Assisted dying in the context of biopower

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Abstract
The aim of this article is to establish a debate over assisted dying in a biopolitical context, i.e. the juridico-medical form of biopower that influences, to the highest extent, issues of life and death. The old rule of the sanctity of life is replaced by a distinction between lives worth and not worth living. In the face of new challenges, issues of death as unsocialised become the object of the calculation in the arguments of biopower. Death is still managed at controlling institutions: doctors are priests, equipped with life supporting devices, deciding whether or not to push a button (e.g. a respirator switch-off) and having means to prolong or to terminate life. National authorities, i.e. courts, coroners, and parliaments, take part in ultimate decisions. However, there are growing margins, "grey zones", to biopower. New bodies are created, between life and death, *neomortos*, hybrids, whose boundaries are blurred. Transgression of these limits is, in the current culture, associated with power and danger. The author asks a fundamental question: do the debates over and social movements concerning assisted dying break the system of biopower or are they simply extensions of the existing discussion?

KEYWORDS: assisted dying, biopower, biopolitics, thanatopolitics, bioethics, physician-assisted suicide, euthanasia, medicalisation, juridification

'Turning death towards life is therefore the basic symbolic operation' (Baudrillard 2007: 164).

Introduction
At the beginning I would like to point out that I do not distinguish between physician-assisted suicide and euthanasia. By the notion euthanasia I mean voluntary, active euthanasia. I introduce the notion of assisted dying, grasping both forms of medically assisted death. In the bioethics debate, there are arguments regarding such a lack of differentiation. For example, Dan W. Brock analyses both types of assisted death (Brock 2009). He observes that despite the obvious difference that in the case of euthanasia it is the doctor who end the patient's life and in the case of physician-assisted suicide it is the patient who commits the suicide, there are many similarities in both cases: 1) the doctor plays an active and indispensable role as the one who delivers the means to die (fatal dose of medication or mechanisms as in the case of Dr. Jack Kevorkian); 2) the intention of

ANTHROPOLOGICAL NOTEBOOKS 21 (1): 23–35.
ISSN 1408-032X

patient and doctor are congruent, i.e. both intend to take the patient's life; 3) the choice belongs fully to the patient; 4) despite that, in chronologic course of euthanasia, it is the doctor who acts last in both cases; in a moral sense, it is the patient who acts last, because it is him/her who until the last moment makes the choice "to be or not to be". The most important fact, from a moral point of view, is that in both cases the doctor and the patient cooperate in order to end the patient's life.

Assisted dying is considered here as an ethical and political concept. By political, I mean its sociological understanding, i.e. analyses of social relationships in the context of power and public matters. It is the area where a symbiosis of medicine and politics takes place to the highest extent. As Giorgio Agamben puts it: 'A biological given is as such immediately political, and the political is as such immediately biological' (Agamben 2008: 201). My aim is to set the debate over assisted dying in a biopower context. My approach builds on that of Michel Foucault's and Giorgio Agamben meaning of biopower. I also follow further development and interpretation of the concept derived from the article *Biopower Today* by Paul Rabinow and Nikolas Rose (Rabinow & Rose 2006). My final task is to start a critique of the authors taking for granted that biopower affects all our decisions and dilemmas. This concerns wider philosophical discussions about subjects in contemporary society, something that is beyond the space of one article. As Achille Mbembe (although speaking on examples of terrorism and concentration camps) reveals, 'the notion of biopower is insufficient to account for contemporary forms of subjugation of life' (2003: 39) and, I would add, subjugation of death. For this, I refer to the concept of "thanatopolitics". Thanatopolitics is a politics of death, in other words: strategies of biopower in contemporary industrialised societies, which take different forms: 'It characteristically entails a relation between letting die (*laissez mouir*) and making live (*faire vivre*) (Rabinow & Rose 2006: 195). In contrast to the authors mentioned above, I argue that the thanatopolitical perspective goes beyond biopower concept.[1]

Aporia of cultural processes: Medicalisation and juridification versus self-reflexivity

The processes that prepared the late-modern context of assisted dying and which set the tone of its discourse are: medicalisation, the bureaucratisation of the dying condition (which influences the publicity of the decisive area of medical staff), the rationalisation of bio-authority, the excessive juridification of issues concerning life (e.g. genetics, new reproductive technologies like in vitro and sperm banks) and death (e.g. abortion, euthanasia, physician-assisted suicide), the pluralisation of an outlook on life and, as a consequence, various understandings of issues related to life, death and suffering.

Medical authority, in the scope of competence, has achieved a high level of interference in nature. A historical project on the control over a human body, whose founding fathers were Rene Descartes, La Mettrie and Francis Bacon, resulted in an ambition to reign over nature (Turner 1997). This is expressed by the conviction that

[1] The discussion of assisted dying in the context of biopower has been started – to my knowledge – by Todd McDorman (2005) and by a short and rather enigmatic essay by John Protevi (2006).

death is a defeat of medicine. The phenomenon of death is rationalised as something measurable, predictable and able to be manipulated (Turner 1997). As far as death is concerned, the most explicit change is a prolonged (and maximally lengthened) process of dying. Medicalisation is accompanied by increasing bureaucratisation, accompanying even the functioning of hospices (Kubiak & Surikova 2010). Officials of particular institutions that follow strict reporting and regulative procedures, replaced former family physicians. In consequence, a publicity of details of death and its causes occurred. If needed, the institutions of court and public prosecutor are included in these proceedings. They became known as part of the wide array of authorities considered competent to speak and intervene in the name of life and death. The excessive codification and juridification of morality eclipses individual ethical decisions. Any activities that violate the law are immediately noticed, restrained and penalised. Bureaucratisation, accompanied by the rationality, of morality precludes privacy of death, from its causes and condition to the funeral.

From the other side, processes of individualisation, the emancipation of "my wish", transferred the responsibility of decisions to individuals. Anthony Giddens elaborates the concept of self-reflexivity (2006). The decay of common symbolic universe created a space of universes competing with each other (Luckmann 1996). At the same time, there has been a growth of diagnosing and prognosing possibilities, and along with the rise of patients' rights and a change of patient-doctor relations, seen especially in the necessity of patients being informed. Thus, terminally ill people are aware of incoming experiences and are given the possibility to make decisions about how to proceed. It is specifically expressed in practice, starting from the role of patients' rights and their decisions regarding ways of treatment, analgesics and life-saving procedures, and "living wills". The value of autonomy and a person's dignity is a crowning argument in the debate over assisted dying. This debate is influenced by various approaches (depending on particular worldviews and doctrines) to the issues of termination of life, medical practices, and the sense of human suffering, and the treating of the bodies of dying and the dead.

Simultaneously, according to Foucault, expanding the space of rights and freedom is followed by the process of mutually superimposing control constraints and inscribing a private life into biopolitics. The right to live is strictly related to the ban to die and the obligation of caring about a biological body, *corpus*. In addition, other authors observe that self-reflexivity (being part of neo-liberalism and the capitalisation of health and life) is consistent with biopolitics (Ryan, Morgan & Lyons 2011). I argue further that this is not necessarily always the case, especially on the border of life and death. Thus, I observe an *aporia* of cultural processes. Individualism, the value of autonomy, self-reflexivity, opening the scope of new decisions on one side, and bureaucratisation, accumulation of authority instruments in the hands of medicine (having practical evidence in the form of the possibility of prescribe medication) and the legislation regarding issues of life and death on the other.

Pluralisation of experts and the issue of death legislation

A decline of authorities and a pluralisation of ethical standards expands an array of advisors (Bauman 1998). For example, one important condition regarding the decision to terminate life is that it should be conscious and requires a psychiatric diagnosis. Bioethicists, doctors, lawyers, members of parliament and philosophers take part in discussions on the social consequences of setting legal precedents and changes of law. There is still, especially in Poland, a high consideration of the Roman Catholic Church, which often takes the floor in discussions over matters of life and death, or rather "letting die". The most powerful form of biopower at the end of the 20th century became the application of legislation. The ground-breaking period indicated by Peter Singer is the 1990s, when a British court permitted doctors to terminate the life of Anthony Bland and the American court acquitted Jack Kevorkian, who aided in the suicide of Thomas Hyde. In United States, as early as in 1975, there was a public debate on this subject matter, when parents of Karen Ann Quinlan asked doctors to allow them to disconnect their daughter, who was in coma, from a respirator. The case was brought into court and, with the support of Bishop Casey, a respirator was acknowledged as an extraordinary life-support measure; thus, it was possible to discontinue its use. After disconnecting her from a respirator, Quinlan started to breathe on her own and "lived" for ten years more. However, it was in the 1990s when American and German courts faced such complicated dilemmas as: whether to support the life of a *foetus* in *utero* of a brain-dead woman (Singer 1997). Singer, in his classical work, with a relentless consideration of the consequences, draws conclusions from an analysis of documents and decisions of parliaments and courts in Western Europe and the United States. He puts in the light of consequentialism those phenomena that are still matters of public debates. He emphatically shows how, in spite of the persistence of the dogma about sanctity of an innocent life, medical and legislative practice have crushed the foundations of this traditional ethic.

The introduction of a new definition of death as "brain death" raised difficult, ambivalent situations. In this case, the theory has not completely been translated into practice. There is a disparity between life and death; there exists a "zone of indistinction", which involves doctors and lawyers in logical contradictions (Agamben 2002). New forms of existence, or as Willard Gaylin calls them, neomortos, are individuals in a vegetative state, occupying an indefinite zone, between life and death (1974). According to the new definition, such a dead person remains fertile and is even able to give birth to a child. New questions arise, such as those asked by Singer when he states: 'Assuming that one is dead when the brain is dead, when does one die if the brain was not possessed in fact?' (1997: 26). Singer observes that the first 'series of dramatic changes' did not face practically any resistance (1997: 31). This bioethicist indicates that it is the second significant factor of changes (heart transplantation) that had an influence on changing the definition of death. Christian Barnard conducted the first heart transplant in December of 1967 in South Africa. Singer presents first documents of the Harvard Committee in which, 'with an unusual sincerity', it is stated that introduction of a new definition of death is necessary to relieve hospital beds for waiting patients, and also for the possibility of transplantations

(Singer 1997: 34). This revolution took place not only without any opposition but also with the support of the Catholic Church. Pope Pius XII ceded the definition of death to doctors (Singer 1997).

This change of the definition of death is moving away from a focus on soul issues and increasing values of consciousness and personality, i.e. those related to the mind. Explanations that functions of the brain are so important due to their integrating task of coordinating the functioning of an organism have proved to be false. Thus, it is not a case of facts but of a dramatic change of the highest esteemed values. Consciousness, a need of controlling one's own life, and autonomy are most valued in the new ethics. As was expressed by Dr Neil Campbell: 'What we care about, and we should care about, is the person rather than the body. We can respect a dead body but we should care about a conscious being' (Singer 1997: 55). In the 1970s, in the case of Karen Ann Quinlan, an apparent avoidance of ethical dilemmas was provided by the distinction between ordinary and extraordinary means of supporting life. However, as bioethicists consequently show, what underlies it is a radical ethical decision regarding which life is worth supporting with extraordinary means and which is not. In the case of decision regarding individuals in a persistent vegetative state, the issue of life quality value is raised. Thus, the old rule of the sanctity of life is replaced by a distinction between lives worth and not worth living.

As I have briefly described, after Singer came the introduction of jurisprudence in the scene of moral choice "to be or not to be" and the right to die, changed the array of experts and pluralised them. This is the juridico-medical form of biopower that influences, to the highest extent, issues of life and death. Life and death became political objects in the hands of medical and legislative mechanisms, which control, monitor, and organise collective vitality, morbidity and mortality from its interior. In "societies of control", existence itself becomes the object of impersonal logic and the reign of calculability and instrumental rationality (Mbembe 2003). As he points out:

> Disregarding this multiplicity, late modern political criticism has unfortunately privileged normative theories of democracy and has made the concept of reason, one of the most important elements of both the project of modernity and of the *topos* of sovereignty (2003: 13).

Assisted dying versus biopower

Let us ask a fundamental question: do the debates over assisted dying break the system of biopolitics or are they its extension? The term *biopolitics* (as Rabinow and Rose explain, while Foucault is imprecise) is focused on the population and means strategies, clarification of knowledge, control and all practices in the name of life necessity (2006: 196–7). It is the efficient system of a society of control where life becomes a political object. The concept of biopower, according to Michel Foucault, is a broadly defined system of power-knowledge expressed in discourses, penetrating and supervising social behaviour.

> Introduced in the age of classicism, the great technology about a double, anatomical and biological profile, individualising and classifying, focused on accomplishments of body, observing life processes, characterises the power, of which the main function is not killing any more but grasping all manifestations of life (Foucault 2010: 96).

The concept of biopower includes, as Rabinow and Rose argue, three elements: 1) discourses on vital characteristics of living human beings and an array of authorities competent to speak the truth, 2) strategies for intervention upon collective existence in the name of life and health and 3) forms of subjectification, by which individuals control themselves in the name of life and health. What is important for Foucault's concept, in contrast to "disciplinary societies" from the 17th to 19th centuries, when the main practices were accomplished in special institutions of exclusions (asylums, hospitals, prisons), is that the mechanisms of contemporary societies of control are immanent in the social texture (Rabinow & Rose 2006).

As Foucault stated, 'one strategy of power can contain various, even contradictive discourses (2010: 96).' Thus, a discourse for or against assisted dying does not have to mean a decision for or against biopower. Here, it should be mentioned that the discourse for and against assisted dying corresponds to a high rank of the body. After all, people ask for assisted dying due to a loss of proper conditions of health. Foucault presents the process of transforming authority of a sovereign, having the right to decide about life and death of tributaries, to biopower, imposing the obligation to live, the power of governing of life and letting die (2010). Modern 'life administrators' are concerned with 'a bare issue of surviving' at the level of the whole population (Foucault 2010: 94). A discourse of authority concentrates on mass population phenomena. Thus, visions of mass-assisted deaths, in the metaphor of the "slippery slope", is the crowning argument against legislation of assisted dying.

As is known, Giorgio Agamben, in contrast to Foucault, regards biopolitics as a phenomenon of antique provenience and as the core of all political activities. Agamben is focused on exposing "bare life": *zoe*, in other words. The above enables a conclusion that a concentration camp is a modern biopolitical paradigm, where a state of emergency becomes a rule, and all people are possible carriers of bare life. The metaphor of *homo sacer* means a figure that is reduced to bare life and belongs to biopower. According to Agamben, the concept of 'life not worth living' is often raised in the debates on assisted dying, 'is a rather political concept, referring to a radical metamorphosis of *homo sacer*, that can be killed, but which cannot be sacrificed, on which a sovereign power is based' (Agamben 2002: 194).

The archetypical importance of the boundary between life and death in a symbolic conversion, and its monopolisation by power are carefully presented by Jean Baudrillard. He writes: 'Power, not at all metaphorically, is a boundary between life and death, a decree revoking a conversion between life and death, a frontier post, controlling contacts between two shores' (2007: 163). Power settled in a gap between a subject, and its body rationalises life and death. These ultimate issue 'separating groups of living from

dead, and each of us from our own death' are, according to Jean Baudrillard, an archetype of all separations made by authorities: 'All forms of power contain a trace of this primary separation, as in the ultimate instance, manipulating and managing death is a base of reigning' (ibid.: 164).

Assisted dying as a continuation of biopower

In some sense, the debate over assisted dying is a continuation of biopower. Debating in the context of medical rationalisation and legislation submits issues of life and death into the hands of life administrators, i.e. a juridico-medical network. Assigning doctors as executors is giving power to representatives of the medical authority.

> … here, significance lies in taking away the possibility to decide about oneself and giving it to somebody else, as no one can freely decide about his own life and death, each of us has to obtain a social permit for it. It is even necessary to forbid dependence of life and death on a biological incidence, as it would be a dose of freedom. Thus, our main moral imperative is not only 'do not kill' but also 'do not die' – at least not in a way chosen by you – you can only die provided that law, supported by medicine allows you (Baudrillard 2007: 225–6).

Using Baudrillard's words, the issue of death being not socialised and facing new challenges becomes an object of calculations on the political level. The problem of lack of socialising is the consequence of the biopolitical system. It closes most "gates" for decisions against biopower. For example, an individual does not have access to medication causing death (assuming that one knows what is needed and what doses to take to guarantee the expected result), unless the doctor prescribes it. Furthermore, the doctor will not agree to issue such prescriptions if it is forbidden by law.

From the other side, the possibility of saving one's life by the means of transplantations is an economical argument for assisted dying. It is illusory that an apparent *yes* to assisted dying is an opposition to biopower, as it constitutes shortening life. The capitalisation of health and life in the form of economical calculations has revealed the facts of excessive financial resources assigned to supporting life. In some cases, these are very high amounts. As Baudrillard writes: 'It is necessary to make a kind of economical choice, which is euthanasia, the half-official doctrine and practice so far' (ibid.: 225). He undermines the humanitarian aspect of assisted dying as (according to him) 'it perfectly matches the medium and long-term logics of the system itself. The aim in this case is empowering the social control' (ibid.).'

Death is still managed at controlling institutions: doctors function as priests, equipped with life supporting devices, deciding whether or not to push a button (e.g., a respirator switch) and having means for prolonging or terminating life. National authorities (courts, coroners, and parliaments) take part in ultimate decisions. In debates over decisions on the terminally ill, they are presented in categories of bare life. They are mentioned only in the context of the somatic side of life, advantages and losses. The paternalistic way of speaking is also revealed in the discourse of "mercy arguments".

Agamben, in his work *Homo Sacer*, referring to modern debates on assisted dying, focuses on extreme cases, e.g. *coma depasse*, brain death (in order to expose bare life), when a person is not able to express their own will. Decisions regarding these beings, located in an "uncertainty zone", between life and death, seem to be evident examples of how concepts of *life* and *death* become political terms, which acquire a specific meaning only on the basis of legal decisions (2002: 225). Agamben draws a suggestive image:

> A reanimation room, in which between life and death *neomortos* float, patients in *coma de passe* and *faux vivants* [a living body from the classical definition of death point of view, ready to provide organs for transplantations], determines a space of exception, in which 'bare life' is first manifested, fully controlled by humans and their technology (ibid.: 225–6).

Thus, it seems evident that assisted dying, in the hands of medical and legislative bodies, is a continuation of biopower. In fact, many authors share this view.

Biopolitics of the Roman Catholic Church

> The institution of death, similarly as life after life and immortality, is an extremely late result of political rationalism of the caste of clergy and churches, which authority is based on controlling such imaginative sphere of death (Baudrillard 2007: 182).

The 'political economy of personal salvation' of the Roman Christian Church requires being an opponent of assisted dying (Baudrillard 2007: 184). The attitude of the Church in the matter of assisted dying originates from the doctrine of the sanctity of life as a gift from God, and from the revelation of God in a human being. The Church has been taking the floor in discussions over issues related to the body for many years, but recently its discourse has intensified on issues of reproduction and dying. One good example is *Dignitas personae*, an instruction of the Congregation for the Doctrine of the Faith, which specifies the Vatican's bioethical interpretation. It focuses on criticising *in vitro* methods and elaborates on sexual life in detail. The notion of "sanctity of life" became the main problem discussed in debates of the Catholic Church, at the instance of Pope John Paul II. He often spoke and wrote against the so-called "civilisation of death". The Polish Catholic Church tried to silence a public debate on assisted dying. For example, Archbishop Sławoj Głódź stated in his sermon during a 2009 resurrection mass that such a debate serves to propagate the civilisation of death and immoral laws and thus should not be discussed.

The importance of the authority of the Catholic Church in medical circles is witnessed in many ways. For example, in 1957, during a medical conference, doctors turned toward Pope Pius XII with questions concerning conditions under which life should be artificially supported and if the patient in a *coma* can be regarded as dead. The Holy Seat approved the division into extraordinary and ordinary life-support systems. Pope Pius XII decreed that artificial life-support of patients who have no chance of recovery is an extraordinary activity and is not morally obligatory.

Assisted dying against biopower

Now, I would like to argue that some parts of the debate on assisted dying, some narratives, individual discourses and acts and social movements are examples of protest against the monopoly of biopower. Anomalies such as neomortos, people in coma depasse, which as a result of technological progress, as well as a change of death criterion into brain death, drive the norms accepted by medical authorities into a crisis. Using Agamben's words, where does bare life start and end? Biopower representatives are forced to work hard in order to set new boundaries. The first and main argument is the problem of *uncertainty* in medical debates and practices.

In the judgement of the court itself, a wide margin of uncertainty is also aroused. The Euro-American juridical order, which had held a traditional code of ethics, is broken and split into different codifications. There is diversified legislation for and against assisted dying. Furthermore, there is also an ambivalence of relations between legislation and practice. For example, in England and Wales, aiding a suicide carries a penalty up to 14 years in prison. However, people who helped their terminally ill relatives in trips to Dignitas clinics in Switzerland have not been penalised. This case was publicised thanks to the campaign of Debbie Purdy, who wanted to provide security for her husband to help her travel to Switzerland to be euthanized. Purdy attempted to obtain an interpretation of court regulations about helping in suicide; she received no answer. The House of Lords turned to the general prosecutor for a specification of regulations; the answer was as follows: 'Each such case shall be considered individually' (Pawlicki 2010: 11). This is a step away from norm-oriented and mass-oriented jurisprudence.

Other areas of ambivalence include blurring the boundary between life and death, and bioethical disputes over numerous points of care for ill people (including palliative care). The area of uncertainty is driving biopolitics into a crisis. This shock to the set order, the Copernican revolution (using Singer's words) may be the only argument for the fact that biopower instruments face resistance. However, let us go a step further.

If we look at presented individual stories of people fighting for assisted dying for themselves, we shall notice their discourse: not of bare life, but moral individuals. They say it is not about a life not worth living (in such time, they write poetry and blogs, and even fall in love) but about their dignity, that they are undergoing devastation and shall not strive for life itself. These are narratives focused on identity associated with the values of dignity and autonomy. It is a discourse enrooted in self-reflectivity, in a conscious constructing of identity projects. The best example is the attitude of bioethicist Ronald Dworkin. He presents a secular form of life sanctity. He refers to concepts of *zoe* and *bios*. In his interpretation, the rigorous supporting of life, emphasises the value of zoe, i.e. bare, biological life. In the secular interpretation, which is more favourable to him, sanctity of life is perceived as bios, i.e. life created by a human being according to his values, needs, plans, and life as a biography (Chańska 2007). Care about life in bios is also care about when, where and how an individual dies. In this regard, Dworkin writes:

> As death is a distinguished, especially weighty event in our life narrative, as the last scene of a play, when everything becomes intensive and is pre-

> sented in the full light. In the first sense [life as zoe], the fact when we die is essential for us because of the things which would happen to us if we would have died later. In the second approach [life as bios], the way in which we die, is important as it is *our* dying (1995: 209).

Exceptions in the paternalistic look at dying (presented by advocates raising arguments of mercy) include the approach of John Hardwig, who points out the subjectivity of individuals and their moral obligations:

> I am still able to do things that have an influence on lives of the people I love. What's more, the fact that I still have obligations, places me inside the community of moral individuals. My illness or decrepitude hasn't led me to the state of solely passive experiencing (2009: 299).

Hardwig recalls examples of cultures in which the obligation of death at the age of decrepitude prevailed. He resists arguments that a seriously ill person can yield to familial pressure, circumstances of economic, physical and mental burden for family related to caring for him or her, and due to these reasons could demand assisted dying. According to this bioethicist, such perspectives treat a patient as an object. Meanwhile, a terminally ill person is still a moral subject and being such, he/she can even accept the obligation of death (not because of society, but because of his/her family and partners). Hardwig states:

> If I terminate my life in order to save future of beloved ones, my death certifies my relation with them. Just because I love and care about these people (and I know that they care about me), I do not want to be a burden for them. And the life in which I can choose whatever I want for myself is a life deprived of relationships with others. Bioethics, treating me as if I had no serious moral obligations, would do everything to marginalise, weaken or even destroy my relations with other people. … I hope that when my time comes, when I will have the obligation to die, I will be aware of this, give courage to my beloved as they could realise this as well, and I will bravely fulfil it (ibid.: 300).

If we examine the discourse of assisted dying advocates, individuals who demand it for their closest people, i.e. people who are not able to speak on their own behalf (we return to the case of coma depasse discussed by Agamben). It is then, once again not only about shortening life but also civic rights, respecting the system of values and beliefs of an individual who is in a certain trap of bare life (as well as a trap of life-supporting technology).

I insist that biopolitics is at the beginning of a crisis, and this is why it is undergoing mobilisation in the form of more and more regulatory agencies applied: medical and bioethics commissions, legislative interventions, church's declarations, social "pro-life" movements and all projects for "making life". I do not suggest that the emancipation movement for "letting die" will be necessary followed by the radical transgression of biopower. I only observe that there are growing margins, "grey zones", beside biopower's

essence, embodied in patient's groups fighting for their rights, individuals claiming the right to their death, and organisations of the kind of the Compassion & Choices (previously, Hemlock Society), working for the legalisation of euthanasia and assisted suicide in the USA, while also helping people to commit suicide. The movements of the "to die in human way" kind and those that have letting die as their *telos*, consisting of diaries and blogs of dying people, all reveal the chaos and horror of dying (while not necessary asking for the right to die).

Conclusions

From the point of view of Foucault's interpretation, we cannot speak about escaping biopower in any way other than by suicide. However, do Foucault and Agamben not, in sensitising to the issue related with bioauthority, take away these residues of the subjectivity that remained? Although some authors argue that the debates about assisted dying are part of the structure of biopower, I attempt to show them in a different light (Ryan, Morgan & Lyons 2011). In my view, the notion of biopower is not enough to embrace the narrations that protest the subjugation of "my dying" to biopower.

Is a hybrid-body (connected to medical, technological instruments) still a bare life? New forms of existence, neomortos, which have emerged in late modernity due to medical *technopol* are forced to live according to telos of modernity (Postman 1995). However, their status can be better grasped by the notion living dead (Mbembe 2003). Their bodily integrity is dispersed into pieces, through demiurgic surgery. These bodies, transformed into bio-technological hybrids, are presented in media as the Other. Let me shortly remind the reader that *Other* is an anthropological notion, functioning always in opposition to *We*. We refers to everything that is "normal", regular and obligatory, whereas the Other embraces all stigmatised bodies, freaks, and monsters. It also labours to produce anomalies, states of exception – in Agamben's words (2008) – and in consequence is the target of emergency forces. This fictionalised Other, being a part of media theatre, are presented in the morbid spectacle of severity (Green 2008). As such, the Other is becoming an object of different kinds of manipulation and cultural interpretation and is not allowed to be the subject. Manipulations are subordinated to 'impersonal logic and to the reign of calculability and instrumental rationality' (Mbembe 2003: 18). Institutions such as Dignitas in Switzerland are, of course, attacked but they are also regarded as zones of exception, an anomaly, useful as a "bad example" and useful as possibilities for the Other, undisciplined citizens, who have this place to go *in extremis*. It helps a nation's biopolitics to prohibit such practices in its own country.

However, increasing numbers of narratives are emerging, which speak from the subject point of view and are reminders that they are We. The trapping of the body in these medical machines and tubes is also trapping of personality, sometimes against "my will", "my choice", and "my dignity". It is a matter of worldviews and very individual attitudes and thresholds of pain and surrender. Here we approach the crucial point. These thresholds became fluid, flexible and individual, so they should not be described in general, normative terms. Narratives of assisted dying advocates are using the rhetoric of

choice, which 'clearly resonates with ethic of autonomy at the heart of advanced liberal modes of subjectification' (Rabinow & Rose 2006: 208).

It was Martin Heidegger who stated that the human being is a "being toward death" and it is 'the decisive condition of all true human freedom. In other words, one is free to live one's own life only because one is free to die one's own death' (Mbembe 2003: 37–8). Today, there is a fight on the borders, on the thresholds that I mentioned above. Transgression of these boundaries in the culture is associated with power and danger (Douglas 2007). Their vulnerability to be shifted, flexibility, and in fact the uncertainty about their place and definition is the main argument that there is the process undermining biopolitics. At least we can see that biopolitics becomes problematised, from one side because of eugenics' accusation in case of genetics, and from the other side because of the revelation of the limits of politics in the name of life necessity. It is a challenge for academics to reinterpret and rewrite the history of biopower. Perhaps it shall be done in the name of quality of life and dignity of human being.

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Povzetek

Namen pričujočega članka je vzpostavitev debate o umiranju s pomočjo v biopolitičnem kontekstu, to je v pravno-medicinski obliki bio-oblasti, ki v največji možni meri vpliva na odločitve o življenju in smrti. Staro pravil o svetosti življenja nadomešča razlikovanje med življenji, ki jih je ali ni vredno živeti. Vzlic novih izzivov je smrt kot nekaj nesocializiranega postala predmet preračunavanj v argumentaciji bio-oblasti. S smrtjo še vedno upravljajo nadzorne institucije: zdravniki so duhovniki, opremljeni z napravami za ohranjanje življenja, ki se odločajo o tem, ali pritisniti gumb (npr. za izklop respiratorja) in ki posedujejo sredstva za podaljševanje ali skrajševanje življenja. Nacionalne avtoritete kot sodišča, mrliški ogledniki in parlamenti delujejo na področju dokončnih odločitev. Vseeno pa se širi marginalni pas "sivih con" bio-oblasti. Nastajajo nova telesa med življenjem in smrtjo, *neomorti*, hibridi, katerih meje so zabrisane. Transgresija the omejitev je v sodobni kulturi povezana z močjo in nevarnostjo. Avtorica si tako zastavlja temeljno vprašanje, ali debate o in družbena gibanja, ki se ukvarjajo z umiranjem s pomočjo, rušijo sistem bio-oblasti ali so zgolj podaljški obstoječih diskusij?

KLJUČNE BESEDE: umiranje s pomočjo, bio-oblast, bio-politika, politika smrti, bioetika, samomor z zdravniško pomočjo, evtanazija, medikalizacija, uzakonjenje

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