

# The Somatechnologies of Canada's Medical Assistance in Dying Law: LGBTQ Discourses on Suicide and the Injunction to Live

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**Abstract:**

In June 2016, the Canadian government passed Bill C-14 on medical assistance in dying, allowing for medically assisted suicide when 'death has become reasonably foreseeable.' While available for ill or physically disabled people at the end-of-life, medically assisted suicide is denied in cases where people are perceived to have a mental disability and whose suffering is strictly emotional/psychological, such as suicidal people. I argue that this distinction results in constructing two classes of suicidal subjects by considering physically disabled or ill people as legitimate subjects who should receive assistance in dying and suicidal people as illegitimate subjects who must be kept alive through what I call the 'injunction to live' and 'somatechnologies of life'. Analysing discourses on suicide targeting lesbian, gay, bisexual, trans\* and queer (LGBTQ) people in LGBTQ scholarship, I argue that, based on the silencing of suicidal subjects through the injunction to live, suicidal people constitute an oppressed group whose claims remain unintelligible within society, law, medical/psychiatric systems and LGBTQ scholarship. This article calls for listening to suicidal people's voices and developing an accountable response to their suffering and claims.

**Keywords:** Suicide; Medically assisted suicide; LGBTQ scholarship; Ableism/Sanism; Injunction to live; Stigmatisation.

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## **Suicide and Medically Assisted Suicide in Canada**

If two people in Oregon ... each take the same quantity of the same prescription pills, each with the identical intention of ending his or her life, and they are discovered to have done so, one will be taken by ambulance to an emergency department and may have his or her stomach pumped or be involuntarily committed to a psychiatric ward. The other will not only be permitted to die but the death that he or she caused and intended won't even be recorded as suicide. The only difference is that in one case a doctor ratified the decision and in the other case, the doctor did not. (Stefan 2016: 127)

Since June 2016, when the Canadian government passed Bill C-14 on medical assistance in dying, the scenarios of suicide and medically assisted suicide<sup>1</sup> described above apply to Canada. Although Bill C-14 allows medically assisted suicide when 'death has become reasonably foreseeable' (Department of Justice 2016), it is not permitted when 'mental illness is the sole underlying medical condition' (Department of Justice 2016).<sup>2</sup> In other words, the practice is available to ill or physically disabled people at the end-of-life but denied to people who have or are perceived to have a mental disability<sup>3</sup> and whose suffering is strictly emotional or psychological, such as suicidal people. Following Michel Foucault's (1997) and Teresa de Lauretis's (1987) definition of 'technologies' as encompassing 'institutionalised discourses, epistemologies, and critical practices, as well as practices of daily life' (de Lauretis 1987: 2) and Sullivan's (2014) mobilisation of 'somatechnics,' I conceive medical apparatuses as well as laws and discourses governing suicide and assisted suicide as somatechnologies that construct legitimate and illegitimate suicidal subjects. Physically disabled or ill people are legitimate subjects who should receive assistance in dying and suicidal people are illegitimate subjects who must be kept alive through what I call the 'injunction to live' and 'somatechnologies of life'. I argue that discourses and laws concerning suicide and medically assisted suicide are neither applied to nor employed by already constituted suicidal subjects/bodies. Instead, they produce subjectivities/corporealities whose desire for death is judged either legitimate or illegitimate, constructing medical assistance in dying and suicide as mutually exclusive realities. Urged to live or forcibly brought back to life by the Canadian legal and medical systems, these subjectivities/bodies include those of trans\* people (the asterisk indicates all trans\* identities, including transsexual, transgender, two-spirit, agender,

genderqueer and more). In Europe and North America, rates of suicidal ideations and suicide attempts among trans\* people are much higher than in the general population.<sup>4</sup> By examining suicide prevention discourses targeting trans\* people – as part of broader efforts for lesbian, gay, bisexual, trans\* and queer (LGBTQ) communities – I uncover the injunction to live and to futurity at work within the ‘soma-techno-logic’ (Sullivan 2014: 188) of suicide and assisted suicide in Canada.

I argue that, based on the sanist<sup>5</sup> silencing of suicidal subjects through the injunction to live and somatechnologies of life, suicidal people constitute an oppressed, stigmatised group whose claims remain unintelligible within society, law, medical/psychiatric systems and anti-oppressive scholarship, including LGBTQ scholarship. I contend that sanism, as well as paternalistic approaches regarding suicidal people, can be found within LGBTQ scholarship on suicide that adopts a social model of suicide. While proponents of the social model have rightly criticised other models of suicide that tend to pathologise and individualise suicide, I assert that the social model produces its own unexamined forms of violence and exclusion. Inspired by anti-ableist and crip critiques of the limits of the social model to theorise disability (Baril 2015; Kafer 2013; Siebers 2008; Nicki 2001), I suggest that the social model of suicide is insufficient and fails to include suicidal subjects’ voices.

The first of this article’s four sections discusses Canada’s medical assistance in dying law and its construction of two classes of suicidal subjects. The second section presents the social model of suicide and its limits, showing how it represents a somatechnology of life that delegitimises suicidal voices. The third section critiques the ‘injunction to live’ produced in LGBTQ scholarship on suicide. The final section calls for listening to the voices of suicidal people and developing an accountable response to their suffering and claims. *I would like to make two things clear: 1) I do not encourage suicide; and 2) I do support suicide prevention.* I believe that frank discussions of suicide will prevent many suicides. However, in cases of a persistent desire to die resulting from rational, critical reflection by people determined to die, I propose a harm reduction approach based on compassion and support.

### **Canada’s Medical Assistance in Dying Law and the Construction of Two Classes of Suicidal Subjects**

Canada’s new law on medical assistance in dying is founded on two forms of ableism: 1) physical ableism against people who are physically

disabled or ill; and 2) sanism against people who have or are perceived as having mental disabilities, such as suicidal subjects. This law's ableist, ageist, capitalist, neoliberal perspective rationalises assisted suicide for subjects with 'no future' who are considered 'unproductive' (Kafer 2013). It seems 'normal' that older, ill and physically disabled people would want to die and receive assistance to do so. However, this sanist law also casts suicidal people as mentally ill/disabled and delegitimises their wish to die by judging them irrational and incapable of consenting. From this perspective, it is unthinkable that a young, physically healthy, employable and 'salvageable' person receive medical assistance in dying. There are several contradictory prejudices regarding mentally ill people. They are sometimes, like physically disabled people, cast as 'unproductive' and denied full citizenship, and sometimes considered as deceptive and lazy people who do not make an effort to overcome their bad moods (Kafer 2013; LeFrançois, Menzies and Reaume 2013; Campbell 2010). According to this second sanist interpretation, mentally ill people, including suicidal people, are 'salvageable' from a neoliberal and productivist perspective because they are not seen as ill (Nicki 2001). Notwithstanding debates about the role of mental illness/disabilities in suicide beyond the scope of this article, I demonstrate that people experiencing psychological suffering who express a need to die are silenced. This silencing is the result of sanist discourses and laws that interpret the desire to die as alienation, be it biological or social, and nullify agency exercised by this desire. Graeme Bayliss, former managing editor of the Canadian magazine *The Walrus*, implicitly discusses sanism in a comment about how suicidal people are in a Catch 22: 'I don't want to live, but the very fact that I don't want to live means I can't possibly consent to die' (Bayliss 2016).

It is striking that the 'right-to-die' agenda is promoted not only by the state and a portion of the general public, but also by many activists and scholars in social movements. I contend that the second form of ableism present in the laws on medical assistance in dying, sanism, as well as paternalistic approaches regarding suicidal people, can be found in anti-oppressive scholarship. For example, the *Vulnerable Persons Standard* (2016), which offers safeguards to protect disabled people in relation to Bill C-14, illustrates that while some disability rights activists and scholars are willing to allow access to assisted suicide to those at the end-of-life, they refuse this access to people belonging to marginalised communities who would prefer to die due to their mental/emotional suffering: '[I]f people are not at the end-of-life with medical conditions that cause enduring and intolerable suffering,

then their request to die must be considered as an expression of their vulnerability – an intolerable level of unmet need that requires response.’ This response calls for social and political change aiming to fulfil these ‘unmet needs’. As Canadian disability activist Catherine Frazee (2016) argues: ‘Assisted death cannot be the remedy for all human suffering ... [in order to] preserve the coherence of suicide prevention.’ Further, as disability activist Tom Shakespeare writes, ‘even people in the eligible category may not always be able to make a rational decision to request death. For example, depression and other mental illness could cloud judgement and may prevent a person with terminal illness making a competent decision to request death’ (2006: 43). Shakespeare adds: ‘The only socially sanctioned case where suicide becomes a legitimate choice is in the case of end stage terminal illness’ (40).

Shakespeare highlights how both irrationality and mental incompetence are associated with suicidal ideation. Scholars in health sciences (Hewitt 2013; Szasz 1999), law (Stefan 2016) and mad studies (LeFrançois, Menzies, and Reaume 2013; Nicki 2001) criticise the delegitimisation of ‘mad’ and mentally disabled/ill people’s agency. Despite the lack of scientific evidence that mentally ill/disabled people, and I would add suicidal people, are delusional, impulsive or irrational, they are treated as mentally incompetent (Burstow 2016; Stefan 2016; Webb 2011; Bayatrizi 2008; Szasz 1999). This form of sanism facilitates forced treatments and institutionalisation and creates stigmas that prevent us from considering suicidal people’s discourses as legitimate. I argue that this silencing results from a monolithic, negative view of suicide that does not question the injunction to live and to futurity.

### **Social Model of Suicide as Somatechnology of Life**

[T]alking about your suicidal feelings runs the very real risk of finding yourself being judged, locked up and drugged. Suicidal people know this and ... will do their best to prevent it happening to them. We hide our feelings from others, go underground. And the deadly cycle of silence, taboo and prejudice is reinforced ... There is a fundamental flaw at the core of contemporary thinking about suicide; which is the failure to understand suicidality as it is lived by those who experience it. (Webb 2011: 5)

David Webb is the first suicidology specialist to draw on his own suicidal experience in a field dominated by researchers who are not

suicidal. He expresses what is evident in testimonials: suicidal people feel they cannot speak or that it is unsafe to speak. Given that breaking the silence is critical for suicide prevention, this silencing is counterproductive. As Stefan observes, 'The people I interviewed were unanimous in saying that the more determined they were to kill themselves, the more they concealed their intentions' (2016: 107–108). I argue that the different models used to conceptualise suicide, based on the injunctions to live and to futurity, all interpret suicide as a choice to be eradicated and constitute somatechnologies of life that create an unsafe environment, preventing suicidal subjects from speaking. Therefore, I ask: What would happen if we questioned dominant conceptualisations of suicide? Which new possibilities of suicide prevention, intervention, and solidarity would emerge?

Many models are used to interpret suicide. Among the most popular are the medical/psychiatric model, which presents suicide as an individual pathology (Marsh 2016; Stefan 2016; Szasz 1999), the biopsychosocial model, including biological and social factors to explain suicide (Beattie and Devitt 2015: 46–49; World Health Organization 2014; Webb 2011: 97) and the social model, which presents suicide as a social pathology (White et al. 2016). The social model, which conceptualises suicide as resulting from systemic factors, including heterosexism, cisgenderism/transphobia and ableism, calls for structural changes such as social, economic, political and legal transformation (Marsh 2016; Reynolds 2016; White et al. 2016; Taylor 2015; Cover 2012). Despite the differences, the social model does share with other models the assumption that suicide is 'abnormal' and agrees that 'suicide is never an option.' I contend that these models are unaccountable to suicidal people's voices, concerns and claims. While most authors recognise the dominance of both the medical/psychiatric and biopsychosocial model, producing a great body of work on the limits of these models (Marsh 2016; White et al. 2016; Taylor 2015; Webb 2011; Szasz 1999), the dominance of the social model in the social sciences and anti-oppressive scholarship is often overlooked.

The social model of suicide is based on two main assumptions: 1) suicide is not a mental illness; and 2) suicide is a social/structural problem (Marsh 2016; Reynolds 2016; White et al. 2016; Cover 2012; Webb 2011). In contrast to a medical/psychiatric model that casts suicidal subjects as mentally ill, the social model offers a 'historicisation and politicisation' (Taylor 2015: 206) of suicidal subjectivities to highlight norms and structures, such as heterosexism, cisgenderism,

colonialism, ageism or ableism, which lead marginalised groups to suicide. Despite countless advantages, one negative consequence of the social model is the silencing of suicidal subjects. On the one hand, people who wish to end their lives must remain silent. Publicly affirming their desire will scuttle their plans due to suicide prevention measures, which can claim that suicidal subjects represent a danger to themselves to justify involuntary commitment to psychiatric facilities (Stefan 2016; Webb 2011; Szasz 1999). On the other hand, if they do express suicidal intent, their desire to die is either conceptualised from an sanist point of view as irrational, due to mental illness (Hewitt 2013), or from a paternalistic point of view as an illegitimate response to social suffering. In sum, the desire to die and suicidal discourses can only be received through the logic of prevention. To be really heard or become intelligible, suicidal thoughts must follow the dominant script of suicide prevention written mostly by non-suicidal people,<sup>6</sup> acknowledging that suicide is bad, harms other people and should not be pursued.

Even in the field of critical suicidology – which criticises the traditional approach’s focus on objectivity, quantitative data and outsider perspectives – scholars who promote qualitative research and work with marginalised communities continue to speak for suicidal people. For example, in the ‘Insider Perspectives’ section of *Critical Suicidology* (White et al. 2016), one chapter examines the perceptions of suicidal people’s families, another is written by two social workers and two ex-suicidal people, and the last presents reflections by an ex-suicidal person. While I appreciate the inclusion of ex-suicidal people’s ‘insider perspectives,’ only two of the six authors in this section constitute first-person voices. Furthermore, giving priority to ex-suicidal people rather than to people who are currently suicidal is an epistemological choice that influences the book’s content. Another example of researchers’ reticence to centre on suicidal subjects is Michel Dorais and Simon Lajeunesse’s (2004) methodological choice to study gay and gender non-conforming youth who attempted suicide that excluded people whose attempts took place in the previous 24 months. Even when using the social model, researchers prefer the discourses of scientists, health-care professionals, activists, family, friends and ex-suicidal people to the thoughts of suicidal people. I am not arguing that non-suicidal people should never speak for suicidal subjects, and I recognise the limits of identity politics. But in reviewing the literature produced by proponents of the social model, it becomes clear that the power differential existing between suicidal and non-suicidal people remains unacknowledged.

We must theorise the injunctions to live and to futurity for what they are: dominant systems of intelligibility that obscure their own historical construction and mechanisms. Extending Sara Ahmed's (2010) arguments on the effect of the injunction to happiness on marginalised groups, I argue that the injunctions to live and to futurity compel us into an uncompassionate and unaccountable politics of suicide. We force people determined to die to do so in atrocious conditions. We push people to commit suicide without having the chance to express/explore their suicidal thoughts with others for fear of negative consequences, to have conversations that could save lives. We rewrite the lives and deaths of suicidal subjects through dominant scripts of suicide, refuse to listen to their discourses by delegitimising them and speak for suicidal people by assuming we know what is best for them.

### **'Fix society. Please.': LGBTQ Discourses on Suicide and the Injunction to Live**

People say 'it gets better' but that isn't true in my case. It gets worse ... That's the gist of it, that's why I feel like killing myself. Sorry if that's not a good enough reason for you, it's good enough for me ... My death needs to mean something. My death needs to be counted in the number of transgender people who commit suicide this year. I want someone to look at that number and say 'that's fucked up' and fix it. Fix society. Please. (Alcorn 2014)

Leelah Alcorn's poignant suicide note generated many reactions in LGBTQT communities. It radicalised the suicide prevention agenda for trans\* people, who are overrepresented in statistics on suicidal ideations and suicide attempts (Reynolds 2016; Dyck 2015; Cover 2012; Goldblum et al. 2012; Smith and Jaffer 2012; Haas et al. 2010; Clements-Nolle, Marx and Katz 2006; Dorais and Lajeunesse 2004).<sup>7</sup> The largest Canadian quantitative study to date estimated that '[a]mong trans Ontarians, 35.1% ... seriously considered, and 11.2% ... attempted, suicide in the past year' (Bauer et al. 2015: 1). Following Alcorn's death, Jake Pyne (2015) wrote: 'Leelah asked for us to fix her world. We couldn't do it in time ... Alcorn's death is a wake-up call to stop fixing trans kids, and start repairing their broken worlds.' As a transgender and disabled man in a society that seeks to 'fix' my identity and body instead of targeting cisgenderism and ableism, I fully agree with Pyne's call for social action. While I applaud the significant results of LGBTQ scholars' research on suicide for trans\* communities, and

agree that we must examine the structural factors influencing suicidal ideations, I would also like to examine these scholars' sometimes unquestioned adherence to the social model of suicide. Rather than calling out what might be 'problematic' in LGBTQ discourses on suicide – discourses that undoubtedly have a positive impact – I ask: What/who is missing from the social conceptualisation of suicide? What can we learn from these absences? How might new understandings of suicide help anti-oppressive scholarship avoid reproducing oppression of suicidal people?

Critical suicidologists and LGBTQ scholars have adopted a social perspective that identifies a 'highly destructive social cancer that undermines self-esteem, faith, and trust in others, and the desire to live. This cancer is intolerance. Intolerance kills' (Dorais and Lajeunesse 2004: 7). According to LGBTQ scholarship, 'hate kills.' Vikki Reynolds writes: 'Youth are not killing themselves. Hate is killing our children,' adding that '[w]e have the power to move things from private pain to public issue . . . and to resist the privatization of the pain of suicide . . . because social injustice, hate, stigma, and oppression create the conditions that make the horrors of suicide possible' (2016: 181, 184). The social model understands suicidal intent as a 'horrific' reaction to social oppression. According to this view, trans\* people end their lives primarily because of cisgenderist norms, institutions, structures, violence, inaccessibility to health care, inadequate transition support and more (Bauer et al. 2015; Dyck 2015; Pyne 2015; Cover 2012; Goldblum et al. 2012; Smith and Jaffer 2012; Haas et al. 2010; Clements-Nolle, Marx and Katz 2006). However, suicide is a complex issue for which a primarily social interpretation may be reductivist. As Jack Halberstam (2010) states, 'just because a teen is gay and kills himself, does not mean that he killed himself because he was gay.' Reducing trans\* and queer people's suicides to their transness/queerness not only erases much of their lives and identities, but also provides a one-dimensional explanation of a multidimensional phenomenon. While cisgenderism/heterosexism may trigger suicidal ideations, the majority of LGBTQ people neither attempt nor complete suicide. These facts invite caution in our conclusions and call for broader thinking about suicide prevention strategies and recommendations.

In addition to a negative, judgemental and stigmatising depiction of suicide, one of the consequences of focusing on social oppression is that the resulting recommendations are based on 'resisting hate, practising solidarity, and transforming society to be inclusive' of sexual and gender minorities (Reynolds 2016: 184). In social analyses of

trans\* people's suicidal ideations and recommendations to decrease suicide rates, scholars presume to know what is best for suicidal subjects. Described primarily in terms of eliminating cisgenderism/heterosexism and other oppressions, suicidal subjects' needs are identified without their input (Dyck 2015; Dorais and Lajeunesse 2004). Suicide is also depicted as a unilaterally negative act. Even scholars who challenge assumptions informing discussions of LGBTQ youth suicides do not question the idea that suicide is never an option. For example, the goal of Jasbir Puar's question, 'why is suicide constituted as the ultimate loss of life?' is not to criticise the injunction to live in discourses on LGBTQ people's suicides, but to highlight the exceptionalism shrouding the 'slow death' caused by capitalism and other oppressions (2012: 152). Because the perception of suicide as a problem to be eradicated is never itself problematised, scholars who subscribe to the social model are often horrified by the idea of helping a person whose desire to die is caused by psychological suffering due partly to structural violence.

Although suicide prevention is critical and concerns about the overrepresentation of suicidal ideations in LGBTQ communities is warranted, the prevailing discourses against suicide cast a shadow over suicidal people's affective experiences and reproduce a form of oppression. Susan Stefan asks:

Does denying assisted suicide to people who are suffering unendurable emotional pain because society is not willing to [change] make them hostages to our desire for social change? ... [A]re we being paternalistic to impose our affirmation of the worth of their lives on their own, more first-hand assessment? (2016: 493)

Although no answer is given, Stefan's implicit response is negative. She concludes that medically assisted suicide should not be permitted. I suggest we do take these people hostage. We force them to live a life beyond their endurance by imposing an agenda dictated by the injunctions to live and to futurity. Alcorn did indeed urge us to fix the world, but her suicide note contains another important but often-overlooked sentence: 'Sorry if that's not a good enough reason for you, it's good enough for me.' I agree with Alcorn and LGBTQ scholars that time and resources must be invested in social transformation. But Alcorn also asked us to respect her reasons and decision, a request that remains unintelligible in LGBTQ scholarship and untranslated into concrete support actions. Although Alcorn asked us to 'fix society', she did not ask us to force her to stay alive while we mount a revolution for social change that, even if it happens,

may take time. In that sense, LGBTQ discourses on suicide represent forms of somatechnologies that force life on suicidal people through the injunction to futurity.

Fighting for social transformation is not antithetical to greater accountability toward the lived experiences of suicidal people, the stigma they face, the prejudices they have to live (and die) with and the forms of violence they experience. Suicidal people are frequently refused psychological treatments by therapists fearing liability, forcibly institutionalised, drugged against their will, refused insurance policies or compensations, expelled from universities, denied custody of their children and dismissed from their jobs, among other forms of discrimination (Stefan 2016; Beattie and Devitt 2015; Hewitt 2013; Webb 2011; Szasz 1999). By focusing on social oppression, the discourses, solutions and recommendations put forward in the social model promoted in LGBTQ scholarship perhaps unintentionally contribute to the stigmatisation of suicidal people, by creating an unsafe environment in which to explore the desires to die.

### **Suicidal Subjects Speak Out: An Invitation to Listen**

In my survey, I asked, 'If you could tell suicide prevention policymakers and mental health professionals three things, what would they be?' There was one message that was by far the most common . . . 'LISTEN for God's sake.' [Survey 40] 'Don't come from a place of preventing – come from a place of connecting . . . Most importantly be present and LISTEN.' [Survey 75] 'Listen, listen, listen. Listen with your whole being.' [Survey 93] 'Be kind. Be understanding. Listen with your heart.' [Survey 209] (Stefan 2016: xxvi)

A key finding of Susan Stefan's interviews with suicidal people is that although they want to speak out, policymakers, health-care professionals, family, friends and society rarely really listen. Even within anti-oppressive and LGBTQ scholarship – where listening to marginalised voices and creating safer spaces are central – suicidal subjects are silenced and their discourses overlooked or rewritten through the dominant trope of the suicidal mind alienated by cisgenderism/heterosexism. I believe that we must work toward greater social justice for all, which will likely reduce suicidal ideations for trans\* people and other marginalised groups, while also recognising that, as a group, suicidal people face systemic oppression. I am convinced that creating a better world for suicidal people begins with cultivating a respectful response, listening without

forcing the ‘will to live’ upon them. My work aims to attempt to eradicate structural factors that can trigger the desire to die and to create safer spaces where suicidal voices can be legitimised and desubjugated (Foucault 1997). Attempting to destigmatise and recognise suicide as an option, albeit one that requires considerable critical reflection with the help of relatives, friends and health-care professionals, may have helped Alcorn find another solution. Furthermore, a harm reduction approach<sup>8</sup> may have allowed her to be accompanied as she prepared her death, given her the opportunity to say goodbye to her loved ones and made it possible for her to choose a less lonely and less violent way to leave this world.

Harm reduction approaches are used in a variety of contexts to support marginalised communities, such as drug users, sex workers, or people who engage in ‘risky’ behaviours. According to Line Beauchesne (2010), harm reduction is founded in humanist philosophy and guided by two goals: 1) increasing the well-being of marginalised groups; and 2) facilitating their social inclusion. As Alan Marlatt, Mary Larimer and Katie Witkiewitz remind us, harm reduction is an ‘attitude’ toward social problems:

This overarching attitude has given rise to a set of compassionate and pragmatic approaches that span various fields, including public health policy, prevention, intervention, education, peer support, and advocacy. These approaches aim to reduce harm stemming from health-related behaviors . . . that are considered to put the affected individuals . . . at risk for negative consequences . . . These approaches also seek to improve QoL [quality of life] for affected individuals . . . [which] grew out of a recognition that some people will continue to engage in high-risk behaviors even as they experience associated harms. (2012: 6)

Current laws, public policies, prevention strategies and models/discourses on suicide do not represent accountable, pragmatic or compassionate responses toward suicidal people. From a harm reduction approach, focused on the voices and well-being of suicidal people, my goal is not to reform the medical assistance in dying law to include suicidal people, but to propose an entirely different socio-politico-legal project.<sup>9</sup> I suggest that this law should be repealed because it is doubly ableist and propose instead that, regardless of physical condition or imminent death, all people who wish to die, including suicidal people, should have access to medically assisted suicide.<sup>10</sup>

Like other ‘social problems’ addressed through a harm reduction approach, I think there is a heuristic value to dealing with suicide using

such an approach, since research shows that, despite prevention campaigns, suicidal people continue to take their lives (Stefan 2016; Beattie and Devitt 2015; World Health Organization 2014; Szasz 1999). I, therefore, call for a politics of compassion and accountability to support suicidal people in their desire to die using a harm reduction approach meant to complement, not supersede, suicide prevention strategies. Grounded in an anti-ableist/anti-sanist perspective and a 'non-coercive suicide prevention' approach, to which Thomas Szasz (1999) alludes, the proposed strategy would offer support both to people whose desire to die may fade during the accompaniment process and to those who wish to see their intent through to its conclusion.

I have revealed paradoxes in current laws, policies and discourses on suicide and assisted suicide, and shown that these somatechnologies, guided by the injunctions to live and to futurity, create two classes of people with regards to medical assistance in dying: those whose voices are legitimised and those whose are delegitimised. I have also shown that the latter remain a marginalised group. Despite strong similarities between the lived experiences of suicidal people and other marginalised groups, including violence, criminalisation, stigmatisation, pathologisation and appropriation of voice/agency, proponents of the social model of suicide, including critical suicidologists and LGBTQ scholars, continue to speak for suicidal subjects. With all this in mind, I ask: when will we allow the suicidal to speak?

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**Notes**

1. In Canada, 'the umbrella term "medical assistance in dying" [is understood] as encompassing what is commonly called voluntary euthanasia (i.e., the administration by a medical practitioner or nurse practitioner of medication that will cause a person's death at their request) and assisted suicide (i.e., the prescription or provision by a medical practitioner or nurse practitioner of medication that a person could self-administer to cause their own death)' (Department of Justice 2016). I favor terms like 'medically assisted suicide' rather than 'medical assistance in dying' because I believe that medically assisted death *is* suicide. Instead of using sanitised expressions such as 'medical assistance in dying,' exclusive of suicidal subjects, I prefer the expression 'medically assisted suicide,' which should, I contend, include suicidal subjects. I think that stigmatised expressions such as 'suicide' and 'suicidal people' could be resignified and used to denounce the violence experienced by suicidal people.
2. Clause 9.1 was added to Bill C-14 to consider including suicidal people for whom 'mental illness is the sole underlying medical condition' (Department of Justice 2016) and a report about this potential inclusion will be available in December 2018.
3. My use of 'mental disabilities' encompasses cognitive, intellectual and learning disabilities, and a variety of psychological/emotional issues, including anxiety, depression, psychosis, schizophrenia, bipolar disorder and more (Baril 2015; Nicki 2001). I consider psychological/emotional suffering a form of mental disability. I am aware of debates in disability/mad studies concerning the classification of emotional suffering as a disability or illness, as well as those regarding the language that should or should not be used to avoid the reductionism of the medical/psychiatric model of mental health (Burstow 2016; LeFrançois, Menzies and Reaume 2013). Despite these debates, studies of suicidal people make one thing clear: psychological/emotional suffering characterises the majority of suicidal experiences (Stefan 2016). Therefore, despite my critical perspective on the medical/psychiatric model of mental health, I refer to suicidal people as suffering from mental health issues.
4. According to Bauer et al., '[s]tudies in Canada, Europe, and the United States have reported suicide attempt prevalences within the trans population that range from 22 to 43% over the lifetime and 9 to 10% for the past year ... In contrast, 3.7% of all Canadians had seriously considered ... and 0.6% attempted ... suicide in the past year' (2015: 2). Statistics for trans\* people are even higher than in Indigenous communities even though 'the rate of suicide among aboriginal youth is at least five to six times higher than among non-aboriginal youth and is three times higher for all groups than in Canada overall' (Grand Council of the Crees 2001: 18). In comparison, trans\* people in North America are nine to twelve times more likely than cisgender people to attempt suicide (James et al. 2016: 10; Bauer et al. 2015).
5. Sanism, also called 'mentalism,' is a form of mental ableism (LeFrançois, Menzies and Reaume 2013).
6. There are peer-support groups composed of ex-suicidal people but, again, they aim to prevent suicide. Since encouraging suicide is criminalised in Canada, there are no peer-support suicide groups that support suicidal people in their desire to die.
7. While suicidal ideation and suicide attempts are more frequent for trans\* people than the rest of the population, insufficient data exists to determine whether trans\* people are overrepresented in rates of completed suicide (Haas et al. 2010;

- Dorais and Lajeunesse 2004). The data does not seem to support the ‘moral panic’ surrounding LGBTQ youth suicide. Most suicides in North America are completed by people associated with more privileged groups, such as white men over 40 (Stefan 2016: 319–371; Beattie and Devitt 2015: 58–74; World Health Organization 2014).
8. Although some authors (Bergmans et al. 2016; Stefan 2016; Webb 2011; Szasz 1999) have suggested that an open-minded approach that allows suicidal subjects to speak freely could be a prevention method, they do not adopt the harm reduction approach proposed here.
  9. I cannot in the limited space of this article develop this socio-politico-legal project.
  10. I differ from Stefan (2016), Webb (2011) and Szasz (1999), who theorise the violence experienced by suicidal people but oppose medical assistance in dying. Both Stefan and Szasz argue that legalising physician-assisted suicide would give too much power to the state and physicians and favour a liberal point of view on suicide.

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