

An Autoethnography on the Liminal Spaces in an Intensive Care Unit

Aimee Nezavdal

Department of Graduate and Undergraduate

Studies in Education

Submitted in partial fulfilment of the requirements for the degree of Master of

Education

Faculty of Education, Brock University

St. Catharines, Ontario

© Aimee Nezavdal 2017

Abstract

Liminality is an in-between space that, as for the teenager who is neither fully child nor adult, accompanies new norms, routines, and expectations while simultaneously remaining in flux. This paper explores the history of liminality, its presence in the literature, and then applies Victor Turner's notion of liminality to various as-yet unexplored aspects of a hospital, its Intensive Care Unit, and life itself within this context. In this autoethnography, the author, an ICU nurse, identifies and describes such liminal spaces as the *Code Blue* where a patient is neither dead nor alive, the challenge of caring for patients for whom the nurse believes treatments to be futile, and the ways in which the nurse finds humour within a context of death. Fictional literature is employed throughout to demonstrate how liminality feels to the author, who invites the reader to look behind the hospital room curtain and see what the ICU nurse sees.

Acknowledgements

While this thesis dwells on a topic one may consider to be morose it was, nonetheless, a joy to write. I attribute this, in large part, to the support I enjoyed from many exceptional people.

First, I must thank my supervisor Lissa Paul who was instrumental in helping me find my path through this topic. Without her guidance, support, and direction, I believe I may still be lost in the woods. It has been an absolute pleasure working with her.

I would also like to thank my committee members, Trevor Norris and Leanne Taylor, who provided generous and thoughtful feedback, improving my paper immeasurably.

I would not have had a topic to write about if it were not for our ICU and my extraordinary colleagues. Their skill, ethics, and humour inform my own practice and it is a privilege to work with them.

Finally, I wish to thank my family. Frank, my husband and best friend, has been a tireless listener and supporter of my writing. My children, Merrick and Ari, have always been the perfect antidote to any gloominess in my life, and the reason my life is so easy to savour.

Table of Contents

Abstract.....	ii
Acknowledgements.....	iii
Table of Contents.....	iv
CHAPTER ONE: INTRODUCTION.....	1
Autoethnography on Liminality.....	4
Ethics of the autoethnography	14
Liminality in Medical Literature.....	15
Exploring Liminality and situating it within a hospital and its Intensive Care Unit	20
Liminality in the Hospital.....	21
CHAPTER TWO: LIMINAL SPACES FOR HEALTH CARE PROFESSIONALS.....	29
Liminality in Nurse Knowing.....	33
Nursing Death, or the Liminality of the Code Blue.....	44
CHAPTER THREE: NURSING FUTILITY—AN EXERCISE IN LIMINALITY	58
Liminality and humour—trickster, the body grotesque.....	63

CHAPTER FOUR: WHAT’S SO FUNNY ABOUT DEATH?	69
The grandest liminal space.....	74
CHAPTER FIVE: CONCLUSION: RAGING AGAINST THE DYING OF THE LIGHT OF HUMANITY, OR WHERE TO FROM HERE?	76
References.....	82

CHAPTER ONE: INTRODUCTION

“Stop that!” Will Turner’s mother snapped at him when he staggered home, howling in pain after being shot in the courthouse gun battle with the Howards. ‘Die like a man, like your brother did!’ She belonged to a world so well acquainted with fatal gunshots that she had certain expectations about how they ought to be endured. Will shut his mouth, and he died.

--Malcolm Gladwell, *Outliers*, 2008, p. 164

My husband enjoys telling the story that his wife is a nurse when the listeners’ response goes something like, “aww, you must be very well looked after.” Their assumption is that nurses are nurturers, or generally more caring people. He tells them, not unkindly, “you obviously don’t know many nurses.” When I share this story with my own peers, they laugh knowingly. The unspoken notion is that nurses are not—at least, not necessarily—caring or nurturing. It is a common refrain among my colleagues: “Unless my husband or children are bleeding profusely, they get no sympathy from me!” Coming from a workplace where mortal injury is fairly commonplace, the ICU nurse has some insight about how sick (or not) their own loved ones really are. There is intimate knowledge of the body, its borders and limits, as well as what mortal injury looks like. Knowledge like this can make the nurse an *other* who must be guarded in her or his knowledge. There is a significant gap between “you don’t know from sick!” and “one time we had to perform emergency surgery at the bedside because there was no time to get the patient to the operating room, but it was too late and they died anyway,” and the latter comment cannot be uttered in random company without evoking a very uncomfortable silence or, conversely, awkward, unanswerable questions.

This kind of knowledge is difficult to classify—it is part of the nurse’s experience but remains unsharable, except with other nurses who have had similar experiences. There are “contradictory orientations” (Navon & Morag, 2004, p. 2343), “in-between narratives” (Bruce et al., 2014, p. 35), and they are typical to liminal states.

This thesis is an exploration of these liminal spaces—where they reside, how their inhabitants change and are changed by their experience. This existential space, neither here nor there, is where the participants (nurses and patients, specifically) forge and practice culture as they go. It is a space where things can flip: power, comedy, and tragedy. As a diver, I liken the liminal to coastal or cavern diving sites where fresh and salt water often mix—the phenomenon is called a *halocline*. If there is only one type of water, there can be clarity. However, when the two very different concentrations mix together, the water looks oily, broiling, and is disorienting when you are immersed: The flux and churning prevent focus. The ICU nurse operates within theoretical and physical margins, where similarly there is churning, flux, and unpredictability. I wish to examine this theoretical halocline, these liminal spaces, the borders where nurses reckon with “groundless incomprehensibility” (Bruce & Davies, 2005, p. 1340), where we are both witnesses and participants.

In looking for a way to speak to the in-between space the nurse inhabits, I explained my thoughts to my Master’s supervisor, who recognized that when I was talking about exploring the physical and philosophical *clefts* between things, I was really talking about liminal spaces. I described these in-between zones to her not knowing how they fit or how to tie them together, but once I explored them through a lens of liminality,

I was surprised how snug a fit they were. During my research, I found one article (which also happens to be an autoethnography) which describes nurse culture as difficult to recognize (Adams, 2007). She describes the purpose of her paper as being, partly, “to present a collection of research methods that are useful tools in analyzing the *largely invisible* [emphasis added] influence of nursing culture” (p. 3). Through exploring liminality and how it fit with my nursing work, I discovered that there are multiple ways and multiple realms the nurse, the patient, and the patient’s family inhabit liminality together. In fact, the more I looked, the more liminal spaces I saw.

This reminds me of the beginning of David Foster Wallace’s (2005) commencement address for a graduating class:

There are these two young fish swimming along, and they happen to meet an older fish swimming the other way, who nods at them and says, “Morning, boys, how’s the water?” And the two young fish swim on for a bit, and then eventually one of them looks over at the other and goes, “What the hell is water?” (para 1)

Nurse culture is difficult to examine because I myself am immersed within it but also because liminal spaces have rituals but paradoxically few rules. Practiced by nurses but influenced by others like patients, families, and doctors, all couched in our surrounding culture, “deep-seated” (Adams, 2007, p. 3), nursing culture has historically been largely unexamined. Adams quotes Suominen, Krovasin, and Ketola (1997):

“Structures of nursing culture have so far remained very much unknown territory and are seldom discussed, either in practice or among nursing researchers” (p. 4). I aim to, in some way, change that. I would like to examine the water in which I am immersed, with the hope that there can be deeper and meaningful understanding.

Autoethnography on Liminality

The autoethnography does not have a very long history and instead represents a more recent shift to include the researcher within the context of culture (Boylorn & Orbe, 2014). Criticized for not conforming to traditional methods of research, and fueled, in part, by feminist theory, the autoethnography has been said to be the product of a more introspective anthropological movement attempting to include the viewer her or himself within the culture being explored, reckoning with anthropology's heritage of potential exploitation and Othering (Young & Meneley, 2005), and as such having emancipatory potential (Peterson, 2015).

I fully acknowledge, also, that this work is not exempt from other criticisms of the autoethnography—that it has potential to be narcissistic, self-absorbed, and self-important, confirming one's own biases by cherry-picking parallels and citations to support one's way of thinking (Duncan, 2004). Duncan goes on: “With its use of self as a source of data, it has been criticized for being self-indulgent, introspective, and individualized” (p. 28). All true. However, I cannot separate my professional work from all the other aspects of my life. I end up connecting death, ambiguity, grief, absurdity, and levity to books by the likes of Kurt Vonnegut, Joseph Heller, Margaret Laurence, Paul Bowles, and others. Literature has been one way I have made sense of my own experiences, by seeing aspects of my own experience in a character. I believe that by showing what authors have written that I have connected deeply to, it may help to illustrate why I view a situation the way I do. I see literature as an artist's interpretation of a scene or scenario that requires an acknowledgment of complexity. There may be no better way to capture the complexity of human relationships than through art, and while I

cannot profess to make art, I can shamelessly use literature to show what I mean.

Through literature, I am making explicit links with my experiences in a this-looks-like-that kind of way.

Before I embarked on my journey to become a nurse, I completed a bachelor's degree in English. I naively believed that once I had completed a degree, my school career would be complete and I would be offered a well-paying job with which I would be able to support my adult self. Instead, I got a job at a chain bookstore and was paid minimum wage. Once the holiday season was over, I was fired. I still used my employee card for discounts. But discounts were not going to get me anywhere, really. I still needed a job.

Coming from a strong heritage of nurses (mother, grandmother, aunt, multiple great aunts, and even my then-future mother-in-law), I should have been proud to continue the line of care givers. Instead, however, I am ashamed to admit that I felt as though entering nursing school was a failure. I had aspirations of becoming a writer and never saw myself as someone's handmaiden (obviously, I had no idea what nursing meant). It was only when I began my Master of Education that I even viewed writing *about* nursing as a possibility. My real point here is that even after working as a nurse for many years, I did not see myself as a nurse. The profession was never a calling, and I did not wish to spend any more time than was necessary with anyone who was sick. However, I was paid to do the job, I was employed at a hospital, and I filled in the blank line on documents such as a passport application with the words *Registered Nurse*. Yet I viewed myself as an imposter—and a lousy one at that. I tried to ignore my persistent cold sweat of fear when I would walk onto the ward, the yet-unidentifiable smells

creating a knot of nausea in my gut. Almost paralyzed with fear that I may harm someone, I could not forget that I was responsible for people's lives. I tried to watch how my coworkers "did" nursing as seemingly easily as conjuring flowers from nothing by anticipating, communicating, providing, and advocating. I honestly did not believe I would ever learn how to do all of that.

I wonder now if my wish to understand what we do is based on my own persistent feeling of doubt in my understanding. Margaret Atwood's (1982) quotation on writers from her book *Dancing Girls* resonates with me: "Everyone thinks writers must know more about the inside of the human head, but that's wrong. They know less, that's why they write. Trying to find out what everyone else takes for granted" (p. 71). Not that I saw myself as a writer, but that I did feel as though I knew less. Without years of experience like many of my coworkers, I had nothing to guide how to nurse. There was this new set of expectations I had never considered—I was unmoored from most of the things that I knew.

I chose an autoethnography for my Master's thesis because that's how I found I was writing about my experience. I didn't know how else to talk about it, and I wanted to write in such a way that the reader would see what I saw and understand why nursing baffled me. Why it still, in many ways, baffles me. It was a member of my committee who said, after reading the initial results of my progress, "So, it looks like you're doing an autoethnography?" And I said: "I guess I am." I thought I would be merely reporting and describing what I saw, making links with theory. What I learned was that I was processing my experiences through writing and making connections with not only theory but literature, and then in an ouroboric manner, connecting with my own experience

again with theory, and then reabsorbing my new learning, the circle continuing (and continuing still).

I approached my thesis with the fullness of my ignorance, not knowing that by writing an autoethnography rather than a more data-collection-oriented method, I may have chosen a path that was rockier, deeper, with more unexpected moments of reflection, and difficult, personal epiphanies. These, I have learned, have also been attributed characteristics of the autoethnography—the learning-in-doing characteristics that are true for me as well (Ellis, Adams, & Bochner, 2011). Ellis (1999) also describes the autoethnographic journey as being potentially much more difficult than more traditional styles of research, particularly in the introspection and then sharing what one has found. I came across Ellis’s description of this kind of discovery in her retell of having a PhD student approach her, asking Ellis to be on her committee. The student was about to begin her thesis and wanted to study the experience of breast cancer survivors. Through their conversation, Ellis learns that the student is herself a breast cancer survivor, and knowing that, Ellis encourages the student to consider writing an autoethnography, weaving in her own experience with those of the women she wanted to participate. The student wonders out loud how difficult it may be to recount her own experience within her research. However, Ellis tells the student that emotionally, writing about one’s own experience is potentially very difficult, and warns: “There’s the vulnerability of revealing yourself, not being able to take back what you’ve written or having any control over how readers interpret it” (p. 672). I found this to be true as well—some of the things I describe in my work are a gamble. I have dug into the compost of my memories and found rich soil, but have had to stop and wonder, are my

memories offensive? I have to wonder if I have crossed an invisible line where my honesty reveals more than I want it to. I have asked myself, what am I revealing, exactly, and to what end? Similarly, this was echoed by a committee member who fairly asked what my “So what?” was. I have a lot to say about nursing and how we do it, but indeed, so what? I puzzled over this for a long time, never quite finding an answer that felt true. Then I stumbled into Orwell’s essay *Politics and the English Language* (2013), when reading Steven Pinker’s (2014) *The Sense of Style*. Pinker notes how good writers avoid dehumanizing their subjects by personalizing and describing in such a way that ignites the text, allowing the reader intimate understanding, allowing the reader to see, in her or his mind’s eye, what is happening on a personal level. Orwell (1946/2013), in *Politics and the English Language*, urges the writer to beware “dehumanizing abstraction” (p. 31), by employing euphemisms or descriptions so separated from their subject as to have lost any connection to their purpose. Orwell says,

In our time, political speech and writing are largely the defence of the indefensible. Things like the continuance of British rule in India, the Russian purges and deportations, the dropping of the atom bombs on Japan, can indeed be defended, but only by arguments which are too brutal for most people to face, and which do not square with the professed aims of political parties. Thus political language has to consist largely of euphemism, question-begging and sheer cloudy vagueness. Defenceless villages are bombarded from the air, the inhabitants driven out into the countryside, the cattle machine-gunned, the huts set on fire with incendiary bullets: this is called *pacification*. (p. 31)

I read this, and as the main character in *The Mezzanine* (Baker, 1988/2011) experiences when he reads something immensely satisfying: “the warped sound of a rinsed saucepan struck against the side of the sink ringing in my head” (p.124). What I discuss in this autoethnography, to me, is like this: There are euphemisms and allusions to what we do without ever having to use any explicit language. There are small islands of clarity surrounded by murky, swift-moving water; life-raft-sized areas of shared understanding in a gulf of shifting, unexplored, misunderstood space. “Codes” known by seemingly benign colours that belie their real purpose, secret languages known to medical staff alone, and situations that are shrouded to patients and their loved ones, and even to many medical staff other than nurses. A family member asks how his or her loved one is doing. The nurse answers but appears to be incredibly vague, noncommittal, and even seemingly glib when she answers incongruously lightly, “okay.” The patient is decidedly *not* okay, but there is too much to explain, the gulf between the family member and the nurse’s understanding of the context and expectations that the nurse’s answer becomes spare instead of probing, asking. Euphemisms and nebulous language for what occurs in liminal spaces can hold the nurse and the patient hostage within it, searching for a way to reconcile what the patient and family want (or simply understand) and what the nurse is bound to enact (often because of a lack of understanding). While not within the scope of this paper, perhaps it could even be suggested that even our nebulous language is a symptom or manifestation of a liminal state.

The notion of liminality fits (however unintentionally) with an autoethnographic approach because the entire theory of liminality is based on the notion that in-between spaces are reciprocal and consist of navigated relationships and rituals between members

of a culture. There is the culture of a place—in this case, an ICU—where the inhabitants are not only recipients of that culture but contribute to it as well. *I* contribute to it as a nurse in the ICU. I am also the autoethnographer imprinted with culture and ostensibly seek to imprint the culture about which I am reflecting. “Autoethnography wants the reader to care, to feel, to empathize, and do something, to act” (Ellis & Bochner, 2006, p. 433), navigating and negotiating our limits, be they physical or philosophical. In this way, I have come to see my writing as moving from personal to political, writing to right, with the aim to outline or describe the nebulous liminal spaces in which I operate when I’m at work (Jones, Adams, & Ellis, 2013).

Victor Turner (1966) recognized the importance and significance of liminal spaces and felt it to be because the flux of a threshold-space prevented long-standing norms from becoming concrete. Originally explored by Van Gennep, liminal theory was further developed by Turner by extensively examining rituals within African communities in the 1960s. Filled with grainy black-and-white photographs and the minutiae of the rituals themselves, *The Ritual Process: Structure and Anti-structure* (1966) describes patterns of initiation, indoctrination, and the importance of those *rites de passage* in either reestablishing social order or shifting to alter the previous norms. The shared and negotiated norms may persist over a long period of time, but the in-betweenness allows those norms to be malleable and more fluid in the liminal culture’s receptivity to newness. In this way, I am a recipient of the ICU culture in which I work, but also may influence how the culture is “done” yet remain “undone” or unfinished. An autoethnography, incidentally, is also, in many ways, reciprocal. As Ellis (1999) describes,

Memory doesn't work in a linear way, nor does life either, for that matter. Instead, thoughts and feelings circle around us; flash back, then forward; the topical is interwoven with the chronological; thoughts and feelings merge, drop from our grasp, then reappear in another contrast. (p. 675)

The autoethnography within a liminal space fits serendipitously well, “speaking from, for, and to the margins” (Boylorn & Orbe, 2016, p. 18), almost as liminal itself, in this case, as its topic.

Liminality is a way of describing as-yet-unfinished processes that punctuate the end of one thing and the beginning of another. These processes are driven by social norms, and the rituals and borders are culturally shared. The *rites de passage*, as van Gennep coined (Turner, 1994), that become norms are forged by all stakeholders, including not only the participants but the witnesses. Marriage, graduation, death—all of these events are recognized as phases that are assumed to change the individual and her or his relationship with and within the culture, and those phases are punctuated by ritual to recognize the event as exceptional. However, although it could be argued that all people, in some way, have lives interrupted or punctuated by liminal phases, it does not necessarily translate to easy passage. While liminal events or spaces are highly ritualized (a bride wears something old, something new, something borrowed, something blue), there are few rules dictating what those rituals must include (a bride may wear white but may choose not to—it does not change that the ceremony is a wedding), or even how long they are to last (teenage years are technically from 13—19, but some youth launch into teen-like behavior earlier during their “tweens,” and similarly may carry on later while simultaneously taking up adult-like responsibilities within this space—current

popular internet memes have recently seen adults humourously noting the difficulties of “Adulthood”). As Mahon-Daly and Andrews (2002) note, “people cannot always move smoothly between these states, but sometimes they are held in a state of liminality” (p. 64). And then there are those who exist in a permanently liminal zone, suspended in a “betwixt and between” state (Navon & Morag, 2004, p. 2344). Turner labels such inhabitants, “liminal *persona*” (1994, p. 6). Again, there is the notion that it is difficult to grapple with cultural constructions when we are unaware of their existence: Turner notes, “as members of society, most of us see only what we expect to see, and what we expect to see is what we are conditioned to see when we have learned the definitions and classifications of our culture” (p. 6).

An autoethnography within a hospital is a move away from the predominantly positivistic model of the hospital and traditional Western medicine. Data, numbers, tests, measurements, and the cataloging of page after page of detailed vital signs are swept aside for a moment. The soft, warm, human in the bed defies measurement, and so does the emotional response we have to each other. *How much?* in a more quantitative piece may be transformed into, simply, *how?* in qualitative research, and then *how do I?* in an autoethnography. And then *what am I?* The subtle shifts allow the conversation to turn from blood pressure measurements and death tolls to experiences and life stories. While I understand the necessity for data, I need to exist within the life stories, to participate in research that “displays multiple layers of consciousness, connecting the personal to the cultural” (Ellis, Bochner, 2000, as cited in Ellis & Bochner, 2006, p. 733). Or, as Ellis and Bochner (2006) state,

Instead of being obsessively focused on questions of how we know, which inevitably leads to a preference for analysis and generalization, autoethnography centers attention on how we should live and brings us into lived experiences in a feeling and embodied way. This is the moral of autoethnographic stories—its ethical domain. (p. 11)

To that end, my autoethnography must convey, with clear language and strength of conviction (Laurence, 2007), the emotional heart—more than just a green line displaying an electrical signature, just blips sliding across a monitor screen. I will explore the ICU experience as it seems to me, and do my best to round out my thoughts with personal anecdotes, conversations with my peers, as well as supporting my assertions with examples from the literature. If “caring for those who are dying is like looking into a living mirror in which our emotional experiences of fear, anger, and attachment rise to the surface” (Bruce & Davies, 2005, p.1331), I believe I need fictional literature to describe what that is like—there seems no better way to explore both the human experience and paradox. Another autoethnographer, Wall (2006), also comes to mind with her thought that “I have lived long enough to have learned that when I am thinking something, I know someone else is, too” (p. 10).

I will begin with discussing liminality in the medical literature, touching on the ways Turner’s theory has been interpreted by various authors in various fields, for there are many interpretations and applications. From there I will explore the ways in which I have interpreted the theory, exploring some spaces that are betwixt and between, neither here nor there, within the hospital, from broad to intimate, then very broad, and discuss limits surrounding these, including those physical and philosophical. These are the places

where we—both the nurses with the patients and their families—may lean on ritual, since there is often little assurance as to the outcome. These are procedures that are often seen as “just the way things are done” but reflect liminality symbolically. As to the order in which I have written about liminal realms, it has been first to establish context, second to give examples of how it looks in my experience in an ICU, then third how it fits in my experience of *the bigger picture*. Beyond this basic framework, there have been no specific reasons for the order in which I have written events or examples other than to satisfy my feeling that it fits a narrative arc. “There is no simple forward or backward: there is only a tangle of present and past, eruptions of memory and conjecture and wishing stitched into the fabric of the moment” (Saul, 2006, p. 111).

Ethics of the autoethnography

Within the context of writing about my work, inserting the *I*, I have also inserted others’ stories as well. I have written about my own experience, but my experience is within the context of a space that regularly deals with life-changing events for others, and those events require a strict adherence to confidentiality. Additionally, my coworkers, although not under patient confidentiality rules but still falling under ethics requirements for the purpose of this paper, have been cited generally but not explicitly. Peterson (2015) points out that using autoethnographies in nursing research pose unique challenges, such as an ambiguous or nebulous process for obtaining consent from others. It is therefore essential to note that all anecdotes and scenarios found in this paper are composites. Not only is this important for ethics purposes, but for the purpose of this paper and my intent being to convey the spirit of our interactions. In other words, no one scenario would be adequate to represent what it means to nurse in a liminal space. There are events that,

once repeated an uncountable number of times, can be (must be?) seen as ritual. These are the events that I will speak to and about. It is the repetitive nature of our experiences that has affected our collective psyche. These are conversations that occur over and over, reinforcing to me the existence of gaps between nurses, doctors, patients, and families. Shared with the reader, here is a conglomeration of things overheard or conversations in which I have joined which may be considered the zeitgeist of a typical ICU.

To eliminate any risk of breaching confidentiality obligations to patients, I have modified the details of their condition, merging details of several patients in order to obscure their identity while retaining the salient elements that make my point. Again, the examples I use are representative of a broader picture, and while autobiographical, the experiences blur together with elements that are interchangeable, becoming something bigger and more broadly applicable and significant in the implications for care than the individuals they represent. In fact, with a few exceptions, this is how they inhabit my memory as well.

Liminality in Medical Literature

Liminality is not a new idea, generally, within medical literature. Illness and hospital anthropologic studies have been undertaken where the physical space—either the hospital or the body itself—is considered liminal. Bruce and Davies (2005) note that liminality points to an in-between space both beyond and within dualities, that is, a space in the hyphen within the living-dying or presence-absence. In this space, opposites meet in-between, where one is both living yet dying, or present yet absent. (p. 1336)

In-between spaces punctuate the passage from one thing to another, inhabiting the hyphen. Put another way, cited by Saul (2006) in her examination of the writing by poet Fred Wah, Wah is quoted as saying of the hyphen:

Though it is in the middle, it is not in the centre. It is a property marker, a boundary post, a borderland, a bastard, a railroad, a last spike, a stain, a cypher, a rope, a know, a chain (link), a foreign word, a warning sign, a 'head tax,' a bridge, a noman's land, a nomadic floating magic carpet, now you see it now you don't. (Saul, 2006, p. 115)

Wah struggled with the notion of mixed race and what it meant to him, and Saul notes that the hyphen “thus puts pressure on assumptions about identity” (p. 115) while it opens and links one idea to another. Similarly, the liminal in-between's hyphen has an indeterminable space, and one that may shift and move. Wah's hyphen seems to have as much to say as the spaces around it, according to Saul, who describes his hyphen as powerful, making its presence known by “rattling and clanging” (p. 127) within the text, slamming doors and punctuating the spaces he and his host of characters inhabit. In the same way, the hyphen in medical literature may be a function of the perception of the in-between and therefore have a myriad of interpretations yet unexplored.

Additionally, sometimes rather than inhabiting a liminal space, ambiguity (or the hyphen) is embodied by *people* who represent the liminal space themselves, and there are again examples of this in multiple iterations and interpretations in the literature. For instance, someone having elevated cholesterol may be said to embody a liminal space because the condition has a label and real repercussions but few palpable effects (Hoel Felde, 2010). Another example is men living with advanced prostate cancer and the

effects of hormonal therapy, as the men living through this treatment feel they have changed and that they represent a between-space, as they are no longer themselves (Navon & Morag, 2004). Infertility has a liminal effect for some women in that they feel that they occupy a marginal space, isolated and away from fertile women (Allan, 2007).

Conversely, physical boundaries mark liminal spaces for some, such as Mexican women who have traversed a perilous border to the United States where they remain undocumented and unrecognized (McGuire & Georges, 2003). Likewise, a condition state such as cystic fibrosis that, in itself, may not change, sees the individual aging, and as such that individual is required to seek new spaces for treatment, transitioning from a children's space or pediatric hospital to an institution built for adults (Tierney et al., 2013). There has been research focused on multiple elements of illness and wellness connected to the idea of liminality ostensibly because the ideas resonated with the authors when they looked at the feelings of those they were studying and their common refrain of feeling *betwixt and between*—a phrase that can be found in many articles dealing with liminality.

Physical spaces researched include liminality of various domains in the hospital such as the ones authors Long, Hunter, and van der Geest (2008) explore. They assert that hospital ethnography was not recognized as a site of research until “post-colonialism moved the anthropological focus from the exotic of the Other to shine a light on the exotic of the Self” (p. 71). The trend to recognize the hospital or illness as a unique backdrop for shared experiences continues to be explored, with “hospital-as-island and hospital-as-culturally-embedded” (p. 71) being a reimagining of this space with anthropologic beginnings. Further recognized and explored has been the idea of

liminality and risk within a context of mental health (Warner & Gabe, 2004), where people with mental health challenges find themselves “caught in the middle” (p. 388) and existing “in between” (p. 388) because “they neither fit fully into society, nor are they fully excluded as in the asylum system” (p. 388). Warner and Gabe (2004) note that liminality and liminal people are “associated with threat or unease” (p. 388), but there is some uncertainty as to which informs which: the boundary-pushing state of an individual making them inhabit liminality or the poorly understood individual forced to inhabit a margin. It would seem that this very ambiguity sums up the nebulous nature of a liminal state. Further literature has investigated liminality and the body (Johnston, 2011; Mahon-Daly & Andrews, 2002), insofar as it explores “spatial divides such as public/private, and work/home” (Mahon-Daly & Andrews, 2002, p. 63), providing, they say, an arguably more modern approach to the study of breastfeeding by exploring the participants’ experiences rather than “purely adding to the existing empirical knowledge base.” Mahon-Daly and Andrews (2002) call these researchers “medical geographers” (p. 64), recognizing both the anthropologic and physical body-related nature of their study.

On liminality in the literature with regards to technology, Lapum, et al (2012) explore how the humanness of caregivers can be regained in an environment where technology threatens to create a dualism, with person-centered practice on one end of a spectrum always seemingly opposite the machine. They discuss traversing the liminal space that divides technology and person-centered practice. They suggest that by recognizing this liminal space, we can maintain our humanity as we care for patients.

Liminality and the mind is discussed in Kelly’s (2008) paper, in which she proposes that while the stages of liminality are well explored and understood, the social

and emotional face of liminality are less so. She explores the notion of living-in-loss rather than living-with-loss, as with patients who are experiencing AIDS dementia.

There is literature on the nature of humour between nurses and their patients as well as nurse staff (Astedt-Kurki & Isola, 2001) that suggests that humour is a form of communication that enables therapeutic exchanges among those who share a laugh. It is important to note that in this case, I am making the link between humour and the liminal because here the humour exists for only a select few: in this case, between the nurse and patient and between the nurse and other caregivers, and the humour is likely nontransferrable. That is, the humour is possible because the participants share the space—it is very context driven. In the case of humour in an ICU, the humour is liminal because the primary participants (the health care workers) are operating at the margins, unable to transfer their humorous experiences anywhere else—they remain unsharable. As the authors state, “Humour is often context-bound, too. The close integration of humour and the situation contributes to some nurses having difficulty in describing that humour afterwards” (p. 453). I would argue that it is not only because the humour is tied to the context or situation, but also because the humour would be considered inappropriate or would simply not be understood by anyone else but a nurse (or sometimes a health care worker). I will speak more on humour and its liminal nature later.

Liminality has been discussed in many realms in the literature, with frequent explorations of the concept within medical and hospital contexts. However, despite this relative abundance, there has been little research done with the idea of liminality in the hospital with a focus on an ICU nurse’s experience, and none that could currently be

found with an autoethnographic approach. I will begin by looking at what liminality means within a hospital and ICU context.

Exploring Liminality and situating it within a hospital and its Intensive Care Unit

Nurses—and for the purpose of this paper ICU nurses—inhabit a region in which they experience flux-in-action. They—*we*—are the liminal persona. In caring for patients who have had unexpected physical trauma through major surgery, a drug overdose, or cancer, the nurse resides at the shore of a patient's and his or her family's attempt to cope. The nurse permanently inhabits a zone that is uncharted and perpetually unresolved. As Turner (1994) would put it, we are liminal in that we are “at once no longer classified and not yet classified” (p. 6). Resolution and transition, however, is not only probably impossible but unnecessary. Nurses learn how to operate in this cleft, and from my own experience, it fosters an existential feel—one which nurse theorists Paterson & Zderad (1976/1988) (gendered language notwithstanding) write, “calls for a recognition of each man as existing singularly in-his-situation and struggling and striving with his fellows for survival and becoming, for confirmation of his existence and understanding its meaning” (p. 4). By discussing this particular liminal space, the one inhabited by the nurse in an ICU, the unspeakable becomes spoken, the concealed becomes revealed. The *rites de passage* that describe the thresholds through which participants must pass are (not surprisingly) quite different phases for the patient and her or his family than for the nurse who accompanies them in their journey. For the patient, their Intensive Care Unit experience is marked by numerous liminal *rites de passage*—beginning with their initial introduction to the hospital to the daily routines foisted upon them irrespective of their feelings about them. For the nurse, the pathway through

liminality is much longer—seemingly unending, even, in that it may last one’s entire career. Early in his or her career, the nurse experiences the paradoxes of the environment, having to reconcile his or her knowing with the not-knowing of others.

Liminality in the Hospital

There are so many liminal spaces in a hospital that there are hardly spaces which could be seen as not in-between, but although initially overwhelmed by the thought that there are a multitude of liminal spaces, wondering where I should begin, I began to view the spaces as connected. Michel Cartry (1992), quotes Wittgenstein on the topic of rituals within a culture: “What one would like to do is trace the lines linking common components” (p. 26). I, too, would like to trace the lines connecting some common components. Once I began to look at the zones of a hospital that are in-between and liminal, I noticed that there are many, and sought to find meaning. As Cartry asks himself and the reader, “How is one to reconstruct from these features a composition that takes multiple linkages into account?” (p. 26). Most broadly, they (liminal spaces and the rituals that accompany them) are connected by place: the hospital. They are also connected in that the hospital is a space that causes upheaval in the patients’ lives. They must endure a passage from one place to another, having no (or very few) bearings, no calibrating signposts to tell them what time of day it is, where they are, or what is expected of them. For nurses, they face daily uncertainty about who they are to care for, how sick or unstable their patients will be, or how a stable patient will suddenly “turn sour” or “go south” (unexpectedly do poorly). In the ICU, the stakes become higher; the rituals may not even be noticed by the patient as they may have a profoundly decreased awareness of their surroundings due to illness and sedation provided to ease their

experience. However, for the families, they have been plunged into uncertainty with the added task of being vigilant for their loved one, the patient, who is possibly unable to speak for her/himself. Even the entrance to the ICU fits Turner's notion of a threshold that must be transitioned across, as the ICU has locked doors that will be opened from inside the unit only after the family member has called in for permission to enter on a dedicated phone located outside those doors.

Let us begin with one liminal event that we have all experienced to some degree: sickness. Health is punctuated with various bouts of sickness that take us out of our usual routines in varying degrees. When you are feeling unwell, but are still able to participate in your normal activities, the feeling of being a little disconnected from your usual routine may be all you experience. The sicker you are, the more disconnected you may become since you cannot participate in work, play, or anything constructive or *normal* according to your usual life. Increasingly sequestered by illness, those around you generally understand you're currently not part of the usual circles you're committed to—you're relieved from work or household duties and are often explicitly told to stay in bed. There are family rituals to sickness—my family has a rain poncho and a dedicated puke-bucket to go over it if one of the kids is sick with a stomach flu, for example. Certainly every family has rote responses to mild sickness in the home, especially for children—clothing one wears, blankets one prefers, or medicine routinely offered.

If you're sick enough, you must get to (or be brought to) a hospital where you'll have professionals attend to your health. This is where sickness, for most, takes an unfamiliar turn. Long et al. (2008) quote Rose Laub Coser's *Life in the Ward* (1962) in their paper about hospital ethnography:

While the patient lies in his bed in the ward, the outside world recedes from view. Through the windows, if any appear within his range of vision, he can only see the roofs of surrounding buildings, all part of the same hospital ... Even his relatives drifting in at 1 p.m., may come to seem “strangers,” divorced from the main problem that faces him now: the problem of cure. Family and friends belong to past or future; and wear an air of unreality. (p. 72)

Illness takes you out of your spheres of relationships and commitments, and you become part of the running of a building dedicated to illness. However, the institution relies on a set of *rules* with which you are unfamiliar—like visiting a different country where you can experience jet lag, new norms, and social rituals—without the time change or stamp in your passport. There are indoctrination procedures, according to Turner (1969), and these would be the rituals that punctuate the entrance into the liminal space. The hospital is like the vehicle to health ... or sometimes the vessel one remains harboured within until death. You arrive in your own clothing, but quickly must swap your outer identity for a hospital gown. You lose your usual hair style—it’s in ruins because you’re unable or unwilling to keep your usual routine of showers or styling. If you’re unwell enough (and wear them), your dentures will be removed and probably generally forgotten or ignored by caregivers—you’ve got bigger fish to fry now, and your collapsed face bears little resemblance to your *out-of-hospital* self. Your mouth will be cleaned, but more likely by a foam swab attached to suction than a tooth brush and tooth paste.

Perhaps you’re too weak to eat or have been deemed unable to safely swallow (an inside joke in the hospital is that most *staff* would be deemed unsafe to swallow, so strict

are the assessments by the speech language pathologists), so you will be fed thickened fluids and soft foods easier to manage with weakened swallowing. If you are unable to swallow—either due to weakness or because you’ve got an endotracheal breathing tube—you may get a feeding tube, uncomfortably threading through your face (your nose or your mouth) into your stomach, trickling a flavoured (but not for you) liquid to satisfy your hunger. But not your need to taste. If you’ve been unable to eat for a long enough period of time and are not expected to improve soon (if at all), you will get a tube punched directly through your abdomen into your stomach. These acts further indoctrinate you into the hospital—reestablishing and negotiating margins. What was unconsidered initially by you or your family—various ever more invasive treatments and invasive procedures—will be presented, one by one, as the illness trajectory denies you immediate recovery. The proof of this existential journey through sickness may be visible only via the literal scars you’ve accumulated, although you have endured much more than what is visible. What you have endured are the symbolic acts that demonstrate to all that you’re not just a citizen but a patient—a citizen of the hospital. You will be washed, often at times that may not suit you (although day from night may be difficult to distinguish anyway), but when it suits the nursing staff. Additionally, you may be unaware of your need to be washed at all—having a feeding tube trickle high-nutritive food day and night will certainly upset the routine bowel patterns you had when you were well, and you may have a bowel movement when you least expect it. Aware patients who experience fecal incontinence are generally mortified, but nurses expect nothing less than bowels that move to their own clock. These are the rituals of illness the patient must endure. The washing itself is sometimes less for the patient and more for the staff---the unwell

human's presence of bodily odour is expected to be removed according to hospital ritual. This, too, is in line with Turner's description of liminality, where the procedures of entering into this new (liminal) space are expected, shared, and reestablished by those who are part of that culture—in this case, the nurses.

To illustrate this, I share this anecdote: Early in my career, I had a patient on a medical ward who was sent for a test (she was stable enough to be taken by a porter unmonitored by me). When she was returned, I received a call from the area in which she had her test done, with the tech wanting to tell me that the patient needed her teeth brushed. This was a patient who was unwell but fairly independent! As a new nurse at the time, I was thoroughly shamed and mortified, as I was clearly not living up to the expectations of others—not behaving like a *good nurse*. My point here is not whether I should have insisted an independent patient perform her own daily hygiene routines (perhaps she neglected this aspect of her life at home) or offered to assist her (awkward for me at the time—I did not yet know how to navigate these conversations), but more to suggest that there are expectations of the nurses, and not just by other nursing staff—there are understood cultural norms and rituals within the hospital that are explicit and repeatedly reaffirmed. The nurse who has left her patient unkempt will be judged as somewhat neglectful, forgiven only if the shift has been exceptionally busy. And then, the nurse usually provides some explanation of her inability to get to washing the patient when giving report to the next nurse. ICU nurses in my unit have, over the years, taken to bringing their own arsenal of scented products, possibly in response to the disappearance of hospital-supplied scented cleaning solutions and salves, no doubt due to budget constraints. While to speak of cleaning products brought by nurses may be a

digression in the discussion on liminality, the ritual of the bath, too, is an important indoctrination into *patientness* and cannot be overlooked. Patients who have, for their entire lives, had a beard, may have their beards shaved in the ICU so that an appliance for holding an endotracheal tube may be fastened to their cheeks. Conversely, patients who are very ill and may have hygiene routines that they have practiced their whole lives—for example, men who *do* shave their face—may have these particular aspects ignored either from the nurse’s discomfort with the procedure or simply because it is an acceptable lapse in a nurse’s “upkeep,” as he or she has to prioritize the patient’s care. In the ICU, the lack of a bed bath will generally do no harm, while allowing an important drug infusion to run dry may. Patients are often rendered nearly unrecognizable by their families, either by their illness or the tubes and wires that run into and on them. It is not uncommon for a family member, disoriented to our unit, to wander into another patient’s room and not realize for a moment that they are not in their own relative’s company (and one family member went so far as to embrace his “mother,” who, it turns out, was not his mother at all!).

To further emphasize the indoctrination into the hospital and establish the person’s position as *patient*, there is a strict identification system in place, where identity must be provided upon arrival and subsequently worn on the wrist or sometimes ankle, available for any “official” to see before blood can be drawn, medication given, or a test carried out. Verbal exchanges are, for most patients, in their native English. However, even when the language of the patient and the provider are the same, there is a different set of vocabulary patients must sort through, with references to new metrics and numbers they must interpret. There is unpredictability, framed within the hospital routine. But the

routine, while composed of rituals (lab work, vital signs, turning and repositioning, suctioning, tests, ICU rounds, visiting hours, visiting hour denial, and on and on) adds little to provide context for time-of-day for the new health-forced émigré. Day and night look similar, seasons are irrelevant since the windows are often mostly occluded or without a view from their bed and do not open to provide warm or cool air or birdsong to orient a person. Patients wearing oxygen very commonly ask me if it is raining, because of the sound cue they are receiving as a quiet hiss they interpret as outside weather.

Generally, festivities are for permanent inhabitants (the staff) alone: the birthday celebration where a hospital stretcher is covered with a hospital sheet and laid out with food or a few decorations at the nurses' station at Christmas. However, while not intentionally hidden, most patients would be completely unaware of the small nods to broader cultural practices. The patient him or herself is stripped down, looking like all the other patients, confined to a bed made with starched white sheets and unadorned, unbleached cotton blankets.

The hospital is a place where questions about meaning present themselves with more urgency than in the routine of everyday life. It could be said that hospital life represents a condensation and intensification of life in general because it reflects the values and beliefs of the larger society, bringing our culture into focus and, with it, the things we collectively find important (Long et al., 2008). Where some rites of passage are the domain of religious leaders such as the wedding or funeral, illness within a hospital is a liminal zone that is devoted to transformations separate from decreed pathways. There are printed plans of care that, say, the surgical nurse is supposed to look to in order to proceed with the patient, through a preset number of preprinted steps that guide care and

help the patient understand what to expect before, during, and after a planned surgery, for example. However, care plans are beneficial only for those who choose to have an elective surgery—those who venture into the hospital willingly. Unfortunately, most ICU patients have not chosen to participate but are thrust into this beeping, whooshing, brightly-lit zone of the hospital, often intubated, sedated, unaware, and stuck in a *state of sick*.

CHAPTER TWO: LIMINAL SPACES FOR HEALTH CARE PROFESSIONALS

Not only does the separation from the family and patient's perspective push the nurse into a liminal space, but there is also a separation between the nurse and her fellow health care providers. Dr. Brian Goldman, notable for his CBC show *White Coat, Black Art* (Goldman, 2007), suggests in his book *The Secret Language of Doctors* (2014) that nurses are unconcerned if care is futile: "After all, futility doesn't come out of their pocketbooks. Publicly funded health care, private, or a mixture of the two—it doesn't matter. Futile or not, we get paid to care" (p. 105). I wonder how he could suggest this in the face of an arsenal of literature to the contrary (McCarthy & Gastmans, 2015). As a respected representative of his profession, as demonstrated by his tenure on CBC, Dr. Goldman has a fairly far-reaching voice. As an esteemed representative of the medical profession, his opinion becomes representative of a larger problem of recognizing the gulf of nonunderstanding. As a medical doctor, he has close knowledge of how his fellow healthcare providers work within the hospital, yet there is such acute disagreement on the response to the idea of futile care. How can there be this gulf between what the nurse is experiencing (and whose Moral Distress experience is documented and well established in the literature) and his off-handed remark that it is a nonissue? If he were to care for patient after patient with irreversible debilitating conditions, rotting bodies, left to languish for months, becoming less and less themselves, perhaps he would understand exactly why we *do* care, and deeply, about futile care. With an objective to help, the nurse is prohibited from providing solace from suffering—the very drugs that are available to help the patient cope are the ones that may lower a blood pressure or, through

the principle of dual effect, hasten death even as they comfort the patient. The research on Moral Distress in the literature supports the presence of nurses' attempt to come to terms with the ethical grappling with 'what is right for the patient.'

Nonetheless, I am not surprised that Dr. Goldman does not "get it." This is a pattern experienced frequently in the ICU. Goldman, and many other physicians, get to remain, largely, on the "clean side" of the curtain, while nurses go forth armed with an arsenal of products from home-supplied premium bath soaps and oils to industrial-strength absorbent dressings and diapers in an attempt to combat physical disintegration and all of the visual, aural, and olfactory stimulus that that provides. When simply turning patients causes pain because they are inadequately anaesthetized, there are only so many times one can say, "I'm sorry" before it feels insincere and inhumane. It is unlikely that Goldman has been exposed to this other side of futile care.

I have added a scenario here which reflects a typical experience with a new coworker—a reminder for me that our actions have palpable effects. When I work with new nurses, I have the benefit of seeing our ICU through their eyes, helping me gain a fresh view. We often care for elderly patients whose delirium becomes compounded by or compounds their preexisting baseline dementia. Frequently brought to the hospital with pneumonia, many clearly struggle with chronic conditions that left them physically very weak and cachexic. Too weak to even swallow, the only choice to provide nutrition is often a feeding tube, in the hope that increasing reserve would see them recover and return to the nursing home. My younger colleagues, although new, see this as a potential problem for the patient: Even the patients who are oriented and cooperative struggle with the presence of a tube that runs from the nostril to the stomach—it is, in my experience,

the first tube to be pulled out by patients themselves simply because it is so annoying even once it is in. Even endotracheal tubes that are used to help patients breathe are often tolerated better than a nasogastric tube—both because we can provide sedation for a tube that has ventilator on the other end (to pick up the respiratory rate if it drops because of medication), but also because nasogastric tubes are just that uncomfortable. Even worse is the insertion of the tube—imagine someone inserting a cold (covered with lubricant), firm tube into the nose and pushing it down the throat, always triggering gagging and many times threaded into the larynx (because the two pathways diverge at the back of the throat and the inserter has no way to know immediately which one she is choosing), causing the patient fits of coughing and an intense feeling of breathlessness. We can attempt to explain this to next-of-kin, partners or children of the patient, who usually insist that a tube be inserted in spite of the risks and discomfort, which is understandable—they see the tube as a means to an end. However, the actual insertion inevitably becomes a wrestling match between the nurse and the patient, with the patient often restrained or held down by a second nurse. Even severely demented patients have yelled hoarsely, “No! I don’t want that! Stay away from me!” all the while gagging, coughing, struggling to breathe, while we wrestle the tube down. These actions have had a profound effect on my young coworkers, who have repeatedly told me, in various ways, that they are becoming used to inflicting horrible actions on patients. Upset and feeling complicit in an abusive situation, my new coworkers—and indeed all nurses—are forced to inflict profound physical and psychological discomfort on the orders of the patient’s family and the patient’s doctor, and I am reminded by their discomfort what it means to feel humane and sorry for the work I do. My years of experience have inured me to some

degree to my own psychological discomfort—I, too, see these actions as ridiculous in their banal cruelty, but accept that the nurse is corralled into performing them. My reaction with having to perform them has transformed from sadness or regret to anger and, often, resentment. There is little I can tell new staff that is reassuring, other than to be optimistic that one day conversations about care and the kindness that may be found within it may be different, and that their reactions of horror are ethical, sound, and humane.

I recall a passage in Hannah Arendt's *Eichmann in Jerusalem* (1963/2006), where she reflects on the tragedy of the “duties of a law-abiding citizen” (p. 135). She says, of the war criminal,

So Eichmann's opportunities for feeling like Pontius Pilate were many, and as the months and the years went by, he lost the need to feel anything at all. This was the way things were, this was the new law of the land, based on the Fuhrer's order; whatever he did he did, as far as he could see, as a law-abiding citizen. He did his *duty*, as he told the police and the court over and over again; he not only obeyed *orders*, he also obeyed the *law*. (p. 135)

Likewise, I feel that nurses are sometimes simply the “law-abiding citizens” who are eventually able to enact questionable procedures without the attention of the families or physicians in order to halt those procedures. Neither are we currently able to have conversations that will articulate exactly why those actions and procedures are difficult. Nursing school equips the student with the how-to knowledge, but less often supports conversations about why, much less how to engage in meaningful discussions with the stakeholders. In one paper examining the nurses' experience with care for the dying, a

nurse is quoted as questioning how she had changed: “I wonder what kind of person I am sometimes” (Kirchhoff et al., 2000, p. 40). We sometimes discuss this at work, and a coworker has named this condition—this process: an *empathectomy*. It is a clever, if not somewhat bitter portmanteau to reflect the removal of empathy. It is an ironic erosion of caring by degrees through caring in terrible ways.

Liminality in Nurse Knowing

Nurses Know. Most broadly, nurses know things medically that patients and families generally do not know. Even if the patient is familiar with some aspects of the body, there are rituals and schedules and norms of which the nurse has knowledge. How the equipment for treatment works—the ventilator with the lungs, the purpose of intravenous fluid, the intravenous catheter and the body’s vessels, the electrocardiogram monitoring and the heart, and so on. There are schedules of medications, feeding via a tube, turning, mouth care, and countless other nurse-related duties. Part of becoming a patient, arguably, begins with learning (or at least, being exposed to) these norms and rituals.

Nurses often know your diagnosis before you do. If you’re a patient in the ICU, the nurse would accompany you to any test you would have out of the unit. Although the information the nurse would get would be “unofficial” (say, a CAT scan or an ultrasound done by technicians would have to be reviewed by a doctor specialist), but the techs certainly know what they’re looking at, and the nurse is included in these conversations. The nurse sees your blood work first and often knows you have a tumour or the results of that biopsy in advance of your receiving that information from a doctor. Nurses do not wish to hide their knowledge of your body but must continue to work with you as though

they don't know. There is a liminal quality to this because it is a knowledge that remains unsharable—the nurse is in-between, gathering information, whether he or she wants to or not, unable to reveal that information to the patient or family.

The nurse knows, but unlike health teaching or explanations of what she is about to do (“I’m going to turn you on your side now,” “I’m going to suction your lungs now,” “these pills are for your blood pressure”), the nurse is unable to share some kinds of information because she or he is without the ability to diagnose, prognose, and build a plan for treatment independent from the physician. Additionally, the nurse cannot, according to the College of Nurses, report on diagnostic findings prior to a physician having a conversation with the patient and family. So although nurses have been found to have the most accurate predictions when it comes to prognosis of a patient (Frick, Uehlinger & Zuercher Zenklusen, 2003), we are bound to withhold any suggestion of such (the same study revealed that, interestingly, nurses are also most pessimistic in their judgement, perhaps reflecting, in my personal experience, the dark bent nurses seem to take the longer they reside in their profession). This liminal space of knowing—in the context of patient wondering—emphasizes again the murky margin in which the nurse operates.

The nurse is also bound to a confidentiality agreement. According to the Confidentiality and Privacy Practice Standards of the College of Nurses of Ontario (2009), nurses are expected to follow a strict code of conduct for the protection of the patient's personal information. The expectation is that nurses will not share information with anyone who is outside the immediate “circle of care” unless it falls within the college's definition of consent (which can be implied or explicit). This means that I can

call report to a nurse at a receiving facility that my patient is being brought to for a test, but I cannot provide information about my patient to someone on the phone who is claiming to be his wife (if I have had no way to establish that is who she is). Additionally, I am unable to talk about my patient with anyone else who is not involved with care, nor can I discuss care with a colleague while we are having lunch in the cafeteria. Staff cannot speak about patients while, say, in the elevator, or even with other staff who have previously cared for that patient in another area of the hospital if they are no longer within the *circle of care*. It also means that I cannot discuss a patient in a way that makes the patient identifiable, such as providing a name, or even a detailed description of their condition, if that could lead someone to identify the patient. If someone could identify a patient by the details I provide, I have breached my obligation of confidentiality and can potentially lose my license to practice. While it is paramount that patients have a safe and confidential space in which to choose what they share about their health and with whom, these necessary limitations have the potential to be a liminal space for the nurse who cannot speak about what she has experienced. The only people she or he can share or debrief the experience with are others who are within that information-sharing circle.

I bring up confidentiality because nurses must be guarded in their knowledge, and it is often very difficult knowledge to share, even when it is “okay” to do so, because the knowledge is of things that are complicated and awkward to share, especially when nursing was not even what the nurse her/himself thought it would be. In the same way that members of the general public often believe they understand what happens in classrooms, people often think they understand what nursing looks like, because it seems like a profession that is easily relatable. One study examining the public’s perception of

nurses found that “the actual public image of nursing is diverse and incongruous. This image is partly self-created by nurses due to their invisibility and their lack of public discourse” (Hoeve, Jansen, & Roodbol, 2013, p. 295). I would suggest that the nurse is not understood ostensibly because of his or her inability to share knowledge that is confidential, and that is compounded by a lack of public discourse because what nurses *do* know is not easily explained. Nurses are caught in this way in an ironic position of knowing too much in a club too exclusive. We cannot share because we are, in many cases, not allowed, and we remain *invisible* because we cannot easily share.

Marginalized, liminal situations are made worse when, say, the nurse has a difficult shift—one in which a patient unexpectedly dies, or dies in a particularly disturbing manner, or the nurse has an altercation with a patient or her or his family. The nurse is limited in those whom she can talk with about a patient or their situation by these confidentiality constraints. This is in no way a suggestion that there be changes to confidentiality agreements—rather, I would like to highlight how a nurse must guard her knowledge. If the situation is discussed with anyone who is not within the circle of care, there may be both confidentiality breaches and awkward conversations with people who do not understand. I sometimes joke (but secretly worry) that I am unfit for general society because I am occasionally oblivious to what is considered “appropriate” conversation. Once, as a guest at a wedding, a fellow guest asked me where I worked. At first I simply told her I was a nurse, avoiding drawing attention to the area in which I work. I have found that telling people I work in an ICU evokes a certain reaction that is clearly misguided, however well intentioned it may be. She asked where and in which department I worked, and when I told her, her eyebrows furrowed and her hand went to

her chest in a gesture of concern and sympathy. “Awwww, that must be very difficult,” she said, with her bottom lip pushed out to emphasize the effect, which made me bristle. I answered unkindly (although not dishonestly), “It’s okay, you get used to looking after people in an ICU. In fact, if you ask any ICU nurse, she’ll tell you our favourite type of patients are vented and sedated.” At the time, I thought I was (albeit lamely) being amusing, but I acknowledge now it was actually an inconsiderate and rude answer which was meant to shut down further conversation about my work. Her sympathy made me angry. She was transparent about her assumptions about my job and the people I look after, and my kneejerk was to shut down any further conversation. My knowledge and experience most comfortably reside at the periphery and do not easily traverse that threshold in a conversation where I can share what I really do. There is just too large a gulf between the nurse and the layman, who could not possibly be expected to understand, and I admit I struggle with this. One paper in which the researchers explore the experience of nurses with end-of-life care quotes a nurse as saying, “You go home and everybody is just doing their regular thing ... , and it is like, you know, yeah, I had somebody die today, and people who don’t do this, don’t get it. They just don’t get it” (Kirchhoff et al., 2000, p. 41). I imagine it is no coincidence that there are nights at bars and clubs that are dedicated to health care workers such as nurses, paramedics, and firefighters at the same time—surely they face a similar gulf in understanding.

The flip side of this is that nurses recognize each other in an uncannily short amount of time of being around each other. I have found I can identify a family member as a nurse when they come to visit—it’s often only a word or two that cue me to their profession, or the way they interact with the patient. It is difficult to describe, but I will

provide a personal example. My father had to have open heart surgery not long ago, and when I went to visit him the first time, he was still sedated and intubated, so I stayed for only a few moments. It was simply nice to see him finished with his surgery. I returned the following day, and although he was pale and puffy, he was awake and extubated and was able to talk with me for a bit. I told him, “I came to see you yesterday, but you were still gorked.” His nurse, who happened to be in the room at the time, immediately looked at me and said, “You’re a nurse, aren’t you?” I laughed, but was not surprised. We see each other.

Nurses also know what death looks like, and it is a knowledge that no one *wants*. Never mind a gulf of poorly understood space between the nurse and other people because of our knowledge of the human condition—the nurse’s knowledge of death is an island no one wants to visit, let alone take up residence.

When I started working as a nurse, it was in an oncology unit. I very quickly learned that everyone dies of cancer. At least, that was what I believed at the time. As a new nurse, I realized that I would need to reckon with my own mortality, seeing as I would surely die young, as most of my patients were, and I quickly grew to be convinced that most people did. I now recognize my skewed and inaccurate perspective, but that experience left a lasting impression on me: that there is little rhyme or reason, mostly, to many patients’ physical events that bring them to the hospital—they do nothing to cause it, deserve it. Even those who have addictions or habits which influenced their cancers or conditions could not be seen as deserving it, with the connections between addiction and illness remaining some of the most nebulous correlated-not-causal issues at large that cannot be explored here.

An ICU is also a place that sees death—the difference is that it can suddenly take much longer for the same, otherwise acute, physical process. We have life-supporting devices that are employed to sustain or suspend a human within that space between life and death. One American study found that “about one fifth of ICU patients die while hospitalized” (Beckstrand, & Kirchhoff, 2005, p. 395), and a nurse would likely make a good guess as to who that would be. However, my point is not that the nurse could predict who survives to leave the unit—my point is the feeling of taking care of a patient for whom life-extending care feels inappropriate. Philpin (2007), in her paper about ambiguity and danger in the ICU, speaks to the ICU patients’ liminality, because of their dependence on machines to survive. She says,

In both conscious and unconscious technologically supported patients the ambiguity of their situation is intensified by their need for connection to a machine: from this perspective they could be described as ‘cyborgs’ [...]; the notion of a hybrid again suggests category confusion and being neither one thing nor another. (p. 53)

Patients may languish for weeks sedated and ventilated, perhaps aware in a groggy, barely-conscious manner (because we keep it that way for their comfort, if possible), not allowed to die, yet not able to recover. There is liminality for the patient when he or she is suspended in this state of not-dead-not-alive, and the nurse shares the experience even though she or he is not living it.

Nurses see the calamity dying brings, but also the stillness and quiet of death, the relief of it. The shift from one state to another is witnessed by the nurse, who is present for these events, even if the patient’s family members are not/cannot be. We have the last

look of the waxy face and mottled body as we close the zipper on a white vinyl bag. There are people, I have heard, who do not wish to live next to a cemetery because it would remind them daily of their own inevitable demise, but the nurse cannot deny and must confront, on a nearly daily basis, what awaits us all in time. Martin Frommer (2005), in his paper “Living in the Liminal Spaces of Mortality”, describes reviewing the obituaries in the morning and savouring not the death of those he knows, but the “psychic space where I become aware of myself as someone who also dies” (p. 481). Even the intensivist (ICU doctor specialist), who is intimately aware of the patient, is arguably not as acquainted with what Rabelais would describe as “the body grotesque” (Bakhtin, 1968, p. 19). The doctor may be in close proximity but remains on the “clean” side of the room curtain. The nurse is thrust into the middle of any body fluid expulsions as they happen, as well as seeing the progression—the slow march—to death. In most cases, vital signs are recorded even when they are barely present until they simply no longer are, and the ECG (electrocardiogram) of the final heart beats are printed and added to the patient record. This arguably macabre practice of examining the tiny moments of the downward spiral, the minutiae of expiring, strikes me as absurdly unnecessary, yet I perpetuate it by also tallying the final breaths and the final electric signals of the agonal heartbeat, unsure of my role as an ICU nurse trained to detail the patient experience in chart form to transition to one who is merely a silent witness—I rely on my rituals, even after they are of no further use.

Nurse knowing is a liminal experience, and we are often alone in this realm. Even the doctors who are present for the patient’s needs sometimes find the nurses’ hesitation, reluctance, or bitterness about our “care” frustrating. I posit that doctors find it frustrating

because of the gap in our experiences: The doctor has a far more clear-cut plan for a patient's care where once a day during rounds the patient is reviewed, the body systems itemized and dealt with, goals for treatment are announced, and the plan carried out. At least, this is their apparent perception. What the nurse sees is problem-solving that deals with trees without addressing the broader forest. Each part of the patient may be addressed but if the whole is a picture of slow decline, the nurse may wonder why there is guidance to provide care that is anything more than measures to comfort and alleviate anxiety and agony. The doctor seems to see it like this: The patient needs to be fed to get better, therefore the patient needs a feeding tube, so she or he orders a feeding tube. The nurse sees this: a frail and frightened patient who cannot understand what is happening, so the procedure to insert a feeding tube cannot be explained, and the patient is scared, angry, fighting the nurse as though the patient's life depends on fending off his or her attackers. Once the nurse wrestles the tube in, the patient's hands are restrained to prevent the patient from pulling the tube out again, which would start the process anew. The nurse carries out the doctor's orders that seem benign and reasonable but are, in practice, terrible acts which lead to the nurse feeling conflicted, cruel or cynical.

There are paradoxes here, within nurse knowing, which go beyond the liminal experience of death and dying. For example, nurses will not necessarily ask you about yourself. In fact, the nurse may not necessarily know anything personal about you except medical details. Very often the patient is unable to communicate other than to nod or shake his or her head *yes* or *no*, and sometimes not even that, yet the nurse can care for your life without actually knowing very much about it at all. Your medical background, which may include a remote tonsillectomy—although technically “medical history”—

likely has little to do with your intestinal obstruction and is therefore left out of the conversation about you. However, that tonsillectomy may have been an important event in your life—the first time you were away from your home and family, the first time you had so much pain, the first time you knowingly embarked on the unknown, or the first removal of part of you from inside your body. However, it is as unexamined as much of your life by the medical staff. Patients' family members often post pictures of their loved one when they were "well," but the photos are too abstracted to change any of the treatment they are receiving from the nursing staff. The paradox can lie in the nurse's knowledge of your body. She or he does not know (or particularly care, honestly) about what your favourite food is, but knows the texture (and smell) of your bowel movements. The nurse knows if you have blackheads on your back, a faded tattoo you may normally try to cover, toenails that look like cashews, and the state of your well- or under-maintained teeth. The nurse is literally wiping, washing, brushing, or suctioning pretty much every part of your visible body while the inner workings are monitored via machines. And although things like a catheter for urine or rectal tube or intravenous catheters are ordered by the physician, it is still the nurse who inserts most of these plastic tubes into your body. We remain professional with the patient, but may recount exceptional experiences to each other, such as a particularly difficult catheter insertion or the way a toe came off in one's hand during gentle cleaning, or a particularly difficult-to-witness death. It is not to suggest we judge any of these—nurses quickly recognize that bodies are varied and exceptional in their own way, carrying any number of random outlying characteristics like unusual skin tags, fused toes, profoundly waxy ears, but I will acknowledge that there is a certain delight in noting the strange details of the human

body: *oh, that's the highest blood sugar I have ever seen! Or I have never seen maggots come out of a wound like that!* At times, it seems as though the more challenging it is to care for a particular kind of body, the more we may privately cherish the memory of those peculiarities.

We are attendants to literally *anybody*. While we may not exactly be reverent, there is an equalizing power to knowing that we are all vulnerable, we are all dependent on our physical selves, and that bodies are all recognizable as being largely the same. There is “an almost universal sameness in body imagery, for all must play on the same basic body and its same functions, and this sameness may be seen as a universal topos” (Koepping, 1985, p. 200). But the body, as well as being a wonder, is ridiculous. And to be alive is to share in that ridiculousness, since to be alive (as far as we know) is to have one. The body, as described by Francois Rabelais and examined by Mikhail Bakhtin, is the reflection of the life cycle, and can be considered “as something universal, representing all the people” (Bakhtin, 1968, p. 19). Bakhtin goes on to describe the Hieronymus Bosch-like interpretation of Rabelais and the exaggerated body: “The leading themes of these images of bodily life are fertility, growth, and a brimming-over abundance. ... The material bodily principle is a triumphant, festive principle, it is a ‘banquet for all the world’” (p. 19). Like a painting of spoiled fruit by Michelangelo Caravaggio, the body is a banquet that also fails, soils, and falls apart and must therefore be tended to, sometimes swiftly, with interventions that mean nothing to the physical body, only serving, perhaps, to placate the psyche of a few.

Nursing Death, or the Liminality of the Code Blue

The most acutely liminal space in an ICU is the Code Blue. Generally referred to as, simply, a *code* (there are many types, but by calling it a *code*, the ICU staff are revealing that it is the only one we think is important) is a highly ritualized set of protocols where the code runners are trained to respond in a systematic fashion to the dying (or dead, technically) patient. There are clear steps: recognition, cardiopulmonary resuscitation (CPR) initiation, the call overhead, the arrival of the code team, and algorithms to respond to the nature of the arrest. What makes it a liminal event is that the patient is neither here nor there during a code. While the patient is dead, the literal hands-on interventions are being carried out to prevent them from *staying* dead. On their own, left to the natural progression of their arrest, they will remain deceased. The interventions are the tubes, drugs, and sometimes electricity inserted into them that jolt their systems into operation again. Their waking is the definitive point at which the interventions (mostly) cease. More often, their heart regains its march, but the patient still never wakes. If the code team does not “get them back,” the code runs as long as those who are participating see appropriate, making it a very existential undertaking. There is only the *now*; plans for dinner are delayed. However, another anecdote fits here: Once during a code, the physician who was leading it heard a text on his phone which he looked at. He said, with incongruent excitement (certainly quite aware of the effect), “Oh hey! Someone wants to know my plans for this Easter weekend!” There were no groans such as one would hear if the audience found a joke inappropriate. Rather, we laughed ... no guffaws, mind you, but there was the implicit understanding by those participating

that the code blue was grim compared with the oblivious cheeriness of the outside world, making for an unexpectedly amusing juxtaposition.

However, as a rule, the code runners are present in the moment, tallying and recording, problem-solving, and planning the next step, but only by a few minutes. Any intervention that would require more time to diagnose is moot unless the treatment can be provided immediately, since CPR is a very temporary fix. I have, however, participated in codes that lasted hours. Even though that is a very long time to run a code blue, compared to the patient's lifetime, those last few hours are insignificant. It is the electricity zap of static at the tip of one's finger when you touch someone on a dry winter day: *blip*. And yet, those hours contain such exhaustive scrutiny as to expand the time passing to its minutes, noting and denoting the punctuating drugs given: epinephrine, sodium bicarbonate, the tallying of micrograms of levophed, dopamine, more epi, more bicarb, 'pressin, blood products, CPR, CPR, and more CPR, and always the recording of the patient's response: sinus tach, PEA (pulseless electrical activity), asystole (no heart rhythm at all). The hours feel like 50, and are exhausting, both physically and emotionally. The code's minutes are recorded, and responses to each intervention are described. And for what? Like recording the final moments of a person's agonal electrical heart signals, there is questionable utility in examining the minutiae of death. Codes, by any measure, go horribly wrong almost every time: The patient dies or is "saved" only to stave off death for another relatively brief amount of time—days or months. In the cases where the codes last for hours, all present know the outcome, and it is grim. In one scenario, a young patient's sepsis evolved into disseminated intravascular coagulation, and she was actively spontaneously hemorrhaging. Because of her youth, and because

there seemed no other choice, we resuscitated multiple times. Every time we would regain a heartbeat, the drugs in her system would wane within half an hour. We feel desperate, knowing and dreading the outcome, while simultaneously feeling resigned to it once it becomes clear that there will be no recovery. Code blues are spectacularly rotten at saving anybody. And yet. And yet they sometimes do, but very rarely, under very specific circumstances.

For the family, it is a different liminal experience; they may know there is not going to be a recovery, but each minute feels so precious that they want to hang on to each and every one they share. There is evidence to support a family's presence during resuscitation—their witnessing of this event appears to help them come to terms with the death, with fewer bereavement-related symptoms (MacLean et al. 2003; Meyers, Eichhorn, & Guzzetta, 1998). In some hospitals, there are support staff on hand, such as social workers, to be with the family at such a time. However, in our hospital, it is a nurse who will stand with the family, either simply being there with them or explaining what is happening. They stand at the edge of the organized chaos, appearing shell-shocked, watching their family member, hopeful of a good outcome. For the nurse, there is the teetering upon that precipice, the wondering, all the while performing CPR (which really gives the provider time to reflect on the nature of the exercise, for their job is to pivot at the waist and compress another human's chest, over and over, looking at her or his dead, blue, sometimes bleeding face), wondering at what point it can be agreed upon that there is *no* point. We “run a code” as many times as those involved see any effect of the interventions. Unless there is a family member who declares that we have done enough, and we can allow the patient to die.

There is a scene from the war novel *Catch-22* (Heller, 1961/1994), where the main character, Yossarian, reassures a seriously wounded soldier, Snowden, that everything will be alright. Yossarian sees the wound the young soldier has acquired during battle, on his leg, and starts to pour upon it small packets of sulfanilamide—a powdered antibiotic found in government-issued first aid kits—as, certainly, some directive would have him do. Yossarian steels himself to apply a tourniquet, “with simulated skill and composure” (p. 336), muttering, “There, there. There, there” (p. 337) to Snowden’s frail and repeated complaints that he is cold. Yossarian persists with trying to treat the leg wound, cutting open the pant leg, pressing a cotton compress to the site, all the while watching Snowden appear more and more pale, his leg waxy, his lips blue. It is then Yossarian sees “a strangely colored stain seeping through the coveralls just above the armhole of Snowden’s flak suit” (p. 338) and discovers that Snowden is wounded profoundly and irreversibly. Yossarian’s use of the powdered antibiotic is ridiculous and tragic in its utter futility, and the devastation of the wound is fully understood:

It was easy to read the message in his entrails. Man was matter, that was Snowden’s secret. Drop him out a window and he’ll fall. Set fire to him and he’ll burn. Bury him and he’ll rot, like other kinds of garbage. The spirit gone, man is garbage. That was Snowden’s secret. Ripeness was all. (p. 339)

I am reminded of this scene because the code blue is arguably the most visceral of the attempts to revive being, and is largely a frustrating venture into delusion—we’re pouring tiny packets of sulfanilamide onto gaping wounds made by forces over which we have no control. The difference is that we nurses, unlike Yossarian, know about the gaping wound under the flak suit. Nevertheless, we push on, pushing drugs, pushing on a chest. The

body is done, whether or not the spirit is too. It feels perverted, paradoxical to run through a code blue where the cure is most certainly worse than the ailment because it will not, cannot work. One may argue that while there is life there may still be hope for life to continue on, but I disagree. There is a difference between the heart having an arrhythmia problem and needing a pop of electricity to reset the beats and contractions to pump blood around the body and the scenario where the body is slowly, piece-by-piece, falling apart, so that the last flicker of life is what can be seen on a monitor that does not reflect the potential of time alive for that patient. The body is already falling out the window, burning, rotten. We cannot catch coding patients any more than the whisp of air moving in and out of their lungs with our hands. And in this endeavor so benignly called a “code blue,” we have failed before we even begin.

It’s not within the scope of this paper to discuss how patients become ill in the first place. There is ample discussion in the literature on the health of patients and populations. What I do know is that by the time someone is nearly dead in the hospital, there is very little we can do about it, and yet we very often try, with the cost of trying having detrimental effects to our cynicism. A patient’s loved ones struggle with issues that they perhaps have been able to ignore for much of their lives—issues such as mortality and expectations from their hospital experience. Hilberman, Kutner, Parsons, and Murphy (1997) note, in their paper on the efficacy of cardiopulmonary resuscitation (CPR), that “outcomes from [CPR] remain distressingly poor. Overuse of CPR is attributable to unrealistic expectations, unintended consequences of existing policies and failure to honour patient refusal of CPR” (p. 361). The paradoxes of life and death, emotionality and rationality, hope and futility are all functions or products of the liminal

space. The patient and family are in limbo, trying to navigate and renegotiate the outcome. In the code I explored involving the young woman for whom I was primary nurse, there was additionally the paradox of youth and vitality and sudden death. It was absurd that she should die. It is nearly irreconcilable for someone to be alive and exuberant one moment and hours later dead. The nursing staff shared her journey that night, and had to humbly acknowledge that we could not prevent the final catastrophe.

These are situations that test your foundation—your own philosophies on the meaning of your work. When you join the patient in his or her journey from illness to death, you begin to see the pattern of the signposts directing the way to the end. Only occasionally do we see an abrupt condition (a sudden death by arrhythmia or respiratory failure) that, if caught immediately, can resolve with a swift—although often somewhat violent—interception. More common is the patient plagued with chronic afflictions that grow in number until the body is overcome and simply gives out.

Atul Gawande speaks to this in *Being Mortal* (2014), saying that “instead of just delaying the moment of the downward drop, our treatments can stretch the descent out until it ends up looking less like a cliff and more like a hilly road down the mountain” (p. 27). He goes on to accurately note that patients “enter the hospital looking terrible, and some of what we do can make them look worse” (p. 27). There are, undeniably, ways to stave off death for indeterminate amounts of time (sometimes months, sometimes days, and sometimes only hours), but the larger story is that patients and families wish for interventions that will provide endless hope for perpetual cobbling, with the dream/desperate delusion for the Shangri-La of the permanent fix or cure, ever just around the corner. The nurse must operate between the hope of the patient and her or his

family on one hand and the physician who is doling out the interventions on the other. Often, the interventions seem absurd to the nurse, whose job it is to shuttle the critical patient from test to test within the hospital or provide resuscitative measures if the patient succumbs to long-standing, chronic conditions. I do not wish to make my position a critique of the physician, who must navigate as she or he can also between offering the possibilities of modern medicine to treat and offering the possibilities of palliation which can be complicated and difficult to discuss. Discussing how the physician is prepared during his or her education—medically and philosophically—for these conversations is not within the scope of this paper. However, I do believe that differences of perspective are perpetuated by the proximity of physical care. The difference is caring for those whose bodies are disintegrating under your hands versus managing care from the doorway, directing the interventions without having to face the physical crisis.

Another author (of another war novel, incidentally), Charles Yale Harrison, wrote *Generals Die in Bed* (1930/1975), describing a context of war occurring with distinct sets of participants who have differing perspectives, ostensibly because of their exposure (or lack of) to the brutality of war. Generals are seen as being unaware (at best) or unconcerned (at worst) with the realities of the trenches. The unnamed protagonist in the novel becomes more and more disillusioned about the goals of the war, presuming the generals are apathetic, seeing the soldiers as pawns or a means-to-an-end, with the end being suspiciously economically driven. I acknowledge that there were certainly generals who were also present at the war fronts, in the trenches, along with the soldiers, with a hearty and visceral understanding of the effects of combat. However, there remains a perception disconnect between those issuing orders (generals), and those who are obliged

to obey (soldiers) that runs parallel to a medical context of doctors and nurses. Doctors issue orders; nurses are obliged to carry out those orders. It is this liminal intersection that provide fertile ground for such issues as “moral distress,” a much-discussed phenomenon in current nursing literature that will be examined here as well.

Martino (2010), writing about *Slaughterhouse Five*, notes that “Camusian absurdity and Bergsonian humour rely on the same basic principles: a lack, a separation, between action and meaning, so that the expected outcome of a course of action is subverted” (p. 5). There certainly is the separation here, between the action (attempts to revive) and the meaning (those attempts are generally futile, so what does the attempt mean?), sometimes making an entire code blue an exercise of acting, of propping only. Many arrests in the ICU are anticipated, as in the case where a patient is horribly ill but family members continue to pursue aggressive treatment despite the (obvious to nurses) writing on the wall. This is a liminal space for multiple reasons. First there is a clear border as to what is considered an arrest: the heart stops beating effectively—although it can occur for a variety of causes, this is the punctuating event that defines a code blue. Second, there are rituals and expected procedures that take place that the community (of health care professionals) are aware of, agree to, and provide. However, because it’s a community-initiated ritual, it has some elements of negotiation. When the arrest is anticipated, the result is inevitably that the efforts will fail, yet the family insists that a code be run, the medical staff (doctors, respiratory therapists, as well as nurses) may negotiate in this way: They will run a code while understanding that it will fail. This is unofficially called a “Hollywood code,” or a “slow code,” meaning either it is acting only, or that the code is run slowly enough to allow the patient to die sooner. There is the

acknowledgement that the enterprise is useless and the attempt is acted out anyway out of respect for the family's wishes. We are legally culpable if we do not follow a "Full Code" order, as though the outcome could be that the patient will survive an arrest if only they have some intervening therapies. In the slow code, the chest is still compressed, the drugs are still given, the minutes still tabulated, but any sense of urgency is absent. In fact, there are often quite cynical comments that may occur, reflecting the frustration with the situation. There is no problem-solving happening, no running through what may have caused the arrest—it is already known: The patient has come to the end of what her or his body can do. And the nurse may even resent the traumatic injury he or she must cause by compressing the chest, feeling the pop of ribs breaking under one's hands. Yet we are stuck in between.

Goldman (2014) speaks to the liminal spaces, although his book, called *The Secret Language of Doctors*, is technically about a hidden language—the one used in the "Bunker" (p. 1)—that doctors and other medical staff use to speak to each other. However, although he writes about language, there are physical and philosophical spaces that run under or between the doctors and the "outside world." The liminal nature of this different language exists in the way it is developed, shared, and where it is used. It is forged within a liminal space—the space where cultural norms are negotiated, as described by Turner. Goldman describes a paper titled "Beyond curriculum reform: Confronting medicine's hidden curriculum," written by Hafferty (1998), a director of the Program in Professionalism and Ethics at the Mayo Clinic in Minnesota:

Hafferty wrote that the hidden curriculum is passed from student to student and from resident to resident not in the classroom but 'outside formally identified

learning environments: in the elevator, the corridor, the lounge, the cafeteria, or the on-call room.’ (p. 13)

In other words, the in-between spaces in the hospital, away from patients.

So the slow code, the Hollywood code, is a small way for the nurse to mitigate the harm done to the dying. The experienced nurse seems to decide whether this code can have any positive effect or outcome, weighs the patient’s comorbidities against the reason she or he “coded” in the first place, and is willing to abandon the project before it even begins. In my own experience, it feels the worst when the patient, already almost dead, is actually revived briefly. This means rapid drug delivery, the making of new drug IV tubing and mixed bags of varied concentrations of drugs, higher detailed tabulation, and hopeful family members who often see this as a sign that their loved one may recover. This experience feels like extensive packing and preparing for a trip that no one will ever take, and the nurse may meet the demands with virtual eye-rolling. Why bother? Why do a tracheotomy on a patient who will not recover? Why prolong the long-drawn-out death? Why do CPR on a patient who has looked literally dead for a month already? Why shuttle the patient to have a CT scan 4 floors away, bringing four other staff members along (two alone to move the bed), taking resources like time and attention away from other equally needing, very alive patients? Occasionally there is a case made by the family to postpone the death of their loved one because there is a far-away family member expected to arrive to the bedside, to say goodbye. But more often there is only the very temporary staving off of death for the sake of hoping that death will wait indefinitely. If family are present during a code blue, the family may understand, eventually, that their loved one is not going to benefit from another round of CPR and cell-jolting drugs or electricity. It is then

that they (sometimes) agree to stop the interventions and they agree to “allow natural death”—an order that, in some hospitals, must actually be issued by a doctor (rather than letting the family decide and a nurse, say, proceeding with their wishes). The order to “allow natural death,” also called an A-N-D order, is like a sigh to the nurse— a recognition of mortality, that we do not have to pretend we will win the war we are waging against death and we can stop “packing” like we are going to. Instead, we can make the patient comfortable, pull up chairs for the family members, and provide peace and reverence for the dying.

I recognize that there is a pragmatism that may come across as callous, but the frustration and impatience with the process are what push the nurse to a liminal space without a way to move conversations about the eventuality of the body failing. Hafferty (1998), in his article, points out that “analyzing the hidden curriculum is neither easy nor free from controversy. What is revealed by such an analysis may appear decidedly strange, shocking, or outlandish to outsiders” (p. 405). Indeed, sometimes the nurses’ resistance or despair with implementing what she or he considers inappropriately violent futile care is met with frustration by doctors, who may have a very different perspective. Susan Sontag (1978) describes in *Illness as Metaphor*, the withholding of realistic prognoses to patients (although in her description the doctors are more forthcoming with the patient’s family):

All this lying to and by cancer patients is a measure of how much harder it has become in advanced industrial societies to come to terms with death. As death is now an offensively meaningless event, so that disease widely considered a synonym for death is experienced as something to hide. (p. 8)

While Sontag is specifically describing a diagnosis of cancer, I would suggest that there is often a lack of transparency regarding many conditions' prognoses, allowing families (and patients, if they can be part of that conversation) to believe they are progressing better than they are. There are phrases used by doctors that are actually euphemisms, since their meaning is so much harsher than the words suggest. Phrases such as "guarded prognosis" are used, meaning the doctor expects the patient to die. However, this term is meaningless to families, who may think, "okay, the prognosis is guarded, but the doctor did not say it was terrible." Sontag links these (in her words) lies with the shame attached to a particular disease. I wonder, as technology and our ability to respond medically have progressed, if death is not seen as something that could not be staved off for good, irrespective of the cause. We have multiple families asking if their loved one's failed or failing organs could not just be switched out with a donor, say a liver, a heart, even a brain. Strictly speaking, yes, receiving a donated organ can happen, but only under very specific circumstances. Once a person is very sick, there is no feasible way to survive the process. Especially when the patient has sometimes minutes to live. These are conversations with the desperate, casting at any possibility, trying to problem-solve without knowing how the problem works. The nurse is in the middle, having to navigate conversations with language she is fluent in, remembering the patients and family are not, having to interpret accurately, gently, truthfully, what the doctor is saying.

Throughout this, the nurse may be having a psychic battle, sometimes becoming entrenched in the position that it is unethical to provide treatment that she or he deems profoundly inappropriate. Conversations are even murkier to navigate under these circumstances. The doctors, who often assume a heroic posture, want to save patients

from dying—they may see it as their moral imperative. Buchman, Cassell, Ray, and Wax (2002) describe the strange intersection of heroism and shame experienced by the surgical physician in their article “Who Should Manage the Dying Patient? Rescue, Shame, and the Surgical ICU Dilemma.” They describe surgeons as “trained to hold themselves entirely accountable for the outcomes of their patients” (p. 665), where patient prognosis is an unacceptable reason to withhold intervention. This article identifies the paradox of the ambitious doctor—the authors ask, “Who, after all, would choose to be operated on by an indecisive or ambivalent surgeon?” (p. 666). The difficulty comes when the patient is dying but the physician will not recognize—at least, to the family—that the attempt to cure is not working. The authors describe nurses as “culture brokers” (p. 667), who navigate conversations between patients, families, and doctors. If there is disagreement as to the expectations of the outcome for the patient, when there is little chance of recovery, “the critical care nurse cannot succeed as culture broker” (p. 667). The authors suggest that this communication and alliance often “unravels near the end of the patient’s life” (p. 667), leaving the nurse to view her position as “powerless,” and “ineffective” (p. 667), the upshot of which leads to frustration and professional exhaustion. The response of individual nurses is often to withdraw from the challenges of ethical decision making, creating further disengagement with conversations that may help patients and families navigate between hopeful and realistic expectations. I would add that, in my personal experience, these repeated scenarios have the frightening potential to erode nurses’ humanity. This is why there is the cynical response to a code blue where the nurse understands that there cannot be success by any measure. This dissonance is what fuels the moral distress that affects most

ICU nurses to some degree, primarily because they are asked to “continue to participate in care for [a] hopelessly ill person who is being sustained on a ventilator, when no one will make a decision to ‘pull the plug’” (Elpern, Covert, & Kleinpell, 2005, p. 523).

CHAPTER THREE: NURSING FUTILITY—AN EXERCISE IN LIMINALITY

In a Canada-wide survey, 95% of nurses polled claimed their ICU provided futile care (Palda, Bowman, McLean & Chapman, 2005). The impact of caring for a patient for whom care would be described by the nurse as “futile” is that the nurse often unwillingly cultivates an opinion on the appropriateness of her or his role in the patient’s care. If the care is considered futile, and the procedures of the daily rituals that go along with the patient’s care are painful and difficult, the nurse may consider her part in that care to be complicit with inhumane treatment driven by either the family or physicians by participating in hurting the patient.

Described initially by a nurse philosopher, Andrew Jameton (1993), moral distress is the response when the nurse cannot provide the care that is consistent with “deeply held ethical values, principles or moral commitments” (McCarthy & Gastmans, 2015, p. 132). Most often, it is the feeling the nurse has when she or he is faced with carrying out or being witness to treatment which is considered futile. The concept was recognized and explored in the 1980s and has since been developed and researched extensively, leading to knowledge of its triggers, manifestations, and implications for not only the nurse but the patient, the patient’s family, and the institutions in which the nurse operates (De Villers & DeVon, 2012). Reading about moral distress, however, I am reminded of how Robert Sapolsky, a neuroendocrinologist and author, describes in *The Trouble with Testosterone* (1997) returning to work after his father has passed away. He is distracted and “bludgeoned by emotions that swirled around a numb core of unreality” (p. 93). When he is asked by someone he works with, a medical student, how he feels, he

replies, “Well, today it seems as if I must have imagined it all,” to which she replies, “That makes sense Don’t forget about DABDA.”

What her shorthand is referring to are the stages of grief, as plotted by psychiatrist Elizabeth Kubler-Ross (Kubler-Ross, Kessler, & Shriver, 2014), who recognized a pattern of predictable stages one passes through (and revisits) after personal loss: denial, anger, bargaining, depression, and acceptance, in this case colloquially known as DABDA. What struck Sapolsky was how easily he fit into an acronym memorized by medical students to rattle off expected phases of grief. He wonders,

We cry, we rage, we demand that the oceans’ waves stop, that the planets halt their movements in the sky, all because the earth will no longer be graced by the one who sang lullabies as no one else could; yet that, too, is reducible to DABDA” (p. 95).

Sapolsky could as easily be speaking about moral distress and the nurse’s response to it.

I hope to draw parallels with the emotional response to looking after a patient who triggers deep moral distress but am aware that, by comparing these ideas, I may be minimizing the agonizing grief someone feels for a lost loved one. There is a disconnect between the benign-sounding phrase *moral distress* and its definition and the emotion one feels about it—again there is a gulf between the two ideas that appears irreconcilable. I wish to convey that the feelings connected with caring for a patient for whom care is considered futile are conflicted, grueling, and the cause of great frustration and anger and yet can be seemingly summed up with two words: moral distress. When the nurse is expected to pretend to anticipate a positive outcome that experience tells her is impossible, it feels like the term moral distress could be renamed moral outrage.

It is a common picture: Two nurses sit by their desk outside a patient's door at change of shift—one giving, and one receiving report on the patient. There are spontaneous (quiet) outbursts of, “oh my god, *what for?*” when being told that the patient is going to get a tracheostomy to replace the endotracheal tube (which can only stay in situ for approximately two weeks before it can do irreversible damage to the vocal cords and is therefore replaced by the more permanent and invasive but long-term tracheostomy), with the other nurse nodding, saying, “I know, I know,” because we all do. We know what this looks like—the patient who not only has terminal end-stage cancer but now has a terrible pneumonia and is requiring a level of care that feels not only inappropriate but absurd. The patient and family's position is often intractable: “I want to live,” the patient says, as though that is enough explanation, and the nurse understands the wish, because who does not? However, when the choices for treatment feel to the nurse to have reached unreasonable levels and costs—physical, financial, and emotional—any extended time alive is a Pyrrhic victory. So one can talk about moral distress, but until you are faced with the person whom you are to, paradoxically, *care for*, it is difficult to convey the depth of the outrage and the acute futility of the treatments, especially to a family who wish only to have their hope reflected and buoyed by yours. Perhaps nurses experience a parallel emotion via moral distress while the patient's family is experiencing anticipatory grieving, but I wonder how this gulf, too, could be crossed.

Another typical scenario: A colleague is at a social gathering outside of work with a group of friends, but also present are some she does not know. We nurses often talk about our experiences such as this at work, telling the group, where we find a common understanding. The oft-recounted situation goes like this: A nurse tells us she is asked by

a young man present at this function what her job is and she tells him that she is an ICU nurse. He is immediately fascinated. He asks, enthusiastically, “What is the weirdest or just grossest thing you’ve ever seen?” She retells the conversation, her face alight when mimicking the man—he seems to be waiting for a gory answer, perhaps to uphold some notion of an ICU nurse managing guts and bleeding eyeballs. However, the party-attending nurse’s affect goes flat when she retells her answer. She shakes her head, and retells: “You don’t want to know what we do to people. He was like, ‘oh you mean guts and stuff?’ and I said, no, the worst is looking after people who are basically dead, *keeping* them here, like this.” She gestures around her now at the patient rooms, containing people who are generally elderly but all frail, not expected to recover, yet receiving full, aggressive treatment. She says, now turning to us, those who are living this experience also: “These people we’re keeping alive—look at them! It’s horrible! *This* is the worst thing I have ever seen.” We laugh, because we know the reply: “But isn’t there, like, some chance they’ll recover? Like, they might, right?” Again, her expression flat, “Nope. You don’t get it, at all.” She says to the group now, “Nobody gets it except for us!” laughing again. This is the liminal space—one which is not generally recognized by these nurses as a liminal space—we have simply learned not to share because “nobody understands.”

To be fair, there are cases in which frail elderly patients recover from pneumonia, get extubated (breathing tube removed), and recover enough to be moved from our ICU. However, it is not so much the unlikelihood that they will recover, but the continual discomfort the nurse inflicts and the feeling that that leaves with us. Indeed there are medications that may assuage the pain of being a gravely ill patient, but it is the nurse

whose imperative it is to care that will hurt the patient frequently throughout his or her shift. We must balance the salve with its unintended effects, which may actually *cause* their demise. So the salve (pain medication, sedative, or a combination of soothing medications) must be given judiciously, lest we need to run a code blue.

Never lose hope: It is an oft-used phrase by families, but is an awful argument against continuing what is tantamount to torture. And yet, families use this line of reasoning to have us carry on mopping up oozing wounds, apologizing for causing pain, restraining arms for days—sometimes weeks—on end to prevent the patient from taking matters into her or his own hands (and removing tubes and wires from his or her own body), and nurses are stuck in the middle.

We fall apart one part at a time, as Atul Gawande (2014) notes. What the nurse wishes for are conversations about treatment that explain the cost of those treatments. And it is not the financial cost that is most bothersome, it is the physical and emotional cost—it is when the family member looks at a loved one and says, “hey, they look better today,” and all the nurse sees is a bruised, swollen, bleeding, dying, suffering human in the bed whom she must keep alive rather than comfort and allow to feel release. Again, there is that liminal zone of existence where the nurse inhabits a region *between*. We are stuck between life and death, explaining the inexplicable, sharing the unsharable, holding a life just this side of death yet not allowing the person to actually die lest we inflict traumatic injuries such as breaking ribs to *save them*. It doesn’t make any sense, it is ridiculous. Incredibly, here we reside.

Liminality and humour—trickster, the body grotesque

Tricia Scott notes in her paper about humour in sudden deathwork that humour is prominent where situations have particular elements: incongruity, the absurd, the unexpected, and the inappropriate (2007). It is no wonder, then, that humour flourishes in an ICU, as it contains all of these elements—in abundance. Humour is an integral part of nursing, and its unhinged nature is recognized by other nurses as having a pervasive quality—almost anything is fair game for a laugh. Established norms and rituals, equally part of liminal spaces, are recognized by the nurse participants and are the ingredients necessary for the joke to occur. The joke becomes the shorthand for a larger statement.

It has been said that any joke that requires explaining will no longer be funny, but at the risk of extinguishing anything humourous about the following scenarios, I feel there should be some acknowledgement of exactly what is funny and where the incongruences reside.

One example, a snapshot: I am sitting in front of my patient's room, looking at him, intubated, comatose, a wreck. I can see by various measures that he will die, likely within the next 24 hours, yet his family hold out hope that he will not only survive that but recover and restore health. Again, I will reiterate that this could describe too many of my patients. There is a disconnect between a family's hopes and expectations and reality. So, we continue to provide uncomfortable treatment. The patient's abdomen is bloated like a frog on its back, and I know he's quietly oozing fluid from various holes under his crisp white sheet that's draped over him, and he will need cleaning shortly (his abdomen is full of fluid—each attempt to manage this by drainage with a long needle has resulted in a hole, and each hole now leaks). His limbs, above the sheets, and face, visible in the

dimmed light, are yellow and gaunt. His teeth are the most prominent feature as his skin has seemingly shrunk on his skull. His eyes are half open, mouth agape. To the uninitiated, he looks horrific. Even those used to this kind of scenario often find care difficult. Many nurses have voiced their frustration with looking after such patients, so broken and irretrievable are they. I search for a picture on the internet—one which I suddenly realize, while looking into the room, looks uncannily like my patient. The picture is of John Torrington, a member of the Franklin expedition, still in his frozen grave. His body and face have been remarkably preserved in the permafrost, where he could almost be mistaken for simply lying down and looking horrible, with a rictus of the nearly dead, yet remaining alive. And I think (not for the first time): I am caring for a corpse. However, my patient really is alive, with an unmeasurable degree of feeling (we assume feeling is intact and try to sedate and provide soothing drugs accordingly, as much as we can while balancing its cost in blood pressure). My response to this situation is weird and inappropriate, but it simultaneously behaves like a salve. To care for a truly long-dead person would be absurd, but to consider that my patient is still alive within this juxtaposition—no matter how corpse-like he is—allows me to view the scenario more tenderly. A picture of a man, frozen and long dead, stated the volumes that are inadequately and unsatisfyingly discussed—or rather, there may be discussion by the nurses in the form of angry indignation that we must nurse someone with the intent to fix when there is quite obviously a zero percent chance of that fix occurring. There is no point, generally, to articulate to each other how difficult it is to look after such cases, because it is already agreed. However, the futile care continues, in spite of nurses' attempts to have meaningful conversations with physicians, patients, and the patients'

families, and in some ways has not advanced whatsoever in spite of the literature growing to support addressing the issue. So this is the kind of humour we find. I would deny that this constitutes a laughing *at*, however—not at the patient, because he or she is, by all accounts, the literal voiceless—we are gentle and are as kind as we can be. If anything, the patient’s pain serves to make us angrier—angry at the doctors who promise hope and health; we are angry at families themselves for hoping and believing, in our opinion delusionally, that *their* loved one will be the one to survive, against all odds. We can be cynical and sharp, and sometimes—the best of times—this morphs into humour. I show the picture to a coworker, also a close friend, who is charting a few desks away. He laughs, and then I laugh too. There is no explanation needed; he “gets it” immediately. The situation is absurd, then suddenly sad and hilarious.

Kurt Vonnegut, American novelist, was known for his satirical take on war and bittersweet take on the human experience. His character from *Slaughterhouse Five* (1969/1975), Billy Pilgrim, who experiences (and reexperiences) war, finds himself inexplicably upset by a song performed by a barbershop quartet. Pilgrim is mystified as to why he is suddenly emotionally crippled because of a song that “made slow agonized experiments with chords—chords intentionally sour, sourer and still unbearably sour, and then a chord that was suffocatingly sweet, and then some sour ones again” (p. 173). The lyrics, sentimental, go: “*So long forever, old fellows and gals, so long forever old sweethearts and pals- God bless’em*” (p. 172). Billy Pilgrim “had supposed for years that he had no secrets from himself” (p. 173). While Pilgrim cries in other places in the book, he does so silently. This time his face is contorted with grief, he is overcome—others in his presence believe him to be having a heart attack. They do not guess that his grief

could be summoned by something sweet—that chords conjuring pleasure could conjure pain. What he had not recognized in himself, perhaps, is how linked his experiences are. This may be what Vonnegut himself asks the reader to reflect upon by having Pilgrim thrust back and forth in his life. Is this not how one lives? In memory, we are thrust, sometimes unwillingly, to a meaningful moment—sometimes meaningful only in its banality. Pilgrim time-hops throughout various points in his life, literally reliving what he has already been witness to. In a Sisyphean/Camusian chain of events, he is stuck rolling his boulder up the mountain, again and again, and perhaps this point when he hears the barbershop quartet is some kind of collision of his experience. I would argue the ICU nurse experiences something similar—the blurring of patients, reexperiencing bodies that are simultaneously unique and all the same, sometimes returning to those experiences that are particularly sweet. Or awful. Frommer (2005) considers these paradoxes in his paper considering the liminal space of mortality and says,

dread and anticipatory mourning may exist alongside the paradoxical consequence that an intensified awareness of one's own mortality can make everything feel both meaningless and extraordinarily meaningful, sometimes leading to the conviction that one's life is truly one's own, and to being able to actually live it as if it were. (p. 484)

Mirth and levity live quite comfortably alongside sadness and tragedy, and often in unexpected ways. In line with the paradoxes that are present in marginal places, situations are highly charged and can flow “positive” or “negative” and flip without warning. Patients—especially young ones—can look surprisingly hale until they are ready to “crash.” Very often the patient is the first to have a feeling that something isn't

quite right, but sometimes we have patients or families who, perhaps by some coping mechanism, are incongruously lighthearted in the face of imminent physical danger. We have had patients who were unsuspecting of how sick they were prior to their admission—or at least, shrugged and were agreeable to our treatments as though they could do without them but approached all procedures as though they were simply humouring us. Chipper demeanors sometimes belie the fatal processes that roll, unchecked, in their systems, anecdotally most often in the young. Similarly, family members may nudge their elbows at each other and roll their eyes congenially, approaching the patient who is intubated and gravely ill. It is too big to understand, sometimes, that the good health that was experienced so recently is now gone, and sometimes for good.

Rituals may guide the process—the code blue algorithms, the chairs placed at the bedside, the privacy given the grieving—but it is still the first time the patient and family participants are experiencing this process. They are painfully living the process. Nurses inhabit this space, and while it is not the nurse's pain, we are witness to some of a family's worst moments. The nurse is what Turner would label “liminal personae” (1969, p. 95), literally people who inhabit the liminal space. And this sets the nurse apart, even from her or his own family. We are present while someone else's family capsizes. But there is a pragmatism that goes with being witness to that, or perhaps, more accurately, a kind of desensitization. When I began working in the ICU, I heard a quip that came from a seasoned nurse about her patient about whom she was very concerned. Looking at me, she said, matter-of-factly, “He's got one foot in the grave and one on a banana peel.” She delivered the line deadpan, and it was clear she was not joking, even though the image

was supposedly comical. Constant exposure inures us, to some degree, to the effects of tragedy, perhaps in the way that tragedy plus time equal comedy. And for the nurse, it doesn't take much time at all to see the humour. It is, perhaps, this desensitization that allows the development of humour and levity in the midst of tragedy and darkness. We are eager to flip the switch, to feel mirth, to savour our own living.

CHAPTER FOUR: WHAT'S SO FUNNY ABOUT DEATH?

Ring the bells that still can ring
Forget your perfect offering
There is a crack, a crack in everything
That's how the light gets in.

—Leonard Cohen (1992)

At first glance, it may seem grossly inappropriate to find levity in a realm of sobriety and somber grief. However, this is not an ordinary space of loss and sadness. It is a liminal space, where the culture is constructed by its inhabitants, and those inhabitants are part of events that are far outside the experience of most. There is a trickster at work here, and the nurse becomes inured to the unexpected, and often there is the suspicion that the worst is yet to come. No nurse will say these words out loud without being soundly chided by her peers or expecting all hell to break loose any minute: “It sure is quiet today.” We are mildly superstitious about declaring it a quiet shift, but also sometimes of full moons, we will often say that two deaths in succession herald a third, and for some nurses even a patient’s impending birthday is cause for bracing against calamity, seeing a birthday as some completion, perhaps, of an invisible circle about to close. I would like to differentiate humour from superstition, but also would like to note that I believe they both are manifestations of residing in a workplace that can be extremely unpredictable. Instead of growing resistant and inflexible, the nurse can grow fatalistic and accepting that there are forces at work that are beyond our control, managing some unpredictability with routines. Routines, as discussed previously as congruous with Turner’s description of liminal space, may be things like monitoring vital

signs at regular intervals, documentation of anything out-of-the-ordinary, as well as having training on how to respond should someone need swift medical intervention.

Somehow, this is a place where laughter may be triggered by things that do not seem all that funny: a burst ostomy bag, a liquid bowel movement so large it streams off the bed like a muddy river, a large, awkward cleaning buggy brought to a code blue instead of a similarly large and awkward crash cart—mistaken by a new nurse who, in her panic, was blind to the difference. It could be confused patients who have pulled out their own arterial line, and their frustrated nurse calls for help “to the murder scene” (as there can be a lot of bright red arterial splash on everything) that is met with laughter from peers as they help stabilize the patient. Jokes described are rarely funny, but their effect on the demeanor of the staff is palpable. Awful events and tragic situations must be followed by some release.

But there is something more happening with humour—there is more going on than what one sees at first glance. Humour is explored in the literature to some degree, but it seems to be often only to categorize or examine whether it is appropriate or not. One article on humour heads one of its paragraphs discussing the topic with the title, “Hospital Humour Explained” (Aultman, 2009), suggesting that it is all simple, really. It then goes on to describe how complex and complicated the actual topic is, breaking it down into multiple theories including “incongruity theory,” “relief theory,” and “superiority theory” (p. 228), and listing attributes of various types of humor, such as “black humor,” “cynical,” “derogatory,” “gallows humor,” “humor,” and “satire” (p. 228). The title *Hospital Humour Explained* belies its complexity.

Humour is sometimes seen as a risk. Often the humour examined in the literature is thought to be a possible detriment to the patient or, at least, encouraging stereotypes and posing a threat to the empathic care of a vulnerable population (Aultman, 2009; Wear, Aultman, Zarconi, & Varley, 2009), as though where there is humour and laughter, there is likely derisive humour and laughter. And I suppose that's possible, but in my personal experience, much of the humour I witness is a manifestation of the frustrations experienced by nurses. Being witness, repeatedly, to the human experience of sickness and death changes one's sense of what's humorous. *There, but for the grace of god, go I* is often the view of the nurse, looking at her or his patient. And often we literally do "go there": Being a community hospital, our intensive care unit has had our own staff and their direct family members as patients. In my 17 years in my current workplace, a loose mental count tallies at least half a dozen ICU staff or their family members as ICU patients at some point. We see ourselves in the bed, yet it is not ourselves. Again, this idea of paradox echoes the liminal, with nurses living on the threshold of those experiences. We earn our unique sense of humour, perhaps, through the discomfort of recognizing ourselves on the other side of the equation, made glaring for me, personally, when, for example, the patient has the same birth year. Watson (2011) writes on gallows humour in medicine and notes Freud's take on the matter, stating that from a Freudian perspective, "a joke is a rebellion against oppressive authority, and few authorities are more oppressive than death, illness, and injury" (p. 41).

However, the notion that humour is most likely to be derogatory may actually be a reflection of what is considered acceptable, especially from predominantly female nurses. Nurses may be expected to simply serve and be kind, not have any kind of

commentary about the care they are expected to give and under what circumstances. It is interesting that one researcher discovered that breaking from the expected stereotype of the good nurse is what made the nurses she was studying laugh (Adams, 2007). While conducting research for her doctoral dissertation on aged care nurses and their perception of their care, Adams “discovered that nurses laughed when saying anything that could be interpreted as their not being ‘good nurses’” (p. 3). Perhaps our acknowledgement of the incongruence between what we feel we *should* be doing and what we *are* doing falls under such a category. Moral distress would, by definition, certainly qualify as being a state in which the nurse does not believe he or she is being a “good nurse,” and one often hears the refrain, “if you don’t laugh, you cry.”

Caring for patients who are at the end of their lives is complicated and often difficult for the nurse, for a variety of reasons. One nurse, interviewed to speak about end-of-life care of patients in a study exploring the nurses’ perspective said, “The minute we stop crying and stop feeling something over the loss of a human life . . . , it is time to get out of there” (Kirchhoff et al., & Clemmer, 2000, p. 40). However, simply “getting out of there” is not necessarily the most desirable or possible, for many reasons. So what is the nurse who simultaneously does not feel the full emotional impact as she once did yet stays to continue her work to do? There is a dissonance between what is broadly expected (and reinforced in the literature) and what actually happens. Perhaps humour is the answer, the response that fills the gap. Maybe humour is what happens when you realize that you do not feel sad about the loss of a human life—or if you do, the impact is so fleeting as to not be worth mentioning, and that is both tragic and ridiculous.

Watson (2011), in her article “Gallows Humor in Medicine,” describes a physician’s residency in an emergency room where he and two other residents had ordered pizza. Their wondering about their order which was late was interrupted by a nurse announcing a trauma patient was arriving with no vital signs. They met the young patient and immediately recognized him as their delivery boy, shot dead as he delivered their food.

That made them work even harder. A surgeon cracked the kid’s rib cage and exposed his heart, but the bullet had torn it open and they couldn’t even stabilize him for the OR. After forty minutes of resuscitation they called it: time of death, 4:00 a.m.” (p. 37)

It was not long after that they wondered what happened to their pizza. It was outside, only steps from the emergency room doors. “They stared at it. Then one of the residents made a joke. ‘How much you think we ought to tip him?’” (p. 37). They laughed, and then they ate. The doctor who does the retell in Watson’s article asks her if it was wrong to make a joke, if it, in some way, was denying the young pizza delivery boy his humanity. Watson goes on to examine the reasons we joke, and how they affect not only the joke-teller but the culture they are encouraging. I am curious about how we use humour, how it has the potential to turn tragedy into comedy, and also how it has the power to give or take away humanity. Lyrics from Bruce Cockburn come to my mind from his song, *Lovers in a Dangerous Time*, that go, “Got to kick at the darkness ‘til it bleeds daylight” (1984). There is an implied cruelty in the kicking, but the result is light—what does that mean for the nurse who finds humour in death work?

The grandest liminal space

When I am able to set aside my outrage with the way we look after the dying, the dead, tolerating the family's perception that their loved one may recover if only we carry on and behave as though they will, I have grown to understand that perhaps the real problem is fairly straightforward: That we are mortal and that humans *are* the grandest liminal space we know. Bookended by nothingness, our life, the only *thing we know*, is just a short blip before it is all over. There is an unfathomable amount of time before and after our existence. And I have come to see this as one reason it is so difficult for families to recognize and reckon with the impending loss of their loved ones. *The Stone Angel*, by Margaret Laurence (1964) has the aged Hagar Shipley taken by her son and daughter-in-law to view a nursing home. She asks a resident, "Do you ever get used to such a place?" (p. 112). The resident replies,

"Do you get used to life?" She says. "can you answer me that? It all comes as a surprise. You get your first period, and you're amazed—I can have babies now—such a thing! When the children come, you think—*Is it mine? Did it come out of me? Who could believe it?* When you can't have them anymore, What a shock—*It's finished—so soon?*" (Laurence, 1964, p. 112)

Sometimes patients struggle with their breathing tube—it makes them cough and choke and they look at me and gesture that they want it out. I reassure them that it is still necessary but that we will remove it as soon as possible. I usually end my oft-repeated rote words of comfort with the phrase, "This is temporary." I avoid saying things like, "Everything will be okay," or, "You're going to be just fine" because I believe these

phrases to be disingenuous. I cannot honestly assure someone that they are going to be “okay.” Perhaps they will not. However, I can tell them, “This is temporary” with a clear conscience, since it is, in every possible way. *All* of this is temporary. *Everything* will fade eventually. Again, that existential element pervades liminality, highlighting the fleeting experience of living.

This brevity is echoed by Paul Bowles, in his *The Sheltering Sky* (1949/2005), where the two main characters talk about death:

[Kit] had quite forgotten the August afternoon only a little more than a year ago, when they had sat alone out on the grass beneath the maples, watching the thunderstorm sweep up the river valley toward them, and death had become the topic. And Port had said: “Death is always on the way, but the fact that you don’t know when it will arrive seems to take away from the finiteness of life. It’s that terrible precision that we hate so much. But because we don’t know, we get to think of life as an inexhaustible well. Yet everything happens only a certain number of times, and a very small number, really. How many more times will you remember a certain afternoon of your childhood, some afternoon that’s so deeply a part of your being that you can’t even conceive of your life without it? Perhaps four or five times more. Perhaps not even that. How many more times will you watch the full moon rise? Perhaps twenty. And yet it all seems limitless.” (p. 232)

CHAPTER FIVE: CONCLUSION: RAGING AGAINST THE DYING OF THE LIGHT OF HUMANITY, OR WHERE TO FROM HERE?

In considering the closing of my paper, I have been wondering how I could possibly write a conclusion when I do not have one “in real life.” I considered, also, the writing I have done prior to this project in the Master of Education program. I wrote on Hannah Arendt and technology, and the meaning of the Archimedean point in the context of an ICU. I wrote on power and the panopticon, comparing the culture in *The Giver* by Lois Lowry (1993) with the culture of the ICU. These papers prepared me to explore the work we do and why, and by writing about my experience, I found I had more to say about the things we do. My autoethnography may have begun for the reader with this paper, but my memories and reflections have been developing for some time. I am still having the same conversations about my work with coworkers, patients, and families, but when I do, I approach them using my experience—including the transformative experience of reflection. This makes me think of the movie *Groundhog Day* (Ramis, 1993). On the surface, *Groundhog Day* is a comedy about Bill Murray as a weatherman, doing a job he sees as repetitive and shallow, dismissing opportunities for a deeper connection with his peers and those he interacts with. However, it is an optimistic existential story. When trapped in the same day over and over again, he is first surprised, then dismayed. He is stuck in an in-between space. He becomes overcome with despair, going so far as to commit suicide over and over, only to find himself waking to the same song on the alarm clock every single morning. Once he learns that the repeat is a blessing, once he stops trying to destroy himself and adjusts his view, he sees something new. He practices: tries multiple times to play the right notes on the piano, say better

words in a conversation, and saves a falling child from injury (or worse) again and again, and the repetition becomes his savior because it's when he has done it as well as he can that he is released from the Sisyphian torment and moves on into the future. This is where the movie is so much more than a comedy. He takes the Camus lens, where he imagines *himself* happy. He does not lose his cynicism, he is not a "changed man," he even keeps his dry, jerky sense of humour. However, he chooses to see the goodness that was there all along, leveraging the potential from time and learning. I am perhaps like Bill Murray's character, moving through the same paths and the same conversations, but maybe I can do it better this time, play the notes that make harmony. I will again evoke the commencement address by David Foster Wallace (2005), because I feel it to be in line with what I have learned:

If you're automatically sure that you know what reality is and who and what is really important - if you want to operate on your default setting - then you, like me, will not consider possibilities that aren't pointless and annoying. But if you've really learned how to think, how to pay attention, then you will know you have other options. It will be within your power to experience a crowded, loud, slow, consumer-hell-type situation as not only meaningful but sacred, on fire with the same force that lit the stars - compassion, love, the sub-surface unity of all things. Not that that mystical stuff's necessarily true: the only thing that's capital-T True is that you get to decide how you're going to try to see it. You get to consciously decide what has meaning and what doesn't. You get to decide what to worship.

(para 9)

One of the unexpected consequences of writing this paper over what has felt like an extended period of time (approximately two years) has been to reflect daily and deeply on the nature of my job and what we do. I have explored the water in which I swim, but now, rather than seeing myself alone with my fellow nurses, I acknowledge that the patients and their families are here too, in the halocline—the mix of broiling salt and fresh water—and are similarly at odds with the situation, albeit for very different reasons. Liminal spaces are filled with machinations that are constructed by all parties, so I can add my piece: To be liminal does not mean to be insignificant, and if I may be liminal, and if we are in the water together, I can cast out a rope—a guide—to move through this process in tandem. That is not to suggest that I pull, or commandeer where my coworkers or patients or families go, but that I recognize that we are travelling together, and there is consolation in that.

Through my research for this paper, I have gained much more than knowledge of in-between spaces—I have learned how better to articulate what is happening to the patient with his or her family as well as about the coming path or paths their loved one may be taking, as well as the impact of such traumatic interventions as CPR, defibrillation, and intubation. I am more equipped to talk about why we may want to avoid such interventions without making the families fret that we will care about their loved one less.

Conversations about end of life, for nurses, are like shifting the meaning of Dylan Thomas's poem *Do Not Go Gentle into That Good Night* from raging against imminent death to fighting against the dying light of humanity, which we are seeking to preserve (both the patients' and, I have learned, our own). There is an ugliness to the truth of why

I wanted to explore what nurses do: I *want* everyone to know what we do to people. I want the reader to look behind the curtain with me, peak under the sheets to view the disaster, to join the nurse in the position of having the impossible task of hoping for a miracle, a panacea. I want people to know that we tend to disintegrating bodies for no other purpose than to allow people to grapple with their discomfort with death. Like Orwell's (1946/2013) *Politics and the English Language*, I want to confront the ambiguity in liminality that feels like it holds us hostage in this situation, allowing disastrous euphemisms or phrases like "moral distress" to inadequately describe what we think about what we are doing. Certainly it is not always the case, but too often the nurse is not caring for the living. We are tending the dying in the same way that bombing and obliterating cities is called "pacification."

The nurse dwells within and reckons with ambiguity and, maybe because of this, comes to some understanding about how to manage knowledge of the limit of one's life. Being witness to the liminal space of an ICU, we grow impatient with families who have not yet acknowledged the "terrible precision" with which they may be faced: the horizon of their loved one's time alive. It is an event of terror and grief for them, but the nurses have accepted it before it is even over. It is not our loss, not our pain. Nor can it be. A code blue is called, elsewhere in the hospital, and two of our staff respond by hurrying to the ward. In charge of the unit that shift, I arrange to receive the patient, if need be. But the nurses return, smiling, throwing their hands up in the air. "Don't worry!, He died!," they laugh. And I laugh too. Our jobs, for the moment, have been made simpler by not having to accommodate another patient, and we are easily able to ignore the fact that it was at the cost of someone's life. We are well aware of our levity being incongruous with

the event, but it would be dishonest to suggest that we feel sad. There is no joy found in death, but there is also, usually, an absence of grief. Nurses I work with often reflect on this, especially after stating something that would, to anyone other than a nurse, seem heartless—they joke that they “have no soul.” Even my husband, on seeing me sit at the computer writing, once asked cheerily, “Oh, writing about your cold, dead, heart again?” which makes me laugh and feel better. But better about what? I think it is because I suspect that I do have a cold, dead heart that having someone, my partner, who does not believe it to be true behaves like a salve. By voicing something that is actually a belief—a fear—of mine, he was naming the darkness that let in the light.

I am simultaneously pragmatic about my own death and sharply, emotionally, aware of the many deaths I have witnessed, with the paradox that they all have *and* lack meaning for me. I inhabit liminal spaces, but perhaps liminal spaces inhabit me as well. Some sense of my self is anchored by the acknowledgement of paradox and humour like Yossarian, facing the tragic absurdity of death—particularly deaths that we “do” to each other as humans. I am encouraged by the idea—the hope—that conversations may yield change.

And yet I still suspect part of me *is* dead inside, and that is okay. I know too much, and cannot make it not so. I and my fellow nurses are caught in the midst of our halocline, trying to make sense of the roiling mix of differences. It is challenging to navigate this collision of experiences, seeing the water but seldom having clarity due to the ever-shifting flux of this liminal space. However, by examining the hospital space and the ICU within it, and comparing these with literature—both fictional and academic—I

may have found my axe, as Franz Kafka (1959/2013) describes the effect of a devastating book, for the frozen sea inside myself.

References

- Adams, V. (2007). Laughing it off: uncovering the everyday work experience of nurses. *International Journal of Qualitative Methods*, 6(1), 1—15.
- Alexander, B. (1991). *Victor Turner revisited: Ritual as social change*. Atlanta, GA: Scholars Press.
- Allan, H. (2007). Experiences of infertility: Liminality and the role of the fertility clinic. *Nursing Inquiry*, 14(2), 132—139.
- Arendt, H. (2006). *Eichmann in Jerusalem: A Report on the Banality of Evil*. New York: Penguin Classics. (original publication 1963)
- Astedt-Kurki, P., & Isola, A. (2001). Humour between nurse and patient, and among staff: Analysis of nurses' diaries. *Issues and Innovations in Nursing Practice*, 35(3), 452—458.
- Atwood, M. (1982). *Dancing girls and other stories*. New York, NY: Simon and Schuster.
- Aultman, J. (2009). When humor in the hospital is no laughing matter. *The Journal of Clinical Ethics*, 20(3), 227—234.
- Baker, N. (2011). *The Mezzanine*. London, UK: Granta Books. (original publication 1988)
- Bakhtin, M. (1968). *Rabelais and his world*. Cambridge: The Massachusetts Institute of Technology.
- Beckstrand, R., & Kirchhoff, K. (2005). Providing end-of-life care to patients: Critical care nurses' perceived obstacles and supportive behaviors. *American Journal of Critical Care*, 14(5). 395-403).
- Bruce, A. & Davies, B. (2005). Mindfulness in hospice care: Practicing meditation-in-action. *Qualitative Health Research*, 15(10), 1329—1344.

- Bruce, A., Sheilds, L., Molzahn, A., Beuthin, R., Schick-Makaroff, K. & Shermak, S. (2014). Stories of liminality: Living with life-threatening illness. *Journal of Holistic Nursing*, 32(1). 35—43.
- Bowles, P. (2005). *The sheltering sky*. New York, NY: Harper Perennial. (original publication 1949)
- Boylorn, R., & Orbe, M. (Eds.). (2016). *Critical autoethnography: Intersecting cultural identities in everyday life*. London, UK, Routledge.
- Buchman, T. G., Cassell, J., Ray, S. E., & Wax, M. L. (2002). Who should manage the dying patient?: Rescue, shame, and the surgical ICU dilemma. *Journal of the American College of Surgeons*, 194(5), 665—673.
- Cartry, M. (1992). From one rite to another: The memory in ritual and the ethnologist's recollection. In D. de Coppet (Ed.), *Understanding Rituals* (26—36). New York: Routledge.
- Cockburn, B. (1984). Lovers in a dangerous time [CD]. On *Stealing Fire*. Toronto, Canada: True North.
- Cohen, L. (1992). Anthem [CD]. On *The future*. Toronto, Canada: Columbia.
- College of Nurses of Ontario. (2009). Confidentiality and privacy—personal health information. *Practice Standard*.
- De Villers, M., & DeVon. (2012). Moral distress and avoidance behavior in nurses working in critical care and noncritical care units. *Nursing Ethics*, 20(5), 589—603.
- Duncan, M. (2004). Autoethnography: Critical appreciation of an emerging art. *International Journal of Qualitative Methods*, 3(4), 28—39.
- Ellis, C. (1999). Heartful autoethnography. *Qualitative Health Research*, 9(5). 669—683.

- Ellis, C., Adams, T., & Bochner, A. (2011). Autoethnography: An overview. *Forum: Qualitative Social Research, 12*(1).
- Ellis, C., & Bochner, A. (2006). Analyzing analytic autoethnography: An autopsy. *Journal of Contemporary Ethnography, 35*(4), 429—449.
- Elpern, E., Covert, B., & Kleinpell, R. (2005). Moral distress of staff nurses in a medical intensive care unit. *American Journal of Critical Care, 14*(6), 523—530.
- Frick, S., Uehlinger, D., & Zuercher Zenklusen, R. (2003). Medical futility: Predicting outcome of intensive care unit patients by nurses and doctors—a prospective comparative study. *Critical Care Medicine, 31*(2), 456—461.
- Frommer, M. (2005). Living in the liminal spaces of mortality. *Psychoanalytic Dialogues, 15*(4), 479—498.
- Gawande, A. (2014). *Being mortal: Medicine and what matters in the end*. New York, NY: Doubleday Canada.
- Gladwell, M. (2008). *Outliers: The Story of Success*. New York, NY: Little, Brown, and Company.
- Goldman, B. (2007). *White Coat, Black Art*. Radio Series. Toronto, Canada: Canadian Broadcast Corporation.
- Goldman, B. (2014). *The Secret Language of Doctors: Cracking the Code of Hospital Slang*. Toronto, Canada: Harper Collins Publishers Ltd.
- Hafferty, F. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine, 73*(4), 403—407.
- Harrison, C. (1975). *Generals Die in Bed*. Hamilton, Canada: Potlach Publications. (Original publication 1930)

- Heller, J. (1994). *Catch-22*. London, UK: Vintage Books. (Original publication 1961)
- Hiberman, M., Kutner, J., Parsons, D., & Murphy, D. (1997). Marginally effective medical care: Ethical analysis of issues in cardiopulmonary resuscitation (CPR). *Journal of Medical Ethics*, 23, 361—367.
- Hoel Felde, L. (2010). ‘I take a small amount of the real product’: Elevated cholesterol and everyday medical reasoning in liminal space. *Health*, 15(6). 604—619.
- Hoeve, Y., Jansen, G., & Roodbol, P. (2013). The nursing profession: Public image, self-concept and professional identity. A discussion paper. *Journal of Advanced Nursing*, 70(2), 295—309.
- Jameton, A. (1993). Dilemmas of moral distress: Moral responsibility and nursing practice. *AWHONN's Clinical Issues in Perinatal and Women's Health Nursing*, 4(4), 542—551.
- Johnston, L. (2011). Surviving critical illness: A case study in ambiguity. *Journal of Social Work in End-of-Life & Palliative Care*, 7, 363—382.
- Jones, S., Adams, T., & Ellis, C. (Eds.). (2013). *Handbook of autoethnography*. Walnut Creek, CA: Left Coast Press.
- Kafka, F. (2013). *Letters to friends, family, and editors*. New York, NY: Knopf Doubleday. (original publication 1959)
- Kelly, A. (2008). Living loss: An exploration of the internal space of liminality. *Mortality*, 13(4), 335—350.
- Kirchhoff, K., Spuhler, V., Walker, L., Hutton, A., Vaughan Cole, B., & Clemmer, T. (2000). Intensive care nurses' experiences with end-of-life care. *American Journal of Critical Care*, 9(1), 36—42.

- Koepping, K. (1985). Absurdity and hidden truth: Cunning intelligence and grotesque body images as manifestations of the trickster. *History of Religions*, 24(3), 191—214.
- Kübler-Ross, E., Kessler, D., & Shriver, M. (2014). *On grief and grieving: Finding the meaning of grief through the five stages of loss*. New York, NY: Simon and Schuster.
- Lapum, J., Fredericks, S., Beanlands, H., McCay, E., Schwind, J. & Romaniuk, D. (2012). A cyborg ontology in health care: traversing into the liminal space between technology and person-centered practice. *Nursing Philosophy*, 13, 276—288.
- Laurence, M. (1964). *The stone angel*. Toronto, Canada: McClelland & Stewart. (Original publication 1964)
- Laurence, M. (2007). *The diviners*. Toronto, Canada: McClelland & Stewart. (Original publication 1974)
- Long, D. Hunter, C., & Van der Geest (2008). When the field is a ward or a clinic: Hospital ethnography. *Anthropology & Medicine*, 15(2), 71—78.
- Lowry, L. (1993). *The giver*. New York, NY: Houghton Mifflin Harcourt.
- MacLean, S., Guzzetta, C., White, C., Fontaine, D., Eichhorn, D., Meyers, T., & Désy, P. (2003). Family presence during cardiopulmonary resuscitation and invasive procedures: Practices of critical care and emergency nurses. *Journal of Emergency Nursing*, 29(3), 208—221.
- Mahon-Daly, P., & Andrews, G. (2002). Liminality and breastfeeding: women negotiating space and two bodies. *Health & Place*, 8, 61—70.
- McCarthy, J. & Gastmans, C. (2015). Moral distress: A review of the argument-based nursing ethics literature. *Nursing Ethics*, 22(1), 131—152.
- McGuire, S., & Georges, J. (2003). Undocumentedness and liminality as health variables. *Advances in Nursing Science*, 26(3), 185—195.

- Martino, J. (2010). Billy Pilgrim's motion sickness: Chronesthesia and duration in Slaughterhouse-Five. *Philament, 16*(8), 4—20.
- Meyers, T. A., Eichhorn, D. J., & Guzzetta, C. E. (1998). Do families want to be present during CPR? A retrospective survey. *Journal of Emergency Nursing, 24*(5), 400—405.
- Navon, L., & Morag, A. (2004). Liminality as biographical disruption: Unclassifiability following hormonal therapy for advanced prostate cancer. *Social Science & Medicine, 58*, 2337—2347.
- Orwell, G. (2013). *Politics and the English language*. London, UK: Penguin Books. (Original publication 1946)
- Palda, V., Bowman, K., McLean, R., & Chapman, M. (2005). “Futile” care: Do we provide it? A semistructured, Canada-wide survey of intensive care unit doctors and nurses. *Journal of Critical Care, 20*, 207—213.
- Paterson, J. & Zderad, L, (1988). *Humanistic nursing*. New York, NY: National League for Nursing. (original publication 1976)
- Peterson, A. L. (2015). A case for the use of autoethnography in nursing research. *Journal of Advanced Nursing, 71*(1), 226—233.
- Philpin, S. (2007). Managing ambiguity and danger in an intensive therapy unit: Ritual practices and sequestration. *Nursing Inquiry, 14*(1), 51—59.
- Pinker, S. (2014). *The sense of style: The thinking person's guide to writing in the 21st century*. London, UK: Allen Lane, an imprint of Penguin Books.
- Ramis, H. (Director), Ramis, H. (Producer), & Ramis, H., & Rubin, D. (Writers). (1993). *Groundhog day* [Motion picture]. United States: Columbia Pictures.

- Sapolsky, R. (1997). *The trouble with testosterone and other essays on the biology of the human predicament*. New York, NY: Scribner.
- Saul, J. (2006). *Writing the roaming subject: The biotext in Canadian literature*. Toronto, Canada: University of Toronto Press.
- Scott, T. (2007). Expression of humour by emergency personnel involved in sudden deathwork. *Mortality*, 12(4), 350—364.
- Sontag, S. (1978). *Illness as metaphor*. New York, NY: Farrar, Straus and Giroux.
- Suominen, T., Kovasin, M., & Ketola, O. (1997). Nursing culture—some viewpoints. *Journal of Advanced Nursing*, 25(1), 186—190.
- Tierney, S., Deaton, C., Jones, A., Oxley, H., Biesty, J., & Kirk, S. (2013). Liminality and transfer to adult services: A qualitative investigation involving young people with cystic fibrosis. *International Journal of Nursing Studies*, 50, 738—746.
- Turner, V. (1969). *The ritual process: Structure and anti-structure*. Chicago, IL: Aldine.
- Turner, V. (1994). Betwixt and between: The liminal period in rites of passage. In L. C. Mahdi, S. Foster, & M. Little (Eds.), *Betwixt & between: Patterns of masculine and feminine initiation* (3—22). Illinois: Open Court. (Original publication 1987).
- Vonnegut, K. (1975). *Slaughterhouse Five*. New York, NY: Dell. (original publication 1969)
- Wall, S. (2006). An autoethnography on learning about autoethnography. *International Journal of Qualitative Methods*, 5(2), Article 9.
- Warner, J., & Gabe, J. (2004). Risk and liminality in mental health social work. *Health, Risk & Society*, 6(4), 387—399.

- Wallace, D. (2005). *This is water: some thoughts, delivered on a significant occasion, about living a compassionate life*. Kenyon Commencement Address, May 21, 2005, Gambier, Ohio.
- Watson, K. (2011). Gallows humor in medicine. *The Hastings Center Report*, 5(41), 37—45.
- Wear, D., Aultman, J., Zarconi, J., & Varley, J. (2009). Derogatory and cynical humour directed towards patients: Views of residents and attending doctors. *Medical Education*, 43, 34—41.
- Young, D. J., & Meneley, A. (2005). Introduction: Auto-ethnographies of academic practices. *Auto-ethnographies: The anthropology of academic practices*, 1—21.