

# Living Within Assisted Suicide: Drawing a Landscape and its Transnational Movements

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Since 1871, upon the inception of the Criminal Code of the German Empire (*Reichsstrafgesetzbuch*), suicide assistance in Germany relied on the principle that the assistance of a legal act cannot be considered illegal: if suicide is legal, it follows that assistance to suicide also has to be legal. However, in 2015, after being the subject of intense political debate in Germany, with four different law proposals being presented at the Bundestag in order to regulate the issue, a new law on assisted suicide was approved by the Parliament. Members of Parliament were granted a free vote from the official parties' position, for the issue was considered a matter of conscience. Throughout the Friday morning of November 6<sup>th</sup>, 29 Members of Parliament took to the podium prior to the vote to express their views on assisted suicide, often sharing personal experiences. When speaking at the Parliament, for instance, Dr. Carola Reimann said:

“Ladies and gentleman, I do not know what it feels like to live with a painful, incurable disease. I do not know what decision I would make in this case. All I know is: should I be in this situation, I personally want to find my own way. As a Member of Parliament I say: I want that others have this freedom.”

Rudolf Henke, also a Member of the Bundestag, shared a private experience:

“I’ll tell you something: I have, I think when I was 22 or 23 years old, stood at the window and asked myself during a relationship crisis: What do I do now? – if there had been one who would have pushed just a bit, who would have promoted a little, then maybe I would not be here.”

The sharing of personal considerations and private experiences filled the debate alongside questions regarding the reach and duty of the Parliament; the role of the State and of the individuals; the breach of traditions; the limits of legalization and the dangers of criminalization; the role of the medical profession and the right for self-determination. Although this particular debate over assisted suicide was being carried out in the German Parliament, this blog piece aims at stressing two main factors: (1) national policies have effects and a reach beyond the political borders of nation-states, and (2) assisted suicide is not only about the procedure *per se*. When discussing voluntary euthanasia in The Netherlands, Norwood (2015; 2009; 2007) stressed an important argument: the trope “voluntary euthanasia” goes beyond the procedure itself. The author differentiates the life-ending act from “euthanasia-talk”, which encompasses “a whole chain of activities – based mainly in dialogue” (2007: 150), i.e. the social permeability of euthanasia, specifically in the necessary discussions between patients and physicians, or

within one's own family. Euthanasia-talk means the creation of a discursive space where end-of-life decisions become an accepted (or contested) topic and all the options in this regard are brought into the conversation.

In light of the debate at the Bundestag, Norwood's argument suggests the relevance of thinking on assisted dying in a more contextualized way, understanding it not only as the act *per se*, but as part of a broader dynamics – in the present case comprising a complex meshwork of norms and regulations, medical knowledge, people's individual preferences and decisions, moral deliberations, as well as political and economic issues. Defining assisted suicide as merely the procedure through which one person ends her own life with the assistance of a third party does not suffice. Even this brief definition might raise questions about assisted suicide that go beyond the act itself, such as who can or cannot have access to it?; where does it take place?; how are the necessary means obtained? Questions to which any answer would have to take account of a wide range of legal aspects, professional regulations, socio-economic and biographical circumstances of individual persons, as well as the possibilities laid out by organizations specialized on assisted suicide.

Specific forms of assisted dying, as an umbrella term for different dynamics and procedures such as assisted suicide and voluntary euthanasia, are a legal – or at least not illegal – option not only in The Netherlands, but also in other different national and local contexts, such as Belgium, Luxembourg, Switzerland, the US American states of Oregon, Washington, Vermont, and, more recently, California. However, as mentioned by Wolf and Hörbst, medical issues can no longer be considered as restricted within “locally and isolated frames of reference such as nation-states” (2014: 183), but should be understood within different forms of association and cooperation that often occur on a transnational level. Therefore, I would expand this argument towards political issues as well: although such frames of reference might provide some help, it also casts an analytical shadow over the effects and influences of certain national policies. In general terms assisted suicide remains a legal option in Germany even after the recent approval of the so-called Brand/Griese law, which targeted mainly organizations that provided suicide assistance and advice on end-of-life issues. Its intention to deter a “businesslike” model of assistance is likely to have an effect in Switzerland, a country with a less restrictive law where foreigners can become members of organizations and, ultimately, apply for suicide assistance if they so decide.

This article outlines some arguments taken from an ongoing multi-sited ethnographic research on transnational movements of assisted suicide in Europe and presents one specific event and two judicial cases to illustrate particular ways of inhabiting the landscape of assisted suicide and medical professionals' (often reluctantly assumed) role of a mediator. Thus, to better grasp the movements and policies associated to assisted suicide I draw from the concept of medicoscapes, as described by Wolf and Hörbst (2014), as a means of presenting, in its many intricacies, the meshwork in which assisted suicide is embedded. As the authors suggested, this concept is a tool to visualize “the complexity of intertwined local, national and global relations” in health-related fields (2014: 183), bringing together dispersed and heterogeneous elements such as practices, policies, individuals, and institutions as part of the same analytical landscape. However, while the concept of medicoscape gives an emphasis on global health and health phenomena, assisted suicide is as much a medical issue as it is a political and moral one. The

political debates that are often triggered by the institutionalization of assisted suicide come with the question of whether the procedure can be considered within the scope of the medical profession – although in every context where the practice was institutionalized physicians are somehow integrated in the dynamics, whether by providing medical reports and examinations, or by prescribing the necessary drugs. Therefore, to soften the emphasis on health-related fields and, at the same time, preserving the authors' original conceptual definition, the more general notion of landscape will be employed here.

The choice for presenting one event and two judicial cases was made with the intention of illustrating two essential parts of this particular landscape where movement plays a significant role. Firstly, the asymmetrical legal situation among national contexts and the different set of medical norms regulating assisted suicide in each of them lead to the association and cooperation of individuals and organizations towards the goal of making assisted suicide a viable option. The event described here is one of such cases of cooperation. This idea follows the argument of Mol (2002), who alludes to the importance of thinking about the collaboration between practices, materialities, discourses, spaces, and government technologies to create specific events. The event, as a result of these collaborations, shifts the focus from the procedure of assisted suicide to the coordination between practicalities and agents within the landscape of assisted suicide. Secondly, while transnational mobility is one way of inhabiting the landscape when the goal is to enable suicide assistance as a feasible option, one other way is through a judicial contestation. As Jasanoff puts it, "Judicial interpretations of the right to die became enmeshed in a complex tapestry of social adjustments to the newly public, technologically assisted, rituals of dying" (1995: 184). The judicialization of life is a way of demanding a right over it, including the one to terminate it under one's own terms. This alternative does not preclude the enactment of transnational movements, but on the contrary leads to their proliferation, as both alternatives often prompt similar cooperations and have the involvement of the same agents.

### *A Journey to Switzerland*

It was about 10 a.m. when she walked into the apartment alongside two companions. Inside, the physician, the organization's manager, and myself were waiting for her. Despite my expectations about this moment, Elise<sup>14</sup> walked into the room with a friendly smile in her face, nodding at us. Walking slowly, as if carefully watching her steps in this unknown place, she moved towards the big desk located in one corner of the room – the desk where we were all waiting for her arrival. As Elise joined us there, coffee was promptly offered by the manager. The windowless apartment, which is used by an organization founded a few years ago by Dr. Preisig, a Swiss physician, and located within walking distance from the borders with Germany and France, is divided into a work space, a kitchen, a bathroom, and a living room furnished with one bright colored sofa, a comfortable chair, and a bed. A stereo alongside a varied collection of CDs is also available. The members of the organization can choose where to perform the procedure, which happens through the insertion of a cannula into a vein and the subsequent administration of a drug by the members themselves. The assistants can only help with the preparations, as the members have to open the valve themselves.

As is the common procedure in organizations in both Germany and Switzerland, one has to be a member in order to request and, ultimately, to carry out an assisted suicide within its premises. At that point, Elise had been a member of the organization for a year and was green-lighted around two months before her arrival. The green light stands for the authorization given by organizations to its members allowing them to schedule an assisted suicide, and its concession requires the fulfillment of mainly health-related steps, such as medical examinations, having been diagnosed with a terminal illness or experiencing unbearable pain. Elise also had to present a letter where she expressed in writing her desire to end her life with the organization's assistance, justifying it on the basis of her daily struggle with her condition. Elise wasn't suffering from a terminal illness. Her condition was chronic and she suffered constant pain. A physical pain that she could not alleviate with treatment and with which she could no longer stand living: as Elise explained, she was there because she felt she could no longer live with her condition and the absence of an effective treatment had led her to consider the options regarding end-of-life care, including assisted suicide.

With everyone sitting around the table, Elise shared that she no longer had any family alive, for her parents were both deceased, and that she had neither siblings nor children. The companions with her at the moment were members of a French organization that provides advice for individuals considering assisted suicide and offers companionship in case they decide for a journey to Switzerland – since in France suicide assistance is illegal. Once green-lighted, she had scheduled an appointment to die in Switzerland. However, over the previous weeks leading to that moment Elise had been through a variety of bureaucratic and logistic issues, while also undergoing heavy emotional experiences.

Upon getting at the airport, she realized that her passport had expired. Since both France and Switzerland are Schengen countries, Elise said most of the airlines did not always ask for a valid document. But that was not the case for her. Not having a passport on hand, she had to go to an office at the airport where she was provided with a temporary and emergency one. Having solved this problem and being able to board the aircraft, it didn't take off. For technical reasons, she was told, the aircraft would remain on the ground. It was the first time during her lifetime that such a situation occurred. Insisting on going to Switzerland, but already facing that she would lose her original appointment, Elise rented a car and with her two companions drove 12 hours from France to Switzerland, despite her pain. After arriving in Switzerland and with a new appointment scheduled for the next day, she received a personal phone call from a friend in need of her company – without the friend being aware that Elise was in Switzerland for her assisted suicide. The friend had suffered a miscarriage.

As Elise went on translating dispersed events into a cohesive narrative, her smiling face turned introspective. She shared that she had dreamt about her parents recently and they had told her that they “do not want her there”. She still has a lot to accomplish, they said. She also mentioned that the expression her mother always used to describe when something was not right was “this plane didn't take off”. Her eyes turned watery. Acknowledging that Elise might have been experiencing second thoughts about her decision, Dr. Preisig told her that she could cancel the procedure at any time, rescheduling it whenever – and if ever – she felt like the right moment was due. The green light did not represent an obligation, but an option. Her companions seconded the physician by telling Elise that the decision was hers and hers alone,

and if she felt that the right moment was yet to come she should not do it at that precise moment. After a brief pause, Elise continued to discuss her situation, but her eyes were no longer watery. Instead of carrying out the assisted suicide, she decided to walk back to the hotel and, afterwards, to take a train to visit her friend in a nearby city.

It was the first time that a member of the organization decided not to go through with the procedure after having it scheduled and already being in the room to carry it out. Elise's decision struck me with relief. Her journey to Switzerland was also my journey, although sharing different intentions and expectations. It was clear that she wanted to stop her suffering through the procedure, but found instead a discursive space where she could openly talk about it and rethink her own life situation – postponing, rather than canceling, what is still a viable alternative to her. Being able to witness that made me anxious, but also relieved. Anxious for not knowing what I was going to see and what to expect of it. Not knowing how I would react or feel. When Elise described her journey to us and all that happened on her way to Basel, shortly followed by her decision to go back to the hotel and visit her friend, I was immediately relieved. And I was not the only one. Everyone present appeared to share a mixed sense of relief and happiness, for it reassured that assisted suicide is not just a synonym of a specific procedure.

### *Inhabiting Norms and the Judicialization of Biopolitics*

As an event, Elise's assisted suicide was not only about the procedure. It was about having the procedure as a viable option in the horizon, but also having a socially accepted discursive space where her situation could be shared and discussed. Where it could be talked about. Elise is from Belgium, a country where voluntary euthanasia is allowed as a medical procedure. A procedure, however, for which she would hardly be eligible, since she has been living abroad for many years – under the principle of “careful consideration”, she would be requested to have a series of consultations with physicians in Belgium and go through all possible treatments, a criteria that might have required her to move back to the country. She lives in France, where assisted dying is illegal. So after considering her options, Elise, a Belgium citizen living in France, decided to become a member of a Swiss organization and to travel to Switzerland to enable her choice for suicide assistance.

The coordination between the illegality of assisted dying in France; the difficulty of carrying out a voluntary euthanasia in Belgium; the comprehensive Swiss legislation; the availability of safe drugs and a space for the procedure; Elise's travel to Switzerland with her companions, and her acceptance, by Dr. Preisig's part, as a member of her organization, composed that specific event. An event that, among many others, transcended the political and legal borders of a nation-state. The regularity with which similar events take place makes it harder to consider them as isolated, decontextualized occurrences. Instead of circumstantial events, their similar dynamics suggest that they are coordinated within one greater context, a landscape, composed not only by individuals directly involved, but also by a set of norms, transnational movements, and organizations. A landscape is an arena where different events can be perceived as coordinated within a larger and globalized scale. In Switzerland, the majority of foreigners who seek suicide assistance from organizations are from Germany, followed by the United Kingdom.

While voluntary euthanasia is considered a crime under Swiss law, assistance to suicide is not. The legal situation in Switzerland derives from the Article 115 of the Swiss Federal Criminal Code (StGB), which reads that: “Every person who, for selfish reasons, incites or assists someone to commit suicide, shall be sentenced to imprisonment of up to five years or a fine.” Therefore, if the assistance takes place without selfish reasons – which is often associated with the absence of financial gain –, the action is not considered to be a crime. The law neither specifies who can offer assistance nor who can ask for it, opening a vacuum ultimately occupied by organizations, medical doctors and non-medical assistants. The role played by some physicians in these dynamics contrasts with the Swiss medical ethics guidelines from the Swiss Academy of Medical Sciences, which states that:

“In this borderline situation [of assisted suicide] a very difficult conflict of interests can arise for the physician. On the one hand, assisted suicide is not part of a physician’s task, because this contradicts the aims of medicine. On the other hand, consideration of the patient’s wishes is fundamental for the physician-patient relationship” (2013: 9).

As the Swiss Academy of Medical Sciences frames it, the physician would be in a conflicting position, having to reconcile the importance of their relationship with patients with the risk of contradicting the goals of their occupation. The dispute over the role of the medical profession often leads to judicial contestations. In 2010, Ms. Alda Gross, a Swiss national born in 1931, filed an application against the Swiss Confederation in order to gain prescription-free access to a lethal dose of sodium pentobarbital – a substance often used in assisted dying proceedings. Alleging that it was her right to decide how and when to end her life, she stressed that this right had been breached due to the imposition of a medical prescription (2013: 11). Earlier, in 2007, another Swiss national, Mr. Haas, also alleged that his right to decide when and how to end his life had been breached. Both cases suggest that this right, lodged under article 8 of the Convention for the Protection of Human Rights and Fundamental Freedoms, was violated by the impossibility of having access to the desired drugs.

The impossibility derived from the necessity of fulfilling specific medical criteria to receive the prescription – which an interlocutor of my research, a physician from the United Kingdom who works closely with Swiss organizations, phrased in terms of “medical gate”: the medical requirements one has to address in order to be able to request an assisted suicide. Criteria that both applicants did not meet, either for having been diagnosed with a psychiatric disorder (Haas) or for being considered healthy (Gross). However, as Gross argued, by doing so the Supreme Court of Switzerland had presupposed “that the applicant’s suicide had to be justified from a medical point of view” (2013: 12), and that this was “incompatible with the assumption that any person who was able to form his or her judgment had the right to decide on the time and manner of their own death” (2013: 12). Both cases were later considered by the European Court of Human Rights (ECHR), a supranational court established by the European Convention of Human Rights. As both cases illustrate, the dispute over the medical profession’s role encompasses not only whether physicians can or cannot assist in a suicide – as posed by the Swiss Academy of Medical Sciences – but, furthermore, the imposition of a medical prescription

in order to access certain drugs, and of a diagnosis that would validate the option for an assisted suicide – or, in more general terms, having to justify the suicide through a medical perspective.

Gross' and Haas' proceedings are among at least 5 cases judged by the European Court of Human Rights since the early 2000s regarding end of life issues – even though the Court has received more cases, they were declared inadmissible. The court's aim is to ensure that the rights foreseen in the European Convention on Human Rights are not “theoretical and illusory”, but “practical and effective” (judgment in *Artico v. Italy*, 13 May 1980, § 33, Series A no. 37). Therefore it is one place of dispute where different ways of inhabiting norms are either contesting or demanding one's right to die, and, by doing so, end up exposing a set of obligations and duties permeating the relation between nation-states and citizens. Relations that are, in the aforementioned cases, mediated by the medical profession. The “medical gate” acts as a mediator between one's demand to die under specific circumstances and the alleged obligation of the State towards its citizens, phrased by the Government's submission in the *Haas v. Switzerland* judgement as following:

“The State is enjoined not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction from acts by others or, where appropriate, from themselves. (...) Where the authorities were aware of the risk of suicide by an individual, it was incumbent on them to do everything that could reasonably be expected of them to prevent the suicide” (2011: 14).

As Biehl wrote about the judicialization of the access to health, the judiciary ends up becoming a “site in which the state's biopolitical disregard (i.e., its willingness ‘to ‘let’ die’) – in collusion with the market – is exposed for public critique” (2013: 424). In regard to assisted suicide, we are facing an opposite process, where the judiciary turns into a place of dispute in which the State denies a positive obligation towards “letting die”, and does so through the imposition of a series of medical technologies. These technologies are synthesized into the routine of organizations by the green light, which combines criteria such as diagnosis and psychiatric evaluation, and acts as a mediator between the individual and the drugs. By acting as a mediator, the green light becomes a “medical gate” that either grants access to the possibility of carrying out the procedure or restrict it. However, as Mahmood formulates it following the footsteps of Foucault, the same processes that restrict access to a specific dynamics by securing one's subordination to norms are the ones that create the conditions for a subject to become a “self-conscious identity and agent” (2006: 45), leading to the emergence of judicial contestations. In this case, the absence of a fully recognized right towards one's own life and death often leads to judicial disputes over assisted dying.

Elise inhabited this landscape of individuals, interwoven norms, and organizations by taking part in a transnational movement that would facilitate the carrying out of an assisted suicide, i.e. she acted out of a situation of restraint in order to emerge as an agent through a set of cooperations. In turn, Dr. Preisig positioned herself within a dispute on the role of the medical

profession, inhabiting the landscape by readjusting the contradictory situation described by the Swiss Academy of Medical Sciences with the possibilities laid out by a loosely written legislation (which, according to Andorno, had the creation of the current assisted suicide dynamics in Switzerland as an unintended consequence [2013]). Therefore, it is safe to consider that assisted suicide – or, in more general terms, assisted dying – is not only about the procedure itself or, as Norwood’s crucial argument states, the creation of a discursive space, but also about the establishment of a landscape where individuals can inhabit their ways to an open conversation about their life situations, emerging as agents and, ultimately, contesting their demands in sites of dispute, such as judicial courts. Elise’s event, alongside Haas’ and Gross’ cases, illustrates how the juxtaposition of heterogeneous elements, such as an entangled set of norms, are inhabited in this landscape, and how the roles within it, especially the physician’s, are disputed.

### *Conclusions*

To discuss assisted suicide is to consider a landscape of heterogeneous elements, such as a set of norms and legislations, individuals, organizations, and different practices and materialities. A landscape that crosses different national contexts through cooperation, coordination, and movement. When the Bundestag debated and ultimately approved a law to regulate the issue, assisted suicide as a practice was the focus. The Brand/Griese law, which had the goal of preventing “the development of assisted suicide to a service offering of health care” (Gesetzentwurf 18/5373: 3), proposed to preserve the principle of legality upon which assisted suicide has been understood, but at the same time criminalizing its businesslike operation. By doing so, without considering the landscape as a whole, it will simply induce its rearrangement, trigger new cooperations and foster further mobility.

Not only many Germans already go to Switzerland to carry out an assisted suicide, but there are also Swiss members of organizations living in Germany. The uncertainties following a change of legislation might have an impact on both situations, with organizations evaluating whether they will continue to provide suicide assistance to Germans and, consequently, risk being the subject of legal prosecution. Under the law, physicians who prescribe drugs for suicide assistance on a regular basis might be considered acting “businesslike”, for the law states that “it is sufficient, if someone wants to make the repetition of similar acts the object of his employment” (Gesetzentwurf 18/5373: 20). However, as a transnational medical-judicial landscape, at least one organization, Sterbehilfe Deutschland, has declared the intention of contesting the law judicially at the Federal Constitutional Court of Germany in Karlsruhe. Either way, if the norms within the landscape change, different associations will follow: It can be by further judicializing assisted suicide or by finding new ways of enacting this possibility through movement.

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