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Medical Eschatologies: The Christian Spirit of Hospital Protocol

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ABSTRACT
If much has been written of the forms of bodiliness reinforced by hospitals, less attention has been paid to the medicalization of the soul. The medical management of death institutionalizes divisions between body and soul, and matter and spirit, infusing end-of-life care with latent Christian theological presumptions. The invisibility of these presumptions is partly sustained by projecting religiosity on those who endorse other cosmologies, while retaining for medicine a mask of secular science. Stories of conflict with non-Christian patients force these presumptions into visibility, suggesting alternative ethics of care and mourning rooted in other understandings. In this article, I explore one such story. Considering the story as an allegory for how matter and spirit figure in contemporary postmortem disciplines, I suggest that it exposes both the operation of a taboo against mixing material and spiritual agendas, and an assumption that appropriate mourning is oriented toward symbolic homage, rather than concern for the material welfare of the dead.

KEYWORDS
Biomedicine; death; Christianity; end-of-life care; South Asia; United States

In 1998 and 1999 I held a position in an urban US hospital for a program oriented toward cross-cultural education and research. I had been hired to conduct research in local immigrant communities on perceptions of medical management of death and dying in the United States. Over the months, calls from health care professionals, facing conflicts with immigrants around death and dying, were frequently referred to me. It was often ambiguous whether the callers were volunteering data for our research, soliciting advice, or simply seeking a sounding board. Usually I did more listening than intervening.

One day I received such a call from a social worker at a local hospital. Bruce, as I will call him, wanted to consult with me confidentially about a conflict between the hospital and the son of a deceased patient. The patient was a North Indian woman—whom I will call Radha—who was visiting her son in North America, Ashok. Bruce did not tell me their names. Ashok was simply “a Hindu man,” and Radha simply “his mother.”

Radha had had a fatal heart attack in her son’s home—actually “in her son’s arms,” according to Bruce. The phrase sounded archetypal, even apocryphal. However, it is not so much the events themselves as the telling of the story, its power as medical parable, I want to consider in this article. Had I been more alert, the phrase “in her son’s arms” might have offered an early clue to the ideal of peaceful dying that underwrote Bruce’s telling. In any event, Ashok called 911, and Radha was resuscitated and taken to the hospital’s Emergency Room, where she suffered another cardiac arrest. This time she could not be revived. She was transferred to the morgue and from there to a funeral home, where Ashok had arranged to prepare her for cremation himself.

When he arrived at the funeral home, he was upset to find his mother unclothed. Per standard hospital practice she had been transported naked, in a plastic body bag, from morgue to funeral home. A married woman, he insisted later to hospital staff, must be clothed at all times. He was also
disturbed that the nightgown his mother had been wearing at her death was missing. Family custom, or else a Brahmin priest or guru whom Ashok was consulting (Bruce was not sure which), required that Ashok burn the garment in which Radha had died, but the garment had been cut away and discarded in the Emergency Room (ER), and the hospital could no longer retrieve it.

Meanwhile Radha’s nakedness had disrupted the mortuary process. Uncertain about appropriate ritual remedies, Ashok waited two weeks before having his mother cremated. He hoped to take her ashes to Benaras (Varanasi, India) and submerge them in the Ganga, but the Brahmin or guru cautioned that his mother’s spirit was not yet “at rest.” At least this was the phrase Bruce used to translate Ashok’s concerns to me. There are multiple layers of translation here: the guru’s translation of esoteric knowledge for the son, the son’s translation of the guru’s advice for hospital personnel, Bruce’s translation for me, and now my own translation filtered through my studies of South Asia, and of relationships with the dead. The opportunities for insight, as in other instances of ethnographic hearsay, lie less in what the guru might have said or meant, than in what the son chose to say to the hospital staff, and how the social worker represented that to me.

By the time of my first conversation with Bruce, Ashok had already had several meetings with hospital personnel, including administrators, physicians, and a patient representative. Initially, the hospital’s position seemed to be summed up by one ER technician, who suggested that Ashok was simply redirecting his anger at his mother’s death toward the hospital. Belatedly a chaplain was called. The chaplain, attempting to mediate, proposed to Ashok that a change in hospital policy might serve as a fitting “legacy” of Radha’s death. When I entered the informational loop, the chaplain, with the help of hospital administrators, was already at work on the wording of a new question to be added to the “death list”—a set of conversation points to be covered with family members of a deceased patient. The “death list,” Bruce explained, consisted of questions about what funeral home had been engaged, a request to sign off on belongings of the deceased that were being returned to the family, and a solicitation of organ donation. Now the death list would also include a question along the lines of: “Are there any religious or cultural practices that might affect caring for your loved one?”

Meanwhile the hospital had also consulted with a cross-cultural expert, a man who led trainings in cultural competence for health care professionals around the country, and who happened to be a Bengali Hindu. The expert suggested a way around Ashok’s concern about the nightgown: if the garment was cut away during the resuscitation attempt, then Radha did not actually die in it (as she was not declared dead until after it was removed), and so it would not need to be burned. Ashok was dismissive of the cultural expertise of the trainer, however, pointing out that Hindu practices vary widely across different regions of India.

A few days later, Bruce called me with an update. The new policy had been presented to Ashok. Besides the addition to the death list, the hospital proposed a change in protocol whereby every corpse would leave the hospital in a paper gown. Ashok, for his part, responded with a written statement outlining three requests. The first was for a sum of money that Bruce described as “huge.” Bruce emphasized that the money was not to cover extra funeral expenses (which were almost certainly incurred with the delay of Radha’s cremation) but to compensate Ashok for “mental anguish.” The second request was for an unqualified apology, and the third for a special service to be held in the hospital chapel. The room got very quiet, Bruce said. Everyone was shocked. All along, Bruce said, Ashok had insisted that people of his class, religion, and culture did not be held in the hospital chapel. The room got very quiet, Bruce said. Everyone was shocked. All along, Bruce said, Ashok had insisted that people of his class, religion, and culture did not wish to hear since most Americans “are only thinking of money.” (In an aside, Bruce told me that he had talked to many people at the end of life, and no one had ever said, I wish I’d made more money. If they had any regrets at all, he said, they wished they had been kinder, or got in touch with their ‘true selves.’) Bruce himself had expected that Ashok would be happy with the policy change. The hospital could simply have added a question about religion to the death list, but instead they had made a commitment to clothe every dead body. According to Bruce, the meeting eventually degenerated into cultural-one-upmanship, with Ashok purportedly claiming that Hinduism was...
“ancient,” and the chaplain opining that the (hypothetical) failure of an Indian hospital to offer last sacraments to a Catholic would be just as inexcusable as Radha’s nakedness.

Several weeks passed before I spoke with Bruce again. In the interim he had grown increasingly frustrated with Ashok. After consulting with social workers and bereavement counselors at other institutions, he was convinced that no other hospital would have spent so much time trying to resolve this conflict. The hospital had now instituted the proposed policy changes, and agreed to the apology and special service. As far as the money went, Bruce said, the hospital “couldn’t just cut a check.” In a move that seemed designed to call Ashok’s bluff, the hospital had invited him to consult a lawyer. Bruce himself had decided that Ashok was taking out on the hospital his own guilt at calling 911. After all, if he had allowed Radha to die in his arms she would have had, Bruce said, “the perfect death.”

Later that day Bruce called a second time. He had just run into Ashok in the hospital hallway, and Ashok told him that he intended to make a donation to a charity within the hospital in honor of his mother. Bruce was elated. “What a turn-about!” he said. The patient representative had commented that Ashok must have finally realized that fighting with the hospital was not an appropriate way to “remember” his mother. Ashok now believes, Bruce said, that his mother’s spirit was responsible for the change in hospital policy; and Bruce agreed.

**Semiotic ideologies**

This story, as told by Bruce, is a fitting allegory for the way that spirit and matter figure in contemporary post mortem disciplines of death.3 ‘Culture’ plays an ambivalent role here too, of course, as the cross-cultural expert mined cultural knowledge for creative mediations of conflict, even to the point of tripping up cultural practice in its own contradictions; and as hospital administration experienced a backlash to its own value of ‘cultural competence,’ retracting from an initial impressionability—when personnel admired Ashok’s anti-materialist values—to resentment at his assertion of cultural antiquity. Surely one reason the hospital staff was so stunned and affronted by the request for money is that Ashok’s claim on their sympathy was entirely underwritten by his cultural capital, which in turn rested on his sincere religiosity. The request for money threw this sincerity into question. All the authenticity alarms went off at once: the authenticity of his grief (now degraded to the litigious category of mental anguish), the authenticity of his religious convictions (now tainted by monetary motives), and the authenticity of his culture (now reread as cultural arrogance). The semiotic ideology of the hospital, to borrow Webb Keane’s phrase (2007), had stumbled over its inevitable and built-in disappointment, the always already posited disparity between outer presentation and inner state. Here I use the phrase semiotic ideology to refer to the governing ideas within a particular community or institution that propose to regulate the relationships between signs and referents. In this case, the semiotic ideology of the hospital worked to insist that the interior intentions of a proper spiritual subject must be disentangled from any external and shallowly *pro forma* performances. This semiotic ideology might be taken as distinctively Protestant, insofar as an emphasis on ritual performance still sets Catholicism apart from Protestantism. I suggest, however, that the shift in the significance of Christian ritual into a more symbolic register, as argued by Talal Asad (2003), has left modern Catholicism also susceptible to a semiotic ideology that labors to separate inner feeling from outer show. In any case, Ashok’s inner sentiments fell under suspicion, the hospital’s cultural liberalism defaulting to distrust of the foreigner. From the hospital’s vantage, Ashok’s response was a betrayal in two senses. On the one hand, he had duplicitously betrayed the hospital’s good faith that he was an authentic spiritual subject. On the other hand, he had inadvertently exposed the hospital’s theological commitment to the opposition of money and feeling, matter and spirit, revealing an (ironically) visceral taboo against mixing material and spiritual agendas.

The relieved response to Ashok’s initially avowed disinterest in money suggests that hospital personnel might have been nagged all along by a worry that Ashok’s complaint was driven by
material self-interest rather than spiritual angst. This worry would not have been specific to Ashok, I suggest, but would simply reflect the presumption of economic self-interest embedded in the comment that “most Americans are only thinking of money.” Ashok’s later demand would then inevitably become a confirmation of this mercenary intent rather than simply the possibility of it. In this reading, the demand for money would have been especially offensive to hospital staff because it so easily slotted into and reiterated an old (Christian) story of the constantly threatened contamination of the sacred (in this case, mourning) by the profane (in this case, greed). This is not to say that Christianity always and everywhere recognizes a contradiction between sacredness and self-interest. The Protestant ethic promises that hard work will earn monetary rewards, while forms of Pentecostalism preach that prayer can be a path to prosperity (Meyer 1998). As will become more apparent, the hospital’s own position on the relationship between mourning and money was complicated. Ashok’s request evoked moral outrage specifically insofar as his spiritual beliefs took on the cast of a masquerade disguising a monetary motive, albeit one intermixed with displaced (and implicitly unconscious) anger and guilt. Note that for the hospital, it was crucial that Ashok’s request was not a plea for assistance with expenses but rather was a demand for compensation for spiritual anguish. Hospital staff either could not or would not recognize a spiritual suffering that could be healed by the receipt of a sum of money.  

In this dance of matter and spirit, the ‘death list’ might be read as a medical ritual for negotiating their bifurcation, and relegating each to its appropriate sphere. The addition of a question about religious and cultural preferences framed concern for the spirit of the deceased as one more item on a checklist for the disposition of the dead. One effect of this amendment to the death list was to assign relations with the dead to the category of religion or culture, which is understood to be an important concern for patients but not for medical institutions themselves. An even more critical effect of this amendment, however, was to formalize the division of the corporeal and the spiritual, sequentially addressing the medical use of body parts, the physical property of the deceased, the transportation of the body to the funeral home, and finally, practices related to the spirit. Body and soul appear on the list as independent entities: one as a passive hunk of flesh that is a potential source of organs and an object to be transported under certain sanitary and aesthetic restraints; the other as a person with religious and cultural desires. Yet the implicit ethical call to partly accommodate mourners’ and caregivers’ aesthetics is a reminder that even for medicine, certain violations of corpses (presumably any dismemberment without a medical or forensic purpose) would constitute a form of desecration. Even for medicine then, the borderline between body and person is not secure and needs to be constantly reiterated (cf. Sharp 2006; Lock 2001). In this sense the revised death list consigned to medicine what is medicine’s and to culture what is culture’s. Meanwhile, the personal effects of the deceased straddle the body-soul divide as those ambivalent traces of ghostly matter, inanimate yet imbued with personhood, which the hospital returns to the family. The death list, then, serves as a distribution of the intimate material and immaterial property (body, clothing, spirit) of the dead. Theoretically the hospital returns the dead to the mourners, but at the same time the mourners grant the hospital custody of the dead until she is passed off to the next set of professionals. Finally, the death list’s bid for another kind of charitable donation (a heart, or eye, or liver) once again turns the allegory toward the problem of the gift. 

For how quickly Ashok’s mourning became legible when he resorted to the convention of making a donation to a hospital charity on his mother’s behalf. The genuineness of his concern for his mother’s spirit was undermined by the act of requesting money, in one moment, and validated by the act of relinquishing it, in the next. The charitable gift was read symbolically as an act of memorial homage to the dead, as surely as the demand for compensation was read as a confusion of monetary gain with spiritual solace. “Talk about materialism,” Webb Keane wrote “seems to incite people to a certain dematerialization in their understandings of the world. This is evident, for instance, in the effort to treat material goods as merely symbolic” (2006:315). The way this dematerialization works, he showed, is by reinterpreting material objects (such as Ashok’s charitable donation) as signs of an immaterial value (the remembrance of his mother).
Charity and the corpse

Yet there is an unsettling paradox in play here. How can it be so laudable for Ashok to make a donation to the hospital, when it would have been only succumbing to culturalist manipulation for the hospital to “cut him a check”? The logic of this apparent hypocrisy hinges on the notion of charity. In Christian framings, charity is often a term through which money can contact the sacred as gift rather than as tainted transaction, rather than, that is, purchase, bribe, or compensation. Distinguishing the gift from other exchanges was evidently, at least in this instance, a less vexing matter for the hospital than it has been for a long line of philosophers and anthropologists. In the abstract, the charitable gift seems to demand no return (except perhaps tax deductions and moral capital). In actual practice, as sensitive ethnography has shown, it often imposes conditions of gratitude or moral virtue on the recipients (Allahyari 2000; Elisha 2008). Charity is given to individuals in need, or to mediating institutions, which themselves lay claim to the moral capital of charity (and of course to more tax deductions or exemptions). Christian charity might be thought of as a concept and practice that simultaneously preserves and polices the boundary between the profane and the sacred, between matter and spirit. As Omri Elisha noted in his work on the charity of evangelical Christians, charity is often imagined as a “sacralized mode of exchange,” which is simultaneously “romanticized to such an extent that its qualities of generosity and sacrifice are presumed to be wholly distinct from the realm of exchange altogether” (2008:180). Yet charity embodies a tension that is never fully reconciled. In practice charity is both encumbered and unencumbered, both beyond rational calculation and linked to specific consequences, ranging from the prestige earned by the giver to the blessings offered by the recipient.5

In this incident, Ashok’s act of charity worked to confirm the charity of the hospital. Through his surprise at Ashok’s demand for money, and his claim that no other hospital would have done so much, Bruce continually signaled his suspicion that Ashok had failed to appreciate and be grateful for the hospital’s largesse. Even as Ashok’s demands for recompense seemed to cast the hospital’s policy changes as concessions, his charitable gift seemed to acknowledge those changes as themselves acts of “generosity and sacrifice.” This miraculous shift whereby the hospital’s own actions could be reread as charitable in the light of Ashok’s act of charity, highlights the way that the interpretation of a given exchange as charity is necessarily situational, subject to negotiation and contestation.

In its critical importance for negotiating the borders of the sacred and the profane, the logic of charity is linked to the logic of the corpse. Within a secular or liberal Protestant understanding, gifts given at the time of death are often not imagined as gifts to or from the dead themselves, but rather as gifts on behalf of or in homage to the dead. The dead, if reachable with prayer, seem to be beyond the reach of material gifts and effects. That is, implicit in the hospital’s rewriting of Ashok’s anger as a response to Radha’s death, rather than to her nakedness, was an inability to imagine that Radha’s nakedness could possibly affect the welfare of her spirit. This particular instance of “dematerialization,” as Lawrence Cohen (personal communication) cogently put it in his comment on an earlier version of this article, “evades the carnal shock of [Ashok’s] mother’s nakedness,” and does so, I would emphasize, by clothing that “carnal shock” in cultural context. Matter-of-fact practices for transporting corpses might even be said to suppress such “carnal shock.” In other words, it is to cover for this evasion, and suppress this suppression, that Ashok’s grievance had to be bracketed as cultural belief in the first place. Hospital discipline appears to operate according to an eschatological assumption that a dead body is almost instantaneously an empty shell. In her ethnography of hospitalized death, Sharon Kaufman recalled a physician who marveled that a man had stayed with his mother for an hour and a half after she stopped breathing. He was similarly “amazed” that it took the son so long to decide to “let her die” (2005:109). In these comments, the excessive time the son took to agree to the removal of the ventilator grades into the excessive time he spent with his mother after her death. The underlying expectation appears to be that mourners will quickly withdraw their affective attachment to the bodies of their loved ones once they are declared to be “dead” or “brain dead,” since those bodies are now simply inanimate matter. In this way, the management of corpses (from organ harvest to unplugging
to autopsy to morgue) can be presented as a secular and logistical matter, even as a modern Christian numinology organizes it from the sidelines.

Yet it must be noted that this version of Christian numinology is not only relatively recent but is far from universalized. In late nineteenth century Britain, Mary Bradbury noted, debates over cremation still weighed a new sensory revulsion and a perceived “barbarism” of visible bodily decay against the lingering possibility of a literal resurrection of the body (1999:15). It is only over the course of the twentieth century that the doctrine of the resurrection of the body has, for some Christians, become increasingly symbolic rather than indexical, in a way that is compatible with the increased repulsiveness of the corpse. Bradbury noted that the majority of British Christians eventually bowed to clerical reassurance that the “immortal soul” is not contiguous or co-substantial with the corpse and so “should, in theory, not be affected by the mode of disposal” (1999:15).

Offering another angle on the connection between charity and the corpse, William LaFleur has argued that within mid-twentieth century Protestant discourse, an emphasis on a nonreciprocal, impersonal agapic love for strangers became aligned with a utilitarian distaste for waste, paving the way for wide public acceptance of organ donation and the redefinition of death as brain-death (2002). This reimagining of corpses as unused resources that could be fashioned into charitable gifts was enabled partly insofar as earlier concerns “for the bodily integrity of the corpse” had lost their “ethical import” (LaFleur 2002:639). On the other hand, Lesley Sharp’s work has shown the extent to which organ recipients and donor families often willingly evoke and participate in decidedly non-agapic relationships of fictive kinship and ongoing reciprocity via organs, bypassing the biopolitical anonymity of organ donation as charity (2006). She also pointed out the extent to which organ donation socialities frequently question the medical claim that body parts are devoid of personhood or spirit, by acknowledging recipients’ experiences of inheriting donors’ temperaments and feelings through the donated organ. Such practices suggest that the corpse is not necessarily detached from the spirit in lay Christian understandings, even if certain theologians have labored to separate them.

In drawing attention to a set of conceptions underlying biomedical protocol that are largely Christian (and primarily Protestant) in provenance, I do not mean to suggest that these conceptions are either self-consistent, or representative of some imagined essence of Christianity or Protestantism. Christianities around the world are enormously varied in their relationships with biomedicine. Elizabeth Roberts (2012), for instance, in her ethnography of in vitro fertilization clinics in Ecuador, details the critical importance of Christian prayer and divine agency in everyday medical practice and discourse. Even within Protestant North America, as Pamela Klassen (2011) has shown, Christian denominations have worked to craft deliberate theories of compatibility between Christian doctrine and medical science. Here, however, I attempt a more diffuse project, which is to track certain Christian theological fragments that inadvertently surface in hospital discourse and practice out of what I will provisionally name a ‘biomedical unconscious.’ With this term I call attention to certain undercurrents of irrational desires and fears that permeate biopolitical projects, and in this case the medical management of death and dying. My objective in interpreting Bruce’s story, therefore, is to attend to those evocative phrases or actions that betray emotional commitments reverberating with Christian undertones, even when Christianity itself is only marginally referenced by any of the key players (most notably, in the defensive comment about the hypothetical fate of a Catholic in an Indian hospital). Insofar as the Christianity in question here is an unacknowledged figure shadowing medicine’s more conscious secular missions, it should not be surprising if, as I mentioned, medicine sometimes lets slip an ambivalence or uncertainty about the stability of the split between body and soul. Elsewhere I have suggested, for instance, that traces of an anxiety about the intermingling of dead body and soul surface in relation to those patients living in a “persistent vegetative state” or “brain death” (Langford 2013). Such patients invoke what appears to be a peculiarly Euroamerican type of restless ghost, a Christian soul locked inside an uncanny cyborgian body being kept alive by mechanical devices.

For Ashok, on the other hand, the connection between corpse and afterlife might perhaps be expected to face less ideological resistance. His concern about his mother’s nakedness reverberates in a panoply of North Indian practices that trace the connection between material remains and spirit
subjectivity. As Ann Gold wrote of Rajasthani mourners who were taking the ashes (referred to as phul or flowers) of their dead to Benares (as Ashok hoped to do):

Villagers taking flowers to the Ganges feel that they are carrying, not lifeless bones, but souls who are aware of everything that happens. . . . One very sensitive person . . . kept hearing the voices of those whose flowers he was carrying, murmuring to him along the way: “We are going happily, we are going happily.” When he placed the bones in the river the voices ceased. (Gold 1988:200)

One might even speculate that for Ashok and the guru he has turned to for guidance, a gift made in the name of his mother could be a way of shedding the maleficent influences attending an inauspicious death (Parry 1994:127), such as one in which the corpse has been stripped of its clothing. In this logic of the gift, that inauspiciousness would be transferred to the hospital, which would then face the problem of absorbing its poison (cf. Parry 1986; Raheja 1988). This possibility casts yet another light on the potential differences between Ashok’s gift and the hospital’s notion of charitable donation. Yet even the partial pursuit of such plotlines of Indian mourning risks once again the slippery slope of projecting all the spirits onto the Indian family, and thereby purging medicine of its own troubled ghosts.

Hospitals as haunted space

If much has been written of the forms of bodiliness reinforced by medical hospitals (Foucault 1973; Armstrong 1987), less attention has been paid to the medicalization of the soul. Hospitals are no doubt disciplinary spaces that separate bodies into individual cases to be compared and classified in relation to certain norms (Foucault 1977), but they are also uncanny spaces teeming with ghostly residues, the traces of souls housed by or departing from these bodies. Hovering in the hallways of hospitals, morgues, and funeral homes, these medicalized souls confer intuitive sense on practices such as the communication of terminal prognosis, autopsy, organ harvesting, embalming, and cosmetic reconstructions of corpses (see Langford 2013). The institutionalization of such practices relies on a conception of subjectivity that shapes not only how many contemporary Euroamericans inhabit our bodies but also how we imagine or most recently used to imagine our souls.

Not only is the hospital “a historically religious institution that reshapes practices of death and suffering,” as physician and anthropologist Barry Saunders observed (2008:8), but it is also an institution that at least within contemporary North America, tends to suppress many of its religious commitments, disguising them in techno-ethical protocols. Medical management of death, I am suggesting, institutionalizes divisions between body and soul, and matter and spirit, infusing end of life care with latent Christian theological presumptions. Such presumptions inform not only an emphasis on premortem confessionalist introspection that posits a reflexive inner soul (Langford 2013), but also the prevalence of postmortem practices that presume the instantaneous departure of an immaterial spirit from a body that is just as suddenly imagined as an inert piece of flesh. How might we keep our attention on the implicit structures of faith that naturalize such practices without shifting the exoticism (with all its attendant shock value) back to non-Christian eschatologies?

A similar question accompanies possible explorations of Indian gifts. One could argue, after all, that the opposition between gift and transaction was not salient for Ashok. One could further evoke Jonathan Parry’s observation that Hindu mortuary culture posits self-interest as essential to the workings of dharma (1994:139). In order to think through the underlying theology of hospital procedure, however, I would rather revisit Parry’s work at a moment of reversed gaze, when he comments that the idea that the gift precludes bargaining is a product of European cultural categories that “postulate a sharp opposition between the morality of the gift and the morality of commodity exchange” (1994:142). Elsewhere Parry pointed out that “(t)he ideology of a disinterested gift emerges in parallel with an ideology of a purely interested exchange” (Parry 1986:458), and he went on to note, with due credit to Marcel Mauss (1990), that the purity of the gift becomes a problem only in social worlds where a clear distinction is drawn between obligation and gift. This
insight has seen further iteration in Alan Klima’s more recent provocation: “What if the practice of exchange were seen through different moral eyes, ones not so full of an unfulfilled desire for the absence of interest, hierarchy, asymmetry, or—and this is forceful—not haunted by the deep cosmological tradition of the ‘evil’ of money?” (2002:269; cf. Kosansky 2002). As Derrida helped to illuminate, the sustained focus on a gift-giving that would be purified of exchange, can be located within a modern Christian ethics marked by solitude, interiority, and a private bargain with God (1995; cf. Cannell 2006:21). It is within that hidden accounting that the believer gives credence to the heavenly credit accumulated through earthly acts of charity.

Finally, the lesson about money and spirit was crucially authorized in Bruce’s story by the voices of the dying themselves, as he evoked that most pervasive of contemporary end-of-life lore, that the dying never speak wistfully about material possessions but only about kindness and self-actualization. It was the hospital’s version of “perfect death” that Ashok ruined by calling 911—a peaceful death preserved from any regret by the retrospective foreknowledge of the futile and excessive technological interventions that it foregoes. It is worth noting that the ideal of a death free of technological prolongation derives its potency from stories of violent resuscitations or prolonged ventilated life that fail to result in restored consciousness; whereas when families face the choice of resuscitation, the patient’s future often still seems an open question. The moral of Bruce’s story is further hammered home not only by the dying but by the dead, in that remarkable convergence whereby Bruce and Ashok agreed that his mother’s spirit deserves the credit for the change in hospital policy. But might there be a confusion of temporalities here? If the son imagined that Radha’s spirit actively influenced the course of events in the present, Bruce was more likely to envision her as the absent figure in whose memory new policy had been made.

Derrida coined the term “globalatinisation” to refer to “the effect of Roman Christianity which today overdetermines all language of law, of politics.” “No alleged disenchantment, no secularisation comes to interrupt it,” he wrote. “On the contrary” (2001:32). Nor does secularization interrupt the Christian entailments of medicalized death—to the extent that the ‘postsecular’ might be rewritten as a Latourian-style recognition that “we have never been secular” (1993). As body and soul are eschatologically disconnected, Euroamerican mourning and medicine seem to be more dominated by an emphasis on memorialization, epitomizing the globalatinization of attention to the dead, wherein active relationships with the dead as dead, give way to memories of the dead as living persons. Hent de Vries noted that globalatinization (Fr. mondialatinisation) involves not only “the becoming Christian of the modern world” but also the “becoming worldly” of Christianity (1999:161). Arguably the latter enables Christian concepts (among them a particular separation of spirit and matter) to become increasingly compatible with scientific medicine.

Meanwhile the invisibility of those Christian eschatologies that I suggest are concealed in hospital practice can only be sustained, it seems, by projecting the burden of religiosity on those who endorse other eschatologies, while retaining for medicine a stance of secularism. Talal Asad observed that “(t) he secular … is neither continuous with the religious that supposedly preceded it (that is, not the latest phase of a sacred origin) nor a simple break from it (that is, not the opposite, an essence that excludes the sacred)” (2003:25). For Asad, it is the siting of the modern Christian god in a separate “supernatural” sphere that “signals the construction of a secular space that begins to emerge in early modernity” (2003:27). It is this space, I suggest, that allows medicine and mortuary science to manipulate corpses while putting spirits in abeyance, banished to a beyond that is declared to be unaffected by corporeal interventions. At least within the practices of biologically based medical and mortuary science, this secular space might more precisely be termed post-Christian, which, like most posts, would entail and rely on what it purports to follow.

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Notes

1. Potentially identifying aspects of this story have been fictionalized in order to protect the privacy of those involved. The location of the hospital has not been specified for the same reason.

2. In the United States, emergency medical protocol requires technicians to attempt to resuscitate a deceased patient who could conceivably be revived, unless they are presented with a Do-Not-Resuscitate order signed by the patient specifying that she does not wish to be resuscitated in the event of death.

3. In this article I offer a close examination of the eschatologies underlying one incident. See Langford (2013) for further exploration of medical eschatologies as illuminated through other moments in the medical management of death.

4. Thanks to Ian Whitmarsh for prompting this clarification.

5. Charity for non-Christians sometimes embodies similar tensions, although arguably the options for negotiating these tensions are somewhat different where there is a clearer recognition of charity as a form of reciprocity (cf. Kosansky 2002; Munzer 2001).

6. See also Lisa Stevenson’s notion of the “psychic life of biopolitics” which has inspired my formulation here, although she primarily uses this term to register the ways that bureaucratic management of life may be inhabited by murderous desires (2012, 2014).

7. For an example of how such anxieties are navigated within relationships of care see Sharon Kaufman’s thoughtful ethnography of persistent vegetative state (PVS) patients (2000, 2005).

8. Commenting on this article Elizabeth Roberts insightfully observed that the notion of imagination itself may be implicated in Christian histories of distinguishing spirit and matter.

9. While various non-Christian mourning practices may resemble memorialization, it is a question of how far these practices constitute interactions with the dead as opposed to invocations of the once-living. That said, a decreased emphasis on relationships with the dead around the world can be understood as itself a sign of globalatinization (cf. Seremetakis 1991).

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