

# The HIV/AIDS crisis and corporate moral responsibility in the light of the Levinasian notions of proximity and the Third

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I

In this paper, I will analyse a set of problems regarding the HIV/AIDS crisis (and similar catastrophes) in sub-Saharan Africa in the domain of corporate moral responsibility. My intention is not to deal with all the ethical issues that are associated with the HIV/AIDS pandemic. It is true that if the conduct of Western pharmaceutical companies can be questioned with regard to the provision of drug treatment, as I argue in this paper, we can also question the conduct of many African governments (whether in terms of denial, corruption, social divisions or conflicts). I do not also deny the very important role that has been played by AIDS activists and by local grassroots groups and associations in fighting not only Western pharmaceutical companies but often, at great cost to themselves, their own local and national governments. My focus is on a much narrower and more specific issue, namely, the set of problems regarding the HIV/AIDS crisis in the specific domain of corporate moral responsibility within a context of the Levinasian notion of proximity (infinite responsibility) and the third.

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Against a totalitarian, homogeneous society, Levinas opens the way to a social pluralism, which has its sources in the disquiet provoked by the strangeness of the Other's face. Corporate responsibility, understood from this point of view, would not reduce institutional relations to an anonymous world of neutrality. Corporate responsibility is unconditional in the sense that to be responsible is not a question of choice, but one of deep liberty, the liberty of taking the burden of the infinite responsibility for the Other – customers, employees, the public at large and those who suffer in the world.

I shall argue that it would then also mean that society (individuals, NGOs and governments) in accordance with the spirit of the Levinasian philosophy of infinite responsibility, could exert pressure on corporations, such as pharmaceutical companies. Owing to their power, they could change their present responsibility policies to a more affirmative and engaged responsibility with regard to those who are ill and who suffer death or debilitation from HIV/AIDS and other prevalent diseases in the poorest parts of the world today.

II

Since AIDS was first identified just over 20 years ago, 22 million people have died from AIDS-

related diseases. According to UNAIDS, 40 million worldwide have been infected (at the end of 2001) with HIV/AIDS, of whom 3 million are children (<15 years of age). 28.5 million are in sub-Saharan Africa. In Botswana, 36%, while in South Africa 20% of the adults have the HIV virus.

The consensus in the scientific community is that the HIV virus is the cause of AIDS. Although there is as yet no cure for AIDS, since the mid-1990s, drugs called anti-retrovirals (or ARVs) have been available to retard and control the spread of HIV, and to reduce, thereby, the manifestation of AIDS itself. For maximum efficacy, these drugs are taken in combination; the most commonly recommended is Combivir (AZT and lamivudine). Other drugs include Viramune (nevirapine) and Efavirenz. The scientific community and the UN regard the use of such drugs as the key strategy to manage the disease, although it may be true that controlling the HIV virus itself through medication alone might not solve all the problems involved in the spread of the disease, especially in developing nations (McGreal 2002).

A significant drawback to the pharmaceutical route is the cost of the drugs. In 1998 alone, the world's top 10 drug companies, on sales worldwide of \$108.1 billion, made profits of \$34.7 billion, yielding one of the highest average profit margins of any industry throughout the world (*New Internationalist* 2002: 18–19). Poor economies just cannot afford to pay for the drugs thus highly priced. Under global public pressure, UNAIDS and five pharmaceutical companies recently entered into a partnership, the accelerating access initiative (AAI), to make ARVs available in certain countries through significant price reductions (Black 2002). For instance, GlaxoSmithKline (GSK) announced a reduction in prices by 90%. The AAI Agreement covers not only ARVs but also drugs to fight TB and malaria. Such a reduction in prices in certain drugs is really not all that new – vaccines and contraceptives have long been available at affordable prices. Now the EU says it wants to set an example by making an equally serious effort with regard to other medicines, such as those needed to

fight HIV/AIDS, TB and malaria. Brussels has drawn up a list of 72 countries eligible to benefit from its scheme (Black 2002).

However, such negotiated reduction, no matter how impressive and welcome, turns out not to be as powerful a tool as direct competition from generic drugs manufactured in the more advanced developing countries (DCs), such as Brazil and India, which possess technical and other capabilities to produce generic equivalents of those drugs for which the patents have expired (Black 2002). This is borne out in the case of Uganda, one of the first countries to sign the AAI agreement in May 2000, but the significant benefits of which were only fully realised when Uganda began to import ARV generics from an Indian company called Cipla in October 2000. By December 2000, the price of branded ARVs fell by 22–70% of the May 2000 price. By March 2001, the price of AZT fell by 44% from the September 2000 price. Combivir fell from US\$220 in May 2000 to US\$71 in February 2001, a reduction of 68% of its original price. The triple combination of Combivir and Efavirenz, under the negotiated reduction, worked out to be US\$119 a month. By replacing Combivir with a generic (Duovir), the cost decreased to US\$83 a month. The cheapest triple ARV cocktail was Triomune, a generic from India, costing US\$40 a month.

Since then, the overall pricing situation itself has altered – the newspapers, on 28 April 2003, reported that GSK is now prepared to almost halve the annual cost of treatment with its drug Combivir, to £206, which makes it much nearer to the cost over the last couple of years of generics produced by countries that ignore international patent laws. However, the price of the latter has itself lowered in the meantime; as a result, in April/May 2003, the GSK announcement to slash the price of Combivir so dramatically remains expensive relative to the generics on offer – for example, the Indian pharmaceutical company, Ranbaxy offers a WHO-approved version of the same drugs, Zidovudine (AZT) and Lamivudine (3TC), for \$167 *per annum*, while Aurobindo (another company) offers its version for only \$128, which, however, does not have the WHO imprimatur (Boseley & Radford 2003).

Hence, it looks as if that the way forward is via the use of generic ARVs, but there lies the rub. Countries like Uganda might soon no longer be able to import generics from India or Brazil. The issue about patent rights continues apace to obstruct the objective that public health should take precedence over intellectual property rights, in spite of the fact that the trade ministers of the rich countries, meeting in Doha in November 2001, committed themselves to finding a solution by the end of 2002. However, to date, nothing has firmly transpired, in spite of continuous campaigning. Paragraph 4 of the Declaration of the World Trade Organisation (WTO) on Trade Related Aspects of Intellectual Property Rights (TRIPS) and Public Health reads:

We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO Members' right to protect public health and, in particular, to promote access to medicines to all.<sup>1</sup>

Under TRIPS, by 1 January 2005, India, Brazil and other countries that manufacture generics would no longer be allowed to export them, even though there may be no patent in force for those drugs in the importing countries. In particular, the least developing countries (LDCs) rightly resent and strenuously resist the TRIPS requirement as its essence is to oblige all countries, whether poor or rich, to grant at least 20 years patent protection for new drugs, thereby making cheap generic substitutes unavailable for that lengthy period of time. TRIPS came into effective existence on 1 January 1995. Developed members of the WTO were given one year to comply with its terms, while developing countries were given until January 2000, although in the area of pharmaceuticals, they were given grace until the end of 2004, before the requirement of product patent protection came into play. However, in the case of LDCs, again in respect of pharmaceutical products, under the Doha Declaration on TRIPS, this requirement has now been delayed until 2016.

However, TRIPS does permit countries to override a patent under certain circumstances, such as if the supplies are limited, if the prices are too high and if certain clearly laid down procedures are followed. This presupposes that all countries do possess their own manufacturing and other facilities, which enable them to take advantage of the provisions to produce generics. However, many countries have no such facilities and would, therefore, be left bereft of cheap drugs as they can no longer import generics from those that do. It is true that in principle the use, for example, of compulsory licensing is available to overcome the problem of drug shortage under certain circumstances – both Canada and the USA resorted to it over the anthrax scare following 11 September 2001 to enable suitable vaccines to be cheaply and quickly produced and made available. However, DCs and LDCs, not being rich and powerful like the USA, who are, after all, primarily the makers of the rules of organisations like the WTO and agreements like TRIPS in any case, are not in a position to invoke such an instrument: they lack both the administrative and legal infrastructures, the know-how to reverse engineer the drugs (and in any case may lack a sufficiently large market to justify the cost of doing so) and most of all they fear sanction. On the other hand, Brazil, which does to a large extent satisfy these conditions, has successfully used the threat of compulsory licensing to negotiate prices with patentees. In June 2001, Brazil won a battle when the USA, under public pressure, dropped a case that was brought under the WTO's rubric against a provision of Brazil's patent law that requires the patent-holder to produce drugs locally.

At the WHO meeting in Geneva in June 2001, developing countries expressed their worries on all these points; unless such problems are seriously addressed and solved, no matter what ringing declarations are made and agreed to on paper, such countries will never have access to essential medicines at an affordable cost, and public and individual health will always be the victim of intellectual property rights insensitively administered globally. What is needed is the political will to ensure that the high cost of drugs should be

ameliorated through a cluster of strategies, each of which may be applied wherever and whenever appropriate, such as the enhancement of local manufacturing capacity, differential pricing, transfer of technologies and generic competition.

To the credit of the UK government, in November 2002, it announced a plan for a two-tier system for drug pricing that would make essential drugs available to the poor countries at cost price, while the developed countries continue to pay for them at the rate charged by pharmaceutical companies. However, Minister for International Development Clare Short's initiative was expected to run into opposition from the US government and its pharmaceutical lobby (Boseley & Radford 2002). And it has; in the following month, Dick Cheney, the US vice-president, at the WTO talks in Geneva ruled out a deal that would have allowed a full range of life-saving drugs to be imported into Africa, Asia and Latin America at cut-price costs. Nevertheless, he seems to enforce the narrowest possible interpretation of the Doha Declaration, and to confine price reduction only to drugs dealing with HIV/AIDS, malaria, TB and a few other diseases unique to Africa but for which the drug companies carry out little or no research. To this policy, George Bush, the US president himself, has also given (February 2003) his imprimatur (Elliott 2002, Denny 2003).

### III

In the HIV/AIDS crisis within the context of today's global politics and economics, perhaps the most relevant Levinasian notions are those of proximity and of the third. Hence, I need to set them out in brief outline.

For Levinas, I do not agree to live ethically with the Other. I am ordered to do so. The encounter with the Other is both singular and disquieting. He characterises the life of the human/moral subject as an answer to a calling – I become a human subject on the condition that I answer for everything and everyone. My responsibility for the Other is neither freely chosen nor actively desired. It is not an episode in my biography.

Before I am even myself, I am responsible for the Other, absolutely and without repeal or further appeal.

*Proximity* is the term Levinas uses to refer to the immediacy on confronting the face of the Other. Proximity is felt as immediate contact that demands a response and hence, that it amounts to responsibility, that is to say the ability to respond.

In proximity the absolutely other, the stranger whom I have 'neither conceived nor given birth to', I already have on my arms, already bear, according to the Biblical formula, 'in my breast as the nurse bears the nursing'. He has no other place, is not autochthonous, is uprooted, without a country, not an inhabitant, exposed to the cold and the heat of the seasons. To be reduced to having recourse to me is the homelessness or strangeness of the neighbour. It is incumbent on me.

(Levinas 1974: 91)

However, although it is true that *via* proximity and the face-to-face relation, the agent is called to an infinite responsibility, it is the notion of *the third (le tiers)* that constitutes the key to social justice.

If proximity ordered only the other alone to me, there would have not been any problem, in any sense, even the most general of the term. The question would not have arisen, not with regarding consciousness, nor self-consciousness. The responsibility for the other is an immediacy antecedent to questions, it is proximity. It is troubled and becomes a problem when a third party enters.

(Levinas 1974: 245)

The central question here is the fact that justice is not viewed as a formal or abstract legality regulating society, with the mere aim of producing social agreements by reducing conflicts. A society regulated by abstract legality is without faces and friendship; in other words, it is a society without a true recognition of human diversity and difference, in which economic abstraction and reification are represented by so-called free and equal autonomous individuals. In Levinasian terms, it is a society without proximity. However, without universalisation, how can the encounter of the Other be at the foundation of morality? Levinas

answers this question by the notion of the third. The face-to-face does not establish a comfortable intimacy between myself and the Other. It shows me the existence of a huge world outside myself. At the same time as I discover the Other, the potential presence of innumerable others is also a reality to me. On the basis of this, the ethical relation may turn into a concern for social justice. Society is not founded on a unity of species, but on a multiplicity of Others, in which each Other is unique, resistant to classification; justice is, therefore, not founded on universal principles or on some social contract designed to tame the 'natural instincts' of the 'human species'. This social justice is fraternity, but this fraternity is not synonymous with equality or some kind of symmetry between people, or even the certitude that they belong to a common genre. According to Levinas, this fraternity comes from the encounter with the Other's face.

The third party looks at me in the eyes of the Other – language is justice. . . . The epiphany of the face qua face opens humanity. The face in its nakedness as a face presents to me the destitution of the poor one and the stranger; but this poverty and exile which appeal to my powers, address me, do not deliver themselves over to these powers as givens, remain the expression of the face. The poor one, the stranger, presents himself as an equal. His equality within this essential poverty consists in referring to the *third party*, thus present at the encounter, whom in the midst of this destitution the Other already serves.

(Levinas 1991: 213)

With the introduction of the third, the asymmetry of the infinite responsibility for the Other is moderated and gives place to the possibility of an institutional political order. In *Otherwise Than Being* (157), Levinas affirms that justice begins 'with the third man' in the sense of the third party (Faessler 1984, Purcell 1996, Bernasconi 1999). The third confronts us with the parameters that are present in the organisation of human plurality (Soares 2000). *Via* the third, my infinite responsibility for the Other is called to respond not only to the face that is in front of me but to all absent faces.

Levinas is against exclusion; the Other is characterised as stranger, foreigner, widow, orphan, namely those who are disadvantaged as outcasts or outsiders, who are needy and who suffer. Our primary responsibility is towards these people, our first and foremost response is addressed to those who are in need in our world. However, no one can deny that one important class of the excluded in today's unequal world are those who suffer from diseases like HIV/AIDS (tuberculosis, malaria, etc.) in the poor developing economies, who face debilitation and/or death because they cannot afford the treatment either to control their ailment or to cure them of their afflictions. Proximity compels not merely each and every one of us in the mature economies to confront our responsibility to these others but also, especially those who are identifiable within the CIDs of pharmaceutical companies in the West with the power of policy articulation and policy execution, to discharge that responsibility by changing the pricing and other policies (such as patenting) of the organisations they control. These individuals are no ordinary intentional actors, so to speak, but owing first and foremost, to their power, their actions have impact upon a large number of people. They have extensive resources enabling them to formulate and articulate certain policies and strategies, for carrying them out, as well as to monitor their outcome.

If the above were admitted, then corporations might even be held to a more stringent level of responsibility than a mere 'flesh-and-blood' private citizen, as its field of action is more embracing than that of individual agents (Soares 2003). Of course, I do not deny the efforts that many corporations try to make in order for a better response in terms of their responsibility and also the effort of many institutions, namely the UN Global Compact Principles, to help corporations towards a broader range of responsibilities towards stakeholders.

Individuals in the affluent economies cannot be said to be totally innocent in the role they might be playing in supporting the extant responsibility policies of such corporations. Individuals themselves may not have money invested in them, it is

true; however, on the whole, they make contributions to pension funds, or buy policies with insurance companies that in turn may invest the money in such corporations. When pharmaceutical companies proclaim that they cannot change their extant policies, otherwise they would be short-changing their shareholders (to which group alone, corporations recognise legal and moral accountability), it is then also up to individuals to use their power as consumers and shareholders to put pressure on pension fund managers to avoid enterprises that refuse their moral responsibility to other groups in the world at large, besides that of the shareholders. However, having said that, it remains the overwhelming case that power holders themselves within the pharmaceutical companies must confront the challenge posed by the Levinasian notion of proximity. The face-to-face relation of suffering in the Other in today's global village is brought into the living rooms of one and all; there is no need to make any effort greater than that of turning on the news to be in the presence of such suffering. For Levinas, compassion fatigue is no excuse, but simply yet another evasion of the responsibility one bears for the Other. Nor is human frailty and weakness to live up to moral ideals an excuse. For Levinas, the pursuit of holiness/saintliness is at the core of his vision. The infinite responsibility for the Other is an answer to a calling; it is even an obsession, an obligation to care for the Other. Saintliness is an expression of this infinite responsibility (Soares 2005). Of course, as frail humans, we may rarely live up to the virtue of saintliness and its onerous demands – failure is not, however, an excuse for acquiescence but is simply the eternal call for further effort. To give up striving to implement the holy and the good is sheer cowardice. And for the CEOs and other relevant figures in corporate management to blame, in the main, shareholders for their responsibility policies is, to use a colloquial expression, 'to cop out'.

The moral force behind the notion of proximity reinforces that of the third, as the latter is 'the whole of humanity, in the eyes that look at me' (Levinas 1991: 213). In particular, it is that part of humanity, which suffers, that is looking at me in the eye. The key power holders of Western

pharmaceutical companies cannot pretend, given the evidence, that there is no direct causal link between their responsibility policies and the suffering in front of their very eyes. As Klaus Leisinger argues, '*A new social contract for globalization with human face* is an idea whose time has come. A credible commitment to enlightened corporate social responsibility will become one of the most important areas of future corporate leadership and success' (Leisinger 2005: 593). For instance, as I have already shown, the availability of generic drugs of an appropriate kind undoubtedly saves many more lives than even price lowering with regard to certain individual drugs. Yet, the pharmaceutical lobby in USA, as we have seen, has got the President and the Vice President to back its refusal to implement the Doha Agreement.

Morality accepts the Kantian dictum that 'ought implies can' and Levinas is not an exception to this view despite his profound disagreement with the dominant tradition of philosophy and moral philosophy in modern Western thought. If a child were drowning in a river, but I literally cannot swim (and assuming that my cries for help turn out to be useless as nobody was within earshot), then should the child drown, society cannot hold me morally responsible for not having saved the child; nor would I need to feel myself morally responsible and, therefore, guilty about the unfortunate death. However, imagine another scenario: I cannot swim but I am sitting on the bank, near to the drowning infant, and if I were to stretch out my hand, with no danger to myself whatsoever, I could have grabbed hold of the child and saved her. But, in so doing, I would have messed up my brand-new outfit, and so I failed to perform that simple act. As a result, the infant drowned. Here, the moral judgement would be the harsh one: I would have behaved less than impeccably, because it is not true in this case that I literally cannot save the child; it is simply the case that in my calculation, the child's life is worth less than the inconvenience/economic loss caused by ruining my clothes. Society rightly judges that this action is morally insensitive.

## IV

We now raise the question: ‘Can the pharmaceutical industry in the West (financially) afford to make the concessions to contain the AIDS/HIV epidemic in some of the poorest parts of the world?’ If they literally cannot, then it follows from the Kantian dictum that such corporations would have no moral obligation to make those concessions. They would then be analogous to the person who did not save the child in the first scenario because s/he could not. However, the evidence available does not seem to support the analogy. Corporations claim that they cannot afford to depart from the *status quo*, citing the argument, with regard to the suspension of patents, that they would become less profitable as enterprises, and therefore, less attractive to potential investors and ultimately harming their ability to deliver new miracle drugs based on research and development. However, in the case of HIV/AIDS drugs, their argument appears not to be watertight. First, as the figures cited in the preceding section show, the profits of the major Western pharmaceutical companies are roughly a third of their sales figures, making their profit margin one of the highest of any industry in the world. Second, those figures of profits and sales do not cover, by and large, transactions in the poorest parts of the world, for the simple reason that those there with HIV/AIDS are too poor to buy their drugs. Hence, it is not as if their overall profits would be depressed should they change their ways, as they are not getting any income from that source anyway. Third, HIV/AIDS is an affliction that affects people indifferently whether they live in affluent or non-affluent economies. It is not like some other ailments, which, by and large, only afflict those in the developed world. As a result, the pharmaceutical companies continue to research and develop their drugs protected by patents for their successful products, and continue to charge purchasers a high price in the developed economies. In other words, in making their products available to patients in the poorest parts of the world, the income derived from patenting would not be affected. And should they make the drugs available at a lower price, their overall income would even increase. Fourth, even if the points raised above were not to hold, it remains

the case that the withholding of the essential drugs for HIV/AIDS is primarily in the hope of boosting existing income and profit margins, which are already one of the highest in the world today. This then means that their behaviour is analogous to the person on the river bank, who failed to save the drowning child under the second scenario. Just as the consensus in that case is a moral thumbs-down, similarly, the moral consensus about the present attitude and conduct of the Western pharmaceutical industry must be one of disapproval. In other words, the industry can afford to act in a stronger morally responsible manner but has chosen not to do so, and to turn its back on Levinas’s notion of infinite responsibility, which consists of ‘hinneni’ (*Me Voici*) to the Other. We can say that responsibility is infinite because:

1. it recognises no distinction between duty on the one hand and supererogation on the other;
2. it does not recognise the distinction between perfect duties on the one hand and imperfect duties on the other;
3. it is inclusive, not exclusive, as it fails to recognise the distinction between family, kith/kin on the one hand and strangers on the other, between insiders (those who share the same history, culture, language, ethnicity) on the one hand and outsiders who do not. It urges one to recognise the humanity in the Other, in all others, not only in some, namely, those who are regarded as ‘persons’ in the philosophical sense or kith and kin in the sociological sense. One should be the good Samaritan and not pass by, indifferent to the life or death, pain and suffering of fellow humans; and
4. one can distinguish between the positive and the negative senses of responsibility for others. While one concedes that it does not need to be understood in the former sense of doing whatever one can to render them ‘happy’, one can, nevertheless, meaningfully discharge that duty in the reduced negative sense of doing what one can to relieve others of suffering and poverty, there being a clear consensus as to what constitutes misery.

The infinite responsibility for the Other is not a question of grasping abstract principles of reason

(like in Kant), of acting on sympathy (like in Hume), of intuiting moral obligations and goodness (like in G.E. Moore or Plato) or of applying a master rule (like the principle of utility). Rather, it is grounded in one's relation to the Other as a concrete, flesh and blood individual whose suffering face should touch one and provoke a positive and loving response.

The ideas behind the Levinasian philosophy might have fallen on stony ground in the latter part of the twentieth century, but there are emerging signs that it may yet, at long last, find fertile ground in the wider politics of the twenty-first century. This would then, hopefully, constitute progress, the manifestation of a new kind of moral vision, which reflects more adequately the contemporary order of globalisation in which powerful trans-national corporations play a vital role in the affairs of humankind.

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## Note

1. [http://www.oxfam.org/eng/pdfs/pp020325\\_trips\\_health.pdf](http://www.oxfam.org/eng/pdfs/pp020325_trips_health.pdf); see also *Journal of International Economic Law*: The Doha Declaration on the TRIPS Agreement and Public Health, by Frederick M. Abbott at <http://www.accessmed-msf.org/prod/publications.asp?scntid=2920021243243&contenttype>

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