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SOCIAL DEATH AS SELF-FULFILLING PROPHECY: David Sudnow's *Passing On* Revisited

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In his classic *Passing On*, David Sudnow described how the presumed social value of patients affects whether the staff will attempt to revive them. Since this study was published, the health care field has undergone dramatic changes and commentators have questioned whether the social rationing described by Sudnow is still relevant. Specifically, critics point to the increased rationalization of medical practice via protocols, a widely accepted resuscitation theory, and legal initiatives to promote resuscitative efforts and protect patient autonomy. Based on observations of 112 resuscitative efforts and interviews with forty-two health care workers, I demonstrate that the recent changes in the health care system did not weaken but instead fostered social inequality in death and dying.

Although death is supposedly the great equalizer, social scientists have abundantly documented the social inequality of death via mortality statistics (see e.g., Feinstein 1993; Kittagawa and Hauser 1973; Waldron 1997). Recently researchers have paid less attention to possible social inequality in the dying process itself. One of the most powerful and detailed sociological formulations to account for social inequality in the process of dying is still David Sudnow's classical study *Passing On* (1967). Sudnow argued that the health care staff decided how to administer their care giving based on *the patient's social value*: patients with perceived low social worth were much less likely to be resuscitated aggressively than patients with a perceived high social value. Since Sudnow's study, the health care field has undergone dramatic change (Conrad 1997; Starr 1982). Especially with the advent and widespread use of resuscitation techniques, biomedical researchers have encapsulated medical knowledge about lifesaving in sophisticated protocols, and legislators have instituted legal protections both to encourage resuscitative efforts and to secure patient's autonomy. The objective of this article is to evaluate the extent to which Sudnow's earlier claims about social inequality are still relevant in a transformed health care context that promotes a rational approach to medical practice and is influenced by extensive legal protections.

The purpose of resuscitative interventions is to reverse an ongoing dying process and preserve human lives. In most resuscitative efforts, however, the final result is a deceased patient (Eisenberg, Horwood, Cummins et al. 1990). When this result is the likely out-

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come of the resuscitative attempt, the staff's task is to avoid prolonged and unnecessary suffering and prepare for the patient's impending death. Saving lives requires an aggressive approach, whereas alleviating suffering demands that the staff intervenes minimally in the dying process and focuses on relieving pain and assisting relatives and friends. An aggressive resuscitative effort for an irreversibly dying (or already biologically dead) patient is not only futile but robs the dying patient of dignity (Callahan 1993; Moller 1996). It becomes a violation of the patient, a caricature of medical acumen (Illich 1976). A low-key resuscitative effort without much conviction for a still viable patient is regarded as passive euthanasia (Siner 1989).

How does the staff—as gatekeepers between life and death (Pelligrino 1986)—decide in the relative short time span of a resuscitative trajectory (Glaser and Strauss 1968) to resuscitate aggressively or to let the patient go with minimal medical interference? In the early 1960s, social scientists demonstrated that those apparently moral questions rest upon deep social foundations (Fox 1976). In death and dying, the fervor of the staff's intervention depends mostly on the patient's perceived social worth (Glaser and Strauss 1964; Sudnow 1967). In one of the first studies of resuscitative efforts in hospitals, Sudnow provided appalling insights into the social rationing¹ of the dying process. He argued that depending on striking social characteristics—such as the patient's age, "moral character," and clinical teaching value—certain groups of people were more likely than others to be treated as "socially dead." According to Sudnow (1967, p. 74), social death is a situation in which "a patient is treated essentially as a corpse, though perhaps still 'clinically' and 'biologically' alive." The most disturbing aspect of Sudnow's analysis was his observation that social death becomes a predictor for biological death during resuscitative attempts. People who were regarded as socially dead by the staff were more likely to die a biological death sooner as well. Under the guise of lifesaving attempts, the staff perpetuated an insidious kind of social inequality.

Zygmunt Bauman has questioned whether Sudnow's observations are still relevant. Bauman (1992, p. 145) postulated that because resuscitative efforts have "lost much of their specularity and have ceased to impress, their discriminating power has all but dissipated."² Biomedical researchers and legislators appear to agree by omitting social rationing from a vast medical, legal, and ethical resuscitation literature.³ The rationalization of medical knowledge was supposed to turn the "art" of medical practice into a "science" (Berg 1997) and eliminate the social problems of a still experimental medical technology. After countless pilot and evaluation studies, national collaborations, and international conferences, medical researchers created uniform and universally employed resuscitation protocols supported by a resuscitation theory (CPR-ECC 1973; 1992). Biomedical researchers have interpreted clinical decision making in terms of formal probabilistic reasoning and algorithms that link clinical data inputs with therapeutic decision outputs (Schwartz and Griffin 1986; Dowie and Elstein 1988). Health care providers reach decisions during lifesaving efforts by simply following the resuscitation protocols until they run into an endpoint. The data taken into consideration consist solely of observable clinical parameters and biomedical test results. In lifesaving, social factors should be irrelevant and filtered out.

In addition, legislators instituted extensive legal protections against any form of discrimination, including social rationing. Legislators made it obligatory for health care providers to initiate cardiopulmonary resuscitation (CPR) in all instances in which it is medically indicated (CPR-ECC 1973). Paramedics and other health care providers have

the legal duty to respond and apply all professional and regional standards of care, that is, they should follow the protocols to the end. Consent is implied for emergency care such as resuscitative efforts. To further legally encourage resuscitative measures, first-aid personnel are immune from prosecution for errors rendered in good faith emergency care under the Samaritan laws.⁴ Failure to continue treatment, however, is referred to as abandonment that “is legally and ethically the most serious act an emergency medical technician can commit” (Heckman 1992, p. 21). Basically, once the emergency medical system is alerted, the health care providers have the legal and ethical duty to continue resuscitating until the protocols are exhausted.

At the same time, ethicists and legislators have tried to boost and protect patient autonomy. The Patient Self-Determination Act of 1991⁵ mandated that patients be given notice of their rights to make medical treatment decisions and of the legal instruments available to give force to decisions made in advance. This attempt at demedicalizing (Conrad 1992) sudden death again is indirectly aimed at diminishing social rationing. When patients have decided that they do not want to be resuscitated, the staff should follow the written directives regardless of the patient’s social value.

Did these scientific and medicolegal initiatives remove the social rationing in sudden death exposed by Sudnow, and Glaser and Strauss? I will show that biomedical protocols and legal initiatives did not weaken but reinforced inequality of death and dying. In the emergency department (ED), health care providers reappropriate biomedical theory and advance directives to justify and refine a moral categorization of patients. Furthermore, although the legal protections indeed result in prolonged resuscitative efforts, this does not necessarily serve the patient. The goal of lifesaving becomes subordinated to other objectives. The result is a more sophisticated, theoretically supported, and legally sanctioned configuration of social discrimination when sudden death strikes. The unwillingness of Western societies to accommodate certain marginalized groups and the medicalization of natural processes neutralize the equalizing potential of the rationalization of resuscitation techniques and legal protections.

METHODOLOGY

This article is based on 112 observations of resuscitative efforts over a fourteen-month period in the EDs of two midwestern hospitals: one was a level-1 and the other a level-2 trauma center.⁶ I focused my observations on medical out-of-hospital resuscitative efforts. This research was approved by the institutional review board of the two hospitals and by the University of Illinois. I was paged with the other resuscitation team members whenever a resuscitative effort was needed in these EDs. I attended half of the resuscitative efforts that occurred in the two EDs during the observation period.

In addition to the observations, I interviewed forty-two health care providers who work in EDs and routinely participate in resuscitative efforts. This group includes physicians, nurses, respiratory therapists, nurse supervisors, emergency room technicians, social workers, and chaplains. These health care providers came from three hospitals: the two hospitals in which I observed resuscitative efforts and one bigger level-1 trauma center and teaching hospital. All responses were voluntary and kept anonymous. The interviews consisted of fifteen open-ended, semistructured questions. The interview guide covered questions about professional choice, memorable resuscitative efforts, the definition of a

“successful” reviving attempt, patient’s family presence, teamwork, coping with death and dying, and advanced cardiac life support protocols.

SOCIAL VIABILITY

The ED staff’s main task is to find a balance of care that fits the patient’s situation (Timmermans and Berg 1997). Based on my observations, whether care providers will aggressively try to save lives still depends on the patient’s position in a moral stratification. Certain patient characteristics add up to a patient’s presumed social viability, and the staff rations their efforts based on the patient’s position in this moral hierarchy (Sudnow 1967; Glaser and Strauss 1964). A significant number of identity aspects that signify a person’s social status and overall social worth in the community (e.g., being a volunteer, good speaker, charismatic leader, or effective parent), are irrelevant or unknown during the resuscitation process. In contrast with Sudnow’s conceptual preference, I opt for social viability to indicate the grounds of rationing because social worth is too broad to indicate the variations in reviving attempts.

During reviving efforts, *age* remains the most outstanding characteristic of a patient’s social viability (Glaser and Strauss 1964; Iserson and Stocking 1993; Kastenbaum and Aisenberg 1972; Sudnow 1967; Roth 1972). The death of young people should be avoided with all means possible. Almost all respondents mentioned this belief explicitly in the interviews. One physician noted, “You are *naturally* more aggressive with younger people. If I had a forty year old who had a massive MI [myocardial infarction], was asystolic for twenty minutes, or something like that, I would be very aggressive with that person. I suppose for the same scenario in a ninety-year-old, I might not be.” A colleague agreed, “When you have a younger patient, you try to give it a little bit more effort. You might want to go another half hour on a younger person because you have such a difficult time to let the person go.” According to a nurse, dying children “go against the scheme of things. Parents are not supposed to bury their children; the children are supposed to bury their parents.” Although respondents hesitated uncomfortably when I asked to give an age cutoff point, the resuscitation of young people triggered an aggressive lifesaving attempt.

A second group of patients for whom the staff was willing to exhaust the resuscitation protocols were patients *recognized* by one or more team members because of their position in the community. During the interview period in one hospital, a well-liked, well-known senior hospital employee was being resuscitated. All the respondents involved made extensive reference to this particular resuscitative effort. When I asked a respiratory therapist how this effort differed from the others, he replied, “I think the routines and procedures were the same, but I think the sense of urgency was a lot greater, the anxiety level was higher. We were more tense. It was very different from, say, a 98-year-old from a nursing home.” A nurse explained how her behavior changed after she recognized the patient,

The most recent one I worked on was one of my college professors. He happened to be one of my favorites and I didn’t even realize it was him until we were into the code and somebody mentioned his name. Then I knew it was him. Then all of the sudden it becomes kind of personal, you seem to be really rooting for the person, while as before you were just doing your job . . . trying to do the best you could, but then it does get personal when you are talking to them and trying to . . . you know . . . whatever you can do to help them through.

When the British Princess Diana died in a car accident, physicians tried external and internal cardiac massage for two hours although her pulmonary vein—which carries half of the blood—was lacerated. Dr. Thomas Amoroso, trauma chief in emergency medicine department at Beth Israel Deaconess Medical Center, reflected, “As with all human endeavors there is emotion involved. You have a young, healthy, vibrant woman with obvious importance to the world at large. You’re going to do everything you possibly can do to try and turn the matter around, but I rather suspect, in their hearts, even as her doctors were doing all their work, they knew it would not be successful” (Tye 1997). The interviewed doctors agreed that “most other patients would have been declared dead at the scene, or after arriving at the emergency department. But with a patient as famous as Diana, trauma specialists understandably want to try extraordinary measures” (Tye 1997).

Staff also responded aggressively to patients with whom they *identified*. A nurse reflected, “incidentally, anytime there is an association of a resuscitation with something that you have a close relationship with—your family, the age range, the situation . . . there is more emotional involvement.” Another nurse explained how a resuscitative effort became more difficult after she had established a relationship with the patient by talking to her and going through the routine patient assessment procedures.

How do these positive categorizations affect the resuscitation process? Basically, when the perceived social viability of the patient is high, the staff will go all out to reverse the dying process. In the average resuscitative effort, four to eight staff members are involved. In the effort to revive a nine-month-old baby, however, I counted twenty three health care providers in the room at one point. Specialists from different hospital services were summoned. One physician discussed the resuscitative effort of a patient she identified with: “I even called the cardiologist. I very seldom do call the cardiologist on the scene, and I called him and asked him, ‘Is there anything else we can do?’” Often the physician will establish a central line in the patient’s neck, and the respiratory therapists will check and recheck the tube to make sure the lungs are indeed inflated. These tasks are part of the protocol, but are not always performed as diligently in resuscitative attempts in which the patient’s social viability is viewed as less.

The physician may even go beyond the protocol guidelines to save the patient. For example, at the time of my observations, the amount of sodium bicarbonate that could be administered was limited, and often the paramedics had already exhausted the quota en route to the hospital. The physician was supposed to order more sodium bicarbonate only after receiving lab test results of the patient’s blood gases. In the frenzy of one resuscitative effort in which the patient was known to the whole staff, a physician boasted to his colleague, “So much for the guidelines. I gave more bicarb even before the blood gases were back.” When the husband of a staff member was being resuscitated, nurses and physicians went out of their way to obtain a bed in intensive care.

How does a resuscitative effort of a highly valued patient end? In contrast with most other reviving attempts, I never saw a physician make a unilateral decision. The physician would go over all the drugs that were given, provide some medical history, mention the time that had elapsed since the patient collapsed, and then turn to the team and ask, “Does anybody have any suggestions?” or “I think we did everything we could. Dr. Martin also agrees—I think we can stop it.”

At the bottom of the assumed moral hierarchy are patients for whom death is considered an appropriate “punishment” or a welcome “friend.” Death is considered a “friend” or even a “blessing” for *seriously ill* and *older patients*. For those patients, the staff agrees

that sudden death is not the worst possible end of life. These patients are the "living dead" (Kastenbaum and Aisenberg 1972). The majority of resuscitation attempts in the ED were performed for elderly patients (Becker, Ostrander, Barrett, and Kondos 1991)—often these patients resided in nursing homes and were confronted with a staff who relied on deeply entrenched ageism. For example, one nurse assumed that older people would want to die. "Maybe this eighty-year-old guy just fell over at home and maybe that is the way he wanted to go. But no, somebody calls an ambulance and brings him to the ER where we work and work and work and get him to the intensive care unit. Where he is poked and prodded for a few days and then they finally decide to let him go." According to a different nurse, older people had nothing more to live for: "When people are in their seventies and eighties, they have lived their lives."

The staff considered death an "appropriate" retaliation for *alcohol-* and *drug-addicted people*. For example, I observed a resuscitative attempt for a patient who had overdosed on heroin. The team went through the resuscitation motions but without much vigor or sympathy. Instead, staff members wore double pairs of gloves, avoided touching the patient, joked about their difficulty inserting an intravenous line, and mentioned how they loathed to bring the bad news to the belligerent "girlfriend" of the patient. Drunks are also much more likely to be nasally intubated rather than administered the safer and less painful tracheal intubation.

These negative definitions affect the course and fervor of the resuscitative effort. For example, patients on the bottom of the social hierarchy were often declared dead in advance. In a typical situation, the physician would tell the team at 7:55 A.M. that the patient would be dead at 8:05 A.M. The physician would then leave to fill out paperwork or talk to the patient's relatives. Exactly at 8:05, the team stopped the effort, the nurse responsible for taking notes wrote down the time of death, and the team dispersed. In two other such resuscitative efforts, the staff called the coroner before the patient was officially pronounced dead.

Even an elderly or seriously ill patient might unexpectedly regain a pulse or start breathing during the lifesaving attempt. This development is often an unsettling discovery and poses a dilemma for the staff: are we going to try to "save" this patient, or will we let the patient die? In most resuscitative efforts of patients with assumed low social viability, these signs were *dismissed or explained away* (Timmermans forthcoming a). In the drug overdose case, an EKG monitor registered an irregular rhythm, but the physician in charge dismissed this observation with, "This machine has an imagination of its own." Along the same lines, staff who noticed signs of life were considered "inexperienced," and I heard one physician admonish a nurse who noticed heart tones that "she shouldn't have listened." Noticeable signs that couldn't be dismissed easily were explained as insignificant "reflexes" that would disappear soon (Glaser and Strauss 1965). In all of these instances, social death not only preceded but also led to the official pronouncement of death.

Some patient characteristics, such as age and presumed medical history, become "master traits" (Hughes 1971) during the resuscitative effort. The impact of other identity signifiers—such as gender, race, religion, sexual orientation, and socioeconomic status—was more difficult to observe (see also Sudnow 1983, p. 280). The longest resuscitative effort I observed was for a person with presumably low social viability because of his socioeconomic status. He was a white homeless man who had fallen into a creek and was hypothermic.⁷ I also noted how the staff made many disturbingly insensitive jokes during the resuscitative effort of a person with a high socioeconomic status: a well-dressed and

wealthy elderly, white woman who collapsed during dinner in one of the fanciest restaurants in the city. During a particularly hectic day, the staff worked very hard and long to save a middle-aged black teacher who collapsed in front of her classroom, whereas two elderly white men who were also brought in in cardiac arrest were quickly pronounced dead.

Epidemiological studies, however, suggest that race, gender, and socioeconomic status play a statistically significant role in overall survival of patients in sudden cardiac arrest. The emergency medical system is much more likely to be alerted when men die at home than when women experience cardiac arrest; this suggests a selection bias in the system (Joslyn 1994). Women also have much lower survival rates than men. In a Minneapolis study, the survival rate one year after cardiac arrest was 3.5 percent for women and 13.1 percent for men (Tillinghast, Doliszny, Kottke, Gomez-Marín, Lilja, and Campion 1991). A similar relationship has been observed for racial differences. Not only was the incidence of cardiac arrest in Chicago during 1988 significantly higher among blacks in every age group than among whites, but the survival rate of blacks after an out-of-hospital cardiac arrest was only a third of that among whites (1 versus 3 percent) (Becker et al. 1993). Daniel Brookoff and his colleagues (1994) showed that black victims of cardiac arrest receive CPR less frequently than white victims. Using tax assessment data, Alfred Hallstrom's research team (1993) demonstrated that people in lower socioeconomic strata are at greater risk for higher mortality. In addition, lower-class people were also less likely to survive an episode of out-of-hospital cardiac arrest: "An increase of \$50,000 in the valuation per unit of the home address increased the patient's chance of survival by 60%" (Hallstrom et al. 1993, p. 247).

Even after twenty-five years of CPR practice, Sudnow's earlier observations still ring true. The social value of the patient affects the fervor with which the staff engages in a resuscitative effort, the length of the reviving attempt, and probably also the outcome. The staff rations their efforts based on a hierarchy of lives they consider worth living and others for which they believe death is the best solution, largely regardless of the patient's clinical viability. Children, young adults, and people who are able to establish some kind of personhood and overcome the anonymity of lifesaving have the best chance for a full, aggressive resuscitative effort. In the other cases, the staff might still "run the code" but "walk it slowly" to the point of uselessness (Muller 1992).

LEGAL PROTECTIONS?

One of the aspects of resuscitation that has changed since Sudnow's ethnography is the drop in the prevalence of DOA or "dead on arrival" cases. Sudnow (1967, p. 100–109) noted that DOA was the most common occurrence in "County" hospital's emergency ward. Ambulance drivers would use a special siren to let the staff know that they were approaching the hospital with a "possible," shorthand for possible DOA. At arrival, the patient was quickly wheeled out of sight to the far end of the hallway. The physician would casually walk into the room, examine the patient, and—in most cases—confirm the patient's death. Finally, a nurse would call the coroner. Twenty-five years later, I observed DOA only when an extraordinarily long transportation time occurred in which all the possible drugs were given and the patient remained unresponsive. For example,

Dr. Hendrickson takes me aside before the patient arrives and says, "Stefan, I just want to tell you that the patient has been down for more than half an hour [before the para-

medics arrived]. They had a long ride. I probably will declare the patient dead on arrival." When the patient arrives, the paramedic reports, "We had asystole for the last ten minutes. We think he was in V-fib for a while but it was en route. It could have been the movement of the ambulance." The physician replies, "I declare this patient dead."

The DOA scenario has now diminished in importance for legal reasons. When somebody calls 911, a resuscitative effort begins and is virtually unstoppable until the patient is viewed in the ED by a physician. After the call, an ambulance with EMTs or paramedics is dispatched. Unless the patient shows obvious signs of death,⁸ the ambulance rescuers start the advanced cardiac treatment as prescribed by their standing orders and protocols. The patient is thus transported to the ED, where the physician with the resuscitation team takes over. Legally, the physician again cannot stop the lifesaving attempt, because the physician needs to make sure that the protocols are exhausted. Stopping sooner would qualify as negligence and be grounds for malpractice. These legal guidelines, more than any magical power inherent to technology, explain the apparent technological imperative and momentum of the resuscitation technology (Koenig 1988; Timmermans 1998).

Patients who in Sudnow's study would be pronounced biologically dead immediately are now much more likely to undergo an extensive resuscitative effort. These patients cluster together in a new group of already presumed low-value patients. They are referred to as *pulseless nonbreathers*, *goners*, or *flat-liners*. Most of these patients are elderly or suffer from serious illnesses. Sudden infant death syndrome babies and some adults might fulfill the clinical criteria for pulseless nonbreathers, but because they are considered valuable and therefore viable, the staff does not include them in this group.

A respiratory therapist described her reaction to these patients, "If it comes over my beeper that there is a pulseless nonbreather, then I know they were at home, I know that they were down a long time . . . I go and do my thing, [but] it's over when they get here." Some respondents added that this group does not leave a lasting impression: "they all blend together as one gray blur."

Instead of prompting health care workers to provide more aggressive care, the legally extended resuscitative effort has created a situation in which the staff feels obligated to go through some useless motions and they spend the time for other purposes. I observed that while they were compressing the patient's chest and artificially ventilating him or her, the staff's conversation would drift off to other topics such as birthday parties, television shows, hunting events, sports, awful patients, staffing conflicts, and easy or difficult shifts. Besides socializing, the staff also practiced medical techniques on the socially but not yet officially dead patient. I did not observe resuscitative efforts in a teaching hospital but still noticed how occasionally paramedics in training would reintubate the patient for practice.⁹

In addition, instead of attempting to save lives with all means possible, the process of accurately following the protocols became a goal in itself. A resuscitative effort could be rewarding for the staff based on the process of following the different resuscitation steps, regardless of the outcome of the resuscitative effort. A physician confessed, "As bad as it sounds, there are many times when I feel satisfied when it was done very well, the entire resuscitative effort was done very well, very efficiently even though the patient didn't make it." In this bureaucratic mode of thinking, following the legal guidelines à la lettre officially absolved the physician of the blame for sudden death. The physician could face the relatives and sincerely tell them that the staff did everything possible within the current medical guidelines to save the life of their loved one.

Finally, the staff used the mandated resuscitation time to take care of the patient's relatives and friends instead of the patient. A physician explicitly admitted that the current resuscitation set-up was far from optimal for the patient or relatives. He saw it as his responsibility to help the family as best he could:

Even when I am with the patient for the sixty or ninety seconds, if that, I almost don't think about the patient. I prepare myself for the emotional resuscitation or the emotional guidance of the family in their grief. The patient was gone before they got there [in the ED]. In a better world, they wouldn't be there because there is nothing natural or sanctimonious about being declared dead in a resuscitation. It is far more natural to be declared dead with your own family in your own home. We have now taken that patient out of their environment, away from their family, brought that family to a very strange place that is very unnatural only to be served the news that their loved one has died.

A nurse also shared the preoccupation with the needs of the family:

My thoughts throughout the entire resuscitative effort, even prior to the arrival, are with the family. Who is going to be with that family? Who is going to support them? And that they are being notified throughout the resuscitative effort what is going on, to prepare them if it is going to be a long haul, or if things are not good and are not going to get better. I think they deserve that. So it is kind of a combined feeling throughout. But I can focus on the one without being bogged down with the emotion of what is going on over there.

The "resuscitation" of the relatives and friends of the patient became more important than the patient's resuscitation attempt. The staff used the resuscitation motions and prescriptions as a platform to achieve other values. They might turn the resuscitative effort into a "good death" ritual in which they prolong the lifesaving attempt to give relatives and friends the option to say goodbye to their dying loved one (Timmermans 1997).

The legal protections guaranteeing universal lifesaving care have not resulted in qualitatively enhanced lifesaving but instead have created a new set of criteria that need to be checked off before a patient can be pronounced dead. In Sudnow's study, social death often preceded and predicted irreversible biological death. The staff of "Cohen" and "County" hospitals did not stretch the lifesaving effort unnecessarily. Once patients of presumed low social value showed obvious signs of biological death, the staff would quickly pronounce them officially deceased. Currently, many patients of presumed low social value in resuscitative efforts are already biologically dead when they are wheeled into the ED. The time it takes to exhaust the resuscitation protocols has created a new temporal interval with *legal death* as the endpoint. Legal requirements form a new instance of what Barney Glaser and Anselm Strauss (1965) originally called the closed awareness and mutual pretense awareness context. The staff is fully aware that the patient was irreversibly dead at arrival in the ED but they go through the motions for legal reasons and to allow the family to come to grips with the suddenness of the situation. If the relatives and friends catch on and know that their loved one is dying, the setup of the reviving attempt encourages them to pretend this is not really happening. This management of sudden death does not reduce any social inequality. The same situational identity features that marginalized certain groups of patients still predict the intensity of lifesaving fervor. As in Glaser

and Strauss's and Sudnow's studies, social death now also has become a self-fulfilling prophecy for legal death.

In the wake of the hospice and patient-right movements, ethicists and legislators have also developed legal means such as advance directives, living wills, durable powers of attorney, and do-not-resuscitate orders to empower people to influence their own deaths. These diverse initiatives culminated in the Patient Self-Determination Act of 1991, that mandated that patients be given notice of their rights to make medical treatment decisions and of the legal instruments available to give force to decisions made in advance. The act is intended to enhance patient autonomy, so that if a patient expressed her or his wish not to be resuscitated, a resuscitative effort should be avoided regardless of how the staff perceives the patient's social value. The actual effect, however, is the opposite.

I observed eight resuscitative efforts in which the patient had signed an advance directive. In only two of those eight situations did the advance directive result in a terminated lifesaving attempt. The main problem with the advance directive was that the health care providers who made the initial decision to resuscitate (paramedics) were not authorized to interpret the documents. A chaplain said, "We tell people who have a living will or have been given power of attorney and wish not to be kept alive, if you have a heart attack at home, don't call 911. Don't call the EMTs because they are automatically obligated to do everything they can." To complicate the situation, physicians often did not find out about the living will until well into the lifesaving attempt (Eisendrath and Jonsen 1983). The inefficiency of the advance directive to stop the resuscitative effort has been confirmed in other studies as well. Medical researchers concluded that "advance directives did not affect the rate of resuscitation being tried" (Teno et al. 1997, p. 505). A retrospective study of 694 resuscitative efforts found that 7 percent of all resuscitative efforts were unwanted, and 2 percent of those patients survived to hospital discharge (Dull, Graves, Larson, and Cummins 1993).

Even when the advance directive was present and known, the extent to which the staff followed the written wishes of the advance directive depended mostly on the assumed social viability of the patient. During resuscitative efforts for patients with presumed high social value, I never observed the staff mention the possibility that the patient might have an advance directive. In an interview, a nurse supervisor prided herself on going against the wishes of a patient and his relatives, even though the patient still thought after regaining consciousness that they should not have revived him. A survey of emergency physicians found that 42 percent did not stop a resuscitative effort when an advance directive instructed them to do so (Iserson and Stocking 1993). Health care providers were only willing to accept a living will when the patient fulfilled their criteria for having one; this meant that the patients were seriously ill or old *and* the staff believed that the patient's quality of life suffered. One nurse explained,

I think if a person has made very clear their wishes beforehand . . . especially in light of a terminal illness, a cancer, or an awful respiratory disease—they know that they don't have long to live and the quality of their life is not very good—then it is very appropriate for these people to make their statements when they have a free mind and are conscious that they don't wish to have resuscitations started.

According to the nurse, the staff should always evaluate whether it is appropriate that a patient had an advance directive.

In contrast, the staff blamed patients with presumed low social value (mostly seriously ill patients) for not signing an advance directive. During a resuscitative attempt, the physician entered the room after talking to relatives and asked the nurse, "Got rid of that pulse yet?" When he saw my surprised expression, he added, "She had all kinds of cancer. They were stupid enough not to ask for a red alert and now we have to go through this nonsense." Normally, an advance directive needed to be verified by the physician in charge, but even when no advance directive could be found in the patient's file, the physician still might stop the reviving effort. In the following observation, the team was not sure whether the patient actually had an advance directive or was going to talk to her physician about it.

The chaplain enters and says, "The neighbor said that she has an aneurysm in her stomach area. She also said that she did not want to be operated. She was going to talk to her doctor tomorrow to discuss this." The physician asks, "Is she a no-code?" "According to the neighbor she is." "Why do we find this out after we have been working on her?" The head nurse takes the patient's file, which the department administrator brought into the room. She looks through it once and looks through it a second time, but she cannot find an advance directive. The physician takes the file, and together they check it again. No advance directive, no official document. The doctor then decides to let the patient go anyway. He considers the patient hopeless unless she wants to have surgery.

Advance directives certainly do not empower the patient. Under the guise of increasing the patient's autonomy, the opposite result—medical paternalism—is obtained (Teaster 1995). Health care providers followed the wishes set forth in the advance directive when these guidelines matched their own assessment of the patient's social value and did not undermine their professional jurisdiction (Abbott 1988).¹⁰

In general, the legal drive to create a resuscitation-friendly environment and the laws to protect patient autonomy have not abolished the social inequality of sudden death. In certain instances, resuscitative efforts are lengthened or shortened, but these changes occur regardless of the legal intentions. The basic problem of administering resuscitative care based on the social viability of the patient remains uncorrected. The staff works around the legal guidelines to enforce their view of lives worth living and good deaths (Timmermans forthcoming b).

RESUSCITATION THEORY

Not only does the staff use legal guidelines to perpetuate existing views of social inequality, but health care providers also reappropriate the accumulated medical knowledge about resuscitations to justify withholding care of *new groups with presumed low social value*. For a technique that is not really proved to be effective with national survival rates, the field of resuscitation medicine has a surprisingly high level of agreement as to what constitutes the best chances for survival.¹¹ From physician to technician to chaplain in the ED, almost all respondents provided a more or less complete reflection of the dominant theory. The basics of resuscitation theory are very simple: the quicker the steps of the "chain of survival" are carried out (Cummins, Ornato, Thies, and Pepe 1991), the better the chances for survival. A weakness in one step will reverberate throughout the entire system and impair optimal survival rates.

The chain of survival is intended as a simple, rational tool for educators, researchers,

and policy makers to evaluate whether a community obtains optimal patient survival. In the ED, however, the same theoretical notions underlying the chain of survival serve as a rationalization for *not* trying to resuscitate particular patient groups. The professional rescuers in the ED are acutely aware of their *location* in the chain of survival's temporal framework. The ED is the last link of the survival chain, and many elements need to have fallen in place before the patient reaches the hands of the team. Anything that deviates from the "ideal" resuscitative pattern and causes more time to elapse is a matter of concern for the staff. One technician estimated how important every step in the resuscitation process is for the final outcome,

One of the most important things would be the time between when the patient actually went down until the first people arrive. That is like, I'd say, 30 percent and then the time that a patient takes to get to the hospital takes another, probably, 30–40 percent. Sixty to 70 percent of it is prehospital time.

A nurse explains the importance of location and timing by contrasting resuscitation of somebody who collapsed inside the ED with somebody who collapsed outside the ED:

A lot has to do with EMS [Emergency Medical System] and family response and getting them there. If you would drop dead right here, your chances would be pretty good that we would be able to resuscitate you without any brain damage or anything else. If you're at home out on a farm, sixty miles away, and you have to call out for help and that takes fifteen minutes for them to get there and nobody in the house knows CPR, I think your chances are pretty slim.

According to the nurse, if the situation had not been optimal in the first steps, the ED staff could not be expected to rectify the situation. The consequence of this acute awareness about their location in the chain of survival is that the emergency medical hospital staff feels only limited control over the outcome of the resuscitative effort. A physician reiterated this: "for a lot of these people, their outcome is written in stone before I see them." A colleague added "there are certainly many, many instances of cardiac arrest where the end result is predestined, where the chance of resuscitation is very slim." Most respondents echoed the nurse supervisor who remarked, "I think there are always factors involved whether a resuscitation is successful or not. But I don't know if there is any personal or even physical control."

Because of this perceived lack of control, health care providers were less willing to aggressively resuscitate patients who deviate from the ideal scenario. Often such a consensus was reached even before the patient arrived in the ED. I observed how the nurse in charge sent a colleague back to the intensive care unit when paramedics radioed that a patient was found with an unknown downtime, saying, "We will not need you. She'll be dead." Sometimes only the name of the patient's town was sufficient for the staff to know that it probably would be "a short exercise." The town would give an indication of the transportation time and the available emergency care. Once a patient with such low perceived survival chances arrived in the ED, the staff would go through the resuscitation motions without much conviction. A technician noted how in many cases he "start[s] to feel defeated already. To the point now, where it is pretty much decided already, we are not going to get anywhere with this."

The staff interprets the official theory of reviving as a justification for only lukewarmly attempting to resuscitate patients who did not fit the ideal lifesaving scenario. This rationing rests not on biological but on social grounds. Underneath the staff's reluctance to revive patients who deviate from the ideal resuscitative scenario lies the fear that the patient would be only partially resuscitated and suffer from brain damage. According to the dominant resuscitation theory (CPR-ECC 1973), irreversible brain damage occurs after less than five minutes of oxygen deprivation. The staff is concerned that if they revive a patient after this critical time period, the patient might be severely neurologically disabled or comatose. When a nurse got a patient's pulse back, she exclaimed, "Oh no, we can't do that to him. He must be braindead by now." A physician stated, "There have been situations where after a prolonged downtime we get a pulse back. My first feeling is, 'My God, what have I done?' It is a horrible feeling because you know that patient will be put in the unit and ultimately their chances of walking out of the hospital without any neurological deficits are almost zero."

A physician described one scenario to be avoided—a resuscitative effort in which an adult survived in a vegetative state:

I remember there was a man who was having just an MRI scan done, and while he was in the machine he had a cardiac arrest for who knows what reason. And they brought him to the ER, and we started to resuscitate him, and as we did, it looked obvious that he probably wasn't going to survive. And we gave him what we call high-dose epinephrine, and with that high dose he actually returned to a normal heart rhythm. Unfortunately, he had an inadequate blood supply to his brain so he ended up having not too much cognitive function . . . I guess I remember that because I thought he was going to die, and I gave him a little more medicine, and he didn't. And I have always wondered whether that was the right thing to do or not.

[Do you think you did the right thing?]

Well, in retrospect I don't think that I did. The man is alive, but his brain is not alive, so he really is not the same person he was before. I think that from the family's point of view, they probably would have had an easier time dealing with the fact that he was dead and sort of would have gone out of their system instead of in the state he is in right now.

Health care providers generally consider this the ultimate "nightmare scenario," an outcome that will haunt them for years to come.¹² The patient survived in a permanent vegetative state, continuously requiring emotional and financial resources of relatives and society in general.

With those "excesses" in mind, several respondents made thinly veiled arguments in favor of passive euthanasia. A nurse stated that she felt that in many cases attempting to resuscitate patients meant "prolonging their suffering." A technician asserted that "with an extensive medical history it is inhumane to try." Another technician reflected, "Sometimes you wonder if it is really for the benefit of the patient." A chaplain even made a case for suicide (or euthanasia, depending on who the "them" are in his sentence): "I feel a bit of relief knowing that if a person couldn't be resuscitated to a productive life, that it is probably just as well to have them have the right to end life." The principle that guides the rescuer's work is that a quick death is preferable over a lingering death with limited cognitive functioning in an intensive care unit. A nurse said this explicitly, "The child survived with

maximum brain injury and has become now, instead of a child that they [the parents] can mourn and put in the ground, a child that they mourn for years."

Although health care providers again hesitated to define a criterion for a quality of life they would find unacceptable, I found implicit in both interviews and observations a view that such lives were not worth living. Drawing from the dominant resuscitation theory, the *prospect* of long-term physical and mental disabilities was reason enough to slow down the lifesaving attempt to the point of uselessness. In an age of disability rights, health care providers reflect and perpetuate the stereotypic assumptions that disability invokes (Fine and Asch 1988; Mairs 1996; Zola 1984). People with disabilities are associated with perpetual dependency and helplessness; they are viewed as victims leading pitiful lives, "damaged creatures who should be put out of their misery" (Mairs 1996, p. 120). Disability symbolizes a lack of control over life, and health care providers fall back on the outcome over which they have the most control. The *possibility* of disability is considered worse than biological death. In a survey of 105 experienced emergency health care providers (doctors, nurses, and EMTs), 82 percent would prefer death for themselves over severe neurological disability (Hauswald and Tanberg 1993).

Along with the dominant resuscitation theory, health care providers support the view that people with disabilities should not be resuscitated. To be fair, the same theory is also invoked as a warning about giving up too soon. Several respondents mentioned that one can never be sure whether a report about downtime and transportation time is accurate. Even if there was a long transportation time, one cannot know for sure when the patient went into cardiac arrest. Exactly because there exists this margin of uncertainty, many respondents considered it worthwhile to at least attempt to resuscitate and follow the protocols. In most observed resuscitative efforts, however, it appeared that the expectations were clearly set and became self-fulfilling prophecies.

SOCIAL RATIONING AND THE MEDICALIZATION OF SUDDEN DEATH

In the conclusion to *Passing On*, David Sudnow discussed the ways in which dying became an institutional routine and a meaningful event for the hospital staff. He emphasized that the staff attempted to maintain an attitude of "appropriate impersonality" toward death and how the organization of the ward and the teaching hospital favored social death preceding biological death. In ethnomethodological fashion, Sudnow (1967, p. 169) underscored how "death" and "dying" emerged out of the interactions and practices of health care providers, "what has been developed is a 'procedural definition of dying,' a definition based upon the activities which that phenomenon can be said to *consist in*."¹³

My update of Sudnow's study indicates that with the widespread use of resuscitation technologies, health care providers now have to make sense of engaging in a practice with the small chance of saving lives and the potential to severely disable patients. They cope with this dilemma by deliberately not trying to revive certain groups of patients. These groups are not distinguished by their clinical potential but by their social viability. The staff reappropriates biomedical protocols and legal guidelines to further refine a system of implicit social rationing. The bulk of resuscitative efforts are still characterized by a detached attitude toward patients. In most reviving efforts, the staff feels defeated in advance and reviving becomes an empty ritual of going through mandated motions. It is only when patients transcend anonymity and gain a sense of personhood that the staff will aggressively try to revive them.

With regard to the broader institutional context, resuscitation is now, less than in Sudnow's study, marked by the health care provider's desire to "obtain 'experience,' avoid dirty work, and maximize the possibility that the intern will manage some sleep" (Sudnow 1967, p. 170) as well as by the requirements of defensive medicine and managed care. With the gradual erosion of physician autonomy because of peer review and utilization boards, the wave of cost-effectiveness in medicine, the proliferation of medical malpractice suits, and the patient rights movement, physicians' practices have become more externally regulated. As several respondents commented, a resuscitative effort is as much an attempt to avoid a lawsuit as an endeavor to save lives. Health care providers try to maneuver within the boundaries of the law, professional ethics, and biomedical knowledge to maintain lives worth living and proper deaths for their patients. Every resuscitative effort becomes a balancing act of figuring out when "enough is enough" based on the clinical situation and prognosis, legal and ethical guidelines, the wishes of the patient and relatives, and—most importantly—the preferences and emotions of the resuscitation team. The latter are in charge, so ultimately their definitions of the situation and their values will prevail.

After thirty years, Sudnow's main contribution to the sociological literature is his disclosure of how the ED staff rations death and dying based on the presumed social value of the patient. Most studies of social inequality in health care rely on showing statistical race, gender, and socioeconomic variations in the prevalence, incidence, morbidity, and mortality rates of particular conditions (e.g., Wilkinson 1996), however, Sudnow showed that social inequality is an intrinsic part of negotiating and managing death. Surprisingly, though, Sudnow did not question the implications of the rampant social inequality he exposed in *Passing On*. His interpretation of social rationing as a routine institutional coping mechanism for death and dying—not as an important social issue—remains unsatisfactory because the former interpretation implies a theoretical justification of social inequality.

From a contemporary point of view, Sudnow's position has become even more problematic because health care providers keep dismissing similar groups of marginalized patients in a very different health care structure. Policies that should have diminished social inequality have instead strengthened it. Instead of concluding that such rampant social inequality is an inevitable part of the interaction between the patient and the care provider, I suggest that the policy changes did not address the broader societal foundations of social inequality.

Unfortunately, the attitudes of the emergency staff reflect and perpetuate those of a society generally not equipped culturally or structurally to accept the elderly or people with disabilities as people whose lives are valued and valuable (Mulkay and Ernst 1991). As the need for and problems with an Americans with Disabilities Act show, the disabled and seriously ill are not socially dead only in the ED but also in the outside world; this is the original sense in which Erving Goffman first introduced social death (1961). The staff has internalized beliefs about the presumed low worth of elderly and disabled people to the extent that more than 80 percent would rather be dead than live with a severe neurological disability. As gatekeepers between life and death, they have the opportunity to execute explicitly the pervasive but more subtle moral code of the wider society. Just as schools, restaurants, and modes of transportation became the battlegrounds and symbols in the civil rights struggle, medical interventions such as genetic counseling, euthanasia, and resuscitative efforts represent the sites of contention in the disability and elderly rights movements (Fine and Asch 1988; Schneider 1993).

In addition to the fact that social rationing takes place under the guise of a resuscitative effort, the prolonged resuscitation of anyone—including irreversibly dead people—in our emergency systems perpetuates a far-reaching medicalization of the dying process (Conrad 1992). Deceased people are presented more as “not resuscitated” than as having died a sudden, natural death. The resuscitative motions render death literally invisible (Star 1991); the patient and staff are in the resuscitation room while relatives and friends wait in a counseling room. The irony of the resuscitative setup is that nobody seems to benefit from continuing to resuscitate patients who are irreversibly dead. As some staff members commented, the main benefit of the current configuration is that it takes a little of the abruptness of sudden death away for relatives and friends. I doubt, though, that the “front” of a resuscitative effort is the best way to prepare people for sudden death. By engaging and investing in resuscitative efforts, we as a society facilitate the idea that mortality can be deconstructed (Bauman 1992) and that crisis interventions will correct a lack of prevention and healthy life habits (Anspach 1993). The result of engaging in resuscitative efforts on obviously dead patients is structurally sanctioned denial, a paternalistic attitude in which staff members keep relatives and friends in a closed awareness context or engage them in the slippery dance of mutual pretense awareness (Glaser and Strauss 1965). For the sake of preserving hope and softening the blow of sudden death, the staff decides that it is better for relatives not to know that their loved one is dying. Relatives and friends are separated from the dying process and miss the opportunity to say goodbye when it could really matter to them, that is when there is still a chance that their loved one is listening.

Rationalizing medical practice or providing legal accountability only accentuated the medicalization of the dying process and social inequality. The biomedical protocols are part of the problem of the medicalization of death because they promote aggressive care instead of providing means to terminate a reviving attempt (Timmermans forthcoming a), and the staff relies upon those theories to justify not resuscitating people who might become disabled. Legal initiatives mostly stimulated the predominance of resuscitative efforts at the expense of other ways of dying and have been unable to protect marginalized groups.

In the liminal space between lives worth living and proper deaths, resuscitative efforts in the ED crystallize submerged subtle attitudes of the wider society. The ED staff enforces and perpetuates our refusal to let go of life and to accommodate certain groups. Exactly because health care providers implement our moral codes, they are the actors who might be able to initiate a change in attitudes. On a personal level, many health care providers seem to have made up their minds about the limitations of reviving. Medical researchers presented emergency health care providers with a common forty-eight-minute resuscitation scenario with a relatively good prognosis and a reasonable time course. Only 2.9 percent of the respondents would prefer to be resuscitated for the entire episode (Hauswald and Tanberg 1993). If those who are the most informed and have the most personal experience with resuscitative efforts are reluctant to undergo lifesaving attempts, there is a simple solution for the twin problems of social rationing and the medicalization of sudden death. Instead of increasing the access to these technologies, we might want to provide overall less resuscitative efforts. I see two ways that such a goal could be obtained.

The most important step to avoid a resuscitative effort is not to alert the emergency system. I don't believe that more regulations and legal protections will circumvent lifesaving attempts. Even with the best intentions, deciding to let people die in an ED is still too much a violation of core medical values (e.g., the Hippocratic Oath). Discussions about

advance directives have an important sensitizing function, but people (and their relatives and caretakers) who choose not to be resuscitated need to realize that the first step of avoiding a resuscitative effort implies not dialing 911. We cannot expect medical restraint from professionals who are socialized and legally obligated to fight death and dying with all means possible.

In addition, relatives and friends should have the opportunity to play a more active role during a resuscitative effort. This occurs already in some midwestern hospitals, where relatives are given the option to attend the resuscitative effort and say goodbye during the last moments that their loved one hovers between life and death. The presence of grieving relatives and friends is a constant reminder for the staff that they are dealing with a person entrenched in a social network and not with a mere body (Timmermans 1997). Such a policy change also entails a more explicit recognition that resuscitative efforts are not only performed for patients but also for relatives and friends who need to make sense of sudden death (Ellis 1993; Rosaldo 1984). These initiatives should stimulate an understanding that “passing on” to the final transition is inevitable and should be the same for everyone, regardless of their presumed social value.

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NOTES

1. Social rationing means the withholding of potentially beneficial medical interventions based on social grounds (see Conrad and Brown 1993).

2. Bauman does not argue that resuscitative efforts are not decided upon patients’ presumed social worth any longer, but that social discrimination has shifted from “primitive” technologies to more advanced medical technologies such as organ donation and “the electronic computerized gadgetry.”

3. Sometimes medical critics will discuss the ethical implications of individualized resuscitation scenarios. Part of Sudnow’s contribution, however, was to show that social rationing was not an isolated, individualized event, but a widespread, social practice.

4. Massachusetts General Law c.111C, Paragraph 14 states that “No emergency medical technician certified under the provisions of this chapter . . . who in the performance of his duties and in good faith renders emergency first aid or transportation to an injured person or to a person incapacitated by illness shall be personally in any way liable as a result of transporting such person to a hospital or other safe place . . .”

5. Omnibus Budget Reconciliation Act of 1990 (OBRA-90), Pub. L. 101–508, 4206, and 4751 (Medicare and Medicaid respectively), 42 U.S.C. 1395cc (a) (I) (Q), 1295mm (c) (8), 1395cc (f), 1396a (a) (58), and 1396a (w) (Supp. 1991).

6. Level 1 and level 2 refer to different staffing requirements and to differences in severity of cases. Level 1 hospitals are required to have a neuro, trauma, and cardiac surgeon always on call in the hospital, and these hospitals take more serious cases than level 2 hospitals (the differences are head injuries, gunshot wounds, multiple complex wounds, etc.). The distribution of level 1 and level 2 trauma centers per region is regulated by law.

7. The staff found this resuscitative effort interesting because it involved the first hypothermic person they attempted to revive in a year. They were a little lost about how to warm up the patient. Some patients gain status because they constitute medically challenging or interesting cases.

8. Death is obvious when rigor mortis has set in, decapitation has occurred, the body is consumed by fire, or there is a massive head injury with parts missing.

9. This practice is not as marginal as one would think. Major medical journals regularly publish articles about the ethical implications of practicing intubation and other techniques on the "newly dead" (see for example Burns et al. 1994).

10. There is also some evidence from other research that having an advance directive is in itself related to age, gender, race, socioeconomic status, education. Schonwetter et al. (1994), for example, found a strong relationship between socioeconomic status and the desire for CPR.

11. Partly this is due to the fact that US (and international) resuscitation medicine is dominated by a limited number of research groups who mostly seem to agree with each other. According to Niemann about 85% of all CPR related research articles in the United States come from a community of 10 research groups (Niemann 1993 p. 8).

12. The physician told me this story six years after it happened. My original question was "Can you give me an example of a resuscitative effort that left a big impression on you?"

13. Although I did not emphasize Sudnow's ethnomethodological legacy in this paper, the idea of life-saving, the technology, and saving lives in itself are jointly accomplished in practice (see Timmermans and Berg 1997). The ironic aspect of resuscitation technology is that resuscitation techniques and practice establish the value of saving lives at all costs while the actual numbers of saved lives remain very low. I discuss this seeming paradox at length in my book (Timmermans forthcoming a). I thank Norm Denzin for drawing my attention to the ethnomethodological importance of Sudnow's study.

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