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Zoe-Ethics: A Posthumanist Proposal for Health Sciences in the Anthropocene

Piqué-Buisan, Joel[1]*

Abstract

Traditional bioethics, centered on liberal humanism and individual autonomy, faces an ontological crisis due to environmental collapse and the rise of the "pharmacopornographic" regime. This paper proposes Zoe-Ethics, a posthumanist evolution that shifts the moral focus from bios (politically qualified human life) to zoe (the vital force shared by all living entities). Drawing on Rosi Braidotti's nomadic theory and Michel Foucault's biopolitics, the proposal replaces "methodological individualism" with relational responsibility. The framework rests on four pillars: displacing the moral center toward non-human life, recognizing universal vulnerability, establishing critical governance of health technologies, and promoting affirmative politics focused on "potentia". Zoe-Ethics transforms clinical practice into an act of planetary care. By utilizing tools like Cartographic AI, it moves beyond diagnostic "black boxes" to map the interdependencies between human health, technology, and ecosystems, fostering a sustainable, nomadic subjectivity in the Anthropocene.

Keywords: *Zoe-Ethics; Posthumanist Proposal; Health Sciences*

Introduction: From Bioethics to Zoe-ethics in Health Sciences

Contemporary bioethics is undergoing a crisis of legitimacy manifested in the inability of its traditional frameworks to respond to phenomena that transcend individual autonomy. Ironically, the concept coined by Van Rensselaer Potter in Bioethics: Bridge to the Future (Potter, 1971) was born with an integrative and ecological vocation but was quickly monopolized by clinical practice. As Diego Gracia warns, bioethics was reduced for decades to mere "medical ethics" (Gracia, 2019, p. 12), a revamped version of professional deontology that marginalized the author's original global vision. Potter himself acknowledged this perversion of his initial role, lamenting that the discipline had moved away from planetary responsibility to focus on a biomedical and individualistic approach (Dupras, Williams-Jones, & Ravitsky, 2017) (Lee, 2017).

This anchorage to medical humanism no longer corresponds to the material realities of the 21st century. In this vein, the work of Henk ten Have (2016) identifies this exhaustion in the "methodological individualism" that prevails in clinical practice. According to Ten Have, the traditional clinical approach ignores the fact that health is a common good and that the real crisis lies in the shared vulnerability that the neoliberal model attempts to render invisible through the

[1] Chair of Medical Education, Faculty of Medicine, Universitat de Vic – Universitat Central de Catalunya, Vic, Spain.
Institute for Research and Innovation in Life Sciences and Health in Central Catalonia (IRIS-CC), Vic, Spain.
Bioethic Professor. Faculty of Medicine, Universitat de Vic – Universitat Central de Catalunya, Vic, Spain.
Observatory of Humanities in Medicine, Hospital d'Olot i Comarcal de la Garrotxa Foundation, Olot, Spain., Email: jpique@hospiolot.cat

rhetoric of patient self-sufficiency.
The field of health sciences today faces an ontological paradox. While biotechnology and biocapitalism blur the boundaries between the natural and the artificial, mainstream bioethics continues to prioritize an individual, rational, and autonomous subject. This model, based on Kantian universalism and classical principlism is insufficient to respond to the challenges of the fourth industrial revolution and the global ecological crisis. As Tony Davies argues, we need greater ethical responsibility to address the legacy of humanism, since all humanisms to date have been imperialistic. They speak of the human in the terms and interests of one class, one sex, one race, and one genome (Davies, 1997, p. 141). What we must emphasize is that *Bios* has ceased to be a natural reality and has become an object of manipulation and public management. Bioethics, as a discipline that seeks to reflect on the ethical problems generated by our interventions around *Bios*, should not be developed without taking into account biopolitical analyses (Quintanas, 2013, p. 103). To counteract this dominant position in the ontology of bioethics, there have been various attempts to think about it from its biopolitical background, mainly coming from peripheral knowledge (Mignolo, 2000) (Said, 2006).
In recent decades, some ethical currents have distanced themselves from ethics that prioritize the Vitruvian subject, and new formulas have been proposed, mainly from feminist and environmentalist movements. In this sense, Carol Gilligan's ethics of care (Gilligan, 1982) Joan Tronto (Tronto, 2013) and the works on gender by Judith Butler (Butler, 2004) and Donna Haraway (Haraway, Manifiesto de las especies de compañía, 2016) (Haraway, Manifiesto para cyborgs, 2014) are essential for understanding this slow transition in the understanding of life through networks of care and relational assembly. Other references in the reflection on the relationship between bioethics and feminism are Françoise Baylis, who addresses the relationship between bioethics and technoscience, Hilde Lindemann on the construction of subjectivities (Lindemann, 2019), Rosamond Rhodes relating bioethics to social justice, and Eva Feder Kittay and Susan Sherwin, researching the ethics of dependency and relational ethics, respectively.
On the other hand, from an environmental perspective, researcher Henk A. M. J. ten Have plays an important role in defending global bioethics. His extensive bibliography on global bioethics confirms the need to propose a transition towards post-anthropocentric medical ethics (Ten Have, Global bioethics. An Introduction, 2016) (Ten Have, Vulnerability: Challenging bioethics, 2016) (ten Have, 2019). In this sense, the physician and philosopher redefines vulnerability as a universal ontological condition that links human existence with planetary sustainability. His proposal for a Global Bioethics shifts the focus from autonomy to relational responsibility, recognizing that an individual's health is inseparable from the social, technological, and ecological structures that sustain it. In his analysis, justice in the health sciences must respond not only to the needs of the political bios, but also to the shared fragility of the planetary zoe, thus establishing an ethical mandate that links public health with the preservation of ecosystems in the Anthropocene. With these ideas, his works criticize current bioethics, accusing it of being a bureaucratic tool for rich countries, ignoring health problems in other subordinate areas. In this way, Ten Have's work follows the line of thinkers from peripheral knowledge (Mignolo, 2000) who seek to counteract this dominant position in the ontology of bioethics by thinking about it from its biopolitical background (Quintanas, 2013). Along the same lines, we find the works of Solomon R. Benatar, who argues that bioethics has been too distracted by the problems of rich countries while ignoring structural crises (Benatar & Gillian, 2011). Other authors such as Darryl Macer and Paul Farmer reinforce Ten Have's idea about the need to move towards a global bioethics.

Given the failure of traditional bioethical frameworks to respond to today's complexity, this research proposes a paradigm shift based on Rosi Braidotti's posthuman theory. Critical posthumanism should not be understood as the end of ethics, but as the end of the hegemony of the Vitruvian subject that has served as the basis for classical principlism. Braidotti offers us a fundamental methodological tool for addressing the problems raised above: the transition from bios (qualified, political, and human life) to zoe (life as a generative, impersonal vital force shared with the non-human). Zoe-ethics emerges here not as a terminological alternative, but as the necessary evolution to unite public health with the preservation of ecosystems in the Anthropocene. It is true that the theoretical approach of this proposal is difficult to implement in clinical practice, but theoretical reflection is essential in order to seek answers to new ethical dilemmas.

From Foucault's biopolitics to Braidotti's posthumanism

If a profound relationship between "life" and "politics" has taken root in society, the possibilities opened up by Potter's bioethics should be combined with Foucault's work on biopolitics. Otherwise, as Ugarte points out, bioethics runs the risk of becoming the "friendly face of biopolitics" (Ugarte, 2005, p. 54). Indirectly, the relationship between biopolitics and bioethics was initiated by Michel Foucault, who understood that the traditional discipline had acted as the normative arm of biopolitics. As Quintanas states: "Since its origins, bioethics has dealt with the power relations that are exercised around life" (Quintanas, 2013, p. 97) . In this sense, medical humanism has functioned as a device that defines which bodies are normal and which are pathological, establishing a technical management of the individual as an isolated unit. Following in the wake of Foucauldian analytics, Preciado emerges as one of the most radical voices in the cartography of contemporary biopower mutations. In *Testo Yonqui*, the philosopher describes a scenario where medical sovereignty is no longer exercised solely over the population, but through the technical, chemical, and digital micromanagement of subjectivity and the body (Preciado, 2008). Given this scenario, it seems clear that classical bioethics is exhausted because it attempts to apply principles of autonomy to subjects whose desires and bodies are already codified by the market and digital governance. This scenario gives rise to the concept of Pharmacopower, which Preciado developed mainly in his work *Testo Yonqui* (2008).

Preciado radicalizes Foucaultian genealogy by proposing that, in late capitalism, disciplinary and biopolitical devices are insufficient to describe the new forms of government of life. Unlike the author of *Naissance de la clínica* (Foucault, 2002), Preciado takes power to a molecular scale: power is no longer inscribed on the body, it is the body itself, in the sense that it operates on a chemical and hormonal scale (he also tells us that it operates on a prosthetic and media scale). Contemporary technologies—synthetic testosterone, birth control pills, psychotropic drugs, medical protocols—do not discipline the body from the outside: they are incorporated, dissolved into its chemical , and reconfigure it. While Foucault identified disciplinary tools, Preciado shows how control becomes immanent in the body.

The journey from Foucaultian disciplinary power to Preciado's molecular power, passing through Derrida's ontology of difference, shows an evolution in contemporary critical theory towards increasingly complex and material forms of governance of life. Power is a techno-scientific matrix that intervenes in the molecular structure of bodies, producing affects and desires, and permanently transforming the way subjectivity is articulated.

Preciado predicts the death of the classical modern subject through the dismantling by pharmacopower of some of that subject's characteristics: autonomy, freedom, will, and control

over oneself. This transition is best understood in light of Deleuze and Guattari's molar/molecular distinction. While molar power targets rigid, binary forms (such as traditional genders), pharmaco-power reveals itself as an update of molecular power. It is no longer a question of disciplining a molar entity, but of modulating subjectivity from within at the level of neural and hormonal flows, dissolving the old binary categories of the modern subject into a continuous flow of chemical control. From this perspective, which stems from the French school of difference philosophy, Rosi Braidotti, under the premise of the thinkers who influenced her, understands that the concept of "human" has always been heavily charged with power relations. Her interest in understanding what forms of knowledge are produced in our world, their connection to power relations, and the possibilities for political and ethical resistance push her to think of new and better alternatives for coexistence. Braidotti argues that medical humanism has historically been linked to the hierarchization of *bios* over *zoe*. This distinction has allowed bioethics to disregard anything that does not fit the canon of "the human," excluding the ecological, animal, and technological environments from its circle of moral consideration (Braidotti R. , 2006), (Braidotti R. , Lo posthumano, 2025). According to the continental philosopher, there is no total consensus on what a human being is, and given that bioethics is the branch of ethics dedicated to promoting the principles of most appropriate human behavior with regard to life, if the concept of human being or subject is fluid, bioethics should adapt to these contexts. Humanism, according to Braidotti, maintains a privileged relationship with other ideas and proposes posthumanism as a historical condition that marks the end of the opposition between humanism and anti-humanism (Braidotti R. , Lo posthumano, 2025, p. 56). The concept of humanism has never been a neutral or inclusive term and has always been loaded with power relations, inclusion, and exclusion.

Posthumanism is a reflection on new forms of becoming triggered by all the surprising things that humans have developed and that force us to redefine our values, representations, and forms of self-understanding in a democratic and critical way. At the same time, Braidotti's post-human nomadic theory challenges the arrogance of anthropocentrism and the exceptionalism of the human as a transcendental category (Braidotti R. , Lo posthumano, 2025, p. 93). Therefore, posthuman convergence can be understood as a movement to deconstruct *anthropos* and *Bios* as distinctive categories of the non-human, that is, of *Zoe*.

Thus, understanding the death of the modern subject as expounded by the thinkers of the philosophy of difference, it is necessary to propose a bioethics that responds to a new postmodern subject in which the hierarchical division between human and non-human matter is blurred. In this way, we propose the concept of Zoe-ethics as a tool for analyzing posthuman bioethics. To substantiate the need for Zoe-ethics, it is essential to articulate the connection between Preciado's somatopolitical critique and Rosi Braidotti's vitalist posthumanism. While Preciado reveals the technical architecture of the contemporary body (the technobody produced by the pharmacopornographic regime), Braidotti offers an ontological way out through the concept of *zoe*. In his various works, Preciado argues that our materiality is colonized by flows of hormones, data, and biopolitical surveillance devices, which empties the traditional notion of autonomy of its content. In this sense, Braidotti's proposal acts as a politics of affirmative resistance: if the body is a technobiological assemblage, ethics should not seek a return to a "human nature" proper to humanism, but rather empower *zoe* that traverses these assemblages.

Zoe-ethics therefore emerges at this meeting point: it is a response to the technomodulation of life denounced by Preciado, but oriented towards the creation of a nomadic subject who, aware of their technological hybridization, demands relational and collective responsibility. In clinical

practice, this means that care is no longer directed at an isolated individual, but at the network of interdependencies that constitute our post-human existence. Zoe-ethics emerges as the affirmative response to a world where life is an indivisible network of interdependence. By recognizing zoe, clinical practice acknowledges that an individual's health is inseparable from the health of their ecosystem and the non-human agents (viruses, bacteria, technological prostheses) with which they coexist.

The nomadic subject and the cartography of vulnerability in clinical practice

Within the framework of this new proposal, the concept of "patient" must be radically reconfigured. According to Braidotti, the essential concept in posthumanism is *Becoming*; we must open up the meaning of individual identity to relationships and to a multiplicity of axes and entities, and understand the subject as something dynamic, in process. Traditional bioethics has operated under the fiction of the liberal subject. This view, based on Cartesian dualism (mind/body), presupposes that the patient is an agent capable of exercising full sovereignty over their body as if it were private property. From Michel Foucault's perspective, this subject is not a natural essence, but a construction of biopower. Modern medicine has operated under a "clinical gaze" that fragments the individual to turn them into an object of knowledge and control. This fiction of autonomy hides the fact that the medical subject is, in reality, a product of social norms and devices of power. To understand the mutation of the clinical subject proposed by Zoe-ethics, it is imperative to refer to Nikolas Rose's analysis in *The Politics of Life Itself*. Rose expands on Foucaultian genealogy by demonstrating that contemporary medicine has moved from a biopolitics of the population to an ethopolitics, where individuals understand themselves through their molecular materiality (Rose, 2007, p. 27) . From this perspective, the patient is no longer a transcendental subject endowed with abstract autonomy, but a biological subject whose identity, desires, and future are mediated by genomic scanning, psychopharmacological modulation, and constant monitoring. This "molecularization of the gaze" (Rose, 2007, p. 6) is what allows Zoe-ethics to propose a nomadic subject who does not seek to return to a pure biological nature, but rather claims a critical agency within the very biotechnological assemblages that constitute him. Classical bioethics, by focusing on the rational decision of the individual, ignores the structural and biopolitical pressures that predetermine that choice, exhausting its critical capacity in the face of a system that manages life as a resource. However, based on Rosi Braidotti's posthuman proposal, we must move towards the figure of the nomadic subject, as an embodied, relational, and constantly flowing entity defined by its capacity to affect and be affected. The subject does not *have* a body, but *is* an intelligent and dynamic materiality. Braidotti's nomadism implies that the patient's identity is in constant flux, traversed by what she calls the "nature-culture continuum" in the structure embodied by extended subjectivity (Braidotti R. , Lo posthumano, 2025, p. 92). We are not isolated individuals, but relational assemblages. This posthumanist vision forces us to recognize that a subject's well-being depends on their network of affective, social, and biological connections. The nomadic subject of Zoe-ethics is a desiring machine that seeks to enhance its capacity to act through its relationship with the other, abandoning the logic of the closed "I" to embrace an interconnected "we." This change in the view of the subject implies that in clinical practice it is necessary to understand the patient as a nomadic subject and to recognize that health is not a private property, but a process of assembly. In this sense, it is necessary to understand the concept of the technobody proposed by Preciado, the contemporary body traversed by prostheses, drugs, and information flows. This conceptual transformation from the modern subject to the nomadic subject forces us to radically rethink the definition of health.

Under the paradigm of Zoe-ethics, health ceases to be exclusively the absence of disease in an individual body and comes to be understood as the sustainability of assemblages of interdependence. In line with the foundations of Gilligan and Tronto's ethics of care and ten Have's global bioethics, a person's health is inseparable from the quality of their relationships and the health of their environment. Health becomes a collective process involving technological, ecological, and social interdependence.

Zoe-ethics aims to use Braidotti's concept of cartography as a tool or methodology to map these power relations, make visible the margins and exclusions and their relations with vulnerability (Braidotti R. , Nomadic Subjects: Embodiment and Sexual Difference in Contemporary Feminist Theory (2nd ed.). , 2011). In this new discipline, it is not just a matter of diagnosing a pathology, but of tracing how that body is connected to networks of care, technological devices, and ecological environments. In this way, the clinical act becomes a shared responsibility: the health professional is no longer an external observer who modifies a body-object, but a node within a network of vital interdependence.

Zoe-ethics seeks not only a theoretical reconfiguration, but also a normative and global application. Henk ten Have's work is fundamental to this purpose, as it provides the necessary framework for translating Braidotti's nomadism into international ethical governance in the health sciences. As ten Have argues, one of the biggest problems with classical bioethics is "methodological individualism," which reduces ethical dilemmas to the autonomy of a single patient in an isolated clinical setting. This view ignores the fact that health problems are collective phenomena. Overcoming this methodological individualism means understanding that the patient is a node in a network.

Traditionally, bioethics has viewed vulnerability as a deficiency or weakness of certain groups (the sick, minors, etc.). However, Ten Have's proposal redefines vulnerability as a universal and inevitable ontological condition. Zoe-ethics not only understands vulnerability as an ontological condition but also proposes that it is not only human; there is, therefore, a shared vulnerability that acts as the link between humans, technology, and ecosystems. It is this vulnerability that generates ethical obligation. By recognizing ourselves as vulnerable and dependent on others (human and non-human), liberal autonomy collapses under its own weight and is replaced by relational responsibility.

In light of this posthuman theory, Braidotti advocates for an affirmative ethics defined as a process of transforming reactive passions into active forces, based on the sustainability of the posthuman subject. Unlike transcendental or deontic ethics (based on universal duty), this is an ethics of immanence: it seeks to determine which encounters increase our capacity to exist and which diminish it. To understand its architecture, it is imperative to distinguish two forms of power that Braidotti rescues from Spinozian terminology: Potestas (power of domination) and Potentia (affirmative power). From this perspective, ethical action consists of the constant effort to move from potestas to potentia. An act is ethical if it expands our power to act without destroying the material (social, ecological, or technological) basis that sustains us. Therefore, affirmative ethics is not a "yes" to everything, but a critical discipline that seeks to generate political joy: the collective capacity to resist death and pain by creating new forms of sustainable life. This affirmative ethics is therefore based on an understanding of the non-unitary subject and the search for empowering relationships, proposing a broader conception of the interconnection between the self and others, including non-human or non-terrestrial others. It aims to be universalist in scope, while remaining critical of any moral universalism, and expresses a deep-rooted and partial form of micro-universals, based on an ingrained sense of collectivity,

relationality, and, therefore, community building. This position forces us to explore some key elements on which Zoe-ethics is based: the displacement of the subject, relational responsibility and transspecies justice, critical governance of technology, and affirmative politics.

The Pillars of Zoe-Ethics Applied to Health Sciences.

The transition from a humanist-liberal bioethics to a post-humanist Zoe-ethics is not merely a terminological adjustment, but a radical reconfiguration of medical *practice* ( ). If we accept, following Braidotti's cartography, that the subject of health is a nomadic assemblage and not an isolated unit, the principles governing clinical decision-making must change. The four fundamental pillars that underpin this proposal are developed below.

Shifting the moral center: The incorporation of non-human life

The principle of autonomy, the backbone of classical bioethics since the Belmont Report, has operated under an anthropocentric bias that Michel Foucault would identify as the core of man's biopolitical sovereignty over nature. Zoe-ethics proposes a shift in the moral center: the entry of the non-human (animals, ecosystems, and technology) not as "objects" of secondary concern, but as interconnected moral agents in the field of medical decision-making. This movement implies transcending the human exceptionalism that has underpinned bioethics since its Enlightenment origins. The traditional clinical paradigm has operated under a Cartesian dualistic ontology that reduces the non-human to an instrumental externality or a mere biopolitical resource. Under this view, health has been strictly defined as a property of bios, deliberately ignoring the vitality of zoe that constitutes the material basis of all existence.

This shift implies redefining the principle of beneficence. In classical bioethics, beneficence is measured by the restoration of the functional autonomy of an isolated individual. In Zoe-ethics, beneficence becomes transspecies justice: an action is ethically good only if it promotes the sustainability of the vital assemblage as a whole.

Likewise, the inclusion of the non-human requires a revision of the concept of moral dialogue. By recognizing that zoe possesses its own agency, what Beatriz Preciado describes as the vibrant materiality that biocapitalism attempts to capture, bioethics must abandon its merely contractualist character. Health professionals, as mediators of life, assume the responsibility of safeguarding the bonds that enable the resilience of the biosystem. In conclusion, shifting the moral center implies that clinical decisions are no longer confined to the hospital bed, but extend to the biosphere, transforming medical ethics into an ethic of planetary habitability.

Relational responsibility and transspecies justice

Traditional bioethics has reduced responsibility to a legalistic contract between two social atoms: the doctor and the patient. In contrast, Zoe-ethics establishes relational responsibility, a concept inspired by the ethics of care, which maintains that subjectivity is constituted by the vulnerability and needs of others. While Pellegrino, in the article *Toward a reconstruction of medical morality* (Pellegrino, 2006) , already warned that vulnerability is the ontological condition of clinical practice, Zoe-ethics expands this notion to so-called global health, recognizing that vulnerability does not end at the patient's skin, but extends to ecosystems (Ten Have, Global bioethics. An Introduction, 2016). In the clinical context, health ceases to be a "state of individual well-being" and is defined as the ability to maintain and nurture networks of interdependence. Health is an assemblage that includes human support networks, but also technological prostheses, pharmacological regimens, and habitable environments. As Henk ten Have argues, vulnerability is not an accident that medicine must eliminate in order to restore a fictitious autonomy; vulnerability is the very fabric of life. Therefore, medical responsibility is the management of

that shared vulnerability by collaborating in the repair and strengthening of a relational network that allows the nomadic subject to continue persevering in their existence.
Another key point in the construction of Zoe-ethics is transspecies justice. This post-human and post-anthropocentric normative framework recognizes non-humans as subjects of moral and political consideration, considering that they possess "agency," that is, the capacity to affect and be affected. In the context of health sciences, transspecies justice implies that the "fair distribution" of resources does not end at the border of the human species. Transspecies justice redefines the clinic as a space of extended responsibility. When the clinician intervenes on a patient's microbiome or prescribes hormone therapy, they are not acting on a closed biological unit, but interfering in a biological continuum. The health of the nomadic subject is therefore a constant negotiation with the radical otherness of the microorganisms and ecosystems that sustain their own viability.

Governance of technology
Technological intervention in health is no longer external to the body but constitutive of it. Preciado has accurately mapped how the pharmacopornographic regime produces subjectivities through the technical management of hormones, data, and desires (Preciado, 2008) . In this scenario, classical bioethics falls short in attempting to regulate technology solely through informed consent. In Rose's publication *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century,* the author explains excellently how technological intervention participates in the construction of subjectivity in the post-human era.
Zoe-ethics proposes a governance of technology based on critical surveillance of biocapitalism. This pillar requires the health sciences to analyze how the digitization of the body (AI, Big Data, telemedicine) and the pharmacologization of existence can become new forms of Foucauldian biopolitical control. Zoe-ethical governance is not technophobic, but posthumanist: it recognizes that we are technobiological hybrids, but demands that technology be placed at the service of Ten Have's vital power and global justice, preventing the patient's body from becoming a mere source of data extraction for biotechnology corporations.

Affirmative politics: Sustainability versus risk culture
This pillar proposes a transition from reactive ethics to affirmative politics. Perhaps this point is the most transformative for everyday clinical practice: contemporary bioethics is obsessed with harm prevention and defensive ethics; zoe-ethics proposes that health is the art of fostering *potentia*.
Affirmative health policy seeks existential sustainability, which implies that the goal of medicine should not only be to prolong biological life (*bios*), but also to enhance the quality of vital life (*zoe*). In contrast to risk management, which fragments life into mortality statistics, Zoe-ethics celebrates interdependence and resilience. In clinical practice, this translates in r models of care that prioritize accompaniment, dignity in vulnerability, and the creation of healthy environments. It is an ethic that does not ask "what hurts?" from the coldness of diagnosis, but rather "what connections can we strengthen so that your life continues to be an affirmative power?"

Clinical applications: Algorithmic cartographies versus "Black Box" AI
Conventional Artificial Intelligence (AI) in medicine tends to operate under a *Black Box* logic, where the opacity of the algorithm prioritizes statistical correlation over understanding the vital context. Classical bioethics examines this technology from the perspective of humanism, without

taking into account the risk of it becoming a biopolitical surveillance device that reduces the subject to a predictable and marketable "molecular materiality." In contrast to this model, Zoe-ethics proposes Cartographic AI, which transforms diagnosis into a dynamic map of potentials and relationships. In fact, the greatest danger of clinical AI is the erosion of patient autonomy, who becomes a passive object of algorithmic prediction. The implementation of Cartographic AI under the Zoe-ethics paradigm should not be understood as the replacement of clinical judgment by algorithmic automatism, but rather as a tool that makes visible the interdependencies that the human eye and linear analysis often ignore, offering a cartography of intensities.

As Nikolas Rose warns, contemporary medicine tends toward a "molecularization" that fragments the individual into isolated genomic and biochemical data. Zoe-ethical AI rejects this fragmentation. Some authors propose a posthuman model of healthcare in which collaboration between humans and machines and distributed responsibility offer a more appropriate response to the normative and epistemic challenges posed by medical AI (Wang, 2026). If we understand AI from the perspective of posthuman zoe-ethics, it must cease to be a tool of "control" and become a tool of "connection." In this sense, algorithms should not be trained solely with endogenous biomarkers (data from inside the body), but with the nature-culture continuum, and should function as a relational prosthesis that increases the *potentia* of the nomadic subject. At the same time, algorithmic design must incorporate universal ontological vulnerability as a positive design variable.

In this sense, we can analyze three specific cases of the application of Zoe-ethics in clinical practice through the analysis of the use of clinical AI.

Case 1

An AI system for managing type 2 diabetes should not only process glucose levels. Health is diagnosed as the sustainability of an assembly and not as a metric of an isolated individual, so the cartographic algorithm should integrate variables from the patient's environment, such as neighborhood air quality, access to community support networks, and the biopolitical stress footprint, for example. Unlike traditional algorithms, cartographic AI would not give us a verdict on the patient's body, but rather an analysis of the viability of their life network. Instead of issuing a risk of hypoglycemia, AI would give us a diagnosis of relational vulnerability. In short, the result of Zoe-ethical AI is not a diagnostic figure, but a cartography of intensities . It tells us where the patient's life is being blocked and where it can be enhanced. AI ceases to be a judge and becomes a facilitator of sustainable connections, transforming the treatment of diabetes into a project of political ecology of health.

Case 2

Instead of an algorithm that simply "dictates" a treatment, Explainable AI (XAI) interfaces are implemented that allow the patient and the doctor to co-design the therapeutic strategy. Informed consent evolves into a process of dialogue of knowledge, where the patient is aware of how their data feeds the market flow and claims their right to a subjectivity not mediated solely by corporate profit. The result is a co-design where the patient can choose a path that is less "efficient" in terms of metrics but more "sovereign" in terms of vitality. At the same time, the patient claims their unmediated subjectivity, that is, ownership of data flows without losing access to basic care. Thus, the applicability of XAI under Zoe-ethics transforms the clinical act into a biopolitical assembly. The result is not a medical order, but a map of transparency, and clinical success is measured by the degree of somatic sovereignty regained in the face of contemporary biocapitalism's data extraction.

Conclusions

The proposal for a Zoe-ethics for the health sciences represents a necessary shift to overcome the exhaustion of classical bioethics. Although Zoe-ethics is a pragmatic necessity in a world where the boundaries between the human, the animal, and the technological have collapsed, we must also understand that it is necessary in the contemporary bioethical debate. Ultimately, it offers a theoretical conceptual framework for health professionals to navigate the complexities of the post-human era. It is not just a new theory, but a call for relational responsibility and planetary justice, where care for life becomes the supreme ethical imperative of the health sciences.

The proposal for a Zoe-ethics for the health sciences does not stem from a desire for terminological originality, but rather from a material and planetary urgency. As we have argued, classical bioethics is trapped in a conceptual architecture that separates humans from the ecosystem and the subject from their technological mediation. In the era of the "Sixth Extinction" and biotechnological convergence, continuing to operate under the principles of liberal humanism is not only a theoretical limitation, but also an ethical irresponsibility. This theory offers us a way out through an ontology of interdependence. By shifting the focus from *bios* to *zoe*, clinical practice is transformed: the patient ceases to be an autonomous monad and is recognized as a nomadic subject, a living assemblage in constant flux. It is imperative to recognize that shared ontological vulnerability constitutes the basis of a trans-species justice that is indispensable for the prevention of future global health crises. From this perspective, human health ceases to be an isolated goal and is understood as the result of the biological integrity of the planet. As demonstrated in the cases of cartographic AI, this transition allows the health sciences to assume a relational responsibility which, as ten Have proposes, is the only one capable of articulating a truly global bioethics. y clinical applications of Zoe-ethics, such as algorithmic mapping and explainable AI (XAI), are not mere technical improvements, but devices of resistance against the biocapitalism data market. Healthcare professionals must act as critical mediators, ensuring that technology empowers patients rather than subjecting them to opaque molecular surveillance.

Undoubtedly, the practical implementation of Zoe-ethics is the main limitation due to the complexity of intersectionality and such extensive relational links. This research aims to contribute to an intellectual debate to shape an ethical practice adapted to the current context in order to move from an ethics of control and risk management (biopolitics) to an affirmative policy. This involves promoting the sustainability of relationships and the power of life in all its forms. In short, Zoe-ethics restores bioethics to its original vocation as a "bridge" (as imagined by Van Rensselaer Potter), but a bridge that no longer only connects science with ethics, but also links human health with the indestructible vitality of the planet.

Declarations

Conflict of interest. The authors have no competing interests to declare that are relevant to the content of this article.

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