media attention (and potential scandal). In order for the Army to be successful in this new form of warfare, soldiers now need not only to be tough, but also to display an enhanced state of 'mental agility' or 'resilience'.

This apparent need has called forth new forms of psychological intervention upon the soldier, most notably through the rise of psychological resilience training, first pioneered in the Australian military, but now taken up in a number of other Western militaries, and being coordinated at NATO. By far the most extensive experiment in enhancing psychological resilience is the US Army Comprehensive Soldier Fitness programme. Indeed, this programme is the largest psychological experiment in human history – a feat made possible by requiring well over one million soldiers and Army civilians to participate.[65]

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63 The US Defense Advanced Research Projects Agency.

64 General Charles Krulak, 'The strategic corporal: Leadership in the three block war', *Marines Magazine* (January 1999).

65 Alison Howell, 'Resilience, war, and austerity: The ethics of military human enhancement and the politics of data', *Security Dialogue* (forthcoming, 2015). Alison Howell, 'Resilience as enhancement: Governmentality and political economy beyond 'responsibilization', *Politics* (forthcoming, 2015).

Based on the notion that 'fitness' can be extended from the body to the mind, the programme involves an attempt to enhance the psychological 'strength' and resilience of all soldiers. In part responding to an imperative to prevent suicide and the diagnosis of (costly) mental health disorders, the programme is based on a public health model, thereby not entailing any one-on-one clinical encounter, but aiming instead to improve the overall resilience and mental agility of soldiers preventively as a population such that each 'strategic corporal' will not only 'cope' with adversity, but thrive or 'bounce forward'.

The programme is being implemented with an eye to cost-effectiveness, and is thus not only about human enhancement, but also about austerity in healthcare. This is significant not only for military health and welfare provision, but also for civilians. Notably, the project was first piloted on a much smaller scale in US schools, and, based on the military experiment, is being more widely disseminated in the education sector, suggesting again the imbrication of social and national security. It is also quite specifically about 'force multiplication', that is, of manning persistent war. In an apparently unguarded moment, one main architect of the programme (a former President of the APA) reportedly asserted that '[w]e're after creating an indomitable Army.'[66] Social and national security, and war and medicine, are imbricated here in the pursuit of the enhancement of the population through work on individuated bodies and minds, whether soldier or civilian.

Warfare and medicine express a shared strategic logic, but this logic is in the process of transforming yet again, taking not only the health, but also the wellness and the perfection of the human body and mind as their aim. Just as it was in the military that the techniques of the welfare state were developed,[67] what we may be witnessing here is the development of new medical modes of enhancement and governance for austere times. But just as was the case with the repurposed technology of triage, this new strategic technology of positive psychology unsurprisingly functions as a strategic technology for doing things to and with populations, just as much in the realm of social security (or the 'norm') as in the realm of national security (the supposed 'exception').

Genetic intelligence

As a third example, biomedical and biometric technologies of identification have come to be seen as essential in a context wherein war values bodies (in order to make them live or kill them). Much recent research has assessed the growing role of biometrics, not only as technologies of border control, but also in fighting contemporary wars. But as I will argue, biomedical forms of identification – and specifically genetics – have also been deployed systematically in these wars. A pointed case is that of the CIA's use of a Pakistani doctor to mount a vaccination campaign to gather genetic intelligence to locate Osama bin Laden. It is not that vaccination has not previously been a tool of warfare. As outlined above, it was an important asset

[66] Stacey Burling, 'The power of a positive thinker', *Philadelphia Inquirer* (30 May 2010), available at: {http://articles.philly.com/2010-05-30/news/24964448_1_positive-psychology-positive-thinker-soldiers#axzz0pc1yKYYW} accessed 31 May 2011.
[67] Cowen, 'Welfare warriors'.

not only in colonial governance, but also in forms of warfare, such as World War I trench warfare, wherein maintaining troop numbers and strength is a major strategic advantage. But something new is afoot when a vaccination campaign is used to identify an individual body. This is what happened when, as *The Guardian* reported in July 2011, the 'CIA Organised Fake Vaccination Drive to get Osama bin Laden's Family DNA'.[68] It is in a context of war turning on the individuated body (in this case the insurgent or terrorist) for the purpose of protecting the homeland population and inoculating the local population against their influence, that bin Laden's genetic material, and that of his family members, became something of value to be sought out through intelligence gathering. Just as medicine now directs itself to the body as a biological entity with genetic markers that reveal its individuality, so too does intelligence gathering in the twenty-first century.

The scale of this turn is revealed if we follow bin Laden's corpse to Afghanistan where it reportedly underwent genetic and other forensic testing[69] in order to verify his identity in advance of President Obama's speech announcing that Navy SEALS had killed bin Laden in Pakistan. Most likely, bin Laden's DNA was analysed in a Joint Expeditionary Forensic Facility, or JEFF lab. The first JEFF lab was set up in Iraq in 2005, and in 2007 General Odierno directed the establishment of JEFF labs in every major division area of operation in Iraq, and soon after, JEFF labs were set up across Afghanistan. Defence contractor BAE Systems was awarded a $175 million contract to design and deploy the forensics labs,[70] while other contractors such as Lockheed Martin developed battlefield-oriented forensic technology.[71] According to one military publication, the purpose of the labs was to 'conduct firearm/tool mark, latent print and DNA forensic analysis … in order to exploit biometric and forensic evidence resulting in the killing, capturing, or prosecution of anticoalition forces'.[72] DNA analysis 'is used extensively in support of U.S. Special Operations Command Units' in 'the tying of forensic evidence to an individual or incident … this immediate feedback provides the unit with expedient, actionable intelligence to target or prosecute'.[73] The medical technique of triage is again used in the JEFF labs, in a system of prioritising cases directed towards capture, prosecution, or killing the target of analysis. As one forensics unit officer put it: '[t]here is no uniformed enemy here, so that often complicates this mission for our troops. That fact doesn't affect us because regardless of whatever they may say, do or try, they've got nowhere to hide … DNA doesn't lie.'[74]

The apparently anomalous vaccination ruse, something that might be understood as the actions of a single 'bad apple' turns out to link into a much broader system for the collection and examination of genetic material as part of warfare that makes

[68] Saeed Shah, 'CIA Organised Fake Vaccination Drive to get Osama bin Laden's Family DNA', *The Guardian* (11 July 2011), p. 1.

[69] 'US analysed Osama bin Laden's DNA after death, secret documents show', The Guardian (29 August 2013), available at: {http://www.theguardian.com/world/2013/aug/30/us-analysed-bin-laden-dna} accessed 9 September 2013.

[70] Bill Freehling, 'BAE Gets $175 million contract' (4 September 2008), available at: {http://fredericksburg.com/News/FLS/2008/092008/09042008/407630} accessed 10 September 2013.

[71] Fawzie Shaikh, 'DOD rushing battlefield forensics capabilities to troops in Afghanistan', *Inside the Pentagon*, 26:13 (1 April, 2010).

[72] Major Michael A. Johnston, 'Expeditionary forensics: The warrior's science revealing the hidden enemy', *Military Police* (1 May 2009), pp. 5–7.

[73] Johnston, 'Expeditionary forensics', p. 7.

[74] Quoted in US Fed News Service, 'Joint Expeditionary Forensic Facilities Labs Tackle Taliban, Train Afghans', US Fed News Service, Washington (20 December 2011).

use of the biological individuality of bodies for the purposes of identifying, and then capturing or killing individual targets from within the population. This kinship between genetics and intelligence, or medicine and warfare should not be surprising. Surveillance and intelligence gathering are intrinsic to medicine in its public health activities. Epidemiology, as the science underpinning public health, is directed foundationally at the surveillance of the population. This kind of surveillance is always strategic: as with Triage and Positive Psychology, it lends itself as easily to use in the domain of national security as in the domain of social security. To understand this application as an example of securitisation would be to misunderstand this always already inherently strategic technology. However, by asking questions instead about the global politics of medicine and the life sciences, it becomes possible to read the supposedly anomalous and insignificant as significant and even representative.

In sum, these three examples, of emergency medicine and triage, of psychology and resilience/enhancement, and genetics and intelligence, illustrate the imbrication of technologies of medicine and warfare in their work at the level of populations in contemporary war. What is significant across these cases is that in each we see how both medicine and warfare are now developing, symbiotically, in new ways. Strikingly, in each case, both medicine and warfare are turning on the population by seeking to address it in its bodily individuation, whether that entails the bodies of soldiers, host nation civilians, or terrorists/insurgents.

These cases illustrate what kinds of empirical research may be opened up by a global politics of medicine approach, specifically as we move beyond securitisation theory's capture of the field of GHS. Finally, they suggest that IR has something unique to offer in the broader social science and humanities enterprise of studying medicine, in further elaborating the strategic nature of medicine in contemporary global politics by drawing from, and developing, knowledge about the specific forms that contemporary warfare is now taking. Further, a field of the Global Politics of Medicine' may be especially necessary if the discipline is going to (re)turn to the serious study of war and its generative effects.[75]

Conclusion

What does a shift to a framework focused on the global politics of medicine, rather than global health or more specifically the securitisation of health, get us? This concluding section draws out the implications of such a framework for: 1. the study of Global Health; 2. Securitisation theory; and 3. IR more generally, in order to demonstrate how attention to the global politics of medicine and the life sciences can challenge or invigorate these fields.

First, in refocusing on medicine, rather than health, the field of Global Health studies could significantly open up the kinds of ethical questions it is able to pose about the conduct of global affairs. Questions of ethics in the scholarly literature on Global Health tend to focus on the inequitable distribution of health goods, thereby assuming that medicine can be treated as a matter of goods in the service of a superordinate goal of 'health'. Shifting to a focus on the global politics of medicine means

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[75] Tarak Barkawi and Shane Brighton, 'Powers of war: Fighting, knowledge, and critique', *International Political Sociology*, 5:2 (2011), pp. 126–43.

we can also start assessing the global politics of the inequitable *imposition* of medicine and medical authority, for example onto the bodies of those defined as 'unhealthy' by virtue of their habits, test subjects in the global clinical trial industry, or those tortured or force-fed by medical means at Guantánamo or other sites.

A focus on the global politics of medicine could also help move the field beyond its focus on infectious diseases and launch new research in the areas of noncommunicable diseases (NCDs, or so-called 'lifestyle' diseases) and mental health. Whilst communicable diseases have historically been the subject of much of the most intense activity in global health governance 'lifestyle diseases' and 'mental health' are now also increasingly coming to be seen as priorities in global health governance. If we are going to begin approaching these areas in earnest, then we will need to keep our critical faculties alert to the politics of medicine and bear in mind the intense involvement of medical disciplines, including psychiatry, in colonial practices both past and present. Calls to 'scale up' psychiatric services in the Global South in the name of making such spaces more 'humane' (forgetting, of course, that asylums were a colonial 'gift' in the first place) may involve de-emphasising institutionalisation, but they also involve the extension of medical authority, and the growth of psychopharmaceutical markets.[76] This may best be understood, then, as the global extension of what one activist-scholar has termed 'chemical incarceration'.[77] If we take seriously the possibility that public health and modern medicine articulate strategic logics at the level of populations, then we must begin to pay attention to the ways in which global health imperatives act as standards of embodiment or cognition that target those whose bodies or minds do not meet those standards. From this perspective, it is very troubling to see greater global health activity in the areas of 'lifestyle diseases' and 'mental health'. Through a framework that interrogates the global politics of medicine, rather than health, we can pose new questions about the ethics of global health in international relations. By moving beyond the economistic reduction of ethics as a matter solely of distributing health goods, we can begin to also ask questions about the extension of medical authority through the injunction to be 'healthy'.

Secondly, what can a global politics of medicine tell us about securitisation theory? As I have illustrated throughout this article, a historical and sociological focus on global practices of medicine invalidates the basic premises upon which securitisation theory rests. While a focus on health seems to further validate the theory by applying it to an empirical area not originally conceived by its proponents, a focus on medicine (perhaps in tandem with a focus on law, police, and actuarial or other forms of professional knowledge) exposes the theory's fundamental and insurmountable flaws. As I have endeavoured to show, it is not that 'health' has come to be recently 'securitised', but rather that, from at least the nineteenth-century onwards modern warfare and modern medicine grew together as homologous strategies for acting upon populations, whether of citizens, soldiers, or colonised subjects. In this sense, it is not possible to excise medicine from warfare, social security from inter/national security, or the norm from the exception (excisions fundamental to securitisation theory). A focus on the global politics of medicine works to make visible the myriad ways in which homefronts, warzones, and colonial spaces are connected

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[76] China Mills, *Decolonizing Global Mental Health: The Psychiatrization of the Majority World* (London: Routledge, 2014).

[77] Fabris, *Tranquil Prisons*.

to one another, for example, in the imbrication of modern warfare and modern medicine.

This leads to the question: does the bankruptcy of securitisation theory entail a loss of ethical possibilities for desecuritisation in practice? Although the original articulations of securitisation theory have been robustly critiqued for not advancing a normative critique of the (so-called) securitisation process,[78] part of the allure of the theory is that it tempts us into the belief that securitisation is a relatively recent process, and one that may be undone through 'desecuritisation' in favour of 'normal politics'. Unfortunately, for those of us who are minded to activist or normative scholarship, this is not such an easy task. The framework advanced here does not posit an innocent or pure politics that can be retreated to. There is no peace within the state, away from warfare, medicine, or other strategic technologies.

But the flipside of this is that attention to the global politics of medicine can also allow us to pay heed to just how intensely contested medicine and warfare are. This is seen perhaps most clearly in the controversies surrounding the role of medical and health personnel in interrogation and detention practices, particularly at Guantánamo Bay and other detention facilities. Vigorous debates erupted in the American Medical Association, the American Psychiatric Association, and the American Psychological Association about whether doctors, psychiatrists, and psychologists should be involved in devising 'enhanced interrogation' techniques or even in 'supervising' interrogations.[79] More recently, the involvement of medical personnel in force feeding hunger-striking detainees at Guantánamo, a brutal process that violates the Declaration of Malta, has reinvigorated debate amongst doctors, other medical practitioners and medical ethicists about whether Guantánamo is a 'medical ethics-free zone'.[80] Similar debate has erupted over the weaponisation of medical knowledge and especially neuroscience.[81] At the same time, the ethics of medicine is too important a field to be left solely to those with medical credentials. For instance, there are growing global movements of deaf people, people who have been defined as disabled, or diagnosed as 'obese', trans activists, those in the mad pride/creative maladjustment movements, and those who identify as cognitively different. All these movements are resisting the ways in which the medical sciences are defining their differences as pathologies or abnormalities.

Third, and finally, what can an approach centred on the global politics of medicine offer to the IR discipline more generally? The analysis I have developed here points to a number of challenges that may be mounted in IR through the study of medicine, including the rethinking of Global Health studies, and the critique of securitisation theory. A focus on medicine could also destabilise the analytical centrality of liberalism in theorising both governance and war. *Contra* Dillon and Reid[82] and the many others who have theorised a 'liberal way of war', this article has proposed, via its focus on medicine, that understanding war via *modernity* or late modernity is much more fruitful than a focus on liberalism. Since the post-9/11 wars began, a number of scholars have been struggling to understand the place of

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[78] Aradau, 'Security and the Democratic Scene'.
[79] Howell, *Madness in International Relations*.
[80] George Annas, Sondra Crosby, and Leonard Glantz, 'Guantánamo Bay: A medical ethics-free zone?', *The New England Journal of Medicine*, 369 (11 July 2013), pp. 101–3.
[81] The Royal Society, 'Brain Waves Module 3: Neuroscience, Conflict and Security' (London: The Royal Society, 2012).
[82] Dillon and Reid, *The Liberal Way*.

violence in liberal rule, the ways in which liberal rule apparently involves authoritarian, exceptional, or illiberal tactics – leaving authors in an analytical bind around the question: where does liberalism begin and end? Viewed through the lens of modernity and late modernity (rather than liberalism or neo/advanced liberalism) this analytical bind dissolves, freeing analysis from the problems of the beginnings and endings of liberalism, or the before and after of politics and security, the norm and the exception.

In proposing a field of the Global Politics of Medicine, my aim is to do much more than merely critique existing conventions in the discipline (whether in Global Health studies, or securitisation theory, or conceptions of liberalism). Such a field of study could open up new and exciting avenues of research that further connect IR to other disciplines. In contradistinction to Global Health in IR, thinking through the global politics of medicine encourages us to approach our research in ways that are less economistic, and more anthropological, sociological, or historical. And it also challenges us to rethink many of the 'bread-and-butter' topics that make up IR. Throughout this article I have focused on how our thinking about war and security can be rethought, but medicine is also an integral feature of a number of other areas of concern to IR scholars. Much more could be said in IR about a number of topics.

Whole books could be written about, for example, the imbrication of emergency medicine and humanitarianism. Such research could challenge the idea that humanitarianism has been recently 'militarised' by tracing how disaster medicine was invented out of the experience of World War II, and how it came to gain authority both through its uses internationally in humanitarian action, and domestically in the recent growth of disaster preparation. Much could also be said about the role of medicine in immigration control and the governance of mobility, for example in order to grapple with how epidemiology has shaped the nature of the international system – a topic now being taken up by historians, but all but ignored by IR scholars,[83] or the use of medical technologies in border control (think, for example, of port health authorities, or recent attempts to use fMRI medical imaging technology in airports). Practices of global social movement activism and citizenship could also be examined as a matter of the global politics of medicine, for instance through emerging forms of biosociality (such as patient activism). A better understanding of the international political economy could be forged through attention to the Global Politics of Medicine, a field which could include not only the study of the global pharmaceutical industry (see Roemer-Mahler, this Special Issue), but also for example the growing global political economies of surrogacy, human tissue exchange, or clinical trials. Such research could also, for that matter, contribute to the growing feminist scholarship in IR on 'the body'. The study of medicine could also be brought to bear in the study of international law, for instance through attention to the use of medical evaluations in determining violations of human rights in conflict situations, or the role of medical authority in international legal proceedings.

Of course, much more could be said about the role of medicine in war, military, and security studies in IR, from examinations of biosecurity and bioterror countermeasures, to the study of empire and histories of colonial medicine. The field is so full with as yet uncharted possibilities that could, potentially, provide opportunities

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[83] See the Wellcome Trust-funded project on 'Reluctant Internationalists' at Birkbeck, available at: {http://www.bbk.ac.uk/reluctantinternationalists/} accessed 14 June 2014.

not only to 'speak to' disciplines that have longstanding traditions of studying medicine (notably sociology, anthropology, history, and science and technology studies), but also to 'speak back' to IR not only by mounting critiques of existing ways of thinking in the discipline, but also by taking up the creative project of moving the discipline in new directions.

Finally, in taking up these possibilities, a Global Politics of Medicine must be a political and ethically engaged area of research. Yet if, as I have argued, politics cannot be 'rescued' from security, and medicine cannot be restored to a mythical pre-political or presecurity status, then what are we left with? Perhaps with contestation. Many articles about global health end with suggestions for a 'way forward' or at least 'a way not forward' for global health policy and practice. This will not be one of those articles. As should be clear by now, my affinities lie mainly with those who are struggling against the potential violences of medicine – doctors and 'lay-people' alike. I would like to see IR take these movements more seriously. They challenge us to rethink the global dimensions of medical authority – from colonisation to global health governance – and the ways in which medicine is not *a priori* 'innocent', but rather always implicated in strategic relations of power and force globally.