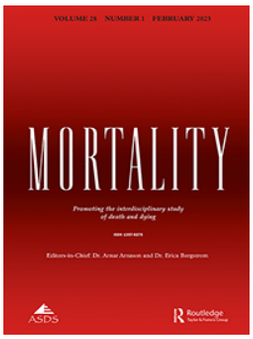

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Mediating worlds: the role of nurses as ritual specialists in caring for the dead and dying

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ABSTRACT

Rituals are central to the everyday life of the nurse, yet the fundamental roles that rituals play in caring for the dead and dying has often been neglected. This paper explores modern palliative and post-mortem care – its practices, practitioners and arenas – against the background of long-held, global concerns regarding the dead and dying. Comparison with the archaeological and ethnographic records demonstrates the ubiquitous and enduring practices surrounding death, and the centrality of ritual specialists to this complex social and biological process. This deep-time perspective highlights the importance of nurses, and their associated nursing rituals, in the transition of patients between life and death, and the difficult journeys that nurse, patient and family undertake in this mediation between worlds. Such a perspective not only empowers nurses in their daily practices, and places nursing rituals firmly at the centre of modern palliative care work, but demonstrates the value of archaeology and ethnography in contextualising the challenges of today.

KEYWORDS

Ritual specialist; palliative care; nursing; rite of passage; death; archaeology

Introduction: archaeology meets palliative care

The socially and cosmologically sensitive mediation between life and death is frequently given over to ritual specialists in societies around the world (La Barre, 1970, p. 161). In modern healthcare, nurses have become the common mediators in this process, constructing and reconstructing society's understanding of death and the relationship between the living and the dead. The increasing professionalisation of Western medicine and secularisation of society throughout the nineteenth and twentieth centuries (cf. Adams, 1993) has, however, had a profound effect on the perception of nurses and attitudes towards ritual practice in caring for the dead and dying.

Nursing rituals such as handovers are frequently portrayed pejoratively (O'Connell & Penney, 2001) and the nursing literature is replete with calls to transcend such practice through an increasing emphasis on empirical evidence (Walsh & Ford, 1989). Where rituals are explicitly identified, these are often framed as well being interventions, such as the

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'sacred pause' after death evaluated in one ICU ward by Kapoor et al. (2018). It is important to distinguish between rituals as 'unsafe and outdated practice' (Holland, 2019) and rituals as a cultural phenomenon that serves a social purpose. Resource constraints have left little time to perform all but the most 'essential' tasks. This focus on efficiency was exacerbated by the onset of the COVID-19 pandemic, which saw a reorientation of nursing roles towards verification of death (Royal College of Nursing, 2021) and infection control (UK Health Security Agency, 2021) and further diminished the role of ritual practices, particularly around death and dying.

In this paper, we argue that rituals help nurses, patients and grieving relatives navigate this important rite of passage. Research among nurses in the US, the UK, Spain and Israel reveals that nurses are not only suffering from physical burnout but also emotional trauma resulting from the inability to adequately process their involvement in these bodily and metaphysical transformations (cf. French et al., 2021; Hines et al., 2020; Mosheva et al., 2021; Soto-Rubio et al., 2020).

We use case studies from archaeology (research into past human societies) and ethnography (recent and contemporary cross-cultural studies of people across the world) to situate the work of modern-day nurses within a broader temporal and spatial context. In contrast to other deep-time perspectives on death and dying (e.g. Kellehear, 2007), we focus specifically on the ritual specialists involved in caring for the dead, and their role in transformative rites of passage across diverse cultures today. We examine this at a number of scales: firstly, the relationship between the nurse and the dead body and, in particular, the cognitive dissonance experienced by nurses in the context of medical concepts of death and the increasing use of life-prolonging technologies; secondly, the shared traits of costume, language and practice, which signify the social role of nurses as ritual specialists; and thirdly, the architecture of hospitals as facilitating transformations of individuals from life to death. Through this, we challenge post-enlightenment attitudes (cf. Brück, 1999) towards the value of ritual in caring for the dead and dying and advocate for greater importance to be placed on these aspects of nurses' identity, both in terms of their own emotional wellbeing and that of patients and families.

Dealing with death: ritual practitioners past and present

> The worldwide distribution of functionaries recognisable as shamans … testifies to their antiquity. (La Barre, 1970, p. 161)

The central role of ritual specialists across diverse societies is well-documented (e.g. Price, 2001). Sometimes termed 'shamans' (a term borrowed from the polar regions and now a misnomer for ritual specialists from a diverse group of non-state societies; Dowson, 2007), these individuals share specialist knowledge, which allows them to undertake or oversee practices not performed by other members of society, including mediation between worlds (living and dead, human and animal, awake and asleep). The presence of such specialists in past societies has been suggested in the interpretation of figures on prehistoric and early modern rock art panels in Siberia and Central Asia (Devlet, 2001), and by the 12,000-year-old elderly female buried with 50 complete tortoise shells and select human and animal body parts in a cave in the southern Levant (Grosman et al., 2008). In many societies, the ritual practitioners responsible for conducting ceremonies and overseeing rites of passage involving the transition of individuals from one social state to

another, such as birth, coming of age and marriage, are also healers, and are consulted to prevent or mitigate against sickness and, by extension, death. They also frequently oversee funerary rites and are thus integral to the ways in which death is perceived, including the maintenance of certain cosmological understandings of the world (Williams, 2001, p. 202). Among the Inuit of Arctic Canada and Alaska, 'the shaman is the individual who, in addition to living in the visible world . . . is also able to function in the reality of myth. He is the one who can readjust the pillars holding up the world . . .' (Saladin D'Anglure, 1994, p. 208). Similarly, many Eurasian and North American cultures see ritual specialists as intermediaries, 'the intercepting axis, between the heavenly and the worldly realms, a nexus for the divine and the human' (Ripinsky-Naxon, 1997, p. 49). It is perhaps no surprise that prior to the end of the nineteenth century (which saw increasing professionalisation of medical practitioners), the *same* individuals (usually women) within local communities across the UK facilitated the birth, death and post-mortem care of individuals (cf. Adams, 1993, p. 152): all rites of passage that involve mediation through transitional social states.

Liminality and the dead body

Moments of death

> Medicine's portrayal of death as a microsecond event attempts to bring order to the chaos of death. (Quested & Rudge, 2003, p. 555)

Death (like birth) is one of the most important rites of passage that we will undergo: our transition from physical, biological individuals to dead bodies and finally, spiritual, ancestral beings. Rites of passage comprise three distinct stages: separation, liminality, and incorporation (van Gennep, 1977, p. 21). The rigidity of this tripartite scheme and universal notions of the liminality of the newly dead body have been contested (e.g. Douglas, 1966, pp. 80, 111), particularly in societies (such as Madagascar) where secondary funerary rites and ongoing interactions with the physical human body are commonplace. Indeed, there is no strict cross-cultural understanding of when, how long, and even how often, a body can be considered liminal, nor when certain rites of passage begin and end (cf. Metcalfe & Huntington, (1991), pp. 108–130). Nevertheless, the model is a useful way of thinking about death in the modern West, where most people die in hospital (Gomes & Higginson, 2008), away from their usual place of residence, and post-mortem care is carried out by trained professionals behind closed doors. The newly dead, liminal body becomes the responsibility of these specialist practitioners and is often returned to the family/community only immediately prior to cremation or interment.

The liminal phase of any rite of passage is socially challenging and cosmologically dangerous. It is the phase most likely to create cognitive dissonance in relation to our understandings of the world and our place in it. The life-prolonging technologies of modern medicine such as ventilation, dialysis and cardiac bypasses have, however, extended this phase, and even created new categories of liminal people (Seymour, 2000, 2001); a situation likely exacerbated during the COVID-19 pandemic with an increased number of individuals on ventilators for extended periods of time. Significantly, many of these people are not going to recover; the technology merely

prolongs the dying phase. Unconscious, comatose (and, in the most extreme cases, brain-dead) individuals, who have no awareness of their surroundings but are still alive in the physical sense, could be considered socially but not biologically dead; these people are, in the words of Turner, (1969, p. 95), 'betwixt and between' worlds. Nurses responsible for caring for these liminal individuals experience high levels of 'cognitive dissonance' (see Royanne, 2009, pp. 91, 96), that is, the psychological discomfort that accompanies the performance of 'inconsistent' behaviours (Festinger, 1957, pp. 2–3). This is particularly true with the introduction of protocols that allow harvesting of organs from non-heart-beating donors who retain some brainstem functions (cf. Wolf, 1994; Figure 1), or in the long-term care of people who are unlikely to recover and are entirely dependent on technology for physiological functioning (Seymour, 2001). Nurses often see it as their responsibility to avoid 'difficult, uncomfortable, frightening deaths' for patients and their families as far as possible (Wolf, 1994, p. 974) and, as such, they may be distrustful of technological interventions. This can be compounded when patients experience agonal breathing patterns after life-support machines are switched off (Wolf, 1994, p. 980), giving the impression that they are still alive. Relatives of brain-dead (but heart-beating) organ donors may also be disturbed by signs of clinical life (such as cardiac activity on monitors and chest movement induced by ventilators), as this appears to contradict their status as brain-*dead* (Wolf, 1994, p. 979, emphasis added).

Even after biological death, nursing and palliative care guidelines stress that perceiving the deceased as a 'person' is integral to 'respectful' treatment (Wolf, 1988, p. 62), including the placing of identification tags on wrists (where they would be worn in life) rather than on the big toe (as was traditionally the case) (National End of Life Care Programme, 2011, p. 12, action point 56). Though not contained within formal guidelines, many nurses continue to talk to the body during post-mortem care (Martin & Bristowe, 2015, p. 173). This practice serves as an overt and deliberate attempt to reduce cognitive dissonance by treating the body as if it were still alive. The conscious deployment of this coping mechanism was acknowledged by one nurse when she admitted that she 'sometimes thought of talking to the dead patient as "a bit silly", since dead people do not hear, but she did so anyway' (Hadders, 2007, p. 211). Indeed, talking to the dead appears to

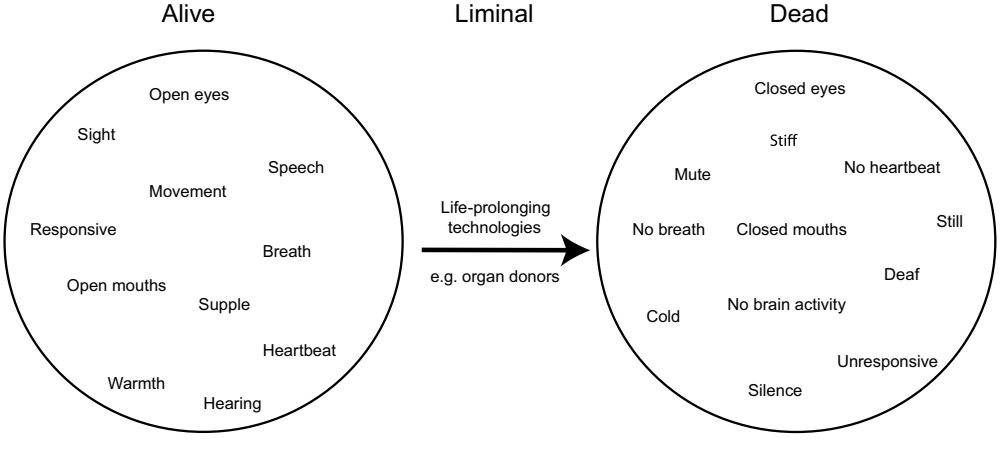

Figure 1. The liminal status of braindead and non-heart-beating organ donors.

represent an attempt by nurses to maintain a degree of 'normality' as part of stress management strategies (e.g. Roynane, 2009, p. 96). Some (e.g. Pearson et al., 2001), however, have challenged its benefits (particularly in front of relatives) on the basis that it has the potential to exacerbate feelings of confusion regarding the ontological status of the deceased, thus prolonging the liminal phase and inhibiting the start of the grieving process.

Transforming the dead

> Once death is detected, screens are drawn which isolate the patient, and the physical segregation of the living and the dead has begun. (Quested & Rudge, 2003, p. 558)

Rituals are fundamental to dealing with the dead body as a liminal entity: separated from the world of the living but not yet incorporated into the world of the dead (cf. van Gennep, 1977). As Robb (2013, p. 442) reminds us, 'the distinction between people and things is so deeply entrenched in our culture that transgressions of it shock us deeply'. It is no surprise, then, that much post-mortem care concerns practices and rituals intended to safely control (both physically and emotionally) this transition from socially-present individual to motionless corpse; 'the biological changes involved in death set an agenda to which the cultural act of dying has to respond' (Robb, 2013, p. 445). Indeed, Meleis (2012, p.100) suggests that managing this transition is one of the central tenets of nursing.

The post-mortem care performed by nurses involves 'a series of actions performed on a body that becomes an object' (Picco et al., 2010, p. 43). After death, the process of transformation begins with washing the body (even when the patient has recently been bathed; G. E. Chapman, 1983, p. 17), which eliminates debris and dirt acquired during life. In one hospital, the procedure dictated that the body be left for an hour before washing commenced, but nurses rarely observed this 'rule' (G. E. Chapman, 1983, p. 17); this indicates a desire to 'process' the body immediately, thus curtailing the liminal phase and restoring the 'status quo' as quickly as possible. Evidence from the archaeological record suggests that a desire to control and hasten the transformative process is not unique to the present. It can, for example, be seen in instances where the natural course of excarnation (that is, exposure of the body for defleshing and disarticulation) was accelerated manually, as seen in the later prehistoric assemblages from the Covesea Caves in north-east Scotland (Büster & Armit, 2016), and in Neolithic assemblages from Scaloria Cave in Italy (Knüsel et al., 2016) and chambered tombs in Orkney, Scotland (Crozier, 2016).

After the death of a patient in the hospital, personal identifiers such as clothes and jewellery are also removed (Quested & Rudge, 2003, pp. 558–559), together with traces of past illness and suffering (e.g. intravenous lines, drains and catheters; National End of Life Care Programme, 2011, pp. 11–12, action point 53; Wolf, 1988, p. 62). This process creates a neutral body upon which to build a new post-mortem identity. Significantly, the National End of Life Care Programme 'last offices' manual states that bodies 'should never go to the mortuary naked' (National End of Life Care Programme, 2011, p. 13, action point 54). It is not clear *why* this should be the case – perhaps to preserve the deceased's 'modesty' —– but perhaps it is because the naked body is still a liminal body, which has not yet acquired its new status as deceased: the transformation is incomplete.

The dead body is experienced differently depending on an individual's former relationship with the dead person. The language used to refer to the dead at this time reveals much about the cognitive dissonance experienced by both nurses and relatives, and their differing relationships with the dead person. These different perspectives are illustrated by the last offices procedure manual of a major urban hospital, which instructs that 'if the relatives wish to see *the deceased* . . . make *the body* presentable' (Quested & Rudge, 2003, p. 557, emphasis added): the relatives view 'the deceased' (a socially present individual with a life lived), but the nurse deals with 'the body' (a passive physical entity stripped of its former identity). Other parts of the manual refer to 'the patient' (Quested & Rudge, 2003, p. 557), and so we see that for the nurse, language is used to signal a change in social and ontological status, and to create a new category of being.

The body at this time is liminal in another sense: it seeps, oozes and leaks (Lawton, 1998). As such, it is physically dangerous: capable of spreading disease (see Hickson & Holmes, 1994, p. 9 for discussion of the dangerous body). This threat is visually manifested through the use of infectious disease labels, which are twice the size of those detailing the deceased's name and other personal details (Quested & Rudge, 2003, p. 559). This 'breaching of boundaries' (Quested & Rudge, 2003, p. 558) between inside and outside also challenges modern Western concepts of personhood, in which the intact, bounded, physical body is central to the perception of ourselves as individuals (cf. Fowler, 2004; Robb & Harris, 2013; Turner, 1992, p. 21). The primacy of this bounded sense of the individual is illustrated in arguments against task-orientated care (in which several nurses are assigned responsibility for different aspects of a patient's well-being) on the grounds that 'it is not possible to be accountable for a *part* of a person' (C. M. Chapman, 1983, p. 271, emphasis added). Meanwhile, Hickson and Holmes (1994, p. 5) note that a nurse's frequent touching of a patient's body is likely a mechanism by which concepts of the 'whole person' are reinforced in the face of processes which monitor the body as constituent systems or parts. Loss of personhood (and thus social identity as an individual) is reflected in the National End of Life Care Programme last offices manual, when it reminds nurses that 'if *the body* continues to leak, place it on absorbent pads in a body bag and advise the mortuary or funeral director' (2011, p. 12, action point 58, emphasis added). Wrapping the body, then, not only contains and minimises the physical risk of disease but also serves to metaphysically consolidate the body and regain personhood by reinstating an impermeable boundary between inside and outside (Quested & Rudge, 2003, p. 559).

As Hickson and Holmes (1994, p. 6) suggest, each person's body is a mirror to our own (and to society more generally), and 'any imperfections that disrupt the aesthetic of the body have to be disciplined, by hiding them, disguising them and controlling them'. This ontological position is reflected in the National End of Life Care Programme last offices manual where dignity is linked to *concealment* of the abject body, and nurses are instructed to 'place the body in an appropriate container to avoid causing distress to others' (2011, p. 12, action point 60). Nurses delivering post-mortem care on one intensive care unit noted that 'the sight of a dead, discoloured body with glazed staring eyes and a gaping mouth is unsettling' (Hadders, 2007, p. 213). When a patient dies, 'the nurse carefully closes the patient's eyes and props up the patient's jaw so that the mouth remains closed, creating a peaceful impression, as a patient in sleep' (Hadders, 2007, p. 211). The inability to close the eyes of the deceased is considered particularly

problematic, with nurses instructed to 'explain sensitively to the family/carers that the funeral director will *resolve this issue*' (National End of Life Care Programme, 2011, p. 11, action point 45, emphasis added). Eyes, ears and mouths thus appear to be integral signifiers of the social and biological status of the dead. Closing the eyes and mouth of the individual – animate elements of the body involved in communication and expression – helps in the ontological transformation of living individual to non-living corpse, whilst inability to achieve this leaves the dead body in a liminal state of classification.

These visual cues are not restricted to the modern western world. In southern France, a set of carved stone pillars dating to the Early Iron Age depict a vertical arrangement of disembodied heads, which are thought to represent the skeuomorphs of decapitated 'trophy heads' displayed nearby (Armit, 2012, pp. 84–96). The eyes are clearly depicted as closed, while the absence of mouths and ears may represent the silence of death (Armit, 2012, p. 90). The cosmological importance of the mouth in representations of death is likewise emphasised by the Maori practice of preserving the heads of ancestors with their mouths closed, but the heads of enemies with their mouths open (Robley, 1896, p. 147). Headhunting (and head preservation) was, in many societies, deemed necessary for the fertility and prosperity of communities (Armit, 2012, p. 36), and so in the latter case, preservation of the head with the mouth open may have been a deliberate act to 'trap' the soul in a liminal state and ensure that its life force could continue to be tapped by the living. These cross-cultural similarities reinforce the centrality of sight and sound (and the organs associated with them) as attributes in our categorisation of animate vs inanimate, both in the past and the present. As such, nursing rituals surrounding the eyes, ears and mouth take on new levels of meaning.

Ritual practitioners as liminal beings

As mediators between worlds, ritual specialists are often considered liminal individuals, with acts of transformation into or hybridisation with animal spirit guides common to many of their performances (see, for example, Price, 2001). Often these journeys involve travelling along the same routes as the dead – the journey representing a symbolic death and rebirth (Williams, 2001, p. 202)—– and thus the dead and the practitioners who oversee their transformation are cosmologically intertwined. Amongst the Chetri of Nepal, for example, the liminality of the 'shaman' (*dhāmi-jhākri*) during their communication with the supernatural is indicated by the perception that they share many attributes with their tutelary deity (*ban-jhākri*): a spirit of the forest and of the otherworld. The forest is a dangerous and threatening place 'free of the constraints that normally impose order on the social world', where the *dhāmi-jhākri* is said to have spent many days or weeks in the company of their *ban- jhākri* (Walter, 2001, p. 112).

These liminal characteristics are equally applicable to modern-day nurses, who in the process of caring for the dead and dying have the permission of society to violate social norms relating to the corporeal body (Estabrooks & Morse, 1992; Hickson & Holmes, 1994, pp. 3, 5) and, as such, operate 'between worlds'. As Hickson and Holmes (1994, p. 11) recount:

> the nurse touched the patient and they both knew that they shared more in that moment than a world of pain and confusion . . . the touch was not of the hand on the shoulder, nor the

shoulder on the hand — [but] the 'bumping of souls'.
(see also Estabrooks & Morse, 1992, p. 453)

Codes through 'costume'

To underline its authority the medical profession shrouds itself in the age old symbols of power and mystery, from outlandish costume to incomprehensible language…
(G. E. Chapman, 1983, p. 18)

Ritual specialists often wear complex 'costumes' and carry a variety of accoutrements. This material assemblage is variously used to mark them out as different, to help them adopt their role as mediator, to disguise them, to transform them into a liminal being, and to allow them to communicate with the supernatural. Each element has specific functional, material and symbolic value in communicating different aspects of the ritual to onlookers; in this way, it both legitimises and facilitates the individual's role as ritual specialist. 'Shamans' (*dhāmi-jhākri*) among the Chetri of Solu Khumbu in Nepal, for example, wear bells around their waist, long necklaces (*mālā*), a headdress, and a white garment that reaches to the ankles (*jāmā*), as well as carrying a drum (*dhyāngro*), which confirms their mastery of particular spirits (Walter, 2001, pp. 106, 112).

Just as *dhāmi-jhākri* in Nepal acquire their costumes and material assemblage as they master their art, so nurses acquire the uniform and accoutrements (e.g. fob-watch) appropriate to their skill and status as ritual practitioners (Table 1). The similarity between nurses' traditional uniforms and nun's habits is noteworthy in this regard, reflecting the religious origins of the profession and symbolically conveying the 'saintly feminine virtues of the Marian ideal' (Hickson & Holmes, 1994, p. 10). Seniority amongst nursing staff was traditionally communicated through the wearing of different coloured belts and dresses (G. E. Chapman, 1983, p. 18); a mismatch between costume and role thus has the potential to create further cognitive dissonance in the hospital setting. G. E. Chapman (1983, p. 19) recounts, for example, that she arrived (as a member of an outside agency) for work at a south London hospital wearing a white dress: the attire normally reserved for cleaners at this particular institution. Performing the tasks for which she was qualified as a registered nurse, but dressed in a 'costume' more usually associated with a lower level of skill and responsibility, created a great deal of consternation and unease amongst the other nursing staff. During the recent COVID-19 pandemic, the use of standardised Personal Protective Equipment (PPE) such as full-body suits has masked many of the subtle differences in uniform that would previously have provided visual cues to rank and skill set; this is perhaps made all the more significant in light of the fact that health practitioners from across a whole spectrum of specialist and non-specialist departments were

Table 1. Comparison between the Chetri *dhāmi-jhākri* ('shaman') and modern nurses.

	Chetri *dhāmi-jhākri*	Nurse
Place	Forest (journeys to)	Hospital (works in)
Costume	*Jāmā* (white garment)	Uniform/gown
Accessory	Bells	Belt
Equipment	Drum	Fob-watch
Language	Glossolalia	Shortened, ethnocentric words
Mediation	Community vs tutelary deity	Clean vs dirty/patient vs physician/living vs dead

drafted into ICU and newly created Covid wards, with large teams of individuals (previously unknown to one another) working closely together.

As well as communicating differential rank and skill level amongst ritual practitioners, costumes can also convey the changing symbolic and cosmological status of a ritual specialist (Walter, 2001, p. 116, figure 7.4). Nurses at one hospital, for example, donned gowns while washing the recently dead body (G. E. Chapman, 1983, p. 17); the gowns not only served as infection control but communicated the liminal nature of both nurse and body (and/or, as C. M. Chapman (1983, p. 17) suggests, provided symbolic protection for the nurse at this time). The same could be suggested for the PPE used on Covid wards, particularly in ICU with patients in extended liminal states on life-prolonging ventilators.

Roles and responsibilities

Just as ritual specialists in other times and places mediate between worlds, nurses learn to successfully transition between the sacred and profane, not least in tending to the spiritual needs of patients and their relatives while at the same time handling the physical products of the dead and decaying body (Wolf, 1988, p. 67). Indeed, certain practices address both elements of this dual role simultaneously, with washing of the body both acting to clean and purify the deceased, and by extension, sanctify the space. It is perhaps no coincidence in this regard that the origins of nursing lie in the monastic hospital and that failing to keep patients clean can be seen as 'violation' of a nursing norm (Wolf, 1988, pp. 62, 65). Transitions between worlds carry risks and must be carefully controlled (see Walter, 2001, p. 113 for a detailed account of the process by which the *dhāmi-jhākri* achieves an altered state of consciousness in the Solu Khumbu region of Nepal), and nurses often handle infected materials with a fearlessness that demonstrates a strong sense of responsibility, bravery, or even denial (Wolf, 1988, pp. 65–66). In this way, we can see the nurse as a controller of 'forces', expertly keeping clean and dirty separate (Wolf, 1988, p. 66), and using their acquired skills and knowledge to stave off or mitigate against illness and death, similar to how Williams (2001, p. 202) describes 'shamans'.

In the same way that 'shamans' must master their art, nurses undergo rigorous training in their roles as ritual specialists. As such, they express discomfort at the possibility of non-nursing staff administering medication, since this undermines their role as mediators between physician and patient (Wolf, 1988, p. 63). In contrast, many nursing rituals are concerned with the concepts of 'concealment' and 'avoidance' – such as screening off the dead person and a reluctance to speak of the death – in order to protect nurses, the dying person, their families and other patients from the realities of death and reflections on their own mortality (G. E. Chapman, 1983, p. 17). As such, we might also see nurses as gate-keepers of order and their ritual practices as 'a shield against terror' (Berger & Luckman, 1966, p. 102).

Specialist knowledge and group dynamics

Secret societies, and individuals that possess restricted knowledge, are well-attested in the ethnographic literature and likely played the same pivotal roles in past societies (Hayden, 2018, p. 3) as they do today. Nurses frequently perform post-mortem care on deceased patients alone, though they also help each other complete unfinished tasks (Wolf, 1988, pp. 62, 67).

Working together helps to legitimise membership of this specialist group. Indeed, a newly qualified nurse recounted that 'during the resuscitation . . . I felt that I was part of the "team"', while another remembered that she was happy that she 'became part of the team' (Kent et al., 2012, p.1262). 'Shift report' and 'shift handover' function as 'hallowed' and 'sacrosanct' time during which responsibilities are taught, tested and reinforced within the nursing cohort, patient ownership is transferred, and where interruptions, particularly by members of the 'out-group', such as physicians, are frowned upon (Wolf, 1988, pp. 66–67). Power and secrecy over specialist knowledge is preserved by the use of a shared language of shortened, ethnocentric words, much in the same way as a religious or ritual practitioner might use glossolalia when communing with the supernatural (cf. Csordas, 1990; Saladin D'Anglure, 1994, p. 208; Table 1). Indeed, among the indigenous Pomo of north-western California, secret society heads were thought so powerful that they could kill enemies by using secret language, which they also used in 'medicine songs' (Hayden, 2018, p. 104; Loeb, 1926, pp. 331, 333, 360). This 'hospital-bound, nursing specific language' (e.g. obs., meds., D&V, TWOC, Rose Cottage, CHC funding, stat., TTOs, script, BP, COPD, etc.; C. Faull, pers. comm.) is intelligible only to those initiated into nursing life and keeps the meaning of the shift handover report somewhat secret from the out-group (Wolf, 1988, p. 66). While reducing the time needed to exchange information on patients, this specialist language also serves to 'maintain an aura of secretiveness and preserve the territoriality' of administering medication (Wolf, 1988, p. 66).

Much of what is learnt in nursing sub-culture is not written down (Wolf, 1988, p. 67). Post-mortem care is more than a step-by-step process, and rather than consulting procedural manuals, many nurses choose to share beliefs, values and information about end-of-life care through demonstration to one another, supporting and helping each other navigate the realities of death through their practice (Wolf, 1988, p. 62). One recently qualified nurse remembered how she 'was fortunate to have a senior nurse with me who talked me through the whole process as we performed *the cares*' (Kent et al., 2012, p.1262).

The recent Covid-19 pandemic may well have impacted on the social dynamics of nursing in a number of ways. The use of PPE, including face masks and visors, will, for example, have reduced the effectiveness of verbal and non-verbal communication (particularly challenging in situations where accepted 'ways of doing things' are not formally documented as written procedures). This may have been especially problematic where new team members were recruited from other departments, not only in terms of their understanding of informal procedures but also in terms of the sense of 'group identity' if time and resource pressures meant that usual processes of 'initiation' (as described by Kent et al., 2012, above) could not be accommodated or observed.

Hospitals as ritual arenas

> Understood phenomenologically, space has no inherent meaning, but is itself a medium constituted through human praxis. (Walter, 2001, p. 105)

The dead can often be found in liminal settings in prehistory. The enigmatic bog bodies of later prehistoric Western Europe are one example (cf. Giles, 2020). These individuals, deposited – and often pinned down by hurdles, or as in the case of 'Haraldskær

Woman' (Denmark) or 'Windeby II' (Germany), stakes – commonly (though not always) show signs of violent death, perhaps at the hands of a ritual practitioner. They are frequently naked or wearing peculiar items of clothing, such as 'Lindow Man's' (Cheshire, UK) fox fur armband or 'Tollund Man's' (Denmark) cap, or have elaborate or unusual hair styles, such as the shaved right side of 'Yde Girl's' (the Netherlands) head. These practices suggest dehumanisation and objectification as strategies for 'moral disengagement' prior to their dispatch (cf. Armit, 2011, p. 14). Whether sacrifices to a deity or social transgressors, their deposition in bogs, themselves liminal places home to otherworldly creatures such as 'boggarts' (Giles, 2020, p. 94), appears deliberate. Kelly (2006) notes that many Irish bog bodies further exhibit this liminality in being found close to important regional boundaries.

Though bog bodies are an exceptional phenomenon, which we might consider outside the usual funerary rites for the prehistoric dead, even normative rites, such as excarnation (see above), appear to have taken place in liminal locations outside settlements. Caves appear to be one such place since, like bodies undergoing dangerous and ritually charged transformations between two categorised states (alive and dead), they were liminal places which straddled worlds (e.g. Büster et al., 2019; Croucher & Richards, 2014, p. 218; Moyes, 2012, p. 1). Furthermore, the journey of bodies (and associated ritual specialists) —– from the light zone at the front of the cave, through the 'twilight zone' (the liminal zone where light gives way to dark) and finally into the dark zone deep underground – served as a physical metaphor for the journey of an individual from the above ground world of the living to the underground otherworld of spirits and ancestors.

Just as the cave in prehistory may have been viewed as a portal to another world – a liminal zone between one physical and cosmological state and another – so too is the hospital. Just as the forest for the Chetri was 'outside' of everyday life, where spirits lived and specialist knowledge was transmitted (Walter, 2001, p. 112), hospitals are the 'dwelling places' of our own ritual specialists. As such, their configuration, and the procedures enacted by nurses, facilitates the physical and symbolic transformation of individuals as they journey from the world of the everyday into this sacred and ritualised space (the 'territory' of the nurse; Barnett, 1972, p. 106). In this sense, immersion in an 'otherwordly' environment changes individuals' cosmological understanding of themselves, aiding the transition from autonomous person to submissive patient.

Journeys in and around these sacred places must be carefully controlled. The houses of the Chetri are characterised by a secular, public space near to the entrance, and a sacred room [the *kulko kothā* or *'kul*-room'] that houses the lineage deities at the rear (Walter, 2001, p. 111). Only certain members of the household are permitted access to the *kul*-room and the platform adjacent to it, and these individuals must approach in a state of ritual purity (Walter, 2001, pp. 109–110). Thus, the Chetri house from front to back becomes increasingly sacred, increasingly ritualised, and increasingly restricted to people from the outside world, as individuals move through 'zones of intimacy and purity arranged in increasing order of importance' (Gaborieau, 1991, p. 53). We could see the spatial arrangement of hospitals in a similar light. Hospitals are complex spatial entities with long branching corridors, multiple doors and segregated spaces leading an individual from the public/secular domain of everyday life to the restricted, ritualised and private spaces of the critically ill; those who are physically and symbolically leaving this world and beginning their journey to the next. In this respect, and though no doubt

designed to aid undertakers in the practicalities of caring for the dead, it is noteworthy that mortuaries are often found in the basement of hospitals. Much like the cave then, the newly dead occupy a liminal zone between the above ground world of the living and a subterranean otherworld.

The organisation of built space has long been recognised as key in communicating and conditioning social structures and world views (cf. Giddens, 1984; Hillier & Hanson, 1984; Parker Pearson & Richards, 1994), and studies have demonstrated that the design of hospitals affects nurses' daily tasks, communication patterns and job satisfaction (e.g. Trzpuc & Martin, 2010). In his study of over 150 Byzantine churches in modern-day Jordan, Chatford Clark (2007, p. 84) noted that 'the intricate organisation of space in the particular ecclesial structures reflected a variety of social, religious and cultic behaviours'; the same is true of hospitals, which themselves began life at the heart of the medieval monastery. Hospitals are designed in a way that allows patients, their families and the nurses who care for them to mediate transitions between public/private and secular/sacred space. When certain thresholds are passed, both space and person take on new characteristics and new roles, much in the same way as entering the twilight and dark zone of a cave marks an ever-deeper transgression into, and closer communion with, the otherworld of ancestors and spirits (e.g. Moyes & Brady, 2012).

A number of processes take place to facilitate the transformation of a person as they move through the hospital space (Table 2). In order for nurses to be sanctioned to operate outside social norms (as discussed above; Estabrooks & Morse, 1992), individuals entering the hospital must undergo 'separation' and 'integration' rituals, which strip them of their outside, everyday identity and reconstitute another: that of 'the patient'. Barnett (1972, pp. 106–107) associates adopting the role of patient with a 'regression to childlike responses' and sees this as an adaptation to the loss of autonomy experienced upon transgression into nurses' territory (Minckley, 1968, p. 512). 'Costume' plays a major part in this act of transformation. Just as nurses, as ritual specialists, don uniforms to signify their role, so too must the patient. Removing 'street clothes' and wearing depersonalised hospital clothes not only makes it easier for nurses to care for patients on a practical level but reaffirms the patient's new identity within the hospital setting. By wearing the costume of a patient, they symbolically take up the identity of the patient (cf. Wolf, 1988, pp. 62–63) and conform 'to the roles they are supposed to play in the social system of the hospital' (Jourard, 1964, p. 149; see also Hickson and Holmes' (1994, pp. 4, 7) discussion of the 'disciplined', 'obedient' and 'sanitised' body). In a reverse scenario, if and when *patients* begin to recover, they are permitted to exchange hospital bedclothes for their

Table 2. The ways in which the spatial arrangement of caves and hospitals facilitates the rite of passage from living to dead.

		Stages in *rite of passage*		
		Separation	Liminal	Integration
Archaeological record	Cave	Light zone	Twilight zone	Dark zone
	Person	Fleshed body	Defleshing/disarticulation	Dry white bone
	Status	Person	Body	Ancestor
Modern nursing	Hospital (dying)	Reception/waiting room	Ward	Side room
	Hospital (dead)	Side room	Trolley	Morgue
	Person	Everyday clothes	Hospital gown and identiband	Shroud/body bag
	Status	Person	Patient	Body

own bedclothes, thus regaining an element of their 'outside' identity. Upon discharge, former patients at one hospital eagerly asked nurses to cut off 'identibands' or borrowed nurses' scissors in order to do this for themselves (Wolf, 1988, p. 63), thus signalling their transformation back to *person*.

If a patient does not recover, however, and imminent death is anticipated, they may be moved to a side room (National End of Life Care Programme, 2011, p. 5; action point 11; Walsh & Ford, 1989, p. 105); physically isolating them from the rest of the patients on the ward and beginning the 'separation' phase, which signals the beginning of a new rite of passage: that of death. This act of separation into a more private (and arguably more cosmologically charged) space also serves to control physical and social access to the ontologically dangerous transformation of patient to dead body, protecting other patients from facing their own mortality (Walsh & Ford, 1989, pp. 105–106). As such, access to this liminal being is further restricted only to ritual specialists (nurses); the patient and nurse have journeyed from the twilight zone into the dark zone of the cave.

Upon death, last offices are performed to convey the deceased through the liminal phase and the body is adorned with mortuary and infectious disease labels (Quested & Rudge, 2003, p. 559), marking out its new ontological status as 'corpse'. Beds are sterilised and disinfected, not only for the practical purposes of infection control (C. M. Chapman, 1983, p. 17) but in order to 'purify' those materials which have been in contact with the abject body. This signals an act of closure on the transformation of a patient to a corpse, and the bed is ready once more for use by the living. Dead bodies are removed from the hospital on trolleys, disguised or hidden under sheets (C. M. Chapman, 1983, p. 17; Walsh & Ford, 1989, p. 106), and they exit the hospital through side or back entrances, avoiding busy public spaces (National End of Life Care Programme, 2011, p. 13, action point 62). The siting of a morgue at the entrance to a car park was branded 'tactless' by one registrar (C. M. Chapman, 1983, p. 17), presumably due to the public, communal and secular nature of the space; the mixing of worlds that should be kept separate. The deceased are not permitted to retrace their steps from private to public and from sacred to profane (from the dark zone into the daylight) because they cannot reverse their transformation; their 'integration' into a new identity, and new being, is complete and they have acquired a new status. And just as the shaman must return to this world from his journeys to the otherworld, so the nurse, as ritual practitioner, must return to (and be reborn into; Williams, 2001, p. 202) the land of the living, to begin the process once more.

Conclusion

Rituals are part of the everyday life of the nurse, and in the treatment of the dead and dying they are borne out of conscious and subconscious attempts to minimise or mitigate against the cognitive dissonance experienced when caring for a recently deceased patient. The liminality of the dead body is an enduring problem for the human psyche, and the places, objects and people associated with it have always required careful control. The role of modern nurses as mediators between worlds has been downplayed, with nursing rituals frequently considered solely as 'anxiety-relieving' mechanisms (e.g. Schmahl, 1964; Walker, 1967) and dismissed as superfluous to the task of caring for the dead and dying (Walsh & Ford, 1989, p. 100). As we have seen, however, the archaeological and

ethnographic record repeatedly signals the cosmologically dangerous nature of social and biological transformations (cf. van Gennep, 1977) and it is for *this very reason* that a whole range of rituals, and ritual specialists, are employed. Rather than being superfluous to caring for the dead and dying, rituals are *fundamental* to it.

By placing nurses and nursing rituals within deep-time and cross-cultural perspectives, through archaeological and ethnographic considerations of ritual specialists and mortuary practice, this paper has demonstrated the ubiquitous nature of cognitive dissonance in dealing with the dead and dying, and the central role of nurses as ritual specialists in navigating this challenging rite of passage. As Roynane (2009, p. 97) notes, 'acknowledgement of this stressor [cognitive dissonance] may not eliminate it, but may help ... nurses to understand why they act in the way they do, enabling them to understand and support one another'. And in this way, nurses can feel empowered in the vital and challenging roles they play in society today.

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