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Marcos Freire de Andrade Neves

Lawful Life:
Itineraries of care and life in a landscape of assisted suicide

Supervisor: Prof. Dr. Arlei Sander Damo

2nd Supervisor: Prof. Dr. Hansjörg Dilger

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Tese apresentada ao Programa de Pós-Graduação em Antropologia Social da Universidade Federal do Rio Grande do Sul como requisito parcial para a obtenção do título de Doutor em Antropologia Social, sob orientação do Prof. Dr. Arlei Sander Damo e co-orientação do Prof. Dr. Hansjörg Dilger.

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Marcos Freire de Andrade Neves

LAWFUL LIFE: ITINERARIES OF CARE AND LIFE IN A LANDSCAPE OF ASSISTED SUICIDE

Esta tese foi julgada adequada para a obtenção do título de doutor e aprovada em sua forma final pelo Orientador e pela Banca Examinadora.

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Prof. Dr. Arlei Sander Damo (PPGAS/UFRGS)

Profa. Dra. Patrice Schuch (PPGAS/UFRGS)

Profa. Dra. Rachel Aisengart Menezes (UFRJ)

Profa. Dra. Cimea Barbato Bevilaqua (UFPR)

To Jay and Karin

I remember what George said and vowed that rather than let Alzheimer's take me, I would take it. I would live my life as ever to the full and die, before the disease mounted its last attack, in my own home, in a chair on the lawn, with a brandy in my hand to wash down whatever modern version of the "Brompton cocktail" some helpful medic could supply. And with Thomas Tallis on my iPod, I would shake hands with Death.

Terry Pratchett (Shaking Hands With Death)

ABSTRACT

There is a difference between life and death that matters. A difference situated at the very core of state and medical rationale, and one that enshrines life as a value to be protected and death as something to be avoided. This rationale frames life as an anonymous value, something that has to be preserved and protected regardless of whose life it is, therefore establishing legal protections to it. This *life*, however, clashes with individual ones that refuse to collaborate in this project of staying alive, therefore requesting professional assistance to suicide. This is the very basis of the process of lawful life: the friction following the juxtaposition between an anonymous life, as seen by the state, and personal ones, constitute from a person's own trajectory, moralities, affects, and perception of themselves. A friction between regulations over life that are implemented on the level of population and their impact over particular ones. Organized assisted suicide, therefore, is a manifestation of this process of lawful life, consequently being subjected to state and medical regulations. Regulations that, on the ground level, are circumvented through cooperation, judicial claims, and the transnational circulation of people, documents, and technologies. Therefore, this dissertation, which is based on a 3-year fieldwork starting at the Swiss organization LifeCircle, is an ethnography of transnational circulations in the context of organized assisted suicide, particularly between Switzerland, Germany, and the United Kingdom.

Keywords: Care; Death; Legal pluralism; Life; Organized assisted suicide.

RESUMO

Há uma diferença fundamental entre vida e morte. Uma diferença localizada no cerne da lógica do estado e da medicina, a qual consagra a *vida* como um valor a ser protegido e a morte como algo a ser evitado. Uma lógica, portanto, que configura a *vida* enquanto um valor anônimo sujeito ao estabelecimento de proteções legais, independentemente das especificidades de vidas individuais. Essa é a base do processo aqui chamado de "lawful life": o atrito que se segue à justaposição de uma *vida* anônima, pensada a partir da perspectiva do estado e da medicina, com vidas particulares, que se constituem através de trajetórias específicas, moralidades, afetos, entre outros aspectos sociais e biográficos. Um atrito entre proteções legais e normativas que são implementadas no nível da população e seus impactos sobre vidas específicas, individuais. Na medida em que se situa em um ponto de convergência e atrito entre *vida* e vidas, o suicídio assistido organizado é uma manifestação desse processo de vida legal [*lawful life*], sendo portanto submetido a regulamentações médicas e estatais. Regulamentações que, no dia-a-dia, são contornadas através do estabelecimento de associações e cooperações heterogêneas entre agentes localizados em diferentes jurisdições, além de processos judiciais e da circulação transnacional de documentos, pessoas e tecnologias. Baseada em três anos de trabalho de campo realizado a partir da organização suíça LifeCircle, a presente tese é uma etnografia do processo de *lawful life* articulado através de circulações transnacionais no contexto de assistência organizada ao suicídio, particularmente entre Suíça, Alemanha e Reino Unido.

Palavras-chave: Cuidado; Morte; Pluralismo legal; Suicídio assistido organizado; Vida.

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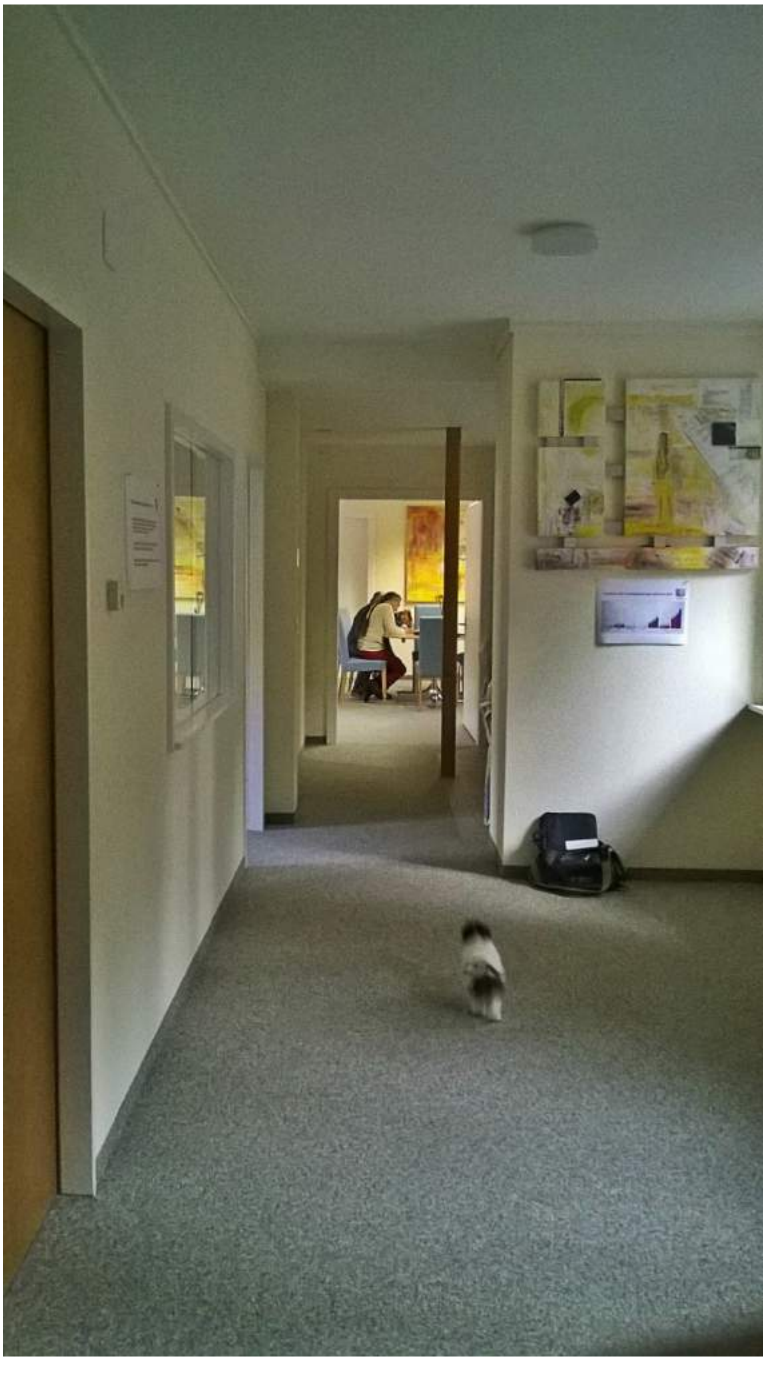

MARGOT AND DR. PREISIG | BASEL | 2016 | MARCOS ANDRADE NEVES

high, mate! You will always be remembered. And to Karin: I’m still dancing, swimming, and enjoying my life. Any thanks would never be enough.

PROLOGUE: MARGOT'S STORY

MARGOT'S LAST DINNER | BASEL | 2016 | MARCOS ANDRADE NEVES

"And for Marcos," Margot said looking at me, "show me your phone."

I was intrigued, but reached out for my cellphone and showed it to her.

"I have a letter for you, you are my last male companion!," she said, laughing. When I was about to grab the envelope, she added: "But wait until I'm not here to open it."

"Okay, I'll wait," I replied, noticing that the envelope and my cell phone were of the same color. When we first met, a few months before, it was my green cell phone that made Margot identify me. We had never seen each other by then, so when we decided to meet I told her I would be holding it.

Margot walked toward the bed and lied down.

"What we will do next is the infusion," said Dr. Preisig. Margot nodded and asked, "so I don't have to stand up anymore, do I?"

She was worried about her incontinence and was visibly relieved to know she would not have to stand up again. She asked for tap water.

“I want to say goodbye. First of all to Marcos,” she opened her arms for a hug. “It was so nice with you, it was a stroke of luck. It was good, wasn’t it? Thank you!”

Now addressing Dr. Preisig, she smiled and said: “It was really nice getting to know you, I’m glad that I came. It was really good with you all.”

Looking at me again, Margot said: “I have practiced a lot: ‘*Muito obrigada*’,” thanking me in Portuguese. As everyone laughed, I thanked her back: “*Muito obrigado.*”

“The situation here couldn’t be better,” she added.

As the procedure was about to start, Dr. Preisig went on to ask the questions that precede it.

“What is your name?”

“Margot.”

“When did you come into the world?”

“1934.”

“And can you explain why you came to LifeCircle?”

“Because I don’t want to suffer from unbearable pain.”

“I have attached an infusion. Do you know what happens if you open this infusion?”

“I’ll die.”

“If you want to die, you can open the infusion.”

Without hesitation, Margot rolled her thumb up on the valve, releasing the flow of sodium pentobarbital.

Dr. Preisig explained to Margot one last time: “At the beginning you won’t feel anything, but in more or less 30 seconds you will sleep. Marcos, you are the most important person for Margot here.”

Margot laughed and said again: “It was nice, a stroke of luck.” I went next to her bed and held her hand. “It was really nice, an honor to have met you,” I said.

She stared at me, waiting for the 30 seconds to pass: “And go swimming. Really, that is important.”

“I will in the weekend.”

“Yes, it’s a pity that you have a bad knee. And enjoy your life.”

I nodded and added: “Dancing and swimming.” Margot laughed.

“We hope to get old the way you did, Margot,” Dr. Preisig said.

Margot laughed again: “You will, but only if you don’t work too much. You need to think about your health. I’m saying this as your elder.”

“I’ll do my best.”

“Yes, now I notice. It’s coming. Ow it’s fast. It’s fast.”

*

Margot’s father was a salesman from Hamburg who moved to China for work. It was there where he and her mother, a third generation Chinese-born of German descent, met and got married. In the early 1930s they decided to move to Berlin, where Margot was born in 1934. When she was 6 years old, already during the Second World War, her family decided to relocate to a safer place. First they went to a nearby village where they had relatives, staying there only until they were able to finally move to Prague, their destination of choice. Margot recounted that during the war in Berlin they were often hungry and afraid of bombs, so in comparison Prague was “paradise.” A paradise where she and her family felt safe and were neither starving nor afraid. After the war was over in 1945 they wanted to go back to her father’s hometown of Hamburg, a journey they endured on a crowded train wagon with no drinking water.

She has lived in Hamburg ever since. It was the place where she met her husband, where their children were born, where she got divorced, and where she was planning to die. When we met for the first time, in 2016, Margot was living in a sheltered accommodation for the elderly in the outskirts of Hamburg. There she had her own apartment: one bedroom, one bathroom, one kitchen, and a balcony. The common areas were shared with 200 other elderly people, some of whom were living in the adjoined nursing home. She said that living together in this setting has led her to grasp how life is toward the end, gradually deteriorating and not getting any better. "There are people who feel comfortable at the nursing home," she said, "enjoying being woken up, getting something to eat, being provided for. But to me this is horror. I want to decide about everything, until the very end. I don't want someone deciding when I should wake up or eat, when I can have a shower. Other people like that, but to me this would be like restricting my freedom."

In the sheltered accommodation assisted dying was not a common topic of discussion. From time to time few residents would talk about specific wishes, but that would be all. "Oh, if I had a pill that would allow me to fall *asleep*," Margot paraphrased, adding: "They only talk about it, but they don't take the initiative. When we only say 'Oh God, I'm in such bad shape now, I don't want it anymore,' it's ok, but nothing happens if you just complain." On the other hand, Margot's plan was close to an open secret. Her oldest friend knew about her wish to carry out an assisted suicide, despite being against it herself. So did her children. Margot's daughter once said to her, "Do it, but don't talk about it." They did not want to know the specifics or to be present at the procedure. "That's difficult," Margot shared, "it's the only thing that's difficult for a mother, the children. I had walked toward this direction [assisted suicide] for years and it's clear to me. I want this. I don't want anything else."

Margot's plan was to focus on planning her assisted suicide once she turned 80, seeking assistance from the German organization *Sterbehilfe Deutschland*, founded in 2009 by Roger Kusch, former Minister of Justice [*Justizsenator*] of Hamburg and currently chairman of the organization. However, her plan was frustrated by a then newly passed law that restricted "businesslike" assistance to suicide and, consequently, the work of organizations such as *Sterbehilfe Deutschland*: "I wanted to go to Roger Kusch, but then came the new law. It doesn't make any sense. It would be so much cheaper to do this in Hamburg. It would be practical, I live in Hamburg, and I expected to do that here. And then the new law came in December. In May I have my birthday." Weighing the situation, Margot asked a friend to search online for other organizations that would be able to assist her with the procedure. It was then when she became aware of the Swiss organization LifeCircle.

She joined the organization shortly afterward and submitted an application for suicide assistance, which partly read:

> As a member of your organization LifeCircle, I hereby request that an assisted suicide be organized for me. I feel my quality of life now — Zero! I cannot cope with all things that give me pleasure anymore (visiting cultural events, hiking, strolling, swimming, meeting friends — the roads are too far) due to physical reasons. In addition, the prospect that my condition will not improve, but rather deteriorate, encourages me to make this request now, because I fear that a trip to Switzerland cannot be physically possible.
>
> For years, my health has worsened, and I live day and night with severe pain. From the foot to the fingertips I have strong arthrosis. At night I wake up every two hours because it hurts a lot. Because of several major surgeries my body has long been decaying. Since the pregnancies I have problems with my back, which can never be remedied and are always more painful in the advancing age.
>
> (…) Since 1970 I have been thinking of suicide [*Freitod*] — when my grandmother had to die painfully. Even my parents had no easy death; But all of them wanted to die sooner than was granted to them. That is why I am really grateful to the fact that your foundation exists and can help suffering people. Of course, I also think about a medication cocktail, but I just do not know where I could get the right ingredients for it. This is why my path leads to your 'association of help' [*Verein der Hilfe*].
>
> My great fear is that at some point something can happen to my body and then I am no longer able to travel. That is why I now apply for suicide assistance [*Freitodbegleitung*] as soon as possible.

After being granted the provisional green light by the organization and having received a provisory date, she eventually received the appointment confirmation. On the day she got the confirmation, roughly one month before the actual procedure, she called me. "Hallo Marcos, hier ist Margot, aus Hamburg." ["Hello Marcos, it's

Margot, from Hamburg"] Despite having talked on a number of occasions by then, she always announced herself as if I would not remember her, giving me tips to recall who she was. She called to inform me that the date had been confirmed, October 20th at 8:30 a.m.. She was a bit concerned that it was very early in the morning, but "oh well," she concluded. She wanted to know when I was going to meet her there. Would it be in the previous day or on the very morning of her appointment? She wanted to see me again, she said, and wanted me there during her procedure. "I need you there," she even stressed. "You know, Marcos, I really want to see you before, and it's very early in the morning." Over the months since we first met in Hamburg, Margot and I developed a friendship. She would call me roughly once a week and would even send me handwritten letters, some of which would tell parts of her life story.

Margot would travel to Basel, in Switzerland, two days before the procedure in order to go through the final steps of the green light process: two final medical and psychiatric consultations. She would stay in a hotel booked for her by the organization—and where we agreed to meet for dinner on the night before the procedure. When I was approaching the hotel for our dinner—Margot's last one—, I kept wondering how her mood would be. A few days earlier she had called me to let me know she was feeling good. She mentioned that she imagined I often hear different reactions from people who request suicide assistance, so she wanted to stress once again that she was feeling rather good, "*viel Freude*" ["much joy"], and was "*wirklich fröhlich.*" ["really cheerful"] Her decision was being "*realistisch*" ["realistic"].

Just seconds after my arrival at the hotel I heard Margot's voice in the hallway. She was anxious because she had no cellphone there, so she decided not to wait for me in her room and headed downstairs to the restaurant instead. We met halfway. It was really nice and comforting to see her again, specially in what appeared to me to be such a good mood, as if she was smiling her way to her last dinner. Over dinner, she shared how relieved she was about being able to carry out the procedure with professional assistance, although not in Hamburg, as originally desired. She kept her mood light and good humored to the point of saving a fraction of her last dinner to lecture me on practicing sports, “preferably group ones.” And before going to bed for an early rest, she ordered a final ice cream *extravaganza*.

After dinner, Margot went upstairs to her room and I took a train to Dr. Preisig’s home, a Swiss physician who founded LifeCircle in 2011, where I would spend the night. The schedule was: wake up at 6:30 a.m., breakfast at 7 a.m., and arrive at the hotel at 7:30 a.m.. In the early hours of the next morning, Dr. Preisig packed her things and drove to the hotel to pick Margot up, so we would all go to the organization’s office together—Dr. Preisig, Margot, the organization’s assistant, and I. After arriving at the hotel and waiting for a few minutes, Margot appeared in the parking lot holding a suitcase and joined us in the car. The office is located in an industrial area in the outskirts of Basel, in Liestal, where they had to relocate due to new zoning regulations. During the ride to Liestal, Margot made jokes and laughed, sometimes highlighting the absurdity of the situation she was in. For instance, she would frequently break off laughing, repeating to herself “nein, nein, what a situation.” But she nevertheless reassured everyone present that she still intended to go forth with the procedure, asking final questions about how her ashes would be transported to Germany.

Because of a conversation about animals they had a few days before, Dr. Preisig brought a puppy with her to show Margot and, ultimately, keep her company during the procedure. When she was already lying in bed, the puppy was playing on her belly. Margot kept laughing and asked Dr. Preisig to record a video to send to her family, as a way of showing them how light the situation was. Her death had an impact on me, as if I had lost a family member. After the procedure was over, while holding back tears, I kept thinking about being there with her during her final moments, from her last dinner to her last word and breath, holding her hand. However, my thoughts about what had just happened were abruptly interrupted about 20 minutes after the procedure was concluded when the police arrived alongside a coroner [*Gerichtsmediziner*] and the state prosecutor [*Staatsanwalt*]. They have to be called after each procedure, so a short investigation can be conducted in order to verify whether or not what happened was in fact an assisted suicide.

HOTEL, THE NEXT MORNING | BASEL | 2016 | MARCOS ANDRADE NEVES

While the coroner dealt with Margot's body, the police analyzed every document (including visual recordings that are made during each procedure) and the prosecutor asked questions to everyone involved. When it was my turn, he sat me down at a round table in a different room from the one where the procedure took place. He asked me how I knew Margot and what my relationship with her was. I explained to him that I had met Margot for the first time earlier in the year and that I was conducting an ethnography on assisted suicide. Intrigued, or rather suspicious, he asked me why this topic, what I would write about it, as well as what I would do with the information I had gathered. I simply replied that so far I just wanted to understand what exactly assisted suicide is as a social dynamics. Since no family member was present and I was the only one who knew Margot from before, he also asked me if I could identify the body. I did. Mildly convinced about my explanation regarding the ethnography and its general argument, he collected all papers—

including a copy of my passport—and cleared the case. Nothing suspicious had occurred, it was indeed a suicide with assistance. The body was therefore allowed to leave with the funeral home.

I said goodbye once again to Margot and watched as her body was moved to the casket and into the hearse. I decided to join the organization's assistant and walk with her to the train station. During our walk, the funeral home's second car drove past us and offered a lift. My mind was struggling with both Margot's death and the prosecutor's question about the topic. So I laughed. It occurred to me that in a phone call a few days earlier she asked me if I was happy with my research. "Well," I replied, "I wouldn't say happy, but I still find it interesting." Sharply, she quickly reacted: "Well, but you were the one who chose the topic, wasn't it?"

POLICE AT THE ORGANIZATION'S OFFICE | BASEL | 2016 | MARCOS ANDRADE NEVES

INTRODUCTION

There is a difference between life and death that matters. A difference that makes life be enshrined as a value and encapsulated by several laws aimed at its protection, among which official law and medical regulations stand out. On a normative level, life is seen as an anonymous value, something that has to be protected and preserved regardless of individual persons. Regardless of whose life it is. On the ground level, however, lives are multiple. They are composed of personal trajectories, moralities, desires, affects, among a number of other aspects. As a result of this contrast, when the anonymous, legally encapsulated *life* is juxtaposed with personal lives, a clash may occur. In this process of juxtaposition, organized assisted suicide poses a challenge in reconciling *life* with lives: it creates a space where the ending of a personal life can be applied for and, possibly, carried out, often with medical assistance and going against legal protections established around *life*. A process through which our relationship with state and medicine is constantly negotiated and, ultimately, reshaped.

In Germany, where Margot lived, assisted suicide is regulated through a plurality of legal orders, from the §217 of the criminal code [StGB] to a number of medical regulations issued by the *Bundesärztekammer,* as well as by 17 other regional doctor's associations. This pluralism of intertwined, and often contradictory, laws generates an ambiguity about the legality of assisted suicide, making it unclear, on the ground level, under which circumstances this practice is lawful. When Margot decided to apply for an assisted suicide, the then recent reshaping of the German legal landscape—which had implemented a new legal protection to *life* against organized suicide assistance—triggered her act of mobility to Switzerland, which was preceded by the circulation of her green light documents. Documents that were obtained through often strained interactions with physicians and state officials, and ended up exposing a regime of care that has *life* located in its very core. Not Margot's life itself, but *life.*

As it was argued during one of the legal proceedings presented in this work, "[l]aws are not made for particular cases but for men in general[1]"—after all, writes Fassin (2009, p. 54), "the art of governing is precisely a process of homogenization of lives." On a normative level, therefore, *life* has to be vague enough in order to encompass personal lives in their own multiplicity. Contrastingly, on the ground level, the complexity of lives composed of personal experiences, particular backgrounds, and social circumstances cannot be reduced to, or limited by, an anonymous, all-encompassing, *life*. This process of juxtaposition in the context of organized assisted suicide [OAS] makes personal lives come to matter to agents and institutions responsible not only to care for *life*, but to enforce the various legal protections established around it. After having taken her own life with professional assistance in an organized setting, Margot's death triggered a visit from state authorities and a coroner. A visit that made it clear that her life and death mattered to them, and how her transition from the former to the latter took place ended up being the subject of medical and state investigation. In this sense, this process of juxtaposition is likewise a process where individual lives come to matter, triggering caring responses from public authorities and medical professionals.

On the one hand, *life* is both an object of, and subjected to, various legal protections. It is enmeshed in a complex tapestry of ever-changing, often contradictory and frequently ambiguous laws and judicial interpretations. On the other hand, this clash between an anonymous *life* and personal lives winds up exposing specific infrastructures of care that operate at the intersection of policymaking, law-enforcement, judicial interpretations, and medical technologies and practice. As Margot's story helped delineate, her cooperation with LifeCircle designed itineraries through which not only her green light documents could circulate, but also herself. She navigated through different jurisdictions and had to interact with both family doctors and state officials in order to have access to the

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[1] Pretty v. United Kingdom, Application no. 2346/02, Council of Europe: European Court of Human Rights, 29 April 2002.

assistance and the pharmaceutical she wished for. “[T]hese peopled accounts,” wrote Biehl and Petryna (2013, pp. 2-3), despite being “so often hidden from view, obscured by more abstract and bureaucratic considerations of public policy, […] are the very fabric of alternative social theorizing.“ As such, it is precisely by looking into stories like Margot’s that we are able to grasp a larger dynamics of association and cooperation, connections and circulations, that constitute a specific landscape of assisted suicide that is composed of, but which cannot be defined by, specific places.

This work, therefore, is an ethnography of a process where personal lives come to matter and caring responses by state and medicine are triggered. A dynamics referred to, here, as the process of lawful life, of which organized assisted suicide is a manifestation. A process that despite occurring in specific places and jurisdictions, cannot be defined by them. Instead, as different associations are formed and new acts of cooperation are established, the circulation of people, documents, and technologies—such as knowledge and pharmaceuticals—end up entangling several jurisdictions into one fluid, rather contradictory and considerably unstable landscape of assisted suicide. Over the course of three years, the research departed from Basel, Switzerland, in order to map this entanglement of connections among right-to-die organizations and their members, professional assistants, politicians, and activists. And by following such connections, this thread took me to six countries (Brazil, France, Germany, the Netherlands, Switzerland, and the United Kingdom—specifically, England and Scotland) and a number of different cities. In each and everyone of the cases identified within these countries, connections were made, cooperation was designed, and some form of circulation took place.

The ground zero of this ethnography was the organization LifeCircle, founded by Dr. Erika Preisig, in Basel, Switzerland. Being one of the very few organizations both domestically and worldwide to accept foreigners as members and allow them to apply for and carry out an assisted suicide with their assistance, LifeCircle provided the ideal institutional setting to observe the final steps of a person’s application process, seeing circulation from its very ending. And this was precisely one of the first realizations I had during the research: despite being in the very core of organized assisted suicide, inside one of the organizations that provide it to its members, I soon came to realize that very little happens there other than the procedure itself and the brief conversation and document signing that precede it. I was at the destination point, but I needed to see the process that leads a person there, how this and other itineraries of circulation are designed, and how one goes about them. And to achieve this, Margot played a fundamental role.

When we first met in Hamburg, her application process was already underway. But even so, not only was I able to see all of her application documents, but I also could witness her own act of mobility, meeting her in Basel for her last dinner and being there when she finally let sodium pentobarbital into her veins. Not to mention, of course, the innumerable times we talked over the phone and the letters she sent me. The friendship we developed granted me access to a process of assisted suicide in its almost entirety, but also made me a firsthand witness to my friend's suicide. Margot provided a structure for my understanding of organized assisted suicide in its many variables, a structure that I pass on to this dissertation and can now be perceived through her role as its organizing thread: whereas a brief version of Margot's story is the very beginning of this dissertation, several aspects of her trajectory will further unfold throughout the chapters. If, following Strathern's (1987) argument, ethnographic writing is not only about bringing certain scenes to life, but also bringing life to ideas, Margot was pivotal in both instances. But while she was unique, Margot was not the only one.

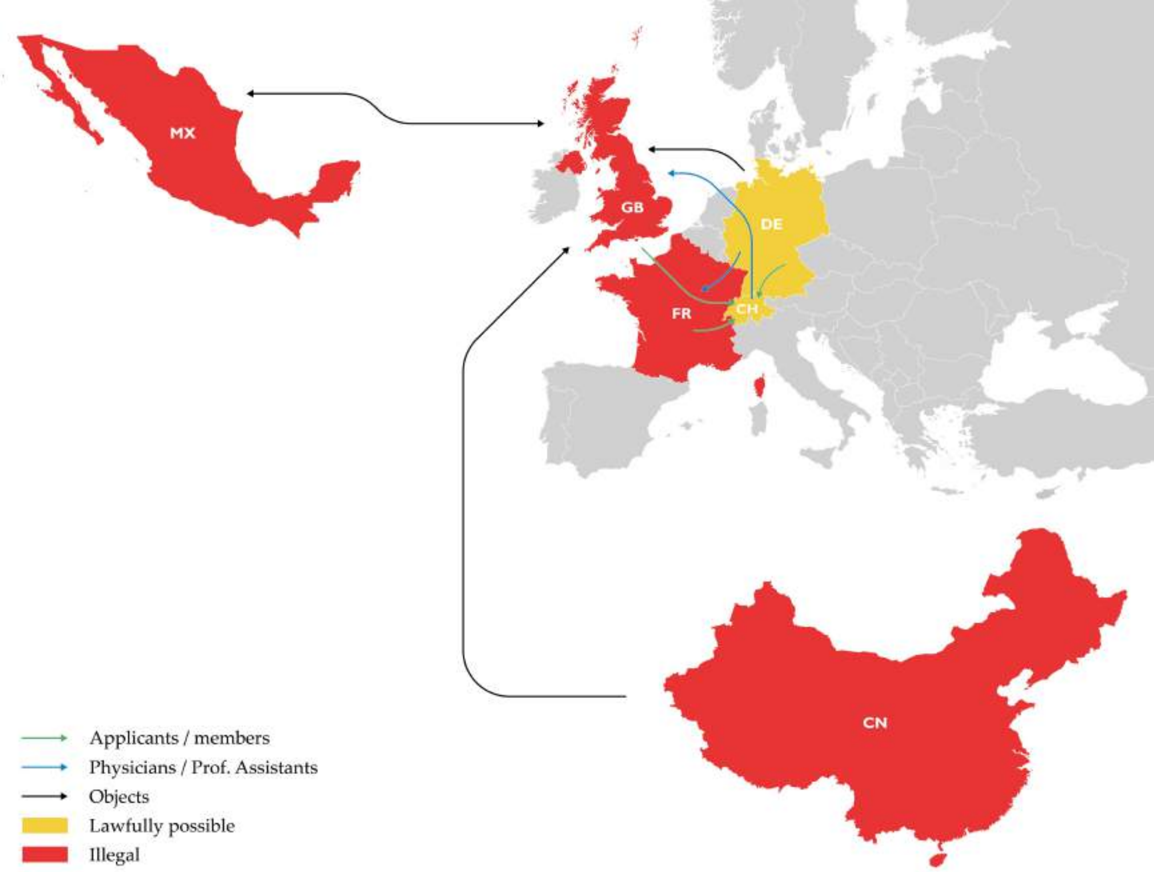
In the course of three years of empirical research and almost five years in total, I had access to four different organizations (LifeCircle [Switzerland], FATE [Scotland], *Sterbehilfe Deutschland* [Germany], and EXIT [Switzerland]), met with politicians, legal specialists, activists, professional assistants, and members of these, as well as other organizations, and was able to witness two procedures. By following how specific forms of circulation are enacted via the cooperation of people and organizations from different places, I was able to perceive organized assisted suicide as something that happens on the move, that is, via the mobility of people, documents, and technologies that can only circulate upon the establishment of a—frequently—cross-border cooperation. Similarly to the definition of end-of-life care employed by Karsoho et al. (2016, p. 190) as a "configuration of health care resources (i.e., people, practices, and technologies) mobilized at the last phase of a person's life," organized assisted suicide is defined here as an event that despite taking place locally, is composed of an interplay of several jurisdictions and medical technologies sewn together by forms of circulation. And underlying this dynamics, an ongoing negotiation over life and care is taking place.

But as Sheila Duffy, then convenor of the organization FATE, in Scotland, once told me, to apply for an assisted suicide is not as easy as one would think. "You just don't get on a plane," she said, "there's paperwork, records, the cost." So, in order to tell this story, the dissertation begins with Margot's. Her prologue presents a brief, yet personal account of her trajectory, providing all key elements that will be further developed and unfolded throughout the chapters. It provides organized assisted suicide with a personal narrative and, by doing so, not only attaches a person to what could otherwise be accounted for as a statistical number, but also presents her process of coming to matter in the aftermath of her procedure. The first chapter, thus, provides a brief overview of assisted dying, its different procedures and gradual incorporation into legal orders. It centers, however, on life as a project of staying alive, one that expects cooperation while setting up legal protections to its preservation. A project that sees the emergence of organizations that provide lawful suicide assistance as a byproduct of its very own legal protections to *life*.

The second chapter, "encapsulating life," focuses on the legal protections put in place around *life* via official and medical laws from three national jurisdictions: Germany, Switzerland, and the United Kingdom. These were the places where most of the acts of cooperation took place and, therefore, will be in the center of this dissertation. This lawful *life*—*life* as both a medico-legal value and something fully regulated by laws—shrouds assisted suicide in an affective tonality of illegality without it necessarily being illegal. In this sense, the legal pluralism in regards to assisted suicide produces a general sense of mistrust and uncertainty in those involved in the practice, either as applicants or professional assistants, creating a situation where the state is perceived through an affective dimension while establishing ambiguity as a mode of government. In this manner, the navigation through this legal pluralism entails a constant negotiation over life and care. A negotiation that is put in motion by frictions surrounding not only the contrast between *life* and lives, but also policymaking processes and law enforcement actions that rely on such distinction to work, as well as medical diagnostics and technologies that inform one's application process and provide a method for the procedure to be carried out. This negotiation, thus, is the focus of the third chapter: "A life that comes to matter: enacting regimes of life."

Whereas the first chapter presents life as a project and the second one focuses on legal encapsulations of *life* by official and medical laws, the third chapter shows how these legal encapsulations are translated into regimes of life. In the fourth chapter, therefore, mobility will be presented. "Drawing routes, enacting mobility," centers on the itineraries of mobility designed via cooperation and circulation of people and technologies that are at the very core of organized assisted suicide. But while mobility is a crucial aspect of OAS, the process of lawful life that works as a friction for this negotiation over life and care assumes yet another shape. If the legal pluralism regulating assisted suicide produces ambiguity, uncertainty, and mistrust on the ground level, oftentimes such laws are contested and judicial clarifications are sought after. When a request for suicide assistance is articulated to the judiciary, not only the relation between an anonymous *life* and a personal one is discussed and debated by the applicant and the state—through the figure of "government"—with the mediation of an institution that produces regimes of truth (Latour, 2010), but they also dramatize discursively the itineraries of mobility that otherwise take place within this landscape. This articulation to the judiciary, often framed as a claim for dignity, is therefore the topic of the fifth chapter.

INITIAL FIELD: LIFECIRCLE'S OFFICE, BASEL | 2016 | MARCOS ANDRADE NEVES



SUBSEQUENT ANALYTICAL LANDSCAPE OF ASSISTED SUICIDE

But this landscape of organized assisted suicide was not a given. After realizing that assisted suicide goes beyond the procedure itself, it became clear that staying only in Basel would not suffice. After all, even if there is where most of the procedures take place, the greater part of a member's application process happens elsewhere. And to connect each individual application process with Basel, itineraries for circulation had to be designed. The conceptualization of organized assisted suicide as something that happens on the move, thus, had methodological implications. It triggered a shift from a well defined field—Basel and LifeCircle—to several threads of heterogenous acts of cooperation that are somehow connected to each other, sharing common elements while occurring in completely different places. Similarly to Tsing's (2000, p. 347) definition of project as "relatively coherent bundles of ideas and practices as realized in particular times and places," organized assisted suicide seemed to be the result of the articulation between locally performed actions with itineraries of circulation within and among different jurisdictions. A project composed of somewhat coherent ideas and practices in time and places, but one rather elastic and unpredictable. In this sense, I had to scape the field of organized assisted suicide I had once imagined to be there, already existing.

Scaping the field: from friction to a landscape of assisted suicide

> Once we see borders as making a world rather than dividing an already-made world, their topological functioning becomes clear. (Mezzadra & Neilson, 2012, p. 59)

In July 2015, I landed in Basel for the first time. Just a few weeks before, Dr. Preisig had opened LifeCircle's doors to me, inviting me to visit the organization and talk to its staff—herself included. On this very first day of fieldwork, I was not sure what to expect. I did not know who I was going to talk to, nor was I aware of what I was going to see. Everything sounded rather secretive: do not share the address; do not take pictures that would make the house be easily identifiable from the outside; do not ring the bell, call instead. Nothing illegal was going on there, on the contrary. In Switzerland, assisted suicide remains a lawful possibility if done so altruistically, that is, without profiting from it. Organizations, thus, make sure to operate within this legal boundary, structuring their assistance offering accordingly. It is precisely this possibility of lawfully carrying out assisted suicides in organized settings, alongside the fact that some organizations—including LifeCircle—accept foreigners and non-residents as members, that makes Switzerland one of the countries most associated with the practice—a dynamics often framed, particularly by the media, as suicide tourism (Andorno, 2013; NEK-CNE, 2005; Ogden, Hamilton, & Whitcher, 2010; Rehmann-Sutter & Hagger, 2013; Richards, 2017; Staples & Widger, 2012).

But, as it turns out, assisted suicide goes far beyond the procedure itself. On this first day of fieldwork, I met Elise—whose story I tell on chapter 4. During our conversation at LifeCircle's apartment, Elise shared her story with us—her two companions, Dr. Preisig, and myself—, recounting the emotional, logistical, and bureaucratic hurdles she had to face in the few weeks leading up to that moment. These few weeks, of course, did not comprehend her application process as a whole, but offered a glimpse into a crucial aspect of organized assisted suicide: it cannot be defined by the procedure itself—and, if this was the case, staying only in Basel for the research would not be enough. Even if assisted suicide-as-procedure takes place there, the application process that authorizes a person to carry out the procedure, that leads them to Basel, happens elsewhere. Mobility, thus, is a fundamental facet of organized assisted suicide.

When it comes to the broader context of assisted dying, Norwood (2006, 2007) has reached a similar conclusion while working with euthanasia in the Netherlands, defining the practice as a "whole chain of activities" (2007, p. 150) based mainly on talk and that cannot be defined by the procedure alone. Both practices, it appeared, were metonymic of larger processes involving not only conversations, but also medical and legal aspects. But despite this similarity, the mobility component of

OAS, which regularly involves the establishment of transnational connections and cross-border circulations—such as Elise’s—, disengages the practice from a single place and, consequently, jurisdiction. Margot’s trajectory, for instance, started in Germany and ended in Basel. And Elise’s, despite also leading to Basel, began in the south of France. So while assisted suicide-as-procedure was in both instances regulated by Swiss laws, their trajectory as a whole—from the beginning of the application process to the procedure itself—encompassed actions within different local and national jurisdictions.

Addressing a global health audience, Biehl (2016, p. 128) wrote that “[e]thnography can serve as an empirical lantern within and beyond the open-source anarchy that global health has become.” This “open-source anarchy” refers to global health’s contemporary assemblage as a field that “brings together a vastly array of actors and interests in elastic relationships.” For instance, he mentions how the Ebola epidemic could not solely be credited to the Ebola virus in and of itself, but rather to a wide range of aspects, from dysfunctional health systems to a lack of trust in authorities, from international indifference to local customs (2016, p. 128). But despite the specificities of global health as a field, Biehl’s arguments resonate here with the fact that organized assisted suicide cannot be merely described as just a procedure, but rather as a chain of connections that enable acts of collaboration and circulation to take place—and that may or may not end up involving the procedure itself—, oftentimes crisscrossing national borders. And if we can identify a convergence point in “different actors and interests in elastic relationships,” ethnography could, in the context of OAS, serve as an empirical lantern as well.

Over our initial conversation in Basel, Dr. Preisig mentioned a number of individual assistants and organizations located outside of Switzerland, but made special reference to a woman who was then living in Glasgow, Scotland, and founded an assisted dying organization upon her retirement as a physician. Since in the

United Kingdom organized assisted suicide remains illegal[2], the organization had to operate without providing the procedure *per se*. So from Basel I had to go to Glasgow, where I met Dr. Wilson for what would be the first of many times over the next year or so. As I went to Scotland more and more often, I also got to know the organization she founded, FATE, as well as some of its members and personnel. Throughout this period, I would visit her for interviews and meet her at FATE meetings—but I would also meet her for coffee or gin tonics at her home. She was a fantastic person who, despite being almost 90-years-old at that time, was as sharp as ever. She would tell me stories about marching in Canberra for the legalization of voluntary euthanasia in Australia, chanting "we will decide our fate, not the church, not the state" while rhythmically stomping her feet on the floor and knocking on the kitchen table with closed fists.

And in no time, just like Dr. Preisig before her, Dr. Wilson became a central character in this ethnography of OAS. They were both two points of connection, living under antagonistically official and professional laws, and among which various forms of cooperation and circulation would take place. But as I continued to follow these chains of elastic relationships, a third name started to emerge. Both Dr. Wilson and Dr. Preisig had occasionally mentioned another retired physician who was living in Germany, telling me stories of him either assisting people by himself or helping them to go to Switzerland. After a few weeks of initial contacts, I ended up meeting Dr. Arnold for the first time in his home in Berlin. It was then clear that the three of them—Dr. Preisig, Dr. Wilson, and Dr. Arnold—knew each other and had already cooperated in some way, even if it was only by exchanging information and leaflets, or referring patients to each other. It was also clear that, because of the different regulations over assisted suicide in Switzerland, the UK, and Germany, the three of them had to facilitate circulation from time to time.

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[2] The specifics of UK law in relation to suicide assistance, including the difference between England and Wales, which are subjected to a specific act of parliament, and Scotland, which is not, will be presented in the second chapter.

While at that moment I already knew some of the actors that cooperated in these elastic relationships, as well as the fact that people circulate, I gradually became aware of other forms of circulation. For instance, if people move, their application documents had to precede them. The circulation of medico-legal documents was then a precondition for the circulation of people. But what if, for a number of reasons, a person's mobility is out of question? By making use of this empirical lantern and following these—rather unstable—threads, I got to know about the circulation of technologies, that is, the ways through which new method ideas for suicide are developed and exchanged, and how pharmaceuticals were—often illegally—acquired and circulated. If organized assisted suicide cannot be defined by its procedure alone, being instead the result of an unstable chain of transnational cooperation and forms of circulation, it can neither be anchored on a single place nor regulated by only one set of laws. For instance, both Margot and Elise were living in countries where organized assisted suicide is illegal[3], that is, where legal protections against the termination of *life* with third party assistance were in place. And while their personal life circumstances made them want to apply for the procedure, within these jurisdictions—on a normative level—*life* was to be protected and preserved.

In this sense, the clash between their personal lives and the lawfully protected *life* acted as a friction that led them to try and establish cooperation as a way of designing itineraries of mobility that would make OAS viable for them regardless of its legal quality in their home countries. As Tsing (2005, p. 5) argues, friction, as a metaphor, "reminds us that heterogeneous and unequal encounters can lead to new arrangements of culture and power." And it is precisely by paying attention to such frictions that we can attempt to accomplish "an ethnographic account of global interconnection." (Tsing, 2005, p. 6) Tsing's metaphor stems from a once popular idea

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[3] While in France the legal situation with regards to assisted suicide (or assisted dying, in general) has been the same for a long time, Margot's situation was more complicated. As already mentioned in the prologue, the German legal landscape changed for the first time in over a century at about the same time that she was planning her assisted suicide.

of global motion where borders would not be an issue and circulation would therefore flow without restrictions. She explains:

> The metaphor of friction suggested itself because of the popularity of stories of a new era of global motion in the 1990s. The flow of goods, ideas, money, and people would henceforth be pervasive and unimpeded. In this imagined global era, motion would proceed entirely without friction. By getting rid of national barriers and autocratic or protective state policies, everyone would have the freedom to travel everywhere. (Tsing, 2005, p. 5)

But whereas in this projected new era of global motion circulation would take place unhampered, both national barriers and protective state policies seem to have persisted. And circulation, once imagined without friction, remained very much affected by it. As Mezzadra (2015, p. 3) argues, there was instead a proliferation of borders. He writes: "[C]itzenship continues to organize the system of political and legal positions that distribute mobile subjects across a varying scale of abjection and protection." However, even if this imagined era of unimpeded circulation has instead been welcomed with a reinforcement of borders and state policies, the global flows of things, people, ideas, and goods continued to take place. Circulation does not continue to happen in spite of borders, but because of them. What we need, Mezzadra suggests, is precisely to rethink our understanding of what borders are: they are not a thing that exists by itself, but a social relation that is constructed and constantly updated. A complex institution that is mediated by things, and not things themselves (Casas-Cortes et al., 2015; Mezzadra, 2006, 2015; Mezzadra & Neilson, 2012).

"This means we do not see borders as devices that obstruct or block global flows," write Mezzadra and Neilson (2012, p. 59), "[r]ather, we see them as parameters that enable the channeling of flows and provide coordinates within which flows can be joined or segmented, connected or disconnected." Borders both enable and hinder mobility. They spark friction, and friction triggers circulation. As several ethnographic accounts have shown, there is a wide array of things that circulate in this world composed of borders and contrasting state policies, from counterfeit goods (Machado, 2011, 2018), to human organs (J. o. Biehl & Scheper-Hughes, 2000; Scheper−Hughes, 2000), and even hair (Berry, 2008; Tarlo, 2016) and embryos (König, 2017; Schurr, 2017; Whittaker & Speier, 2010), used for manufacturing extensions and wigs, and gestational surrogacy, respectively. Furthermore, beyond things and human material, we can also see other forms of circulation in the context of global health, such as the migration of physicians (Schühle, 2018) and the constitution of transnational patients (Zeldes et al.). All of these itineraries are faced with different border formations which either hinder or facilitate mobility following the connection or disconnection of several aspects, oftentimes exposing global inequalities.

In the context of organized assisted suicide, the process of lawful life acts as a friction that sparks various forms of circulation, from members of organizations to professional assistants, from medico-legal documents to method ideas and pharmaceuticals. And as different agents act upon cooperation, their circulation end up entangling distinct jurisdictions, moralities, practices, and technologies into one single, ever-changing, social space—a process similar to what Povinelli coined as "embagination." According to her, the circulation of things "can close a world, but never seal it," therefore "spheres of life emerge and collapse, and expand and deflate, as things move and are moved across space and time." (2011, p. 1) Similarly, if organized assisted suicide happens on the move via the establishment of cooperation and the drawing of mobility itineraries, it operates in a cross-border, transnational space that, despite being composed of locally performed acts, can neither be defined as local nor global. An unstable and elastic space, regulated by a configuration of often divergent sets of official and medical laws, which is being constantly reshaped by individual cases throughout an interplay of cooperation and mobility.

As Dilger and Mattes (2018) have pointed out, this transnational dynamics of connectivity and flows is likewise constitutive of a larger process of medical globalization. A process through which, the authors argued (2018, pp. 265-266), several heterogenous actors interact and, by doing so, wind up composing different assemblages (Ong & Collier, 2005), intersections (Cambrosio, Young, & Lock, 2000) or medicoscapes (Hörbst & Wolf, 2014). Concepts that, despite their specificities, help us to understand the relation between local and global and, ultimately, the increasing complexity of the world (Dilger & Hadolt, 2015, p. 138). When it comes to the concept of medicoscapes, Wolf and Hörbst (2014, p. 183) argue that medical issues can no longer be understood as restricted within frames of reference like nation-states, but rather through different forms of association and cooperation that take place on a transnational level. According to them, the concept of medicoscapes is a tool to visualize "the complexity of intertwined local, national and global relations" in health-related fields (Hörbst & Wolf, 2014, p. 183), and does so by bringing together once dispersed and heterogeneous elements, such as policies, practices, people, and institutions as part of the same analytical landscape.

Underlying these concepts resides the assumption that global networks cannot be simplified to a single logic and are frequently based on elastic, unstable relations that are prone to transformations (Dilger & Hadolt, 2015, p. 138). In this sense, upon identifying organized assisted suicide as something that happens on the move, based on association and cooperation among a number of heterogeneous elements, from professional assistants to members of organizations, from official and medical laws to method ideas, from pharmaceuticals to medico-legal documents, I draw from the concept of medicoscapes—which, in turn, comes from Appadurai's (1990, 1996) notion of scapes—in order to analytically frame this space enacted by the aforementioned elements and their itineraries of circulation. Thus, by identifying the friction that sparks circulation and, subsequently, following both its itineraries and the establishment of a cooperation that precedes it, I ended up drawing a landscape of assisted suicide. A landscape enacted by cooperation and circulation, and within which the procedure may occur in spite of particular national jurisdictions—not without legal or law-enforcement consequences, as the following chapters illustrate. However, it was a landscape I also inhabited.

Inhabiting the landscape

Inhabiting this landscape of OAS enabled me to experience things I had never experienced before, and meet people that had a profound impact on me. Whereas during the beginning of the research I was trying to transform my understanding of organized assisted suicide from a local dynamics to something that happens on the move, with local actions but which cannot be reduced to a single place or logic, on a subsequent stage I became aware of the very infrastructure of this landscape of assisted suicide, its inner workings and constitutive elements. By drawing this landscape, I ended up inhabiting it. I have befriended some people. Others I have met frequently by following some of the same itineraries as they have, such as the Euthanasia conference, in Amsterdam[4]. I have made connections and circulated myself, oftentimes walking a fine line between *being there* and assisting. As Roger Kusch, founder of the organization *Sterbehilfe Deutschland*, once joked with me over coffee in Hamburg a few minutes before I left to meet Margot for the first time, "You're here now, but in a few minutes you'll be a criminal." Even though I was only going to talk to Margot, Kusch's joke alluded precisely to this fine line that separates, in a confusing legal landscape and ambiguous ethical issue, assistance from everything else. Where to draw the line?

In this manner, to inhabit this landscape was also a matter of defining a terminology. Assisted suicide, some argue, can wrongly associate this practice with suicide itself, therefore implying an irrational and impulsive decision rather than a carefully thought out, long considered, process. And this was precisely one of the

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[4] Which I describe on chapter 4.

first things I heard about the topic. In one of my first conversations with Jay, a friend of mine who was considering the possibility of suicide assistance due to a congenital disease, he told me: “I see the difference between suicide and going out with some dignity, as I believe suicide is doing something totally irrational and I don't want to do anything irrational and hurt other people in the process. I don't want to hang or shoot myself and have my mum find me, neither do I want to jump off a bridge or in front of a train and traumatize other people’s lives in the process.” Jay was not alone in refraining from using the term assisted suicide. Over the years, several alternatives were brought into discussion: from humane dying to dignicide; from self deliverance to rational suicide and hastened death. Others preferred assisted voluntary death. In Germany, this is usually referred to as *Sterbehilfe*, which, despite being literally translated as “assisted death” and, more commonly, as “euthanasia,” refers specifically to suicide assistance. Contrastingly, at LifeCircle, in Switzerland, this if often referred to as *Freitodbegleitung* [“suicide accompaniment”] and, in the UK, as assisted suicide.

During one of our conversations, Sheila Duffy, who succeeded Dr. Wilson as FATE’s convenor, shared with me her personal view on the issue of terminology: “Assisted suicide tells you what it is and that is the phrase we should be using.” In a context where the line separating legality from illegality is often ambiguous, if not fragile, the difference between euthanasia and assisted suicide can have serious legal implications to everyone involved. So Sheila’s logic was simple: to explicitly “tell what it is.” In this sense, while acknowledging the different terminologies and its ramifications—such as the reasons that informed Jay’s preference—, the term assisted suicide will be used here as a way to avoid any ambiguity about the procedure itself.

According to Stodulka (2015, p. 85), fieldwork comprises an intersubjective process of making sense of “messy field realities in which we position ourselves,” and do so by both affecting others and letting ourselves be affected by them

(Goldman, 2003). "The emotions[5] that we express (or suppress) and articulate (or mute) in the encounters with our research protagonists," Stodulka writes, "shape the ways in which stories are told and social realities are conveyed." (2015, p. 86) Following such assumption, it becomes essential to acknowledge not only the work done by other people's emotions during our fieldwork encounters, but also our own emotions, how they shape our understanding of a particular social reality. As also noted by Dilger, Huschke, and Mattes, every fieldwork is a relational, intersubjective, and emotionally charged endeavor (2015, p. 5), and therefore positionality plays a fundamental role. It entails a form of identity, adopted by the researcher in relation to their field, composed of emotional, political, ethnic, social, biographical, and moral aspects (2015, p. 5) that inform both their day-to-day engagements within the field and their work. An identity that allows us to navigate our field while, at the same time, opposing simplifications that distinguish between personal and professional selves, which are, as the authors stress, frequently fluid (Dilger et al., 2015, p. 6).

In this manner, I was aware that by inhabiting this landscape of assisted suicide I would likely have an impact on others, but I also kept myself vulnerable to them and attentive to my own emotions. I could no longer disentangle myself from some of the relations I made during fieldwork, and was very much aware that these relations would not only last longer than the fieldwork itself, but continue to live even after one's death. For instance, as I already mentioned, my relation with Margot both changed my perception over organized assisted suicide and informed the writing process of this dissertation by providing it with a structure. But it also had an impact on several other aspects of my life. The very "inter-affectivity" (Stodulka, 2015, p. 86) quality of my research data permeates this dissertation and is translated into a personal narrative that keeps me vulnerable. A vulnerability that made me walk a fine line into a gray zone. After all, assisted suicide was not only a controversial subject that mobilized political, emotional, moral, religious, and

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[5] Stodulka defines emotion as "embodied biocultural processes between and within persons." (2015, p. 85)

medical actors and arguments, but also one whose legality was questionable, if not rather delicate, even in countries where the procedure can be lawfully practiced.

Under these circumstances, one of the alternatives to guide my steps, albeit rather controversial, was to submit this project to ethics review. On the one hand, it would provide my walking with a map containing my formal limitations, a framework within which my research would be deemed ethical on an institutional level. On the other hand, as noted by many anthropologists and qualitative researchers (Dilger et al., 2015; von Unger, Dilger, & Schönhuth, 2016), the process of ethics review often contrasts with the conditions and circumstances of ethnographic fieldwork, imposing a clear distinction between professional and personal selves while building an inflexible framework to a method that has flexibility in its very nature. When the necessary flexibility of ethnographic research collides with the predictability required by ethics reviews, the institutionalization of research ethics winds up creating an illusion of ethical conduct (Cannella & Lincoln, 2007; Lincoln & Cannella, 2009). An illusion that, while oftentimes opening doors to institutional settings, does not necessarily imply an ethical conduct on the ground level. And this is a crucial aspect: to perceive ethics through experience, as a dimension of everyday life (Das, 2014). Since the navigation through this landscape of assisted suicide entails frequent encounters with state authorities and medical professionals, which may or may not take place in institutional settings, I submitted this project for ethics review while following a descent into the ordinary (Das, 2007).

First and foremost, beyond possibly facilitating access to institutional settings, its approval by the ethics review would officialize, so to speak, an informed consent letter [ICL]. A document that, as Hoeyer and Hogle point out, holds “its appeal or political force” despite its persistent failure to deliver on its promises (2014, p. 355). The ICL provides a bureaucracy to what should otherwise be a relational, day-to-day, conduct, of which the letter is perhaps the most visible expression. Following the project’s approval by the ethics review, the ICL was presented to and signed by every research participant. Even if this illusion of ethical conduct did not necessarily imply an ethical conduct *per se*, it did, however, exert a reassuring impact on some participants. A reassurance over confidentiality and anonymity. In a context where the line separating legality from illegality is not only fine, but also uncertain, and, oftentimes, ambiguous, this possibility could have been a necessary condition for the research to take place—otherwise, I thought, people would not be willing to participate and share. For instance, anonymity was crucial for several ethnographic accounts on contexts of vulnerability, where exposure could risk legal consequences—such as Goffman's (2014) account on fugitive life in the United States and Huschke's (2013) research on healthcare access for undocumented Latin American immigrants in Germany.

Even though the ICL provided the research participants with the possibility of remaining anonymous, the vast majority of them opted against it. They wanted their names exposed. This situation has led to me a conundrum. It was clear that the controversies regarding assisted suicide could not be detached from political disputes over its legalization or prohibition and that those taking part in the research wanted to provide a face to individual cases that could, somehow, weigh in on such disputes. As Fassin (2013, pp. 625-626) notes, there are two distinct, albeit related, operations between ethnography and its public. The first one is popularization, that is, to make a specific knowledge accessible to larger audiences. And the second one is politicization: to inform and change a political debate. Their relatedness, however, is only partial. Fassin argues that communication is necessary to transform the terms of a political debate, but increasing the audience does not necessarily imply any commitment to social change. By taking part in the research, many participants wanted to inform a political process by sharing their stories and exposing their names. But in a context of political disputes and legal vulnerability, anonymity was a key factor in reconciling popularization with politicization.

While in this landscape of organized assisted suicide vulnerability was a matter of legality, of crossing—often, but not always, inadvertently—red lines into legal gray zones, most of the research participants were not living in vulnerable situations. They were physicians, lawyers, politicians, academics, and retirees, who were willing to risk exposure. But even though they knew their stories, they were not aware of how their stories would fit within the landscape as a whole. Their willingness to openly share their actions and expose themselves contrasted with my unwillingness to expose them to unpredictability. If, on the one hand, to follow the bureaucracy of ethical conduct would mean respecting their positions in regards to anonymity, on the other hand, the day-to-day conduct, this ordinary ethics (Das, 2015), suggested otherwise. In order to solve this, personal anonymity was determined on an individual basis, carefully considering their assigned choices in relation to their positions within the analytical landscape as a whole. Of course, those who requested to be anonymous have remained so. Organizations and places have not been anonymized. Otherwise, there will be no further indication of which names are pseudonyms.

In sum, as Margot's prologue has already initiated this story of organized assisted suicide and lawful life, the next chapter provides a brief overview on assisted dying procedures and their encapsulation by laws as *life* turns into a project of staying alive. A project that expects cooperation and, therefore, enshrines *life* as a value to be protected. However, such encapsulations, despite establishing legal protections to *life*, created the conditions for the emergence of a specific bureaucracy to die. If *life* is a project, death becomes organized.

1. LIFE AS PROJECT, DEATH AS ORGANIZATION

> Have we been so entranced by the image of power working through life that we haven't noticed the new problems, figures, strategies and concepts emerging all around us, suggesting another formation of late liberal power—or the revelation of a formation that is fundamental to but hidden by the concept of biopower? Have we been so focused on exploring each and every wrinkle in the biopolitical fold—biosecurity, biospectrality, thanatopoliticality—that we forgot to notice that the figures of biopower (the hysterical woman, the Malthusian couple, the perverse adult, and the masturbating child; the camps and barracks, the panopticon and solitary confinement), once so central to our understanding of contemporary power, now seem not as decisive, to be inflected by or giving way to new figures: the Desert, the Animist, the Virus? (Povinelli, 2016, p. 2)

> [I]f politics is about issues and not just games, life is such an issue, maybe the most crucial one. (Fassin, 2009, p. 49).

Assisted suicide is one among several forms of assisted dying, an umbrella term also comprising active, passive, voluntary, and involuntary euthanasia. While active euthanasia entails third party assistance to administer a lethal injection, passive euthanasia consists on halting life sustaining medical care, such as feeding, hydration, and pharmaceuticals. In turn, voluntary or involuntary euthanasia indicates, respectively, whether or not a person retains the ability to consciously request the procedure (Howarth & Leaman, 2002, p. 177; Menezes, 2011, pp. 139-140). When it comes to assisted suicide, the act of assistance is more restricted. It does not entail the final act itself, which must be done by the person themselves. As similar as voluntary euthanasia and assisted suicide can be, with both practices involving third party assistance, who performs the final act can have serious legal consequences. For instance, in Switzerland, while assisted suicide can be lawfully performed, euthanasia remains a criminal offense.

As some authors (Minois, 1999; Norwood, 2018; Porter, 1996) have pointed out, medically assisted dying not only was a common practice since the beginning of modern medicine, but continues to happen nowadays regardless of its legality. What is new, Norwood (2018, p. 461) argues, is that now there are several official laws being passed to authorize some form of assisted dying. For instance, the first law on voluntary euthanasia was approved in the Northern Territory, Australia, in 1995—the Rights of the Terminally Ill Act 1995, which entered into force in 1996. This law, however, was in force for only 8 months, until the federal parliament of Australia passed the Euthanasia Laws Act 1997[6], which nullified the territory's law (Menezes, 2011). Even though in the Netherlands euthanasia had already been the subject of several court cases since the 1980s (Griffiths, Bood, & Weyers, 1998; Griffiths, Weyers, & Adams, 2008), it was not until 2002 that a specific law on the subject was implemented[7]. Subsequently, Belgium and Luxembourg passed similar laws, respectively in 2002 and 2009. In Canada, a law on physician assisted dying was passed following the country's Supreme Court ruling on Carter v. Canada (Karsoho et al., 2016; Karsoho, Wright, Macdonald, & Fishman, 2017) and, in Colombia, a law went into effect in 2015 after two rulings from the country's Constitutional Court, one in 1997 and the other in 2004. And in the United States, besides the District of

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[6] http://www6.austlii.edu.au/cgi-bin/viewdb/au/legis/cth/consol_act/nta1978425/. Last accessed 12th June 2018.

[7] This was the "Termination of Life on Request and Assisted Suicide (Review Procedures) Act of 2002". It can be read here: https://www.eutanasia.ws/leyes/leyholandesa2002.pdf. Last accessed 12th June 2018.

Columbia and the 7 states[8] where assisted dying laws are already in effect, there are 30 other states considering official legislation on the topic (Norwood, 2018, p. 461).

While Norwood points out that this new legal situation in the United States—where she was focusing her argument on—speaks to a shift in cultural norms regarding death and dying[9] (2018, p. 462), this scenario also addresses a new stance in a long, ever-changing, entanglement between life, politics, and medicine. An entanglement that has enabled the emergence of political struggles through which life as a political object turns against different forms of regulation over it (Rabinow & Rose, 2006, p. 196). Struggles that saw the emergence of new medical specialties and judicial claims, such as the development of palliative care (Clark, 1999; Menezes, 2004; Saunders, 2001; Seymour, Clark, & Winslow, 2005) and the right of access to healthcare and pharmaceuticals (J. Biehl, 2013; J. o. Biehl, 2004; J. o. Biehl & Eskerod, 2007). This dimension of power working through life has often been dealt with, albeit differently, through the lenses of biopower and biopolitics. When Foucault first conceptualized biopower, he argued that "power is situated and exercised at the level of life," (1978, p. 137) and, therefore, one of the main privileges of the sovereign was precisely the right to decide over life and death. In other words, a right to take life and to let live (1978, p. 136). One of the figures of this power formation, according to Foucault, was the death penalty: a response to those who act against the sovereign, his will, and his law (1978, p. 137).

Over time, however, power dynamics progressively assumed the role of managing life, placing its protection and preservation at the very core of its logic and rationale. It was no longer a matter of letting live and making die, but rather making

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[8] Oregon (Oregon Death with Dignity Act; 1994/1997); Washington (Washington Death with Dignity Act; 2008); Montana (Rights of the Terminally Ill Act; 2009); Colorado (End of Life Options Act; 2016); Vermont (Patient Choice and Control at the End of Life Act; 2013); California (End of Life Option Act; approved in 2015, in effect from 2016); Hawaii (Our Care, Our Choice Act; 2018/2019); District of Columbia (Death with Dignity Act; 2016/2017).

[9] Other shifts in cultural and social attitudes toward death and dying has been the subject of several classic works (Ariès, 1974, 1981; Ariès & Rigolet, 1983; Ariès & Stannard, 1975; Elias, 1985; Gorer, 1955; Mitford, 1978; Rodrigues, 1979, 1983).

live and and letting die (1978, p. 138). This shift was a significant one. *Life*, now, was to be protected, invested through and through (Foucault, 1978, p. 139), and medicine played a significant role in this logic. As power is diffusely exercised at state and sub-state level, Rose and Rabinow (2006, p. 200) reinforced medicine's part as "perhaps the oldest site where one can observe the play of truth, power and ethics in relation to the subject, and to the possibilities of a good, or as the Greeks would have it, a flourishing, life." Now, if the rationale of power was to manage and protect *life*, suicide posed a threat to the very core of state and sub-state institutions. A threat that, even today, identifies suicide as a place for medical and state intervention[10] despite it no longer being a criminal offense in most national jurisdictions[11]—including the three ones within this landscape of assisted suicide. If *life* is to be preserved, suicide has to be prevented.

For instance, speaking about the relationship between Inuit communities and the Canadian government in the context of a tuberculosis and suicide epidemics, Stevenson (2012, 2014) shows how a desire to make live at the level of population, which is operated through a form of anonymous, bureaucratic care, can be experienced as murderous on the ground level by individual lives. According to her (2012, p. 593), "[i]t has become a matter of good manners for agents of the state to invoke the sanctity of life" when dealing with the risk of suicide, thus fostering a regime of care that tries to prevent it. "When life becomes an indifferent value," she writes, "it no longer matters who you are—simply that you cooperate in the project of staying alive." (2012, p. 601) When *life* is detached from individual ones, it emerges as a value in and of itself. A value that is fundamental to the state and medicine and, therefore, becomes subjected to legal protections and forms of care. But while this

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[10] Such interventions, which are oftentimes enforced through wellness checks by police officers and psychiatric sectioning, are based on a collaboration between state and medical institutions (Conrad, 1979)—as described on chapter 3.

[11] In Europe, the only country where suicide remains criminalized is Cyprus.

infrastructure of bureaucratic care is designed on the level of population, of *life*, they are enforced over personal lives.

In this sense, whereas the state needs one clear definition of *life* to "sanctify" and protect, one that can easily be framed by law and translated into forms of protection and enforcement, its generalizing quality often results in conflict. While, on the one hand, it is precisely by seeing *life* as something anonymous and generalizing that regulations can be implemented on the level of population (Scott, 1998), on the other hand, these regulations exert an impact on particular lives, thus opening up space for care to be perceived and experienced as something entirely different from its original conception. As Fassin (2009, p. 44) points out, the politics of life is not only a question of rules and governmentality, but also of meanings, values, and stakes. "What politics does to life—and lives—," he writes, "is not just a question of discourses and technologies, of strategies and tactics. It is also a question of the concrete way in which individuals and groups are treated, under which principles and in the name of which morals." (Fassin, 2009, p. 57)

If, as seen by the state, *life* simply *is,* from the outside perspective it can lead to more complex definitions. As Marsland and Prince (2012, p. 464) argue, not even the moments when life starts and ends are a given, as debates about abortion, neglect, and brain death dramatize (J. o. Biehl, 2005; Kim, 2016; Lock, 2002; Morgan & Michaels, 1999; Scheper-Hughes, 1992). Life may not even be a substance or a state, but a process of becoming that integrates social and biological aspects, thus enabling us to capture it in a variety of facets, processes, and relations (Kohn, 2013; Lien, 2015; Paxson, 2013; Tsing, 2015). It may be something that can be put to death (Agamben, 1998) or something operated through discourses, decisions, and actions (Fassin, 2009, p. 48). Or, as Stevenson (2014, p. 82) phrased, it can be a project of staying alive. Life as a project is crucial in this landscape of organized assisted suicide, for it captures, on the one hand, an ideal of life that has to be preserved, protected, and invested regardless of whose life it is, and, on the other hand, personal lives that are relational, constituted through actions and decisions, values and affects. Life as a project captures the friction between a *life* that expects cooperation and personal lives that refuse to do so.

As Margot's case dramatized, while from her standpoint she was applying to end her own life, to the state she intended to terminate a *life*. After all, the §217 StGB was not drafted to protect her personally against professional or organized assistance to suicide, but rather to protect every life within Germany. To protect its population. In this sense, the §217 StGB, just like the other aforementioned regulations on assisted dying, encapsulate *life* as something anonymous, as a value detached from individual persons and fundamental to the preservation and maintenance of the state. A value that provides both a clear subject of protection and a target for biopolitical care (Stevenson, 2012, 2014). To Margot, however, the life she was negotiating was not an anonymous, indifferent one. It was hers. A life that was relational and personal, constituted from her own experiences and trajectory. They were negotiating different things.

While the state cannot control death, it can control mortality (Foucault, 2003, p. 248; Stevenson, 2014)—it can control dying. The bureaucratic anonymity around which the state enacts and provides care needs one specific conception of *life* in order for it to work, one that needs protection and preservation, but one that often clashes with individual lives applying for organized suicide assistance—such as Margot's. Underlying this interplay of life, state, and medicine that constitute life as a project of staying alive lies a fundamental distinction between life and death that matters. A distinction that can be maintained and shaped through discourses, affects, and tactics (Povinelli, 2016, p. 3) or through forms of sociality connecting the living and the dead (Kim, 2016, p. 2). For instance, when it comes to the latter, Kim stresses the importance of analyzing the state's management of the wellbeing of its population in a context of neglect and isolated death. In this project of staying alive, life is something to be protected, preserved, and cared upon. A value that expects cooperation, is encapsulated in the form of laws[12] and enforced via a cooperation between medicine and state[13]—and against which suicide poses a crucial threat. In this sense, when Margot applied for organized assisted suicide, she was formally requesting to terminate her life within a medico-political environment that was designed to be life-oriented.

This environment, which Stevenson—albeit speaking from a different context—describes as a regime of life[14] (2014, p. 68), put in place infrastructures of care and legal protections to the preservation of *life,* oftentimes going against personal lives. Infrastructures of care and legal protections that, despite their good intentions, can be perceived as something entirely different on the ground level—as violent, for instance. But it is precisely the enforcement of this project of staying alive that created the conditions for the emergence of organizations that provide suicide assistance, as well as of tactics—often through mobility—to circumvent forms of enforcement. That is, if this regime of life tried to shape the distinction between life and death through the establishment of legal and nonlegal protections, the uncertain and ambiguous nature of legal rules (Asad, 2004; Das & Poole, 2004; Yonucu, 2017) provided enough interpretative leeway for organizations—such as LifeCircle—to operate within this same framework.

Therefore, if legal and nonlegal regulations over life and death were designed to prevent the voluntary termination of a life with third party assistance, these same regulations created the framework that enabled the establishment of professional organizations. But organizations of this kind operate on a fine line. After all, they provide lawful suicide assistance within a medico-legal environment—a regime of life—designed to prevent it. So in order to both safeguard their work and distance themselves from the image of non-assisted suicide, these organizations establish a

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[12] Chapter 2.

[13] Chapter 3.

[14] According to Stevenson's definition, a regime of life entails a political system "in which keeping people alive has become the primary goal." (2014, p. 68)

bureaucracy that would reconcile their assistance offering with the legal framework within which they operate: not a bureaucracy of death (Andrade Neves, 2017), but a bureaucracy to die.

1.1 Organizing assisted suicide

In 2011, the Swiss physician Erika Preisig founded LifeCircle, one of the five organizations in Switzerland—and the only one in Basel—that provide professional assistance to suicide. Out of these five organizations, two accept only Swiss citizens or residents while three extend their assistance offering to include foreigners as well: LifeCircle (Basel), Dignitas (Zurich), and EX International (Bern). As Dr. Preisig argued, organizations such as EXIT, which is located in Zurich and has over 100.000 members, have so much demand from Swiss residents and citizens that they could not afford to also accept foreigners. After all, she said, it is more complicated to accept people from outside of Switzerland, since they need to submit more documents for the Swiss authorities [*Behörden*] and the organization has to organize their cremation.

After having worked for five years at Dignitas, Dr. Preisig decided to start an organization of her own in the canton where she used to work and live. During her time at Dignitas, she felt as if there was not enough room there to campaign for the legalization of assisted suicide abroad. She felt it was necessary to inform the debate through lectures, interviews, and, fundamentally, by making assisted suicide a topic of discussion in everyday life. Even in Switzerland, where the procedure can be lawfully practiced, assisted suicide has a discreet existence. On the one hand, it has the support of a vast majority of the Swiss population (Schwarzenegger, Manzoni, Studer, & Leanza, 2013) and has long resisted the opposition of mostly religious groups and the prospect of legal changes—in 2011, it survived a vote aimed at hindering "suicide tourism." (Staples & Widger, 2012) On the other hand, organizations like LifeCircle operate discreetly, carrying out procedures in places with almost to no identification[15].

Dr. Preisig's goal was to provide this service in a canton where there was previously no local alternative, as well as to take part in and inform broader political debates by making her work visible. So besides LifeCircle, she also founded the organization Eternal Spirit. While the former provides both information on end-of-life care and organizes the procedure itself, Eternal Spirit maintains a political focus. Its task is precisely to campaign for the legalization of assisted suicide abroad. As Dr. Preisig has told me on several occasions, if other places legalize assisted suicide there will be no reason for people to travel to Switzerland in order to die with professional assistance. "The worst thing about assisted suicide," she told me, "is that people have to come to Switzerland to do it. There is nothing more negative than this, people wanting to do it at home, but having to travel instead. And that's our main goal, that someday other countries will legalize assisted suicide and then people will no longer need to travel." By establishing the two organizations, Dr. Preisig would be able to simultaneously "promote life" and "assist dying." (Preisig, 2014, p. 103)

Dr. Preisig first got involved with assisted suicide after a personal experience with her father, who had expressed his wish to commit suicide on several occasions throughout his life. When he was 82-years-old, living with Dr. Preisig and her family, he suffered a stroke for the second time. This time, however, he was left aphasic—lucid, but barely able to communicate orally. As his health became increasingly frail, his wish to die intensified. In 2005, Dr. Preisig arrived home and found her father in his bedroom with empty drug packages and two dry bottles of red wine by his side. He was still alive, but unconscious. This scenario left her stunned, not sure what to do and how to react. She felt torn between calling an ambulance or letting him die, as he so frequently expressed to be his wish; torn between fulfilling what she then

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[15] Some organizations prefer to carry out procedures at the applicants home, whenever possible. This is the case of EXIT.

perceived as her duty as physician to protect and preserve life or her obligation as a daughter to respect her father's wish. She went for the latter.

According to her, he laid in a coma for three days and two nights, until finally waking up. Upon gathering enough strength to speak, he muttered "Why?." (Preisig, 2014, p. 15) After his suicide attempt, Dr. Preisig's father continued to manifest his wish to die as soon as possible—but since he was almost unable to communicate orally, he turned to gestures, such as strangling himself. He had no intention of waiting for death to come naturally, and she was worried that if she and her family did nothing he would find another way to suicide. So they decided to approach the organization EXIT and inquiry them about their suicide assistance. EXIT, for instance, is the first organization of this kind in Switzerland, founded in 1982, with a current membership of over 100.000 Swiss residents[16]—around 1,2% of the country's population.

EXIT's approach, however, left them frustrated. As they soon found out, from the moment of registration as a member until the actual procedure there would be a waiting period of at least 6 months. But Dr. Preisig knew her father would not want to wait that long. This was when she first contacted Dignitas. There, they were relieved to find out the waiting period was more flexible. And so, having considered both EXIT and Dignitas, they applied for suicide assistance with the latter. When the day finally arrived, she recounts:

> At 2 pm my father was allowed to drink the stomach-soothing medicine, Paspertin, and 20 minutes later Mr Ron [the assistant] dissolved the life-ending white powder in a small amount of water. Beforehand he had told my father he would have to say "I want to" when he was really ready to go. *He can't! That's harassment!* I wanted to shout but held myself in check. The old man looked again at the Dignitas attendant for a long time. The eyes of both men seemed to sink into each other. "I want to," I heard Dad say

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[16] EXIT offers some data regarding membership on their website: https://www.exit.ch/en/en/who-is-exit/. Last accessed 15th June 2018.

> loudly. (…) There was Mr Ron again, holding the small glass with about 100 ml of clear liquid that looked as harmless as water. (…) For the last time he stroked my hair and looked at me for a long time. Tears rushed to my eyes. Then he lay his head on my shoulder and fell asleep. His body relaxed more and more, let go, and his spirit set off on its eternal journey. (2014, pp. 21-22)

After his death—and similarly to Margot's procedure, who was assisted by Dr. Preisig herself 11 years after her first contact with organized assisted suicide—, they had to call in the police. When her father's assistant informed Dr. Preisig that it was finally time to call the police and report the procedure, she was instantly taken aback, rushed away from her emotions and into the prospect of a criminal investigation. When two police officers arrived at Dr. Preisig's home, where the procedure took place, they informed her that more officials were also on their way—after all, they explained to her, an unnatural death has to be investigated as a potential murder. And so, also in a similar way to Margot's case, the cantonal doctor, the state prosecutor, and the coroner arrived, joining the two police officers in the investigation. They found no evidence of illegality or wrongdoing. Shortly after they were gone, Mr. Ron left as well. "[A] stranger just 4 hours ago," Dr. Preisig writes, "supported me at the hardest moment of my life." It was this experience that made her want to engage herself with the subject, assisting people in similar situations.

It was then a family experience that triggered Dr. Preisig's professional involvement with assisted suicide, leading her to work at Dignitas and, subsequently, to the establishment of LifeCircle and Eternal Spirit. But unlike Dignitas, which has a considerable number of staff and offices in both Switzerland and Germany, LifeCircle operates on a comparatively small scale. Its first headquarters was a house then owned by Dr. Preisig's brother, who rented it to her. And, besides herself, its staff comprises one administrative secretary and one—eventually two—assistant to help organize the procedure. LifeCircle, however, was not Dr. Preisig's only professional occupation. She continued to work as a physician outside of the organization, managing to reconcile both works by only assisting in two procedures per week.

The second organization is *Sterbehilfe Deutschland*, founded by Roger Kusch in Hamburg. A lawyer and politician, Kusch's first contact with the topic was during a business trip to Berlin, when a friend told him about the movie "*Mar Adentro,*" which tells the story of Ramón Sampedro, a Spanish seamen who was left quadriplegic after a diving accident in 1968. The story was told to him in such a way that kept his mind busy for days on end, making him curious about the legal situation of assisted suicide in Germany. At the time, Kusch was serving as minister of justice of Hamburg[17], and then, upon his return from Berlin, he asked his staff at the ministry of justice to prepare a paper describing the German legal situation in regards to assisted suicide. As he told me during a conversation in Hamburg:

> After reading the paper I realized there were lots of problems here. And then Horst Köhler, our president at the time, made a speech where he said "*Nicht durch die Hand eines anderen sollen die Menschen sterben, sondern an der Hand eines anderen*" [loosely translated as "they shouldn't die by the hand of another, but with someone holding their hand"]. And I read this stupid sentence… And, on the same weekend of this speech, both the bishop of Hamburg and the bishop of Hannover said the same stupid thing, that life is a gift from God and so we are not able to decide and that sort of thing. After this weekend with speeches from the *Bundespräsident* and the two bishops, I called a journalist from the leading newspaper in Hamburg, *Hamburger Armblatt*, and asked him if he would give me a little space for a small article. So I wrote something about assisted suicide. And after that I saw that there was no one in Germany [concerned with assisted suicide], except Minelli[18], but Minelli only offers assisted suicide in Switzerland. So I thought what a stupid thing, everyone think they have to go to Switzerland for suicide assistance, but we have the same legal situation in

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[17] He was then a member of the Christian Democratic Party (CDU).

[18] Ludwig A. Minelli, founder of the Swiss organization Dignitas, which has an office in Hannover, Germany.

> Germany. Why don't we have the same thing here? And because of this, maybe half a year later, I had to leave office. The mayor [of Hamburg] was under pressure from members of his party, saying that it was not acceptable for a minister who is a member of the Christian Democratic Party (CDU) to have the opposite of the Christian democratic ideas.

Hours after leaving his position at the Ministry of Justice, Kusch also left the CDU. Three years later, in 2009, he founded *Sterbehilfe Deutschland*—the organization Margot originally intended to apply for her assisted suicide. Whereas Switzerland has 5 organizations that provide professionally assisted suicide, StHD was Germany's first and only[19]. From its founding in 2009 to 2016, StHD assisted 254 suicides (Kusch, 2016)—in comparison, as of 2015, it had about 200 members in Germany and 300 in Switzerland[20]. But as its membership increased over the years, the number of suicide assistances remained more or less stable.

The third organization, Friends at the End (FATE), was founded by Dr. Elizabeth Wilson and a group of people in 2000. After having worked with family planning throughout her professional trajectory as a GP[21], she focused her attention on assisted suicide upon her retirement. This shift was not at all unthinkable to Dr. Wilson, who can place it on a professional continuum. As she explained to me:

> I don't think life in itself is something which must be so precious it's got to be preserved at all cost. What is life, you know? That's my own philosophy about it, of course, as you can see, I don't have any theistic believes. But, you see, I was involved with family planning before I retired, that was my profession alright. And we had all these battles about abortion, huge battles, of course, mainly with the catholic church.

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[19] There are other organizations in Germany involved with assisted suicide, such as DGHS [*Deutsche Gesellschaft für Humanes Sterben*]. However, DGHS does not provide assistance in the procedure itself.

[20] The organization maintains an office in Hamburg, Germany, and in Zurich, Switzerland.

[21] General Practitioner.

> But it seemed quite logical, I mean, when I retired, that we won the battle to stop life when we wanted to, and now it was time to have a battle to be able to choose when we end life. You know, it just seemed a logical thing.

Because assisted suicide remains a criminal offense in England and Wales—and, arguably, in Scotland—FATE does not provide assistance in the procedure itself. Rather, it offers information on assisted dying, handing out literature about Dignitas and LifeCircle. Sheila Duffy, who succeeded Dr. Wilson as the organization's convenor, called attention to the importance of establishing a platform where information about assisted suicide can be provided and shared among, specially, elderly people: "Young people can go on the internet and find out how to obtain Nembutal," she said, "but old people don't even know where to start." Despite not organizing procedures *per se*, FATE is the UK's main point of contact to the three organizations in Switzerland that provide suicide assistance to foreigners and non-residents (Richards, 2017, p. 350). But despite its importance, FATE remains a relatively small organization, with around 320 members.

But, according to Duffy, while Dr. Wilson wanted to be more hands on, going to see and talk to people, others in the organization were more involved on political campaigning, trying to push forward legislation on the issue. So what was initially one organization, ended up becoming two different, yet complementary, ones: Friends at the End [FATE], on the campaign side, and Befrienders at the End [BATE], on "the befriending side"—as Duffy put it. These two organizations, in a similar way to LifeCircle and Eternal Spirit, share the same main structure. As Dr. Wilson once joked, they are "siamese twins," sharing the same finances and structure, but otherwise different. Yet, splits are not that uncommon—and FATE itself was the result of one. "Voluntary organizations always split," said Dr. Wilson to me, "there are always power struggles between individual people, and whatever the reason is, they split." She continued:

> We split from a Scottish organization, because the man who was running it was not good about money, he was actually taking money… Well, using it for his own purposes and things like that, you know. Then we split off. Actually, we were cast out, because it was said we were bringing the society in disrepute, but actually it was the other way around, of course. And, actually, one of the great things about FATE and SOARS[22] is that we haven't split. In fact, we have a joint meeting in London and SOARS wouldn't even exist without FATE. SOARS was founded because of the people who attended the London FATE meeting, who were all our members. Michael's [Irwin, former medical director of the United Nations who founded SOARS in 2009] original core of SOAR's members was actually FATE members.

All of these organizations operate differently within specific legal frameworks. For instance, while LifeCircle and StHD provided assisted suicide-as procedure, the latter temporarily halted its operations after the passing of the §217 StGB in Germany. In turn, FATE does not provide suicide assistance in itself, but operates by disseminating information on end-of-life issues, a work that placed the organization as the UK's main point of convergence to Swiss organizations. But despite the specificities of their work, their differences and similarities, connections and disconnections, all of these three[23] organizations operate within this normative space between life and death, and do so by acting upon a plurality of often divergent, and frequently ambiguous, laws, as well as by establishing a bureaucracy to die and designing itineraries of circulation.

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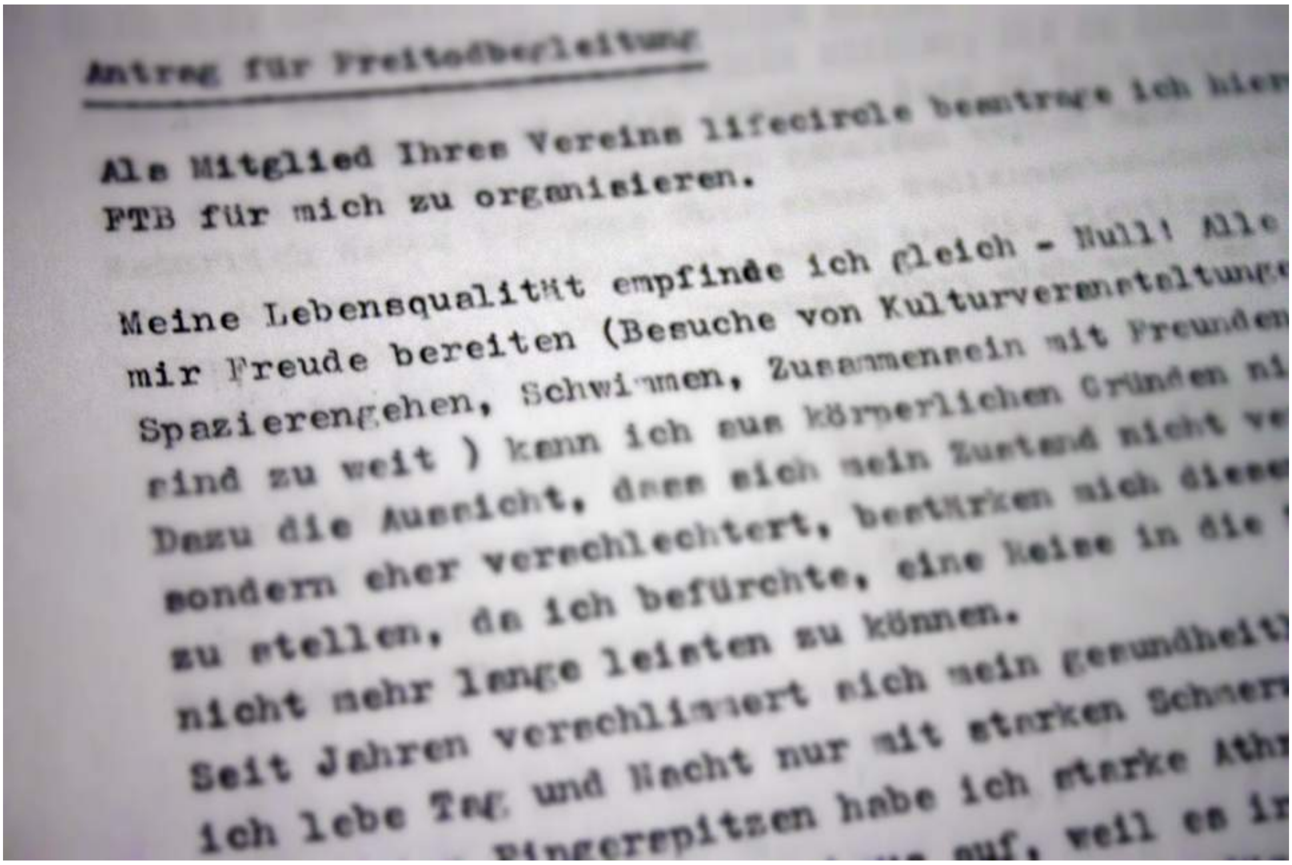
[22] Society for Old Age Rational Suicide (SOARS), which has since changed its name to My Death My Decision (MDMD).

[23] Because of their similarities, proximity, and shared structure, LifeCircle and Eternal Spirit, as well as FATE and BATE, will be henceforth described simply as LifeCircle and FATE respectively.

EXIT DOORBELL | ZURICH | 2015 | MARCOS ANDRADE NEVES



Antrag für Freitodbegleitung

Als Mitglied Ihres Vereins lifecircle beantrage ich hier
FTB für mich zu organisieren.

Meine Lebensqualität empfinde ich gleich - Null! Alle
mir Freude bereiten (Besuche von Kulturveranstaltunge
Spazierengehen, Schwimmen, Zusammensein mit Freunden
sind zu weit) kann ich aus körperlichen Gründen ni
Dazu die Aussicht, dass sich mein Zustand nicht ve
sondern eher verschlechtert, bestärken mich diese
zu stellen, da ich befürchte, eine Reise in die
nicht mehr lange leisten zu können.
Seit Jahren verschlimmert sich mein gesundheit
ich lebe Tag und Nacht nur mit starken Schmer
Fingerspitzen habe ich starke Athr
auf, weil es ir

"MEINE LEBENSQUALITÄT EMPFINDE ICH GLEICH — NULL!" | 2016

When Margot wrote her request for suicide assistance she graded her own quality of life as zero with the perspective of even further deterioration. Having witnessed the death of her parents and grandmother—and later on of some people living in the same sheltered accommodation as she did—Margot decided early on to try to avoid what she perceived as a prolonged process. Assisted dying, therefore, was a possibility she considered for decades and one she was willing to pursue in case she felt necessary. Margot's initial plan was straightforward: after her 80th birthday she would contact the German organization *Sterbehilfe Deutschland*—which was conveniently located in Hamburg, where she also lived—and apply for an assisted suicide to be carried out at her place of choice. When the time arrived, however, Germany approved its first official law on assisted suicide, thus restricting so-called businesslike operations with death and, consequently, the work of assisted dying organizations based in the country. As a result of the new legal landscape, *Sterbehilfe Deutschland*, Margot's first choice and Germany's only organization of its kind, put a temporary halt to the preparation of procedures until the law is challenged at the Federal Constitutional Court of Germany, in Karlsruhe. If carrying out the procedure in Hamburg was no longer viable, Margot had to look elsewhere for professional assistance. That is when one of her friends became aware of LifeCircle and, all of a sudden, traveling to Switzerland turned into her most feasible possibility.

Margot's decision to end her life clashed with a newly implemented official law aimed at protecting *life* precisely against threats of suicide assistance. While Germany had previously no official law on the issue, there were already 18 sets of medical regulations governing the participation of physicians in assisted dying procedures, as well as pharmaceutical regulations restricting access to the necessary pharmaceuticals. The newly implemented §217 StGB (criminal code), therefore, was not the first law regulating the issue—but had an impact that reshaped the legal landscape of assisted suicide as a whole. Differently from official law, the regulations that were already in effect were not binding to everyone—but only to registered physicians. Whereas Margot was not subjected to professional laws passed by medical associations, being able to experience them only through her interactions with physicians, the §217 StGB encompassed everyone in Germany, regardless of profession or institutional affiliations.

By regulating assisted suicide with a specific legislation, the §217 StGB incorporated a new protection to *life* in the realm of criminal law[24]: *life*, regardless of whose, is to be preserved and protected from businesslike assistance. Despite being implemented in Germany only in 2015, similar protections were already in effect in other countries, such as The United Kingdom and Switzerland. In both of them, assisted suicide has also been incorporated into criminal law, but there are differences on what constitute this offense. Laws have exceptions, their content is

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[24] Alongside other criminal offenses such as "killing on demand" [*Tötung auf Verlangen*, §216 StGB], "manslaughter" [*Totschlag*, §212 StGB], and "murder" [*Mord*, §211 StGB].

uncertain, and their applicability is unclear. When someone moves to a different jurisdiction in order to carry out an assisted suicide, their personal lives end up being positioned and repositioned within legal landscapes. In this way, their personal lives —composed of a person's own experiences, desires, affects, and moralities, such as Margot's—are juxtaposed with an anonymous one, as seen by the state and encapsulated by different laws. Laws such as the German §217 StGB, but also the Suicide Act 1961, in the UK, and Article 115 StGB, in Switzerland.

Notwithstanding their differences on legibility, content, and application, all of these official laws coincide in their inscription of *life* as something to be protected from suicide assistance, albeit with variations on what constitute the offense. This chapter, thus, presents the production of a legal pluralism composed of official and non-official laws from three national jurisdictions that, while regulating assisted suicide within their political borders, end up composing a transnational legal landscape that is enacted through itineraries of circulation. A legal landscape that, on a normative level, protects *life* from third party assistance while producing, on the ground level, a general sense of mistrust and uncertainty that crafts an image of the state forged in suspicion.

2.1 The encapsulation of assisted suicide in Germany

BUNDESTAG* DEBATE ON ASSISTED SUICIDE LEGISLATION | 2015 | *STREAMING

> "Dear Colleagues, the state cannot and will never be able to regulate all facets of dying. That would be presumptuous. But we can clarify as legislators that we do not want assisted suicide as a medical rule or as a freely available club offer."[25] (Kerstin Griese, member of the German parliament)

Margot's original plan was derailed on a Friday, November 6th 2015, when the German parliament voted for the first time on an official law aimed at regulating assisted suicide in the country. The session started precisely at 9 a.m., when Dr. Norbert Lammert, then president of the German *Bundestag*, opened its 134th Plenary Session. He asked for everyone to take their seats and shortly afterward called to order item 26 of the agenda. The parliament was considerably full and chancellor

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[25] *"Liebe Kolleginnen und Kollegen, der Staat kann und wird nie alle Facetten des Sterbens regeln können. Das wäre auch vermessen. Aber wir können als Gesetzgeber klarmachen, dass wir den assistierten Suizid als ärztliche Regelleistung oder als frei verfügbares Vereinsangebot nicht wollen."*

Angela Merkel was also in attendance. After months of discussions, four bills on assisted suicide were getting to their final stages of debate, reaching their second and third consultations to be followed by a vote. As the issue was considered a matter of conscience by the political parties with parliamentary representation, all factions in the *Bundestag* allowed their members to vote as they wished, that is, without reprisals in case votes were cast against party platforms.

President Lammert briefly introduced all four bills and their main proponents: (1) *Gesetz zur Strafbarkeit der geschäftsmäßigen Förderung der Selbsttötung*[26], proposed by Michael Brand and Kerstin Griese (CDU[27]/SPD[28]); (2) *Gesetz zur Regelung der ärztlich begleiteten Lebensbeendigung* (*Suizidhilfegesetz*)[29], by Peter Hintze, Dr. Carola Reimann, and Dr. Karl Lauterbach (CDU/SPD/SPD); (3) *Gesetz über die Straffreiheit der Hilfe zur Selbsttötung*[30], by Renate Künast and Dr. Petra Sitte (*Bündnis 90-Die Grünen/Die Linke*); and, (4) *Gesetz über die Strafbarkeit der Teilnahme an der Selbsttötung*[31], by Dr. Patrick Sensburg and Thomas Dörflinger (CDU/CDU). Since the inception of the German criminal code in 1871, there has been no official law on assisted suicide in the country, a period in which the legal understanding was by means of "accessoriness of complicity" (Birnbacher & Dahl, 2008, p. 88)—the assumption that if suicide is not a crime, aiding and abetting one cannot be a crime either. The absence of an official law, alongside this legal understanding, has led to a *de facto* legalization of assisted suicide in Germany, which, during this period, saw the establishment of only one organization that provided this kind of assistance—*Sterbehilfe Deutschland*. In 2014, StHD assisted 44 suicides and hence was involved in 0,4% of all suicides in the

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[26] "Law on criminal liability of business promotion of suicide."

[27] *Christlich Demokratische Union Deutschlands* (Christian Democratic Union of Germany).

[28] *Sozialdemokratische Partei Deutschlands* (Social Democratic Party of Germany), then chaired by Sigmar Gabriel.

[29] "Law to the regulation of medically assisted dying (law on assisted suicide)."

[30] "Law on the impunity for assistance to suicide."

[31] "Law on the criminal liability of participation in suicide."

country, as noted by Dr. Sabine SütterlinWaack (CDU/CSU) during her speech to the *Bundestag*.

Although the four bills had the intention of filling the absence of official law by replacing a legal interpretation—accessoriness of complicity—with a written regulation, they have sought to do so differently. Whereas the bill presented by Brand/Griese focused on halting businesslike operations with death, while, at the same time, legalizing the possibility of suicide assistance as a nonprofessional exceptionality, others followed different routes. Routes such as the complete criminalization of suicide assistance[32], its legalization through a piece of legislation that would diminish legal uncertainty[33], or regulating it strictly as a medical practice[34]. Each member of the *Bundestag* would have the chance to address the parliament for five minutes, expressing their points of view in relation to the subject. Amongst 630 members of the parliament, of which 602 were present, only 29 took to the podium to debate the issue on that occasion. Michael Brand was the first to speak from the podium, and did so in order to convince his colleagues to vote for the bill he coauthored with Kerstin Griese and others. In his opening statement, Brand said:

> Ladies and gentlemen, in today's decision it is important that we all know what we choose and what we do not decide upon. To expand the help and stop the abuse—that is, in short, the core concerns of our group, which has supporters from all factions. (…) Today lawmakers are called upon to stop abuse (…). It is essentially a shift of an important axis of our society. It is also about the protection of people from dangerous pressure by dangerous business offers for suicide assistance[35].

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[32] Deutscher Bundestag, 18. Wahlperiode, Gesetzentwurf, [2015] Drucksache 18/5376 (Ger.).; For citation of German legal documents I use the bluebook citation format.

[33] Deutscher Bundestag, 18. Wahlperiode, Gesetzentwurf, [2015] Drucksache 18/5375 (Ger.)

[34] Deutscher Bundestag, 18. Wahlperiode, Gesetzentwurf, [2015] Drucksache 18/5374 (Ger.)

[35] The transcription of the 134th Plenary Session is available at: http://dip21.bundestag.de/dip21/btp/18/18134.pdf. Last accessed 11th June 2018.

As Brand noted, his bill had supporters from all factions of the parliament—since, as already mentioned, this subject was considered a vote of conscience—and was by a considerable margin the one with most chances to win the forthcoming vote. Instead of focusing on the criminalization of assistance itself, their proposal tried to hinder the work of both organizations and professional assistants through the criminalization of what they framed as "businesslike" [*geschäftsmäßig*] assistance. The Brand/Griese bill clarified that to be considered "businesslike" it suffices when assistance is the object of one's employment[36]. Therefore, in contrast to the Swiss legislation, where the illegality of assisted suicide relies on the existence of selfish motives—i.e. not profit-oriented—, the Brand/Griese bill established that providing suicide assistance repeatedly, or as part of a person's professional occupation, is enough to constitute a criminal offense—regardless of its being provided altruistically or without any economic reward.

The intention of the Brand/Griese bill, thus, was to hinder the work of organizations and professional assistants who make assisted suicide part of their professional remit. It was precisely these terms that Kerstin Griese, coauthor of the bill, used to justify the importance of approving an official law on assisted suicide. She stated:

> We need a law because there are clubs and individuals in Germany who promote, support, and carry out self-killing as their main occupation. We want to punish those who deal with suicide with the intention of making business—that is, on repetition and

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[36] Deutscher Bundestag, 18. Wahlperiode, Gesetzentwurf, [2015] Drucksache 18/5373 (Ger.), p. 20.

> as the focus of their activity. Those who support our bill are clearly saying that we do not consider the business with people's death to be ethically sustainable[37].

She was applauded by many, but her statement was also counterweighted by other members, such as Katja Keul (*Bündnis 90/Die Grünen*) and Dr. Karl Lauterbach, who argued that having no law is better than having a bad one—after all, Germany had no official law on assisted suicide for almost 150 years (Renate Künast). But according to Michael Brand and Kerstin Griese, organized assisted suicide, as provided by *Sterbehilfe Deutschland,* would potentially risk normalizing suicide assistance: "Today, I would never want to give up my life," said Brand at the *Bundestag*, "On the contrary, the recurrent debates about simplifying assisted suicide frighten me. I sometimes fear that our society, in its delusion of optimization, could accept the automatism of this method."[38] On a similar note, Hermann Gröhe (CDU/CSU) stated that to signalize "the normalization of suicide as a course of action is wrong."[39]

Once the debate was over, the vice president of the *Bundestag* explained the procedure for the vote, which later resulted in the passing of the Brand/Griese bill with 360 votes for, 233 against, and 9 abstentions, and its subsequent transformation into the §217 of the German criminal code. The new law reads:

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[37] *"Wir brauchen ein Gesetz, weil es in Deutschland Vereine und Einzelpersonen gibt, die als ihr Hauptgeschäft die Selbsttötung fördern, unterstützen und durchführen. Wir wollen unter Strafe stellen, wenn jemand mit der Absicht der Selbsttötung geschäftsmäßig handelt – das heißt, auf Wiederholung angelegt und im Mittelpunkt seiner Tätigkeit. Diejenigen, die unseren Gesetzentwurf unterstützen, sagen ganz klar, dass wir dieses Geschäft mit dem Tod von Menschen für ethisch nicht tragbar halten."*

[38] *"Heute würde ich mein Leben niemals aufgeben wollen. Im Gegenteil: Die wiederkehrenden Debatten um eine Vereinfachung der Sterbehilfe ängstigen mich. Ich fürchte manchmal, unsere Gesellschaft könnte in ihrem Optimierungswahn einen Automatismus dieser Methode akzeptieren."*

[39] *"Das Signal der Normalität einer Selbsttötung als Handlungsoption ist falsch."*

> (1) Anyone who, for the purpose of encouraging the suicide of another person, gives him or her the opportunity to do so, will be punished with imprisonment for up to three years or a fine.
>
> (2) Participation remains exempt from punishment if the participant does not act for commercial purposes and is either a relative of or in a close personal relationship with to the other person referred to in paragraph 1.[40]

By forbidding businesslike [*geschäftsmäßig*] operations with death, the §217 StGB targeted precisely the work done by professional assistants and organizations—particularly, as the only organization that provided suicide assistance in Germany, *Sterbehilfe Deutschland*. However, the Brand/Griese bill could not have been written to address one particular individual or organization, so StHD was mentioned in the bill only as an example of commercial, for-profit organization[41]. But during the parliamentary debate StHD and Kusch were also mentioned a number of times by members of the *Bundestag* of various parties: Kai Gehring (*Bündnis 90/Die Grünen*) criticized the Brand/Griese bill by saying that they have tried to frame "The evil Dr. Kusch," but ended up framing every doctor and professional assistant in the country. Dr. Petra Sitte (*Die Linke*) stated that Kusch and his organization are considered Germany's "black sheep," and Katja Keul (*Bündnis 90/Die Grünen*) went as far as to say that Kusch was the reason for the whole debate to occur in the first place. Even though the bill was drafted in a way that avoided addressing specific organizations or persons, the debate often hinted at a political dispute with Kusch—who, until 2006, was also a member of CDU, just like Brand.

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[40] *(1) Wer in der Absicht, die Selbsttötung eines anderen zu fördern, diesem hierzu geschäftsmäßig die Gelegenheit gewährt, verschafft oder vermittelt, wird mit Freiheitsstrafe bis zu drei Jahren oder mit Geldstrafe bestraft.*
(2) Als Teilnehmer bleibt straffrei, wer selbst nicht geschäftsmäßig handelt und entweder Angehöriger des in Absatz 1 genannten anderen ist oder diesem nahesteht.

[41] Deutscher Bundestag, 18. Wahlperiode, Gesetzentwurf, [2015] Drucksache 18/5373 (Ger.), p. 16.

With the law now at-working (Scheffer, 2010), StHD temporarily ceased its activities in order to appeal the §217 StGB through constitutional complaints [*Verfassungsbeschwerde*]. At the time, StHD had already established an office in Switzerland as a way of attending to their German members there, but shortly after the implementation of the §217 StGB the Swiss office also stopped organizing procedures. As Roger Kusch, the organization's chairman and founder, explained to me:

> In this moment, we are not offering anything, neither the Swiss nor the German organizations [StHD]. Even the Swiss organization is involved in the German law, since its members are living in Germany. We have to respect the German law. And nobody is coming from Germany, knocking on our door in Switzerland and saying, 'Hello, I'm coming here for assistance, for suicide,' their first contact with us will be made from their home, in Germany. So we have to respect the law even if the contact is only between the German member and the Swiss organization.

Similarly, Swiss organizations such as EXIT, the biggest organization of this kind in Switzerland, were also affected by the German law. As the organization's director, Bernhard Sutter, stated to me once, they will no longer organize procedures for their members living in Germany—which then made up 0,5% of their membership. "EXIT follows the law very strictly," he said, "even if it's the law in another country and we are not directly touched by it. Even our magazine can be seen by German authorities as propaganda to kill yourself, so our members living in Germany won't get anything from EXIT anymore. If they want anything, they will have to come to Switzerland." In this way, the lack of clarity about the then newly-passed §217 StGB, just as the uncertainties regarding its reach and applicability, has made the law exert an impact beyond its own national jurisdiction.

In sum, following the passing of the §217 StGB by the *Bundestag*, Germany ratified its first official law on assisted suicide, shifting its legal landscape from an interpretation based on the absence of official law to the creation of a specific criminal offense. By doing so, the §217 StGB incorporated yet another protection to *life* into the realm of criminal law, thus reinforcing it as something to be protected and preserved. Similarly, Switzerland and the United Kingdom have also implemented official laws aimed at regulating assisted suicide, but despite sharing a similar goal to Germany's §217 StGB—that is, the protection of *life* against suicide assistance—, each of them diverge on the criteria necessary to constitute the criminal offense.

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R WOCHE

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d Darauf hatte die Weltöffentlich-
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Debatte des Bundes-
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vor den Parlamenta-
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tert", trat sie diesmal
auf die Bremse – mit-
ten in einer turbulen-
itischer Beratungen nach dem Aus-
ttungspakete und der anberaumten
ung der Griechen. Vor dem Plebiszit
en Grund für neue Gespräche mit
sie – im Dissens zur Position Frank-
großen Einvernehmen mit dem Ko-
r SPD. „Wir können auch in Ruhe
agte Merkel an die Adresse von
terpräsident Tsipras, dem die Zeit
kru ▪

ER WOCHE

Milliarden

den hat der griechische Staat bis-

Das Sterben regeln

SUIZIDASSISTENZ Abgeordnete debattieren intensiv über Gesetzentwürfe zur Sterbehilfe

Für Bundestagspräsident Norbert Lammert (CDU) ist es eines der „anspruchsvollsten und schwierigsten Gesetzgebungsprojekte dieser Legislaturperiode": die Verrechtlichung der Sterbehilfe. Für das Vorhaben gelten ganz eigene Regeln. Fraktionsübergreifende Gruppen streiten über das Für und Wider ihrer Positionen. Partei-, Koalitions- oder Oppositionszugehörigkeit stehen zurück. Nach einer teils sehr emotionalen Orientierungsdebatte im November 2014 hat der Bundestag vergangenen Donnerstag eher sachorientiert vier Gesetzentwürfe (siehe unten) zu dem Thema in erster Lesung beraten. Fokus aller Entwürfe: Die Regelung der Hilfe zur Selbsttötung. Sie ist bisher nicht strafbar. Zwei Vorschläge (Brand-Griese und Sensburg-Dörflinger) streben, grob gesagt, eine Einschränkung an. Die anderen beiden Entwürfe (Künast-Sitte und Hintze-Reimann) wollen diese Option rechtlich sicher für Ärzte und/oder Sterbehilfevereine ermöglichen.

Autonomie Im Kern geht es bei der Frage nach der Sterbehilfe um die Freiheit des Willens und die Autonomie der Sterbewilligen. Jene, die gegen eine Einschränkung

Menschliches, Allzumenschliches: Fragen des Lebens, Sterbens und Todes beschäftigen die Menschheit in vielfacher Form. Hier zu sehen ist ein Ausschnitt eines Bildes des französi-

"REGULATE DYING: MEMBERS OF PARLIAMENT DEBATED INTENSELY OVER BILLS ON ASSISTED SUICIDE | 2015 | ***DAS PARLAMENT***

2.2 Switzerland and the United Kingdom

In the early days of the 20th century, a high-ranked Swiss military man realized that his wife was having an extramarital affair. Feeling cheated and dishonored, he decided to end his own life. Despite being in the military, he did not have a gun at that moment and decided to ask a friend to lend him one. The friend complied with the request. After the man's suicide, however, the friend ended up being charged with murder—after all, he provided the weapon that was used to take someone's life. This anecdote concerns a romantic idea of suicide, one based on principles of honor and tradition—but one that, perhaps, might have unfolded somewhat differently. Instead of a dishonored military man the protagonist, in this case, was an ashamed businessman whose business went bankrupt and the friend was the one who was actually in the military. In this version, the story would be something along these lines: after his business went under, the businessman was overcome with shame and thus asked a friend, who was in the Swiss military, to lend him his pistol. After doing so, the businessman killed himself and the friend, just as before, was charged with murder. Both—or neither—anecdotes might have actually happened, but this is beyond the point. They were used to illustrate why Switzerland has its current law on suicide assistance. The first version was told to me by a former president of the Swiss National Advisory Commission on Biomedical Ethics [NEK-CNE], while the second one was phrased by EXIT's Director [*Geschäftsführer*], Bernhard Sutter.

When Switzerland's Criminal Code was first drafted and submitted for parliament's consideration in 1918, it was precisely this scenario the kind of suicide the legislators had in mind. Article 115 StGB, Switzerland's official law on the subject, was approved by the Parliament in 1937 and reads that "[e]very 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."[42] This article would therefore protect from legal prosecution those who assist a suicide without any ulterior or selfish reasons, as was the case with the allegorical friend. Under this article, their actions could have been deemed altruistic and, ultimately, freed from legal sanctions.

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[42] In the original: "Wer aus selbstsüchtigen Beweggründen jemanden zum Selbstmorde verleitet oder ihm dazu Hilfe leistet, wird, wenn der Selbstmord ausgeführt oder versucht wurde, mit Freiheitsstrafe bis zu fünf Jahren oder Geldstrafe bestraft."

However, Art. 115 StGB did not legalize assisted suicide *per se*, but rather established a legal framework within which assistance to suicide would not result in prosecution as long as specific criteria are met. The objective of the law was neither to establish the basis of the current Swiss dynamics nor to foster the development of assisted suicide as an organized practice. Rather, it was conceived as a way of freeing from prosecution isolated acts of assistance deemed as altruistic.

The article's trajectory was not embedded in consensus. In 1893, Carl Stoos—considered the father of the Swiss Criminal Code—noted that Swiss laws were right not to consider suicide a crime, but, one year after, he added: "But anyone who induces the unfortunate [suicide] to commit the act or assists him therein deserves punishment." (NEK-CNE, 2005, p. 28) Stoos was not the only prominent voice in Switzerland against suicide assistance at the time. Viktor Wellauer, author of a monograph on assisted suicide published in 1896, called the practice "an act of such immoral nature" that "the imposition of a specific penalty is advisable." (NEK-CNE, 2005, p. 28) Following this line of argumentation, a preliminary draft of the Swiss Criminal Code was published in 1894, containing an article proposed by Stoos, which read: "Whosoever deliberately induces someone to commit suicide or assists him therein shall be liable to a penalty of imprisonment from three months to a year." (NEK-CNE, 2005, p. 29) Different from what today's Art. 115 StGB might suggest, assistance to suicide was then widely considered to be a crime in Switzerland, being already punishable by law even before this preliminary draft of 1894, but at cantonal level. The core question was not whether participation was to be considered a crime or not—it was—, but rather what elements were to be required in order to form this offense. This was when the "selfish reasons" device was brought into the picture: as a way of preventing the "overextension" of the proposed article (NEK-CNE, 2005, p. 29).

The opinion on assisted suicide published by the Swiss National Advisory Commission on Biomedical Ethics highlighted two more arguments made during that period. The first one was made by Ernst Hafter, professor of criminal law, who said that whoever participates in a suicide creates the "conditions for the destruction of a human life," therefore demanding punishment—although only to acts motivated by "self-interested motives." The second one, provided by the Swiss Federal Council during the discussion of the StGB, stated that "because persuading someone to commit suicide and providing assistance may be an act of friendship, penalties are here only threatened for self-interested incitement and assistance." (NEK-CNE, 2005, p. 29) In this manner, the consensus in Switzerland that suicide should not be considered a criminal offense contrasted with the position that assistance to it endangers a life and thus must be punishable by law—unless such assistance is an act of friendship, stripped of any selfish motives. The regulation of assisted suicide was one device of protection against the endangerment of one's own life with assistance from a third party, encapsulating a specific threat against life in the Criminal Code, while at the same time allowing for its termination through altruistic —or friendly—assistance.

The social life (Appadurai, 1986) of what is today Article 115 StGB started from a consensus that assistance to suicide should be punishable under criminal law, thus restricting the discussion as to what would constitute the offense of suicide assistance—weighing the state's claim of an obligation to protect *life* with the possibility of a friendly gesture of assistance. Yet, Article 115 StGB is not a positive legislation allowing suicide assistance in Switzerland. Due to its formulation, the law needs to be read on the negative. If it establishes the possibility of either imprisonment or a fine in case of assistance motivated by selfish reasons, one can logically imply that in the absence of such reasons suicide assistance offers no ground for prosecution. The law, after all, was drafted to protect the "altruistic friend." This protection of romantic suicide turned into what Andorno (2013, p. 1) called an "unintended permissive policy" that laid the foundations for the current Swiss dynamics. Altruistic forms of assistance are often understood as non-profit, that is, without economic gains from the suicide—be it through inheritance or overcharging for procedures. By not stipulating any other criteria other than the prohibition of selfish reasons, the Article 115 StGB was broad enough to prepare the ground for the emergence of a very specific dynamics with regards to suicide assistance: it ended up enabling the establishment of non-profit organizations that offer assisted suicide to their members.

The Social Life of Swiss official law

1894 - preliminary draft of the Swiss Criminal Code:
"Whosoever deliberately induces someone to commit suicide or assists him therein shall be liable to a penalty of imprisonment from three months to a year."

1918 - Article 102 - draft of the Criminal Code:
"Whosoever, from self-interested motives, incites someone to commit suicide or assists him therein shall be punished, if the suicide was carried out or attempted, by confinement in a penitentiary for up to 5 years or by imprisonment."

1937 - Article 115 - Swiss Criminal Code:
"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."

If Switzerland's legal trajectory on suicide assistance was a way of reconciling the protection of life with the possibility of assistance to terminate it, not every legislative movement ends up resulting in lawfully enabling procedures. In the United Kingdom suicide remained a criminal offense until 1961, when Westminster passed the Suicide Act, decriminalizing suicide in Wales and England while, at the same time, maintaining restrictions on assisted suicide. According to Section 1 of the Act, suicide ceases to be a crime, but Section 2 states that aiding or abetting someone else's can lead to fourteen years of imprisonment[43]. Thus, the focus of criminal prosecution shifts from the person who commits suicide to the one who assists,

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[43] "A person who aids, abets, counsels or procures the suicide of another, or an attempt by another to commit suicide, shall be liable on conviction on indictment to imprisonment for a term not exceeding fourteen years." The Suicide Act 1961, Section 2.

regardless of motive—be it altruistic or not. Since the implementation of the Act, there has been several attempts on legislation reform, the most recent of which was spearheaded by Labour Peer Lord Falconer, a former Cabinet Minister who chaired the "Commission on Assisted Dying." The Commission's goal was to analyze the current legal stance on assisted suicide in both England and Wales, as well to propose adjustments to their legal framework. As a result, the Commission published a report concluding that "[t]he current legal status of assisted suicide is inadequate and incoherent," and that "there is a strong case for providing the choice of assisted dying for terminally ill people." (CAS, 2011, p. 19) The Commission was composed mainly of experts in different fields, such as law, medicine, palliative care, social care, mental health, disability, and theology, and its conclusions toward law reform were supported almost unanimously, with the exception of Reverend Canon Dr. James Woodward, "who believes that until greater ethical, moral and social consensus has been generated on this issue, it is not the right time to consider a change in the law." (CAS, 2011, p. 20)

According to the Commission's report, the need for new legislation on assisted suicide derived from a unique situation in England and Wales due to the contrast between the letter of the law, as stated in the Suicide Act 1961, and the Director of Public Prosecution's [DPP] policy with regards to assisted suicide—the consent of the DPP is needed to open any prosecution. In 2010, the DPP issued an "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" (DPP, 2010), which weighs the public interest both in favor and against prosecution. This policy was the outcome of a judicial review brought up against the DPP by Debbie Purdy, who requested clarification over the office's prosecution policy in relation to assisted suicide (Harper, Kelly, & Khanna, 2015; Rehmann-Sutter & Hagger, 2013; Richards, 2014, 2017; Ward, 2015). Since the publication of the DPP's policy, the Commission's report noted, over 40 cases of assisted suicide have been reported, although none of them resulted in prosecution—leading to a "public perception that assisted suicides that meet the criteria stipulated by the DPP policy are decriminalised." (CAS, 2011, p.

23) This public perception pairs with a source of legal uncertainty, since the DPP's policy diverges from the Section 2 of the Suicide Act 1961.

The Commission proposed that any person aged 18 or over, diagnosed with a terminal illness, should be allowed to request an assisted death. The applicant would also have to be of sound mind and able to make a voluntary and informed decision. A set of safeguards, such as independent assessments of at least two physicians, as well as regulatory oversight, was suggested. The report added: "We also recognise that new legislation would be only one (albeit very important) piece of the picture. Professional training, guidance and support are essential features of all assisted dying regimes to promote responsible, exemplary practice and adherence to the spirit and letter of the law." (CAS, 2011, p. 21) The so-called Lord Falconer's Assisted Dying Bill, which was based on the Commission's report, was then introduced in the House of Lords in 2013. In its Second Reading, Lord Falconer said:

> My Lords, in the last stages of a terminal illness, there are people who wish to end their life rather than struggle for the last few months, weeks, days or hours. Often it is not the pain that motivates such a wish, but the loss of independence and dignity. Those who love them often try to help, sometimes by going with them to Switzerland. Nobody wants assisters who are motivated by compassion to be prosecuted. The courts and the prosecution authorities recognise this impulse and have tried to steer a course between Section 2 of the Suicide Act 1961 and the desire not to enforce it. But the current situation leaves the rich able to go to Switzerland, the majority reliant on amateur assistance, the compassionate treated like criminals and no safeguards in respect of undue pressure. Many people, caring so much for those they leave behind, are dying earlier and alone because they fear implicating their loved ones in a criminal enterprise. They hoard pills or put a plastic bag over their head when they are alone. It is time for a change in the law, but only a very limited and safeguarded change[44].

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[44] Transcript available on: https://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/140718-0001.htm. Last accessed 13th June 2018.

After being passed at its Second Reading in the House of Lords in 2014, Lord Falconer's Bill was amended by Lord Pannick's suggestion of extra judicial oversight[45], but no further progress was made on the bill due to a scheduled General Election. Rob Marris MP, however, introduced Lord Falconer's Bill as a private member's bill in the House of Commons shortly after the General Election, but it was voted down at its Second Reading by 330 to 118 votes in 2015. In turn, Scotland, despite being part of the United Kingdom, is not directly affected by both Westminster law and the DPP's policy on the topic. There is no law on assisted suicide in Scotland, since the Suicide Act 1961 encompasses only England and Wales. Although not on official books, Lord Carloway, head of the Scottish judiciary, stated in an opinion published in 2016 that despite not having a specific law on assisted suicide, the act of assistance may fall under different criminal offenses, such as reckless endangerment of life or even murder[46].

So whereas the United Kingdom, Switzerland, and Germany do not consider suicide a crime, they still inscribe assistance to it within the realm of criminal law—albeit with different sets of criteria as to what constitutes such an offense. By doing so, these countries reinforce their alleged obligation toward the protection and preservation of life. The social life of the Swiss legislation on assisted suicide from its first draft through Article 102 to Article 115 StGB denotes that this specific protection was not based on consensus, and that there were concerns about the risk of overextending the law. A similar concern was addressed during the *Bundestag* debate

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[45] Transcript available on: https://www.publications.parliament.uk/pa/ld201415/ldhansrd/text/141107-0001.htm. Last accessed 13th June 2018.

[46] Lord Carloway stated: "The criminal law in relation to assisted suicide in Scotland is clear. It is not a crime 'to assist' another to commit suicide. However, if a person does something which he knows will cause the death of another person, he will be guilty of homicide if his act is the immediate and direct cause of the person's death. (…) Depending upon the nature of the act, the crime may be murder or culpable homicide. Exactly where the line of causation falls to be drawn is a matter of fact and circumstance for determination in each individual case. That does not, however, produce any uncertainty in the law." Transcript available on: https://www.scotcourts.gov.uk/search-judgments/judgment?id=363108a7-8980-69d2-b500-ff0000d74aa7. Last accessed 11th June 2018.

in Germany, where some members of the parliament expressed concerns over reconciling an official law on assisted suicide with already granted individual rights. During her speech to the *Bundestag*, Petra Sitte said:

> People in this country want to live their self-determination. With a prohibition or an aggravation of the criminal law, the *Bundestag* would be restricting essential self-determination rights stemming from article 1 of the Basic Law [constitution]. And to the dignity belongs not only their life and its self-determined character, but also their death and dying[47].

Similarly, Hermann Gröhe questioned:

> How do we bring together the obligations of our legal system to protect the dignity and life of the people and to respect their self-determination? (…) So it is very legitimate to ask: what is the state allowed to do?[48]

As seen by the state, *life* is something to be protected and preserved, but to reconcile these goals with constitutional rights of self-determination poses a challenge: how far can the state go in order to reconcile its perception of *life* as an all-encompassing, anonymous value, with particular lives that enjoy constitutional rights of self-determination? However, the legal landscape of assisted suicide is not only composed of official laws. As Michael Brand addressed during his opening remarks in the *Bundestag* session, the German Medical Association [*Bundesärztekammer*], as

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[47] *"Menschen in diesem Land wollen ihre Sinnwelten und ihre Selbstbestimmung leben. Der Bundestag würde mit einem Verbot oder mit einer Strafrechtsverschärfung essenziell Selbstbestimmungsrechte aus Artikel 1 des Grundgesetzes einschränken, und zur Würde des Menschen gehört eben nicht nur sein Leben und dessen selbstbestimmte Gestaltung, sondern es gehören auch Sterben und Tod dazu."*

[48] *"Wie bringen wir die Verpflichtung unserer Rechtsordnung zusammen, Würde und Leben des Menschen zu schützen und seine Selbstbestimmung zu achten? (…) Da ist es sehr legitim, zu fragen: Was darf der Staat?"*

well as state associations [*Ärztekammer*], play a role in the writing and implementation of regulations that govern the participation of physicians in assisted dying procedures—a situation that can likewise be extended to Switzerland and the United Kingdom. Oftentimes medical guidelines and professional regulations coincide with official law, but time and again they do not—as is the case in many German federal states following the implementation of the §217 StGB. The complexity of assisted suicide from a legal viewpoint lies not only on its legal status —its legality or criminalization—, but also on medical guidelines and regulations that are binding to physicians, but not to their patients.

2.3 Medical life

From the standpoint of medical regulations, the role of physicians on assisted suicide is far from consensual. In some jurisdictions, such as Scotland and the UK in general, medical regulations coincide with official law, but in others the landscape is more challenging to navigate. In such contexts, laws do not necessarily coincide with each other, often positioning official and medical laws on opposing sides. As a consequence, physicians in jurisdictions where assisted suicide can be lawfully practiced because of official law end up distancing themselves from any form of assistance offering due to the fear of losing their medical licenses. In both the UK and Scotland, where assisted suicide is criminalized, respectively, under Section 2 of the Suicide Act 1961 and other criminal offenses such as reckless endangerment of life, medical regulations tend to coincide with official law.

While the Commission on Assisted Dying was in place, they received a number of evidence submissions, one of which was from Paul Philip, then Deputy Chief Executive of the General Medical Council [GMC]. Whereas the British Medical Association [BMA] stated in a letter to the Commission that its policy is "firmly opposed to assisted suicide and to doctors taking a role in any form of assisted dying," (CAS, 2011, p. 84) Philip said that the GMC does not have a specific policy, but that physicians "must follow the law" and that "assisted dying is unlawful." (CAS, 2011, p. 84) The British Medical Association represents over 200.000 doctors from all over the UK, covering almost half of all registered physicians in the country—including Scotland. As Ward (2015, p. 32) notes, its stance on assisted suicide has shifted over the years: in 2005, its annual representative meeting recognized that there were different positions on assisted suicide within society, agreeing that it should be up to the parliament to legislate on the issue, thus adopting a neutral stance toward it. A stance that was reverted back to "oppose" in 2006. In 2016, the BMA reinforced its opposition to assisted suicide, although one third of its members supported the retaking of a neutral stance.

If in the UK and Scotland the official position of medical associations coincide with the letter—or spirit—of official law, the situations in Switzerland and Germany are somewhat different. One of the particularities of Swiss law is that Article 115 StGB does not stipulate assisted suicide as a medical remit, nor does it prescribe any role for physicians on organized suicide assistance (Andorno, 2013; Hurst & Mauron, 2003; NEK-CNE, 2005). The article, after all, was not written with the purpose of legislating on medically assisted suicide, but to protect the assisting "friend." If we consider the history of Swiss organizations, only a few, such as LifeCircle, was founded by physicians—Dignitas, for instance, was founded by Ludwig A. Minelli, a lawyer, and EXIT's first proponent was Hedwig Zürcher, a retired teacher. But all of them end up involving physicians one way or another.

Until 2018, the Swiss Academy of Medical Sciences [SAMS] considered that the task of physicians at the end of life "is to alleviate symptoms and to support the patient" and not "to directly offer assistance in suicide." (SAMS, 2013, p. 9) But in the same guideline the Academy recognized that

> 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. This dilemma requires a personal decision of conscience on the part of the physician. The decision to provide assistance in suicide must be respected as such. In any case, the physician has the right to refuse help in committing suicide (SAMS, 2013, p. 9).

In a similar way to the vote at the *Bundestag*, where the issue was acknowledged as a matter of conscience, the SAMS considered that when faced with end-of-life requests physicians should act according to their conscience and preserve their right of refusal. In 2018, however, the SAMS published new guidelines on assisted suicide, but this time recognizing that "assisted suicide is not a medical action to which patients could claim to be entitled; it is, however, a legally permissible activity." (SAMS, 2018, p. 22) According to the SAMS: "If an autonomous desire for suicide persists in a patient who has been carefully informed and assessed, a physician may—on the basis of a decision for which he or she is personally responsible—perform assisted suicide." (SAMS, 2018, p. 23) To this end, physicians must follow certain requirements, making sure of (1) the patient's mental capacity to make such a request; (2) the absence of external pressure and that the request was well-considered; (3) the existence of intolerable suffering; (4) that medical treatments have been previously pursued or proved ineffective and/or rejected by the patient; (5) that the request is justifiable to the physician on the basis of the patient's history and overall circumstances (SAMS, 2018, p. 23).

Swiss organizations, despite not being obligated by Art. 115 StGB to involve physicians during the course of procedures, rely on them for access to the necessary pharmaceuticals. In this sense, as EXIT's director, Bernhard Sutter, once told me, "in Switzerland assisted suicide is always medically assisted, meaning that the doctor has to prescribe the medication." And although he wished that physicians were always present during procedures, he knew time would be scarce for this. Thus, medical participation, despite not being a legal requirement, remains a practical reality. In Switzerland, assisted suicide procedures are carried out with sodium pentobarbital, a barbiturate that requires a medical prescription and is subjected to the Swiss Narcotics Law—the *Betäubungsmittelgesetz* [BtMG]. According to Art. 11 of the Swiss BtMG, medical doctors (as well as veterinarians) can only prescribe and administer narcotics in accordance to "recognized rules of medical science."[49] Such rules might refer to Health Law, which regulates medical practice on Swiss cantons, as well as to a number of court decisions regarding the role and limits of medical involvement in assisted suicide (Griffiths et al., 2008). Two of such decisions, from the Zurich and the Aargau Administrative Courts, reached in 1999 and 2005 respectively, determined that physicians must assess the competence of their patients who request suicide assistance (Griffiths et al., 2008, p. 473).

By inhabiting this legal landscape, physicians in Switzerland are then able (if they accept to do so, following the SAMS' guideline) to prescribe pentobarbital (if in compliance with recognized rules of medical practice, as stated in the BtMG) to patients (if their competence to make this decision is verified after careful medical assessment, following court rulings by Zurich's and Aargau's Administrative Courts) as long as they are not influenced by selfish reasons (Art. 115 StGB). In this manner, even though the cooperation of physicians is not a legal requirement for organized assisted suicides in the country, they are both a channel to pentobarbital and a way of assessing an applicant's competence.

In Germany, the legal landscape is likewise not restricted to official law. Even before the passing and implementation of the §217 StGB, assistance to suicide was already subjected to a series of regulations, from Narcotics law—that imposed restrictions of access to specific barbiturates used in the procedures, particularly

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[49] In the original, Art. 11 of the BtMG states the following: "*Die Ärzte und Tierärzte sind verpflichtet, Betäubungsmittel nur in dem Umfange zu verwenden, abzugeben und zu verordnen, wie dies nach den anerkannten Regeln der medizinischen Wissenschaften notwendig ist*." — "Physicians and veterinarians are obliged to use, administer, and prescribe narcotics only to the extent required by the recognized rules of medical science.": The BtMG is available here: https://www.admin.ch/opc/de/classified-compilation/19981989/index.html. Last accessed 11th June 2018.

pentobarbital—to medical norms regulating the participation of physicians on end-of-life procedures. When it comes to the latter, there are currently 18 different medical associations in Germany, the federal one [*Bundesärztekammer,* or BÄK] plus one for each German federal state[50] [*Ärztekammer*]—therefore leading to 18 different sets of norms on the same issue. Norms that are binding only to registered members of each association, but which nevertheless help compose a landscape of contradictory, although not overlapping, provisions on the possibility of medical participation on assisted suicide procedures[51].

In 2007, a physician from Berlin, Dr. Uwe Arnold, launched a website where he publicly voiced his support for assisted suicide, disclosing that he had already helped patients to die[52]. Following his disclosure, the medical association of Berlin tried to impose sanctions against him, setting a fine of 50.000 euros in case he provided suicide assistance once again. In 2011, the *Bundesärztekammer* adopted an official stance on assisted suicide, stating that "[a]ll physicians have to assist dying persons under full protection of their dignity and their will. Direct active euthanasia, killing a patient on request, is forbidden. Physicians are not allowed to help with

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[50] The exception being *Nordrhein-Westfalen*, which has two regional associations, one for *Nordrhein* and one for *Westfalen-Lippe*. Hence the 18 associations.

[51] There are different types of quasi-normative products in the medical context. *Richtlinien*, which are grounded on a legal basis; *Leitlinien,* which have no legal basis and act strictly as recommendations; *Empfehlungen,* that is, recommendations to medical professionals, and Stellungnahmen, statements that convey opinions on specific issues. In this sense, when it comes to norms implemented by regional medical associations, "rules" will be used to stress their binding quality to registered physicians. The differentiation between different types of norms is further explained here: http://www.bundesaerztekammer.de/richtlinien/. Last accessed October 2018.

[52] This story can be also read here: https://www.nvve.nl/files/5714/6530/4430/Referat-SM-2016-05-12-NVVE-Amsterdam.pdf. Last accessed 11th June 2018.

suicide."[53] As a response to BÄK's stance, each of the regional associations drafted their own guidelines, resulting in a split: 10 out of the 17 associations ended up restricting the involvement of their members in assisted suicide. In 2012, the Administrative Court of Berlin sided with Dr. Arnold, ruling that his rights under articles 4 and 12 of the country's constitution, respectively the right for freedom of belief and conscience and the freedom to practice a profession, are above professional law.

In July 2015, during the first debate on assisted suicide at the *Bundestag*, members of parliament such as Dr. Carola Reimann, Katherina Reiche (CDU/CSU), and Sylvia Kotting-Uhl (*Bündnis 90/Die Grünen*)[54] addressed this plurality of medical regulations, as did Dr. Karl Lauterbach, who is also a physician and coauthor of one of the bills. He said during the debate:

> This law [the bill proposed by Michael Brand and Kerstin Griese, later on the §217 StGB] will lead to doctors no longer providing assistance to suicide. I start with myself: I am a member of an association that threatens to withdraw my medical license if I do so. This is the Medical Association of North Rhine; Perhaps I could still say: 'Okay, I can risk it, I don't necessarily need the license anymore.' (…) But what if I am threatened with three years' imprisonment?[55]

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[53] In the original, §16 of the *Berufsordnung* states that: "*Ärztinnen und Ärzte haben Sterbenden unter Wahrung ihrer Würde und unter Achtung ihres Willens beizustehen. Es ist ihnen verboten, Patientinnen und Patienten auf deren Verlangen zu töten. Sie dürfen keine Hilfe zur Selbsttötung leisten.*". The guideline can be read here: http://www.bundesaerztekammer.de/fileadmin/user_upload/downloads/pdf-Ordner/MBO/MBO_02.07.2015.pdf. Last accessed 11th June 2018.

[54] Alongside Dagmar G. Wöhrl (CDU/CSU) and Dr. Eva Högl (SPD), who also made the same comment.

[55] Lauterbach's quote, in the original: "*Dieser Gesetzentwurf wird darauf hinauslaufen, dass Ärzte Sterbehilfe nicht mehr leisten. Ich fange mit mir selbst an: Ich bin Mitglied in einer Kammer, die für den Fall, dass ich das machen würde, mit dem Entzug der Approbation droht. Das ist die Ärztekammer Nordrhein; da bin ich registriert. Da würde ich vielleicht noch sagen: Okay, das riskiere ich, ich brauche die Approbation nicht unbedingt, und es ist auch noch so: Es wird nicht durchgezogen. Vielleicht komme ich damit durch. Aber wenn mir möglicherweise drei Jahre Haft drohen?*"

As Lauterbach put it, by going against binding rules of his association's *Berufsordnung*[56] he would risk losing his medical license; by going against the soon-to-be implemented official law, he could end up in prison. So, if the legal pluralism in regards to assisted suicide in Germany was then composed of a complex set of 18 different medical regulations and the Narcotics Law [BtMG], the *Bundestag* vote was about to rearrange this situation. Before the 217 StGB, physicians were the only ones subjected to this pluralism, being bound by the rules of their respective regional associations. Despite the coexistence of these 18 sets of rules in regards to assisted suicide, each physician was subjected to only one of them—since the BÄK's *Berufsordnung* lacks binding quality. Therefore, while these rules coexisted within one federal jurisdiction, they did not at state level—which prevented them from overlapping, regardless of their different and contradictory provisions.

"Legal reality," Griffiths notes, is "an unsystematic collage of inconsistent and overlapping parts" (1986, p. 4). It is a meshwork of intertwined norms that oftentimes coincide with each other, but that have different reach and are binding to different subjects. In Germany, if the legal landscape was indeed one composed of contradictory parts, such parts were hardly overlapping. But even if, as part of professional law, medical norms are only binding to registered members of each association, they affected the landscape as a whole by making it more complex to find doctors willing to provide assistance. Therefore, even though assisted suicide was already regulated prior to the implementation of the §217 StGB, these contradictory rules were binding only to certain medical professionals. The criminal code, on the other hand, is all-encompassing within a specific jurisdiction. Consequently, the implementation of the §217 StGB has reshaped the landscape by imposing overlaps in situations where professional law authorizes medical participation in suicide assistance, but the criminal code does not.

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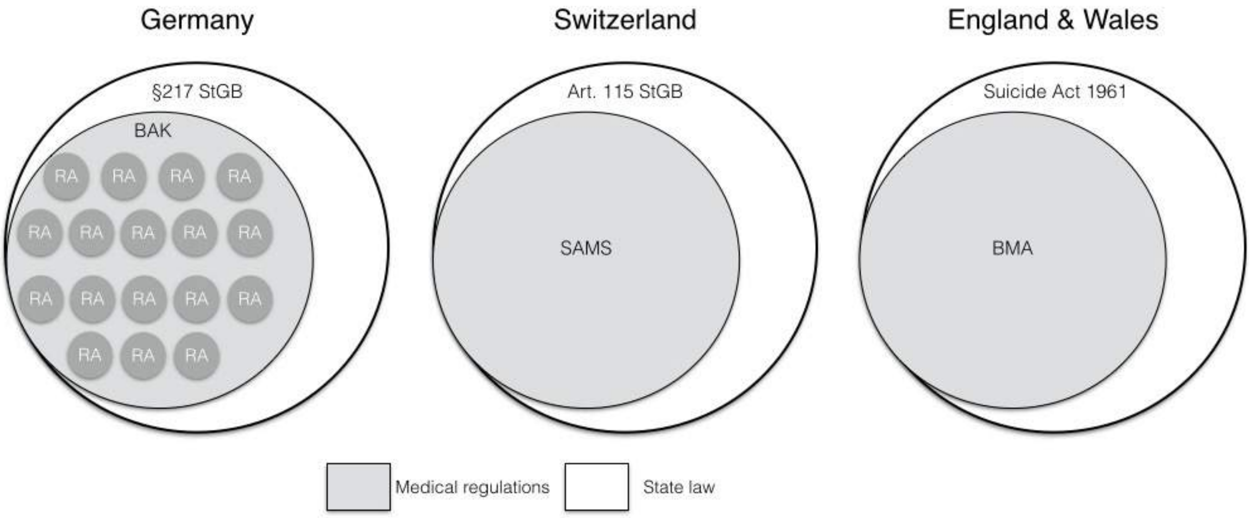
[56] Its binding quality is stressed here: https://www.aekno.de/page.asp?pageID=123. Last accessed October 2018.

Renate Richter, a German professor of criminal justice who publicly criticized the §217 StGB by qualifying it as unconstitutional, is a critic of the German Medical Association's stance. During one of our conversations, Richter said that under the tenure of Dr. Montgomery, BAK's president, the association acted as if assisted suicide was illegal in the country—which was not the case before the §217 StGB. The *Bundestag*, in her view, did the same. Prof. Richter's criticism is based on what she calls the "Montgomery way," that is, the attempt to make it look like as if medical rules are binding to persons offering assistance to suicide as well. So, according to her, the danger relies on medical associations turning their professional ethics into professional law, or overextending its reach to non-medical professionals.

Following Richter's argument, one of the core concerns regarding the legal pluralism regulating assisted suicide in Germany is now one of reach and scale among different normative orders. That is, if before the approval and implementation of the §217 StGB contradictory norms used to coexist within a federal jurisdiction, after it, because of their different reach, some rules are now subjected to other rules, thus enabling the possibility of overlaps. As Tamanaha (2008, p. 375) argues, this situation of "overlapping bodies of law" might lead to conflicts for "individuals and groups in society who cannot be sure in advance which legal regime will be applied to their situation," a circumstance similar to Prof. Richter's suggestion that Dr. Montgomery was trying to make it look as if professional law was binding to everyone, physicians and non-physicians alike.

2.4 States of uncertainty



LEGAL PLURALISM: OFFICIAL AND NON-OFFICIAL LAWS

> The long dominant view that law is a unified and uniform system administered by the state has erased our consciousness of the extended history of legal pluralism. (Tamanaha, 2008, p. 376)

Uncertainties regarding laws and their applicability have permeated Margot's trajectory. When she decided to go to Switzerland instead of staying in Hamburg, she opted for a jurisdiction where her wish to pursue an organized, professionally assisted suicide, was easier to be carried out. She chose one jurisdiction over another, one where the legal landscape was simpler to navigate. However, her closest friend was afraid of accompanying her to Switzerland for she feared being subjected to prosecution upon her return to Germany. To avoid this, she told Margot she would only go with her as long as she remained anonymous, a condition LifeCircle's policy vetoed—everyone present in a procedure will have their names made available to Swiss authorities. Margot decided to go without her. Her friend's fear of prosecution was based on the §217 StGB, which was drafted to address assisted suicide as a "cross-border service,"[57] thus allowing the possibility of prosecution even if the procedure occurs outside of Germany. The bill stated that the "place of the crime"[58] has to be taken into consideration and corresponding sanctions might range from trade to criminal ones[59]. It was a new law, and uncertainty over its reach and applicability was a cause of concern and uncertainty.

The legal pluralism of assisted suicide, in association with the affective imaginaries regarding the role of the state, open up space for the possibility of mobility, whereupon people try to choose a jurisdiction where it would be easier to carry out an assisted suicide—just like Margot did. In a similar way to Keebet von Benda-Beckmann's notion of forum shopping (1981), Margot shopped for one specific jurisdiction over another. Already as a member of LifeCircle, she balanced the risks and difficulties of carrying out an assisted suicide in the post-§217 StGB Germany with the hurdles of enduring a train ride from Hamburg to Basel, including all of the costs associated with both the journey—mostly train ticket and accommodation—and the procedure itself. If, on the one hand, Margot's circulation through jurisdictions made it possible for her to pursue organized suicide assistance, on the other hand it made her do it without the company of her closest friend, who feared being subjected to prosecution in Germany. They would both physically leave the jurisdiction of the German criminal code, but Margot's friend would have to return to it afterward—possibly being liable to prosecution.

Just like applicants for assisted suicide, professional assistants have also been affected by the uncertainties and suspicions caused by the new legal landscape. One of such assistants, Stefan, worked in northern Germany. As I walked out of the Central Station toward the café where we agreed to meet, I saw a man waving at me.

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[57] "*Grenzüberschreitende Dienstleistung.*"

[58] "*Tatort.*"

[59] Deutscher Bundestag, 18. Wahlperiode, Gesetzentwurf, [2015] Drucksache 18/5373 (Ger.), pp. 24-25.

We had never seen each other before and had only contacted via email. He was sitting outside, enjoying the warm weather of summer—despite occasional, but persistent light rain. In his sixties, he had gray hair and a beard, and was wearing oversized clothes, *Birkenstock* and dark socks. For many years, Stefan worked in cooperation with a Swiss organization that provided suicide assistance, but now he was assisting people privately. Since the implementation of the §217 StGB, Stefan was being more discreet with his assistance offering—although he only performed this task exceptionally and not as his main occupation. Now constantly cautious, he refrained from signing documents in relation to the research and from having his voice recorded.

Looking constantly at passersby, as if to make sure no one was watching us or eavesdropping, Stefan shared that since December 2015 he had been somewhat involved in three suicide assistances. In two of them the applicants wanted to die at home, in Germany. It was the case of a man diagnosed with amyotrophic lateral sclerosis (ALS), and a woman who was involved in a car crash and had had many health complications since then. The third assistance—and the only one that has actually been carried out by the time we met—was of a woman he accompanied to a Swiss organization. Because of his fears and doubts about the new law, not knowing exactly whether he would fall into the "businesslike" criteria—since, despite not being his main occupation or a source of income, his assistances were not exceptionalities—, Stefan was now being more resistant to accepting requests. As he said to me, he was deciding "emotionally" on whom to assist, hearing their cases and assisting only people he sympathized with. He had recently refused to assist two applicants.

In the post-§217 landscape, Stefan was not only being extra careful with his assistance offering, but also suspicious toward the state. He was afraid of being arrested because of a law he did not fully understand. Stefan's confusion and uncertainties about the §217 StGB crafted a skepticism toward the state that produced it, making him question its ambiguity in passing a law that criminalizes businesslike operations with assisted suicide while, at the same time, allowing exceptions under specific circumstances. Carey (2017) alerted to the fact that mistrust, rather than being a "social acid" (2017, p. 2) that merely corrodes social bonds, can also be a generative force. It can build relations, not only destroy them. This sense of mistrust, then, cannot be defined solely as a negative of trust, but as a quality in and of itself. Stefan's mistrust toward the state and the §217 StGB made him apprehensive, cautious, to the extent in which he needed to rethink the ways through which he offered assistance, making it more discreetly. His general sense of mistrust encapsulated a new law that he did not fully understand, but which made him perceive his assistance as possibly, but not surely, illegal.

Suspicion and doubt, Asad (2004, p. 285) writes, occupy "the space between law and its application," to the point of "all judicial and policing systems of the modern state" presupposing "organized suspicion, incorporate margins of uncertainty." And suspicion goes both ways, explaining the reasons why laws—which are more often than not unknown, misunderstood, and rarely read—exert such an impact on those subjected to it and, on the other hand, why investigations over its breach are initially based on suspicions of wrongdoing. When it comes to the impact laws exert on people, it does so precisely because of the uncertainty they cause, and not despite of it. It is the uncertainty and suspicion over their applicability and reach that amplify their impact: despite the §217 StGB, Margot could have sought nonprofessional assistance in Germany, or her friend could have travelled with her to Switzerland to keep her company, but doubts over the content of the then newly approved law prevented these actions from taking place. The uncertainty of laws—or the illegibility of legal rules (Das & Poole, 2004)—has an impact on how people engage with them and how the state—where the authority, or force of law, ultimately comes from—is perceived and imagined on day-to-day life.

And it is precisely by questioning how the state becomes a subject in everyday life that Aretxaga (2003, p. 395) writes that there is a fiction mirror, whereupon the state in its multiple representations has its own fantasies about the people, while the latter imagine the state in different ways. It is a question of mutual, yet divergent, legibility. Considering this fiction mirror where the relation between state and people is mediated by mutually divergent imaginaries, the state—in the context of this legal pluralism on assisted suicide—is often perceived through uncertainties and a general sense of mistrust. And as Carey (2017) argued, mistrust does not emerge out of particular situations, but precede them as an *a priori* disposition. A disposition that can come precisely out of uncertainties regarding laws, such as the ones composing this legal pluralism. On the ground level, the legal illegibility of this pluralism ends up, similarly to Yonucu's (2017, p. 9) research context, making "law an utterly inconceivable force" that "actively produces ambiguity."

In this sense, following the approval by the *Bundestag* of the §217 StGB, Germany has seen the ratification of its first official law on assisted suicide. Consequently, if until 2015 Germany's legal landscape on assisted suicide was the outcome of the interplay of a series of non-official and official laws which were binding to different people and had distinct jurisdictional reach, the adding of the §217 StGB drastically reshaped this landscape. The impact of the new law was immediate: *Sterbehilfe Deutschland* stopped providing assistance and some Swiss organizations, such as EXIT, stopped their contacts with German members. But confusion about its content, reach, and applicability has led to affective responses to the law. Fear and uneasiness; mistrust and disbelief. A general sense of uncertainty that emerged out of this legal pluralism and shrouded assisted suicide with an affective tone of illegality.

Consequently, the new legal pluralism was one of overlaps. Physicians could now be subjected to an interplay of conflicting norms, being allowed by professional law to do something the criminal code sanctions. Thus, uncertainties about the laws composing this legal pluralism, be it in relation to their reach, impact, or content, crafted an image of the state forged in uncertainties and suspicions, a sense of mistrust that impacted the ways suicide assistance is both provided and applied for. This governance—triggered by the lack of previous applications of the law and its ambiguous content—not only crafted an affective image of the state, but also reshaped the ways suicide assistance is provided, fostering acts of transnational mobility. In this sense, the inclusion of the §217 StGB to this legal pluralism has not only triggered overlaps that previously did not exist, but also produced an affective environment within which the legal quality of assisted suicide was ambiguously uncertain. While the law is new, and there is always some degree of uncertainty on how to enforce newly implemented laws, the divisive quality and moral ambiguity of organized assisted suicide—as the debated conducted by MPs at the *Bundestag* implied—is translated into the text of §217 StGB, thus inscribing this ambiguity in the plural legal landscape.

If, on the one hand, an anonymous *life* was the object of protection of these legal encapsulations, on the other hand these protections can only be enforced when a particular life is threatened—such as Margot's. When she started her application process by gathering medico-legal documents, her trajectory ended up exposing a regime—an all-encompassing space of negotiating practices (Tsianos & Karakayali, 2010, p. 375)—within which caring responses can be triggered upon perceived threats against *life*. A regime where the distinction between life and death is vital, thus making a person's voluntary and processual transition from the former to the latter the target of caring responses by state and medical agents. Whereas this chapter drew a legal background for this landscape of assisted suicide based on the protection of *life* as a value, the following chapter focuses on how personal lives come to matter in light of this legal pluralism—from law to jurisprudence; from abstract lives to particular ones; from regulations over life to their impact on personal lives (Fassin, 2009, 2010).

3. A LIFE THAT COMES TO MATTER: FROM LEGAL PLURALISM TO REGIMES OF LIFE

Gültig bis Ende	Monat	Jahr	Monat	Jahr	Monat	Jahr	Merkzeichen
	unbefristet gültig						

Sondervermerke des Landes

Schwerbehindertenausweis

für [redacted]
(Familienname)

[redacted]
(Vornamen)

geboren am: [redacted]

Az: [redacted] Hamburg, den [redacted]

Im Auftrage

Behörde für Soziales, Familie,
Gesundheit und Verbraucherschutz

[redacted]
(Ausfertigende Behörde, Unterschrift)

Bundesdruckerei
7. 01 - 64008/0000

MARGOT'S CERTIFICATE OF DISABILITY

It was about 20 minutes after Margot's assisted suicide that Dr. Preisig decided to notify the authorities. She had already explained to me that it is always necessary to wait a few minutes before calling the police as a way of avoiding any attempt to reanimate the body. Even though what had just happened was not a criminal offense under Art. 115 of the Swiss criminal code, she argued that the police claim a positive obligation to protect life and would therefore try to reanimate the body if there were any chances of survival. Margot's death needed to be irreversible. I was by her side throughout the procedure, and at that moment, roughly 20 minutes later, her death seemed real enough to me. Her skin was no longer white, but pale. Her hands got cold. As her body changed by the second, everything around her continued to move, to live. And while she was silently lying still, what had initiated as a voluntary procedure had suddenly turned into a potential *Tatort* [crime scene]. Nothing was to be moved before the authorities arrived, and when they finally did, it became clear to whom Margot's life and death mattered.

As soon as Margot's procedure was over, the atmosphere in the room changed. It was no longer the same place as before, where the realization of what was about to happen seemed to be shrouded by an unexpected veil of happiness, if not sheer relief. From the moment she joined us in the car until the very end, Margot was constantly chatting, telling stories and laughing at anecdotes. She cracked jokes and dispensed life advices. She even complained that I had forgotten to show her a recent picture of my niece, which I had promised over dinner in the previous night. Differently from what I had initially expected, her attitude created a light atmosphere, as if nothing out of the ordinary was about to happen. Never mind the amount of documents next to her, the fact that we were not in Hamburg, or the small bottle of sodium pentobarbital with her name on it, it was just another day in Margot's life. From the outset, she wanted everyone there to feel comfortable, at ease with the situation. An atmosphere she ably created, but one that did not outlive the procedure's conclusion.

For a few minutes after Margot's death, no one there spoke a single word. Silence seemed to reign supreme, as if any noise would suddenly be amplified tenfold. While I was trying to make sense out of my emotions, holding back tears I was not sure were mine to cry, the atmosphere became delicate. It was no longer relaxed, but gentle. Fragile. When words started to be once again heard, they were mere whispers. It appeared as if Margot was simply sleeping and we were trying hard not to wake her up. While waiting for the right time to notify the authorities, Dr. Preisig was occupying herself with the documents she would have to present to the police officers and the state prosecutor. Meanwhile, her assistant went on to upload the video footage of the procedure to the computer—and I was walking around in circles. Once Margot's death was irreversible and the paperwork was set, Dr. Preisig proceeded to call the police and notified them about the assisted suicide. With the exception of the documents, which were further organized after the procedure, everything was exactly as before. No equipment was moved and Margot continued to steadily rest in bed.

Regimes of life can be subtle, if not imperceptible. Sometimes they manifest themselves through acts of care, even resorting to police action and psychiatric sectioning. Stevenson (2014, p. 3) defines care "as the way someone comes to matter and the corresponding ethics of attending to the other who matters." It is not, thus, a matter of good intentions or necessarily a positive aspect, but rather a complex, messy, and ambivalent set of relations within which one can come to matter for various reasons. Margot's assisted suicide, once notified to the authorities, triggered caring reactions that exposed a specific regime of life that already existed, although not as evidently. Even before the procedure, her life—albeit framed as an anonymous one—was already encapsulated by several laws aimed at its protection, and she had faced considerable difficulties with state authorities and medical professionals throughout her application process. She was already living a project where staying alive was the main goal, but it was only after her death that this relation became evident. When the police, the coroner, and the state prosecutor arrived at the scene, it was explicit that her death—and life—mattered to them.

Over the course of the short investigation that followed Margot's assisted suicide, the state prosecutor had to question everyone present, including me. He invited me to sit next to him on a round table in the organization's office, a separate room from where the procedure had taken place. Despite being routinely performed, investigations of this kind install an atmosphere of suspicion. The authorities needed to make sure the occurrence was indeed an assisted suicide, one that was both applied for voluntarily by the member and assisted altruistically by the organization —only then the OAS would be in accordance with Swiss law. But knowing that everything was in order did not prevent a different atmosphere from setting in. One that made each and every one of my answers be pantomimed by involuntary, yet persistent, shaky hands.

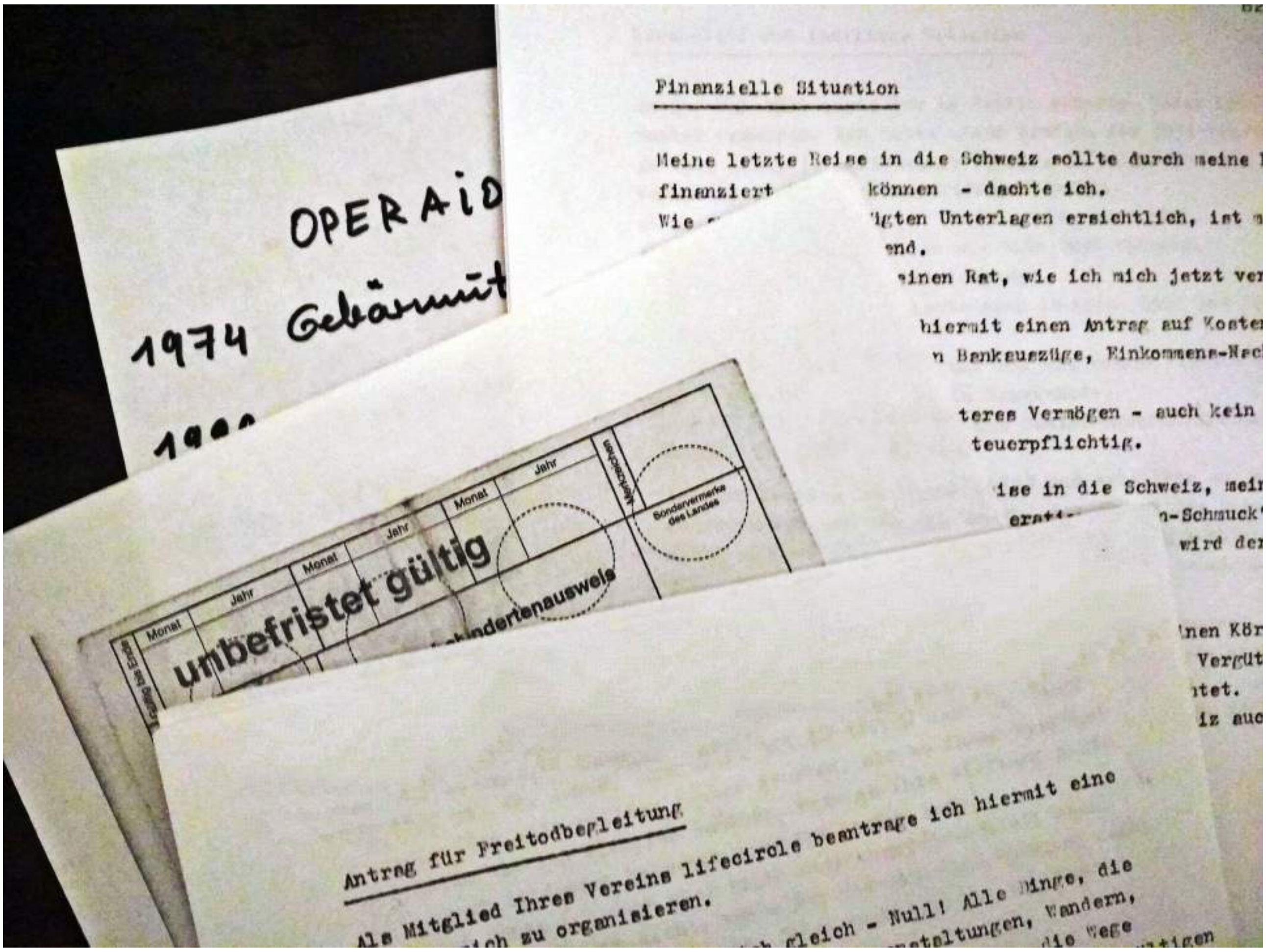
The state prosecutor went on to question not only the nature of my relationship with Margot, but of my research itself. Expected questions, such as how, when or under which circumstances I had first come into contact with Margot, were interlaced with ones regarding the content of my writing. He even came to question what and why I was going to write about assisted suicide. Besides the questioning, he checked and made a copy of my passport, which is common procedure in such investigations—but one that did not contribute in making the atmosphere any lighter. Anthropology has been dealing with different ways of perceiving, imagining, and capturing the state empirically for a long time, and despite conceptual divergences on what the state is, I could not help but think that this thing we call the state (Das & Poole, 2004) was there, by my side, posing questions while staring inquisitive at my dancing hands.

Together in the same room, next to Margot's body, the state was wearing uniform and medicine was carrying an examination bag. Their presence created a charged atmosphere composed of a mix of uncertainty, suspicion, and inquiry. The authorities were asking questions and checking the body. Knowing who comes after the suicide enables us to circumscribe those to whom her life came to matter, but it is only by reverse engineering her trajectory, by tracking back her application process, that we can perceive how this regime of life was dramatized—how it was put in motion via acts of care. From the moment she became a member of LifeCircle to the request and preparation of the actual procedure, Margot had to live this regime through several personal interactions, as well as by producing and gathering a number of documents requested by the organization—and it was precisely these documents that the police and the state prosecutor were after when they arrived at the organization.

Whereas the coroner occupied himself exclusively with Margot's body, examining it in order to assess both the cause and the time of her death, the state prosecutor and the police officers were checking each one of the documents previously submitted by her. They wanted to make sure that the request for the procedure had been made voluntarily and that she was of sound mind, able to have made this decision on her own—and the documents she presented were the posthumous tools to assert this. At LifeCircle, as well as in most organizations that provide suicide assistance, each individual process starts with applying to a provisional green light, that is, the authorization to carry out the procedure with the organization's assistance. An authorization that is granted—or denied—by the organization itself and has the production, gathering, and circulation of documents in its very core. In order to apply for the green light, one needs to collect documents that can only be given after interactions with family doctors and state officials, and later on submit them to the organization—which, in its turn, circulates them forward.

Along these lines, this chapter sets out to analyze how a regime of life is brought to the surface when threats against a particular life go against the protection of an anonymous one—as encapsulated by several laws. This dynamics, though, presents the process of lawful life at-work, where someone comes to matter following the juxtaposition of different conceptions of life. In other words, this chapter sets out to analyze how a legal landscape of interwoven, and often contradictory, laws and jurisdictions is translated into regimes of life that forge an affective image of the state and trigger caring responses based on a collaboration between medical and state agents (Conrad, 1979). Regimes in which documents play a fundamental role, as both the materialization of a bureaucratic rationale that organizes the process of suicide assistance and the visible expression of one's interactions with state officials and medical professionals. Regimes of life, however, have an internal contradiction: they normatively protect life while expecting, if not fostering, death on the ground level (Medeiros, 2018; Stevenson, 2014).

3.1 The rules of care and the care with rules: the provisional green light



OPERAID
1974 Gebärmut
1900

Finanzielle Situation

Meine letzte Reise in die Schweiz sollte durch meine
finanziert können - dachte ich.
Wie ligten Unterlagen ersichtlich, ist
end.
einen Rat, wie ich mich jetzt ver
hiermit einen Antrag auf Koste
n Bankauszüge, Einkommens-Nac
teres Vermögen - auch kein
teuerpflichtig.
ise in die Schweiz, mei
erst n-Schmuck'
wird de
nen Kör
Vergüt
tet.
iz auc

Gültig bis Ende | Monat | Jahr | Monat | Jahr | Monat | Jahr | Merkzeichen | Sondervermerke des Landes

unbefristet gültig

hindertenausweis

Antrag für Freitodbegleitung

Als Mitglied Ihres Vereins lifecircle beantrage ich hiermit eine
ich zu organisieren.
gleich - Null! Alle Dinge, die
staltungen, Wandern,
die Wege
tigen

MARGOT'S PROVISIONAL GREEN LIGHT APPLICATION

"I don't get why I have to present a *Curriculum Vitae* [*Lebenslauf*] to die!," said Ingrid to me over a phone call, sounding mystified by this while at the same time clearly holding back a laugh. It was Ingrid Bender, an 81-year-old German member of LifeCircle. As summer was running its course and autumn was slowly approaching, Ingrid was occupying herself with gathering all documents necessary to applying for a "provisional green light" from the organization, for she wanted to carry out her assisted suicide before winter arrived. Due to her restricted mobility and the usage of a walker—to which she refers as her "Mercedes"—, she said getting out of her apartment is enough of a challenge without the snow and slippery sidewalks that winter brings with it. Staying only inside, on the other hand, would not be an option because of her claustrophobia. So the perspective of either enduring winter in her apartment or risking a fall by going outside played a role in her decision to speed up the process—to which she was going to apply due to other health issues. As we talked on the telephone that Thursday morning, she shared how perplexed she was with some of the documents she had to collect.

The *curriculum vitae* is one among a series of documents that have to be produced and submitted to the organization in order to apply for a green light, which is a common feature among organizations that provide assistance to suicide. In Switzerland, where Art. 115 imposes a protection of *life* against non-altruistic forms of assisted suicide, organizations had to establish ways of providing assistance without jeopardizing their altruistic motives. Altruism, in this context, is usually understood as forms of assistance freed from any ulterior motives that could lead to suspicions of profit-making. The article, after all, was not written to legalize organized suicide assistance. On the contrary, by the time of its writing the consensus was that OAS endangers a life and should therefore by punishable by law. The question then, as already stated in the previous chapter, was how to define the criminal offense in a way that would avoid the overreach of the legislation, establishing sanctions against wrongdoing while protecting the "altruistic friend." So when it comes to organizations that provide suicide assistance for a fee within a jurisdiction where profit-making would risk their criminalization, the green light becomes an essential factor to break the connection between money and profit.

As an authorization that has to be applied for, the green light organizes a process to be followed by each individual applicant, designing a set of criteria to be met and documents to be delivered. It bureaucratizes organized suicide assistance by establishing a process permeated by a series of necessary interactions, mediations, and documents to be collected—and, by doing so, ends up reconciling the work of organizations with the legal framework within which they operate, in the Swiss case, under the general guise of altruistic assistance. In other words, the drawing of a pre-defined bureaucratic process, with clear steps and pre-requisites, detaches the offering of suicide assistance from the assumption that all it takes to receive it is, ultimately, being able to afford it. Each individual application has to go through the same process, subjected to the same criteria, regardless of the member being able to afford it or not.

The green light, however, is only provisional. It represents neither an obligation for the member to carry out the procedure nor an assurance that the procedure will actually be approved by the organization at a later date. In this sense, this device is both optional and conditional. When the green light is first approved, members are allowed to schedule a provisory date for their procedure and they are expected to arrive in Basel—in the case of LifeCircle—at least two days prior to it. There, they will meet the organization staff and undergo two psychiatric evaluations, one on each day. The aim of such evaluations is to psychiatrists personally talk to the member and their companions in order to assess whether they are indeed of sound mind, conscious of their decision and its consequences. Also, these evaluations are a way of assessing whether someone is pressuring them to carry out the procedure—which would go against the idea of altruistic assistance, since pressure can be understood as a way of acting on selfish grounds, such as cases involving inheritance. To this end, it is only then that the green light can be either revoked or confirmed, potentially turning its provisional quality into an actual authorization. According to data published by Dignitas, 70% of its members who received the provisional green light never contacted the organization again[60]. Similarly, StHD provides data (Kusch, 2016, p. 111) regarding the discrepancy between the increase in its membership numbers and the amount of procedures they have actually assisted in, which remained more os less stable:

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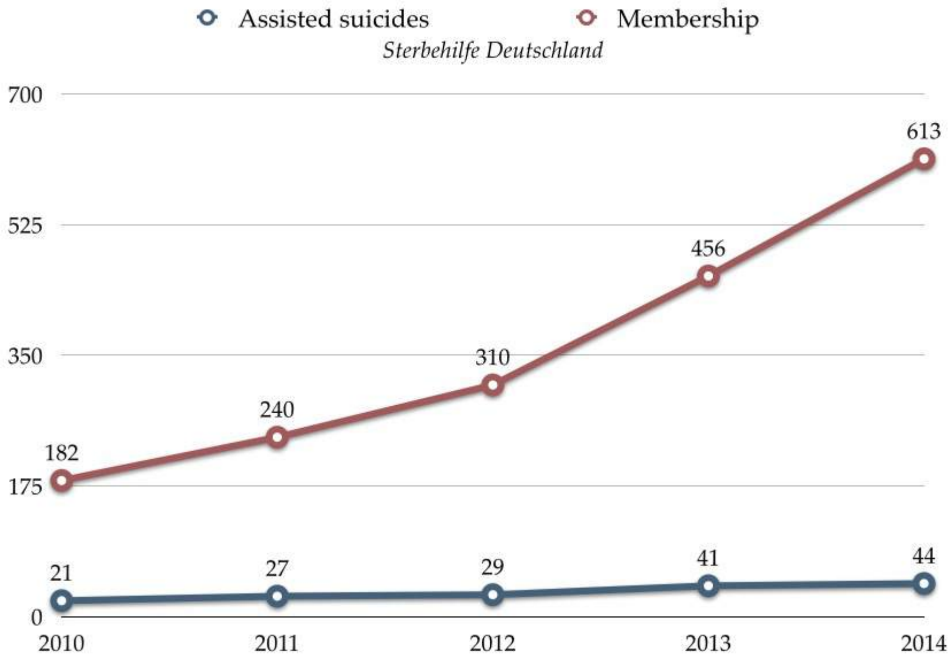
[60] Information available at: http://www.dignitas.ch/index.php?option=com_content&view=article&id=23&Itemid=84&lang=en. Last accessed 11th June 2018.



Nevertheless, these are the last stages of the green light process, and to get there one has to first prepare an application. Ingrid's intention was to go from southern Germany to Switzerland, crossing the border in order to receive professional assistance to die. However, before leaving her home country she had to prepare her green light application and follow a pre-established bureaucratic process—of which, as Ingrid's reaction implied, the *curriculum vitae* was at first glance its most ironic feature. The CV is necessary as a way for applicants to describe their family situation in writing, stating whether their relatives are both informed about their wishes and in agreement with them. However, LifeCircle requires more than the CV to apply for a green light. In addition to it, it is necessary to write a personal letter in which members have to explicitly request the organization to prepare the procedure, expressing their reasons for applying. A recent medical report, not older than three to six months, has to be likewise presented. In it, physicians have to describe their patient's current health situation, disclosing possible diagnostics, as well as therapies and treatments pursued. Whereas the *curriculum vitae*—the one that perplexed Ingrid

—is an individual act of translation that has to be written by applicants themselves, other documents can only be collected after interactions with medical professionals—such as the medical report—and state institutions—birth, marriage, and divorce certificates.

While still flabbergasted by the need to write a "'*curriculum vitae*' to die," Ingrid followed up her own comment with a conclusion: "Well, I suppose that's how they do things in Switzerland." "They," in this case, was not an allusion to organizations that provide suicide assistance in general, nor to LifeCircle in particular. It was an abstract they. The "bureaucratic" they. Filling out forms and requesting documents from state and medical professionals are common practice in day-to-day life, specially when it relates to key ritualized moments, such as birth, marriage, and death—to which the issuing of official certificates is an essential step. In this utopia of rules, as Graeber (2015, p. 10) phrased it, we deal with routine bureaucracy more than ever before, although the term itself seems to have been gradually left aside. However, if this ordinariness of documents was one of the reasons why they might have remained "analytically invisible" (Brenneis, 2006, p. 42) for so long, it is precisely this ordinariness, their permeability in everyday life, that makes documents analytically interesting. We should not only look at them as mediators capable of transforming meanings (Latour, 2005, p. 39) and generating entities (Mol, 2002), but also as material expressions of life regimes. Expressions of a project of staying alive.

Documents play a fundamental role throughout a member's application process. They are necessary not only for the procedure to be even considered—and possibly authorized—by the organization, but also for the investigation that takes place after it. But documents are also methodologically relevant: as Riles (2006, p. 2) argues, they are "paradigmatic artifacts" that offer a "ready-made ground for experimentation with how to apprehend modernity ethnographically." So, if they are essential to have the procedure considered by the organization, it is precisely by following how such documents are produced, circulated, and acted upon that we can find an analytical entry point into this regime of life and the acts of care enacted by it. The green light, thus, is metonymic of a bureaucratic rationale that frames the process of reconciliation of assistance offering with legal regimes aimed at the protection and preservation of *life*.

As a device that synthesizes this process of reconciliation, the green light defines a list of criteria and requirements that, once met, can possibly grant a person's access to this procedure. Among such requirements, medical ones stand out —such as health reports. But criteria of this kind, differently from the CV or the personal letter, require interactions with family doctors. By the time I met Ingrid in her apartment in Nürnberg, she had a full binder with all of the documents she was going to send to LifeCircle, but to produce and collect them was not an easy task. Even though the navigation through bureaucracy is a common routine both to those who have to request documents in general and to agents and institutions that issue them, when it comes to the context of applying for assisted suicide this routine is broken. Since within some jurisdictions there are overlapping laws regarding assisted suicide, as well as uncertainty over them, from a legal standpoint requesting both medical records from a hospital and a medical report from a physician with the explicit aim of applying for an assisted suicide might prove to be a difficult effort, for it breaks the bureaucratic routine—a break that triggers reactions that turn the bureaucratic ideal of impersonal relations into a living experience of uneasy interactions.

Ingrid's case was caught up in one of such breaks of routine. When we met for the first time, she received me in her two-bedroom apartment in Nürnberg where she used to live with her son, who died of cancer not long before in his forties. The floor in every room was covered by a cream colored carpet, including the kitchen and the bathroom. For balance, or, as she said, as a way of "feeling grounded," she walked around the apartment barefoot. Everything else in the apartment, from furniture to decoration, shared the same light color scheme. In her living room, a plastic binder rested on the coffee table. For quite some time Ingrid had been gathering all documents required to apply for the provisional green light, including some extras—like photographs—that presented a clearer picture of her life and family history. To comply with the rules that could possibly grant her the green light for her assisted suicide, Ingrid had to write a personal letter and her *curriculum vitae*, but she could not do the same with the medical report—nor could she forge her medical records.

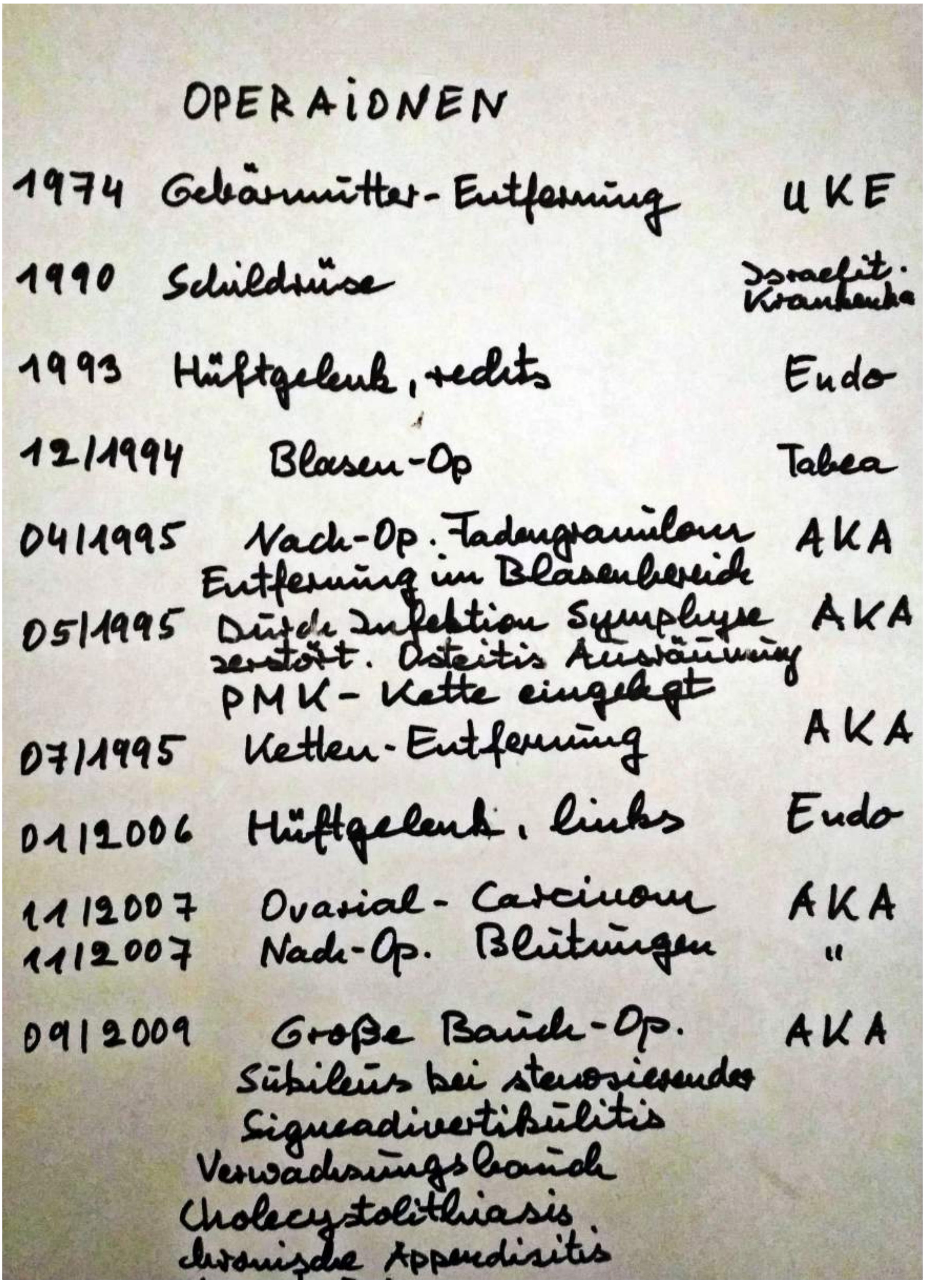
To produce these documents, Ingrid first tried to meet with her ophthalmologist, to whom she requested a report on her poor eye-sight—which was easily given to her. Subsequently, she visited her family doctor and requested a report on her general health condition. That was when she faced resistance. "My family doctor is completely against this system," Ingrid shared, "Because she already said to me, 'Frau Bender, I can report you to the police and then you will be taken to the nuthouse.' See? My family doctor said that. I find this criminal." Ultimately, Ingrid's doctor agreed to write the report, but did so in a technical language she would not be able to fully understand. Ingrid recounted:

> **IB**: My family doctor was so against assisted suicide, that that's how she wrote the report.
> **MFAN**: She wrote she is against it?
> **IB**: No, she didn't, but she abbreviated everything. I said, 'Why? I would also like to be able to read it, I don't know this specialized language, but I would like to at least know what my physician writes about me, I've been coming here for 30 years now.' And the doctor answered 'The physician who reads this will understand it.'

So Ingrid's medical reports were ultimately given to her by her ophthalmologist—who confirmed her poor eye-sight and provided exams as evidence—and her family doctor—who, despite the threats and inaccessible language, provided a general report on her health. Once everything was set, Ingrid sent the documents she collected to the organization in Switzerland and shortly afterward received a letter stating that her documentation had been forwarded back to a psychiatrist in northern Germany for evaluation. The letter suggested that Ingrid could consult with him, which she was not too eager to do considering she was living in southern Germany and mobility was one of her main day-to-day obstacles.

Ingrid's uneasy interaction with her family doctor was far from unique, and Margot underwent similar experiences when trying to request medical reports on her health. Upon becoming a member of LifeCircle, Margot triggered her application process by requesting the organization to prepare her assisted suicide. In her initial letter, she stated: "As a member of your organization LifeCircle I hereby request that an assisted suicide be organized for me," claiming that her quality of life was nonexistent, since everything that has once given her joy was no longer feasible to her, such as hiking, practicing sports, and going out with friends. Attached to this letter, Margot added a handwritten list of operations she had to undergo from 1974 to 2009, counting more than a dozen. Among other long-term consequences of such operations, Margot was left incontinent.

The medical aspect of her application was not limited to the operations she had to undergo throughout her lifetime or her incontinence. She also mentioned the arthrosis that consumed her body "from feet to the tip of her fingers" and the need for using a walking stick. Margot's general justification to request suicide assistance was based on her fear that her health might further deteriorate, distancing her even more from the things she enjoyed doing. But her justification was, in its turn, grounded on medical reasons that would corroborate her narrative: her impossibility to practice sports and meet friends was due to her restricted mobility, a consequence of her arthrosis; her difficulty to hike, or to stay outdoors for long periods of time, was a result of her incontinence. In this sense, Margot justified her deteriorating quality of life on the grounds of not being able to perform activities that used to give her



OPERAIONEN

1974	Gebärmutter-Entfernung	UKE
1990	Schilddrüse	Israelit. Krankenha
1993	Hüftgelenk, rechts	Endo
12/1994	Blasen-Op	Tabea
04/1995	Nach-Op. Fadengranulom Entfernung im Blasenbereich	AKA
05/1995	Durch Infektion Symphyse zerstört. Osteitis Ausräumung PMK-Kette eingelegt	AKA
07/1995	Ketten-Entfernung	AKA
01/2006	Hüftgelenk, links	Endo
11/2007	Ovarial-Carcinom	AKA
11/2007	Nach-Op. Blutungen	"
09/2009	Große Bauch-Op. Subileus bei stenosierender Sigmadivertikulitis Verwachsungsbauch Cholecystolithiasis chronische Appendisitis	AKA

MARGOT'S HANDWRITTEN LIST OF OPERATIONS

joy, but she had to anchor such difficulties on medical diagnostics that had to be proved by her physicians. Consequently, while her own justifications could have easily be written by her, the medical reasons that would offer a ground for them could not—so just like Ingrid, Margot had to go visit her family doctor.

> **MFAN:** Have you shared your intention with your family doctor?
>
> **M:** God no! God no! She would not have given me any papers. I needed to send LifeCircle the medical report, can you imagine how much I had to fight to get anything? I think they [doctors] make many mistakes in their paperwork (…) For example, I fell and got a huge bruise, and we first thought that I'd broken my rib, I had terrible pain. And that's not in the doctor's paperwork at all. He had only copies of my operations, but nothing else. So I also tried to get something from my orthopedist, and it's always like: 'Why do you need this? What do you want this for?', 'Well, I'm 80 now, and my children and I want to organize my paperwork', 'When you need something I can fax it to you'. So what is one supposed to say to the doctor?
>
> **MFAN:** So how did you get the report?
>
> **M:** I have a certificate of disability graded 90%, so I said I wanted to try to get a 100% one. And for this the doctor had to fill something to the authorities. That's what I sent to LifeCircle. (…) I believe this happens not because of bad will, but because this demands much work and the doctors are so overwhelmed. (…) It's so much paperwork, it gets bigger and bigger, and paperwork is not the profession of a doctor. (…) I was told by the organization's secretary, 'You could say that you will travel and that's why you need the papers', but a doctor would not accept that. (…) But what occupies one the most is, and I just got it yesterday, is the certified birth certificate. It has to be certified by the authorities. I was born in Berlin, so I had to write first to the Berliner authority, which is completely overwhelmed. Nothing happened after I wrote, so I called them and they said they were completely overloaded because of the refugees, so it takes around 5 weeks to receive it. I got it yesterday—I had to send them 10 euros for the stamp. That takes a long time, and then the paper has to go to Basel. Divorce certificate. What else? Certificate of residence. Everything with the authorities takes a long time.

Margot suspected that her family doctor would not agree to write her the report if she knew the reasons behind her request. To circumvent this, Margot decided to justify it on other grounds, such as applying for a disability certificate and the urge to organize her papers. Whereas Margot's suspicion has led her to come up with different reasons to request the report, Ingrid's openness with her family doctor has not only driven their interaction toward strained paths, but even included a threat to call the police. In this way, while requesting and issuing medical reports are mundane occurrences that can be necessary for various reasons, suspicions that such reports would be used to apply for, and ultimately facilitate an assisted suicide, can lead to uneasy interactions between patients and physicians.

3.2 Medical Gates

The clinical encounter is central to the green light process, since it exposes different moralities at play during the interaction between patient and physician. It articulates legal insecurities and uncertainties concerning the legality of assisted suicide with moral experiences (Kleinman, 1999; Kleinman & Benson, 2006) where what is at stake are different conceptions of care and life. Conceptions grounded on personal and professional expectations that are not always compatible with each other. According to Fassin, "[m]edicine is not solely a technical activity based on biological and biochemical knowledge" for "it also implies a moral intervention grounded on values and expressing sensibilities, with claims of altruism by professionals and expectations about the role the sick should play in the management of their illness." (2012, p. 12) To this extent, Ingrid's request for a medical report that would be used for applying to the green light clashed with her physician's sensibilities and expectations regarding what would an appropriate response to her health condition be. The clinical encounter, such as Margot's and Ingrid's, casts light on moral experiences that are grounded on different backgrounds, sensibilities, expectations, and values attributed to ordinary things (Kleinman, 1999, p. 77). This last aspect relates to Fassin's (2012, p. 15) perspective, who, on a similar note, argued that it is precisely "in the course of action rather than on the occasion of formal dilemmas" that moralities are revealed. If one of such moments of revelation can be attributed to the clinical encounter, this clash of moralities also becomes a clash of positionalities.

Throughout the application process a member has to interact with the organization, family doctors, and state authorities in order to gather all of the requested documents. Interactions that imply different relational matrices: member-staff, patient-physician, and citizen-state official. Being a member of the organization is a necessary first step to set out the green light process by producing, collecting, and circulating the documents requested for the green light, but when it comes to being patients and citizens these relational matrices become more complex. They lay out specific positions and, often, inequalities among the agents involved in the interactions. If the patient is a "complex phenomenon" constituted "in interplay with both science and medical or social intervention," (Fainzang, Hem, & Risør, 2010, pp. 18-19) the patient condition is a relational one where the person in this role is subjected not only to this interplay, but also to legal orders, as well as claims of professional altruism and moral intervention, as indicated by Fassin (2012). In both matrices, justification plays an important role, but on different stages: as patients, they had to justify their request for health reports, and subsequently use the medical justifications to ground their application to the organization. In contrast, to state officials justification was not an issue during the stage of document gathering. Margot's request for her birth, marriage, and divorce certificate could not be refused—but only, perhaps, delayed. The state's concern with documents, as her case illustrated, comes afterward, when the organized, professionally assisted, end to her life clashed with legal provisions that protected it as an anonymous one—therefore triggering an investigation.

If medical justifications are then necessary for the procedure to be considered and, possibly, authorized by the organization, these justifications will only be analyzed by state officials after—and if—the procedure has been actually carried out. By establishing a set of criteria for the green light that has to be responded through documentation, the bureaucratic rationale ends up, on the one hand, circumventing the institutions and agents to which the end of a life matters, and, on the other, managing relations that are already characterized by extremely unequal positionalities (Graeber, 2015, p. 81). As members of LifeCircle, Ingrid and Margot were able to start their application processes, but only as patients they could have had access to the necessary medical reports. And it was precisely while they were being patients that positional inequalities were then exposed: over the course of clinical encounters, it became clear to them that their physicians could refuse to issue the requested reports.

The obligation to present a medical report implies the need for patients to convince physicians to issue them. To this end, patients can either disclose their real intentions or develop strategies that would cover their real motives while, at the same time, grant them access to the report. This requirement, alongside clinical encounters with psychiatrists that can turn a provisional green light into a definitive one, invests medicine in the role of "gatekeeper," (Conrad, 1979, p. 5) placing a series of "medical gates" along one's application trajectory. Dr. Wilson was the one who mentioned "medical gates" to me. She was referring to the predominance of medical steps and criteria—such as clinical encounters, medical justifications, reports, and records—that have to be met in order for the green light to be considered by the organization.

Despite being a general practitioner herself, Dr. Wilson fiercely opposed what she perceived as medicine's role as gatekeeper. Underlining this role, she claimed, lies the assumption that assisted suicide can only be carried out upon medical authorization. Whenever she and I met—usually in her home in Glasgow, sitting across each other in her kitchen table—, Dr. Wilson would say that she was "a great believer in autonomy:" if a person is able to make decisions on her own, no one should have the right to contest or forbid them, not even physicians. But her belief in autonomy was not enough to blind her to the practicalities of the application process. She knew it would be difficult to design any system without “medical gates,” even if the legislation were to allow it. In Switzerland, where Art. 115 StGB did not establish the need for medical participation, various medical gates were nonetheless in place—one of which, said Dr. Wilson, was Dr. Preisig herself. After all, she had to follow medical guidelines in order to avoid any risk of having her license revoked—a fear that Dr. Wilson did not share for being already retired.

If the medical report and the clinical encounter are both medical gates that need to be crossed, so are hospitals in cases where medical records are requested. As Dr. Wilson explained to me, despite the fact that UK law assures a person’s right of access to their own medical records, there is a let-out clause granting physicians the right of refusal if they consider it to be in their patient’s best interest[61]. In Scotland, where assisted suicide is neither legalized by official law nor allowed by medical rules, when someone asks for their records in order to go to Switzerland they usually have a clear idea about which direction this conception of best interest might go to. So, in order to avoid complications, Dr. Wilson used to provide advice on how to request access medical records. According to her: “Our method is to go right to the hospital records department, don’t go to your GP, go to the hospital records, either go yourself or get somebody to go for you, and nowadays the records are all computerized, so go through it, pick out and than highlight the bits which are relevant and only send, you know, three or four sheets with the relevant bits.”

The investing of medicine as gatekeeper to OAS or, in Dr. Wilson’s words, the placement of medical gates throughout the green light application process, winds up entangling organized assisted suicide within a process of interactions that revolve around the interplay of moralities and legality, exposing positional inequalities. Medical reports can be denied; medical records, despite legally accessible by patients,

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[61] According to the “Access to health records: guidance for health professionals in the United Kingdom,” issued by the BMA Ethics. It can be read in full here: https://www.bma.org.uk/advice/employment/ethics/confidentiality-and-health-records/access-to-health-records. Last accessed 11th June 2018.

can equally and lawfully have its access denied by physicians. Medical gates, thus, are points of intersection where different moralities meet, positional inequalities are reinforced, and strategies are drafted. In the context of OAS, where the possibility of lawfully applying and carrying out an assisted suicide coexist with life-oriented political formations, documents represent a paradox: in order to get hold of some of the documents necessary to end a life a person needs to engage with agents that see life as a value to be protected and assisted suicide as something to be avoided. But it is only through the documentary practices of these representatives of a life-oriented state that such regimes of life can be circumvented. Ingrid's physician, for instance, made her position against assisted suicide explicit, but her report on Ingrid's health was essential for the green light to be considered and, possibly, granted.

3.3 Enforcing life

Upon being requested a medical report, Ingrid's family doctor threatened to call the police to take her to the "nuthouse." While in Ingrid's case this has remained a threat, on other occasions similar threats were translated into action. As Conrad (1979, p. 5) argues, medicine exerts a type of social control that often relies on collaboration with other institutions and authorities, such as the police force. This collaboration entails an interface between medicine and the state, where medical justifications can help grant or deny a person's access to certain procedures, such as abortion—as exemplified by Conrad—or organized suicide assistance. Despite writing the requested report, Ingrid's long time family doctor threatened to call the police as a way of preventing her from going forward with her application process, suggesting that they would section her in a psychiatric facility. A threat that was grounded on a style of thought described by Marsh (2013) as "compulsory ontology of pathology," that is, a regime of truth that centers on suicide as a necessary act of "insanity"—dismissing other truths that might understand it differently. As Marsh argues (2013, p. 752), this regime of truth linking suicide with insanity "provided the emerging psychiatric profession with a rationale; namely, the protection of individuals and the public from the perceived dangers inherent in madness." As a result, this conceptualization often steers medical and political debates toward regimes of prevention and ends up framing suicide within a single perspective, usually that of an asocial and impulsive act grounded on depression (Staples & Widger, 2012).

During the interaction with her physician, Ingrid found herself in a stressful situation where her wish to pursue an assisted suicide clashed with her physician's will to prevent it. But Ingrid was not breaking any law. As contradictory, overlapping, and confusing as this entanglement of laws can be, they were nevertheless implemented with the goal of protecting *life*. The anonymity of a legal, bureaucratic *life*, detaches it from individual ones, enshrining it as a value in and of itself. In this way, *life* assumes a legal form that triggers acts of care aimed at its protection. The enforcement of such protection, however, has multiple facets—among which the clinical encounter and the production of documents.

Regimes of life are established by laws that protect *life* and structured as a bureaucracy that provides a framework to organized assisted suicide, incorporating the practice to legal orders and consequently emphasizing the role played by documents. And while documents are one of the most visible expressions of this bureaucratic way of proceeding, bureaucracy is not restricted to documents. As Graeber (2015, p. 73) puts it, "police are bureaucrats with weapons" who spend considerable part of their time enforcing "endless rules and regulations." The role played by the police varied in different places throughout history. But despite these variations, which ranged from forms of government to prerogatives of power, Fassin (2015b, p. 95) argues that what binds these different definitions together "is the principle of monitoring for the supposed welfare of the population." And to protect the welfare of the population, that is, to preserve *life*, the police can resort to threats and violence.

When Weber (1919) first conceptualized the state, he highlighted the state's claim to the monopoly of the legitimate use of physical force in the enforcement of its order, to the extent in which the state can be defined by violence. This link between violence and state has been revisited differently by various anthropologists (Das & Poole, 2004; Graeber, 2015; Nixon, 2011), although with variations on how violence is perceived. One of its mains features, however, is "violence's capacity to allow arbitrary decisions." (Graeber, 2015, p. 66) As has been previously noted, the space between the implementation of laws and their applicability is filled with uncertainty, therefore it is not surprising that their enforcement can also be arbitrary. But police action derives not only from written regulations and their possible illegibility: according to Fassin (2015, p. 2), the police force is an institution located in the heart of the state that represents, alongside other state institutions, a "dual dimension of order and benevolence, of coercion and integration." It is an institution where the state is also produced under "an ideological environment and under regulatory constraints." (2015, p. 6)

This situation, which emerges as a result of the interplay of legal illegibility, moralities, uncertainty, and arbitrariness, leads to circumstances where violence is employed with the goal of protecting *life.* "In this most recent phase of total bureaucratization," writes Graeber (2015, pp. 32-33), we have seen "men and women in a variety of uniforms acting in either public or private capacities, trained in tactics of menacing, intimidating, and ultimately deploying physical violence (…) just about everywhere," even in hospitals. In the context of regimes of life, which are designed through a meshwork of official and non-official laws, the welfare of the population can be enforced through a collaboration between state and medicine. When Ingrid expressed her wish to apply for an assisted suicide, the uncertainties regarding its legality, as well as the transfiguration of medical documents into artifacts that could be used to circumvent the very goal of protecting *life*, made her life come to matter to both state and medicine. And, as a response to her coming to matter, the collaboration upon which such regimes rely on was exposed: the police would take her to the "nuthouse."

The association between manifesting a wish to die to a medical professional and its translation into police issue can take even more concrete shape. In Scotland, Dr. Wilson shared a patient's case where this kind of association went beyond the hypothetical. She said:

> It was only a week before he had a date to go [to Switzerland], and he went to say goodbye to his sister who lived in some other part of the country [England]. And I think he was staying in some kind of establishment just for two or three days to say goodbye to his sister. And he got crossed and threw something through the window and somebody who observed reported it to the police. And of course he was already under psychiatric care because of his early Alzheimers at the place that he lived in, so he was whisked back there and he was sectioned. You know, he was detained in a locked ward. So she [his wife] and her son weren't allowed to see him for a month, and he was dragged away you know, calling out for her, "where are you? come back," you know, "let me go." And up to that point he's been able to walk, play nine holes of golf. With a little baggy, you know. He could dress himself, feed himself, and I've spoken to him on the phone twice, perfectly competently, you know. After a month she was allowed to visit him, and she took me, it was about six weeks after him being arrested, as it were. She took me to see him, you know, he was just like a zombie, he was so drugged that he was in a wheelchair, he couldn't really stand, and although he did know his wife and son, he didn't… he was very courteous, because he was that kind of generation of men, you know, but he didn't really have a clue who I was, even though of course only two months before we've been talking on the phone completely normally. So, I mean, it was absolutely terrible. And of course he was allowed out after the locked ward, I think he went out into some other kind of residential care, but he died nine months later.

The enforcement of the protection of *life*, thus, can assume a more direct, and rather violent, trait—and what was a threat to Ingrid, became action to Dr. Wilson's patient.

In order to prevent his act of mobility to Switzerland, police officers took him to a psychiatric facility, where he was sectioned under the Mental Health Act 1983. This violent facet of bureaucracy speaks to fundamental aspects of regimes of life: the translation of uncertainty into arbitrariness; the enforcement of *life* over lives; and the collaboration between medicine and state. Dr. Wilson's patient's coming to matter was responded through police action and, subsequently, psychiatric sectioning—a response that prioritized the protection and preservation of *life* in detriment to his plans concerning his own life. Even though the Suicide Act 1961 has no effect within Swiss jurisdiction, where the criminal offense—as seen by the UK state—would be committed, the police intervene preemptively in order to protect his life against the threat of suicide assistance. And, under the Mental Health Act 1983, acted to section him with the collaboration of medicine. By acting within an ideological environment and under regulatory constraints (Fassin & Brown, 2015, p. 6), the police reinforced the perception of *life* as a value: it does not "matter who lives or dies, only that everyone complies with the injunction to keep living as long as possible." (Stevenson, 2014, p. 107)

If, on the one hand, the police is one of the institutional sites where the state is being constantly produced, on the other, such institutions can also "contravene the laws that the state enacts and the norms it promotes." (Fassin, 2015a, p. 3) This situation speaks to the ongoing process of state formation, but also, and more importantly, to its contradictory, arbitrary, and uncertain character. Uncertainty, thus, refers not only to the letter of the law, its legibility, reach, and applicability, but also on how such laws will be enforced. Dr. Wilson has been visited by the police on several occasions, including one situation where she was placed under arrest due to suspicions she had facilitated a suicide. She recounts her experience:

> It was so stupid… There was a lady down… Highly intelligent woman, who lived in the south of England, and somebody else had given her the Final Exit book, and it has a chapter on helium, so she decided to end her life with it. She phoned me up… I think

the same person who gave her the book was a member of FATE. Anyway, twice she phoned me up in the week before she died, and she did it on her own, she died using helium. Perfectly, straightforwardly, and no problems. But the police, of course, it was an unexpected death, so they were called in, and they found my telephone number on her telephone records. So I had the Strathclyde police coming on, sitting in that table where you are now, and… Actually I had the police here three times, so I'm sort of used to it. And I had to go down to Surrey, where she lived, to the local police station there. Fortunately I have a daughter who lives near there, so, you know, it was business with pleasure really [*laughs*]. I mean, the whole experience at the police station was quite… Funny actually, I really quite enjoyed it in a way. I had to give my fingerprints and my DNA, and then I had to… I was allowed to have a solicitor while I was being interrogated, and they had to wait for an hour for this local solicitor, lawyer, to come, so they put me in a cell, which was exactly like television, white-washed cube with a sort of shelf with a blue plastic mattress thing on it, and a lavatory without any seat on it, you see. That was all it was in the cell. They even took my shoelaces away, and they took my handbag away, and I said, 'well, can I have my crosswords?' I'm a great addicted to crosswords, you see. So they allowed me to have my crosswords, and I said 'well, I'd have to have a pen,' I wasn't allowed to have my own pen, I don't know what they thought I could do with that pen, so they gave me one, which was almost identical with the one which I had left in the handbag. So I went and I stayed in the cell for an hour, and then the police woman came to fetch me because the solicitor had arrived. So I said, well, I said I need to go to toilet and if you think I'm going to use that, you are very much mistaken [*laughs*]. You must take me somewhere where I have some privacy [*laughs*]. They took me around the back of the station, it wasn't a very big police station… I said, there's no toilet paper, so… [*laughs*]. So it was quite… It was funny actually. I could hear this police woman saying toilet paper, toilet paper, toilet paper [*different tones, like an echo*], and eventually somebody emerged with some [*laughs*]. And so I was questioned for about two hours by these two women policemen, and I was just quite honest, I said I was just giving information, you know. She already knew how to do it. I said she already tried once and it haven't worked, and she wanted to be sure that this time it really did work. I wasn't encouraging her to take her own life, she was quite determined to do it. She just wanted to make sure it worked. So actually I was given bails they call it, which means you are in a sort of limbo, you can be called

> back there… They kept saying they were going to call me back and charge me. Being arrested, it doesn't go in any record or anything, but once you are charged, that's in the records forever. Specially if you are convicted. If you are charged you have to go to court and have a legal, you know, judge and all the rest of it, you see. I was pretty sure they would never do it actually, and they never did. I mean, a date was put on for this reexamination about four times and then by June or something around then, I eventually found out that they didn't think it was in the public interest to pursue… They would have egg all over their faces you know, I was 86 or something and a great grandmother already, '86 year old charged with…' Well, and I would never be convicted.

Her description of the time she was arrested for questioning as "business with pleasure," and "funny actually, I really quite enjoyed it in a way," hints at her perception over her own positionality within the case being investigated. She was certain that, all things considered, the police were not going to press charges against her.

Dr. Arnold, from Germany, experienced a similar situation. When the police visited him in Berlin during the course of an investigation regarding a procedure that took place in Hamburg, they searched his apartment—but not quite:

> The police came and I wasn't here. I have a big lock on the door, so I said over the phone 'you can't get in, it's locked.' They asked me if anybody had a key, and I said my wife is not there and I'm here. I said I have a cleaner, she has the key. They were waiting outside, everybody saw it. She opened the door, and they were looking in my desk. They were all looking for some data, from the guy from Hamburg, but they couldn't find it because I didn't have my laptop at home. I had it with me. They took another laptop which had nothing on, only my book, the book I wrote, and they went down the cellar to look for helium. Unfortunately, I had some helium, but only in a small cache. They took that. And I don't know what they did with that. But these policemen, they were not interested in helping the guys from Hamburg. They didn't do any damage, if they had looked a little bit better they would have found a few

> interesting things. I have two big ones here [canisters of Helium], but I have them in another cellar. I don't think they are so interested in me, personally. They were very unhappy that they lost their time with me. 'Ow, you prepared a suicide?,' I replied "Yes, is that a crime here?,[62]" "You will see, you will see!," and I saw nothing. The State Attorney said no, we are not suing. Because they know better about the law, but the stupid police know nothing.

Whereas the Berlin police were investigating Dr. Arnold's involvement in a suicide assistance, an action that, regardless of the subsequent legal status deriving from the §217 StGB, was then not regulated by official law. At the time, assisted suicide was regulated only by medical rules—which are not enforced by the police. Dr. Arnold described their lack of interest in collaborating with the authorities from Hamburg. If their search had been any better, he stressed, they would have found something. Furthermore, although the enforcement of official law is within the police's remit, he says they know "nothing" about it, in contrast with the State Attorney, who knew "better" and decided not to prosecute.

If this entanglement of laws regulating assisted suicide translates into the establishment of regimes of life, their caring responses aimed at enforcing this life are often experienced, perceived, and imagined differently on the ground level. Throughout the green light process, where the bureaucratic ideal of impersonal interactions turns into a stressful, if not confrontational, series of personal interactions, care was perceived as a reluctance to produce the necessary documents. The affective and emotional perception of care during the green light applications highlight the importance given to *life* as a value by the state and medicine. However, the lives being negotiated are different. And if during the application process the clash between *life* and lives is perceived mostly over the course of strained interactions with family doctors, it can also assume the form of police action. As an institution in the heart of what we call the state (Fassin & Brown, 2015), responsible

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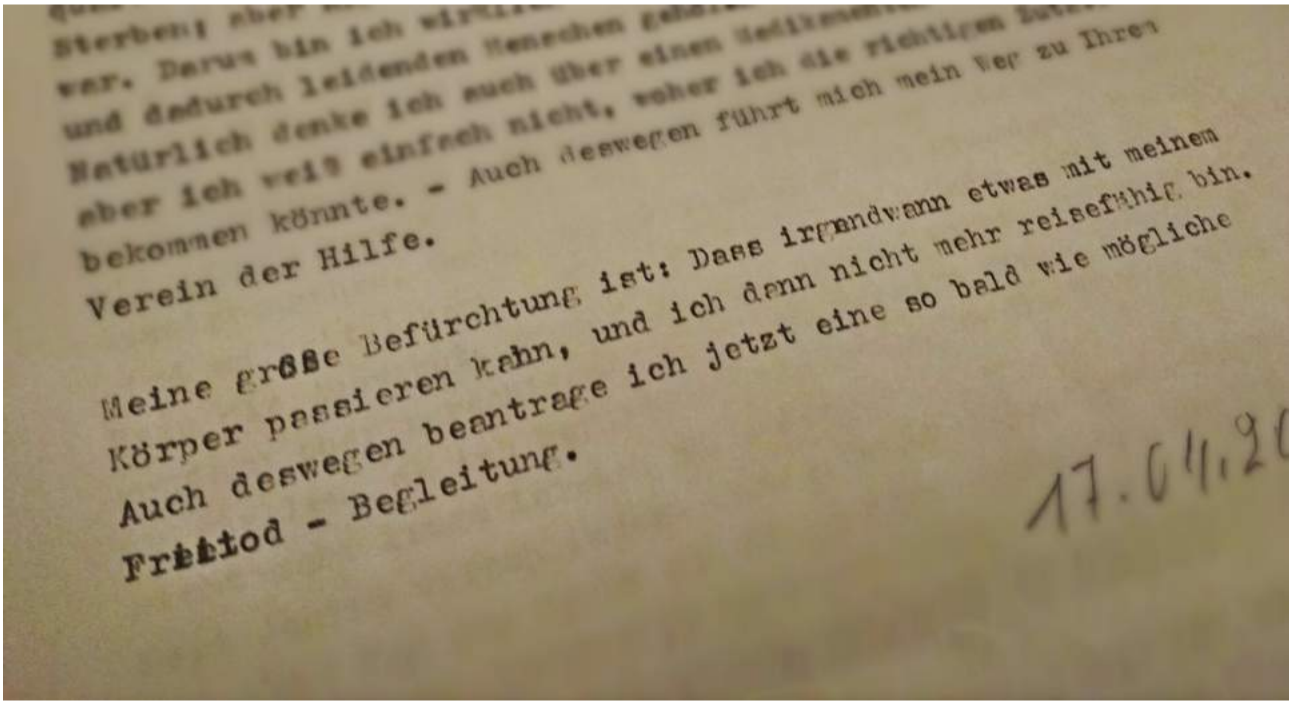
[62] This event took place before the implementation of the German §217 StGB.

for the enforcement of its norms and, even, for their contravention, the police acts to forcefully protect *life*, oftentimes in detriment of personal lives. The establishment of such regimes of life evokes the perception that assistance to suicide, regardless of its legality, is to be prevented. As a way of avoiding, if not circumventing, caring responses, people resort to tactics that are based upon acts of collaboration among organizations and individuals from different places and jurisdictions. Among such tactics, acts of mobility stand out. They encompass different trajectories and routes, enacting itineraries of circulation that involve the mobility of individuals; pharmaceuticals, as well as of technologies.

4. DRAWING ROUTES, ENACTING MOBILITY: ITINERARIES OF CIRCULATION



bekommen könnte. - Auch deswegen führt mich mein Weg zu Ihrem
Verein der Hilfe.

Meine größe Befürchtung ist: Dass irgendwann etwas mit meinem
Körper passieren kahn, und ich dann nicht mehr reisefähig bin.
Auch deswegen beantrage ich jetzt eine so bald wie mögliche
Freitod - Begleitung.

17.04.2

MARGOT’S APPLICATION LETTER

“My biggest fear,” Margot wrote on her application letter for suicide assistance, “is that at some point something may happen to my body, and then I am no longer able to travel.” By the time she expressed her fear, Margot had already decided to carry out her assisted suicide in Switzerland—but, as is the common procedure among organizations, she had to apply for a provisional green light first. The reshaping of Germany’s legal landscape through the incorporation of assisted suicide to the criminal code was the first step for Margot’s subsequent acts of mobility, from her traveling to Switzerland to the circulation of documents that preceded it—and, ultimately, made it all possible. Acts of mobility, such as Margot’s, are usually based on unofficial cooperation among people and organizations from different places and jurisdictions. Acts of cooperation that are established in order to design tactics and draw routes that can help an applicant to circumvent regimes of life and their acts of care.

By opting for one jurisdiction over another, Margot had to establish contacts that would help facilitate her journey. In this scenario, LifeCircle's assistance was essential: it not only walker her through the application process step-by-step, but also helped with her logistics. The organization provided Margot with a route that would enable her assisted suicide, dispensing advices on how to get hold of the necessary documents for the provisional green light—thus circumventing possible resistances from her family doctor—as well as assisting with bookings and accommodation. Such routes, or itineraries of circulation, are essential to turn the procedure of organized assisted suicide into a feasible possibility for people living in jurisdictions where OAS is either illegal (the United Kingdom) or entangled in a confuse, and often illegible, set of laws (Germany). Beyond its practical value, however, circulation is also crucial to understand this landscape of organized assisted suicide through broader lenses, going beyond the procedure itself.

In so far as the laws governing OAS are both created and implemented locally, within specific jurisdictions, from a legal standpoint it can be seen as a local dynamics. That is, its legality varies among jurisdictions according to the letter of their respective criminal codes: the §217 StGB was drafted and approved by the *Bundestag* as a way of regulating organized assisted suicide within Germany—and even though the risk of prosecution still stands for people who assist professionally outside of Germany, this can only occur upon their return to the country—; likewise, the Suicide Act 1961 was approved by Westminster and can only be enforceable in England and Wales, leaving Scotland in a different legal situation. In this sense, as something that is both regulated and enforced within a stable, circumscribed, and fixed location, organized assisted suicide may be seen as a local dynamics, something that happens within bureaucratic frameworks and regulatory constraints that were designed for specific *places*.

Moving from Hamburg to Basel was Margot's route to enable her assisted suicide, but that could only have occurred following the transnational circulation of her green light documents. Documents that were produced and gathered in

Hamburg, and subsequently sent to Basel and back to Germany for evaluation. And although Margot's procedure took place in a specific place, in a fixed address in the outskirts of Basel, most of her application process took place while she was still in Germany. Margot's cooperation with LifeCircle, as well as the itineraries of circulation enacted throughout her process, created a *space* where both German and Swiss laws had an impact on her trajectory, influencing her friend's decision not to accompany her due to fears of prosecution; frustrating Margot's plans to have her ashes buried at her daughter's backyard in Germany; and, above all else, fostering her very own decision to move from Germany to Switzerland.

On the one hand, there are fixed places with specific sets of laws. On the other hand, itineraries enable the circulation of documents, people, and pharmaceuticals among different jurisdictions, interweaving divergent sets of laws—which were meant to exert an impact locally—into one single, dynamic, space. This situation presents a conundrum: itineraries of circulation, such as the ones concerning Margot's case, which were based on association and cooperation among people and organizations from different jurisdictions, sew together a *space* that is composed of, but not limited to, *places*. A space that crisscrosses different border relations (Casas-Cortes et al., 2015; Mezzadra, 2015; Mezzadra & Neilson, 2012) and entangles various jurisdictions. As Povinelli (2011) argues, "things do not simply move," for "[r]outes *figure* space—they create worlds[.]" A world, or space, that is both relational and circumscribed through the circulation of things and people among a variety of places. Similarly to the question posed by Müller-Mall (2013) when discussing a topological conception of law, the challenge is how to reconcile the relational and ever-changing quality of spaces (created through itineraries of circulation) with the stability and specificity of places (within which laws are designed to operate).

As the reason behind these entanglements, circulation is vital to understand organized assisted suicide as something that happens on the move, something that is locally performed, but which cannot be defined, or even circumscribed, to one single place or places. It is a process that include places, but cuts across them and, by doing so, intertwine them all together. This chapter, therefore, lays out two different itineraries of circulation based on cooperation: (1) circulation of people, where members of organizations, professional assistants, and physicians travel in order to carry out, or facilitate, an assisted suicide; and (2) circulation of technologies, where global pharmaceutical objects are moved across jurisdictions and knowledge regarding technical and legal aspects of new suicide methods are exchanged.

4.1 Mobilities of people

LIFECIRCLE | BASEL | 2016 | MARCOS ANDRADE NEVES

It was about 3 a.m. when I woke up to go to the airport. The flight from Berlin to Basel takes around one hour and I was expecting to arrive at the EuroAirport Basel-Mulhouse-Freiburg in the early hours of that Thursday morning. The airport is strategically located in France, at walking distance from both the Swiss and German borders, offering different exits to each one of these countries. Upon my arrival, I went directly to the house then occupied by LifeCircle. When I got there, a green façade was hiding the building behind its leaves. It was a charming but rather simple house in Basel, where the leaves would only make space for the house number, one discreet window, and the front door. The wind was blowing the leaves, which were dancing from side to side without ever leaving their assigned places. The house, however, remained static. Remained hidden from the outside view. The only window was closed and the front door had frosted glass. No one could see through it, and whatever happened inside remained protected from the outside world.

If by any chance you were allowed in, a very small and unimpressive gray hall would welcome you. A room decorated with a few paper boxes, some piled chairs and a working Xerox machine. A door on your right would lead to an even more unimpressive room, apparently used for storage. Inside this room, a very narrow staircase would invite you to the attic. In front of you, a second door leads into a windowless apartment. There, the air was stale and the atmosphere, stuffy. The apartment had one room, so office, kitchen, and bedroom had to share the same space. Only the bathroom had a separate area and was granted the privacy of walls and the perks of a ventilation system. The office had one conference table on which a number of papers was resting and a computer was waiting to be used. A bookcase was separating this area from the bedroom, where a violet sofa, a black armchair, and one hospital bed, with red blankets and a duvet, were the only decoration. Alongside the left wall, which separated the bedroom from the bathroom, there were kitchen cabinets and a sink. There was plenty of options for tea and coffee, which were usually offered when a meeting was about to start. After the tea was served, the staff would use this area to prepare both the medication and the necessary materials for the procedures.

The green outside had nothing to do with the inside, where everything was designed to be, and to look, aseptic. But discretion was a key feature. What the green façade helped to hide on the outside, the vestibule reinforced on the inside. The goal was to not attract attention to the building. No signs other than what was strictly necessary. Ideally, cars would drive by, people would walk past it, and no second thoughts or questions would emerge. The goal was to be conventional, simple. To merge with the surroundings. Whoever needed to be there, however, would walk through the vestibule and into the apartment, hanging their coats, purses or backpacks on the left side, where hangers and a wardrobe were at their disposal. The office would be the next stop, walking to the right corner and toward the conference table. The discretion of the house also provided a route to be followed. A path from vestibule to office to bedroom, with random stops at the kitchen and bathroom. While the attic was never visited, the vestibule was only a transition space between the outside and the windowless apartment—except for the moments when the Xerox machine was needed. The house was equipped to offer some comfort to whoever was inside it, but its dullness, its indifferent interior, imposed a distance. Comforting but detached. Careful but unconcerned. The house was welcoming, but made sure to affirm that this greeting was not intended to last long.

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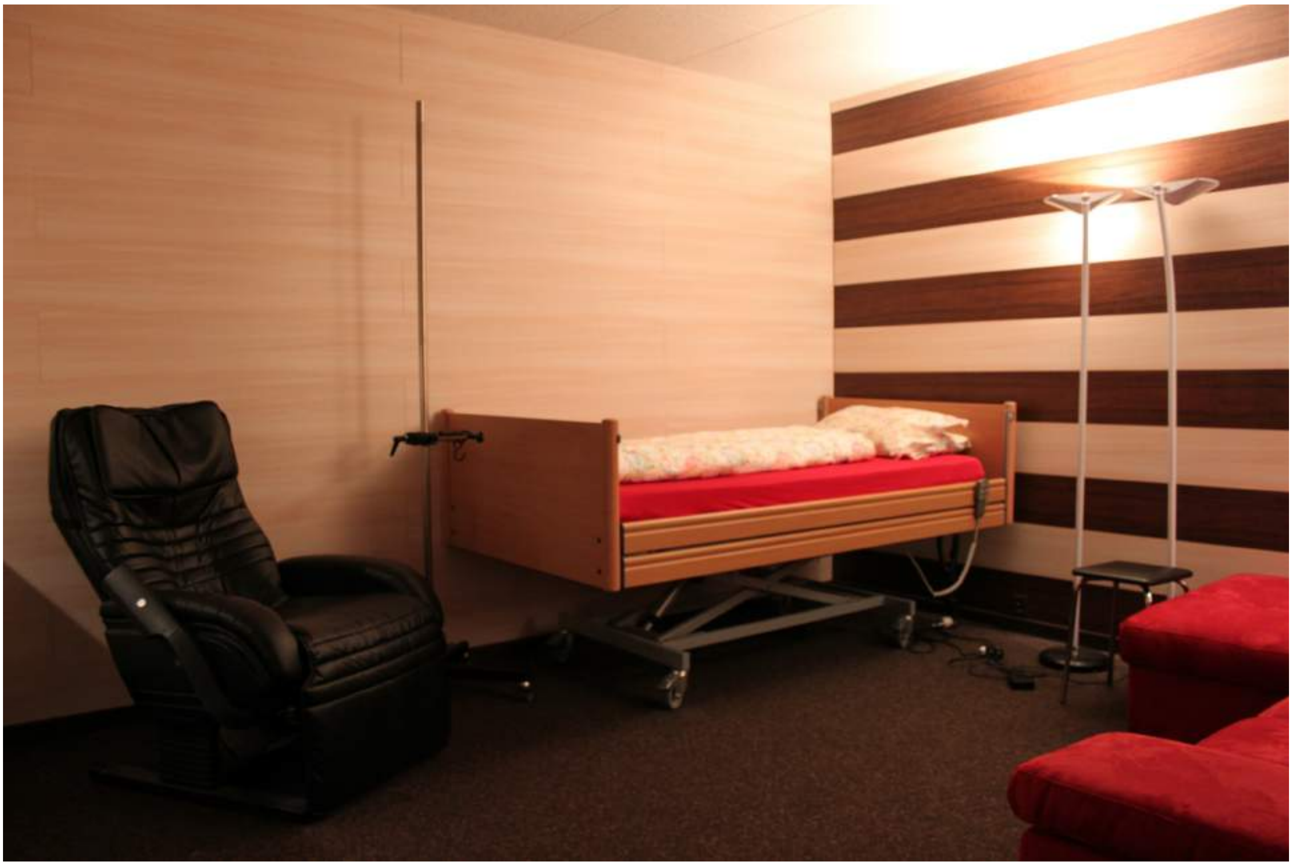
The house belonged to a member of Dr. Preisig's family. Initially, her plan was to rent a building in the canton of Basel-Landschaft, where she used to live and work as a physician. As her search progressed, however, it became clear that it would be nearly impossible to rent an apartment there. No one in Basel-Landschaft wanted to rent out a place that would be used to carry out assisted suicides. As she grew increasingly frustrated with her search, it finally came to her: her brother had a house in the nearby canton of Basel-Stadt, which he was using as a photo studio. The place was ideal. It had enough room to accommodate both LifeCircle and the studio; it had no windows, so no one would try to look inside the building; and, finally, it had a garage for the hearse, so bodies would be able to be discreetly removed by the funeral home. The house, thus, would not only provide the discretion and privacy desired by Dr. Preisig, but also, due to its location in Basel-Stadt, which borders France and Germany, would be easily reachable by applicants living in neighboring countries.

Dr. Preisig and I had already met before in Berlin during a panel on the role of physicians on assisted suicide, but that Thursday morning was my first time at LifeCircle—and I had received strict instructions on how to proceed. Upon arriving there from the airport, I was supposed to call Dr. Preisig and wait for her to open the door. She asked me not to ring the bell, as a way of not disturbing the meeting in case it was already underway. So, just like she asked, I called her and waited. As it turned out, the meeting had not yet started. Once inside, I joined Dr. Preisig and her assistant in waiting for the member to arrive. And so, not long after, she walked through the door accompanied by two women. Elise, the member, was a Belgium citizen living in France who opted to go to Switzerland to carry out her assisted suicide. The companions were French, members of an organization based in France that provides advice on end-of-life care. At that moment, Elise had been a member of LifeCircle for about a year and her procedure was approved two months prior to her arrival. Once she received the green light, Elise went on to schedule her procedure with the organization. For that, however, she would have to travel from France to Switzerland.



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Belgium, Elise's home country, allows the termination of life with professional assistance, both through assisted suicide and euthanasia[63]—which is not a legal possibility in Switzerland. But according to Belgium law, under the principle of due care (Dierickx, Deliens, Cohen, & Chambaere, 2016; Verhofstadt, Thienpont, & Peters, 2017), Elise would have to spend a considerable amount of time in Belgium before being able to request assistance in dying. Under this principle, one has to consult with a physician in Belgium for a long period of time, which would either mean frequent travels to Belgium or moving there permanently—options that did not appeal to her. Since carrying out the procedure in France, where she was then residing, was not an option due to the illegality of assisted suicide in the country and

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[63] The Belgian Act on Euthanasia of May, 28th 2002. It can be read here: http://www.ethical-perspectives.be/viewpic.php?TABLE=EP&ID=59. Last accessed on 18th March 2018.

Belgium would mean radical changes in her lifestyle, as well as the prospect of intense mobility, Switzerland's jurisdiction appealed the most to her. After all, not only there were direct flights from her city in the south of France to Basel, but she would also be able to apply for the provisional green light from home. And that was precisely what she did.

When we were sitting around the desk at the apartment in Basel, Elise shared that after arriving at the airport in France she realized that her passport had expired. Even though Switzerland is not a member of the European Union, it is part of the Schengen Area—a free travel zone among 26 european countries that abolished mutual border control—, so the request for a valid passport struck her by surprise. Without a valid document the airline would not let her board the plane, so she had to apply in the airport for an emergency passport, which is issued with a shorter expiration date. Given the circumstances surrounding her traveling to Switzerland, Elise told us she did not mind this condition. The bureaucratic obstacle was, however, in vain. Due to technical reasons, the plane would not take off. Facing the fact that she would miss her appointment in Basel, Elise rescheduled it for two days later and alongside her two French companions decided to rent a car and endure a 12-hour ride to their destination. Albeit still in her early sixties, her frail health due to a pain syndrome turned the car journey into a potential challenge.

Upon her arrival in Basel, however, Elise received a call from an old friend of hers, who was crying on the phone while sharing that she had recently given birth to a stillborn baby. Unaware of the fact that Elise was not in France, but in Switzerland to carry out her assisted suicide, the friend told her she needed company. She needed Elise's company. As she recounted her own journey to us, Elise's face changed. She was no longer looking directly at us, sharing her story while confidently making eye contact. Instead, she kept looking down, laying her eyes on some random, yet fixed, spots on the ground. We no longer could see her face and her voice could barely be heard. She kept talking, albeit slowly, as if she was processing and reprocessing each and every word she was able to utter. When her face made itself visible again, diverting her stare from the ground and into an abstract horizon, it was concealed behind a veil of doubt. Not even one hour before, Elise had walked past the vestibule and into the room expressing confidence, smiling timidly at us while shaking our hands. Now, her voice was losing its strength, her stare was getting lost, and her confidence, once clear to us all, was disappearing behind watery eyes.

As Elise talked, Dr. Preisig was scribbling some notes on a pad. It was getting more and more evident to everyone present that Elise was having second thoughts about going forward with the procedure. At that moment, she had already painted an eventful depiction of her journey, filled with bureaucratic, logistical, and emotional hurdles. Nonetheless, Elise was not done. She recounted a dream she had had in the previous week, where her parents told her no one wanted her "here," because she still had plenty of things to do "there." Elise had no immediate family. Her parents were already deceased, and she had neither siblings nor children. Sharing this dream had a clear impact on Elise, and it finally came to her: when something was off, either not working or not going to work, Elise's mother used to say "*l'avion n'a pas décollé* [the plane did not take off]." After having said this, possibly noticing the connection between her narratives, Elise started to sob. She was hugging Dr. Preisig, who, in turn, was trying to comfort her back. At this point, Dr. Preisig, alongside the organization's assistant, and Elise's companions, made it clear to her that she could cancel the procedure at any moment, stating that the last thing she should do is to go forward with the assisted suicide while having second thoughts about it. No one there would get disappointed, on the contrary: their goal was for people to live for as long as it is possible, and everyone there would prefer if she opted for life. If she wanted to, she could still reschedule the procedure at a later date.

Elise did cancel her procedure after this conversation, deciding to go and visit her friend instead. Throughout Dr. Preisig's professional trajectory, which included 7 years working at Dignitas and 3 years at LifeCircle, it was the first time that someone canceled the procedure while already in the room to perform it[64]. Leaving her two companions behind, Elise decided to walk back to the hotel and, later on, ended up taking a train to the outskirts of Geneva where she would meet the friend who called her on the previous day. Elise's journey to Switzerland from France was an act of mobility that would allow her to carry out her assisted suicide within an organized setting while, at the same time, alleviating the risk of prosecution for whoever was to accompany her—in France, where she lived, assisted suicide remains illegal. In order to design an itinerary that would enable her to arrange organized assistance to suicide, she had to consider Belgium's provision on "careful consideration," France's stance on the legality of OAS, Switzerland's requirements for assistance offering, and, finally, her own health condition and ability to travel.

Elise's association with LifeCircle and the French organization created the necessary conditions for the emergence of a cooperation between them, which had to take into consideration different legal provisions as well as her health situation in order to design itineraries of circulation. By opting for carrying out the procedure with LifeCircle's assistance, the first itinerary would necessarily have to enable the circulation of documents. Similarly to Margot's or Ingrid's trajectories, Elise would then have to produce, gather, and act upon all the necessary personal, legal, and medical documents for the green light process. The circulation of these documents created a space within which her own mobility to Switzerland would be possible, therefore circumventing both regimes and acts of care that saw her life as something to be protected against assisted suicide. In this sense, acts of cooperation and the circulation of documents lay out itineraries, strategies, that enable further circulations, which, in Elise's case, meant her own act of mobility to Switzerland. Luckily to Elise, there were direct flights from her city to Basel, and even unexpected occurrences, be they bureaucratic or logistical, did not deter her from finding alternative solutions. And as uncomfortable as it was for her, she was nonetheless able to withstand a lengthy car journey to Basel.

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[64] Elise has returned to LifeCircle a few months later and carried out her OAS.

When inhabiting jurisdictions where organized assisted suicide remains a criminal offense, the establishment of a cooperation that can design itineraries of circulation become even more critical. In the United Kingdom, during the legislative debates on the Lord Falconer's bill, in 2013, the mobility of UK citizens to Switzerland—often framed as "suicide tourism" by media reports—has been repeatedly mentioned as one of the reasons why it was necessary to reform the Suicide Act 1961. In such cases of mobility, the cooperation between organizations in Switzerland, such as LifeCircle, and in the UK is vital. One of these organizations was Friends at the End, FATE, based in Scotland. Founded in 2000 by Dr. Wilson, FATE does not offer suicide assistance, acting only as a political pressure group and by offering advice on end-of-life care to its members—usually referred to as befrienders. Dr. Wilson and Dr. Preisig, however, used to cooperate in cases where mobility was deemed necessary. As Dr Wilson said to me, "[w]e got a leaflet, you know, it's called 'The UK Guide to Dignitas,' you see. I mean, I also got all of Erika's [Preisig] application stuff, so I've got copies of all that, which I can give to people who can't get it themselves on the internet, and so on." On the one hand, FATE does not offer to assist in suicides due to legal uncertainties evoked by the absence of an official law governing the issue in Scotland—after all, the Suicide Act 1961 encompasses only England and Wales. On the other hand, FATE does provide information on how to contact Swiss organizations, outlining their application procedures. When it comes to Dr. Wilson personally, however, cooperation oftentimes went beyond handing out leaflets. Nevertheless, Dr. Wilson was well aware of the legal risks associated with providing assistance to suicide in Scotland, and in spite of her pro-legalization stance, she did not provide assistance with the procedure itself. Rather, she used to cooperate with Dr. Preisig—as well as other Swiss organizations—in order to design itineraries that would enable the circulation of people from the UK to Switzerland.

During one of our conversations in her home in Glasgow, Dr. Wilson started to repeatedly look at her watch. She was always very friendly and polite, so her restlessness suggested that something was bothering her. After a few minutes of discreet agitation, she finally explained to me that she had scheduled a phone call with a patient of hers and asked me if I would mind her absence for a few minutes. Excusing herself from the room, she handed me a newspaper "for distraction" and left to her study. About 15 minutes later, Dr. Wilson opened the study door and asked me: "Can I offer you something to drink, like alcohol? After this call I feel like I need it." Accepting her offer, we moved to the kitchen, where she got a bottle of gin and two small cans of tonic. The phone call, Dr. Wilson explained, was with a 28-year-old patient of hers who suffered from a rare medical condition. She had tried to commit suicide twice before and even warned her parents not to call an ambulance if they ever found her unconscious. She wanted Dr. Wilson's assistance to go to LifeCircle and, after this last call, she decided to refer this case to Dr. Preisig, even though this decision was weighing on her. Dr. Wilson knew it was a delicate case and, as she later shared, she used to avoid referring delicate cases to Dr. Preisig as a way of protecting her from controversies that could jeopardize her assistance offering.

"Poor Erika," said Dr. Wilson, "because she's not going to thank me the next day or two… I'm going to tell her about two ghastly cases." In her role as mediator, Dr. Wilson had to weigh the circumstances of each individual case with both the feasibility and the impact of mobility. After all, Dr. Preisig has more than once found herself in the spotlight after assisting people who traveled from the UK, and Dr. Wilson was well aware of that. She said to me: "She's [Dr. Preisig] overwhelmed, isn't she though? She's got… Because she had publicity… You see, for a year or two she has been helping us with… I hate the word client… With people, and we always said that if there has been any publicity we would say they've 'gone to Switzerland' [and not specify the organization], because she has only herself, you know. But unfortunately there's been two cases recently, specially this one, very recently, that had lots of publicity." Dr. Wilson was referring to a case where a nurse from the UK received LifeCircle's assistance to die. However, despite claims that the nurse was healthy, Dr. Wilson stressed that she was suffering from herpes zoster:

“[W]e call it shingles, that’s the ordinary name… And shingles on elderly people you have what they call post herpetic pain, the pain can last for years afterwards, very severe.”

This sense of protection was essential to preserve the cooperation between Dr. Wilson and LifeCircle, and, by extension, preserving itineraries that were essential for the circulation of people in the context of organized assisted suicide. Nonetheless, the circulation of people was not limited to members of organizations or to individuals requesting suicide assistance. As Dr. Wilson explained, there were cases where the mobility of physicians and/or organization staff is also necessary:

> Last February I think, there was an elderly couple who were actually cousins, they weren’t married, which was one of the interesting things, but they’ve lived together in a little coastal town not far from Glasgow, about 40 miles away. She was totally deaf and he was completely blind, but they’ve lived together for 40 years, they never married, and they both worked independently, they never had any relationship with anybody else, and they’ve bought a house together. For 40 years they’ve shared accommodation and then when they became frail they bought a flat in a sheltered housing, you know, where there’s a warden, they own the place, but there’s somebody there available who comes round once a week. Ethel, the lady, she was very well organized, she was much better mentally than… The man was ok, but he was beginning to lose the place a bit, you know, get up in the night not knowing where he was and that sort of thing, but he was blind as well of course. Her GP had written a letter to the housing people saying that they were cousins and lived together, but they needed two separate bedrooms, and she kept this letter, because the Swiss authorities demand a certificate of celibacy if you’re not married. Well, Dignitas demand it very much, of course it doesn’t really mean celibacy, it means you have to swear you’ve never been married. And Erika [Preisig] came to visit them herself, she flew from Switzerland to see them, but before that you have to go to a commissioner for oath to swear that you’ve never been married, you know, ‘I solemnly declare that I have never been married,’ and it costs about 200 pounds. Well, they lived in this little small coastal town and I found on the internet there was one of this special kind of lawyers and they

went to this person and she refused to do it for them because they wouldn't say why they wanted it. So I said to Erika 'help help' and then Ethel found the certificate, this letter from the GP, so Erika flew to Edinburgh, and she came and stayed with me. We went down to visit them, and because she saw them herself and she's a doctor and so on, they didn't have to get an up to date medical report for both of them. The reason why they have decided that they wanted to die together was because Ethel had had a fall, she was 89, and she's had a fall and although she hasn't been badly hurt, she might have easily broken her hip or anything, or she might have had a stroke, and they knew that if they were separated, they couldn't… It was sweet watching them together because they just worked completely together, they knew exactly what the other was going to do, and he couldn't walk very far, perhaps 500 yards or so, but there was a little garden, very near to the flat and they used to go sit in the seat if the sun was shining. So they lived sort of symbiotic you know, and they just thought 'well if something happens to one or the other of us the other one…' Life could not be possible without the other, they would automatically be taken to some kind of residential care, so… It was a very reasonable question. Neither of them had very severe medical problems, but you know, they had arthritis and all this sort of things, so Erika's assistant flew to Edinburgh and he hired a car, and stayed here the night and then we drove in convoy down there, so I took him up to meet them and so on, and he stayed in the hotel there overnight. I came back to Glasgow. But the next morning at nine o'clock he collected them and he drove them to Edinburgh and he escorted them into the plane. And they went all the way right to the place where the accompaniment [the procedure] happens. But you know, it's just so considerate and kind. So in the end they both… They died side by side holding hands you know, very very peacefully. It was lovely. But I mean, to go to such lengths and her assistant coming over and escorting them and so on… They had really, virtually no relatives at all. One of them had a brother or something in Canada and the other one had a nephew in Glasgow who sent them a Christmas card once a year, you know, never came to see them. So between them, of course they had enough money to afford the airfares and things, because they didn't really mind if they didn't leave it all to this horrible nephew who never came to see them. We always call them the cousins. But I mean, such care, such compassion…

For the cousins, any itinerary of circulation that would enable them to go to Switzerland had to involve the circulation of physicians—who would evaluate them in person and, therefore, spare the need of recent medical reports—and assistants—to help them with their mobility, with transportation to and from the airport, as well as boarding the plane with them. In their case, Dr. Wilson's personal cooperation with Dr. Preisig—and LifeCircle—was crucial to set up the cousins' mobility and, ultimately, their joint assisted suicide.

The uncertainty regarding the legal status of assisted suicide in Scotland, where the lack of a specific official law on the issue leads to suspicions that other criminal offenses might occupy this legal vacuum, makes any form of cooperation be covered by a veil of discretion, if not secrecy. The cousins, as Dr. Wilson recounted, did not want to reveal why they were requesting their certificate of celibacy, therefore being denied the document and triggering a visit from Dr. Preisig herself. However difficult it is to establish itineraries of circulation to Switzerland from countries where assisted suicide is shrouded by legal uncertainties, there are circumstances where legal changes end up reshaping itineraries that have already been established. In Germany, the implementation of the §217 StGB in 2015 has led to the criminalization of organized suicide assistance in the country, and the lack of clarity regarding the content, reach, and scale of this newly created criminal offense has impacted both the ways such assistance is provided domestically and the itineraries usually used by Germans to go to Switzerland.

According to LifeCircle, the majority of applicants for their assistance in suicide used to come from France, followed by Switzerland, and, in close tie, Italy and Germany. However, after the §217 StGB in Germany, the number of Germans applying for suicide assistance with LifeCircle has increased almost tenfold—as Dr. Preisig shared with me. Even before the passing of the §217 StGB, its possible impact on Swiss organizations was a cause of concern to Dr. Preisig. She suspected the law would not be able to hinder the mobility of Germans to Switzerland, fostering it instead. "I'm very worried about the law," she once said to me, "I heard a lawyer talking about an article he read, it said ‘let Switzerland do the dirty job, we don’t need to legalize assisted suicide.’ And that is exactly what is going on in Germany right now, they don’t want to take any responsibility over the issue.” In this sense, Germany went the opposite direction by tightening the state regulation on assisted suicide, which led to an exponential increase of German applications with LifeCircle. There, where “businesslike” assistance to suicide has been criminalized, thus forbidding organizations and professional assistants to operate, the work provided domestically by StHD has been replaced by an increase in international mobility.

However, while organizations are more exposed and consequently more susceptible to law enforcement, unorganized professional assistance can operate through different methods—even in Germany. If before the §217 StGB *Sterbehilfe Deutschland* provided an alternative to mobility through which people could receive professional assistance to die at home, its shutdown had an impact on how assistance is provided in the country. An impact that went beyond a hike in mobility to Switzerland, affecting the very itineraries of circulation themselves. In other words, the reshaping of Germany’s legal landscape on assisted suicide has impacted the ways through which different forms mobility are designed and organized to operate. With the previous itineraries under the threat of criminalization, new ones had to be drafted.

Whereas StHD had to stop providing assistance in Germany following the passing of the §217 StGB, other forms of assistance continued to operate, such as assistants who work independently from organizations. One of them was Stefan, whose story I tell on chapter 2. However, Stefan was not alone. Long before the implementation of the §217 StGB, Dr. Arnold had already started working with organizations that provided assisted suicide, such as Dignitas, of which he was vice-president in Germany. Now retired as a physician and with no formal ties to any organization, Dr. Arnold continued to assist people domestically and abroad. He shared:

> There's a lady in Vienna who will get help very soon. I'm not going to Austria. Austria is more dangerous than England and France. Even talking about it... I went to a talk show there once, but asked if they would let me in and out of the country after being on TV. Yes, of course, they said. But it could have been different. The police could have come to the studio and arrested me. I was lucky. The Austrians are crazy. So this lady will be helped by my contact, he lives there. (…) When it's too dangerous I don't go, somebody else goes. This lady wants to do it alone, so she got instructions from somebody else, my contact, but she wants to do it alone. (…) The next one is in France. If I don't find a doctor who signs it, who makes it a normal death, then I'll tell officials it was a suicide, no connection to me. (…) We have to be careful, they [applicants] tell the neighbors. They mention my name… That cannot be, that's very dangerous.

Already retired as a physician, Dr. Arnold was not worried about losing his medical license: "[t]hat doesn't bother me," he said, "[before the §217 StGB] I can work everywhere in Germany, I'm registered at the *Ärztekammer Berlin*, but it's different when I go to another country. In England and in France and in Spain, you have to do it secretly. Because you can go to jail, it's terrible. But you try not to get caught. Libby [Dr. Wilson] got caught once. I don't give a shit about the *Ärztekammer*." When the risk of prosecution became a reality in Germany as well, Dr. Arnold had to develop new ways of providing assistance. He explained:

> But people ask me to help, and I say, 'Ok, you can send me a letter with your problems, but first of all only send letters, don't call me. And secondly, I'll not promise, I'll not give you much hope that I will help you because of the law.' [There was this man], he tried to kill himself again and was found in a forest three days later. He had a neurological problem with his arm, and he said he will stop eating and drinking. If you are in a psychiatric facility, they force you to it. He didn't want it. He couldn't jump through the window. So my wife said, 'You must help him.' What can I do? I talked to his mother, who was always crying on the phone. 'Ok, tell your son he should start eating and drinking, and in three or four weeks I'll see him at home.' It's actually what happened. Then we met, we organized something, and we did it, and we did it so

> cleverly, that the police said 'He did it again, it was a suicide.' So I cheated the police. I told him to bring all those psychiatric drugs, loads of it, so he took all five or ten of them, he threw some on the floor, some on the bed, then he died. They found all these drugs, the empty drugs, so they thought he had taken all of the drugs. If they had made an autopsy, they would have found the drugs in the stomach. So at least they would say 'Ok, he has the drugs.'

However effective the §217 StGB might have been for organizations inside of Germany, its impact on non-organized professional assistance, like Stefan and Dr. Arnold, was less one of determent than that of a reshuffling. It rearranged the system by preserving forms of assistance that are more discreet over organizations—which are more exposed to the public eye and visible to the state. As not to attract any attention to their respective assistance offering, both Stefan and Dr. Arnold had to operate discreetly, with the latter trying to make assisted suicides be perceived as either natural death or non-assisted suicide. In the last case described by him, Dr. Arnold had to articulate the applicant's history of previous suicide attempts with a set of evidences that would corroborate it, such as spreading psychiatric drugs across the room. In other words, Dr. Arnold acted upon the compulsory ontology of pathology (Marsh, 2013), that is, the psychiatric regime of truth that links suicide with acts of "insanity," to arrange a scenario that would emphasize the man's history of suicide attempts and prevent further investigations by the police. And in order to do this, drugs played a major role.

Method, thus, is a key factor in the articulation of itineraries. Since both Dr. Arnold and Stefan were based in Germany, they did not have access to the same pharmaceuticals as organizations in Switzerland do—and the same applied to Dr. Wilson in Scotland. As a result, the itineraries drafted upon their respective acts of cooperation were mostly designed for the circulation of people, safely enabling a channel to LifeCircle's assistance and, most important, to barbiturates. Nonetheless, in cases where the applicant's mobility is not possible—due to personal preferences or health issues—, itineraries for the circulation of pharmaceuticals are likewise designed, thus enabling their transnational circulation. The most common of such drugs is sodium pentobarbital, a barbiturate considered a safe, painless, and fast way to die. Its legality, however, varies within different jurisdictions, making cooperation a key factor to get hold of it.

4.2 Mobilities of technologies

4.2.1 Pentobarbital

If the new German legal landscape reshaped the ways through which professional suicide assistance is provided in the country, fostering acts of mobility to Switzerland over domestic assistance offering by organizations, the work done by individual assistants has become essential. Besides assisting in the actual procedure, their associations with individuals and organizations from other jurisdictions often facilitate forms of cooperation and, above all, the drawing of itineraries that can help circumvent regimes of life and acts of care. Similarly to Stefan, Dr. Arnold kept providing assistance after the §217 StGB went into effect. During one of our meetings, in his apartment in Berlin, Dr. Arnold shared that he used to recommend people to go to Switzerland, despite not always being possible for those who seek his assistance. "If they come to me," he said, "it's because they don't want to go to Switzerland. Also, sometimes Switzerland calls me, asking 'can't you take over?' They have too many people going there, and sometimes a person can't wait that long… Usually Germans who cannot travel." But despite involving mobility and a waiting period due to the high number of applications, Switzerland remained a good option for Dr. Arnold: "I prefer Switzerland anyway, because they have Nembutal there, it's easier and a quite uncomplicated way of going out. Doesn't taste very good, but…"

Nembutal, the reason for Dr. Arnold's predilection for Switzerland, is one of the commercial names of sodium pentobarbital, a barbiturate synthesized for the first time in 1930 that acts on the central nervous system as a depressant. Because of their effects, barbiturates such as Nembutal and Seconal[65] were commonly used as sleeping tablets and sedatives (Malamed, 2018, p. 277), but their addictive quality, as well as their high risk of accidental overdose, have led them to be progressively replaced by benzodiazepines—such as Valium, Xanax, and Ambien. If, on the one hand, barbiturates were too dangerous to be used as treatments against anxiety and insomnia, on the other hand, it was precisely their perilous quality that made them safe resources for assisted dying procedures, from assisted suicide to, even, veterinary euthanasia. According to the American Veterinary Medical Association's guideline for the euthanasia of animals[66], "[a]ll barbituric acids derivatives used for anesthesia are acceptable for euthanasia when administered IV," stressing that "[d]esirable barbiturates are those that are potent, nonirritating, long acting, stable in solution and inexpensive." As a result, the AVMA states that "[s]odium pentobarbital best fits these criteria and is most widely used, although others such as secobarbital are also acceptable." (AVMA, p. 28)

Besides its employment in veterinary euthanasia, barbiturates are also used in assisted dying procedures in other jurisdictions, such as Switzerland. There, organizations that provide suicide assistance to their members, like LifeCircle, use barbiturates as their main, if not sole, method to carry out the procedure. For instance, in the beginning of the 1990s, both secobarbital and pentobarbital were commonly used in Canton Zurich, but, between 1997 and 2000, pentobarbital started to be used almost exclusively (Bosshard, Ulrich, & Bär, 2003, p. 313). Despite its availability in the country, access to pentobarbital still requires a medical prescription —one of the reasons why assisted suicide in Switzerland remains in the medical

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[65] Brand names of pentobarbital and secobarbital, respectively.

[66] The AVMA guideline can be read here: https://www.avma.org/KB/Policies/Documents/euthanasia.pdf. Last accessed 11th June 2018.

remit, even though there are no legal provisions requesting medical participation in procedures (Andorno, 2013, p. 4). As a physician, Dr. Preisig can prescribe pentobarbital to members of her organization. But access, however, is not the only challenge when it comes to pentobarbital. According to her:

> It's not difficult to order it online. It comes mostly from China, but also from Mexico. But the biggest problem is that we don't know what we receive. I know a couple from Canada, the man travelled to Mexico, bought the drugs there and brought them over illegally across the border to Canada. He and his wife took the drugs and nothing happened. It was a white powder, they paid a lot of money for it, and nothing happened. When this happens it's not so bad, but there are cases where people take the wrong drugs and end up suffering more and not dying. That's really, really bad. And the other problem with sodium pentobarbital is that we need instructions on how to use it. If we drink it without drinking something first to prevent vomit, the body will immediately reject it and throw up. That's a big problem, people don't know how to use it. Then maybe it's not lethal anymore, but only harmful.

In this sense, there are two main issues regarding pentobarbital: where to get it and how to use it. Indeed, similar questions were raised by Margot when she wrote her application letter to LifeCircle: "[o]f course, I think about a cocktail of medications, but I just do not know where I could get the right ingredients for it." If, as Dr. Wilson put it, medical prescriptions act as one of the medical gates standing between the applicant and the actual procedure—thus investing medicine in the role of gatekeeper (Conrad, 1979)—, having a medical doctor involved in an organized setting, like Dr. Preisig and LifeCircle, facilitates both access to pentobarbital and to the knowledge of how to safely employ it.

As already mentioned in the first chapter, the Swiss Narcotics Law—the *Betäubungsmittelgesetz* (BtMG)—, allows physicians to prescribe pentobarbital to their patients, providing that they do so in accordance with recognized rules of medical and pharmaceutical practice. Since the Swiss Academy of Medical Sciences recognizes that, due to the very nature of the doctor-patient relationship, physicians need to make a personal decision of conscience on whether to provide suicide assistance, the BtMG's provision on "recognized rules of medical and pharmaceutical practice" leads to subjective paths. As Andorno (2013, p. 4) notices it, "[t]his introduces a matter of interpretation as to whether prescribing a lethal drug to a person seeking to commit suicide is in conformity with medical practice." As the outcome of this legal intertwinement, physicians in Switzerland can only prescribe pentobarbital if in accordance with recognized rules of medical practice—but, in the context of end-of-life care, these recognized rules are based on a personal decision of conscience.

Julien was the first person I have seen using pentobarbital. He was a Swiss member of LifeCircle who had applied for a provisional green light about two years before his procedure took place. When I arrived at LifeCircle's apartment that morning alongside Dr. Preisig, her assistant and Julien were already there. While the assistant, Peter, was preparing the procedure, Julien was looking for something in his suitcase—which was filled with papers and drug packages. As Dr. Preisig and Julien reunited in the organization's office for a chat, I went on to accompany Peter's work. In front of him, on the kitchen's countertop, there was a small flask containing a white powder, labeled "*Dosis Letalis*." He explained to me that 0,2g of pentobarbital is enough for a deep anesthesia—after all, barbiturates like pentobarbital have been used for many years as sleeping aid and anesthetic—and half a gram would be enough to die. The flask, however, had 15g of it. Since access to pentobarbital is highly restricted and regulated, with each label stating the name of the person who is supposed to take it, the content has to be used in full. By doing so, there are no leftovers that could be used without prescription by somebody else.

Because pentobarbital is a very aggressive drug, it is necessary to take an antiemetic beforehand to avoid vomit: "[n]ature is smart," said Peter to me, "the body fights against death." But even an antiemetic is not enough to prevent burning sensations. To illustrate what he meant, Peter took me to the organization's vestibule, where he showed me a plastic table and pointed at a stain: he once prepared the procedure there, and just a bit of the powder on the surface was enough to burn the table. In contrast to other organizations in Switzerland, where pentobarbital is usually taken orally after an antiemetic, LifeCircle applies it intravenously. But, while the assistant is responsible for preparing the procedure, the applicant has to open the valve that releases the flow of pentobarbital themselves. When administered intravenously, Peter explained, the effect is faster and safer: it takes 30 seconds for the person to fall into a deep sleep and around two minutes to die. In comparison, if ingested orally death usually comes after half an hour. In some occasions, however, it can take hours to act. Peter shared that in one organization where he has previously worked, it once took 26 hours for one member to die after swallowing pentobarbital. Administering it intravenously, thus, would not only offer the member a safer way to die, but also a more peaceful—or less stressful—experience to their family members and companions.

DOSIS LETALIS — SODIUM PENTOBARBITAL | BASEL | 2016 | MARCOS ANDRADE NEVES

WARNING - <Party Balloon Time> products

Be sure that any 30-balloon tanks you purchase are marked thus on the box and tank:

NET CONTENTS 8.9 ft
HELIUM (.25 m)

If any size of tank or box (30 or 50-balloon) has the words:

HELIUM/AIR

These are unsuitable for self-deliverance. Do not use. The manufacturer is now diluting some helium tanks with 20 percent air because of world shortage of helium.

They will be clearly labeled.

Older tanks which you might have stored are OK, but just in case check the small print on the box and tank. Repeat: Don?t use tanks with the words <helium/air> on them (although with 80% gas they will still inflate party balloons).

-- Derek Humphry, Oregon 23 April 2015

EXIT International, based in Australia, posted this message 24 April 2015:

Balloon Time Helium - WARNING

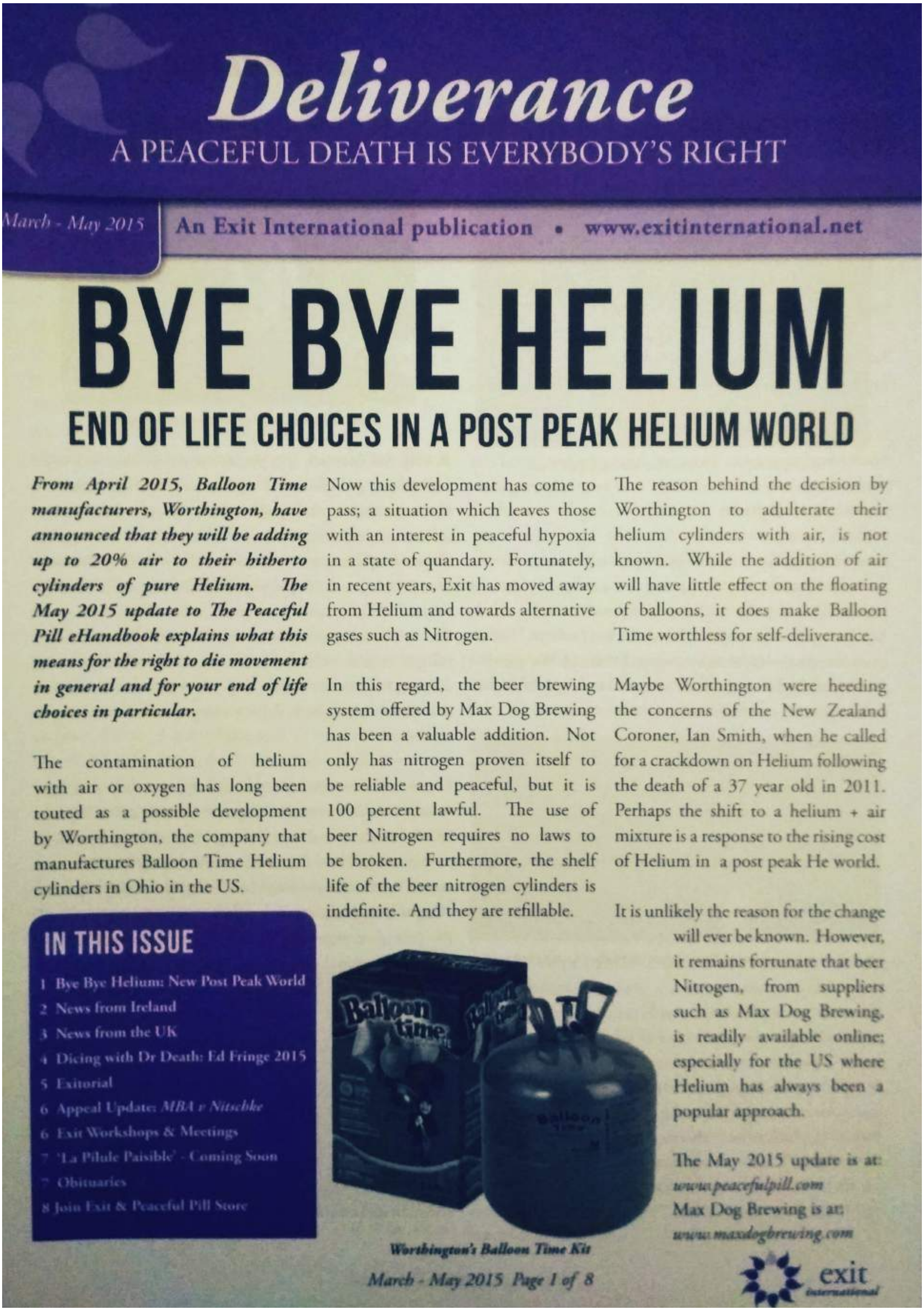
The largest manufacturer of disposable helium cylinders, Worthingtons in Columbus, Ohio, who make Balloon Time kits have announced on its website that from April 2015 their cylinders will guarantee only 80% helium, with up to 20% air. While an 80:20 helium:air mixture is suitable for floating party balloons, its use to provide a peaceful death is lost.

In June 2014 in Auckland, Dr Nitschke conducted gas purity testing using Balloon Time helium sourced from various centres in New Zealand. At that time, all cylinders tested were found to have oxygen contamination levels of < 0.5%.

Exit recommends that those with recently-acquired Balloon Time cylinders either test the gas to ensure that there is no oxygen contamination. Alternatively, the cylinders should be discarded and replaced with a reliable alternative like Max Dog nitrogen, where the purity of the gas (& absence of any oxygen) is guaranteed by the distributors.

At this stage it is not clear if the manufacturers of Balloon Time's equivalent products, such as BOC/ Tesco product marketed in the UK will follow suit. Purity testing of BOC Balloon Time clones will take place this week. Results will published in the May 2015 update to the Peaceful Pill eHandbook along with the gas purity testing procedure, including the equipment required.

Excerpts of the warnings issued by Derek Humphry and Exit International.



Deliverance

A PEACEFUL DEATH IS EVERYBODY'S RIGHT

March - May 2015 An Exit International publication • www.exitinternational.net

BYE BYE HELIUM

END OF LIFE CHOICES IN A POST PEAK HELIUM WORLD

From April 2015, Balloon Time manufacturers, Worthington, have announced that they will be adding up to 20% air to their hitherto cylinders of pure Helium. The May 2015 update to The Peaceful Pill eHandbook explains what this means for the right to die movement in general and for your end of life choices in particular.

The contamination of helium with air or oxygen has long been touted as a possible development by Worthington, the company that manufactures Balloon Time Helium cylinders in Ohio in the US.

Now this development has come to pass; a situation which leaves those with an interest in peaceful hypoxia in a state of quandary. Fortunately, in recent years, Exit has moved away from Helium and towards alternative gases such as Nitrogen.

In this regard, the beer brewing system offered by Max Dog Brewing has been a valuable addition. Not only has nitrogen proven itself to be reliable and peaceful, but it is 100 percent lawful. The use of beer Nitrogen requires no laws to be broken. Furthermore, the shelf life of the beer nitrogen cylinders is indefinite. And they are refillable.

The reason behind the decision by Worthington to adulterate their helium cylinders with air, is not known. While the addition of air will have little effect on the floating of balloons, it does make Balloon Time worthless for self-deliverance.

Maybe Worthington were heeding the concerns of the New Zealand Coroner, Ian Smith, when he called for a crackdown on Helium following the death of a 37 year old in 2011. Perhaps the shift to a helium + air mixture is a response to the rising cost of Helium in a post peak He world.

It is unlikely the reason for the change will ever be known. However, it remains fortunate that beer Nitrogen, from suppliers such as Max Dog Brewing, is readily available online; especially for the US where Helium has always been a popular approach.

The May 2015 update is at: *www.peacefulpill.com*
Max Dog Brewing is at: *www.maxdogbrewing.com*

IN THIS ISSUE

Worthington's Balloon Time Kit

After his last conversation with Dr. Preisig, during which he also had to sign several documents, Julien went outside to enjoy a last cigarette. He was away for just a few minutes, walking back and forth on the sidewalk while holding his cigarette. Once back inside, Julien hung his jacket on the coat rack and walked toward the bed, offering his arm to Peter. The infusion needed to be attached. The preparation is relatively simple, but Julien needed first to rehearse the procedure, opening the valve a few times without the solution of pentobarbital attached to the IV tubing first. Once everything was set, Dr. Preisig proceeded with the usual questions: "What is your name?; What is your date of birth?; Do you know what will happen if you open this infusion?." To the last question, Julien replied, laughing: "Yes, I'll go back to nature." "Well, Julien," said Dr. Preisig, "you can open the infusion whenever you want." Immediately after having heard Dr. Preisig's final instruction, Julien rolled the valve open, allowing the pentobarbital to slowly drip down the IV tubing and into his body. Meanwhile, Peter was recording each and everyone of Julien's movements with a handheld camcorder, a key element to provide the police visual evidence of assisted suicide.

While the solution of pentobarbital was slowly dripping, Julien closed his eyes and adjusted his head on the pillow. Dr. Preisig and I were standing by the bedside, and while we were both silently waiting for his death to come, she was comforting him by caressing his hands. And within just a couple of minutes, death did arrive. Everything happened fast. From full consciousness through deep sleep to death, pentobarbital acted faster than the time it took Julien to enjoy his last cigarette. Now, he was neither making sounds nor moving. His mouth was open and his hue turned different, a grayish white. He was no longer breathing. With a stethoscope, Dr. Preisig approached the bed to check his vitals. Julien was dead.

The way Julien's death transpired was illustrative of Dr. Arnold's preference for Switzerland—and, more precisely, for pentobarbital: it was fast and without complications, with death coming after just a couple of minutes of deep sleep. But

Julien was a Swiss citizen and resident, and mobility was not a major issue to him. And by going to LifeCircle, the medical prescription for pentobarbital would likewise not be an issue as well. In contrast, as Dr. Arnold mentioned, not everyone applying for suicide assistance with him can go to Switzerland, nor can he access pentobarbital in Germany. Similarly, Roger Kusch also has a predilection for pentobarbital. "The German BtMG [narcotics law]," Kusch said to me, "has the same structure as the Swiss BtMG, but we have no offer of pentobarbital in Germany. If a German doctor prescribe pentobarbital to someone, it's legal, but if you go with this prescription to a pharmacy they won't be able to give it to you. And to import it from Switzerland… that would be against our BtMG, it's not possible. It should be offered in Germany, but we don't have it, so there's no way."

In this scenario, where either the intertwinement of medical and official laws or the availability of pentobarbital prevents access to it, itineraries for the circulation of pharmaceuticals are drawn and situations like the one described by Dr. Preisig emerge. Transporting barbiturates across state borders, however, can be illegal. Speaking to an UK audience, Docker (2015, p. 69) warns that barbiturates "can generally only be obtained by importing them somehow from a country that allows them on open sale," but "[h]eavy penalties are possible for anyone caught bringing illegal drugs into the country, whether by person or through the post." Finally, he stresses that "[p]ossession of barbiturates without a valid prescription is also a serious offence." Within this context, Dr. Wilson presented a similar case to the one recounted by Dr. Preisig:

> His name is Robert, he is 90, and he is completely, absolutely, aware. He was a professor at the department of Law at the university here. He was… Both of them I think have been married before, but he married a very well known journalist called Mary. Mary got all sorts of… I can't remember, different medical conditions, this was probably about ten years ago now. And her son went to Mexico and got some veterinary Nembutal. And he got a double lot. So, anyway, Mary actually took her own

> life in her own home with her husband and her son with her. They had a celebratory meal afterwards. [*laughs*]. But David is a quiet, but very supportive, sensible, member. Now, he has actually recently got… I think it was Mexico, but it might have been in China, very recently actually, within the last month, I gave him the email address [of a supplier] as a medical insurance. He hasn't got any illness at the moment, life-endangering, but he wants medical insurance. So now he's got it. But, in fact, Mary, before she died, she asked her son to give me the other half of the dosage drops, you see. [*laughs*]. I can't remember where that went, but I think it went to a good home. [*laughs*]. But David is a very sensible, quiet, sort of chap, and, as I see, he has no intention of ending his life now, he just wants something there in case something happens. So as a sort of medical insurance.

In this case, two different strategies for the circulation of pentobarbital were designed, the first of which involved the son's own act of mobility to Mexico and back to the United Kingdom. Given the impossibility of lawfully acquiring pentobarbital in the UK, her son travelled to Mexico, where veterinary nembutal is widely available, and brought it over to the UK with him. But the illegality of both possessing and importing barbiturates, alongside the health risks associated with buying pharmaceuticals from unknown sources, lead to uncertain, if not dangerous, paths.

After Mary's death, her son followed through with her request and sent Dr. Wilson the other half of his stash. But Dr. Wilson could not rely solely on circumstances like this, and just like Robert, Mary's husband, she also resorted to online sources. She recounted:

> **Dr. Wilson:** because most people who contact me are not desperate to die next week, they had a very very poor prognosis given to them and they want what I call a medical insurance policy. They want to have something available that they can take themselves when they feel necessary, and they might never need it, but they want to know it's there. So I have two email addresses, one in China and one in Mexico, for getting Nembutal, but I can't help feeling that… The cost of buying Nembutal in the United

States has now gone, and I can't help feeling that as soon as the Mexican and the Chinese suppliers realize this the cost will go shooting the moon.

MFAN: Because there you can buy it over the counter?

Dr. Wilson: Well, you have to go get it at a veterinary pharmacy, it's a veterinary preparation, and it's liquid, because it's what can be injected into an animal to put it to sleep. So it comes in 100 ml bottles with a plastic cap and a rubber diaphragm which the vet puts a needle through and aspirates how much the right dose for the right size of the animal, you see. So it comes in bottles about this size. Actually, the last lot I had… It was obviously veterinary Nembutal, just vets can get it, because it was sort of straight from the manufacturers, it had a label on it, you know, with all the stuff on it, there was no reason to think it was… Probably it wouldn't be worth any money trying to falsify it, but China's… Well, it's more dodgy in a way, although so far we've had 100% as far as we know. It's a powder from China and it comes in a sort of… A little plastic package, and inside there's a little cardboard box usually labelled with something other than Nembutal. And actually about a month ago I had two policemen sitting where you are because I… You see, some people… To order it, you have to have the internet, you also need to be able to go to a Western Union, and they are all over the place, I mean, there are three in Byres Road in the backs of shops I think. Because there you pay cash, you see, obviously, no one wants to leave a paper trail so you pay cash, and you have to get a form, which has a number on it, and then you email the number back to China and say 'I've sent you the cash.' Of course you already emailed them to find out how much it was going to be, probably it'd be up… Probably something in the order of 400 dollars or something like that, it's about 300 pounds. So you email back to the source and say 'I've sent so much via Western Union and this is the MTCN[67] number,' which is a tracking number, you know, on the form, and than on the form you've sent through Western Union it's got a man's name and also the location, the town that he lives in. You don't have the exact address, you just have to have the town that he lives in, and than he can go and claim it. So when he's got the money, he confirms it and than he says 'where do you want it sent?' Because sometimes I get it sent to somebody else, you see. [*laughs*]. Mind you, most people don't know about all this, I don't tell people because I don't want to get all messed up within their pants,

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[67] Money Transfer Control Number.

but, these two policemen… It was Saturday night and I've just been across the road to post a letter, and I was coming back, on my steps, and these two policemen asked me if they could have a word? They were perfectly friendly, nice, and… They were here for over an hour. And apparently customs, it's called something like… In effect it's the customs, they have intercepted a parcel, a package, from China, which was actually labelled, inside of it, of course, Phenacetin. Now, Phenacetin is actually a drug which hasn't been used in the UK for about 30 or 40 years. I mean, when I was a student, that was a very long time ago, there were tablets called APC, Aspirin-Phenacetin-Caffeine tablets, and they were used for headaches and things like that. Just mild. You know, just like Aspirins. It wasn't particularly illegal stuff anyway, but some idiot in China had put Phenacetin on the label. So they wanted to know if I was able to swear that I haven't ordered Phenacetin from China you see, because I think I said I had ordered something else. The older of the two men said, 'well, to tell you the truth I've got a lot of sympathy for your… I have every sympathy, but you know, this is sort of a banned substance' and so on and so forth. So we had this long conversation. So, the trouble was, you see, I've ordered a double dose, and the policemen said that it was 200g. Well, of course, actually, the amount I've had actually ordered was 50g, because it comes in packages of 25g, and you only need half of it. Sometimes I got the other half sent to me by arrangement… [*laughs*]. But, you know, if you've got two for the price of one sort of thing, you've got 100 dollars off it. So I've ordered two lots, so I couldn't even pretend it was for my own use if they found out. And I can't imagine, they've said 200g, no way I've ordered it. 200g is a lot. I mean, I would never order that sort of amount for all sorts of reasons. So I think he probably just made a mistake about that actually, but the fact remains that they've had it confiscated. So we put an embargo on China for a bit, and I've sent a message via another member who had ordered some recently from China, and hadn't got it satisfactorily, and I've said 'would you email the address in China and say on no account label the stuff Phenacetin.' And I think probably it is still pretty safe if you are just ordering one lot. And it won't be intercepted. Anyway, apart from that you might get in trouble for importing banned substances, but it's perfectly legal to end your own life if somebody hasn't assisted you. So, I also ordered a double lot from Mexico, and I was very worried. [*laughs*] I thought, if they intercept this Mexican lot I'm really in a shit in a big way. [*laughs*]. But thank goodness about five days later the Mexican stash arrived. [*laughs*].

> **MFAN:** What did you tell the police? Did you say it was Phenacetin or did you say it was…
>
> **Dr. Wilson:** I just said… I was able to swear I haven't ordered Phenacetin. That was perfectly true to the letter of the law. Not perhaps the spirit, but the letter.

Both the legality of pentobarbital and the criteria to acquire it vary among jurisdictions, and while in Mexico it may not be illegal to buy pentobarbital, its circulation to other jurisdictions can change its legal quality. Moreover, it may change pentobarbital itself. Its contemporary use in Switzerland as an assisted suicide drug, for instance, diverges from its initial purpose as a sleeping aid and anesthetic. In the Benelux countries, in turn, it is used for euthanasia procedures, whereas in the United States it was frequently used as an execution drug for capital punishment convicts, until a legal controversy with the European Union—where the drug was then manufactured—put an end to the commercialization of Nembutal for this purpose. And, of course, parallel to these different uses, pentobarbital remains being widely employed as a veterinary drug—thus crisscrossing different medicines.

As Pordié (2014, pp. 51-53) argues, global pharmaceutical objects acquire its meaning when "embedded in a relational network at a specific point in space and time," therefore allowing the "absorption of ideas, epistemologies, materials, or even policies." In this sense, pharmaceuticals not only carry messages and ideologies (Sjaak van der Geest, Susan Reynolds Whyte, & Hardon, 1996, p. 169), but are also metonymic of political processes and societal changes. They are technologies enmeshed in a tapestry of social relations, power disputes, and economic transactions, often finding themselves as subjects of judicial contestations (J. Biehl, 2013). As a porous pharmaceutical object, pentobarbital goes beyond its chemical composition and commercial names, for as important as these aspects are, the materiality "does not suffice in making the object what it is." (Pordié, 2014, p. 52)

To look beyond the materiality of the pharmaceutical object is to see it as enmeshed in different relational matrices, where not only they become susceptible to social, political, and medical circumstances (Behrends, Park, & Rottenburg, 2014; Law, 2002; Pordié, 2014), but also turn into unstable objects with a life of their own. Van der Geest et al. (1996) have proposed three life stages for pharmaceuticals: (1) their manufacture; (2) their trading; and, finally, (3) their usage by the consumer. However, they argue (Sjaak van der Geest et al., 1996, p. 156): "Someone will take the medicine with the purpose of restoring, improving, or maintaining his or her health," concluding that "[t]he fulfillment of their life purpose lies in their effect on the well-being of the person who took them. The pharmaceutical's efficacy is its ultimate and decisive life stage."

Whereas this definition might have been accurate when pentobarbital was first developed for anesthetic purposes, the contemporary efficacy of pentobarbital is frequently measured by its lethality, and not well-being. This was precisely Dr. Preisig's concern in regards to purchasing pentobarbital from unknown sources or misusing it: it ceases to be deadly, becoming only harmful. Similarly, it is also the reason why pentobarbital is considered by Dr. Arnold, Kusch, and Dr. Wilson a *safe* drug for assisted suicide procedures. It is not, thus, about dividing pentobarbital into life stages where efficacy is necessarily associated with well-being and health (Geest, 2011, p. 10), but rather considering it an unstable object through time and space. An object enmeshed in different sociopolitical contexts that, because of its porosity, becomes sensitive to societal changes, technologies, and policies. Despite its high risk of overdose, pentobarbital remains being produced and employed, for instance, in treatments against intracranial pressure and refractory status epilepticus. And precisely because of its high risk of overdose, pentobarbital is the preferred drug for assisted dying procedures, such as voluntary euthanasia and assisted suicide (Bosshard et al., 2003, p. 313), as well as for the execution of prisoners sentenced to death in the United States.

When pentobarbital, as a pharmaceutical object, travels from one place to the other, it traverses different policies, ideas, values, and moralities. For instance, when it traveled from Mexico—a country where assisted suicide remains illegal and pentobarbital is used as a veterinary drug—to Scotland, it absorbed different sets of laws and "regimes of values" (Sjaak van der Geest et al., 1996, p. 156): from veterinary to human consumption; from legal to illegal. If, as Povinelli (2011) argues, routes create worlds—that is, relational spaces that cannot be reduced to place or places—, the circulation of pharmaceutical objects, alongside that of people, reinforce such worlds by adding an unstable technology to safely carry out OAS procedures. Nevertheless, pentobarbital in specific, and pharmaceutical objects in general, are not the only technologies that circulate in this landscape of assisted suicide.

As Dr. Wilson explained to me, she had to walk a fine line between legality and illegality each time she involved herself with pentobarbital, and because of this she had to look for other options:

> That is actually much more than giving advice, and I know that I'm actually over the border. To actually order something for somebody is different from telling them how to do it. So I try to protect myself in that sort of a way. And there's another… Another method which is advocated in some of the books and things, which is taking chloroquine, which is an anti-malarial drug. Which, in this country, you can still get over the counter, without a prescription. And you will be taking it with a sleeping tablet, with a long acting sleeping tablet. Quite lot of them, like Valium, as they used to call it. It's a long acting tranquilizer thing. It's quite a good long term sleeping thing. So, if they can get hold of Valium and they can buy chloroquine over the counter, you see, the combination of the two will kill you, because chloroquine kills you and there isn't an antidote, and if they find out what it is… But it takes about three or four days, so you need to be in a deep coma, because it's not very nice what is happening to you. So, I have, on occasion, of course, bought chloroquine for people who… And sent them. Absolutely ludicrous you know, wiping my finger prints off the boxes and things. Absolutely loopy, really. [*laughs*]. I think I only got them about four times and I never heard from the people afterwards, I'm sure they have died.

While both chloroquine and Valium[68] have each an original purpose and ideal of efficacy, when employed in this world composed of itineraries of circulation their purposes change and their criteria of efficacy shift. Even their legality becomes questionable. Chloroquine is no longer an anti-malarial drug, just as Valium is no longer used to treat conditions such as anxiety. In this world, once combined, their efficacy is their lethality. Similarly to pentobarbital, they are variable, global pharmaceutical objects, whose constitution changes in accordance to a broader context.

Nonetheless, in this specific case what was circulated was not the pharmaceutical objects themselves, their materiality, but the knowledge on how to *safely* employ them. To use this combination of drugs was not Dr. Wilson's own idea. It was suggested to her by Dr. Arnold, and therefore it only became a possibility after their joint cooperation. So while association and cooperation can lead to itineraries of circulation that enable the mobility of people, they can also be designed for the mobility of pharmaceutical objects, such as pentobarbital, as well as for the exchange of knowledge regarding their usage.

4.2.2 Mobilities of knowledge

The interplay of legal issues, source unreliability, and difficulty of access, has made pentobarbital a risky object to circulate, triggering a search for alternative methods—from easily accessible pharmaceuticals, to inorganic salts and gases. But to find methods that are safe, reliable, fast, and painless, is not an easy task. Because of his medical background and interests, Dr. Arnold was able to came up with the mix of pharmaceuticals mentioned by Dr. Wilson. However, despite being easy to acquire, this method does not act fast. Once, during a conversation in her home, she explained to me:

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[68] Now known as Diazepam.

> **Dr. Wilson:** I've been in touch with him [Dr. Arnold] for four, five years I think. He sent me the instructions about this method, and he sent me on three different occasions, he sent me liquid Diazepam from Germany, and I've got some now actually. But, it's, you know, it does take time, so on the other hand if you are desperate enough you would do it, and obviously you are asleep, so it doesn't affect you all that much. But you must be in a position where people are not gonna find you very quickly
>
> **MFAN:** Because otherwise someone might just rescue you?
>
> **Dr. Wilson:** Yes, although I believe chloroquine is a very difficult. Once it gets to a certain stage it's almost irreversible. That's one of the great things about it, you see.

In Germany, Dr. Arnold's home country, the difficulty of acquiring pentobarbital led to similar situations. For instance, when Roger Kusch was thinking about founding *Sterbehilfe Deutschland*, he needed medical expertise in order to develop methods of assistance that would be lawful, reliable, and easy to access. During one of our meetings in Hamburg, Kusch said:

> **Kusch:** you need the practice of Mr. Arnold or our organization to know how to do it. In our organization we have three times more physicians as members as there are physicians in the general society, because they know that they don't know how to practice suicide. It's very difficult. And if you speak with a doctor about suicide, and you ask him 'Do you know how to do it?,' he will answer, 'Oh, of course, it's not so difficult.' And if you ask 'Please, explain to me how to do it,' then he will tell you something about injections. But if you speak about drinking medicine, then nobody knows what to drink, what medicine, what concentration, anything. There is a book that explains how to do it, and this book, it's the only book with this idea. But in this book you'll find a lot of mistakes. Here you see all the components [showing me the book], but it's for nothing, because you don't know how to use them. And you see this list and you don't know how to buy them in a pharmacy, how to work, and the concentration... So without the experience of Mr. Arnold… And sometimes I talk with him directly, or a doctor, who is a friend of mine, about experiences. Without knowing

> the details you cannot do it, and all physicians who are members of our organization know they need our professional experience.
>
> **MFAN:** So before the law [§217 StGB], what was the method?
>
> **Kusch:** Most of our assistances followed the idea of Mr. Arnold. It was a mixture of Diazepam with Chloroquine. If you take a lot of pills, normally you would take two pills each day to protect against malaria, but if you take more it will bring you close to a secure death. (…) The first contact [with Dr. Arnold] wasn't very successful, because I offered him a method, a measure, and asked him what he thought about it. And he said 'With this measure you would need a doctor to find an intravenous entry point.' But he wasn't interested, he has his own method and so he wasn't interested on working together on this measure. And after this contact I had a lot of doubts about the structure of the measure, so I thought that the most secure way was to follow him. He had experience with his mixture, so I followed him. And sometimes I get in contact with him to ask about experiences with... Details about drinking, the time between the first and the second dose.

Dr. Arnold has provided Dr. Wilson and StHD with alternative methods that, despite relying on pharmaceuticals, would dispense the need for pentobarbital—and, in extension, avoid both the legal and health risks associated with acquiring, circulating, and using it without the proper expertise. But even if his new mixture consists of drugs that are not as regulated as pentobarbital, they still require specialized knowledge for achieving the right dosage—making the work of professional assistants essential. Nonetheless, his explorations with methods did not stop at pharmaceuticals. Dr. Arnold's interest on providing a reliable, painless, and fast way to die has led him to further experiment with other methods, such as gases.

Differently from pharmaceuticals, which are bounded by a number of state and medical regulations throughout their "social lives" (Whyte, Geest, & Hardon, 2002), from manufacture through distribution to further circulation, gases such as helium can be easily bought and moved around. For instance, Dr. Arnold's own stash of helium, a gas he considers "better than Nembutal," came from Portugal. He shared: "I've tried it on myself once. It's wonderful, it's so wonderful! You wake up and ‘wow, what was that?’” But Roger Kusch had a different opinion regarding the use of gases for suicide assistance due to both historical and technical aspects:

> We didn't use helium because… It's a question of German history. There are two things. The first is German history. To speak about gas is too close to our history. 6 million Jewish people were killed by gas, and this association with gas is not possible in Germany. It may be in other countries, no problem, but I'll not handle this in any way. That's the first. The second is: there's a person who wants to die, and then in the last ten, twenty minutes of this person’s life she has to do some technical things. Put a plastic bag over her head and handle something. I’ll not assist in this thing. To drink something is normal. Everybody drink something everyday. Maybe the taste isn’t good, but drinking is a normal thing. But to put plastic bags and to open something and to handle helium, that's very unusual.

Be it helium, other gases, or a combination of different pharmaceuticals, the efficacy of each of these methods is evaluated in relation to pentobarbital. Even in situations where helium is considered a fast and uncomplicated way of dying, its advantages are always exposed in comparison to pentobarbital. For instance, if one of the main advantages of helium and Dr. Arnold’s mixture over pentobarbital is ease of access, this can only be due to the restricted environment surrounding the barbiturate. Restrictions such as drug regulations, the need for medical prescription, and its own availability in pharmacies, obstacles that can only be circumvented through strategies of mobility and circulation.

The itineraries designed for the circulation of pharmaceutical objects, as well as other methods such as helium cylinders, are not without obstacles. Even when lawful objects circulate in this landscape, their newly absorbed qualities—such as deviance from their original use in order to become methods of achieving assisted or non-assisted death—make them clash with life-oriented policies and acts of care, turning them targets for police action. Dr. Wilson was visited by the police under the suspicion of importing Phenacetin, which, despite not being an illegal drug, raised suspicions because it has not been used for years. Dr. Arnold, in turn, also had his apartment in Berlin visited by the police, which did not confiscate his cylinders of helium because they were hidden somewhere else.

Global pharmaceutical objects, as well as other objects used for assisted suicide, are not only susceptible to contexts, but their circulation also helps to figure these contexts out. They help to create the very worlds, landscapes, to which they are susceptible, transfiguring themselves according to a newly formed, and ever-changing, entanglement of policies, laws, values, and moralities. In this sense, these objects are affected by the landscape they helped to enact, affecting them in return. When Dr. Wilson received part of a stash of pentobarbital that came from Mexico, what was originally a veterinary drug turned into a method for human suicide, leaving behind its previous qualities as a legal drug for animal euthanasia and becoming an illegal drug for human suicide. And while its circulation transfigured pentobarbital from veterinary to human usage, from legal to illegal, it was precisely this circulation that helped to enact the space within which assisted suicide became viable regardless of local legal pluralisms. It helped to create, and was affected by, a landscape of assisted suicide.

4.2.3 NuTech

The establishment of associations between people and organizations from different places in the context of developing and circulating new methods goes beyond informal and occasional exchanges. For instance, NuTech was founded in 1998 by John Hofsess, Rob Neils, and Philip Nitschke, with the goal of developing and exchanging new ideas for suicide methods. The group, which describes itself as "a loose assembly of individuals interested in, and working on, the development of practical solutions for stakeholders (rational adults) who are interested in access to a peaceful, reliable (and non-medical) death, regardless of where in the world they live," has members in several countries and, therefore, links with many organizations —such as FATE.

When helium manufacturers started to dilute it with oxygen in order to avoid hypoxia—oxygen deficiency—and, consequently, the possibility of using this inert gas as a method for [assisted] suicide, NuTech called for a panic meeting. Dr. Wilson had ties with some of its members and explained the situation to me:

> NuTech is a group of people who belong to the World Federation of Right to Die Societies. And they are all people, what I call boys with their toys, Hugh Wynne is very prominent on it. They love all sorts of gadgets… They don't admit, this is what's really fascinates them… They are all involved… Hundreds of emails have been batting around about nitrogen replacing helium, you see, but you have to have a flow meter, and you have to have all sorts… They don't seem to realize that the people who want to die are not people who are interested in flow meters. And they have all sorts of gadgets for testing whether there's enough helium in the jar… I mean… However, they've got quite a sensible side, it's me taking the Mickey out of them a bit. But, you know, because of the correspondence between the American ones we've discovered about the helium being depleted. And I'm pretty sure… Well, as I say, I told you we've had few instances… So we actually said no helium at the moment, because they can't find out… I've actually suggested to Hugh that he should go and find out about helium in the UK now. He didn't take me up on it yet. We call him our technical advisor, but actually it's helium he's really keen on. He's now interested in nitrogen, you see.

As Dr. Wilson mentioned, in April 2015 Derek Humphry, a British-born American journalist and right-to-die campaigner who, in 1980, cofounded the Hemlock Society[69] and was, from 1988 to 1990, president of the World Federation of Right to Die Societies, issued a warning about helium cylinders being diluted with oxygen. On the next day, a similar warning came from Exit International, an Australian

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[69] Hemlock Society was an American-based right-to-die organization that advocated for the legalization of assisted suicide. It operated from 1980 to 2003.

organization founded by Philip Nitschke—NuTech's cofounder. Both warnings triggered, on the one hand, doubts about the viability of helium as a method and, on the other hand, a rush for new methods to replace it.

But even before these warnings, Dr. Wilson suspected there was something odd going on with helium, as two people she knew had troubles while using it. She recounted:

> There's one man, who wasn't very intelligent and when he said it hadn't worked and he jerked about it and so on I thought it was quite possible that he hadn't followed the instructions, but the next one was a lady who was highly intelligent and had a friend with her and she followed the instructions and she didn't lose consciousness. And they thought the cylinder was faulty, so they did another cylinder and did it again and exactly the same thing happened. So it was obviously the helium supplier. Unfortunately, in both cases they didn't record the manufacturer's name, so I must confess I asked one or two people if they would go into shops where they could buy helium and see if they can see… The trouble is that they are all in a party balloon kit, you know, and I don't think you'd have the manufacturer of the helium on it, it would only be on the cylinder, you'd have to open it to find out.

One of the people asked by Dr. Wilson to find out more about helium was Hugh Wynne, an engineer who was a member of the FATE's council and acts as treasurer of Right to Die Europe. He is also a member of NuTech, which he first heard about through some of its members, like Derek Humphry and Faye Girsh—who, among other positions, also occupied the presidency of the World Federation of Right to Die Societies.

Wynne and I met on a number of occasions, from FATE meetings to cafés in Edinburgh and over gin and tonic in Glasgow, where he lives. On one of our meetings in Scotland, he weighed in on the helium issue, as well as on NuTech's importance in developing—and circulating—new ideas and technologies:

> Gas is probably one of the easiest ways to do it [to die], but the trouble of not going to Switzerland is you don't really have the confidence building of saying to yourself 'well, you know, others have gone this way before, these people who are helping me know what they are doing. I trust them.' If I go there I'll die and that will be as simple and straightforward as possible, so you have a comfort factor. If you suicide on your own, things may go badly. Things can go wrong, specially when you are passing out unconscious. So the confidence of being assisted must be a help. (…) There's always problems with the purity of substances and you can't always be sure that nitrogen or helium are really nitrogen or helium until you try it. I did toy, I wasted a whole cylinder of helium trying out various ways of detecting its density, but I didn't perfect my technique until all the gas was gone. But what I was going to do was to use the helium, or any gas, to blow a whistle. And if you blow the whistle with a known gas like air, and then you blow it with an unknown gas, the frequency of the whistle will be different.

Wynne's proposed solution to easily identify whether a helium cylinder is actually filled with helium is one example of NuTech's work. In 2017, the group held an event in Toronto, Canada, where it offered a US$ 5.000 prize for the "best new technological development in end of life strategies.[70]"

Despite several connections among them, from Dr. Preisig in Switzerland, through Dr. Arnold and Roger Kusch in Germany, to Dr. Wilson and Hugh Wynne in Scotland, I have always met them separately. Their work created itineraries that enabled the circulation of people, objects, and knowledge—and if such itineraries played a fundamental role in creating this landscape of assisted suicide, from a methodological standpoint mobility has likewise been essential. However, in May 2016, we have all met in Amsterdam for the "Euthanasia 2016: professional challenges" conference[71], organized by the *Nederlandse Vereniging voor Vrijwillige*

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[70] https://exitinternational.net/nutech/. Last accessed 11th June 2018.

[71] With one exception, as described in the next section.

Euthanasie[72] [NVVE], an Amsterdam-based right-to-die organization with more than 165.000 members. For the first time, we were all going to be together in the same venue.

• NuTech Design Innovation Award •

A $5000 cash prize has been established - made possible by a generous bequest to Exit International - to an innovative proposal that advances the use of technology in an DIY peaceful, reliable solution.

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[72] Dutch Association for Voluntary Euthanasia.

4.2.4 Going to Amsterdam

DR. PREISIG AND LIFECIRCLE'S STAFF | AMSTERDAM | 2016 | MARCOS ANDRADE NEVES

For a few days in 2016, Amsterdam was at the crossroads of several itineraries of circulation, providing a unique opportunity for professionals and interested parties to share experiences and exchange ideas and information in relation to assisted suicide and euthanasia—which is a particularity of the Benelux countries. Because the event was going to be organized by the NVVE and be held in the Netherlands, euthanasia lent the conference a title—but it did not exclude assisted suicide from the agenda. The goal there was to discuss professional challenges in relation to assisted dying, and the conference was therefore divided into four axes: Medical; Legal; Science; and Campaign. This structure speaks to assisted suicide and euthanasia in a broader perspective, as medico-legal dynamics that are subjected to political disputes and controversies, as well as reliant on medical knowledge and technological innovations for correctly using certain methods.

When it comes to itineraries of circulation, the ones described so far enabled the mobility of documents, people, and technologies, aspects that are intertwined with one another, but do not necessarily overlap. When the Canadian couple traveled to Mexico to buy veterinary Nembutal there in person, they circulated alongside pharmaceutical objects, traveling with them back to Canada—and a similar case was described in relation to Mary and David's son, who also bought veterinary Nembutal in Mexico for his mother and brought it with him to the UK. Nonetheless, these overlaps happen seldom, after all, itineraries are designed precisely to facilitate assisted suicide by enabling the circulation of whatever fits best the particularities of each individual case. Applicants, members of organizations, or professional assistants may circulate; or, sometimes, what circulate are pharmaceuticals objects and the knowledge of how to safely employ them. If the goal is to facilitate assisted suicide-as procedure, overlaps are avoided.

In other words, itineraries of circulation are designed to navigate regimes of life by overcoming obstacles of various sorts, such as legal uncertainties and health issues that may prevent a person's own act of mobility to Switzerland. And while each itinerary is designed to better respond to individuals' circumstances, thus avoiding overlaps, the itineraries provided by the conference were of a different kind —they were meant to overlap, but under unique circumstances. For three days in May 2016, Amsterdam brought together in the same venue professional assistants and staffers from organizations from every continent—but, differently from the itineraries described so far, these were not designed to attend to specific cases. Rather, it was a gathering where broader issues would be discussed, possibly leading to new forms of cooperation and itineraries.

To spend their time in Amsterdam, Dr. Preisig rented a houseboat that would offer enough space to accommodate both her family and LifeCircle's staff—and she kindly extended the invitation to me. At that point, I had already met her family a few times, since on some occasions I had stayed at their house in Basel during fieldwork. But this time it would be different. Not only would we be in a different country, but we would also share our daily routines with other research participants, among which Dr. Arnold, Roger Kusch, and Hugh Wynne. Unfortunately, Dr. Wilson did not have the chance to go. Not long before going to Amsterdam, I met Dr. Wilson in Glasgow and she shared with me her plans and expectations about the conference. Soon after this last meeting, however, she stopped returning my emails. This was odd. With few exceptions over the past couple of years, she had always swiftly returned my messages. Until one day, an email arrived in my inbox: "Libby is very ill."

The message was from Iain Kerr, a retired GP who I got to know in Glasgow during FATE meetings. Iain and I were making plans for meeting each other again two months after the conference, and during our last email exchange he broke the news to me about Dr. Wilson. Last time I met her, she looked as healthy and sharp as ever, and if she already knew about her illness she did a good job not disclosing it to me. So I asked Iain what was going on. "Not sure," he replied, "but I do not think she has long to live." As vague as his answer was, Iain was right. Just 12 days after his message, Dr. Wilson passed away of cancer in Glasgow. Hearing about Dr. Wilson's death made me feel deeply sad. Ever since our first meeting, I had always enjoyed our chats over coffee with "proper milk," as she would say, or gin tonics. At that point, she had even met some of my Glaswegian friends. But as sad as I was about her passing, I somehow rejoiced the memory of our last meeting. It was in a dinner following one of FATE's assembly general meeting where several of its members were present. Dr. Wilson was telling stories from her past and cracking jokes about her professional trajectory, which began in family planning and ended up on assisted suicide. When she was about to go back home that evening, saying her goodbyes to everyone there, I awkwardly offered her my hand for a shake. In return, she opened her arms for a hug. "You can hug me," she said, laughing, "it has been a long time since I was last hugged by a man." She never missed on a joke opportunity.

When I arrived at the conference venue for registration, FATE's booth was the first one I saw. Standing next to it were Hugh Wynne and Amanda Ward, Dr. Wilson's long-time assistant at the organization and, later on, FATE's CEO. Whenever we met, Dr. Wilson would speak about Amanda at length and with great affection.

By this point, we had already met on a number of occasions, but this would be the first time since Dr. Wilson's death. When Amanda and I met at the conference, I could finally get to know more about Dr. Wilson's illness. But it was also during this conversation that I ended up mentioning who broke this news to me, as well as my plan to meet Iain at a later date. To my dismay, hearing my plan made Amanda's expression change. As it turns out, she went on to explain, soon after Dr. Wilson's death Iain was likewise diagnosed with cancer. And just as unexpectedly as her death was to me, I heard about Iain's passing merely two days after this conversation.

Nonetheless, before her diagnosis, Dr. Wilson was getting more and more concerned about the recent issues with helium, and she turned to Dr. Arnold for advice. According to her:

> The other thing that he's [Dr. Arnold] told me about is carbon monoxide, which I think is a really good option actually, and I'd like to know more about it. (…) But you see, I have a friend in the south of England… Well, one of our members really, who… She's a very rich widow, who is still perfectly *compos mentis,* but she always been very much in control, you know, sort of real kind of English lady. And she's also devoted to her dog. She and her husband had no children, and she was absolutely devoted to him, and he died probably about ten years ago now. So, she has decided that she… She's got a big Range Rover, so she's gonna put the barbecue on the front seat, in some sort of a way, and she and her dog are going to curl up in the back seat, and she's just going to take sleeping tablets and die in the car with the dog. And to me that seems to be perfectly reasonable. If anything, I'm worried about whether the heat from the barbecue would actually ignite something in fire.

Her concerns were shared by several participants of the conference, which included some members of NuTech, among them Faye Girsh and Hugh Wynne. In order to address such concerns, a number of panels were organized to debate different methods, such as "Methods of self-deliverance," by Faye Girsh; "The use of Nitrogen for self-deliverance;" "Evaluating medications from China and other countries," "New formula as alternative to Seconal," and "Lethal drugs: what a layperson should know and do." The aim of the conference was to provide a safe space where professional assistants, staff, and members of organizations could exchange their experiences on assisted dying, and in order to do so some of the panels had assurance of confidentiality. Thus, before their start, journalists were requested to leave the room. In this way, despite the conference being open to the general public, some meetings could have restricted access.

By bringing people from several countries together in the same venue to discuss political, legal, medical, and technical facets of assisted dying, the conference was metonymic of the different itineraries of circulation that cooperation can design. In the process of lawful life, the legal encapsulation of the protection of life against suicide assistance, from medical to official laws, is translated into regimes of life. Regimes that seek the preservation and protection of *life* and are circumvented through itineraries that enable the circulation of applicants, professional assistants, pharmaceutical objects, as well as other methods such as helium cylinders and the knowledge on how to safely employ them. This process, however, only happens following the juxtaposition of the bureaucratic, anonymous *life*, as seen by state and medical institutions, and personal ones, constituted of a person's own biographical trajectory and social background. However, if the fundamental distinction between life and death can be shaped by tactics, such as the establishment of cooperation and itineraries of circulation, such tactics can assume different shapes. One alternative, therefore, is to try and change the legal pluralism itself, instead of circumventing it through itineraries of circulation. In this scenario, people articulate their claims to the judiciary, suing the state over what they perceive as infringements of specific rights.

EUTHANASIA — PROFESSIONAL CHALLENGES | AMSTERDAM | 2016 | MARCOS

ROGER KUSCH | AMSTERDAM | 2016 | PHOTO BY ANNE MEYER

DR. PREISIG AND DR. ARNOLD (BACK) | AMSTERDAM | 2016 | PHOTO BY ANNE MEYER

HUGH WYNNE | AMSTERDAM | 2016 | PHOTO BY ANNE MEYER

5. V. THE STATE

It was after a FATE meeting that Iain first approached me. We had just attended the organization's assembly general meeting, which took place at a library in the West End of Glasgow. Iain and I had never met before, but he was curious about my presence there. In fact, as I soon found out, he was not the only one. Right after the meeting was over, several befrienders approached me with variations of "what are you doing here? you're too young to be thinking about death." Some of them even spontaneously shared with me their reasons to attend the meeting, such as a woman who told me her husband had Alzheimer's and was sure he would have opted for assisted suicide, had he had a chance. A befriender himself, Iain was a friendly, soft-spoken, retired GP who used to work in Clarkston, a small town just south of Glasgow. Just like the others there, it was my age that first triggered Iain's curiosity—an exception among the generally older befrienders. During our chat, Amanda came to inform us that Dr. Wilson had invited us to her house before an organization dinner scheduled for later at night. And since I had walked to the library, Iain offered me a lift to Dr. Wilson's.

The car ride lasted about 15 minutes and was rather uneventful. However, once we got there, I learned more about Iain's trajectory. "He's a great hero," said Dr. Wilson to me, once we were all reunited at her living room. Iain and Dr. Wilson seemed to be good friends. He even entered the house without knocking and went straight up to the kitchen to make some coffee before joining her in the living room. "He had his medical license suspended for helping in a suicide, isn't it, Iain?" asked Dr. Wilson, waiting for his confirmation. Despite knowing him for just a couple of hours at that point, Iain gave me the impression of being a rather shy person. In return to her question, he simply nodded in agreement and recounted that he assisted a patient to die by prescribing him the necessary amount of morphine for an overdose. When the patient's wife asked him if he had helped her husband to die, Iain was apprehensive about her possible reaction and, afraid to admit it, told her instead he had just given him morphine and that this usually involves some risk. His explanation, however, was cut short by the wife, who promptly thanked him for his assistance. She read between the lines. When Iain finished to share his recollection, he discreetly smiled while staring inwards with his thoughts, as if reliving that interaction once again.

In 2008, due to an unrelated allegation of assisting a patient to suicide, the General Medical Council's [GMC] Fitness to Practice panel found Iain guilty of misconduct and of failing to refer his patient to a hospital, therefore revoking his medical license for six months. During his panel hearing, Iain stated that the "law is an ass and it was out of step with what a significant minority of people thought," and that "[t]here have been times when owning slaves was legal and women did not have the right to vote and these things we now think of as untenable.[73]" Because of Iain's assistance, the GMC concluded that he had a "serious misjudgment and embarked on a potentially criminal act," thus deeming his actions "inappropriate, irresponsible, liable to bring the profession into disrepute and not in [his] patient's best interest." John Donnelly, then chairman of the Fitness to Practice panel, stated that it considered "necessary to send a message to the medical profession that this behaviour is unacceptable.[74]" But despite the GMC suggestion of a potential criminal act, Iain was judged and suspended by a professional body and no criminal charges were brought against him.

Following his retirement in 2013, Iain went public with other instances where he assisted patients to suicide. Around this time, then MSP[75] Margo MacDonald was

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[73] Records for this session are not available, but there are various reports about it. Such as: https://www.friends-at-the-end.org.uk/news/death-of-dr-iain-c-kerr/; http://www.carenotkilling.org.uk/press-releases/suicide-pill-gp-suspended; http://alexschadenberg.blogspot.com/2008/07/euthanasia-gp-suspended-in-scotland.html; https://www.pressreader.com/uk/evening-times/20160527/281681139123942. Last accessed 11th June 2018.

[74] https://www.independent.co.uk/life-style/health-and-families/health-news/gp-gave-sleeping-pills-to-suicidal-patient-876292.html. Last accessed 15th June 2018.

[75] Member of the Scottish Parliament.

introducing an Assisted Suicide Bill in the Scottish parliament for the second time, following a first defeat in 2010 (Ward, 2015). By informing the public and policymakers about his assistances, Iain intended to take part in the debate over the legalization of assisted suicide in the country, thereby suggesting that laws do not necessarily follow what is socially acceptable at a given time. Laws—be they official or professional ones—enshrine as criminal or irregular actions that can, overtime, no longer be considered as such on the ground level. Besides the general sense of uncertainty and mistrust stemming from the illegibility of laws (Das & Poole, 2004) or their intentional production of ambiguity (Yonucu, 2017), their letter articulates a particular morality into the political, and, by doing so, makes it strained by societal changes throughout time.

As Iain pointed out, the encapsulation of assisted suicide by laws may no longer be in touch with its social approval—which, according to a YouGov poll, is currently at 75% in Scotland[76]. But despite its social acceptance, assisted suicide remains regulated by official law in England and Wales and regarded as illegal in Scotland. And when a person's intention to apply for and carry out an assisted suicide clashes with a lawful protection of *life* against third party suicide assistance, the establishment of associations and cooperation that can help design itineraries of circulation becomes a possibility to navigate such regimes. But while circulation becomes a possibility, it is not the only one. If, coming back to Asad's (2004, p. 285) argument, the space between law and its application is occupied by uncertainty and doubt, such qualities are enhanced when this space is produced not by one law, but by an entanglement of several ones. On the ground level, the uncertainty produced by this legal pluralism can also be a stepping stone for seeking legal clarification: it is precisely because of their ambiguity and uncertainty that laws can be legally questioned. As McGee (2015, p. 141) argues, "[e]ven if legislation and executive

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[76] https://www.thetimes.co.uk/article/75-per-cent-of-scots-back-change-to-assisted-suicide-law-cm3plmglv. Last accessed 12th June 2018.

orders are important formal sources of the law, their specific articulation to the judiciary necessarily implies that at least a bit of uncertainty remains."

Whereas mobility has been the outcome of every act of cooperation described so far, from Margot's case to the circulation of people and technologies such as pharmaceutical objects and new method ideas, there are circumstances where instead of designing itineraries that enable a specific form of circulation through regimes of life, the very own laws that compose such regimes are challenged. A challenge that dramatize, in a discursive level, this clash between an institutional disregard for personal lives in light of an anonymous care for *life*. But, in contrast to the establishment of itineraries that enable the circulation of people and objects, these challenges are mediated by the judiciary. Arguments are exchanged, facts are construed, and a verdict is reached. But despite being the judiciary's role to clarify legal uncertainties and ambiguities, Jasanoff (1995, p. 184) alerts that "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." Laws are not merely applied and a verdict is not just reached. They are fabricated.

In the process of lawful life, the lives at stake are different ones: on the one hand, a personal, individual life composed of a person's own trajectories and background. On the other hand, an anonymous *life* as seen by the state and medicine. One that needs to be protected and preserved and, to this end, has its protection encapsulated by several laws. And while this clash may be circumvented through itineraries of circulation, they keep the conversation about different things. About different *lives*. However, when laws themselves are questioned and challenged, the negotiation shifts. "[A]long this judicialized front," writes Biehl (2013, p. 420), "the relations between individual bodies, political subjectivities, medical technologies, and state institutions are compellingly rearranged." Under such circumstances, the negotiation is no longer about a personal life and an anonymous one, but on their mutual connections and disconnections.

In this sense, the legal pluralism that enshrines *life* as a value while establishing protections around it produces uncertainties on the ground level that shrouds assisted suicide in an affective tonality of illegality, but these uncertainties can also be the gateway to judicial contestations that engage all parties in a dispute about a specific juxtaposition of lives. As Jasanoff's put it, the process of legal clarification is also enmeshed in social adjustments, making this move from uncertainty to clarity likewise unpredictable. According to McGee (2015, p. 141), "[j]udicial decisions, although formally constrained by law's regime of enunciation, are after all still to be fabricated and taken, and thus created." In this landscape of assisted suicide composed of different legal orders and jurisdictions sewn together by the circulation of people, documents, and technologies, each judicial case starts from personal life circumstances and goes on to question whether this life can be encompassed by the *life*, and therefore be subjected to caring responses by state and medicine.

But while the relation between *life* and lives could so far only be perceived during green light applications and itineraries of circulation, be it through a general sense of mistrust and uncertainty, strained interactions between applicants, state officials, and family doctors, threats or violence in its many shapes, judicial cases dramatize this relation discursively. Now, the state—through the figure of government—and the applicant are put in direct, yet mediated, conversation into the specificities of one particular case, and how this case, this personal life, connects or disconnects itself from the legal protections established around *life*. This chapter, thus, sets out to analyze cases lodged at the European Court of Human Rights [ECHR] by people against their respective countries, therefore adding a new set of legal rights, obligations, and responsibilities—under the European Convention on Human Rights [Convention]—to this pluralism. These cases, initiated by citizens of Switzerland, Germany, and the UK, articulate domestic law with supranational law, triggering legal disputes fueled by personal circumstances and official and non-official laws.

Disputes that, by exposing points of connections and disconnections and the subsequent creation of verdicts, end up reorganizing the relation between life, state, and medicine. While the first section of this chapter focuses on the aforementioned cases and the ECHR, the subsequent ones will delve into the judicialization of dignity and diagnostics and then go on to focus on one particular case, "Lamb v. the United Kingdom." As personal lives and trajectories are clouded by the specificities of judicial proceedings, their bureaucracies and disputes (J. o. Biehl & Petryna, 2013, pp. 2-3), this final section will go beyond the case itself in order to tell Paul Lamb's story, who, besides having articulated his case and claims to the UK judiciary and the ECHR, was a friend of Dr. Wilson's as well as a befriender.

5.1 ECHR

> The thrust of this is to reflect the sanctity which, particularly in western eyes, attaches to life. (Pretty v. The United Kingdom, Application no. 2346/02, p. 4)

In 2001, a letter was sent to the UK Director of Public Prosecution on behalf of Diane Pretty, a British national diagnosed with motor neuron disease, a neurodegenerative disorder that includes, among other diseases, amyotrophic lateral sclerosis. In her letter, she requested the DPP not to prosecute her husband in case he assisted her to commit suicide. Since her diagnosis in 1999, her condition deteriorated quickly: she became "paralysed from the neck down, [had] virtually no decipherable speech and [was being] fed through a tube." But despite her life expectancy being "measurable only in weeks or months," her "intellect and capacity to make decisions [was] unimpaired." (Application no. 2346/02, pp. 2-3) About two weeks after her request, the DPP sent her a response letter denying the possibility of immunity. "Successive Directors," the DPP wrote, "have explained they will not grant immunities that condone, require, or purport to authorise or permit the future commission of any criminal offense, no matter how exceptional the circumstances." (Application no. 2346/02, p. 3)

Diane Pretty's letter was sent before the DPP's issuing of its "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide," which was published only in 2010—9 years after her request. Shortly after receiving the DPP's refusal, Pretty applied for judicial review arguing that the Suicide Act 1961 was incompatible with Articles 2, 3, 8, 9, and 14 of the European Convention on Human Rights[77]. The Articles, respectively the "right to life," "prohibition of torture," "right to respect for private and family life," "freedom of thought, conscience and religion," and "prohibition of discrimination," were incorporated into UK law by the Human Rights Act 1998[78], which aligned domestic law with Convention rights. By doing so, the Act made it unlawful for domestic laws to go against established Convention rights, therefore allowing domestic courts to issue declarations of incompatibility in case of infringements. And beyond the suppression of the DPP's decision, this was precisely what Mrs Pretty asked for in her request for judicial review—which was based on an alleged incompatibility between section 2 of the Suicide Act 1961 and her aforementioned Convention rights.

However, her request was likewise refused by the Divisional Court, which stated that the DPP had no authority to grant such immunity and that the Suicide Act 1961 was not incompatible with the Convention. Following both the DPP and the Divisional Court's refusal, Mrs Pretty went on to appeal to the House of Lords—which, until 2009, was the last judicial resort for the majority of cases regarding UK

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[77] The European Convention on Human Rights can be read here: https://www.echr.coe.int/Documents/Convention_ENG.pdf. Last accessed 11th June 2018.

[78] The Act can be read here: https://www.legislation.gov.uk/ukpga/1998/42. Last accessed 11th June 2018.

law[79], and has since been replaced by the Supreme Court. In his leading judgement, Lord Bingham of Cornhill stated:

> In discharging the judicial functions of the House, the appellate committee has the duty of resolving issues of law (…). The committee is not a legislative body. Nor is it entitled or fitted to act as a moral or ethical arbiter. (…) The questions whether the terminally ill, or others, should be free to seek assistance in taking their own lives, and if so in what circumstances and subject to what safeguards, are of great social, ethical and religious significance and are questions on which widely differing beliefs and views are held, often strongly. (…) The task of the committee in this appeal is not to weigh or evaluate or reflect those beliefs and views or give effect to its own but to ascertain and apply the law of the land as it is now understood to be. (Application no. 2346/02, p. 4)

In his statement, Lord Bingham suggested that the law, despite addressing a sensitive topic, should only be applied as "it is now understood to be," disregarding that it was precisely its lack of clarity that enabled the law to be contested in the first place. His statement suggested that the law should be analyzed as a free-standing entity, without consideration to social circumstances that trigger different believes and, consequently, lead to social and political controversies—as he himself mentioned. However, as McGee's (2015, p. 141) argued, "there always remains some interpretative leeway." On a similar note, Latour (2010, p. 269) acknowledges that during his ethnography of the *Conseil d'Etat*, in France, he had not witnessed "the slightest case of a mere application of a rule of law." Connections are made and unmade, documents and legal texts are juxtaposed, but the law itself is not merely applied. "One can never say of a human action, that it 'obeys', that it 'follows' or

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[79] Due to devolution issues, the House of Lords had jurisdiction as a court of last resort in both civil and criminal law only in cases originated in England, Wales, and Northern Ireland. In regards to Scotland, it had jurisdiction only in civil cases.

‘applies’ a rule,” writes Latour (2010, p. 269) based on Wittgenstein’s argument, “one can only say that it *refers to it*.”

Law cannot be defined as, nor can it be reduced to, rules (Latour, 2010, p. 269)—and therefore cannot be simply applied. For instance, if official law is the result of a process marked with disputes and controversies—like it was the case during the passing of the §217 StGB in Germany—, its letter gives way to uncertainties and doubts, as well as to the—often intentional—production of ambiguity (Das & Poole, 2004; Yonucu, 2017). Nevertheless, in his attempt to “apply the law of the land as it is now understood to be,” Lord Bingham framed Pretty’s argument in regards to Art. 2 of the Convention as such:

> 4. On behalf of Mrs Pretty it is submitted that Article 2 protects not life itself but the right to life. The purpose of the Article is to protect individuals from third parties (the State and public authorities). But the Article recognises that it is for the individual to choose whether or not to live and so protects the individual’s right to self-determination in relation to issues of life and death. Thus a person may refuse life-saving or life-prolonging medical treatment, and may lawfully choose to commit suicide. The Article acknowledges that right of the individual. While most people want to live, some want to die, and the Article protects both rights. The right to die is not the antithesis of the right to life but the corollary of it, and the State has a positive obligation to protect both. (Application no. 2346/02, p. 4)

Subsequently, Lord Bingham went on to cite the court’s decision in “Osman v. United Kingdom” in order to refute her argument:

> 115. The Court notes that the first sentence[80] of Article 2(1) enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard lives of those within its jurisdiction. It is common ground that the

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[80] “Everyone’s right to life shall be protected by law.” It can be read here: https://www.echr.coe.int/Documents/Convention_ENG.pdf. Last accessed 15th June 2018.

> State's obligation in this respect extends beyond its primary duty to secure the right to life by putting in place effective criminal law provisions to deter the commission of offences against the person backed up by law-enforcement machinery, suppression and sanctioning of breaches of such provisions. It is thus accepted by those appearing before the Court that Article 2 of the Convention may also imply in certain well-defined circumstances a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual. The scope of this obligation is a matter of dispute between the parties. (Application no. 2346/02, p. 5)

And similarly to what his argument did with Pretty's claim in regards to the alleged incompatibility of Art. 2 of the Convention with section 2 of the Suicide Act 1961, Lord Bingham extended his dismissal to the subsequent articles, sustaining the view that there were no breaches in Diane Pretty's Convention rights. And while acknowledging her strenuous life circumstances, which included "the prospect of a humiliating and distressing death," (Application no. 2346/02, p. 3) Lord Bingham upheld the Divisional Court's ruling by dismissing her appeal in November 2001. As a British national and resident, Diane Pretty was subjected to UK law, including the Suicide Act 1961, which raised the possibility of prosecution against her husband, the person she asked for assistance to die in case she felt necessary. And although her application suggested that this scenario would most likely be in violation of the Act, it did not fail to acknowledge that breaches in the law can only result in prosecution through DPP action[81]. Therefore, in order to navigate the UK jurisdiction in a way that would enable her wish for suicide assistance to be fulfilled without triggering criminal prosecution against her husband, Diane Pretty required the DPP to grant him *a priori* immunity from prosecution—which ended up being refused by that

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[81] This is the case in England and Wales, as previously noted in the first chapter. In Scotland, public prosecutions are within the remit of the Crown Office and Procurator Fiscal Service, led by the Lord Advocate. In Northern Ireland, the equivalent office is the Director of Public Prosecutions for Northern Ireland.

office. A decision that was subsequently upheld by the Divisional Court and the House of Lords.

When it comes to UK law, both the Court and the House of Lord's decisions stated that the DPP cannot grant immunity from prosecution to violations of the Suicide Act 1961, regardless of personal circumstances. However, in her appeals Pretty went beyond issues concerning strictly domestic laws, arguing for an incompatibility between an act of parliament and her Convention rights—which would be unlawful according to the Human Rights Act 1998. By this point, Diane Pretty had already exhausted all domestic remedies to appeal the DPP's refutal, but it was precisely by exhausting these possibilities that she was then able to take her case before the European Court of Human Rights. Now, it was no longer a domestic issue between the possibility of a future breach of the Suicide Act 1961 and the DPP's power of prosecution, but rather about an incompatibility between the UK law and the Convention. In other words, what had initiated as a question regarding her personal life circumstances under specific legal provisions of a national jurisdiction was now a question regarding a friction between these very own provisions and a supranational set of rights of which the UK is signatory.

According to the Human Rights Act 1998, the piece of legislation responsible for bridging and aligning UK law with Convention rights, issues of incompatibility can be resolved by the European Court of Human Rights. The ECHR is an international court established on a permanent basis by Article 19[82] of the Convention and is composed of judges from the 47 members states of the Council of Europe. According to a former president of the ECHR, the unique role of the court was presented as such:

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[82] Article 19 states: "To ensure the observance of the engagements undertaken by the High Contracting Parties in the Convention and the Protocols thereto, there shall be set up a European Court of Human Rights, hereinafter referred to as "the Court". It shall function on a permanent basis."

> There is an infinite variety of international agreements, from bilateral to multilateral treaties, from military alliances to trade agreements, from double taxation agreements to the Charter of the United Nations, from the moon treaty to treaties for the prevention of transfrontier pollution. However, compared with most other international agreements, human rights treaties have a unique character. They are not concerned with the mutual relations and exchange of benefits between sovereign States. Instead, they proclaim solemn principles for the humane treatment of the inhabitants of the participating States. It is the internal order of these States and their behaviour towards their own citizens (…) which are the subject of human-rights treaties. What was in former times considered to be part of unfettered domestic jurisdiction and within the exclusive competence of the sovereign States has become the subject of international protection and supervision. (Mowbray, 2005, p. 60)

In this manner, the Convention provides a set of rights to citizens of contracting states against state abuse, and it falls under the responsibility of the ECHR to observe such rights and to act in case of infringements. Therefore, by being a citizen of a contracting state and having exhausted all domestic remedies, Diane Pretty was able to take her case to the ECHR. The outcome, however, was the same as her previous attempts: the court held that no Convention rights were breached. Specifically in respect to Art. 3 (prohibition of torture), they wrote:

> The Court cannot but be sympathetic to the applicant's apprehension that without the possibility of ending her life she faces the prospect of a distressing death. It is true that she is unable to commit suicide herself due to physical incapacity and that the state of law is such that her husband faces the risk of prosecution if he renders her assistance. Nonetheless, the positive obligation on the part of the State which is relied on in the present case would not involve the removal or mitigation of harm by, for instance, preventing any ill-treatment by public bodies or private individuals or providing improved conditions or care. It would require that the State sanction actions intended

> to terminate life, an obligation that cannot be derived from Article 3 of the Convention.[83]" (Application no. 2346/02, pp. 31-32)

If the state has any positive obligation to life, said the verdict, is to protect it and not to terminate it. Diane Pretty acted upon this legal pluralism not only by seeking judicial clarification over what she relayed as a contradictory set of life-protecting laws, but by exposing how her personal life circumstances were incompatible with the *life* lawfully subjected to state protection. For example, whereas section 1 of the Suicide Act 1961 decriminalized suicide, her specific life circumstances and disability made her unable to do it herself without third party assistance. But to provide assistance to suicide, however, remained illegal under section 2 of the same Act. This clash between her impossibility to carry out a lawful act due to her disability made way for her argument that the law was discriminatory, and therefore in violation of her right against discrimination under Art. 14[84] of the Convention. This argument spoke to a disconnection between a life that can be lawfully terminated by suicide and her personal one, where the effects of a neurological disorder made her be unable to enjoy the provisions of section 1 while being trapped within the restrictions of section 2. Diane Pretty's case, despite being unsuccessful—she died 10 days after the ECHR's ruling (Ward, 2015)—dramatized how the legal protections established around *life* are translated into regimes where personal lives are to be preserved, regardless of their specific circumstances or trajectories. Where she saw a disconnection, the court ruled for a connection.

Filed in 2002 at the European Court of Human Rights, Diane Pretty's was the first case judged by the Court in relation to assisted suicide. It was not until 9 years

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[83] Pretty v. United Kingdom, Application no. 2346/02, Council of Europe: European Court of Human Rights, 29 April 2002.

[84] Article 14 of the Convention reads as follow: "The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

later when Ernst Haas, a swiss national, sued Switzerland at the ECHR for the right to obtain sodium pentobarbital without medical prescription. Similarly to Pretty's case, Ernst Haas alleged that his right to terminate his life "without pain and with no risk of failure" (Application no. 31322/07, p. 4) had been violated in Switzerland as a result of the conditions he would have to meet in order to have access to sodium pentobarbital, that is, having a medical prescription written to him. Ernst Haas, who was diagnosed with bipolar affective disorder for more than 20 years at the time of his application, had already tried to commit suicide twice before and had stayed in psychiatric facilities on a number of occasions. He argued that his life was no longer able to be lived with dignity and, therefore, asked the organization Dignitas to assist him in suicide.

In his application, Mr Haas requested access to pentobarbital without medical prescription—which, as Dr. Wilson phrased it, is one of the medical gates on the path to organized assisted suicide. Successively, the Federal Office of Justice, the Federal Department of Public Health, the Health Department of the Canton of Zürich, the Federal Department of the Interior, as well as the Federal Court, have all dismissed his requests. In its decision, the Federal Court argued that:

> The State has a fundamental obligation to protect life. Admittedly, such protection is not generally extended against the will of a person who is capable of forming his or her own views… Nonetheless, it does not follow that the State has a positive obligation to ensure that a person who wishes to die has access to a dangerous substance, selected for the purpose of suicide, or to tools intended to be used for that purpose. In such circumstances, the right to life guaranteed by Article 2 of the Convention obliges the State, at the very least, to put in place a procedure to ensure that a decision to commit suicide does indeed correspond to the free will of the individual in question. (Application no. 31322/07, p. 3)

According to the court, despite the state's fundamental obligation to protect life, it does not follow that such protections will necessarily be imposed against "the will of a person who is capable of forming his or her own views" (Application no. 31322/07, p. 3)—alluding to the possibility of suicide, which, despite remaining a lawful act in Switzerland, as well as in the other jurisdictions within this landscape, is not always within reach from everybody, as Diane Pretty's case illustrated. The court's argument, however, stresses that the outcome of the interplay between the state's main obligation to protect life and the risk of overextending such protections over those considered of sound mind cannot be deemed as a positive obligation, on the part of the state, to grant a person's access to the necessary means to suicide—in this particular case, sodium pentobarbital. In other words, despite being a lawful action, the state does not need to positively assist or facilitate a suicide. Instead, protections —or gates—such as the need for medical prescriptions are to remain in place.

When his case arrived at the ECHR, the application stated that Haas was of the opinion that:

> [T]he obligation to submit a medical prescription in order to obtain the substance necessary for suicide, and the impossibility of procuring such a prescription — which, in his view, was attributable to the threat that hung over doctors of having their license withdrawn by the authorities should they prescribe the substance in question to mentally ill persons — amounted to interference with his right to respect for his private life. He argued that while the interference was admittedly in accordance with the law and pursued a legitimate aim, it was not, in his case, proportionate. (Application no. 31322/07, p. 3)

As the legal basis for his claim, Haas turned to Art. 8 of the Convention—which was likewise used by Diane Pretty in her application to the ECHR—by alleging that his right to a private life had been infringed. The ECHR, however, has no clear definition of what "private life" stands for, making Art. 8 a legal resort for a wide array of issues regarding “personal independence” (Santolaya Machetti & García Roca, 2012, pp. 337-338). But because the Convention was first drafted in the late 1940s, the challenges it faced at the time—and was written to address—were not the same ones as nowadays. And since, as already put it, judicial interpretations are created (McGee, 2015, p. 141) while enmeshed in sociopolitical adjustments (Jasanoff, 1995), the loose definition of private life as personal independence allows a variety of claims to be brought to the ECHR. Claims that reshape the legal boundaries of “private life” and, ultimately, end up updating the scope of the convention.

Yet, to inform the Convention in light of challenges brought to the ECHR almost 70 years after its passing requires a degree of creativity. A feature that, according to Mowbray (2005), is mainly achieved through techniques of interpretation, among which the living instrument doctrine. This doctrine, writes Mowbray (2005, pp. 64-69), “can be used to adapt the application of Convention rights to reflect modern, higher expectations of member States,” thus creatively updating “the interpretation of a number of Convention Articles in varied situations.” Similarly to Scheffer’s (2007, 2010) analysis of court proceedings as event and process, the living instrument doctrine is invoked by the ECHR to deal with cases through both spatial and temporal concerns, that is, where and when the situation brought before the court is occurring. As such, this makes the ECHR take into consideration present-day circumstances when creating a verdict, juxtaposing the letter of the Convention with sociopolitical aspects at a given time and place. For instance, when Diane Pretty brought her case to the ECHR the court looked not only into her personal life circumstances and the domestic law to which she was subjected, but also to the acceptance of assisted suicide in other member states and elsewhere. As Mowbray (2005, p. 68) explained:

> The international and domestic consensus was against allowing the assisted suicide of persons in the predicament of Mrs Pretty; consequently, it would have been difficult for the Court to contend that the established interpretations of Articles 2 and 3 were not in

> accordance with contemporary standards. To have met her claims would have required the Court to undertake a significant, and controversial, extension of the scope of Convention obligations beyond its authority. Such developments, however desirable some may feel them to be, are matters of policy-making which member States may legitimately claim to be for themselves to resolve via Protocols to the Convention.

And while this doctrine has been instrumental in cases concerning, among others, the prohibition of corporal punishment and labor relations, it failed to address Diane Pretty's claims due to a lack of domestic and international consensus regarding assisted suicide. But her case helped to stretch the definition of private life: the ECHR acknowledged that a person's ability to decide where and how their life will end falls within the scope of Art. 8 of the Convention. There was no infringement of her Convention rights, but the issue is, indeed, a matter of "private life."

In turn, in response to Haas's claim regarding the infringement of his rights to a private life, the government argued that under Art. 2 of the Convention (the right to life) "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 of others or, where appropriate, from themselves." (Application no. 31322/07, p. 14) On the one hand, Haas claimed that his right to decide how and when to die—which falls under Art. 8 of the Convention, as acknowledged by the ECHR on Diane Pretty's case—had been breached due to the necessity of presenting a medical prescription to obtain sodium pentobarbital. On the other hand, the state invoked not only drug regulations that restrict access to the barbiturate, but also Art. 2 of the Convention to justify its duty to safeguard individual lives. In its ruling, the ECHR stated:

> It should be noted that the vast majority of member States seem to attach more weight to the protection of the individual's life than to his or her right to terminate it. (…) [T]he Court is sympathetic to the applicant's wish to commit suicide in a safe and

> dignified manner and without unnecessary pain and suffering. (….) However, it is of the opinion that the regulation put in place by the Swiss authorities, namely the requirement to obtain a medical prescription, pursue, *inter alia*, the legitimate aims of protecting everybody from hasty decisions and preventing abuse, and, in particular, ensuring that a patient lacking discernment does not obtain a lethal dose of sodium pentobarbital. (Application no. 31322/07, p. 17)

Just as in Pretty's case, the Court refuted the claim that Haas's right to a private life had been breached by the requirement to present a medical prescription. Despite sharing a common goal, Pretty's and Haas' cases have each followed singular itineraries: whereas the former claimed a right to die with third party assistance (immunity from prosecution), the latter required prescription-free access to sodium pentobarbital. And although court proceedings such as theirs enable us to see the law-in-action (Scheffer, 2010, p. 33), that is, its juxtaposition with actual cases and the subsequent production of a verdict composed of socially enmeshed (Jasanoff, 1995) connections and disconnections (Latour, 2010; McGee, 2015), Scheffer (2010, p. 34) stresses that "criminal law-in-action operates in a complex field of discourse practices." In this manner, both of their cases[85] dramatized, on a discursive level, the itineraries through which assistance can be provided, such as opting for third party assistance or through obtaining specific pharmaceuticals.

But even though they sought different itineraries to enable the possibility of suicide assistance, their underlying arguments had a main convergence point: they both presented medical diagnostics that were articulated in the figure of dignity. On the one hand, Diane Pretty argued that because of motor neuron disease she was facing not only a life with severe disability, but also an undignified prospect in the final stages of the disease. On the other hand, Ernst Haas claimed that living with bipolar affective disorder for over 20 years had made it impossible for him to live

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[85] Following Mr Haas' case against Switzerland, others were likewise brought to the ECHR: Koch v. Germany (2012); Gross v. Switzerland (2013); and Nicklinson and Lamb v. the United Kingdom.

with dignity. And while both arguments departed from specific medical diagnostics whose impact on personal lives were framed in the form of dignity—or lack thereof —, their similarity conceal a fundamental aspect in this landscape of assisted suicide: it operates on a clear opposition between physical and mental illnesses.

5.2 Physical and mental illnesses

In its submission to the ECHR concerning Haas' request for prescription-free sodium pentobarbital, the Swiss government wrote that the regulation of assisted suicide posed difficult ethical questions to state authorities, specially in cases where the applicant is not considered terminal. In its view, such cases indicate that the applicant is not choosing an "easy death" instead of one with "severe suffering"—which, it claims, was the case of Diane Pretty—, but opting "to prefer death to life." (Application no. 31322/07, p. 14) Thus, if this was the case, the government argued that the state is obligated, under Art. 2 of the Convention, to take the appropriate steps to protect the life in question. Also, in another comparison to Diane Pretty's case, the government suggested that differently from her illness, Ernst Haas' did not "prevent him from acting autonomously," since "there were numerous other solutions available to able-bodied persons wishing to commit suicide." (Application no. 31322/07, p. 12)

But besides the specificities in relation to being considered terminal or not, the government's argument concerning the difference between Diane Pretty and Ernst Haas' diagnostics lays out a contrast between physical and mental illnesses. It stated:

> The Government submitted that, in psychiatry, the wish to commit suicide was seen as a symptom of mental illness, to which the appropriate response was suitable therapy. In their view, it was therefore necessary to draw a distinction between the wish to commit suicide as an expression of illness and the wish to commit suicide as an autonomous, considered and sustained decision.

The government’s allusion to the psychiatric perception of suicide as a symptom of mental illness and, consequently, an act preventable through therapy[86], speaks to the process of medicalization of suicide described by Marsh (2013) as the “compulsory ontology of pathology.” As already pointed out[87], his argument centers on the emergence of a medical discourse that framed suicide as an “individual, internal, and pathological act,” therefore requiring “expert knowledge to understand, and specialist medical services to manage and treat.” (Marsh, 2013, p. 746) An expert knowledge that would be placed within the remit of psychiatry. The normalizing power of psychiatry, its control and capture of the patient’s body, actions and history through tactics of management (Das, 2016, p. 4), seek to impose the real over madness “on the name of medical science, of psychiatry.” (Foucault, Marchetti, Salomoni, & Davidson, 2003, p. 133)

For instance, when Dr. Wilson’s patient became aggressive in his hotel room during his farewell visit to his sister, the police took him to a psychiatric facility that, under the Mental Health Act 1983, sectioned him in a locked ward[88]. This collaboration between state and medicine, in light of his *abnormal* wish to commit suicide, made him be transformed into a patient who, due to the risk he posed to his own life, was subjected to a process of normalization through—mainly—pharmaceutical interventions. Similarly to what Biehl described about Catarina (2005), he himself became a drug—or, as was Dr. Wilson's impression after first seeing him in the psychiatric facility, *quasi* zombie-like. An object and subject of

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[86] A similar remark was made during the court case Carter v. Canada, which ended up legalizing physician assisted death [PAD] in Canada. As Karsoho et al. (2017, p. 6) explain, the opponents of PAD—including the country’s Attorney General—suggested that “the PAD patient was likely to be motivated by depression or other psychiatric conditions, thereby seeing the request for PAD as suicidal ideation, deserving mental health intervention rather than hastened death.” As they indicate, this was made to associate PAD with suicide, therefore pathologizing the act. “If a PAD request could be seen as a ‘cry for help,’” they write, “then the appropriate medical intervention would be psychiatric or psychological, rather than an ‘early death.’” (2016, p. 6)

[87] Chapter 3.

[88] As described on chapter 3.

psychiatric intervention. And underlying the interplay of medical and social interventions that constituted him as a patient (Fainzang et al., 2010, pp. 18-19) targeted for psychiatric and state care is precisely the notion that mental illnesses are internal and individual, and, therefore, can be treated through body and lifestyle interventions (Fainzang et al., 2010, p. 19). Foucault, however, raises a question about the connection between psychiatry and medicine. He writes (2003, p. 12):

> Leaving aside for the moment the problem of why in fact such a practice could be seen as medical practice, and why the people who carried out these operations had to be doctors, it seems that, in its morphology, in its general deployment, the medical operation of the cure performed by those whom we think of as founders of psychiatry has practically nothing to do with what was then becoming the experience, observation, diagnostic activity, and therapeutic process of medicine.

But while the techniques then employed by psychiatry within asylums had already been previously used in other institutions, it was not until "the opening of the law to psychiatry as 'expert testimony,'" that "these techniques come to be redefined as 'therapeutic' for the patient who are also cast in the role of guardians for protection of the social body." (Das, 2016, p. 5) Whereas Marsh argues that the medicalization of suicide was strategic in providing the then emerging discipline of psychiatry with a rationale (2013, p. 752), one of imposing reality over abnormality through techniques of intervention (Das, 2016, p. 4; Foucault et al., 2003, p. 133), others reinforce the role played by the interaction between medicine and law (Harper et al., 2015).

For instance, before the decriminalization of suicide in the United Kingdom in the 1960s, suicide could lead to serious legal consequences in the country. In the 17th Century England, for example, properties and possessions of a person who committed suicide could be reverted to the Crown, leaving their heirs without inheritance (Alvarez, 1971). According to Tatz (2005, p. xvi), it was precisely this loss of properties and possessions that led to a legal strategy toward the psychiatrization of suicide. “[T]hat diagnoses of ‘suicide while of unsound mind’, or ‘suicide while the balance of the mind was disturbed’, had nothing whatever to do with the medical profession until relatively recently,” he writes, defending that “[l]awyers, not doctors, deliberately concocted a protection against such a silly law and got the suicide’s estate, assets and inheritors ‘off the hook’ by declaring him not responsible for his actions.” (Tatz & Australian Institute of Aboriginal and Torres Strait Islander Studies., 2005, p. XVI) The combination of a specific truth of suicide as within the realms of medicine and, more specifically, psychiatry, with its criminalization through official law has led to a situation, in England, where if you tried to commit suicide and failed, you were regarded as a criminal; if you succeeded, as a lunatic (Alvarez, 1971; Tatz & Australian Institute of Aboriginal and Torres Strait Islander Studies., 2005).

It was precisely this particular truth of suicide as mental illness that based the Swiss government’s claim that a differentiation between suicide as an “expression of illness” or as an “autonomous, considered and sustained decision” is needed. And the sole way to determine which one was Haas’ situation would be through a thoroughly psychiatric assessment. This distinction goes beyond the court. As Dr. Wilson once explained to me, to facilitate organized suicide assistance to people diagnosed with psychiatric disorders can be a challenge. She said:

> Dignitas [which was the organization to which Ernst Haas requested assistance] is naughty, because, you know, they really hardly ever accept psychiatric cases. They do occasionally, but in my experience the ones they’ve accepted have been patients who had schizophrenia or bipolar disease, sometimes psychotic psychiatric disease. But stop people with depression, anxiety disorders, personality disorders, and all those. They really won’t have them, because they have trouble getting a psychiatrist. Erika [Preisig] won’t have anything to do with anybody with psychiatric disease, because she is not a psychiatrist who can assess the medical records from a psychiatric point of view.

Finding a psychiatrist to evaluate him in light of his wish to apply for suicide assistance was, likewise, a problem to Haas. As stated in his case, he sent a letter to 170 psychiatrists requesting professional assessment to conclude whether his decision to commit suicide was an expression of mental illness or a considered, weighed-up, rationally made decision. However, none of the psychiatrists he contacted agreed to conduct a psychiatric evaluation, with some alleging lack of time, competence, or even ethical issues (Application no. 31322/07, p. 8). But the government called attention to the wording of his letter, suggesting that it was not written to encourage doctors to respond in a positive way, for he rejected in advance the possibility of treatment (Application no. 31322/07, p. 14).

Haas' letter to psychiatrists

"Dear Sir/Madam,

Please find attached a copy of a Federal Court judgment in my case. I had asked the Federal Court to be granted direct access to sodium pentobarbital so that, with the help of Dignitas, I could commit assisted suicide without risk of failure and without pain. Admittedly, the Federal Court has accepted that the right to choose the time and manner of one's death is a human right. At the same time, it has held that direct access to sodium pentobarbital is impossible, since a medical prescription is necessary in order to obtain the said product.

Given that I suffer from mental illness, the Federal Court also stated that a preliminary in-depth psychiatric examination was also necessary (p. 75, paragraph 6.3.5.2.). This should determine whether my wish to die is the expression of a psychological disorder that is open to treatment or whether it results from an autonomous, considered and sustained decision by a person who is capable of discernment (see also p. 75, paragraph 6.3.5.1.).

I hereby ask whether you would be willing to accept me as a patient, for the sole purpose of conducting such an assessment.

In addition, I draw your attention to the fact that I am unlikely to commit suicide at present; I have not taken neuroleptics since November 2006."

The resistance against accepting members with mental illness can be perceived in the green light process, for the provisional authorization only becomes a definitive one after two psychiatric evaluations. Evaluations that, besides assessing whether the member is under external pressure, seek to weigh in on signs of mental illness, particularly depression. Moreover, the combination of a physical diagnosis while being of sound mind is a legal requirement in several assisted dying laws. Because of this, Dr. Wilson had also experienced difficulties in finding assistance to patients of her diagnosed with mental illnesses. As she recounts:

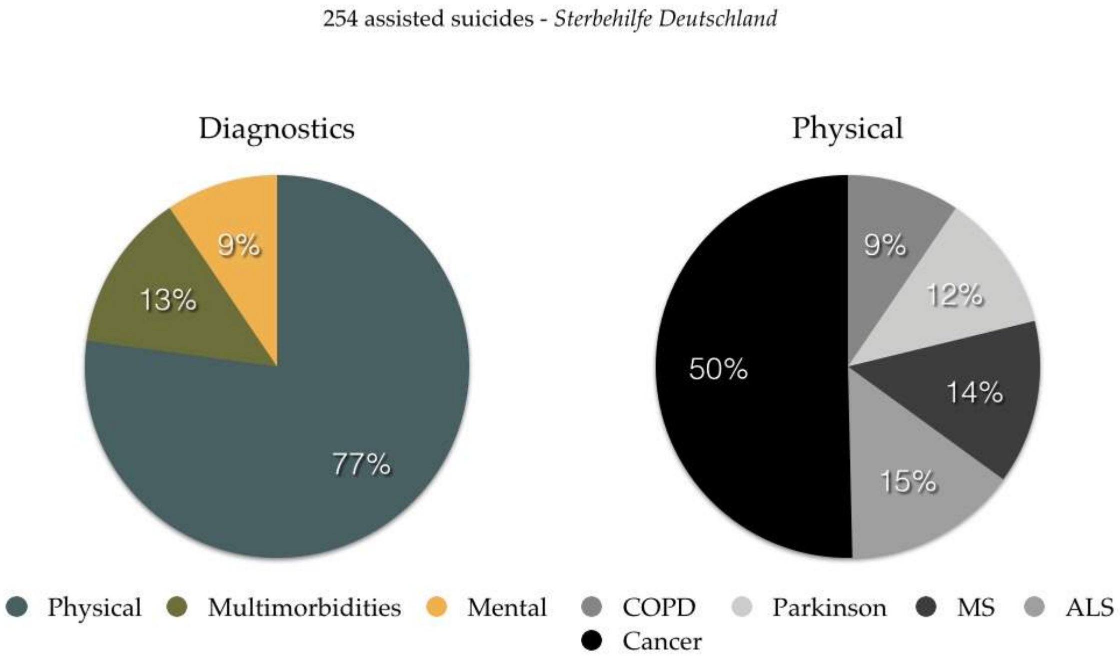
> There's one [patient] who is incredibly paranoid, she's told me she is called Stefanie, but she won't give me… Well, she doesn't want to give her name or address or anything like that, and, again, she's got one of these really weird, sort of new, psychological disorders, you know? Dignitas won't touch her with a bargepole. They would never touch personality disorders and things like that. They like diseases where you can take a little bit out and put under a microscope, you know?

But while diagnostics of mental illness trigger a greater resistance within this landscape of assisted suicide, diseases you can "put under a microscope" yield an easier path. Data provided by LifeCircle shows a wide array of diagnostics used as justifications by members of the organization to apply for and carry out an assisted suicide. Diagnostics such as Huntington's and Parkinson's, multiple sclerosis, and ALS. Nonetheless, the prevalent diagnosis is cancer—almost more than all other diagnostics combined. Similarly, out of the 254 suicide assistances provided by the StHD until 2016 (Kusch, 2016), 69 were because of cancer, followed by ALS (20 cases), multiple sclerosis (19), Parkinson's (16), and chronic obstructive pulmonary disease ([COPD], 13). The other cases were due to mental illnesses (24) and multimorbidities (34).

Taking into consideration the data provided by the organizations, cancer stands out among the diagnostics considered to be physical. Sarah Lochlainn Jain (2007, p. 79) argues that the high incidence of cases of cancer contrasts with the perception that the disease is a "tragic exception." But cancer cannot be solely defined by its physical facet. It goes beyond what you can put under the microscope, affecting a person's perception over their own life and reshaping their relationships. Once, in Basel, this perception of cancer as a tragic, yet common, disease that exerts an impact over a person's relationship became clear.

As Dr. Preisig was organizing some documents and her assistant was preparing the solution of sodium pentobarbital, the member was looking for something inside of his briefcase. There, he had a stash of drug packages. Many years ago, he had been diagnosed with HIV, and the drugs in the briefcase were the ones he had to take daily. Over the years, he developed chronic fatigue syndrome, a disorder characterized for intense fatigue and tiredness with no underlying medical condition. But despite being informed about his decision to apply for suicide assistance, his family was not aware of his HIV diagnosis. He managed to hide it from them for years and now that he was about to die, he did not want it to be disclosed afterward as well. In a signed, handwritten letter, he informed both the organization and the authorities that his HIV diagnosis was to remain a secret from his family. A request to which his family doctor had likewise agreed with. After becoming aware of his wish, Dr. Preisig asked him what would then be the public reason for his assisted suicide. And since he was a heavy smoker, he promptly replied lung cancer.

The "quasi-mystical nature" (Jain, 2007, p. 78) of cancer provides the ideal justification for seeking suicide assistance. It was a disease that his family would find compatible with his smoking habits, and one whose incidence is high enough as not to raise suspicions. During conversations with colleagues and friends after fieldwork, it was common for them to ask me about the reasons why people seek assistance to suicide. But it was also equally common to hear shocking reactions to reasons such as arthrosis and pain syndrome be followed by nods of agreement and signs of understanding after the word cancer being uttered. As Jain (2007, p. 78) points out, for some people receiving the diagnosis of cancer feels like being “diagnosed with death,” and this reinforces a fundamental aspect within this cancer culture (Jain, 2007): it often focuses on “cancer-as-disease” while ignoring “cancer-as-social interaction.” (J. McMullin, 2016, p. 252) As something that, as Livingston (2012, p. 6) stresses, “happens between people.” So despite being a disease you can put under the microscope—and therefore facilitating one’s access to this landscape of assisted suicide—the social dimension of cancer (Balshem, 1993; Jain, 2007, 2013; J. McMullin, 2016; J. M. McMullin, Weiner, & School for Advanced Research (Santa Fe N.M.), 2009) blurs the line between physical and mental, impacting both the diagnosed person and their relations with family and friends. Following McMullin’s (2016, p. 252) arguments, cancer is integrated into the intimate life.



But despite cancer being, simultaneously, “cancer-as-disease” and “cancer-as-social interaction,” this landscape of assisted suicide operates in a clear distinction between physical and mental illnesses. On the one hand, diagnostics of mental illness can not only be experienced as disempowering and stigmatizing, often leading to psychiatric interventions and institutionalization (Ben, Renata, Huong, & Chris, 2010; Crossley, 2004; Das, 2016; Desjarlais, 1994; Mathieu, 1993), but also impose more barriers on the path to organized, professionally assisted, suicide. Ernst Haas’ diagnosis of bipolar affective disorder, for instance, made the Swiss government put in question his ability the rationally decide over the termination of his own life through assistance, all the while alluding to the fact that he was able-bodied enough to pursue other ways to suicide—which, despite being against the state’s aim to protect life, was both lawful and difficult to prevent. Similarly, Dr. Wilson could not enact a cooperation to facilitate Stefanie, her patient, to die with organized assistance. On the other hand, “physical diagnostics” provide paths which, despite its own hurdles, challenges, and gates, more often than not lead to the procedure being actually authorized.

This was the case with Margot (who offered a number of physical diagnostics in her application, such as incontinence, arthrosis, and constant pain), Ingrid (who was losing her eyesight, alongside an overall poor health condition due to old age), and Elise (pain syndrome). For instance, the medical diagnostics presented by Margot, as physical as they were considered to be, were metonymic of restrictions on her day-to-day routine, such as the arthrosis that prevented her from doing the activities she enjoyed and were dear to her. And while these restrictions motivated her to apply for an assisted suicide, it was her diagnostics of physical diseases that facilitated her passage through medical gates and granted her access to the procedure. Margot, just like Ingrid and Elise, walked a fine line between expressing frustration about her decreasing quality of life—based on her inability to practice sports and meeting friends—and justifying this perception on medical grounds. She could not be seen as depressed. Similarly, whereas the HIV and chronic fatigue syndrome diagnostics were the reasons employed to justify his application and enabled his procedure to take place, these were not the public diagnostics. HIV was a hidden one. It was a publicly unknown underlying medical condition to his request, which would be exposed on the grounds of lung cancer[89]. A disease that would be both believable to his family and socially acceptable as justification. His double diagnosis was therefore necessary for his request to be accepted by the organization while being likewise accepted by his family.

Despite this landscape operating on a mental/physical dichotomy, particularly over the course of green light applications, when diagnostics are articulated to the judiciary they are often framed within a common figure. Haas and Pretty are illustrative of this dichotomy: they both presented their diagnostics to the courts, not failing to mention the restrictions and limitations they imposed on their day-to-day lives, but while the former had been diagnosed with a mental illness, the latter was suffering from a physical one. On the one hand, the perceived nature of their diagnostics raised different arguments by the governments. On the other hand, both Pretty and Haas framed their claims as one for dignity.

5.3 Articulating diagnosis with dignity

In their court cases at the ECHR, both Pretty and Haas framed their life circumstances and future prospect as lacking dignity because of specific medical diagnostics, respectively motor neuron disease and bipolar affective disorder. They combined their medical diagnostics with a specific perception over their own quality

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[89] Despite his request being respected, his case was officially accounted for as HIV.

of life, articulating this combination in the form of dignity[90]. In its ruling regarding Pretty's case, the ECHR stated:

> The very essence of the Convention is respect for human dignity and human freedom. Without in any way negating the principle of sanctity of life protected under the Convention, the Court considers that it is under Article 8 that notions of the quality of life take on significance. In an era of growing medical sophistication combined with longer life expectancies, many people are concerned that they should not be forced to linger on in old age or in states of advanced physical or mental decrepitude which conflict with strongly held ideas of self and personal identity. (Application no. 2346/02, p. 34)

Following the ECHR's argument, the respect for human dignity is the very essence of the Convention, but dignity is also a key component in right-to-die discourse, political campaigns, and legislations. The organization Dignitas, for instance, not only is named after "dignity" in latin, but also has "to live with dignity, to die with dignity" as its slogan. Likewise, 18[91] out of the 51 right-to-die organizations affiliated with the World Federation of Right to Die Societies have dignity in their names[92].

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[90] Similarly, Karsoho et al. (2016, p. 189) have questioned how "proponents articulate suffering with the role of medicine" in the context of end-of-life care. They defined articulation as the "process of forming discursive linkages between two different entities or concepts."

[91] Not including Dignitas-Switzerland and Dignitas-Germany.

[92] Those are: Dignity South Africa (South Africa); Japan Society for Dying with Dignity (Japan); Association pour le Droit de Mourir dans la Dignité (Belgium); Association pour le Droit de Mourir dans la Dignité (France); Association pour le Droit de Mourir dans la Dignité (Luxembourg); Direito a Morrer com Dignidade (Portugal); Dret a Morir Dignament (Catalunya, Spain); EXIT A.D.M.D. Suisse romande (Switzerland); The Israel Society for the Right to Live and Die with Dignity (Israel); Association Québécoise pour le Droit de Mourir dans la Dignité (Canada); Dying With Dignity Canada (Canada); DMD Mexico - "Por el derecho a morir con dignidad" A.C. (Mexico); Death with Dignity National Center (United States); Dying with Dignity ACT (Australia); Dying with Dignity NSW (Australia); Dying With Dignity Victoria Inc (Australia); Dying with Dignity Western Australia (Australia); Fundación Pro Derecho a Morir Dignamente (Colombia). Source: https://www.worldrtd.net/member-organizations. Last visited: May 11th 2018.

When it comes to legislations, three out of eight state legislations regulating assisted dying in the United States are titled "Death with Dignity Act.[93]" As a common figure in both legal discourse and right-to-die groups, dignity articulates the interplay of medical diagnostics and quality of life into legal discourse, shaping judicial claims in one single common language. In a similar fashion to Pretty's and Haas' cases, Griffiths (2008, p. 63) shows how the language of dignity has been similarly used in other contexts, such as a court case, in the Netherlands, where the Supreme Court acknowledged the claimant's "prospect of increasing 'loss of personal dignity'" and "the risk that it might become impossible for the patient to 'die in a dignified manner.'"

But the role played by dignity in the interplay of medicine and law is not restricted to end-of-life cases. As Biehl and Petryna point out, a similar dynamics occur in claims regarding right to health. As one of their interlocutors—a public defender in Brazil—told them, "[t]he person (…) comes here sick. Her right to health has been profoundly injured by public power. Even if the medicine might not bring them life, the claim is also for their dignity." (J. o. Biehl & Petryna, 2013, p. 1) Paula, the interlocutor in question, even comes to defined her work as a kind of medicine: "[t]his is the medicine that I practice here: to help people survive with dignity." (J. Biehl, 2013, p. 423) A similar situation can also be found in a collective action, judged in 2007, in Brazil, that sought the right for transexuals to undergo gender reassignment surgery in the public health system. As Biehl (Schuch, 2016, p. 412) suggests, the judge's ruling—in favor of the claimants—was not based on the right to health, but on broad principles such as freedom, equality, and respect for human dignity.

As Lambek (2012, p. 354) argues, personal dignity is "anchored in the performance of rituals," and "where the conditions for dignity break down, whether at the collective or individual level, an ethical crisis ensues." In a similar way, when the applicants' perception over their quality of life reached a point where they no

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[93] Oregon, Washington, and District of Columbia.

longer believed to be able to live with dignity—and both Pretty and Haas have made such claims—, the conditions for what they perceive as a dignified life breaks down and a demand for a particular right is articulated to the judiciary. They depart from a diagnosis that affects their quality of life by making them experience physical and emotional obstacles, rearranging their desires, affects, routines, and goals, to ultimately combine such aspects in a claim for dignity that can be articulated through a common language. And while court cases provide a gateway to exchanges of arguments mediated by an institution that produces regimes of truth (Latour, 2010), discursively dramatizing some of the itineraries of mobility otherwise enacted in this landscape, they simultaneously cloud the people behind it.

In other words, following Lambek's argument, court cases expose how the ethical crisis are dealt with, but hide the day-to-day circumstances that made the conditions for dignity to break down in the first place. Peopled accounts (J. o. Biehl & Petryna, 2013, p. 2), therefore, are essential to unveil what bureaucracy and court proceedings help to conceal. They enable us to go beyond finely constructed court arguments that articulate the applicant's personal circumstances with the laws to which they are subjected, offering a glimpse into their own personal narrative.

5.4 Lamb v. the United Kingdom

> In 1990 the second applicant was involved in a car accident as a result of which he sustained multiple injuries leaving him paralysed. He is completely immobile with the exception of his right hand which he can move to a limited extent. His condition is irreversible. He requires constant care and spends everyday in a wheelchair. He experiences a significant amount of pain, as a consequence of which he has to take morphine. He feels that he is trapped in his body and that he cannot enjoy or endure a life that is so monotonous, painful and lacking in autonomy.

ECHR, on Paul Lamb[94]

Paul Lamb is a British national, born in 1955, who used to work as a builder. Ever since his car accident, his routine has changed dramatically, starting to require intensive and constant home care. In 2014, Paul lodged an application at the ECHR, arguing that his Convention rights under Articles 6 (right to a fair trial), 8 (right to respect for private and family life), 13 (right to an effective remedy), and 14 (prohibition of discrimination), were infringed due to the absence of a domestic "judicial procedure to authorise voluntary euthanasia in a case like his." (Application no. 1787/15, p. 22) Also, he alleged that the UK Supreme Court has acted unfairly by dismissing his claim regarding the procedure. Within this landscape, Paul's case was unique. He did not ask for third party assistance to suicide, as did Diane Pretty on her request for criminal immunity for her husband, as well as Ernst Haas on his request for prescription-free access to sodium pentobarbital. In contrast to these cases, Lamb wanted someone to actually perform the procedure on him.

According to the ECHR ruling, Lamb's legal challenge before the UK Court of Appeal was against both the prohibition of assisted suicide and voluntary euthanasia. However, before the Supreme Court his challenge concerned only the prohibition of assisted suicide. Under these circumstances, the ECHR stated that Lamb "did not provide the Supreme Court with the opportunity (…) of addressing, and thereby preventing or putting right, the particular Convention violation alleged against it." (Application no. 1787/15, p. 23)—and therefore unanimously dismissed his application for non-exhaustion of domestic remedies.

The first time I heard Lamb's name was during a conversation with Dr. Wilson at her home in Glasgow. While we were chatting about Diane Pretty's case, Dr. Wilson remembered she wanted to call a FATE member, Paul, mentioning that they had not spoken for two months by then. She used to check on him frequently,

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[94] Application no. 1787/15, p. 2.

sometimes visiting him in Leeds, where he lives, but more often than not by phone. It was clear from the beginning that Lamb mattered a great deal to her, as she not only sounded worried about his situation, but also somewhat angered. She told me he can speak and swallow normally, but is almost completely paralyzed from the neck down, with the exception of a "very very slight movement in one hand" that he uses to work his wheelchair by pressure. But his main problem, according to Dr. Wilson, is the risk of getting an infection—which, if you are immobilized, "is only too likely." For instance, if he gets an urinary tract or a chest infection, he would have to go to the hospital, "where he doesn't get a voice." And since Lamb already has chronic pain in his neck and pressure sores are always at risk of occurring, this would demand high dosages of morphine. "But if he takes too much of it," Dr. Wilson says, "it confuses his brain. He says 'I can't take too much of it because I don't want to be a zombie."

She explained to me that Lamb had filed a judicial claim for the right to die with third party assistance—but, since he was almost completely paralyzed from the neck down, he would need someone else to actually administer the drugs for him. And while from a medical standpoint his request would be regarded as voluntary euthanasia, when it comes to UK law it would amount to murder[95]. Organizations such as LifeCircle have ways of dealing with physical disabilities. There, for instance, they developed a small device that allows the influx of sodium pentobarbital to be released by a gentle movement of the head. But Lamb's situation was more complex, as mobility itself was a major issue for him. In order to use a device such as the one created by LifeCircle, he would have to be able to travel to Switzerland in the first place. In his application to the UK Court of Appeal, he even made reference to the possibility of using an "'eye-blink' computer connected to a machine preloaded with lethal drugs." (Application no. 1787/15, p. 23) But similarly to the logistical problem

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[95] As mentioned in the "Relevant domestic law and practice" section of his ECHR case, the Court notes that "[t]here is no specific offence of voluntary euthanasia in English law. The intentional killing of another person, including with their consent, would constitute the common law offence of murder." (Application no. 1787/15, p. 17)

with using LifeCircle's gadget, to arrange a procedure with the eye-blink computer would be an off-chance.

LIFECIRCLE'S DEVICE (LEFT) | 2016 | MARCOS ANDRADE NEVES

During our conversation, Dr. Wilson shared that Lamb's original case was taken up by a "very well known human rights organization" and a main lawyer, S.C. But when Paul needed to go to London for the trial, the reality of a judicial case, its everyday hurdles and difficulties, started to sink in. "She was totally unhelpful about the practical arrangements," said Dr. Wilson, "he's tetraplegic, you know." Because of his disability, Lamb needed constant care for his most basic chores, so when it comes to traveling the difficulty increases even more. Mobility was a main challenge. According to her, the BBC offered to pay for Lamb's accommodation in a hotel near the court and to facilitate his traveling in exchange for an exclusive interview. His lawyer, however, advised against this deal. She continued:

> So about a week before the thing, he had to find a hotel, and he has terrible trouble getting into taxis, even the taxis for people with disability. He hits his head on the roof and so on. He's got an electric wheelchair, and he had to actually, I think, go about a mile on the pavements of London in an electric wheelchair from the hotel, and that sort of thing. It's all because she said that he mustn't have an exclusive interview with the BBC.

Dr. Wilson was clearly upset about this situation. To her, Lamb's claim to dignity was not only something he articulated to the judiciary in order to claim a right to die with assistance, but rather his own quality of life and everyday challenges as someone in need of constant, intensive, care. Dignity was not only a common language that would make his claim legible to the judiciary, but rather a daily struggle. A struggle to sleep and wake up, to eat and to clean himself. A struggle to move from one place to the other within his home, let alone traveling about 300 km from Leeds to London. It was not about the content of the case, but the circumstances of his everyday life.

After his case failed, Lamb's lawyer informed him that it would be necessary to raise about two-hundred thousand pounds in order to take it to the ECHR. But Paul did not have that much money. He even received legal aid for his first judicial attempts—but now, his lawyer said, legal aid to go to the ECHR was not possible. "I was just sort of thinking," said Dr. Wilson to me, "how on earth can we raise two-hundred thousand pounds? She just sort of abandoned him at that stage and said, you've got to get two-hundred thousand pounds, it will take about two or three years, we are not so interested anymore." As they approached a different law firm, they found out about the statute of limitations: if they wanted to go to the ECHR, they would have to apply within six months from the national decision. It was not a matter of two to three years, as Lamb's former solicitor had advised, but of six months. Cases like Lamb's attract publicity and, according to Dr. Wilson, that was precisely the reason why S.C. represented him. She said: "Once it failed, she wasn't interested on him. She was completely callous, really, about the human side." Dr.

Wilson's take on Lamb's case was not one of arguments and relevant domestic and international policies and legislations, of jurisdictions and rulings, but one sensitive to daily struggles. Sensitive to what it means, on the ground level, to file an application without legal aid and poor legal advice.

Just a few months after this conversation with Dr. Wilson, I found myself on a train to Leeds. By that time, Paul Lamb and I had already been in touch for a while, mostly to arrange my travel there. It was FATE, through Dr. Wilson and Sheila Duffy, who put us in contact—after all, both of them knew Lamb very well and were frequently in touch with him. Once I got there, I was invited in by his carer. It was a two story house in the outskirts of Leeds, adapted with elevator for his mobility needs. Following his carer's instructions, I walked up the stairs and into a study, where Lamb was sitting on his wheelchair with his back facing me. Since I knew he was almost completely paralyzed from the neck down with the exception of his right hand—which he could move just enough to control his wheelchair's joystick—, I simply said "Hello Paul," while gently, and rather awkwardly, tapping on his shoulder. But this was clearly not enough for him. As friendly and welcoming as he was during our previous contacts, he just opened a smile and asked me to give him a proper handshake. So I did. At that moment, I felt as if I had immediately understood why Dr. Wilson cared so deeply about him.

"I never thought I would walk again," Paul shared in our initial talk. "And after 26 years now, going to the 27th year, the things that happened to my body… I have all kinds of things. And this right to die is something that… When I feel I can't do it anymore, and that will come, I've been told it will come, if I got at that stage somebody better put me out of my misery." Paul looked serious, but not sad. He appeared to be very calm and centered. He was living this reality for almost 30 years now, almost 15 years more than his original prognosis. During his stay in the hospital in 1990, Paul was given 12 years to live by a specialist who warned him to get his affairs in order. And so, for 12 years, Paul lived with a grim prospect. He shared:

> And I remember, it came to July 2002 and I thought I'm going this year. My 12 years are up. It was so implanted in my head. And within a week or so, I wanted to fly back to the hospital and tell this specialist what I thought about his 12 years to live, how it affected me. I'm over 26 years now and I still don't think like I'm going anywhere. I have hope, and to me, hope means getting up on a daytime and then go back to bed at night, and I'm happy. My family is actually proud of me.

At the time of his accident, Paul's son was 11-year-old and his daughter, 9. But despite growing up with him in that very same house, Paul said they have never even seen a catheter. He did not want them to care for him, to be a burden on his children. By the time we met, Paul had seven carers in rotation, day and night, everyday, all of them public funded through caring agencies. Similarly to what Dr. Wilson had previously told me, Paul also said that his biggest fear is to go to the hospital or having pressure sores. He once had a small one on his butt, he shared, and it lasted for five months. "And I've seen people with huge ones, you know they are not gonna heal. Not a chance," he explained, "and this little one made me very concerned, because I was on one side and than the other for five months, in bed, and after that it took me a month or so to getting used to get up again and sit in the chair and build my strength up. I want to hang on to life as much as I can, but I'm only too aware of what can happen to my body." In order to avoid his biggest fear, care is essential.

It was online, while he was looking into caring options, that Paul came across FATE's website and first got to know Dr. Wilson. Over time, as they began to talk to each other more frequently, Dr. Wilson offered him assistance to go to Switzerland in case he decided the time was right, even if it meant for her to travel with him herself. But Paul's decision was to try and claim what he perceived to be his fundamental right to stop suffering when it becomes unbearable. His pain, after all, was constant and unmanageable without becoming quasi zombielike with morphine, as Dr. Wilson first told me and Paul later reinforced. His involvement with the judicial claim, however, came unexpectedly. As he recounted, Tony Nicklinson, a British citizen with locked-in syndrome, had already commenced proceedings at the High Court to challenge the law on assisted suicide and murder, which did not recognize the possibility of voluntary euthanasia (Richards, 2014; Ward, 2015). After his case failed, Tony Nicklinson refused nutrition and died six days after the High Court's ruling. As Paul told me, "Tony was legally allowed to take his case to the Supreme Court, but he didn't have the strength, he gave up."

After Nicklinson's death, his solicitor and his widow, Jane Nicklinson, contacted Dr. Wilson to ask her if she knew anyone who could help them in the case, to take it back to court. So Dr. Wilson contacted Paul, and they went to visit him in Leeds. Jane Nicklinson and her solicitor then asked if he would be willing to help them. "We will put you down as a fictitious character," they told him, "this way you don't have to come out in the open." Following Paul's consent, he became "L." His time as a "James Bond character"—as he joked to me—went on for weeks, until the solicitor got back in touch with Paul to inform him that everyone was thinking "L" did not exist. "Would you mind coming out in the open?," the solicitor finally asked him. Paul was not all that sure about what coming out in the open entailed. "Well, it means there might be a few people coming to see you," she clarified. Once again, Paul consented. To his surprise, he started to receive phone calls every half an hour from 11 a.m. to 7.30 p.m., he was on the television, on newspapers. He told me he feared people would go to his house, placing placards on his lawn saying what a bad person he is, "going against God and all that." But it was quite the opposite, he convey. He was mostly being supported.

"That's why I joined in," said Paul, "to get it going again in the system. But they sent us to the High Court first and, lo and behold, it failed again." During the court proceedings at the High Court, however, he was filled with frustration: "I barely nearly opened my mouth there." And while he was there, silently watching his life circumstances being the subject of legal arguments, he heard a judge saying he had "sympathy for the likes of Mr. Lamb." Paul was surprised, uncertain if he had heard it correctly. But then "he said it again and again" and Paul could not take it any longer: “Please don’t say that word sympathy again. I don’t want you sympathy. I don’t want anybody’s sympathy.” And Paul’s carer rushed in to give him some medicine. Afterward, he was asked why he said that to “the highest court in the land.” As he was looking at me, Paul continued: “It’s just ridiculous if you can’t say something. I mean, you want people to have sympathy for you?”

His and Nicklinson’s case failed at the High Court and, subsequently, at the Supreme Court in a 7 to 2 decision—which, to Paul’s perception, was not “an absolute loss.” Around this time, Paul’s solicitor said to him that if they fail the Supreme Court, they would take his case to the ECHR. However, money became an issue:

> I’ve been on legal aid from the beginning and, on money terms, it’s not the kind of money that… Top solicitors earn a lot more on private cases. So when the legal aid ran out after the Supreme Court, they said they didn’t want to take it to the ECHR now. And that was that. And S.C. said to me, ‘Is there anyway you can earn 100 to 200 thousand pounds?’ And I went, ‘No, apart from selling my house, and that’s going to my children and grandchildren.’ And she said, ‘Oh well, we can’t go any further unless you can get that money together.

With Dr. Wilson’s assistance, Paul found another solicitor who agreed to take it to the ECHR pro bono. Paul’s life circumstances, his everyday challenges and hurdles, hopes and frustrations, fears and future prospects, continued with him throughout his itineraries in the justice system. But these aspects, however, were hidden behind the court case itself. The personal life was hidden behind court proceedings and legal arguments. How his case was built upon a collaboration mediated by Dr. Wilson, or how money played a fundamental role in taking the case forward to the ECHR, cannot be accessed by watching the court proceedings or reading their applications and subsequent rulings. There, dignity was a figure that can translate his life circumstances in the form of a claim, thus enabling its articulation to the judiciary. It hides, coming back to Lambek's (2012) argument, the everyday struggles that made the conditions for personal dignity to break down in the first place.

"I wonder sometimes what do you have to do to shake something up," said Paul to me. "I mean, for all intents and purposes, would it make a difference if I was to say 'By the way, country, I'm going to Switzerland in these next 20 days unless you can do something proper to sort this out.' How far would they allow me to go? The whole way? Would anybody care?"

PAUL LAMB'S HOUSE | LEEDS | 2016 | MARCOS ANDRADE NEVES

CONCLUSION

What does organized assisted suicide means in a world of ever-increasing complexity, one of connections and disconnections, border relations and transnational circulations within and among different legal landscapes and infrastructures of care? How to reconcile a procedure that occurs in specific places, being regulated by one set of—often divergent—official, medical, and pharmaceutical laws, with a larger dynamics that happens on the move, crisscrossing border relations and entangling different jurisdictions via itineraries of circulation? As this ethnography intended to show, organized assisted suicide is neither a local nor a global phenomenon, and cannot be defined by the procedure itself. Instead, it entails a set of transnational and heterogeneous actors and institutions, medical practices and knowledge, pharmaceutical objects, state policies, and forms of care that are sewn together by acts of collaboration and circulations into one single, ever-changing, landscape. And underlying this ongoing process of landscape formation, lies a friction between an anonymous *life*, as seen by the state and encapsulated in the form of laws, and personal ones.

Life as necessity, as Foucault (1978) put it, lies at the very heart of state and sub-state institutions, becoming a value in and of itself. A value to be protected and invested. It no longer matters whose life it is. The state, seeing through the rationale of population, sees simply *life*. One that is vital to its very own existence. Once detached from individual persons, *life* becomes a project of staying alive. A project that demands cooperation and against which suicide poses an unbearable threat. In order to carry out this project, *life* is encapsulated by legal protections and enforced through—mostly—a collaboration between state and medical institutions. These encapsulations set up legal protections to *life*, establishing criminal sanctions in case of violations. For instance, the three main official laws presented and discussed in the context of this landscape of assisted suicide, that is, the Art. 115 (Switzerland), the §217 StGB (Germany), and the Suicide Act 1961 (England and Wales) have all established *life* as something to be protected against suicide assistance. However, they lay out different criteria as to what constitute this criminal offense.

While in Switzerland and in Germany official laws offer some leeway for lawfully carrying out suicide assistance, be it via altruistic assistance or on exceptional grounds, in England and Wales the Suicide Act is clear in criminalizing suicide assistance. However, when its unambiguously criminalization of assisted suicide domestically meets the DPP's policy for prosecutors, an ambiguous situation emerges. As the report published by the Commission on Assisted Dying noted, this entanglement leads to a perception that suicide assistance is in effect decriminalized in the country. Nevertheless, official laws are not the only normative regulations that affect organized assisted suicide. Medical regulations, albeit only binding to registered physicians, affect the landscape as a whole by making more difficult to find medical assistance in dying or, even, legally accessing pharmaceuticals that require medical prescriptions.

The entanglement of different legal orders within one specific jurisdiction often leads to confusion and uncertainty, particularly in situations where medical and official laws do not coincide—as is the case in the post-§217 StGB Germany. Thus, organizations that provide professional suicide assistance within regimes of life, such as LifeCircle and StHD, are a byproduct of this very process of encapsulation of *life* in the form of laws. If laws are intrinsically—and often intentionally—ambiguous and unclear on the ground level, they wind up offering some interpretative leeways that enable their operations—such as being altruistic or non-commercial. An operation that transitions a person from life to death in a regime that has this distinction at its very heart.

Also as an outcome of this entanglement of different legal orders composed of frequently contradictory and often ambiguous laws, the state ends up being perceived through affective lenses. A general sense of mistrust emerges out of uncertainty, crafting an image of the state while impacting on the ways suicide assistance is applied for and provided. As both Stefan's and Dr. Arnold's cases illustrate, to operate within legal uncertainties and a general sense of mistrust does not prevent the assistance from happening. Instead, it reshapes its offering by making it more discreet. However, uncertainty also affects people applying for suicide assistance—and Margot's trajectory is perhaps the clearest example of this. After all, the German legal landscape changed around the same time she wanted to apply for suicide assistance, after having considered for a long time StHD as her most viable option. Once a new legal protection to *life* was enshrined in Germany's criminal code, StHD had to stop its operations and Margot became uncertain about the viability of going forward with her plan of receiving assistance in Hamburg. So she decided to go to Switzerland.

Margot's noncooperation with the project of staying alive—the clash between her personal life and *life* as seen by the state—was met with resistance by her family doctor and, following her death, became the subject of state and medical investigation. If *life* is a project, its transition to death matters to the actors and institutions responsible to enforce it. The legal pluralism of mostly official and medical laws with direct or indirect impact on suicide assistance end up creating a space where the protection of *life* can be enforced with caring responses. Care, however, is not to be taken as something intrinsically positive. Rather, drawing from Stevenson's (2012, 2014) definition, it refers here to actions triggered by state and medical institutions in order to enforce this project of staying alive, oftentimes resorting to forms of violence. These life-oriented spaces where infrastructures of care are designed and put in motion were framed here as regimes of life.

In this way, if the legal pluralism both produces an affective image of the state and enacts regimes of life, it is necessary to understand the impact such regimes have on personal lives. To understand, as Fassin (2009, p. 44) argues, the stakes of regulations over life. In this sense, the green light application process was essential. On the one hand, because organizations operate on a sensitive space where the transition between life and death takes place, they establish a bureaucracy to dying that safeguards the lawfulness of their operation—therefore, requiring medico-legal documents from their applicants. On the other hand, it is precisely in order to gather such documents that their personal lives start clashing with *life*, triggering conflictive interactions with some of the very own actors and institutions that can issue them. This situations poses a conundrum: if *life* as project is enforced and invested mostly by the collaboration of state and medical institutions, it is precisely these institutions that produce and issue the documents required to enable access to organized assisted suicide. In this context, when it comes to the role of medical documents and diagnostic technologies, Dr. Wilson framed this dynamics as "medical gates."

These interactions, as some cases have shown, often involve threats of violence, such as police action or psychiatric intervention. Threats that, sometimes, ended up being actually enforced. This was the case of Dr. Wilson's patient, who was taken by the police to a locked-ward in a psychiatric facility. People inhabiting this landscape as applicants to organized assisted suicide, therefore, try and establish a cooperation with people or organizations from different jurisdictions in order to find ways of navigating such regimes of life and, consequently, acts of care. Each cooperation weigh personal circumstances with the legal pluralism within which this life is enmeshed, therefore designing strategies that render organized assisted suicide as a viable possibility. Strategies such as the circulation of people—applicants or professional assistants—, pharmaceuticals, or method ideas. These strategies, and the routes that follow, are called here itineraries of circulation.

Itineraries of circulation are at the very core of this landscape of assisted suicide, being responsible for the entanglement of different jurisdictions into one single space of heterogenous actors, practices, policies, and materialities. As assisted suicide and pharmaceuticals—such as pentobarbital—enjoy distinct legal statuses within specific jurisdictions, their circulations among different jurisdictions can be either fostered or hindered by border relations, triggering specific caring responses. For instance, when Dr. Wilson ordered pentobarbital from China, she was visited and questioned by police officers. But such strategies are not limited to itineraries of circulation. If legal pluralisms trigger the establishment of itineraries of circulation for their navigation, sometimes these very own legal pluralisms are questioned via judicial claims and requests for clarification.

Throughout this process of lawful life, the articulation to the judiciary represents an important shift: with the mediation of judicial institutions—such as the ECHR—, a conversation is established whereupon the state has to clarify why legal protections to *life* should encompass one specific personal life. For the first time, they are addressing the same life. With the goal of sharing a common language, specific life circumstances are articulated to the judiciary as a claim for dignity. But while dignity, or lack thereof, sets off a legal debate, these very debates act to hide the everyday circumstances that made this perception of dignity to break in the first place. In order to tackle this, court cases were contrasted with Paul Lamb's own narrative with regards to his life and court case, pointing out the day-to-day challenges of carrying out a judicial claim while living with severe mobility restrictions. Dignity, thus, was not only a matter of legal arguments and shared language. It was first and foremost metonymic of everyday life struggles.

The process of lawful life, thus, is the friction that sets this landscape formation. It is a way of analytically capturing the—often strenuous—relation between populations and personal lives; between life regulations and their stakes; state policies and their enforcement; law and jurisprudence. It is a way, fundamentally, to make sense of the interplay between life, lives, state, and medicine on the ground level, perceiving how their mutual connections and disconnections are both enforced and circumvented through tactics such as itineraries of circulation and judicial contestation. Assisted suicide as an ongoing, and ever-changing, process of landscape formation is then one manifestation of the process of lawful life, but a drastic one. It touches the heart of this interplay, threatening the very rationale of state and medical institutions, which is the preservation and protection of life as an anonymous value: life as necessity, as a project of living. After all, this landscape of assisted suicide acts to reshape a crucial distinction between life and death, and does so by—not always—lawfully assisting people in their transitions from one pole to the other. If this distinction between life and death matters and is therefore maintained by the state and medicine through legal protections and their enforcement, this landscape of assisted suicide provides tactics to reshape it. While the former maintains this distinction to protect *life*, the latter reshapes it to favor lives. But this distinction between life and death, however reshaped or maintained throughout tactics of circumvention and enforcement of life, remains.

REFERENCES

Agamben, G. (1998). Sovereign power and bare life. Stanford, Calif.: Stanford University Press.

Alvarez, A. (1971). The savage god: a study of suicide. London,: Weidenfeld and Nicolson.

Andorno, R. (2013). Nonphysician-Assisted Suicide in Switzerland. Cambridge Quarterly of Healthcare Ethics, 22(3), 246-253. doi:10.1017/S0963180113000054

Andrade Neves, M. (2017). Por Onde Vivem os Mortos: O processo de fabricação da morte e da pessoa morta no complexo funerário de Porto Alegre. Porto Alegre: Editora da UFRGS.

Appadurai, A. (1986). The Social life of things : commodities in cultural perspective. Cambridge Cambridgeshire ; New York: Cambridge University Press.

Appadurai, A. (1990). Disjuncture and Difference in the Global Cultural Economy. Theory, Culture & Society, 7(2-3), 295-310. doi:10.1177/026327690007002017

Appadurai, A. (1996). Modernity at large : cultural dimensions of globalization. Minneapolis, Minn.: University of Minnesota Press.

Aretxaga, B. (2003). Maddening States. Annual Review of Anthropology, 32(1), 393-410. doi:10.1146/annurev.anthro.32.061002.093341

Ariès, P. (1974). Western attitudes toward death: from the Middle Ages to the present. Baltimore,: Johns Hopkins University Press.

Ariès, P. (1981). The hour of our death (1st American ed.). New York: Knopf : distributed by Random House.

Ariès, P., & Rigolet, S. (1983). En face de la mort. Toulouse: Privat.

Ariès, P., & Stannard, D. E. (1975). Death in America. Philadelphia: University of Pennsylvania Press.

Asad, T. (2004). What Are the Margins of the State? In V. Das & D. Poole (Eds.), Anthropology in the Margins of the State (pp. 279-288). New Delhi: Oxford University Press.

Balshem, M. L. (1993). Cancer in the community : class and medical authority. Washington: Smithsonian Institution Press.

Behrends, A., Park, S.-J., & Rottenburg, R. (2014). Travelling models in African conflict management : translating technologies of social ordering. Leiden ; Boston: Brill.

Ben, K., Renata, K., Huong, T., & Chris, D. (2010). A Care−Full Diagnosis. Medical Anthropology Quarterly, 24(1), 108-123. doi:doi:10.1111/j.1548-1387.2010.01087.x

Berry, E. R. (2008). The zombie commodity: hair and the politics of its globalization. Postcolonial Studies, 11(1), 63-84. doi:10.1080/13688790801971548

Biehl, J. (2013). The judicialization of biopolitics: Claiming the right to pharmaceuticals in Brazilian courts. American Ethnologist, 40(3), 419-436. doi: 10.1111/amet.12030

Biehl, J. o. (2004). The Activist State: Global Pharmaceuticals, AIDS, and Citizenship in Brazil. Social Text, 22(3)), 105-132.

Biehl, J. o. (2005). Vita : life in a zone of social abandonment. Berkeley: University of California Press.

Biehl, J. o. (2016). Theorizing global health. Medicine Anthropology Theory. doi:doi.org/10.17157/mat.3.2.434

Biehl, J. o., & Eskerod, T. (2007). Will to live : AIDS therapies and the politics of survival. Princeton, N.J. ; Woodstock: Princeton University Press.

Biehl, J. o., & Petryna, A. (2013). When people come first : critical studies in global health. Princeton: Princeton University Press.

Biehl, J. o., & Scheper-Hughes, N. (2000). O Fim do Corpo: Comércio de Órgãos para Transplantes Cirúrgicos. In G. Debert & D. Goldstein (Eds.), Políticas do Corpo e o Curso da Vida (pp. 49-81). São Paulo: Sumaré.

Birnbacher, D., & Dahl, E. (2008). Giving death a helping hand : physician-assisted suicide and public policy. An international perspective. Dordrecht: Springer.

Bosshard, G., Ulrich, E., & Bär, W. (2003). 748 cases of suicide assisted by a Swiss right-to-die organisation. 133, 310-317.

Brenneis, D. (Ed.) (2006). Reforming promise. Ann Arbor: Univ. Mich. Press.

Cambrosio, A., Young, A., & Lock, M. (2000). Introduction. In M. Lock, A. Young, & A. Cambrosio (Eds.), Living and Working with the New Medical Technologies: Intersections of Inquiry (pp. 1-18). Cambridge: Cambridge University Press.

Cannella, G. S., & Lincoln, Y. S. (2007). Predatory vs. Dialogic Ethics: Constructing an Illusion or Ethical Practice as the Core of Research Methods. Qualitative Inquiry, 13(3), 315-335. doi:10.1177/1077800406297648

Carey, M. (2017). Mistrust : an ethnographic theory. Chicago, IL: Hau Books.

CAS. (2011). The Commission on Assisted Dying: "The current legal status of assisted dying is inadequate and incoherent...". Demos.

Casas-Cortes, M., Cobarrubias, S., De Genova, N., Garelli, G., Grappi, G., Heller, C., . . . Tazzioli, M. (2015). New Keywords: Migration and Borders. Cultural Studies, 29(1), 55-87. doi:10.1080/09502386.2014.891630

Clark, D. (1999). `Total pain', disciplinary power and the body in the work of Cicely Saunders, 1958–1967. Social Science & Medicine, 49(6), 727-736. doi:http://dx.doi.org/10.1016/S0277-9536(99)00098-2

Conrad, P. (1979). Types of medical social control. Sociology of Health & Illness, 1(1), 1-11. doi:10.1111/j.1467-9566.1979.tb00175.x

Crossley, N. (2004). Not being mentally ill. Anthropology & Medicine, 11(2), 161-180. doi:10.1080/13648470410001678668

Das, V. (2007). Life and words : violence and the descent into the ordinary. Berkeley: University of California Press.

Das, V. (2014). Ethics, the householder’s dilemma, and the difficulty of reality. HAU: Journal of Ethnographic Theory, 4(1), 487-495. doi:10.14318/hau4.1.031

Das, V. (2015). What does ordinary ethics look like? In M. Lambek (Ed.), Four lectures on ethics : anthropological perspectives. Chicago, IL: HAU Books.

Das, V. (2016). Psychiatric Power, Mental Illness and the Claim to the Real. Paper presented at the Medical Anthropology Symposium in honor of Arthur Kleinman, Asia Center, Harvard University. https://www.academia.edu/30922196/Psychiatric_Power_Mental_Illness_and_the_Claim_to_the_Real

Das, V., & Poole, D. (2004). Anthropology in the margins of the state (1. ed.). Santa Fe, NM: School of American Research Press u.a.

Desjarlais, R. (1994). Struggling Along: The Possibilities for Experience among the Homeless Mentally Ill 886. American Anthropologist, 96(4), 886-901. doi:doi:10.1525/aa.1994.96.4.02a00090

Dierickx, S., Deliens, L., Cohen, J., & Chambaere, K. (2016). Euthanasia in Belgium: trends in reported cases between 2003 and 2013. CMAJ : Canadian Medical Association Journal, 188(16), E407-E414. doi:10.1503/cmaj.160202

Dilger, H., & Hadolt, B. (2015). Medicine in context: Towards a social and cultural anthropology of medicine(s) in an interconnected world. Medicine Anthropology Theory. doi:doi.org/10.17157/mat.2.3.333

Dilger, H., Huschke, S., & Mattes, D. (2015). Ethics, Epistemology, and Engagement: Encountering Values in Medical Anthropology. Medical Anthropology, 34(1), 1-10. doi:10.1080/01459740.2014.960565

Dilger, H., & Mattes, D. (2018). Im/mobilities and dis/connectivities in medical globalisation: How global is Global Health? Global Public Health, 13(3), 265-275. doi:10.1080/17441692.2017.1414285

Docker, C. (2015). Five Last Acts - The Exit Path: The arts and science of rational suicide in the face of unbearable, unrelievable suffering. Edinburgh: Exit.

DPP. (2010). Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide. The Code for Crown Prosecutors.

Elias, N. (1985). The loneliness of the dying. Oxford, UK ; New York, NY, USA: B. Blackwell.

Fainzang, S., Hem, H. E., & Risør, M. B. (2010). The taste for knowledge : medical anthropology facing medical realities. Århus: Aarhus University Press.

Fassin, D. (2009). Another Politics of Life is Possible. Theory, Culture & Society, 26(5), 44-60. doi:doi:10.1177/0263276409106349

Fassin, D. (2010). Ethics of Survival: A Democratic Approach to the Politics of Life. Humanity: An International Journal of Human Rights, Humanitarianism, and Development, 1(1), 81-95.

Fassin, D. (2012). A companion to moral anthropology. Hoboken, New Jersey: Wiley-Blackwell.

Fassin, D. (2013). Why Ethnography Matters: On Anthropology and Its Publics. Cultural Anthropology, 28(4), 621-646. doi:doi:10.1111/cuan.12030

Fassin, D. (2015a). Introduction : Governing Precarity. In D. Fassin & P. Brown (Eds.), At the heart of the state : the moral world of institutions. London: Pluto Press.

Fassin, D. (2015b). Maintaining Order : The Moral Justifications for Police Practices. In D. Fassin & P. Brown (Eds.), At the heart of the state : the moral world of institutions. London: Pluto Press.

Fassin, D., & Brown, P. (2015). At the heart of the state : the moral world of institutions (First English language edition. ed.). London: Pluto Press.

Foucault, M. (1978). The history of sexuality (1st American ed.). New York: Pantheon Books.

Foucault, M. (2003). Society Must Be Defended: Lectures at the Collège de France, 1975-76. New York: Picador.

Foucault, M., Marchetti, V., Salomoni, A., & Davidson, A. I. (2003). Abnormal : lectures at the Collège de France, 1974-1975 (1st Picador USA ed.). New York: Picador.

Geest, S. v. d. (2011). The urgency of pharmaceutical anthropology: a multilevel perspective. Curare, 34(1+2), 9-15.

Goffman, A. (2014). On the run : fugitive life in an American city. Chicago ; London: The University of Chicago Press.

Goldman, M. (2003). Os tambores dos mortos e os tambores dos vivos. Etnografia, antropologia e política em Ilhéus, Bahia. Revista de Antropologia, 46, 423-444.

Gorer, G. (1955). The Pornography of Death. Encounter, 5, 49-53.

Graeber, D. (2015). The utopia of rules : on technology, stupidity, and the secret joys of bureaucracy. Brooklyn London: Melville House.

Griffiths, J. (1986). What is legal pluralism? Journal of Legal Pluralism, 24.

Griffiths, J., Bood, A., & Weyers, H. (1998). Euthanasia and law in the Netherlands. Amsterdam: Amsterdam University Press.

Griffiths, J., Weyers, H., & Adams, M. (2008). Euthanasia and law in Europe. Oxford ; Portland, Or.: Hart Pub.

Harper, I., Kelly, T., & Khanna, A. (2015). The clinic and the court : law, medicine and anthropology. New York: Cambridge University Press.

Hoeyer, K., & Hogle, L. F. (2014). Informed Consent: The Politics of Intent and Practice in Medical Research Ethics. Annual Review of Anthropology, 43(1), 347-362. doi:doi:10.1146/annurev-anthro-102313-030413

Hörbst, V., & Wolf, A. (2014). ARVs and ARTs: Medicoscapes and the Unequal Place-making for Biomedical Treatments in sub-Saharan Africa. Medical Anthropology Quarterly, 28(2), 182-202. doi:10.1111/maq.12091

Howarth, G., & Leaman, O. (2002). Encyclopedia of death and dying. London ; New York: Routledge.

Hurst, S. A., & Mauron, A. (2003). Assisted suicide and euthanasia in Switzerland: allowing a role for non-physicians. BMJ, 326(7383), 271-273. doi:10.1136/bmj.326.7383.271

Huschke, S. (2013). Kranksein in der Illegalität: undokumentierte Lateinamerikaner/-innen in Berlin ; eine medizinethnologische Studie. (Zugl. Berlin, Freie Univ., Diss., 2012), Transcript, Bielefeld.

Jain, S. L. (2007). Living in Prognosis: Toward an Elegiac Politics. Representations, 98(1), 77-92. doi:10.1525/rep.2007.98.1.77

Jain, S. L. (2013). Malignant : how cancer becomes us. Berkeley: University of California Press.

Jasanoff, S. (1995). Science at the bar : law, science, and technology in America. Cambridge, Mass.: Harvard University Press.

Karsoho, H., Fishman, J. R., Wright, D. K., & Macdonald, M. E. (2016). Suffering and medicalization at the end of life: The case of physician-assisted dying. Social Science & Medicine, 170, 188-196. doi:http://dx.doi.org/10.1016/j.socscimed.2016.10.010

Karsoho, H., Wright, D. K., Macdonald, M. E., & Fishman, J. R. (2017). Constructing physician-assisted dying: the politics of evidence from permissive jurisdictions in Carter v. Canada. Mortality, 22(1), 45-59. doi:10.1080/13576275.2016.1157061

Kim, J. (2016). Necrosociality: isolated death and unclaimed cremains in Japan. Journal of the Royal Anthropological Institute, 22(4), 843-863. doi:10.1111/1467-9655.12491

Kleinman, A. (1999). Moral Experience and Ethical Reflection: Can Ethnography Reconcile Them? A Quandary for 'The New Bioethics' Bioethics and Beyond. Dædalus, 128(4), 28.

Kleinman, A., & Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. PLOS Medicine, 3(10), e294. doi:10.1371/journal.pmed.0030294

Kohn, E. (2013). How forests think : toward an anthropology beyond the human. Berkeley: University of California Press.

König, A. (2017). Embryos on the Move: Transnational Networks of Surrogacy. Allegra lab - Thematic Thread. Retrieved from http://allegralaboratory.net/embryos-on-the-move-transnational-networks-of-surrogacy-medtech/

Kusch, R. (2016). Der Ausklang (Edition 2016): §217 StGB verändert Deutschland. Norderstedt: Books on Demand.

Lambek, M. (2012). Religion and Morality. In D. Fassin (Ed.), A companion to moral anthropology (pp. xix, 644 pages). Hoboken, New Jersey: Wiley-Blackwell.

Latour, B. (2005). Reassembling the social : an introduction to actor-network-theory. Oxford ; New York: Oxford University Press.

Latour, B. (2010). The making of law : an ethnography of the Conseil d'Etat. Cambridge, UK ; Malden, MA: Polity.

Law, J. (2002). Objects and Spaces. Theory, Culture & Society, 19(5-6), 91-105. doi: 10.1177/026327602761899165

Lien, M. E. (2015). Becoming salmon : aquaculture and the domestication of a fish. Oakland, California: University of California Press.

Lincoln, Y. S., & Cannella, G. S. (2009). Ethics and the Broader Rethinking/ Reconceptualization of Research as Construct. Cultural Studies ↔ Critical Methodologies, 9(2), 273-285. doi:10.1177/1532708608322793

Livingston, J. (2012). Improvising medicine : an African oncology ward in an emerging cancer epidemic. Durham: Duke University Press.

Lock, M. M. (2002). Twice dead: organ transplants and the reinvention of death. Berkeley: University of California Press.

Machado, R. P. (2011). Made in China : (in)formalidade, pirataria e redes sociais na rota China-Paraguai-Brasil. São Paulo: Hucitec Editora : ANPOCS.

Machado, R. P. (2018). Counterfeit itineraries in the global south : the human consequences of piracy in China and Brazil (First Edition. ed.). New York: Routledge.

Malamed, S. F. (2018). Sedation : a guide to patient management (Sixth edition. ed.). St. Louis, Missouri: Elsevier.

Marsh, I. (2013). The Uses of History in the Unmaking of Modern Suicide. Journal of Social History, 46(3), 744-756. doi:10.1093/jsh/shs130

Marsland, R., & Prince, R. (2012). What Is Life Worth? Exploring Biomedical Interventions, Survival, and the Politics of Life. Medical Anthropology Quarterly, 26(4), 453-469. doi:10.1111/maq.12001

Mathieu, A. (1993). The Medicalization of Homelessness and the Theater of Repression. Medical Anthropology Quarterly, 7(2), 170-184. doi:doi:10.1525/maq.1993.7.2.02a00030

McGee, K. (2015). Latour and the passage of law. Edinburgh: Edinburgh University Press.

McMullin, J. (2016). Cancer. Annual Review of Anthropology, 45(1), 251-266. doi: 10.1146/annurev-anthro-102215-100217

McMullin, J. M., Weiner, D., & School for Advanced Research (Santa Fe N.M.). (2009). Confronting cancer : metaphors, advocacy, and anthropology (1st ed.). Santa Fe: School for Advanced Research Press.

Medeiros, F. (2018). Linhas de Investigação: Uma etnografia das técnicas e moralidades numa Divisão de Homicídios da Polícia Civil do Rio de Janeiro. Rio de Janeiro, Brasil: Autografia.

Menezes, R. A. (2004). Em busca da boa morte : antropologia dos cuidados paliativos. Rio de Janeiro, RJ: Editora Fiocruz : Garamond.

Menezes, R. A. (2011). Demanda por eutanásia e condição de pessoa: reflexões em torno do estatuto das lágrimas. Sexualidad, Salud y Sociedad (Rio de Janeiro), 137-153.

Mezzadra, S. (2006). Citizen and subject. A postcolonial constitution for the European Union? Situations, 1(2), 31-42.

Mezzadra, S. (2015). The proliferation of borders and the right to escape. In Y. Jansen, R. Celikates, & J. de Bloois (Eds.), The Irregularization of Migration in Contemproary Europe. Detention, Deportation, Drowning (pp. 121-135). London-New York: Rowman & Littlefield.

Mezzadra, S., & Neilson, B. (2012). Between Inclusion and Exclusion: On the Topology of Global Space and Borders. Theory, Culture & Society, 29(4-5), 58-75. doi:10.1177/0263276412443569

Minois, G. (1999). History of suicide : voluntary death in Western culture. Baltimore: Johns Hopkins University Press.

Mitford, J. (1978). The American way of death. New York: Simon and Schuster.

Mol, A. (2002). The body multiple : ontology in medical practice. Durham: Duke University Press.

Morgan, L. M., & Michaels, M. W. (1999). Fetal subjects, feminist positions. Phildelphia: University of Pennsylvania Press.

Mowbray, A. (2005). The Creativity of the European Court of Human Rights. Human Rights Law Review, 5(1), 57-79. doi:10.1093/hrlrev/ngi003

Müller-Mall, S. (2013). Legal Spaces: Towards a Topological Thinking of Law. Berlin, Heidelberg: Springer.

NEK-CNE. (2005). Opinion no. 9 - Assisted Suicide. Swiss National Advisory Commission on Biomedical Ethics.

Nixon, R. (2011). Slow violence and the environmentalism of the poor. Cambridge, Mass.: Harvard University Press.

Norwood, F. (2006). A hero and a criminal: Dutch huisartsen and the making of good death through euthanasia talk in The Netherlands. MEDISCHE ANTROPOLOGIE, 18(2).

Norwood, F. (2007). Nothing More To Do: Euthanasia, General Practice, and End-of-Life Discourse in the Netherlands. Medical Anthropology, 26(2), 139-174. doi: 10.1080/01459740701283165

Norwood, F. (2018). The New Normal: Mediated Death and Assisted Dying in the United States. In A. C. G. M. Robben (Ed.), A companion to the anthropology of death. Hoboken, NJ: Wiley.

Ogden, R. D., Hamilton, W. K., & Whitcher, C. (2010). Assisted suicide by oxygen deprivation with helium at a Swiss right-to-die organisation. Journal of Medical Ethics, 36(3), 174-179. doi:10.1136/jme.2009.032490

Ong, A., & Collier, S. J. (2005). Global assemblages : technology, politics, and ethics as anthropological problems. Malden, MA: Blackwell Publishing.

Paxson, H. (2013). The life of cheese : crafting food and value in America. Berkeley: University of California Press.

Pordié, L. (2014). Pervious Drugs. Asian Medicine, 9(1-2), 49-76. doi:doi:http://dx.doi.org/10.1163/15734218-12341292

Porter, R. (1996). The Cambridge illustrated history of medicine. Cambridge ; New York: Cambridge University Press.

Povinelli, E. A. (2011). Routes/worlds. e-flux, 27. Retrieved from http://www.e-flux.com/journal/27/67991/routes-worlds/.

Povinelli, E. A. (2016). Geontologies : a requiem to late liberalism. Durham: Duke University Press.

Preisig, E. (2014). Dad, You Are Allowed to Die: A physician's plea for voluntary assisted death. Basel: LifeCircle.

Rabinow, P., & Rose, N. (2006). Biopower Today. Biosocieties, 1(2), 195-217. doi: 10.1017/S1745855206040014

Rehmann-Sutter, C., & Hagger, L. (2013). Organised Assistance to Suicide in England? Health Care Analysis, 21(2), 85-104. doi:10.1007/s10728-011-0191-y

Richards, N. (2014). The death of the right−to−die campaigners. Anthropology Today, 30(3), 14-17. doi:doi:10.1111/1467-8322.12110

Richards, N. (2017). Assisted Suicide as a Remedy for Suffering? The End-of-Life Preferences of British "Suicide Tourists". Medical Anthropology, 36(4), 348-362. doi:10.1080/01459740.2016.1255610

Riles, A. (2006). Documents : artifacts of modern knowledge. Ann Arbor: University of Michigan Press.

Rodrigues, J. C. (1979). Tabu do corpo. Rio de Janeiro: Achiamé.

Rodrigues, J. C. (1983). Tabu da morte. Rio de Janeiro: Achiamé.

SAMS. (2013). End-of-life care. Swiss Academy of Medical Sciences.

SAMS. (2018). Medical-ethical guidelines: Management of dying and death. Swiss Academy of Medical Sciences.

Santolaya Machetti, P., & García Roca, J. (2012). Europe of rights : a compendium on the European Convention of Human Rights. Leiden ; Boston: Martinus Nijhoff Publishers.

Saunders, C. (2001). The evolution of palliative care. Journal of the Royal Society of Medicine, 94(9), 430-432.

Scheffer, T. (2007). Event and Process: An Exercise in Analytical Ethnography. Human Studies, 30(3), 167-197. doi:10.1007/s10746-007-9055-8

Scheffer, T. (2010). Adversarial case-making: an ethnography of English Crown Court procedure. Leiden ; Boston: Brill.

Scheper-Hughes, N. (1992). Death without weeping : the violence of everyday life in Brazil. Berkeley: University of California Press.

Scheper−Hughes, N. (2000). The Global Traffic in Human Organs. Current Anthropology, 41(2), 191-224. doi:10.1086/300123

Schuch, P. (2016). Antropologia entre o inesperado e o inacabado: entrevista com João Biehl. Horizontes Antropológicos, 22, 389-423.

Schühle, J. (2018). State-of-the-art or the art of medicine? Transnational mobility and perceptions of multiple biomedicines among Nigerian physicians in the U.S. Global Public Health, 13(3), 298-309. doi:10.1080/17441692.2017.1337799

Schurr, C. (2017). From biopolitics to bioeconomies: The ART of (re-)producing white futures in Mexico's surrogacy market. Environment and Planning D: Society and Space, 35(2), 241-262. doi:10.1177/0263775816638851

Schwarzenegger, C., Manzoni, P., Studer, D., & Leanza, C. (2013). Attitudes towards euthanasia and assisted suicide in Swtizerland - Results of a national study. In A. Kuhn (Ed.), Kriminologie, Kriminalpolitik und Strafrecht aus internationaler Perspektive: Festschrift für Martin Killias zum 65. Geburtstag (pp. 425-445). Bern: Stämpfli.

Scott, J. C. (1998). Seeing like a state : how certain schemes to improve the human condition have failed. New Haven: Yale University Press.

Seymour, J., Clark, D., & Winslow, M. (2005). Pain and palliative care: the emergence of new specialties. Journal of Pain and Symptom Management, 29(1), 2-13. doi:10.1016/j.jpainsymman.2004.08.008

Sjaak van der Geest, Susan Reynolds Whyte, & Hardon, A. (1996). THE ANTHROPOLOGY OF PHARMACEUTICALS: A Biographical Approach. Annual Review of Anthropology, 25(1), 153-178. doi:doi:10.1146/annurev.anthro.25.1.153

Staples, J., & Widger, T. (2012). Situating Suicide as an Anthropological Problem: Ethnographic Approaches to Understanding Self-Harm and Self-Inflicted Death. Culture, Medicine, and Psychiatry, 36(2), 183-203. doi:10.1007/s11013-012-9255-1

Stevenson, L. (2012). The psychic life of biopolitics: Survival, cooperation, and Inuit community. American Ethnologist, 39(3), 592-613. doi:10.1111/j.1548-1425.2012.01383.x

Stevenson, L. (2014). Life beside itself : imagining care in the Canadian Arctic. Oakland, California: University of California Press.

Stodulka, T. (2015). Emotion Work, Ethnography, and Survival Strategies on the Streets of Yogyakarta. Medical Anthropology, 34(1), 84-97. doi:10.1080/01459740.2014.916706

Strathern, M., Crick, M. R., Fardon, R., Hatch, E., Jarvie, I. C., Pinxten, R., . . . Marcus, G. E. (1987). Out of Context: The Persuasive Fictions of Anthropology [and Comments and Reply]. Current Anthropology, 28(3), 251-281.

Tamanaha, B. (2008). Understanding Legal Pluralism: Past to Present, Local to Global. Sydney Law Review, 30.

Tarlo, E. (2016). Entanglement : The secret lives of hair. London: Oneworld.

Tatz, C. M., & Australian Institute of Aboriginal and Torres Strait Islander Studies. (2005). Aboriginal suicide is different : a portrait of life and self-destruction (2nd ed.). Canberra: Aboriginal Studies Press.

Tsianos, V., & Karakayali, S. (2010). Transnational Migration and the Emergence of the European Border Regime: An Ethnographic Analysis. European Journal of Social Theory, 13(3), 373-387. doi:10.1177/1368431010371761

Tsing, A. L. (2000). The Global Situation. Cultural Anthropology, 15(3), 327-360. doi: 10.1525/can.2000.15.3.327

Tsing, A. L. (2005). Friction : an ethnography of global connection. Princeton, N.J.: Princeton University Press.

Tsing, A. L. (2015). The mushroom at the end of the world : on the possibility of life in capitalist ruins. Princeton: Princeton University Press.

Verhofstadt, M., Thienpont, L., & Peters, G.-J. Y. (2017). When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study(). The British Journal of Psychiatry, 211(4), 238-245. doi:10.1192/bjp.bp.117.199331

von Benda-Beckmann, K. (1981). Forum Shopping and Shopping Forums: Dispute processing in a Minangkabau village in West Sumatra. Journal of Legal Pluralism, 19.

von Unger, H., Dilger, H., & Schönhuth, M. (2016). Ethics Reviews in the Social and Cultural Sciences? A Sociological and Anthropological Contribution to the Debate. 2016, 17(3).

Ward, A. (2015). Who Decides? Balancing competing interests in the Assisted Suicide debate. (LLM), University of Glasgow, Glasgow.

Weber, M. (1919). Politik als Beruf. München u.a.: Duncker & Humblot.

Whittaker, A., & Speier, A. (2010). “Cycling Overseas”: Care, Commodification, and Stratification in Cross-Border Reproductive Travel. Medical Anthropology, 29(4), 363-383. doi:10.1080/01459740.2010.501313

Whyte, S. R., Geest, S., & Hardon, A. P. (2002). Social lives of medicines (1. publ. ed.). Cambridge u.a.: Cambridge University Press.

Yonucu, D. (2017). The Absent Present Law: An Ethnographic Study of Legal Violence in Turkey. Social & Legal Studies, 0(0), 0964663917738044. doi: 10.1177/0964663917738044

Zeldes, N., Dilger, H., FitzGerald, K., Kohls, N., Moore, E., Nöfer, E., & Giordano, J. Transnational Patients: Practical and Ethical Implications for Medical Practices and Health Promotions Policy. World Medical & Health Policy, 0(0). doi:doi: 10.1002/wmh3.263