

Sharon R. Kaufman, ...*And a time to die: How American hospitals shape the end of life*. Chicago & London: University of Chicago Press, 2006. 412 pp., \$18.00 (paperback). ISBN 0-226-42685-8.

“... And a time to die” is a direct quote from the book Ecclesiastes where the biblical philosopher argues that in life there is time for everything: for planting and uprooting, for breaking down and building up, for mourning and dancing, etcetera. He starts that list with the two fundamental life events: there is a time to be born and a time to die. The title of Kaufman’s book seems misleading, therefore, because it is mainly about ‘no time to die.’ Or is it irony? Or an attempt to ward off what she encountered in the hospitals where she did her research? Death, which used to be a natural part of human life, has become a technical event that one must choose or not choose. Most people in her study prefer not to choose death.

Sharon Kaufman has written a moving study about life and death in three American hospitals. She has captured the viewpoints (and their absence) of physicians, nurses, patients and, in particular, relatives of patients. The central intuition of her book is well expressed in a quote from Paul Rabinow:

‘Life’ is problematic today because new understandings and new technologies that are involved in giving it a form are producing results that escape the philosophical self-understanding provided by both the classical world and the Christian tradition. No new political or ethical vocabularies have adequately come to terms with it either (p. 273).

In other words, medical technology has created a new type of death. Death used to be the end of human responsibility; now it is the epitome of it. Hospitals have become stages where characters argue and fight over death as in classic Greek tragedies. Kaufman has described those dramas with patience, respect and empathy. She followed the course of more than hundred critically ill patients who died or did not die during a period of two years in 1997 and 1999-2000. She accompanied them through countless procedures and spoke with about one third of them. She stood with family members at patients’ bedsides, kept them company in waiting rooms and met them over coffee in hospital cafeterias. The most telling episodes in her book are the 27 narratives of patients and the people that surround them. The stories demonstrate more than anything else the near impossibility of making decisions about something that no one knows about: death.

The book is also an ethnography of the place where this impossible decision-making takes place. The hospital, quoting a patient’s relative, is a space of disorder:

Two in a room is disordered, especially when your relative is lying next to a dying person. Even the cleaning process is disordered – this is crucial. You’re not supposed to hear certain conversations, or see body fluids. But there is nowhere not to. It is a place of smell, sound, space, and time disorientation. You see these tubes, bags, fluids, and overflowing wastebaskets, with unsettling debris, with blood. And it is all over the place. Swabs and waste are everywhere. And old food trays, waiting for someone to take them

away. It's a boundaryless place. There is no classification, yet it is all about classification – charts, bureaucracy... (p. 85-86).

Kaufman has divided her study into three parts. In the first part she poses the problem of death in modern society. Thanks to medical technology, aging and death have been turned into experiences that are neither normal nor natural. This new situation raises the questions that prompted her to undertake the study.

The second part is the ethnographic body of her book. She discerns three 'pathways' of managing death in the hospital. All the pathways are characterised by uncertainty and contradiction: people doing things they had previously decided not to do. One pathway is the 'heroic intervention,' or the continuation of life supporting treatment. A long fragment from Philip Roth's novel *Patrimony* illustrates this pathway's major dilemma. Roth must decide on whether or not to extend his father's life with machines, or else essentially choose death:

How could I say no to the machine if it meant that he needn't continue to endure this agonizing battle to breathe? How could I take it on myself to decide that my father should be finished with life, life which is ours to know just once? Far from invoking the living will [which his father had made], I was nearly on the verge of ignoring it and saying, "Anything! Anything!" (p. 101).

Kaufman's observations show the same dilemmas. Ironically, patients and their relatives often demand more 'heroism' than doctors are prepared to give.

The heroic pathway reaches a 'climax' when the patient dies and CPR (cardiopulmonary resuscitation) is applied (the second pathway). Only eight to fifteen percent of patients that survive CPR are finally discharged, and hardly anything is really known about post-CPR life. Television and other media tend to present a return to life of people who once were dead, thus elating the miracles of modern medicine. But Kaufman remarks that CPR is rather one of the technologies that may bring death into life. Again several detailed case histories demonstrate how difficult decisions around CPR are. Family members disagree among each other and may even decide to take a vote; doctors prefer to wait for a family decision or "try to err on the side of giving more treatment."

Another pathway Kaufman identifies is that of the 'revolving door,' that is, the heroic postponement of death consists of repeated admissions to hospitals and other institutions that lead to more heroic interventions, often at the family's request and sometimes even against the patient's own wish. A complicating factor that enters the decision-making is the limited coverage of long-term care by the American insurance system.

The corollary of heroic intervention is 'waiting.' Kaufman describes three varieties of waiting for death. The main question here is what strategies health professionals employ to manage waiting that does not make sense to them: how do they communicate this to relatives? And how do relatives react? Again, Kaufman portrays the many nuances of waiting in elaborate and moving narratives. The uncomfortable complica-

tion of the waiting scenario is that active intervention to end the waiting is not only not 'heroic', but mostly against existing human and medical ethics. One wonders, however, if helping people to die in order to end their suffering is perhaps more heroic – especially if the alternative is endless rounds of treatment.

Kaufman broadens the problem of *a time to die* in part three of her book by posing questions back onto society, outside the hospital, and linking them to public discussion. She also confronts her readers with the consequences of heroic pathways and indecisive waiting by taking them to the 'Zone of Indistinction', institutions where patients are nursed who are doomed to 'live on' as a result of doctors and relatives making wrong decisions or not making a decision at all. About one third of them are in what is called PVS (persistent vegetative state).

Kaufman refrains from making explicit recommendations; she just describes. The reader must decide for himself. That restraint seems correct to me. Death remains the 'Great Unknown.' Of course, the patient should be the ultimate decision-maker but – as Kaufman points out – a terminally ill person may be incapable of making a decision. Researchers and others often overestimate the autonomy of patients. The ethnographer may not have any other choice than to 'wait' as well. On the other hand, I believe that Kaufman's incisive and empathic description of the suffering that occurs during and after heroic interventions and senseless waiting can not but raise people's awareness of the need for alternative pathways to death.

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Winy Koster, *Secret strategies: women and abortion in Yoruba society, Nigeria*. Amsterdam: Aksant, 2003. 385 pp., €35,00. ISBN 978-90-5260-103-8.

Toyin is a 16-year-old Nigerian secondary schoolgirl who died tragically after a late, secret, and unsafe abortion. In *Secret strategies* medical anthropologist Winy Koster poses the question why so many Nigerian women like Toyin resort to abortions, while these are often (known to be) unsafe due to their illegal status and could have been prevented by using effective contraception. She explores women's motivations and experiences and situates these within complex social, economic, political, and health-care contexts. Combining various qualitative and quantitative research methods in both an urban and rural area in Southwest Nigeria, this study is not only extremely *comprehensive*, but also explicitly *applied* – which, according to the author, is almost an unpreventable stance in research on moral and crucial issues like abortion. The book thus not only presents a general overview of the reproductive health situation and prevalence of abortion in Nigeria, but also describes the daily life dynamics underlying these statistics through numerous personal accounts from women, men, youngsters, traditional birth attendants, and biomedical staff. It ends with some recommendations to improve women's reproductive health in these settings. This is done in three subsequent sections.