Florian Greiner | Michael Zok (Eds.)

The Circle of Life

Birth, Dying, and the Liminality of Life in Modern Times

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Introduction: Liminality and the Circle of Life in Modern Societies

Human life is defined by transitions that build a »Circle of Life« for every human being with a beginning and an end. These transitions are not only framed by political, social, cultural, societal and medical contexts, they also mark a frame for political, social and cultural spheres. They are thus subject to historical change. We would like to add some arguments as to the historicity of the »Circle of Life« and look especially at the transitions connected to the beginning and ending of human life, since they were (and are) often in the center of loud debates.

First of all, transitions at the beginning and the end of life were prolonged due to certain developments in the last centuries. This is important, because there is a crucial difference between life transitions themselves and the liminal stages accompanying them. Whereas in the latter, individuals find themselves at a threshold phase in an ambiguous condition, transitions tend to be marked by simplifying either/or-demarcations. There is a before and an after, one is either alive or dead. For centuries, that was more or less true; however, with biomedical and technological progress as well as cultural changes like secularization, these boundaries became blurred—and so did the understanding of »life« itself.

Life always has a beginning—birth or conception, depending on different perspectives—and an end, dying and death (however defined). Those experiences are common to all human beings and each of us experiences them in an individual way. However—and that is what makes the beginning and the end of life so special among other transitions and liminal stages in human life (such as childhood, coming of age, adulthood)—, although experienced by every being, no *communicable* experience and no exchange of experiences exists: all (human) beings transit those special phases at life's beginning and end, but no one can share his or her impressions with others, and communication is impossible during or after these transitions, leading to uncertainty and to an »ultimately individualized« experience.

Despite this lack of common experience and communication with a person in transition, every culture has developed approaches to cope, regulate and (try to) define these liminal stages of human life. Thus, different

perspectives evolved in every society—be it legal, cultural, theologically, social, etc. In historical research, those transitions at the beginning and the end of human life have often been analyzed in isolation from each other. Anthropologists and ethnologists, on the other hand, have been interpreting them as entangled practices for a long time, as envisioned in the concept of liminality and rites of passage by Arnold van Gennep[1] and Victor Turner.[2] In observing that cultures have different approaches to these phenomena, they argued that their functions depend on the specifics of a given society and its cultural beliefs and performances.

Since the Age of Enlightenment—and with the growing importance of what Michel Foucault called »biopower« or »biopolitics«[3]—, »life« has become a very important term; we can observe it today in debates on »life-work-balance« and the establishment of, theoretically and medically grounded, »Life Sciences«. Current debates on the characteristics and the definition of »life« differ from the philosophical considerations of Greek scholars during antiquity or religiously motivated debates in medieval or early Modern times. Even more, we can assume that thinking about liminal stages at life's beginning and end began in the moment when human beings began to recognize they were subjects to time and, ultimately, mortal—thus death being a part of the »Circle of Life«, not necessarily its end, since some religions consider transcendence to be possible, but a meaningful transition for sure. Neither philosophy nor religion nor science could give a holistic answer to the question of what »life« actually is that convinces everybody. Also, related fundamental questions like »Where do we come from?« and »Where are we going?« remain unsolved and are bothering every new generation in a (technologically and socially) changing world. This can be seen in modern societies where processes such as secularization, modernization, identification, and rationalization have a major impact on (religious) systems of belief as well as everyday life. Undoubtedly, these processes also have an impact on the meaning of liminality and rites of passage that are also subjects to public discourses, political decisions, and legal requirements.[4]

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1 Van Gennep, Arnold: The Rites of Passage, New York 1960.

2 Turner, Victor: The Ritual Process: Structure and Anti-Structure, New York 1995.

3 Foucault, Michel: The history of sexuality, vol. 1, New York 1978; Foucault, Michel, Bertani, Mauro, Ewald, François: Society must be defended. Lectures at the Collège de France, 1975-76, London & New York 2004.

4 See e.g. Bruce, Steve: God Is Dead. Secularization in the West. Oxford 2002.

Therefore, despite the uncertainty and ambiguity in the above-mentioned fundamental question, legal debates about the »Right to Life«, sometimes »Life with Dignity« or even a »Right to Die with Dignity« gained influences in political, philosophical and ethical discussions in recent centuries. Indeed, in modern societies, negotiations between different interest and pressure groups—political elites, religious leaders, medical specialists, social workers, NGOs, etc.—aim to control the different liminal stages at the beginning and the end of a human's »Circle of Life«, despite their »in-betweeness« and uncertainty. Laws regarding prenatal testing, abortion and registration of newborns on the one hand, and provisions regarding palliative care, euthanasia, death criteria and burial rites on the other, regulate human lives in modern societies. Looking at laws on in vitro fertilization and cryonic procedures, one could even say that modern societies try to control human life prior to conception and after its end. Although part of everyday life, these transitions and liminal stages are subjects to highly theorized discussions led by circles of »experts«—including theologians, religious leaders, lawyers, medical staff, politicians, the mass media, etc.

To give just one example of the high level of theorization of those questions and the attempts to regulate them in modern societies: during the early 1980s, Irish politicians and society discussed the implementation of the state's obligation to »protect the life of the unborn« into the Constitution that was meant to outlaw abortion in the Republic once and for all.[5] However, this seemingly unambiguous aim caused tremendous debates, e.g., about the wording of such an amendment to the Constitution of the Republic, and lasted for almost three years in what proved to be only the first round of a longer struggle. Central to the discussions in the early 1980s was the question of how to define »unborn«[6] just as a heated debate on the brain death criteria illustrated the struggle to define »dead« at the same time.[7] Although used in unison by anti-abortion activists, what did »unborn« actually mean? Critical observers feared that using this, in

5 Earner-Byrne, Lindsey/Urquhart, Diane: The Irish Abortion Journey, 1920-2018. Cham 2018 (Genders and sexualities in history), chapter 5.

6 Mahon, Evelyn: Abortion Debates in Ireland: An Ongoing Issue, in: McBride, Dorothy E. (ed.): Abortion politics, women's movements, and the democratic state. A comparative study of state feminism. Oxford et al. (Gender and politics), pp. 157–179, here p. 160.

7 Belkin, Gary S.: Death before Dying, New York 2014; Barfield, Raymond: Brain Death, in: Bryant, Clifton D./Peck, Dennis L. (eds.): Encyclopedia of Death and the Human Experience, Los Angeles 2009, pp. 112–115.

their eyes, imprecise expression in the most important legal document of a society would lead to misuse and would not solve conflicts, but create new ones. Questions that arose also hinted at developments neither individual humans nor collectives, such as societies, could influence—such as miscarriages, or unsuccessful nidations, i.e., when the fertilized ovum did not nest in the uterus.

Similar examples are known from the Polish discourse on the introduction of a restrictive law on abortion—even a ban was discussed—in the early 1990s: as in the Irish case, »unborn human life« should be protected by the state from conception onwards. But how should the state, the doctors—let alone the couple—know precisely when conception actually occurred?[8] Similar questions were (and are) discussed regarding dying and the search for a distinct definition of »death« as the opposition to »life«, especially as technological progress provided modern medicine with new and better methods to sustain life.[9] One of the most prominent cases was the case of American Karen Ann Quinlan. The young woman, just 21 years old, had suffered a cardiac arrest following a visit to a bar in April 1975 and had fallen into a coma, because of which she developed apallic syndrome. When it became clear that the severe brain damage she suffered was irreversible, the parents requested that the ventilators be switched off. The doctors refused, and a legal battle ensued that lasted several months. After several courts dismissed the family's lawsuit, it took nearly a year before the New Jersey State Supreme Court ruled that the ventilators could be turned off. But when that ruling was implemented in May 1976, Quinlan began breathing on her own, contrary to most expectations that regarded her as being in fact dead. From then on, she was artificially fed and lived in a home requiring severe care. When Quinlan finally died in 1985, her body weight had dropped to 34 kilograms, with most media outlets agreeing that her life actually ended ten years ago and that keeping her body somehow »alive« for that long was in fact a (very expensive) folly.[10] These cases illustrate the unknown we are confronted with even in modern societies when looking at liminal stages at the beginning and the end of human life—despite or precisely because of all medical progress.

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8 See chapter 6.

9 Marklan, Claire W. et al. (eds.): Life-Sustaining Technologies and the Elderly, Washington 1987.

10 Greiner, Florian: Dämonen in Weiß? Medizinkritik in der deutschen Zeitgeschichte, in: Historische Zeitschrift 315 (2022), No. 3, pp. 633–667, here pp. 639–641.

Thus, regulations regarding the different stages and transitions of human life do not appear ex nihilo in modern societies. They are instead the results of long-lasting discussions and were influenced by changes in discourse and values among elites, ›average‹ members of society, technological innovations and advances in medicine and sciences—to name just a few. Thus, these questions and their implications are constantly being renegotiated, for example, with regard to the protection of unborn life and the issues of transplantation medicine. Although human life inherits a variety of different transitions and liminal stages, the beginning and the end of life are regularly debated in a particularly highly emotional and unforgiving tone. In the last decades, discussions have become increasingly heated, as recently demonstrated by the abortion debate in Poland[11] or the controversy over euthanasia and assisted suicide in Germany.[12] This vehemence cannot be understood without analyzing the historical shifts that characterized birth and death in the nineteenth and, especially, twentieth centuries. Initially, this impacted general conditions and processes, as can be seen with particular clarity in the development of the settings in which birth and death occurred: while only about 5% of all births in industrial societies took place in hospitals at the turn of the twentieth century, by 1970 almost all of them did—home births, which had been common in the past, became an exotic exception within a very short time. And whereas in 1900, 80% of all people died at home, the ratio fell to around 25% in the last third of the twentieth century—with almost 70% of the population now dying in medical institutions, where less than 10% of all deaths had occurred at the beginning of the twentieth century.[13]

Behind this development lay the consequences of increasing medicalization, as well as the transformation of family structures, the growth of the welfare state and new treatment options made possible by medical technology. As a result, care for women in childbirth did indeed improve, as did treatment of the critically ill; infant and maternal mortality rates fell, while at the same time life expectancy for the elderly increased. Nevertheless, although the institutionalization of birth and death ultimately

11 Zok, Michael: (K)Ein ›Kompromiss‹? Der Konflikt um die Neuregulierung des Schwangerschaftsabbruchs in Polen in den 1980er/1990er Jahren, in: Ariadne. Forum für Frauen- und Geschlechtergeschichte (77) 2021, pp. 164–182.

12 See Greiner, Florian: Die Entdeckung des Sterbens. Das menschliche Lebensende in den beiden deutschen Staaten nach 1945, München 2023, pp. 222–224.

13 Greiner, Entdeckung, pp. 27–57.

was the result of an improved health care that allowed more and more people to participate in the benefits of medical progress, it has been increasingly seen as a grievance since the 1960s. For example, in the last third of the twentieth century, the models of »home birth« and »home death« alike flourished and spread rapidly with their encouragement of home births and dying at home, respectively. In terms of personnel, structure and content, there were close points of contact between the actors and interest groups at the beginning and end of life. Naturalness became a major buzzword, and the efforts quickly took on the character of a movement, claiming for itself nothing less than the preservation of human dignity. In the 1970s, for example, a »Natural Birth Movement« emerged, which categorically rejected hospital deliveries according to a »feminist critiques of the medical management of labour«, followed shortly by a »Natural Death Movement«.[14] Its founding father, the English social activist Nicholas Albery, claimed that he first had the idea for the »Natural Death Centre«, which he later established, in the mid-1970s, when his pregnant wife gave birth to their child in a haystack.[15] Among other things, the agenda contained compulsory public speaking about death and improvements in end-of-life care, as well as the promotion of »Do-It-Yourself« funerals using inexpensive and environmentally friendly coffins made of recycled materials.[16] In both cases, the focus was on appeals for a return to naturalness. This entailed a rigid rejection of medical interventions at the beginning and end of life and an active, self-determined control and planning of births as well as of one's own dying process—which, at the same time, was supposed to mark the basis for understanding human life.

What clearly emerges is the instructional character of the movement, which aimed at human self-optimization. A natural birth and a natural death marked the sense-making objectives of human life, for which the individual had to prepare oneself systematically. For example, Albery described death as a kind of school leaving qualification (»Death as graduation«), following a well-known quote by Elisabeth Kübler-Ross, in which

14 Bourke, Joanna: Becoming the ›Natural‹ Mother in Britain and North America: Power, Emotions and the Labour of Childbirth Between 1947 and 1967, in: Past & Present 246 (2020), pp. 92–114, here p. 96.

15 Albery, Nicholas/Elliot, Gil/Elliot, Joseph: The Natural Death Handbook, London 1993, pp. 7–13.

16 ibid., pp. 117–151.

the process preceding death was likened to the decisive learning period of schooltime.[17]

Now one might object that the movements mentioned were short-lived, exotic and of minor significance. This is true, but only superficially, as we would like to illustrate with an example—and here we limit ourselves to the end of life. The Natural Death Movement was closely related to the hospice and palliative movement, which shared many of its core demands—especially for a well-prepared death in the comfort of one's own home—and which, at the end of the twentieth century, not only gained international acceptance in modern societies in terms of health policy, but even rose to become a cultural norm. The ideal type of dying and a »good death« are, in fact, almost identical. Until today, the death of the American aviation pioneer Charles Lindbergh is often invoked as a shining example in thantology and hospice circles.[18] After being diagnosed with cancer, Lindbergh lived actively for another two years and accepted treatment but rejected an unavailing »prolongation of suffering«. He arranged his last affairs, bid farewell to his family, and organized the funeral and memorial service himself, arranging it according to his own ideas, before finally dying »peacefully« in Hawaii in the summer of 1974, a death that, according to his wishes, had been just as »natural« as his birth.

Since the 1960s, various actors have been trying vigorously to influence liminal stages at the beginning and end of life for different reasons. First of all, we should not overlook the fact that optimized medical care did not always represent a real improvement but in some cases actually created new deficiencies, as became especially obvious at the beginning and end of life. The horrific images of impersonal assembly-line deliveries and dying patients shunted off to storerooms in large hospitals are manifestations of this. But much more was at stake, specifically the very basic problems of providing meaning and sense, which triggered new insecurities. Behind the demand for more naturalness at the beginning and end of life, for example, was the argument that modern-day man had lost former certainties, even securities, in these two liminal phases, despite or precisely because of all progress. This referred to the consequences of individualization processes as well as to those that had the power of interpretation and here, of course, especially to the dwindling importance

17 Albery/Elliot/Elliot, Death, p. 12.

18 DeSpelder, Lynne Ann/Strickland, Albert Lee: The Last Dance. Encountering Death and Dying, 2nd ed., Boston 1987, pp. 489–493.

of the churches. Already in the course of the nineteenth century, doctors had increasingly replaced clergymen at sickbeds;[19] in modern societies, trends toward scientification and secularization at the beginning and end of life went hand in hand. Nevertheless, this development is less linear than it might seem at first glance. So, today, it is possible to observe a continuing influence of churches and religious interpretation patterns in all questions pertaining to the »Circle of Life«.[20] However, this was not apparent to contemporaries. Their diagnosis was different: the unsolved riddles of modernity surrounding life and death unsettled people, especially where previous ritualized certainties based on religion had been lost. The demands for more humanity, familiarity and solidarity at the beginning and end of life were a direct reaction to this. They are also an expression of that peculiar interplay between tendencies toward both individualization and group formation which—as Frank Bösch recently remarked—is so typical for contemporary history.[21]

Structure of the Book

In this volume, we focus on the liminal stages at the beginning and the end of human life and contextualize them with related (on-going) debates and discourses. Because we are interested in the social, cultural, and legal processes that aim at regulating the beginning and the end of human life up to the present time, we concentrate on the late nineteenth and the entire twentieth and twenty-first centuries. As the liminal stages at the beginning and the end of the »Circle of Life« are so central to the discussions in modern societies, we decided to follow this »natural cycle« and look first at processes and discussions about life's beginning (chapter 2–6) and afterwards concerning death and dying.

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19 Abel, Emily K.: The Inevitable Hour. A History of Caring for Dying Patients in America, Baltimore 2013; Nolte, Karen: Todkrank. Sterbebegleitung im 19. Jahrhundert: Medizin, Krankenpflege und Religion, Göttingen 2016.

20 See Greiner, Florian: Säkulares Sterben? Die Kirchen und das Lebensende in der Bundesrepublik Deutschland nach 1945, in: Vierteljahrshefte für Zeitgeschichte 47 (2019), No. 2, pp. 181–207.

21 Bösch, Frank: Arbeit, Freizeit, Schlaf. Alltagspraktiken als Perspektive der bundesdeutschen Zeitgeschichte, in: Bajohr, Frank et al. (eds.): Mehr als eine Erzählung. Zeitgeschichtliche Perspektiven auf die Bundesrepublik, Göttingen 2016, pp. 301–313, here p. 313.

In their chapter, Christoph Egen, Cornelia Weiß, Christoph Gutenbrunner and Anne Ostermann situate recent debates on pre-natal diagnosis (PND) and its ambiguities, which were at the center of the debates about its ethical implications, especially in (Western) German discourse, in a long-term context. The authors highlight the (historical) dilemmas concerning health since the Age of Enlightenment and look at the effects of medicalization on (prenatal) life. They show the changing meaning of »health« understood not only as a desirable condition, but also as a »right« as well as a »duty to society« and highly individualized prevention in the late twentieth century. However, medicalization was met with resistance in history, just as PND and preimplantation genetic diagnosis (PGD) are today.

Wiebke Lisner takes a step back (chronically) and shows how difficult it was to determine whether a woman was pregnant or not in times before pregnancy tests were invented. Her chapter focuses on midwives who were accused of having conducted abortions before and/or during the Nazi occupation of Poland. Set in a highly nationalist and racist setting, the court proceedings aimed at limiting (ethnic German) women's »subversive agency« (Isabel Heinemann), but also showed a lack of unambiguousness. However, those midwives (had) acted not according to the rules of the German occupiers but instead in accordance with the norms of their local (pre-war) environment.

The next chapter also traces totalitarian politics concerning reproductive rights. Marina Bantiou takes a look at one of the most repressive reproductive regimes: late socialist Romania. Connected to a said »demographic crisis«, the country run by dictator Nicolae Ceausescu introduced an almost total ban on abortions—with a few exceptions. Banitou analyzes the efforts to control procreation by law and administrative means, including mandatory gynecological testing, spying, and denunciation. The chapter puts an emphasis on the massive side-effects that were not intended by the legislation and hit women instead of »protecting unborn life« and positively stimulating demography. Illegal abortions, female extramortality, and a growing number of abandoned children were characteristic of the Communist-Romanian efforts to control the beginning of human lives and survived the transition to democracy.

However, the Romanian experience did not represent all totalitarian Communist regimes. In her chapter on reproductive rights in the German Democratic Republic (GDR), Luisa Klatte shows the non-linear developments in the reproductive regime of the Sozialistische Einheitspartei

Deutschlands (SED), leading to a liberal but still pro-natalist approach. Because its pharmacological industry was one of the most advanced among the state-socialist countries, new methods—especially the introduction and general availability of the hormonal pill, called »Wunschkindpille« (›pill for a dream child‹)—, but also changes in discourse opened opportunities for women to consciously decide when and whether to have children. However, German unification led again to a questioning of women's decision-making and reproductive rights.

While the developments in the GDR led to a specific liberal reproductive regime, Michael Zok looks at a unique Polish phenomenon during Communist rule (and afterwards): the strong position of the Catholic Church and its impact on discourses on life's beginning. He shows how the »in-betweenness« and uncertainty about prenatal life were neglected in the Catholic discourse in Poland. Instead, Catholics saw (and see) it solemnly as the first—and not even special—phase of human life. Moreover, the chapter highlights how historical and cultural developments shaped the discourses on liminal stages in very particular ways. In the Polish case, the experience and remembrance of genocide and (totalitarian) foreign rule influenced the debates about the »protection of unborn life« as well as euthanasia.

Thorsten Benkel explores liminal states as irritations of knowledge. He discusses the dichotomy of life and death, using Antoine de Saint-Exupéry's disappearance and posthumous fame to illustrate the ambiguity between physical death and cultural survival. In examining the concept of »social death«, Benkel shows that, vice versa, individuals can become socially invisible despite their physical existence, as seen with marginalized groups and legal declarations of death. The disappearance of Flight MH370 and its passengers is used to highlight the blurred boundaries between life and death, emphasizing that intermediate states challenge clear distinctions between existence and non-existence. Borderline states, such as near-death experiences, cryonics, and post-mortem digital avatars, reveal the ambiguity in determining the end of life.

Julia Dornhöfer, too, is focusing on the challenges individuals and societies face in defining boundaries between life and death. Living wills provide a legal document that promises a planned passage in end-of-life situations as well as an active engagement with death and dying. She argues that although public discourse has increased since the mid-twentieth century, death-denying strategies remain in place, particularly within families. The chapter thus highlights the importance of addressing these

taboos and improving communication about end-of-life wishes to create more meaningful living wills and optimize palliative care in general.

Anna Bauer highlights the differentiation and specialization in multi-professional palliative care. With modern societies being characterized by extensive organizational structures, it calls for high specialization and a deeply interconnected »circle of life«. Within the dying process, Bauer is tracing a paradigm shift from the »closed awareness context«, where patients were kept unaware of their imminent death, to an »open awareness context« promoting informed and autonomous decision-making. Furthermore, the evolution of end-of-life care is discussed, involving multi-professional teams addressing physical, spiritual, social, and psychological pain. This division of labor results in a fragmented view of the patient rather than a unified one. The concept of »death brokering« is distributed among various professionals, creating a complex, multi-faceted organizational system with various contradictions and dependencies.

In discussing the history of euthanasia, assisted suicide and withdrawal of treatment in India, Boopathi P is able to show that the cultural and religious background of a society determines the way the end of life is handled medically and legally. While in most Western countries as well as the former Eastern bloc, at least passive euthanasia has become commonplace and ethically possible in the last third of the twentieth century, it was only in 2011, when India's Supreme Court finally legalized it following the prominent Aruna Shanbaug case, sparking nationwide debates. The verdict sanctioned passive euthanasia and introduced living wills, balancing modern medical practices with traditional beliefs. Legal discourse has thus shifted from religious to constitutional considerations.

Drawing on a completely different case study, namely Switzerland, Eric Franklin shows how and why the small European country pioneered in the institutionalization of assisted suicide, a concept that gained acceptance in the late 1970s and was implemented in the 1980s. The legal framework has its roots in the late nineteenth century, emphasizing honor over shame, with the debate being influenced by criminologists Carl Stooss and Emil Zürcher. Article 115 of the Swiss Criminal Code, passed in 1938, already allowed altruistic assisted suicide without selfish motives. After the Second World War, the concept of honor transitioned to dignity, aligning with human rights principles. In the 1970s, movements advocating for self-determined dying emerged, leading to legal precedents expanding eligibility for assisted suicide, including for mental suffering. The notion of dignity now underpins the right to assisted suicide.

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Christoph Egen, Cornelia Weiss, Christoph Gutenbrunner, Anne Ostermann

Social implications of Prenatal Diagnosis (PND) and Preimplantation Genetic Diagnosis (PGD). A sociological trial

Introduction and Background

In Germany, prenatal diagnosis (PND) has been used to detect possible gene deviations in fetus since the late 1980s.[1] While the aim of standard prenatal care is to monitor pregnancy and identify health risks for mother and child, PND, beyond that, includes tests that specifically look for genetic malformations in the fetus. PND allows to predict a limited number of hereditary diseases, hereditary functional limitations or pathological dispositions for diseases. In practice, the distinction between standard care and further PND is often unclear, as standards in prenatal care change and pathways lead from standard to additional diagnostic tests, when there is an abnormal result in the former. In addition to that, PND is often also used as a self-pay service. PND can be divided into invasive and non-invasive procedures. Non-invasive procedures are ultrasound examinations and genetic blood tests of maternal blood. They pose no risk to mother and child and in most cases predict only a relative probability of genetic deviation. Invasive procedures are used to confirm the findings of non-invasive tests. They include examination by punctuation of placenta and fetal cavity. This carries a risk of miscarriage of 0.5–1%. Regarding the punctuation of the umbilical cord complications occur in 1–3%.[2] In many cases, PND has only little significance with regard to the severity of the diagnosed genetic deviation or outbreak of disease. Therefore, the diagnostic finding is rather a statistical risk calculation than a reliable clinical fact. The consequences of PND can be prenatal therapies, which are only possible to a very limited extent. It can be useful for appropriate

1 Stengel-Rutkowski: Vom Defekt zur Vielfalt. Ein Beitrag der Humangenetik zu gesellschaftlichen Wandlungsprozessen, in: Zeitschrift für Heilpädagogik 53 (2002), No. 2, p. 46.

2 Bundeszentrale für gesundheitliche Aufklärung: Pränataldiagnostik–Beratung, Methoden und Hilfen. https://shop.bzga.de/praenataldiagnostik-beratung-methoden-und-hilfen-c-394/ (15.04.2024), pp. 22–24.

preparations, e.g. to choose a clinic with a perinatal center as place of birth. Apart from that, PND often results in a decision to be made for or against an abortion. To which purpose PND is applied is therefore a crucial question, often not well considered in advance. These ›selective abortions‹ are only a small fraction of all abortions and can be defined as those cases in which a particular fetus is perceived as having not desired characteristics.

Historically, the development of a series of procedures for prenatal diagnostics started in the 1930s. A starting point was Amniocentesis, the examination of the amniotic fluid by means of a puncture of the amniotic sac, which was first performed in 1881/1882. Initially, the procedure was used to treat the abnormally increased volume of amniotic fluid (hydramnios). From the 1950s onwards, the procedure continued to develop into a diagnostic method with increasingly controllable risks for mother and child. It was used for the detection of rhesus incompatibilities between mother and child, as well as a possibility of early sex determination and later for analyzing the chromosome set.[3] It still is one of the most common invasive procedures.

From the beginning, the introduction of PND was accompanied by a discourse on its ethical implications. Beck-Gernsheim discussed the growing demand for PND in Germany as early as in 1996.[4] The rough lines of the discourse span between self-determination of woman and medical feasibility/disease avoidance on the one hand and protection of ›inappropriate life‹ and the ideal of an inclusive society on the other. Thereby, the general focus of this discourse seems to have changed. The bio-political problem of modernity, the social question of »what should we do with people who do not fit into society or whose performance value makes them industrially useless?«,[5] has been solved without any explicit rating of humans, e.g. a racist ideology.[6] In Germany, abortion of life that does not fit into society has currently been normalized and privatized due to

3 Paul, Norbert: Pränatale Diagnostik, in: Gerabek, Werner E. (ed.): Enzyklopädie Medizingeschichte. Berlin et al. 2011, pp. 1178–1180.

4 Beck-Gernsheim, Elisabeth: Die soziale Konstruktion des Risikos — das Beispiel Pränataldiagnostik, in: Soziale Welt, 47 (1996), No. 3, pp. 284–296.

5 Dörner, Klaus: Tödliches Mitleid. Zur Frage der Unerträglichkeit des Lebens oder: die Soziale Frage: Entstehung – Medizinisierung – NS-Endlösung – heute – morgen. Mit einem Beitrag von Fredi Saal. Gütersloh 1989.

6 Rösner, Hans-Uwe: Behindert sein – behindert werden. Texte zu einer dekonstruktiven Ethik der Anerkennung behinderter Menschen, Bielefeld 2014, p.129.

the primacy of self-determination. Consequently, giving birth to a child with genetic deviations appears as a matter of individual choice. What was once understood in 1970s as a right to defend against state interference is now increasingly asserting itself as a right to claim a healthy child, with recourse to all medical options[7]. This is also what the providers aim for when they establish and expand new processes. Each decision is always about individual cases and problems, which is a valuable achievement in itself. But socio-ethical considerations, social contexts and effects are being left out.[8] A critical perspective is occupied by mostly conservative and religious voices of Pro-Life-Movements, which have been politically successful e.g. in USA, Poland and other Eastern European countries recently. Any interference with natural or divine destinies at the beginning and end of life is rejected by them and protection of ›inappropriate life‹ is prior to the choice or even health of the pregnant woman.

This chapter examines the social impact of PND, but also of PDG (Preimplantation Genetic Diagnosis) from a sociological perspective in Germany. We want to highlight the social risks and side effects or downsides and ambivalences of a preventive examination method that is often euphemistically presented by medical staff in everyday routine and which, from the authors' point of view, play only a subordinate role in social discourse. To this end, we attempt to synthesize the prevention literature and various sociological approaches.

PND and PGD as treatments of prevention

PND can be described as part of the broader societal phenomenon of prevention, which is by some authors pointed out as a general modus operandi in modern time.[9] The term ›prevention‹ is derived from the latin word ›praevenire‹, which means ›to come before‹. Preventive action there-

7 Achtelik, Kirsten (2018): Selbstbestimmte Norm. Feminismus, Pränataldiagnostik, Abtreibung, 2nd ed., Berlin.

8 Baureithel, Ulrike: Das ist keine rein private Frage. Pränataldiagnostik: Soll der Test auf das Down Syndrom Kassenleistung werden? Nächste Woche debattiert der Bundestag, in: der Freitag, No. 14, 04.04.2919.

9 Bröckling, Ulrich: Vorbeugen ist besser… Zur Soziologie der Prävention, in: Behemoth. A Journal on Civilisation 2008, No. 1, pp. 38–48, id.: Gute Hirten führen sanft. Über Menschenregierungskünste. Berlin 2017.

fore refers to ›pre-empting‹ an anticipated undesirable development,[10] but also to preventing certain events or conditions altogether.

While the concept of prevention could be clearly assigned to the legal sciences with regard to crime prevention towards the end of the nineteenth century, the conceptual attribution has been increasingly shifted to the area of health risk prevention from the twentieth century onwards.[11] Before industrialization, health and especially the prevention of illness of the population was not a major political issue. In the course of industrialization due to the increasing demand for labor, rapid population growth in the cities and associated risks of illness, health became increasingly important as a capital factor in the economic system.[12]

Already in 1779, Johann Peter Frank's »System einer vollständigen Medicinischen Polizey« provided a basis for legitimizing governmental regulation of people's lives according to medical rules that went far beyond medical expertise, but remained a paper claim for the time being. At the same time as these socially disciplinary measures of late absolutist police science, concern for health in bourgeois society became the most important element of an enlightened and rational lifestyle, with which the politically powerless educated bourgeoisie set itself apart from the nobility and at the same time integrated other social classes into bourgeois society.[13] This also can be associated with the fact that scientific knowledge has always been and usually still is regarded as value-neutral.

In the course of modernity, the authority to interpret inexplicable phenomena relating to illnesses and functional limitations was passed from the hands of theologians to those of doctors, who, after turning to natural science, were able to achieve ever greater success in healing. It should be

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10 Brockhaus: Enzyklopädie in 30 Bänden, 21., völlig neu bearbeitete Auflage, Band 22, POT-RENZS, Leipzig 2006, p. 54f.; Papenkort, Ulrich: Prävention: Wort, Felder und Begriff, in id. (ed.): Prävention. Fachübergreifende Einführung in eine besondere Intervention. St. Ottilien 2008, p. 9.

11 Labisch, Alfons: Gesundheitskonzepte und Medizin im Prozeß der Zivilisation, in: Labisch, Alfons/Spree, Reinhard (eds): Medizinische Deutungsmacht im sozialen Wandel. Bonn 1989, pp. 15–36

12 Mutz, Gerhard: Sozialpolitik als soziale Kontrolle am Beispiel der psychosozialen Versorgung, München 1983, p. 204ff.; Stöckel, Sigrid / Walter, Ulla (eds.): Prävention im 20. Jahrhundert–Historische Grundlagen und aktuelle Entwicklungen in Deutschland. Weinheim & München 2002, p. 11.

13 Welsh, Caroline: Brauchen wir ein Recht auf Krankheit? Historische und theoretische Überlegungen im Anschluss an Juli Zehs Roman Corpus Delicti, in: Frewer, Andreas/Bielefeldt, Heiner (eds.): Das Menschenrecht auf Gesundheit. Normative Grundlagen und aktuelle Diskurse, Bielefeld 2016, p. 224.

noted here that they had already received this power of interpretation a long time ago through their proximity to the middle class, through moral arguments and justifications.[14] »It was only when natural science became the reference science of medicine that the subject and morality were repressed and the health theory of the previous epoch was relegated to the realm of speculation: the objective method of natural science became the truth par excellence, health/illness as a manifestation of life became statistical and physical-chemical norms and laws in ›measure, number and weight‹ «.[15]

In the course of the nineteenth century, citizens were given a right to health, but also had a duty to society to maintain their health in the sense of maintaining an appropriate lifestyle.[16] According to Labisch, this represented the birth of *Homo Hygienicus*, who regarded health as the primary goal of life and subjected his lifestyle entirely to health principles derived from medicine[17]—admittedly not yet with the same preventative view as today. This was the beginning of medicalization of life.

With a view to today's lifestyle, preventive measures and fitness trackers, the path of internalization of the former social constraints into self-constraints can be outlined in terms of civilization theory.[18] Nowadays, very few people doubt the value of a medically recommended lifestyle, whereas at the end of the nineteenth century there were still so-called sick visitors who checked on behalf of the large local health insurance funds whether the doctor's instructions were being followed and, for example, whether the prescribed medication was actually being taken.[19]

Today, people monitor their own health with the help of fitness trackers, for example, and take advantage of a wide range of preventive services

14 Roelcke, Volker: Vom Menschen in der Medizin. Für eine kulturwissenschaftlich kompetente Heilkunde, Gießen 2017, p. 155.

15 Labisch, Alfons: Medizin und soziale Kontrolle. Zum Verhältnis von Sozialgeschichte und Soziologie der Medizin am Beispiel neuerer Literatur aus der Bundesrepublik Deutschland mit einem Exkurs: Neuere Forschungen zur Medizin im Nationalsozialismus, in: Dynamis. Acta Hispanica ad Medicinae Scientiarumque Historiam Illustrandam 1987-1988, No. 7–8, pp. 437.

16 Roelcke, Volker: Vom Menschen in der Medizin, p. 154.

17 Labisch, Alfons: Homo hygienicus: soziale Konstruktion von Gesundheit, in: Wagner, Franz (ed.), Medizin. Momente der Veränderung. Berlin et al. 1989, p. 116.

18 Elias, Norbert: Über den Prozeß der Zivilisation. Soziogenetische und psychogenetische Untersuchungen. Band II. Wandlungen der Gesellschaft. Entwurf zu einer Theorie der Zivilisation. 2nd ed., Frankfurt a. M. 1977.

19 Labisch, Alfons: Homo hygienicus, p. 126.

to prevent potential illnesses in good time. All these actions are carried out also in the interest of the state, but without real government pressure (surely with some exceptions like mandatory vaccinations). In the second half of the twentieth century, responsibility for health has shifted from the state to the individual, flanked by the healthcare market.[20] Overall, prevention is perceived as rational, positive and socially desirable. No doubt, the utilized preventive services have improved health in all ages and are a factor for increasing life expectancy. Nevertheless it is important to consider side effects of prevention, especially potential negative aspects that seem to be consequently underexposed in individual perception, public discourse and often also in science. Side effects may concern the unreflected norm-building power of facts, as discussed in this chapter. Also, over treatment and stirring up fear can be an effect of preventive rationality.

The statistical understanding and mathematical development made it possible to anticipate future dangers and calculate risks. In this context, evidence-based medicine aims to reach the best possible results for a person's future by taking into account what we know from the past of other individuals. Since evidence-based medicine and therapy in a neoliberal society saves costs in the healthcare system and at the same time gets people back to work more quickly, there is a corresponding demand for it. Naturally, in other cultures or societies the social system has a different orientation. The inherent logics thereby differ between that of intervention in curative medicine and the logics of prevention. While curative intervention always refers to a *diagnosis*, that is to say a (more or less) secured and present health issue, prevention aims to eliminate or minimize a risk, a vague future health issue that might occur and is not yet *diagnosed* but *prognosed*. In other words, prevention strives to replace a calculated version of the future by a not defined other. In both cases, curative intervention as well as prevention, it is only the declined situation that is defined and guiding the action. In medicine, the focus is on diseases that are diagnosed and treated as deviations from a desired norm. Therefore, prevention in this sense also has an exclusively negative perspective: deviations should

20 Martschukat, Jürgen: Das Zeitalter der Fitness. Wie der Körper zum Zeichen für Erfolg und Leistung wurde. Frankfurt am Main 2019.

be recognized and corrected. A more lifeworld-centered perspective also opens up positive scenarios for dealing with deviations.[21]

Prevention approaches differ in terms of the time perspective in the course of the disease according to primary prevention (before the onset of the disease, for example vaccination), secondary prevention (in the early stages of a disease, for example early detection measures) and tertiary prevention (when a disease manifests itself, for example patient training).[22] Gordon criticized the division into primary, secondary, tertiary prevention because it overstretches the concept of »prevention«. As an alternative, he developed a categorization that distinguishes between universal, selective and indicated prevention approaches, using a narrower concept of prevention. Universal prevention starts before a specific problem occurs in target groups that do not exhibit any abnormalities or an increased risk. In contrast, targeted prevention measures take effect when risk factors are already recognizable (selective prevention) or when the first signs of a problem appear (indicated prevention). Prevention is therefore only considered if something can still be prevented, namely the full manifestation of the undesirable phenomenon.[23]

From a sociological perspective, PND can be described as a social selective prevention, as in the case of positive findings (e.g. trisomy 21), the ›prevention‹ of ›inappropriate life‹ is usually carried out as a measure (selective abortion). On the other hand, a positive result can also be used to prepare for this life and, if necessary, to prevent or alleviate the potential disease and/or impairment through prenatal surgery. Fetal surgery is currently still at an experimental stage, but may offer (in the future) the possibility of prenatal treatment and thus the desired reduction in later impairment.[24] How high the risks of these surgical interventions are for mother and child can only be estimated at present. However, from this point of view PND can also be seen as behavioral prevention, which focuses on the individual behavior. In contrast, social responsibility, which could reflect aspects of environmental prevention, is barely recognizable in public discourse.

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21 Schütz, Alfred/Luckmann, Thomas: Strukturen der Lebenswelt. Konstanz & Stuttgart 2003.

22 Caplan, Gerald: Principles of Preventive Psychiatry, 5th ed., New York, NY 1964.

23 Gordon, Robert S.: An operational classification of disease prevention. Public Health Reports, 83 (1983), No. 98 (3), pp. 107–109.

24 Tchirikov, Michael: Intrauterine fetale Chirurgie, in: Deutsche Hebammenzeitschrift 14 (2017), No. 1, pp. 32–46.

Historically, dealing with impairments was a matter for the individual or the domestic community. It only became a »social problem« with the changes in the world of work during industrialization. The value of a person was increasingly based on his or her ability to work, to be fit for military services and perform, so that anyone who did not meet these requirements was devalued.[25]

Viewing disability as a participation problem was a milestone caused by the disability movement—similar to the 1968 motto ›the private is public‹. PND shifts the ›problem‹ back into the private sphere and, from this perspective, can be seen as a push back of the achievements of the disability movement.[26]

State control over whether individuals meet the ideal and whether they are productive, as envisioned by the eugenicists of the nineteenth and twentieth century and implemented in practice in the Third Reich, has become obsolete. Wherever control is possible, it is demanded by society and regarded as normal.[27] In most cases, the result is an abortion, although the extent of the impairment is often unforeseeable. It should also be borne in mind that with some measurement procedures, such as nuchal translucency measurements, an abnormal finding does not necessarily lead to a real impairment of the child. The diagnostic methods usually work with probabilities. In order to better confirm the positive result, the pregnant woman ends up in a ›diagnostic spiral‹. Forecasts and probabilities do not provide absolute security. The uncertainty of the pregnant woman is in this case a significant side effect of PND. The measurement results can be viewed in some cases sociologically as a kind of pseudo-control. This is because only around 25% of congenital impairments can be detected prenatally and 96% of impairments are experienced by people in the course of their lives.[28]

The responsibility to decide for and to deal with the results of PND lies with the mother, who—if she decides against an abortion—›acts irre-

25 Egen, Christoph: Was ist Behinderung? Abwertung und Ausgrenzung von Menschen mit Funktionseinschränkungen vom Mittelalter bis zur Postmoderne. Bielefeld 2020.
26 Hartwig, Susanne (ed.): Behinderung. Kulturwissenschaftliches Handbuch. Berlin 2020.
27 Egen: Was ist Behinderung?, p. 194ff.
28 Nicklas-Faust, Jeanne: Behinderung als soziale Konstruktion und Pränataldiagnostik, in: Duttge, G. (ed.): »Behinderung« im Dialog zwischen Recht und Humangenetik. Göttinger Schriften zum Medizinrecht 17, Göttingen 2014, pp. 59–70.

sponsibly‹ according to survey results.[29] In addition to the (consciously) taken risk, the parents/mother now bears the burden of justification for rejected prevention offers. The implementation of PND corresponds to a ›voluntary compulsion‹.[30] Prevention is always viewed euphemistically, but selective prevention in the context of PND means prevention not only of an impairment or disease but of human life and should be clearly named as such. Here, prevention reveals its normative character. With the introduction of PND, control over life is possible with the consequence that decisions now have to be made where previously fate decided.[31] The possibility of averting disaster also gives rise to the duty of prevention.[32] The future price of rejecting PND may be partial exclusion from solidarity communities. Politically, these procedures are merely declared to be an extension of choice; however, the decision and responsibility are individualized. But individual decision-making autonomy always takes place in social space, which is structured and limited by institutional rules and constraints and by the interpretation and relevance systems of medical experts.[33]

Preimplantation Genetic Diagnosis (PGD) is an even more far-reaching biomedical measure that examines embryos created in vitro and only inserts embryos with ›healthy‹ genetic material into the uterus. The worrying trend that is becoming apparent here leads to the point that it may no longer seem reasonable to give birth to a child with an increased risk of disease, but that babies with desired characteristics, so-called ›designer babies‹, will become the norm. The avoidance of ›undesirable‹ genetic dispositions possibly leads to the production of a type of human with a ›desired‹ genetic make-up. PGD shifts the boundary from avoiding a hereditary child (PND) to producing a child with desirable characteristics.

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29 Beck-Gernsheim, Elisabeth: Genetische Beratung im Spannungsfeld zwischen Klientenwünschen und gesellschaftlichem Erwartungsdruck, in: id. (ed.): Welche Gesundheit wollen wir? Dilemmata des medizinischen Fortschritts. Frankfurt a. M. 1995, pp. 111–138.

30 Beck-Gernsheim, Elisabeth: Gesundheit und Verantwortung im Zeitalter der Gentechnologie, in: Beck, Ulrich / Beck-Gernsheim, Elisabeth (ed.): Riskante Freiheiten. Individualisierung in modernen Gesellschaften. Frankfurt a. M. 1994, pp. 316–335.

31 Lemke, Thomas: Veranlagung und Verantwortung. Genetische Diagnostik zwischen Selbstbestimmung und Schicksal. Bielefeld 2004.

32 Leanza, Matthias: Die Zeit der Prävention. Eine Genealogie. Weilerswist 2017

33 Bogner, Alexander: Grenzpolitik der Experten. Vom Umgang mit Ungewissheit und Nichtwissen in pränataler Diagnostik und Beratung. Weilerswist 2005.

Habermas warns against ›liberal eugenics‹ with regard to the increasing availability and use of biomedically intervening procedures.[34] Other authors speak of ›eugenics from below‹, which, in contrast to ›eugenics from above‹, no longer requires state planning or encouragement.

Both representatives of the disability movement and bioethics therefore understandably regard the possibility of PGD, but also of PND, as humiliation for people with disabilities and perceive it as a questioning of their existence and a signal of not being welcome and not belonging.[35] There are also fears that the willingness to assume the costs of therapy and care costs, as well as the necessary investment in medical research projects, could decline.[36]

The concern that PGD has already opened a door to eugenics that needs to be defended is not entirely unjustified from the perspective of people with functional limitations. On the contrary, all existing studies indicate that even after (or despite) the introduction of PND and PGD, the situation of people with functional limitations tends to improve, to the extend that once they are born, their dignity is fully respected legally and socially and they are not regarded as objects of possible selection. In this context van den Daele speaks of a ›moral watershed‹ in the consciousness of the population. Acceptance of prenatal selection does not automatically and causally lead to acceptance of postnatal selection. Prenatal selection and discrimination against living people with functional impairments must therefore be regarded as two completely independent phenomena.[37]

Conclusion

One can identify two partly contradictory currents of social reaction to people with functional impairments in the postmodern era: legal equality combined with an increasing public presence of people with functional

34 Habermas, Jürgen: Die Zukunft der menschlichen Natur. Auf dem Weg zu einer liberalen Eugenik? Frankfurt a. M. 2001.

35 Deutscher Ethikrat: Präimplantationsdiagnostik. Stellungnahme, https://www.ethikrat.org/fileadmin/Publikationen/Stellungnahmen/deutsch/stellungnahme-praeimplantationsdiagnostik.pdf (15.03.2024), p. 64f.

36 Lemke, Thomas/Rüppel, Jonas: Reproduktion und Selektion. Gesellschaftliche Implikationen der Präimplantationsdiagnostik. Wiesbaden 2017, p. 71.

37 Daele, Wolfgang van den: Vorgeburtliche Selektion: Ist die Pränataldiagnostik behindertenfeindlich?, in: id. (ed.), Leviathan Sonderheft Biopolitik 2005, No. 23, p. 106f.

impairments and simultaneous efforts to avert the lives of these people through prenatal biomedical interventions.[38] The ›ambivalences of modernity‹[39] (e.g. optimism of healing through science with the simultaneous existence of incurable diseases or a homogeneous view of humanity with the simultaneous existence of diversity/heterogeneity) have not been resolved in postmodernity. What has changed, however, is the processing, which has shifted from the state to the individual, where it often causes orientation problems and feelings of being overwhelmed and therefore repeatedly triggers counter-movements (xenophobia, unscrupulousness of the sciences, etc.). This can ultimately be seen as a reaction to the inability to come to terms with the ambivalences.

However, there is a risk that biologically defined health will develop into a central social value, which will have an impact on the image of humanity. It should be borne in mind that only 4% of severe disabilities in Germany are present from birth; all others are acquired in the course of life. Sooner or later, we will all have to deal with impairments directly or indirectly—anything else would be a very utopian and unrealistic view. Disability studies therefore describe non-impaired people as ›temporarily abled‹. Nonetheless, prenatal health conditions attract outstanding attention regarding the dealing with disability in society. While there is – at least theoretically – great consensus about equal opportunities and support for people with impairments, the situation is regarded differently at the very beginning of life (and also the end of life, as the discussion about euthanasia shows). As Graumann points out, birth marks the dividing line for the constitution of a social person.[40] Birth or a legally defined age of pregnancy also marks the line between whether health might be prioritized over life. To emphasize the sociogenesis and psychogenesis of this liminality of life is important to recognize the achievement of individual degrees of freedom as well as its potential for unwanted social control.

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38 Köbsell, Swantje: Behinderte Menschen und Bioethik. Schlaglichter aus Deutschland, Großbritannien und den USA, in: Hermes, Gisela/Rohrmann, Eckhard (eds.): Nichts über uns – ohne uns! Disability Studies als ein neuer Ansatz emanzipatorischer und interdisziplinärer Forschung über Behinderung, Neu-Ulm 2006, pp. 59–79.

39 Bauman, Zygmunt: Moderne und Ambivalenz. Das Ende der Eindeutigkeit, Neuausgabe 2005, 2nd ed., Lemförde 1992.

40 Graumann, Sigrid. Die Geburt als Grenze zur Konstitution sozialer Personen: Ein soziologisch-theoretischer Beitrag zur bioethischen Diskussion über Spätabbrüche und die Behandlung von Frühchen, in: Joerden, Jan/Hilgendorf, Eric/Petrillo, Natalia/Thiele, Felix (eds.): Menschenwürde in der Medizin: Quo vadis? Baden-Baden 2012, pp. 13–32.

Life always means risk, not everything in the course of a life will ever be controllable.[41] Learning to live with the resulting feelings of powerlessness is the only thing that helps here, German history shows how much worse their counterparts—the fantasies of omnipotence—can be.

Elias' statement remains: the social existence of people is not least dependent on the image that people have of each other, on the meaning and value that they ascribe to each other.[42] As long as our thinking about human coexistence increasingly corresponds to a cost-benefit analysis, the image of humanity will certainly not change for the better. However, it would definitely be helpful to extend the many efforts to establish and maintain biological health also to promote social coexistence or health.

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41 Castel, Robert: Die Stärkung des Sozialen. Leben im neuen Wohlfahrtstaat. Hamburg 2005, p. 128.

42 Elias, Norbert: Sozialer Kanon, soziale Existenz und das Problem der Sinngebung. Ein soziologischer Essay. Wiesbaden 2022, p. 79.

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»Halted Blood« or Pregnancy? On the Liminal Perception of Life and Death between Biopolitics and Social Practice in Occupied Western Poland, 1939 - 1945[1]

Wiebke Lisner

Introduction: Pregnancies as a liminal stage of life and death at the center of Nazi biopolitics

Midwife Helena K. was accused of having performed an abortion on a young ethnic German woman in the summer of 1941. At the Special Court in Litzmannstadt/Łódź, she testified that she had examined the woman carefully and had not detected a pregnancy. She claimed that she hadn't performed an abortion, but rather a douche of the vagina and the uterus. »During the war«, she said referring to the First World War, »there were frequent cases of young girls with halted blood«, which she had been able to treat in a similar manner.[2] She regarded the absence of the menstruation as an anomaly to be remedied. According to her, she intended to restore the woman's »normal« menstruation by rinsing the uterus. The midwife proposed that the absence of menstruation could be attributed to the war, suggesting that violence and existential threat had a negative impact on women's health. Neither the midwife nor the accused woman discussed the possibility of pregnancy or expecting a child.[3]

In legal proceedings concerning abortions, it was often challenging to ascertain with certainty whether a pregnancy had indeed occurred. During the initial stages of fetal development, it was not possible for midwives and physicians to accurately differentiate between a non-pregnant and a pregnant woman. Hormonal pregnancy tests were not yet available.[4]

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1 The following text is based on my habilitation thesis, Hannover Medical School in 2024. I would like to thank Vanessa Walter for proof reading.

2 Minutes of the trial against the midwife Helena K., 13 April 1942, in: Archiwum Państwowe w Bydgoszczy (APB), Fordon 90/962.

3 Minutes of the trial against the midwife Helena K., 13 April 1942, in: APB, Fordon 90/962.

4 Hormone-based tests using frogs were known, but not available for widespread use. Cf. Malich, Lisa: Die hormonelle Natur und ihre Technologien. Zur Hormonisierung der Schwangerschaft im 20. Jahrhundert, in: L'Homme 25 (2014), pp. 71–86.

It was only through the first movements of the baby, which occurred around the beginning of the fourth month of pregnancy, that a woman's condition could be determined with certainty, explained the director of the Landesfrauenklink [Regional Women's Hospital] in Gliwice in 1943.[5] This very state of »not knowing« was sometimes used as the midwives' argument in court. Pregnancy and abortion, thus became, as Barbara Duden and Cornelie Usborne point out, a ›gray area‹ in which it was often more a matter of hunches and feelings than of medical certainty.[6] The early stage of pregnancy and the very beginning of the circle of life, thus, could be described as a state of uncertainty, based on perceptions and choices.[7]

The midwife Helena K. addressed the ambiguity between an abnormality of blood flow and the uncertainty of pregnancy. She attempted to persuade the court that in this instance the issue was merely an anomaly, a stagnation of the blood flow, which she had successfully reversed. Pregnancy became only one possible reason when menstruation stopped. In this case, the midwife ruled out the possibility of pregnancy. She justified her actions by stating that she felt obliged to heal the woman. Her experience of interwar Poland may have led her to assume that this argument would convince the court. In the countryside of interwar Poland, midwives were often the only trained medical professionals and, therefore, possibly took care of all women's health issues.[8] In Germany, and presumably in Poland as well, »mother syringes« for vaginal irrigation were readily available from the early twentieth century onward. As Cornelie Usborne observes, the use of »mother syringes« was associated with notions

5 Director of the Landesfrauenklinik in Gliwice, Opinion, 28 January 1943, in: Archiwum Państwowe w Katowicach (APK), 117/2143. See also Duden, Barbara: Zwischen wahrem Wissen und Prophetie. Konzeptionen des Ungeborenen, in: Duden, Barbara/Schlumbohm, Jürgen/Veit, Patrice (eds.): Geschichte des Ungeborenen. Zur Erfahrungs- und Wissenschaftsgeschichte der Schwangerschaft, 17.-20. Jahrhundert (Veröffentlichungen des Max-Planck-Instituts für Geschichte), Göttingen 2002, pp. 11–48.

6 Usborne, Cornelie: Gestocktes Blut oder verfallen? Widersprüchliche Redeweisen über unerwünschte Schwangerschaften und deren Abbruch zur Zeit der Weimarer Republik, in: Duden, Barbara/Schlumbohm, Jürgen/Veit, Patrice (eds.): Geschichte des Ungeborenen. Zur Erfahrungs- und Wissenschaftsgeschichte der Schwangerschaft, 17.-20. Jahrhundert (Veröffentlichungen des Max-Planck-Instituts für Geschichte), Göttingen 2002, pp. 293–326.

7 Heinemann, Isabel: Wert der Familie. Ehescheidung, Frauenarbeit und Reproduktion in den USA des 20. Jahrhunderts (Family Values and Social Change vol. 3), Berlin, Boston 2018.

8 Cf. Kassner, Elzbieta/Lisner, Wiebke: Zwischen staatlichen Vorgaben und gesellschaftlichen Bedürfnissen. Berufskarrieren von Hebammen und die Geburtshilfe

of health and hygiene and constituted a prevalent method of feminine hygiene.[9] The accused midwife Helena K. also explained her uterine rinses within this context. It was not until 1933 that the National Socialists prohibited the free sale of »mother syringes« through the reintroduction of § 219 of the German Penal Code, which criminalized the advertising of »abortifacients« and also »mother syringes« in Germany.[10]

However, women in occupied Poland did not merely engage in discourse on the topic of abortion in the context of uncertainty; they also made deliberate decisions, even when they became pregnant. In the absence of contraceptive options and constrained reproductive choices, Isabel Heinemann argues that women seek to regulate their pregnancies and births through alternative means.[11] She refers to this as women's »subversive agency«.[12] What were women's choices based on and how did they justify them in occupied western Poland?

The framework for women's decision-making was (and still is) defined by legal, religious and political discourses and regulations, as well as by social practices. During the interwar period and the war, the Catholic Church was a strong social force in Poland.[13] It prohibited abortion. However, the church's influence in certain social groups declined during the interwar period. Researchers cite this as one reason why women increasingly made reproductive decisions.[14] Concurrently, in Poland, as in numerous other countries, a eugenic movement emerged that, from

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in Polen zwischen 1918 und 1945, in: Barelkowski, Matthias/Schutte, Christoph (eds): Neuer Staat, neue Identitäten? Deutsch-polnisch-jüdische Biografien nach der Wiedererrichtung Polens 1918 (Polono-Germanica), Osnabrück 2021, pp. 121–156.

9 Cf. Usborne, Gestocktes Blut oder verfallen?, p. 323. »Mother syringes« are also referred to as »douche syringes«.

10 In January 1941, a ban on contraceptive advertising was imposed. Cf. Czarnowski, Gabriele: Frauen – Staat – Medizin. Aspekte der Körperpolitik im Nationalsozialismus, in: Beiträge zur feministischen Theorie und Praxis 8 (1985), pp. 86–87.

11 Cf. Heinemann, Isabel: From »Children by Choice« to »Families by Choice«? 20th-Century Reproductive Decision-Making between Social Change and Normative Transitions, in: Gembries, Ann-Katrin/Heinemann, Isabel/Theuke, Theresia (eds.): Children by Choice? Changing Values, Reproduction, and Family Planning in the 20th Century (Wertewandel im 20. Jahrhundert), München 2018, pp. 215–236.

12 ibid.

13 Cf. Huener, Jonathan: The Polish Catholic Church under German Occupation. The Reichsgau Wartheland, 1939-1945, Bloomington, Indiana 2021.

14 Cf. Sołga, Przemysław: Społeczny, medyczny i prawny kontekst aborcji w Drugiej Rzeczypospolitej, in: Res Historica 53 (2022), pp. 429–454; Zok, Michael: Körperpolitik, (staatstragender) Katholizismus und (De-) Säkularisierung im 20. Jahrhundert. Auseinandersetzungen um Reproduktionsrechte in Irland und Polen, in: bodypolitics 7

the mid-1920s onwards, politically campaigned for options to plan and regulate births, thus, affording women greater freedom of choice and action.[15] This was due to the high number of women who fell ill and died as a result of abortions performed by non-professionals.[16] Family planning clinics were established in major urban centers to offer counseling and contraceptive options, though not abortions. However, in smaller cities and rural regions, this knowledge was not accessible.[17] In the event of an unplanned pregnancy women from the community frequently provided practical assistance instead.[18]

The invasion of Poland by Nazi Germany on 1 September 1939 and the subsequent occupation resulted in a fundamental shift in the circumstances of women's choice regarding pregnancy. On 26 October 1939, the western Polish territories were incorporated into the German Reich as the Reich districts [Reichsgaue] of Danzig-West Prussia and Wartheland as well as the administrative districts of Zichenau and Katowice (later Upper Silesia).[19] The German occupiers sought to Germanize and to transform the annexed territories into a German living space [Lebensraum]. Therefore, among other things, they sought to reorganize and to govern the population through the application of biopolitics.[20] Pregnancy and

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(2019), pp. 123–158. http://bodypolitics.de/de/wp-content/uploads/2020/04/ch07-zok.pdf (24 June 2024).

15 Cf. Zok: Körperpolitik, (staatstragender) Katholizismus. See also Titkow, Anna: Poland, in: David, Henry P. (ed.): From Abortion to Contraception. A Resource to Public Policies and Reproductive Behavior in Central and Eastern Europe from 1917 to the Present, Westport, Connecticut, London 1999, pp. 165–190.

16 Cf. Maniszewski, K.: Rola położnej i jej praca na wsi. Referat wygłoszony na V Zjeździe Związku Położnych R.P. w Warszawie und Fortsetzung, in: Nowiny Akuszeryjne, 1939, pp. 6–11.

17 Cf. Kuźma-Markowska, Sylwia: »Zbudź się, żydówko!«. Genderowe ujęcie tematu kontroli urodzeń wśród żydów w międzywojennej Polsce, in: Lisek, Joanna (ed.): Nieme dusze? Kobiety w kulturze jidysz, Wrocław 2010, pp. 465–480.

18 Sołga, Społeczny, medyczny i prawny kontekst aborcji w Drugiej Rzeczypospolitej.

19 The eastern part of Poland was occupied by the Soviet Union in accordance with the Hitler-Stalin Pact. The central parts of Poland around the cities of Lublin, Warszawa and Kraków were placed under German administration as the General Government. Cf. Pohl, Dieter: Die Reichsgaue Danzig-Westpreußen und Wartheland. Koloniale Verwaltung oder Modell für die zukünftige Gauverwaltung?, in: John, Jürgen/Möller, Horst/Schaarschmidt, Thomas (eds.): Die NS-Gaue. Regionale Mittelinstanzen im zentralistischen »Führerstaat«, München 2007, pp. 395–405.

20 Haar, Ingo: Biopolitische Differenzenkonstruktionen als bevölkerungspolitisches Ordnungsinstrument in den Ostgauen, in: John, Jürgen/Möller, Horst/Schaarschmidt, Thomas (eds.): Die NS-Gaue. Regionale Mittelinstanzen im zentralistischen »Führerstaat«, München 2007, pp. 105–122.

childbirth, as part of the circle of life and women's individual experience and choice, became the focus of Nazi biopolitics. Michel Foucault characterizes biopolitics as a novel technique of power in »modernity«, designed to regulate populations and discipline individual bodies in accordance with specific norms.[21] During National Socialism biopolitics became inextricably linked with racism.[22]

While the Nazi occupiers sought to increase the birthrate of the German population, they emphasized the necessity of undermining the »biological power« of the Polish population and of completely excluding the Jewish population.[23] In order to encourage German births, physicians and health policymakers proposed that German mothers receive care and advice from German midwives and enforced restrictive abortion regulations. The German legislation, exemplified by § 218 and § 219 of the German Penal Code, which prohibited abortion and the advertising of contraceptives and abortifacients, was directly transferred and as such introduced to the annexed Polish territories.[24] In contrast, Polish women were discouraged from having children. The implementation of a minimum age for marriage was among the measures introduced. Additionally, Polish women were encouraged to undergo abortions.[25] In the territories that were annexed by Nazi Germany, the occupiers introduced a system of racial segregation that influenced all aspects of life, including reproduction. The objective was to control reproduction and achieve Germanization.[26] How

21 Cf. Foucault, Michel: Sexualität und Wahrheit. Der Wille zum Wissen (vol. 1), Frankfurt am Main 1977; Stingelin, Martin: Einleitung: Biopolitik und Rassismus. Was leben soll und was sterben muß, in: Stingelin, Martin (ed.): Biopolitik und Rassismus (Suhrkamp Taschenbuch Wissenschaft), Frankfurt a. M. 2003, pp. 7–26.

22 Cf. Haar: Biopolitische Differenzenkonstruktionen, pp. 105–122.

23 Cf. Lisner, Wiebke: »[A]ls deutsche Hebamme im befreiten Osten«. Geburtshilfe und Reichshebammengesetz als Instrumente des Volkstumskampfes im Warthegau 1939-1945?, in: Pfütsch, Pierre (ed.): Die Rolle der Pflege in der NS-Zeit. Neue Perspektiven, Forschungen und Quellen (Medizin, Gesellschaft und Geschichte), Stuttgart 2024, pp. 309–340.

24 Cf. Majer, Diemut: »Fremdvölkische« im Dritten Reich. Ein Beitrag zur nationalsozialistischen Rechtssetzung und Rechtspraxis in Verwaltung und Justiz unter besonderer Berücksichtigung der eingegliederten Ostgebiete und des Generalgouvernements, Boppard am Rhein 1981.

25 Epstein, Catherine: Model Nazi. Arthur Greiser and the occupation of Western Poland, Oxford 2010; Vossen, Johannes: Gesundheitspolitik als Teil der »Volkstumspolitik«. Der öffentliche Gesundheitsdienst im »Reichsgau Wartheland«, 1939-1945. Final report to the Fritz Thyssen Stiftung, not published, November 2005.

26 Haar, Biopolitische Differenzenkonstruktionen.

did Polish and German women living under occupation respond to the regime's effort to exert control over the beginning of life?

This chapter offers an examination of abortion as a social practice employed by women to regulate births on the one hand, and its restriction as a biopolitical measure in the annexed Polish territories on the other hand. It serves as an example of the government's efforts to regulate the circle of life. Consequently, an analysis of proceedings concerning abortion illuminates the conceptualization of the beginning of life and provides insight into women's social practices related to birth control and reproductive choices. What concepts of life were negotiated and how were they valued in relation to biopolitical goals?

The primary sources for this chapter are the files of the Special Court in Katowice and the Fordon Women's Prison near Bydgoszcz (Bromberg). The files were created as part of the investigations and trials of women suspected of having undergone abortions or of being so-called »abortionists«. These files were maintained by German police officers and court officials. Some of the women subjected to interrogation were only able to communicate in Polish. The statements were subsequently translated by interpreters and recorded in German.[27] It is important to note that some of the accused women provided testimony under duress. The testimonies of the accused women repeatedly include statements such as »I was admonished again to tell the truth«[28] or »In a long preliminary talk, I was familiarized with the subject of my interrogation. I am prepared to provide a full and accurate account of the facts, particularly given that I am aware that I have no alternative.«[29] In their statements, the women frequently attempted to present arguments in their favor, hoping that these would result in a reduced sentence or acquittal. These statements are noteworthy for their indication of the women's understanding of the permissible scope of discourse.

In several court hearings conducted under the auspices of the German occupation authorities, the issue of abortions that had taken place during the interwar period were investigated. Previously performed abortions and

27 Cf. Statement from a clerk who translated the statements of Angela T., who spoke only Polish during the interrogation, 5 April 1940, in: APK, 134/920, folio 148. In another case, the witness was initially unable to give her statement because no one at the police station spoke Polish. The next day, the witness brought her friend with her to translate her statement. Waleria M.'s statement, 9 February 1940, in: APK, 134/911, folio 22–24.

28 Interrogation Angela T., 8 April 1940, in APK, 134/920, folio 144–147.

29 Interrogation Rosa B., 29 March 1940, in: APK, 134/920, folio 54–63, 57.

cases were frequently reopened with the intention of proving that the defendants were »commercial abortionists«, thereby, justifying more severe punishments. Additionally, the German occupation authorities sought to utilize past cases to identify and expose »abortion networks« with the objective of preventing future abortions among German women.

Pregnancies: Perceptions and Choices

In the court interviews the women provided detailed accounts of their physical sensations. When menstruation was absent the women did not always consider pregnancy as a potential explanation. For example, the 20-year-old ethnic German Rosa B. stated in 1940: »It was in September 1939 that I missed my period for the first time. I waited another month because first I thought I had caught a cold.«[30] It was only upon the occurrence of a second missed period that she was certain of her pregnancy and informed her partner. She did not seek confirmation from a medical professional, such as a doctor or midwife. She was certain of her pregnancy, despite her partner's initial skepticism.[31] In contrast, widowed ethnic German Johanna B. assumed she was pregnant in 1944 but desired confirmation. She sought a medical professional to verify her pregnancy. She chose to undergo an abortion, although it was illegal, after the doctor confirmed that she was two or three months pregnant.[32] In 1936, the 32-year-old ethnic German Hildegard S. was convinced that she was pregnant. She asked a Polish midwife to terminate the pregnancy. The midwife conducted an examination but was unable to confirm the pregnancy. Nevertheless, Hildegard S. persisted in her demand for uterine rinsing, as she informed the police in 1940.[33] In her testimony, Hildegard S. referred to the ambiguous situation described by the midwife mentioned at the outset and the uncertainty surrounding the possibility of pregnancy. In its reasoning, the German court in 1940 followed Hildegard S.'s testimony and relied to some extent on the findings of the accused midwife. The court deemed

30 Testimony Rosa B., 29 March 1940, in: APK, 134/920, folio 54–63, folio 58.
31 ibid.
32 Indictment against Luziana K., 24 November 1944, in: APK, 134/774, folio 22–30.
33 Testimony Hildegard S. 28 March 1940, in: APK 134/920, folio 16–23.

the case to be merely an »attempted abortion«, as it was not possible to ascertain whether a pregnancy had in fact occurred.[34]

As the women recounted in their interrogations, abortions were often painful and always carried the risk of infection.[35] They were also aware of the possibility of punishment. In many cases, the women in question claimed during interrogation that they had opted to terminate the pregnancy because of financial constraints or fear of losing their jobs.[36]

Nevertheless, some of the women also asserted that their partners had refused to become fathers and pressured them to consent to an abortion. The 28-year-old unmarried ethnic German Gertrud J. recounted that in 1941 her boyfriend Heinrich P. compelled her to terminate the pregnancy in her fifth month, »because otherwise he wanted to take his own life«. In the face of her fear, she ultimately consented and underwent a termination of the pregnancy by a Polish midwife.[37] In the case of Rosa B., the father of the unborn child also decided to terminate the pregnancy in December 1939. He was married to another woman and did not want his wife to know about the extramarital pregnancy. Rosa B. finally agreed and he accompanied her to a Polish midwife who performed the abortion.[38] Gertrud J. and Rosa B. presented themselves as passive participants in the decision-making process surrounding the abortion. They subordinated themselves to their partner's desires. The depiction of men as active agents and decision-makers aligns with the gender-specific role attributions. It is also possible that the women presented themselves in this way in order to possibly receive a lighter sentence.

An extramarital or pre-marital pregnancy resulted in social ostracism for women. In 1940, 24-year-old ethnic German Martha R., articulated her rationale for undergoing an abortion in 1935 as follows: »The man who impregnated me was my present husband. Because of shame before my parents and economic hardship, we were not yet in a position to get married. So together we decided to terminate the pregnancy.«[39] As Przemysław Słoga elucidates, in interwar Poland abortion was a more socially acceptable practice than pregnancy outside of wedlock.[40] Although

34 Verdict against the midwife Angela T., 13 June 1940, in: APB, Fordon 90/1933.
35 Cf. Testimony Rosa B., 29 March 1940, in: APK, 134/920, folio 54–63.
36 Process file Luziana K., 1944, in: 134/774, folio 24–25, 27.
37 Testimony Gertrud J., 21 October 1943, in: APK, 134/885, folio 181–185.
38 Testimony Rosa B., 29 March 1940, in: APK, 134/920, folio 54–63.
39 Testimony Martha R., 1 April 1940, in APK, 134/920, folio 97–102.
40 Sołga: Społeczny, medyczny i prawny kontekst aborcji, pp. 429–454

National Socialists such as Heinrich Himmler campaigned for improved treatment of »good-blooded« children born out of wedlock and against the stigmatization of their mothers, there was minimal change of opinion during the National Socialist era.[41] This social stigma was also evident in the statements of the 26-year-old ethnic German Agnes P. in February 1940. She stated on the record that she had decided to terminate her pregnancy due to fear of her parents. »My father is very strict, and I hid my pregnancy from him and also from my mother. I was afraid that he would throw me out of the house if he found out that I was pregnant. [...] I asked the midwife to abort my fetus because I was afraid of my father.«[42]

For the accused women, abortion appeared to be the easiest way out of their desperate situation. The women's statements also indicate that they only desired to carry a pregnancy to term if they had the financial, familial, and professional resources to not only give birth, but also to raise a child. Cornelie Usborne characterizes the social practice of abortion as a »variant of female self-help« that enables women to »get oneself and the family through« challenging periods.[43]

In the trial files, the accused women frequently stated that they had not contacted the person who performed the desired abortion themselves. For example, Gertrud J. testified that her partner, Heinrich P., contacted the Polish midwife, Helena I., and took her there. P. stated on the record that he had met the midwife a few weeks earlier during a train ride and had learned from casual small talk conversations with her »that she terminated pregnancies«.[44] In the case of Rosa B., it was also her partner, who contacted a midwife of whom he knew that she performed abortions: »W. knew the abortionist T. well because, as he told me himself, his own wife had also been to her for an abortion«,[45] Rosa B. told the police.

Hildegard S. initially consulted with the Polish fortune teller [Kartenlegerin] Janina P. in 1936 when she experienced two weeks of amenorrhea. She wanted to know »what was wrong with me«.[46] She assumed

41 Cf. Buske, Sybille: Fräulein Mutter und ihr Bastard. Eine Geschichte der Unehelichkeit in Deutschland 1900-1970 (Moderne Zeit: neue Forschungen zur Gesellschafts- und Kulturgeschichte des 19. und 20. Jahrhunderts, vol. 5), Göttingen 2004.

42 Testimony Agnes P., 9 February 1940, in: APK, 134/911, folio 17–21.

43 Usborne: Abtreibungen in der Weimarer Republik.

44 Field verdict against Heinrich P., 6 January 1944, in: APK, 134/885, folio 208–210.

45 Interrogation protocol Rosa B., 29 March 1940, in: APK, 134/920, folio 54–63.

46 Testimony Hildegard S., 28 March 1940, in: APK, 134/920, folio 16–23. In some documents the name is spelled »Janina P.«, in others »Joanna P.«. Cf. ibid.

that she was pregnant and sought reassurance from the fortune teller. During the course of the conversation, she informed Janina P. that she was not inclined to continue the pregnancy for reasons related to her parents' strict disciplinary approach and her boyfriend's lack of interest in marriage. The fortune teller promised to provide assistance and a few days later, accompanied her to the residence of the Polish midwife Angela T. There, Janina P. initially negotiated with the midwife alone, without Hildegard S.'s presence. Subsequently, the midwife conducted an examination of Hildegard S. and performed a uterine rinse with soapy water, which resulted in the onset of menstruation.[47]

The court records indicate that the pregnant women initially consulted a person they were closely acquainted with and whom they trusted. The partners and the fortune teller utilized social networks to establish contact with a midwife who consented to perform the abortion. Moreover, it appears that information regarding pregnancies, miscarriages and abortions was a topic of discussion within the community. Martha R. indicated in 1935 »T. was already well known as an abortionist in Laurahütte (Huta Laura) [village close to Katowice].«[48] Luzie J., an ethnic German from Huta Laura, informed the police that she had conversed with the German midwife, Mrs. U., during the delivery of her sister-in-law in February 1940. The topic of their discussion was the prevalence of abortions within the village. Luzie J. was aware of a case in which a young woman had undergone an abortion for the sum of 40 Reichsmarks. The information had been conveyed to her by a young man. »It was well known in town that T. had been performing abortions for years«, she continued.[49] The provision of practical assistance in the event of an unplanned pregnancy was not a matter of »secret knowledge«, accessible only to a select few. Rather, it was a form of informal exchange within the community, which could be readily accessed when needed.[50] This knowledge served to regulate social conduct and also to provide room for maneuver. The intensification of criminal prosecution by the German occupation authorities initially had little effect on this situation. Nevertheless, informal community exchanges and rumors also served as a catalyst for police investigations.

47 Testimony Hildegard S., 28 March 1940, in: APK, 134/920, folio 16–23.
48 Testimony Martha R., 1 April 1940, in: APK, 134/920, folio 100.
49 Interrogation Luzie J., 29 March 1940, in: APK, 134/920, folio 45–46.
50 Cf. also Usborne, Abtreibungen in der Weimarer Republik.

Abortions: Biopolitical Goals and the Politics of Germanization

As Anna Titkow points out, in interwar Poland abortion can be described as a social practice of self-determined birth control, particularly in rural areas. In general, the Polish courts handed down relatively lenient sentences.[51] Since 1932, abortions performed by physicians were permitted in cases where there was a medical indication. The same applied if the pregnancy was a result of a criminal act or if the pregnant woman was under the age of 15.[52] The 1932 Penal Code, thus, established legal avenues for abortion in Poland.

The German occupying forces intensified the criminal practice and implemented the law of the German Reich analogous in the »incorporated territories« prior to establishing specific regulations.[53] This resulted in the general prohibition of abortions in accordance with § 218 of the German Penal Code. The 1935 amendment to the *Law on the Prevention of Hereditary Diseases* [Gesetz zur Verhütung erbkranken Nachwuchses] permitted abortion on medical and eugenic grounds at the request of an appointed medical commission. In this instance, an abortion could be performed without legal repercussions. The law, in no case, permitted abortions to be carried out on women's requests. Conversely, abortions performed without authorization were now considered not only a »crime against life«, but also a violation of »the Volk« and the »Volksgemeinschaft« [ethnic community] and its »reproductive power«.[54] The German Reich courts made less frequent use of the possibility of imposing a fine following the advent of 1933. Nevertheless, until the beginning of World War II, the maximum penalties of several years imprisonment or even imprisonment in a concentration camp were seldomly imposed in the German. With the onset of the war the practice of sentencing became increasingly severe.[55] In the »annexed« Polish territories, German courts frequently imposed the maximum penalties for those they deemed to be »professional or commer-

51 Cf. Titkow, Poland; Sołga: Społeczny, medyczny i prawny kontekst aborcji, pp. 429–454.

52 Cf. Zok, Körperpolitik, (staatstragender) Katholizismus.

53 Cf. Majer: »Fremdvölkische« im Dritten Reich.

54 Cf. Czarnowski, Gabriele: Women's crimes, state crimes. Abortion in Nazi Germany, in: Arnot, Margaret/Usborne, Cornelie (eds.): Gender and crime in modern Europe (Women's and gender history), London 1999, pp. 238–249.

55 The *Dangerous Habitual Criminals Act* of November 1933 made it possible to increase the penalty for abortion up to and including imprisonment in a concentration camp. Cf. ibid.

cial abortionists« and who were Polish nationals. These penalties included several years in prison. The accused were well aware of the intensified persecution and condemnation of abortion that was common practice under occupation. For instance, Polish midwife Maria W. stated during her interrogation: »I admit that I was involved in abortions in Polish times, but I deny that I continued to do so after the Germans came to power.«[56]

However, the imposition of severe sentences against Poles who performed abortions on Polish women somewhat contradicted the defined biopolitical objective of reducing the birth rate within the Polish population in the »incorporated« territories. In October 1941 the NSDAP-Public Health Department wrote to *Reich Health Leader* Leonardo Conti: »the severe sentences against Polish midwives for abortions on Polish women are incomprehensible and highly dangerous.«[57] Conti endorsed this perspective and, in March 1942 transmitted the same assessment to Heinrich Himmler, *Reich Commissar for the Consolidation of German Nationhood* [Reichskommissar für die Festigung Deutschen Volkstums] and head of the police and SS. Himmler agreed with Conti. Abortions performed on Germans, however, were to be punished with the utmost severity in their opinion.[58]

This perspective was expressed in the 1943 *Ordinance on the Protection of Marriage, Family and Maternity*, which exempted abortions performed on »foreign« women from legal ramifications. Conversely, the penalties for abortions performed on German women were significantly intensified. In addition to the previously applicable penalties of imprisonment and confinement, the death penalty could now be imposed.[59] The decree, thus, established the penal practice in the incorporated Polish territories. As early as December 1941, the introduction of the *Polish Criminal Law Ordinance* [Polenstrafrechtsverordnung] defined death penalty the standard punishment for Poles and Jews for attacks or unruly behavior against

56 Interrogation of the midwife Maria W., 12 February 1940, in: APK, 134/911, folio 29–31.

57 Letter of the NSDAP Hauptamt für Volksgesundheit [Public Health Department], 2 October 1941, in: BArch, R 1501/3806.

58 Correspondence between *Reich Health Leader* Leonardo Conti and Heinrich Himmler on the punishment of abortions on Polish women, March 1942, in: BArch, R1501/3806.

59 Cf. Czarnowski, Women's crimes, state crimes; Czarnowski, Gabriele: Frauen als Mütter der Rasse. Abtreibungsverfolgung und Zwangseingriff im Nationalsozialismus, in: Staupe, Gisela (ed.): Unter anderen Umständen. Zur Geschichte der Abtreibung, Neuaufl., Dortmund 1996, pp. 58–72.

Germans. In the event that the court deemed an abortion to be an attack against Germans, it could impose several years in prison, in penal camp or even the death penalty.[60] Although Conti and Himmler expressed reservations about the harsh penalties for abortions performed on Poles, German prosecutors, nonetheless, investigated every suspected abortion. In light of the proclaimed »ethnic struggle«, the objective was to identify social structures that facilitated abortions. A 1941 ruling by the Łódź district court put this straight: »Since Germans and Poles live together in many cases, it is all too easy for these crimes against life to be committed against the German population. The danger of weakening the German nationality is particularly great.«[61] In the view of the law enforcement authorities, the close cohabitation and the associated lack of racial segregation in everyday life made thorough investigations and harsh sentences for Poles inevitable.

Detecting Abortions: Denunciations and Investigations

The German occupation authorities relied on the assistance of the local population to investigate cases of abortion.[62] Investigations were frequently initiated by a complaint from someone within the woman's social circle. For example, in February 1940, Hedwig K., a 54-year-old Polish woman, filed a complaint against her husband's 39-year-old mistress with the police. Janina P. had been residing with Mr. K., Hedwig's husband in Wirek (Antonienhütte) near Katowice since 1932. She had a reputation as a fortune-teller. Hedwig K. asserted that, three weeks prior to filing her complaint, Franziska R. had informed her that Janina P. derived income not only from fortune-telling but also from providing assistance in abortions. Franziska R. was Mr. R.'s second wife, who had been married to the defendant Janina P. in his first marriage. As Franziska R. asserted, she and

60 Cf. Schlüter, Holger: »…für die Menschlichkeit im Strafmaß bekannt…«. Das Sondergericht Litzmannstadt und sein Vorsitzender Richter (Juristische Zeitgeschichte NRW 14), Recklinghausen 2014; Becker, Maximilian: Mitstreiter im Volkstumskampf. Deutsche Justiz in den eingegliederten Ostgebieten 1939-1945 (Quellen und Darstellungen zur Zeitgeschichte vol. 101), München 2014.

61 Judgment against the midwife Florentina Ch., 25 May 1941, in: APB, Fordon 90/282.

62 As Cornelie Usborne elucidates, abortions are frequently undetected when they are concealed by the social environment. Cf. Usborne, Cornelie: Abtreibungen in der Weimarer Republik. Weibliche Forderungen und Erfahrungen, in: Niethammer, Lutz/Satjukow, Silke (eds.): »Wenn die Chemie stimmt…«. Geschlechterbeziehungen und Geburtenplanung im Zeitalter der Pille, Göttingen 2016, pp. 96–120.

Janina P. were enemies. However, Franziska R. was concerned about her husband's 14-year-old daughter, who resided with Janina P. Mr. R. was unable to comment on the case as he had been drafted into the Polish army at the beginning of the German invasion and was missing since then.[63]

The conflict over the daughter was evidently the catalyst for the complaint.[64] With assistance of the German occupation authorities Hedwig K. and Franziska R. sought to demonstrate the consequences of her actions to Janina P. Obviously, the rumors that she earned her income through the provision of abortions constituted a convenient pretext, despite the reported incident having already occurred seven years earlier.[65] However, the two women's complaint initiated a series of investigations by the German authorities, during which the 39-year-old Polish midwife Angela T. became the primary suspect. Janina P. acknowledged that she had sent women to Angela T. for abortions and had undergone three abortions herself. The authorities constructed a narrative portraying Angela T. as a »commercial abortionist« who had been engaged in the practice of abortion on a regular basis during the interwar period, up until the time of the investigation.[66]

In 1943, 28-year-old Gertrud J., an ethnic German women, reported her boyfriend, Heinrich P., to the police. The couple had been together for five years and Gertrud J. was the mother of a seven-month-old child. »Since I see no other way out and must assume that P. does not want to marry me, I am reporting the following«, she told the police.[67] Gertrud J. informed the police that she had already been pregnant by Heinrich P. in 1941 and that he had urged her to have the pregnancy terminated. Upon becoming pregnant once more, he had pledged to wed her, yet he failed to fulfill his promise and was now also conscripted into military service. Gertrud J. and her mother had previously threatened

63 Interrogation of Franziska R., 27 March 1940, in: APK, 134/920, folio 12–15. It is not uncommon for court clerks to Germanize Polish names, as evidenced by the case of Hedwig (Jadwiga) K.

64 In contrast, the daughter informed the authorities that her mother had terminated the relationship with her father due to his violent conduct towards her. Interrogation of Christine R., 3 April, 1940, in: APK, 134/920, folio 115–120.

65 Vgl. Interrogation of the wife Hedwig K., 21 February 1940 and Interrogation of the wife Franziska R., 27 March 1940, in: APK, 134/920, folio 12–15.

66 Cf. Investigation file P./T., in: APK, 134/920, folio 1–166.

67 Interrogation Gertrud J., 21 October 1943, in: APK, 134/885, folio 8–15.

Heinrich P. that they would report the abortion to the police if he continued to refuse to marry Gertrud J. Heinrich P. was unmoved by this threat. His brother further insulted Gertrud J. and expelled her from the house. Consequently, Gertrud J. felt compelled to act on her threat.[68] Like the wives K. and R., she evidently sought to demonstrate to Heinrich P. the consequences of his actions with the assistance of the German police authorities and hoped to persuade him to marry her. In her formal complaint, however, she incriminated not only her boyfriend, Heinrich, but also herself and most significantly, the Polish midwife, Helena I., whom she identified as the person who had performed the abortion. The German police authorities took her complaint seriously and initiated an extensive investigation. While Heinrich P. was sentenced to three months in prison, suspended on the condition of »front-line probation«, midwife Helena I. was charged as the primary perpetrator and »commercial abortionist«.[69]

In both cases, the complainants demonstrated a greater interest in intimidating the accused than in seeking retribution for the act of abortion. The denouncers sought to utilize the German legal system as a means of exerting pressure on the accused and to advance their concerns and interests.[70] The German prosecutors took the reports seriously and initiated investigations. However, rather than attempting to resolve the conflict between the complainants and the accused, the German prosecutors aimed to identify and convict those they deemed to be »abortionists«. In the two cases cited, Polish midwives became the primary targets of the investigations as a result of the complaints.

Prosecution Practices

The Polish midwife Angela T. was unable to substantiate her innocence. During the interrogation she stated:

I deny that I have ever been involved in the performance of abortions in my lifetime. Should the accusation be made that I have been involved

68 ibid.

69 Cf. Case file Gertrud J., in: APK, 134/885.

70 As Barbara Engelking shows, this was a frequent motive for denunciations to the German occupation authorities. Cf. Engelking, Barbara: »Sehr geehrter Herr Gestapo«. Denunziationen im deutsch besetzten Polen 1940/41, in: Mallmann, Klaus-Michael/Musiał, Bogdan (eds.): Genesis des Genozids. Polen 1939–1941 (Veröffentlichungen der Forschungsstelle Ludwigsburg der Universität Stuttgart), Darmstadt 2004, pp. 206–220.

in abortions, I attribute this solely to the envy of the other midwives of Laurahütte [Huta Laura], who now seek to eliminate me as a midwife. Despite the repeated accusations, I declare once again that I was not involved in abortions during the Polish period.[71]

In her testimony, Angela T. described the accusations of performing abortions as an attempt to discredit her as a Polish midwife and named rivalry as a reason. Nevertheless, her assertions were refuted by the testimonies of three ethnic German midwives and several women who claimed that she had performed abortions on them.[72] In June 1940, the Special Court in Katowice passed a sentence of three years and six months imprisonment to Angela T.

As Angela T. steadfastly maintained her innocence and refused to confess to the crimes with which she was charged, the court's decision was based on the testimonies presented against her.[73] The indictment prioritized the testimony of one of the ethnic German midwives, who claimed that women and men repeatedly came to her, confusing her with Angela T. and demanding an abortion. The prosecution presented this confusion as evidence against Angela T. Additionally, the indictment cited rumors as evidence. A woman in the village had succumbed to blood poisoning. It is alleged that she was unintentionally pregnant and had been in company of Angela T. prior to falling ill. The indictment claimed that Angela T. had performed an abortion on the woman and that she had subsequently died as a result.[74] However, the court considered it a mitigating factor that the majority of the offenses with which Angela T. was charged were committed during the Polish administration preceding the annexation of Upper Silesia to the German Reich.[75] Hence, the testimony of Rosa B. was of particular significance to the court. She stated that Angela T. had performed an abortion on her in December 1939, which was after the annexation of Upper Silesia to the German Reich. In their indictment, the prosecution authorities argued that: »The case of B. also demonstrates [...] that she [the midwife Angela T.] was not inclined to integrate herself

71 Interrogation of the midwife Angela T., 8 April 1940, in: APK, 134/920, folio 141–143.
72 Investigation report, 9 April 1940, in: APK, 134/920, folio 148–150.
73 Verdict of the special court Katowice against the midwife Angela T., 13 June 1940, in: APK, 134/920, folio 189–194.
74 Indictment of the public prosecutor's office Katowice, 16 May 1940, in: APK 134/929, folio 163–168.
75 Verdict of the special court Katowice against the midwife Angela T., 13 June 1940, in: APK, 134/920, folio 189–194.

into the ethnic community [Volksgemeinschaft], despite being aware for some time that the German prosecuting authorities acted with ruthless severity against such offenses.«[76] The court underscored the following: »As the results of the investigation yielded clear evidence that T. not only performed abortions for financial compensation on fellow women, but she also did so on women from the Reich and ethnic Germans.«[77] Following the completion of her sentence, Angela T. was not released but instead transferred to the custody of the Gestapo. In the majority of cases, this resulted in the individual being transferred to a concentration camp.[78] This procedure was based on a decree dated April 21, 1943, which ordered that Poles sentenced to more than six months in prison [Straflager] were to be handed over to the Gestapo.[79] The fate of Angela T. during the Second World War remains unknown.

Midwife Helena I. received a sentence comparable to that of Angela T. In June 1944, she was sentenced to two years and six months in an aggravated penal camp under the *Polish Criminal Law Ordinance*. The reasons for this sentence were as follows: »She [the defendant] is Polish. The act of terminating a German woman's pregnancy has harmed the well-being of the German people, as the offense in question impairs the vital force of the German people.«[80] In March 1941, the Reich Ministry of the Interior introduced the *German People's List* [Deutsche Volksliste] in the annexed Polish territories. The purpose of this list was to differentiate between Poles and Germans and to Germanize parts of the Polish population. However, Jews were excluded from this process.[81] As Birthe Kundrus points out, this led to a flexibilization of the criteria for being German, as it was not always possible to draw clear ethnic lines.[82] This was particu-

76 Investigation report, 9 April 1940, in: APK, 134/920, folio 148–150.
77 ibid.
78 Intake form women's penitentiary Fordon, in: APB, Fordon 90/1933.
79 Vgl. Schlüter, »…für die Menschlichkeit im Strafmaß bekannt…«, p. 141; Becker, Mitstreiter im Volkstumskampf, p. 157.
80 Verdict against the midwife Helena I., 29 June 1944, in: APK, 134/885, folio 109–113.
81 In the Reichsgau Wartheland the German People's List was introduced already in October 1939. Cf. Stiller, Völkische Politik, pp. 1136–1137.
82 Cf. Kundrus, Birthe: »Regime der Differenz. Volkstumspolitische Inklusionen und Exklusionen im Warthegau und Generalgouvernement 1939-1944«, in: Bajohr, Frank/Wildt, Michael (eds.), Volksgemeinschaft. Neue Forschungen zur Gesellschaft des Nationalsozialismus, Frankfurt am Main 2009, pp. 105–123. See also Stiller, Alexa: Völkische Politik. Praktiken der Exklusion und Inklusion in polnischen, französischen und slowenischen Annexionsgebieten 1939-1945, –Bd. 2, Göttingen 2022, pp. 1328–1334.

larly evident in the trial against Helena I.[83] The court found that Helena I was unaware of the nationality of Gertrud J. and Heinrich P. Both had spoken Polish and had not identified themselves as Germans.[84] Consequently, the court declined to impose the death penalty, in contrast to the prosecution's request.[85] In this case, the court interpreted the flexibility of ethnic scales in a way that was favorable to Helena I. The testimony of the midwife, who stated that she had only »dutifully intervened as a midwife with Gertrud J., because J. had only come to her when a miscarriage was already underway«[86] was not deemed credible by the court though.[87]

Midwife Helena I. presented a legal argument regarding the ambiguous boundary between an intervention and a spontaneous miscarriage. It is likely that she anticipated that she would only be convicted if there was clear and convincing evidence. Nevertheless, as the verdicts demonstrate, the German Special Courts were content with evidence presented in the form of witness testimonies or, as evidenced in the case of Angela T., even hearsay. Above all, the potential of performing an abortion on a German woman was sufficient grounds for a conviction. Polish midwives, who had been trained in the medical procedures necessary to perform abortions and whom the Nazi occupiers, because of their Polish identity, suspected in general of working against the Germanization policy, were accused and convicted of »commercial abortion«.[88]

A total of 44 Polish midwives and one Jewish midwives were incarcerated at the Fordon Women's Prison near Bydgoszcz as a consequence

83 In contrast to the Reichgau Wartheland, where Arthur Greiser pursued a restrictive ethnic policy and enrolled only about 12 % of the population in the *German People's List,* Fritz Bracht promoted the Germanization of the district of Upper Silesia through a broad Germanization of the former citizens of the Second Polish Republic. By 1944, 56% of its population had been included in the »ethnic community« via the *German People's List*. Cf. Wolf, Gerhard: Exporting Volksgemeinschaft. The deutsche Volksliste in Annexed Upper Silesia, in: Steber, Martina/Gotto, Bernhard (eds.): Visions of community in Nazi Germany. Social engineering and private lives, Oxford 2014, pp. 129–145; Stiller, Völkische Politik, pp. 1192–1209, 1240.

84 Cf. Verdict against the midwife Helena I., 29 June 1944, in: APK, 134/885, folio 109–113.

85 As an alternative to the death penalty, the public prosecution demanded a sentence of five-to-six-years in hard labor camp. Letter from the senior public prosecutor in Katowice, 15 March 1944, in: APK, 134/885, folio 144.

86 Verdict against midwife Helena I., 29 June 1944, in: APK, 134/885, folio 109–113.

87 ibid.

88 Investigation report in the case of the midwife Angela T., 9 April 1940, in: APK, 134/920, folio 148–150.

of their involvement in abortion. The average sentence was 4.6 years in prison or penal camp.[89] Many midwives convicted as »commercial abortionists« like Antela T., were sent to harsher concentration camp sentences after 1943. The conditions in prison and penal camps were marked by brutality of the guards, forced labor, a lack of food and medical care. For the midwives, many of whom were in their 40s, 50s or even 60s, a prison sentence under these harsh conditions of the German occupation could easily result in a death sentence.[90]

Conclusions

The analysis of the case files from the Katowice Special Court in Upper Silesia and the Fordon Women's Prison near Bydgoszcz (Danzig-West Prussia) demonstrates that women and couples made conscious reproductive choices. In the absence of effective contraceptives, abortion was frequently the only means of limiting births. The biopolitical objective of the German occupiers was to increase the number of births among the German population and to limit the number of births among the Polish. In this regard, abortions were strictly forbidden for German women, whereas, they were desirable and even encouraged for Polish women. The Medical Review Board, which had been established to assess the legal grounds for abortion, granted numerous approvals for Polish women.[91] In 1943, all abortions within the »fremdvölkische« [foreign ethnic] population were excluded from punishment. Conversely, abortions performed without state supervision and within a social network were perceived as a security risk and a threat to the »German national strength«. The authorities were concerned that German women might gain access to these abortion-facilitating networks at any time.

For women, an abortion performed by a midwife was often perceived as a straightforward and uncomplicated method of terminating an unwanted pregnancy. As experts in pregnancy and childbirth, the accused

89 The sentences ranged from 6 weeks in prison to 8 years in a penal camp. All together 56 women were imprisoned in Fordon because of abortion. Cf. Abortion Files, in: APB, Fordon 90.

90 Cf. Schlüter, »…für die Menschlichkeit im Strafmaß bekannt…« and abortion files of the women's prison Fordon, in: APB, Fordon 90.

91 Cf. Reichsärztekammer, 1 April 1944, list of allowed abortions by the Medical Review Board, in: Archiwum Państwowe w Łodzi (APŁ), L-15055.

Polish midwives, who were usually located in the close neighborhood of the women seeking their assistance, facilitated low-threshold access to abortion. In doing so, they supported the »subversive agency« of pregnant women as described by Isabel Heinemann. Those midwives acted in accordance with their »own logic« and in response to a sense of obligation to their social environment.[92] In contrast, the biopolitical objectives of the Nazi health authorities and fear of punishment appear to have had little influence on the actions of midwives. It is possible that they hoped to avoid punishment by claiming that they had not performed an abortion but had merely assisted the women in healing blood flow disorders. The said midwives subsequently presented a series of arguments pertaining to the concept of »not knowing«. These included the assertion that they were operating within a ›flex area‹ between pregnancy and »halted blood«, and that they had only examined the women, detected complications such as bleeding, and sent them to a doctor for curettage.

In contrast, the three ethnic German midwives who testified against Angela T. made it clear that they had opposed abortions even before the war and considered the performance of abortions a »defilement« of their profession. The midwife Klara U. stated: »I consider the dismissal of midwife T. to be an absolutely necessary measure. It is challenging to convey the extent of all the professional midwives' suffering because of her.«[93] Furthermore, midwife Agnes W. said: »I am not making my statements here out of envy or hatred towards the [midwife] T., but because I feel obliged to maintain the integrity of our profession which is of benefit to the Volksgesundheit [people's health]«.[94] The midwives Agnes W. and Klara U. made it clear that, as German midwives, they placed greater value on legal regulations and the boundaries of their competencies than on social networks and low-threshold reproductive choices for women. Above all, they perceived it as a professional political necessity to take action against (Polish) midwives who performed abortions.[95]

The trials point out different conceptions of life and its beginning, as well as different conceptions of competence to decide about it. Nazi

92 Cf. Lüdtke, Alf, »Eigensinn«, in: Jordan, Stefan (ed.), Lexikon Geschichtswissenschaft. Hundert Grundbegriffe 2002, pp. 64–66.

93 Interrogation of the midwife Klara U., in: APK, 134/920, folio 38–39.

94 Interrogation of the midwife Agnes W., in: APK, 134/920, folio 34–37.

95 The Polish Midwives' Associations of the Second Polish Republic also opposed abortions and their colleagues who conducted them. Cf. Kassner/Lisner: Zwischen staatlichen Vorgaben.

authorities, however, were less concerned with determining the beginning of life than with regulating reproduction for racist biopolitical purposes: the guiding principles for decisions regarding reproduction were not individual needs, values or standards, but rather those of »ethnic community«. The historical example, thus, illustrates the disparate and conflicting interests and claims to access and govern pregnancy and the unborn as liminal perceptions of life and death. This prompts the question of who, under what conditions and with what intentions, determines reproductive choices.

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Marina Bantiou

Ceausescu's abortion restriction and its implications for orphanages in communist Romania (1966-1989): A historical review

Introduction

During the communist period in Romania, the state exerted significant influence on family life, implementing a series of measures aimed at reshaping family dynamics. This influence evolved over distinct sub-periods and was enforced through coercive measures such as strict restrictions on abortion and access to contraception.[1] The state's regulation of family life involved both strengthening existing laws and introducing new legal principles aimed at transforming the institution of the family to align with the socialist vision.[2] This vision involved promoting gender equality, with a strong emphasis on integrating women into the workforce, while the state actively participated in child rearing and education through state-run facilities.[3] Following the example of the Soviet Union and other state-socialist countries, Romania legalized abortion on demand in 1957 and became one of the most liberal countries in Europe.[4] However, in October 1966, a year after Ceausescu assumed power, the Communist Party enacted stringent legislation banning abortion in all but a few exceptional cases in the name of national sanctity with Ceausescu declaring childbirth a patriotic duty.[5] He also declared that the practice of terminating a pregnancy violated »the laws of nature, the laws of the State and the laws of social development.«[6]. The *Scotsman* newspaper on 21 July 21 1966 reported

1 Dumănescu, Luminița: Family upbringing in communist Romania, in: Wychowanie w Rodzinie IX (2014), No. 1, pp. 49-61, DOI: 10.23734/wwr20141.049.061. (01.02.2024).
2 ibid.
3 ibid.
4 For further reading on the liberalization of abortion in Romania (1957-1966) refer to: Kligman, Gail: The Politics of Duplicity: Controlling Reproduction in Ceausescu's Romania, University of California Press, Berkeley and Los Angeles California 1998, pp. 47-49.
5 Anton, Lorena: On Memory Work in Post-communist Europe. A Case Study on Romania's Ways of Remembering its Pronatalist Past, in: Anthropological Journal of European Cultures 18 (2009), No. 2, pp. 106–122, pp. 5-6.
6 Balmforth, Richard: Police monitor pregnant women in abortion drive, in: The Canberra Times, 30.06.1985, p. 10, www.nla.gov.au/nla.news-article122519735 (21.02.2024).

that Ceausescu announced in a recent speech that he planned to impose stricter regulations on liberal abortion laws in Romania in response to concerns about declining birth rates.[7] This resulted in a temporary rise in birth rates followed by a decline as women sought alternative methods of contraception. This pronatalist policy, driven by nationalist, economic and moral factors promoting a vision of a strong nation and an abundant workforce, lasted for 23 years until the fall of the regime in 1989, when restrictive abortion laws were reversed.[8] This study investigates the impact of Nicolae Ceausescu's restrictive reproductive rights regulations and abortion policies on the proliferation of orphanages in the Socialist Republic of Romania from 1966 to 1989.

Methodology

The methodology includes several key elements aimed at providing a nuanced understanding of sociopolitical dynamics underlying the proliferation of orphanages during this period. Initially in addition to the academic literature on the subject documenting the rapid growth of orphanages during the Ceausescu regime and the harsh conditions, primary and secondary sources are considered. Based on content analysis and critical discourse analysis, historical evidence is examined. Specifically legislative documents and government decrees, which are crucial for understanding the official policies and legal framework imposed by the Ceausescu regime. Also documents from the National Council for the Study of the Securitate Archives (CNSAS), which offer information on the enforcement of policies and surveillance methods used by the state documenting the extent of state control over family planning and reproductive health. In addition, relevant official reports and announcements related to pronatalist policies are taken into account in order to aid our understanding of the regime's public discourse and to interpret the implementation and enforcement of Ceausescu's policies on the issue under investigation and their impact in the welfare system. Selected newspaper articles from the Romanian communist era reflect the official narrative disseminated by the regime, offering insight into state propaganda. These articles reflect

7 The Scotsman, 21.07.1966, p. 9, www.britishnewspaperarchive.co.uk/viewer/bl/0000540/19660721/211/0009 (24.02.2024).

8 ibid.

the government's efforts to control information and shape public opinion. However, due to media censorship in the country, these sources present a biased view of events. To balance this, Western newspapers are also used, as they were not subject to the same level of state control and can provide a critical perspective by examining outside views for a balanced overall analysis. By combining and comparing reports from Romanian and Western newspapers, the analysis aims to achieve a more complete and nuanced understanding of the impact of Ceausescu's policies. Testimonies of individuals are also taken into account, providing valuable qualitative data about about lived experiences under the Ceausescu regime, offering insights into the human impact of policies, which are not always visible in official documents. All the aforementioned data will be analyzed using qualitative methods to draw out patterns and themes related to Ceausescu's policies and their impact on orphanages in communist Romania.

The Impact of Ceausescu's Pronatalist Policies on Reproductive Rights

According to Decree No. 770 of 1 October 1966, issued by the State Council of the Socialist Republic of Romania and published in Official Bulletin No. 60 on the same day, termination of a pregnancy was prohibited, except in special circumstances such as a threat to a woman's life, serious hereditary diseases, serious physical or mental disabilities of a pregnant woman. Furthermore, those regulations contained advanced age of the mother, care of (at least) four children or pregnancy due to rape or incest. Procedures were to be performed by obstetrician-gynecologists in specialized health facilities and authorization granted by a medical committee established by regional or municipal councils.[9] Minor adjustments to the Decree 770/1966 were introduced in 1972 and 1985. The legal criteria for obtaining an abortion remained consistent between 1966 and 1972, except for a reduction in the eligible age from 45 to 40 for women seeking the procedure.[10] Alterations were made to the legislation in 1985. Among others article 2/1985 permitted women to undergo an abortion, if they were

9 Consiliul de Stat al Republicii Socialiste România. (1966, October 1). DECRET Nr. 770 din 1 octombrie 1966 pentru reglementarea întreruperii cursului sarcinii [Decree No. 770 of October 1, 1966 for the regulation of interrupting pregnancy]. BULETINUL OFICIAL NR. 60 din 1 octombrie 1966, www.legislatie.just.ro/Public/DetaliiDocumentAfis/177 (02.02.2024).

10 Kligman: The Politics of Duplicity, p. 61.

already responsible for the care of at least five children or if they were over the age of 45.[11] The decree was enacted as a response to the »demographic crisis«. It is worth noting that this term, as used by the Ceausescu government, referred to a decline in the birth rate in Romania in the early 1960s, which was seen as a threat to the country's economic and social future. However, it has been argued that this decline was part of a wider trend towards modernization and the adoption of the nuclear family model, which is typically characterized by fewer children. According to scholar Adina Maria Pop, the decline in household size and the shift from extended families to nuclear families was influenced by several factors, including lower fertility rates and urban living conditions.[12] While urban areas saw a decline in multigenerational households, rural areas continued to maintain extended family structures with higher fertility rates.[13] The changes, as she points out, were part of a wider social evolution and not a crisis. According to Dumănescu, changes in family structure in communist Romania, driven by legislation, industrialization, urbanization, and mass education, were not indicative of a demographic crisis but rather the result of complex social transformations.[14] These included shifts towards gender equality, the displacement of rural families by urbanization, and the acceleration of women's emancipation through education.[15]

Nicolae Ceausescu's government pursued industrialization in Romania by expanding the workforce. This led to agricultural decline and exacerbated food shortages, while this pronatalist policy, combined with the taxation of the childless, led to insufficient economic incentives for childbirth, worsening economic hardship and creating a demographic imbalance that burdened social support systems, leading in high maternal mortality rates and increased institutionalization of children.[16] In addition, a formidable security force with a wide network of informants was

11 Ileanu, Bogdan-Vasile: Time Lag Evidence of Anti-Abortion Decree and Perturbation of Births' Distribution. A Benford Law Approach, preprint arXiv:2106.15520 [physics.soc-ph] (2021), p. 5, DOI: 10.48550/arXiv.2106.15520. (24.02.2024).

12 Pop, Adina Maria: The Romanian government and demographic policies. Ceauşescu's regime and contemporary perspectives, Università degli studi Roma Tre 2020, pp. 89-90, http://hdl.handle.net/2307/40772 (30.05.2024).

13 ibid.

14 Dumănescu: Family upbringing in communist Romania, p. 58.

15 ibid.

16 Morrison, Lynn: Ceausescu's Legacy: Family Struggles and Institutionalization of Children in Romania, in: Journal of Family History 29 (April 2004), No. 2, pp. 168-182, DOI: 10.1177/0363199004264899. (02.02.2024), p. 170-171.

established, the Securitate. A physician stated that there were numerous instances of maternal deaths and a significant number of abandoned children due to the abortion policy, mentioning also that in Iasi medical instruments potentially utilized for abortions were securely stored and could only be accessed under the supervision of a state security police officer.[17] In Romania, institutionalized care arose from social deficiencies in social services, leaving families vulnerable, exacerbated by the lack of foster care facilities and the systematic placement of children by the Ministry of Education based on developmental criteria, leading to neglect and misdiagnosis.[18] Ceausescu's prenatal policies further contributed to the increase in children with developmental disabilities due to economic hardship and malnutrition during pregnancy.[19] In addition to restricting access to legal abortions, Ceausescu's government, which declared the fetus socialist property, instituted monthly gynecological examinations for working women, imposed taxes on celibates and childless marriages, and with the active policed by Securitate, punished those involved in illegal abortions resulting in increased maternal deaths and injuries from unsafe procedures.[20] According to the article on Financial Times, if the woman was not pregnant after a year of marriage, the couple, under the supervision of the Securitate, was examined by gynecologists to determine whether they were fertile and if the couple was over 25 years old and still childless, an additional tax of 250 lei was deducted from each of their monthly wages, on suspicion that the couple had access to illegal contraceptives.[21] However regarding infertility specifically, there was not a direct citation or provision within the decree that outlined consequences for infertility itself. According to the 8 March 1984 Decree, doctors were mandated to conduct quarterly visits to factories, examining all women aged 20 to 30.[22] Any gynecological issues potentially linked to miscar-

17 Binder, David: Upheaval in the East; Where Fear and Death Went Forth and Multiplied, in: The New York Times, 24.01.1990, p. 12, www.nytimes.com/1990/01/24/world/upheaval-in-the-east-where-fear-and-death-went-forth-and-multiplied.html?searchResultPosition=9 (24.02.2024).

18 Morrison: Ceausescu's Legacy, p. 171.

19 ibid.

20 Hord, Charlotte et al.: Reproductive Health in Romania: Reversing the Ceausescu Legacy, in: Studies in Family Planning 22 (Jul.-Aug. 1991), No. 4, pp. 231-240, DOI:10.2307/1966479. (02.02.2024), pp. 232-233.

21 The Financial Times: Bedrooms no barrier to the tyrants, in: The Canberra Times, 03.02.1990, p. 20, www.nla.gov.au/nla.news-article131176192 (21.02.2024).

22 ibid.

riages (suspected by the Securitate to be induced) had to be reported to the police. Pregnant women had their pregnancies monitored monthly, with the Securitate opening a file on them upon confirmation of the pregnancy. Anca Alexandru, gynecologist at a central hospital in Bucharest, describes the unbearable conditions in the factories, where women resisted this treatment, lined up for examinations every three months.[23] Despite initial disbelief, Alexandru and her colleagues reassured them, that they were not »pregnancy hunters« and that they were only looking for any infections. They discreetly dealt with those who miscarried or had abortions, avoiding reporting to the Securitate and tried to treat them secretly in hospital.[24] An article in 1985 highlights these controversial measures in Romania, where female employees face regular gynecological checks, sometimes with police present, at their workplaces and once pregnancy is confirmed, it is closely monitored by state agencies until birth, regardless of a woman's desires, prompting comparisons with Western societies' privacy and reproductive rights standards.[25]

A document from the Ministry of Internal Affairs dated 21 March 21 1984 signed by the by the then Minister of the Internal Affairs George Homoştean reveals an important aspect of the authoritarian control exercised by the regime under Ceausescu, particularly over reproductive health care and surveillance mechanisms. It is the issuance of a secret order »regarding the implementation of the demographic policy and ensuring a corresponding population increase«, which highlights the interventionist tactics of the regime, through the police, in monitoring and controlling medical professionals, especially doctors working in maternity hospitals, general hospitals and clinics.[26] By assigning police officers to supervise health professionals, the regime sought to ensure compliance with its strict policies on childbirth and abortion, which were characterized by prohibitive measures such as termination of pregnancy and the

23 ibid.
24 ibid.
25 Balmforth, Richard: Police monitor pregnant women in abortion drive, p. 10.
26 Consiliul National pentru Studierea Arhivelor Securitatii, Republica Socialistă România, Ministerul de Interne, Program de măsuri cuprinzând sarcini ce revin unităţilor de miliţie pentru îndeplinirea Hotărârii Comitetului Politic Executiv al C.C. al P.C.R. din 02.03.1984 privind înfăptuirea politicii demografice şi asigurarea unui spor corespunzător al populaţiei (Direcţia secretariat-juridică nr. S/95380 din 21.03.19), Dosar Nr. XIII-II-I | 1984, no. vol. 4, 21.03.1984, f. 27-30, www.cnsas.ro/documente/acte_normative/D%203642_004%20fila%20027-030.pdf

enforcement of prenatal policies aimed at increasing birth rates. Another secret document of the Ministry of Internal Affairs, which was approved by George Homoştean, dated 12 February 1979, mentions the plan to improve the work of the militias for the consistent implementation of the legislative provisions regulating the interruption of the course of pregnancy, as stated in the document, and the intensification of the activity of prevention and suppression of this »crime«[27]. Commencing with a directive to improve the functioning of the militia in enforcing abortion laws, the document underscores the regime's stringent control over reproductive rights and its determination to curb unauthorized terminations of pregnancy. The language used, particularly the categorization of abortion as a »crime«, reflects the regime's moralistic and authoritarian stance on reproductive matters. This archival document provides valuable insight into the surveillance and enforcement tactics employed by the Romanian Ministry of Internal Affairs under the communist regime of Ceausescu. Specifically, it is written that the leaders of the county militias (municipality of Bucharest) will analyze the activity of the center for the prevention of illegal abortions. Particular attention was to be paid to the recruitment of informants in maternity hospitals and general hospitals, clinics and other places where illegal terminations of pregnancies are carried out.[28] In addition, it was written that they would take measures to improve the information taken of persons employed in the medical field and health professionals, but also faculty and students of the medical school.[29] This strategy highlighted the pervasive atmosphere of suspicion and fear cultivated by the regime, wherein individuals were coerced into reporting on their colleagues and peers. Finally, it was reported that officers and non-commissioned officers will be trained to gather information to »defeat the crimes of illegal abortion« and identify Romanian citizens or foreigners importing illicit substances or drugs against conception or

27 Consiliul National pentru Studierea Arhivelor Securitatii, Republica Socialistă România, Ministerul de Interne, Plan de măsuri privind îmbunătăţirea muncii organelor de miliţie pentru aplicarea cu fermitate a dispoziţiunilor legale care reglementează întreruperea cursului sarcinii şi intensificarea activităţii de prevenire şi reprimare a infracţionalismului pe această linie, Arhiva Fond Informativ, Dosar Nr. 10428, vol. no. 11, 12.02.1979, f. 33-37, www.cnsas.ro/documente/acte_normative/D%20000125_011%20fila%20033-037.pdf

28 ibid.

29 ibid.

abortion.[30] Overall, this archival document sheds light on the mechanisms of surveillance and coercion employed by the Ceausescu regime in its quest to enforce strict reproductive policies. It serves as a testament to the authoritarian nature of the regime and its disregard for individual autonomy and rights in pursuit of its ideological objectives. As it can be understood, the implications of this policy, both on a social and an individual level, were numerous. Furthermore, the veiled nature of the aforementioned orders suggests a deliberate attempt to hide the extent of government intervention in reproductive health care practices from the public. The secrecy surrounding the directive reflects the regime's authoritarian tendencies and its reliance on secret measures to maintain control and suppress dissent. Despite government restrictions, the birth rate increased marginally, while maternal mortality and disease increased significantly, and unsafe self-induced methods of abortion remained widespread, leading to infertility, psychological traumas, or even death.[31] An article in the *Financial Times*, republished by the *Canberra Times* on 3 February 1990, sheds light on the measures imposed by Ceausescu. In the article, there is the testimony of above mentioned gynecologist Anca Alexandru, who claims that: »If the infection got worse after one of these abortions, the possibility of infertility increased. Many families broke up under the pressure. The women became helpless«.[32] Many women were also afraid to go to the hospital because they knew it was full of informers. The gynecologist states that: »Under Them [a common euphemism for the Ceausescu's regime] the Securitate were turned overnight into doctors«. The state secret policy could suddenly be transformed into pseudo-medical authorities monitoring medical procedures. The gynecologist testifies that: »They would hang around the operating theatre. If we carried out a dilation and cauterization, they wanted to see if the uterus had been infected. If it was, they concluded that the woman had had a failed, illegal abortion«. This situation forced medical professionals to withdraw to their families, as trust became scarce and the pervasive atmosphere of suspicion made everyone distrustful. He adds: »all of us had to retreat to our family. We could not trust anybody, not even friends or relatives. We were all

30 ibid.

31 Hord, Charlotte et al.: Reproductive Health in Romania, pp. 232-233.

32 The Financial Times: Bedrooms no barrier to the tyrants, in: The Canberra Times, 03.02.1990, p. 20, www.nla.gov.au/nla.news-article131176192 (21.02.2024).

suspicious, and the suspicion made everyone else suspicious.«[33] Ion, a 30-year-old engineer from Bucharest, recounted having had six girlfriends since he was 18. Five of them underwent abortions in the homes of their mothers' friends, except for one instance where they sought medical help for the abortion at a hospital, paying a doctor 10,000 lei, equivalent to at least two months' salary; following this, he admits he stopped having relationships due to the fear and irresponsibility associated with such experiences.[34]

A hard case is the story of a 35-year-old woman in January 1987 in a hospital in Zalău, which was found and brought to light by historian Florin Soare based on the CNSAS archive.[35] The woman, it is stated in the Securitate records, reported that she was diagnosed with an impending miscarriage and that the medical staff were not allowed to provide her with medical care, in order to obtain the information and make her confessed the means by which she induced the abortion, as she was suspected of an illegal abortion. This procedure resulted in her enduring five days of suffering without treatment until her demise.[36] According to Florin Soare, the unfortunate reality of this case is that there were no indications of an induced abortion, based on the conclusion of the forensic report.[37] Ion Tudor, a 46-year-old museum worker, recounted a tragic incident in February 1975 when he returned home to find his 26-year-old wife, Florica, in critical condition after undergoing an abortion by a medical technician. He describes in *New York Times* as follows: »I called an ambulance. It took 12 hours for the ambulance to arrive. We went to the Giulesti Maternity Hospital. They called the police, who said she could not receive treatment until she confessed who had performed the abortion. She received no care for two days. Then she had a kidney collapse. The doctors sneaked her over to the Emergency Hospital, where the doctors treated her. The doctor there told me if she was strong, she had a chance to live. She died 18 days later.«[38]

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33 ibid.

34 ibid.

35 Coman, Octavian: Guardians of the Decree: The Hidden World of the Anti-Abortion Enforcers, in: The Decree Chronicles, 03.12.2021, www.decreechronicles.com/guardians-of-the-decree-the-hidden-world-of-the-anti-abortion-enforcers/ (25.02.2024).

36 ibid.

37 ibid.

38 Binder, David: Upheaval in the East; Where Fear and Death Went Forth and Multiplied, in: The New York Times, 24.01.1990, p. 12, www.nytimes.com/1990/01/24/world

It has also been argued that Decree 770, initially aimed at population growth, eventually became a tool of »ethnic cleansing«, as Roma women were often still allowed to have abortions, which were granted in hospitals.[39] However, Corina Dobos, researcher and associate lecturer at the University of Bucharest, argues that the policy of Decree 770 had a limited impact on the Roma, while acknowledging the lack of documentation about the group during the communist era.[40] This discussion underscores the necessity for further examination and in-depth research into the multifaceted implications of Decree 770, particularly regarding its potential impact on ethnic minorities such as the Roma.

In addition, it is noteworthy that Romanian newspapers during that era regularly featured short articles detailing the tragic outcomes of women who succumbed to fatal complications arising from clandestine dangerous abortions performed outside the bounds of legality. For example, the newspaper *Flamura Prahovei* published in 1985 the indicative story of Elena J., who died at the age of 25, after suffering severe toxicosis due to the induced abortion.[41] The article stated that »this is sometimes the price of ignorance«. The inclusion of specific details, such as the amounts paid for the procedure by young women and the identity of those involved in the induced abortion, underlined the seriousness of the situation in the context of propaganda. Specifically, it was written that Elena J. paid 700 lei for the procedure. Even the full name of the woman who empirically operated the girl as well as her assistant were published. This could already been observed in other cases, noting that according to article 185 of the criminal code the penalty for the offense of performing an abortion could reach up to 12 years imprisonment, while for complicity in the action 5 to 10 years of imprisonment were foreseen. One of the regime's tactics

/upheaval-in-the-east-where-fear-and-death-went-forth-and-multiplied.html?searchResultPosition=9 (24.02.2024).

39 Adam, Elena & Mitroiu, Simona: Remembering the past. Representations of women's trauma in post-1989 Romanian cinema, in: Cogent Arts & Humanities 3 (2016), No. 1, p. 7; DOI: 10.1080/23311983.2016.1182718.

40 Cerezuela, Castillo Queralt: »We no longer want to be second-class citizens. We do not beg for rights, but demand them«. The Roma struggle in Romania, in: Nationalia, 19.12.2019, www.nationalia.info/new/11277/the-roma-in-romania-from-ceauescus-communism-to-the-current-struggle-for-rights-and-recogn (28.02.2024).

41 Oncioiu, Diana & Meseşan, Diana: The Party State Tasked Women with Having Children. The Repercussions Are Still Felt, in: The Decree Chronicles, 14.11.2021. Flamura Prahovei, 1985. www.decreechronicles.com/the-party-state-tasked-women-with-having-children-the-repercussions-are-still-felt/ (25.02.2024).

to enforce strict anti-abortion policies and punishing those who violated them was to expose people who performed illegal abortions to the media. A typical example was the public exposure of a doctor and the women who performed illegal abortions in the newspaper *Flamura Prahovei* in June 1986, where it was written that the 84-year-old retired doctor—name given—terminated the pregnancies of four women—names given—from whom he received 1500 lei each.[42] It was added that during the search at the residence of the doctor, precious metals and foreign currencies were found, and he was taken to court.[43] However, the article does not provide any further information of this case. First, the public exposure of doctors and women who performed abortions aligns with the regime's propaganda efforts to vilify and exterminate individuals deemed to transgress state-imposed moral and ideological boundaries. By highlighting these individuals in the media, the regime aimed to publicly stigmatize them, thereby deterring others from engaging in similar practices and enhancing compliance with anti-abortion laws. Additionally, the use of media exposure as a punitive measure highlights the regime's use of mass media as tools of social control and manipulation. Through the selective dissemination of information, the regime sought to shape public perceptions and foster a climate of fear and compliance. These examples demonstrate the concerted secret efforts of the Ministry of Internal Affairs to strengthen propaganda by using the militia to stage public trials and forcing law enforcement agencies to supply communist news media with propaganda material in an effort to create a climate of fear and of condemnation around illegal abortions.[44] The involvement of law enforcement agencies in disseminating information to the media underscores the regime's authoritarian control over the flow of information and its manipulation of public opinion to align with its ideological agenda.

42 Stoicescu, Vlad & Oncioiu, Diana: »I Secretly Performed Over 100 Abortions on Kitchen Tables«, in: The Decree Chronicles, 18.11.2021. Flamura Prahovei, June 1986. www.decreechronicles.com/i-secretly-performed-over-100-abortions-on-kitchen-tables/ (25.02.2024).

43 ibid.

44 Coman, Octavian: Guardians of the Decree. (24.02.2024).

Consequences of the Decree: Children in Orphanages and State Institutions

After the overthrow of Ceausescu on 22 December 1989, the world was confronted with the harrowing images of Romania's more than 100,000 orphaned children, especially infants with disabilities and HIV/AIDS, who mostly resided in dismal, understaffed orphanages, which the regime had established to manage the effects of its coercive pronatalist policies.[45] In 1985, Romania reported its first case of HIV/AIDS, but due to limited communication with the West and underdeveloped healthcare services, the true extent of the epidemic remained hidden, as local and central authorities tended to withhold information that could have a negative impact on the regime.[46] Dr. Patrascu, a virologist, was convinced that HIV was present in Romania, despite official policy statements at the time that the disease did not exist in the country, persuading a group of doctors to test some patients for HIV.[47] The results were overwhelming showing that 10% of children in hospitals were HIV positive and over half of children in orphanages were infected.[48] According to *Washington Post*, Dr. Patrascu was the first doctor to sound the alarm about the AIDS situation in Romania, declaring in July of 1990: »In theory we have done things, but in practice, not really. We still don't know the extent of the problem.«[49] In the same year, an HIV/AIDS surveillance system was established with the support of the World Health Organization, revealing thousands of infected children in state institutions and orphanages. Accurate reporting showed that more than half of the HIV-infected children in Europe were in Romania, marking the beginning of a more transparent approach to tackling the epidemic.[50] In Romania, though the numbers of infected were relatively low compared to Western countries, it was unusual that the majority of those infected were children, with 428 out of 478 recorded

45 Romania's Orphans: A Legacy of Repression, in: News from Helsinki Watch 2 (December 1990), issue 15, p. 1.

46 HIV Outcomes: Case study. Romania. Ceausescu's Children. https://hivoutcomes.eu/case_study/romania-ceausescus-children/ (08.06.2024).

47 ibid.

48 ibid.

49 Battiata, Mary: Romania lacks means to fight growing outbreak of AIDS in children, in The Washington Post, 10.07.1990, https://www.washingtonpost.com/archive/politics/1990/07/10/romania-lacks-means-to-fight-growing-outbreak-of-aids-in-children/f611419f-ede7-467b-af30-fe56b458d95a/, (08.06.2024).

50 HIV Outcomes: Case study. Romania. Ceausescu's Children. https://hivoutcomes.eu/case_study/romania-ceausescus-children/ (08.06.2024).

cases being children under four years old. This situation was attributed by Patrascu to bureaucratic inertia within the Ministry of Health: »They're playing with AIDS like they're playing with the flu. [..] This is typical communist behavior«.[51] Many infants in Romania were suspected of contracting HIV through blood transfusions to treat premature and malnourished babies—a common medical practice until the government's ban.[52]

During a period characterized by a shortage of food resources in communist Romania, the enactment of the new legislation restricting termination of pregnancy coincided, exacerbating the prevailing issue of infant malnutrition, where a significant proportion of newborns were underweighted. Also, during the 1980s, Romania's standard of living sharply declined, rendering it among Europe's poorest nations, as Ceausescu's prioritization of repaying foreign debt[53] led to the exportation of the majority of agricultural products, culminating in economic collapse by 1989, consequently exacerbating child malnutrition and prompting desperate parents to abandon their children in state institutions ostensibly tasked with addressing such issues.[54] An interesting article was published on 21 June 1984 in the Australian newspaper *Canberra Times* by journalist Gwynne Dyer in London, which dealt with the authoritarian rule of Nicolae Ceausescu in Romania and the miserable economic conditions facing the Romanian people.[55] The economic mismanagement of the Ceausescu regime led to delinquency and serious hardship for the population. The article criticized Ceausescu's justification for rationing, citing his claim that disease in Romania was caused by gluttony and recommending a restrictive diet for the people.[56] It highlights the stark contrast between the sacrifices suffered by ordinary Romanians and the privileges enjoyed by Ceausescu and his family members in positions of power.[57] Despite the hardships which the Romanian people were facing, there was skepticism as to whether these sacrifices would actually solve the country's problems,

51 Battiata, Mary: Romania lacks means to fight growing outbreak of AIDS in children.
52 ibid.
53 The attempt to industrialize the country through the utilization of foreign credits led to a growing external debt, which was paid off during the 1980s after the implementation of strict austerity measures.
54 Romania's Orphans: A Legacy of Repression, p. 4.
55 Dyer, Gwynne: No guarantee sacrifices will solve problems. Romania ›a family business‹, in: The Canberra Times, 21.06.1984, p. 6, www.nla.gov.au/nla.news-article127004236 (24.02.2024).
56 ibid.
57 ibid.

given the regime's flawed plans and projections.[58] Moreover, according to the same article, the portrayal of Romania as a »family business« dominated by Ceausescu and his relatives further highlighted the nepotism and corruption within the regime.

The phenomenon of Romanian mothers sending letters directly to Nicolae Ceausescu, expressing through their adherence to their »patriotic duties«, their imperative need for material and financial support to raise their children, highlights the complex socio-political dynamics of the Ceausescu regime in Romania during the second half of the twentieth century. Through the act of writing directly to Ceausescu, framing their needs in the rhetoric of patriotic duty, as he argued, these mothers sought to leverage their »loyalty to the state« as a means to rally support for their family needs. In addition to direct appeals for support via written correspondence, another notable move by mothers seeking support amid the socioeconomic challenges prevailing in communist Romania was the symbolic gesture of naming newborns after Ceausescu, inviting him to participate in the christening ceremonies of these children. By giving names directly associated with Ceausescu to their children, mothers engaged in a deliberate act of symbolic relationship, aligning their family identity with the ideological constructs propagated by the regime. The choice of names such as »Nicolae« or »Nicoleta« can be said to reinforce the narrative of his paternalistic role as leader and protector of the nation. The very need for mothers to resort to such practices highlights systemic deficiencies, particularly in social welfare and family support. An indicative example is the letter by a Romanian mother sent to Ceausescu in December 1968, extending an invitation for him to attend the baptism ceremony of her tenth child, within the correspondence, she expressed her intention to christen the child with the name Nicolae or Nicoleta.[59]

The infant mortality remained high, with many children abandoned due to economic hardship, resulting in overcrowded and under-equipped orphanages and increased rates of psychological and neuropsychological disorders among these children.[60] However, the high infant mortality

58 ibid.

59 Fiscutean, Andrada: Romania's communist-era abortion ban harmed hundreds of thousands of children. Is history repeating itself?, in: Grid News, 08.08.2022. Document by Dobos Corina / The National Archives of Romania, www.grid.news/story/global/2022/08/08/romanias-communist-era-abortion-ban-harmed-hundreds-of-thousands-of-children-is-history-repeating-itself (02.09.2022).

60 Hord, Charlotte et al.: Reproductive Health in Romania, pp. 232-233.

rates in Romania during this period cannot be attributed solely to the decree and its consequences. While restrictive abortion policies may have contributed to some extent, other factors such as economic hardship, inadequate health care infrastructure, and social conditions also played an important role. An article in *New York Times* by Kathleen Hunt, reporting from Romania for National Public Radio on 24 June 1990, documents the devastating impact of Ceausescu's policies on Romania's children, focusing in particular on the consequences of the strict ban on abortion and the subsequent abandonment of tens of thousands of infants due to economic hardship.[61] Even after the fall of Ceausescu, the situation of these children remained, with many living in squalid conditions in state institutions. According to the aforementioned article: »Approximately 100,000 children and adolescents up to 18 years of age remain in the care of the state, many confined to institutions indescribable in their filth, degradation and misery—understaffed and ill-equipped nurseries, preschool orphanages and homes for the handicapped and ›irrecoverables‹«.[62] Systemic damage was compounded by bureaucratic negligence, as government agencies deflect accountability for children's suffering. The article depicts the harsh and squalid conditions in Romanian institutions, highlighting practices such as tethered to the crib for agitated children and head shaving. This practice was often employed for reasons, such as maintaining cleanliness and preventing the spread of lice. In addition, the reporter highlights the tragic toll of the AIDS epidemic among Romanian children, with many infected due to uncontrolled blood transfusions and unsterilized needles, claiming that based on studies about 10 percent of the 8,000 orphans under the age of three examined, were infected with HIV.[63] Despite some improvements in health care facilities, Romania's recovery from these crises remained slow and challenging, as discussed in the article, which concludes with a reflection on the country's ongoing struggles and the urgent need for humanitarian assistance to address the challenges facing Romania's children and ensure their well-being.[64]

61 Hunt, Kathleen: Romania's Lost Children. A Photo Essay by James Nachtwey, in: The New York Times, 24.06.1990, p. 28, www.nytimes.com/1990/06/24/magazine/romania-s-lost-children-a-photo-essay-by-james-nachtwey.html (24.02.2024).
62 ibid.
63 ibid.
64 ibid.

An article from 8 January 1990 by the news agency Reuter stated that 64 Romanian orphans had arrived in Paris from Bucharest on a government-chartered flight, marking a new chapter for these children as they prepare for adoption by couples in the West after the freeze in adoptions abroad was lifted in Romania.[65] The lifting of restrictions on foreign adoptions in Romania signaled a significant shift in adoption policies, spearheaded by the National Salvation Front (FSN). This transition occurred under the leadership of the Provisional Council of National Unity, the initial governing body following the fall of Nicolae Ceausescu, which was predominantly composed of FSN members. Subsequently, the FSN, led by Ion Iliescu, formed the first elected government post-Ceausescu era. It was also stated in the article that despite administrative obstacles, the children, ranging from infants to teenagers, have found new families in countries such as the United States, Italy, France, Belgium, Switzerland and Britain.[66] The article concluded that this change comes after Ceausescu's policies aimed at increasing Romania's population led to an increase in orphaned children, many of whom now have a chance for a better life abroad.[67] It was claimed in *New York Times* that a significant number of children, estimated at around 5,000, were embraced into new families through adoption from Western nations; among those adoptions, it is reported that about 1,500 children found homes specifically in American families.[68] Dr. Alexandra Zugravescu, a pediatrician in Bucharest, stated in the *New York Times* on 3 October 1991 that she was making efforts to tackle one of the nation's most notorious scandals: the trafficking of babies for adoption.[69] It ran that under her guidance at the Romanian Committee for Adoptions, significant changes were underway, particularly affecting American families who had adopted a large number of children from Romania. Worth noting is the point in the article, which mentions that Romania's troubled history, including bans on abortion and contraception,

65 Reuter: Romania orphans head West, in: The Canberra Times, 08.01.1990, p. 6, www.nla.gov.au/nla.news-article120871154 (21.02.2024).

66 ibid.

67 ibid.

68 Associated Press: U.S. Limits Adoptions of Romanian Children, in: The New York Times, 28.07.1991, p. 7, www.nytimes.com/1991/07/28/world/us-limits-adoptions-of-romanian-children.html?searchResultPosition=1 (21.02.2024).

69 Lawson, Carol: Doctor Acts to Heal Romania's Wound Of Baby Trafficking, in: The New York Times, 03.10.1991, p. 1, /www.nytimes.com/1991/10/03/garden/doctor-acts-to-heal-romania-s-wound-of-baby-trafficking.html?searchResultPosition=2 (24.02.2024).

combined with widespread poverty that had made children a commodity, sometimes even sold on the streets. However, approximately 100,000 children in Romanian orphanages were in a state of legal uncertainty, as they were neither officially claimed by their biological families nor available for adoption because their families did not relinquishing their legal rights. Thus, the adoption process for these children was slow and inefficient.[70] The effects were still evident as late as in 1994. According to a *New York Times* article, which depicted the bleak conditions in Romanian children's institutions, neglected infants in cribs struggled to grow and playrooms remained locked, because of the children's caretakers considering it too much trouble to supervise, despite marginal improvements after the fall of Ceausescu.[71] The article stated: »As the children shuffle from institution to institution, they suffer from poor and hostile care at the hands of untrained staffs, Romanian and Western experts say«.[72] It also reported that Western aid had failed to prevent alarming rates of baby abandonment, highlighting the government's reluctance to promote family care. Experts, according to the article, identified the presence of Iulian Mincu as Minister of Health as a significant obstacle to improving conditions in Romanian orphanages. He had previously been involved in the medical practices during Ceausescu's regime of giving micro-infusions of blood, much of which turned out to be H.I.V.-infected, to underweight Romanian babies in the 1980s.[73]

In reflecting on the communist era in Romania, it is evident that the influence of the state on family life went through several stages, characterized by coercive measures such as strict restrictions on abortion and limited access to contraception. Concluding this study, it is worth mentioning statistics illustrating the significant fluctuations in live births, maternal mortality rates, and infant mortality rates over the years in communist Romania based on the article of the *New York Times.* According to Bruke, a demographer and economist, from 1966 to 1967, live births in

70 Altstein, Howard: Rescuing Romania's Orphans, in: The New York Times, 28.11.1992, p. 19, www.nytimes.com/1992/11/28/opinion/rescuing-romanias-orphans.html?searchResultPosition=2 (25.02.2024).

71 Perlez, Jane: Bucharest Journal; Little Care and Less Love: Romania's Sad Orphans, in: The New York Times, 27.10.1994, p. 4, www.nytimes.com/1994/10/27/world/bucharest-journal-little-care-and-less-love-romania-s-sad-orphans.html?searchResultPosition=1 (24.02.2024).

72 ibid.

73 ibid.

Romania nearly doubled to 528,000, coinciding with a decline in factory production as a significant portion of the workforce went on maternity leave.[74] With a declining standard of living due to prevailing economic inefficiencies, Romanian women turned to illegal abortions, leading to a subsequent decline in birth rates between 1967 and 1970. This trend was accompanied by a predictable rise in maternal deaths, reaching 506 in 1968, with Romania's maternal death rate significantly high. By 1983, the crude birth rate returned to its 1966 level. In 1985, the reported infant mortality rate in Romania was 25.6 deaths per 1,000 infants in their first year of life.[75] Ceausescu's 23-year pronatalist policies, reinforced by state propaganda, were overturned with the overthrow of the regime in December 1989, leading to the legalization of abortion on demand (by qualified personnel within the first trimester of pregnancy) and the approval of modern contraceptives. Yet despite changes in demographic and public health policies after 1989, Ceausescu's pronatalistic era in Romania remains a taboo subject in the public sphere and continues to exert impact on the nation's reproductive health landscape.[76]

Epilogue

Summarizing, this chapter focused on Nicolae Ceausescu's strict reproductive regulations and abortion policies due to »demographic concerns« and the impact on the proliferation of orphanages in the Socialist Republic of Romania. Initially strict restrictions on contraception and abortion, combined with harsh economic conditions, led to an increase in abandoned children. Families, faced with significant financial difficulties and unable to cope with the burden of raising additional children, handed them over to state care. This influx of abandoned children overwhelmed existing social services, necessitating the establishment of new orphanages to accommodate them. As a result, orphanages in Romania became overcrowded and under-resourced, unable to provide adequate care and support to the growing number of children in their care. The quality of life for

74 Bruke, B. Meredith: Ceausescu's Main Victims: Women and Children, in: The New York Times, p. 27, www.nytimes.com/1990/01/10/opinion/ceausescus-main-victims-women-and-children.html?searchResultPosition=1 (20.02.2024).

75 ibid.

76 Anton: On Memory Work in Post-communist Europe, p. 6.

these institutionalized children was often dismal, characterized by neglect, malnutrition and inadequate medical care. The pronatalist policy endured for 23 years, from 1966 until the collapse of the regime in 1989. Subsequent amendments in 1972 and 1985 introduced minor modifications, but the fundamental criteria for terminating a pregnancy remained largely unchanged, strengthening state control over reproductive rights. Through the historical sources presented and analyzed, this chapter explored the implementation of decree no. 770 as a solution to the »demographic crisis« and the significant impact on the social fabric of Romania, with an emphasis on »Ceausescu's orphans«. These institutionalized children suffered from abuse, malnutrition and severe developmental and mental health problems. Despite the regime's demise, many children continued to endure appalling conditions within state institutions, trapped in a cycle of neglect and despair. Through the analysis of this historical case, this article offers valuable contributions to the academic discourse by shedding light on the complex nature of state intervention in reproductive rights and its far-reaching implications for welfare systems.

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Luisa Klatte

Population Planning and Gender Equality—Abortion in the GDR

Introduction

In 1972, the abortion law in the German Democratic Republic (GDR) underwent a significant liberalization process. Abortions were no longer prohibited, and it became possible to terminate pregnancies up to the twelfth week without providing legally recognized reasons. The new law replaced the restrictive legislation enacted during the founding period of the GDR. The legal reform of 1972 brought about two significant changes regarding unintended pregnancies: Firstly, the decades-long and partially humiliating practice of obtaining approval for abortion from a commission was abolished. Secondly, and perhaps more crucially, unintended pregnancies no longer needed to be terminated illegally. The broader public welcomed the new law, with exceptions from certain groups, including Christian churches and conservative parties, notably the Christian Democratic Union (CDU). Despite the endorsement, the liberal approach to abortions came to an abrupt halt with the reunification of the two German states and the reinstatement of the (West-) German Section 218 of the Criminal Code—commonly known as § 218. Even in current debates surrounding § 218 in Germany, the liberal approach of the GDR's abortion law plays a minor role, if any at all.

However, upon closer examination of the GDR's scientific debates and population policy strategies of the 1960s, the 1972 law appears far from surprising. Instead, it aligns with a series of gender equality measures aimed at fostering economic growth through a high birth rate and simultaneous integration of women into the workforce, justified based on the constitutionally guaranteed principle of gender equality. These measures have been criticized for their shortcomings in effectively promoting genuine gender equality, a subject extensively discussed.[1] Moreover, many of these initiatives, particularly the right to legal abortions, were motivated by population planning objectives rather than solely by principles of gen-

1 Ferree, Myra Marx: After the Wall: Explaining the Status of Women in the Former GDR, in: Sociological Focus 28 (1995), No. 1, pp. 9–22.

der equality. Nonetheless, by situating the history of abortion rights in the GDR within the context of relevant political and scientific debates of the respective era, this analysis aims to contribute to the exploration of the intricate relationship between women's rights and (state) socialism.

Controversies around § 218

Before exploring the legal aspects of abortion in the Soviet occupation zone (SBZ) and later in the GDR, it is essential to delve into the history of the German abortion paragraph briefly. § 218 of the Criminal Code was established with the formation of the German Empire in 1871, defining abortions as criminal acts against human life. The enactment of § 218 in 1871 must be examined in the context of the discursive shifts observed in abortion debates worldwide. For centuries, the so-called right to life of the fetus played a minimal role. However, starting in the Middle Ages, the question of when human life begins gained increasing importance. Both canon and secular law began to refer to Aristotle's considerations, which posited that the fetus undergoes gradual ensoulment after conception, reaching completion at 40 days for male and 90 days for female fetuses.[2] In secular jurisprudence, the perception of the fetus evolved further during the Enlightenment, transforming into a protected entity. At the same time, the ›nascent human‹ was redefined as a ›future citizen‹, even though abortions initially remained non-punishable.[3] This shift is closely tied to the building process of sovereign nation-states, including Germany. With the establishment of the German Empire, a constitution came into effect that, for the first time in German legal history, codified supra-regional regulations on abortion. As punishment, imprisonment or fines were prescribed. The law did not recognize any exceptions for legal abortions.[4] By addressing abortions in the Criminal Code under the section ›Crimes and Offenses against Life‹, German legislation consequently attributed human

2 Jerouschek, Günter: Mittelalter. Antikes Erbe, weltliche Gesetzgebung und Kanonisches Recht, in: Jütte, Robert (ed.): Geschichte der Abtreibung: von der Antike bis zur Gegenwart, München 1993, pp. 27–43.

3 Jerouschek, Günter: Zur Geschichte des Abtreibungsverbots, in: Staupe, Gisela/Vieth, Lisa (eds.): Unter anderen Umständen: zur Geschichte der Abtreibung, Berlin 1993, pp. 18–23.

4 Strafgesetzbuch für das Deutsche Reich vom 15. Mai 1871: Paragraf 218. Schwangerschaftsabbruch, lexetius.com/StGB/218/schwangerschaftsabbruch (29.02.2024).

life to the fetus and established the immediate beginning of human life at conception.

Since its introduction, § 218 has been the subject of societal debates and political reform movements. In the early twentieth century, various women's movements advocated liberalization, particularly the radical women's movement led by Helene Stöcker. In the 1920s, the permissibility of abortions became a fundamental demand of the proletarian health movement in the Weimar Republic. It is essential to distinguish that feminists like Helene Stöcker aimed to strengthen reproductive self-determination, while the proletarian health movement saw the criminalization of abortions primarily as perpetuating a two-class society. The latter argued that privileged women would always have access to safe abortion methods, while less privileged women would rely on riskier approaches and unqualified practitioners. In the Weimar Republic, political parties like the *Communist* or *Social Democratic Party* called for legal liberalization. However, the lack of a parliamentary majority in the 1920s prevented any fundamental reform of § 218. In 1927, a legal change was enacted, exempting abortions from punishment if medically indicated, specifically when the life or health of the pregnant woman was at risk. The penalty was also significantly reduced.[5]

Shortly after the Nazis seized power in 1933, German abortion laws were revised once again, establishing a state-coordinated control over female reproductive capacity in two directions: An abortion ban was imposed on ›genetically healthy‹ and ›racially superior‹ women, who were expected to give birth to a minimum of four children to sustain the German »Volkskörper«, while pregnancies identified as ›genetically inferior‹ (for example, those of foreign women) were compelled to be terminated coercively. Consequently, both abortion prohibition and forced abortion coexisted under National Socialism.[6]

This brief digression into the history of § 218 illustrates both the significance of definitions of the beginning of human life as well as the crucial aspects of population planning strategies within abortion discourses. For

5 Soden, Kristine von: ›§ 218 - streichen, nicht ändern!‹ Abtreibung und Geburtenregelung in der Weimarer Republik, in: Staupe, Gisela/Vieth, Lisa (eds.): Unter anderen Umständen: zur Geschichte der Abtreibung, Berlin 1993, pp. 36–50.

6 Czarnowski, Gabriele: Frauen als Mütter der ›Rasse‹. Abtreibungsverfolgung und Zwangseingriff im Nationalsozialismus, in Staupe, Gisela/Vieth, Lisa (eds.): Unter anderen Umständen: zur Geschichte der Abtreibung, Berlin 1993, pp. 58f.

centuries, there have been debates about when human life begins and—seemingly automatically—the right to reproductive self-determination ends. In this context, the significance of women's bodies as political bodies must be emphasized. In particular, through the restriction of the right to abortion, women are still held accountable for the continuity of society through (re)production.[7]

Liberal handling in post-war Germany

As sexual violence escalated toward the end of the war, with mass rapes perpetrated by soldiers against women of enemy states, the Nazi abortion laws were amended through an additional decree in 1945: henceforth, pregnancies resulting from rape were permitted to be terminated. However, this exception applied exclusively to cases of rape committed by Russian soldiers, while abortions resulting from other forms of sexual abuse remained prohibited. After the end of World War II, the Allied Control Council revoked all Nazi decrees, including those related to abortion, and reinstalled the legal framework of 1927. In practice, abortions due to rapes by Russian soldiers were often maintained.[8]

The challenging post-war circumstances, coupled with widespread sexual violence, sparked discussions for an expanded spectrum of indications for legal abortions. The Allied Control Council, as the supreme governing authority, failed to reach a unified solution on the issue of abortion; instead, various zonal laws were enacted.

In the Soviet Occupation Zone, the Military Administration advocated early liberalization. Among the reasons were the challenging post-war living conditions and the occupiers' concern that the ongoing rapes by members of the Red Army would undermine the moral acceptance of the liberators. A draft created in 1946 included not only medical and criminological indications but—for the first time in German law—social reasons for the legal termination of a pregnancy. However, due to jurisdictional limitations, the draft could not be enacted as a zone-wide decree.

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7 Ankum, Katharina von: Political Bodies: Women and Re/Production in the GDR, in: Women in German Yearbook, vol. 9, Lincoln 1993, pp. 127–144.

8 Poutrus, Kirsten: Von den Massenvergewaltigungen zum Mutterschutzgesetz. Abtreibungspolitik und Abtreibungspraxis in Ostdeutschland, 1945-1950, in: Bessel, Richard/Ralph Jessen (eds.): Die Grenzen der Diktatur: Staat und Gesellschaft in der DDR, Göttingen 1997, p. 179.

Instead, corresponding draft laws were introduced into the state parliaments (*Länderparlamente)* of the Soviet Occupation Zone and adopted in different forms. All five states enacted a so-called ›ethical indication‹, allowing abortions in case of rape. All parliaments, except Saxony-Anhalt, agreed upon approving social circumstances, e.g., poverty or general living conditions. In Saxony-Anhalt, the introduction of a social indication failed to garner majority support. Additionally, in all five states, commissions were established at the Health Departments to decide on submitted abortion applications. These commissions were an integral part of the abortion practices in the GDR and existed until the liberalization in 1972.

As previously explained, the enactment of the state laws (*Ländergesetze*) was primarily motivated by the challenging living circumstances in postwar Germany. The liberalizations aimed to become a pragmatic solution to the ›abortion dilemma‹ and should be repealed once economic stability was restored. Arguments of reproductive self-determination appeared to be irrelevant. Moreover, the criminalization of abortions should be maintained, as evidenced by a quote from Maxim Zetkin, the former Vice President of the Central Administration for Health Care: »Grundsätzlich sind wir für eine Aufrechterhaltung des Paragraphen 218. Dieses sogenannte Recht der Frau auf den Körper könne man nicht anerkennen, müsse aber der Zeit Rechnung tragen.«[9]

Nation-building and motherhood

The GDR was officially established on October 7, 1949. The »Gesetz über den Mutter- und Kinderschutz und die Rechte der Frau« (›Maternal and Child Protection and Women's Rights Act‹) was introduced shortly after its founding. The act refers to the constitutionally guaranteed equality of men and women while emphasizing a high birth rate to secure the nation's future. In addition to birth-promoting measures such as appropriate support services, a nationally applicable abortion law was also included. »Im Interesse des Gesundheitsschutzes der Frau und der Förderung

9 Translations in this document were provided by the author: ›Essentially, we are in favor of maintaining Paragraph 218. This so-called right of women to their bodies cannot be recognized, but we must take into account the current times.‹ Poutrus: Von den Massenvergewaltigungen zum Mutterschutzgesetz, p.184.

der Geburtenzunahme[…]«[10] abortions were no longer allowed, only in case of medical or genetic reasons. Even terminating a pregnancy resulting from rape was no longer legally allowed.

The strategy of promoting population growth through child-related social benefits and restricting abortion rights are closely interwoven with the founding of the GDR as a Socialist state, following the Soviet-Stalinist model. In the Soviet Union, abortion had been banned since 1936. Simultaneously, the full integration of women into the workforce was essential for increasing labor and economic productivity.[11]

The only remaining element from the former state laws was the presence of the commissions, where pregnant women still had to ask for permission to abort the pregnancy. Approval rates varied significantly by region, partly due to widespread uncertainty about the interpretation of the new abortion law. There were unpredictabilities both among medical professionals as well as the women seeking approval to terminate their pregnancies. The new law promised a regulation that would clarify medically accepted reasons for legal abortions, but this was not published in the years following the law's enactment. Numerous letters from physicians to the Ministry of Health have been preserved, requesting specific information on these medical criteria.[12] For the women, the uncertain outcomes of often inquisitorial commission hearings, the unclear legal status, lack of legal recourse, and the risk of compromised anonymity, especially in rural areas where commission members might be known personally, led to significant hesitation. Consequently, many women chose not to appear before the commissions, opting instead for illegal and often unsafe abortion methods.[13]

Overall, it is evident that the number of applications decreased—as expected—with the restrictive introduction of the law. According to Lykke

10 ›In the interest of protecting women's health and promoting an increase in the birth rate‹, Gesetz über den Mutter- und Kinderschutz und die Rechte der Frau, 1950, www.verfassungen.de/ddr/mutterkindgesetz50.htm, (29.02.2024).

11 Merkel, Ina: Leitbilder und Lebensweisen von Frauen in der DDR, in: Kaelble, Hartmut/Kocka, Jürgen/Zwahr, Hartmut (eds.): Sozialgeschichte der DDR, Stuttgart 1994, pp. 359–382.

12 »Wie Ihnn bekannt ist, ist […] vor über 2 Jahren, das Gesetz über den Mutter- und Kinderschutz und die Rechte der Frau erschienen. […] Seit Herausgabe des Gesetzes verlangen die Ärzte verständlicherweise nach einer Richtlinie bezüglich dieser Indikationsstellung.«, #1 Bundesarchiv.

13 Maleck-Lewy, Eva: Und wenn ich nun schwanger bin? Frauen zwischen Selbstbestimmung und Bevormundung, Berlin 1994, p. 94f.

Aresin, a gynecologist in the GDR, in 1950, there were still a total of 32,000 applications for termination of pregnancy; however, in 1951, there were only about 9,000. By 1958, the number of applications had fallen to 1,730.[14] Simultaneously, the number of illegal abortions increased significantly, with experts estimating up to 70,000 illegal procedures occurring annually.[15]

Despite the return to a restrictive stance on abortion, it is crucial to emphasize that, unlike § 218, abortions in the GDR were not treated as criminal acts against human life. Therefore, no direct link between definitions of the beginning of human life and abortion in the GDR can be made. Generally, definitions regarding the beginning of human life are seldom central to abortion debates in sources from the GDR Ministry of Health and scholarly literature. Instead, the discussions are framed around socialist health policy and women's health protection. This perspective reactivates patriarchal reasoning, implying that women rely on the state's paternalistic protection, as they are perceived as incapable of taking responsibility for themselves and their bodies.

However, the restrictive abortion law led to various forms of protest, mainly because of the inquisitorial methods of interrogation within the commissions.[16] The process was described as humiliating and degrading.[17] Nevertheless, the practice continued for over a decade because population growth became even more critical for the GDR after establishing the Berlin Wall in 1961.[18]

Internal and External Pressures for Liberalization

Despite all efforts of population growth, the fertility rate continued to decline, from an average of 2,51 children per woman in 1964 to 1,51 chil-

14 Aresin, Lykke: Schwangerschaftsabbruch in der DDR, in: Staupe, Gisela/Vieth, Lisa (eds.): Unter anderen Umständen: zur Geschichte der Abtreibung, Berlin 1993, p. 90.

15 Maleck-Lewy, Eva: Und wenn ich nun schwanger bin?, p. 93.

16 Grossmann, Atina: ›Sich auf ihr Kindchen freuen‹. Frauen und Behörden in Auseinandersetzungen um Abtreibungen, Mitte der 1960er Jahre, in: Becker, Peter/Lüdtke, Alf (eds.): Akten, Eingaben, Schaufenster: die DDR und ihre Texte: Erkundungen zu Herrschaft und Alltag, Berlin 1997, pp. 241–257.

17 Thietz, Kirsten/Michalski, Bettina/Fritzsche, Andrea (eds.): Ende der Selbstverständlichkeit? die Abschaffung des § 218 in der DDR, Berlin 1992, p. 59.

18 Weber, Hermann: DDR: Grundriß der Geschichte; [1945–1990], 1st ed. rev., Hannover 1992, p. 115.

dren in 1971.[19] The decrease posed a significant threat to socialist society and its political leaders. Therefore, they attempted a turnaround, moving away from prohibitions and regulations towards a positive framing of population growth and childbirth by introducing the term *Wunschkind* (›dream child‹). The term has been used not only for promoting childbirth by showing the advantages of having children but also, e.g., when introducing the birth control pill in the GDR in 1965. The *Wunschkindpille* promised better planning and, consequently, a high combability of family and work.[20]

Alongside the declining birth rate, the increasing number of illegal abortions, often accompanied by severe medical complications and even deaths, became a significant political issue. Additionally, other factors pushed for a liberalization of the restrictive abortion law: In 1956, a liberal abortion law was introduced in the neighboring country of Poland. Foreign tourism to the allied states of the socialist Eastern Bloc, namely to the People's Republic of Poland, led to a so-called ›abortion tourism‹ towards the East. Furthermore, a liberalization of abortion law was underway in West Germany, and the GDR was determined not to fall behind its bourgeois system counterpart in matters of women's rights.[21]

At the same time, women—occasionally even men—submitted protests, known as *Eingaben* (›submissions‹), to the Ministry of Health against the legal rulings and practices. The U.S. historian Anita Grossmann provided a detailed analysis of these *Eingaben*. Grossmann notes that they took over the rhetoric of socialist modernization and population policies. They do not argue for the right to reproductive self-determination but instead use the socialist notion of progress: more women could be integrated into societal, economic, and political life if they were allowed to decide for themselves whether they want to carry out a pregnancy or not.[22]

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19 Statistisches Bundesamt: Entwicklung der Fertilitätsrate in der BRD und in der ehemaligen DDR von 1950 bis 1990, 2016, de.statista.com/statistik/daten/studie/554952/umfrage/fertilitaetsrate-in-der-brd-und-ddr/ (29.2.2024).

20 Leo, Annette/König, Christian: Die ›Wunschkindpille‹: weibliche Erfahrung und staatliche Geburtenpolitik in der DDR, Göttingen 2015.

21 Schwartz, Michael: Frauen und Reformen im doppelten Deutschland. Zusammenhänge zwischen Frauenerwerbsarbeit, Abtreibungsrecht und Bevölkerungspolitik um 1970, in: Jarausch, Konrad (ed.): Das Ende der Zuversicht? Die siebziger Jahre als Geschichte, Göttingen 2008, p. 203.

22 Grossmann: ›Sich auf ihr Kindchen freuen‹, p. 251.

In this climate of internal and external factors pressuring for reform, Inge Lange entered the political stage, effectively advocating for the liberalization of abortion law. By then, she was chairwoman of the *Demokratischer Frauenbund Deutschland* (›Democratic Women's Federation of Germany‹, DFD), a mass women's organization in East Germany, installed by the government.[23] As chairwoman of the DFD, she was tasked with drafting a proposal on the abortion law in December 1971. Only two weeks later, Lange presented a draft of several pages, which, in addition to the general liberalization of abortions up to the twelfth week of pregnancy, also contained detailed information on implementation and realization. The draft was approved by the central political bodies of the GDR, the *Politbüro*, *Zentralkomitee*, and *Ministerrat*, and submitted to the parliament for final approval.[24] Already in March 1972, the law was passed by the parliament—although, for the first and only time in the history of the GDR, not unanimously.[25] No further information exists regarding the draft law work, including other actors' involvement. Inge Langes stated that it took three attempts to pass the liberal legislation, suggesting an extensive and challenging drafting process.[26]

Subsequently, terminating a pregnancy, up to the twelfth week, without stating reasons became possible—a significant shift from the restrictive legislation of 1950. The law's introduction occurred without public debate; not even sporadic media reports hinted at the liberalization. It appeared to many as an overnight liberalization. Critics had warned of an increase in abortions following the deregulation, and initially, this seemed to be accurate. The number of registered abortions surged dramatically, reaching a provisional peak of over 113,000 in 1973.[27] In the subsequent

23 The DFD was a women's organization in East Germany, founded in 1947. While officially advocating for women's empowerment, it was also closely aligned with the ruling Socialist Unity Party (SED) and supported state policies.

24 Leo/König: Die ›Wunschkindpille‹, pp. 183ff.

25 Specifically, there were four opposing votes and eight abstentions, mostly from the CDU-party; Lembke, Ulrike: Schwangerschaftsabbruch in DDR und BRD, in: Digitales Deutsches Frauenarchiv, www.digitales-deutsches-frauenarchiv.de/angebote/dossiers/30-jahre-geteilter-feminismus/schwangerschaftsabbruch-in-ddr-und-brd (29.02.2024).

26 Bock, Jessica: Die Fristenlösung in der DDR: Inge Lange, Digitales Deutsches Frauenarchiv, 2021, https://www.digitales-deutsches-frauenarchiv.de/angebote/dossiers/218-und-die-frauenbewegung/die-fristenloesung-in-der-ddr-inge-lange (05.06.2024).

27 Bock, Jessica: Der Schwangerschaftsabbruch in der DDR, 2023, www.bpb.de/themen/deutschlandarchiv/542838/der-schwangerschaftsabbruch-in-der-ddr/ (29.02.2024).

years, the number of abortions steadily declined, reaching just under 74,000 in 1988.[28]

Critics often argue that legalizing legislation leads to an increase in their numbers. Proponents of liberal legislation emphasize that not the number of abortions is increasing after liberalization, but rather the number of legal and, therefore, registered abortions. Notably, no law in the world can prevent individuals from terminating pregnancies if they choose to do so. Laws can only ensure that abortions occur within a medically, legally, and socially secure framework. Furthermore, the warnings about an increase in abortion rates following law liberalization perpetuate the stereotype of irresponsible women who don't care about contraception or pregnancy.

Abortion in GDR's civil rights movements

In the 1980s, as criticism of the communist government grew, different women's rights groups debated the female living conditions under socialism in the GDR. Among other topics, the right to reproductive self-determination under the current abortion law has been discussed.

The role of literature seems crucial when considering the nongovernmental women's rights movement in the GDR. Various scholars, e.g., Ilse Nagelschmidt, developed the thesis of an emerging feminist consciousness through literature in the 1970s and 1980s, especially when examining influential authors such as Christa Wolf, Irmtraud Morgner, or Brigitte Reimann.[29] When discussing the topic of abortion, this thesis seems to hold, as various novels addressing abortion were published, especially in the 1970s and 1980s.

Published in 1982, the novel *Meine ungeborenen Kinder* (›My Unborn Children‹) by Charlotte Worgitzky seems of particular importance regarding the topic of abortion.[30] The novel, contrary to its initial title's implication, is not a tale of mourning for children lost through abortion but rather a strong advocacy for maintaining the liberal law as one of the

28 Aresin: Schwangerschaftsabbruch in der DDR, p. 94.

29 Nagelschmidt, Ilse: Über Erfahrungen im Aufspüren von Differenzen: schreibende Frauen in der DDR, in: Nagelschmidt, Ilse (ed.): Frauenleben - Frauenliteratur - Frauenkultur in der DDR der 70er und 80er Jahre, Leipzig 1997, pp. 39–55.

30 Worgitzky, Charlotte: Meine ungeborenen Kinder, 5th ed., Berlin 1989.

most significant achievements in GDR's women's politics. Protagonist Martha Trubec reflects on her abortions, some of which occurred illegally, involving dangerous methods, such as direct use of violence. Following the novel's argumentation, to spare other unintentionally pregnant individuals from such experiences, abortions should be legal.

Despite the solid feminist implications, the title already indicates a phenomenon of the non-state women's movement in the GDR regarding the topic of abortion. *Meine ungeborenen Kinder* (unintentionally) equals a fetus with a child—a human life that already began—and therefore abortion with murder.

This coexistence of abortion as murder while discussing women's rights issues from a feminist point of view seems striking for feministic debates in the 1980s in the GDR. The same rhetoric was repeated at a meeting of the *AG Schwangerschaftsabbruch* (›Working Group Abortion‹) during a *Frauenforum* (›Women's Forum‹), which took place in Erfurt in 1988. Before meeting in Erfurt, over 200 women wrote letters about abortion to the organizers, some of them sharing their own experiences. Unfortunately, the letters are no longer available, but many of the speeches at the meeting refer to or summarize the contents of these letters. The speakers unanimously agree that abortions should remain legal and accessible without restrictions. At the same time, women who had undergone abortion(s) write about murder and the enduringly burdensome experience. »Natürlich muss Schwangerschaftsabbruch frei bleiben. Aber daß die Trauer danach oft so unerwartet groß ist, ist überdeutlich. […] Es ging vor allem über Schuldgefühle, die Scham und die Angst, darüber mit jemanden zu sprechen.«[31]

Within abortion discourses in the GDR, it can be observed that the beginning of human life and questions of its liminality played virtually no role in the abortion legislation of the GDR. Both laws and political discussions were characterized by a pragmatic approach focused on population growth through incentives and encouragement of childbirth. The beginning of human life and, therefore, the question of homicide in abortion did not appear in political sources; instead, the societal mission to shape a prosperous socialist society took precedence. Discussions become more emotional when looking at personal experiences with abortions.

31 ›Of course, abortion must remain free. But the fact that the grief afterwards is often so unexpectedly huge is abundantly clear. [...] It was mainly about feelings of guilt, shame and the fear of talking about it with someone‹, #2 Robert-Havemann-Gesellschaft.

References to the beginning of human life with fertilization can be observed, framing abortion as murder.

This coexistence appears surprising given that contemporary feminist debates often reject such an equation. Rather, the right to self-determination is typically decoupled from the question of when human life begins. Consequently, affected individuals are frequently deprived of a platform to articulate the challenges that may accompany the decision to undergo an abortion. The debates within the independent women's movement in the GDR offer valuable perspectives on alternative approaches to handling abortions, even within feminist movements.

Abortion during German reunification

With the gradual collapse of communism and the approaching reunification of the two German states, concerns arose about undermining the liberal abortion law of the GDR. Protests, organized by different women's rights groups, took place at the beginning of the 1990s in East German cities, such as Leipzig and Berlin. The slogans were similar: »Gegen die Einverleibung der DDR – für ein selbstbestimmtes Leben«.[32] The various forms of protest combined feminist efforts to preserve the liberal abortion law from the GDR with criticism of the accession process of the GDR to the Federal Republic of Germany (BRD).

Political protests also took shape. In 1989, the *Unabhängiger Frauenverband* (›Independent Women's Association‹, UFV) was founded and became a political party in 1990. The UVF aimed to affiliate the GDR's non-governmental and loosely organized women's rights groups to increase political influence for women's rights issues during German reunification.

Also, UFV called for different actions at the beginning of the 1990s. In June 1990, a signature campaign brought over 17,000 letters and postcards to the GDR-parliament *Volkskammer*, advocating the liberal abortion law in the GDR. A year later, after the federal elections in December 1990, even more letters were submitted to the *Bundestag*, the just reunited German federal parliament, in Bonn. According to a letter by the German authorities, over 40,000 letters have been received.[33]

32 ›Against the incorporation of the GDR - For a self-determined life‹, #3 Robert-Havemann-Gesellschaft.

33 #4 MONAliesA

Initially, during reunification, the GDR abortion law remained in effect in the former state territory. The political authorities were working on a new, nationwide draft law, which should combine the liberal GDR abortion law with aspects of § 218, which was and still is in place in the FRG. The efforts eventuate in the »Schwangeren- und Familienhilfegesetz« (›Pregnancy and Family Support Act‹), adopted in 1992 by the *Bundestag*. The draft incorporated elements from both the former Western and Eastern German laws, maintaining the right to abortion until the twelfth week of pregnancy with the legal duty of consulting.[34] Therefore, the law represented a compromise between both legal practices.

Shortly after the law was passed, however, the Bavarian State Government, as one of 16 federal state governments, along with 247 politicians from the *CDU/CSU* fraction,[35] obtained a temporary injunction from the supreme constitutional court, preventing the law from taking effect. A year later, the Federal Constitutional Court accepted the objection and declared the law unconstitutional. The court reasoned that the state's duty to protect its citizens could not be ensured.

Therefore, after decades of the definition of the beginning of human life having no relevance for the political abortion discourse in the GDR, the connection between terminating a pregnancy and ending human life resurfaced. The Federal Constitutional Court proposed a return to § 218 granted in 1995. Abortions became again a criminal act against human life, with only a few exemptions from penalty. Furthermore, a legal duty of consulting had been installed.[36]

Conclusion

The abortion legislation underwent significant changes during the 40-year existence of the GDR. Initially rooted in a liberal-pragmatic legal approach due to challenging post-war conditions, a restrictive law was implemented after the founding of the GDR. Once again, terminating

34 Deutscher Bundestag: Gesetzentwurf, 1992, https://dserver.bundestag.de/btd/12/026/1202605.pdf (01.03.2024).

35 The Christian Democratic Party (CDU) and the fraternal party, the Christian Social Union in Bavaria (CSU), are both Christian democratic and conservative parties, arguing already in 1974 against a liberalization of § 218 in Western Germany.

36 Bundesamt für Justiz: Strafgesetzbuch: § 218a Straflosigkeit des Schwangerschaftsabbruchs, https://www.gesetze-im-internet.de/stgb/__218a.html (01.03.2024).

pregnancies became nearly impossible, as social or criminological circumstances were no longer recognized. By the mid-1960s, the restrictive law could no longer prevent the declining birth rate in the GDR. Various internal and external factors pushed for liberalization, resulting in the adoption of a more liberal law in 1972. From then on, abortions were permitted up to the twelfth week of pregnancy without the need for specific reasons.

The growing public protest against restrictive legal practices and the declining birth rate notably influenced the introduction of new legislation. The liberalization process can thus be understood as a political attempt to counteract the declining birth rates. Accompanied by a pronatalist population policy, it aims to reshape the concept of childbearing and motivate it by creating incentives. This upholds the portrayal of women as crucial for society's survival. The construction of women as mothers persists, along with the hope of maintaining state control over the female body despite the legalization of abortions. Simultaneously, there were concerns, not just over the rising instances of severe complications from illegal abortions but primarily due to the socialist state's inability to fulfill its duty of protection. References to the necessity of reproductive self-determination are scarcely found in political debates.

Instead, abortion and necessary legal modifications are handled quite pragmatically. The (perceived) moral dilemma arising from the beginning of human life and the termination of pregnancy is only addressed by the women's rights movement of the 1980s. At various points, there are mentions of the loss of ›unborn children‹ or feelings of guilt, occasionally even drawing parallels to murder.

The relevance of the beginning of human life in abortion discourses, particularly on the political level, only emerges during reunification and the following socio-political transformation processes. This is primarily due to the judgment of the Federal Constitutional Court, which argues that a proposed liberal legalization of abortions would not be compatible with the state's duty to protect its citizens. The political argument against the legalization of abortions is thus based on the concept of the beginning of human life starting from the moment of fertilization.

However, the analysis of different abortion laws within one political system has been somewhat underrepresented and is indeed valuable. This is especially true when considering the societal conditions preceding the implementation of legal changes. As demonstrated in this chapter, such an analysis not only provides information about the various societal domains

affected by abortion laws but has also brought to light a German feminist legal practice that is scarcely known in current public discourses.

This exclusion of East German abortion history from the overall German abortion discourse stands in line with the decades-long ideological competition between the democratic West and socialist East and the process of German reunification. Rather than a genuine alignment of both states, the reunification resembled more of an accession of the formerly socialist East Germany to the Federal Republic of Germany, establishing a continued Western dominance reflected in the history of German abortion law.

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Michael Zok

Neglecting Liminality? The Question of the Beginning of Life in Polish Post-war Discourses

Introduction

Liminal stages played an important role in Polish discourses and led to emotional discussions, especially about the beginning, and, to a lesser extent, to the end of life. Similar discussions can be found in other (European) countries, but it seems that the identification with Catholic faith as well as the position of the Catholic Church in public and in public discourse influenced the debates about the »protection of human life from its beginning to its end.« Especially debates about the permissibility of abortion were (and are) in focus of such discourses about liminal stages at life's beginning and its end and erupt regularly. However, what makes the Polish example unique—at least until today, future developments cannot be foreseen—is the fact that Poland (besides Nicaragua) was the only country with a Catholic majority in which abortion was restricted in the 1990s—paradoxically, during the transition from Communist dictatorship to a democratic state. Other Catholic societies in Europe like Ireland, or diverse ones in Latin America (Mexico, Argentina) liberalized—although not without resistance—their legislations on abortion, thus loosening the state's power over the beginning of the »Circle of Life« and this very liminal stage.

This chapter focuses on the Polish discourses on pre-natal life in the second half of the twentieth century and traces the shift leading to a growing dominance of 'Catholic' understandings of pre-natal life that ultimately found its way into Polish law in the early 1990s. In the second part, the chapter shows the discursive connection to »euthanasia« and its influence on the Polish discourse about nation. I argue that these discourses were shaped by Polish experience of the Second World War and thus will begin with a short overview on Polish history in the twentieth century in the next section.

Some background

The Polish experience of the Second World War and the German occupation had a massive influence on these discourses after its end. At first, the lives of »unborn children« were seen as worthy of protection, because they should »restore the biological substance of the nation«[1] which had been severely damaged during war and occupation. Thus, it is not surprising that the regulations and requirements for terminating pregnancy from the interwar years that had been introduced in 1932 and widened during the German occupation were restored after 1945. However, what is—especially from today's perspective—quite surprising is that those regulations had been far more liberal than in other (Western) countries at that time.

Poland was the second country (after the Soviet Union) that allowed termination of pregnancies, although they were not to be performed on a woman's request. The reformed (and unified) 1932 Penal Law allowed to perfom such an operation in case that the pregnancy would endanger the woman's life and health as well as in cases where the pregnancy was result of a crime (incest, sexual intercourse with minors, rape). There is little research for this period of time, but the scarce literature shows that abortions and their availability (as well as contraception in general) remained a highly class-based experience.[2] Women from the higher and middle-class in cities could easier obtain methods of family planning than their counterparts in rural areas. Also, the (lack of) literacy was a problem.

The German occupation changed this, because—in accordance with the Nazi racist ideology—from 1941 onwards Polish women were entitled to have an abortion performed on request. This policy of the occupant aimed of course at holding the number of newborn Poles low.[3]

After the war, there was a short period of time, when women who became pregnant »as a result of war«, i.e. raped by Soviet soldiers, had the opportunity to obtain a termination of pregnancy in this special case —besides the regulations of 1932 that were restored after the war, as mentioned above. However, such women had first to apply to a special

1 Archiwum Akt Nowych (hereinafter: AAN), Urząd do spraw Wyznań (hereinafter: UdsW), 2/1587/0/7.23/125/119, n.p.

2 Kuźma-Markowska, Sylwia: »Walka z babkami« o zdrowie kobiet: Medykalizacja przerywania ciąży w Polsce w latach pięćdziesiątych i sześćdziesiątych XX wieku, in: Polska 1944/45-1989. Studia i Materiały (2017), No. 15, pp. 189–215, p. 192.

3 However, this could also lead to (juridical) problems, as Wiebke Lisner shows in this volume.

commission which of course caused delays. Afterwards, those women were often ostracized. The existence of the short-lived legislation and of the commission as well as the reasons for terminations of pregnancies, i.e. rapes by Soviet soldiers, were silenced and forgotten and the whole issue became a taboo in Polish society.[4]

Critics attacked the post-war regulations. On the one hand, evidence can be found in the Polish state archives, e.g. letters demanding—after the »demographic catastrophe« of occupation and the monstrous population losses[5]—a total ban on abortions as well as outlawing contraceptives (that were rarely used and of low quality, a problem that should exist until the 1990s). On the other hand, Church representatives condemned the »plague« of terminations of pregnancies (as well as pre- and extramarital intercourse) which were regarded as a clear proof for the »demoralization of society« due to the Nazi policies. Those perceptions were articulated already during the occupation as well as in its aftermath, e.g. in a pastoral letter by the Bishops' Conference in 1946.[6]

However, the so-called reconstruction of Poland and construction of socialism, as Communist propaganda called this period, led to new problems and new fears. Church representatives as well as members of the Communist Polish United Workers« Party (PUWP) that gained control over everyday life since the late 1940—although being ideological rivals—, both feared the effects of forced industrialization and urbanization: mass migrations to the new build industrial complexes in cities were perceived as leading to a loss of social control that the young migrants had been subject to in their home towns and villages. Those young migrants were said to »run sexually wild« in their new urban environment. The press, after 1956 partly liberalized but still controlled and censored, wrote about sex orgies in worker's hostels that became a synonym for »uncontrolled and irresponsible sexual encounters«. The result was a perceived growing number of children born out of wedlock and illegal abortions (as I men-

4 Gałęziowski, Jakub: »The sense of justice and the need for eugenics require instant and effective intervention« – terminating pregnancies resulting from wartime rapes in Poland in 1945, in: Zeitschrift für Ostmitteleuropa-Forschung 71 (2022), No. 2, pp. 235–259.

5 Klich-Kluczewska, Barbara: Making Up for the Losses of War: Reproduction Politics in Post-War Poland, in: Röger, Maren/Leiserowtz, Ruth (eds.): Women and Men at War, Osnabrück 2012 (Einzelveröffentlichungen des Deutschen Historischen Instituts Warschau), pp. 307–328, pp. 309–312.

6 Zaremba, Marcin: Trauma Wielkiej Wojny. Psychospołeczne konsekwencje drugiej wojny światowej, in: Kultura i Społeczeństwo 52 (2021), No. 2, pp. 3–42.

tioned before, those were only allowed in cases of medical emergencies, because of crimes and eugenic reasons). No precise numbers on abortions existed, but the Ministry of Health referred to more than 300,000 women who were treated because of »spontaneous aborts«, probably self-inflicted miscarriages, in state-run hospitals in 1955.[7] Whether all of those attempted abortions were inflicted by women, their partners, or doctors to whom they reached out to terminate an unwanted pregnancy, is not clear, but the officials saw these high numbers of »spontaneous aborts« as a hint of large-scale illegal abortions.

But, the perception of this »threat to women's health and their reproductive abilities« was reason enough for, maybe the first, open discussion about a change of current policies in a State-socialist country. Its result was the introduction of the 1956 law on termination of pregnancies that broadened the reasons for applying such a procedure. Despite the already existing regulations, the new law included »difficult social situations« as a new reason. This condition for abortion was, however, not very precise and caused problems. Despite that, this legal change was meant, as the preamble of the law announced, to »protect women's health from negative effects of terminating pregnancies in inadequate circumstances or by persons who are not physicians«.[8] After three years, the regulations were re-defined in a decree by the Ministry of Health: the restriction that women had to apply to a doctors' commission for an abortion was removed. Women could now decide for themselves whether they had an abortion performed.[9]

7 Klich-Kluczewska: Making Up, p. 321; Ignaciuk, Agata: »Ten szkodliwy zabieg«. Dyskursy na temat aborcji w publikacjach Towarzystwa Świadomego Macierzyństwa/Towarzystwa Planowania Rodziny (1956-1980), in: Zeszyty Etnologii Wrocławskiej 20 (2014), No. 1, pp. 75–97, p. 81.

8 Dziennik Urzędowy: Ustawa o warunkach dopuszczalności przerywania ciąży, 1956, https://isap.sejm.gov.pl/isap.nsf/download.xsp/WDU19560120061/O/D19560061.pdf (15.05.2024).

9 Czajkowska, Aleksandra: O dopuszczalności przerywania ciąży: Ustawa z dnia 27 kwietnia 1956 r. i towarzyszące jej dyskusje, in: Piotr Barański (ed.): Kłopoty z seksem w PRL, Warszawa 2012, pp. 99–186.

»Little Human Beings«. The Catholic Church, the Beginning of Life and the Absence of Liminality

The decision of the Sejm, the Polish parliament, on 26 April 1956 led to harsh critique and resistance from Catholic actors—laypersons (MPs, intellectuals etc.) as well as clerics. They saw the state's task in protecting human life »from conception to natural death« (although the death penalty remained until the end of Communism). And, despite that the core of the arguments given for outlawing abortions remained the same (protection of life) over the whole period investigated, different strategies emerged during the cause of time.

In the years immediate after the end of the Second World War, »moral« arguments played an important role in the discourse of the anti-abortionists. Those were closely connected to the experiences during war and a certain demoralization of society. Later, from the 1970s onwards, »negative demographic developments« became more and more important because of a decline in births. Church representatives and Catholic laypersons saw the liberal 1956 law on abortion and (propaganda in favour of) contraception—although, as I mentioned before, contraceptives were rarely available and often ineffective[10]—as being responsible for this trend and demanded a change to the 1956 law.[11] However, neither clerics nor Catholic laypersons recognized that family patterns were changing and that even families in rural areas wanted to have less children than the previous generations. Statisticians and demographers interpreted the trend towards smaller nucleus families as a »normal development in an industrializing society«.[12]

As early as 1952, documents of the Bishops' Conference called the zygote »conceived child«,[13] but at least at this time, the authors did not define this instant as the moment when, in their eyes, human life began

10 Ignaciuk, Agata: The Introduction and Circulation of the Contraceptive Pill in State-Socialist Poland (1960s-1970s), in: Medicina nei Secoli-Arte e Scienza 26 (2014), No. 2, pp. 509–536.

11 E.g. in two memorandums by the Bishops' Conference addressed at the government and the Party leadership in the 1970s. AAN, UdsW, 2/1587/0/7.23/125/119; AAN, UdsW, 2/1587/0/7.23/125/120; Kosek, Mirosław: Troska o małżeństwo i rodzinę w memoriałach Episkopatu Polski do rządu w latach 1970-1978, in: Studia Płockie (2010), No. 38, pp. 259–269.

12 AAN, UdsW, 2/1587/0/7.23/125/119, folio 37.

13 Libera, Piotr/Rybicki, Andrzej (eds.): Listy Pasterskie Episkopatu Polski 1945-2000, Marki 2003, część 1, pp. 101–110.

to exist. This became more important in the following decades and was characteristic of the anti-abortion discourse, since Catholic actors—laypersons as well as clerics—stated that indisputably human life began in the moment of conception, i.e. in the moment when a male and a female gamete met.

The consequence of acknowledging this new entity as a human being was, in the eyes of Catholics, that the state (and the society) was obligated to protect it from this moment onwards. This was repeated in various outlets, such as sermons,[14] publications,[15] or during (centralized) pre-marital courses organized in every parish[16] (the latter remain a requirement for a Catholic Church wedding until today). Thus, the »moment of conception« became the one (and only) point of reference for the beginning of human life in Catholic discourse—although this had been different in recent centuries. Since the Middle Ages (and based on different traditions, e.g. from the Talmud and Greek philosophers like Aristotle), a male fetus was said to become a human being in the moment when it received its soul (forty days after conception), a female fetus after 80 days.[17] This idea dominated the official teaching of the Catholic Church regarding the moment of humanization of the fetus, until scientific knowledge forced the clergy to adept to new knowledge of the nineteenth century, thus connecting the moment of incarnation (and ensoulment) to the moment of conception.[18]

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14 Most prominent in sermons by pope John Paul II during his visits in Poland, see: Paweł II, Jan.: Jan Paweł II w Polsce, 2-10 VI 1979, 16-23 VI 1983, 8-14 VI 1987: Przemówienia, homilie, Warszawa 1989, passim; Chałubiński, Mirosław: Polityka, kościół, aborcja, in: id. (ed.): Polityka i aborcja, Warszawa 1994, pp. 89–153, pp. 143–144.

15 Wyszyński, Stefan: Dzieła zebrane, vol. 5: 1959, Warszawa 2006, p. 164; Wojtyła, Karol/Stalony-Dobrzański, Adam: Miłość i odpowiedzialność: Studium etyczne, Kraków 1962; Wojtyła, Karol/Styczeń, Janusz (eds.): Miłość i odpowiedzialność, 4th edition, Lublin 1986 (Źródła i monografie).

16 AAN, Kluby Inteligencji Katolickiej (hereinafter: KIK), 2/2212/0/13.2/525, n.p.; Kuźma-Markowska, Sylwia/Ignaciuk, Agata: Family Planning Advice in State-Socialist Poland, 1950s-80s: Local and Transnational Exchanges, in: Medical history 64 (2020), No. 2, pp. 240–266, p. 259.

17 Klimowicz, Ewa: Filozoficzne i etyczne podstawy poglądów na temat aborcji, in: Chałubiński, Mirosław (ed.): Polityka i aborcja, Warszawa 1994, pp. 7–40, p. 27.

18 For a discussion on the diverse (historical) concepts and moments of ensoulment, see: Tauer, Carol A.: Abortion: Embodiment and Prenatal Development, in: Shelp, Earl E./Sowle Cahill, Lisa/Farley, Margaret A. (eds.): Embodiment, Morality, and Medicine, Dordrecht 1995 (Theology and Medicine), pp. 75–92, pp. 77–80.

And, to support this notion, scientific »indisputable facts« from biology and genetics became an important tool in the anti-abortion discourse in the second half of the twentieth century and can be often found since the 1970s in Poland[19] (but also worldwide, e.g. stressed by the Congregation for the Doctrine of Faith[20]). Those authors and anti-abortion activists underlined that »the protection of unborn life« was not religiously motivated, but had its founding in science and knowledge, and ultimately in human rights. This became evident during the parliamentarian debates on the permissibility of abortion in the now democratic Polish Republic after 1989. During the final debate in January 1993 that ultimately led to a restriction of abortion, the chairperson of the extraordinary commission that had been formed to present a draft bill on regulations about terminations of pregnancies stated that religious arguments did not play any role during the commissions proceedings.[21] However, it was clear that the different drafts to restrict abortions originated all from right-wing parties that were closely connected to the Catholic Church and did not make any secret of it. Even more, the first draft bill actually based upon a draft formulated by a commission of the Bishops' Conference in late 1988. Other right-wing politicians did not even care to claim that the (attempted) introduction of a total ban was meant to be »a present« to pope John Paul II.[22]

The usage and instrumentalization of science for the cause of restricting abortion was already criticized by contemporaries.[23] In his statement, Krzysztof Łastowski, professor for epistemology, rejected the notion of an embryo being »just a miniaturization« of an adult human being, as which Catholic authors tended to present them.[24] The philosopher Ewa Klimowicz on the other hand stressed that the criteria for help were different when it came to the beginning and the end of life: while at life's end medical help was indicated until the brain waves vanished, the new

19 Kuźma-Markowska/Ignaciuk: Family Planning Advice.
20 Klimowicz: Filozoficzne i etyczne podstawy, p. 18.
21 AAN, Zjednoczenie Chrześcijańsko-Narodowe (hereinafter: ZChN), 2/2410/0/-/6, n.p.
22 Staśkiewicz, Joanna: Katholische Frauenbewegung in Polen?, Bielefeld 2018 (Gender Studies), pp. 110–111.
23 Łastowski, Krzysztof: Uczłowiecznie a kategorie rozwoju biologicznego, in: Chałubiński, Mirosław (ed.): Polityka i aborcja, Warszawa 1994, pp. 45–51, p. 45.
24 ibid., pp. 46–47.

regulation on abortion included protection of the foetus even before its first brain activity could be measured.[25]

In Catholic anti-abortion discourse, this was ignored. Alternative moments that could be defined as the beginning of life—and thus the starting moment for its protection—, such as nidation (the moment when the fertilized egg nested in the uterus), first EEG readings of the fetus, or its first movements were marginalized or even removed from this discourse. This also applied to fertilized ova that did not nest.[26] The latter was commonly not present in Catholic discourse, instead Catholic authors constructed an inevitability of nidation after fertilization.[27]

Instead, the »moment of conception« was glorified as an instant »to bow the head« in appreciation[28] and that there was no other »breakthrough moment« than »conception«.[29] This statements can be found in drafts of handbooks for middle schools written in the early 1990s on behalf of the Ministry of Education. One of these drafts also included a »diary« of a fetus that should teach pupils about their »younger siblings in utero«[30] and Catholic authors underlined that partners were obligated to »love their child«, once the female and male gamete had met.[31]

Furthermore, they constructed the zygote/fetus as being »autonomous« and able to make decisions, such as (almost consciously) choosing the place of nidation in the womb. In the eyes of the authors—in this case of a draft to a school handbook on sexuality written in the early 1990s—, the zygote was able to communicate and to take part in a »dialogue« with the pregnant woman from this moment onwards. Also, the authors assigned the ability to learn actively to the zygote, later the fetus.[32] Similar descriptions of the zygote/fetus can be already found in pastoral letters from the Bishops' Conference. In one of them, the authors stated that the »conceived child« had not only an immortal, but a »rational soul« that would exist from the moment of conception onwards and

25 Klimowicz: Filozoficzne i etyczne podstawy, pp. 23–25.
26 AAN, KIK, 2/2212/0/2.6/51, n.p.
27 AAN, KIK, 2/2212/0/5/389, n.p.; AAN, KIK, 2/2212/0/5/394, n.p.; AAN, KIK, 2/2212/0/5/396, n.p.
28 AAN, Ministerstwo Edukacji Narodwej (therafter: MEN), 2/2521/0/4/20945, folio 22.
29 AAN, MEN, 2/2521/0/4/21201, folio 288.
30 AAN, MEN, 2/2521/0/4/20945, folio 23–35.
31 AAN, KIK, 2/2212/0/5/394, n.p.
32 AAN, MEN, 2/2521/0/4/20945, folio 75–76, 79–80; at this time the Minister of Education was Zdobysław Flisowski, although non-alliant to any part with strong sympathies for the far-right Christian National Union.

would differentiate humans from animals.[33] So, »[e]very woman is created in such a way that in her body exists a cradle for the child. It is in the abdomen where it is save, quiet and warm for the child.«[34]

The documentation of a pre-marital course held in 1970s shows that clerics and Catholic instructors stressed the visual similarity of fetuses to adult persons. Pictures and descriptions should convince the participants that in this early state of pregnancy, fetuses already »had a human face with eyes.«[35] Thus, it is not surprising that termination of pregnancies were equaled with »murder«[36] or »infanticide«.[37] The humanization of the fetus also played an important role during the parliamentarian debates at the beginning of the 1990s. Opponents of the liberal law on abortion called the fetuses—and not the pregnant women—»patients« that were at the center of the medical treatment in cases where pregnancies had to undergo (pre-natal) testing.[38] Moreover, (hypothetical) fetuses were given first names[39] to further stress their »human character«.

This all were means to counter the demands to recognize women's rights to self-determination of their bodies that was *in toto* rejected by most of the Catholic actors.[40] Being autonomous—this was underlined by publications of American origin that were translated into Polish and distributed in Poland in the 1970s showing examples of fetuses that survived outside the wombs in fairly early stages of pregnancy (18 week and less[41])—was used as a synonym of being a human individual. Thus, »the pregnant woman has no right to destroy this little human being, since it is not«—as feminists claimed—»a part of her body.«[42] This was a key

33 Libera/Rybicki: Listy Pasterskie, część 1, p. 622.
34 AAN, KIK, 2/2212/0/5/396, n.p.
35 AAN, KIK, 2/2212/0/5/389, n.p.
36 ibid., n.p.
37 AAN, KIK, 2/2212/0/5/394, n.p.
38 AAN, Porozumienie Centrum (hereinafter: PC), 2/2764/504, n.p.
39 Kuźma-Markowska/Ignaciuk: Family Planning Advice, p. 262.
40 Zok, Michael: (K)Ein Kompromiss? Der Konflikt um die Neuregulierung des Schwangerschaftsabbruchs in Polen in den 1980er/1990er Jahren, in: Ariadne. Forum für Frauen- und Geschlechtergeschichte (2021), No. 77, pp. 164–182; but also in the discourse of the supporters of legal abortions, at least during the Communist period, the right of female self-determination, was of minor priority, compared to the protection of women's reproductive abilities. Id.: Körperpolitik, (staatstragender) Katholizismus und (De-)Säkularisierung im 20. Jahrhundert. Auseinandersetzungen um Reproduktionsrechte in Irland und Polen, in: Body Politics 7 (2019), No. 11, pp. 123–158, p. 155.
41 AAN, KIK, 2/2212/0/5/389, n.p.
42 AAN, KIK, 2/2212/0/5/396, n.p.

element to reject the idea of »women's rights to decide« and a counter-argument to »my body, my choice« (which was not so popular among female activists in Poland until the early 1990s).

Nonetheless, we can also find some inconstancies in the Catholic discourse, e.g. when the authors of pastoral letters urged that a child had to be baptized »in the first weeks of its life«, meaning after birth.[43] Despite that, birth as an important liminal stage and meaningful moment of human life (and the beginning of social interaction) was in general marginalized in the Catholic discourse—birth was just a » minor transition« from one early stage of human existence into another.[44]

Legal Debates and Distribution of Believes

Initiators of draft bills to restrict abortion claimed that their aim was to overcome »negative demographic trends« as well as to protect the reproductive potential of women—this argument had been put forward already during the parliamentarian debates prior to the liberalization in 1956.[45] This applied especially to the first gestation.[46] Catholic actors were convinced that terminating the first one would—in *every case*—lead to infertility[47] and a »decline of quality« of children.[48] Furthermore, on a macro-scale, abortions would endanger the »biological substance of the nation«, as two memorandums by the Bishops' Conference[49] as well statements by laypersons and Catholic organizations[50] claimed. First draft bills to outlaw abortions during the first gestation were already formulated by

43 Libera/Rybicki: Listy Pasterskie, część 1, p. 894.
44 Kraśko, Nina: O życium ludzkim, wartościach, odpowiedzialności i wygodnictwie życiowym: Przycznyek do kwestii ustawy antyaborcyjnej w pracie katolickiej, in: Chałubiński, Mirosław (ed.): Polityka i aborcja, Warszawa 1994, pp. 68–88, p. 70.
45 Czajkowska: O dopuszczalności, pp. 147, 152–153.
46 AAN, Komitet Centralny Polskiej Zjednoczonej Partii Robotniczej (hereinafter: KC PZPR), 2/1354/0/2.1.1/I/365, folio 244.
47 Ignaciuk, Agata: In Sickness and in Health. Expert discussions on Abortion Indications, Risks and Patient-Doctor Relationships in Postwar Poland, in: Bulletin of the History of Medicine 95 (2021), No. 1, pp. 83–112.
48 AAN, KIK, 2/2212/0/2.6/58, n.p.
49 AAN, UdsW, 2/1587/0/7.23/125/119; AAN, UdsW, 2/1587/0/7.23/125/120.
50 AAN, UdsW, 2/1587/0/5.1/127/271, folio 1–4.

Catholic MPs in the 1970s, but they did not succeed in parliament and started another attempt in the early 1980s.[51]

This happened at a time when Polish society witnessed a major economic and political crisis that emerged at the beginning of the 1980s and would ultimately change the political landscape. In November 1981, prior to the introduction of martial law a month later, four ministries (among others: Health, Internal Affairs) published a decree that would limit the possibility to obtain an abortion on request.[52] This happened during one of the main (and last) crisis of Communist rule in Poland (that would ultimately lead to its downfall), when the Communist leadership tried to overcome the difficulties by »reforming socialist economies«. This reforms effected mainly women in an effort to remove them from the labor market.[53] The economic policies caused harsh critique from the Party's Women's Commission and the National Council of Women—both institutions installed by the state and Party administration and loyal (until then) to them. Its female members accused the Party leadership of betraying the aim of gender emancipation.[54] Members of the commission even criticized social policies in public[55]—a clear hint at the erosion of power inside and outside the Party.

This change did not have long-lasting effects although births rose for the first time in 1984,[56] but have been falling ever since. The above-mentioned restriction was finally removed in 1983 when the then Minister of Health declared a return to the regulations of the 1956 law.[57] However,

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51 AAN, Kancelaria Sejmu, 737/0/760, folio 299–307, 363-369; Zabłocki, Janusz: Dzienniki: Tom 3: 1976-1986, część 1: 1976-1981, Warszawa 2013 (Relacje i wspomnienia / Instytut Pamięci Narodowej, Komisja Ścigania Zbrodni przeciwko Narodowi Polskiemu, vol. 19), p. 661, entry 22 czerwca (June) 1981.

52 Ignaciuk: In sickness and in health, p. 91.

53 Zok, Michael: Gendered Social Policies in (Post-)Communist Countries. The Case of Poland, in: N Macedonian Journal of Social Policy (2022), pp. 37–54, pp. 44–47.

54 AAN, KC PZPR, 2/1354/0/2.4.1/XL/118, n.p.; AAN, KC PZPR, 2/1354/0/2.4.3/XLII/30 , n.p.

55 Stańczak-Wiślicz, Katarzyna/Perkowski, Piotr/Fidelis, Małgorzata/ Klich-Kluczewska, Barbara: Kobiety w Polsce 1945-1989: Nowoczesność, równouprawnienie, komunizm, Kraków 2020, p. 84.

56 AAN, Patriotyczny Ruch Odrodzenia Narodowego. Rada Krajowa (hereinafter: PRON RK), 2/1590/0/4/138, n.p.

57 Mishtal, Joanna Z.: How the Church became the State: The Catholic Regime and Reproductive Rights in State Socialist Poland, in: Penn, Shana/Massino, Jill (eds.): Gender politics and everyday life in state socialist Eastern and Central Europe, New York 2009, pp. 133–149, p. 144.

times had changed and also the political as well as social conditions. Representatives of Catholic Social Thought were on the advance and found also their ways into state bodies, e.g. the Council for Family Affairs (Rada do spraw Rodziny) and gained influence on the discourse about the beginning of human life, »conceived children« and their protection.[58] This growing influence can also be found in reviews of governmental reports, e.g. on living conditions of young couples from the 1980s. The reviewer stressed the necessity not only to invest in housing and social policies, but also to protect »human [life] from the moment of conception«.[59] Here, I want to point out that this were state bodies and the changes in wording show the shifts in discourse in this very decade.

The discursive shifts could also be observed in legal discourse: in 1952, the Supreme Court ruled that a fetus—this case concerned fathering—would »receive« its legal capacity only in the moment of birth.[60] This was, of course, not acceptable for Catholic actors and conservatives, as a study produced at the Law Department of the Catholic University Lublin (Katolicki Uniwersytet Lubelski, KUL) underlined. Its author who conducted his study under the supervision of a right-wing politician and future speaker of the Lower House (Marszałek Sejmu), Wiesław Chrzanowski, stressed the legal ambiguity regarding legal capacity of fetuses (the author used in his study the term »conceived child« that had been juridical uncommon until then).

The unified and reformed 1964 Civil Law gave the fetus—in the case that it was born alive and capable to live outside the womb (»whatever that meant«, as the author commented)[61]—the right to inherit. This derived from the tradition of Roman law. On the other hand, the study's author argued, legal protection was not given, since terminations of pregnancies were allowed. Thus, in context of the existing Polish law, he stressed that currently there were two possible positions: either the fetus had in general no legal capacity, or it had conditional legal capacity.[62] Referring to Natural Law, the author stated that the existence of a human being, in this case a »conceived child« would mean that it also inherited

58 E.g. Wanda Półtawska, a known Catholic psychatrist and close friend to Karol Wojtyła, the future John Paul II., or Elżbieta Sujak. AAN, Rada do spraw Rodziny (hereinafter: RdsR), 2/1938/0/1/1/35, folio 15, 17; AAN, RdsR, 2/1938/0/1/1/4, folio 73.

59 AAN, RdsR, 2/1938/0/1/1/36, folio 32.

60 AAN, Archiwum Wiesława Chrzanowskiego, 2/2859/0/-/208, n.p.

61 ibid., n.p.

62 ibid., n.p.

human rights. Thus unsurprisingly, and also in line with the conservative stance of the supervisor, the author came to the conclusion that this legal ambiguity could only be solved by accepting the unconditional, full legal capacity of »the unborn child«.[63] This was also acknowledged by a ruling of the Supreme Administrative Court in the mid-1980 that implied that the fetus had the same rights as a child that already had been born. Thus, theoretically the fetus could claim compensation for harm illegally done to it during pregnancy. Summing up the current legal regulations, the study came to the conclusion that there was no precise definition when life began in Polish Penal Law. However, birth was seen as the moment which caused the differentiation between termination of pregnancies and infanticide (in his commentary, the study's authors criticized that in current law pregnant women did not have to take responsibility for abortions). Referring to »advances in medicine [and] psychology«, he was convinced that more people would recognize the fetus was an autonomous being »and not a possession of the mother«.[64]

This was also the standpoint of theologian and philosopher Janusz Gula who elaborated the different juridical positions about the protection of the fetus and the moment from when this protection should obligate. During his explanations at a conference at the Holy See in 1985, he came to the conclusion that to define the moment of conception as the instant when human life began was the »only logical« moment for the legal implementation of protection.[65]

Polish sociologist Małgorzata Fuszara disagreed. She underlined that the state—although obligated by the new (1993) law on abortion to »protect human life from the moment of conception onwards«—could not do so, because the precise moment of conception was unknown—to the state (authorities), doctors, and even, to the pregnant woman.[66]

Closely connected to this legal discourses was the rejection of a zygote as a »potential human being«.[67] This was put forward by supporters of abortion, since they argued that, especially the zygote was not a »completed« and »developed« human being, but had (only) the potential to

63 ibid., n.p.
64 ibid., n.p.
65 AAN, KIK, 2/2212/0/2.6/51, n.p.
66 Fuszara, Małgorzata: Debata o aborcji a kształtowanie się sceny politycznej w Polsce po upadku komunizmu, in: Chałubiński, Mirosław (ed.): Polityka i aborcja, Warszawa 1994, pp. 52–67, p. 59.
67 AAN, KIK, 2/2212/0/2.6/51, n.p.

evolve into such a human being. Those notions were rejected by pro-life politicians and groups, stressing that the whole idea of a »potential« human being (and conflicts of interest between these »potential« individuals and »real« persons)[68] was contrary to Natural Law.

Anti-abortionists in Poland had a variety of means to spread their convictions and believes in the 1980s—at that very time often supported by »scientific facts«. One such means was a lecture cycle entitled »The Human Being before Birth«. It was organized by members of the Polish Catholic Social Union (Polski Związek Katolicko-Społeczny) which had been established in the late 1970s as a split-off of ZNAK, the parliamentarian circle of Catholic MPs. Prominent Catholic sexologists like Włodzimierz Fijałkowski, one of the main propagator of »natural family planning« and opponent of artificial contraception as well as abortions, was one of its organizers. The courses were well received by clerics and laypersons and their activities were extended—even during martial law.[69]

One can find evidence that attempts were made to include these notions into handbooks on human sexuality in the early 1990s. In one draft, we can find a rejection of scientific wording, as the authors stated that »the term embryo, although correct, is not able to show the whole richness of this individual, unique little human being.«[70] Additionally, the drafts of several handbooks rejected all reasons for abortions, including rape, since »an innocent human being« would be »condemned to the most severe punishment—death.«[71] Or, eugenic resp. embryopathological reasons were rejected because »we cannot know whether the child will be born handicapped.«[72]

Two Sides of the Coin: Abortion and Euthanasia

The last example points to another element of the Polish (Catholic) discourse on pre-natal life which became more and more common since the

68 Klimowicz: Filozoficzne i etyczne podstawy, pp. 31–34, 38.
69 Zabłocki: Dzienniki 1976-1981, p. 635, entry 16 lutego (February) 1981; Zabłocki, Janusz: Dzienniki: vol. 3: 1976-1986, część 2: 1982-1986, Warszawa 2013 (Relacje i wspomnienia / Instytut Pamięci Narodowej, Komisja Ścigania Zbrodni przeciwko Narodowi Polskiemu, vol. 21), p. 152, entry 6 marca (March) 1983.
70 AAN, MEN, 2/2521/0/4/21201, folio 310.
71 ibid., pp. 289–290.
72 ibid., p. 290.

1980s: the connection (and condemnation) of abortion and euthanasia. It showed (and shows) the interest of the Church and its allies in life's beginning and its end (contemporary (and today's) critics blamed the Church and right-wing politicians for being solemnly interested in those two liminal stages and that they did not show any interest in the time between, since both supported economic transformation and the reduction of social welfare that targeted children and their upbringing[73]).

During the 1970s, the Communist censorship was very active and erased critical statements by Catholic authors. Passages about »a massacre of unborn children« or that claimed that the number of »Polish unborn children« that had died due to »abortions in Poland [was higher] than the loss of population during the Second World War« had to be deleted.[74] In a similar fashion, the Bishops' Conference addressed the issue. Its member wrote in pastoral letters that »Poland was flooded with the blood of unborn children« creating a »bloody harvest«.[75] Those statements reached—except in the case of the latter—only rarely the public, because of the tight surveillance by censors. However, in independent spheres like the Clubs of Catholic Intelligentsia,[76] but also new organizations and movements to challenge the existing law on abortion in the 1980s[77] such notions circulated openly and unchallenged.

The political changes at the end of the 1980s, i.e. the downfall of Communism in Poland and the accompanying abolition of censorship led to a more statements of this kind. Also, to stress the »monstrous scale« of »population loss« due to abortions, leaflets with maps representing »murdered conceived children« with crosses all over Poland—thus resembling the visual style of a widely known and used map of Nazi atrocities published by the Central Commission for the Investigation of Nazi Crimes in Poland since the 1960s[78]—were sent to MPs during the parliamentarian debates on the permissibility of abortion.[79]

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73 Kraśko: O życium ludzkim, p. 87.
74 AAN, Główny Urząd Kontroli Prasy, Publikacji i Widowisk (hereinafter: GUKPPiW), 2/1102/0/7.3.4/3684, folio 130.
75 Libera/Rybicki: Listy Pasterskie, część 1, pp. 779, 910.
76 AAN, KIK, 2/2212/0/5/389, n.p.
77 AAN, Akta Jerzego Świderskiego, 2/2610/0/-/79, n.p.
78 See: Cornell University Library, Digital Collections: Zbrodnie Hitlerowskie na Ziemiach Polski w Latach 1939-45 [Hitler's Crimes in Poland 1939-45], 2017 [1968], https://digital.library.cornell.edu/catalog/ss:19343462 (13.07.2024).
79 AAN, Archiwum Stanisława Stommy, 2/2218/0/3.3/156, n.p.

The connection between Nazi atrocities and abortions was not the only connection that was discursively constructed by anti-abortion activists. Ultimately, the »Holocaust of the Unborn« was constructed as to be connected to another crime of Nazi Germany: forced euthanasia. Already in the 1970s, members of a grass-root pro-life organization, supported by the Church, called the 1956 law a »genocidal law« and accused family planning to be a method of introducing »forced widespread euthanasia«.[80] Its members claimed that this was imposed on the Polish people by »neo-Malthusians« or »a neo-Malthusian mafia« to which they counted the Club of Rome.[81] Abortion and euthanasia became increasingly intertwined in Catholic pro-life discourse in Poland.

Although it would take until 2020 (decision of the Constitutional Tribunal) to outlaw eugenic, or: embryopathological, reasons, national-Catholic politicians closely connected to the Catholic Church trying to impose »Christian values« onto public life heavily attacked these regulations during the debates in the early 1990s. In the Lower House[82], MP Mariusz Grabowski from the far-right party Christian National Union (Zjednoczenie Chrześcijańsko-Narodowe) spoke of a »holocaust of the feeble, a euthanasia of old people« that would follow if the Lower House would not approve the restrictive bill on abortion. In his opinion, the existing law allowing terminations because of embryo pathologies was the »same method the Hitlerists used« in their extermination camps.[83] Sławomir Siwek, MP from the ranks of Jarosław Kaczyński's first right-wing political party Centre Agreement (Porozumienie Centrum) supported this view during his speech. He stated »this law is necessary to avert a possible law that would allow killing of elderly, ill and feeble people, a right to euthanasia.«[84]

Similar statements were not only made by politicians, but can also be found in documents, such as drafts for school books, from the Ministry of Education that had been written at that time. There, abortion was equaled to »terminations of retirees«[85] as well as in general with »euthanasia« (ex-

80 AAN, UdsW, 2/1587/0/5.1/127/271, folio 4–5.
81 AAN, UdsW, 2/1587/0/7.23/125/120, n.p.; AAN, KIK, 2/2212/0/5/395, n.p.; Kuźma-Markowska/Ignaciuk: Family Planning Advice, p. 257.
82 In 1989, the historical Upper House of the Polish parliament, the Senate, had been re-established.
83 AAN, ZChN, 2/2410/0/-/6, folio 86–87.
84 ibid., folio 95.
85 AAN, MEN, 2/2521/0/4/20945, folio 23–25.

emplified on a »handicapped person« for whom »mercy killing« would be a »release from pain«).[86] Statements and pastoral letters by the Bishops' Conference pointed in the same direction: in a letter from 1984, the authors criticized the notion of »unproductive humans«,[87] an (un-)conscious reference to Nazism. Others, e.g. right-wing politicians were far more direct and accused the defenders of the liberal law on abortion, in this case the successor of the Communist party, the Social democrats, to be »the same as the NSDAP«.[88]

During those debates prior to the 1993 decision, this constructed connection between (at that time legal) terminations of pregnancies and »euthanasia« in the context of Nazi reign was rejected by left-wing parliamentarians. They called the equation »demagogic«. In their argumentation, it were, instead, the supporters of a restrictive law on abortion that would construct »hierarchies of better and worse« forms of life resulting in a superiority of the fetus' life over the woman's one, as Social democratic senator Zofia Kuratowska criticized in the Upper House.[89] This was countered by her right-wing colleague Alicja Grześkowiak. The senator and professor of law called abortions an »assassinations on human life« and »no one« gave the right of life to the fetus (except God, in some statements), because the fetus inherited the right from being a human. And—as always—, she stated that indisputably »life begins with conception…and ends when the human life fades.«[90]

Additionally, there was also a new tone in the Polish discourse. Since the end of Communist rule, it became possible (and fashionable among right-wing politicians) to underline that it were not only Nazis who tried to biologically eradicate the Polish nation, but also Communists. Or, totalitarian regimes in general, as Reverend Tadeusz Pieronek, member of the Bishops Conference, stated in an interview: »totalitarian systems did not only murder millions of people in concentration camps«, but they also »legalized the murder of innocent and defenseless children in women's wombs.«[91]

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86 AAN, MEN, 2/2521/0/4/21201, S. 291.
87 Libera/Rybicki: Listy Pasterskie, część 2, p. 1454.
88 Raciborski, Jacek: Kościół i wybory, in: Chałubiński, Mirosław (ed.): Polityka i aborcja, Warszawa 1994, pp. 154–172, p. 165.
89 AAN, PC, 2/2764/504, n.p.
90 ibid., n.p.
91 Kulczycki, Andrzej: Abortion Policy in Postcommunist Europe: The Conflict in Poland, in: Population and Development Review 21 (1995), No. 3, pp. 471–505, p. 486.

Interestingly, there were also exceptions to this among right-wing politicians. Although the introduction of legal regulation to »protect human life from conception to natural death« was a common goal of right-wing (partly centrist) parties,[92] one of most prominent supporters of death penalty that had been abolished during the transition was Jarosław Kaczyński. In an interview, he stated that he personally would not support a law that would outlaw abortion *and* death penalty. Instead, he was even willing to accept terminations of pregnancies if death penalty would be reinstated.[93] Needless to say that this could cause irritation with his followers and the Catholic Church, as he often presented (and presents) himself as a devout Catholic.

And the representatives of the Church had a clear standpoint on this, as the Bishops' Conference announced in an pastoral letter from 1991: Recurring on the current debates on the new law on abortion, its authors underlined the ambiguity of »democratic decisions« if they were not in line with the conception of Natural Law (and thus official teaching of the Catholic Church). They underlined that laws existed that were not made by humans (Natural Law) and were thus not to be altered by humans. Abortion and euthanasia were said to violate not only God's law, but »nature« in general.[94]

Social Consequences and the Question of Nation

The resistance against restricting abortion at the beginning of the 1990s was futile. The new regulations, called »a compromise«, since they did not outlaw termination of pregnancies in total, but left medical, criminological and (until 2020) embryopathological reasons for an abortion untouched, influenced massively the official numbers of pregnancies that were terminated. According to the official statistics, the number of abortions already began to drop in the second half the 1980s. The new Code of Medical Ethics as well as the 1993 law accelerated this development.

One can only assume how the reality looked behind the official numbers. Some documents from the Ministry of Health and Social Welfare

92 AAN, Chrześcijańsko-Demokratyczne Stronnictwo Pracy (hereinafter: ChDSP), 2/1807/0/13/261, n.p.
93 AAN, PC, 2/2764/18, n.p.
94 Libera/Rybicki: Listy Pasterskie, część 2, p. 1705.

and the Ministry of Justice produced in the mid-1990s—after a left-centrist coalition came into office—suggest that the attempt to control (and protect) the beginning of human life with the aid of repressive regulations did not work, as the initiators wanted it to do.

Two trends became visible: first, the ministries saw that the ban on terminations of pregnancies on women's request led to the emergence of abortion tourism. The files from the ministries tell us about an incident with a couple that had organized such a trip to neighboring Czechia for over 200 women who wanted to have their pregnancies terminated. The couple had been arrested and was trailed (unfortunately, the files do not tell us how the trial ended).[95]

Another tendency that emerged was a rise in violence against pregnant women, as the Ministry of Justice observed. Thus, it came to the conclusion that the 1993 law was not able to protect »unborn life«, as its creators intended.[96]

Ultimately, there is a third trend that intensified due to the new regulations and is very strong until today: the decrease of the number of newborn children in Poland.[97]

This demographic problems were even worse in the 1980s due to the »other side of the coin«: Polish society, or at least the state institutions, observed a massive rise in male mortality. Men's »extramortality«, especially for the age groups between 18 and 45 and in rural areas (that were already dominated by a male surplus), became a severe problem and was often discussed among state experts.[98] The reasons for this phenomenon were manifold and included cultural (tobacco, alcoholism, suicides[99] etc.) as well as environmental factors—Poland's air and rivers were very toxic due to rapid industrialization, lack of (environmental) protection and innovation. In 1980, 17.5 per cent more men than women died, after that year the gap began to close very slowly.[100]

The fear that the Polish nation would »vanish«, as the Bishops' Conference had articulated in the 1970s, has never gone. The bad shape of Polish

95 Zok: (K)Ein Kompromiss?, p. 175.
96 AAN, Ministerstwo Zdrowia i Opieki Społecznej (hereinafter: MZiOS), 2/1939/0/-/19/248, folio 35.
97 Zok: (K)Ein Kompromiss?, p. 176.
98 AAN, RdsR, 2/1938/0/1/1/12, folio 9; AAN, RdsR, 2/1938/0/1/1/18, folio 9; AAN, RdsR, 2/1938/0/1/1/59, folio 301.
99 AAN, MZiOS, 2/1939/0/-/19/100, folio 281.
100 AAN, RdsR, 2/1938/0/1/1/18, folio 11.

economy, environment, but also the lack of (psychological) resilience in times of crisis from the 1980s onwards and the resulting uncertainty had a massively negative influence on the demographic development of Polish society, so that even during the campaign prior to the 2015 presidential election those questions were at the center of attention.[101]

Conclusion: The Liminal Stage That Was Not

Thus, speaking with Michel Foucault,[102] Poland's Communist as well as Post-Communist governments had to turn towards biopolitical mechanisms and policies to combat demographic developments that were perceived as negative and leading to a demographic catastrophe (again). The threat of a »vanishing nation«, experienced during the Second World War and since the 1970s by Catholic actors, remained strong in Polish discourse and influenced it.

The analysis shows that the end of Communism and the transformation did not change the discourse on both sides and continuities between pre- and post-1989 prevailed. However, the downfall of Communism altered the modes of communication: the end of (Communist) censorship allowed Catholic anti-abortion activists, laypersons and clerics alike, to spread offensively their belief that life began at conception and thus had to be protected. And, it allowed to criticize past totalitarian regimes as »genocidal«, because they aimed at the biological *and* moral destruction of the Polish people as a Catholic nation.

Yet, this does not mean that this was left unchallenged. Instead, surveys from the early 1990s showed that a majority of Poles were against a restrictive legislation and wanted a liberal law on terminations of pregnancies. A majority in the Catholic country disagreed with Church teachings regarding sexuality and procreation[103]—despite a growing influence of the Church in public discourse and a »Polish pope«.

The liminal stage at the beginning of life—and to a lower extent the one at life's end—was in the focus not only of the government and its

101 Zok, Michael: Wider die angeborene und nationale Mission der Frau? Gesellschaftliche Auseinandersetzungen um Abtreibungen in Polen seit der Entstalinisierung, in: Zeitschrift für Ostmitteleuropa-Forschung (2019), No. 2, pp. 249–278, p. 278.

102 Foucault, Michel: The history of sexuality, vol. 1: Introduction, New York 1978.

103 Zok, (K)Ein Kompromiss, p. 171.

experts, but also among Catholic elites, including clerics as well as laypersons, most prominently pope John Paul II. Or to be precise: the moment of conception and the development of zygote and fetus as non-liminal stages was at the center. As I have shown, Catholic discourse—prominently articulated and propagated by Church representatives and laypersons alike—did not recognize pre-natality as something »in-between« and unknown, as Arnold van Gennep[104] or Victor Turner[105] conceptualized them. Instead, for Catholics, zygotes and fetuses were simply the »first and earliest stage« in human life. They also assigned abilities to embryos that are connected to infants and adults—such as make (conscious) decisions or communicate.

And this had, of course, profound implications for debates on abortion, family planning, contraception etc. Although »historians are unfortunately bad futurologists«,[106] it is, in my opinion, clear that the debates on the permissibility of abortion, of »protection of unborn life« and liminal stages will go on in Polish society. Maybe in a never-ending »Circle of Life«.

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Thorsten Benkel

Some Thoughts on Liminal States as Irritations of Knowledge

> So long as I live, I am a mortal man, but when I die, ceasing to be a man, I cease also to be mortal, I am no longer capable of dying, and the death which announces itself horrifies me because I see it for what it is: no longer death, but the impossibility of death.
> Maurice Blanchot[1]

In the following, I attempt to develop some thoughts on liminal states as irritations of knowledge. My starting point is the definition that Victor Turner gave to the word »liminal«: »This term, literally ›being-on-a-threshold‹, means a state of process which is betwixt-and-between the normal, day-to-day cultural and social states and processes of getting and spending, preserving law and order, and registering structural status.«[2] This context is related to one, if not *the* most fundamental dichotomy of human existence, namely the relationship between life and death. I will try to show that this popular juxtaposition actually misses the heart of the matter and that there are numerous case studies, cultural references and aesthetic reflections that productively question the supposed two-sidedness of life and death.

Disappearance

Ironically, the namesake for the Airport in Lyon, France, was an aviator who lost his life in a plane crash. In 1944, Antoine de Saint-Exupéry, today much more famous as the author—among other writings—of the novella *The Little Prince*, disappeared from both the radar and the sky. He vanished somewhere near Marseille, never to be seen again. Was he *dead* when he was suddenly gone?

As the proverb goes, nothing is known for sure; therefore, until the year 2000, one could theoretically have come up with the idea that Saint-Exupéry might still be alive somewhere—in a hiding place, maybe, where

1 Quoted in: Guyer, Sara: »The Pardon of the Disaster«, *SubStance* 35 (2006), No. 1, pp. 85–105, 94.

2 Turner, Victor: »Frame, Flow and Reflection: Ritual and Drama as Public Liminality«, *Japanese Journal of Religious Studies* 6 (1979), No. 4, pp. 465–499, 465.

he gradually became an old man. By then he would have been a good hundred years. Though unlikely, it would not have been entirely impossible. But was it *probable*?

In 2000, his machine was found beneath the surface of the Mediterranean Sea. In it lay his mortal remains, as little as was still left of them. Saint-Exupéry had indeed died in 1944, shot down by a German Messerschmidt to whom the author's military plane was both a threat and an appropriate target.[3] Yet, Saint-Exupéry was not ›evidentially dead‹ in the following more than five decades. Since his corpse was outside of anyone's visibility, his death was outside of anybody's knowledge. A person that vanishes[4] is, of course, not automatically considered dead—although he or she is *factually dead* to family and friends: there are no more encounters, no more communications, no more reassurances. For the time being, these cases are, at the very least, cases of *social death*.[5] Detached from the need to have physical evidence, social deaths at the very least involve someone falling out of the framework of possibilities of interaction; be it through mere disappearance or, this is more often the case, through targeted mechanisms of exclusion. The socially dead person thus becomes silent through action, through fate—or through a power that deliberately makes him or her remain silent, if not invisible.

Socially dead is someone who no longer acts as a person or is no longer recognized as one, i.e. someone who is forced into living conditions without interpersonal connectivity (or who possibly puts him- or herself there intentionally). Social death thus concerns, for example, lepers, slaves, serious criminals, disgraced rulers, etc., who are no longer recognized as members of society. Some of them fall victim to *damnatio memoriae*, the strategic suppression of all evidence of their actual existence—a practice

3 The Luftwaffe pilot that allegedly killed Saint-Exupéry during his recon flight was Horst Rippert, who later became sports reporter at the Olympic games for ZDF, one of Germany's biggest TV stations, and who deeply regretted shooting down the plane. See Cassier, Philip/Kellerhoff, Sven Felix: »Ich habe den Piloten nicht erkennen können«, *Berliner Morgenpost*, 18 March 2008, https://www.morgenpost.de/printarchiv/kultur/article102642027/Ich-habe-den-Piloten-nicht-erkennen-koennen.html [accessed 21 April 2024].

4 Kiepal, Laura Christina/Carrington, Peter J./Dawson, Myrna: »Missing Persons and Social Exclusion«, *Canadian Journal of Sociology* (37) 2012, No. 2, pp. 137–168; Greenwood, Elizabeth: *Playing Dead. A Journey through the World of Death Fraud*, New York 2016; Huttunen, Laura/Perl, Gerhild (eds.): *An Anthropology of Disappearance. Politics, Intimacies and Alternative Ways of Knowing*, New York/Oxford 2023.

5 Králová, Jana/Walter, Tony (eds.): *Social Death. Questioning the Life-Death Boundary*, Abingdon/New York 2018.

carried out mainly in antiquity.[6] Slavoj Žižek reports on a more recent example in his blog.[7] As a young man, he witnessed how tennis player Martina Navratilova, who had fled to the West, was world-famous on the one hand, but was hushed up in her native Czechoslovakia on the other. Even in the sports coverage of major tennis events, her name was suppressed rather than mentioned. Czechoslovakian newspapers therefore reported on the participants in the semifinals of a tournament by mentioning only three of the four names. Navratilova was alive and kicking on the tennis court, but in the minds of political officials, she should have been as dead as possible.

Even in the light of such ›expansions‹ of forms of death, in Saint-Exupéry's peculiar case, his ›state of deathness‹ was even more doubtful, for as author of *The Little Prince*, he lived on within his works. He was, and he still is, addressable as the person as whom he was regarded during his lifetime—as Antoine de Saint-Exupéry. When someone talks of the significance or splendor or clichéness of *The Little Prince*, its author's name supposedly is mentioned often. The book is constantly being reprinted all over the world, thus guaranteeing Saint-Exupéry as a reference. And by still being referenced, Saint-Exupéry is still present. He has escaped death insofar as his social death in 1944 has been transformed into a social ›living on‹ in the years that followed. Having achieved some sort of ›cultural immortality‹ (from today's Western well-educated perspective on literature, that is), Saint-Exupéry has never been dead and maybe never will be. But there can be little doubt that his *body* has died more than 80 years ago.

The German missing person's act (*Verschollenheitsgesetz*) was established in 1939. There are similar laws in many other countries. (France, Saint-Exupéry's home country, has a law on the »disparition d'un adulte«, which was verified in June of 2023.) These laws list legal ways to die. It is a death by declaration—a method by which a body is not necessary, be it dead or in any other condition. In fact, this bureaucratic strategy of imposing death upon a person ultimately proofs that the end of life, just as its

6 Varner, Eric: *Mutilation and Transformation. Damnatio Memoriae and Roman Imperial Portraiture*, Leiden 2004; Östenberg, Ida: »Damnatio Memoriae Inscribed: The Materiality of Cultural Repression«, in: Andrej Petrovic/Ivana Petrovic/Edmund Thomas (eds.), *The Materiality of Text. Placement, Perception, and Presence of Inscribed Texts in Classical Antiquity*, Leiden 2018, pp. 324–347.

7 Žižek, Slavoj: »Navalny was Naïve, but not a Fool«, *Goads and Prods*, 19 February 2024, https://slavoj.substack.com/p/navalny-was-naive-but-not-a-fool [accessed 21 April 2024].

continuity, can indeed be separated both from physical matters and from the status of the person at stake. If relatives apply, people that have been missing without a trace for 10 years or more can be declared dead. A small fee and a rubber stamp are all that is needed—and someone who might still be living, might still be missed and loved, becomes a former someone. Uncertainty about the status of the person gives way to an officially pronounced, almost ›ordered‹ certainty. If the missing person is over 80 years of age, then 5 years of non-appearance are already sufficient to declare him or her dead; and under special circumstances (e.g. deliberately jumping into the deep ocean at night), even six months can be enough.

The latter constellation is exactly what applies to German pop singer and TV personality Daniel Küblböck, who fell/jumped over the railing of a luxury liner at around 4 a.m. during a cruise off the coast of Newfoundland in September 2018. A body was never found. Küblböck was pronounced dead in February 2021. The official documents even state a fictitious point in time for his death: 8h55 in the morning, five hours after dipping into the water.[8] Following on that matter-of-fact bureaucratic approach, the assumed separation of body and state of existence implies that people can legally be dead while being alive physically. This is, of course, a thought well established in old caper movies or in documentaries on war criminals: The protagonist's true vanishing point is society's ability to forget he's still existing. After all, the dead aren't prosecuted. Going in hiding, then, and taking on a false identity is an act akin to a resurrection: Life has ended, but this life's end has served a purpose. It grants a different life to a person with a different name, but with the same body.[9] It should

8 Stern: »Gericht erklärt Daniel Küblböck offiziell für tot«, *Stern.de*, 25 March 2021, https://www.stern.de/lifestyle/leute/gericht-erklaert-daniel-kueblboeck-offiziell-fuer-tot-30450052.html [accessed 21 April 2024]

9 A recent example that made global news is the case of Satoshi Kirishima, a Japanese man on the run since 1975, when he was prosecuted for participation in the bombing of a Mitsubishi Industries building that killed eight people. He confessed to police on his deathbed (Japan Times: »DNA Tests Show Dead Man Likely 1970s Bombing Fugitive in Japan«, *Japan Times*, 2 February 2024; https://www.japantimes.co.jp/news/2024/02/02/japan/crime-legal/bombing-fugitive-dna/ [accessed 21 April 2024]). Kirishima was never officially declared dead since he disappeared intentionally; it was regarded likely that he had either left the country and/or changed his identity. The latter was the case. After having been a different person to the outside world, Kirishima finally succumbed to merge his current life and his original identity shortly before his demise from cancer. His tombstone will now carry the name given to him upon his birth, thereby negating crucial aspects of the past almost fifty years. His confession reestablished the traditional order of things: In Kirishima's case, the ›right‹ corpse lies in the right coffin.

come as no surprise that there are people who accuse Küblböck (and others) of secretly going into hiding and faking their deaths.

According to the *Verschollenheitsgesetz*, literally getting lost ›in the air‹ is a circumstance so peculiar that it requires only a three-month waiting period before the missing person can legally be declared dead. This leads back to the disappearance of people in lofty heights. As Saint-Exupéry was an avid pilot, it is not a far stretch to connect his fate to an equally puzzling airborne mystery: the case of Malaysian Airlines 370. MH 370 was a plane that went missing during a flight to Beijing in March 2014. The passengers and crew aboard virtually ›vanished into thin air‹, whereas in reality, their bodies most likely have done nothing like that. On some remote location, probably, as in Saint-Exupéry's case, beneath the sea, a few remains of their bodies may still exist. It is not the body that *vanishes*, it's the person; the body *disappears*, which means that for at least a few decades, chances are that parts of it will resurface.

The distinction between person and body has always been the vexing point at the borderland between life and non-life. If an elderly person, seemingly exhausted, takes a nap on a sofa, observers from afar might not be able to distinguish whether this person is alive and sleeping or dead and therefore outside the state of ›being human‹. There might be clear signs (breathing, small movements) for the continuing of life in this particular body, but they may be unnoticeable. Moreover, and more importantly, observers might not be able to grasp an actual transformation from life to non-life. If said person suffers a heart attack and dies in the very minute when the observers have left the room for a moment,[10] would these observers be able to realize what has happened at first glance once they return? To them, it might seem as if nothing of significance has changed: The person on the sofa is still the same. The position of the body might even be unchanged. However, the short moment of transition that is commonly called death altered the scene entirely, for with the occurrence of the heart attack and the subsequent death, the person no longer is a person. This is at least what is commonly attributed to dead

10 Medical records show that time frame of dying—the amount of time needed until all nerve cells in the brain cease to work following the actual moment of death—oscillates between 13 and 266 seconds (Dreier, Jens: »Die letzte Entladungswelle vor dem Tod ist ein Riesenereignis«, in: Stiftung Humboldt Forum (eds.), *Un_endlich. Leben mit dem Tod*, Leipzig 2023, pp. 102–109, 104). Therefore, in the scenario presented, leaving the room for a mere five minutes would be more than enough to miss the moment of death entirely.

bodies: they used to be persons when they were *animated*—and they are no more than (physical) bodies when their ›soulfulness‹ has disappeared. In German language, a differentiation can be made in this regard between *Leib* and *Körper*, but it escapes translation. Let's assume the elderly person had indeed died when his/her observers took a break. This person, represented by her body (because identity in face-to-face-situations is attributed towards bodies), was alone in the room for a short amount of time. When the observers came back, that body was still there, but in the meantime, the room had become deserted. The person is gone – the body remains.

While the process of dying is usually considered as if it were heading towards the crossing of the boundary line between clearly defined states —namely: life and non-life—, intermediate states and shades of gray can actually be found in many respects. The natural scheme of physiology that Canadian sociologist Erving Goffman spoke of in the 1970s—a part of the natural framework that is »deterministic, will-less, nonmoral«, according to him,[11] is no longer so easy to talk about today, since the perspective has shifted and room (and attention) has been given to liminal states.

The passengers and crew of MH 370, just one of many examples,[12] have reached an intermediate state between *being there* and *nonexistence*. Some of their relatives still store hope and are willing to embrace all sort of miraculous circumstances without further inquiry if their loved ones were to emerge alive out of this strange tale of sudden disappearance. To these hopeful people, the inaccessibility of the dead body, which must be assumed here, is a driving force of confidence. They may perhaps even underpin their hope with the—actually entirely different—case studies in which abducted people were released after many years of captivity. These cases seem to ›prove‹ that even after many years of absence, and after the irrefutable arrival of social death, a resurrection is possible. Unlike Saint-Exupery, whose fame kept him alive as a name (or rather, as an address, as stated above) while his physical condition was uncertain, the passengers of the airplane are not well-known enough to be remembered on the long term. And that is precisely why they, more than the French writer, are in the paradoxical position of being able to ›resurrect‹. For to

11 Goffman, Erving: *Frame Analysis. An Essay on the Organization of Experience*, New York 1974, p. 188.

12 For more, see Benkel, Thorsten: »Fragwürdig eindeutig: Eine Exkursion in die Schattenzone des Wissens«, in: Thorsten Benkel/Matthias Meitzler (eds.), *Zwischen Leben und Tod. Sozialwissenschaftliche Grenzgänge*, Wiesbaden 2019, pp. 1–29.

achieve this stadium, you have to have been dead enough without being *too dead*.

Reappearance

With regard to determining the beginning and the end of life, borderline states are by no means rare exceptions. The cultural history of determining criteria for the end of life, to focus on this particular discourse, speaks volumes about the ambiguities involved. It underlines the driving need for clarification that has not only haunted various academic disciplines for centuries, but has also affected the comprehending minds of committed citizens.

It is effortlessly possible to cite examples which show that it is not *unambiguousness*, but rather *transition* that shapes the images of dying and death. These transitional phenomena are not academic constructions, but are interwoven into social negotiations, and they take place on the lifeworld level. Particularly vivid are forms of expression in the popular cultural frame of reference that recapitulate actual (e.g. medical) borderline states in a pointed form. They also serve to illustrate their potentials and dangers and are therefore, especially in a concentrated form of presentation, preferable to presuppositional legal and medical specializations. In addition to the episodes mentioned above, these include, among many others, the following.

(a) The millennia-old idea that *spirit beings* continue to have a para-social presence after death has been shipped off in all kinds of cultural disguises. This is, on the one hand, fairy tale content; yet on the other, it is also an expression of sincerely felt observations. These observations are for the most part considered frightening and terrifying, but at the same time, they are what some have just been longing for. That spirits do appear is a long-disproved rumor, but also the content of diverse religious belief systems; it is never quite tangible—but also never quite distant. As I have tried to show elsewhere,[13] this phenomenon can be productively examined by engaging with Jacques Derrida's post-struc-

13 Benkel, Thorsten: »Leben in Klammern: Über sozialontologische Grenzbereiche«, in: Manuel Stetter (ed.), *After Life. Die soziale Präsenz der Toten*, Bielefeld 2025 (forthcoming).

turalist perspective, if one does not want to take the ethnographic route through the sub-sensory world of ghost hunters.[14]

(b) The *cryonic procedure* promises a further life of the body by having it frozen in at below -300 degrees Fahrenheit (around -200 degrees Celsius). Future generations will then have the chance to defrost said body and revive it, and afterwards possibly even heal ailings that it might have had at the time of being cryonized. (The implication is that this will also stop the aging process.) The commercial companies that offer cryonics as a sort of time-consuming sleep also offer cheaper freezing methods and monitored storage of just the head. This has nothing to do with death in the conventional sense, those providers usually claim; and yet, the cryonization procedure, where it is legal at all, is usually set in motion once a traditional (medical) determination of death has been fulfilled.[15] Here, too, the notion of resurrection is apparent, for cryonics promise to turn anyone into a Jesus-like figure—into a person that was once bid farewell, but that reappears on the social stage with the help of powers that almost seem supernatural. Even if all of that were true, which is highly doubtful,[16] the resurrection and continued existence would not necessarily lead to a life in paradise, however, but into a foreign social world and a high pressure to adapt quickly.

(c) The (originally religious) concept of the *zombie*. While spirits—as the term suggests—carry a transcendental component and are therefore considered subtle and ethereal (making them all the more frightening in the imagination of those who belief to encounter them), zombies, on the contrary, are the pure ›afterlife‹ of primitive flesh. According to film history and popular culture in general, they are powered by an irrepressible lust for living people's flesh, which can easily be read as a moral metaphor for too much sexual greed. Interestingly,

14 Eaton, Marc A. »›Give us a Sign of your Presence‹: Paranormal Investigation as a Spiritual Practice«, *Sociology of Religion* 76 (2015), No. 4, pp. 389–412; Ruickbie, Leo: »The Haunters and the Hunters: Popular Ghost Hunting and the Pursuit of Paranormal Experience«, in: Darryl Caterine/John W. Morehead (eds.), *The Paranormal and Popular Culture. A Postmodern Religious Landscape*, Abingdon/New York 2019, pp. 92–104.

15 Cohen, Jeremy: »Frozen Bodies and Future Imaginaries: Assisted Dying, Cryonics, and a Good Death«, *Religions* 11 (2020), No. 11, Art. 584.

16 Hart, Amalyah: »Can Human Bodies Really be Cryogenically Frozen?«, *Cosmos Magazine*, 12 May 2020, https://cosmosmagazine.com/news/can-human-bodies-really-be-cryogenically-frozen/ [accessed 21 April 2024].

whether zombies are humans or not has even been clarified in Germany by the constitutional court, the *Bundesverfassungsgericht*, in 1992 in a verdict concerning the movie *The Evil Dead*. They are not, the court says.[17] This distinction lends a revealing ontological status to the factually non-living in two respects—zombies do not exist ›in real life‹ *and* are ›undead‹ within the corresponding horror narratives. It places them (probably involuntarily) in discursive proximity to debates about the living status of patients in comas or vegetative states. In a completely different way, these patients are often also thrown back to the basic vegetative functions of the body, but from an ethical perspective, they are unquestionably considered living beings.

(d) The phenomenon of so-called *near-death experiences*. This refers to the more or less exemplary experiences of supposedly deceased people who just managed to escape death through medical rescue intervention, but were able to look into its face beforehand. While the scientific explanation tends to assume that neurological effects under the extreme stress of an accident or other tense situations trigger the apparent death,[18] quite a few of those who have had the experience affirm that it is a ›real‹ death—or at least something that feels like it.[19] According to this narrative, however, an intermediate state must have been entered, for neither has life ended completely, nor has non-life been fully realized. This is also suggested by the terminology which speaks of a ›near‹ death. Within this context, there are reports from antiquity[20] that imply that an intermediate zone between life and non-life is part of the cultural-historical heritage of modernity.

(e) The idea of *transmortality*. This refers to the question on the validity of organ donations in the light of the uncertainty of ›objective‹ features for certain death.[21] Were the body parts that are transferred during an

17 Möller, Kai: »Die Verhältnismäßigkeit des Gewaltdarstellungsverbots«, *Kritische Vierteljahresschrift für Gesetzgebung und Rechtswissenschaft* 88 (2005), No. 3, pp. 244–254.

18 Fischer, John Martin: »Near-Death Experiences: The Stories they Tell«, *Journal of Ethics* 22 (2018), No. 1, pp. 97–122.

19 Knoblauch, Hubert/Schmied, Ina/Schnettler, Bernt: »Different Kinds of Near-Death Experience: A Report on a Survey of Near-Death Experiences in Germany«, *Journal of Near-Death Studies* 20 (2001), No. 1, pp. 15–29.

20 Sluijs, Marinus van der: »Three Ancient Reports of Near-Death Experiences: Bremmer Revisited«, *Journal of Near-Death Studies* 27 (2009), No. 4, pp. 223–253.

21 Pfaller, Larissa/Hansen, Solveig L./Adloff, Frank/Schicktanz, Silke: »›Saying no to Organ Donation‹: An Empirical Typology of Reluctance and Rejection«, *Sociology of Heath and Illness* 40 (2018), No. 8, pp. 1327–1346.

organ transplant operation *dead* and were they subsequently *resuscitated*—or were they still ›a little bit alive‹ and therefore easy to migrate from one body into another? This is an uncomfortable question since it suggests a transitional stage between life and non-life, which has not yet been sufficiently outlined in medicine. It may also describe an extension of the death phase. Either way, such declarations can at best function as an analytical tool; the corresponding debates do not generate any added value for empirical problems in the medical field.[22]

(f) Among various similar cases from all over the world in which *a dead womb contained a living fetus*, the 1992 incident from Erlangen stands out. Under unexplained circumstances, a young woman drove her car into a tree. She was declared brain dead three days after the crash. However, the fetus in her womb continued to show vital signs and was therefore cared for at the hospital for weeks—which was achieved by keeping the dead mother's body alive artificially with the help of medical equipment. The case caused an outcry that went beyond German borders as it touched on fundamental ethical issues:[23] Who would have the legitimacy to decide which course of action was appropriate? And what does this say about the reliability of the brain death criterion? The case can also be linked to many previous and current debates in the field of medical ethics.[24] To this day, the case circulates under the title ›Baby of Erlangen‹, although the fetus never had the opportunity to exist as a baby. It died 38 days after the accident, in the 21st week of pregnancy. For these 38 days, the mother's body encompassed both life and death.

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22 Nor, incidentally, does the use of language in medical practice to speak of ›revival attempts‹ when dealing with people whose serious injuries take them to the brink of death; saving them at the last moment is not an act of raising the dead.

23 Anstötz, Christoph: »Should a Brain-Dead Pregnant Woman Carry her Child to Full Term? The Case of the ›Erlanger Baby‹«, *Bioethics* 7 (1993), No. 4, pp. 340–350.

24 See for example: Dzeng, Elizabeth: »Navigating the Liminal State Between Life and Death: Clinician Moral Distress and Uncertainty Regarding New Life Sustaining Technologies«, *American Journal of Bioethics* 17 (2017), No. 2, 22–25; Heywood, Rachel: »Live or Let Die? Fine Margins between Life and Death in a Brain-Dead Pregnancy«, *Medical Law Review* 25 (2017), No. 4, pp. 628–653; Willig, Carla/Wirth, Luisa: »Liminality as a Dimension of the Experience of Living with Terminal Cancer«, *Palliative and Supportive Care* 17 (2019), No. 3, pp. 333–337; Feldman, Deborah M./Borgida, Adam F./Rodis, John F./Campbell, Winston A.: »Irreversible Maternal Brain Injury during Pregnancy«, *Obstetrical and Gynecological Survey* 55 (2000), No. 11, pp. 708–714.

(g) Post-mortem survival enabled through the powers of *artificial intelligence and digitalization*. While the dead body usually is stored out of plain sight and rots away, there are many entrepreneurs now testing the possibilities of overcoming dead corporeality by resurrecting it on the monitor. Through the use of AI and deepfake technology, it should be possible in the near future to allow the deceased to live on as avatars based on data provided during their lifetime. Limited to the conditions of existence as a computer simulation, the dead can hypothetically live on forever, answer questions, give advice, reassure, and certainly also frighten. The opportunities and dangers emerging from this prospect are currently the subject of extensive debates.[25] Its relevance is reflected in its prominence as a popular cultural theme. In various films, one of them being *Another End* (directed by Piero Messina in 2024), corresponding science fiction and, moreover, social fiction considerations are imagined, with drama usually taking its place alongside consolation.

(h) Lastly, to sum up this short panorama, there is a sketch hailing from the first season (1969) of the British TV show *Monty Python*. A visitor to a pet shop complains to the sales clerk that the parrot he had bought there hours before had on closer inspection turned out to be dead. It had in fact been nailed to its perch, but was clearly no longer alive. The dealer disagrees: the animal is by no means dead, but rather fast asleep. It ends with the angry buyer, in an absurd rage, repeatedly banging the stiff parrot's body on the sales desk to demonstrate that Polly Parrot can indeed no longer wake up. The joke is that there are fixed states that seemingly cannot be faked—although that is exactly

25 Osler, Lucy/Krueger, Joel: »Communing with the Dead Online. Chatbots and Continuing Bonds«, *Journal of Consciousness Studies* 29 (2022), No. 9/10, pp. 222–252; Belén, Jiménez-Alonso/Brescó de Luna, Ignacio: »Griefbots: A New Way of Communicating with the Dead?«, *Integrative Psychological and Behavioral Science* 57 (2023), No. 2, pp. 466–481; Benkel, Thorsten: »Dynamiken der Delokalisierung: Körper, Tod und Digitalität«, in: Dorothee Arnold-Krüger/Sven Schwabe (eds.), *Sterbebilder. Vorstellungen und Konzepte im Wandel*, Stuttgart 2023, pp. 87–107; Morse, Tal: »Digital Necromancy: Users' Perceptions of Digital Afterlife and Posthumous Communication Technologies«, *Information, Communication and Society* 27 (2023), No. 2, pp. 240–256; Recuber, Timothy: *The Digital Departed. How we Face Death, Commemorate Life, and Chase Virtual Immortality*, New York 2023; Meitzler, Matthias/Heesen, Jessica/Hennig, Martin/Ammicht Quinn, Regina: »Digital Afterlife and the Future of Collective Memory«, in: Sarah Gensburger/Frédéric Clavert (eds.), *Is Artificial Intelligence the Future of Collective Memory?*, Leiden 2024 (forthcoming).

what the shop owner attempted here. Today, the punch line would probably have to be different, at least when it is presented to people who are in the thanatological sector and who know that there is not simply dying and being dead, but also something that Werner Schneider calls »doing dying«[26].

As can be seen, my examples mix fictional and not-so-outlandish episodes to demonstrate that the borderline states that I am concerned with can be found on many cultural levels. Many of these intermediate states have their origins in the fact that the prevailing definitions in the judicial or medical field cannot actually be as objective as they often claim to be. As mere attributions, they do not define existing factual conditions. Rather, they describe the consensus of the (mostly) academic, (mostly) Western world, through which uncertain situations are given a supposedly unambiguous definition or solution.

After a long period of differentiation, the Harvard criterion of brain death (defined in 1968) seems to have established a largely reliable instrument to distinguish between the states of living and non-living.[27] However, this criterion is a kind of red herring for the largely unproblematic everyday life of physicians, since it is only valid as long as there are no serious counter-arguments. Upon closer inspection, this seemingly stable partition was invalid from the beginning, as a comparative cultural view could easily reveal. In non-Western cultures, the transitions between life and non-life are more fluid, less strongly bound to the body, and are therefore sometimes even reversible.[28] And even in the West, there has never been a ›balance‹ between the supposed antipoles of life and non-life

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26 Schneider, Werner: »Risky Dying. How to Address End of Life Issues as Scientists in Reflexive Modernity?«, manuscript (used with permission of the author), s. l. 2015.

27 Truog, Robert D./Pope, Thaddeus Mason/Jones, David S.: »The 50-Year Legacy of the Harvard Report on Brain Death«, *Journal of the American Medical Association* 320 (2018), No. 4, pp. 335–336.

28 Probably the most famous example is an indigenous group in Indonesia, the Toraja, who live on the island of Sulawesi. The Toraja have the tradition (which survived their Christianization by Dutch missionaries) of unburying the dead bodies of their loved ones in certain periods of time in order to reintegrate them into their families for a few days. Although the soil's specific chemistry preserves the corpses to a certain degree, the signs of decay on these bodies cannot be overseen; and yet, there is no fear of contact on the side of the relatives (Hollan, Douglas: »To the Afterworld and Back: Mourning and Dreams of the Dead among the Toraja«, *Ethos* 23 (1995), No. 4, pp. 424–436). This ceremonial procedure has made Sulawesi a popular destination for tourists with a taste for the macabre.

that would have corresponded to an ›ideal-typical‹, unrelatable purity. In other words, the very presentation and cultivation of these two existential core states has always been a tool to cover those situations that could not correspond to dualism.

Despite all of that, it must be noted that the understanding of physical ›final states‹ in general is still widely regarded as a well-grounded perspective. Yet at the same time, it is continuously changing. This transformation of knowledge is gradually leading to alternative insights into the merely provisional validity of a dead, or rather of a ›no-longer-alive‹ body and/or human being. This is at least true for circles of experts who are interested in corresponding shifts and breakdowns.

What presents itself as a problem to the layperson is ›everyday life‹ for the expert group: All insights are only temporarily valid and will be overtaken by later/deeper/better findings. It is remarkable in itself that the scales of »elementary forms« such as life and death, speaking with Emile Durkheim's classic book of 1912,[29] can be subject to this changeability—but they obviously are. What is decisive in this context is not only the process of change within science, which at first seems to be more evolutionary than revolutionary, but rather the more or less subsequent understandings of death in the general population.

The intrusion of uncertainty into the seemingly crystal-clear medical systematics causes uneasiness—more so, perhaps, than curiosity. And this uncertainty of physical border states obviously motivates many people in search of reliable alternatives guidelines to redraw the verges of life as well as of death on the basis of ideological concepts. Traditional ideas are thus being replaced by neo-hegemonies. As a result, increasing struggles over the right interpretation (in German: the *Deutungsmacht*) take place—struggles which are, of course, not new, for they have always been part of the discourse history of the liminal body.

Science and art

Without clarification on death, life cannot be understood either. This is, trivially, conditioned by the fact that the central »mode of existence«,

29 Durkheim, Emile: *The Elementary Forms of Religious Life*, New York 2001.

to allude to Bruno Latour,[30] begins through what we conceive as birth. We thereby (most of us, at least) become socially addressable beings.[31] Therefore, the starting point not only of life, but also of this text, is the longevity of the name, a name such as Saint-Exupéry. The very attribution of this identity to a (mortal) body creates a fundamental independence of both variables: the body can disappear or be destroyed. The personal identity can be affected by this—but under certain circumstance, *it does not have to be*.

Often misunderstood as the end of life, death is actually the short-term transition that separates life from its actual counterpart, non-life. Death therefore only *seems* to end a life-long process and progress. In poetic fashion, death is often said to ›close the cycle‹. However, this idea is solely plausible if not only all religious concepts of the afterlife, but also all ideas of social reference to the deceased were invalid. And this is impossible to claim empirically. Even the mere thought of the deceased and the associated mental regression to situations lived through together (a sort of *transcendence*, as Thomas Luckmann claims[32]) already contradicts the idea of life as a simplistic cyclical model.

Moreover, the cited examples and the implied hints of uncertainty, of intermediate stages, of liminality and so on are anything but a ›conclusion‹. Cyclical concepts become contentious due to the incompleteness of the mode of existence in question, which is by no means a disadvantage—quite the contrary. As is known from many case studies, irritations of knowledge are likely to become generators of *new* knowledge. And whatever new knowledge is generated in the process can be irritated in turn.

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30 Latour, Bruno: *An Inquiry into Modes of Existence. An Anthropology of the Moderns*, Cambridge 2018.

31 It has become established as a cultural convention in many regions of the world that (para)social relationships are also developed towards foetuses—and therefore to a life that does not yet (legally) exist, but is socially anticipated (Völkle, Laura/Wettmann, Nico: »The Process of Pregnancy: Paradoxical Temporalities of Prenatal Entities«, *Human Studies* 44 (2021), No. 4, pp. 595–614). On the other hand, times and spaces can be identified in which certain population groups were actively denied the quality of ›sociality‹ with the consequence of cultural acceptance for the killing of newborns or the infirm, for example. Consequently, the label of liminal existence was imposed on these groups as well, declaring them not only as socially dead, but also as immediate candidates for the active destruction of their life by others (Shalinsky, Audrey/Glascock, Anthony: »Killing Infants and the Aged in Nonindustrial Societies: Removing the Liminal«, *Social Science Journal* 25 (1988), No. 3, pp. 277–287).

32 Luckmann, Thomas: *The Invisible Religion*, New York 1967.

Since the early 1960s at the latest,[33] it has been clear that it is actually not the gradual build-up of knowledge in the sense of an evolution of knowledge that brings progress exclusively. Progress also comes irregularly, unpredictably and often with an open end, with the revolutionary leaps that science is capable of and to where science is being driven precisely by its engagement with intermediate states.

Cultural facets that shed light on the border demarcation problem described in this text can be found in many reports from many different regions of the world.[34] The confrontation with them does not always take place against the background of irritated knowledge. Instead of being discussed within scientific discourse, in the past, they were often addressed in an aestheticized way. To make up one's mind on whether the end is really the end or a new beginning, or whether there has been something at all that could have ended in the first place etc. is also of importance in religious circles (although some of these questions, while broadening the mental horizon, certainly border on blasphemy). Ideas concerning the *unfinishability* of life and/or of the *conquerability* of death—ideas that may initially have been regarded as threatening to dominant beliefs and then, later, were viewed differently in terms of their value, for example as ›romantic‹[35]—have undoubtedly changed their character once the natural sciences successfully began their triumphal march as the primary source of knowledge and explanation of the world. At the same time, however, there has been no long-term acceptance of a resounding positivism, nor are there any objective explanations for the phenomena described here that would be valid worldwide. It is therefore possible to devalue the sci-

33 Kuhn, Thomas: *The Structure of Scientific Revolutions*, Chicago 1962.

34 See Geest, Sjaak van der: »Between Death and Funeral: Mortuaries and the Exploitation of Liminality in Kwahu, Ghana«, *Africa* 76 (2006), No. 4, pp. 485–501; Berger, Peter/Kroesen, Justin (eds.): *Ultimate Ambiguities. Investigating Death and Liminality*, New York/Oxford 2015; MacArtney, John I./Broom, Alex/Kirby, Emma/Good, Phillip/Wootton, Julia: »The Liminal and the Parallax: Living and Dying at the End of Life«, *Qualitative Health Research* 27 (2017), No. 5, pp. 623–633; Zulato, Edoardo/Montali, Lorenzo/Bauer, Martin W.: »Understanding a Liminal Condition: Comparing Emerging Representations of the ›Vegetative State‹«, *European Journal of Social Psychology* 51 (2021), No. 6, pp. 936–950; Tripathi, Khyati: »Exploring the ›Liminal‹ and ›Sacred‹ Associated with Death in Hinduism through the Hindu Brahminic Death Rituals«, *Open Theology* 8 (2022), No. 1, pp. 503–519, and many others.

35 Praz, Mario: *The Romantic Agony*, New York 1956.

entific perspective itself as a kind of religious conviction.[36] And inevitably, at least in some cases, a fundamental openness is required regarding the question of when death has arrived and when it has not (the same applies to life). While it is debatable whether these very special contexts are of interest for everyday routine, it is undeniable that death is thus—after all—itself a lively topic if observed closely enough.

As mentioned above, exciting examples of the re-emergence of liminal states can also and especially be found in art. They were painted several times by Edgar Allan Poe, the icon of gothic horror literature in the nineteenth century. When I stood in front of Poe's grave in Baltimore, it didn't look as if the stone monument was going to shift any time soon to make way for a resurrection of the famous man buried here. But that would be unnecessary; after all, Poe the author was never as dead and buried as some of his most prominent figures—and never as dead as his own body.

In the short story *The Premature Burial* (written exactly 100 years before Saint-Exupéry disappeared), a rich man fears nothing more than apparent death. Consequently, he has a pompous tomb built for himself, which has numerous technical devices through which he would be able to convince the outside world of his (factual, not just spiritual) continued life in the event of his apparent death. It comes as it must: of course, he ›dies‹. He suffers a suspended animation, awakens after his funeral, and one by one, all mechanisms that should save him from his prison fail. Finally, it turns out that everything is a misunderstanding, a delusion caused by mental confusion.[37] It was this mental confusion that, within the story, enabled the experience of a strange state between obvious vitality and the impossibility to prove it. Poe emphasizes that his stories, though fictional, are animated by his need to always remain »within the limits of

36 Cortés, Manuel E./Río, Juan Pablo del/Vigil, Pilar: »The Harmonious Relationship Between Faith and Science from the Perspective of Some Great Saints«, *Linacre Quarterly* 82 (2015), No. 1, pp. 3–7.

37 Whereas Roger Corman's film version from 1962, the year Kuhn's famous book came out, is set in the British Victorian era and rather assumes a mean staging by the unfaithful wife. The following slogan was emblazoned on the advertising poster, intertwining the audience with the fate of the protagonist (cf. Alexander, Chris: *Corman/Poe*, London 2023, p. 140): »It's going to happen! You are there in sudden darkness when the heart beat starts… Will *you* be the first to crack?«

the accountable«, i.e. »of the real«,[38] in this case in order to say something about real life by talking about false death.

Read in the light of liminality, the plot of *The Premature Burial* is about the fear that there could be an ›unfinished situation‹. It is all about a condition that one seemingly could encounter as experience, while no one can grasp or explain or define beforehand what this means for the spectrum of the traditional life/death-dualism. One could argue that the fear of death in Poe is a fear of dying *the wrong way*. In this respect, his story in a sense is ›prolife‹ without simultaneously being ›contra death‹; for there is, it is implied, a good death, which is death without intermediate states. The problem is not dying, but being caught between two stools, so to speak.

In other stories by Poe, however, it is conveyed that death itself is a problem and that one can overcome the crucial dualism through willpower. This is the essence of his own favorite tale, *Ligeia* of 1838.[39] Here, Poe quotes an unknown poem (most likely authored by himself) as a motto, which states: »And the will therein lieth, which dieth not. […] Man doth not yield him to the angels, nor unto death utterly, save only through the weakness of his feeble will.«[40] *Ligeia* is about a man living on the river Rhine who loses his lover Ligeia due to illness. She was a woman of great beauty, wisdom and passion, the reader learns, and obviously an avid reader of the philosophy of Arthur Schopenhauer. Following this tragic loss, the man re-marries in England, but his second wife, Lady Rowena, becomes sick and threatens to die as well. This, however, saddens the husband little as he still mourns for Ligeia. Rowena is as good as dead, then suddenly recovers, falls back in a state of deadness, then seems to recover yet again. Finally, she emerges from her deathbed, fully alive, but with her physique changed. She has somehow transformed into Ligeia, who has come back to life through her sheer will. This does not fill the man with joy, but with deep shock.

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38 Poe, Edgar Allan: »Philosophy of Composition«, in: id., *Literary Criticism*, Lincoln 1965, pp. 20–32, 31.

39 *Ligeia* was also made into a movie by Corman. It was created in 1964, with Corman's usual artistic liberties compared to the original, under the title *The Tomb of Ligeia*. Poe explores the connection between deathbed, intimate longing and transgression, which is central to *Ligeia*, also lyrically, for example in his poem »Annabel Lee«, which incidentally was published two days after his death, becoming a sort-of literary requiem to its author.

40 Poe, Edgar Allan: *The Complete Tales and Poems*, Toronto 1938, pp. 655-656.

In Poe's day, the prospect of states being ambiguous was worrisome. Even if death is conquered and the beloved is back, a sin has been committed against nature, decency, and order. And those who expressly intend to act this way act all the more frighteningly. In some respects, not much has changed since then—except that some of the made-up stories of yesteryear are the ›medical exceptions‹ of today. And the closer you look at them, the less exceptional they seem. Even today, one can hope for the overcoming of death, ask for a delay, or may be frightened that not everything goes ›according to plan‹. Thus, one can still be afraid for the fact that *unambiguity* does no longer exist—which would, if it did, without doubt make everything much, much easier.

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Julia Dornhöfer

Planning the Passage: How Living Wills Could Help Breaking the Death Taboo and Give Cultural Change a Nudge

Death is when other people's body clocks
strike the hour every minute
(Heathcote Williams, 1973)[1]

The lines mentioned above are taken from Heathcote Williams' poem *Death is taboo but there's no taboo against dying* in which the author tries to catch multiple occurrences of death and obviously wants to break the taboo. The English writer pursues his goal not only with poetry, but also visually, when he begins 37 lines one below the other with the word »Death«, which looks pretty impressive in print. The elected quote may evoke different images among readers, but the common ground should be that dying and death are omnipresent in human life although both might be out of sight. Especially in Western societies like Germany most people die in the secluded space of institutions nowadays, primarily in hospitals and senior homes. The medical supply in German hospitals is highly advanced. Like in many other wealthy countries institutional medical care is characterized by huge technical progress. In intensive care units patients can be kept alive by machines that manage many existential body functions like breathing and nutrition supply. As a consequence, death can be artificially avoided—theoretically (and if affordable)—for an undetermined period. In addition, studies circulate that predict an increasing number of patients who will receive intensive care in future especially at the end of life.[2] Facing growing opportunities for life-prolonging measures people are requested to describe their wishes for medical treatment

1 Williams, Heathcote: Death is Taboo but there's no Taboo against Dying, in: The Transatlantic Review (1973), No. 48, p. 31.

2 E.g. Carolin Fleischmann-Struzek et al. evaluated retrospectively the case-based hospital statistics in Germany from 2007 to 2015 and come to the conclusion, that among hospital deaths, the proportion of patients receiving intensive care increased by 2.8% annually from 20.6% (2007) to 25.6% (2015). In the 65+ age group, the number of people who died in hospital and received intensive care rose three times as fast as the number of hospital deaths. Fleischmann-Struzek, Carolin et al.: Hospitalisierung und Intensivtherapie am Lebensende. Eine nationale Analyse der DRG-Statistik zwischen 2007 und 2015, in: Deutsches Ärzteblatt 116 (2019), No. 39, pp. 653–660. – Direct and indirect quotes from

in a living will in case they are not able to consent or deny certain treatments. Citizens are asked to figure out their personal conditions under which they finally want to die.

The aim of this chapter is to provide a cultural studies perspective on the living will in recent German society. As the anthropologists Billy Ehn, Ovar Löfgren, and Richard Wilk put it, cultural studies »explore the mysteries of everyday life, all those seemingly trivial tasks and routines that shape people's lives, often in unconscious ways« and which »play a powerful role, especially in the reproduction of society.«[3] Although the history of living wills in Germany began back in 1978, when a German-language version of a patient letter was published by Wilhelm Uhlenbrock for the first time,[4] they have only gained wider attention over the last 20 years.[5] The legal regulation of living wills and their incorporation into the German Civil Code in 2009 to safeguard patients' rights can be seen as an important marker for the relatively young broader relevance of the topic in the everyday lives of ordinary people.

I will show a) how the preparation of a living will challenges the authors when they are asked to define their personal boundaries within the passage from life to death, and b) how a taboo around death and dying inflicts the whole endeavor, and finally c) point out the transformative power of liminality and taboos. Above all, the chapter strives to emphasize the potential of living wills to overcome the unconscious social reproduction of a death taboo that still remains in certain contexts.

In this light it might become clearer why I have chosen Williams' quote at the beginning. It was not just because it looked appealing with »Death« and »taboo« in the title—I chose it, moreover, because of the artist himself and Williams' general attitude towards taboos. The artist, who died in 2017, is known for being a »fire-eater« with »anarchist ener-

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literature and sources in German language were translated by the author. Bibliographical references are given in accordance with the German-language originals.

3 Ehn, Billy/Löfgren, Ovar/Wilk, Richard: Exploring Everyday Life. Strategies for Ethnography and Cultural Analysis, Lanham et al. 2016, p. 1.

4 Uhlenbruck, Wilhelm: Der Patientenbrief. Die privatautonome Gestaltung des Rechts auf einen menschenwürdigen Tod, in: NJW (1978), No. 12, p. 566–570.

5 Florian Greiner provides a detailed historic overview in his recently published postdoctoral thesis, in which he analyses the change in ideas about ›good‹ and self-determined dying in the second half of the twentieth century in West- and East-Germany. Greiner, Florian: Die Entdeckung des Sterbens. Das menschliche Lebensende in beiden deutschen Staaten nach 1945, Berlin 2023.

gy«[6] and was one of the founders of *Suck*, an underground porn-magazine in the UK that contributed to a liberal sex life including queerness in the 1970s.[7] So, one can say, Heathcote Williams had a taste for taboos and pushing the limit. I find this quite inspiring here. But how can I get on board like this? Are dying and death still taboos in recent Western societies? Different voices give different answers. I turn to that question first.

Taboo or not Taboo?[8]

Looking backwards it can be said very briefly that from the middle of the twentieth century—when Geoffrey Gorer noted in his *Pornography of Death*[9] in 1955 that death had replaced sex as a taboo—until the early twenty-first century the dominant idea in the humanities was that death had vanished as a social experience as it was more and more institutionalized, mainly in hospitals. During this period several prominent academics felt an urge to raise awareness on the significant absence of death in everyday life and testified that we lived in a »death-denying culture.«[10] In the late 1960s Walter Benjamin stated that »in the course of modern times dying has been pushed further and further out of the perceptual world of the living.«[11] French sociologist Philippe Ariès described the *mort inter-*

6 Gowrie, Grey: Heathcote Williams. A Tribute, in: London Magazine (2017), Aug/Sep, pp. 10–13.

7 Coveneye, Michael: Heathcote Williams Obituary, in: The Guardian 02.07.2017, www.theguardian.com/culture/2017/jul/02/heathcote-williams-obituary (23.01.2024).

8 For the genealogy and scientific history of ›taboo‹, starting with captain James Cook's explorations and focussing on Sigmund Freud's implementation in psychology, see: Gutjahr, Ortrud: Tabus als Grundbedingungen von Kultur. Sigmund Freuds Totem und Tabu und die Wende in der Tabuforschung, in: Benthien, Claudia/Gutjahr, Ortrud (eds.): Tabu. Interkulturalität und Gender, München 2008, pp. 19–50.

9 Gorer, Geoffrey: The Pornography of Death, in: Encounter 5 (1955), No. 4, pp. 49–52. I like to add private economical resources as another crucial taboo in Germany.

10 E.g.: Kellehear, Allan: Are we a ›Death-denying‹ Society? A Sociological Review, in: Social Science and Medicine 18 (1984), No. 9, pp. 713–721; Blum, Mechthild/Nesseler, Thomas (eds.): Tabu Tod, Freiburg im Breisgau 1997; Callahan, Daniel: Death and the Research Imperative, in: New England Journal of Medicine 342 (2000), No. 9, pp. 654–656; Feldmann, Klaus: Tod und Gesellschaft. Sozialwissenschaftliche Thanatologie im Überblick, Wiesbaden 2010, p. 77; Jüchen, Aurel von: Das Tabu des Todes und der Sinn des Sterbens, Stuttgart 1984.

11 Benjamin, Walter: Illuminations, New York 1969, p. 93f.

dite, the forbidden death, in his *Western Attitudes toward Death*[12] in 1974 and some years later the *invisible death*[13] in Western societies. German sociologist Norbert Elias published his observations on *The Loneliness of the Dying*[14] in 1985, and in the early 1990s Polish sociologist Zygmunt Baumann reminded us that the awareness and knowledge of human mortality provides the way to the »major source of life's meaning.«[15] At the beginning of the twenty-first century Hubert Knoblauch and Arnold Zingerle again stressed the displacement of death from social frames into institutional contexts.[16] But at the same time different evaluations came up as well leading to the assumption that the death taboo had become less relevant or even had been overcome.[17]

Gerd Göckenjan, a specialist for German health politics, clearly doubts that death still is repressed and tabooed completely in recent German society. He explicitly states that it would be wrong to say that dying and death are not communicated about. In his view rather a division of the topic can be observed: There would be actually little to say about death in our society, death would be the incomprehensible non-existence, essentially left to its own devices—on the other hand, a great deal would be said about dying, dying would be a widely discussed, public topic.[18] Göckenjan also notes that the public discussion of death started in the

12 Ariès, Philippe: Western Attitudes toward Death. From the Middle Ages to the Present, London 1974.

13 Id.: Invisible Death, in: The Wilson Quarterly 5 (1981), No. 1, pp. 105–115.

14 Elias, Norbert: The Loneliness of the Dying, New York/London 2001 [1985].

15 Baumann, Zygmunt: Mortality, Immortality and other Life Strategies, Cambridge 1992, p. 9.

16 Knoblauch, Hubert/Zingerle, Arnold: Thanatosoziologie. Tod, Hospiz und die Institutionalisierung des Sterbens, in: Knoblauch, Hubert/Zingerle, Arnold (eds.): Thanatosoziologie, Berlin 2005, pp. 11–27.

17 E.g.: Lee, Raymond L. M.: Modernity, Mortality and Re-Enchantment. The Death Taboo revisited, in: Sociology 42 (2008), No. 4, pp. 745–759; Scharf, Susan: Ein Tabu bricht auf. Vom sich wandelnden Umgang mit Sterben, Tod und Trauer, Hamburg 1999; Staudt, Christina: From Concealment to Recognition. The Discourse on Death, Dying, and Grief, in: Bartalos, Michael K. (ed.): Speaking of Death. America's new Sense of Mortality, Westport, CT/London 2009, pp. 3–41; Walter, Tony: Modern Death. Taboo or not Taboo?, in: Sociology 25 (1991), No. 2, pp. 293–310; Wong, Paul T. P.: Meaning Making and the Positive Psychology of Death Acceptance, in: International Journal of Existential Psychology & Psychotherapy 3 (2010), No. 2, pp. 73–82; Zimmermann, Camilla/Rodin, Gary: The Denial of Death Thesis. Sociological Critique and Implications for Palliative Care, in: Palliative Medicine 18 (2004), No. 2, pp. 121–128.

18 Göckenjan, Gerd: Sterben in unserer Gesellschaft – Ideale und Wirklichkeiten, in: Aus Politik und Zeitgeschichte (APuZ) 4 (2008), pp. 7–14.

1970s and is closely connected to the ideas of the hospice movement until today.

Göckenjan makes a good point with his reference to the hospice movement that started in the UK and quickly spread upon Western countries during the 1960s and which has to be recognized as a big influence for a growing public discourse of death and dying throughout the last decades. But can dying and death be separated so strictly as topics? I guess at least when it comes down to conversations in everyday life you cannot be so decisive. Besides that, not everybody necessarily shares the very secular opinion that death is an »incomprehensible non-existence«. Imaginations of an after-life can be very diverse in Western societies nowadays because of their pluralism and a growing attraction of alternative spiritual concepts. I find it more fruitful to take a closer look at the explicit spheres where death and dying are matters of communication and to focus on differences in quantity and quality of dying- and death-related communication in various contexts.

Philipp A. Mellor observed already in the early 1990s an »explosion of academic and popular interest in the subject of death« and saw a growth in the »sociology of death« in contrast to a lack of considerations of death in social life. As a logical consequence he states the »presence and absence of death« at the same time.[19] According to Mellor's observation, many recent authors notice a large increase in death topics in the media sphere, in public broadcasting, movies, and computer games.[20] And they are very right! The television program offers more than enough crime scenes, portrays of serial killers and takes viewers into the pathology department. The news report about disaster deaths and war victims, documentaries describe the conditions in hospices or palliative care units, and on the radio, on the internet, and in magazines professional advice is given regularly on what to do in the event of the death of a relative—or why and how one should draw up a living will.

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19 Mellor, Philip A.: Death in High Modernity. The Contemporary Presence and Absence of Death, in: Clark, David (ed.): The Sociology of Death. Theory, Culture, Practice, Oxford/Cambridge 1993, pp. 11–30, here p. 11.

20 See e.g.: Douglas, Davies: Essay. Death, the Great Taboo, in: New Scientist 196 (2007), No. 2625, pp. 48–49; Mohr, Ernst: Tod und Tabu in der Pandemie. Kulturökonomische Lehren aus der Covid-19-Politik, Bielefeld 2023, here p. 32; Walter, Tony/Littlewood, Jane/Pickering, Michael: Death in the News. The Public Invigilation of Private Emotion, in: Sociology 29 (1995), No. 4, pp. 579–596.

Hence, the following findings are at first surprising: according to the latest representative study from 2022 by the German Hospice and Palliative Association (DHPV), in which over 1000 adults were surveyed, 60% were convinced that the German population does not pay enough attention to dying and death.[21] People in Germany obviously feel that something is missing in the communication about death and dying, even though a superfluous amount of material is offered non-stop. Dying and death seem to be very present somehow, somewhere—but at the same time very absent elsewhere. What exactly is missing and where? As so often when dealing with cultural phenomena, and especially under the guiding topic of liminality, it is fruitful to look at the ambiguities and the *in-betweens*. In the following I will show what I think is missing and where, by diving deeper into my own empirical data and analytical findings.

Presence and Absence of Death in the Context of Living Wills

Ernst Mohr, a professor of cultural economics, analyzed the dynamics of political decision-making during the Covid-19 pandemic in Germany. Although I do not share Mohr's rigorous point of view that the *mort interdite* as a taboo generator was the biggest driver of governmental pandemic decision-making in Germany,[22] he catches a good notion when he asks: »what exactly is taboo?«[23] Mohr says that death and dying are not taboos in general anymore—they are always, similar to Mellor, present and absent at the same time. Therefore he places his comment under the leading concept of a ›differentiated taboo‹.[24]

I follow Mellor and Mohr and frame a living will as a representation within that ›differentiated taboo‹. Starting from there I will show how a qualitative investigation of living wills on the micro-level of everyday

21 DHPV: Sterben in Deutschland – Wissen und Einstellungen zum Sterben. Repräsentative Umfrage der Forschungsgruppe Wahlen Telefonfeld GmbH im Auftrag des Deutschen Hospiz- und PalliativVerbands e.V., 2024. URL: www.dhpv.de/presseinformation/wie-deutsche-ueber-das-sterben-denken.html (25.01.2024).

22 There is more to say but for instance Mohr neglects the possibility that the governmental protection of intensive care units during the Covid-19 pandemic served the goal to prevent individuals from an agonising death by asphyxiation at home.

23 Mohr: Tod und Tabu in der Pandemie, p. 54.

24 ibid. See also: Feldmann: Tod und Gesellschaft. Feldmann provides a differentiated overview on sociological discourse on death.

life in combination with the theoretical concepts of liminality and taboo can help to reveal concrete social and cultural structures of the so far somewhat wobbly term. But beforehand I provide some more central features of living wills, especially concerning Germany.

Living Wills in Germany

In a living will, German adults can declare their wishes for medical treatment in the case of emergency when they can no longer approve or reject measures, for example after a serious accident, a stroke, or in an advanced stage of dementia. The document belongs to the group of advanced directives, which are set up for a situation in future when the author is not able to give instructions anymore. The best-known example of an advanced directive is the last will, in which a testator specifies how his estate is to be distributed in the event of his/her death. The living will does not deal with material possessions but with one's own body and being and is a result of the patients' rights movement. Its function and effectiveness are anchored by law since 2009 and it must be obeyed by caregivers, yet there is no official obligation to have one. A living will is a voluntarily matter as well as to register it officially in a particular data base, which is the *Central register of precautionary measures of the Federal Chamber of Notaries*. Thus, living wills can be done and stored in a very private way. Consequently, there are no exact figures on living wills in Germany[25] but different organizations regularly try to collect data on the topic. According to the German Institute for Public Opinion Research 28 % of German adults possessed a living will in 2014.[26] Looking at the German Elderly People Survey (DEAS), a regular German representative study among people aged 40+, it can be estimated very carefully that about half of Germans aged 50+ have a living will today.[27] So overall, there has been an upward trend over the last past years. The trend is supported by institutions providing medical services as

25 Cf. Deutscher Bundestag (German Parliament): Zahl der Patientenverfügungen. Kurzmeldungen, 2020. URL: www.bundestag.de/webarchiv/presse/hib/2020_07/707306-707306 (Jan 26 2024).

26 IfD Allensbach (Institute of Demoscopy Allensbach): Deutlicher Anstieg bei Patientenverfügungen, 2014. URL: www.ifd-allensbach.deuploads/tx_reportsndocs/PD_2014_20.pdf (Feb 03 2024).

27 Wurm, Susanne et al.: Verbreitung von Patientenverfügungen bei älteren Erwachsenen in Deutschland, in: Journal of Health Monitoring 8 (2023), No. 3, pp. 59–65.

they have a serious interest in the availability of a living wills as it gives medical professionals guidance and security in critical situations. Thus, living wills undoubtedly can be seen as a widespread phenomenon in German everyday life.

The following findings and thoughts are based on a qualitative ethnographic study I conducted in 2018.[28] I wanted to investigate the development processes of living wills of common people in Germany. Participatory observation at a patient rights organization and fourteen semi-structured interviews were implemented. The latter included owners of living wills as well as advisors who provide information.[29] The core results revealed how patients' autonomy is limited as the composition of a living will is embedded in an interactive ›assemblage‹[30] that is highly influenced by juridical and medical expert knowledge and contingent assumptions of a ›preventive self‹[31] that becomes active in medical future planning and ›risk management‹.[32]

Although this is not a representative study, the first significant finding is that all owners have drawn up a ›lethal‹ living will, which means that the purpose of the directive is to avoid an artificial prolongation of life

28 Dornhöfer, Julia: Sterben? Mit Sicherheit! Die Patientenverfügung und die Konstituierung eines Präventiven Selbst, Freiburger Studien zur Kulturanthropologie, Special Issue, No. 3, Bielefeld 2019.

29 The sample included owners of living wills aged from 40 to 85 years. All owners were of good health at the time they composed their living wills. Empirical data was collected and analysed by following the standards of Grounded Theory including the identification of central categories. Further information on methods and methodology: Bernard, H. Russell: Research Methods in Anthropology. Qualitative and Quantitative Approaches, 5th ed., Lanham et al. 2011; Glaser, Barney G./Strauss, Anselm L.: The Discovery of Grounded Theory. Strategies for Qualitative Research, New Brunswick et al. 2009.

30 The concept of ›assemblage‹ was originally developed by Gilles Deleuze and Félix Guattari. For Michi Knecht the concept supports heuristic orientation in the empirical analysis of heterogeneous, social-technical or bio-cultural imaginations and interactions. See: Knecht, Michi: Nach Writing Culture, mit Actor-Network. Ethnografie/Praxeografie in der Wissenschafts-, Medizin- und Technikforschung, in: Hess, Sabine/Moser, Johannes/Schwertl, Maria (eds.): Europäisch-ethnologisch Forschen. Neue Methoden und Konzepte, Berlin 2013, pp. 79–106. For more information see also: DeLanda, Manuel: Assemblage Theory, Edinburgh 2016.

31 Lengwiler, Martin/Madarász, Jeannette: Präventionsgeschichte als Kulturgeschichte der Gesundheitspolitik, in: Lengwiler, Martin/Madarász, Jeannette (eds.): Das Präventive Selbst. Eine Kulturgeschichte moderner Gesundheitspolitik, Bielefeld 2010, pp. 11–28. See also: Bröckling, Ulrich: Vorbeugen ist besser… Zur Soziologie der Prävention, in: Behemoth. A Journal on Civilisation 1 (2008), No. 1, pp. 38–48.

32 Beck, Ulrich: Risk Society. Towards a New Modernity, London 1992.

in certain circumstances. Theoretically, it is also possible that the directive specifies that everything possible should be done to keep the patient alive. But in the case of a lethal living will the owners themselves must reflect and define when they want to pass away, although they, maybe, could be kept alive. The question they have to answer is no less than: under what specific conditions do I *not* want to live anymore? What are my personal criteria under which I prefer to die?

Countless websites provide answers to this question, which can be accessed very quickly. Many organizations offer templates for costless download, even the German Federal Ministry of Justice (*BMJ*) presents modules for an individual living will online without charge.[33] At the same time a veritable market for advice on living wills has evolved. For example, the *German Society For Humane Dying* (DGHS) or *DIPAT*, which is a commercial enterprise for living wills and medical emergency data, charge regular annual contributions. The clear majority of my sample wanted professional assistance, because as non-experts they are aware that they do not feel capable to evaluate the offered examples. They feel insecure and look for help. The authors of a living will want to talk to experts who illustrate diverse health scenarios and explain the consequences of different choices. Since a change in the law on living wills in 2016, professional advice is highly recommended. This is because living wills are now only binding if the treatment situations and wishes are described as detailed and specific as possible.[34] But although living wills primarily deal with medical content, people very often seek help from lawyers and notaries as the costly service benefits another common motivation: the authors want to stress the official character of the document and its importance. It makes them feel safer about the validity of their wills although they know that a juridical form is not mandatory. The mentioned observations led to my interpretation that common people tend to feel overwhelmed by setting up a living will on their own as the requirements concerning the content seem to be too demanding.

33 BMJ (German Federal Ministry of Justice): Patientenverfügung. Wie sichere ich meine Selbstbestimmung in gesundheitlichen Angelegenheiten? URL: www.bmj.de/SharedDocs/Publikationen/DE/Broschueren/Patientenverfuegung.html (05.02.2024).

34 BGH (Federal Court of Justice): Anforderungen an Vorsorgevollmacht und Patientenverfügung im Zusammenhang mit dem Abbruch lebenserhaltender Maßnahmen. URL: juris.bundesgerichtshof.de/cgi-bin/rechtsprechung/document.py?Gericht=bgh&Art=pm&pm_nummer=0136/16. (08.02.2024).

Many researchers have already shown a multitude of limitations of advanced health directives like the contingency of future health planning,[35] the situational and influential context of personal decision making,[36] and the danger of a normative perception of a well-organized ›successful dying‹ in contrast to ›bad dying‹ without any forward planning.[37] In my view another major challenge lies in the task of figuring out personal boundaries for a *new liminal condition*, namely the very emergency for which living wills are made.

The Emergency Case as a Liminal Period

Through my research I met the couple Carol and Tom.[38] By the time I interviewed them they were in their late forties and it was about one year ago when they saw their personal notary to get their living wills fixed. The trigger for this was that Tom's younger cousin had suffered a dramatic accident with serious brain damage and with expected severe impairment for the future. After a shocking visit to the hospital, Carol and Tom decided that they themselves did not want life-sustaining measures in this case and should take precautions. Furthermore, Carol was involved in conversations with a friend about this topic around that time.

A central question in all interviews was about people's personal ideas when they think life prolonging treatments should be stopped—the main purpose of their living wills so to say.

35 Cf. Fagerlin, Angela/Schneider, Carl E.: Enough. The Failure of the Living Will, in: Hastings Center Report 34 (2004), No. 2, pp. 30–42.

36 Cf. Drought, Theresa/König, Barbara A.: »Choice« in the End-of-Life Decision Making: Researching Fact or Fiction?, in: The Gerontologist 42 (2002), No. 3, pp. 114–128. Also: Knecht, Michi: Jenseits von Kultur. Sozialanthropologische Beiträge zum Verständnis von Diversität, Handlungsfähigkeit und Ethik im Umgang mit Patientenverfügungen, in: Ethik in der Medizin 20 (2008), pp. 1–12.

37 Cf. Schneider, Werner: Der ›gesicherte‹ Tod. Zur diskursiven Ordnung des Lebensendes, in: Knoblauch, Hubert/Zingerle, Arnold (eds.): Thanatosoziologie. Tod, Hospiz und Institutionalisierung des Sterbens, Berlin 2005, pp. 55–79.

38 The author uses anonymisation to protect the privacy of the participants. The interviews were originally conducted in German, quotations were translated into English by the author.

I: Could you describe your ideas on when, under what circumstances, you would not want life-sustaining measures?

Caro: Perhaps I can start, I have a concrete example: a friend of mine, her mother had a stroke. Machines could stabilize her but she was not able to communicate with anybody in any form, neither by eye blink, nor by facial expressions or handgrip, absolutely nothing. She lived for another eight years in a body that was like a prison so to say […] So, perhaps, if it turns out that you are extremely depending, that you are not yourself anymore and just alive by machines, medication, with an extremely low quality of life or nearly no quality of life at all, that would not be desirable for me.

Tom: Yes, well, if conscious living is no longer possible, if you are totally controlled by doctors, nurses, a law, whatever, if you are deprived of all personal freedom, then I would have the idea that I no longer want to be there just to maintain my life.

Carol stresses in her description the ability to interact socially. She would not like to live forth in a state of isolation from the surrounding world, in her »own prison«. Tom's ideas are a bit more about his conscious function and his ability of self-determination. Particularly remarkable is that all narrators imagine themselves as patients who are no longer alive, but not yet dead. They are neither one nor the other, but an exact term for that seems to be missing.

Diane, 41 years old, is another person I interviewed. She and her husband had drafted their living wills ten years ago and also consulted a notary for help. This was because Diane's husband got scared when his father was reanimated in hospital, even though he had terminal cancer and unbearable pain. Diane's idea about her end of life is very similar to Carol's. She says:

Diane: […] so when life is only possible by artificial respiration and the person, one's self, is absolutely gone, for me personally that would no longer be a life. The imagination of being imprisoned in my body scares me terribly.

Maybe Carol and Diane got the »prison picture« from their notaries. To be honest, I did not ask about the origin of the image. Nevertheless, it is striking that both use the prison metaphor to describe their personal boundary between life and death which is associated with ideas of apathy, the incapability of interaction, exclusion, and isolation. Even Tom's »loss of freedom« matches with this. Their words could be interpreted to mean

that the narrators use the prison metaphor as they cannot classify the boundary any better than by »when you are locked up in yourself, this is no longer life«. The expression »dying« does not seem to fit here, because dying is generally perceived as a process, sometimes a very slow process, but nevertheless as a continuous movement towards death whereas the described situations are static. Processuality is absent in these end-of-life descriptions, it is banned by machines and medication. From the perspectives of the agents the linearity of their being is frozen, but classifying the state with an exact term seems to be problematic as they use personal normative metaphoric descriptions of »a life worth living or not«.

In her work *Purity and Danger* Mary Douglas identifies classifications as the foundation for social order.[39] In a later article she writes: »Anyone who is prepared to support the social system finds himself impelled to uphold the classification system which gets meaning from it.«[40] By analyzing social images of purity and pollution Douglas concludes that any social structure is based on applying distinctive classifications that are interwoven and mutually dependent like ›alive/dead‹, because »classification involves definition; definition involves reducing ambiguity.«[41]

In his highly acclaimed contribution on liminality *The Forest of Symbols* Victor Turner directly refers to Douglas' work: »Dr. Mary Douglas, of University College, London, has recently advanced […] the very interesting and illuminating view that the concept of pollution ›is a reaction to protect cherished principles and categories from contradiction‹.«[42] The inspiration Turner received from Douglas' work cannot be emphasized enough. At least it was Douglas' discovery on the functional task of classifications that led Turner to his characterization of liminal beings:

> From this standpoint, one would expect to find that transitional beings are particularly polluting, since they are neither one thing nor another; or may be both; or neither here nor there; or may even be nowhere (in terms of any recognized topography), and are at the very least ›betwixt and between‹ all the recognized fixed points in spacetime of structural classification.[43]

39 Douglas, Mary: Purity and Danger. An Analysis of Concept of Pollution and Taboo, London/New York 2002 [1966].
40 id.: Taboo, in: Cavendish, Richard (ed.): Man, Myth, and Magic, Vol. 21, London 1979, pp. 2767–2771, here 2770.
41 ibid.
42 Turner, Victor: The Forest of Symbols. Aspects of the Ndembu Ritual, Ithaca/London 1967, p. 97.
43 ibid.

Besides as »betwixt and between« Turner specifies liminal beings as »twofold« and as characters who »are at once no longer classified and not yet classified.«[44] Turner's description of liminal beings corresponds to the narrations of Carol, Tom, and Diane when they anticipate criteria for when their lives should end in an emergency case. Therefore, I argue, that the emergency case as one of the biggest drivers of living wills can be conceptualized as a liminal state. This conclusion becomes even more comprehensible by the words of the anthropologist Bjørn Thomassen who notes that »liminality refers to something very simple and universal: the experience of finding oneself at a boundary or in an in-between position, either spatially or temporally.«[45] In the context of living wills the liminal emergency case occurs spatially located not only in hospitals, but within one's own body, and has a—at least theoretically anticipated—determined ending.

Several researchers have already applied the concept of liminality to patients in vegetative state.[46] But obviously one can disagree to conceptualize the emergency case as a liminal period because something crucial is missing here about liminality, which is namely a ritual or at least some kind of symbolic ritual. Douglas' and Turner's contributions are located in the field of ritual theory. Turner himself developed the concept of liminality by analyzing an initiation ritual among the Ndembu in Africa that marks the transition from ›boy‹ to ›man‹ as a ›rite of passage‹. As a ritual the transition is conducted in a very specific choreography that resembles a certain series of ritualistic performances and in which ›masters‹ guide ›neophytes‹ through the liminal period as instructors who themselves have passed that passage before and inherit first-hand knowledge of the transition.[47] Hence, concerning the context of living wills, besides a ritualistic choreography also guiding masters are absent in the scenario of a medical emergency case. Patients in an emergency case can be interpreted as neo-

44 ibid., p. 96.

45 Thomassen, Bjørn: Thinking with Liminality. To the Boundaries of an Anthropological Concept, in: Horvath, Agnes/Thomassen, Bjørn/Wydra, Harald (eds.): Breaking Boundaries. Varities of Liminality, New York/Oxford 2015, pp. 39–58, here p. 40.

46 Cf. Kuehlmeyer, Katja/Borasio, Gian Domenico/Jox, Ralf J.: How Family Caregivers' Medical and Moral Assumptions influence Decision Making for Patients in the Vegetative State. A Qualitative Interview Study, in: Journal of Medical Ethics 38 (2012), No. 6, pp. 332–337; Zulato, Edoardo/Montali, Lorenzo/Castro, Paula: Regulating Liminality. Making Sense of the Vegetative State and Defining the Limits of End-of-Life Action, in: British Journal of Social Psychology 51 (2023), No. 6, pp. 1733–1752.

47 Turner: The Forest of Symbols, pp. 93–111.

phytes in transition, but neither lawyers nor doctors can guide through the passage by first-hand knowledge as it is impossible that they have ever crossed the passage to death themselves before. But as Thomassen writes: »liminal experiences are not always safely embedded within a ritual structure—liminality, applied to a broader social science and historical perspective, can also refer to events that simply happen, and happen *to* us.«[48] Thomassen cites revolutions or the collapse of a society caused by catastrophe as examples. By doing so, he clearly distinguishes between liminality in ritual passages and forms of liminality without rituals and masters. When we have to deal with the second type, Thomassen states, the central question should be: »what happens in liminal situations that unfold outside the spatial and temporal boundaries of expert-led ritual passages?«[49]

My own research concentrated on narratives about individual configurations of prospective medical treatments in emergency cases and in my opinion individual imaginations of the future patients have a lot in common with neophytes. To answer Thomassen's question, more research is required with a special focus on liminality in situations when living wills become effective in people's lives. Nevertheless, framing the emergency case as a liminal state helps to understand central difficulties authors of living wills have to face as the challenges are medical ones, but also cultural ones evolving from dichotomic categories. Furthermore, dealing with the *in-between* inherits the possibility of rearranging existing power relations and the alternative distribution of self-empowerment and agency because, according to Turner, liminality can be »partly described as a stage of reflection.«[50] Liminal occasions are »privileged spaces where people are allowed to think about how they think, about the terms in which they conduct their thinking, or to feel about how they feel in daily life«.[51] Understanding the living will as a guideline for a liminal state could help actors to engage more self-aware and perhaps more suitable because actors who are »thinking with liminality«[52] can explore ways of change and improvement. But that involves the task of overcoming a fundamental taboo on dying and death which still exists as I will now show.

48 Thomassen: Thinking with Liminality, p. 41.
49 ibid.
50 Turner: The Forest of Symbols, p. 105.
51 Ibid., p. 102.
52 Thomassen: Thinking with Liminality, p. 41.

Missed out Conversations about the End of Life

As already mentioned, the majority seek professional help for drawing a living will and it is actually surprising how broad the circle of providers is that disseminate information on dying and death. But when the situational context changes and family members are engaged, it suddenly gets very quiet. This becomes clear when you take a closer look at the role of the representative who is responsible for enforcing a living will in the end.

It is common standard that consultants recommend to name a legal surrogate in a living will, often with the advice that the person should be a bit younger than the author, and a second surrogate, in case the first one is not able to do the job. A frequently used example of this is when both spouses who have appointed each other as representatives are in a coma after a car accident. If there is no surrogate named in the document at all the Guardianship Court appoints a person. This might be a relative, yet can also be a complete stranger, depending on the patient's social network and the court's assessment. The legal procedure in Germany is such that the surrogate is involved in the medical decision-making process and speaks on behalf of the patient. In my sample most people chose a person as surrogate they feel very close to. Middle-aged people in committed relationships choose mainly the partner as first surrogate and younger relatives as substitutes, older single people prefer their daughter or son if they have children.

Similar to Carol and Tom, Diane chose her partner as first surrogate and, in case he might not be able to fulfil the job, her younger sister. I asked Diane to describe how she involved her sister in the process.

> Diane: I was told to ask her [by the notary] and I asked and she needed time to think it over. She was very shocked at first, yes, totally shocked at first, she didn't know if she could do it, so, well, she needed time to think it over and then I simply wanted a clear yes or no. I could have accepted a no, as it is a difficult burden, but then she came around for a cup of coffee, read through it and then there was just: okay, I'm in.

Diane and her sister did not share any more words on the content and this is quite typical. People frequently told me that their surrogates were simply informed about being named, but did not even get a copy of the living will. Some advisors told me that they keep hearing that people make a living will, but the document disappears in a drawer without a

single word being said about it. In practice, this is risky. Because if the drafters do not have the confidence to draw up the directive with the specific medical descriptions of situations and treatment wishes required by the court, it can be assumed that their representatives, as medical non-experts, will find it difficult to interpret the living will in an emergency. The recommended standard turns the living will into a highly formalized and hypothetical medical document. Its content challenges interpretation skills and does not always fit with the real situation. Is a particular treatment necessary for pain relief or is it life-prolonging? Does the treatment support a feasible recovery? What indeed is actual life-prolonging? Often it is very difficult to tell one from the other. Furthermore, as Carol, Tom, and Diane have described, authors themselves are much more concerned about their social death as a reason for withdrawing life-support measures than about specific medical issues. When I asked people why they had not spoken to their surrogates and explained their wishes in their own words, the most common answer was: »he/she knows me well«. But this is simply a convenient assumption, at best a wish, but not necessarily the truth. How much do we really know about what our parents and siblings want in an emergency, what ideas and wishes they have about their death? There may be exceptions, however, but in my study topics like these were avoided in communication among close family members like the ›elephant in the room‹.

In a podcast titled »Are we not talking about death enough?« the philosopher and cultural scientist Thomas Macho says, that death would be always present in our everyday lives, that it is shown in countless pictures, but as soon as death affects us or a close relative, we would still find it difficult to talk about it. Death would be, so to speak, a ›second-order taboo‹.[53] Janina Wildfeuer, Martin W. Schnell and Christian Schulz share the opinion that talking about dying and death involving relatives is mostly limited to »a particular environment, namely, with patients and their relatives undergoing palliative care, thus in a clearly medicalised situation.«[54] So there is actually a lot of talk about death, but not in the family circle. Dying and death are still taboo there. It is therefore not

53 Podcast (in German language) available under: www.detektor.fm/gesellschaft/zurueck-zum-thema-tabuthema-tod (10.06.2024).

54 Wildfeuer, Janina/Schnell, Martin W./Schulz, Christian: Talking about Dying and Death. On New Discursive Constructions of a Formerly Postulated Taboo, in: Discourse & Society 26 (2015), No. 3, pp. 366–390, here p. 367.

surprising that numerous studies have shown that choosing a relative as surrogate is not a guarantee that one's wishes will be fulfilled on the deathbed.[55]

Norbert Elias observed that people in modern Western societies feel insecure how to behave the right way especially when close ones are dying. They »find it difficult to press dying people's hands or to caress them, to give them a feeling of undiminished protection and belonging. Civilization's overgrown taboo on the expression of strong, spontaneous feelings ties their tongues and hands.«[56] Following Elias the source of that insecurity is in an existing taboo on showing strong emotions in connection with a rising »threshold of repugnance.«[57] Elias explains the existence of taboos as consequences of a Western civilization process very convincing, but Mary Douglas offers a general theory on taboos for cultural analysis. Douglas shows how dichotomic classifications form cultural patterns, shape the language of thoughts and thus the way members of a community interpret the world around them. And according to Douglas, these patterns are never perfect. They have weaknesses as the world is not organized in the fixed categories that human societies apply to it: »human classifications are always too crude for reality« and taboos would work like blinds that cover up the weaknesses of a classification system.[58] Ortrud Gutjahr sharpens the character of taboos further. According to her, there is a consensus in recent scientific research that taboos would be understood as rules of avoidance that regulate human behavior in social communities beyond explicit prohibitions and laws.[59]

Although it is not officially forbidden, Diane and her sister avoid a deeper conversation about the content of Diane's living will, about her personal wishes and ideas—because a taboo is at work and influences the sisters' behavior in this situation. The power of taboos and their huge

55 E.g.: Kuehlmeyer, Katja/Borasio, Gian Domenico/Jox, Ralf J.: How Family Caregivers' Medical and Moral Assumptions influence Decision Making for Patients in the Vegetative State. A Qualitative Interview Study, in: Journal of Medical Ethics 38 (2012), No. 6, pp. 332–337; Wijdicks, Eelco F. M./Rabinstein, Alejandro A.: The Family Conference. End-of-Life Guidelines at Work for Comatose Patients, in: Neurology 68 (2007), No. 14, pp. 1092–1094; Vig, Elizabeth K. et al.: Beyond Substituted Judgment. How Surrogates Navigate End-of-Life Decision-Making, in: Journal of the American Geriatrics Society 54 (2006), No. 11, pp. 1688–1693.

56 Elias: The Loneliness of the Dying, p. 28.

57 ibid., p. 30.

58 Douglas: Taboo, p. 2770.

59 Gutjahr: Tabus als Grundbedingungen von Kultur, p. 19f.

impact on human actions are clearly evident here. Following Gutjahr, taboos should be understood as silent agreements that reach from speaking habits over lifestyles up to feelings, wants and wishes deep into the interpretations of the world and the self of everybody. Taboos would be passed on to the next generation in the socialization process and guide actors, very often unconsciously.[60]

With this knowledge about taboos, it might look like there would be no way out of the dilemma and that society is stuck in a dead-end-street. But this is not the case at all. Scientific discourse including Gutjahr regularly stresses that taboos are not static. Mary Douglas herself emphasizes that we need to »correct our tendency to think of taboo as a rigidly fixed system« as »the classifying process is always active and changing. New classifications are being pushed by some and rejected by others.«[61] Consequently, taboos which are interwoven and dependent on classifications must have a dynamic character, too. In addition, existing taboos can be intentionally broken by community members. Hence, for Gutjahr the transformation of a taboo or even its final abolition can be seen as a significant indicator of cultural and social change.[62] The current reorganization of sexual categories enhanced by the queer movement is a good example. To break a taboo is a critical act as the taboo breaker risks social exclusion—but it is not impossible.

Michael Hebb from the University of Washington saw a need to break the death taboo by intention when he realized that individuals »haven't talked to their families about their preferences, and no one had asked.«[63] Hebb initiated *Death over Dinner*[64] to get the missing conversation started, »the most important and costly conversation America isn't having.«[65] In 2013 a website was launched as a helping tool to create an occasion and a space for exchange with family members and friends about the end of life. Users can book a virtual *Death over Dinner* but are mostly encouraged to take the offer as an inspiration for a real dinner at home with a good meal in a cozy atmosphere. Campaigns like *Death over Dinner* are needed in Germany, too. Creative and easy-to-implement ideas on how to talk

60 ibid., p. 47.
61 Douglas: Taboo, p. 2769.
62 Gutjahr: Tabus als Grundbedingungen von Kultur, p. 20.
63 Hebb, Michael: Let's Talk about Death (over Dinner), Cambridge 2018, p. 7.
64 https://deathoverdinner.org
65 ibid.

about death in the family are extremely rare. Such ideas would not only help to support representatives in an emergency case, they would also help the authors to reflect, find out and express their personal wishes.[66] As Lambert South and Elton state: »talking about death may help people work through their fears and better understand what they want during the end of life and also makes one's care preferences known to others.«[67] This insight is reminiscent of Elisabeth Kübler-Ross, who encouraged people to speak more openly and less fearfully about death back in the 1960s. Taboos have endurance.

Conclusion: Think Liminal and Break the Death Taboo!

Authors of living wills are challenged by many difficulties and scientific research does its best to improve the tool by identifying pitfalls and generating solutions for improvement. Especially medical orientated disciplines create a considerable and helpful output on the topic of living wills. Yet, underlying cultural influences are easily overseen and living wills are rarely perceived in regard to liminality although exactly that perspective can offer precious insights.

As I have shown, the medical emergency case in which a living will comes to its practical terms can be seen as a liminal state. Authors of living wills therefore have to deal with a matter that is not only medically and legally demanding, but also beyond common categories of life and death. Advances in medical technology have created an »anomalous event«[68] with the possibilities of prolonging life that does not fit into the existing cultural classification system. Mary Douglas distinguishes five ways how societies react to anomalous events: 1. reduction of ambiguity and imposed classification, 2. elimination, 3. ignorance, 4. stigmatization, and 5. incorporation.[69] Contemporary living wills represent the first strategy as authors more or less have to reduce the ambiguity of the anticipated liminal by mainly biological criteria in order to impose the

66 Cf. McCormick, Sheila: Conversations on Death and Dying. Exploring Performance as a Prompt, in: Palliative Care & Social Practice 17 (2023), pp. 1–10.

67 Lambert South, Andrea/Elton, Jessica: Contradictions and Promise for End-of-Life Communication among Family and Friends. Death over Dinner Conversations, in: Behavioral Science 24 (2017), No. 7(2), pp. 1–12, here p. 1f.

68 Douglas, Mary: Purity and Danger, pp. 48.

69 ibid., pp. 48–50.

labels ›alive‹ or ›dead‹ on the state. The task becomes even more difficult as there are no ›masters‹[70] with reliable first-hand knowledge. Furthermore, the effectiveness of living wills is limited by an existing taboo on dying and death within family bonds. Although many authors of living wills choose close relatives as their representatives, probably many children, sisters, and brothers are left behind with not much more than assumptions about the true wishes of close family members at the end of their lives. Combining research on living wills with liminality and taboos not only reveals the limitations and hurdles of the everyday search for meaning in relation to decisions and actions at the end of life. This very approach also offers starting points for improvement as liminality and taboos themselves inherit the potential of change and transition. Taboos have socially inclusive and protective functions and at the same time limit sociality when blind spots of a classification system occur like the emergency case in end-of-life treatment. In the context of living wills the blind spot is exactly the matter of fact that has to be thought through. Promoting a way of ›thinking with liminality‹ toward end-of-life decisions more resolute could encourage people to enter a deeper stage of reflection on the existential issue and to develop their own expressions and selection of categories—to create and share their *personal end-of-life narratives*. The hospice movement and the patient rights movement have successfully shown that it is possible to break the death taboo in the public sphere. But at the level of common everyday life, there is still more initiative required. Counselling institutions and interest groups that deal with the topic of living wills should always be aware of this fact and continue to take it into account. Adoptable role models are still needed.

Taboos are powerful, persistent but not sacrosanct. To those who doubt this, I heartily recommend the reception of Heathcote Williams' work as an empowering introduction.

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70 Turner: The Forest of Symbols, see above.

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Anna Bauer

Organization and Agony. Transfigurations of Dying in Multi-Professional Palliative Care

Introduction

One of the main characteristics of modern societies, which differentiates them from archaic or stratified societies, is that they mostly consist of organizations. It is the emergence of organizations that allows an ever-increasing division of work through specialization. We spend most of our lives within them, from beginning to end: In Germany, 98 percent of births occur in hospitals.[1] We then go to schools and universities. Nearly all workplaces are characterized by a high degree of specialization. The ›circle of life‹ not only begins in organizations—it is also very likely to come to an end in an organization.[2] The fabric of modernity is inextricably intertwined with organizations.

This chapter is dedicated to a specific part of the ›circle of life‹: death and, more precisely, the dying process, which is characterized by its high degree of liminality between life and death. The perception of the dying process has undergone significant changes during the course of modernization. One major component was a paradigm shift when it comes to awareness of dying.

Dying patients were usually kept unaware of their situation. In hospital settings, doctors, nurses, and even relatives avoided talking about dying. Patients didn't know about their impending death, thus were unable to make any preparations or any decisions about what might come after their death. This is what the sociologists Barney G. Glaser and Anselm L. Strauss famously called the »closed awareness context«.[3] According to Glaser and Strauss, the more desirable situation is an »open awareness context«, where information about the patients' situation is evenly distributed. This should allow the patient to be in charge and to participate

1 Ramsayer, Beate: Die physiologische Geburt, Hannover 2020, p. 29.
2 Saake, Irmhild: Wir sterben heute in Organisationen. Und die sind wichtiger als gedacht., in: AVISO – Magazin für Kunst und Wissenschaft in Bayern (2020), No. 4.
3 Glaser, Barney G./Strauss, Anselm L.: Awareness contexts and social interaction, in: American Sociological Review 29 (1964), No. 5.

in decision-making. The Swiss-American psychologist Elisabeth Kübler-Ross even developed a five-stage model outlining the path to acceptance of dying.[4] This model suggests that every patient will eventually make up his or her mind and achieve open awareness. However, the research following the publication of Kübler-Ross' »On Death and Dying« was quite skeptical about open awareness: it cannot always be achieved, since patients regularly refuse an open conversation about their situation.[5] Studies also show that it depends on the actor constellation whether patients display open awareness or not, and whether open awareness is needed for the provision of care.[6]

The second component of this major shift in paradigm was that medical care for the dying was replaced by so called ›total care‹. Corresponding to the concept of »total pain«, developed by Cicely Saunders in the 1960s,[7] palliative and hospice care is supposed to not only care for a dying patient, but for a ›whole‹ person (as in ›whole person care‹[8]). Medical care, focused on physical pain, was replaced by ›comprehensive‹ or ›holistic‹ care. Apart from physical pain, spiritual, social, as well as psychological pain are also treated by palliative and hospice care. To achieve this total, comprehensive care, multi-professional teams were established. In German hospice and palliative care,[9] those typically consist of specifically trained palliative care physicians, palliative care nurses, social workers, various therapists, pastoral care workers, and volunteers.

The goal of the following chapter is to demonstrate what happens when multi-professional ›comprehensive‹ care is put into practice. Using two case studies as empirical examples, this chapter reveals the multiplici-

4 Kübler-Ross, Elisabeth: On Death and Dying, New York 1969.

5 Richards, Naomi et al.: Awareness contexts revisited: indeterminacy in initating discussion at the end-of-life, in: Journal of Advanced Nursing 69 (2013), No. 12.

6 Saake, Irmhild/Nassehi, Armin/Mayr, Katharina: Gegenwarten von Sterbenden. Eine Kritik des Paradigmas vom ›bewussten‹ Sterben, in: Kölner Zeitschrift für Soziologie und Sozialpsychologie 71 (2019), No. 1.

7 Saunders, Cicely: The symptomatic treatment of incurable malignant disease, in: Prescribers Journal 4 (1964), No. 4.

8 McKee, Margaret et al.: It takes a whole community: the contribution of rural hospice volunteers to whole-person palliative care, in: Journal of Palliative Care 26 (2010), No. 2.

9 In the German discourse the differences between palliative and hospice care are usually emphasized. Palliative care is supposed to denote the medical care aimed at improving the ›quality of life‹ of the patient. However, hospice care refers to so-called ›holistic‹ care, which encompasses the family and friends of the patient. For further information: Radbruch, Lukas: White paper on standards and norms for hospice and palliative care in Europe: part 1, in: European journal of palliative care 16 (2009), No. 6.

ty of perspectives that is generated by just one single patient. The underlying assumption is that the revealed differences in perspectives are not completely determined and at the same time not entirely random. Building on Stefan Timmermans' concept of »death brokering«, which focuses on all medical activities rendering deaths culturally acceptable,[10] I want to highlight that these death brokering activities in multi-professional settings are not limited to medical activities. All professions that take part in death brokering participate in rendering deaths culturally acceptable. Although the empirical data is not suitable to corroborate this point, I would like to assume, drawing upon the results of other studies, that »culturally acceptable« holds different meanings for different professionals. This means that there is no single, unified, common ideal, but rather distributed ideals across multiple professions. To conclude, it is further argued that cultural acceptability could be more precisely described as the patient undergoing a transformation, where each profession transfigures the agony of the patient in a different way, where suffering takes on different meanings. This ambiguity of meaning further emphasizes the situation of liminality at the end of life. This, however, is not the fault of the organization but a normal, expected and unavoidable effect, which makes them so efficient and pervasive throughout modern society.

Analysis of Actor Constellations

This chapter is about a specific part of a larger study.[11] It is focused on the different actor constellations and different perspectives that emerge from these constellations. The term ›actor constellation‹ denotes all the relations around a single patient in a multi-professional environment: patient-relative, patient-physician, patient-nurse, patient-therapist, among others. Several patients were interviewed, followed by interviews with all professional and non-professional individuals (e.g. relatives and volunteers) who provide care for this specific patient. All of them were asked

10 Timmermans, Stefan: Death brokering: constructing culturally appropriate deaths, in: Sociology of Health & Illness 27 (2005), No. 7.

11 DFG-Project »About ›Dying Well‹. Actor constellations, normative patterns, different perspectives«; Project #343373350; Project management: Christof Breitsameter, Armin Nassehi, Irmhild Saake. Data collection: Niklas Barth, Katharina Mayr, Andreas Walker. Website: https://www.gutessterben.uni-muenchen.de/

questions about the patient. During the course of this research project, it was possible to gather enough data for 20 actor constellations.

The underlying assumption of this study is that different contexts generate different meanings. In sociology, differentiation theory has a longstanding tradition, from Emile Durkheim to Max Weber and Talcott Parsons up to Niklas Luhmann, Luc Boltanski and Laurent Thévenot[12] or even parts of Bruno Latour's œuvre[13]—to just mention a few representatives. This conceptual background leads to the expectation of the emergence of different meanings in each actor constellation. Death and dying of a specific patient do mean something different, for example, for a nurse than for the pastoral care worker. The individuality of each patient is reconstructed differently in each constellation. To go even further: each patient *is* someone different for each actor. This is no fault or defect but rather a characteristic of modern society, as these different perspectives do not occur randomly but are institutionalized in organizations. Returning to the aforementioned dominance of organizations in modern societies, this means that the so-called ›whole person‹ is constantly deconstructed in order to generate endpoints for different ways of addressing a person: as a customer, voter, student, citizen, pensioner, and patient, among others.

Results: Two Cases

It was possible to analyze 20 actor constellations. For this chapter, two constellations were selected for illustrative purposes, since not all constellations can be presented in such detail in one book chapter.

During the analysis of the actor constellations, a very clear pattern could be observed, which was very much in line with the expectation coming from differentiation theory: Professionals from different backgrounds, as well as relatives and volunteers, all achieve different interpretations of the patient's individuality, of the wants and needs of a patient. Sometimes, these differences are more nuanced and, sometimes, they are very obvious or contradict each other directly. Yet, they are visible in every case.

12 Boltanski, Luc/Thévenot, Laurent: De la justification. Les économies de la grandeur, Paris 1991.

13 Latour, Bruno: An Inquiry Into Modes of Existence. An Anthropology of the Moderns, Cambridge 2013.

In the following, two very different cases will be presented: they will be called Martha and Tom.[14] The cases were selected not despite but because of their differences, since they reveal that these differences in perspectives do not depend on a specific case or certain characteristics of a patient, but are commonplace throughout multi-professional palliative care. The actor constellation of Tom consists of five interviews, the one of Martha of six interviews including an interview with the patient herself. The actor constellations are never perfectly symmetrical since each individual case is different. Table 1 gives an overview of the data available.

Table 1. Overview of the interviews used for this book chapter

Patient/Resident	**Martha**	**Tom**
Age (years)	61	23
Participants	Hospice Resident	Chief Physician
	Friend	Physician
	Physician	Physician
	Nurse	Nurse
	Nurse	Physiotherapist
	Hospice Manager	

Case #1: Martha – »The illness simply rips you out of your life«

The hospice resident Martha is 61 years old and suffers from lung carcinoma. Just before the interview took place, brain metastases were also diagnosed in her. Before entering inpatient hospice care, she lived alone at home. In the following, the different perspectives on the hospice resident are shown, until Martha's own statement will be discussed. We will start with a friend who visits her from time to time.

14 All names are pseudonyms, which are in no way related to the real names of the participants.

What does the friend say?

Her friend Heidrun has accompanied Martha for a long time. Since she lives in the inpatient hospice unit, Heidrun has observed positive changes.

> Well, I have the feeling, I was prepared for the worst. I already visited her in August when she was still at home. During chemo... there, I mean, *now she has physically deteriorated.*[15] But back then, I would say she was a wreck, to put it frankly. Very bad! And now, she has regained more joy of life. For me now. And yes, she is well cared for. Everything she needs is there. And I believe, it's good not having to worry about anything anymore. She has enough to deal with herself. With the situation. Yes. And... she's also happy. She has a very nice, bright room. Nature. She now has a deck chair so that she can lie outside. It is peaceful here. That's good for her, yes.

While at home, Martha's physical decline became increasingly apparent, her condition in hospice seems to be improving. At least she has more »joy of life«, according to her friend. An important factor for this positive development is the relief from the tasks of everyday household chores in the hospice.

> Of course, the fact that *she doesn't have to go shopping, that she doesn't have to cook, that she doesn't have to clean.* Yes, such things, which are increasingly difficult for her. She says, she still makes her bed herself. But even that is a great effort for her. There is always less she can do herself. Therefore, I mean that everything she needs is here.

The hospice staff now takes care of everything. Martha is comprehensively relieved. The only activities worth reporting now are the few that Martha takes on herself: making the bed. Everything else is provided by the hospice. Despite all these conveniences, Heidrun also discusses the topic of dying with her friend.

> She's afraid of suffering. She's afraid of the ›how‹. She isn't afraid of dying per se, but of the ›how‹. I think everyone fears this ›how‹, don't they? You wish to just drift off to sleep... but we had a chat about this too, if it does get too tough, then max out the painkillers. Then it doesn't matter, yes. Then you don't need to remain conscious and all... She just fears that she can't die. Because she's not that old yet. That was her fear. That while all other organs may fail, if the heart continues... If the heart doesn't stop, you can't die.

According to Heidrun, dying is something that Martha evidently thinks about. She knows she has to die. However, she is concerned that the

15 Important passages have been typeset in italics.

process of dying will be painful and distressing for her. The sedative effect of strong painkillers is her only hope. The reason why this question regarding the ›how‹ preoccupies both Martha and her friend is not discussed explicitly here.

Martha's friend Heidrun has not been to an inpatient hospice unit often before. Therefore, she carefully observes the peculiarities of this establishment and its residents.

> I saw her in the kitchen this way. We sat together at dinner in the kitchen yesterday. And... yes for *an outsider, who is not sick,* for me...that was my feeling, some patients...how should I say this... are *a bit grumpy.* When...one complained because she was woken up at half past five with a ›Good morning‹. That was likely meant as a joke, but she was very angry about it. Such trivial things...the patients are very sensitive. Or how do you say it? The guests.

Heidrun sees herself as an »outsider«, as »not sick«, surrounded by the sick, now getting to know this new environment up close. She observes the residents and seems to wonder why they are not always in a good mood and are rather »grumpy«. Her position as an outsider is further emphasized by her insecurities regarding the proper terminology (patients or guests).[16]

What does the physician say?

The physician is providing palliative care to Martha. For her, an important aspect when treating Martha is her being aware of the situation. She specifically talks about a decision she made together with her.

> Take Martha as an example, she said: ›Now I do have brain metastases.‹ I had already talked to her about it before. ›Do you really want this? Do you want to have another CT or MRI.‹ I think she had a CT. ›What does this imply for you?‹ Then she was very ambivalent. [...] And then she had it done and then she said: *›You know what, I feel relieved. I know it now. I don't have the uncertainty. I know, the disease is progressing. And maybe my memory or my cognition will be affected at some point. But honestly: I am glad about it.‹* And then I talk to her about it. ›What does this mean for you?‹ Then, she has a very strong need to talk, so she says: ›I'm still doing well.‹ Today she is still celebrating, I don't know, she is having a party with her friends. She confronts the topic very actively and then I talk to her about it. What this means for her, whether this takes away some of

16 In some German inpatient hospice units, the term patient is uncommon. The staff prefer to talk about guests or residents. In this specific case, it could also be irony.

> her fear of dying. *Actually, I talk to all patients about dying, because I always find that often unspoken fear puts a lot of pressure.*

Martha is described as a patient who is aware and actively wants to be fully aware of her situation, her progressing disease. Even though the CT was bad news for Martha, she still feels »relieved«, according to the physician. The wish to diagnose the brain metastases signifies Martha coming to terms with her illness. The physician talking about dying—which is sometimes referred to as ›breaking bad news‹—does something good for the patients, since it relieves them from »a lot of pressure«.

What does the hospice manager say?

For the hospice manager Martha is an example to discuss whether or not a patient is a good fit for inpatient hospice care.

> With Martha, one might think that she has an illness and an environment *where you might wonder, why didn't she stay at home longer.* And due to her reaction, how she suddenly said: now it has to be very quick and she can't stand it at home. We were also in conversation, where at first it was like: in the next weeks we will probably get in touch, we will keep in touch, but at some point the time will come. She couldn't handle that well. So, you could tell what kind of fears probably arose at home. Insecurities, fears, linked with pain, fear, loneliness. So, there's a lot to it. She is certainly, so to speak, a well-established woman in her surroundings with good social contact and still the fear speaks for something. And that's how I see her. *At the beginning I thought, it's too early and the circumstances are the major issue*, but I believe, she truly is and she is lucky, that everything worked out so well, that she can really benefit from this. And I think, she also requires the time, the accompanied time, I would suspect.

For the hospice manager, it is about fundamental issues, namely whether Martha is actually a hospice guest. The hospice manager expected her to stay at home for longer. In the beginning she was suspicious whether Martha might have entered hospice care too early. But now, she has come to the conclusion that Martha entered hospice just at the right time and that she is able to benefit from it.

What do the nurses say?

The nurse who cares for Martha uses her as an example for how patients retain their autonomy inside the inpatient hospice unit.

> And it is actually intended that way, *that they retain some autonomy.* So, ideally they should not be... and that's not our claim, to tell them how things run. For example, with Martha, we also do this in a way, it's a small story, that *she has her own medicine, manages it herself.* We actually never let other people here manage their own medication; usually, the staff handles it.

Martha managing her own medication is her autonomy's last resort. For nurses, it is about what patients are physically and also cognitively still able to do and what they are unable to do.

Another nurse who was interviewed about Martha approaches a much more difficult topic:

> I believe, about a week ago, she had an MRI to check why she is having certain symptoms. And metastases were detected: three bigger ones. And I think she was already aware of it, but she was very scared. And above all, she's afraid of giving up control. And I think that's simply the case with her—and we often agree on this in the team—that we say: *Ok, if we now tell her that she could vomit blood so severely that we would need darker towels to absorb this blood, she would worry more and I believe it would actually hinder her existence.*

Contrary to the physician, the nurse here emphasizes the advantages of Martha being more or less unaware of her situation. Telling Martha that the dying process might involve vomiting blood and that hospice staff are already preparing for this situation is seen as a hindrance to »her existence«. According to this nurse, they have collectively decided to not approach this topic with Martha.

What does the hospice resident say?

Lastly, for the hospice resident Martha herself everything is first and foremost about her long medical history.

> So, *I've been through the whole package* as well. I couldn't undergo surgery. Although, I also don't know if it's a blessing or a curse [being unable to undergo surgery, A.B.]. I have no idea. But I've been through everything including chemotherapy, immunotherapy, antibodies, and radiation therapy. And I was supposed to undergo chemotherapy again. But I decided against it.

Martha has undergone a long treatment. She has been »through the whole package«. However, she sees herself having agency in her medical history, as it was ultimately her who decided against the final chemotherapy and thus ended the treatment. As she is now in the hospice, the issue for

her now is acclimatizing and adjusting to the new environment, as the transition from her own home to the hospice is a turning point for her:

> That I could let myself go, if I could. That's what I'm learning right now. (laughs) So that's very, very difficult for me. Because *I have always been an independent person and the act of giving up your own, well, I always say freedom, giving up control*, realizing that I am becoming more and more dependent. And that's the special thing here. I am cared for. That means, if I want, they'll butter my bread roll and bring it to my bed. *They are really lovely here.*

She observes her own physical decline and loss of autonomy. While she could do everything herself before, now everything is done for her. For Martha, this is an ambivalent situation: on the one hand, it is difficult for her to »give up [...] freedom« and lose self-determination. On the other hand, it is also »really lovely« when she doesn't even have to worry about preparing a sandwich and everything is brought to her bed.

Similarly to the hospice manager, she wrestles a lot with the question of whether it was right to move to the hospice at all. Again and again, she explains why it was ultimately the right decision for her:

> And for me, this current feeling of not knowing anymore how sick I really am or whether I'm just letting myself go over these past few months, where I would say, the strength isn't there anymore. I can't judge it anymore. Of course, if there is more pain, I always think, whoa, the tumor is growing. And that's not necessarily the case. Because it could simply be that my medical tuning is not good. And that the tumor hasn't changed at all. But that is something, I am no longer in control of the situation.

The main reason she could no longer stay at home was the inexorable progression of her disease and the associated physical decline. The tumor is something unpredictable for her, that she cannot gain control over. She notices how she is gradually losing judgment over her own physical condition. Therefore, coping with the disease is a significant topic for her:

> I also have to see about letting go of my job. That was also because of... those are the things. *The illness simply rips you out of your life.* And the body... I always call it ›forcing me to my knees‹. […] And I have to *mentally catch up with that now.* To become aware of *where I am currently.* And that it's not so easy for me to accept. We talk a lot about that at the moment. The disease is where it is. So, I will talk about that with the therapist, who also comes once a week. That's really nice too.

What is quite obvious here is that the biographical disruption and the physical decay must be processed and accepted. »The illness simply rips you out of your life« is a strong statement that is typical for hospice

residents. They have gone through very significant changes during the course of their illness and also when arriving at the inpatient hospice unit. Eventually, they will have to come to terms with these changes. Conversations with a therapist help Martha with this.

Getting used to the new environment also involves observing the other residents.

> We mostly get together at mealtimes here. And then we eat together. We try to joke a little. Everyone is somewhat different in their structure, in their illness. *I believe I'm quite the youngster here. And probably still the fittest.* But we do exchange as much as we can. Yes, yes. *And laugh a lot too.*

The other hospice residents primarily appear as carriers of diseases and are individualized through this. Meeting the other residents allows Martha to draw comparisons: unlike others, Martha sees herself as somewhat younger and as a relatively »fit« woman. Contrary to what her friend told us about hospice residents being »grumpy«, Martha talks about herself joking and laughing with them.

As has already been made clear from the other interviews, Martha is very preoccupied with the way she will die.

> At the moment, I also say that I have no fear of death. I'm more afraid of the ›how‹. I have lung carcinoma. That really worries me. So that I simply say, *I don't want to suffocate,* or something like that. I just want to fall asleep peacefully. I want to be able to say, people, now give me something so that I sleep. I don't know yet if I want to see friends from a certain point on. I have no idea! I'll have to decide that along the way.

The diagnosis of lung carcinoma and the fear of suffocation greatly troubles her in this context. All other circumstances of dying seem to be of no great importance against this background. The possibility of bleeding mentioned by the nurse, however, is never explicitly mentioned by Martha. Her wish, to »give me something so that I sleep«, which could be interpreted as requesting assisted suicide, is seemingly not acknowledged by the staff members, since hospice care and assisted suicide are in direct opposition to each other.

At the end of the interview, it becomes clear that Martha, who at 61 years old is indeed one of the relatively ›younger‹ residents, primarily does not want one thing: to die.

> The only thing I would still like to do or would have liked to have done is to learn Italian. And for that, *I simply need more time.* And generally, *I would like five more years of life!* And then I would like to explore Europe. And, and I always traveled a lot in Asia. I didn't get to know Europe... But I would also take much

> more time for myself. For me and my friends. This was always neglected in the past. […] But I simply… *I would like five more years.* But I think somehow you always need more time. *Always a few more years.*

Despite her overall rather positive evaluation of the situation in the hospice, it is becoming quite obvious that she actually does not want to die yet. She wants to have more time to learn languages, to travel, to have time for herself.

Case #2: Tom – »I'm a footballer, he's also a footballer«

The second patient to be discussed is Tom, who is in a hospital palliative care unit. His diagnosis is carcinoma in the throat area. The unique thing about this patient is his age: he is 23 years old. Not only, but also because of this peculiarity, no interview could be conducted with the patient himself and the relatives, his parents. Interview data on Tom is available from the following professional groups: chief physician, physician 1, physician 2, physiotherapist, nurse. In addition, Tom was mentioned in two observation protocols that could be produced during team meetings on the palliative care unit.

What does the chief physician say?

In Tom's case, the medical competency of ›breaking bad news‹ is especially required. For the chief physician interviewed, it is the main professional competence that sets him apart from other professional groups, to clarify the unvarnished truth about the patient's future prospects to the relatives.

> The son [Tom, A.B.], he can hardly speak, he just writes on his phone. Or not ›hardly‹. He can't speak at all. And I then said: ›I dare to be honest here about how it is. And that we're trying, but we can't cure this. And that we can't make you healthy and you will die.‹ And the parents also feel that. But I understand that they can't talk about it, and so on. *Then it's out there.* And the upshot is; of course some are *maybe even shocked:* ›How can he say it so clearly?‹, or: ›How can he say that?‹ But I would say, 98 out of 100 are extremely grateful to you, *that it's out there and that it might also be an occasion to talk about it.*
> That's how it got started, because I, or rather, we, as this team, would say: ›They are so awfully religious and they find this so awfully hard.‹ Then I say: ›Well, hello? Who wouldn't find it hard, that your 23-year-old son is lying there and dying?‹ But to try, *to slowly approach this in a conversation: Where are these parents?* Then you see, the father is completely lost. He can't even have a sensible

> conversation with you because he is always crying. The mother is a bit more composed, but of course also totally lost.

The patient Tom is an example for the chief physician to demonstrate the necessity of an open conversation about the patient's situation. Even though other team members might find excuses for not talking openly about Tom's prospects to his parents—because they are »awfully religious«—the chief physician emphasizes the need to disregard these fears. It is recommended not to use brute force but instead to »slowly approach« the parents. By talking openly, the chief physician tries to help the parents. Even though they might not like to hear what he has to tell them, his assumption is that they are nevertheless »extremely grateful« for him telling the truth.

Initiating these kinds of conversations is still seen as a domain of the physician, since this is the only long-standing member of a classic profession in modern society, which attributes a particular competence to them. The physicians' words still carry more meaning and hold more weight in conversations with patients and relatives than those of other professions. While religion is usually seen as helpful regarding dying and bereavement, in this case, it is perceived by the chief physician as a misleading and false source of hope, as well as a hindrance to acceptance.

What do the other physicians say?

One doctor reported several failed attempts to start a conversation with the young patient's mother. She feels that the mother actively wants to avoid the conversation. This is a problem for the doctor:

> We should not blame ourselves. We do not leave them *with a false picture*, so to speak. Yes, we also need to tell them how it looks, that things are getting worse, so that they can cope with it.

In the same vein as the chief physician, it is about telling the parents the truth, to not »leave them with a false picture«. Another physician corroborates on this point even further:

> It's a burden. It was especially a big burden at the beginning, because it's truly a huge effort in terms of medical, nursing, wound care. It's a complex family surrounding him, they have a very own approach, which is very much carried by faith, *they believe that they can heal the young man through prayers*, and they keep expressing this and also expect that this will succeed sometime, and every little improvement is seen as a step towards healing. *Every success, even the fact of*

> *placing a venous cannula, is immediately seen as a sign from God that he will become healthy,* and you really have to continually involve yourself and naturally, this could be the son of many employees here.

Again, the religiousness of the family is mentioned as the main obstacle for acceptance. Everything the palliative care staff does is interpreted in a hopeful way by the parents. They still strongly believe that the patient will not die and will become healthy again. Telling the truth and accepting death is clearly a major theme for all three physicians interviewed.

What does the nurse say?

Interestingly, the nurse has something entirely different to say about Tom:

> Yes, everything comes together there. Youth comes together, exulcerating comes together, and ENT[17]. So, it's quite intense right now, having thirty[18]. That's why it's also important for me to always know how the patients are, *because I say that the person who takes care of the patient at thirty, absolutely cannot do four.* So, you always have to look and differentiate. These are patient groups where care sometimes becomes difficult. But they also come, for whatever reason, in phases, the ENT tumors for example. And when they exulcerate, *the acute risk is higher, I'd say, that they'll bleed.* It's also there when you just do it, but it's always in the back of your mind, it could bleed.

The nurse's focus is immediately on the strain and workload of the nursing staff and the division of labor within the nursing team. It's all about the diagnoses and the risks coming with it. The issue with Tom's tumor is that it is exulcerating and could easily bleed. The difference to the physician's perspective is pretty striking here: the parents, religion or acceptance play no role at all for the nurse, while this was the main issue the doctors talked about. However, the doctors only talked very little about the disease and the risks which it entails.

What does the physiotherapist say?

Lastly, the physiotherapist was interviewed.

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17 Abbreviation for ear, nose and throat
18 The patients room number.

> Well, yeah, right now, in room 37, there is a young man, he is 23 years old. *And I'm a footballer, he is also a footballer, a goalkeeper.* Well, we talked about stuff and that is a pleasant encounter, he is happy, he always wants me to come. And yes, and he has lost interest in many things and doesn't want to carry on and you say, are you coming back tomorrow. That's a question then. *And yes, his family is there, we talk, he enjoys the conversation.* And it does him good, then, I also enjoy it, it's, yes, something like that, exactly.

For the physiotherapist, Tom is first and foremost not a patient but a footballer. Interestingly, the physiotherapist does not talk about performing any physiotherapeutic tasks with Tom. Instead, he talks about the conversations he has had with him while Tom was still able to speak. Tom and the physiotherapist share a common interest in football. He depicts Tom as »happy«. The family is also mentioned, but they don't seem to bother the therapist in any way.

Discussion – Multi-Professional ›Death Brokering‹

Before entering the sociological discussion of the results, a brief summary of the two cases and the different perspectives should be given. The two cases of Martha and Tom are vastly different from each other, yet there are similarities, and they are suitable to demonstrate the main argument of this book chapter, as it was already outlined in the introduction.

Summary of the two cases

It became very apparent, that *physicians*—in both cases—typically focus on telling patients the truth, in order for them to be able to accept the situation. Physicians are the ones who are experts in breaking bad news. They are the only ones, who are forced to talk about death and dying with patients and relatives. They try to walk the fine line between confronting them with the hard truth while also avoiding brute force by being compassionate and empathetic. On the other hand, *nurses* tend to talk about the body, about bodily fluids and about the workload a certain patient puts on their team—but, of course, not necessarily with the patients. With them, they seem to talk about matters of everyday life and not so much about dying. The example of Martha shows that *hospice residents* typically talk about their medical history and the biographical disruption they have gone through and with which they have to come to terms now. *Friends*

and relatives, in this case Martha's friend Heidrun, talk about themselves getting used to hospice care and about feeling relieved that they or the patients themselves are in a safe environment and not in charge anymore. The *hospice manager* talks about whether or not someone is a proper fit for hospice care. Interestingly, the *physiotherapist* is able to talk freely about more or less everything he wants to, giving the patient the opportunity to take on a different role—the one of a football player.

These results are not surprising at all. The fact that physicians talk differently about patients than nurses or physiotherapists is hardly news for anyone working in hospice or palliative care or any kind of multi-professional environment. Everyone talks to patients, but in a different way and with different goals in mind. The so-called ›whole person‹ of the patient is reconstructed through different lenses and different perspectives. However, the result from that is not a single, unified view of the patient, but in fact a fractured picture. The patient is decomposed into many parts and there seems to be no way of putting these parts together again. The two cases presented above are given multiple different meanings, which do not necessary overlap or complement each other.

For example: Physicians clearly stress the importance of Martha knowing everything about her disease and that it might be beneficial for her to know about her brain metastases. However, Martha herself seems to be very worried about this and it seems questionable whether she is really relieved. In a similar vein, physicians see Martha as a hospice resident who has accepted dying, while Martha herself gives mixed signals: on the one hand, she talks about having accepted her fate, on the other hand, she talks about not wanting to die and needing more time. For the hospice manager, the dying process itself seems to be nothing to worry about. The physicians in Tom's case are very much preoccupied with the acceptance of his parents, since they need to be put in a position where they can anticipate their son's death. This is important for the physicians, as the parents are the ones who will survive Tom's death and are likely to accuse the physicians of not having done enough. The physiotherapist, however, does not seem to care about this at all. All of this is only possible through differentiation, specialization, and the division of labor in modern hospice and palliative care.

Distributed ›death brokering‹

Within sociology, a quite critical discourse around these practices of multi-professional palliative and hospice care has been established, usually employing Michel Foucault's concepts of »biopolitics« or »governmentality«.[19] More than twenty years ago, David Clark already diagnosed a »creeping medicalization« in palliative care.[20] Medical sociologist Stefan Timmermans stated that in so-called »late modern societies« it »is virtually impossible to die or be dead without encountering some medical involvement.«[21] He argues that medical practitioners and health care workers perform what he calls »death brokering«. The term refers to all kinds of practices and activities that »render individual deaths culturally appropriate.«[22] This means that medicine steers the dying process in such a way that it takes on an acceptable form (such as good death, natural death, dignified death), to deflect attention away from the question of medical involvement in death and dying. According to Timmermans, »death brokering« thus undermines the activities of the hospice movement, which »aimed to de-medicalize the dying process, change the practices of health care professionals, institute alternative forms of dying, and, most importantly, give more autonomy to the dying and their relatives.«[23]

The analysis of the different actor constellations allows for a more nuanced perspective on this assumed medicalization of death and dying. While Timmermans is certainly right about the fact that medicine has a »sustained stronghold over death and dying«[24] with physicians and nurses playing a major role in multi-professional hospice and palliative care, it seems obvious that other professional perspectives still remain relevant, such as the hospice manager or even the physiotherapist, in Tom's case. For example, a recent study was able to demonstrate the significant contributions pastoral care workers make to multi-professional hospice care.[25] One of their core competences which cannot be fulfilled by medical

19 Clark, David: ›Total pain‹, disciplinary power and the body in the work of Cicely Saunders, 1958-1967, in: Social Science & Medicine 49 (1999), No. 6.
20 Clark, David: Between hope and acceptance: the medicalisation of dying, in: Bmj 324 (2002), No. 7342.
21 Timmermans: Death brokering, p. 1005.
22 ibid., p. 993.
23 ibid., p. 995.
24 ibid., p. 1006.
25 Nassehi, Armin et al.: »Do you Really Believe that There is Something More?«–The Offer of Transcendental Communication by Pastoral Care Workers in German Hospices

staff lies in giving transcendent meaning to death as well as performing rituals.[26] In addition to that, social workers also contribute to palliative care, while not necessarily following a medical script.[27] Moreover, hospice volunteers have no medical education at all and are just there to add spontaneity to the organization,[28] to be the other, more accessible »face« of nursing.[29]

Timmermans is right in his assumption that dying is certainly medicalized, but this is amongst many other things, which not necessarily have anything to do with medicine. Medical practice was not entirely replaced by »total care« of the dying process, as it was mentioned in the beginning, but it has undergone a shift towards a more polycontextural[30] phenomenon. »Death brokering« thus cannot be described just as a medical task but as a distributed and differentiated practice that is carried out through a multi-professional organization and division of labor.

Conclusion – Liminality and the Transfiguration of Agony

To conclude: This chapter presented two cases out of a research project, which was focused on the actor constellations in inpatient hospice and palliative care units: Martha and Tom. Even though these cases appeared very different, they tell a similar story when it comes to multi-professional division of labor. Doctors' »death brokering« activities are focused around managing expectations of patients and relatives. They wanted them to know everything in order to be prepared for things to come. On the other hand, nurses' »death brokering« activities centered around the more

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and Palliative Care Units: A Qualitative Study, in: American Journal of Hospice and Palliative Medicine 41 (2024), No. 7.

26 Mayr, Katharina et al.: Organized rituals – ritualized reflection on mourning culture in palliative care units and hospices, in: Mortality 29 (2022), No. 1.

27 Bitschnau, Karl W./Firth, Pam/Wasner, Maria: Social work in hospice and palliative care in Europe: Findings from an EAPC survey, in: Palliative and Supportive Care 18 (2020), No. 6.

28 Nassehi, Armin et al.: Adding spontaneity to organizations – what hospice volunteers contribute to everyday life in German inpatient hospice and palliative care units: a qualitative study, in: BMC Palliative Care 23 (2024), No. 81.

29 Vanderstichelen, Steven et al.: The liminal space palliative care volunteers occupy and their roles within it: a qualitative study, in: BMJ supportive & palliative care 10 (2020), No. 3, pp. 3f.

30 Günther, Gotthard: Life as poly-contexturality, in: Günther, Gotthard (ed): Beiträge zur Grundlegung einer operationsfähigen Dialektik, Hamburg 1979.

physical aspects of dying: bodily autonomy and physical reactions to different kinds of dying (vomiting, blood, etc.) as well as the strain and workload this puts on their team. Martha's friend Heidrun is also part of »death brokering«, since she seems to be prepared for her demise and also talks with her about it. The physiotherapist's contribution to »death brokering« seems to be simply talking to Tom about football, which the patient seemed to appreciate.

What we observe are the ambivalent results of differentiation and specialization. That the physiotherapist in Tom's case is able to talk to the patient about football and doesn't have to worry about the parents, who refuse to accept the dire situation of their son, is the result of the division of labor. Only because the physicians are focused on the medical side, the physiotherapist is able to freely talk to the patient. In Martha's case, the nurses don't talk to her about her dying process, which will very likely lead to her vomiting blood, which is only possible, because the physicians will take care of that. On the other hand, this division of labor makes it impossible to achieve a unified holistic picture of the patient.

Literature about dying processes often describe dying as a transformation from one ontological status to another, the dying process thus becoming a liminal space between life and death. For example, the aforementioned Elisabeth Kübler-Ross suggests that there is a transition taking place, starting from the denial of death, proceeding through various stages, and ultimately achieving the acceptance stage. This transition doesn't occur spontaneously, but it requires the patient's work.[31] Only if the patient has done their ›homework‹, they will reach the final stage of acceptance and be finally delivered from suffering and agony. Similarly, the sociologist Debra Parker-Oliver employs the metaphor of a »hospice drama«. This drama narrates the transformation from the patient role to the dying role, wherein, in the very end, when »the final deathbed scene begins«[32], all conflicts are resolved, and everything comes to a close. The »drama is over«[33] and a peaceful state is achieved. According to Parker-Oliver, the acceptance of the dying role imparts »authenticity to the moment.«[34] It appears that, to be ›culturally acceptable‹, the narratives

31 Kübler-Ross, On Death, p. 99.
32 Parker Oliver, Debra: The Social Construction of the ›Dying Role‹ and the Hospice Drama, in: OMEGA – Journal of Death and Dying 40 (2000), No. 4, p. 509.
33 ibid., p. 510.
34 ibid., p. 511.

being told about the dying process invariably must include a transfiguration moment of the patient's agony—a *periptery*, to extend the drama metaphor—to arrive at the final deliverance and to resolve the precarious liminal situation.

Through the multiple lenses of the multiple perspectives on patients and relatives detailed in this book chapter, it seems like that this transfiguration does not only pertain to the dying process, but also applies to the person of the patient. The person is undergoing multiple transfigurations through multiple perspectives, each one of them transforming the patient's agony in a slightly shifted, unique and different way. However, the differences created by these transformations can never consolidate into a singular, harmonious and homogenous perspective, because they are the result of the very structure of the multi-professional organization. Dying here is not a »hospice drama« where everything comes to a close, reintegrates and becomes whole again, but rather a complex, messy and distributed occurrence where very different perspectives emerge. Organizations ultimately only offer difference rather than deliverance.

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P. Boopathi

Dying with Dignity: Religious, Legal and Ethical Implications of the Euthanasia Debate in India

Introduction

The intense discussion on euthanasia in India began in 2011 when the Supreme Court consented to passive euthanasia by bestowing power upon doctors to execute while delivering the verdict in Ms. Aruna Shanbaug's case, who was in a vegetative state for 42 years. Euthanasia, a process of taking someone's life through medical intervention, is largely characterized into two types: active and passive. Active Euthanasia refers to voluntarily ending one's life by injecting lethal injection, whereas, passive euthanasia indicates withdrawing life support to the patient who is terminally ill. Although the plea for legalizing euthanasia was filed in the high courts of Bombay and Hyderabad earlier following the Euthanasia Acts of the Netherlands and Belgium, the legal intervention and the subsequent validity for passive euthanasia approved by the apex court through a set of guidelines passed in 2011 and subsequently solidified in its 2018 verdict. Through Shanbaug's case, the euthanasia debate on life and death was brought in to reveal the views from religious, legal, and ethical dimensions. The story of Shanbaug being in a vegetative state for 42 years following a brutal rape and strangling by her hospital ward boy evoked several debates on the circle of life and death, the right to life with dignity (article 21 of the Indian Constitution), and the right to have a peaceful death, etc. in Indian public sphere. Besides the legal discussion inside the courtrooms, in the social and mainstream media, one could notice debates on ideas of death and end of life being extensively discussed against religious and ethical backgrounds in India, for it has followers of different religions.

The followers of the Hindu religion, who are the majority do not approve of passive euthanasia as it voluntarily takes away those who are terminally ill, and, interestingly, the Karma theory of Hinduism puts the blame on their misdeeds committed during previous incarnations. Thus, the illness and suffering that one undergoes in the present life, according to Hinduism, is due to one's Karma. Further, polytheistic beliefs of Hinduism and monotheistic beliefs of Islam and Christianity widely

prevalent in India demonstrate the idea that only God has the right to end someone's life. Hence, the Western notions of providing living wills and advance directives are staunchly opposed by followers of Hinduism and other religions in India. By looking at the history of euthanasia debates in India through the significant story of Shanbaug, this chapter attempts to analyze how the legal interventions on euthanasia were received by different religious and social groups. Further, it tries to show how euthanasia debates engage with the circle of life and death with regard to those who are terminally ill, disabled, and aged people from religious, legal and ethical backgrounds. The chapter uses court verdicts, newspaper articles, research works, interviews of caregivers, the biography of Aruna Shanbaug, etc. as reference documents to establish the argument.

Historical Views on Death in India

A land of different religious followers from antiquity to the present, India has a rich legacy of beliefs and practices of the circle of life: birth and death. From the two major culturally significant periods in Ancient India—the Sangam and the Vedic periods to the modern age, India witnessed numerous practices of death and strident thoughts about afterlife abound in oral stories, religious scripts and literary writings. Thoughts on ways of dying, different funeral ceremonies and life after death, in fact, dominated the discourse of death in the pre-colonial period, which was mainly fraught with religious connotations. During the Sangam period, a widely held practice of dying among kings and other noble origins was called ›Vatakkiruttal‹, wherein they would sit and fast to death by facing in the north direction.[1] Notably, this practice of dying was held by the kings who had lost their honour in battles. In the Sangam age, people also believed in an afterlife, which has been well-documented in its poetry collections. In the anthology of poems entitled Kurunthokai, poem 49 brings out how the speaker ›Thalaivi‹ (heroine) ensured her husband ›Thalaivan‹ (chieftain) about their life after death:

1 Subbiah, G: King, Kingship and King-poets in Early Tamilakam, in: Proceedings of the Indian History Congress 44 (1983), pp. 86–100, here pp. 96–97.

> I want you to be my husband
> and me to be your wife in our
> next life, as we are in this one.[2]

This demonstrates how in the ancient period of South India, people had a strong notion about the afterlife.

In the Vedic period, an age marked by Hindu religious doctrines, the idea of death was conceived and practiced in three different ways: natural; unnatural (being killed); and self-willed.[3] The idea of natural death refers to life up to 100 years or till the end of lifespan as prescribed by Hindu religious scripts: »Those men who died naturally became the ancestors who were sustained through the offerings, ostensibly until they were reborn (though the offerings also ensured that they became gods (visvadeva) as part of the process, thereby creating a double buffer against the idea of death as annihilation).«[4] Unnatural death, on the other hand, was marked by murder, accident and death in battle, referring to what was termed in Hindu religious scripts as violent one, and thus did not deserve ›Sraddha‹ (funeral). In the ancient period, any death that occurred through unnatural means such as untoward violence, accidents and cowardly attack on the battlefield was nonetheless considered unnatural as opposed to the gallant fight in warfare, for it was voluntary and was devoid of any religious endeavours. However, the violent death of warriors on the battlefield was thought to be powerful from the religious perspective, for it was believed to lead to heaven or deification. Besides natural and unnatural deaths, there existed another form of death called ›self-willed death‹, which was primarily practiced in three different ways: »suicide; what we shall term heroic, voluntary death (mors voluntaria heroica); and religious, self-willed death (mors voluntaria religiosa).«[5] While suicide committed due to depression and uncontrollable circumstances was prohibited, voluntary and religious self-willed deaths were given religious sanction as they were done during religious rituals or to attain deification.[6]

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2 An Analysis of History of Tamil Religion / part: 17: Theebam.com, 2016, www.ttamil.com/2016/09/an-analysis-of-history-of-tamil_8.html.

3 Young, Katherine K, Euthanasia: Traditional Hindu Views and the Contemporary Debate, in: Coward, Harold G., Lipner, Julius, Young, Katherine K. (eds.): Hindu Ethics: Purity, Abortion, and Euthanasia, New York 1989, pp. 71–130, here p. 74.

4 ibid., p. 74.

5 ibid., p. 74.

6 ibid., pp. 74–75.

Besides Hindu religious perspectives, other religions followed in India also have viewpoints on the idea of death. For instance, Jainism, one of the religions in India, has the practice of fasting to death (Sallekhana) for those who suffer from incurable diseases and debilitating old age. This type of death was considered to be the most non-violent one in self-willed deaths.[7] On the contrary, as argued by David Brick, the practice of ›Sati‹ in which the wife ascends to the funeral pyre of her husband during the ritual to express her devotion to him is, in fact, considered to be the most brutal form of ritual suicide in the world.[8] While it was ostensibly seen as a cruel form of dying, such practice was, however, thought to be religious, for fire (Agni) till the modern period was worshiped as a god. This practice of widow burning was put to an end in 1829 during the colonial period with the intervention of Hindu reformists and colonial administrators. In the Sikh religious tradition, interestingly enough, the Sikhs who fought against the Mughal rulers, who were trying to destroy Sikhism in the seventeenth and eighteenth centuries were revered as martyrs. Notably, the Sikhs who lost their lives in such battles to save their religion and uphold righteousness were celebrated as heroes.[9] In Buddhism, one of the ancient religions in India, the ordinary suicide by volition was denounced, for it was seen as an immature activity and decided out of the mistaken desire to non-exist in the world. On the contrary, Indian Buddhism, as stated by Reiko Ohnuma, conceded to two types of self-willed deaths, which were widely celebrated: »These are self-sacrifice, which I define as compassionately sacrificing one's life for the welfare of others, and self-immolation, which I define as killing oneself as a sacrificial offering in a ritual act of devotion.«[10] An overt sympathy was, however, shown to those who committed suicide in classical India for debilitating old age and chronic health-conditions, as freedom to leave and easy death were

7 Kitts, Margo, Introduction: On Death, Religion, and Rubrics for Suicide, in: Kitts, Margo (ed.): Martyrdom, Self-Sacrifice, and Self-Immolation: Religious Perspectives on Suicide, New York 2018, pp. 1–17, here p. 15.

8 Brick, David, Sati, in: Kitts, Margo (ed.): Martyrdom, Self-Sacrifice, and Self-Immolation: Religious Perspectives on Suicide, New York 2018, pp. 163–182, here p. 163.

9 Fenech, Louis E, The Tropics of Heroic Death: Martyrdom and the Sikh Tradition, in: Kitts, Margo (ed.): Martyrdom, Self-Sacrifice, and Self-Immolation: Religious Perspectives on Suicide, New York 2018, pp. 206–226. here p. 206.

10 Ohnuma, Reiko, To Extract the Essence from this Essenceless Body: Self-Sacrifice and Self-Immolation in Indian Buddhism, in: Kitts, Margo (ed.): Martyrdom, Self-Sacrifice, and Self-Immolation: Religious Perspectives on Suicide, New York 2018, pp. 242–264, here p. 243.

encouraged.[11] Nonetheless, such forms of death through the act of suicide were prohibited, during the British period through legal intervention.

Euthanasia Debate in India

A re-visitation of the idea of death in different religious practices in India reveals the fact that albeit natural, unnatural and self-willed deaths, a uniform ritual of dying did not exist across religions. Similarly, the recognition and rejection of dying practice, in fact, varied from religion to religion, particularly in the case of self-willed death. The practice of euthanasia, closely connected to the idea of suicide in the ancient and medieval periods, was freely left to the choice and willpower of individuals till the modern age. While the practice of suicide was strictly prohibited in the Hindu religion from the tenth century C.E. onwards, both religious and self-willed deaths, as mentioned above, became illegal through the Indian Penal Code-309 enacted by the British Raj in India. With the prohibitory law on suicide in the colonial period, all forms of self-willed deaths including religious ones, indicating euthanasia practices, were completely halted in the subcontinent. The IPC sections, such as 309 and 306 have stringent punishments for those who attempt to commit suicide and provoke others to commit suicide respectively. It is in this context that the practice of euthanasia and its discourse in the Indian public sphere gain greater significance as it is viewed from religious, legal, medical and ethical viewpoints.

Prohibition of suicide under the IPC section 309 met with stiff resistance in religious and legal discourse, particularly in the post-independent period. Besides numerous voices of dissent stemming from religious context to the said IPC section on suicide, a staunch challenge came from justice T.K. Tukol, who argued in his series of lectures entitled *Sallekhana is Not Suicide* (1976) that the Jainist practice of ›Sallekhana‹ (fasting to death) cannot be called suicide.[12] Further, the legal developments that took place in India in the last decade, such as the enactment of the Mental Healthcare Act (hereinafter MHA) in 2017, the Supreme Court's verdict in permitting passive euthanasia and the Supreme Court's notice to the Central Government, seeking clarity on the punishment for suicide

11 Young: Euthanasia: Traditional Hindu Views, p. 76.
12 ibid.

survivors under the IPC 309 in 2020 all have questioned the validity of the IPC section on suicide.[13] Particularly, in the mentioned clarification notice to the Central Government in 2020, the Supreme Court said that the IPC section 309 contradicts MHA section 115, which reads: »Notwithstanding anything contained in section 309 of the Indian Penal Code any person who attempts to commit suicide shall be presumed, unless proved otherwise, to have severe stress and shall not be tried and punished under the said Code.«[14] Thus, the 2020 Supreme Court notice again reiterated its 2018 verdict on passive euthanasia that the survivors of suicide require care, treatment, and rehabilitation, not punishment.

The euthanasia debate acquired significance in the post-independent period where the Indian practice of self-willed death was juxtaposed with Western views on compassionate murder, which is carried out by withdrawing life-support treatment in hospitals. While the latter can be surmised as passive euthanasia in the present context, especially after the approval of the Supreme Court, in the early years, the Western euthanasia practice involving advanced medical technologies was staunchly resisted. The growing acceptance of the idea of peaceful death with assisted suicide in Western societies, was, seen in opposition to Hindu religious worldviews. These conflicting views on death, emanating from the Western notion of modern humanism and Indian views on traditional religious viewpoints, led to the lively euthanasia debate in India, for both views continue to have considerable numbers of supporters, even in present times. While the former places importance on the role of physicians in assisting the patients in committing suicide, the latter, however, regards the individual's choice in dying, which is always guided by the respective religious precepts. The landmark verdicts of the Supreme Court in 2011 and 2018 in approving passive euthanasia, notably, attempt to conflate these two opposite viewpoints on death by sanctioning withdrawal of treatment for those who are terminally ill and falling into the medical condition of a Persistent Vegetative State (hereinafter PVS).[15] Furthermore, the 2018 verdict also authorized the ›living will‹, a legal document to be signed in

13 Mahapatra: Attempt to suicide punishable or survivor requires rehabilitation, asks SC, 12.9.2020, timesofindia.indiatimes.com/india/should-suicide-bid-be-punished-or-survivor-treated-with-care-sc/articleshow/78069068.cms.

14 The Mental Healthcare Act: Ministry of Health and Family Welfare, 2017, main.mohfw.gov.in/sites/default/files/Mental%20Healthcare%20Act%2C%202017_0.pdf.

15 Menon and Mohanty: India's top court upholds passive euthanasia, allows living wills in landmark judgment, 9.3.2018, www.reuters.com/article/us-india-court-euthanasia/ind

front of a district magistrate or government officer who belongs to the same rank and which will be executed when the person concerned falls into a PVS. Central to the euthanasia debate in India is the story of Ms. Aruna Shanbaug, who remained in a PVS for 42 years, evoking numerous discussions on the right to life, dignified death, living will, etc.

The Case of Aruna Shanbaug

Ms. Aruna Shanbaug, who worked as a staff nurse at King Edward Memorial (hereinafter KEM) Hospital in Mumbai was raped by a ward boy named Sohanlal Walmiki after he strangled her with a dog chain on the evening of 27 November 1973. This severely affected her body and left her in a PVS for 42 years. Further, the strangling led to the obstruction of oxygen supply to her brain, leaving her in permanent unconscious condition. Living in the liminality of life and death, Shanbaug had cortical blindness, paralysis, conjoined fingers and toes, an extremely fragile body, brittle bones, etc., and had food only through a feeding tube.[16] Not being able to recognize anybody including her family members, she was prone to shouting, weeping and laughing without any reason, and ended up becoming the person who lived in a PVS for the longest number of years, after Terri Schiavo in the USA had been in a PVS for 15 years. Shanbaug, due to the unstable financial condition of her family, was admitted to KEM hospital and till her death, her treatment was solely taken care of by the hospital. Further, she was left to the care of nurses in the hospital as after some years into the attack, her only sister who was visiting her stopped coming.

After the plea to mercy kill her, advocated by journalist Pinki Virani, who posed herself as next friend of Shanbaug was turned down by the Supreme Court in 2011, she died of pneumonia in 2015. Shanbaug's life in PVS engendered debates on euthanasia, Article 21, Section 306 of IPC, Section 309 of IPC, self-willed death, ethics and ethos of physicians, religious dogmas and social values more prominently in the first two decades of the present century. Her PVS life period is, however, said to be the

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ias-top-court-upholds-passive-euthanasia-allows-living-wills-in-landmark-judgment-idUSKCN1GL0MF/.

16 Aruna Shanbaug: Brain-damaged India Nurse Dies 42 years after Rape: BBC, 18.5.2015, www.bbc.com/news/world-asia-india-32776897.

history of serious euthanasia debates in India, connecting it with advance medical technologies and constitutional validity, while at the same time trying to detach it from any religious precepts.

Besides debates on euthanasia and the right to have a dignified death, Shanbaug's story, notably, invoked discussions on penal punishment for rape, for in her case, the offender Walmiki served only seven years of imprisonment for robbery and attempt to murder as per the sections 307 and 397 of IPC. Furthermore, Shanbaug's case also revealed the narrow understanding of rape in India as the gynaecologists, who examined her female reproductive organ submitted the report by saying that the hymen is intact.[17] This led to Walmiki not being punished for rape, and thus resulting in less years of imprisonment for him. The journalist Pinki Virani, who fought for peaceful death for Shanbaug and who wrote her biography by tracing her life-story and her hospitalization in KEM hospital after the sexual assault, told to BBC after she died: »My broken, battered baby bird finally flew away. And she gave India a passive euthanasia law before doing so.«[18] As mentioned earlier, Shanbaug's condition in a PVS for 42 years intensified the euthanasia debate in India in the spheres of religion, law, ethics, and medicine and finally, as Ms. Virani said, paved the way for the approval of passive euthanasia by the apex court in 2011 and 2018 judgments.

In a similar vein, the death of Shanbaug was critically reflected by many scholars in the fields of medicine, anthropology, law, sociology, etc., situating her case in the larger context of the euthanasia debate in India. For instance, in the opinion »Aruna Shanbaug: Is Her Demise the End of the Road for Legislation on Euthanasia in India? « in the journal Science and Engineering Ethics published in 2016, Kanchan et al., maintain that the death of Shanbaug is not the end of the individual plight in PVS, rather the end of the road for well-defined guidelines on euthanasia in India. While talking about how passive euthanasia came to be approved by the supreme court in India, Virani writes emotionally in her article »The Motives of Mercy« re-published in her biography of Shanbaug titled *Aruna's Story: The True Account of a Rape and its Aftermath* (2000): »My poor, poor Aruna. All I have, standing in this one corner of the court, is my choice to be morally accountable for you, no matter the consequences in the court

17 Virani, Pinki: Aruna's Story: The True account of a Rape and its Aftermath, Amazon kindle 2000.

18 ibid., www.bbc.com/news/world-asia-india-32776897.

of God. And then, his voice cutting through the clutter of righteousness, I hear the judge use the words ›Passive Euthanasia.‹ This, too, is how landmark judgments come to a country.«[19] With the recognition of passive euthanasia by the apex court, people who are brain-dead and in a PVS can be recommended for the withdrawal of life-saving treatment and food intake after getting a proper opinion from a physician. Furthermore, Shanbaug's case also paved the way for legalizing living will in India just like last will, as mentioned earlier, to state how much medical intervention one wants in the case of being in PVS in the future. The sanctioning of passive euthanasia, arguably, has engendered several debates and dissent both in the courtroom and outside the public sphere. One of the major spheres of the euthanasia debate in which the discussion was held extensively was religion.

Religious Implications

Self-willed death or suicide in India, as explained earlier, has a complex and multidimensional history, particularly if seen from a religious perspective. Evidently, the complexity and multifariousness of suicide arise merely out of a plurality of religious practices in India, testifying to what is proudly pronounced as ›unity in diversity‹. Furthermore, the three phases of Indian history: ancient, medieval and modern witnessed numerous practices and beliefs of self-willed death followed in different religions. While in the ancient period, nearly all the major religions tacitly approved suicide, albeit for pious people, terminally ill people, old aged persons and others who wanted to end their life due to bodily and religious reasons, in the medieval period, however, there emerged disapproval of suicide, particularly in Hindu religion since sixth century C.E. onwards. Nevertheless, the practice of ›Sallekhana‹, as discussed earlier, continued into the modern period without any injunction, for it was given religious sanction in Jainism. Arguably, when suicide was brought into a criminal offence during the colonial period, almost all forms of self-willed religious deaths were met with punitive action. Furthermore, in the twentieth century, there were attempts by social activist groups to bring all forms of suicides including religious ones into section 309 of IPC.

19 Virani: Aruna's Story.

Prohibition and criminalizing the abetment of suicide sparked many debates in the ¯twenty-first century in the spheres of religion, law, ethics and culture. Interestingly, the blanket prohibition of suicide, however, by the turn of the twentieth century, introduced the Western discourse of euthanasia in India. In the post-independent period, particularly after the 1980s, euthanasia discourse gained traction among the elite section of India, emerging as a reasonable solution for those who lived in a PVS, brain-dead conditions, terminal illnesses and others. This advancement of knowledge in euthanasia, and withdrawal of life support, became possible due to the introduction of information about advanced medical technology and allied developments in the field of medicine in India from the early 1980s onwards. The establishment of palliative care centres, fostered by the idea of healing symptoms rather than curing through medical intervention, became widely popular in the Indian context after WHO emphasized it. Introduced as part of End-of-Life (hereinafter EOL) care, the palliative care system tries to mitigate pain and improve the quality of life of terminally ill patients. In the religious and spiritual contexts, however, this system has varied responses, for each religious strand on death is distinct from one another. Notably, the palliative care system extensively uses spiritual and religious coping methods while other methods fail to provide patients with solace.[20]

In Hinduism, death is piously seen as a »transition to another life by reincarnation, life in heaven with God or absorption into Brahma (ultimate reality).«[21] Due to this view, death in Hinduism is largely seen as good and bad ones. Needless to mention, voluntary death occurs in the form of suicide and is identified as a bad death. Furthermore, the karma theory of Hinduism makes this taxonomy more conspicuous as it is believed that good karma leads to good death. Additionally, the sufferings and pain of an individual in the present birth are thought to have been caused by their bad deeds in the previous birth. A dying person, nonetheless, can refuse medical treatment, for pain is seen to be an expurgating sin.[22] Buddhism, on the other hand, advocates for the idea of ›afterlife‹, for its eventual aim is to reach ›nirvana‹ (freedom from the cycle of suffering

20 Sharma et al: End-of-life care: Indian perspective, www.ncbi.nlm.nih.gov/pmc/articles/PMC3705699/.

21 ibid., www.ncbi.nlm.nih.gov/pmc/articles/PMC3705699/.

22 ibid., www.ncbi.nlm.nih.gov/pmc/articles/PMC3705699/.

and rebirth).[23] Similar to Hinduism, relying on medication to alter one's state of mind is prohibited in Buddhism as it is believed to affect the transition to the afterlife. While in Christianity, death is believed a consequence of sin and is a separation from body and soul, in Islam, submission to suffering is considered to be a submission to God, and death by medical intervention is strictly prohibited.

Approval of passive euthanasia in India by the Supreme Court was opposed by religious groups on the grounds that human life is a gift of God, and any means to end one's life amounts to playing the role of God. As stated earlier, those who suffer from pain have inherited karma from their previous birth according to Hinduism. Thus, the practice of euthanasia, as argued by religious people, devalues the God-given human life.[24] Notably, this view is upheld by religious followers of almost all religions in India. As it has been stated by Sharma et al., withdrawal of life support is seen differently by followers of different religions in India, which impacts their perspectives and their ideas of death largely.[25] Thus, western modern concepts like living will and advance medical directive do not find resonance in the Indian public sphere largely due to the widely-held notion that they are against religious doctrines. In Hinduism, it is widely believed that dying is a natural process, and thus, the end of the lifespan of any human being is determined by God without any external intervention. Moreover, it is also thought that the longevity of lifespan is provided by God to human beings for 100 years or more as per Hindu religious beliefs.

In India, notably enough, the euthanasia debate is centred on two important streams of thought: death with dignity and death with divinity. While the former has modern legal validity, originating from the Western socio-cultural, medical and legal matrix, the latter finds its root in longstanding diverse religious doctrines and practices in India by drawing on different forms of religious deaths. When these two diametrically opposite traditions of dying interact with one another in contemporary times, particularly after the endorsement of passive euthanasia by the apex court in 2011 and 2018 judgments, they have created several conflicting views in the Indian public sphere both in support of the verdict and their

23 ibid., www.ncbi.nlm.nih.gov/pmc/articles/PMC3705699/.
24 Krishanu: Euthanasia in India, www.legalservicesindia.com/article/787/Euthanasia-in-India.html.
25 ibid., www.ncbi.nlm.nih.gov/pmc/articles/PMC3705699/.

disagreement to it. Furthermore, as discernible from the socio-cultural implications of the two modes of dying, the boundary, however, between them is very thin, for both of them emphasize voluntary death. The distinction, nonetheless, needs to be made between euthanasia for terminally ill patients and debilitating old aged people, and self-willed death for those who opt with religious connotations. Though the above-mentioned verdicts underscore the choice for passive euthanasia for those who live in a PVS, religious beliefs regarding dying dominant in India did not let people like Shanbaug die peacefully, arguing for natural death. However, with the sanctioning of passive euthanasia and legalizing living will, the Supreme Court has affirmed the autonomy of individuals to choose their death as it was practiced in ancient and medieval periods in the form of self-willed death.

Legal Implications

The euthanasia debate from the mid-1990s onwards entered into the legal discourse and created the space both inside and outside courtrooms for discussing the right to have dignified death for every citizen of India. Evidently, the euthanasia debate that took place in legal space has shifted its course from full-fledged religious perspectives to constitutional aspects. Considered to be a taboo subject in the socio-cultural context in India, death acquired pivotal significance in the legal circle as it was viewed and discussed purely from constitutional validity. Terminal illness, debilitating old age, PVS, brain-dead and other similar conditions, notably, necessitated the courts in India to intervene in the euthanasia debate and look at it from a constitutional perspective. Central to the euthanasia debate in both high and supreme courts was Article 21 of the Indian constitution, which reads: »No person shall be deprived of his life or personal liberty except according to procedure established by law.«[26] The major emphasis in the said article is ›right to life‹, which received numerous interpretations over the years from judges, focussing on dignity, safety, control of the body, liberty, etc. In the case of those who have above said bodily conditions, which require euthanasia to have a peaceful death, the Supreme Court has stated in the Gian Kaur vs. State of Punjab case that the right to have life

26 Article 21 in Constitution of India: Indian Kanoon, indiankanoon.org/doc/1199182/.

under Article 21 also has the right not to have life.[27] Further, the quote underscored the intrinsic nuances in the said article, which permits the citizens to have death with dignity as part of the right to have a dignified life.

Article 21, being part of the set of Articles that provide fundamental rights to people, has been frequently evoked in the courts to discuss the feasibility of having the right to have death with dignity. By expanding this Article to bring in the right to have dignified death as a fundamental right, the high and supreme courts have critically reviewed sections 306 and 309 of IPC from the 1980s onwards. The challenge to the validity of section 309 of IPC was raised in the case P. Rathinam vs Union of India wherein the supreme court said that, according to Article 21, which includes the right to die as part of the right to life, the person assisting other person to commit suicide cannot be punished.[28] Because he/she is only helping the other person to have a dignified death. Further, in the case Gian Kaur vs. State of Punjab, the Supreme Court once again affirmed that, according to the said Article, section 306 of IPC (abetment of suicide) cannot be invoked to punish the person who assisted other person in committing suicide.[29] As stated in the judgment of Gian Kaur vs. the State of Punjab, the judges mainly relied on the ruling of the apex court in P. Rathinam vs Union of India, besides several high courts' judgments, to declare the section 306 is unconstitutional if seen from Article 21. These two verdicts, notably enough, laid the foundation for the strong euthanasia debate that took place in the Supreme Court from the mid-2000s onwards till the pronouncement of landmark verdicts in 2018, sanctioning passive euthanasia and legalizing living will.

Besides the above said two cases dealing with IPC sections 306 and 309, the Supreme Court, perhaps for the first time, extensively engaged with the euthanasia petition with the crucial case Aruna Ramchandra Shanbaug vs Union of India and Others filed in 2009 by the journalist Pinki Virani, who claimed to be the next friend of Shanbaug. The case was filed by Virani under Article 32, which provides a constitutional remedy

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27 Smt. Gian Kaur vs The State of Punjab on 21 March, 1996: Indian Kanoon, indiankanoon.org/doc/217501/#:~:text=The%20appellants%20Gian%20Kaur%20and,of%20suicide%20by%20Kulwant%20Kaur.

28 P. Rathinam vs Union of India on 26 April, 1994: Indian Kanoon, indiankanoon.org/doc/542988/.

29 ibid., indiankanoon.org/doc/217501/#:~:text=The%20appellants%20Gian%20Kaur%20and,of%20suicide%20by%20Kulwant%20Kaur.

when fundamental rights are violated, appealing to the apex court to permit euthanasia for Shanbaug, who was in a PVS for 36 years in 2009.[30] The said Article is crucial and it is evoked in the rare cases when someone feels that their fundamental rights are violated by any system. In such cases, the apex court has the power to provide a constitutional remedy. In the judgment of Aruna Ramchandra Shanbaug vs Union of India and Others case, in paragraph two, the judges opined that euthanasia practice was new to India and they found it difficult to arrive at a legal solution:

> Euthanasia is one of the most perplexing issues which the courts and legislatures all over the world are facing today. This Court, in this case, is facing the same issue, and we feel like a ship in an uncharted sea, seeking some guidance by the light thrown by the legislations and judicial pronouncements of foreign countries, as well as the submissions of learned counsels before us.[31]

After hearing all the respondents, the court said that Ms. Shanbaug should be left to live in the same condition as there was no reason to perform euthanasia on her until she died a natural death. Further, for those who live in a PVS, the court alone would act as ›Parens Patriae‹, added the judges, for the chances of misuse are high. However, the parents and immediate relatives would have a say in this regard. Lastly, the court in the said verdict approved passive euthanasia in the rarest of the rare cases with the consent of patients' family members and treating doctors.

However, it did not stay for a longer period regarding euthanasia as the petition was filed in the Supreme Court to review the judgment, and thus, the case was referred to the constitutional bench in 2014. The petition to review the judgment stated that Euthanasia is a complex issue and thus requires deeper legal engagement to arrive at an amicable solution. Further, the 2011 judgment which was challenged in the review petition was understood by the large section of intelligentsia and civilians of India that it was internally inconsistent, and it was against Article 21 which guarantees the right to life. From the Central Government side also, the Ministry of Health and Family Welfare did not take any step-in support of approving euthanasia. Mr. Ghulam Nabi Azad, the Minister of Health and Family Welfare in 2013, led by the Congress Government, clarified in the Upper House of the Indian parliament that »The Ministry of Health and Family Welfare is not in favour of enacting the Bill [on mercy killing].

30 Article 32 in Constitution of India: Indian Kanoon, indiankanoon.org/doc/981147/.

31 Aruna Ramchandra Shanbaug vs Union of India and Others on 7 March, 2011: Indian Kanoon, indiankanoon.org/doc/235821/.

There is no proposal under consideration at this stage for making law on this subject.«[32] Similarly in 2014, in a written reply to the Upper House of the Parliament, the Minister of Health and Family Welfare, led by the BJP Government, Mr. J. P. Nadda said that after consulting with the Ministry of Law and Justice, it was decided that the government would follow the judgment of the supreme court in 2011 regarding passive euthanasia, and it did not have any proposal to enact it in the Parliament.[33] The Law Commission of India, a commission established to advise the Ministry of Law and Justice regarding legal matters, in its 241st report on »Passive Euthanasia — A Relook«, largely agreed to the 2011 judgment of the supreme court and recommended exempting doctors and patients from penalizing under IPC sections 306 and 309.[34]

In the 2018 landmark judgment of the Supreme Court regarding euthanasia in the case Common Cause (A Regd. Society) vs Union of India, the constitutional bench chaired by then chief justice Dipak Misra declared that passive euthanasia is valid after the due procedure set out by the court is followed. In paragraph seven of the said judgment, the chief justice reflects on life and death, and the right to have dignified death: »It is asserted that every individual is entitled to take his/her decision about the continuance or discontinuance of life when the process of death has already commenced and he/she has reached an irreversible permanent progressive state where death is not far away. It is contended that each individual has an inherent right to die with dignity which is an inextricable facet of Article 21 of the Constitution.«[35] The bench, for delivering this judgment, relied on the earlier cited cases, such as P. Rathinam vs Union of India and Smt. Gian Kaur vs The State of Punjab, and notable verdicts of the apex court in the USA and in other Global Northern countries. Further, as discussed earlier, besides permitting passive euthanasia, the Supreme Court in this verdict legalized advance medical directives (living will) for adults with mental faculty. With this judgment, the longstanding

32 Govt. not in favour of euthanasia, says Azad: in: The Hindu, 14.8.2013, www.thehindu.com/news/national/Govt.-not-in-favour-of-euthanasia-says-Azad/article11933988.ece.

33 Comprehensive Guidelines on Passive Euthanasia: Press Information Bureau, 23.12.2014, pib.gov.in/newsite/PrintRelease.aspx?relid=113942.

34 241st Report On Passive Euthanasia - A Relook: Indian Kanoon, indiankanoon.org/doc/133438875/#:~:text=Both%20the%20Supreme%20Court%20and,or%20constitutional%20point%20of%20view.

35 Common Cause (A Regd. Society) vs Union of India on 9 March, 2018: Indian Kanoon, indiankanoon.org/doc/184449972/.

euthanasia debate in the legal circle came to an end, although it was received with huge uproar and severe criticism by certain sections of Indian society embedded in religious, ethical, and cultural precepts. On the other hand, euthanasia supporters looked at it as a victory for their long-lasting struggle in the courtrooms and perceived it as a revolutionary intervention by the apex court in ensuring the right to have dignified death as a fundamental right under Article 21 of the Indian constitution. In the ethical realm, however, this judgment created considerable criticism among civilians, doctors, caregivers, social activists, patients, people with disabilities and others, fearing that the verdict would be invoked in the future to euthanize chronically ill patients, disabled and old-aged people.

Ethical Implications

The sanctioning of passive euthanasia by the Supreme Court both in the 2011 and 2018 verdicts resulted in staunch criticism, and considerable debates were conducted in media houses and social realms to discuss the ethical implications. The ethical core of Hindu and other religions practiced in India, nonetheless, advocates for natural death as opposed to medically assisted suicide (passive euthanasia). Further, the moral values prevalent in Indian society also do not approve of suicide or assisted suicide, for it is against the extant value system. India, a country with a rich tapestry of cultures and civilizations, approaches the euthanasia practice mainly with ethical connotations formed by religious beliefs and cultural practices. The impermeable taboo attached to death and related conversations, in fact, makes people not discuss death openly in social spaces. Interestingly enough, the rituals performed in houses if someone dies or during the funeral ceremonies are seen from religious perspectives.[36] Put differently, any death is accompanied by an array of elaborate religious rituals to secure Moksha (emancipation from the eternal cycle of life, death and rebirth) for the person who passed away and for their family members. This belief is so strongly entrenched in followers of many religions.

The worrying factor related to the approval of passive euthanasia is its misuse by relatives and family members of the patients as said by

36 Laungani, Pittu: Religious rites and rituals in death and bereavement: An Indian experience, in: International Journal of Health Promotion and Education 44 (2013), No. 1, pp. 7–13, here p.8

the judges in the judgments and general public. In a country where poverty and low-income dominate the majority of households, it is largely believed that the implementation of passive euthanasia would lead to patients being killed for inheriting properties and wealth and selling their organs through illegal means. Thus, it was proposed to permit passive euthanasia on a case-by-case basis. Further, in certain cases, people who earlier opposed euthanasia on ethical grounds started agreeing to it owing to the larger perspective about terminal illness and the resultant death imparted through the easy availability of advance knowledge in medicine. For instance, Ms. Sujatha, the mother of Venkatesh, who moved to Hyderabad High Court to euthanize him and then donate his organs due to progressive illness caused by his muscular dystrophy condition said: »I was also not in favour of my son seeking euthanasia but knowing his grave medical condition and his own keenness to donate his organs, I did not come in his way of approach the High Court.«[37]

The cost factor in the healthcare system, as argued by Sanjay Nagral, in fact, is leading to tacit passive euthanasia for many economically low-income families, for good healthcare in India is beyond reach for such families due to exorbitant treatment charges.[38] Owing to excessive charges levied by the hospitals for EOL care treatment, low-income families are forced to shift their patients to cheaper hospitals or to their houses, which eventually results in the death of the persons who are on life-saving treatments. Alongside the cost factor, another important aspect that plays a considerable role in the euthanasia debate is the drastic privatization of the healthcare system in India, as maintained by Nagral: »In a system where out-of-pocket payment is the norm and healthcare costs are booming, there has to be a way of differentiating a plea made on genuine medical grounds from one that might be an attempt to avoid financial ruin. This may not be easy for any court or institution. The state and judiciary, which are proactive in granting such permission, will also need to look at vested interests that are forcing futile but costly treatment in a

37 Passive euthanasia should be on case-by-case basis: in: Times of India, 7.3.2011, web.archive.org/web/20120323081452/http://articles.timesofindia.indiatimes.com/2011-03-07/hyderabad/28665220_1_passive-euthanasia-muscular-dystrophy-patient-k-sujatha.

38 Nagral: Euthanasia: cost factor is a worry, in: Times of India, 13.3.2011, web.archive.org/web/20130510131223/http://articles.timesofindia.indiatimes.com/2011-03-13/all-that-matters/28685344_1_passive-euthanasia-patient-legal-sanction.

healthcare system that aims to profit through any means.«[39] Notably, this aspect of the euthanasia debate has hardly been paid any attention in legal, medical and social realms.

Talking about how the approval of passive euthanasia would intervene in one's fate destined by God, Ravinder Kaur, a social anthropologist said: »To intervene is to defy fate«,[40] echoing many who believe that life is given by God. On the other hand, the four core values of medical ethics, which the doctors are expected to uphold: autonomy of patients; acting in the best interest of patients; not harming patients and equal distribution of health resources, make them not to assist patients in committing suicide in the palliative care system as practiced in India. Further, the other two values such as maintaining dignity, and upholding truth and honesty in having informed consent for carrying out treatment also play a major role in the palliative care system.[41] Due to these medical ethics adopted in the Hippocratic oath, which is taken during the convocation ceremony, many physicians fear that withdrawal of life-saving support for terminally ill patients would lead to punitive action, cancelation of their professional license and violation of their professional ethics. This apprehension, indeed, emerges from the existing discordance between Article 21 and IPC sections 306 and 309. While the apex court has extensively debated and arrived at a convenient position regarding this, the guidelines for passive euthanasia and living-will still rest with the government officials, who often hold ethical views fraught with socio-cultural and religious perspectives, making it difficult in execution. Furthermore, though the IPC section 309 has been declared by the court as constitutionally invalid, section 306 regarding abetment of suicide continues to remain without proper clarification, particularly in physician-assisted suicide (passive euthanasia).

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39 ibid., web.archive.org/web/20130510131223/http://articles.timesofindia.indiatimes.com/2011-03-13/all-that-matters/28685344_1_passive-euthanasia-patient-legal-sanction.

40 Magnier: India's Supreme Court lays out euthanasia guidelines, in: Los Angeles Times, 8.3.2011, www.latimes.com/world/la-xpm-2011-mar-08-la-fg-india-euthanasia-20110308-story.html.

41 Sharma et al: End-of-life care: Indian perspective, www.ncbi.nlm.nih.gov/pmc/articles/PMC3705699/.

The Present Situation

In the post-2018 period, though passive euthanasia and living will are legally valid in India, the majority do not approve of it. Even six years after living wills were approved by the Supreme Court, very few officially authorized living wills exist in many states.[42] Except for the southernmost state of Kerala, which has a slightly higher number of living wills, all the other states have very few wills, testifying to the fact that the legal entitlement of death with dignity still has not reached the majority. However, in the case of passive euthanasia in terms of withdrawing life-support or food intake, the middle and upper-class families do not approve of it, instead, they approach private hospitals for terminally ill patients and those who are on the verge of death to temporarily extend their lifespan. Such concern of family members by relying on money to save their dear ones, as argued by many euthanasia supporters, ends up causing heavy pain and more misery to those who are in the final days of their lives, leaving them to die alone with several tubes connected to their orifice. Notably enough, in the present times, physicians and medical professionals have divided views on passive euthanasia: some of them agree to its practice, while others, influenced by religious, moral and cultural values, do not approve of it.

Protests against the passing of passive euthanasia were organized in many parts of India by several groups such as human rights, religious, disabled, social activists and others. It is strongly believed that in India, the EOL of someone is determined by social, religious, cultural and regional factors.[43] However, in the educated elite section of society, passive euthanasia is considered to be a viable solution for upholding the dignity of terminally ill patients and those who live in a PVS. As Kanniyakonil states about the positive changes in accepting passive euthanasia, »A change in the attitude of the Indian people regarding passive euthanasia happened due to the inability to treat incurable and painful diseases, financial issues, liberal policy, and post-modern ways of reasoning.«[44] On the other hand,

42 Rajagopal and Sharma: A Dignified Peaceful Passing is Everyone's Right, in: The Hindu, 8.5.2024, www.thehindu.com/opinion/lead/a-dignified-peaceful-passing-is-everyones-right/article68150530.ece.

43 Kanniyakonil, Scaria: New Developments in India Concerning the Policy of Passive Euthanasia, in: Wiley Bioethics (2018), pp. 1–6, here p.4, onlinelibrary.wiley.com/doi/abs/10.1111/dewb.12187.

44 ibid., p. 8.

in rural areas, people generally resort to assisted dying for those who are on the verge of death by using their own native methods, such as making them drink tender coconut water, feeding raw paddy, giving them oil baths, etc. This is generally done in the families that fall in the lower social and economic strata of society to give easy and quick death to those who are in the final days of their lives. This practice, notably enough, does not come under legal purview and has been in existence with mutual agreement for several centuries.

Conclusion

The most mundane aspect of human life, death has received several views, rituals and practices in the history of India. From antiquity to the present, ways of dying, and religious and ethical values related to death have been staunchly upheld by people. When assisted dying was introduced in the form of euthanasia, Indians had varied views on its practice due to the fact that EOL is deeply connected to religious, cultural, moral and regional factors. The majority, however, supported religious self-willed death over the modern medical method of euthanasia. Conversely, when the British Government came out with IPC sections such as 306 and 309 against assisting suicide and voluntary death, religious self-will deaths met with stiff legal resistance. Enlightened by the Western medical discourse on euthanasia, the elite intelligentsia from the mid-1990s onwards started approaching the high and supreme courts to seek legal remedies for euthanasia implementation in India on a case-to-case basis for their family members, relatives and friends. One such case that got legal attention and paved the way for the ruling of passive euthanasia in India was Aruna Ramchandra Shanbaug vs Union of India and Others (2011) filed by the journalist Virani, appealing the court to permit passive euthanasia to ensure the dignified death for Shanbaug.

Though the court did not permit passive euthanasia for Shanbaug, it provided detailed guidelines for passive euthanasia. Nonetheless, this legal victory did not stay for long as the apex court in 2014 referred the euthanasia matter to its constitutional bench by stating that the 2011 judgment was internally inconsistent. Finally, in 2018, the constitutional bench of the Supreme Court ruled in favor of passive euthanasia and legalized living will with a set of guidelines for adults with mental faculty. Although this verdict is the law in India as the central government did

not enact any legislation pertaining to passive euthanasia, it has not been fully realized till date, for people have divided views on it. The most vulnerable sections, such as disabled, chronically ill people, patients with incurable disease and old aged people genuinely fear that this will be used to euthanize them with absolute impunity.

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Eric Benjamin Franklin

A Meddle with Honour. The Legislation of the Contemporary Assisted Suicide Law at the *Fin-de-Siècle*.

On a global scale, Switzerland has played a trailblazing role in institutionalizing assisted suicide. The notion of aiding someone in ending their life had already gained acceptance in the wake of claims for more self-determination the late 1970s. Actual implementation of such ideas began in the 1980s. However, the roots of the legal framework granting impunity to the altruistic assistant run deep into the soil of contested perspectives. Beginning in the late nineteenth century, the need to compile a national criminal code brought together various scholars from different schools of criminology. In a plebiscite, the creation of a national civil law as well as a criminal code was approved in November 1898. The committee of legal scholars, established by the federal council, was to draft a new, national criminal code. This task proved to be convoluted for it took three consecutive committees to agree on a bill to be passed on to parliament. Suicide had been decriminalized in many parts of the country after the Napoleonic legal reforms post 1798, which had proliferated ideals from the enlightenment. By some legal scholars in the committee to deliberate on such matters, committing suicide considered worthy of pity because it was regarded as pathological. However, the majority of law professors, high court judges and attorneys of the committee shared the view that taking one's life must be perceived as a viable last-remaining means of upholding one's honor. The accent was hence placed on living in honor as opposed to living in shame, opening the door to liberal changes in the law. Consequently, a specific clause within Article 115 of the Swiss Criminal Code was added to the law enabling a third party to assist another in committing suicide, yet only in the absence of selfish motives, such as greed or hatred. After a long-lasting political process that circled around other changes the bill proposed, the bill passed in 1938. This chapter studies the pivotal notion of honor, which had remained dormant until a movement promoting the self-determination of patients made use of that legacy by shifting the discourse towards the notion of dignity.

To understand the paradigms in the delineation of legality of suicide assistance, an in-depth analysis of the scholarly debate is of essence. Exam-

ples of discourse within the debate reflect the participants' understandings of then current mores with regard to justifiable aid in another person's suicide. Moreover, a study of the two dominant schools of criminology and their respective perception of *the criminal* furthers understanding of the proceedings that led to the legal framework still in place today. The notion of honor among the legal scholars of the committee marks a crucial distinguishing feature of the class-based society, whose elite compiled the new criminal code. It was precisely the fear of losing the honor and therein being ostracized from the own class that explains the legal leeway. However, the shift from the class-based society to the post-war mass society ushered in dignity as guiding notion. Dignity as a safeguard from arbitrary treatment of individuals by the state evolved into a concept of self-determination. The guiding question in this chapter focuses on the invocation of the hibernating article of the criminal code, cast in a bygone era, by the self-determination movement of the 1970s and onward. Furthermore, the question of how the concept of dignity filled the void left by the waning notion of honor in advocating for assisted suicide

The emergence of national criminal codes in the nineteenth century

In 1888, Switzerland as a democratic nation state had been evolving for forty years. After the economic boom of nation-building that took flight in the mid-nineteenth century, known as the *Gründerfieber*, an era of waning growth ensued.[1] Crime rates rose and some spectacular murder cases made the headlines.[2] What's more, the resultant pessimistic outlook nudged public opinion in favor of re-introducing the death penalty. Having been abolished in 1874, the death penalty returned as a deterrent in 1879, albeit with limitations. Historian Thomas Widmer has traced the spread of this economic crisis into the social, political and cultural fabric following the backlash caused by the excessive growth in the middle of that century.[3] The euphoria of historic positivism, embodied in growth made way for a conservative reflex, which echoed in calls for simplistic

1 Maissen, Thomas: Geschichte der Schweiz, Ditzingen 2022, pp. 262ff.
2 Siegenthaler, Hansjörg: Kapitalbildung und sozialer Wandel in der Schweiz 1850-1914, in: Jahrbücher für Nationalökonomie und Statistik 193 (1978), pp. 1–29.
3 Widmer, Thomas: Die Schweiz in der Wachstumskrise der 1880er Jahre, Zürich 1992, p. 9.

answers. In the public discourse, the growth of past years was rejected as a craze, which had furthered immoral behavior, which this review of 1884 reveals:

> Alienation from God is growing and with it its fruits: hedonism, frivolity, dissatisfaction, dishonesty, impoverishment and suicide, even among children. [...] How it looks in some families! No love, no peace, no desire to work, no child-rearing! Drunkenness and luxury, laziness and high-mindedness in abundance.[4]

It was during that period of moral pessimism intertwined with economic crisis that the association of lawyers initiated their lobbying for a national criminal code in 1887. Since the foundation of the Swiss Confederation in 1848, the codification of criminal acts had been a cantonal prerogative. The Confederation hence launched a referendum in 1898 proposing the unification of the diverse cantonal civil laws as well as the various criminal laws. Men enjoyed suffrage as of the age of 20, except paupers, tax debtors, bankrupts or convicts.[5] Approval for the reform was overwhelming. 70 percent of voters voted in favor of the federalization of these legal codes. Smaller conservative cantons that rejected the proposal were overruled.

The criminologist and professor of law, Carl Stooss, was chosen to compare the existing legal frameworks and subsequently to chair the first committee designated to elaborate a new national criminal law. His preliminary work compiled and contrasted the various criminal codes of the country. The focus of this chapter, suicide assistance, was unlawful in some cantons[6], while the act of suicide itself was not. According to Stooss, a person who intended to end their life deserved pity and not punishment.[7] Bearing in mind the shadow of moral and social crisis imbuing late nineteenth-century Switzerland, it was now up to the assembled committee to define moral reprehensibility and codify this into a legal framework. In Europe, the era of nationalism brought about the codification of unified criminal codes. The modern legal framework introduced the notion of participation in criminal acts. In the case of suicide assistance, this raised a question. If suicide was not a criminal offence in itself, participation as an accessory could not be punished. *Nulla poena sine lege* applied to the German criminal code, which did not mention suicide

4 »Des Pilgers Weltumschau«, 1884, cited in Widmer, p. 65.
5 Vatter, Adrian: Das politische System der Schweiz, Baden 2020.
6 Bern, Schaffhausen, Neuchâtel.
7 Stooss, Carl: Grundzüge des Schweizer Strafrechts, Zweiter Band, Basel 1893, p. 15.

assistance. In contrast to that, the Austrian criminal code outlawed any form of participation in suicide explicitly.

The legal scholars involved in drafting the Swiss criminal code were divided into two schools, which can be detailed by two major characters of the debate. Carl Stooss was a student of the social positivist school, believing that criminal behavior stems from poor education and moral neglect. Therefore, society at large and the environment of the individual criminal were deemed a root cause for such behavior.[8] This approach strongly mirrors the sense of moral deprivation experienced in the *fin-de-siècle*.

Despite being friends in private, professor Emil Zürcher stood at the other end of the criminological spectrum professionally. For the criminal anthropologist, delinquency was not learnt but innate. The school of Cesare Lombroso, which is based on a social Darwinist conception of man, held as true that only degenerate humans become criminals. According to the teaching of criminal anthropology, a criminal is an atavist character for they lack compassion as well as respect for the rights of others, two defining characteristics of modern society.[9] For Zürcher, the criminal code was therefore a utilitarian tool, which applied repression in accordance with the danger a culprit posed. In other words, not the harmfulness of the deed, but the infraction on human feelings ought to determine that constitutes a crime. Of all the legal scholars involved, Zürcher stood alone with his criminal anthropologist mindset.

This paradigmatic rift was of crucial importance in drafting the new criminal law. It presented itself in manifold ways beyond the discussion around criminal offences against life and limb. Scaling down the wider debate to focus particularly on the topic of killing on (the initiator's) demand and assisted suicide (articles 114 and 115 of the penal code) allows the contours of the honor-conception as understood by the debaters to emerge in the melting pot of mores.

In the new bill, the fundamental prohibition on taking another person's life was unanimously acknowledged.[10] However, the legal scholars showed some degree of understanding for acts of mercy. The reflections

8 Germann, Urs: Kampf dem Verbrechen. Kriminalpolitik und Strafrechtsreform in der Schweiz 1870–1950, Zürich 2015, pp. 106f.

9 Holenstein, Stefan: Emil Zürcher (1850 – 1926) – Leben und Werk eines bedeutenden Strafrechtlers, Zürich 1996, p. 250.

10 Baumgarten, Mark-Oliver: The Right to Die?, Bern 1998, p. 170.

and arguments that circulated in the committee were recorded in the minutes. Some of the arguments produced found expression in the comment to the bill which serves as an explanatory document on the *ratio legis*. In the case of killing on demand for honorable reasons, the minimum sentence was set low. This concession was intended to reconcile the new acknowledgment of honorable motive with the still standing sanctions against killing. A doctor who relieved his patient of their suffering on their request was not to be severely punished for it happened for respectable reasons. However, crossing the line to take someone's life was felt to deserve punishment in any case. The second example ushers in the defiled daughter who begs her father to stab her to death.[11] Serving as an addition to the first case, it highlights not just the respectable motive of the perpetrator, but the mindset of the time. While pity is at the heart of both cases, the sentiment of honor becomes apparent in the latter. The daughter's chastity had been compromised, which imperiled her honor. This presents the readers with an extreme example of the importance of sexual virtues of that time, it also begs the question why the defiled is asking to be made away. The honor code of the patriarchal society at the time tied unwedded women's sexual virtuousness, in this case chastity, to the reputation of her father.[12] This exaggerated importance of honor is key to understanding the class-based society whose elites drafted the legal framework from which such conceptions are ultimately rooted. The German philosopher Arthur Schopenhauer poignantly defined the characteristics of honor:

> Honor is the outward conscience, and conscience the inward honour; as such this might appeal to some; but would be more a brilliant than a clear and thorough explanation. Hence I say that honour is, objectively, the opinion of others of our worth, and subjectively, our fear of that opinion. In the latter capacity it *often* has a very salutary, though by no means purely moral effect, in the man of honor.[13]

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11 Stooss, Carl: Schweizerisches Strafgesetzbuch, Vorentwurf mit Motiven. Basel 1894, p. 148.

12 Speitkamp, Winfried:. Ohrfeige, Duell und Ehrenmord. Eine Geschichte der Ehre, Stuttgart 2010, p. 20.

13 Haack, Hans-Peter und Carmen Haack (eds.): Schopenhauer: Aphorismen zur Lebensweisheit 1851, Leipzig 2013, p. 58. *»Die Ehre ist das äußere Gewissen, und das Gewissen die innere Ehre; so könnte dies vielleicht manchem gefallen; würde jedoch mehr eine glänzende, als eine deutliche und gründliche Erklärung sein. Daher sage ich: die Ehre ist, objektiv, die Meinung anderer von unserm Wert, und subjektiv, unsere Furcht vor dieser*

Historian Winfried Speitkamp deems honor in the nineteenth century to be a fading concept upheld at the time by backward reactionaries, hard-hearted officers or misguided students who endorsed a feudal lifestyle. To them, he surmises, honor served as a social regulator with a moral compass.[14] However, the importance of honor in the reasoning of the committee shows that honor was not yet on the retreat. To the bourgeois class-based society, honor as an outward manifestation of conscience served as guidelines for individuals of the same class. Infringements such as corruption, sexual misconduct or homosexuality could mean an individual's ostracism from their class if not contested in court or in a duel.[15]

Understanding the structuring moment of honor in the class-based society is paramount to comprehending the difficult discussion on killing on demand. It took several attempts to assemble a commission that was able to compromise on a final draft. On the morning of 19 September 1912 the commission assembled to discuss article 66, concerning the inducement and aiding of suicide.[16] A dispute about the wording of this article between the two legal scholars Stooss and Zürcher had preceded the discussion. Stooss, who considered suicide pitiable, and hence the provision of assistance in committing the act illegitimate, met resistance from his friend, who was determined not to outlaw any abetting of the deed. It is here illuminating to quote the legal article:

»Any person who *for selfish motives* incites or assists another to commit or attempt to commit suicide shall, if that other person thereafter commits or attempts to commit suicide, be liable to a custodial sentence not exceeding five years or to a monetary penalty.«[17]

Stooss aimed to criminalize any aiding and abetting. However, Zürcher masterminded the implementation of the three words in italics. This specification would, in contrast, legalize altruistic suicide assistance. The professor of criminal law expounded on this specification with the following example: »We don't want to hit suicide. The law stops at its tragedy. But the most cunning of murderers, who knows how to choose his own

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Meinung. In letzterer Eigenschaft hat sie oft eine sehr heilsame, wenn auch keineswegs rein moralische Wirkung, im Mann von Ehre.«

14 Speitkamp, Ohrfeige, p. 10.

15 ibid., p. 148.

16 Schweizer Strafgesetzbuch, Protokoll der zweiten Expertenkommission, zweiter Band, Luzern 1912, p. 168.

17 Article 115, Swiss Criminal Code, 1.1.2024.

victim, is the one we want to target: the self-serving accomplice.«[18] To Emil Zürcher, the criminal law was in service of the perfection of humankind by preventing all that was detrimental to the general interest of mankind.[19] This notion of a general interest of mankind epitomizes Zürcher's positivistic and social-Darwinist paradigm, which aims to remove obstacles on the path of a progressively developing society. The yardstick of an individual's societal aptitude was their compassion. Therefore, if the punishment was to exclusively reflect the fault of the aide, the altruistic helper was not to be culpable. Alfred Gauthier seconded this view by adding: »This article is determined by a subsequent circumstance which is, moreover, beyond the control of the offender. […] The motive that gives the act the character of an offence is self-interest. Where this does not exist, e.g. where honorable motives are at stake, there is no offence.«[20] Gauthier, the third of the triumvirate that spearheaded the development of the criminal code, saw the possibility for honorable motives that need not necessarily lead to an indictment of the assistant. Zürcher provided an anecdote that illustrates an example of such an honorable cause.[21]

> I know of a case where an officer was remanded in custody for a common offence he had committed, and a friend brought him a revolver into the cell to give him the opportunity to commit suicide; had the prisoner really made use of the revolver, it would have been best for him and his family, and I think the friend, who acted merely in the interest of the prisoner, deserved no punishment.[22]

Through a dishonorable act, the officer in question had lost his reputation and was given the opportunity to restore the honor of his family by ending his own life. In the eyes of Emil Zürcher, this provision of a salvatory opportunity was altruistic and need not be deemed incriminating. This clearly exemplifies that the notion of honor and its preservation remained a pressing issue and that it informed Zürcher's convictions. Zürcher gave this statement in 1894, but his three-word addendum was removed by the committee in the process. In the third committee of 1912, his reintro-

18 Schweizer Strafgesetzbuch: Protokoll, p. 170.
19 Holenstein: Zürcher, p. 298.
20 Schweizer Strafgesetzbuch: Protokoll, p. 171.
21 Zürcher: Verhandlungen der Expertenkommission, Bd. I, Bern 1894, p. 324.
22 Quotes from the original documents were translated into English by the author, in a manner intended to convey the often-dated expressive characteristics of the original German formulations.

duced stance was met with some resistance. Among the contenders of this wording was Professor Philipp Thormann who opposed the permissive 3-word loophole because »that someone incites another to commit suicide because he knows that this will be a service to one of his friends, or out of pleasure in scandal and cruelty. There are no selfish motives here, and similar cases can be thought of even more.«[23]

This criticism lay bare the difficulty of what could be construed as altruistic motives. Albert Calame, a scholar from Neuchâtel, did not deny the aforesaid but added that if the three-word specification were to be withdrawn, many a case of honorable motive would become punishable. Loyal and honorable men could not act in friendship or camaraderie in assisting a friend who had lost his honor.[24]

In the end, eight members voted against the addendum and were defeated by the 13 members of the committee who voted to keep the three words, therein enabling assisted suicide. In the Federal Council's dispatch on the new criminal law, the committee's winning argument is clearly reflected:

> Suicide is not an offence in modern criminal law, and there is no reason to return to the previous law, for example for reasons of population policy. Persuading someone to commit suicide and aiding and abetting such an act can be a friendly deed, which is why only self-serving incitement and aiding and abetting are punishable, e.g. persuading a person to commit suicide who the perpetrator is obliged to support or from whom he hopes to inherit.[25]

The draft on suicide assistance was not a topic of discussion in the various readings of the bill. Rather, smaller, conservative cantons and their representatives had quite different concerns and opposed the very idea of nationalizing the criminal code. They feared a loss of sovereignty and saw the end of federalism looming. That the entire code was subject to debate rendered the parliamentary debate into a showcase for biopolitical ideas of normativity. Hence, a definition of soundness of mind was sought, the demand for sterilizing lunatics or the decriminalization of homosexuality was debated and initiatives to strengthen sexual morality were promulgated.[26] Even though suicide assistance was not an issue, the liminality of life

23 Schweizer Strafgesetzbuch: Protokoll, p. 171.
24 ibid., p. 172.
25 Botschaft des Bundesrates an die Bundesversammlung zum Entwurf eines schweizerischen Strafgesetzbuches (23.7.1918), BBl 1918 IV, p. 32.
26 Germann: Kampf, p. 198.

overshadowed the debate. Matters such as abortion or the death penalty received great attention. Akin to their fears of centralizing power, the conservative cantons endorsed capital punishment, which the new code aimed to abolish once and for all. The bill was passed through parliament in 1937. A plebiscite was demanded and, one year later, the referendum resulted in a minute margin of 53.5% in favor of the new criminal code. This is testimony to the rift in the general populace.

In Stooss' hostility towards allowing suicide assistance, we can see a converging of Christian doctrine, which cherishes life per se, with a pathologization of the suicidal drive. Zürcher opposed such conceptions and saw in the termination of one's own life a way to avoid shame. He regarded *Pietà* as a quality of the fully developed man in society. The conviction of the latter is emblematic of the hierarchical construct that was the class-based society out of which it emerged. Once ostracized by society, the pariah who had betrayed the code could only endure their new state of being after having suffered social death.[27] The new option provided by the law issued a legal way out of unbearable social shame for the defiled based on compassionate grounds. The ones whose inner honor, one's self-respect, had been violated by the extinction of one's outer honor were now given the choice to end their very existence. This corset of honor seems archaic. However, within this system, it provided an option of self-determination. This self-determination is what was enshrined in the law.

Countries like Germany, France or Belgium forwent any mention of assisted suicide in their legal codes. Austria, on the other hand, banned rendering aid in committing suicide.[28] At the time, Switzerland, as we have seen, stood out with its legal framework on suicide, which criminalized accessories to an act that itself was decriminalized, which entailed a loophole for altruistic motives. While a minority of the committee aimed to punish suicide assistance altogether, the majority considered compassion in the case of honorless offenders a convincing argument to justify this loophole. Therein, the lawmakers of the late nineteenth century granted an option for an act of compassion. However, the exemplary situations cited in the law are immensely relative to their periods. There is no evidence that assisted suicide was intended for the sick and suffering who harbored a death wish. On the contrary, the anecdote of

27 Speitkamp: Ohrfeige, p. 9.
28 Schaffer-Wöhrer, Peter: Das Recht am eigenen Leben. Marburg 2010, p. 59.

the compassionate doctor who relieved a patient from his pain revealed the committee's appreciation for the honorable motive. However, such acts were nonetheless not to go unpunished because of the breach in the absolute prohibition on killing.

The second half of the twentieth century

The Third Reich exaggerated and perverted honor into a cult and transformed it into a question of allegiance. The overstretch of this dated concept led to a backlash which ultimately diminished the role of honor post 1945.[29] Not only did National Socialism pervert the dated concept of honor to forge cohesion but it also marked the end of the continental European class-based societies which stratified its classes based on the code of honor. The rise of democratic mass society heralded the equality of all citizens before the law. In such an egalitarian society, honor lost its social and cultural legitimation. Remnants of it can still be found in competitive sports and in various cultural practices. However, it has lost its importance as a normative value. The cultural anthropologist Dagmar Burkhart has traced a shift from honor to the notion of dignity. While the dual nature of honor as both self-perception and outside perception of the self by others still exists, it prevails in the modern notion of dignity.[30] The universal declaration of human rights 1948 propagated the inalienable human dignity of persons regardless of their respective material, social or ideational attributes. The experience of genocide underlined the need for safeguards for the sake of human life. Dignity emerged as a hallmark concept in numerous constitutions. Honor by contrast, especially violations of it, were relegated to criminal offences.

The notion of dignity evolved from a right to life to a personal ideal of self-determination, which the legal scholar Mark-Olivier Baumgarten explains as follows:

> According to the practice of the Federal Supreme Court, the constitutional principle of human dignity includes the procedural guarantee of the subject quality of the person concerned, a minimum degree of personal freedom of development, elements of public-law protection of personality and criteria prohibiting the abuse of power. In addition, there are hints of the topoi of individu-

29 Speitkamp: Ohrfeige, p. 11.
30 Burkhart, Dagmar: Eine Geschichte der Ehre. Darmstadt 2006, p. 113.

> al autonomy, communication and transparency of relationships, as well as the importance of intimacy, living space and participation in human community for the individual and the priority of the person over material value, as well as the principle of personality-related interpretation of fundamental rights.[31]

Drawing on this interpretation, it is the responsibility of government to provide the conditions in which such ideals can be realized and thrive. In Switzerland, the groundwork for this paradigm was established through the adoption of the European Convention on Human Rights (ECHR) in 1974. Its article 8 grants the right to privacy, from which freedom of choice is deduced.[32] In end-of-life matters this conception of autonomous human agency rose to particular importance in patients wishing to decline treatment.

The development of the notion of self-determination was propelled by the growing means and measures applied in intensive care. The discovery of penicillin and intravenous barbiturate-narcosis laid the foundation for intensive care interventions, even though the latter was «deadly easy, but easily deadly» at the same time.[33] Instruments such as the heart-lung machine are symbolic of the rapid developments in intensive care in the second half of the twentieth century. This increasing degree of technologization harbored the danger of shifting the doctor's attention to technical readings and findings and away from the wellbeing of the patient.[34] This paradigm shift resulted in the possibility to keep a body alive regardless of the incumbent personality. Two intensive care professionals describe the situation at the time:

> The material battle against death, which is unilaterally focused on the survival of the patient, leaves little room for help in dying. But helping the terminally ill also means dedicating oneself to them, not leaving them alone in this last stage of their life amidst a tangle of tubes and apparatus. Medical staff often wrap themselves in a 'cloak of correct objectivity', as otherwise they would not be able to bear the emotional strain of the intensive care unit. So, the patient dies in the style of our time, in the midst of the hectic bustle of super-technical and over-medicated medicine, in sterile rooms, shielded from the non-germ-free outside world after days of the doctors' struggle with death. Cut off from all

31 Baumgarten: The Right to Die?, p. 61.
32 ibid., p. 93.
33 Lawin, Peter and Hans Wolfgang Opderbecke: Die Intensivmedizin in Deutschland, Berlin 2002, p. 5.
34 Nauck, Friedemann: Palliativmedizin und Intensivmedizin, pp. 220–225, in: Junginger Theodor and Christian Werner (eds.): Grenzsituationen in der Intensivmedizin. Heidelberg 2008, p. 220.

> communication with relatives, friends, acquaintances, and the clergy, etc., dying becomes a mental ordeal. The intensive care unit becomes a hell of loneliness, a plunge of the soul into nothingness, a scientific testing station and torture chamber that prevents the patient from recognizing and perhaps coming to terms with the meaning of his death, the completion or conclusion of his life.[35]

This expansion of intensive care ushered in, on the one hand, a debate on death. In connection with organ transplantation, a new definition of death based on contemporary scientific means had to be found.[36] On the other hand, in intensive care treatment, the paternalistic doctor-patient relationship attitude, which left the patient with little to no say in choosing his treatment, compounded by people's perception of the inhumane »intubisation« process, were crucial in the rejection of such treatment.[37]

In Switzerland, this practice culminated in 1975 in the widely reported scandal around the chief physician Urs Hämmerli. He served as a senior doctor in the city's new Triemli hospital. Under his aegis, chronically ill patients with irreversible brain damage were fed water through a gastric tube, as opposed to a drip, which had often caused embolisms.[38] Beyond the technical advantage, the change further meant that the relief of a patient's suffering might possibly entail the end of prolongation of life. The flamboyant doctor explained his practice to the city councilor Regula Pestalozzi, who had him arrested for manslaughter. He was quickly released and later rehabilitated, whereas the politician was not re-elected. The central issue in the 1975 discussion was what triggered agony and what process led to the patient's death.[39] Without much attention, a political initiative had been launched in 1974. It demanded that the canton Zürich bring in an initiative on national level to allow mercy killing. The proposal won enough signatures and was, therefore, voted on in a cantonal plebiscite. Surfing on the tumultuous wave of the Hämmerli scandal, the initiative won a majority. Despite being bogging down in the national parliament, this movement heralded the changing notion of dignity in political discourse. By means of advanced declarations, patient

35 Lawin, Opderbecke: Intensivmedizin, p. 190.
36 Greiner, Florian: Die Entdeckung des Sterbens, Berlin 2023, p. 252.
37 Simon, Gerhard: Die Sterbehilfe-Bewegung, Erlangen 1985, p. 35.
38 Saner, Hans: Vom Anspruch auf humanes Sterben, , in: Helmut Holzhey: Euthanasie: zur Frage von Leben- und Sterbenlassen, Basel 1976, pp. 9–23, here p. 21.
39 Dirlewanger, Dominique: Autour de l'affaire Hämmerli, in 20&21. Revue d'histoire 147 (2020) No. 3, p. 105–117, here p. 108.

organizations aimed to oblige doctors to respect the patient's will regarding further treatment.

In its further evolution, the conception of dignity gradually surpassed its association with self-determination in the narrow context of rejection of treatment. Dignity became synonymous more generally with self-determination of the individual who strives to live in accordance with their ideals. This broader conception lies at the heart of the term authenticity. Living with and dying in pain was regarded by liberal progressive forces as an unnecessary burden in a society which had the means to end someone's life «peacefully».

Inspired by the long-running but ineffective British Voluntary Euthanasia Society and the persona of the Scottish surgeon George B. Mair, individual, progressive Swiss nationals formed an association in 1982 dedicated to aiding suffering people in terminating their life successfully. The new Swiss association, EXIT, accumulated members rapidly.[40] The fear of overtreatment in hospital provided a widespread motivation to join. At the beginning, EXIT joined the struggle to have patients' living wills accepted by the medical profession. This defiance was triggered by a historic expansion in the scientific methods available to doctors since the 1960s to keep a human organism alive. In addition to this reactive approach, the association issued a guide to self-deliverance. The same had been attempted in Britain. However, in 1982 the distribution in Britain was stopped by court order.[41] In Switzerland, a member of EXIT was entitled to borrow a brochure at a certain age and following a specified membership duration. These measures were meant to cater exclusively to the needs of persons with a well-grounded will to die.

Article 115 had lain dormant since the Swiss Criminal Code came into law in 1942. Only a handful of convictions based on illegitimate suicide assistance are recorded for the years between 1960 and 1983. According to the criminal law expert Christian Schwarzenegger, the article played an extremely marginal role in legal practice.[42] Despite being irrelevant in terms of convictions, this norm became pivotal among the homicide articles. Its importance lies in the definition of *accessory to a deliberate*

40 Lüönd, Karl: Selbstbestimmt bis zuletzt. Basel 2022, p. 46.

41 Kemp, Norman: Merciful Release, Manchester 2002, p. 217.

42 Schwarzenegger, Christian: Selbstsüchtige Beweggründe bei der Verleitung und Beihilfe zum Selbstmord, in: Petermann, Frank (ed.): Sicherheitsfragen der Sterbehilfe, St. Gallen 2008, pp. 81–124.

act of suicide. Consequently, the interpretation of the nature of assistance changed. Whereas the original definition referred to suicide assistance as a «friend's deed», having an altruistic motive in mind, the interpretation altered toward that of *indifferent* motivation.[43]

Formalizing the status quo versus legalizing mercy killing

Social agitation for self-determination at the end of life and resulting political demands surged in the 1970s. EXIT, the association to facilitate self-determined dying, became the flagship of this movement in 1982. Inspired by the Right-to-Die movement in Britain, a group of like-minded people assembled to institutionalize their fight for self-determination. Gradually, the Swiss Academy of Medical Sciences moved towards greater recognition of the patient's will. However, mercy killing has remained illegal and tabooed within the medical profession. Advocates for assisted suicide have repeatedly demanded the widening of legal end-of-life options.[44] The euthanasia model in the Netherlands serves as an ideal for their orientation. Despite the original, liberal legal framework, which allows for suicide assistance, an extension of legal options has been discussed but rejected in the Swiss Parliament. While the legislature refused to amend the law, the number of persons exercising their right to assisted suicide began to rise. In 1998, the break-away radical liberal spin-off association, *Dignitas*, committed itself to »ensuring a life and a death with dignity for its members […]«.[45] Harking back to the enlightenment ideal of the free-born human being and driven by a vigorous liberalism, Dignitas provides suicide assistance for foreign nationals from abroad.

The judiciary subsequently set a precedent, which altered eligibility for assisted suicide in 2006. Whereas a moribund diagnosis used to be prerequisite for assisted suicide, a Swiss national who had been suffering from bipolar disorder requested suicide assistance, hence overstepping the original criteria. He claimed that, being *compos mentis*, he was able to discern what this request entailed. Furthermore, he had been suffering for

43 Engi, Lorenz: Die »selbstsüchtigen Beweggründe« von Art. 115 StGB im Licht der Normentstehungsgeschichte, in: Jusletter 4. Mai 2009, p. 4.

44 Suter, Daniel: 30 Jahre Einsatz für Selbstbestimmung, Zug 2012, p. 13.

45 Dignitas Switzerland: www.dignitas.ch, (25.2.2024); note: the German version statutes *dying* with dignity, not *death*.

years and all therapeutic interventions had been to no avail. The plaintiff argued that his life was undignified. The Federal Supreme Court ruled that Article 8 clause 1 of the ECHR safeguards the individual choice to end one's own life. More importantly, the court levelled the difference between bodily suffering and mental suffering, the caveat being that the wish to die not be construed as an expression of the disorder, but a well-reflected will to end this life.[46] With its statute, the supreme court ruled that the manifest suffering of a person of sound mind who harbors a well-reflected wish to die represents grounds for assisted suicide.

Conclusion

The bourgeois class-based society of the nineteenth century, whose legal scholars drafted the compiled national criminal code, produced a code of honor, which furthered the debate on pity. While some considered suicide to be pitiful, the majority regarded felo de se—committing a felony to oneself—a viable option to avoid shame and subsequent social death. This dated concept gradually mutated into a secular idea of self-determination. It can be regarded as a blueprint of a societal system of constraint. The long-debated code was passed into law before the code of honor found its demise in the middle of the twentieth century. Subsequently, the loophole of assisted suicide went into hibernation until it was rediscovered by a society focused on dignity, which meant living life in self-determination to fulfil the hopes and dreams of an authentic life. This meant defying the medical profession, whose aim was to preserve life at all cost. Out of this defiance, the movement of positive self-determination was born. It propagates the option to end one's own life of one's own accord. Having catered to the moribund sufferers who terminated their lives in avoidance of pain and prolonged suffering, the ideal of dignity was extended to encompass termination of one's own life based on the notion of suffering.

To conclude, in the nineteenth-century class-based society, a person of considerable standing could ruin their reputation and therefore their social persona and standing through shameful infringement of the code of honor. The law reacted by facilitating a terminal way out to avoid the

46 Petermann, Frank: Das Recht, über Art und Zeitpunkt der Beendigung des eigenen Lebens zu entscheiden. Eine Urteilsbesprechung von BGE 133 I 58 – 76., in: Petermann, Frank (ed): Sicherheitsfragen der Sterbehilfe, St. Gallen 2008, pp. 357-378.

shameful ostracism. More than one hundred years on, the honor code has long yielded to the paradigm of dignity. On 13 February 2024, the Swiss Federal Court acquitted a doctor who prescribed an 86-year-old woman a lethal dose of pentobarbital. The aged woman considered it her dignity to die because she could not bear the thought of outliving her husband. The practice of prescribing lethal doses of barbiturates to healthy persons in order to die is ruled out by the code of ethics issued by the Swiss Academy of Medical Sciences. However, the court found that the legal framework does not outlaw this practice. Thereby, the judges sanctioned the status quo. If changes were to be made, the ball would be in the parliament's court again.[47] If the guide to life is dignity, the question arises as to what the factors are that shape the environment, which influences the individual in the notion that runs on the tracks of the absolutistic assumption of human autonomy.

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