

## Temporal Aspects of Dying as a Non-scheduled Status Passage<sup>1</sup>

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### ABSTRACT

In this paper we conceptualize dying as a non-scheduled status passage, which has led us to consider problems of how the people involved handle its timing. The analysis focuses on temporal aspects of the central issues of (1) legitimating *when* the passage occurs, (2) announcing the passage to others, and (3) co-ordinating the passage.

Our purpose in this paper is to conceptualize dying as a non-scheduled status passage. That is, we see a dying person as passing between the statuses of living and dead according to no man-made or imposed schedule. When study turns to the non-scheduled status passage, timing becomes a crucial problem and raises problems not considered in studies of scheduled passage, which tend to focus on how an occupant gets through the passage and what benefits and deficits he gets out of it.<sup>2</sup> For the non-scheduled status passage, the important questions are how the occupant in passage, as well as those people around him, even know in the first place *when* he will be, and is, in movement between statuses. Further, how do these people define

the succession of transitional statuses (which occur between the two principal statuses of living and dead) so as to establish where the person is when in passage, when the next transition might occur, where the next transition will take him, and how the occupant is to act and be treated by others at various points in the passage? Also, what happens when the occupant in passage and those around him have *different perceptions* pertaining to when the passage started and where he is going—and what kinds of interaction are consequent upon these differential perceptions? When differential perceptions of timing exist, then legitimation, announcement, and co-ordination of the passage become problematic, and interaction strategies to handle these issues become crucial.<sup>3</sup> In contrast, how the person in a scheduled status should act and be treated, hence how his passage is legitimated, announced, and co-ordinated, is usually a matter of routine, even ceremonial, consensus.

<sup>1</sup> This paper derives from an investigation of terminal care in hospitals, supported by N. I. H. Grant NU 00047. We wish to thank Fred Davis, Howard S. Becker, Jeanne Quint, and Norman Storer for helpful comments and criticisms on an early draft.

<sup>2</sup> For studies of scheduled status passages see Robert K. Merton, George Reader and Patricia Kendall (eds.), *The Student Physician* (Cambridge, Mass.: Harvard University Press, 1957); Howard S. Becker, Blanche Geer, Everett C. Hughes and Anselm Strauss, *Boys in White* (Chicago: University of Chicago Press, 1961); James S. Coleman, *The Adolescent Society* (Glencoe, Ill.: Free Press, 1961); Aaron V. Cirourel and John I. Kitsuse, *The Educational Decision Makers* (Indianapolis: Bobbs-Merrill, 1963); and Barney G. Glaser, *Organizational Scientists: Their Professional Careers* (Indianapolis: Bobbs-Merrill, 1964).

### METHOD

The material for this paper is drawn from a study of how hospital personnel handle terminal patients. The data were collected over a two-year period through

<sup>3</sup> For a theoretical discussion of some of these questions on status passage see Anselm Strauss, *Mirrors and Masks* (Glencoe, Ill.: Free Press, 1959), pp. 124–31.

field observations and interviews at a teaching hospital of a medical center, a veteran's hospital, a state hospital, a county hospital, a denominational hospital and a private hospital, all in the San Francisco Bay area. Co-operation was excellent, so that the field-workers were unimpeded and able to range widely. Participant observation is an especially reliable method of data collection when one is interested in sequential interactions within natural situations.<sup>4</sup> It is also the most "adequate" and "efficient" method of obtaining information on many "properties of the same object."<sup>5</sup> In this paper we utilize our data to illustrate theoretical points.

#### LEGITIMATING THE PASSAGE

A central problem in viewing dying as a non-scheduled status passage is that of who can legitimately determine *when* the passage occurs. This determination typically cannot be left to just any relevant party, but is *the obligation and responsibility* of an institutionally designated legitimator: the doctor. He is someone with sufficient expertise, knowledge, and experience to be most able to judge accurately when the patient (the status occupant) is in passage, through what transitional statuses he is passing and will pass, how long a period he will be in each transitional status, and what his rate of movement will be between the transitional statuses. Three interrelated problems of importance for which the doctor is held responsible are (1) defining temporal dimensions of the status passage, (2) timing announcements about the status passage to the patient and to other involved parties, and (3) co-ordinating the passage itself. In this first section we shall discuss the defining of the

<sup>4</sup> Howard S. Becker and Blanche Geer, "Participant Observation and Interviewing: A Comparison," *Human Organization*, XVI (No. 3), 31-32.

<sup>5</sup> Morris Zelditch, Jr., "Some Methodological Problems of Field Studies," *American Journal of Sociology*, March, 1962, pp. 567-69, 575.

status passage; in the next the timing of announcements on the passage; and in the following section co-ordinating the passage.

Dying is divided by medical personnel into four death expectations, which we conceive of as the transitional statuses of dying that define the patient's status passage from living to dead: (1) uncertain about death and unknown time when the question will be resolved, (2) uncertain about death and known time when the question will be resolved, (3) certain about death and unknown time when it will occur, and (4) certain about death and known time when it will occur.<sup>6</sup> In defining which dying or transitional status the patient is in and which he is passing to, it is often far easier for the doctor to say whether or not death is *certain* than at what *time* either uncertainty will be resolved or death will occur.

It is easier to establish certainty than time because of the two principal kinds of cues upon which the doctor bases his judgment: physical attributes of the patient and time references made about him. Physical cues, which vary in their severity from those that spell hope to those that indicate immediate death, for the most part establish the certainty aspect of death expectations. As for temporal cues, they have many reference points. A major one is the typical progression of the disease against which the patient's actual movement is measured

<sup>6</sup> It is important to note the theoretical step forward that we have taken from the two articles by Fred Davis, each of which brought out the notion of differential perceptions: "Uncertainty in Medical Prognosis," *American Journal of Sociology*, July, 1960, pp. 41-47; and "Definitions of Time and Recovery in Paralytic Polio Convalescence," *American Journal of Sociology*, May, 1956, pp. 582-87. In the medical prognosis article, Davis discussed the differential perceptions of certainty of prognosis held by doctor, patient, and family. In "Definitions of Time . . .," the differential perceptions of time of recovery held by these people were discussed. In our study, each participant defines the dying patient situation in terms of both certainty and time.

(he is "going fast" or is "lingering"). Another temporal reference is the doctor's expectation about how long the patient will remain in the hospital compared to how long he does remain. For instance, one patient's hospitalization was "lasting longer than the short while" that had been anticipated by the physician. Work schedules also provide a temporal reference: doctors adjust their judgment on whether or not the patient can continue being bathed, turned, fed, and given sedation regularly.

In combination, physical and temporal cues have interesting consequences. Since physical cues are easier to read, without their presence—which helps establish some degree of certainty about death—temporal cues remain rather indeterminate. That indeterminacy is reflected in such phrases as that the patient may die "some time" or "any time." As both types of cues accumulate, they can support each other: for example, a patient's condition becomes more grave as his hospitalization becomes longer. But physical and temporal cues can also cancel each other: thus undue hospitalization can be balanced and even negated by increasingly hopeful physical cues. When cues cancel each other, the more hopeful cue (he is going home sooner than expected) can be used to deny the less hopeful (he looks bad). As physical and temporal cues accumulate in severity and speed, respectively, deniability decreases, while a correspondingly determinate death expectation is gradually established. Then, doctor and staff are less likely to be surprised because of an inaccurate expectation.

While other parties to the status passage (including the patient) are not institutionally designated to define either the patient as dying or his current transitional status, they privately engage in trying to ascertain whether he is in passage and where he is, in order to guide their own behavior. For instance, nurses who have not received information from the doctor

will try to read the same cues as he does, but their definitions will usually be imbued with *doubt*, especially when they try to ascertain the temporal dimension of the transitional status that the occupant is in or passing to and the period of time he will be in each status. If the doctor does tell them the patient is in passage and his definition of transitional status disagrees with their own, then they will usually accept his, since he is the responsible expert. However, in some cases of disagreement, experienced nurses will not change their view, since they feel familiar with the timing of this passage. While family and patient may never really believe that the latter is dying unless the doctor discloses the news, after a while they can hardly avoid the temporal cues—such as undue hospitalization—even though they are not expert at recognizing physical cues. Thus they may start suspecting the occurrence of dying however undefined such a status passage may be to them.

When establishing the various temporal aspects of the dying status passage, the doctor, as legitimator, may also set forth the probable sequence of transitional statuses that the patient is expected to follow. While the transitional status-sequence in dying is not institutionally prescribed, many typical ones are known that help the doctor to anticipate a schedule of periods in transitional statuses and rates of movement between them. For instance, there is the "lingering" pattern in which the patient stays in the "certain to die but unknown when" status. Even in this case there are temporal limits to holding on to that status: though the patient is expected to remain for some time, after a while the nurses, doctors, and family may feel that he is taking more time than is proper in dying. Other sequences are the "short-term reprieve," in which the patient seems "certain to die at a known time" but suddenly begins to linger for a while and then dies; the "vacillating" sequence, in which the patient

alternates over and over from "certain to die on time" to lingering; and the "heroic" sequence, in which a patient in the "uncertain, unknown time of resolution" status passes to the "uncertain, known time of resolution" status, while the medical staff heroically tries to save him. This patient may then pass either directly to death or through both certainty statuses first.

#### ANNOUNCING THE PASSAGE

Since the behavior of others toward a status occupant is temporally oriented<sup>7</sup>—that is, how long he has been in the status, when he will move on to another, what his rate and period of transition will be, and what his next status will be—it is crucially significant that announcement of dying, since it is an unscheduled status passage, be the obligation of the doctor. Only he is institutionally designated both to legitimate and to announce that the patient is dying. For in the end the doctor is the person held socially and perhaps legally responsible for the diverse outcomes resulting from changes in the behavior of the patient, of other parties to the patient's passage, and of the hospital organization occasioned by his legitimating and announcing temporal aspects of the dying. These outcomes can range from being most *beneficial*, as when the doctor announces to the staff that a patient is about to die in order quickly to co-ordinate heroic measures to save him, to being most *adverse*, as when a family, unaware that their relative is dying, is thereby given no time to prepare for his death and may be deeply shocked by the surprise of it, which, in some cases, can cause a family member to have a heart attack. The proper timing of announcements can forestall such surprises.

In view of his responsibility for the effects on all parties of changes in behavior of all parties, the doctor has many decisions to make about to whom, how much and

when to announce. In some cases, he is guided, or forced, by hospital rules to make various kinds of announcements (principally to the family who "must be told something") at certain points in the status passage. In some hospitals, the doctor is required at least to legitimate for the medical staff a degree of the certainty dimension of the dying or transitional status by putting the patient on a critically, dangerously, or seriously ill list or by including the information on an admitting card. He will often be reminded of this rule "before it is too late." The patient's being posted on such a critical list usually requires an announcement of dying by the doctor to the family. If they are not on hand, a family member is sent a wire stating that "Your (kin) has been put on the critically ill list, please come at once." The doctor then has a talk with the family. After this announcement, the family is allowed to visit around the clock with the patient. Thus the family's awareness of dying changes its temporal approach to contact with the patient, because the hospital allows relaxation of the temporal aspect of visiting rules. This announcement also allows the family time to prepare for the demise of its relative and time to get estates and wills and other social and personal responsibilities properly in order.

When the patient passes from a dying status to death, only the doctor can pronounce death (a professional as well as hospital rule), and only he is supposed to announce death to the family. These two announcements must be made as soon as possible after death, both to forestall other parties from leaking the news, possibly irresponsibly, and to keep nurses and families fully abreast of developments as they happen so these people can adjust their behavior accordingly.

Since the doctor's responsibility is very great, he is allowed much discretion—unguided by formal rules—on when, what, and how to announce dying to others.

<sup>7</sup> Strauss, *Mirrors and Masks*, *op. cit.*

Short of the critically ill list, which doctors may try to avoid, doctors vary considerably as to whether or not they give nurses information; however, these variations are patterned under certain temporal conditions of the status passage. The temporal and physical cues on the patient's condition may be so obvious that the doctors feel that there is no necessity for informing the nurses about the patient's current and expected status. For instance, the patient is obviously near death, or obviously nothing more can be done for the patient, and now it is just a matter of waiting. Also, the doctor may be quite oblique in telling nurses about dying in the initial uncertainty statuses; but as the patient passes through the certainty statuses, the doctor becomes more direct and explicit about certainty as well as expected time of death. Thus he varies the clarity of his announcements in line with the patient's passage from one transitional status to another.

Some doctors may try to avoid announcing to others altogether; but this is difficult, as we have seen, because these others are defining the dying on their own and basing their behavior on their own definitions. Thus the doctor is forced at points to make sure that the others' definitions are correct, so that their behavior will not result in adverse outcomes for the patient, themselves, or other parties. For example, a strategic passage in dying is from the transitional status of "uncertainty and time of its resolution known" to either of the two certainty statuses. Accompanying this passage is an important change in the goals of nursing care: that from working hard to recover the patient to routinely providing him comfort until death. If nurses perceive the passage inaccurately they can cease trying to save a patient, although he still may have a chance to survive. Therefore, the doctor will make sure the nurses realize that the patient is still in the uncertainty status until he himself

is sure all hope is lost. He will often give them a time limit on when they may expect the outcome. If the doctor sees a nurse not wishing to accept the passage from uncertainty to certainty, he may delay telling her it is occurring or has occurred in order to keep her alert to possible reversals. However, if this delay interferes with her providing adequate comfort to the patient, say giving enough pain killers, he will have to tell her that the passage has occurred. Sometimes when a doctor will not stop his attempts to save a patient who is obviously lost, a nurse will have to tell him that the passage has actually occurred. She will tell him that more blood will do no good or that continuing the heart massage is useless. Conversely, often the doctor's actions are enough to announce this crucial passage to nurses: for example, he stops using equipment or giving blood transfusions. If a nurse does not understand and blurts out, "Do something, doctor," she will have to be told, "It's all over" or "There is nothing more to do."

Various temporal organizational conditions can literally wipe out a doctor's announcements if the hospital has no formal provisions for diffusion of information on dying. Thus doctors' announcements often are informal and directed at a few nurses in attendance. If these nurses do not informally pass on the information among themselves, it can be lost in the change of work shift or in the rotation of nurses between wings, wards, or patient assignments; and relevant parties will not be aware that the patient is dying. Dying is not the easiest news to pass on, especially if the doctor is vague or unsure in announcing it. Another organizational condition that may preclude a nurse from being "in" on the informal distribution of information about dying is the temporary assignment of students to a patient. Thus a student may have no idea her patient is dying and may be quite shaken to hear afterward that the patient has died.

Whether or not to announce dying to the patient can be quite problematic since the status passage may be inevitable as well as undesirable. While supposedly the doctor is allowed the maximum of discretion for each patient, it would appear that the professional rule is not to disclose dying to the patient, since surveys show that few American doctors do. Thus the dying patient typically knows neither his true transitional or dying status nor his rate of movement between statuses, and is thereby denied the time necessary to prepare himself for death and to settle his financial and social affairs. He therefore may either complete his status passage unaware that he ever was in passage between life and death or be very shocked almost at the end to discover he is and has been in passage for some time.

The doctor may have several temporal problems in deciding whether or not to disclose a patient's dying to him. Three problems are (1) spending enough time with the patient to judge how he will take the news; (2) timing a disclosure in order not to risk losing the patient's trust in his expertise and responsibility; and (3) deciding how much to tell the patient about the direction, periods of transition, and rates of movement of his passage.

Doctors often do not have enough time to spend with dying patients to make an adequate judgment as to whether or not, say, the patient will become despondent, commit suicide, or actively prepare for death. Under this condition, they prefer not to tell the patient. However, if the doctor realizes the patient is becoming aware that he is dying, the doctor may feel forced to disclose to the patient, and he must time the disclosure just right in order not to risk losing the patient's trust in his care. In disclosing, the doctor will typically leave out the temporal dimension of the dying status, as a way of softening the blow for the patient and perhaps giving him interim hope. The doctor will also

avoid details of the illness that may give the patient temporal knowledge about his dying. He also may follow his disclosure with a temporal rationale, such as "You've had a full life," or "Who knows, maybe next week, next month, or next year there will be a drug that can save you." Leaving out the temporal dimension of the dying status also reduces chances of error, since, as we have seen, it is easier to judge certainty than time.

When the doctor decides not to inform the patient that he is dying, several temporal problems of announcement are created for other parties who must deal with the patient. One problem is how to ascertain whether or not the patient actually needs to be told, since he might really have discovered his passage on his own. If the doctor has decided the patient should not be informed, the nurses are not allowed to ask the patient if he is aware he is dying. Therefore, they may engage in endless debates, stimulated by changes in the patient's behavior, as to whether or not he "really knows." These debates may never be resolved and can even last long after the patient has died.

Two other temporal problems created for parties to the dying passage are those of handling unwitting and witting announcements to the patient. They must avoid providing temporal cues to the unaware patient that will clearly indicate he is dying. Because of the nature of his dying, this may be impossible. For instance, when the patient passes from "certain to die—time unknown" to "certain to die—time known," it may be important to move him to a dying room or to an intensive care unit. Implicit in these moves is a timing that indicates quite clearly to the patient that he soon will die. To counteract this realization, some nurses will mention that these spatial moves are done to provide the patient better care, as a way of trying to deny their temporal meaning to him. Another clear temporal cue to the

patient is the appearance on the scene of a chaplain or priest, whom the nurses are supposed to call when the patient is still sentient and on the verge of death. It is difficult to forestall the patient's reading of this cue.

One way nurses avoid unwitting disclosures to a patient is to take a temporally neutral stand in the face of his questions about his condition: they say things like "We all die sometime," or "I could leave here and be killed walking across the street." Another strategy is to maintain, in all talk and work with the patient, a constant time orientation that is linked with his certain recovery. Thus he sees himself being constantly placed in the recovery status.

Sometimes nurses will wittingly break the institutional rule that only the doctor may disclose dying to the patient. In some hospitals, enforcement of this rule is based on legal action as well as less formal sanctions against the person who would disclose against the wishes of the doctor. A navy corpsman told us that disclosure would be grounds for a court-martial, and a nurse who discloses can lose her job in a hospital or her place in a referral system.

Several temporal conditions, however, may stimulate disclosure by nurses to unaware patients against the doctor's orders. One condition is that the family is with the patient while he is dying, and it is clear to the nurse that if the patient knew what was happening he could then take adequate farewell of his wife and children in such a manner as to benefit all—such as awarding social responsibilities to a son for care of the mother. It is also clear to the nurse that there is no time to convince a doctor of this pressing need for action, and that she must disclose either now or never. An inaccessible doctor may also force the nurse to disclose in order to accomplish an immediate medical treatment. She, like the doctor, may also be forced to tell a patient in order not to lose his trust if

he is starting to realize his condition; otherwise, after he is certain enough of dying, not to have acknowledged it to him (or to disclose later) makes the nurse sound "phony." The patient will feel he is being "strung along" and "getting the run-around."

In spite of the doctor's announcement of dying to relevant parties, he cannot actually guarantee the occurrence of a transitional status or death since it is unscheduled. If the passage does not go through as announced, difficulties can be caused between the doctor and family and hospital personnel who might have a stake in the passage being finished and who are making plans accordingly. These parties may not trust the doctor's expertise in future cases. For instance, in an unexpected short-term reprieve sequence, a doctor announced that a patient would die within four days. This patient had no money but needed a special machine during his last days. A hospital at which he had been a frequent paying patient for thirty years agreed to receive him as a charity patient. He did not die immediately but started to linger indefinitely, even to the point where there was some hope that he might live! His lingering created a money problem that caused much concern among both his family and the hospital administration. Paradoxically, the doctor had continually to reassure both parties that this patient—who lasted one and one-half months—would soon die.

#### CO-ORDINATING THE PASSAGE

Our discussion has indicated that the essential element in shepherding the patient through the dying status passage is co-ordination of the definitions of the passage held by those parties involved, since these parties adjust their behavior according to their definitions. In order to work sufficiently well together, each relevant party must know how the others are defining the passage. It is the doctor's re-

sponsibility to make sure that everyone knows what they need to know at certain points during the status passage so that difficulties do not develop.

Since many people can be involved, diverse sets of patterned differential definitions can be the basis of co-ordination, each with its own mechanisms for shepherding the occupant from one transitional status to another. In this last section we have space to consider only a few temporal aspects of the co-ordination of passage under two patterned conditions: (1) only the doctor and his staff know of the passage; and (2) all parties, including the patient, are fully aware of the passage.<sup>8</sup> These two sets of differential definitions include the two basic alternatives considered by the doctor who is co-ordinating the passage: to tell or not to tell the patient.

*Occupant is unaware.*—When the patient is unaware that he is dying, the doctor and his staff have considerable control over the passage. However, since the patient cannot purposively help his own passage, his unawareness can present temporal problems to those in control—such as unduly slowing down or speeding up the passage. Some treatments to sustain life do not make sense to a patient who does not know he is dying.<sup>9</sup> He may refuse a medicine, a machine, an awkward position or a diet, thus shortening his life. A temporally oriented tactic to cope with the problem is proffering a momentary transitional status. The patient is delicately rendered a few cues that indicate he might die if he does not agree to the treatment. As soon as he takes the treatment, the prof-

ferred dying status is immediately withdrawn, say, by laughing it off. The reverse of this example is also true: an unaware patient may ask for treatment that would needlessly prolong his life into a period of uncontrollable pain or deterioration. Thus he may be denied treatment of this sort. These illustrations show that the patient will be managed by doctor and staff in ways enabling work to go on for the passage, while the patient's awareness remains unchanged despite changes in his transitional status.

Part of working with the unaware patient while shepherding him through his passage consists of talking with him. Therefore, if he is to be kept unaware he is dying, the temporal dimension of this talk must be managed to prevent giving cues. The doctor and his staff will tend to manage their talk with the patient according to the transitional status they define him in and expect him to pass into. One strategy noted above is to use a constant time orientation that refers to one status only. Coexistent with this strategy may be another in which talk is managed on a present-future oriented continuum, so as not to raise a temporal reference for discussion that would lead the patient to suspect and schedule his dying. For example, when a patient is defined as certain to die in a few days, nurses will tend to focus their talk upon the immediate present. They discuss with him current doses of medication for pain relief, ask to fix his pillow, or focus upon matters relevant to his comfort. However, if they do not know when he is going to die, they will extend the temporal range implied in their talk. One nurse thus said, before leaving for a weekend, "See you next week." Another told her patient about his needing another x-ray in two weeks. Similarly, blood tests that will be done next week or the family's visit of next weekend will be discussed. Frequently the nurses cautiously manage such temporal references without clear intent. One young nurse told us how

<sup>8</sup> For a full discussion of these patterns of awareness conditions see Barney G. Glaser and Anselm L. Strauss, "Awareness Contexts and Social Interaction," *American Sociological Review*, XXIX (October, 1964), 669-78.

<sup>9</sup> Similarly it is difficult for polio patients who anticipate being cured to take full advantage of rehabilitation programs for the handicapped. Davis "Uncertainty . . .," *op. cit.*, p. 45.

she used to chat with a young patient about his future dates and parties. After discovering his certain and near death, she unwittingly cut out all references to the distant future, because this kind of talk was "inappropriate" for a patient who is to die in a matter of hours or days.

When it is uncertain whether the patient will die but nurses know that a definite answer is soon coming, some will engage in faith-oriented talk about the near future. An example is, "You'll probably be going home soon after your operation." Such statements support the patient's hope about the near future—although they do not actually detail exactly how he is going to live out his life. However, if the nurses are uncertain both about his death and about when the issue will be resolved, then their talk becomes less guarded. They tend to talk of the patient's return to home and work.

*Occupant is aware.*—Once the patient is told by the doctor that he is dying—and recovers from the shock if the passage is both inevitable and undesirable—he must make the decision either to accept or deny dying. With this disclosure and acceptance or denial, the balance of control over the status passage can shift from the doctor and his staff to the patient.

If the patient *accepts* that he is dying, the doctor and his staff can help to prepare him for the passage on many levels—medical, psychological, social, and financial. And the more active the patient is in his preparation, the more others can help during the remaining time. In this way, the doctor and staff can regain a measure of control potentially lost at the initial disclosure, since they have had experience in helping other patients prepare—some are professional preparers, for example, chaplains and social workers—and the patients accept their aid.

Since the doctor has allowed everyone to know the patient is dying, there may be as much free discussion as people can reasonably take in helping prepare the

patient. Family and patient can obtain fairly uncensored information on the latter's condition. The patient can focus his remaining energy on settling his affairs properly before death, instead of trying vainly to get well. One cancer patient whom we observed held off on sedation as much as possible so as to put his financial and social affairs in order with the aid of a social worker. Another told his son about various duties that would befall him as man of the house. One young man tried to get his wife potentially married off to another man who worked in the hospital. Nurses and chaplains do not have to walk on "conversational eggs," but can devote themselves—if they can manage their own feelings—to helping the patient settle his affairs, discuss his past life and coming death, and make a graceful exit from life.

There is a temporal pitfall in this active preparation allowed by the fact that all people are aware. Typically the doctor will give both certainty and time dimensions of the patient's status passage to nurses, chaplains, and social workers, but not to family and patient. Thus patient and his helpers can talk politely past each other temporally; yet problems of preparation may arise. The social worker or chaplain who expects the patient to die in a month might wish to hurry up certain preparations in co-ordination with reviewing the patient's past life, such as, respectively, his making a will or taking up religion. But the patient, left to his own time orientation, may give himself a year or two and be in no rush for either his will or religion.

Acceptance of the passage does not always mean active preparation. The patient can fight dying, no matter how inevitable, and often with the help of others. In this situation, the doctor and his staff lose much control over the passage. For example, the dying patient may reject his doctor and with the support of family go to a quack or marginal doctor who will help him "beat

this thing." One way a doctor can maintain and then regain much temporal control is to permit the patient to go for the "cure" with the idea of keeping a general watch over his physical condition and of preventing premature death. Thus it will only be a matter of time before the "cure" fails and the patient returns to his doctor. If the doctor does not give permission, the patient may be too embarrassed to return after the failure. Indeed, he might take complete temporal control over his passage by scheduling and committing autoeuthanasia (suicide). Other patients will proceed directly to autoeuthanasia as a way of putting temporal order into an interminably unschedulable dying.

If the patient *denies* he is in passage, he sees himself in a living status—recoverable—although the surrounding people see him in a transitional status of dying. Then it is hard, if not impossible, to help the patient in his passage, and much control is lost. The doctor and staff must develop ways to do it unbeknownst to the patient. At the same time, the patient is trying to get the people around him to join in the definition that he will never have to leave his living status. Thus both the patient and the others are trying to obtain shared definitions: the patient to get everyone to deny his passage, the others to get him to accept it.

The dying patient may use several temporal strategies to get others to help deny his impending passage. One we have seen is that the patient thinks up his own time schedule, which can amount to living several years, and then gets nurses and family to engage in this time orientation which becomes, then, circumstantial proof to him that he is really not dying. The patient will also ask the doctor or nurses for explanations of extended hospitalization or slow recuperation in a way that begs for denial that he is dying. Another strategy is a game of temporal polarity—asking an extreme question that may force the doctor or nurse into a denying re-

sponse. To the question, "Am I getting worse, the medicine is not working?" the staff may have to answer, "Give yourself a chance—medicines take a long time." So, the patient ends up with the idea that he has a long time.

It is also likely that the denying patient's passage will be lonely. Since he has been told he is dying, the staff will expect him to act according to the requirements of this status passage, in contrast to the unaware patient who is expected to go on as before. When he does not, because of his denial, he will frustrate their efforts to relate to him according to how he is supposed to act (he will not let the preparers prepare him). They may give up, leave him alone, and turn to patients they can help. The source of their frustration is the differential defining by the patient, who sees himself as staying in his present recoverable status, and by the staff, who see him in passage toward death. Needless to say, the denying patient is liable to complete his passage with neither preparation for the change in status or understanding of the effect of his dying on others.

#### CONCLUDING REMARKS

Other dimensions of status passage bring our own study into more precise focus. We have been writing about *unscheduled* passage. Another dimension is whether or not a status passage follows an institutionally *prescribed transitional status-sequence*. For instance, many of the ethnographic descriptions of growing up and aging and many descriptions of organizational careers delineate prescribed passages. (Such passages may or may not be precisely scheduled.) Transitional status is a concept denoting *social structural time*.<sup>10</sup> If we ask how a

<sup>10</sup> Transitional status, as a concept for handling social structural time, may be contrasted with the concepts suggested by Moore of synchronization, sequence, rate, rhythm, routine, and recurrence. All help us talk of the social ordering of man's behavior, but the Moore concepts lack the re-

social system keeps a person in passage between two statuses for a period of time, the answer is: He is put in a transitional status or sequence of them which denotes a period of time that he will be in a status passage. Thus the transitional status of "initiate" will, in a particular case, carry with it the amount of time it will take to make a non-member a member—a civilian is made a soldier by spending eight weeks as a basic trainee.

Another dimension of status passage is to what degree it is *regulated*; that is, to what degree there are institutionalized operations for getting an occupant in and out of beginning, transitional, and end statuses and keeping others informed of the passage. Rites of passage are instances of such regulated operations. It is notable in the case of dying that the non-scheduled status passage involves both fairly regulated and fairly unregulated temporal elements. An example of the former is that at certain points in the passage the doctor must announce dying to a family member. An example of the latter is the typical problem: When (if ever) does the physician announce to a patient? Together the regulated and unregulated elements of the non-scheduled status passage generate one structural source of differential definitions among parties to the passage. Further dimensions of status passage are to what degree the passage is considered *undesirable*, whether or not it is *inevitable*, and the degree of *clarity* both of the relevant transitional statuses and of the beginning and end statuses of the passage itself.

We believe that it is important to distinguish clearly among such structural dimensions of passage, and among the vari-

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quirement of linking a discussion to social structure. They must be applied to it, whereas transitional status requires that the analyst locate his discussion within social structure. We need many such concepts for handling time from a distinctly social structural view. See Wilbert E. Moore, *Man, Time and Society* (New York: John Wiley & Sons, 1963), chap. i.

ous possible permutations. Thus dying in hospitals can be located in the following way: the status passage is non-scheduled, non-prescribed, undesirable, and after a point, inevitable. The passage is sometimes regulated but sometimes not, and sometimes relatively unambiguous—except for its end status—and sometimes not.

A crucial step in the study of status passage is to compare different types in order to begin generating a general theory of status passage.<sup>11</sup> Various combinations of the above dimensions provide both ways of typing different status passages and some of the conditions under which the passage is managed. Differences between two sets of these conditions will, therefore, tend to explain why two types of status passages are managed differently.

For example, the *engagement* status passage between the statuses of single and married in America is usually institutionally non-scheduled like dying; but, unlike dying, it is desirable to the parties in passage. Therefore, because of its desirability, the status occupants are their own legitimators of when they are in passage, what the transitional statuses will be, and for how long a period they will be in each one. In contrast, in cases of undesirable or forced engagements, such as found in Europe and Japan among the upper class, the occupants are not their own legitimators.

The *defendant* status passage linking the statuses of citizen to prisoner is an undesirable, scheduled passage. Here we find that the definition of the transitional statuses of sane or insane usually lacks clarity. In contrast to dying, the institu-

<sup>11</sup> For an example of a general theory based on the consideration of many diverse substantive findings pertaining to an abstract category see Erving Goffman, *Stigma, Notes on the Management of Spoiled Identity* (Englewood Cliffs, N.J.: Prentice-Hall, 1963), p. 147. For a method of generating theory through comparisons of similarities and differences see Barney G. Glaser, "The Constant Comparative Method of Qualitative Analysis," *Social Problems* (in press).

tional legitimator of these statuses is often not a clearly designated person. Should he be a lawyer, a general practitioner, or a psychiatrist, and if the latter, of what persuasion? Thus the person who would be a legitimator must develop tactics both to make his claim as such "stick" and to have his definition of the defendant's sanity status be accepted by the court. What are the characteristic tactics he uses?

A study of the polio patient provides us with useful comparisons between the *recovery* and *dying* status passages.<sup>12</sup> This recovery passage is also non-institutionally scheduled or the status-sequence prescribed; it is undesirable, and, after a point, inevitable. One difference between it and dying is that the end status, where the passage will lead, is frequently unclear. As a result, the doctor as legitimator is often very chary with information to family and patient both in the hospital and after discharge (even though after a time he may form a clear idea of where the patient will end up. This lack of clear announcements on the end status stimulates the

patient and family to engage in a vigorous search for defining cues to just how much better the patient can be expected to get.

There is in Davis' account very little information or analysis bearing upon the coordination of people's behavior by giving them correct definitions. The reason is easy to find: while our study was focused upon medical personnel *in* the hospital, his study was focused largely—especially in later phases of the passage to "getting better"—upon the family outside the hospital. The medical personnel would not be so concerned with co-ordinating a passage outside their organizational jurisdiction.

Last, our study of a non-scheduled status passage highlights the usefulness of taking explicit account of the participants' differential concepts of transitional statuses and their timing in the study of *all* types of status passage and consequent behavior. Typically, in the study of scheduled status passage, the sociologist implies that participants operate consensually, not differentially, and behave only according to the institutionally designated timing in status passage.

<sup>12</sup> Fred Davis, *Passage through Crisis* (Indianapolis: Bobbs-Merrill, 1963).