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Obstinacy and suicide

Rethinking Durkheim's vices

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This article takes Durkheim's *Le suicide* as a conceptual testing ground for an ongoing field inquiry into assisted suicide in Switzerland. It tackles the question of the extent to which a Durkheimian approach to the social facticity of human practices can adequately grasp the ethico-pragmatic variation in which people give form to their lives, especially under heavily constrained circumstances. The article makes two interventions: it first draws out the conceptual significance of the asymmetry in the architecture of *Le suicide*, namely, of Durkheim's explicit refusal to elaborate a fourth type of suicide (fatalistic suicide). It then presents the blind spot, and asymmetry, as constitutive of his normative scientific posture: that social science, in its modern modalities, has the means to identify the normative ends toward which social life should aim, to the detriment of a more pluralist ethical and anthropological postulate through which to grasp and understand the multiplicity of moral forms pertaining to suicide, of which assisted suicide in Switzerland provides the test case.

Keywords: anthropology of ethics, Durkheim, pragmatic social thought, *Le suicide*, a death in Switzerland

February 2015, in a small Swiss agricultural commune in the northern part of the Canton of Vaud, between Lausanne and Neuchatel, I met Dr. Milner, a retired family doctor. Dr. Milner's wife had ended her life by assisted suicide in the summer of 2013. Mrs. Milner had been accompanied by Mrs. Pinelli, a volunteer with *Exit: Association pour le droit de mourir dans la dignité* (ADMD), an association that provides its members with aid in conducting voluntary death. Mrs. Pinelli suggested I talk with Dr. Milner, that his experience of his wife's death could be pertinent for an anthropologist curious about this historically recent form and manner of dying: the first associations (Exit: ADMD and Exit *Deutsche Schweiz*) were created in 1982

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and a coherent practice of accompanied suicide developed only in the mid-1990s.[1] Briefly put, unlike in the vast majority of countries worldwide, helping someone to end their life is not a crime in Switzerland. Moreover, unlike in the Benelux countries, and unlike in several states of the United States, the person who provides such assistance does not have to be a medical doctor, and the relevant legal article does not stipulate any positive conditions limiting such a practice, such as the state of health of the individual (e.g., time-limited prognosis) and nor does it stipulate the technical means to be used. Article 115 of the Swiss penal code underlines the one condition on which helping with suicide is a crime: "Any person who for selfish motives incites or assists another to commit or attempt to commit suicide is liable to a custodial sentence not exceeding five years or to a monetary penalty." It should be recalled that the vast majority of such deaths for Swiss residents happen at home, with a tiny minority occurring in the few hospitals that allow it, or else occasionally in care homes (établissements médico-sociaux) in the Cantons that have voted in favor of a law mandating the right of residents to request such help (Vaud was the first Canton to vote for a such law in 2013). There are also associations, such as Dignitas and *lifecircle*, which accept requests from foreigners and who maintain private residences in which to facilitate assisted suicide for nonresidents.

Nevertheless, the associations that provide such aid have their own norms about who can do it and how: to have a request accepted a person must experience either an "incurable illness," "intolerable suffering," "significant disabilities," or "multiple pathologies" that limit quality of life; the individual must also have the faculty of discernment; additionally, in terms of the technical means, such a death is carried out through a massive overdose of barbiturates, a means that can only be obtained through a prescription written by a doctor who must accept the request.[2]

Mrs. Milner was diagnosed with a glioblastoma, a kind of brain tumor, in 1993. It was regularly checked on and for fifteen years she went about her life, the tumor showing benign tendencies. In 2008 their eldest daughter had a child. She looked after her grandchild five days a week while her daughter was at work. She refused more scans on the grounds that if they found something, then she'd no longer be able to do this. She wished, in effect, to care for the child as long as she was physically capable, without concern for her own medical situation. At the end of 2012 her husband persuaded her to do a new scan. It showed that the tumor had grown considerably. She underwent surgery, which was unable to remove it entirely. Two months later more scans showed it had grown back significantly. The couple had a friend who suffered from the same illness: "she spent the last years of her life as a vegetable in a local home," Dr. Milner explained to me, an effect of the tumor on the frontal lobe of the brain.

His wife's situation was followed at the major teaching hospital, an hour and half from where she lived. The medical team suggested she undergo a new form of chemotherapy, available only there. She refused: too many side effects for a treatment whose aim, ultimately, was comfort care rather than cure. Also of concern

1. Personal communication with the president of Exit: ADMD.

2. These orienting criteria are publicly stated on the Exit website and are criteria shared by all associations that facilitate voluntary death.

to Mrs. Milner were practical things, such as the exhaustion of travelling regularly from the rural commune to the city to be seen at a "factory"—that is to say, the big, impersonal, teaching hospital. Mrs. Milner telephoned the hospital to explain that she did not wish to go through with the proposed chemotherapy. The neuro-oncologist did not react well, Dr. Milner explained: "He washed his hands of her, like Pontius Pilate. The oncologist said that if she did not do the chemotherapy, then he wanted nothing to do with her." This moment marked a turning point for Mrs. Milner, as narrated by her husband, a turning point in her illness and in her attitude: "Her behavior became more aggressive; she had incontinence and became extremely dependent. And then, soon after the phone call with the oncologist, she made a decision to contact Exit."

I returned to see Dr. Milner on several occasions and we revisited together the event of her suicide: "It went very well: she even managed to sleep the night before. Me too. She didn't sleep *very* well, of course, but still she was able to sleep. We stayed up late that night confiding in each other. We had gone walking in the forest on the Sunday afternoon. We went and had a look where she wanted me to put her ashes. Holy smokes to think of that!! Then on the day, Mrs. Pinelli arrived. My wife wasn't allowed to drink or eat anything. She said again to my wife, if you don't want to do it I will gladly go home, it's good weather, it's the summer. We'd be happy if you didn't take it, but the decision is yours."

Mrs. Milner had been resolute about the date. Once Mrs. Pinelli had told her that there was the possibility of doing it in mid-August, nothing would change her mind. Dr. Milner explained that he himself, Mrs. Pinelli, the prescribing doctor, friends, and their two daughters had all tried to persuade her to wait until after the summer, but she would not consider it. They insisted on the fact that her eldest daughter was pregnant with a second child, to be born in September, but this did not shake her resolve: "I don't know why she was so stubborn about it," Dr. Milner stated simply. "Then she drank the potion [the barbiturate solution]. The potion is a bit bitter so I gave her a piece of chocolate. Me, I like *Ragusa*,[3] so I gave her some, for after the potion, and then, she shouted at me saying 'you know I hate it when there are nuts in it!' Then *pof*: she died. The last words she said to me. It's a bit tragic, but that shows the character of my wife. Even at the end, she made a scene: (Imitating her) '*No! You put nuts in the chocolate; right to the end you annoyed me*' (A chuckle from Dr. Milner). You know, she was an aristocrat; her family was part of the Crusades. It's crazy, eh."

Although in many respects singular, unmarked by what is typically considered to be "violence," Mrs. Milner's death was nevertheless neither normal, nor ordinary, nor customary (Chatterji 2016; Das and Han 2016). As a kind of prepared and chosen death, it exhibited the opposite hallmarks of practices ranging from Jains in Jaipur to Buddhists in Kathmandu: namely, in those cases, a valorized ritual practice of dying realized through the diminishment of attachment and desire in the world (Desjarlais 2016: 648; Laidlaw 2005: 193). Mrs. Milner's death, on the contrary, exhibited many kinds of attachments, including attachment to the timing,

3. A Swiss chocolate invented in 1942. During the Second World War chocolate was in limited supply and so the company made a chocolate bar characterized by the large quantity of nuts in it.

to the form, and to the taste of her death. Her suicide was not the result of a lack or breakdown in "social relations" (for such a classic Durkheimian argument see, e.g., Widger 2012), and the control she sought to exert did not lead it to be qualified as a "bad death" (Broz and Münster 2015: 6). Although a fine-grained demonstration of the mechanics of negotiation is beyond the scope of this article (taken up in forthcoming work), it is necessary to insist on the fact that the control she was able to assert, as a subject, was precisely the *outcome of*, rather than a mere *baseline for*, such a form of death, justified, negotiated, and mediated with others.

It was thus on the one hand not a normal death, and yet also, not unique. She was one of a small number of people in Switzerland—a small number that is nevertheless growing—who, when faced with a situation they consider blocked and intolerable, choose to die rather than live on in available ways. One of the anthropological stakes in inquiring into this practice is to understand beyond the contours of an individual choice, the signification of such a practice for the transformation of the parameters of ethical living today. As such, it is indispensable to confront the observation of such a practice, with prior manners in which the moral and political significance of suicide as a social fact has been determined.

Le suicide

Emile Durkheim considered voluntary death as a privileged phenomenon for indexing and characterizing the moral temper of society—an object that took on its specific reality through the long nineteenth century (Boltanski 2014). Not only was Durkheim claiming that suicide rates could indicate the social (sui generis) causes of suicide, thus defying those sciences that would reduce acts of suicide either to mental pathology (Esquirol 1838) or psychic imitation (Tarde 1898), but furthermore and moreover, he aimed to establish sociology as a science of moral facts and thus a science of the normative orders that are given form under modern conditions of the organization of work and life. Studying suicide as a specifically social phenomenon was therefore a way to study the moral forms of social life through their exaggeration in this specific gesture.

A central thesis of *Le suicide* is thus that suicides "are not an isolated class of monstrous phenomena, with no relation to other manners of conduct" (Durkheim 1897: 7). Rather, they are "only the exaggerated form of ordinary practices" (Durkheim 1897: 7). As such, suicide is an ethically qualified social phenomenon not reducible to individual psychological reasons (or causes) because of which people end their lives. As Bruno Karsenti has underscored (forthcoming),[4] the originality of Durkheim's analysis was precisely his specification of its ethical character: "Every sort of suicide is thus only the exaggerated or diverted form of a virtue" (Durkheim 1897: 263). The sociological challenge for Durkheim was then to identify the moral forms and social causes through which these virtues are exaggerated, and hence the

4. It was thanks to Bruno Karsenti that I began this work of engagement with Durkheim's *Le suicide*, rethinking what I thought I knew about the text and engaging with it, as he argues for, as a treatise on ethics. I equally thank Gildas Salmon for his philosophic counsel and patient reading of this text.

standards and forms with respect to which such exaggerations (excesses and deficiencies) can be judged as vices. Crucially, the "exaggeration" of these forms of conduct can be judged as excessive or deficient in the individual, that is to say, exaggerated from a mean, only with respect to the social environment that encourages or demands the form of conduct and the virtue in question. Such a qualification should then lead us to specify these exaggerated virtues—hence vices—as "social" in the specific sense Durkheim gives to the latter term, that is to say, pertaining to a sui generis object, a standard "collective representation" and form for living called society.[5]

The presupposition of such sociological determination is that the articulation between societies and moral orders, although historical and subject to possible transformation, is nevertheless the outcome of what we can call a large-scale eighteenth- to nineteenth-century social, political, and juridical institutional solidification such that at the end of this "heroic" age of science (Callegaro 2012: 455), sociology could finally be professionalized and authorized to pronounce truth claims about this object—society—and more specifically the virtues with respect to which the moral order of society is supposed to be regulated. Sociology as a science was able to occupy a discursive position so as to articulate the rapports between social structures and normative orders.

Durkheim, ethics, and a pragmatic anthropology

In the last decade there has been renewed interest in Durkheim's legacy and a question of the continued relevance of inquiry based on Durkheimian methodological and philosophical postulates (Karsenti 2012; Lemieux 2009, 2012; Rawls 2004). As an anthropologist, such readings have involved questioning what I thought I knew about Durkheim, to wit, a deterministic view of the isomorphism of social forms and normative orders. James Laidlaw summarizes a version of one such view succinctly: "Durkheim's conception of the social so completely identifies the collective with the good that an independent understanding of ethics appears neither necessary nor possible" (Laidlaw 2002: 312). At stake in this article then is the question of how Durkheim's *Le suicide* can be read in relation to an anthropological endeavor to grasp the "subject of virtue" (Laidlaw 2014a), that is to say, the ethico-pragmatic variation in which people give form to their practices, their lives, and crucially, to the ending of their lives, specifically relative to modern institutions for the management of health and illness (hospitals, doctors, treatments, prognoses, etc.; Pinell 2012). If Laidlaw seeks to valorize an anthropological attentiveness to a plurality of modes and forms of ethicality in human practice (see also Das 2015; Lambek 2010), practices whose domains are resolutely open and dynamic (Faubion 2011: 6–7), an anthropological endeavor I wholeheartedly share, I would nevertheless like to confront Durkheim's text with an investigation into what Kant named as the core *pragmatic* anthropological problem: what the human being as a free

5. My approach is thus orthogonal to that of Cheryl Mattingly (2012), who identified two "virtue ethics," a humanist first-person virtue ethics and a "poststructuralist" ("Foucauldian") virtue ethics.

acting being can and should make of itself" (Kant [1798] 2006: 3; cf. Rabinow and Stavrianakis 2014: 1–30). Simply put, I do not want to presuppose that a pragmatic anthropology of ethics has either no point of articulation (Laidlaw 2014b), or else a necessary connection (Lambek 2015b), with Durkheim's social science of moral facts, and his modality of inquiring into virtue. Rather, the critical limits and possible fruits of such a confrontation for anthropological inquiry must be tested and shown. I am thus purposefully constraining the conceptual stakes in this article to an engagement with, and testing of, Durkheim's model, sidestepping recent calls from anthropologists such as Jarrett Zigon to qualify Durkheim's "ontological assumptions" as "Cartesian" and thus to jettison such assumptions in favor of, in his case "Heideggerian ontology that conceives of being and the world as coeval" (Zigon 2014: 20), or else to focus on "moral moods" and narrative forms (Throop 2014; Mattingly 2010). The latter orientation is one I otherwise think fecund (cf. Rabinow and Stavrianakis 2014: 69), however in this article I am engaging in a step-wise reading of the significance of Durkheim's assumptions in order to better diagnose the critical limitations of his model for grasping plural ethical practices today.

I take up such a task with a conceptual and methodological aim in mind, to better orient myself in the ongoing field inquiry in Switzerland. An organizational form has developed in recent decades in Switzerland for a new variant on the practice of voluntary death: assisted suicide. That is to say, since the 1980s and more visibly since the mid-1990s, there has been a significant morphological change in suicide, which Durkheim assiduously defined as "cases of deaths which result directly or indirectly from a positive or negative act accomplished by the victim herself and that she knew would produce that result" (Durkheim 1897: 5). Although often appropriately taken up in its connection and continuity with medical ethical questions of euthanasia and doctors' capacity and legitimacy to hasten the dying process of the sick, the invention of such a new form of assisted suicide can also be taken up in relation to the longer durational anthropological and sociological problem of the moral forms of acts of voluntary death. I thus use my ongoing inquiry into assisted suicide as a testing ground and conceptual gauge for clarifying the limits to (and hence also interest of) a Durkheimian sociological approach to inquiry into moral forms and practices. Specifically by confronting my inquiry with my reading of *Le suicide*, I probe the conceptual limits to Durkheim's conception of the relation between the sociality of practices and the moral forms they both imply and produce. Such a confrontation indexes what Paul Rabinow and I have named as the demand for a contemporary anthropological reconceptualization of the breakdowns and remediations in the plurality of ethical forms that can be observed as modernity's *ethē* and institutions undergo change (Rabinow and Stavrianakis 2014: 41–57), and in this case, with respect to assisted suicide as a novel response to the question of how to die (in Switzerland) today.

The key point of conceptual breakdown and remediation, which I will outline in the section that follows, is a demonstration of the significance of the well-known lacuna in Durkheim's presentation of the social facticity of the moral forms that can be grasped with respect to suicide as a human practice. I will argue for observing Durkheim's conceptual blind spot as constitutive of the character of his modern, normative, scientific posture, which is crucially also a political one: that sociological

science has the means to identify *the* political ends toward which social life should aim (Callegaro 2015). That is to say, Durkheim's normative political posture is a regulative one. The article poses the question of how a pragmatic anthropological inquiry can adequately take up social practices that are obstinate to regulation. As such it is oriented to what Lisa Stevenson (2016: 714) has called the "affront" of voluntary death to certain *specifically modern* forms of institutional reason, in her case "colonial" and "bureaucratic" forms (Stevenson 2014), a practice whose obstinacy, in my case, consists in opposition to moral demands, an opposition "eventalized" in the opening scene with the neuro-oncologist "washing his hands" of his patient and of the patient transforming her renunciation of treatment into an active search for a means to leave her experience of illness and to give that leave-taking a form. I will describe how such social practices are a blind spot for Durkheim, and as a counterpoint will suggest how his conceptual scheme can be opened up in order to adequately grasp and understand the multiplicity of moral forms and practices, including those that might be conceived as anti- or countersocial.

A problem of symmetry: Durkheim's typology

Durkheim's typology of moral tempers of modern society exaggerated in voluntary death is both canonical and incomplete: egoism, altruism, and anomie reflect forms of social life that are excessive or deficient along two axes, each with poles of excess and deficiency: (1) social integration and (2) moral regulation. Let us briefly recall them: *Egoism* is a social condition of deficient integration correlated to an ethos and virtue of individualism. In his deductive account Durkheim links the egoistic aetiology to a specific form ("morphology") of suicide, "melancholic languor" (Durkheim 1897: 314). *Altruism* as a social condition can produce excessive social integration and deficient individuation, indexed to an ethos of obligation and virtues of honor. Although primarily conceived as archetypical of nonmodern societies, Durkheim shows that this virtue reemerges in excessive form with respect to voluntary death in modern arrangements around warfare. The corresponding moral form is "active renunciation" (Durkheim 1897: 336) of a self for a common endeavor or *telos*. Finally, *anomie* as a social condition is characterized by breakdown in moral regulation and practices indexed to unbridled desire for progress (Durkheim 1897: 420). The subjective form that Durkheim associates with such deficient regulation of desire is "exasperated lassitude" (Durkheim 1897: 321).

For Durkheim a balance must be established between the types of suicides. What is normal is the right composition of virtuous exaggerations, a normal rate of vice, expressed as a stable rate of suicide. The stability and regularity of the suicide rate across the plane of "the social" is indicative of the effectiveness and vitality of the corresponding virtues. The mean (i.e., virtue in Aristotle's sense),[6] for Durkheim, can

6. Virtue (*aretē*), for Aristotle, is a question of the excellence of a practice, which admits of excesses, deficiencies, and "the middle" or mean in the conduct of different kinds of *technē* and moreover *technē tou biou* (the art of ordering life, producing, in its critical dimension, a worthwhile manner of living). Work on the human good, or reflection on ethics, is preparatory for concerns about how people can live together. But as Aristotle

be conceived only with respect to society and thus conceived through the judgment of someone authorized to pronounce in its name. Sociologically what is problematic is when one virtue (and vice) is exaggerated at the expense of the others, which was the historical diagnostic concern of Durkheim; namely that individualism was exaggerated at the expense of altruism with an accompanying effect in terms of moral deregulation under conditions of historical progress, hence an increase in both egoistic and anomic suicide. The vice of any particular act is conceived and judged with respect to the extraparticular plane of the social calibration of the three ethical topics, to wit, individuality, obligation, and progress. Crucially, since duty or social obligation is characteristic of nonmodern societies, and modern differentiated societies tend to express exaggerations of individuality (egoism) and the desire for progress (anomie), the normative posture of the sociological scientist can easily be justified through the claim to a remediation of the lack of regulation or control in social forms under modern conditions and in modern institutions.

This nineteenth-century picture and model of social causes is clearly missing one type: excess along the axis of moral regulation. Durkheim is aware of this, of course. A footnote in the section on anomie explains the following:

> We see from the preceding considerations that there exists a type of suicide which is opposed to anomic suicide, much as egoistic and altruistic types of suicide are opposed. It is that which results from an excess of control [*règlementation*]; that type of suicide committed by those subjects whose future is mercilessly worn, whose passions are violently held in check by an oppressive discipline. It is the suicide of husbands who married too young, of the married woman without children. To be comprehensive we should therefore constitute a fourth type of suicide. But it is of such little importance today, beyond the cases we have just cited, it is so difficult to find examples that it seems needless for us to stop there. However, it could be that it would have an historical interest. Is it not to this type that the suicides of slaves are linked, which it has been said were frequent under certain conditions, all those, in a word, which can be attributed to immoderation of moral or material despotism? To render visible the unavoidable and inflexible character of the rule under which we can do nothing to change, and in opposition to that expression "anomie" that we just used, we could call it fatalist suicide. (Durkheim 1897: 311)

If, as Durkheim writes, his typology shows the exaggerated or deflected form of a virtue, then we must ask, what is the virtue of which the vice of suicide due to "overregulation" or "excessive control" (*excès de réglementation*) is the exaggeration? Furthermore, if, as he writes, in the late nineteenth century it was "difficult to find examples," we can nevertheless ask whether this fourth term, already present on the surface yet inactive at the beginning of the twentieth century, nevertheless can be read as virtually opening a space of a future problematization whose significance, for us at the beginning of the twenty-first century as observers in the present, can be grasped?

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explains, even this seems incomplete, as possession of virtue is not enough; one actually has to exercise virtues.

Said another way, if, for example, the social cause of "deficient regulation," responsible for a high rate of suicide (anomic), is connected to the exaggeration of the virtue of the "love of progress," then what is the corresponding virtue calibrated to material or moral despotism? How can "moral or material despotism," as a type of social environment cause a particular form of suicide and as an exaggeration of what kind of ethical practice? Where could we look for cases?

My argument will be that from the point of view of dominant norms, exemplified in the first story with respect to the medico-moral injunction instantiated by the doctor who "washed his hands" of his patient, and from a strictly Durkheimian perspective, it is an exaggeration that should be qualified as a refusal to advance in line with a range of instituted expectations about how one should conduct one's life, in this case when ill. What I will argue is that Durkheim couldn't understand the social significance of such counternormativity, which from the point of view of those engaging in assisted suicide, and those facilitating it, is sometimes also a search for a virtuous manner of moving against stasis, including the stasis of those dominant norms. I will propose that we test this conceptual question with the case of assisted suicide in Switzerland.

Let's begin with the three examples Durkheim suggests: (i) "the young man who marries too early"; (ii) "the married woman without children"; (iii) the historical example of "the slave." The examples should produce a set, if they are coherent. In what does their coherence consist? I suggest that each example gives an instance of a situation in which a person is aware of a normative conception of the appropriate conduct of life—a normative conception of married life for the young man, a normative conception of family for the married woman, and the normative naturalization of inequality for the slave—yet finds him- or herself blocked with respect to that expectation, and/or seeks to challenge it, materially and morally.

These persons are subject to the "despotism" of social norms and the unwillingness or incapacity to fulfill the expectation. Such a distinction between being unwilling or unable is moot from a nonpsychological perspective. What is crucial here is that while there may be a biological determinant for the incapacity or unwillingness to fulfill a social expectation, for example in Durkheim's use of the case of a woman unable to have children, or closer to my own inquiry, an illness that it likely to take a particular trajectory, or that produces a particular experience of suffering, it is the normative expectation of a certain comportment, or qualification of such a form of life, that produces contestation. It must be underscored here that the cause of suicide is not the excess of regulation itself or the moral demand itself—we are not dealing with the case of social obligations that result in or produce voluntary death, as is the case with altruistic suicide (e.g., the obligation to end your life when you are sick in old age without chance of recovery, an example Durkheim gives of an Old Norse custom among warriors). We are rather in the domain of the kick back against excessive regulation, judged as excessive by the person, in negotiation with others, and whose action in turn is open to be being judged on moral scales of excess, deficiency, and appropriateness. As such, this is the only type of suicide in Durkheim's model that is expressed through a countermovement by subjects against social norms.

Aside from the empirical claim that this forth kind of suicide barley existed in the late nineteenth century, we lack in Durkheim's account an understanding of

the ethical character of this fourth type of suicide and its relation to social forms. Given the rapport that Durkheim constitutes between moral order, social causes, and juridical regulation (sanction), I argue that regardless of his empirical claim, he cannot grasp the significance of this fourth virtue, which is crucial for a pragmatic anthropology of the plural ethical characters of living, and particularly with respect to the case of assistance with suicide.

Whether he was unable to grasp the content of the fourth virtue because empirically it did not exist across the nineteenth century, or whether he was unable to grasp the empirical phenomena because of a blind spot in his conception of the relation of society and moral order, is a crucial question. The empirical question of the existence of the phenomena in the nineteenth century greater than the examples given by Durkheim is, however, beyond the scope of the present analysis.

Nevertheless, logically, it seems to me, we can first take up the problem of the fourth virtue as a conceptual blind spot that closed the possibility of such an inquiry, for a modern such as Durkheim, at the end of the nineteenth century. Furthermore the incapacity to grasp this fourth virtue is significant for showing us a historical transformation in moral forms from the point of view of today, based in an experience in the present. We can see the significance of this historical transformation, it seems to me, in the invention of new manners of suicide and in particular in the fact that this manner of suicide indexes the importance of intransigence against the social determination of moral forms; a kind of social activity that has no place in Durkheim's asymmetrical schema.

Mrs. Milner's virtue?

How to name the virtue at stake in this fourth bracketed type of suicide? Taking up Durkheim's model it should be a counterpart to "the love of progress," which in the anomic variant is the excessive exaggeration of the virtue of participating in sociohistorical progress. Let us characterize this fourth virtue as follows: the endeavor and effort of a subject to produce movement and motion toward ends, to act in a situation of the experience of stasis. Such a virtue is irreducible to that which is grasped under the term "individualism," along the axis of integration, since here our subjects demonstrate many kinds of attachments, and it is precisely the character of the normative social relations they encounter against which they purposively act, with the assistance of others. It is also irreducible to political and psychological tropes of "resistance" (passive or active), or "rebellion," as I will later demonstrate. Let us for now state that the exaggeration of such a virtue is then perhaps appropriately described by Durkheim as "fatalist," as it is a countermovement that under blocked conditions and with a degree of obstinacy, produces motion toward death as the only movement judged as possible by and for a subject, albeit crucially, with the help of others. Such obstination, I am arguing, as a moral form of practice, is aimed at producing countermotion under conditions of stasis experienced with respect to normative injunctions.[7]

7. As such, while there could appear to be an analogic rapport between the virtue I am trying to name and what Gilles Deleuze, writing of Melville's "Scrivener," called "The

The significance of this fourth virtue, hard to name as it is, emerges I think only under changed historical circumstances. Or at the least its significance can be shown with respect to our starting point: that over the last thirty years a new modality and form of suicide has emerged, one that did not exist before. Grasping *assisted* suicide in terms of this fourth virtue is of interest with respect to how sociologists and epidemiologists have typically attempted to grasp the phenomenon. Statistical interpretations in the last ten years confirm an orthodox Durkheimian view of the social causes of this new form and practice: those living alone, educated, and divorced are statistically more likely to end their lives through assisted suicide (Steck et al. 2014). We are given an image in these statistical studies of what should properly be called egoistic and anomic suicide, which is to say, among those who are experiencing serious illness, there are moral and social forms—a lack of integration and a lack of psycho-social or even moral regulation—that shape the fact that a certain percentage of these suffering individuals seek to end their lives. Indeed, this narrative is confirmed in studies today that characterize these suicides as "potentially vulnerable" (Steck et al. 2014: 8). These studies are concerned with the social environment and the psycho-social causes of the increasing numbers of people who seek assistance with suicide.

Inquiry, however, indicates that the morphology does not fit the proposed causes: in *Le suicide*, Durkheim writes that those lacking social integration inhabit a subjective form of "melancholic languor"; those lacking moral regulation inhabit a form of "exasperation and weariness." Durkheim characterizes these forms with specific kinds of motion: centripetal motion for the melancholy of the excessively individuated suicide, centrifugal motion in the case of the exasperation of the deficiently regulated person. Among those suffering persons who, together with others, come to the judgment that they can be assisted in the wish to exit their experience of illness, neither melancholy nor exasperation adequately capture the phenomenon of those engaging in assisted suicide, and nor do the forms of motion proposed by Durkheim adequately capture the movement of their thinking and their steps toward suicide.

Melancholy associated with detachment from social relations fails to adequately grasp the phenomena of those seeking assistance with suicide given that, first of all, those seeking assistance with suicide must engage in making and maintaining a series of (frequently strong and intimate) relations with those willing and able to assist, and often with the help of a particular family member or friend. It takes a lot of work of arrangement to go through the sequences necessary for assistance with suicide. Mrs. Milner, for example, was ensconced in different kinds

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Formula" (Deleuze 1998: 68–90)—Bartleby's "I would prefer not"—the latter is resolutely about producing stasis ("I like to be stationary"). As such, arguably, The Formula is both "ironic," insofar as its mood endeavors to produce a static distance between characters as well as between the reader and the events narrated, and heroic insofar as it is a political allegory of "resistance" read at the level of psychology (Desmarais 2001). By contrast, what I am naming as the virtue of "obstinacy" is neither static nor heroic nor modernist and is resolutely "social" in Durkheim's sense, although not in a modern modality. It is rather a countersocial, contemporary manner, a manner that I argue Durkheim was unable to grasp. I thank Giovanni da Col for this inspiring suggestion.

of relation: kinship, friendships, and the demands of the hospital to be a "good patient." She refused certain kinds of obligation, including refusing the projection of self as grandmother-to-be, as well that of "the good patient" who should either follow the doctor's orders or else be left to her own devices. Mrs. Milner sought out a different support, from Exit and Mrs. Pinelli, as well as support from her family to assist her in her endeavor to actively shape her experience of giving up on the hope of ameliorating her situation.

The result of such refusal was therefore not isolation or lack of attachments. Although initially she asked her husband to keep her decision a secret from their daughters, with the mediation of the prescribing doctor, who became a family friend, and with the intervention of Mrs. Pinelli, the family came to an open discussion in which Mrs. Milner's judgment was worked through collectively and shared. This is not to say that all were in total accord but that disagreement and thoughts about her suicide and her refusal to continue treatment and her positive decision to end her life could be reflected on together. Furthermore, it must be underscored, that suicidal ideation due to depression ("melancholic languor") is a core criterion for exclusion by assisted suicide associations.

By contrast, it is more difficult to establish that "exasperation" is not part of the morphology of assisted suicide: anger, from accounts during my inquiry so far, is regularly seen as part of the affect field of those living with debilitating (although not necessarily "terminal") illness. Indeed, Mrs. Milner's last words were in keeping with what her husband called her "forceful character" and in keeping with the increasing anger she expressed through the last months of her illness, according to him. Nevertheless, as a morphological type, in Durkheim's model, exasperated weariness connected to a lack of moral regulation due to an excess of progress connects exasperation or anger to a centripetal motion, an outburst consequent to the lack of moral direction, standards, and forms.

My fieldwork thus far suggests that an affect of anger in the search for assistance with suicide is on the one hand clearly connected to the experience of illness but more pointedly is directed toward those viewed as blocking the path to an assisted suicide, or else toward those who uphold norms and forms against which the person endeavors to kick back, which results often in the creation of secretive dyads who then operate with the assistance of a medical third party for the realization of the suicide (cf. Gamondi et al. 2015).

Such a situation becomes all the more clear when we observe a situation of a British man who wished to end his life and had to persevere in working through the impediments to such a goal, given the effort required of getting from the United Kingdom to Switzerland, and given the many blockage points he found in the medical field in the United Kingdom in order to secure the relevant documentation. During my inquiry into Mr. Smith's illness with Amyotrophic Lateral Sclerosis, his request for assistance with suicide, and ultimately his death in Switzerland, I came across a letter written by Mr. Smith to the director of the Swiss association that was to assist him. The letter is of interest insofar as it outlines in a simple and modest way Mr. Smith's ethical and political stance, germane, it seems to me, for contextualizing his rapport with the form of his death, and of the political and ethical pertinence of the term freedom, constituted in terms of a countermovement against

tyranny, albeit framed in terms of a political conception of "individuals" as the unit of political life: "In a free society," he wrote,

> individuals are encouraged to follow their own beliefs, providing they do not adversely affect others. Those religious zealots who oppose assisted suicides are free to reject such activities for themselves. However, they are not entitled to make such decisions for other people. Many UK citizens are not Christians and have varying religious convictions, many at odds with Christianity. I suspect the UK government as well as the Swiss authorities tend to appease those with such Christian views, in the mistaken view that they are appealing to the majority. At least in Switzerland it appears that such specific issues are put to a democratic vote. It is interesting to note how enlightened are your countrymen in this and other matters. One can already recognise the enlightenment exercised by your country in the seventeenth century on providing sanctuary to exiled regicides, such as Edmund Ludlow, one of my forebears, now buried in the English churchyard in Vevey. It is well recognised that Switzerland was unique in its support of democracy and freedom of the individual. It viewed the oppressive practices of King Charles I and his coterie of royalist supporters with distaste and when action was taken to end this dictatorial and undemocratic practices [*sic*] resulting in the English Civil War Switzerland responded in seeking to safeguard those persons being pursued following the restoration of the monarchy and reintroduction of many of the former oppressive practices. Switzerland has good reason to be proud of its impressive record in these matters.

In Mr. Smith's final letter outlining his request and arrangements for an assisted suicide in Switzerland, he further specified his antinomian stance with respect to the legally suspect nature of his action as seen from the point of view of the United Kingdom, and he specified the lengths he would be willing to go to in order to subvert the blockages he experienced:

> In order to avoid any proceedings against anyone accompanying me on such a journey, who may be deemed to have assisted me, it is necessary for me to undertake my journey far earlier than I would otherwise do in order that I can still travel unassisted, other than with the usual assistance provided to all travellers at airports and on airplanes. This is manifestly unjust and unkind to be confronted with such an undesirable set of conditions at such a sensitive and distressing time. In the absence of our societies' abject failure to confront this obvious need, or to make any provision for those afflicted or indeed to fashion the law in a humane and caring way, whilst still retaining any safeguards required, creates a cruel and uncaring situation for so many people in similar situations such as mine.

As such, with these specifications in mind, I would like to suggest that the force and directionality at stake in the fourth type of suicide seems to be best characterized neither as centrifugal nor centripetal but rather as obstinate: a refusal to comport oneself in line with a received normative injunction. The range of affect is vast, composite, and changeable: anger, serenity, assuredness, ambivalence, and in which these passions are configured with thought and action, which manifests in

this specific form of motion toward a highly determined *telos*: an ending of life that is considered to be a form of death that is able to give control back to the suffering person. What are important to characterize is the possible and virtual motion of a subject consequent to the situation experienced and the form given to that experience. The configuration of thought, passion, and action of this fourth type of suicide distinguishes its form and motion from that which could be grasped as either renunciation or exasperation, or despair or melancholy.

The term obstinate has at least two senses that are of interest: (1) defiant of authority and (2) difficult to overcome. For those whose experience of illness is that it is not responsive to treatment, or that they no longer wish to carry on with treatment, or that they no longer wish to live with a certain experience of illness, there is a question of what to do. The question of authority is an accompanying one: modern medicine has, to a degree appropriately, a normative orientation toward cure and sustaining life as long as possible. There can also be excess, however, in modern medicine's normative orientation to the sick and dying. In situations where medicine cannot cure, those who are sick live under a dual moral demand: hope and courage, which as a discursive norm was institutionalized throughout the nineteenth century (Szabo 2009). The creation of associations in the 1980s for assisting with voluntarily ending life was defiant with respect to such a normative orientation, experienced by some as a form of moral and material tyranny. Some people would rather not to participate in phase 1 experimental trials. Some would rather not to be governed in the ways proposed by modern institutions for managing sickness: they may choose no interventions, or may choose to end their lives (cf. Noll 1989). Nevertheless, as historian of medicine Harry Marks pointed out about his own experience of illness and treatment, even for someone who "for a long time" thought they didn't want an extended "medicalized death," there is the realization that "it is hard to avoid once one starts the medical grand slalom" (Marks 2012: 524).

The motion of such a moral form of recalcitrance is neither centripetal nor centrifugal: it is refractory with respect to the stasis-inducing combination of exterior forces and the moral and material demands of the institutions in which people are embedded. Such motion can indeed be surprising: I met the husband of Gaby Mosa in December 2015. Mrs. Mosa had ended her life in April 2014 with the assistance of Exit. She had begun to have speech problems in late November 2013 and was finally diagnosed with a motor neurone disease in March 2014. On hearing the diagnosis, the prognosis, and management of the illness, the need for an artificial feeding tube, then an oxygen mask at night, and then intubation in hospital, she turned to her husband in the consultation room, in front of the doctor and immediately said, "Josy, you will stay with me. I won't go to the hospital. Not for intubation or anything else. When I can longer breathe well, I will leave (*je m'en irais*). You will help me and will hold my hand." Joseph Mosa promised her. He is, however, a devout Catholic who grew up in the mountains around Sion. His wife was likewise a faithful Catholic. "It was surprising," he explained to me: "we're religious: we don't do that around here." Joseph made sense of this surprising spontaneous request, as well as his promise to her, with respect to her character: her courage and her formidable decisiveness.

This fourth type of suicide puts in question the role of society, or more accurately, the professional groups and institutions dealing with specific problems, as

legislators within society. It questions, furthermore, the authority and normativity of those who instantiate and attempt to regulate what they would consider to be "the" moral order relative to which persons give form to their lives. As such, it puts in question the nineteenth-century figuration of *l'Homme* in terms of doubles, to wit, in the case of Durkheim, of that doubling between Society and individuals. In attempting to grasp the social form of normative order Durkheim presupposed his object in terms of a duality between two abstract general concepts: "In so far as we are at one with the group and share its life, we are open to their influence; but inversely in so far as we have a personality distinct from their own, we are refractory to them [*nous leurs sommes réfractaires*], and try to escape from them. Since there is no one who doesn't lead this sort of double existence concurrently, each of us is animated at once by a double movement. We are drawn in a social direction and tend to follow the inclinations of our own natures" (Durkheim 1897: 360). Within this figure of "Man and His Doubles," refractory motion is taken up, indeed can only be taken up by Durkheim in terms of a remainder of socialization: rebellion, or strife, or courage, or decisiveness, as with Gaby Mosa, is reduced by Durkheim to the level of psychological experience.

Sociology becomes the moral legislator of order: the right mix of egoism, altruism, and anomie consequent to progress. Heterotopias of governing oneself and others differently are unintelligible in this problematization of modern society: "*Volenti non fit injuria*. This is an error," writes Durkheim: "Society is injured because the sentiment is offended on which its *most respected moral maxims* today rest, a sentiment almost the only bond between its members, and which would be weakened if this offense could be committed with impunity. How could this sentiment *maintain the least authority* if the moral conscience did not protest its violation?" (Durkheim 1897: 383; emphasis added). The moral conscience that seeks to maintain the moral authority that binds society is that of the sociologist. The sociologist, furthermore, takes on a figurative character, as we will see, that of the "hero," a figure with a long afterlife in the social sciences.

French modern, contemporary Swiss

As Francesco Callegaro has well indicated, Durkheim's scientific attitude is heroic, which is as much an effect of the social environment as any factor of personality (Callegaro 2012: 455). His heroism, a mean form of the altruistic social aetiology he diagnosed in *Le suicide* is counterbalanced by the specificity of the individual sociologist-as-hero, who is able to remove himself from attachments to the relevant degree such that he can "see" what others are blind to (i.e., Bourdieu's critical distance; Bourdieu 1982). Moreover, the sociologist partakes of, observes, and contributes to the modernity that produced his own subject-position. The accelerated progress observed by the sociologist provides him with a counterbalancing aspect of irony: Durkheim the sociologist is heroic enough not to be taken in by progress; he is ironic enough to keep a fixed distance from this so-called progress, as well as his own heroism.

What is crucial in terms of this veridictional and subjectivational position, as we see clearly in Durkheim's account of rebellion in "Man's" doubling, is that obstinacy

is treated psychologically, and thus externalized as a form of motion. Such a psychological rendering is an effect of what we must consider to be the jurisdictional counterpart to the sociologist's scientific position: his role as support for the figure of the legislator. As Callegaro points out (vis-à-vis Durkheim's criticism of Montesquieu), "Durkheim will not try to establish the laws of modern societies himself, but rather [he will] indicate the social institutions that would enable modern individuals to build themselves the new modern order" (Callegaro 2012: 453). I note and repeat Callegaro's use of the definite article: the new modern order, which requires the sociological hero to indicate the means to build it.

By contrast, for the more modest anthropological observer, for the observer who seeks neither heroism nor irony, there is brazenly on the surface of Durkheim's own model of suicide a critical pivot point from the past, one that from our present position and with a contemporary ethos can index the movement of a future problematization of the object he has founded through his science: the fourth virtue opens a door to multiplicities of norms and forms of living, and not an opposition of "collective force" to "individual personality"; not "Man and His Double" but rather a plurality of indeterminate norms and forms for governing oneself relative to others, a possibility Durkheim was unable to grasp. Moreover, he was unable to grasp it precisely insofar as it appeared as insignificant given the stability of the nineteenth-century historical configuration within which he was operating.

Paul Rabinow's nominalist genealogy of the emergence of "the social" explains how by the 1840s "historical development, statistics, and industrial and moral topography" could be elaborated for major urban centers (e.g., a study of the industrial and moral topography of Nantes 1835), contextualizing Durkheim's sociological intervention as the outcome of rather than the starting point for a new science of society (Rabinow 1989). Indeed, it is only as the outcome of this more-than-a-century-long development that the stability of the object can be understood, and hence his inability to grasp its points of fracture and rearticulation. Of critical importance in the emergence of this object is a relation between norms and normativity. Rabinow quotes Georges Canguilhem in order to grasp the beginning of a type of normalization specific to social arrangements at the end of the Enlightenment, "one that was more dynamic, restless and expansive" (Rabinow 1989: 10). "Between 1759, the date of the first appearance of the word normal, and 1834, the date of the first appearance of the word normalised, a normative class conquered the power to identify social norms with its own uses and its own determination of content" (Canguilhem 1966: 182–83). As Rabinow indicates, synthesizing Canguilhem's arguments, such a "power" was provided in part through an epistemological intervention, the "metaphoric transfer of concepts from a newly emergent physiology–function, hierarchy norm–to the social realm" (Rabinow 1989: 10).

In order to seize the effect of such metaphoric transfer we can revisit Durkheim's observations in the chapter of *Le suicide* treating anomie and against which fatalist suicide is opposed. It is worth observing that the explanation of anomie as a type of suicide is the only one to proceed by way of analogy with biological organisms. The chapter on anomic suicide introduces the phenomenon in the following terms: "society is not only something attracting the sentiments and activities of individuals with unequal force. It is also a power controlling them" (Durkheim 1897: 264).

Anomie is Durkheim's manner of grasping an exaggerated phenomenon of the way this regulative action is performed. As is well known his first scientific gesture is to use economic data to show that industrial or financial crises increase suicides not because they cause poverty but because they disturb the collective order. How is it possible, he asks, that men are more inclined to self-destruction when social readjustments occur, whether due to growth or catastrophe? Especially in the case of economic growth, he asks himself how a phenomenon that could be considered to improve existence increases the rate at which people end their lives. His answer begins with biological reasoning: "No living being can be happy or even exist unless his needs are sufficiently proportioned to his means. . . . Movements incapable of production without pain tend not to be reproduced. Unsatisfied tendencies atrophy, and as the impulse to live is merely the result of all the rest, it is bound to weaken as the others relax" (Durkheim 1897: 272). That is to say, the more unsatisfied tendencies the weaker the impulse to live. Animals, Durkheim goes on to reason, given that they depend on purely material conditions, establish the equilibrium between needs and means automatically: "This is not same with man" (Durkheim 1897: 272). Clearly. "Beyond the indispensable minimum which satisfies nature when instinctive, a more awakened reflection suggests better conditions, seemingly desirable ends craving fulfilment . . . how to determine the quantity of well-being, comfort or luxury legitimately to be craved by a human being? Nothing appears in man's organic nor in his psychological constitution which sets a limit to such tendencies" (Durkheim 1897: 273). It is here that the biological analogy is made operational: if nothing biological sets the limit to man's needs, as pertains to other biological organisms, there must be something else, something social that sets limits to his wants: "A regulative power [*puissance*] must play the same role for moral needs which the organism plays for physical needs" (Durkheim 1897: 275). In order to think about the problem of the analogy and of the (lack of a) place of the fourth virtue in Durkheim's conception of the social, it is worth displacing our reading of Durkheim by way of the work of Canguilhem.

In a lecture originally published in 1955 titled, "The problem of regulation in the organism and in society" (2015), Canguilhem offers an incisive intervention into the problem of biological and social analogism: "in the order of the organism, we commonly see the whole world debate the nature of ills [*mal*], and no one debate the ideal of the good" (648), for the simple reason that the ideal of the organism is the organism itself. By contrast, "the existence of societies, of their disorders and unrests, brings forth a wholly different relation between ills and reforms, because for society, what we debate is how to know its ideal state or norm" (Canguilhem 2015: 648). As Canguilhem puts it, there is precisely a "multiplicity of possible solutions calculated or dreamt up by men to put an end to injustices" (2015: 648). Society, in Canguilhem's text, is a means for the pursuit of these multiple possible solutions. Thus, insofar as society becomes a medium for the administration of diverse solutions and to the degree that they are institutionalized, society is stabilized relative to the problematization to which it is conceived as the means of solution.

Canguilhem draws out a point implicit in Durkheim's view of society when he writes that precisely the limit of the analogy is that societies are not self-regulating, hence the need to institutionalize regulation, and hence the need, as Canguilhem writes, drawing on Henri Bergson, for "heroes," the philosopher or sociologist

included. The same point holds true for Durkheim as well, as we saw: moments of social crisis, of too much disequilibrium, of pathos tipped over into exaggerated pathology is a moment that Bergson has named "the call of the hero" (Bergson [1932] 2012). Durkheim, Bergson, and Canguilhem are moderns to the degree that they think the hero is the one whose ethos renders such a subject capable of grasping and resolving breakdown, even if they disagree on the correct configuration of life and the social in the reconstruction of those breakdowns.

Durkheim (heroically) assumes discursive responsibility for the ethical, and then juridical, character of the sociological judgments he claims: "the first and most important question which concerns the subject is to discover whether or not suicide should be classed among the actions permitted by morality or among those proscribed by it. Should it be regarded, to any degree whatever, as a criminal act" (Durkheim 1897: 396)? Crucially, and in keeping with what should be termed, following James Faubion, the tendential modality of his analytic apparatus (Faubion 2011: 273), the persistence and legitimate qualification of suicide as immoral, for Durkheim, stems from the fact that "it has preserved something of its old criminological character. According to the most widespread jurisprudence, an accomplice of suicide is prosecuted as a homicide. This would not be so if suicide were considered an act indifferent to morality" (Durkheim 1897: 371). Let us note here an important historical and sociological fact: that, unlike in France, which decriminalized suicide after the Revolution, many European countries, for example, only decriminalized the act in the 1970s, at which point they reinscribed and insisted on the fact that assistance with suicide was still regarded as a criminal act. It is precisely a transformation in the ethical character of the human relations and social forms at stake in assistance with suicide that is increasingly in question today.

Durkheim notes two historical exceptions to the general interdiction: forms of legitimate suicide specific to city-states in Ancient Greece and in Rome. The legitimacy of suicide in these cases turns on political-legal institutions administering the demands of citizens to end their lives. The relaxation of former interdictions against suicide, as well as the gradual lengthening of the list of "legitimate excuses," was, for Durkheim, consequent to "serious disturbances that afflicted these societies" (Durkheim 1897: 376). He thus makes two arguments to retain the distinction and distance between modern and ancient relations of power between the individual, his life, and the state: on the one hand the fact that these societies had political means of judging whether and how a person may dispose of his or her own life indicates the symptom of a morbid condition; that is to say, a state's legitimation of forms for suicide is, for Durkheim, in itself an index of breakdown in social and political life. More fundamentally, however, the modern character of the rapport between persons, death, and political power is, in Durkheim's judgment, that "with the progress of history, the prohibition, instead of being relaxed, only becomes more radical" (Durkheim 1897: 377).

The strictness of this historical progress comes, of course, not from what Faubion has called the "themitical" (homeostatic and regulatory) modality of ethical life (Faubion 2011: 104–15) but rather from a socio-historical and pragmatic disruption of ethical life: more specifically, Durkheim identifies the progressive development of severe interdictions against a person ending their own life in "Christian

societies" as due to their new conception of the human personality. That is to say Durkheim offers a sketch of the general transformation in the worth of the human person from a "social value" belonging "wholly to the state" to "a kind of dignity which places him above himself as well as above society . . . man has become a god for men" (Durkheim 1897: 378). He puts the point succinctly when he writes that what had been uniquely a civil matter has become a religious one.

Durkheim challenges his own thesis: "but if *this* is why suicide has been classed among illicit actions, should we not henceforth consider the condemnation to be without basis? It seems that scientific criticism cannot concede the least value to these mystical conceptions " (Durkheim 1897: 379). In order to retain the authority of his science of the social Durkheim then encompasses the valorization of the human person, beyond the value any single individual could give to it, by way of the "collective sentiment" that is expressed in such valorization. Otherwise put, the individual can have worth only because and insofar as that worth is indexed to practices that refer to collective (i.e., social) life. Moral worth by definition for Durkheim is extrapersonal and the moral form of that worth, which attracts, pushes, and pulls our actions, enjoys "real moral supremacy." His coup de grâce then follows, "If it is demonstrable that *exaltation of human personality* is one of the aims pursued, and which *should be* pursued, by modern societies, *all moral regulation* deriving from this principle is justified by that fact itself, whatever the manner of its usual justification" (Durkheim 1897: 381; emphasis added). More persuasively still, in his judgment, it is a "law of history" that societies progress from valorizing society over the individual to valorizing the individual as the object and objective whose worth is indexed to social life. Historically, he concludes, "the moment approaches when the only remaining bond among the members of a single human group will be that they are all men" (Durkheim 1897: 382). Societies constrain and dominate persons while societies are constrained by the ideal of humanity and the human person. Hence societies are no longer able to dispose with persons or to articulate the ideal of the person as they see fit.

Durkheim was unable to imagine the turn that the twentieth century took. To his credit he was blind to the gratuitous capacity of political regimes to bend the idea of the person and political justifications for the use of persons to their own ends. He was thus also blind to the fact that groups of persons wish to forge other forms of life, instantiate other norms and seek to reorganize power relations between people. Durkheim could not see, indeed did not need to see, the capacity of persons to produce heterogeneous and obstinate forms of autonomy, with ambivalent relations to regulation: given the variegated and variously mediated forms of autonomy observable in Switzerland (Lambek 2015a: 128) one could say *le bonheur suisse* passed him by. We can return to Durkheim's own test, however, to gauge his judgment of the historical development of moral forms of suicide: if exaltation of the person is and should be pursued by society, then society is justified in regulating morality according to this principle. For Durkheim the question is then finished: society no longer has the right to intervene on the person as it wishes and therefore if society no longer has this right to do with persons as it wishes then neither does any particular individual. He concludes that "under these conditions suicide must be classed among immoral acts; for in its main principle it denies this religion of humanity" (Durkheim 1897: 383).

Problematizing humanity after 1975: Norms, counternorms, and power

Following Durkheim's own logic, we are in a position now to observe the push back against excessive moral regulation derived itself from a principle of humanity, or dignity, and the valorization of the idea of the person. The post–Second World War moral and political landscape witnessed the invention and formation of venues for the discursive production of statements about protection of the intrinsic worth of human beings, as Gaymon Bennett has artfully shown in his anthropology of the figuration of human dignity (2015). The 1970s and 1980s then witnessed an inflection of this discursive formation through the reuse of the figure of human dignity within a configuration of power relations around medical authority, medical practice, and judgments about care at the end of life.

There has been a historical development in which suicide as the denial of humanity is put in question: that in fact societies have produced forms for the management of illness, both physical and psychiatric, that are heteronomous at minimum and morally despotic at a maximum. Such ethical disruption has political stakes for the management of requests for assistance with suicide. In its most extreme (and logical) form, the rendering symmetric of Durkheim's schema poses the challenge of the legitimacy of suicide requests beyond and aside from any basis in a biological *cause* that would on its own act as justification (e.g., the justification of assisted suicide with reference to a "prognosis").

From the mid-1970s onward, in Europe and the United States, a distinct *topos* emerged: "death with dignity." What then to make of serious institutional developments since the 1980s and particularly the emergence of institutional forms for legitimating suicide under certain conditions along with juridical immunity (for the most part) of those who assist with suicide? We are in a position to respond to the test that Durkheim suggests. In order to undo a prohibition the burden of proof is that some profound change in the basic conditions of collective life has occurred.

1975 was a crucial year for the development of the theme of "death with dignity": a murder accusation of the head of medicine at the public hospital of Zurich launched a public and political debate in Switzerland, which coincided (arguably launched) reflections at the level of the European Union: a year after the murder accusation and exoneration of the doctor for facilitating passive euthanasia, the European Council subsequently published resolution 613, on the "Rights of the sick and dying." This resolution declares that recourse to techniques for the prolongation of life does not always correspond to the veritable interests of suffering people. We see after this date a growing preoccupation with questions of what the interests of patients consist in, and who can represent these interests. A debate had thus emerged on the relation of vital and social norms, and of the manner in which ethical judgments are made in their articulation.

In a radio emission from 1975, Canguilhem and Henri Péquignot, also a medical doctor and thinker, discussed the then-emerging question of the so-called "right to die" in this context. Canguilhem says the following:

> It seems to me that the question of the "right to die" could be taken up first of all outside of all reference to the current state of medical knowledge. . . . And well, I think that there is a right to die as there is any other right. Rights are the awareness, at a given moment, of the fact

> that, without having wanted it and without having sought it out, we are engaged in a situation that we can take up. . . . So then, the right to die is only the expression of this fact that the only thing I am able to do for life, for my life, at a given moment, is to choose the manner in which I will leave it. (Canguilhem [1975] 2011)

This is, of course, consistent with his approach to the vital normativity of living beings. What distinguishes a "right to die" however, in particular in the case of Switzerland, is precisely the manner and the means of ending one's life, which poses an awkward question of the institutional relations—and power relations—between the practice of medicine and this modality of voluntary death.

An assisted suicide is supposed to reduce the violence of voluntarily ending one's life. It is precisely in accessing the means to end one's life in a less violent manner (barbiturate overdose requiring a medical prescription), that heterogeneous norms come into contact and sometimes conflict, in the judgment about whether to facilitate such access or not. The problem of such access and the pragmatic question of how to end life requires a refinement of Canguilhem's coherent but limited suggestion that the question of assistance with dying can be dealt with in the first place outside of medicine, since in the second place, medical authority and power frequently frames the means and manner of making the judgment to leave life. It is interesting to note that between 1982 and 1999 access to nonviolent means for accompanied suicides occurred largely with the hidden support of a small number of doctors. As of the late 1990s, the associations that facilitate such suicides vowed to operate in a visible manner, highlighting points of tension between medical practices and the facilitation of assisted suicides.

Where does that leave us with respect to Durkheim and a fourth virtue? Pragmatically, if we hypothesize the existence of the fourth virtue of obstinacy—amid a plurality of norms—and if the norms and normativity of clinical practice are part of that configuration, how then to view the relation of a medical practice, oriented to cure, the experience of illness for the sick person, and the biological and institutional parameters that sustain any possible relation between a doctor and the suffering person, and particularly in a situation in which a person who is ill seeks medical help to end their life?

On the one hand Canguilhem was right to say that there is no moral medical calculus that says *if* disease x, with prognosis y, after failed therapy z, *then* assisted suicide, or "the right to die." Furthermore, the fourth virtue indicates that it is precisely not a social institution instantiated in a single authority that will judge for the person whether or not they can leave their experience of illness. And yet, it is not true for Canguilhem to suggest that a practice of a right to die is able to take place outside any reference to medical knowledge and judgment, or outside of the power relations constituted by this major field and institution, modern medicine: obstinacy is configured in relation to a range of norms, virtues, practices, and the judgments of others, including doctors willing, or else not willing, to write a lethal prescription or facilitate the practice.

Attention to force and power relations were primed for me in a conversation with the head of psychiatry at a major hospital in Vaud, which nominally allows assisted suicide on its premises, as well as in conversation with Mrs. Pinelli (the Exit

accompanier). On the one hand assisted suicide has been allowed in the hospital since 2006, although formalization of official procedure occurred only in 2014. The initial acceptance of cases in 2006 was brought about by the head of psychiatry with whom I was talking, in collaboration with the head of palliative care, both of whom had to deal with the situation of a man who in 2004 was suffering from advanced prostate cancer. This particular man was described to me as having an "incredible spark," and his character and uniqueness seems to have been important in the capacity of those who cared for him to listen to him and to reform their practice on the basis of what they heard (and subsequently saw).

The man told the team that he wanted to end his life by assisted suicide. Due to hospital regulations he was forced to do it at home, since the hospital up until then would not allow assistance with suicide on its premises. Because of his physical state and the configuration of his apartment, on the fifth floor of the building, he had to be lifted and moved into the apartment with a furniture lift through the window—"like an object" the head of psychiatry explained, still affected years later at the memory of the man's situation. This episode prompted a move to change hospital policy: "not for political or moral reasons, but just so as patients have the same rights in the hospital as out," the psychiatrist explained. The use of force on the patient prompted the exercise of power by the doctors to make a change of policy.

Nevertheless, as Mrs. Pinelli explained to me later, as we continued our discussions of assisted suicide and of the rapports between Exit and the medical milieu, the psychiatric team of that same hospital is also known to exercise power against requests for assisted suicide, power relations that Exit is not well disposed to countereffectuate:

> Every time we have a request for assistance with suicide from within the hospital the services mobilize the psychiatric team in order to say that the person no longer has their decision-making capacities. The last time, the neuro-oncology team called psychiatry and a team of five came down. They said that the cerebral tumor of the person whom I was accompanying had advanced so as to make her incapable of expressing herself clearly and thus of making decisions. I knew the woman well, even before she had trouble expressing herself. She was a bit simple. But we can't help only intellectuals.

Since she was unable to be moved home, which they knew, she had to stay in the hospital. Power relations and countereffectuations between Exit and the hospital are indicative of breakdowns for which there are no clear solutions. What remains then is an active work for the association to continue to listen to the experience and wishes of patients, and to give a form to these wishes, under the reigning power relations within the hospital setting.

Canguilhem himself offers resources for a gesture of symmetry, so as to think about the relation of norms, counternorms, and power in the relation of clinical practice, illness, and ethical judgment. Canguilhem, in fact, provides a resource that can be used with respect his own suggestion that the ethical judgment of ending life can be taken up in the first place distinct from the epistemic and ethical contours of medicine. In a text titled, "The idea of nature in medical theory and practice," Canguilhem observes the historical change in doctors' relation to

"nature" and he specifies the emergence in the nineteenth century of virtues associated with the legitimacy of not treating "nature" as that which contains within itself the secrets of both cure and healing. He cites what could be taken for a nineteenth-century medical maxim: "ignorance would consist in not asking of nature what is not its own" (Canguilhem 2002: 29).

Virtue, for a physician after the nineteenth century, is specified through a double negation of vice (understood as excessive or deficient practice): not to ask nature what it is but to ask of it what it is not, so as to know better how to intervene on it with what is not its own. We are squarely within the bounds of the legitimacy of modern virtues of curiosity, care, and intervention (Blumenberg 1983; Stavrianakis, Bennett, and Fearnley 2015). Canguilhem offers to us a glimpse of the development of virtues in medical practice, after the 1800s, a historical moment in which curiosity and impatience are rendered in positive ethical terms. The mid-eighteenth-century doctor Théophile de Bordeu is quoted diminishing the ethical virtue of the "expectant"—"wait and see," "let nature take its course"—method: "Those who employ it have always made up only a small number of the doctors, especially among people who are naturally *sharp*, *impatient*, and *apprehensive*" (Canguilhem 2002: 33). It is a small step then to symmetrize (and thus countereffect) these virtues of heroic modern doctors to a contemporary ethos of those who suffer, and indeed it is in this ethical terrain that today, in our contemporary, doctors, the suffering, families, as well as legal and political actors, must meet: sharpness (in the discernment over how one wishes to die); impatience (to end an experience of suffering); apprehension (for what a prognosis may bring) are not virtues unique to a profession that seeks to cure but also to an existence that asks "what to do?" when neither cure nor healing is possible.

References

Bennett, Gaymon. 2015. *Technicians of human dignity bodies, souls, and the making of intrinsic worth*. New York: Fordham University Press.

Bergson, Henri. (1932) 2012. *Les deux sources de la moralité et de la religion*. Paris: PUF.

Blumenberg, Hans. 1983. *The legitimacy of the modern age*. Cambridge, MA: MIT Press.

Boltanski, Luc. 2014. *Mysteries and conspiracies: Detective stories, spy novels and the making of modern societies*. London: Polity.

Bourdieu, Pierre. 1982. *Leçon sur la leçon*. Paris: Editions de Minuit.

Broz, Ludek, and Daniel Münster. 2015. "The anthropology of suicide: Ethnography and the tension of agency." In *Suicide and agency: Anthropological perspectives on self-destruction, personhood, and power*, edited by Ludek Broz and Daniel Münster, 3–26. Farnham, UK: Ashgate.

Callegaro, Francesco. 2012. "The idea of society and its relation to the individual: Recovering the novelty of Durkheim's sociology. Part I: The ideal of the person." *Journal of Classical Sociology* 12: 449.

———. 2015. *La science politique des modernes: Durkheim, la Sociologie et le Projet d'Autonomie*. Paris: Economica.

Canguilhem, Georges. 1966. *Le normal et le pathologique*. Paris: PUF.

———. (1975) 2011. "Le droit à la mort." In *Les cahiers du Centre Canguilhem n°4*. Edited by Claude-Olivier Doron, Céline Lefève, and Alain-Charles Masqueletet. Paris: PUF.

———. 2002. *Ecrits sur la Médecine*. Paris: Seuil.

———. 2015. Œuvres complètes: *Tome IV, Résistance, Philosophie, Biologie et Histoire des Sciences 1940–1965*. Paris: Vrin.

Chatterji, Roma. 2016. "The experience of death in a Dutch nursing home." In *Living and dying in the contemporary world: A compendium*, edited by Veena Das and Clara Han, 696–711. Berkeley: University of California Press.

Das, Veena. 2015. "What does ordinary ethics look like?" *Four lectures on ethics: Anthropological perspectives*, 53–127. Chicago: Hau Books.

Das, Veena, and Clara Han. 2016. *Living and dying in the contemporary world: A compendium*. Berkeley: University of California Press.

Deleuze, Gilles. 1998. *Essays critical and clinical*. New York: Verso.

Desjarlais, Robert. 2016. "A good death, recorded." In *Living and dying in the contemporary world: A compendium*, edited by Veena Das and Clara Han, 648–61. Berkeley: University of California Press.

Desmarais, Jane. 2001. "Preferring not to: The paradox of passive resistance in Herman Melville's 'Bartleby.'" *Journal of the Short Story in English. Les Cahiers de la nouvelle* 36: 25–39.

Durkheim, Emile. 1897. *Le Suicide: Etude de sociologie*. Paris: Felix Alcan.

Esquirol, Jean-Etienne Dominique. 1838. *Des maladies mentales* (2 vols.). Paris: J. B. Baillière

Faubion, James D. 2011. *An anthropology of ethics*. Cambridge: Cambridge University Press.

Gamondi, Claudia, Murielle Pott, Karen Forbes, and Sheila Payne. 2015. "Exploring the experiences of bereaved families involved in assisted suicide in Southern Switzerland: A qualitative study." *BMJ Supportive and Palliative Care* 5 (2): 146–52.

Kant, Immanuel. [1798] 2006. *Anthropology from a pragmatic point of view*. Cambridge: Cambridge University Press.

Karsenti, Bruno. 2012. "Sociology face to face with pragmatism: Action, concept, and person." *Journal of Classical Sociology* 12 (3–4): 398–427.

———. Forthcoming. "Durkheim et le judaïsme. " *Archives de Philosophie*.

Laidlaw, James. 2002. "For an anthropology of ethics and freedom." *Journal of the Royal Anthropology Institute* 8: 311–22.

———. 2005. "A life worth leaving: Fasting to death as telos of a Jain religious life." *Economy and Society* 34 (2): 178–99.

———. 2014a. *The subject of virtue: An anthropology of ethics and freedom*. Cambridge: Cambridge University Press.

———. 2014b. "Response to Hau Book Symposium on 'The subject of virtue.'" *Hau: Journal of Ethnographic Theory* 4 (1): 497–506.

Lambek, Michael. 2010. *Ordinary ethics: Anthropology, language, and action*. New York: Fordham University Press.

———. 2015a. "Le bonheur suisse, again." *HAU: Journal of Ethnographic Theory* 5 (3) (2015): 111–34.

———. 2015b. "Living as if it Mattered." *Four lectures on ethics: Anthropological perspectives.* 1–52. Chicago: HAU Books.

Lemieux, Cyril. 2009. *Le devoir et la grâce*. Paris: Economica.

———. 2012. "What Durkheimian thought shares with pragmatism: How the two can work together for the greater relevance of sociological practice." *Journal of Classical Sociology* 12 (3–4): 384–97.

Marks, Harry M. 2012. "Chemonotes." *Social History of Medicine* 25 (2): 520–39.

Mattingly, Cheryl. 2010. *The paradox of hope: Journeys through a clinical borderland*. Los Angeles: University of California Press.

———. 2012. "Two virtue ethics and the anthropology of morality." An*thropological Theory* 12 (2): 161–84.

Noll, Peter. 1989. *In the face of death.* New York: Viking.

Pinell, Patrice. 2012. "The genesis of the medical field: France, 1795–1870." *Revue française de sociologie* 52 (5): 117–51.

Rabinow, Paul. 1989. *French modern: Norms and forms of the social environment*. Chicago: University of Chicago Press.

Rabinow, Paul, and Anthony Stavrianakis. 2014. *Designs on the contemporary: Anthropological tests*. Chicago: University of Chicago Press.

Rawls, Anne W. 2004. *Epistemology and practice: Durkheim's the* Elementary Forms of Religious Life. Cambridge: Cambridge University Press.

Stavrianakis, Anthony, Gaymon Bennett, and Lyle Fearnley. 2015. *Science, reason, modernity: Readings for an anthropology of the contemporary*. New York: Fordham University Press.

Steck, N., C. Junker, M. Maessen, T. Reisch, M. Zwahlen, and M. Egger. 2014. "Suicide assisted by right-to-die associations: A population based cohort study for the Swiss National Cohort." *International Journal of Epidemiology*: 1–9.

Stevenson, Lisa. 2014. Life *beside itself: Imagining care in the Canadian Arctic*. Berkeley: University of California Press.

———. 2016. "Life beside itself." In *Living and dying in the contemporary world: A compendium*, edited by Veena Das and Clara Han, 712–28. Berkeley: University of California Press.

Szabo, Jason. 2009. *Incurable and intolerable: Slow death in the nineteenth century*. New Brunswick, NJ: Rutgers University Press.

Tarde, Gabriel. 1898. *Etudes de psychologie sociale*. Paris: Giard and Brière.

Throop, C. Jason. 2014. "Moral moods." *Ethos* 42 (1): 65–83.

Widger, Thomas. 2012. "Suicide and the Morality of Sinhalese kinship." *Contributions to Indian Sociology* 46 (1&2): 83–116.

Zigon, Jarrett. 2014. "Attunement and fidelity: Two ontological conditions for morally being-in-the-world." *Ethos* 42: 16–30.

Obstination et suicide: Repenser les vices de Durkheim

Résumé : Cet article confronte le modèle théorique élaboré par Durkheim dans Le suicide à mon enquête de terrain sur le suicide assisté en Suisse. L'enjeu est de déterminer dans quelle mesure une approche durkheimienne est capable de rendre justice à la variation pragmatique montrée par les personnes concernant leurs démarches vers un suicide assisté ? L'article se concentre sur deux problèmes : il cherche d'abord à mesurer les conséquences conceptuelles du déséquilibre créé dans l'architecture du Suicide par le refus de Durkheim d'élaborer un quatrième type de suicide, le « suicide fataliste ». Il met ensuite en évidence l'asymétrie constitutive de sa posture scientifique normative, selon laquelle la science sociale a les moyens d'identifier les finalités normatives vers lesquelles la vie sociale devrait viser. Une telle position revient à écarter une approche éthique et anthropologique pluraliste qui se donnerait pour objectif de saisir et comprendre la multiplicité des formes morales relatives au suicide, en particulier les formes de pratiques éthiques qui peuvent être saisies actuellement en Suisse.

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