

Death brokering: constructing culturally appropriate deaths

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Abstract Death brokering refers to the activities of medical authorities to render individual deaths culturally meaningful. Social scientists and others agree that mortality provokes existential ambiguity in modern life requiring cultural coping mechanisms. In contemporary Western societies, medical professionals have sequestered the dying in institutions, and have classified the causes of death to explain suspicious death. Over the last decades, the institutionalisation of the dying process has been challenged by social movements and the sudden onset of some deaths while forensic medicine has struggled for professional legitimacy in the borderland between mainstream medicine and the legal system. I argue that medical death brokering persists in spite of challenges because medical experts offer increasingly flexible cultural scripts to render the end-of-life socially meaningful while accentuating death's existential ambiguity. Medical professionals help create the ambiguity they promise to resolve, reinforcing the cultural need for more expert death brokering.

Keywords: death, dying, cultural authority, death brokering, hope

Death Brokering

I use death brokering to refer to *the medical activities of authorities to render individual deaths culturally appropriate*. In contemporary late modern Western societies, medical experts establish the 'mortality connection' (Bauman 1992: 9); their therapeutic interventions are aimed at postponing death for as long as biologically and normatively feasible. When death occurs, they help negotiate a culturally acceptable passing, and after death they rationalise the inevitability of its occurrence with a classification of its causes. Similar to people's reliance on insurance brokers to negotiate the arcane and complex issues of insurance, medical experts now broker the existentially frightening and ambiguous

aspects of death and dying. While other authors have emphasised that medical experts stage or orchestrate the dying process within clinical settings (Glaser and Strauss 1965, Prior 1989, Seymour 2001), death brokering specifically highlights medical professionals' cultural authority, *i.e.* the 'probability that particular definitions of reality and judgments of meaning and value will prevail as valid and true' (Starr 1982: 13). Death brokering distinguishes the *acceptable* line between curing or letting go, achieving a '*good*' death and avoiding '*bad*' deaths, attributing *legitimate* responsibility for the death, and determining *relevant* lifestyle and therapeutic changes to keep on living. Death brokering is a professional accomplishment and, as such, is subject to incursions of competitors and critics on professional jurisdiction (Abbott 1988).

Influential philosophers, psychoanalysts, historians and social scientists have argued that mortality forms the ultimate limit in modern societies because it constitutes the defeat of reason (for a review see Bauman 1992). While questioning the inevitability of death, modernity added anguish to it (Freud 1918): security of small victories over some acute, devastating diseases enhanced insecurity in light of the ultimate demise. One much publicised reaction in modern societies to this frontier of reason is *seclusion and professional management*: hide death in institutions, disavowing its existence through spatial and social segregation under supervision of medically-trained experts (Elias 1985, Glaser and Strauss 1965). Second, while mortality itself cannot be avoided, individual *causes of death* can be *determined*, and then manipulated and postponed. Bauman characterises this frantic search for pertinent causes while losing sight of the ultimate futility of the endeavour as the 'analytical deconstruction' of mortality in which 'fighting the causes of dying turns into the meaning of life' (Bauman 1992: 137–140). The result of those twin modern death brokering strategies is simultaneously a professionalisation of the dying process and an 'excessive preoccupation with the risk of death' in daily life (Gorer 1965: 114) leading to a society organised around the distribution of risk (Beck 1992).

If 'societies are arrangements that permit humans to live with weaknesses that would otherwise render life impossible' (Bauman 1992: 17), medical experts thus form a crucial social group for mediating mortal anguish. In late modernity, any mandate of medical experts can no longer be taken for granted but is subject to incursions of competitors (Abbott 1988); requiring flexibility and institutional reflexivity (Giddens 1994) to respond to scepticism and new informational and technoscientific developments. In the broader healthcare field, professionalisation theorists have debated the decline of traditional professional power (Light 1995, McKinlay and Marceau 2002). In this respect, Light (2000) noted 'the revolt of the buyers' eroding professional autonomy. Reed (1996) has argued that professions have partly been displaced by technology-based expert groups.

Over the last decades, both strategies of death brokering in modern societies have been challenged. With regard to dying in hospitals, two social movements

– hospice and right-to-die – have problematised the isolation and professionalisation of contemporary dying, demanding greater control over the dying trajectory (Fox *et al.* 1999, Hillyard and Dombrink 2001, Walter 1994). These movements aimed to de-medicalise the dying process, change the practices of health care professionals, institute alternative forms of dying, and, importantly, give more autonomy to the dying and their relatives. As such, those social movements question the legitimacy and ability of medical death brokers to respond to the needs of the dying. Another challenge to professional death management in institutions has come from the unexpected character of some deaths. Sudden, unexpected deaths threaten the social order because they suggest unexplainable randomness and exemplify the limits of medical acumen.

Forensic death investigations have also been criticised. Autopsies have always been controversial (Richardson 1987), and hospital autopsy rates have drastically declined worldwide, partly because relatives have refused to grant permission (Lundberg 1996). Only in the small but important niche of forensic medicine has the autopsy maintained its role as a source of knowledge. Promising a scientific rationalisation for suspicious, unexpected and violent deaths, forensic specialists have been able to maintain a legal mandate to autopsy under the assumption that the knowledge they generate will benefit the living. Still, forensic experts have to classify profoundly equivocal deaths into contested moral categories. They are faced with questions of the reliability of their findings when allegations are made that they under-report certain categories of suspicious death such as suicide and infant deaths.

The purpose of this article is to locate culturally-specific answers contemporary medical experts offer to the ambiguity of finite living. In light of sustained criticism of medical involvement in death and dying, I am interested in how health professionals maintain the authority to negotiate culturally appropriate deaths. I argue that in clinical and forensic settings, medical professionals implement a variety of cultural scripts of how we should make sense of apparently senseless deaths. Rather than questioning the authority of medical professionals to manage and explain suspicious death, deaths that fail to follow cultural scripts underscore the need for more expert death brokering. Death brokering thus contains a self-fulfilling principle: medical practitioners define problems and offer solutions that never completely address the problems or raise new issues, underscoring the need for further expert involvement in the end-of-life. Medical death brokering rests on the hope that with more professional involvement dying will be improved and deaths have not been in vain.

Dying in the hospital

Although challenged by the right-to-die and hospice social movements, mortality statistics show that medical experts have kept a close hold on

contemporary dying. In the UK, 71 per cent of people die in hospitals, hospices or nursing homes (Field and James 1993). More than 80 per cent of American adults die in healthcare institutions rather than at home, 25 to 35 per cent receive intensive care or other high-tech treatment before their death, 70 to 75 per cent die after a prolonged chronic illness, with the time from diagnosis to death usually exceeding two years (Field and Cassel 1997). Over 75 per cent of adults are hospitalised at some point during the year before they die, and almost 60 per cent see a physician at least five times during the last year of their life (Seeman 1992). People keep dying in the workplaces of healthcare providers, but who determines the terms of the dying process? Dying in institutions has been challenged by the hospice movement, the right-to-die movement, and sudden, unexpected deaths.

In some death trajectories, however, no challenge is possible because people are unaware that death is pending. Even with repeated interactions with medical professionals, some people might not know that they are terminally ill or their care might not be organised around the spectre of impending death. When Glaser and Strauss (1965) conducted their pioneering study of death awareness contexts in the 1960s, they described the structural and cultural factors that limit patient's knowledge about their terminal condition. Patients received euphemisms, embellished diagnoses, or were simply lied to (Sudnow 1967: 89). Even if they figured out fortuitously what was wrong with them, they might not be able to address their condition because everyone involved might still pretend that nothing was wrong; leading to great isolation and loneliness (Elias 1985). While personal experiences indicate that this situation might still exist (Rier 2000), its incidence has greatly diminished (Chambliss 1996: 141–4). Over the last 30 years clinicians have increasingly shared a terminal diagnosis with patients, to the point that 'truth dumping' or 'terminal candor' is now an exemplar of bad physician-patient communication (Jaffe and Jaffe 1976).

Death without dying

Even when health professionals keep the patient in a state of 'closed awareness', the care providers by default broker an ideal death, in this case a death without dying. If the patient dies the staff are not surprised, although they do not explicitly communicate this awareness to the patient and relatives. The advantages for the patient and relatives of this death might be the unexpected abruptness – a death that strikes in a sleep or a quiet slipping away – but the disadvantages include the impossibility to prepare for impending death. While this ideal is the opposite of the death most professionals and lay people identify as the 'good' death, it receives some organisational momentum. As Anspach (1993) has documented, a consensus among healthcare providers is only necessary to withdraw or withhold care; as long as at least one key member of the medical team wants to continue with therapy, the treatment paradigm will prevail. Not telling the 'truth' to patients has been interpreted as a prime instance of misguided medical paternalism (Illich 1974), but

Christakis (1999) offers an alternative explanation in his study of prognostication: many internists subscribe to self-fulfilling prophecies. They do not only believe that giving a bad prognosis might make the patient and care-givers lose all hope and withdraw from treatment, but that, their words might make things happen – ‘to predict death is almost the same as to withdraw life support’ (1999: 144). Rather than being an exception to death brokering, the self-fulfilling prophecy underlying a death without a dying ideal illustrates the tremendous – bordering on magical – powers physicians attribute to managing death.

Once patients are informed about their terminal condition, challenges to medical interventions are possible. The hospice and right-to-die movements have advocated the preserving of autonomy and dignity in life’s final moments. Recent sociological studies have shown, however, that rather than displacing or usurping the healthcare provider’s role at the deathbed, medical staff have incorporated some of the criticism in their clinical practice. Even if patients formulated advance directives, health providers’ understanding of a fair and just death often prevail, particularly when clinicians see an opportunity for successful treatment (Field and Cassel 1997, Teno *et al.* 1997). Relatives seem to have residual impact when care providers have determined that too much uncertainty prevents a clear medical course of action (Anspach 1993, Seymour 2001). Medical staff aim to broker one of the three most common ideals of death depending on where the patient dies, perceived patient characteristics, interactions with relatives and the disease trajectory: *the natural death, the good death and the dignified death*. These deaths react against the default death to be avoided, technocratic dying or a lonely death in hospitals among strangers surrounded by advanced technologies that needlessly stretch the dying process without facing up to the fact that the end-of-life is pending (Moller 2000).

Natural death

While intensive care symbolises modern medicine’s belief in the eradication of ‘untimely’ death, between 15 and 35 per cent of patients die in these units (Rosenthal *et al.* 2002). In intensive care, a natural death does not entail an abrupt removal of all technologies but the staff actively harnesses drugs and technologies to mimic a gradually declining ‘natural’ dying trajectory by a piecemeal withdrawal of therapies (Harvey 1997). Because most patients are comatose in intensive care units (Zussman 1992) and admittance signifies life-threatening conditions, there is little emphasis on the patients’ death acceptance. Still, assent of relatives to withdraw and withhold care is crucial in US intensive care units where relatives have legally supported proxy decision making powers (Anspach 1993) and the actual time and manner of death is often brokered in difficult ethics conferences between clinicians and relatives (Kaufman 2002). The staff’s ‘orchestration’ (Seymour 2001: 128) of the death as an inevitable transitory process with a measured balance of action and non-action involves matching their interventions with the expectations

of relatives, including actively shaping those expectations when relatives are 'unrealistic,' showering them with technical information, presenting ready-made decisions, relieving guilt feelings, and 'psychologising' them when they resist staff (Anspach 1993). Staff also invite relatives to be present at the moment of active dying, quietly say their goodbyes, and keep physical contact (Harvey 1997). In addition, the staff's decisions to withdraw care are measured in such a way that they obliterate the impression that the staff 'killed' the patient but that the death was preordained by the terminal disease, lowering the possibility of litigation (Zussman 1992).

Good death

While hospice care was originally developed as an autonomy-centred alternative to hospital dying, it is now institutionalised around the highly specific 'ideology' (Hart *et al.* 1998) of the 'good' death. The good death involves aggressive symptom management, and attention to the religious, social and psychological needs of the dying and their loved ones to achieve the normative goal of accepting impending death (Kubler-Ross 1969, Saunders 1978). Many social observers have noted that during the past decades the hospice has lost its alternative, holistic edge with institutionalisation (McNamara *et al.* 1994, Siebold 1992) while hospice workers have 'routinized' the good death into 'a socially approved form of dying and death with powerfully prescribed and normalized behaviours and choices' (Hart *et al.* 1998). As with the ideal of the natural death, staff broker this death through active management of both the physical condition of the patient and the actions and expectations of the dying and their relatives. Hospice workers aggressively treat thirst, bed sores, constipation and pain (Seale 1991) – even if the pain management with morphine might depress breathing (the 'double effect') (Twycross 1982) – in order to keep the dying patient comfortable, but draw the line at curative interventions, including prescribing antibiotics for infections. While some critics have charged that pain management has overshadowed the psychodynamic and religious acceptance of death (Bradshaw 1996), relatives and the dying patient still have to 'assent' to the ideology of hospice care aimed at a particular kind of good death. Thus, for example, while hospice workers might take pride in facilitating the smoking habit of a dying patient (Parker-Oliver 1999–2000: 508), relatives are instructed not to call an ambulance in a crisis and possibly negating the cost-savings of hospice care (Leich 2000). Even the sequence of saying goodbyes is optimised in hospice care. When the stage of active dying or 'death watch' (Glaser and Strauss 1968) occurs, the hospice worker takes the relatives in to say their goodbyes, and leaves the dying person with a close 'confidant' (Hamilton and Reid 1990). With such tight management of expectations and dying trajectories, patients might request to die but hospice care workers, largely for religious reasons, oppose hastening death (Logue 1994). Instead, hospice workers offer comfort care as the alternative to assisted suicide (Mesler and Miller 2000). Yet some patients might not respond to such care (Lawton 1998, Munley 1983). Currently, about

four per cent of UK deaths and 10 per cent of US deaths occur in settings following hospice principles (Field and James 1993, Field and Cassel 1997).

Dignified death

Legal physician-assisted suicide is likely to be the most orchestrated and scripted death involving medical practitioners and patients. Here, death is viewed as a relief from suffering and maintaining personal autonomy in end-of-life decision making. Since Kevorkian and other right-to-die proponents, the ideal of this death is a dignified death, where dignity refers to preserving a socially acceptable integration of self and body. In Oregon, physician-assisted suicide is closely regulated (Hillyard and Dombrink 2001): an adult Oregonian diagnosed with a terminal condition can voluntarily make a written request in the presence of two witnesses for medication to end their life. The physician functions as the gatekeeper to make sure that the patient is indeed terminally ill, capable, and made the request voluntarily. The physician refers the patient to a consulting physician to examine the patient and will counsel the patient to notify their relatives. After a waiting period of at least 48 hours but not longer than 15 days the patient needs to make a second oral request for medication in order for the prescription to be written. Between 1998 and 2001, physicians wrote 140 prescriptions and 70 Oregonians died this way (Hedberg 2001). No studies have evaluated the actual process of managing these deaths. The anonymous accounts of active euthanasia show physicians and nurses acting from a motive to reduce suffering (Chambliss 1996: 174).

Resuscitated death

The social order of contemporary dying might seem most threatened by a death that is sudden and unexpected for relatives and for healthcare providers (Sudnow 1967: 72), but even those deaths are now closely managed by clinicians. In hospices sudden death generates feelings of unfinished work (James and Field 1992) and in intensive care these deaths harbour suspicions that something important was missed (Seymour 2001) and might thus derail the aim of a natural or a good death. Sudden deaths used to be prime candidates for autopsies to figure out the cause of the demise, offering a scientific rationalisation for sudden death (Sudnow 1967). In light of the decline in autopsy rates, healthcare providers engage in post-factum diagnosing to explain the turn for the worse but, considering the continuous medical surveillance, such explanations remain dissatisfying (Zussman 1992). Instead, the specific meaning of sudden unexpected deaths is now offered by resuscitation techniques, turning a sudden death into a stretched standardised dying process, leading to the paradoxical situation of the resuscitated death. In light of the remarkably low survival rates of resuscitative efforts inside and outside hospitals, several social observers have noted that resuscitation procedures soften the abruptness of sudden death (Tercier 2002, Timmermans 1999). With relatives waiting in separate counselling rooms, physicians 'stage' information, gradually informing relatives about the worsening situation, occasionally even stretching

the reviving effort to facilitate informing relatives or running 'slow codes' to give the impression that life-saving efforts took place even if the staff did not believe in them (Chambliss 1996, Muller 1982). In some hospitals, relatives are invited to attend the tail end of the reviving effort and say their goodbyes (Timmermans 1999, Tsai 2002). The emphasis on restoring ventilation and circulation during resuscitative efforts frames the sudden death as a cardiac failure, offering a ready made 'cause' of death. Because resuscitative efforts ultimately aim to save lives, the ideal of the resuscitated death reassures relatives and clinicians that the death was painless, unpreventable and quick, with everything medically possible done. Particularly for elderly patients dying outside the hospital, clinicians and relatives often prefer such passing over any of the lingering trajectories (Myerhoff 1978, Timmermans 1999).

Rebuffing the challenges to medicalised hospital deaths

The right-to-die and hospice movements have not been able to undermine the cultural authority of healthcare providers to broker deaths. The challenges of alternative dying movements have been absorbed in medical practice and its more radical edges smoothed out. Rather than a drop in cultural authority, the last decades have seen a proliferation of ideal deaths tailored to specific dying situations. Instead of threatening medical professionals, hospice care, sudden death, and even assisted suicide are now firmly under medical control. Contemporary institutional death brokering involves an active management of the physiological aspects of dying with medical technologies in order to preserve life, to allow dying to occur uninterruptedly, or to hasten death but without being held accountable for the actual death. Most studies have reiterated that medical personnel do not simply take their clues from relatives but manage the expectations of relatives and patients in an attempt to align them with a medically acceptable notion of dying, even if this involves not informing relatives to avoid giving up 'hope.' Dying ideals depend on the anticipation of the death, the length of dying, the disease process, available resources and, to a limited extent, on the activism of relatives. The contemporary normative ideals fuelling the actions of medical experts are aimed at rendering dying meaningful for an intimate social network of relatives and care providers without disturbing institutional routines.

Emotional gratification more than the actual use of interventions forms the currency of contemporary death brokering (Seymour 2001). Social scientists have detailed how the staff often fail to obtain an ideal death. Barriers include opposing opinions among clinicians (Anspach 1993), diagnostic and prognostic uncertainty and ambivalence (Christakis 1999), patients refusing to die, wanting to die, or dying too quickly, relatives abandoning the dying or refusing to let go, divided families or relatives intending to speed up dying (Seymour 2001), staff shortages, staff apathy, diverse staff cultures (Zussman 1992) budget cuts, failing technologies (Timmermans 1999), medical errors (Bosk 1979), apparently divine interventions (Christakis 1999), lack of resources (Field and James 1993), and other unforeseen contingencies. The deaths that

clearly deviate from the ideals might provoke anger, embarrassment, expense, suspicions of medical error and iatrogenics, and possible litigation if the relatives feel wronged. If relatives disengage, the staff might get away with an approximation of acceptable deaths (Lawton 1998).

Paradoxically, failure to obtain the ideals reinforces the need for specialised guidance. The extensive literature on medical errors shows that medical experts are rarely blamed for 'bad' deaths (Bosk 1979, Kohn *et al.* 2000). Occasionally, individuals are held personally accountable, yet 'the condemnation of the individual practitioner only reinforces the authority of the art' (Bauman 1992: 139). Medical interventions offer hope at the end-of-life, but also foster clinical uncertainty, existential questions and social anxiety. These residual dissatisfactions underscore the need for further professional guidance. The result is a self-reinforcing circular process that firmly consolidates the cultural power of medical experts to mediate death. Medical experts now define what is problematic in death and dying, offer solutions and hope, implement alternative ways of dying when solutions are insufficient, in turn installing new forms of hope that dying will improve.

Forensic death investigation

In late modernity, the truly unsettling deaths are suspicious, unwitnessed, unexpected (making resuscitative efforts moot) and violent passings. About 20 per cent of people die in 'suspicious' circumstances, meaning out of place and time (Bonnie 2003). By definition, these deaths cannot be managed by medical personnel while they are occurring and they become subject to the second modern strategy of coping with death: determining its biomedical cause through a forensic investigation.

In Anglo-Saxon countries the death investigation is legally delegated to an expert working on the intersection of medicine and law. In Britain, Australia, and Canada, most forensic investigations are performed by coroners, who are independent judicial officers and can call public inquests, and who rely on qualified practitioners for medical expertise. In Scotland, death investigation falls under the jurisdiction of the Procurator Fiscal working with attending physicians, police surgeons and forensic pathologists (Bloor 1991, Davison *et al.* 1998). In the US death investigations might be conducted by an elected or appointed coroner who consults forensic pathologists, or by a medical examiner who is usually a certified forensic pathologist. Each institutional set-up offers specific advantages and challenges for forensic death investigators rendering generalisations difficult (Davison *et al.* 1998, Hanzlick and Combs 1998, Pescosolido and Mendelsohn 1986), but death investigation of equivocal deaths usually relies on a medically-trained and certified expert – often a pathologist – to determine the cause of death. The various professionals have legal jurisdiction over well-defined categories of deaths. For example, section 8 of the UK *Coroners Act* 1988 provides that when a person has died

'a violent or an unnatural death', 'a sudden death of which the cause is unknown', or 'in prison', then the coroner shall 'as soon as practicable hold an inquest into the death of the deceased'. Section 20 further specifies that the coroner may request 'any legally qualified medical practitioner to make a postmortem investigation' (Smith 2003: 151–3). When those criteria are met, there is no alternative to the legally-mandated death investigation (although the death investigator can still decline the case or conduct a limited postmortem investigation to accommodate requests from relatives (Bloor 1994)), as organ and tissue procurement organisations looking to retrieve spare parts from child abuse victims found out (Timmermans 2002). When foul play is suspected, however, the death investigation trumps religious customs about body burial.

Protected by legal mandates, medical death investigators have achieved a rare instance of 'full jurisdiction' (Abbott 1988). Full legal jurisdiction, however, does not guarantee cultural authority, it only assures a continued workload. Similar to other medical experts, death investigators' cultural authority depends on how their decisions shape public consciousness and resonate as valid, fair and just in the public realm (Prior and Bloor 1993). For example, following the discovery of more than 215 murders by a primary care physician, the third report of the Parliamentary Shipman Inquiry in 2002–2003, under High Court Judge Dame Janet Smith, critically reviewed the functions and operating procedures of the coroner system in Britain and recommended changes that would limit the power of medical professionals (Smith 2003).

Medical investigators' death brokering consists of classifying deaths into morally-wrought manner of death categories including suicide, homicide, accident and natural death (but this is not a universal requirement, see Prior 1989). Similar to their clinical colleagues, the primary audience of death brokering consists of the relatives and friends of the deceased but unlike clinicians the determination of death investigators also contain invaluable public health and law enforcement information. Those audiences have different stakes in the death investigation: relatives are presumed to be primarily motivated by the moral memorisation implied in the death category, while public health officials and law enforcement officers care about the reliability of findings. Take, for example, suicide; relatives and friends often contest their loved one's death classification as a suicide while public health officials demand accurate mortality statistics. In fact, there is a large sociological literature suspecting death investigators of under reporting suicide because of pressure from relatives (Atkinson 1978, Douglas 1967, Pescosolido and Mendelsohn 1986, Speechley and Stavraký 1991). Similar to hospital dying, cultural authority is further complicated by profound epistemological uncertainties in the death categories. The US Center for Disease Control and Prevention circulates 'Operational Criteria for Determination of Suicide', specifically geared to medical examiners and coroners (Rosenberg *et al.* 1988). In order to classify a death as a suicide in the US, the death investigator needs to establish that the death is both *self-inflicted* and *intentional* (see Atkinson 1978 for an analysis of suicide in the UK). The first criterion is

ascertained from autopsy findings, witness reports, toxicology and scene information. Yet even if one knows what to look for, bodies rarely reveal conclusively whether injuries have been caused by the self or another. The second criterion poses even more problems. Intentionality can be established explicitly from verbal or nonverbal expressions of a wish to kill oneself, or it can be inferred from implicit evidence including preparations for death, signs of farewell, expressions of hopelessness or great physical pain, previous suicide attempts, precautions to avoid rescue and serious mental disorder. According to death investigators, the heavy weight put on intentionality renders the criteria inoperable because they require the death investigator to 'second-guess' the deceased's mind set (Goodin and Hanzlick 1997).

How do forensic experts determine the cause of equivocal deaths in the midst of the countervailing forces of relatives, public health officials and criminal justice officials who have a different stake in the outcome of the forensic investigation? Glossing over institutional differences, medicolegal experts generally rely on three sets of values to broker deaths:

1. Scientifically backed-up utilitarian altruism

The guiding principle of a forensic investigation is a specific form of utilitarian altruism: while this life is lost, someone else might benefit from the acquired knowledge. Utilitarian altruism generates solidarity between the private quasi-property rights of relatives to dispose of the body in an undisturbed state and the sovereignty rights of the state to protect its citizens from possible future harm. Forensic experts' explanation of a cause of death promises future preventive value with better trained medical experts and a developing knowledge base. One death investigator articulated his mission, 'I can't give people back their loved ones. I can't restore their happiness or innocence, can't give back their lives the way they were. But I can give them the truth. Then they will be free to grieve for the dead, and then free to start living again. Truth like that can be a humbling and sacred gift for a scientist to give' (Bass and Jefferson 2003: 275). This specific kind of altruism grounded in scientific authority has been used to justify postmortem investigations for centuries in medical pathology and safety research when the corpse became a placeholder for pulsating bodies (Richardson 1987, Roach 2003). It finds its roots in the emergence of the shift toward the pathological-anatomic model in the 18th century (Foucault 1973). Utilitarian altruism gains convincing power from institutionalisation in professional guidelines, scientific procedures, legal statutes and the incorporation of forensic findings in bureaucracies. Scientific expertise aims to counteract the 'cultural rejection' that might occur when conducting postmortem investigations (Joralemon 1995).

2. A measured use of legal incentives to subscribe to forensic goals

While relatives are usually kept at a distance during the actual postmortem (Charmaz 1974), forensic death brokering depends on a working relationship

with the deceased's relatives who have much to gain or to lose from the final determination. The legal mandate of forensic experts requires them to take jurisdiction over the corpse but it does not create an environment conducive to collaboration. The knowledge generated from the death investigation runs into an existential barrier; it will not bring the deceased back. Ultimately, however, the legal power of death investigators forms an incentive for relatives to participate in the expert-client relationship because next to explaining the death, the investigation also constitutes an official validation of the relative's role in the tragedy (Hallam *et al.* 1999). Each classified death implies clear consequences: natural and undetermined deaths do not lead to legal action while homicides and accidents might do (Green 1999). In the sudden death of infants, for example, the adult care taker might be held responsible if abuse is detected or might be exonerated if the death is considered natural. When the carrot of altruism is insufficient, therefore the stick of legal coercion compels acquiescence.

3. Defining the moral standard of equivocal deaths

The gatekeeping role of forensic experts inevitably raises the question whether they over- or under-diagnose certain categories of death such as suicide and child abuse. Allegations of misreporting doubt the cultural authority of death investigators by questioning their scientific expertise. For child abuse, the question of under-reporting has gained urgency in the last decades with widespread reports of violent infant deaths (Best 1990, Dingwall *et al.* 1983, Pfohl 1977), yet, detection depends on the cultural understanding of what constitutes lethal child abuse. Forensic experts help construct the cultural standards of abuse and they do the measuring. They, for example, classify infant deaths without any positive finding in an extensive post-mortem investigation as SIDS (Sudden Infant Death Syndrome) and write down that the manner of death is 'natural', even though they cannot exclude the possibility that the infant was smothered, and admit in textbooks that probably 10 per cent of cases signed out as SIDS are homicides (DiMaio and DiMaio 1989). At the same time, the classifications follow a growing consensus in scientific circles that the many deaths signed out as SIDS are actually instances of accidental smothering by overlying. Recently, due to questions posed by British coroners, the category of accidental overlying has regained prominence in death classifications, rendering such deaths accidental rather than natural. Shifts in forensic classification practices lead thus to attributions of abuse in equivocal deaths. The reclassification of multiple deaths in the same family as homicide rather than SIDS is thus not due to the discovery of new pathological evidence but because of an emerging consensus in forensic circles that it is virtually impossible to have more than two SIDS in the same family (Gawande 2002: 202–8)¹. As Bloor (1991, 1994) noted, forensic death certification constitutes a form of moral ordering without a normatively enforced order.

Forensic experts execute cultural work: they align individual deaths with culturally relevant but epistemologically unclear categories and in the process help shape what those categories are about. The death categories conceptualise experience as well as document it. The words written on the death certificate offer a language to communicate between the state bureaucracy, the legal institution and the realm of medicine. Rosenberg (2002) noted that 'disease entities are social realities, actors in complex and multidimensional negotiations that configure and reconfigure the lives of real men and women' (2002: 250). Similar conclusions can be drawn about death categories: their power does not reside in their abstracting quality but in their ability to acquire social texture and to legitimate actions of others. Along with their clinical colleagues, forensic experts counter the sting of mortality with the salve of hope while simultaneously confirming that death is equivocal and requires an expert explanation. An 'undetermined' cause of death constitutes not the limits of medical knowledge but a professional challenge to prove that even these deaths have not been in vain.

Death brokering in late modern societies

The twin strategies of clinical and forensic death brokering render most deaths in contemporary developed societies culturally manageable and understandable. It is virtually impossible to die or be dead without encountering some medical involvement. Most people die surrounded by medical professionals; even when dying occurs at home, hospice staff or visiting nurses mediate the dying process. The aim of professional clinical dying is to render the dying process meaningful for the dying person and the people in contact with him or her: relatives, friends and medical staff. People dying without healthcare professionals able to account for the passing are caught in the safety net of emergency medicine (if discovered in the midst of the dying process) or forensic medicine (if discovered after undeniable signs of death have set in). The aim of the forensic investigation is to render the death explainable for relatives, public health, consumer safety and criminal purposes. At the same time, forensic classifications elaborate what it means to die naturally, accidentally, through suicide or homicide. Medical experts are contemporary society's primary death brokers; they establish the cultural link between life and death.

Compared to pre-modern societies, many observers have noted the loss of a tight religious and social grip on the dying process (Aries 1977). Instead of a culture based on predetermination, beliefs in a religious after-life and social community, we now expect recovery, potentially life-saving interventions, treatment options for pain and dying in specialised settings. Thanatologists often bemoan the overreach of medicine in death and dying (Moller 2000) because contemporary dying has become existentially more ambiguous (Bauman 1992). With hope came high expectations of how dying should be,

creating a gap between event and reality. Even the hopes invested in forensic experts to determine the true cause and manner of death have often remained unfulfilled. Still, these criticisms, reflecting a deep unease with the domination of medicine in death and dying, have not been able to undermine medicine's cultural authority. In diverse institutional settings, medical experts have remained death brokers.

Medicine's sustained stronghold over death and dying runs counter to the predictions of a decline in traditional, modern professional power. In the realm of death and dying, no 'countervailing powers' (Light 2000) wrestled away control over the administrative organisation of dying, no rationalisation has usurped professional power (Reed 1996), no competitors have absorbed the jurisdiction of the medical profession (Abbott 1988), and neither do we encounter a situation of deprofessionalisation (Haug 1975) or proletarianisation (McKinlay and Marceau 2002). In contrast, forensic medicine has remained unaffected by the larger financial and policy forces shaping the healthcare field in the last decades and palliative care has become a flourishing, recently-established medical subspecialty. Freidson (1994) is the social theorist who holds on to the notion of professional dominance. But even Freidson locates professional dominance in the structural characteristics of the professions.

I suggest that medicine's continued dominance in death and dying is largely cultural: authority rests on the self-fulfilling cultural principle of hope that more professional involvement will improve dying and explain suspicious deaths. Health experts offer collective trust and stability by rendering the end-of-life *socially* meaningful while inevitably accentuating the existential ambiguity that death invokes. Healthcare workers provide relatives with a cultural script of how to behave and what to expect in the dying process. They socialise patients and relatives to die well: with dignity, naturally, quickly without realisation or slowly with time to say good-byes, or while everything medically has been done to keep patients viable but not so much that suffering ensued. They tailor their interventions and technical expertise at the end-of-life to the expectations of relatives, confirming the kin and friends network as the relevant social unit. Critics have focused on the suffering generated by high-tech dying (Moller 2000), overlooking the hope and solace that is part of the same interventions. Forensic pathologists promise an answer to suspicious and unexpected dying by mobilising values of altruism and justice. They validate the importance of the dead person for the broader community. Again, observers have criticised the 'pathologisation' of death (Herringer 1997, Prior 1989), but this same pathology allows knowledge about death to emerge and reduce the unresolved uncertainty of these deaths.

The values enacted by medical personnel are not shared by everyone, and healthcare providers often fail to obtain the desired outcome, amplifying the existential ambiguity of death and dying that health workers promise to reduce through interventions. Healthcare providers now have great leeway in the ideal deaths they broker: some deaths are ideally quick, others should unfold slowly, some ideals prefer consciousness at the end while others aim

for a death in a sleeplike state, some depend on aggressive interventions at the end-of-life, others avoid these same interventions by all means possible. Even with this wide spectrum, some hospital deaths will remain 'bad' in spite of all efforts because relatives, staff, or dying bodies refuse to co-operate with the cultural script. In forensics, some violent deaths will remain equivocal after a postmortem investigation. Rather than questioning the expertise and authority of healthcare providers, deviant deaths emphasise the need of more and better terminal care and for more and better death investigation. Medicine's continued professional jurisdiction in death and dying rests on the hope that dying can be improved and that deaths did not needlessly occur. Each improvement, however, creates new ambiguities leading to a self-fulfilling cycle. Death brokering emphasises that medicine's involvement in death and dying does not depend on technological, clinical or scientific expertise but on the ability to use this expertise dynamically to define cultural needs.

The cultural legacy of death brokering is further authenticated in daily clinical interventions based on knowledge generated from death and dying. The work of physicians at the death bed and forensic pathologists in the morgue offers the basic ammunition in the battle to reduce mortality of individual causes of death. Death is made useful for the living. The knowledge generated from death feeds back into everyday life through public health measures and health preserving guidelines. SIDS determinations lead to 'back to sleep' campaigns, and forensic experts are further involved in suicide prevention, homicide profiles and accident reviews. Palliative care in hospices produces a specialisation in pain management, while dying in intensive care units might generate organs for transplantation, and some dying in research hospitals creates knowledge for drug development. Seemingly useless deaths become useful when aggregated in mortality statistics to form the elementary building blocks for a large public health and biomedical industry of research, risk prevention, lifestyle changes, surgical treatment, and drug regimes (Clarke *et al.* 2003, Lupton 1999). Even here, however, the self-fulfilling principle operates. Observers have noted the paradoxical effect that the late-modern fight against death requires an obsession with death in every aspect of life (Bauman 1992). While it is unclear whether mortality is explicitly addressed in routine everyday and medical interactions (*e.g.* see the ideal of death without dying), the implicit goal of avoiding death secures the cultural rationale for expert death brokering at the end-of-life because death can only be delayed, and even delaying requires close medical monitoring. The postponement of death again carries its own existential ambiguity and anguish because it is expressed in risk factors that offer probabilities but no guaranteed results.

The twin strategies of contemporary death brokering in late-modern societies are thus hermeneutically reinforced by inevitably futile death avoidance during life, unintended effects of medical treatment in clinical settings, and both the successes and failures of clinical end-of-life care and forensic investigations. Medical personnel offer cultural scripts of when, how, with whom,

and where to die, and why death occurred; these affirm the purpose of contemporary dying. They render death simultaneously socially meaningful and existentially ambiguous – confirming a need for further expert guidance. Death brokering can then be viewed as a paradigmatic rationale for expert intervention in healthcare: it forms the final focus and – indirectly – the foundation of medical interventions.

Conceptualising death and dying as cultural brokering opens up possibilities for further sociological research. A still unresolved challenge is to anticipate and explain change. Over the past 40 years the institutionalisation of death has been criticised but the final result seems a further entrenchment of medical authority in spite of differences in healthcare systems. There is more variation in dying but not a loss of medical power. The many deaths that stray from the cultural ideals reinforce rather than undermine medical hegemony. So, how is radical change possible in such a configuration? A second and maybe related topic of inquiry constitutes the financial benefits of death brokering. Cultural brokering by definition implies that the main issue is in the cultural scripts of appropriate dying and death rather than any financial payoff. To my knowledge, however, the financial benefits of terminal and forensic care have rarely been studied but they have been well documented in the funeral industry (Mitford 2000). Does anyone benefit financially from managing the dying and dead? Although most assume that there is little money to be made in death management, this is still largely an unexplored question.

Thirdly, cultural death brokering challenges social scientists to address what healthcare providers actually obtain with their interventions. All too often, social scientists focus on the micro- and macro-structural aspects of care-giving without addressing what additional values, if any, medicine achieves: the ultimate purposes of interventions, their implicit and explicit endpoints, are glossed over. Terminal and forensic care abandon curative ideals to install hope for those left behind. What are the many kinds of hope in death and dying, how are they accomplished, and what part do such multiple endpoints play in other aspects of care-giving? Finally, cultural death brokering moves away from the deathbed or the autopsy stretcher as the primary site of action to ask how others are implicated in creating and sustaining cultural ideals of death and dying. It is insufficient to study the formation of cultural scripts without their diffusion, reception, distortion and the multiple feedback loops that project various responses back to professionals (Hacking 1999, Mol 2002). This latter challenge is particularly important because – as the influential work of Glaser and Strauss, Kubler-Ross and others has shown – social scientists participate in the broader process of death brokering.

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Note

- 1 Although this consensus might again be shifting in the aftermath of the British Angela Cannings case having previously been convicted of the murder of two of her children (now held to have been cot deaths) (Carvel 2004) in which a mother was set free on appeal.

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