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# Governing death. Organizing end-of-life situations

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## Abstract

This paper examines the organization of death. Through an ethnographic study, we examine how a geriatrics department guides the end of life. Drawing on Agamben, we show that organizations that are dedicated to life, but regularly confronted with death, develop dispositifs (mechanisms, technologies, practices, and relationships) to turn biopolitics (power over life) into thanatopolitics (a regime of death). We also show how the inherently political meaning of life disrupts such government of death. The inclusion of political life in a regime of death disrupts organizational practices that find themselves facing fundamental questions of what makes a life worth living, who can decide not to prolong life, and based on which criteria.

## Introduction

‘The defensive attitudes and the embarrassment with which, today, people often react to encounters with dying and death fully bear comparison with the reaction of people to overt encounters with aspects of sexual life in the Victorian age. As regards sexual life, a limited but noticeable relaxation has set in; social and perhaps individual repression is no longer quite so rigid and so massive as it used to be. But with regard to dying and death, repression and embarrassment have, if anything, increased. Clearly, the resistance to bringing death into the open, into a more relaxed relation to dying, is greater than in the case of sexuality.’ (Elias, 1985, pp.43-44)

The parallel drawn by Norbert Elias between the ‘social repression’ of death in contemporary times and sexuality in the Victorian age shows that death remains an awkward subject. But as Foucault (1978) stressed in relation to sexuality, there has been a dramatic rise in the number of discourses on death, in the media and cultural spheres, but also in science and

politics. Although our societies talk endlessly about death and sex, strict conditions for an acceptable discourse appear to have become established, with an approved vocabulary and rules of decency that must be respected: ‘where and when it was not possible to talk about such things became much more strictly defined; in which circumstances, among which speakers, and within which social relationships. Areas were thus established, if not of utter silence, at least of tact and discretion’ (Foucault, 1978, p.18). And finally, like sex, death has to be managed, regulated, and organized: it ‘was in the nature of a public potential; it called for management procedures; it had to be taken charge of by analytical discourses’ (*ibid.*, p.24).

This article studies the organization of death. Previous research describes organizations dedicated to death (Chwastiak, 2001, 2006; Stokes & Gabriel, 2010; Clegg et al., 2012, 2013; Pina e Cunha et al., 2012; Marti & Fernandez, 2013) or participating in the management of global violence (Banerjee, 2008). Here, we are more interested in the mundane, everyday aspects of the organization of death. An emerging stream of research has started to question the meaning and consequences of death for organizations (Reedy & Learmonth, 2011). Noting that death anxieties and fantasies of immortality produce alienation and oppression (Sievers, 1990, 1993), it encourages a more ‘authentic’ engagement with death (Smith, 2006) as a form of emancipation, as our feeling of finitude provides us with a ‘sense of ourselves as autonomous moral agents’ (Reedy & Learmonth, 2011, p.124). To contribute to this stream of literature, we study what Agamben (1998) calls a ‘regime of death’. We draw on his conceptualization of thanatopolitics and describe a set of mechanisms, technologies, discourses and power relations that together produce a ‘dispositif’ aiming at governing death<sup>1</sup>. We also relate these organizational dispositifs to fields of normativity that lead to the definition of what makes a life ‘not worth living’. We thus extend the literature on death and organizations by showing how,

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<sup>1</sup> On the concept of a dispositif, see Foucault (1978, 2004a, b) and Agamben (2009).

when an organization handles, manages and organizes support for the end of life, the organization of life itself – or biopolitics – is intertwined with attempts at governing death itself.

Specifically, this article looks into the way the end of life is handled in a particular context: hospital geriatrics departments. It is based on an ethnographic study of the acute-care and palliative care geriatrics department of a French hospital. For two years we shadowed geriatricians to trace different points of view, organizational technologies, and discursive and material practices surrounding the end of life. We also filmed the department for two weeks, day and night, to make visible thanatopolitical practices, including the related material dispositifs. We thus contribute to the study of death and organizations by following people working on the front line of defence against our death anxieties (Willmott, 2000; Smith, 2006).

The hospital units we study make death less visible and less disruptive for the other hospital departments, as well as for our everyday lives, but have to ‘face up’ to death (Reedy & Learmonth, 2011). Organizing end-of-life situations, they develop practices to guide life toward death (Sudnow, 1967; Seymour, 2000; Iedema et al., 2005). In response to death anxieties, they also provide rituals, guidance, discourses, and protocols to help others accept the idea that death is coming. We thus analyse the micro-practices and technologies that participate in the production of ‘normal death’, ‘comfortable death’ and ‘authentic’ engagements with death.

Hospitals are not dedicated to death but to saving and prolonging life. Informed by biopolitics, they often make death invisible and taboo. They also tend to focus on what Agamben (1998) called ‘bare life’, conceived as biological minimum (Butler, 2004) or a merely bodily existence (Marti & Fernandez, 2013), thus denying the political dimension of life. We thus describe how hospitals set up dispositifs aiming at governing death that tend to deny the political life of the dying. However, we also show how political life can re-emerge and disrupt such organizational thanatopolitics. Instead of making political life invisible, death actually makes it impossible to conceal (Agamben, 1998). Geriatricians’ daily practices confront them

with the inescapably political dimension of life. The organization of death and related debates about what makes medical intervention appropriate raise fundamental questions about what makes a life worth living, who can decide not to prolong life, and based on which criteria.

The remainder of this article is structured as follows. In the first section we review studies of death and organizations, and draw on the work of Agamben to propose a framework to study the organization of death. We then present the methodology, focusing on the specific difficulties raised by the practice of filming and observation in such a sensitive setting. The findings are reported in relation to three main issues. First, discussions between doctors and nurses illustrate how they collectively set up dispositifs aimed at governing death. Second, discussions between a doctor and a patient's daughter show how geriatricians offer advice, rituals, and guidance to cope with our death anxieties, thereby including political life in the organization of death. Third, failures in the government of death illustrate how questions of what makes a life worth living influence organizational processes that are focused on life yet informed by death. The final discussion brings out the theoretical contributions of these results.

## Power over life and the organization of death

### *Power over life, finitude and the management of death anxieties*

Literature on death and organizations remains scarce. And yet death increasingly occurs inside organizations. As Smith (2006) notes, this is probably due to the increasing separation of death from life in modern societies, which has been described as a social repression (Elias, 1985) or the 'sequestration' (Giddens, 1991) of death. Studies of death and organizations tend to focus either on death as a metaphor or on the significance of death for organizational ethics.

The research on death and organizations that treats death as a metaphor (Reedy & Learmonth, 2011) includes studies of 'organizational death' (Sutton, 1987; Barton Cunningham, 1997; Bell & Taylor, 2011; Bell, 2012; Bell et al., 2014; Cullen, 2014; Kelly & Riach, 2014), analyses of organizational identification as a struggle for immortality (Sievers,

1990, 1993), and descriptions of alienation as a form of symbolic death (Cederström & Fleming, 2012; Fleming, 2014). However, Reedy and Learmonth (2011, p.119) argue that thinking of death as a metaphor ‘distances us from its brute materiality and (...) its capacity to make us face fundamental ethical questions about how we live our lives.’ Recent organization studies are now starting to treat death ‘as something more profound than merely a metaphor’ (Reedy & Learmonth, 2011, p.119).

For instance, several studies analyse how organizations produce what Mbembe (2003) calls necropolitics, or the subjugation of life to the power of death. Slavery, camps, ‘terror formations’ and colonial occupations all illustrate forms of necropower (Mbembe, 2003). Banerjee (2008), in particular, describes the role of organizations in such necropolitics. The organization and management of global violence (e.g., military coups, support for dictatorial regimes, violent repression of progressive parties and unions), the resurgence of privatized military forces, and communities being dispossessed of their land and access to natural resources illustrate the role of private corporations in the creation of ‘death worlds’ (Banerjee, 2008, p.1547). Other studies concern organizations dedicated to violent death (Chwastiak, 2001, 2006, 2013; Stokes & Gabriel, 2010; Clegg et al., 2012, 2013; Pina e Cunha et al., 2012; Marti & Fernandez, 2013). These articles have highlighted how organizations systematize and rationalize violence, dehumanization, and murder. They raise fundamental questions about the purpose of organizations in regimes of oppression and dispossession.

The other main focus in studies of death and organizations is on the role our feeling of finitude can play in organizational ethics. If alienation and oppression can be related to organizational members’ death anxieties and fantasies of immortality (Sievers, 1990, 1993) then their ability to ‘face up to death’ becomes central to questions of emancipation (Reedy & Learmonth, 2011), as contemplating death exposes the vanity and futility of the constant striving for organizational position and status. More fundamentally, for Smith (2006, p.229),

‘an authentic engagement with death is necessarily and inevitably uncomfortable, but it is only through this discomfort that we can genuinely come to know ourselves’. An awareness of our finitude, because it ‘encourages a more intersubjective view of our relations to others in organizations’, ‘can restore a sense of ourselves as autonomous moral agents’ (Reedy & Learmonth, 2011, pp.124-125). Death confronts us with our vulnerability, and hence other people’s vulnerability, encouraging identification with suffering itself, shaping ethical encounters and more generally the ties we have to others (Butler, 2004).

However, an awareness of our finitude can trigger death anxieties (Grant & Wade-Benzoni, 2009) and the feeling that ‘we are left alone to face death’ (Smith, 2006). Smith (2006) mentions the strategies people develop to ‘manage’ death and become more comfortable with its presence. Organizations are important in that respect, as they provide the attendants of death ‘employed to render death invisible or, at least, minimally disruptive of normal appearances’ (Willmott, 2000, p.649), and who ‘occupy the front line of defence against our death anxieties’ (Smith, 2006, p.229). Yet according to Smith (2006, p.230), when ‘relegated’ to ‘the anonymity of the hospital’, death is ‘divested of meaning (deliberately so) [so that] we lack the resources to understand its significance. Moderns lack ritual; a shared response to death has been lost. We struggle alone even to find the right words’.

Studying dying processes in a hospital setting, this paper observes rituals and analyses how meaning is restored through collective practices of ‘authentic’ engagement with death and attempts at fostering a ‘comfortable death’. Some people are ‘left alone to face death’, but this is not necessarily the case. Below, we review literature on the ‘orchestration’ of the process of dying in hospitals.

### *Orchestrating the process of dying*

Literature describes the routines healthcare organizations produce to tame death anxieties (Candrian, 2014). Ethnographies of end-of-life settings have illustrated caregivers’ efforts at

negotiating (Glaser & Strauss, 1965, 1968), organizing (Sudnow, 1967), orchestrating (Seymour, 2000) and choreographing (Iedema et al., 2005) dying processes. These studies also highlight the ethical complexities attending end-of-life decisions. Seymour (2000), in particular, describes these decisions as processes of withdrawing or withholding medical treatment, that is, as 'non-treatment decisions'. In trying to draw a line between 'killing' and 'allowing someone to die', medical practitioners have to resolve definition problems between euthanasia and natural death (see also Glover, 1977, pp.191-200; Smith, 2006). This leads them to strive to orchestrate a 'good' death through 'strategic' withdrawal of treatment that creates a seemingly 'natural' death (Seymour, 2000).

The orchestration of a 'good death' involves formalized organizational processes and less formal, ad hoc adjustments. Although 'death must be made to seem an outcome of dying' (Sudnow, 1967, p.95) this is achieved through a process involving extensive technical and human intervention. The medical staff manages the timing of treatment withdrawal to actively construct a 'good death', that is a death occurring at the 'right time' as 'nature takes its course' (Seymour, 2000). This is a way to maintain discretion and latitude in a situation of high uncertainty, but it also enables the doctors to include members of the patient's family in the decision. Iedema et al. (2005) also include considerations of professional disputes and jurisdictions in their study of end-of-life care. They note that 'a particularly sensitive area concerns the way that care vacillates between life-sustaining clinical intervention and modes of care that privilege comfort and support' (p.846). A specific group of doctors, palliative care specialists, emerges to deal with patients who are close to death 'on the assumption that dying has become inevitable', which makes any intervention beyond pain control very difficult (*ibid.*, p.852). They are called in by other medical practitioners only when 'the patient is going to leave here to die' and, for that reason, find their work labelled as 'a low status specialty because it's



not about doing' (*ibid.*, p.851). As these quotes unambiguously show, providing comfort and support for the dying – that is, guiding them from dying to death – is not considered 'doing'.

These studies describe the complexities attending end-of-life decisions and illustrate the processes that take place around the timing of death. They show that the organized care of end-of-life situations relates to the organization of 'appropriate' dying processes. They highlight how specific conceptions of 'good' and 'natural' death influence definitions of 'normal' dying processes. What remains largely implicit in these studies is the idea that this definition of normal dying is embedded in the dispositifs, technologies, and discourses related to contested fields of normativity. This is the focus of Agamben's (1998) theorization of thanatopolitics. The next section thus discusses Agamben's conceptualization of 'regimes of death' as attempts at governing death.

### *Regimes of death and the politicization of life*

Ariès (1975) and Elias (1985) have shown that humans' relationship with death depends on representations and rituals that are historically situated and socially constructed. Agamben (1998) complements these views by conceptualizing thanatopolitics as sets of dispositifs – mechanisms, technologies, discourses, and power relations that together produce a 'regime of death'. Foucault (2004a, 2004b) conceptualizes biopolitics as a regime of government through which life itself becomes enmeshed within power relations (Rose, 2001; Munro, 2012; Fleming, 2014). Agamben examines biopolitics in their final ramification, where the power over life extends to the very site which by definition escapes it, the site of death.

Thanatopolitics is interesting when studying the organization of death as it relates the dispositifs that produce a regime of death to the fields of normativity that lead to the definition of what makes a life 'not worth living'. Agamben (1998) looks at the thinking behind the definition of the value (or lack of value) of life as such. To understand what gives a life value, he examines the criteria used to designate an individual as *homo sacer*, i.e. a person who can

be killed without the killing counting as homicide. Agamben argues that a *homo sacer* is reduced to ‘bare life’, a life conceived as the biological minimum (Butler, 2004), a mere bodily existence (Marti & Fernandez, 2013) that has lost its political meaning and become ‘less-than-human’ (Ten Bos, 2005). For Agamben, the loss of (legal) value of life is an eminently political event. It is even a ‘politicization’ of life, a generalization of politics to bare life, biopolitics. It is ‘a new decision concerning the threshold beyond which life ceases to be politically relevant, becomes only “sacred life”, and can as such be eliminated without punishment. Every society sets this limit; every society – even the most modern – decides who its “sacred men” will be’ (Agamben, 1998, p.81)<sup>2</sup>.

This connects biopolitics and thanatopolitics by showing that the question of life is inseparable from the question of death. This is most visible in extermination camps where genocide is made possible through ‘othering’ and the related denial of people’s essential humanity (Stokes & Gabriel, 2010; Pina e Cunha et al., 2012; Marti & Fernandez, 2013; Annisette & Prasad, 2017). Fassin (2012) also shows how the organization of refugee camps tends to deny refugees’ political life. Chwastiak (2001, 2006) examines how planning, programming and budgeting in the US Department of Defense in the 1960s served to ‘normalize’ nuclear war, transforming it from a horrific potentiality into a series of problems to be solved, thus converting ‘the unthinkable’ into a technical and mundane resource allocation

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<sup>2</sup> Agamben does not refer to the contemporary definition of the ‘sacred’. Instead he studies the notion of ‘*homo sacer*’ in ancient Roman law, which he translates by ‘sacred life’ and ‘sacred men’. He shows that some individuals were designated as *homo sacer*, which meant that they were not to be sacrificed yet could be killed by anyone without the killing counting as homicide. They entered a ‘state of exception’, becoming a figure of exception embodying a life that only has legal existence through its exclusion. He goes on to show that this state of exception can be found today in many forms, including camps, where people are reduced to ‘bare lives’ – or, at least, treated as such. He debated this idea with Judith Butler during a ‘public conversation about Eichmann, Law and Justice’ held at the European Graduate School in 2009.

problem. Organizations dedicated to death tend to reduce people to the state of bare life, denying their political life and treating them as *homo sacer*.

Thanatopolitics also operates on a more everyday level. One particular example given by Agamben (1998) is euthanasia, which in his opinion illustrates the ‘fundamental biopolitical structure of modernity’ (*ibid.*, p.80) since ‘from the perspective of modern biopolitics [...] euthanasia is situated at the intersection of the sovereign decision on life that may be killed and the assumption of the care of the nation’s biological body. Euthanasia signals the point at which biopolitics necessarily turns into thanatopolitics’ (*ibid.*, p.83).

Agamben analyses several different situations, including that of the individual no longer able to decide between life and death (no longer displaying the will to live nor a desire to die) – then, the expert (a doctor, psychiatrist or legal professional) will make ‘the final decision’ (*ibid.*, p.81). This is particularly visible in ‘resus’ departments, when a doctor must decide whether or not to resuscitate a person. Agamben writes that this point in time ‘delimits a space of exception in which a purely bare life, entirely controlled by man and his technology, appears for the first time. And since it is precisely a question not of a natural life but of an extreme embodiment of *homo sacer* (...), what is at stake is, once again, the definition of a life that may be killed without the commission of homicide’ (*ibid.*, p.94). The very concept of death is becoming ambiguous and indeterminate, and its definition is a source of controversy (Sudnow, 1967; Agamben, 1998; Butler, 2004; Smith, 2006). Death is no longer an event for scientific observation, it only acquires clear meaning through a decision: it is not noted, but performed.

This paper focuses on the organization of death in geriatrics departments. As we show below, geriatrics departments bring out a number of questions concerning the end of life and what makes a life worth living. We thus examine thanatopolitical dispositifs – the rituals, the mechanisms, the technologies used to accompany the dying. Through this examination we try to understand the extent to which the dying are reduced to bare lives, or instead whether their

political life is recognized and included in thanatopolitics. We now detail the methods we followed to examine these questions empirically.

## An ethnographic study of an acute-care geriatrics department

### *Our approach to the field*

This article is part of a broader research project concerning hospital management. In this project's first stage we studied the succession of public hospital reforms in France. We obtained access to acute-care and palliative care geriatrics units at a hospital in the Paris region. In June 2010, one of the department's doctors said: 'To understand us, it's important to follow our work'. They asked us to see things through their eyes, to observe what was involved in their practice. And we decided to follow them, quite literally. This was the start of our ethnographic field study, which was spread over two years. The first author and Carine (a documentary director) were present throughout the entire field study, and two co-authors joined the team after the data collection.

We drew inspiration from the organizational ethnographic approach developed by the symbolic interactionists (Geer et al., 1961; Glaser & Strauss, 1965; 1968; Strauss & Glaser, 1970; Hughes, 1971; Becker, 1998), and immersed ourselves in the organization for a prolonged period of time to understand the actors' stances and daily practices. We practiced 'shadowing' (Czarniawska, 2007), following a doctor around every day, wearing a white coat with notebooks and coloured pens in the pocket as a way of blending in to the department (although we always introduced ourselves as management researchers). We were assigned a specific place, as we shadowed doctors rather than other medical staff. To gain acceptance, we embarked on a socialization process that was not entirely dissimilar to the socialization of junior doctors, including learning the tacit rules and norms of appropriate behaviour, and only took notes once back at home. Little by little, relationships with the doctors and junior doctors were developed to the point of becoming actual friendships.

The doctors showed us how they work and how their day is organized, but they also talked about the questions they ask themselves, their doubts, pleasures and pains. Their openness about their doubts was a specific characteristic of this unit. The head of department requires newcomers to question their assumptions, remain humble and accept their own vulnerability. As he observed: 'To treat a patient, you have to connect with him, and therefore be willing to be vulnerable'. He considered vulnerability a prerequisite for meaningful contact with patients in 'their fragility as dying people'. Our overall attitude mirrored our informants' attitude toward their own work. This particularly sensitive field of observation required considerable commitment and aroused continuous reflexive consideration of our role as researchers. As well as exercising empathy and paying constant attention to what was important to the people under observation, we needed to be accepted as legitimate researchers by our informants, and that required acknowledgement of our own vulnerability. This vulnerability also meant resisting temptation to introduce preconceived ideas and interpretations. As we wrote in the fieldnotes: 'This field deals with death and how to die. Among other questions, it raises the question of end-of-life care' (Fieldnotes, 29/06/2010). Empathy entails an openness to surprise, and in fact we frequently experienced genuine emotional difficulty. Vulnerability entails acceptance of potential unsettlement.

### *Video ethnography*

After a year, the staff and patients became used to our presence, and in March 2011, we decided to spend two weeks in the department, day and night, with a camera. All the people filmed or interviewed gave us informed, written consent. It is unsettling having a camera in an acute-care and palliative care department, yet both the staff and patients were receptive to our arguments. We explained what we wanted to understand, and how the camera would enable us to observe and record what the medical staff repeatedly referred to as 'the invisible work', in order to make it visible. One of our objectives is to propose the final documentary film as a

learning tool for junior doctors, although it has not been edited yet for reasons of time and budget.

Filming is both a research method (Kunter & Bell, 2006, p. 169-189), and a product of research (Sooryamoorthy, 2007, p. 547-563). We filmed emergency situations, and situations where nothing appeared to be happening. We used a medium-sized camera and a boom microphone – so we were not discreet. This unmissable physical presence made our identity very clear, thus avoiding any misleading impression. We filmed in a wide shot to capture all the different interactions. We filmed the morning meetings, handovers, discussions with families, conversations in the hospital rooms with patients, doctors and junior doctors, meetings with the social worker, and the doctors' routine work. We deliberately refrained from filming actual medical care given to the patients. We did not obtain permission to film administrative meetings, but were allowed to attend and take notes.

To make our documentary, we had to sift through more than 30 hours of unedited film. The analysis began with the first viewing, which lasted several months. We noted the timecodes, with a description of the pictures, the picture quality, what each sequence showed, and what was on the soundtrack, including silences and machine noises. The first author and the documentary maker then put together a preliminary cut. The first author produced a 'shot-by-shot analysis', which served as raw material to produce initial interpretations. A turning point in the analysis arose when the first author watched the film again, seeing each scene several times, over several months. Out-of-shot matters were made visible by the work done with the camera. Barthes was helpful for this, with his distinction between the *studium* (photography in general) and the *punctum* (a particular detail) (see also Davison, 2007). 'In this habitually unary space, occasionally (but alas all too rarely) a 'detail' attracts me. I feel that its mere presence changes my reading, that I am looking at a new photograph, marked in my eyes with a higher value. This 'detail' is the *punctum*' (Barthes, 1980, p. 71). The initial team of

researchers had embarked on the field study with the objective of focusing on medical reforms, the *studium*, but a major question emerged from the field and took them to an ‘out of shot’ *punctum*: the question of dying.

When two further researchers joined the team after the fieldwork ended, the film considerably facilitated their engagement with the field. The film clips themselves provided more depth and direct exposition, leading us to seek out additional details and explanations, and fostering collective reflexivity within the team of researchers as we realized that we were each struck by a different ‘*punctum*’. This process brought the ‘new’ researchers to act as film editors<sup>3</sup>, and the coding emerged from our reactions and interactions concerning the *punctum* we found important. Ultimately this led to the first author being asked to provide additional material (interviews, journal excerpts) that could further explain or contradict our interpretations.

It became clear that the film clips constituted key materials to grasp the political life of dying, sometimes voiceless patients. They displayed presences and absences, provided access to non-verbal communication between actors such as eye contact or silences in conversations, and allowed the researchers to feel the emotions surrounding the patients. However, videos are not self-explanatory and need to be retranslated back into the context from which they were extracted (Zundel et al., 2018)<sup>4</sup>. To do that, instead of providing the videos themselves, we quote written transcripts and contextualised scenes taken from the videos.

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<sup>3</sup> In a traditional configuration, the film editor is usually unfamiliar with the field, and their only access to it is through the footage. Footage is the raw, unedited material as originally recorded by a video camera. Film editing is thus comparable to the writing of the story that emerges from analysis of the footage. To borrow Wiseman’s metaphor (Wiseman and Clouzot, 1976, p.24), ‘the footage is the experience of the novelist, and the editing is the writing’.

<sup>4</sup> We would like to thank Mike Zundel, acting editor, for his suggestion to engage in this debate.

### *The geriatrics department studied*

This geriatrics department we study covers two floors, with 22 beds on each floor. There are 33 nurses and nursing auxiliaries for the two floors, supervised by a nursing manager. Two doctors and two junior doctors work on the second floor, where all of our research took place. Each room contains two beds, except in palliative care which uses single rooms (an extra bed can be added for a family member). The nurses and nursing auxiliaries work in three shifts (6am-2pm, 2-9pm, and 9pm-6am). The night shift is covered by one nurse and two nursing auxiliaries for all 44 beds.

The department manager wanted to develop a geriatrics service appropriate to the specific characteristics of the age group, and has trained his teams in palliative care. All the nurses in the department are young (under 30), except for the night nurses (who are over 40). The work is not easy in these departments, and nurses generally move on after a short while, despite a bonus paid to newly-qualified nurses joining a geriatric department.

Each day begins with a handover meeting involving two nurses and two doctors. The doctors add notes to their paper files and give the nurses their instructions. Next, the doctors begin their rounds to see all the patients, pushing two very large trolleys, one for the computer and the other holding the patient files. The nursing auxiliaries change the beds and wash the patients. The nurses are in charge of giving out the medication. At lunchtime, if any patients are being discharged, the doctors must dictate the discharge letters to the medical secretaries. During the afternoon, the doctors fill in the patient discharge and admission files. They then see the new incoming patients and meet their families. At the end of the day, the doctor assesses the cost of the discharged patients by putting data into management databases.

### **Empirical findings**

This paper studies the organization of death in a setting dedicated to biopolitics. We now present various scenes that highlight interactions between caregivers and relatives around the



death of a patient. First, discussions between doctors and nurses illustrate how they collectively set up dispositifs aiming at governing death. Second, discussions between a doctor and a patient's daughter show how geriatricians offer advice, rituals, and guidance to cope with death anxieties, thereby including political life in the government of death. Third, failures in the organization of death illustrate how questions of what makes a life worth living influence organizational processes that are focused on life yet informed by death.

### *Managing the unmanageable*

Geriatricians help patients' families prepare themselves, by raising their death awareness. Yet death often remains unpredictable, catching both doctors and families unprepared. Surprisingly, unexpected recoveries can also create tensions between doctors and patients' families, as the following scene illustrates:

*The 95-year-old patient Mrs G had stopped eating, she was very weak and visibly no longer wanted to live. Her family, which includes several doctors and surgeons, decided to send her to the palliative care unit in agreement with Philippe, the head of the department. So the whole family is sure, and has accepted the idea, that she is going to die there. But it so happens that in the last few days the patient's attitude and discourse have changed. She has agreed to eat a little. She calls the junior doctor 'dearie'. The junior doctor (and the geriatrician) have the impression she wants to get better, get over her condition. Philippe has to call the family to review the 'medical plan', in other words convince them they need to change tack. He explains in some embarrassment that this is made more difficult by the fact they are doctors.*

This is an illustration of a case when a death surprises people by its absence. Since Mrs G was behaving as if she felt her life was no longer worth living, her family have prepared for her death. But she suddenly regains a will to live. The doctor suggests discharging her from palliative care, which means treating her as a person who is going to live, not a person who is going to die. Her life is worth living after all. The condition of *homo sacer* is not always inescapable and thresholds are not points of no return. Although pleased to see their patient come 'back to life', the geriatricians have to negotiate with the patient's family: they have already been through the difficult step of death awareness, and will now have to go through it

a second time. A recovery can be as disturbing as a loss, and this needs to be dealt with by the caregivers.

In the subsequent sections we examine how the medical staff actually organizes and ‘manages’ the dying process and create a dispositif around death to guide our conduct in response to death.

### *Dying patient, homo sacer and political life*

In palliative care units, the medical staff expect death to come for a large number of patients, and protocols and routines are set up accordingly. In the hospital studied, the palliative care unit is part of the geriatrics department. The medical team simultaneously works with ‘dying’ and ‘non-dying’ patients, and some patients pass from one status to the other during their stay. As the following transcript of a scene we filmed illustrates, the medical team meets to question the relevance of treating a particular patient, collectively discussing whether a dying patient should be considered as a bare life.

*[During the morning handover meeting, in the nurses’ office, as the files are passed on to the next team from the night shift. The people present are Philippe, a doctor in the palliative care unit, and two nurses, one of whom is called Aurélie. The nurses read their notes to the doctor. But when it comes to the case of Mrs M, Aurélie dares to put a question directly to Philippe.]*

*Aurélie [putting down her files, and instead looking Philippe in the eye, as he calmly returns her gaze]: I’ve got lots of palliative care patients in my section, one of them is a lady, Mrs M, in room 10. She’s in palliative care, she came in for respiratory distress. (...) She’s asleep, but you can tell that breathing is still difficult for her. (...) So if you can go and see her, just to see about her breathing. Yes, just to see, so we can adapt the medication if necessary.*

*Philippe: We’ll see whether we keep on increasing the morphine; if we should leave her on the oxygen... Well the problem is, if we stop the oxygen, that’s bound to speed things up. It’s another stage.*

*A [slightly agitated]: What I don’t understand about this lady is that she’s on antibiotics, she’s on a high-dose drip...*

*P [calmly]: Well, everything we’re doing that can be justified because it makes her more comfortable, that’s not a problem. I mean if we think that*

*giving her oxygen and [an antibiotic] will help her breathe better, it's not a problem even if she's in palliative care, why shouldn't we? (...) But we still need to ask ourselves if there's any benefit, if even the antibiotics have any benefit, we can reduce her infection and her congestion, and make her more comfortable.*

*A: At the moment, there's no congestion...*

*P: But after a while, the question arises of whether we should continue, that's the thing, should we continue? In any case, it has to be reassessed. It isn't to prolong her life, it's to try and improve her living conditions. But I'll have a look anyway, see how long it's been prescribed and maybe cut back a little bit.*

*A: Yes, OK.*

*P: The only certainty is that if she starts taking breaks, and if she's at 77% saturation and we stop the oxygen, that'll speed things up. But we're really within the legal framework. We can stop treatments that aren't necessary to keep her comfortable even if stopping them means things will move faster.*

*A: All right. [Aurélie goes back to her notes and reads them silently].*

This scene illustrates how caregivers 'face up' to death, engaging in reflexivity through collective discussion, and constitute themselves as moral subjects. The nurses actively question the treatments given. They express concerns neither because of the fear of killing, nor the cost of irrelevant treatment, but over the perceived risk of excessive medication. Since the patient 'is asleep', meaning she can no longer move or communicate, she might be considered to have a life no longer worth living, to have become *homo sacer*, which raises questions about the usefulness of treatment. The doctor acknowledges that the aim is no longer to restore health, yet refuses to consider the patient as a bare life. Keeping her 'comfortable', allowing death to happen yet 'improv[ing] her living conditions' – even in death the political life of the patient, not mere physiology, guides the process. Caregivers set up a dispositif of death, by comparing their impressions and discussing what makes a life worth living but also by defining the technical organization of death, including the protocols to follow, i.e. the practices, techniques, and tools (molecules, life-support systems) to be used. The regime of death, which is centred on the comfort of the patient, recognizes political life and aims at producing a 'peaceful' death.

## *Orchestrating without controlling: taming anxieties and creating comforting rituals*

Collective coordination to set up a dispositif of death is important, as caregivers must explain the various stages of the treatment to the patient's family. The presence of relatives makes political life particularly visible. The following scene we filmed concerns the same patient as above and starts in her room, where the doctor has come to talk to the daughter:

*Philippe: We reviewed the situation with the nurses this morning. Apparently she [Mrs M] isn't in any pain.*

*C. (the patient's daughter): That's really what we wanted from the beginning. As soon as she had her accident, as soon as they called me at the care home, as soon as she had her accident, straight away they made it clear... and even when you know... well... it's hard to accept... so what my brother and I wanted most of all was that Mum shouldn't be in pain, that's essential to us, because we know very well that the only outcome...*

*Philippe: We assess the situation thoroughly when we come and see to her, when we change her position, when we wash her, if we have to give her an injection... So apparently, every time we do something for her, we haven't seen any sign of suffering or distress, not even indirectly. Yes, that's right, so that's the main thing.*

*C: Yes, you're right. In the beginning, just after she'd been in A&E, her face was starting to look drawn, and Mum has always been strong... We could see her eyes screwing up... Since she's been here she's been peaceful... You sometimes suspect when her breathing gets a bit too loud... and so then I was told 'come and tell us'... and you do something straight away to help her rest, well, er...[C becomes very emotional]*

*P: Perhaps we should go and talk outside. [They leave the patient's room and stand in the corridor.] So I went to examine her and see her again this morning. What's happening is that she's being given certain types of medication to keep her comfortable, like the antibiotics, like the diuretics as well, to reduce the symptoms that could in fact cause a few more breathing problems and discomfort; all this medication, and the oxygen too, obviously have the benefit of prolonging her life a little bit. There's no doubt that some of this medication, well, we might find ourselves having to stop them gradually, that could result in things moving faster.*

*C: You mean you're going to reduce the antibiotics...*

*P: Yes, that's right.*

*C.: ...and give her more morphine?*

*P: That's right, morphine, Hypnovel... in fact Dr B must have discussed that with you.*

*C.: Yes, he has, he said that for the moment he was keeping a balance between the two so, um, if...*

*P.: Yes, that's right.*

*C.: But that could mean taking her off the antibiotics and in that case the end would be near.*

*P: If we stop the antibiotics, if we stop the diuretics, and maybe at some stage we'll have to stop the oxygen. [The patient's daughter looks surprised] But if we take her off the oxygen, that would only be if we were certain, and were actually increasing the sedatives enough, that it wouldn't be uncomfortable for her.*

*C. [in a choked voice]: Yes, what we mustn't do is make her feel she's suffocating.*

*P: No, no, we'll really do everything that has to be done so she's even faster asleep when we get to that point.*

*C.: But will you tell me when you do?*

*P: Of course, we won't do anything, we'll tell you every time, no, no we won't change anything without you being informed.*

How can death awareness be raised despite social repression and sequestration of death?

This scene shows caregivers creating rituals to help relatives acknowledge what cannot be said or shown: 'Death is approaching'. Rituals require the involvement of participants and reaffirm the political life of the dying, even when the patient is unconscious and voiceless. The doctor takes time to listen to the fears of the patient's daughter, guides her through her vulnerability, evokes the dying process, and explains how the caregivers will 'manage' the patient's pain. They move together from a sequestration of death to a sequestration of pain in an attempt to tame their death anxieties and produce shared responses to death.

However, the medical techniques of pain management can be misleading. By hiding the symptoms, pain management can give the impression that the patient's general condition is

improving – ‘Since she’s been here she’s been peaceful’. The doctor clarifies the situation and makes sure it is understood that ‘the end [is] near’ – dying will be peaceful, but death is inevitable. The patient will not ‘feel she’s suffocating’ but ‘will be even faster asleep’, a metaphor which reintroduces a passing reference to the quintessential peaceful death (at least in the general imagination), which is fantasized as natural – dying in one’s sleep. The dispositifs and rituals of death aim at producing a peaceful death to sequester the pain of both patients and their relatives.

The ritual does not serve to isolate a bare life so much as to include political life in the dying process. It helps to convey a sense that the situation is well-organized and under the control of a group of experts, while also acknowledging the political life of the dying person – family and relatives are included (‘we won’t change anything without you being informed’). The doctor explains the details of the treatment, including the stages to come. This helps create a feeling that what is to follow can be anticipated and hence prepared for. As the further development of the interaction shows, the doctor even takes time to answer non-medical questions:

*C.: Because I’ve just sent my brother back home to his family. My brother and sister both live a long way away... My sister’s just got here [they live in a different town]. I keep them informed all the time, so I mustn’t take them by surprise.*

*P.: I’m not going to change anything today, we’ll reassess the situation tomorrow, I’m just going to make sure that she really isn’t in pain. That means examining her a bit and seeing if she’s free of congestion and there’s no pain or discomfort in her stomach. That’s all I’m going to look at today, I won’t change the medication. It’s possible that in the next few days we might have to make changes but those changes, of course you’ll be informed. Are you bearing up OK? because you’re here all the time...*

*C.: No, I’m OK, my sister took over for two nights (...) it’s true that it’s a bit stressful but what’s also good about it is that it’s the balance with life (...) a balance with home because my little girl, I tell her [what’s happening], she knows her gran’s in hospital (...), and that if I come home then she’s feeling better... but I can’t tell her anything more because there’s no point, I don’t know what I should do, in fact I don’t know what I should or shouldn’t say.*

*(...) Can my little girl, she's 12, would she be allowed to come and give her gran a kiss?*

*P.: That's absolutely no problem, we're very flexible about that sort of thing. Of course it's not a problem. (...)*

*C.: Perhaps we should do that today?*

*P.: You could... Anyway things can always take a turn for the worse. We have no control at all over the duration. Which is just as well.*

The political life of the dying person is at the heart of the discussion between the doctor and the patient's daughter. The ritualized orchestration of visits from relatives serves to acknowledge and include the political life of the dying. The caregivers enable the passage from life to death to be shared by the family, who do not explicitly ask to be present at the death but must be prepared for separation and the mourning process. However, the anticipation, preparation, and organization of the event should not give a feeling that death is organized and decided. Although the outcome is now certain, the moment of death remains unclear. The process is organized and under control ('I'm not going to change anything today, we'll reassess the situation tomorrow') but 'things can always take a turn for the worse'. As the doctor concludes: 'We have no control at all over the duration. Which is just as well.' The doctor can suggest dying and mourning rituals but, to remain 'natural', death cannot be controlled.

As this scene highlights, organized dying is or should be unsurprising to both the medical staff, and to the patient's family. In this sense, a 'normal' death becomes a death that can be anticipated and organized. Yet the idea of 'managing' death remains ambiguous: the idea of a 'natural' – and therefore uncontrollable – process must be retained, and yet that process must be anticipated, planned for, and organized. Although such a process involves extensive technical and human intervention, 'death must be made to seem an outcome of dying' (Sudnow, 1967, p.95). Beyond technical aspects, medical staff draw on metaphors and euphemisms – patients are 'asleep' – to create an imagined natural death. They try to perform a good death, which is a dying process that is both peaceful and orchestrated.

Working on the front line in the sequestration of death, geriatricians have to organize dying processes to help people manage their death anxieties. They orchestrate the ‘passing’ in a way that must look organized but not entirely controlled. Such a dispositif combines techno-medical aspects with ethical issues and sociological rituals, which together produce a government of death. This, we argue, answers Smith’s (2006) remark that late modernity lacks rituals and shared responses to facing death. As we have shown, specialized caregivers can organize dying processes in a hospital setting. Rituals include pain management and the patient’s bare life but also the political life of the dying person. They help guide relatives as their identity evolves from a patient’s family to a dying person’s family to a deceased person’s family, in a process of socialization of death (Elias, 1985). These dispositifs of death support collective participation and coordination, preparedness, and the emergence of a sense that the process is under control. Below, we examine what happens when such organization of death fails.

### *Governing death: ethical decisions and collective reflexivity on what makes a life worth living*

The caregivers we followed strive to organize dying processes in an attempt to manage the unmanageable. Their attempts are not always successful. The following scene happened during the geriatricians’ morning rounds:

*[Two doctors, Philippe and Marine, enter a patient’s room] A shock awaits them: the patient has just died, probably four or five minutes before the two doctors walked in. The patient was weak, which is why he was in a room alone, but was ‘recovering well’ despite complicated heart problems. The nurses washed him twenty minutes ago and he seemed to be doing very well.*

*Philippe decides it is too late to resuscitate. A silence follows. He then explains that there is too great a risk that the man might then remain in a vegetative state. Philippe says ‘Life is violent, we know that when we’re born.’ The two doctors appear to be genuinely moved, and have tears in their eyes.*



*The team that had been looking after this man wonder about this death and feel the need to talk about it. Lucie (a nurse) goes into the room and stands still there for a few minutes in silence, with tears in her eyes. Christian (a doctor) comes in – he was absent because he had gone to get an opinion from the cardiology department, in order to adjust the treatment for this very patient. The three doctors discuss the patient’s death. Philippe regrets having had a meeting with the psychiatrist immediately beforehand: if the cardiac arrest had happened before their eyes, they would have resuscitated the patient. Marine, the junior doctor, asks Christian later in the morning whether they should have sent the patient to intensive care the day before. Christian answers that he’d shown a significant improvement, and intensive care would never have accepted him because there were no signs of emergency. They are palpably troubled by this sudden death. They need to talk it over together for around fifteen minutes. Then they resume their rounds, but they seem upset all morning. At the very end of the morning, one of the nurses again talks to me about the patient who died.*

Despite being in regular contact with death (there is around one death a week), the medical team are sometimes surprised, and saddened, by the death of a patient. The death was discovered peacefully, with no fuss: no alarm was triggered, there was no emergency situation, the patient simply passed away quietly – this could easily be considered the picture of a good, peaceful, ‘natural’ death. And yet this death upsets the medical staff. Two factors are notable: the unexpectedness of this death, and the feeling that they could have prevented it. They feel challenged regarding their ability to act and anticipate. Their role is either to cure, or to set up the rituals of the dying process. In this case they failed in both of these duties.

Despite the feeling of powerlessness, it should be noted that the scene opens with an important decision by the doctors: whether or not to resuscitate the patient, or ‘bring him back to life’. This option is ruled out in consideration of the potential outcome for the patient: ‘there is too great a risk that the man might then remain in a vegetative state’. There is thus ambiguity in the action of restoring life: the same action, depending on the situation, can be considered as a way to save a patient, or as overzealousness; they would have liked to save him (keeping him in his previous condition) but do not want to resuscitate him to a future condition deemed unsatisfactory. There is no point in resuscitating a bare life.

The unanticipated death, despite its strong resemblance to a 'natural' death, exposes the vanity of attempts at governing death. Beyond any inward, introspective feeling of finitude (Reedy & Learmonth, 2011), 'bare' death causes intersubjective confrontations with vulnerability (Butler, 2004, 2009). To tame their anxieties, the caregivers engage in spontaneous gatherings, discuss their views, or simply stand silently together in front of the body. They examine and talk over what happened, engage in critical reflexivity in a struggle to restore the meaning of death ('Life is violent, we know that when we're born'). Beyond the ethical complexities of deciding that a life is no longer worth living, and beyond the socio-political issue of choosing how people should die, thanatopolitics here appears as an attempt at governing death in a process that is not entirely determined, but guided and orchestrated. The fragility of such attempts is exposed by the elusiveness of political life and the impossibility of ruling out bare death.

## Discussion

Our sense of finitude makes us aware of our vulnerability, which Butler (2004, 2009) describes as the first step to our confrontation with the vulnerability of others and hence to our constitution as moral subjects. Such feelings also trigger death anxieties and discomfort in modern societies marked by a 'social repression' of death (Elias, 1985). To make death less visible and disruptive, specialized organizations 'sequester' death (Giddens, 1991; Willmott, 2000; Smith, 2006) to isolate us from the ethical, political, and organizational complexities of the 'management' of death. Death increasingly occurs inside organizations, such as hospitals and hospices. Yet little is known about how 'natural' death occurs, and is 'managed', inside organizations. Even when it is anonymous and mundane, death creates what Agamben (1998) calls a 'state of exception', a disruption of governmentality that, instead of destabilizing sovereign power, in fact acts to establish the exceptional as a naturalized norm (Butler, 2004).

We thus analyse the micro-practices and technologies that participate in the production of ‘normal death’.

Death increasingly takes place in organizations that are chiefly dedicated to life. Hospitals aim at prolonging, maintaining, and even restoring life – they are governed by, and organize, the aim of caring for the nation’s biological body, or biopolitics (Foucault, 2004a, b). Life becomes the main target and objective of power (Rose, 2001; Munro, 2012; Fleming, 2014). In a setting dedicated to biopolitics, the occurrence of death can prove disruptive. Death becomes a taboo and must remain invisible. The intrusion of death is not only a source of anxiety, but also an indication of failure and limitation in biopolitics.

Geriatrics departments, dedicated to the care of ‘older patients’, are recurrently confronted with death. Previous studies note that a historical ‘brutal revolution’ in Western attitudes toward death (Ariès, 1975) has led to more social repression (Elias, 1985) and sequestration (Giddens, 1991) of death, with organizations working to protect us from the associated anxieties (Willmott, 2000; Smith, 2006). These organizations of death sequestration, however, are dedicated not to facing up to death but to governing it. If ‘we are left alone to face death’ (Smith, 2006) even when death happens inside highly-populated organizations, this is because the purpose of these ‘attendants of death’ is not necessarily to help us to face up to the idea of death but rather to provide routines, mechanisms, and processes to follow while dying.

When death becomes inevitable then it must be organized. Previous studies analyse this phenomenon, but without resituating it in the context of governmentality and biopolitics (Foucault, 2004a, b). Glaser and Strauss (1965; 1968) long ago described how death disturbs hospital routines. But they also show that caregivers encourage what they perceive as acceptable styles of facing death, and acceptable styles of living while dying. Acceptable dying is about accepting yet fighting death, avoiding too much disruption (unacceptably ‘disgraceful’ deaths) but also too little (apathy and withdrawal), striving until the end to prolong and

maximize life. Supporting biopolitics remains the purpose of these organizations. Biopower dictates legitimate practices even for dying.

An organization of the end of life is focused on life and biopower yet informed by death. Organizations that are frequently confronted with death develop mechanisms, technologies, practices, and relationships to make it less disruptive. These dispositifs constitute a regime of death (Agamben, 1998), a form of power which reaches life through its final ramification – death itself. In such a setting, organizations operate where sovereign power over life intersects with the governmentality of death. Biopolitics turns into thanatopolitics.

Hospital thanatopolitics – official mechanisms, technologies, and discourses of how to govern death – tend to be founded on a definition of life that negates its political meaning – which Agamben (1998) calls bare life. A patient’s remaining lifetime, or physiological aspects as reified in the utterance of technical constants, are used to assess whether life remains recognizable as such. The organizational guidance regarding death tends to ignore political life. This is visible in the focus on bodies, which are treated as a collection of organs, and moved from ward to ward and from bed to bed. In some cases, being moved from a double room to a single room is the one and only signal that ‘the patient’s end is near’.

Our ethnographic study shows how political life can re-emerge, intrude into this carefully-orchestrated scene, and disrupt organizational thanatopolitics. Although the organization is focused on bare life, individual caregivers include political life in their assessments of whether a life remains worth living. For instance, they constantly mention the quality of life with associated labels such as ‘vital energy’, ‘intellectual faculties’, ‘independence’ or ‘loss of autonomy’, and consider the patient’s relatives. In such moments, political life can take precedence over bare life. The organization of the end of life ‘delimits a space of exception’ (Agamben, 1998, p.94) but this space of exception is not a space where a

purely bare life emerges. Death eludes attempts to separate its political and physiological manifestations.

Organizations dedicated to the end of life thus constitute places where people work to face up to the irreducible political dimension of death. Beyond mere negotiations to claim control over the process and maintain work routines (Glaser & Strauss, 1965; 1968), interactions with families and the time caregivers take to guide them through thanatopolitics are attempts at including the political life of the dying in their practice. Some caregivers may remain reluctant to see political life disrupt thanatopolitics, and strive to focus on bare life instead. But through biopolitical discussions and dispositifs, organizational thanatopolitics meets the socio-political aspects of (end-of-)life. Death does not make political life invisible but impossible to conceal (Agamben, 1998). Death disrupts life, but (political) life disrupts (power over) death. An organization of the end of life is focused on death and thanatopolitics yet informed by (political) life. Political life constitutes a partial and fragile destabilization of thanatopolitics.

These findings contribute to our understanding on how the end of life can be humanized or dehumanized. According to Smith (2006), inside organizations, death becomes anonymous and divested of meaning. Beyond work routines around dying processes (Glaser & Strauss, 1965; 1968), Smith (2006) argues that we need rituals to deal with death. In hospitals, the medical experts are the people who can create such rituals for us and guide us towards death. When depoliticized mechanisms of rational calculation take the place of ethical judgment and collective action, death becomes dehumanized. The constitution of new rituals, efforts to ensure a ‘comfortable death’ and the provision of guidance and shared responses to death can help humanize the end of life.

Organizations thus provide us with experts whose job it is to assess the political relevance of a life, deciding what makes the value of life as such. Yet, as Agamben (1998) argues, there

is no consensus about what makes a life worth living. Organizations dedicated to the end of life work at the intersection point between alternative fields of normativity regarding what gives a life value. Organizational thanatopolitics thus develops despite the absence of any unified field of normativity to assess what makes a life not worth living (Agamben, 1998) or unrecognizable as life (Butler, 2009). The people we followed for this research have to decide when it is appropriate not to prolong life. To do so, they regularly share and discuss their doubts about what makes a life worth living, designating the point at which life ceases to be politically relevant. They can thus designate (or 'let die') someone as *homo sacer* (Agamben, 1998), a life that can be eliminated with impunity. And yet they are not entirely free to make these decisions, as they work in cooperation with other departments, most of which are dedicated to biopolitics and remain outside thanatopolitics. Death itself is enmeshed within power relations. Organizational dispositifs, biopolitics, and thanatopolitics all influence the end of life in ways that are not always consistent with the caregivers' ethics.

A more 'authentic' engagement with death constitutes a form of emancipation (Smith, 2006; Reedy & Learmonth, 2011) from biopolitics, but we show that death disrupts biopolitics only to turn it into thanatopolitics. Governmentality itself remains. We thus argue that political life, not death, can disrupt governmentality. We also argue that acknowledging our vulnerability is how we include political life in our idea of what makes a life worth living, and thus disrupt dehumanizing forms of power. This challenges common views of organizations, which themselves tend to reproduce the social repression of death. Organization studies rarely recognise the central importance of our vulnerability or the significance of our feeling of finitude. When they do, they see it as a weakness. Instead, drawing on our vulnerability and sense of finitude is a way to circumvent dehumanizing organizational practices. The acceptance of vulnerability could help organizational members disrupt organizational tendencies to

‘othering’. Vulnerability could influence the conditions through which organizations foster, rather than repress, the conditions of what Butler calls a ‘livable life’. As she argues:

‘my dependency on another, and my dependability, are necessary in order to live and to live well. Our shared exposure to precarity is but one ground of our potential equality and our reciprocal obligations to produce together conditions of livable life. In avowing the need we have for one another, we avow as well basic principles that inform the social, democratic conditions of what we might still call ‘the good life.’’ (Butler, 2012, p.18; 2015, p.218)

Accepting our vulnerability and that of others, then, is the way to lead a good life in an organizational life. This calls for more studies of the aesthetics of existence, and of the practices of political life in organizations.

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