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Palliative Care as a Necropolitical Technology

Hamish Robertson and Joanne Travaglia

Introduction

We live in a century characterised by the phenomenon of population ageing . This is entirely new for humankind and it occurs at a time of many other significant societal changes; but also, we argue, some serious lags in political and economic ideologies. One of the consequences of this delay in the intellectual understanding of, and appreciation for, the success that population ageing represents is a wide-ranging, and often ageist, discourse in many public policy domains and areas of professional practice. Much of this discourse is underpinned by a medical paradigm that continues to focus on pathological interpretations of biological and physiological changes across the lifetime. Many social beliefs about ageing and old age are deeply culturally embedded, driven by capitalism's intersection with other aspects of national cultures. Thus, ageing is often represented as ugly and deforming, as in the common use of a disembodied, wrinkled hand image for ageing. Normal human dependency is considered undesirable because capitalism and its proponents see human needs and relationships as either monetiseable opportunities (the grey market etc) or individual failings (the result of bad 'lifestyle' choices). In other words, dependent ageing is framed within a wider deficit discourse and while this is not new, it has a variety of implications under contemporary health and social policy paradigms.

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A correlate of these negative positionings, of both the ageing process and the status of old age, is a growing discourse about the 'quality of life', how this is measured, and how it can be used to inform medical treatment including what is provided, what is rationed and when and what forms of care may be withdrawn. This situation runs in parallel with a 'right to die' sub-discourse, which, not entirely unreasonably, positions issues such as chronic pain and terminal illness as experiences where any person might want to take some part in the 'decision-making' processes. The problematic issue is of course just how engaged the sick older person can be in such circumstances, and how they, and their carers, can be expected to negotiate complex scenarios when acutely medically unwell. While these issues are often framed around the issue of 'capacity', they can and should go well beyond the presence or absence of cognitive impairment. Clinicians will talk about 'letting your family member go', as increasingly aggressive treatments fail and human mortality looms despite the treatment regime, and regardless of the ideology of 'interventional successes at all cost' to the individual and their family. Our position is that advance directives may simplify this scenario but only because they are themselves an inherently neocritical technology in their own right, in which the patient may be asked to pre-empt their own response to critical health events. This rising tide of 'end-of-life' discourse, and the complexities it only partially acknowledges, raises the issue of one particular technological healthcare discourse, which is palliative care. In this piece, we explore palliative care in the context of population ageing and its broader sociopolitical implications.

In an ageing century, there is a need for critical scholarship on the ways in which age and ageing are represented in societies and how these representations are used by systems and professionals to justify specific interactions including when they choose not to act, or to withdraw care. Palliative care offers a highly illustrative case study for engaging with these issues as it is increasingly being represented as *the* caring and scientific option in end-of-life care policy and practice.[1] This includes the development of guidelines, agreements to implementation (eg advance directives) and a tranche of procedural and administrative practices that go alongside its implementation. While it is clear that the paradigm of palliative care is implemented in varying ways and to different degrees (ie not always in its 'ideal' form), this makes it all the more interesting as a case

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1   Australian Government Department of Health, *National Palliative Care Strategy 2018* (2018).

study and exemplar of the issues considered here. We acknowledge that palliative care may be implemented well, just as it may be implemented badly. In this piece we seek to unpack and examine some of the persistent assumptions around ageing, illness and end-of-life care through the exemplar of palliative care.

Institutional power and individual vulnerability

One of the important considerations in this discussion is to take a closer look at the disproportionate power of institutions over individuals, and especially so over vulnerable individuals such as older people with various health conditions. This is not a passive relationship in which, for example, sick people enter hospital and come out well or die. Rather, what needs to be acknowledged is that the level of institutional and professional power is disproportionately in favour of the healthcare system, resulting in situations where the patient and their social supports may be dominated and encouraged to make decisions that are convenient for the institution rather than the patient. In this context, then, the institution (and its agents, the professionals) have the capacity to reinforce existing vulnerabilities, such as asking people to make pivotal treatment decisions in a time of crisis (often represented as another dimension of personal choice). The institution may also *generate* new vulnerabilities such as the types of incidents identified in patient safety research.[2] The field of iatrogenic harms illustrates this all too well. People die in hospitals not only because they are old and/or sick, but also because hospitals and health professions may fail to act appropriately in the patient's best interests or, more problematic still, they make the patient more vulnerable due to acts of omission (failing to act) or acts of commission (doing the wrong thing).[3] The complexities of this situation are likely to grow in scope and number as population ageing progresses, because ageing and death are intimately connected not only at a pragmatic level ('it happens') but also because there is a *necropolitics* associated with ageing and death,

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2   Susannah Jane Long et al, 'What is Known about Adverse Events in Older Medical Hospital Inpatients? A Systematic Review of the Literature' (2013) 25(5) *International Journal for Quality in Health Care* 542; Eric J Thomas and Troyen A Brennan, 'Incidence and Types of Preventable Adverse Events in Elderly Patients: Population Based Review of Medical Records' (2000) 320(7237) *BMJ* 741.

3   Charles Vincent, *Patient Safety* (Wiley-Blackwell BMJ Books, 2nd ed, 2011).

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in that there are individuals and institutions who '*exercise sovereignty* [by] *exercis*[ing] *control over mortality and … defin*[ing] *life as the deployment and manifestation of power*'.[4]

The issue of who lives and who dies, and when, arises frequently in acute healthcare environments.[5] The people who make the most informed decisions in such circumstances are the medical practitioners, both because of their professional training and because rather than the one specific scenario a family might experience, they see many similar cases on a regular basis. In addition, this situation may be skewed by specialist services in which a narrow clinical focus is adopted in relation to a large client population, such as a cancer treatment facility. Here the vulnerability of the patient and their family/social supports may in fact be magnified.[6] The unequal power of the institution is itself magnified by the unequal knowledge base that the general public and patients usually have in comparison to the treating facility and its staff. This too can be seen as a source of vulnerability in that the treatment decisions a patient may be asked to make are rarely contextualised in this fashion, the clinicians know much more than the patient but the mythology of 'choice' in effect acts to reinforce institutional power rather than that of vulnerable patients.[7]

What we propose here is that this situation creates spaces of unequal knowledge and power. Healthcare can be understood as a territorial claim backed up by political and social authority. It may be mediated by factors such as money and experience, with few communities possessing the knowledge to negotiate directly with healthcare systems and the policies and practices they provide as 'choices'. Doctors' offices, nursing stations, wards, hospitals, pathology laboratories are all quite specific places with their own authority and systems of control. They are, at the aggregate level, a form of territory that only partially includes the people treated in them. As money is a factor in all healthcare treatment, this too creates a level of territorialisation and territorial separations (eg marketised versus public sector). This makes the concept of territory important in

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4   Achille Mbembe, 'Necropolitics' (2003) 15(1) *Public Culture* 11, 11 (emphasis in original).

5   Albert R Jonsen, *Bioethics Beyond the Headlines: Who Lives? Who Dies? Who Decides?* (Rowman & Littlefield Publishers, 2005).

6   Miles Little et al, 'Liminality: A Major Category of the Experience of Cancer Illness' (1998) 47(10) *Social Science and Medicine* 1485.

7   Natalie Joseph-Williams, Glyn Elwyn and Adrian Edwards, 'Knowledge is Not Power for Patients: A Systematic Review and Thematic Synthesis of Patient-Reported Barriers and Facilitators to Shared Decision Making' (2014) 94(3) *Patient Education and Counseling* 291.

healthcare environments generally, and more particularly in technologies such as palliative care, where the care delivered may be provided in quite different environments and according to quite different principles.[8]

Healthcare as a territorial ambition

In following Agamben's use of Schmitt's notion of sovereignty, it can be suggested that any biopolitical agenda has specific *territorial* ambitions.[9] These ambitions may be geographical, ontological or epistemic in nature, without necessarily being exclusive to any one domain. So, for example, medicine can be seen as having territorial ambitions through its extensive use of political influence and a variety of epistemic strategies aimed at producing quite specific ontological effects. Medical practitioners have influenced the political system to make claims for control over and expertise in a variety of biopolitical domains including not solely 'illness' or 'disease', but 'life' itself. These territorial ambitions can be seen in the frequent objection to 'alternative' health paradigms and in their dominance over other types of health practitioner and their associated disciplines (pharmacy, nursing etc) as well as over 'alternative' treatments.[10] This is by its very nature a continually expanding territorial strategy. Medicine has also *affiliated* with various sciences (eg biochemistry, microbiology) but avoided deference to them, making claims for a unique interpretive perspective and an often imaginary 'partnership' between the doctor and the patient. The 'sacred' nature of the doctor–patient 'relationship' is itself a territorial claim in that it is frequently used to limit the agency of the patient and the role that other professionals might, potentially, play in the health of patients generally.

This kind of territorialisation is a necessarily incomplete agenda because medicine, and the health sciences more generally, keep extending their claims for expert management of various elements of human experience as healthcare knowledge and technologies grow. This frequently goes well beyond explicit disease states, an argument made forcefully by Illich

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8   N Bradley, M Lloyd-Williams and C Dowrick, 'Effectiveness of Palliative Care Interventions Offering Social Support to People with Life-Limiting Illness—A Systematic Review' (2018) 27(3) *European Journal of Cancer Care* e12837:1–12.

9   Giorgio Agamben, *Homo Sacer: Sovereign Power and Bare Life* (Stanford University Press, 1998).

10   Mike Saks, *Orthodox and Alternative Medicine: Politics, Professionalization, and Health Care* (Sage, 2003).

in the mid-1970s and by a variety of medical sociologists since then.[11] This is acutely observable in ageing and end-of-life scenarios but can be seen to engage with almost any element of so-called 'lifestyle' factors in which individualised decisions are marked out from, and treated separately to, broader social, cultural and economic factors (eg obesity and diabetes) or what Michael Marmot calls 'the causes of the causes'.[12] This strategy permits the medicalisation of many factors arising from the intersectional nature of contemporary capitalist economics and associated political conditions.

Public health, once concerned directly with social conditions, can be seen to function in this manner in the richer economies, where infectious diseases are becoming less common and 'lifestyle' conditions (usually chronic diseases rising from environmental and social conditions) are framed in a discourse of 'choice'. This positioning suggests that no other societal factors need be considered in the 'choice' equation of health outcomes (pollution, housing, food access and quality, education etc). Marmot's 'causes of the causes', for example, would consider the higher number of fast food outlets in poorer socio-economic areas, rather than stopping with an analysis of the 'willingness' of individuals to adhere to a healthy eating regime.[13] Individualising health behaviour and its consequences allows both for an aggressive territorial claim (we know best) and an interventional paradigm that has very limited accountability (failure or success is located within the actions of the individual patient or client). This too is a form of territoriality since it sets the terms of state and state agent actions and accountabilities in relation to citizens.

This general epistemic strategy has profound ontological effects and can be analysed as the current iteration of a form of territorialisation of the body and society that has been developing for close to four centuries.[14] The first step was a deliberate acquisition of control over the human body, auspiced through claims to scientific reproducibility in medical diagnostic and treatment regimes. By the nineteenth century, medicine was well

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11   Ivan Illich, *Medical Nemesis: The Expropriation of Health* (Pantheon Books, New York, 1977); Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders* (JHU Press, 2007).
12   Michael J Marmot, 'Inclusion Health: Addressing the Causes of the Causes' (2018) 391(10117) *Lancet* 186, 186.
13   Daniel D Reidpath et al, 'An Ecological Study of the Relationship Between Social and Environmental Determinants of Obesity' (2002) 8(2) *Health and Place* 141.
14   Nick J Fox, 'The Ill-Health Assemblage: Beyond the Body-with-Organs' (2011) 20(4) *Health Sociology Review* 359.

down the path of desacralising the human body through its dissection of cadavers drawn from prisons, slave plantations and workhouses, places where human life was already institutionally devalued.[15] This strategy was further developed using the umbrella term 'science' to produce a political right of medicine to use (and more recently to commodify) human bodies (gradually including parts of bodies, genetic material and even health data) for its own purposes, including the production of new medical knowledge, often with a variety of powerful social effects.[16] The authority of medicine to comment on and influence how human 'pathologies', social as well as clinical, were shaped and reproduced being a case in point. The idea that only women exhibit 'hysteria', for example, or that enslaved black bodies experience pain differently to and less than white ones are examples of medical knowledge and authority being used to produce social power over particular categories of person.[17]

To die in a hospital, as in prison, increasingly meant the loss of determination of how the individual's mortal remains were treated. Indeed, judicially directed dissection by medical practitioners was often included as a part of an individual's (post-mortem) punishment and, consequently, involuntary autopsy reduced the individual to a commodity, since individual identity and personhood could be harmed both in and beyond death.[18] This process of growing corporeal control was *territorially* extended by the mechanism of the autopsy. Even now, the right to dissect, remove and retain parts of the dead person's body remains a contested, and sometimes abused, part of this territorial ambition (for example as identified in the Alder Hey (Royal Liverpool) Inquiry 1988–1995,[19] and the case of Henrietta Lacks).[20] Traditional social and religious values are

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15   See, eg, Michael Sappol, *A Traffic of Dead Bodies: Anatomy and Embodied Social Identity in Nineteenth-Century America* (Princeton University Press, 2002); Edward C Halperin, 'The Poor, the Black, and the Marginalized as the Source of Cadavers in United States Anatomical Education' (2007) 20(5) *Clinical Anatomy* 489.

16   Bryn Williams-Jones, 'Concepts of Personhood and the Commodification of the Body' (1999) 7(3) *Health Law Review* 11; Kara W Swanson, *Banking on the Body* (Harvard University Press, 2014).

17   Todd Lee Savitt, *Medicine and Slavery: The Diseases and Health Care of Blacks in Antebellum Virginia* (University of Illinois Press, 2002) Vol 82.

18   Kenneth C Nystrom, 'The Bioarchaeology of Structural Violence and Dissection in the 19th-Century United States' (2014) 116(4) *American Anthropologist* 765.

19   JL Burton and M Wells, 'The Alder Hey Affair: Implications for Pathology Practice' (2001) 54(11) *Journal of Clinical Pathology* 820; C Lawrence, 'Alder Hey: The Taken for Granted and Professional Practice' (2002) 56(1) *Journal of Epidemiology and Community Health* 4.

20   Rebecca Skloot, *The Immortal Life of Henrietta Lacks* (Crown Publishers, 2010); Sandra S-J Lee et al, '"I Don't Want to be Henrietta Lacks": Diverse Patient Perspectives on Donating Biospecimens for Precision Medicine Research' (2019) 21(1) *Genetic Medicine* 107.

rendered subordinate to medicine's authority, making the process of dying and the material fact of death part of an expansive *necropolitical* territory, often with the acquiescence of the law. Yet, these processes are deeply historical and themselves exhibit a necropolitics in relation to who was most at risk of punishment *by* death and punishment *in* death through the mutilation of the body for 'scientific' purposes.

The subjective body gradually became an objective site of medical inquiry and control. The socio-medical control over specific types or categories of bodies (criminals, the mentally ill, women, 'non-whites', people with disabilities, and people designated 'monsters') provided a premise for an authority over human bodies in a more general sense, living and dead. The ability to generalise from particular bodies to the concept of population(s) invests the medical perspective with sociopolitical authority. Yet much of this is achieved without any historical inquiry and the 'scientific' nature of the acquired right to dissect the dead is actively dehistoricised. This brings us to the situation of older people in this shifting sociopolitical regime.

Necropolitics and population ageing

As a consequence of the above points, it is possible to observe a rising necropolitics of ageing that exhibits some very familiar characteristics where medicine extends its control of situations in which it might usefully intervene and a contrarian position in which it maintains control over situations in which it feels unable or unwilling to intervene. In other words, medicine gets to choose when and if it intervenes while constituting patient 'choice' as the determining ethic. This scenario is especially notable in the context of population ageing, a scenario in which the numbers of older, frailer individuals (a majority of them female) will continue to grow in coming decades. Firstly there is the historical disinterest medicine has had in older people generally.[21] Secondly, when medicine has been interested in ageing, broadly conceived of as pathology in motion, it has often been deeply unhappy with older people and their illnesses because of their perceived social and clinical irrelevance. Even at its inception, the medical specialty of geriatrics was enmeshed in the social politics of

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21   Desmond O'Neill, 'Do Geriatricians Truly Welcome Ageing?' (2016) 45(4) *Age and Ageing* 439.

ageing, gender and poverty because much of what we conceive of as the medical care of the elderly emerged in and through the institutional form of the workhouse infirmary.[22]

'Older people's medicine', now known as geriatric medicine, has remained a marginal player in the internal politics of medicine and, additionally, has been a nexus for both ageism and racism within medicine.[23] Geriatrics has now been a specialty on the medical margins for a century or so, and geriatricians in the UK National Health Service, for example, were frequently drawn from South Asian doctors who could not readily access the racially closed shop of British medicine.[24] In this context, geriatric medicine is not 'just' an uncontested clinical specialty addressing the medical needs of a specific population and category of person, it is a contested field of practice in which the patient is often secondary to the politics of medicine itself. This makes it a 'territory' that can be controlled and a technology through which that control can be acquired and maintained.

Consequently, this territorialisation intersects with the established necropolitics of medicine itself and produces a dynamic that invites serious consideration as population ageing progresses. One of the key reasons for doing so is that as new knowledge and 'technologies' emerge in the ageing space, they need to be accounted for against the historical backdrop of how medicine has developed, its influence on society and associated institutions (such as the law), and the implications for older people who find themselves framed in and through this expanding necropolitical environment. One of the means by which this interventional authority is exhibited is through the various technologies that healthcare gives rise to, including emergent clinical paradigms, policies and practices. A case in point is palliative care.

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22   Alistair J Ritch, 'English Poor Law Institutional Care for Older People: Identifying the "Aged and Infirm" and the "Sick" in Birmingham Workhouse, 1852–1912' (2014) 27(1) *Social History of Medicine* 64.

23   Parvati Raghuram, Joanna Bornat and Leroi Henry, 'The Co-Marking of Aged Bodies and Migrant Bodies: Migrant Workers' Contribution to Geriatric Medicine in the UK' (2011) 33(2) *Sociology of Health and Illness* 321.

24   See, eg, Joanna Bornat, Leroi Henry and Parvati Raghuram, 'The Making of Careers, the Making of a Discipline: Luck and Chance in Migrant Careers in Geriatric Medicine' (2011) 78(3) *Journal of Vocational Behavior* 342.

Palliative care as a technology

Our interpretation here is that palliative care can be seen as a technology on multiple levels. As an area of medical subspecialisation and practice, it is an increasingly prominent component of the political technologies that healthcare as an industry seeks to control. It is also a territorial technology in the sense that a wide variety of spaces and places are explicitly (and many implicitly) connected to a 'systemic' focus on health and associated treatment modalities. For example, to die in hospital versus a hospice or other 'dedicated' dying space can engender very different types of experiences for a dying person and their family. This 'territorialism' is also an expansionist one in that, as Nikolas Rose has identified, the aim is control of 'life itself'.[25] It is also a necropolitical technology in that healthcare already sees itself as the quasi-secular custodian of the process of dying, of death itself and of the body after death. Not only can the autopsy be seen as part of this process but so too can the 'cause of death' determination that medical doctors make when a person dies in hospital. In this context, palliative care is an outgrowth of this growing medicalisation of life.[26]

As noted above, the assumptive control of the dead body and its component parts has been well entrenched in medicine for more than a century now. This was itself a political manoeuvre to gain access to corpses for anatomical and experimental purposes. Access to bodies was a significant problem in early modern medicine when the body was still seen as, mostly, sacred property.[27] However, the medical gaze and influence asserted itself through the acquisition of compliant bodies such as slaves, the workhouse dead, war casualties, occupants of mental asylums and so on.[28] The right to abuse the body under the rubric of 'science' persists in the present day. Even now, it is possible to see how the assumption of power over the dead offends those whose relatives (young or old) die in hospitals and whose

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25   Nikolas Rose *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton University Press, 2007).

26   Denis Pereira Gray, Eleanor White and Ginny Russell, 'Medicalisation in the UK: Changing Dynamics, but Still Ongoing' (2016) 109(1) *Journal of the Royal Society of Medicine* 7.

27   See, eg, Piers D Mitchell et al, 'The Study of Anatomy in England from 1700 to the Early 20th Century' (2011) 219(2) *Journal of Anatomy* 91.

28   Stephen C Kenny, 'The Development of Medical Museums in the Antebellum American South: Slave Bodies in Networks of Anatomical Exchange' (2013) 87(1) *Bulletin of the History of Medicine* 32.

family members have had organs removed without familial consent.[29] This asks of us a closer inquiry on how the actual process of dying is framed, represented, communicated and clinically managed. This critical perspective becomes more important as population ageing progresses and societies respond to the growing numbers of very old, and often unwell, older people.

This scenario is extended into the politics of life itself through the technology of palliative care. While palliative care is often represented as a coherent and consistent application of medical care to the dying patient, in practice it can be a much more varied and variable form of intervention. At its most extreme, the use and abuse of opioids in treating older patients has led directly to situations such as the Gosport Inquiry in the United Kingdom in which older patients were being 'unlawfully killed' by a doctor, and affiliated health professionals, at the Gosport War Memorial Hospital.[30] This killing was frequently prefaced by the medical instruction 'please make comfortable',[31] as though differentiation of medical status and need in clinical environments is not a key aspect of treatment and care.[32] In other words, the elision of palliative actions can lead to the pre-emptive ending of lives even in cases where many older people might be (and were at Gosport) expected to recover and return to their homes.[33] This case, while an extreme one, is far from unique in the annals of aged care in the NHS or elsewhere. Older people are highly vulnerable in acute and subacute healthcare environments, as the Francis Inquiry into the Mid-Staffordshire Trust and the Harold Shipman affair

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29   Edward A Glasper and Catherine Powell, 'Lessons of Alder Hey: Consent Must be Informed' (2001) 10(4) *British Journal of Nursing* 213.

30   Kieran Walshe, 'Gosport Deaths: Lethal Failures in Care Will Happen Again' (2018) 362 *BMJ* k2931; Simon Kenwright, 'Understanding Gosport' (2018) 362 *BMJ* k3422; Clare Dyer, 'Gosport Hospital: GP Prescribed Opioids that Shortened at Least 456 Lives' (2018) 361 *BMJ* k2706.

31   For a more in-depth discussion of the Gosport Inquiry, see Penny Crofts's contribution to this collection, 'Gosport Hospital, Euthanasia, and Serial Killing'.

32   Daniel Knights, Felicity Knights and Stephen Barclay, '"Please Make Comfortable": Prescribing Opioids in the Wake of Gosport' (2018) 68(675) *British Journal of General Practice* 462.

33   House of Commons, *Gosport War Memorial Hospital: The Report of the Gosport Independent Panel* (Report, June 2018).

showed.[34] Ideas about and attitudes towards palliation of the older patient may actually generate their own risks to those patients because older age is generally seen as inherently flawed and risky.

The technological nature of palliative care can also be observed in the more extreme examples through the ways in which regulatory authorities tend to support the authority of medicine and healthcare more broadly. This can be seen in the medical inquiry system, which is used in response to major abuses of, usually, highly vulnerable patients.[35] Patients, families and communities, and their concerns, often receive very limited and rarely any timely recognition (see the Gosport Inquiry, for example), a characteristic of many patient safety inquiries being the often considerable time it took for public concerns to be acknowledged and taken seriously. In both the Gosport and Mid-Staffordshire cases, patients and families had been voicing concerns for up to a *decade* before official inquiries into the activities of those services were launched. The result is that policies and practices in association with the established authority of medical and medically controlled or mediated systems generally prevail over the interests of vulnerable groups in these scenarios. By the time formal mechanisms such as inquiry processes are undertaken, the harms associated with these situations have generally multiplied significantly. This in turn raises the question of the current and potential impact of such technologies under conditions of population ageing and the enormous growth in older, frail and disproportionately female patients that this will produce.

Conclusion

This chapter draws together a number of concepts and ideas normally treated in isolation. More particularly, we put forward the concept of a *necropolitics of ageing* in which 'standard' medical strategies, palliative

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34 Christopher Newdick and Christopher Danbury, 'Culture, Compassion and Clinical Neglect – Probity in the NHS after Mid Staffordshire' (2015) 41(12) *Journal of Medical Ethics* 946; DJ Roberts, 'The Francis Report on the Mid-Staffordshire NHS Foundation Trust: Putting Patients First' (2013) 23(2) *Transfusion Medicine* 73; Robert Francis, *Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust January 2005 – March 2009* (The Stationery Office, 2010) Vol 1; Janet Smith, *The Shipman Inquiry* (Stationery Office, 2003); Richard Baker and Brian Hurwitz, 'Intentionally Harmful Violations and Patient Safety: The Example of Harold Shipman' (2009) 102(6) *Journal of the Royal Society of Medicine* 223.
35 See, eg, Kieran Walshe and Stephen M Shortell, 'When Things Go Wrong: How Health Care Organizations Deal with Major Failures' (2004) 23(3) *Health Affairs* 103.

care being a particular example, can be seen as territorial technologies of control in their own right. In this context, we suggest that medical responses to population ageing exist at a number of different levels but all of them are premised on medicine's right to determine and intervene in the politics of life itself. This right is a historically situated one, embedded in medicine's acquisition of political and social authority during the nineteenth century, long before clinical medicine became a safe option for patients seeking treatment for disease.[36] Furthermore, this authoritative positioning needs to be seen as a dynamic territorial strategy, one adaptive to changing situations and emerging themes, such as 'patient choice' and the 'right to die'. In this sense then, palliative care can be critiqued as a *territorial* technology just as many others identifiable within medicine and across healthcare policy and practices more broadly.

The right to govern and control the bodies of the vulnerable and powerless has been gradually expanded into an authority over many types of bodies – women, people with disabilities, the elderly and so forth – and hence to 'the body' more generally. The authority this right provided has extended from the bodies of the dead to those of the living and now increasingly encompasses transitional states such as still-birth, frailty, acute illness, people with delirium and those experiencing an imminent death. At every stage, then, medicine has extended its territorial authority as a social and political vehicle. Now, under conditions of growing numbers of older people and a deeply enmeshed politics of population ageing, we can observe palliative care as one more technology for maintaining and extending medical authority. The demographic reality of population ageing is often represented, rightly in our opinion, as a (partly) medical success story, with many more people living relatively healthy and longer lives than was the historical norm. Yet underneath this rhetoric of success lies a deep social history of contempt for the weak, the vulnerable, the dependent and the elderly. These attitudes are not exclusive to medicine but their interactions with an expanding medical territoriality represent a crisis in the making, one in which a necropolitics of ageing may be observed in many health and medical technologies of care. It is in this dynamic context that we have positioned palliative care as a component of a broader necropolitics of ageing.

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