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under the Global Condition

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Cross-border Assemblages of Medical Practices

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Abstract

The project investigates assemblages in the field of border-transcending medical practices. The case studies focus especially on cross-border cooperation in the provision of health care and on the conflictive negotiation of organ transplantation. Here we enquire about the function and meaning of "space" in transnational assemblages of medical practices. By studying the de-bordering of the supply and demand of therapeutic services, spatializations under conditions of globalization can be better understood together with the impact they have on biopolitical regimes in Western welfare states, which are subject to national-territorial regulation. These national-territorial regulations emerge from the commodification of (individual) health and therapy while being conflictingly transformed through the greater organizational and institutional reach of medical actors and actions as well as technical, pharmacological, biological, and biochemical innovations. De-bordering is often a response to global mobilizations of labour markets, people, goods, and finances.

Zusammenfassung

Das TP untersucht, welche Funktion und Bedeutung „Raum" in grenzüberschreitenden Assemblages medizinischer Praktiken hat. Dabei wird davon ausgegangen, dass Verräumlichungen sowohl im Moment der Entgrenzung von Praktiken, in ihrer Formierung wie auch in der Aushandlung ihrer Regulation relevant werden. Ziel ist die Rekonstruktion der durch die jeweiligen Assemblages hervorgebrachten Raumformate und die Analyse ihres Verhältnisses zu (hegemonialen) Raumordnungen. Entgrenzungen des Angebots und der Nachfrage therapeutischer Leistungen sind für das Verständnis von Verräumlichungen unter Globalisierungsbedingungen von Interesse, weil sie – in westlichen Wohlfahrtsstaaten – als Gegenstand biopolitischer Ordnungen einem nationalstaatlich-territorialen Regulativ unterliegen. Dieses wird derzeit durch Prozesse der Kommodifizierung von (individueller) Gesundheit und Heilung, aber auch aufgrund der größeren organisatorischen und institutionellen Reichweite medizinischer Akteure und Handlungen sowie technischer, pharmakologischer, biologischer und biochemischer Innovationen konfliktreich transformiert (bio-medicalization). Diese Entgrenzungen sind vielfach Reaktionen auf globale Mobilisierungen von Arbeitsmärkten, Personen, Waren und Finanzen. Sowohl in den Entgrenzungen wie auch in den (Neu-)Regulierungen, so die These, spielen Verräumlichungen im Sinne der (Re-) Produktion von Orten, Skalen, Netzwerken und Territorien eine zentrale Rolle für strategische und taktische Interessen der beteiligten Akteure, indem sie einerseits De-Territorialisierungen ermöglichen, andererseits aber auch Ansatzpunkte für Re-Territorialisierungen bilden. Das Teilprojekt stützt sich auf zwei Teilstudien, von denen sich eine auf grenzüberschreitende Zusammenarbeit bei der Bereitstellung medizinischer Versorgung konzentriert, die u. a. im Kontext von Transnationalisierung und Regionalisierung an europäischen Grenzen zu beobachten ist, und die zweite die konflikthafte grenzüberschreitende Aushandlung von Organ- und Gewebetransplantationen fokussiert.

Keywords / Schlagworte

border-transcending practices, spatialization, transplantation, Europeanization, assemblage
grenzüberschreitende Praktiken, Verräumlichung, Europäisierung, Transplantation, Assemblage

Content

1 Introduction

The project is predominantly a qualitative study of health care practices in the context of cross-border movements. In concordance with the general focus and objective of the Collaborative Research Centre — which is to examine the role of spatialization under the global condition — the project intends to investigate the role of spatialization in the organization of medical practices in order to understand how practices produce and are produced by *spatial formats* and *spatial orders*.[1] However, this working paper — provided at the beginning of the project — has a more limited scope: it locates the research interest within the field of existing literature on border-transcending health care and provides first insights into the guiding ideas of the planned case studies. Furthermore, it aims at conceptualizing an analytical framework with regard to the different forms of spatialization underlying and informing these practices.

We define cross-border medical practices as a specific field of practices — intentionally isolated from the vast field of social practices — that is characterized by two traits. Firstly, it focuses on the relations between illness and health; secondly, we assume that borders — and as such, space — play a crucial role in regulating both aspects. Such practices are specifically unpredictable due to the imperative nature of motives and decisions related to urges of leaving a juridical realm and entering another for medical therapy.

The project is entitled "Cross-border assemblages of medical practices", which implies that we work with two theoretical-conceptual tools: assemblages and practices. Though the project will examine both tools, the working paper introduces them only briefly and does not discuss them in detail (see ch. 4). Instead, the following chapter gives a brief overview of three bodies of literature dealing with the growing "spatial range" of medical practices. We particularly emphasize medical treatments — diagnosis and therapy — that are thought to attract people from abroad and that are sought by people from abroad. This is followed by a discussion of our criteria for the definition of our case studies. Chapter 3 provides first insights into two fields for which we assume is particularly significant with regard to the overall aim of the Collaborative Research Centre and to specifically identifying spatial formats. The first example (3.1) revolves, on the one hand, around processes of collaboration on the supply side of what could be called an emerging — though (still) incomplete, eclectic, and fragmentary — European regime of cross-border health care regulation and, on the other hand, around the mobilization of people in need of and/or seeking medical treatment. The second example (3.2) focuses on organ transplantation and its current state of organization, including loopholes and shortcomings identified on the basis of existing literature as well as preliminary interviews. Both cases will show — despite the limited range of this working paper — that *offering and seeking medical treatment* is, at the same time, subject to practices of de-bordering/de-territorialization as well as to constant attempts of regaining control through regulatory authorities. At the end of the chapter, we provide some premises inductively derived from the examples for analysing spatialization. Chapter 4 briefly develops a conceptual approach to border-transcending medical practices by using practice theory, subject theory, and the concept of assemblage in order to sketch out the theoretical perspective from which we will address the respective practice. Here, we discuss how spatialization — as a distinct dimension of practices — might be approached from a number of disciplinary geographical debates. A systematic analysis of spatializations deriving from case studies is assumed to be the precondition for identifying spatial formats at work in the field of cross-border medical practices.

1 Collaborative Research Centre (SFB) 1199: "Processes of Spatialization under the Global Condition", Financial application, Leipzig, 2015, Unpublished.

2 Seeking Medical Treatment Abroad

2.1 Existing Bodies of Literature

With regard to recent developments rooted in (West) European and North American contexts, there are at least three bodies of literature – mainly from sociology, ethnology/anthropology, as well as geography – that concentrate on the interconnectedness of medical practices across borders. A first body of literature has been revolving around the topics of medical traffic and medical tourism; a second – though probably smaller one – can be identified with regard to issues of cross-border provision of health care and cooperation of institutions and professionals; a third one focuses on questions of global governance of health care and diseases.

a By applying labels such as *medical tourism* and *medical traffic*, scholars from different disciplines have focused on a rapidly growing market of therapeutic measures for patients from abroad.[2] Among them, dental treatment,[3] assisted reproduction and embryo screening,[4] organ and tissue transplantation,[5] orthopaedic treatment,[6] stem cell treatment[7] as well as cosmetic surgery[8] are among the investigated treatments. Some of these developments have arisen at highly specialized places of treatment in Asia,[9] in North Africa,[10] as well as in Europe,[11] with some of them receiving patients from all over the world. Organ transplant plays a specific role in this field due to its involvement in illegal practices of organ harvesting and organ trade.[12]

Reasons for seeking treatment abroad vary remarkably:
- treatment is illegal in the country of abode (e.g., embryo screening, euthanasia, egg donation, in vitro fertilization for unmarried partners, abortion);
- treatment is cheaper (which is often the case for dental treatment and cosmetic surgery);

2 See, e.g., P.S. Cook, "Constructions and Experiences of Authenticity in Medical Tourism: The Performances of Places, Spaces, Practices, Objects and Bodies", *Tourist Studies* 10 (2010) 2, pp. 135–153; N. Lunt and R. Mannion, "Patient Mobility in the Global Marketplace: A Multidisciplinary Perspective", *International Journal of Health Policy and Management* 2 (2014) 4, pp. 155–157; A. Whittaker, L. Manderson and E. Cartwright, "Patients without Borders: Understanding Medical Travel", *Medical Anthropology: Cross Cultural Studies in Health and Illness* 29 (2010) 4, pp. 336–343.

3 See, e.g., K. Bünten, "Dentaltourismus in Ungarn. Bestandsaufnahme und perspektiven einer neuen Form des Gesundheits-tourismus", *Europa Regional* 14 (2006) 3, pp. 132–142.

4 See, e.g., D. Martin, "Perilous Voyages: Travel Abroad for Organ Transplants and Stem Cell Treatments", in: J.R. Hodges, L. Turner and A.M. Kimball (eds.), *Risks and Challenges in Medical Tourism: Understanding the Global Market for Health Services*. Santa Barbara: Praeger, 2012, pp. 138–166; A.P. Ferraretti et al., "Cross–Border Reproductive Care: A Phenomenon Expressing the Controversial Aspects of Reproductive Technologies", *Reproductive Biomedicine Online*, 20 (2010) 2, pp. 261–266. www.sismer.it/images/stories/pubblicazioni/infertilit/328.pdf (accessed 13 May 2016); M.C. Inhorn and P. Patrizio, "The Global Landscape of Cross–Border Reproductive Care: Twenty Key Findings for the New Millennium", *Current Opinion in Obstetrics and Gynecology* 24 (2012) 3, pp. 158–163.

5 See, e.g., I.G. Cohen, "Transplant Tourism: The Ethics and Regulations of International Markets for Organs", *The Journal of Law, Medicine and Ethics* 41 (2013) 1, pp. 269–285.

6 See, e.g., E. Kovacs, G. Szocska and C. Knai, "International Patients on Operation Vacation – Perspectives of Patients Travelling to Hungary for Orthopaedic Treatments", *International Journal of Health Policy and Management* 3 (2014) 6, pp. 333–340.

7 See, e.g., Martin, "Perilous Voyages", pp. 138–166.

8 See, e.g., R. Holliday et al., "Brief Encounters: Assembling Cosmetic Surgery Tourism", *Social Science and Medicine* 124 (2015), pp. 298–304, http://dx.doi.org/10.1016/j.socscimed.2014.06.047 (accessed 13 May 2016).

9 Cohen, "Transplant Tourism", pp. 269–285; N.S. Pocock and K.H. Phua, "Medical tourism and policy implications for health systems: a conceptual framework from a comparative study of Thailand, Singapore and Malaysia", *Globalization and Health* 7 (2011), pp. 1–12; F. Smyth, "Medical geography: therapeutic places, spaces and networks", *Progress in Human Geography* 29 (2005) 4, pp. 488–495.

10 Holliday et al., "Brief Encounters", pp. 298–304.

11 J. Gunnarsson Payne, "Europeanizing Reproduction: Reproductive Technologies in Europe and Scandinavia", *NORA – Nordic Journal of Feminist and Gender Research* 21 (2013) 3, pp. 236–242; J. Gunnarsson Payne, "Reproduction in Transition: Cross–Border Egg Donation, Biodesirability and New Reproductive Subjectivities on the European Fertility Market", *Gender, Place & Culture* 22 (2013) 1, pp. 1–16.

12 See, e.g., Martin, "Perilous Voyages", pp. 138–166; J. Sándor et al., "Organ Trafficking, Organ Trade. Recommendations for a more Nuanced Legal Policy", in: F. Ambagtsheer and W. WeiMarch (eds.), *The EULOD Project Living Organ Donation in Europe Results and Recommendations*, Lengerich: Papst Publishers, 2013, pp. 147–174, see chapter 3.2; L. Turner, "'Medical Tourism' Initiatives Should Exclude Commercial Organ Transplantation", *Journal of the Royal Society of Medicine* 101 (2008) 8, pp. 391–394.

- treatment is not available in the home country as it is newly developed and has not yet been disseminated (e.g., specific operation procedures);
- treatment is not available in due time (because of waiting lists, e.g., for organ transplant);
- there is a lack of specialists or specialized hospitals or quality of treatment (e.g., treatment of fire victims);
- treatment facilities in the neighbouring country are more easy to reach (e.g., in peripheral and sparsely populated border areas); and
- specialized and innovative treatment procedures have been created in cooperation between the neighbouring countries but only offered on one side (e.g., cancer and cardiological treatments, emergency services).

Global medical traffic has been closely linked with the economization, privatization, and commodification of health as well as with neoliberal tendencies to optimize bodies and to intensify self-guidance. Scholars have addressed a broad range of aspects so far, including marketization, ethical problems, as well as distributional justice, for example, in the field of organ transplantation.[13] Furthermore, some attention has been paid to the effects on national health systems, especially in poor countries when globally acting medical centres acquire the highest qualified medical staff of a country.

b Cross-border provision of health care, in contrast, aims at enabling both outpatient and inpatient care abroad. A number of parallel developments can be observed (see chapter 4.2), namely cooperation in the treatment of certain disorders, cooperation in peripheral, densely populated border regions, as well as efforts regarding better efficiency and enhancement of movements within Europe (e.g., of workforce, students, and tourists).[14] During the last decades, several strategic regional policy programmes have been set up that — though not primarily focusing on health care — have supported health care initiatives (e.g., Euregional Cooperation in Trauma and Large-scale Incidents [ECTLI] (Interreg IVa); Acute Health Care Region [ACRE] (Interreg IVa)). A number of studies have concentrated on evaluating practices and policies by gathering both quantitative and qualitative data about mobile patients.[15] Besides institutionalized projects of cooperation, grass-roots solutions have been reported, for example, in the sparsely populated area of the Finnish-Norwegian borderland with its transborder Sámi community.[16] Moreover, some studies regard cross-border mobilization of patients — which is not only on the agenda of the European Commission but also strengthened by the Organisation for Economic Co-operation and Development (OECD), the World Health Organization (WHO),[17] McKinsey,[18] and the World Bank — as part of far-reaching policies of privatization and liberalization.

c A third field of scholarly focus is *global health care*, i.e. the governance of health issues and diseases on a global scale.[19] Attempts of governance have arisen both in the field of disease control and prevention, with a special concentration on diseases with pandemic potential. This can be addressed as a scalar

13 R. Ghaoui et al., "Impact of Geography on Organ Allocation: Beyond the Distance to the Transplantation Center", *World Journal of Hepatology* 7 (2015) 13, pp. 1782–1787.

14 However, the extent of patient mobility is debated (see J.-W. De Neve, "Intra-European Medical Travel Remains Minor: A Commentary in Response to 'Hermesse J, Lewalle H, Palm W. Patient Mobility Within the European Union", *European Journal of Public Health* 20 (2010) 3, pp. 249–250).

15 F. Pennings, "The cross-border health care directive: more free movement for citizens and more coherent EU law?", *European Journal of Social Security* 4 (2011) 13, pp. 424–452; M. Wismar et al., *Cross-border health care in the European Union: Mapping and analysing practices and policies*, London: WHO, 2011, www.euro.who.int/__data/assets/pdf_file/0004/135994/e94875.pdf (accessed 17 May 2016).

16 R. Lämsä, I. Keskimäki and S. Kokko, "Official Projects, Grass-Roots Solutions: The Sami People Using Cross-Border Health Services in the Teno River Valley (Finland–Norway)", in: I.A. Glinos and M. Wismar (eds.), *Hospitals and Borders*, Copenhagen: WHO Regional Office for Europe, 2013, pp. 93–108.

17 See, e.g., K. Footman et al., "Cross-Border Health Care in Europe", Policy Summary (2014), www.euro.who.int/__data/assets/pdf_file/0009/263538/Cross-border-health-care-in-Europe-Eng.pdf?ua=1 (accessed 15 May 2016); I.A. Glinos and M. Wismar (eds.), *Hospital and Borders. Seven Case Studies on Cross-Border Collaboration and Health System Interactions*, Copenhagen: WHO, 2013, www.euro.who.int/__data/assets/pdf_file/0019/233515/e96935.pdf (accessed 17 May 2016); Wismar et al. 2011.

18 See, e.g., T. Ehrbeck, C. Guevara and P.D. Mango, "Mapping the Market for Medical Travel", *The McKinsey Quarterly*, (2008), www.medretreat.com/templates/UserFiles/Documents/McKinsey%20Report%20Medical%20Travel.pdf (accessed 13 May 2016).

19 See, e.g., T. Brown, S. Craddock and A. Ingram, "Critical Interventions in Global Health: Governmentality, Risk, and Assemblage", *Annals of the Association of American Geographers* 102 (2012) 5, pp. 1182–1189; A. Ingram, "The New Geopolitics of Disease: Between Global Health and Global Security", *Geopolitics* 10 (2005) 3, pp. 522–545.

("global") practice of securitization reacting to globalized and mobility-induced processes, especially to a global spread of infectious diseases due to globalized markets and mobilities.

These points prompt at least three interventions: First, the prevalent literature mainly gives emphasis to medical travellers from Northern and Western countries and, thus, privileges a European perspective with regard to "demands" and "offers". Second, they focus predominantly on recent developments made possible through medical, biochemical, and infrastructural inventions. And finally, they concentrate on recent power relationships performed through medical practices, but without referring to a broader understanding of power asymmetries in the field of medical practices, specifically under colonial conditions. In order to deal with these limitations, we will refer to a rich body of literature through which these interventions can be articulated and, thus, become productive for the project. Research in these fields include:

- questions of health inequalities and unequal access to treatment among indigenous communities and societies that have to be addressed in a broader socio-political context, including the legacies of colonialism;[20]
- studies dealing with the longer history of understandings of global health complemented by historical approaches to, for instance, epidemiology;[21]
- enquiries concerning the formation of specific fields of medicine that are related to colonial aspirations, especially "tropical medicine";[22]
- and insights into entanglements of "local" practices and "colonial" medical systems.23

A commonality present amongst the three identified strands of enquiry — medical tourism/traffic, cross-border provision of health care, and global health care — is the research on the dissolution of boundaries in a field of well-established and nationally contained practices — including regulatory practices — *within* welfare states. Insurances, financial flows, hospitals, professional admissions, therapeutic practices and procedures, surveillance of epidemics, drug approval procedures, ethical orientations, etc. are highly structured by norms, regulations, institutions, and procedures bound to the modern nation state and intimately linked to its history and current shape.

Emerging topics within the field of globalizing medical mobility echo in conceptual debates in the broader field of medical geography. Referring to a growing constructionist understanding of health and illness,[24] medical geography has pointed to the necessity for a stronger theoretical debate of spaces, places, and networks informing understandings of spatial dimensions of health and disease.[25] On the one hand, the concept of "therapeutic landscapes", for instance, draws attention to the entanglement of health, therapy, material geographies, and socio-politically produced spaces. On the other hand, therapeutical practices are increasingly understood as situated and contextualized through socio-spatial arrangements. Besides a focus on place-bound aspects, networks of care as well as in the field of new and alternative treatments have gained interest with respect to their space-producing capacities. However, the national territory remains the dominant spatial framework to which studies of medical geographies refer — particularly with regard to spatial distributions and inequalities of basic supplies of health care.

Though cross-border relations are anything but new — for example, drug manufacturers have been operating on a global scale for decades and patients seeking (and feeling forced to seek) a cure abroad is a rather

20 See, e.g., P. Axelsson, T. Kukutai and R. Kippen, "The Field of Indigenous Health and the Role of Colonisation and History", *Journal of Population Research* (2016), pp. 1–7.
21 See, e.g., A. Bashford and C. Strange, "Thinking Historically About Public Health", *Medical Humanities* 33 (2007), pp. 87–92.
22 See, e.g., I. Amaral, "The Emergence of Tropical Medicine in Portugal: the School of Tropical Medicine and the Colonial Hospital of Lisbon (1902–1935)", *Dynamis* 28 (2008), pp. 301–328.
23 See, e.g., N. H. Al-Azri, "Sent to Explore, Conquer and Heal: History of The Evolution of Biomedicine in Oman During the 19th Century", *Sultan Qaboos University Medical Journal* 11 (2011) 2, pp. 187–195.
24 Smyth, "Medical geography", p. 490.
25 G. Kearns, "The History of Medical Geography After Foucault", in: J.W. Crampton and S. Elden (eds.), *Space, knowledge and power: Foucault and Geography*. Aldershot: Ashgate, 2007, pp. 205–222; R. Kearns and G. Moon, "From Medical to Health Geography: Novelty, Place and Theory After a Decade of Change", *Progress in Human Geography* 26 (2002) 5, pp. 605–625; Smyth, "Medical geography", pp. 488–495.

old phenomenon[26] — a number of processes and factors have been identified implying a new dynamic in the field.[27] Among them are:

- An increased mobility of workforce, which, in addition to tourism and leisure traffic, has also generated a growing demand for medical treatment abroad;[28]
- Processes of commodification of health and privatization of health care in Western welfare states, including a growing self-responsibility of subjects regarding their physical and mental health and concepts of an optimized and health human body;[29]
- Extensive changes in travel habits and costs, notably with regard to low budget and low-cost flights;[30]
- A partial redefinition of social relations in the field of medical practices turning from a patient-doctor relation to a consumer-supplier relation;[31] and
- Biomedicalization as socio-technological process consisting of technoscientific innovations coinciding with economic opportunism, leading to societal transformation.[32]

Though some of these dynamics are related to wealthy and prosperous consumers — often elites from relatively poor countries — seeking medical treatment abroad is anything but an exclusive "upper class phenomenon". The picture is much more complex: A number of authors, for instance, underline that "the middle class" both from Western/European countries as well as from the Middle East plays a crucial and driving role, such as in the field of cosmetic surgery and assisted reproduction. In some cases — especially in the United States — treatment abroad is actively propagated by health insurance companies and provided under special payment schemes addressing employees with insufficient insurance cover. In other cases, private agencies offer leisure-and-treatment "package solutions" for people who cannot afford, for example, dental treatment in their home country.

Such dynamics possess social and political traits, both which are entangled and resulting in an overall fluidity regarding the state of cross-border medical practices in Europe, sometimes bringing about new differences, inequalities, and disparities, and sometimes reproducing old lines of social differentiation.[33] These dynamics are conditioned by societal changes, some being partially induced by technological advances (such as information or procedures being ubiquitously available) and by political processes (such as liberal and more restrictive regimes of assisted reproduction). However, all of them have — so far — not systematically been investigated with regard to their complex spatialities. Furthermore, from a scientific point of view, cross-border medical practices have so far been tackled from a structure-oriented and supply perspective, lacking works elaborating on the subjective perspective involved in choices to leave one's own country for medical treatment of whatever kind. Additionally, studies highlighting the recent emergence of cross-border medical cooperation in relation to continued efforts of integrating more policy areas into the framework of the European Union (EU) are absent so far.

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26 See, e.g., M. de Montaigne, *Tagebuch der Reise nach Italien über die Schweiz und Deutschland von 1580 bis 1581*, Frankfurt am Main: Eichborn Verlag, 2002.

27 For a recent attempt to quantify impact factors, see M. Fetscherin and R.–M. Stephano, "The Medical Tourism Index: Scale Development and Validation", *Tourism Management* 52 (2016), pp. 539–556.

28 See, e.g., M. Calnan et al., "Cross–Border Use of Health Care: A Survey of Frontier Workers' Knowledge, Attitude and Use", *European Journal of Health* 7 (1997), pp. 26–32; I.A. Glinos et al., "A Typology of Cross–Border Patient Mobility", *Health & Place* 16 (2010) 6, pp. 1145–1155; M. Rosenmöller, M. McKee and R. Baten, *Patient Mobility in the European Union. Learning from experience*, Copenhagen: WHO, 2006.

29 See, e.g., J. Connell, "Medical Tourism: Sea, Sun, Sand and … Surgery", *Tourism Management* 27 (2006) 6, pp. 1093–1100.

30 See, e.g., N. Lunt and P. Carrera, "Medical Tourism: Assessing the Evidence on Treatment Abroad", *Maturitas* 66 (2010) 1, pp. 27–32; Glinos et al., "A Typology of Cross–Border Patient Mobility", pp. 1145–1155; for a critical enquiry about the importance of costs, see A. Whittaker and A. Speier, "'Cycling Overseas', Care, Commodification, and Stratification in Cross–Border Reproductive Travel", *Medical Anthropology: Cross–Cultural Studies in Health and Illness* 29 (2010) 4, pp. 363–383.

31 See Whittaker and Speier, "'Cycling Overseas', Care, Commodification, and Stratification", pp. 363–383.

32 A.E. Clarke, "Biomedicalization", in: W. Cockerham, R. Dingwall and S.R. Quah (eds.), *The Wiley–Blackwell Encyclopedia of Health, Illness, Behavior and Society*. Wiley: Oxford, 2014, pp. 137–142; A. Clarke et al., "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine", *American Sociological Review* 68 (2003) 2, pp. 161–194.

33 For gendered disparities, see, e.g., B. Greenhough et al., "The Gendered Geographies of Bodies Across Borders", *Gender, Place & Culture* 22 (2014) 1, pp. 1–7.

2.2 Criteria for the Definition of Case Studies

The case studies aim at reconstructing assemblages of border-transcending medical practices, being situated at the nexus of statehood, territory, and border. They markedly involve orientations, attempts and acts of regulation, as well as deregulation and subversion respectively; they are all associated with a transgression of the nationally bound organization of health care.

Each case study elaborates the needs, motives, necessities, and expectations of the people involved as well as the respective regulatory and subversive practices, with special regard to processes of spatialization. In sum, the corresponding findings shall contribute to modelling governmental relations and attempts in the field of European health policy.

Systematically deducing suitable topics, several criteria have been taken into account:

- *Supply and demand*: The respective assemblages shall be expounded with regard to the relation between supply of, organization of, and demand for therapeutic services.
- *Urgency*: The respective assemblages shall focus on a medical good whose scarcity can be overcome by transgressing national regulatory differences (e.g., regarding the costs, quality, juridical or ethical/moral contexts, etc.).
- *Conflicts*: The respective assemblages shall be the subject of public problematization (e.g., regarding competing interests, conflicts, diverging demands, etc.).
- *European dimension*: The respective assemblages shall be characterized by the discursive presence of the European Union as a transnational actor with regard to debates about and attempts of regulation and deregulation as well as in relation to acts of scalar reorganization.

We decided to concentrate, firstly, on cross-border medical initiatives and, secondly, on the cross-border organization of organ transplantations. Both case studies involve notions of scarcity that coincide with spatial strategies and tactics as reactions: For both cases, explicitly diverging interests can be concluded with regard to ways of (de-)regulation and (de-)territorialization. Nevertheless, they differ regarding the scope and intensity of potential conflicts between the respective subject and the regulation in question.

3 Cross-border Medical Practices: Cases from Europe

3.1 Transcending European Borders in the Field of Health Care

3.1.1 Towards a Europeanization in the field of health care (regulation)

Seeking medical treatment abroad is a dimension of "Europeanization". Europe has undergone tremendous processes of political restructuration throughout its history. Yet from a territorial perspective, the borders within Western Europe have remained predominantly stable since World War II, although in the aftermath of the war a profound change in the perception between the European countries took place — from being enemies or competitors to cooperation partners — and in the perception of Europe as a common territory. As a result, the European Economic Community (EEC) was founded in 1957 with the objective of fostering the economic integration of its member states. Ever since, the now called European Union has undergone sweeping changes in terms of organizational integration, notably from the 1980s onwards when a severe economic crisis was countered by establishing a single market. Following the end of the Cold War, the dissolution of the "Iron Curtain" between Eastern and Western Europe, and also the rise of armed conflicts in the territories of former Yugoslavia and along the former Soviet border, an often taken-for-granted territorial order was shattered, lifting borders and shifting others eastward. On the emerging territory of the European Union, which — at the same time — has been transformed into an internal market of today more

than 508 million inhabitants,[34] a regime of gradual openness between conjoined and associated countries was stabilized, thereby challenging established statehood sovereignty and the scalar fundaments of political hierarchies in Europe. In some respect, forms of collaboration between actors of statehood practices, such as police and courts that had formerly been strictly confined to the respective nation state and its territory, gained new momentum in the 1990s through a series of European treaties.[35] Their implementation has been accompanied by a political rhetoric routinely conjuring up common ethical standards and shared fundamental values.[36] From 2008 onwards, this way of framing has been replaced and, actually, has called into question financial and fiscal politics that undermine understandings of solidarity. Since 2014, the so-called refugee crisis has brought forth more sceptical and dismissive positions concerning an (even deeper) "integration" of European countries. Moreover, the crisis has given evidence to a limited state of integration in many respects. As a result, the existing internal border regime has become much more negotiable today than in the years before 2015.

In contrast to the freedoms the European citizens are continuously reassured to possess — particularly the freedom of travel between countries without border checks and the freedom of movement for workers — the process of Europeanization has often been translated into new ways of regulating such freedoms by modifying the respective border regime. Attempts of de-/re-bordering require the elaboration of mechanisms levelling, for example, the standards of education, working, taxation, etc. in order to prevent different (in)formal ways to exploit the abolishment of border checks (in the case of Schengen member states) or customs (for the members of the European customs union). For multiple societal matters, mechanisms have been introduced to control practices that otherwise would allow laws to be bypassed that were formerly tailored according to a territorially contained nation state.

Mechanisms of de- *and* reregulation mainly revolve around three key logics: (1) In order to establish a common practice, an equalization or homogenization of standards is claimed by political or economic actors. This is justified by the assumption that a common standard of regulation would not only avoid an exploitation of differences between nation states but also facilitate cross-border mobility. (2) In this regard, it has become popular to claim that such an equalization could only be reached by relocating formerly national regulatory sovereignty in specific matters to the transnational level (hence the European Union).[37] (3) Such a move equally implies the attempt to redirect financial flows in order to support regional entities (often spanning borders). Such strategies revolve around spatial — territorial and scalar — strategies and tactics[38] and attempts to adjust the relationship between interweavement and control.

Within the field of health policy, a consistent common European policy is still missing. The European health policy that was introduced at the beginning of the 1990s is today a mainly voluntary cooperation between the several national health systems whose heterogeneity is not restricted. The main emphasis of the EU in this field is to realize the respective EU Health Strategy through EU Health Programmes implemented since 2003. In 2014, the 3rd Health Programme (2014–2020) was launched by the EU Commission, which funds different projects, joint actions and grants endeavouring to (1) promote health, preventing diseases, and foster supportive environments for healthy lifestyles; (2) protect Union citizens from serious cross-border health threats; (3) contribute to innovative, efficient, and sustainable health systems; and (4) facilitate access to better and safer healthcare for Union citizens.[39] However, beyond common strategic activities, the field of health policy has proven to endure a heterogeneous patchwork of diverging jurisdictions deeply rooted in national legal systems, normative orientations, and historical experiences (e.g., in the field of euthanasia, organ transplantations, preimplantation genetic diagnosis, reproductive treatment), organizations,

34 Eurostat, "Population on 1 January", 2015, http://ec.europa.eu/eurostat/tgm/table.do?tab=table&language=en&pcode=tps00001&tableSelection=1&footnotes=yes&labeling=labels&plugin=1 (accessed 13 May 2016).

35 For an overview, see J. Miggelbrink, "Crossing Lines, Crossed by Lines: Everyday Practices and Local Border Traffic in Schengen Regulated Borderlands", in: R. Jones and C. Johnson (eds.), *Placing the Border in Everyday Life*, Farnham: Ashgate, 2014, pp. 137–166.

36 See, e.g., F. Meyer, "Scale up, Harry! Discursive Transition (and Continuity) in the EU's 'Area of Freedom, Security and Justice'" Between 1995 and 2014", in: B. Bruns, D. Happ, and H. Zichner (eds.), *European Neighbourhood Policy. Geopolitics Between Integration and Security*, New York: Palgrave MacMillan, 2016, pp. 23–46.

37 See Ibid.

38 See, e.g., B. Belina, *Raum. Zu den Grundlagen eines historisch–geographischen Materialismus*, Münster: Westfälisches Dampfboot, 2013.

39 Consumers, Health, Agriculture and Food Executive Agency, "Health Programme", http://ec.europa.eu/chafea/health/index.html (accessed 31 March 2016).

and financing of health care systems. European attempts of harmonizing the different regimes of health regulation, therefore, often remain on a more general regulatory level, providing guidelines while avoiding specific binding common stipulations. Therefore, patients willing to transgress national borders within the European Union face a multitude of differing juridical frameworks and supranational bodies, each in current flux regarding their respective specific regulation. This means that, in practice, the patient is forced to navigate such heterogeneous fields according to the possibilities available (innovations, regulations) in contrast or accordance with his/her motives, expectations, and emotions.

Despite a number of governance attempts, the topic of a *European* health care is quite unregulated until now, and often the EU has been reactive in formulating new regulations to different innovative steps of EU citizens. Until now, cross-border medical practices in terms of patients seeking treatment is facilitated both through the (general) right to free movement of people and the mutual acceptance of national health insurance companies, reclaimed by EU citizens at the European Court of Justice (ECJ) at the end of the 1990s.

3.1.2 Cross-border provision of health care

According to Glinos et al.,[40] cross-border medical practices within the EU are one special type of patient mobility, terminologically referring to a wider range of circumstances than, for example, medical tourism. The term medical tourism designates long-distance cross-border medical offers for people from wealthy to developing countries. This kind of tourism is supposed to indicate a change in the global order:[41] European and North American centres do not seem to be able to compete with the main centres of medical tourism in Asia, the Middle East, as well as in the emerging locations of health care in Eastern Europe, Africa, or Latin America. Typically, "medical tourism" is considered to involve combined activities such as sightseeing, wellness, and medical treatments in sites dedicated to the requirements of the patients; such tourism remains disconnected from the local needs and circumstances in these countries and regions. Glinos et al. highlight that this industry-driven term in general "does not capture the seriousness of most patient mobility" (ibid.), often entailing high costs for medical treatments, long waiting lists, juridical or ethical illegalization, and a constant shift to privatized health care services in rich countries.

For that reason, several authors propose to replace the term. For example, Glinos and Baeten use the term patient mobility, preferring its openness with regard to various patient's movements, the varying spatial scopes, and the patient's heterogeneous ideas and necessities in relation to their search for treatment outside their country of residence.[42] Meanwhile, others prefer to use the term medical travel, indicating both regional and long-distance cross-border medical practices as well as encompassing medical tourism.[43] We prefer the term patient's mobility/medical travel to indicate the search by patients for medical treatment abroad.

In general, the EU is supporting the national organization of health services and the almost exclusive authority of its member states. Notwithstanding, since 1971 the question of social security and access to medical treatments for migrant workers within the European Communities was formalized by the European Economic Community's Regulation 1408/71. In 1999, the then new Article 152 (former Article 129) of the EU Treaty of Amsterdam stipulates the EU's support to foster cooperation between member states in the field of public health. Meanwhile, the patients' free access to medical services in other EU member states remained a matter of regulation by the national health insurance companies within the national borders. Only the ECJ's judgements (e.g., in 1998 and in 2001) strengthened the rights of patients against national health insurance companies. The ECJ subsumed the patients' freedom of choice of medical treatment within the EU under the four freedoms of the European Union, which legalized the free movement of goods, persons, services, and capital and decided accordingly that health insurance companies have to reimburse patients for sought treatments in other European countries.[44]

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40 Glinos et al., "A Typology of Cross–Border Patient Mobility", p. 1146.

41 See, e.g., Ehrbeck, Guevara and Mango, "Mapping the Market for Medical Travel".

42 I.A. Glinos and R. Baeten, "A Literature Review of Cross–Border Patient Mobility in the European Union", OSE (2006), pp. 1–114, at 18, www.ose.be/files/publication/health/WP12_lit_review_final.pdf (accessed 15 May 2016).

43 See. e.g., D. McMahon, "*Medical Tourism and Cross–border Care*", Background Paper (2013), pp. 1–15, at 1–2, http://nuffieldbioethics.org/wp–content/uploads/Forward_look_background_paper_on_medical_tourism_and_cross–border_care.pdf (accessed 15 May 2016).

44 C.B. Blankart, E. Fasten and H.P. Schwintowski, *Das deutsche Gesundheitswesen zukunftsfähig gestalten. Patientenseite stärken – Reformunfähigkeit überwinden*, Wiesbaden: Springer, 2009, p. 89ff.; J. Hajdú, "Worker's Compensation and Employer's

Since then, the implementation of a new legal European framework has been intensified. One obstacle, as Glinos et al. put it, has been the problem for national health insurance companies to calculate the provision, supply, and the need for health care under the perception of the changing state of territoriality in the European Union because cross-border patient mobility transgresses this conventional logic.[45] In 2010, EU Regulation 1408/71 was expanded by Regulation 883/2004, which introduced, for example, form E 106 — meanwhile replaced by form S1 — allowing residents of border areas to easily seek medical treatment on both sides of the respective border. Furthermore, form 111 ensures tourists and travellers to receive medical help in the case of emergency within the EU.

In cases of emergency during temporary stays in other European countries, the European Health Insurance Card (EHIC) was implemented in 2006. Both form S1 and the EHIC card can be obtained from one's national health insurance company.[46] The card guarantees medical treatment in cases of emergency in all public medical institutions (hospitals and practitioners) of the EU member states as well some other European states according to the conditions of the respective country; it further allows for reimbursement according to the standards of the patients' health insurance company. In 2011, the directive on patients' rights was introduced, obliging the EU member states to implement it until October 2013, thereby allowing European citizens to plan medical treatment in other EU countries.[47]

3.1.3 Criteria for selecting sites of cross-border cooperation in health care

Currently, the European Union encourages multiple cross-border initiatives and — in the recent past — has introduced several supranational and subnational regulations, contracts, and cooperation initiatives in a more or less institutionalized or (in)formal way. Such a heterogeneous environment requires the systematic elaboration of criteria for the research on cross-border medical cooperation. Therefore, several aspects should be taken into account:

- The first aspect of consideration is the historically induced regional variety between the everyday relevance of the respective European borders. For example, Western European countries can look back to a continuous tradition of various forms of connectivity since the 1950s. Nevertheless, there has often been mutual mistrust among residents from both sides of the borders. In contrast, Eastern Europe has been — irrespective of its recent affiliation to the EU — affected by the emergence of new borders and divisions that have been partly due to ethnic conflicts and the emergence of new nation states.
- Despite the alleged dichotomy between Western and Eastern Europe, Western countries themselves differ remarkably regarding their respective regimes of social and economic policy. For instance, the Scandinavian countries are known for their tradition of state-centred welfare policy. Hence, different national economic situations as well as social and labour policies have created different health care systems, offering specific ranges of medical services. As a consequence, some countries have predominantly faced outpatient and some inpatient flows.
- Moreover, the range, scope, and quality of medical practices and offers in Europe may provide insights into possible national differences and alleged motives for mobility. For example, particular moral premises may lead to an illegalization of specific medical practices (e.g., assisted suicide, reproductive services) in some countries, while being handled differently in others. Concomitantly, information on such practices may be represented differently in the social and public media, leading to a varied visibility, thus influencing the accessibility to medical offers.

In order to illustrate the object of research, in this working paper we focus on the German-Dutch border region as the site of many existing examples of cross-border cooperation. The decision for the German-Dutch border region was made, firstly, on the premise of availability of sources in German and, secondly, on the

Liability in Hungary", *Aplikované Právo* (2007) 2, pp. 67–89, at 67.

45 Glinos et al., "A Typology of Cross–Border Patient Mobility", p. 1145.

46 In Germany, it is an integral part of the national health insurance card.

47 European Parliament, "Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the Application of Patients' Rights in Cross–Border Healthcare", *Official Journal of the European Union* L 88 (2011), pp. 45–65.

premise of being able to draw on existing knowledge about arrangements and procedures like national regulations, face to face cross-border cooperation, and ways to cope with problems of medical services. An additional point underpinning the decision is the long history of institutionalized cross-border cooperation at the German-Dutch border, having lasted for more than 50 years since the establishment of the very first European Region, named Euregio, in 1958.

Euroregions are financial instruments set up to support local actors within border regions in regard to the development of ways to overcome certain obstacles associated with peripherality. They are undertaken at the local level and may lead to institutionalized forms of cooperation, and at the same time — from a more supraregional point of view — the socio-economic conditions in the peripheral border areas are improved. Consultancy for citizens regarding everyday border problems is often provided.[48] With the emergence of various forms of cross-border networks and cooperation, these regions are no longer exclusively regulated and subsidized by nation states but are subject to two national frameworks as well as supranational institutions and funding schemes. Ultimately, this reframes the imagination, planning, and organization of daily life within the respective border region. Though some borders have been determined to be almost permeable through these activities, they usually have not lose their significance for the people's orientation. However, the shape of the domestic borders of the European Union was changed radically by the second Schengen agreement that came into effect in 1995, eventually paving the way for a spatial, processual and institutional deregulation in many economic areas, and potentially in the case of the provision of cross-border health care.

3.1.4 Examples of cross-border medical initiatives

As presented in the following section, the examples of cross-border medical practices of different subjects according to their needs are formalized to a different degree. Furthermore, they possess different qualities regarding their specific continuity, temporality, and visibility in the (digital) media. The list of examples illustrates the interplay between different actors and institutions involved on different scales and therefore seem to make these kinds of "movements" a viable alternative:

Practice	Initiator	Aim
(1) Form S1/regulations	European Union	Cross-border health care for individuals
(2) Institutional contracts on cross-border offers	Local entities	Cross-border health care for individuals
(3) Division of labour	Local actors with the support of several sub- and supranational institutions	Improving the situation of health care structurally
(4) Networks of communication	Local actors supported by several sub- and supranational (funding) institutions	Establishing an information flow between professionals on the local level
(5) Knowledge transfer	Initiated by (2), (3) and (4)	Transferring knowledge to the public

Table 1: Examples illustrating cross-border cooperation in the field of medical practices

(1) Form S1, formerly E 106

The German and the Dutch health care systems are based on private and public health insurance companies that compete with each other.[49] In both countries, public health insurance is mandatory, being partially paid by the respective employer but which can be substituted by private insurance companies. Since com-

48 See M. Schöne, "Bedeutung, Typologie und Entwicklungsperspektiven der deutsch–polnischen und deutsch–tschechischen Euroregionen", Dissertation, 2006, pp. 1–264, www.qucosa.de/fileadmin/data/qucosa/documents/1758/11611598266 91–2552.pdf (accessed 13 May 2016).

49 See J. Muiser, "The New Dutch Health Insurance Scheme Challenges and Opportunities for Better Performance in Health Financing", Discussion Paper 3 (2007), pp. 1–38, http://apps.who.int/iris/bitstream/10665/85673/1/HSS_HSF_DP.07.3_eng.pdf (accessed 17 May 2016); M. Wörz and R. Busse, "Analysing the impact of health–care system change in the EU member states — Germany", *Health Economics* 14 (2005) 1, pp. 133–149.

muting is common in the border region between the Netherlands and Germany, using medical treatment in the country of residence has become a problem. Therefore, the European Union introduced the form S1, which cross-border commuters have to request from their health insurance company. It guarantees full access to medical services in both countries with regard to the respective services of one's health insurance company.

Form S1 is a product of regulatory efforts at the supranational level, which circumvents national regulations and is implemented through the national health insurance companies. Patients can obtain information about the form via the Internet[50] or telephone from the staff of each national health insurance company, and at the National Contact Points for cross-border health care, which had to be established according to the EU patients' rights directive until October 2013 in each European country.[51]

From an interpretative point of view, form S1 can be regarded as a regulatory effort that aims at incorporating practices under ambiguous circumstances: Cross-border commuters draw on fundamental European freedoms, yet subvert the formerly strictly national organization of health care. As such, these kinds of regulation create and expand spaces of action for commuters, enabling them to transgress national borders. Having been initiated by informal routines of commuters, such practices became regulated, formalized, and normalized — in terms of their everyday relevance — through the interplay at the supranational and national levels.

(2) Institutional contracts on cross-border offers

The problem of long waiting lists for medical treatments is a well-known problem in many countries. Several Dutch health insurance companies (Menzis, Anderzorg, Azivis, Multizorg VRZ) solved this problem by signing contracts with twelve German hospitals in the German-Dutch border region. This allows patients to have surgery in Germany, covered by their respective health insurance company, thereby evading long waiting lists in the Netherlands. According to the Eurobarometer, 67% (425) of Dutch interviewees in 2014 showed openness to the possibility of seeking medical treatment across the border, putting Netherlands in second place among EU countries.[52] According to statements of some German medical staff made to us, the Dutch and the German health care systems are perceived to be quite different. German professionals value the Dutch health care system for its emphasis on questions of care; however, our respondents thought this to be the reason for long waiting lists, for example, for several types of surgery. Notwithstanding this downside, our German respondents praised Dutch hospitals for their successes in handling infectious diseases in Dutch hospitals.[53]

This specific kind of cooperation involves organizations on different scales, such as national health insurance companies and local/regional institutions like hospitals. Some have undergone additional institutionalization, for example, in the form of the German association Euroregionaler medizinischer Verein in 2001, realized with the creation of an office and a website, which aims at coordinating and supporting the German hospitals. Furthermore, in consultations between the Dutch health insurance company Menzis and patients, the cooperation with German hospitals is mentioned as one option, among others, for the patients.[54] From an interpretative point of view, such contracts constitute new cross-national networks between medical institutions funding and administering health care, health care infrastructures (e.g., hospitals), and patients.

(3) Division of labour between doctors

Local medical practitioners characterize the health care situation in the Dutch and German border area as insufficient, especially regarding the number of practitioners, dentists, and caregiver staff.[55] Despite this, these shortcomings are not only specific to border regions (see National and Regional Association of Statutory Health Insurance Physicians (KBV) 2015).[56] According to their data, the number of practitioners in the

50 For example from EU websites (European Union, "S1 — Eintragung zwecks Inanspruchnahme des Krankenversicherungsschutzes", https://www.kvg.org/stream/de/download---0--0--0--73.pdf (accessed 13 May 2016)), or from national websites; in Germany, the National Association of Statutory Health Insurance Physicians (NASHIP) offers information.

51 See, e.g., EU-Patienten.de, www.eu-patienten.de/en/ (accessed 13 May 2016).

52 R. Busse, "*Cross-Border Healthcare in the EU (Movement of Services and/or Patients)*", 2015, pp. 1–37, at 8, https://www.mig.tu-berlin.de/fileadmin/a38331600/2014.teaching.ws/2015.06.01_EU_Patient_Movement_01.pdf (accessed 13 May 2016).

53 Telephone talk, 9 February 2016, public health office, district Grafschaft Bentheim.

54 See, e.g., M. Borck, "D-NL: Zusammenarbeit im Gesundheitssektor", December 2009, https://www.uni-muenster.de/NiederlandeNet/nlwissen/soziales/vertiefung/zu-sammenarbeit/gesundheitsraum.html (accessed 15 April 2016).

55 Telephone talks, 9 February 2016 and 30 February 2016, Health region Euregio.

56 Kassenärztliche Bundesvereinigung, "Regionale Verteilung der Ärzte in der vertragsärztlichen Versorgung", Gesundheitsdaten,

German-Dutch border region is ranked amongst the lowest two of five categories (between 63.3 and 54.7 per 100,000 inhabitants). The same is true for caregivers. With regard to specific medical disciplines, the situation seems to be more diverse within the border region; for example, in the case of paediatricians and surgeons the border regions of Borken or Bentheim are ranked in the middle or even better within the five categories.[57] This situation is quite common for more than half of German rural areas. The specific problem of this undersupply everywhere is that the problem cannot be solved by relying on the mobility of, for example, elderly or persons in situations of emergency.

Therefore, different kinds of cooperation have been initiated to improve the provision of health care in the Dutch-German border region: By way of illustration, the joint project PREpare (in German: Rettung ohne Grenzen) runs from 2015 to 2018 and is financed by Interreg V by the European Regional Development Fund (ERDF) of the EU. Its objective is to ensure medical emergency treatment in the German-Dutch border region, being admitted to the nearest hospital regardless of the patient's health insurance company. The project provides a legal and financial and organizational framework, even providing training for medical staff. Under its auspices, pilot projects are funded, specifically those with the goal of transferring knowledge and experiences. It includes an interactive website in Dutch and German, with a reporting office that can be contacted via the website or telephone, with the goal of collecting and analysing feedback and suggestions from the population.

Another example for shared responsibilities and the division of labour is the cooperation between the German Johanneswerk, a provider of geriatric care, and a Dutch nursing home for elderly in Dinxperlo. Dinxperlo and its neighbouring village on the German side — Suderwick — are divided by just one street.[58] Preceding this cooperation, elderly people from Suderwick in need of geriatric care would have to go to the next German city. To improve this situation and to create synergies between both sides, an apartment house for assisted living for elderly was built in Suderwick and connected with the Dutch nursing home by a bridge between the two buildings. This project was financed under the auspices of the EU Programme Interreg IIIa and other national and regional actors, providing accommodation for German and Dutch pensioners in the assisted living units and ensuring the necessary night-time supervision by the Dutch side. However, our first search showed that — according to a representative of the German organization Johanneswerk — the cooperation was suspended due to a mutual lack of trust in in the quality standards of each side. That is why Dutch pensioners never settled in the German flat units and the German side did not want to rely any longer on Dutch nursing services.[59]

We also witnessed that the respective opinions on both sides were still influenced by national stereotypes. Acting as a phantom border, these attitudes may interrupt the establishment of cooperation and the consolidation of common spaces of knowledge, information, and action. Yet, the material remnants of the cooperation are still present — a bridge and a website.

(4) Networks of communication

With regard to cross-border medical cooperation, communication involves the creation of common spaces of knowledge and networks between their members, thereby ensuring a flow of information. Thus, common interests and ideas may be identified and promoted, enabling — but not guaranteeing — common spaces of action. Three different examples can be highlighted in the German-Dutch border regions that demonstrate a variety of shapes of institutionalization: the Euregio, the Health Region Euregio, and the information telephone hotline between the public health authorities on both sides in Enschede (the Dutch Gemeentelijke Gezondheidsdienst (GGD)) and in the German district of Grafschaft Bentheim.

The Euregio — established in 1958 — underwent extensive institutionalization in the meantime and expanded its scope of influence, consisting of a network of different institutions, a professional administration, and infrastructures such as offices and information points as well as various digital representations. It serves as an umbrella for upcoming cross-border projects and as a provider for information about possible

http://gesundheit sdaten.kbv.de/cms/html/16402.php (accessed 15 April 2016).

57 The five categories are grouped numerically but are different for each physician group; for better clarity, we differentiated the five categories by describing their features as lower, low, middle, better, and good. See Kassenärztliche Bundesvereinigung.

58 Both villages are part of medium-sized towns — Aalten in the Netherlands and Bocholt in Germany, respectively. In both cases, the city centre is more than 10 km away from the village, which is rather rural and is located in an agricultural landscape. From 1949 until the Dutch-German treaty of 1963, Suderwick belonged to the Netherlands.

59 Telephone talk, 1 March 2016, Johanneswerk.

financial support from the EU regarding the realization of cross–border cooperation initiatives. Specific information, knowledge networks, and administrative frameworks were incorporated into this institution, promoting regional (business) interests on the sub- and supranational scale.

The Health Region Euregio (Gesundheitsregion Euregio) was founded in 2011 (independently from the Euregio) as a cross-border network focusing exclusively on questions of health care. The network consists of professionals and supporting entities as well as organizes meetings and lectures about medical topics. Recently, the association has applied for EU funds to conduct a research project about the health care situation in the German border region.

The third example, the (informal) telephone hotline between the local public health offices, is the least formalized communication network. Its basic purpose is to exchange information via telephone in cases of emergency concerning infectious diseases. Sometimes the partners of the network meet in the informal atmosphere of a restaurant for getting to know each other and make the future information call easier. The network is sporadic and highly dependent on individuals' decision and time to communicate.

Although in the presented three examples the degree of formalization and respectively of institutionalization and materialization differs very much, it is interesting to review the degree of coverage of the communication practices and the role of the border. The third and less formalized example shows how much the communication between both sides is considered to be just as necessary for questions of local health care. The other cases provide examples for a high degree of institutionalization; however, they also show the respective actors' reimagination of their professional space of action and their imagined reframing of national health politics.

Irrespective of the degree and intensity of the networks, the presence of the border remains dominant in all three examples although it is almost devoid of daily relevance since the Schengen agreements. The necessity to organize and push the information flows is proof of the more thorough division between the regions on both sides of the border. Additionally, upcoming initiatives have to be officially established on one side, which ultimately reproduces national differences. With the example of the Health Region Euregio, it can be determined that the majority of its members are German and — as we were informed by their staff — that the participation of Dutch partners is difficult due to structural differences between the health care systems. Moreover, the number of medical practitioners on the Dutch side of the border is lower, hence they have a comparably bigger workload. Specifically, we were informed by a representative of the Health Region Euregio[60] that — unlike their German colleagues — Wednesdays cannot be used for further medical qualification courses by Dutch medical practitioners. Essentially, the network is indirectly reproducing the border within its own institutional structure.

(5) Transfer of knowledge

In terms of infrastructural capacities, for many people it is easy to cross the border between Germany and the Netherlands. That being said, it requires specialized knowledge to use medical services on the other side. Therefore, several institutions — such as the Euregio, the European Union, or National Association of Statutory Health Insurance Funds (GKV) — have created different spaces of knowledge with varying materials to distribute knowledge on patients' cross-border medical opportunities. For instance, websites provide directions, checklists for organizing the trip and instructions in case of problems, information on private businesses providing medical services, and information on individual experiences in various online message boards. Correspondingly, contact points of the Euregio can be visited or contacted via its telephone hotlines in order to gain information on the respective medical services.

In sum, the Dutch-German border region has experienced a rise of cross-border initiatives since the introduction of the Schengen agreements and — as such — the four freedoms of the European Union. For this point forward, working, living, travelling, and obtaining health care across the border has become far easier for citizens of Germany and the Netherlands. The border disappeared as a material landmark, having partially been transformed into a historic symbol in the landscape. However, this fact did not ultimately involve its disappearance as a mental order for the citizens of the border region. In consequence, at least from these examples, health care seems still to remain predominantly nationally organized. The different networks of cooperation and initiatives — while being devoted to reduce the border's significance — appear rather as indications of the border than signals of its abolishment.

60 Telephone talks, 3 February 2016 and 9 February 2016, Health Region Euregio.

Thorough qualitative research that highlights cross-border medical initiatives is still missing. The presented examples show that cross-border medical initiatives are an interplay of agency on different societal levels. Therefore, an analysis should approach out of necessity the respective initiatives in a multi-sited perspective and in an ethnographic way.[61] This would allow for the reconstruction of the practices of those initiatives in the context of:

- the regulations on various scales like the EU, the nation state, the health insurance companies and the respective interactions between them, and their reaction to cross-border movements of medical staff and patients;
- different possibilities shaped by these regulations, as well as their limits and loopholes, that are expanding spaces of agency for patients and medical staff;
- different public and social information channels, networks, platforms, and contact points;
- different spaces of knowledge that emerge from these different information flows; and
- possibilities and difficulties to transgress the spatial distances and borders that often represent cultural, i.e. mental, borders.

Finally, this multidimensional reconstruction of cross-border medical initiatives allows the respective spatial implications to be evaluated: how far do they open up new spaces of action in the field of providing and seeking health care, and how far do these new spaces imply a fresh impetus fostering the process of Europeanization.

3.2 Cross-border Organization of Organ Donations

3.2.1 Conditions and contexts of cross-border organ transplantation and trade

Medical-technological advancements in organ transplantation since the first attempted kidney transplant in 1933 have made possible numerous treatments to otherwise life-threatening diseases concerning vital organs such as the heart, liver, kidneys, and lungs. At the same time, global economic inequalities have risen to unprecedented heights.[62] This has triggered increased transplantation-related mobility despite indications pointing to higher chances of complications.[63] Such activities are deemed as transplant travel, meaning acts of travelling internationally in order to benefit from differing regulations for organ transplantation and then using financial means to purchase organs.[64] In the wake of these developments, many states have issued regulatory acts concerning the transplantation of human tissues, defining legal and illegal practices of explantation, compensation, allocation, and implantation. Notwithstanding these efforts, studies on the so-called organ black market have repeatedly highlighted the ever-rising number of illegally transplanted organs:[65] Whereas recipients of these illegal transactions often originate from wealthy countries and classes, donors equally often come from the poorest or most marginalized groups.[66] The latter group is commonly seen as being unable to evaluate the quality of care received and unable to afford proper medication to avoid negative ramifications of the donation.[67] Future aggravation of this situation seems likely: Due to a globally growing population, a statistically increasing life expectancy in combination with a continuous spread of unhealthy lifestyles related to nutrition, a rising consumption of drugs, and a growing lack of bodily activity,

61 S. Coleman and P. Hellermann, *Multi-sited Ethnography*, London: Routledge, 2011; G.E. Marcus, "Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography", *Annual Review of Anthropology* 24 (1995), pp. 95–117.

62 See Organisation for Economic Co-operation and Development (OECD), *In It Together: Why Less Inequality Benefits All*, Paris: OECD Publishing, 2015, pp. 16–58, at 23ff.

63 For the case of US citizens travelling abroad, see, e.g., J. Gill et al., "Transplant Tourism in the United States: A Single Center Experience", *Clinical Journal of the American Society of Nephrology* 3 (2008) 6, pp. 1820–1828; for Australian citizens, see S.E. Kennedy et al., "Outcome of Overseas Commercial Kidney Transplantation: An Australian Perspective", *The Medical Journal of Australia* 182 (2005) 5, pp. 224–227.

64 See, e.g., Cohen, "Transplant Tourism", pp. 269–285.

65 See, e.g., O. Greenberg, "The Global Organ Trade: A Case in Point", *Cambridge Quarterly of Healthcare Ethics* 22 (2013) 3, pp. 238–245.

66 R.K.L. Panjabi, "The Sum of a Human's Part: Global Organ Trafficking in the Twenty-First Century", *Pace Environmental Law Review* 28 (2010) 1, pp. 1–144, at 26ff.

67 See, e.g., N. Scheper-Hughes, "Commodity Fetishism in Organs Trafficking", *Body Society* 7 (2001) 2–3, pp. 31–62, at 55.

an increasing number of people on kidney and liver donation waiting lists is expected by institutional actors in the field of organ transplantation (for statistical figures, see statistics.eurotransplant.org).[68]

Given the wealth-related global disparities and the continued — sometimes called epidemic — need for organ replacements,[69] numerous scholars, politicians, and journalists have investigated and revealed exploitative practices of organ donation, trade, and harvesting.[70] Such inequalities may manifest nationally and regionally; for instance, Saunders et al. have revealed that regional belonging as well as race may play a role in the process of waitlisting for renal patients in the US.[71] Moreover, economic disparities are claimed to be key prerequisites for the presence of organ trafficking and other illicit transplantation-related practices. Therefore, this topic has increasingly become a focal point of — in international terms but still barely legally binding — efforts in order to contain the exploitative aspects of organ transplantation. However, knowledge about loopholes and subversive practices in this field, often caused by economic interests, has repeatedly surfaced.[72] This assumes the conclusion — from a scientific point of view — to continuously monitor the changing regulatory frameworks, societal conditions, and subjective needs and perceptions in order to adequately give account of the current state of affairs regarding transplantation regulations and practices.

3.2.2 Systematizing the field of organ transplantation: terminology and procedures

Considering its long history since the middle of the nineteenth century,[73] modern organ transplantation — as a subdiscipline of medicine — is a highly differentiated field. As a consequence, a multitude of efforts have taken part in shaping it, for example with regard to the actors and institutions involved, the practices and related knowledge needed, as well as endeavours to regulate it. Therefore, we will map out the terminological framework concerning organ transplantation as a medical practice:

Transplant material
In principle, transplants in human medicine revolve around cells (such as islet cells in the pancreas, bone marrow, or stem cells), tissues (such as bones, cornea, or skin), liquids (such as blood), organs (such as the heart, kidneys, liver, lungs, or pancreas), or organic systems or composite tissue transplants respectively (such as hands).

Protagonists involved
The act of transplantation consists of the explantation of the target entities from a donor (a person providing it) and their implantation into a recipient. The donor himself/herself can be a living donor who — often in cases of renal and liver transplants — may (up to a certain degree) or may not be related to the recipient (which in turn is usually nationally regulated).[74] In other cases, deceased donors can be considered for having organs explanted that, otherwise, are not available for living donor transplants (such as hearts).

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68 World Health Organization (WHO), "World Health Statistics 2015", Geneva, 2015, pp. 1–161, at 52, http://apps.who.int/iris/bitstream/10665/170250/1/9789240694439_eng.pdf?ua=1 (accessed 17 May 2016).

69 F. Delmonico et al., "A Call for Government Accountability to Achieve National Self-Sufficiency in Organ Donation and Transplantation", *Lancet* 378 (2011) 9800, pp. 1414–1418, at 1417; L. Hopkins et al., "Medical Tourism Today: What Is the State of Existing Knowledge?", *Journal of Public Health Policy* 31 (2010) 2, pp. 185–198.

70 In general, see N. Scheper-Hughes, "The Global Traffic in Human Organs", *Current Anthropology* 41 (2000) 2, pp. 191–224; in China, see E. Gutmann, *The Slaughter: Mass Killings, Organ Harvesting and China's Secret Solution to its Dissident Problem*, New York: Prometheus, 2014; in India, see S. Glaser, "Formula to Stop the Illegal Organ Trade: Presumed Consent Laws and Mandatory Reporting Requirements for Doctors", *Human Rights Brief* 12 (2007) 2, pp. 20–22; in Kosovo and in Albania, see D. Marty, "Inhuman Treatment Of People And Illicit Trafficking In Human Organs in Kosovo", Report (2010) 46, pp. 1–27.

71 M. Saunders et al., "Racial disparities in reaching the renal transplant waitlist: is geography as important as race?", *Clinical Transplantation* 29 (2015) 6, pp. 531–538.

72 For Germany, see, e.g., H. Haarhoff (ed.), *Organversagen. Die Krise der Transplantationsmedizin in Deutschland*, Frankfurt am Main: Referenz Verlag, 2014.

73 D. Hamilton, *A History of Organ Transplantation. Ancient Legends to Modern Practice,* Pittsburg: University of Pittsburg Press, 2012; T. Schlich, *Die Erfindung der Organtrasnplantation. Erfolg und Scheitern des chirurgischen Organsersatzes (1880–1930)*, Frankfurt am Main: Campus, 1998.

74 See WHO, "Global Glossary of Terms and Definitions on Donation and Transplantation", 2009, pp. 1–15, at 12, www.who.int/entity/transplantation/activities/GlobalGlossaryonDonationTransplantation.pdf (accessed 13 May 2016).

Legal framework
The decision about a possible organ donation of a deceased person predominantly depends on nationally organized frameworks and is usually related to the respective person's own wish and the decision of his/her relatives. National regulation can roughly be classified as opt-in and opt-out systems. Opt-in systems like Germany stipulate an explicit consent of the potential donor (an organ donor card) or the legal guardian, placing him/her into a very delicate role; opt-out systems like Austria stipulate compliance. The diagnosis of a donor's death is legally specified and usually revolves around neurological criteria (often called brain death or brain stem death) or cardiopulmonary criteria (called cardiac death).[75] However, both the criteria defining brain death as well as the procedure of diagnosing brain death according to (national) guidelines are controversial.[76] Beyond this, numerous cases around the world have been reported in the past regarding so-called organ harvesting from deceased or living persons against their wishes.[77]

Forms of transplantation
Terminologically, transplants may be autografts — in cases where donor and recipient are the same person — or allografts — in cases where donor and recipient are different persons.[78] Furthermore, isograft transplantation involves genetically identical donors (such as monozygotic twins), whereas xenograft transplantation involves the transplantation of entities from one species to another (such as with the heart valves of a pig).

Legal dimension of donor organ allocation
The WHO condemns organ trafficking and thus the:

> recruitment, transport, transfer, harboring or receipt of living or deceased persons or their cells, tissues or organs, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of cells, tissues and organs for transplantation.[79]

Many European countries have introduced laws meant to regulate the market for organs, most of them penalizing financial compensation for organ donations, thereby attempting to prevent an organ black market. Moreover, the number of states opting for a transnational coordination of the supply and demand of donor organs has increased in past decades, ultimately supporting the efforts of supranational organizations such as Eurotransplant.

The formal procedures
There are frequent innovations related to the complexity of the transplant (recently, for example, in cases of so-called composite tissue transplants such as faces and hands) and the extent up to which differences between tissue and blood characteristics between donor and recipients can be moderated through medication. Procedurally, the process of transplantation involves the designation of potential recipients that — often due to chronic or acute diseases of one or multiple organs — are in the need of substitute organs in order to survive. Potential recipients undergo compatibility testing in order to determine specific tissue characteristics. In addition, their medical state is continuously monitored. In many countries, specialized and centralized databases — often called waiting lists — are maintained, which contain all relevant recipient information. On the other side, people willing to donate organs (whether it being post-mortem or not) are identified and their tissue characteristics are analysed and matched with possible recipients. The respective organ is then allocated according to specified criteria to a donor and medical centre where the transplantation is about to

75 See Ibid., p. 9.
76 See, e.g., S. Müller, "Wie tot sind Hirntote? Alte Frage — neue Antworten", *APUZ — Aus Politik und Zeitgeschichte* 20–21 (2011), pp. 3–9.
77 D. Matas and D. Kilgour, "Bloody Harvest. Revised Report into Allegations of Organ Harvesting of Falun Gong Practitioners in China", Report (31 January 2007), pp. 1–237, http://organharvestinvestigation.net/report0701/report20070131-eng.pdf (accessed 13 May 2016).
78 See US National Library of Medicine, *Medical Subject Headings: Transplants*, 2016, https://www.nlm.nih.gov/cgi/mesh/2016/MB_cgi?mode=&term=Transplants&field=entry (accessed 13 May 2016).
79 WHO, "Global Glossary of Terms and Definitions", 14.

take place. The transplantation itself involves last-minute medical screenings for the respective organ, and the process of implantation itself. Post-operatively, the recipients are forced to undertake a lifetime regime of immunosuppressive drugs of varying intensities in order to minimize the risk of their immune system rejecting the transplanted organ.

3.2.3 Regulating organ transplants in the Eurotransplant region

Politically, regulatory efforts are dominated by national bodies, and, often inspired by several supranational declarations since 1985. To some extent, past attempts of regulating a field dominated by frequent technological advancements have led to a concurrence of rather similar shapes of regulation that differ in detail, for example, regarding the respective procedures for the diagnosis of death or the criteria for the allocation of donor organs. The resulting arrangements of actors, institutions, practices, and norms — nationally and on a European level — are highly complex and differentiated, consisting of a multitude of instances of control. While these instances are dialectically entangled with the principles of European freedoms, sometimes they overlap and possess loopholes that provide opportunities for strategies for exploiting regulatory differences.

In the face of frequent reports about rising numbers of medical travellers in search of donor organs, almost all of the world's states have adopted regulatory acts condemning illicit organ trade and organ trafficking under the impression of demands from various transnational organizations. On a global level, the United Nations has illustrated the relation between the trafficking of humans and transplantation tourism and organ trade.[80] Furthermore, the World Health Organization updated their "Guiding Principles on Human Cell, Tissue and Organ Transplantation", which revolves around ethical principles of organ donation and transplantation.[81] Several studies have revealed that those willing to receive a donor organ outnumber those willing to donate an organ themselves.[82] Some scholars have stressed the need to "raise the rate of kidney transplantation to 50 or more transplants per annum per million population in all countries".[83] Such demands epitomize general concerns about the implications of regional organ shortages in the wake of global inequalities, leading to increased political efforts to contain the negative implications. For instance, the "Declaration of Istanbul"[84] was created following the Istanbul Summit on Organ Trafficking and Transplant Tourism (organized by the Transplantation Society and the International Society of Nephrology) in 2008, condemning transplant tourism and trafficking. Most of the European states have committed to these supranational programmatic contexts articulated by political and disciplinary institutions alike.

Whereas — legally — such global political efforts have to remain mere guidelines, several European institutions have introduced more binding approaches. The European Union — in its Charter of Fundamental Rights of the European Union — has prohibited "making the human body and its parts as such a source of financial gain" (European Union 2000: Art. 3[2]).[85] This paradigmatic document was inspired by the European Convention on Human Rights of the Council of Europe, which itself was essential to its Convention for the Protection of Human Rights and Dignity of the Human Being with respect to the Application of Biology and Medicine.[86] From a legal perspective, the EU's Charter of Fundamental Rights has been legally binding following the Treaty of Lisbon of 2009. Since then, legislative acts undermining the Charter may be ruled inconsistent by courts within the European Union.

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80 United Nations Human Rights Office of the High Commissioner, "Special Rapporteur on Trafficking in Persons, Especially Women and Children", www.ohchr.org/EN/Issues/Trafficking/Pages/TraffickingIndex.aspx (accessed 13 May 2016).

81 WHO, "WHA63.2, WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation", 2010, http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_R22-en.pdf (accessed 17 May 2016).

82 For the United Kingdom, see L. Coad, N. Carter and J. Ling, "Attitudes of Young Adults from the UK Towards Organ Donation and Transplantation", *Transplantation Research* 2 (2013) 9, pp. 431–435.

83 J. Chapman, "What Are the Key Challenges We Face in Kidney Transplantation Today?", *Transplantation Research* 2 (2013) S1, pp. 1–7, at 6.

84 Transplantation Society and the International Society of Nephrology, "The Declaration of Istanbul on Organ Trafficking and Transplant Tourism", International Summit on Transplant Tourism and Organ Trafficking, 2008, www.multivu.prnewswire.com/mnr/transplantationsociety/33914/docs/33914-Declaration_of_Istanbul-Lancet.pdf (accessed 15 Apr 2016).

85 EU, "Charter of Fundamental Rights of the European Union", 2000, http://eur-lex.europa.eu/legal-content/EN/ALL/?uri=CELEX-:12012P/TXT (consolidated version as of 2012; accessed 6 February 2017).

86 Council of Europe, "Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine", 1997, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168007cf98 (accessed 17 May 2016).

Nevertheless, such supranational legislation happened, for example, *after* Germany introduced the transplantation law (Transplantationsgesetz) in 1997, which regulates the principles of transplantation nationally.[87] Thereafter, the German Medical Association (Bundesärztekammer) has been obliged to define the medical standards for transplantation that the respective hospitals and doctors have to abide by. The law also includes the principles of potential donor's declaration to donate organs, waiting lists, education on transplantation, organization of transplantation centres, and prohibition of organ and tissue trade. In 1998, the transfusion law (Transfusionsgesetz) was adopted, regulating the collection, handling, and application of blood fluids as well as integrating transplantation matters into the jurisdiction of the German medication law.[88]

Following this and other national regulatory efforts, the European Union introduced a directive on "standards of quality and safety" for human tissues and cells in 2004,[89] aiming at equal standards of health care and setting the basis for a European Commission directive on technological standards of coding human tissue and cells.[90] Subsequently, Germany introduced acts in 2007,[91] further implementing the European legislation into the German tissue law, transplantation law, medication law, and transfusion law. As it were, national efforts preceded and informed transnational acts. However, the sum of these national acts is sought to be coordinated by the European Union, leading to the conclusion of a more dialectical — rather than unilateral — legal process in terms of establishing an attuned regime of legislating organ transplantation.

Under the impression of a perceived organ shortage, the Commission of the European Union adopted an Action Plan on Organ Donation and Transplantation,[92] with the goal of intensifying the cooperation among EU member states in order to increase the number of organ donations. The European Union as well attempted to harmonize formerly distinct transplantation regimes in Europe by introducing a directive on "standards of quality and safety of human organs intended for transplantation".[93] Under the impression of the various forms of organizing transplantation among the member states, an implementing directive aimed at elaborating the principles of information exchange in 2012 in order to develop the fundament for an EU-wide organ exchange.[94] Up to now, several initiatives promoting cooperation have been introduced on a European level as a result of the EU's attempts to harmonize the topic of organ transplantation.

Although such processes may lead to greater unification in a Europe having grown accustomed to transnational policy-making, there still are many differences between the national legal frameworks. Moreover, some incidents have had considerable impact on the national scale, such as the transplantation scandal in Germany.[95] In the latter case, doctors were accused of having manipulated their patients' data in order to increase their chances of being offered a donor organ. Subsequently, the German transplantation law was altered, stipulating that institutions evaluate the validity of decisions concerning organ donation and trans-

87 Deutscher Bundestag, "Gesetz über die Spende, Entnahme und Übertragung von Organen und Geweben (Transplantationsgesetz — TPG)", *Bundesgesetzblatt*, 1997, Teil 1, Nr. 74, 2631–2639.

88 Deutscher Bundestag, "Gesetz zur Regelung des Transfusionswesens (Transfusionsgesetz — TFG)", *Bundesgesetzblatt*, 1998, Teil 1, Nr. 42, 1752–1760; See Deutscher Bundestag, "Gesetz über den Verkehr mit Arzneimitteln (Arzneimittelgesetz)", *Bundesgesetzblatt*, 1998, Teil 1, Nr. 80, 3586–3648.

89 EU, "Directive 2004/23/EC of the European Parliament and of the Council of 31 March 2004 on Setting Standards of Quality and Safety for the Donation, Procurement, Testing, Processing, Preservation, Storage and Distribution of Human Tissues and Cells", *Official Journal of the European Union* L 102 (2004), pp. 48–58.

90 EU, "Commission Directive 2006/86/EC of 24 October 2006 implementing Directive 2004/23/EC of the European Parliament and of the Council as Regards Traceability Requirements, Notification of Serious Adverse Reactions and Events and Certain Technical Requirements for the Coding, Processing, Preservation, Storage and Distribution of Human Tissues and Cells", *Official Journal of the European Union* L 294 (2006), pp. 32–50, last updated 2015.

91 Deutscher Bundestag, "Gesetz über die Qualität und Sicherheit von menschlichen Geweben und Zelle (Gewebegesetz)", *Bundesgesetzblatt*, 2007, Teil 1, Nr. 35, 1574–1594.

92 EU, "Communication from the Commission: Action Plan on Organ Donation and Transplantation (2009–2015): Strengthened Cooperation Between Member States", Action Plan, 2008, http://ec.europa.eu/health/ph_threats/human_substance/oc_organs/docs/organs_action_en.pdf (accessed 17 May 2016).

93 EU, "Directive 2010/45/EU of the European Parliament and of the Council of 7 July 2010 on Standards of Quality and Safety of Human Organs Intended for Transplantation", *Official Journal of the European Union* L 207 (2010), pp. 14–29.

94 EU, "Commission Implementing Directive 2012/25/EU of 9 October 2012 Laying Down Information Procedures for the Exchange, Between Member States, of Human Organs Intended for Transplantation", *Official Journal of the European Union* L 275 (2012), pp. 27–32. This transnational exchange of organs is — of course — limited by the organ-specific possible ischemic time (the time span between the organ's disconnection from the donor's and the connection to the recipient's blood vessels) and in relation to the distance between the places of explantation and implantation. Nevertheless, there is considerable debate on whether the resulting potential "deaths by geography", for example in peripheral regions or regions with scarce donors are to be handled politically, juridically, and in terms of individual response to such circumstances (for the case of the US, see, e.g., S. Pondrom, "News and issues that affect organ and tissue transplantation", *American Journal of Transplantation* 9 (2009) 3, pp. 437–438).

95 See Haarhoff, *Organversagen*.

plantation (such as transplantation advisory boards in the transplantation centres) and further specifying the principles of educating German citizens regarding transplantation.[96]

The ever-evolving juridical frameworks — setting up and adjusting the legislative background for organ transplantation — have been implemented in complex ways. In Germany, several institutions execute existing law, thereby, at least in theory, safeguarding medical and ethical principles, guiding the medical and juridical procedures, and monitoring the validity of decisions taken in the course of allocating organs. On the supranational scale, Germany is part of the Eurotransplant Network that[97] aims at coordinating deceased donor organ offers and requests by comparing the outcome of analyses regarding specific tissue characteristics.[98] Such institutions are believed to increase the chance of finding proper recipients for donor organs or finding the suitable donor organs for recipients in need, respectively.

Although upscaling the demand for organs is common throughout parts of Europe, some states do not participate in such organizations by default. Still, a European Commission's study from 2010 highlighted that of the 29 countries surveyed, 14 have been found to having delegated some responsibilities to international organizations. Of the surveyed countries, 25 have national bodies, sometimes in addition to the international organizations, in charge of organ transplantation and exchange, and 3 have more decentralized regional bodies.[99] For the case of Germany, the German Organ Transplantation Foundation (DSO) was established for organizing the process of donation nationally, generally providing technical and staff assistance to the institutions taking part in the process. Furthermore, multiple organizations participate in setting up medical guidelines,[100] negotiating funding,[101] applying political guidelines,[102] and implementing scientific and organizational advancements.[103]

Furthermore, the activities of the patients' associations (themselves partially being transnationally organized,)[104] include counselling patients and organizing community-based activities as well as information events nationally and regionally. They act as intermediary institutions that bridge the gap between the patients' intentions, subjective expectations and perceptions, and medical institutions' requirements. They also organize local and regional support groups for those waiting for, having received, or being related to someone going through a transplantation surgery. So far, the relation between such instances of counselling and the professional medical institutions has not yet been illuminated in terms of supporting, enforcing, or subverting regulatory efforts. Quite frequently, however, their importance for patients in a changing health care system devoted to reducing costs is often highlighted in public discourse.

In Germany, this public discourse — however — is also subject to governmental efforts by the Federal Centre for Health Education (BZgA),[105] which has taken up the task of informing and influencing the societal discourse about organ donation and transplantation as well as about the procedures of transplantation. A second institution, the German Ethics Council,[106] defines ethical guidelines for the life sciences, including aspects related to organ transplant. This institutional manifold complexity is further increased given the multiple organizations and projects involved. For instance, several international cooperative initiatives — such

96 Deutscher Bundestag, "Gesetz zur Änderung des Transplantationsgesetzes", *Bundesgesetzblatt*, 2012, Teil 1, Nr. 35, 1601–1612; Deutscher Bundestag, "Gesetz zur Regelung der Entscheidungslösung im Transplantationsgesetz", *Bundesgesetzblatt*, 2012, Teil 1, Nr. 33, 1504–1506.

97 Eurotransplant is a non-profit organization and was set up in 1967. While at first restricted to kidneys, it now is responsible for the coordination and allocation of kidneys, livers, hearts, pancreas, lungs, and intestines. It covers Austria, Belgium, Luxembourg, Germany, the Netherlands, Slovenia, Croatia, and Hungary.

98 Similar institutions exist, for example Balttransplant for Estonia, Lithuania and Latvia; Scandiatransplant for Iceland, Denmark, Norway, Sweden, and Finland; and NHS Blood and Transplant (formerly UK Transplant) for England, Wales, Scotland and Northern Ireland

99 European Commission, "Human Organ Transplantation in Europe: An Overview", Report (2010), pp. 1–20, at 12, http://ec.europa.eu/health/ph_threats/human_substance/documents/organ_survey.pdf (accessed 13 May 2016).

100 Such as the Bundesärztekammer (German Medical Association), www.bundesaerztekammer.de/ (accessed 13 May 2016).

101 Such as the National Association of Statutory Health Insurance Funds, https://www.gkv-spitzenverband.de/ (accessed 13 May 2016); or the German Hospital Federation, www.dkgev.de/ (accessed 13 May 2016).

102 Such as the Assembly of the Ministers for Health of the German Federal States, www.bmg.bund.de/ (accessed 13 May 2016); or the Assembly of the Ministers for Health of the German Federal States, https://www.gmkonline.de/ (accessed 13 May 2016).

103 Such as the German Transplantation Society, d-t-g-online.de (accessed 13 May 2016).

104 Such as the European Heart and Lung Transplant Federation, http://ehltf.info/ (accessed 13 May 2016).

105 Federal Centre for Health Education, www.bzga.de (accessed 13 May 2016).

106 German Ethics Council, www.deutscher-ethikrat.de/ (accessed 13 May 2016).

as the Collaborative Transplant Study[107] and the FOEDUS Joint Action[108] — that monitor current practices in the field of transplantation compare success rates and procedures.

While such manifold actors involved may be interpreted as a panopticon, attempting to minimize the possibilities of opinions remaining unheard and loopholes undermining the democratic premise of equality, the complexity entails potential blind spots in multiple senses. Institutionally, the division of labour requires cooperation and strict obedience to regulatory mechanisms among nation states, institutions, and people. In contrast, several of our interviewees have confirmed so far that some doctors refrain from notifying their respective national and international organization due to the costs and organizational effort involved with explantation. There may be differences, for example, regarding whether donation after circulatory death can be achieved in controlled or uncontrolled circumstances with regard to the local situation and resources. In scalar terms, different international organizations take up different tasks, some being restricted to allocation, and some to cooperation through joint research or knowledge transfer. Paradigmatically, some organizations seem to be inspired by a European ideal when encouraging supranational cooperation, and some pursue a more practical vision related to needs and ends. Therefore, enquiring into this field entails elaborating the various shapes, procedures, and processes with reference to the respective regulatory and subversive efforts.

3.2.4 Loopholes and inconsistencies within the regulatory regimes of organ transplantation

In concordance with regulatory efforts to prevent illegal practices related to organ transplantation — such as the Eurotransplant's procedures attempting to track the path each organ takes — detailing any decision provides legitimacy to the respective actions taken in order to enhance the credibility of the process, being considered against the background of the interest to increase the donors within the population. However, fraudulent practices were made public in Germany in 2012 concerning cases of waiting list manipulation by altering patients' records in a way to increase their chances of receiving a donor organ.[109] Such incidents highlight the possibility to subvert the seemingly complete monitoring system by interfering with patients' records on the level of diagnosis and protocolling. Furthermore, the German journalist Haarhoff more generally identifies structural problems in the field of transplantation. Although the German system may suggest a separation of powers — where the German Medical Association defines specific procedures and standards and the DSO and Eurotransplant conceptualize and execute the process of explantation, allocation, and transplantation accordingly — she instead highlights entanglements between their respective personnel.[110]

The respective national regulations and the population's willingness to donate organs differ across Europe.[111] Yet, they are comparable with respect to (1) the decision-making process of potential donors, (2) the international entanglement of the national organization of transplantation, (3) the respective procedures for diagnosing a patient's death using various medical criteria, and (4) the legal status of organizations in charge of allocating organs and coordinating transplantation.

1 In Europe, at least three kinds of jurisdictions can be distinguished in relation to the way the decision-making concerning the will of a deceased donor is carried out. Some states presume the deceased person's objection to an organ donation if no explicit written statement is available. In case of death, no organs will be explanted. Some states presume the deceased person's consent to an organ donation if no explicit written statement is available, leading to an organ explantation after death. In both cases, there may be solutions allowing the deceased's relatives to make the choice whether to donate an organ or not. In Germany, the so-called extended decision solution (erweiterte Entscheidungslösung) was adopted in 2012, calling for the information of every German citizen on matters

107 Collaborative Transplant Study, ctstransplant.org (accessed 13 May 2016).
108 FOEDUS Joint Action, www.foedus-ja.eu/ (accessed 13 May 2016).
109 See, e.g., C. Berndt, "Neuer Organspendeskandal in Leipzig", *Sueddeutsche Zeitung*, 2 January 2013, www.sueddeutsche.de/gesundheit/manipulierte-daten-am-transplantationszentrum-neuer-organspende-skandal-in-leipzig-1.1562857 (accessed 13 May 2016); H. Haarhoff, "Alle Organe einbeziehen", *taz*, 15 August 2012, https://www.taz.de/Organspende-Skandal-in-Hamburg/!5086398/ (accessed 13 May 2016).
110 H. Haarhoff, "Die Altherrensauna. Das System und seine Akteure", in: H. Haarhoff (ed.), *Organversagen. Die Krise der Transplantationsmedizin in Deutschland*, Frankfurt am Main: Referenz Verlag, 2014, pp. 237–266, at 253ff.
111 G. Kirste, "Organ Exchange in Europe — Barriers and Perspectives for the Future", *Annals of Transplantation* 11 (2006) 3, pp. 52–55.

of organ donation by their respective health insurance provider in relation to the appeal to explicitly decide and fill out the respective donor card, but not obliging them so do so. If no explicit statement was given, the person's relatives are able to make a choice for them. In any case, such a legislative act avoids explicit rulings and rejects promoting a specific position in pondering ethical assumptions and the usual need to increase the number of donors per million of the population.[112]

2 Some European states have opted for coordinating the organ allocation and matchmaking process transnationally to increase chances of finding suitable recipients for donors (and vice versa). Yet, some states seem to rely on the primacy of national organizations, and others opt for cooperation with other organizations if no suitable recipient can be found (e.g., Swisstransplant turning to France, Spain, Italy, and Germany in such cases). In some instances, subnational distinctions can be found, such as in the case of the Catalan Transplant Organization (OCATT). Nevertheless, international cooperation is frequent in Europe.

3 As a prerequisite for becoming a Eurotransplant member, the respective state has to agree to introduce a definition of death and accordingly proper diagnostic procedures. Such procedures, however, may differ between the current members.[113] Whereas special procedures to determine brain death have to be followed in Germany,[114] the Netherlands, for example, has introduced in 1999 the concept of "donation after circulatory death".[115] As a result, this leads to inconsistencies between the ethical standards of different countries and complicates the allocation process; as such organs cannot be transplanted to recipients from countries that themselves reject organ donation after circulatory death

4 In relation to the German transplantation scandal, Haarhoff highlights a lack of democratic control over and juridical accountability of Eurotransplant, the German DSO, and the Bundesärztekammer due to their respective legal statuses.[116] She indicates that overlapping personnel may lead to a conflict of interests in case of further conflicts. The respective state of affairs in other European countries has yet to be determined. Despite that, examining these aspects may provide insights into the patterns of regulation and the respective notions of spatiality.

3.2.5 Researching organ-related transplants, trade, and travel: methodological consequences from past studies

Taking into account the multitude of actors, regulations, contexts, ethical norms, as well as social aspects involved in the field of organ transplants, Cohen highlights the complexity of the field of transplant tourism and organ trade.[117] First of all, this field of research is to a great extent structured by the fact that such practices may be allowed under some circumstances and in some regions of the world, whilst they are condemned and penalized in others. Enquiring into the nexus of regulation and deregulation of organ transplantation, answering the question whether and how such efforts are informed by notions of spatiality, as well as clarifying the respective affirmative and subversive practices will therefore have to take the topic's conflictive and sensitive nature into consideration when contemplating its methodological design.

On the one hand, regulatory efforts can be traced as they are usually accompanied by press coverage. The main tasks from the researchers' perspective may revolve around understanding the respective actors' and institutions' tasks, backgrounds, and entanglements with other nodes in the network. Furthermore, institutions handling the allocation procedures are quite open about their inner workings following the recent transplantation-related scandals. On the other hand, the subversive dimension of organ transplantation requires significant scholarly efforts since individuals travelling abroad for transplantation, together with the often economically motivated actors involved, usually avoid revealing their actions under the impression

112 For an international overview, see C. Rudge et al., "International Practices of Organ Transplantation", *British Journal of Anaesthesia* 108 (2012) 1, pp. 148–155.
113 The paths and reasons for the development of such differences have not yet been clarified.
114 Bundesärztekammer (German Medical Association), "Richtlinie gemäß § 16 Abs. 1 S. 1 Nr. 1 TPG für die Regeln zur Feststellung des Todes nach § 3 Abs. 1 S. 1 Nr. 2 TPG und die Verfahrensregeln zur Feststellung des endgültigen, nicht behebbaren Ausfalls der Gesamtfunktion des Großhirns, des Kleinhirns und des Hirnstamms nach § 3 Abs. 2 Nr. 2 TPG, Vierte Fortschreibung", *Deutsches Ärzteblatt* (2015).
115 See J. De Jonge et al., "Organspende nach Herz– und Kreislauftod", *Der Nervenarzt* 87 (2016) 2, pp. 150–160.
116 Haarhoff, "Die Altherrensauna", in: *Organversagen*, pp. 244ff.
117 Cohen, "Transplant Tourism", pp. 269–285.

of the present-day suppressive legislation concerning organ trade and trafficking. As a result, numerous studies — mainly from anthropology — have attempted to structure the field. For instance, Cohen provided a meta-analysis of prevalent literature, distinguishing between studies of organ sellers (that under individual circumstances could be called donors), recipients, and organ brokers.[118] Yet, such roles are taken up against the background of specific national, regional, and local socio-economic conditions, subjective socio-cultural practices and traditions,[119] and the respective political and juridical regulations.[120] As a matter of fact, the regulatory aspects are topics of scientific debates.[121]

While research on the regulatory aspects usually entails document analysis and a variety of interviews with officials from the respective institutions, research into the illicit aspects of organ transplantation involves a more non-linear methodological approach that manages to deal with a multitude of fates, motivations, and a general sense of unpredictability. For instance, Scheper-Hughes stresses the difficulties of collecting information on the private sector of transplantation, pointing out the need to take a look behind the official curtains of public relations;[122] she even went so far as pretending to be in search of an organ herself. She recommends cooperating with local anthropologists, journalists, and human rights activists when focusing on the "donors",[123] proposing the method of "snowballing" her way through the personal networks using trust and reputation. In general, a broad spectrum of people within different professions are interviewed, sometimes face to face, sometimes using telephone or e-mail, sometimes openly stating the researchers' intentions, and sometimes covertly. Concentrating on the need to access such "hidden populations", Moniruzzaman stresses the role that managing the information needed to gain access to the field of research — and in this case to her key informant, an organ broker called "Dalal" — plays:

> I introduced myself to Dalal, stating that I was neither an undercover police officer nor a journalist, but a "harmless" researcher. My local family background, university teaching in Bangladesh, institutional affiliation abroad, and my partner's identity as bedeshi (foreigner) played an essential role in gaining Dalal's trust, while my familiarity with the Bengali language aided me in sharing my thoughts and determining my initial approach to Dalal without any confusion. [124]

While in most countries donors and recipients can sometimes be extracted from national registries,[125] Moniruzzaman contacted such persons through her information broker.[126] Nevertheless, the quality and validity of the information gained through such channels remains in question, leading scholars to develop improvised methods of verifying them. Like Scheper-Hughes in her research on kidney sellers in Brazil,[127] Naqvi et al. attempted to observe the nephrectomy scar for confirmation in their research on kidney sellers in Pakistan.[128] In contrast, Kennedy et al. used renal units facilitating dialysis as entry points for gathering information on patients and transplant tourists.[129] When able to access patients' files under the pretence of prevalent jurisdiction on patients' information, a systematic retrospective analysis of a multitude of records is possible and enables researchers to identify those having undergone transplantation abroad.[130]

However, such an account does not ultimately provide the ability to understand the individual motives behind attempts of subverting prevalent regulation. Given this methodological blind spot, Smith-Morris and

118 Ibid., pp. 269–285.
119 For the practices of living-donor transplants, see, e.g., N. Scheper-Hughes, "The Tyranny of the Gift: Sacrificial Violence in Living Donor Transplants", *American Journal of Transplantation* 7 (2007) 3, pp. 507–511.
120 See, e.g., Greenberg, "The Global Organ Trade", pp. 238–245.
121 See, e.g., J.V. McHale, "Organ Transplantation, the Criminal Law, and the Health Tourist. A Case for Extraterritorial Jurisdiction", *Cambridge Quarterly for Healthcare Ethics* 22 (2013) 1, pp. 64–76.
122 N. Scheper-Hughes, "Parts Unknown. Undercover ethnography of the organs–trafficking underworld", *Ethnography* 5 (2004) 1, pp. 29–73, at 77ff.
123 Ibid., p. 41.
124 M. Moniruzzaman, "Living Cadavers in Bangladesh", *Medical Anthropology Quarterly* 26 (2012) 1, pp. 69–91, at 74.
125 D. Segev et al., "Perioperative Mortality and Long–term Survival Following Live Kidney Donation", *The Journal of the American Medical Association* 303 (2010) 10, pp. 959–966.
126 Moniruzzaman, "Living Cadavers in Bangladesh", pp. 69–91.
127 Scheper-Hughes, "Parts Unknown", pp. 29–73.
128 A. Naqvi et al., "A Socioeconomic Survey of Kidney Vendors In Pakistan", *European Society for Organ Transplantation* 20 (2007) 11, pp. 934–939.
129 Kennedy et al., "Outcome of Overseas Commercial Kidney Transplantation", pp. 224–227.
130 See, e.g., M. Sever et al., "Outcome of living unrelated (commercial) renal transplantation", *Kidney International* 60 (2001) 4, pp. 1477–1483.

Manderson highlight the complexity of the various aspects and conditions enabling the exploitation of different medical systems through travel and infer the benefits of anthropological research in understanding them. In sum, enquiring into such a sensitive field that revolves around (il)legality in the face of existential issues entails combining several methods as well as reflecting on the ethical implications of the various approaches needed and possible.[131]

This empirical complexity includes consequences when focusing on the scientific goal of the Collaborative Research Centre. Clarifying the spatial aspects involved in the contested and complex processes of negotiating the regulation of organ transplantation on various scales and with respect to its stabilization as well as subversion will have to, at least, acknowledge the socially and politically constructed nature of spatial concepts. Nevertheless, some of the practices utilized may not exist on the basis of spatial imaginations but instead reflect more subjective drives for well-being. These occur in the context of the multitude of actors shaping this field, which in turn react to these practices.

3.3 Aspects of Researching Border-transcending Medical Practices

In the course of our preliminary analysis, we noticed that in investigating the research questions with reference to the spatial dimension of cross-border medical practices there are several aspects having a significant influence on the developments shaping the research field. Therefore, we have to consider them in the context in which the selected cross-border medical practices evolve:

3.3.1 Regulation and subversion

Taking into consideration prevalent research on borders and governmental issues and — more fundamentally — on Foucault's concept of governmentality,[132] we aim at analysing the aspects of regulation and subversion related to cross-border assemblages of medical practices. We will investigate juridical and political attempts of regulation — situated at different scales — as well as the perception of such attempts from a (prospective) patient's perspective. Moreover, examining subversive practices may highlight prevalent difficulties and tensions for patients. We additionally intend to analyse their impact on regulatory efforts as possible impulses for changes in legal frameworks on different scales. The relation between regulatory acts — such as encouraging or limiting specific possibilities for cross-border entanglements — and the subsequent practices can illuminate the effectiveness of regulatory efforts.

3.3.2 The role of technology

Harvey has prominently claimed that technological innovations were able to condense spatial distances.[133] He specifically refers to technologies related to communication, travel, and economy. Such technologies are the very central prerequisites for transgressing distance and, subsequently, territory and borders, which are the bases of our enquiry. Firstly, more advanced medical technologies and technological differences between regions and countries provide motives of transgression as recent studies on medical tourism and medical travel have shown for the disciplines of cosmetic surgery and reproductive therapy.[134] Secondly, it appears that the ability to overcome distance nowadays merges with reasons and conditions for undertaking medical therapy, each being fused together by rising global inequalities. We come to the conclusion that we need to shed light on the impact of technological innovations in order to understand ruptures and continuities in the field of cross-border medical practices.

131 C. Smith-Morris and L. Manderson, "The Baggage of Health Travelers", *Medical Anthropology* 29 (2010) 4, pp. 331–335.
132 See M. Foucault, *Security, Territory, Population. Lectures at the Collège de France 1977–78*, Houndmills: Palgrave Macmillan, 2003/1977–78.
133 D. Harvey, "Between Space and Time: Reflections on Geographical Imaginations", *Annals of the Association of American Geographers* 80 (1990) 3, pp. 418–434.
134 For an overview, see Glinos et al., "A Typology of Cross–Border Patient Mobility", pp. 1145–1155.

3.3.3 Information flows

The digitalization of information has generated completely new and heterogeneous forms of organization and flows of information (e.g., digital media, centralized communication networks such as Facebook, and decentralized communication structures such as message boards and mailing lists). Such services facilitate the circulation of images, information, ideas, and knowledge — concerning both legal and illegal practices. Appadurai states that such conditions encourage reimaginations of lifestyles and actions as well as permits subversion and social change.[135] As such, information transcends local and individual conditions by establishing new connections between ideas, places, offers, interests, and communities; therefore, it is to be considered a fundamental condition of cross-border medical practices. From an empirical point of view, we will take into account and examine the various ways new social media are used to disseminate the information and, as a consequence, to make cross-border medical practices possible.

3.3.4 Sites of negotiation

Public demands are usually negotiated in different contexts. By way of illustration, patients' rights are a matter of debate in hospitals, support groups, online message boards, and in regional, national, and transnational patients' associations where patients' rights, their needs, as well as demands are articulated and communicated. These discussions sometimes have no concrete addressees, and sometimes they confront patients directly (such sites may involve conferences, legislative procedures, or counselling sessions for the boards of medical institutions). We will investigate the various sites for negotiating perceptions, needs, and demands by elaborating upon them for each epistemic group and clarifying the ways such groups come into contact with each other, debate certain orientations, as well as have particular impact on the field of cross-border medical practices.

3.3.5 Aspects of discursivity

Regulations and negotiations are part of the discursive field of cross-border medical practices. Moreover, cross-border medical practices and initiatives are communicated and remembered in a discursive way. By focusing on the field of linguistic practices, it is possible to give account of phenomena that have so far not undergone institutionalization and formalization (e.g., informal practices). Concentrating on discursivity provides insights into the relations between subjects, practices, and rules deemed illicit or illegal, and into the dynamic constitution of the field of European health care. In sum, we intend to clarify the role of discursive practices in processes of negotiation between regulation and subversion as well as the means and aims involved.

3.3.6 The relationship between dynamic and stability

Since the introduction of the European Communities and their expansion into domestic policies through the treaties of Maastricht (1993) and Amsterdam (1997), member states of the European Union have de facto increasingly refrained from claiming exclusive territorial sovereignty and transferred responsibilities onto the transnational scale in relation to almost every policy area, thereby opting to coordinate politics in order to further entanglements regarding the movements of goods, people, capital, and services. In comparison with other fields such as fiscal and asylum policy, our preliminary enquiry into the field of cross-border medical practices in Europe has confirmed that health care is still predominantly regulated at the national level. However, we were able to confirm various ruptures and new developments, many drawing from the citizen's needs, aspirations, imaginations, and movements. Bearing this in mind, we acknowledge the need to stress the temporality of regimes of regulation and subversion, and intend to illuminate the dynamics of negotiation as well as periods of stability in certain policy areas.

135 A. Appadurai, *Modernity at Large: Cultural Dimensions of Globalization*, Minneapolis: University of Minnesota Press, 1996.

4 Interpreting Spatial Dimensions of Cross-border Medical Practices

4.1 Introductory Notes on the Role of Space as being Constitutive of and Constituted through the Social

So far, our report has — though in an unsystematic manner — highlighted the empirical relevance of spatialization at work within the field of cross-border medical practices, in the field of cross-border cooperation and in organ transplantation. Based on existing literature, one underlying assumption of the project is the increasing cross-border mobility of patients, hence an increasing mobility of people making use of medical treatment abroad. Already by definition, *territories* and their *borders* play a crucial role in the project: *Borders* mark and define the limits of legal frameworks and binding regulations as well as the spatial range of institutions, whose limits are being sidestepped by cross-border practices for very different reasons, ranging from the availability of treatment to saving of costs. State borders mark the validity of norms. Likewise, and importantly, borders often mark the space of belonging in terms of being familiar with the language, habits, procedures, and mutual expectations, thus playing a decisive role in medical treatment. *Scaling*, as already indicated in chapter 3.2.3, is an important aspect of governmental efforts in the field of organ donation and harvesting as well as of the allocation of donated organs. Hospitals can be understood as *places* embedding — intended or through "happenstance juxtaposition" and "throwntogetherness of place"– doctors, patients, infrastructures, ethical regulations, and highly specialized expert knowledge into more or less stable configurations.[136]

These disperse indications need to be approached more systematically through an interpretative scheme that is able to provide accounts on how each empirical and analytical step has drawn from previous steps. Subsequently, we distinguish between two major steps of research:

1 An empirically based reconstruction of assemblages; and
2 An elaboration of the role of spatiality — due to the overall interest of the Collaborative Research Centre — within these assemblages in order to identify spatial formats as concrete configurations of spatializations.

"The last few decades", as Paasi states, "have witnessed a mushrooming tendency to reflect theoretically upon the increasingly complex spatialities of the globalizing world, the spatialities of power and changing (or at times less-changing) identities".[137] Indeed, contemporary geographical works aiming at theorizing the spatial nature of "the social" have created a large corpus of intertwined rationales and arguments, often informed and inspired by non-geographical works (e.g., from philosophy and political science) from a socio-ontological perspective.[138]

The objective of the Collaborative Research Centre is to identify spatial formats and spatial orders under the global condition. *Spatial formats*, from our point of view, have to be separated from processes of spatialization as a first interpretative step. Processes of spatialization — inspired, initiated, or exerted by particular actors (e.g., institutions) — may be adopted (or resisted) by other actors, providing exemplary practices for

136 D. Massey, *For Space*, London: Sage Publishers Ltd., 2005, p. 141; D. Massey, "Spacetime, 'Science' and the Relationship Between Physical Geography and Human Geography", *Transactions of the Institute of British Geographers* 24 (1999) 3, pp. 261–276, at 265.

137 A. Paasi, "Is the World More Complex than Our Theories of It? TPSN and the Perpetual Challenge of Conceptualization", *Environment and Planning D: Society and Space* 26 (2008) 3, pp. 405–410, at 405.

138 See, e.g., B. Jessop, N. Brenner and M. Jones, "Theorizing Sociospatial Relations", *Environment and Planning D: Society and Space* 26 (2008) 3, pp. 389–401; A. Paasi, "Europe as Social Process and Discourse. Considerations of Place, Boundaries and Identities", *European Urban and Regional Studies* 8 (2001) 1, pp. 7–28; A. Paasi, "Place and Region: Regional Worlds and Words", *Progress in Human Geography* 26 (2002) 6, pp. 802–811; J. Painter, "Rethinking Territory", *Antipode* 42 (2010) 5, pp. 1090–1118; B. Werlen, *Sozialgeographie alltäglicher Regionalisierungen. Band 1: Zur Ontologie von Gesellschaft und Raum*, Stuttgart: Franz Steiner Verlag, 1995; B. Werlen, *Sozialgeographie alltäglicher Regionalisierungen. Band 2: Globalisierung, Region und Regionalisierung*, Stuttgart: Franz Steiner Verlag, 1997.

regulative (or subversive) opportunities. However, they may be used as blueprints for socio-spatial entanglement and regulation, together with a set of key concepts[139] that in turn may serve as a further basis for more regionalized and distinct implementations. As a second interpretative step in our research, we will expound upon spatial formats as heuristics of socio-spatial modes of governing by comparing different processes of spatialization and the arising ways of proliferation and adoption. Hegemonic spatial formats can be traced historically: If they can be observed to be emerging and vanishing during a specified period of time under defined circumstances, several persistent regimes of spatial formats — namely *spatial orders* — may be deduced in a third interpretative step. Notwithstanding, before spatial formats and spatial orders can be discussed, we have to identify the spatializations at work in the practices.

The following two chapters contribute with a heuristic for understanding cross-border medical practices (see fig. 1). As a precondition for reconstructing spatializations as logics of modulating practices, we first need to empirically reconstruct the assemblages emerging form entangled practices and subjects (or subjectivities) (4.2). In a second step, the project plans to expand on the role of spatiality, for which we provide preliminary assumptions in chapter 4.3; this in turn is a precondition for interpreting spatial formats as concrete configurations of spatialization.

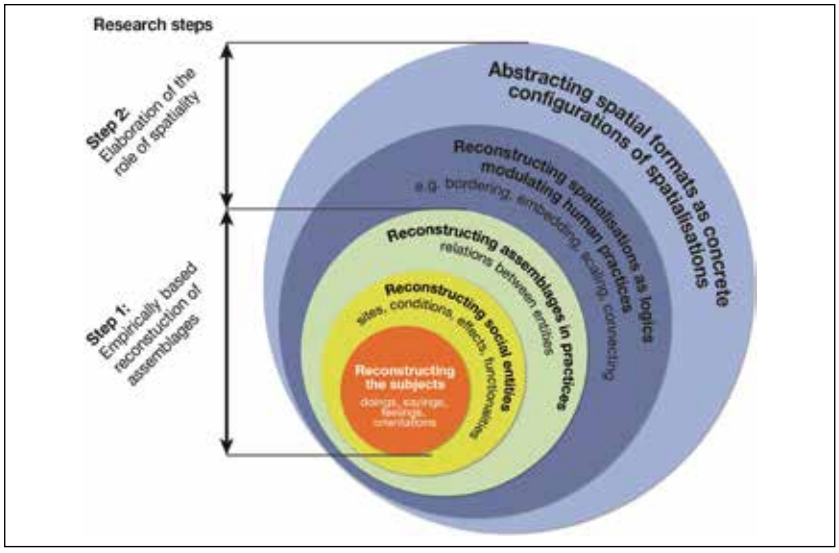

Figure 1 Research steps within project B5 with regard to the general focus of the Collaborative Research Centre

4.2 Conceptualizing Cross-border Medical Practices

4.2.1 Subjects, practices, and assemblage

Considering the wide range of factors and phenomena, it is necessary to understand cross-border medical practices as *a specific field of practices*, consisting of social, political, and technological aspects, and emerging from the relationship between the subjective needs for therapy and the collective-organizational need for equal distribution of medical treatment and therapy (such as with emergency services, organs, etc.) under rapidly changing conditions of de- and re-territorializing statehood sovereignty. For this reason, it is necessary to empirically reconstruct the recent social and political changes within this field by combining the respective vantage points, emphasizing the patient's perspective, either as the entity for deciding on the practical significance of prevalent regulatory process or deciding on ways of subverting it. We aim at illuminating the very innovations, motives, necessities, expectations, and emotions that prove to be relevant for prospective travelling patients as well as the influence by discursive conditions and strategies of legitimization. In contrast, we will elaborate upon practices of establishing and stabilizing entanglement and control in relation to emerging modes of spatial formats adopted in order to operationalize and execute sovereignty and authority.

139 See as comparison, for example, the concept of parliamentarian democracy and the related guiding principles and institutions.

Taking into account this conceptual concentration, we draw from recent contributions from, first, subject theory and contributions from practice theory.[140] In addition, doings and sayings[141] of the subjects involved in such practices will be investigated together with the respective subject's — in terms of imagination as prerequisites for expression[142] — orientations informing, enabling, and motivating actions. Inspired by Appadurai's notes on the changing role of the diaspora, we will distinguish between daily and exceptional practices, ultimately examining factors of change.[143]

With relation to contemporary works on subject theory,[144] we specifically focus on the respective subject's integration into the prevalent — political, juridical, and ethical — regulative frameworks and adaptive or subversive behaviour.[145] Following Butler and others, we understand subjects as being called into a certain position and gaining identity through acts of identification. Attempts of identification are taking place throughout a subject's life from the first appellation of gender and (first) name until, and even beyond, one's death. Constantly repeated and overridden, a subject's identity is never completed nor entirely determined by attempts of identification. Agreeing with this argument, we assume a dual nature of the subject as both being subjected to identification and capable of undergoing, rejecting, and subverting subject positions provided in practices.

Schatzki stresses that practices — "a temporally evolving, open-ended set of doings and sayings linked by practical understandings, rules, teleo-affective structure, and general understandings"[146] — form the basic structure of the social through which aspects such as knowledge — both formal and explicit, or tacit — aims, ends, and intentions blend into actions. Such practices, being the second focus, can involve regulatory as well as subversive acts and attempts, both not being fixed entities or in relation to each other but rather temporal and thus open to change, for instance regarding their categorization, the respective ways of execution, and the related motives. However, from a geographic point of view, the role of space and spatiality for practices is underdeveloped in this approach — although Schatzki repeatedly underlines the necessity to include the site of practices into its analysis.[147] Here, a differentiated perspective is needed to address the role of space as an instrument in practices and to dissect the different forms of spatiality that inform these practices. Despite its missing approach to a more systematic of spatiality, Schatzki's understanding of practices as "doings and sayings", their modifications, and the role of material arrangements for them is central to the project. It, consequently, includes both processes of signification (e.g., ascription of identity) and the materiality of actions (e.g., bodies, emotions, artefacts, material arrangements, etc.).

A third focus, thus, lies on assemblages. In order to grasp the emergence and temporal stabilization of practices through doings and sayings of subjects, the project builds on an understanding of assemblages as wholes characterized by "relations of exteriority".[148] "Relations of exteriority" addresses the relation itself; an assemblage, thus, is characterized by its components through the way a relation between its components is established. Furthermore, concentrating on relations of exteriority implies that components of one assemblage might be an element of another assemblage too, though playing a different role. The role of an element or component is, therefore, not predetermined. It varies, as DeLanda underlines, from "purely *material*" to a "purely *expressive* role".[149] Though one might call into question if anything that gains meaning (and importance) in the social world can exclusively be located only at one end of this axis (and if it is an axis at all), the statement underlines that assemblages are constituted and gain meaning through acts of assembling. The notion of assemblage grapples with the instability and multiplicity of the ways "things" are arranged by practices. "The relationship", as Collier puts it, "among the elements in an assemblage is not

140 For subject theory, see, e.g., J. Butler, *The Psychic Life of Power. Theories in Subjection*, Stanford: Stanford University Press, 1997; for practice theory, see, e.g., T. Schatzki, *The Site of the Social. A philosophical account of the constitution of social life and change*, University Park: Penn State University, 2002.
141 Schatzki, *The Site of the Social*, p. 72.
142 Appadurai, *Modernity at Large*, p. 7.
143 Ibid., p. 6.
144 See Butler, *The Psychic Life of Power*; E. Laclau, *New Reflections on the Revolution of Our Time*, Brooklyn: Verso, 1990.
145 See *dislocation* in Laclau, *New Reflections*.
146 Schatzki, *The Site of the Social*, p. 87.
147 See J. Everts, M. Lahr-Kurten and M. Watson, "Practices Matters! Geographical Inquiry and Theories of Practice", *Erdkunde* 65 (2011) 4, pp. 323–334.
148 M. DeLanda, *A New Philosophy of Society. Assemblage Theory and Social Complexity*, London: A&C Black, 2006, p. 10, referring to Deleuze.
149 Ibid., p. 12, emphasis in original.

stable; nor is their configuration reducible to a single logic".[150] State borders, which we identify as formative components of medical practices, are not a priori understood as a regulation of practice but are regarded as elements enacted through assemblages. Consequently, meanings of (state) borders depend on how practices make sense of it, such as in terms of regulating flows or making profit. In some respect, practice theory is already a hybrid formation based on action theory as well as on "arrangement theories", including Deleuze and Guattari's notion of assemblage,[151] because it conceptualizes arrangements as constituted and stabilized through action and action as taking place through arrangements.

The concept of assemblage has been applied to biomedicalization in order to grasp the multitude of elements that are related through inventions in the fields of research, diagnosis, therapy, and institutional organization:

> Biomedicalization is characterized by its greater organizational and institutional reach through the meso-level innovations made possible by computer and information sciences in clinical and scientific settings, including computer-based research and record-keeping. The scope of biomedicalization processes is thus much broader, and includes conceptual and clinical expansions through the commodification of health, the development of risk and surveillance, and innovative clinical applications of drugs, diagnostic tests, and treatment procedures. This includes the production of new social forms through "dividing practices", which specify population segments such as risk groups (Rose 1994). These groups are to be given special attention through new "assemblages" (Deleuze and Guattari 1987) of spaces, persons, and techniques for caregiving. Innovations and interventions are not administered only by medical professionals but are also "technologies of the self", forms of self-governance that people apply to themselves (Foucault 1988; Rose 1996).[152]

The concept of assemblage has already been applied to medical practices in the field of organ transplant.[153]

4.2.2 Consequences for addressing spatialization

Subjects, practices, and assemblages are the three major concepts guiding the empirical research in our project. Subjects are understood as the human entities constituting, arranging, and navigating assemblages in practice; their agency utilizes or avoids certain institutions, representations, or norms. Still, as the general goal of the Collaborative Research Centre is to investigate spatialization under conditions of globalization, these concepts have to be (re)framed in the light of a debate on the role of space in human agency. There is a broad range of literature addressing space and spatiality either from a mentalist point of view focusing on subjective perceptions and cognitive processes, or from a structural perspective on societal arrangements. Against this dichotomy, and in line with the aforementioned theoretical standpoints, we argue for an understanding of spatiality as being produced and, thus, an effect of practices.[154] "Spaces", therefore, should be considered as products of *spatializing*, emerging from strategic and tactical practices. Spatializing elements — and sometimes even aims — of practices are, for example, territorializing, bordering, bounding,

150 S.J. Collier, "Global assemblages", *Theory, Culture and Society* 23 (2006) 2–3, pp. 399–401, at 400.
151 Everts, Lahr-Kurten and Watson, "Practices Matters!", p. 325.
152 A. Clarke et al., "Biomedicalization: Technoscientific Transformations of Health, Illness, and U.S. Biomedicine", *American Sociological Review* 68 (2003) 2, pp. 161–194, at 165; see also A.E. Clarke, "Biomedicalization", in: W. Cockerham, R. Dingwall, and S.R. Quah (eds.), *The Wiley–Blackwell Encyclopedia of Health, Illness, Behavior and Society*. Wiley: Oxford, 2014, pp. 137–142.
153 S.J. Collier and A. Lakoff, "On Regimes of Living", in: A. Ong and S.J. Collier (eds.), *Global Assemblages. Technology, Politics, and Ethics as Anthropological Problems*, Oxford: Blackwell, 2005, pp. 22–39; A. Ong and S.J. Collier, *Global Assemblages. Technology, Politics, and Ethics as Anthropological Problems*, Blackwell: Oxford, 2005; N. Scheper-Hughes, "The Last Commodity: Post–Human Ethics and the Global. Traffic in 'Fresh' Organs", in: A. Ong and S.J. Collier (eds.), *Global Assemblages. Technology, Politics, and Ethics as Anthropological Problems*, Hoboken: Blackwell, 2005, pp. 145–168.
154 See Painter, "Rethinking Territory", pp. 1090–1118.

scaling, connecting, networking, and placing.[155] As such, they are assumed to have structuring effects on actions as well as on subjectification.[156]

We assume that several shapes of spatiality are at work in strategies and tactics within the field of cross-border medical practices, each representing distinct links between knowledge and practice. While some spatial strategies and tactics are clearly visible, it still remains unclear whether and how specific spatial formats — certain heuristics of spatialization — may become apparent as effects of such practices in the course of enquiring and comparing processes of spatialization across different areas. For instance, certain practices of strategic regionalization — such as the proclamation of health regions — may be used in different regions and different time periods, each connected to particular motifs, means, and ends, and each connecting actors, knowledge, and institutions in specific ways. It can be assumed that technoscientific innovations (e.g., exchange of data, pharmacological innovation) may facilitate as well as restrict agency. Going beyond mere logics of scarcity, they are the prerequisites for the subsequent assemblages and also for the definition and enforcement of institutions and procedures deemed legitimate. In contrast, such innovations may have other — more general — prerequisites themselves, such as certain relationships of trust in already established regimes of cooperation. Moreover, technoscientific innovations might frame new modi of spatialization (e.g., techniques enlarging the time-space range of organ transports). Such observable processes can be tackled by adopting the notion of assemblage, which enables the incorporation of such heterogeneous sources of data as motifs, intentions, actors, and materialities as well as their respective perceptions, interpretations, and significance into a non-hierarchical understanding of the social, thereby integrating the subjects' daily practices and their construal by other actors.

4.3 Elaboration of the Role of Spatiality

In geography's sometimes enthusiastic spatial terminology, spatialization is not the most frequently applied term. Some authors employ it in order to indicate the necessity to enrich social theory by pointing to the often overlooked spatialities of the phenomena in question. In this respect, adapting theoretical ideas from the disciplinary outside into a geographical perspective often means to spatialize them. Harvey's seminal work on *Social Justice and the City*, for instance, is but only a consequent (immersion of) spatialization of Marxian political economy. However, more often the term applies to grasp *that and how* fields of action yield, are informed by, and rely on certain kinds of spatiality.[157] Delaney, by way of illustration, argues that — in modern Western societies — law relies on territorialization as a specific form of spatialization:

> It is easy to show how law is constitutive of space or implicated in social spatializations, most obviously through legal territorializations of different kinds at various scales. "Law" draws lines, constructs insides and outsides, assigns legal meanings to lines, and attaches legal consequences to crossing them.[158]

In our project, we understand spatialization as the way(s) practices appropriate space and contribute to the production of spatial formats. This is, needless to say, a very broad definition that comprises, for example, taking medicaments — insofar as taking medicaments is a bodily practice and the body might be understood as scalarly positioned — as well as searching for a kidney beyond state-run systems of allocation.[159] From this perspective, almost every practice is spatialized from the beginning as every practice is accomplished through embodied acts. Spaces, in turn, inform practices and are informed by practices.

155 See, e.g., B. Belina and J. Miggelbrink, "Am Ostrand des ‚wettbewerbsfähigsten Wirtschaftsraums der Welt. (Raum–) Theoretische Überlegungen zur Produktion der EU–Außengrenze als Territorialisierungs– und Skalenstrategie", in: W. Lukowski and M. Wagner (eds.), *Alltag im Grenzland*, Wiesbaden: Springer, 2010, pp. 215–240; B. Belina and J. Miggelbrink, "Raum, Recht und Indigenität — Zu den Kämpfen um Landrechte indigener Völker am Beispiel der Sámi in Finnland", *Peripherie* 126/127 (2012) 32, pp. 190–217.

156 J. Miggelbrink, "Crossing Lines, Crossed by Lines", pp. 137–166.

157 D. Harvey, *Social Justice and the City*, Baltimore: John Hopkins University Press, 1973.

158 D. Delaney, "Legal Geography I: Constitutivities, Complexities, and Contingencies", *Progress in Human Geography* 39 (2014) 1, pp. 96–102.

159 N. Brenner, "The Limits to Scale? Methodological Reflections on Scalar Structuration", *Progress in Human Geography* 25 (2001) 4, pp. 591–614; N. Smith, "Homeless/global: Scaling places", in: J. Bird et al. (eds.), *Mapping the futures: Local Cultures, Global Change (FUTURES: New Perspectives for Cultural Analysis)*, London: Routledge, 1993, pp. 87–119.

The definition also allows diverse dimensions of the spatial that intersect with concrete spatial formations to be analysed. Regions, for instance, have been described as complex socio-spatial formations that are institutionalized through a number of processes such as identification.[160] "Regions and communities", as Paasi assumes in one of his early publications, "are spatially constituted social structures and centres of collective consciousness and socio-spatial identities".[161] In the same article, he also states that "a region cannot be reduced to [...] one regional level or unit without taking into account wider socio-spatial connections".[162] "Wider socio-spatial connections" implies that a region — though a produced space in itself — depends on *various* spatializing practices, such as scaling, connecting, etc.

These are only a few hints supporting the idea that complex socio-spatial formations should be (and could be) analytically traced back to underlying spatializing practices. One of the above-mentioned authors of *Theorizing Sociospatial Relations*, Jessop defines them as territories, places, scales, and networks that are forming zones of relative stability.[163] Following this perspective, regions can be analytically explored as being formed through a number of spatializing practices, such as through scalar practices putting them into a sub- or supraposition to the nation state. Although regions often lack a clear definition in terms of a "regional territory", bordering and bounding might play a role in terms of who and what belongs to it. Bordering has been identified as one of the most influential practices of spatialization. Bearing this in mind, Rob Shields highlights not only the significance it has been attached to but underlines the fundamental role of drawing boundaries in enactments of the social:

> In modernist spatializations, borders are thus part of a set of metaphoric and metonymic boundary structure. This allows extended literary conceits to work back and forth in culture. Thus, inside and near have been to outside and distant as inclusion is to exclusion. The entanglement of the spatial forms of inside-outside and near-far with the absolute binary of presence and absence (existing and non-existing) is akin to the mixing of notions of boundary with a border. This spatialization makes boundaries into limit conditions which are ideal for founding fixed categorical identities and thereby stabilizing the dynamism between the different ontological registers of border and boundaries in an equilibrium.[164]

As a (minor) conceptual term, spatialization is also present in critical geopolitical thinking, indicating that and how space, identity, and politics intermesh with political practices ranging from elitist to banal (geo)political thinking:

> Critical geopolitics is particularly interested in analyzing the interdigitation of all these practices, in examining how certain conceptual spatializations of identity, nationhood and danger manifest themselves across the landscapes of states and how certain political, social and physical geographies in turn enframe and incite certain conceptual, moral and/or aesthetic understandings of self and other, security and danger, proximity and distance, indifference and responsibility.[165]

Spatialization is the way(s) practices make use of space: However broad this understanding might be, the definition allows the *instrumental* as well as the *produced* character of space to be examined.[166] Elaborating processes of spatialization, along these lines, means to explore contested attempts and acts of structuration by following certain principles such as (but not limited to) territorialization, place-making, scaling, and

160 A. Paasi, "Regional Planning and the Mobilization of 'Regional Identity': From Bounded Spaces to Relational Complexity", *Regional Studies* 47 (2013) 8, pp. 1206–1219; A. Paasi, "Regions Are Social Constructs, But 'Who' or 'What' Constructs Them? Agency in Question", *Environment and Planning A* 42 (2010) 10, pp. 2296–2301; A. Paasi, "The institutionalization of regions. A theoretical framework for understanding the emergence of regions and the constitution of regional identity", *Fennia* 164 (1986) 1, pp. 105–146.

161 A. Paasi, "Deconstructing Regions: Notes on Scales of Spatial Life", *Environment and Planning A* 23 (1991) 2, pp. 239–256, at 241.

162 Ibid., p. 243.

163 B. Jessop, "Kulturelle politische Ökonomien, räumliche Vorstellungswelten und regionale ökonomsiche Dynamiken", in: O. Brand, S. Dörhöfer and P. Eser (eds.), *Die konflikthafte Konstitution der Region, Kultur, Politik, Ökonomie*, Münster: Westfälisches Dampfboot, 2013, pp. 42–73, at 48.

164 R. Shields, "Boundary–Thinking in Theories of the Present: The Virtuality of Reflexive Modernization", *European Journal of Social Theory* 9 (2006) 2, pp. 223–237, at 231.

165 G. Ó Tuathail and S. Dalby, "Introduction: Rethinking Geopolitics: Towards a Critical Geopolitics", in: G. Ó Tuathail and S. Dalby (eds.), *Rethinking Geopolitics*, Routledge: London, 2002/1998, pp. 1–15, at 4.

166 Belina, *Raum*, 2013.

networking.[167] Although actually acknowledging that the relation between intention and spatialization is not imperative, we intend to limit our interpretative view to strategic and tactical operationalizations and usages of spatial categories (such as territory, place, scale, and network[168]) in the field of cross-border assemblages of medical practices. Such a perspective emphasises agency and intention.[169] But in Jessop et al., these accentuations are said to be left under-conceptualized, ultimately inspiring Paasi's call for accounts that are equipped to develop "perpetually useful" approaches "for analyzing the dynamism of the social world".[170] By building our notion of socio-spatial principles on the basis of empirically enquireable entities such as the subject's practices and orientations, we are provided with a rich amount of data ready for being scanned for guiding logics of structuration, ultimately resulting in interpretative conclusions on prevalent attempts, acts and — if deemed successful — contentious processes of spatialization.

Accordingly, Jessop, Brenner, and Jones deploy four heuristic dimensions — territory, place, scale, and network (TPSN) — that are not deduced from a philosophical perspective but are inductively extracted from studies on "historically specific social relations" and explore "contextual and historical variation in the structural coupling, strategic coordination, and forms of interconnection among the different dimensions of the latter".[171] The authors of TPSN are rooted in regulation-theoretical and state-theoretical approaches from which they draw their main inspiration. This is reflected in the way they emphasise the role of state formation and capitalist production, articulated in a so-called strategic relational approach. Consequently, the scheme privileges TPSN ensembles emerging from "new geographies of accumulation, state power, and hegemony".[172]

This approach gives rise to some fundamental questions: First, although the authors anchor their concept in the strategic relational approach, it remains rather unclear where the categories come from. Shapiro quite rightly asks for "the social imaginary within which the approach is relevant".[173] The categories at stake in TPSN seem to be mainly justified by their frequent articulation in (certain) social sciences' debates in general and in geographical studies in particular. This, however, does not automatically coalesce into a coherent and enumerative system. Instead, it implies a rather static system, suggesting that all concrete spatializations result from combinations of the dimensions identified by Jessop et al. Indeed, Paasi feelings reminds one of a Rubik's cube.[174] The TPSN approach does not reflect its contextuality or its (inevitable) limitations sufficiently and, in this way, tends to mask its Anglo-American origin — despite its self-positioning within the field of political economy.[175] As a consequence, it might be taken as an analytical machinery rather than an interpretative tool addressing socio-spatial realities.

Therefore, a major critique arises from the question which "way of knowing" is elucidated by TPSN categories and if these categories — given their rootedness within specific formations of discourse and practices (or dispositives) — do have the capacity to work as meta-categories in our analysis of spatialities of social life.[176] Put the other way around: Any attempt to understand the role of space within those epistemologies that organize knowledge, behaviour, feelings — in short, at work in assembling practices and subjectivities — has to reflect its own preconditions. Being a product of modern societies, social sciences are saturated with them, sharing and reproducing (as well as contributing to) societies' principle certainties and knowledge. In a Foucauldian understanding, they, furthermore, "re-act" to the problems of governing social relations.[177] Being so intertwined with modern thinking, the limits of thinking in TPSN categories have to be reflected carefully. Spatial idioms — be them concrete or abstract — are inevitably contextual as they are transferred from one context to the other. Shapiro, accordingly, warns of falling into the trap of a hegemonic obsession with particular spatialities because:

167 See Jessop, Brenner and Jones, "Theorizing Sociospatial Relations", pp. 389–401.
168 See Ibid.
169 Paasi, "Is the World More Complex than Our Theories of It?", p. 408.
170 Ibid., p. 409.
171 Jessop, Brenner and Jones, "Theorizing Sociospatial Relations", p. 392.
172 Ibid., p. 395.
173 M.J. Shapiro, "Jessop et al's more is better: a political rejoinder", *Environment and Planning D: Society and Space* 26 (2008) 3, pp. 411–413, at 411.
174 Paasi, "Is the World More Complex than Our Theories of It?", p. 406.
175 Ibid., p. 407.
176 Shapiro, "Jessop et al's more is better", p. 412.
177 See, e.g., J. Chilvers and J. Evans, "Understanding Networks at the Science–Policy Interface", *Geoforum* 40 (2009) 3, pp. 355–362.

> in the contemporary geopolitical world of states, the dominant discourses on space reflect the acts of settlement that imposed the spatial problematics of a colonizing people while dismissing rather than negotiating a bicultural practice of space that would heed the alternative cultural geographies of indigenous peoples.[178]

Although one could object against the assumption of a pre-existing bicultural practice, he rightly reminds us that imposing separate schemes tend to foster an ahistorical and acontextual understanding of spatialization. Territoriality, which is often thought as being inescapably co-evolutionary with the modern nation state,[179] might not work (or not even be informative) as an analytical category for ways of living that are not based on this kind of spatiality but follow *a different logic*.[180]

This has consequences. Firstly, stuck in the TPSN mode of understanding spatiality — and without recognizing the limitations inherent to the approach — one risks of failing to fully understand the epistemologies that are organizing ways of knowing and behaviour. Secondly, applying TSPN in a way that is not sensitive to its genealogy — and, accordingly, insensitive to the socio-spatial realities it aims at understanding — not only compromises negating other epistemologies but also imposes its own epistemology in a subjugating manner. As Shapiro underlines:

> [T]here is an alternative way of treating concepts and theorizing, one that recognizes the radical entanglement between technico-epistemological and political modes of apprehension. Inasmuch as every concept has a history, often the most cogent, that is, problem-specified, enquiries recover the context and thus the dominant problematics that shaped those concepts.[181]

For this reason, applying TPSN as an "objective" heuristic — rather than an "objectified" heuristic — runs the risk of missing the formative epistemologies of concrete spatialities.

The authors of TPSN have already anticipated some of these critiques. They explicitly point to the openness of their scheme and potential contradictions when applied to a certain field:

> Our approach also rejects any premature harmonization of contradictions and conflicts through the postulation of a well-ordered, eternally reproducible configuration of socio-spatial relations. Instead, it emphasizes the importance of contradictions, conflicts, dilemmas, marginalization, exclusion, and volatility, at once within and among each of these socio-spatial forms.[182]

Being aware of contradiction, marginalization, etc. when addressing a certain field of practices by the scheme, however, is not exactly the same as the blind spot resulting from the logic of the dispositive it emerges from. Therefore, concerning the project, we have to keep a number of potential shortcomings and specifities in mind:

1. Reflecting upon epistemological background and shortcomings: Socio-spatial relations appearing in the empirical material might not be fully covered by a scheme extrapolated from the strategic-relational approach that is biased according to its interest in "the historical geographies of capitalist development".[183] Thus, the TPSN model clearly associates scale — for example — with political power, (inter) governmental regimes, and actors of statecraft. Nevertheless, there have likewise been attempts to expand the notion of scale towards "the community", "the home" and "the body" regarding them as sites of political struggle.[184] In order to be consistent in terms of our methodological approach, the TPSN scheme stimulates a structured analysis but does not cover its potential outcomes.

178 Shapiro, "Jessop et al's more is better", p. 413.
179 S. Elden, "Land, Terrain, Territory", *Progress in Human Geography* 34 (2010) 6, pp. 799–817.
180 For a discussion of the spatialities in conflicts between state authorities and indigineous representatives, see, e.g., N. Mazzullo, "The Nellim Forest Conflict in Finnish Lapland: Between State Forest Mapping and Local Forest Living", in: J. Miggelbrink et al. (eds.), *Nomadic and Indigenous Spaces. Productions and Cognitions*, Farnham: Ashgate, 2014, pp. 91–112.
181 Shapiro, "Jessop et al's more is better", pp. 412f.
182 Jessop, Brenner and Jones, "Theorizing Sociospatial Relations", p. 394.
183 Ibid., p. 397.
184 Smith, "Homeless/global: Scaling places", in: J. Bird et al. (eds.), *Mapping the futures: Local Cultures, Global Change (FUTURES: New Perspectives for Cultural Analysis)*, London: Routledge, 1993, pp. 87–119.

2 Identifying methodological problems: As a major specification, we see the necessity to adjust the approach to our qualitative and subject-centred methodology. As sketched out above, our focus is on how people talk about the medical practices they are involved in as patients, professionals, customers, travellers, workforce, parents, etc. This means that we have to develop the question how we can infer certain structuring principles from articulations of interviewees. Any interpretation intending to delve into the structuring principles has to take into account the complex relation between articulations within interviews, group discussion, etc. on the one hand and contextual conditions of practices people refer to within their articulations on the other. As a consequence, we need to discuss in how far we will be able to reconstruct spatializations informing practices and not only spatializations articulated in *conversations about* practices.

3 Dealing with ambiguity: Articulations within the material, therefore, have to be identified as spatial articulations; for this, linguistic concepts provide more detailed approaches than the TPSN approach,[185] which does not differentiate between speech acts and "other" forms of action. It is essential to tackle the gap between what is articulated and how an articulation indicates and performs certain kinds of spatiality. A *toponym* naming a "region", for instance, cannot easily and unambiguously be reduced to structuring principles as it works as a polyvalent, blurry (and potentially even empty) signifier that eludes a clear dissection. Moreover, it might also be intentionally used as a polyvalent sign offering connectivity to actors and future communications. If a hospital is named as a site of (certain) practices, it could be a *place* in terms of embedded people and practices, a *territory* in terms of a limited ("bordered") space of regulation, a *node* in one or more network(s), etc. The TPSN approach repeatedly underlines the necessity to acknowledge multidimensionalities like this, but it does not help to decide whether all potential dimensions are present (or meant) within a distinct articulation. In terms of an empirical identification of spatialities, the approach remains relatively vague and requires specifications that have to take into account the practice-related perspectives of subjects.

4 Reflecting the objectified nature of TPSN: The TPSN scheme should neither be considered as an exhaustive list or matrix — as the authors themselves admit — but as non-enumerative collection of structuring principles. But if the list of dimensions is augmented, how can "new" dimensions of spatialization be identified? In a deductive perspective, this could be followed from a once identified epistemology or dispositive (as Shapiro suggests, see above); in an inductive perspective, a "new" category or dimension has to be extracted from empirical material. This is not to repeat that the social is more complex than our theories of it[186] — which is anyway either simply true or beyond our scope and thus "unreachable" — but to underline the instrumental nature of the TPSN scheme. This scheme should not be mistaken as a neutral and objective tool but as an instrument that allows spatializations emerging within the field of political economy to be analysed.

Keeping this critique in mind, the conceptual orientation promoted by Jessop et al. allows for a first rereading of our empirical material in light of "structuring principles" as well as "fields" in which they operate. For example, scale, on the one hand, can be understood as a structuring principle with respect to the way power is hierarchically distributed between actors. The power to regulate organ donation and allocation according to moral and ethical principles as well as the control of illegal practices, for example, is not centralized but divided between states, suprastate European and global formations, as well as public and private actors. It, on that account, includes scalar and non-scalar spatializations. On the other hand, scale is defined through the structuring capacities of territorial, place, and scale relations, for example through networks with entry points that do not follow a scalar order. Depending on their capacities and resources, actors might use strategies of "upscaling" or "downscaling" of a certain problem by framing it as subject to "local" or "global" attempts of governing.[187] Scaling strategies and tactics, as well as placing or territorializing or networking strategies and tactics, can be *assumed* relevant in border-transcending practices. Furthermore, it can be

185 A. Schlottmann, *RaumSprache — Ost–West–Differenzen in der Berichterstattung zur deutschen Einheit. Eine sozialgeographische Theorie*, Stuttgart: Franz Steiner Verlag: Stuttgart, 2005; A. Schlottmann, "Sprache, Staat und Raum", in: B. Belina (ed.), *Staat und Raum*, Wiesbaden: Franz Steiner Verlag, 2013, pp. 59–76.

186 See Paasi, "Is the World More Complex than Our Theories of It?", pp. 405–410.

187 For an upscaling strategy, see Belina and Miggelbrink, "Raum, Recht und Indigenität", pp. 190–217; and N. Mazzullo and J. Miggelbrink, "Winterweide und Holzlieferant. Indigene und andere Interessen im Konflikt über die Nutzung nordfinnischer Wälder", *Geographische Rundschau* 63 (2011) 7–8, pp. 36–43.

assumed that they produce marginalization, exclusion, and new junctions countered by additional acts that again use "space" as an instrument or medium. This, however, requires an empirical reconstruction of spatialization *at work*.

Consequences

To sum up, the aforementioned conceptual elements inform the way the empirical material produced in the two case studies will be elaborated in order to identify relevant spatializations, thereby allowing for spatial formats and spatial orders in the field of border-transcending medical practices to be identified. Conceptually, we refer to assemblages as a concept that is understood as an analytical response to problems revolving around the transformation of society under the global condition. Here, a further discussion is needed with regard to the role of biomedicalization, which is assumed to be a socio-technological process consisting of technoscientific innovations coinciding with economic opportunism that will have far-reaching implications for the field of health care and therapeutical treatment. One of the next steps will be to examine and determine the respective assemblages and their guiding principles. This requires an empirical, bottom-up analysis of individual actions for which practices are the point of entry.[188] Practices — including rules, teleo-affectivities, practical understandings,[189] and related materialities, emotions, and knowledge — through which heterogeneous elements are assembled, accordingly, are at the core of our empirical analysis.

First insights into the fields addressed in our case studies — organ transplantation and cross-border medical treatment — have shown the complexity of spatial forms or spatializations that inform the practices within these fields. In order to identify spatial formats and — in a further step — spatial orders, the project needs to systematically dissect the role of those spatializations. Several debates — especially within geography — allow for spatialization to be identified, but, however, have to be discussed carefully in relation to their epistemological implications. The working paper has started this discussion.

188 See, e.g., M. Bevir and R.A.W. Rhodes, "Interpretation and its Others", *Australian Journal of Political Science* 40 (2005) 2, pp. 169–187, at 171.

189 Schatzki, *The Site of the Social*, p. 87.

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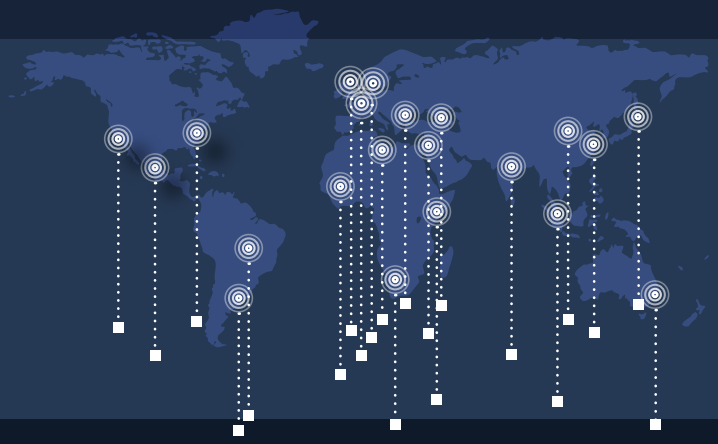

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