

Speaking about dying in the intensive care unit, and its implications for multidisciplinary end-of-life care

RICK IEDEMA, ROS SORENSEN, JEFFREY BRAITHWAITE and ELIZABETH TURNBULL

Abstract

This article addresses how professionals working in an intensive care unit in Australia speak about dying, with particular reference to the contradictions and complexities that characterize their work in this setting. The article reflects on the incommensurabilities in these clinicians' talk, and the consequences of this for how different professionals work together and care for extremely ill patients. Examples are drawn from talk recorded during ward rounds and focus groups. The article argues that intensive care units are settings where being reflexive about one's work and assumptions is especially difficult because it involves negotiating decisions and taking moral responsibility for decisions affecting very sick patients. These decisions and responsibilities put into sharp relief the 'wicked problems and tragic choices' of end-of-life existence and of intensive care in specific. This article shows some of the complex ways in which specific clinicians' discourse absorbs and manifests these tensions and responsibilities. The article concludes that these kinds of complexities are unlikely to be resolved with reference to formal knowledge or in-principle conviction, and that a new interactive basis needs to be found where clinicians can rehearse alternative ways of speaking with which to approach each other, the dying, and their families.

Keywords: intensive care; incommensurability; discourse; performativity; reflexivity; community of practice.

1. Introduction

Because they are not representative of something larger (a 'theory'), cases are able to do all kinds of other work. For instance, they may sensitise the reader to events and situations elsewhere that have not been recognised so far and that may well be improbable. ... They may suggest ways of thinking about and tackling other specificities, not because they are 'generally applicable' but because they may be transferable, translatable. They may condense ... a range of experiences, relations of a variety of different kinds. They may act as irritant, destabilising expectations. ... Or they may work allegor-

ically, which means that they may tell not just about what they are manifestly telling but also about something else ... (Mol and Law 2002: 15)

This article explores the talk of individual clinicians in an 'ICU' (intensive care unit) at a local metropolitan teaching hospital in Sydney, Australia. The reason for studying these people's talk as 'discourse' arose from our twofold concern to avoid personalizing the problems that affect intensive care ('this happened because of them'), while yet wanting to locate intensive care practice in the situated conducts that constitute it. Thus, our research confirms difficulties such as medical decision making about biophysiological deterioration of individual patients (Brody et al. 1997), managing the transition into dying (Brown et al. 1994; Denk et al. 1997; Wenrich et al. 2003), negotiating cross-specialty variations in opinion (Larkin 2002; Ravenscroft and Bell 2000; Sheldon 2003; Walter et al. 1998), and so on (Sorensen et al. to appear). In confirming the prevalence of these kinds of difficulties, however, our research throws into relief the ways in which clinicians enact their professional self as a factor that may be central to understanding the sources of those earlier-mentioned difficulties. For the purposes of this article, we have chosen to render such enactment of professional self tangible and researchable through focusing on specific stretches of hospital-situated talk. The analysis of such talk enables us to reflect on the relationship between the incommensurabilities that characterize people's professional and personal position takings in the face of dying and ICU clinicians' decision and communication processes more generally.

Over and above revisiting the by now quite common view that clinical professionals operate according to incommensurable values (Degeling et al. 1998), this article seeks to elaborate the following argument. While the literature is quite explicit about clinical professions enacting end-of-life care in ways that negatively affect their communications about life and death across professional and social boundaries (Manias and Street 2001; Miller 2001), the literature is less vocal about linking these problems to the specificities of individuals' enactments of self. This article homes in on people's enactments of self or their 'performativity' (Butler 1996) as a site that *in itself* is not unproblematic or without tensions (Lemke 2003). In

the context of intensive care, moreover, it appears that the iteration of tensions in talk may be a means through which the turmoil of end-of-life's 'wicked problems' and 'tragic choices' (Calabresi and Bobbitt 1978; Harmon and Mayer 1986) is currently pragmatically and strategically 'contained' (Sorensen et al. to appear). Put simply, the tensions that characterize the ICU context in which people work are not arbitrary to those that permeate people's own performativity.

As context, intensive care receives an increasing number of sick people who might in the past have died elsewhere, due to ICU's capacity to handle higher levels of acuity and attract seemingly endless resources (Seale 2000). For that reason, too, end-of-life treatment is now inevitably a highly complex legal and often prolonged process. It is now also widely acknowledged that because an intensive care unit is a busy and highly technological environment, the experience of dying by all involved can be filled with greater anxiety, discomfort, pain and isolation than often necessary (Kuhl 2002). This is not unrelated to the not infrequent phenomenon that many hopelessly ill patients in the last days of their lives are nevertheless admitted to intensive care to be subjected to clinical intervention (Fisher 2001), even if many intensivists are now increasingly conscious of the need to balance intervention and quality of life (Curtis and Rubenfeld 2001).

The critique of technologized care for how it runs the risk of silencing the dying and backgrounding the gravity of impending death is by now well-documented (starting with Kübler-Ross 1969). While the impact of the tenor of such care on individual clinicians has been described sociologically (Zussman 1992) and psychologically (e.g., Coomber et al. 2002; Goodfellow 1997), there has been limited exploration of what it means for how clinicians discursively construct self in relation to dying and death, and what this means, in turn, for communication and decision making surrounding the dying.

In sum, care decisions concerning the use of treatments to prolong life or to withdraw or withhold treatments are complicated by intractable differences of perspective and uncertainties about the efficacy and moral legitimacy of the treatment given. These differences and uncertainties arise not merely out of physiological and technological factors, but also out of the increasingly complex interplay of attitudes, values and expectations on the part of clinical staff, clinical specialties and families (often excluding patients as they are frequently unconscious).

For the purposes of situating our research, we feel that this level of interplay requires an explanation that cannot be served by gauging medicine's colonization of the patient's body versus its acknowledgement of the patient's voice¹ (cf. Mishler 1984). We believe accounts are needed of not only cross-professional aspects of interaction (Iedema 2003; Iedema et al. 2004), but also of how professionals perform self in

such interactions. There are many descriptions of clinical work that have highlighted problems in terms of how people structure their situated encounters (West and Frankel 1991), but few if any have foregrounded people's enactment of self as a factor in the unfolding of clinical relationships. For us, the kinds of ICU interplays referred to above, apart from being constituted in how participants interact, how they enact power and deploy other interactive resources, are also spaces where people modulate their personal and professional self in relation to end-of-life treatment in specific, and to death in general. It is in the spirit of refocusing the locus of social-organizational explanation that we want to describe the kind of end-of-life care in ICU that involves having to negotiate 'final' decisions for people who are often unconscious using the lens of individual clinicians' discourse about such 'tragic choices and wicked problems'.

The talk analyzed in this article is collected from two kinds of activities. The first is the ward round, with comments elicited by the researcher from medical clinicians in between patient visits. The second activity is a somewhat more contrived focus group discussion attended by nurses. Finally, we need to re-emphasise that the extracts of talk are analyzed not to expose individuals' intentions, emotions or idiosyncracies. Rather, the analysis aims to shine a light on how they as professionals typify the interstices between self, other and dying. Put thus, their discursive performance provides a window on how professionals inflect the 'routine pressures' that have been found to permeate intensive care (Coomber et al. 2002; Cronqvist et al. 2001; Goodfellow et al. 1997).

This article is structured as follows. First, in section 2, we outline the discursive stance of two medical clinicians, to exemplify the ways they realize the complexities and uncertainties referred to above. Section 3 addresses the ways in which two nurses position themselves in relation to similar dilemmas. Our analytical focus in both sections is on how the clinicians' discourse becomes a site of struggle between apparently incommensurable discourses. This then leads into the concluding discussion in section 4 where we tease out the implications of these divergent performativities for conducting multidisciplinary discussions about end-of-life care in ICU.

2. Medical performativity: Enacting moral dilemmas

Let us consider an extract drawn from a longer comment made by a medical intensivist during a ward round in between patients:

- (1) Extract 1: Ward interview, staff specialist intensivist, 24/04/01
I guess our decisions from society's point of view are pretty huge, but they're pretty easy. It's difficult isn't it. Like we were looking at a very

interesting sign in a lady that was dying the other morning and I was thinking to myself well this is very interesting but she's 42 with you know, with a young baby and we're focusing on this very interesting sign and basically she's condemned to dying basically with this little baby on her and her partner next to her and we were focusing on this very interesting classical reflex in the leg and you know it was like this is totally bizarre. But it's that business of separating the clinical everyday work from the personal implications for that person. And you must see that all the time you know, you see this division which is always blurring isn't it, it's like it's not that you don't know the personal implications.

This extract is used here to illustrate a general fashion of speaking that is not at all unusual for intensive care doctors (cf. Christakis 1999; Murray 2000). The extract shows that the doctor experiences a tension between the medical worldview and that of the dying patient. Here, this tension is lucidly enunciated by the clinician himself:² they show themselves to be conscious that they as a doctor objectify dying, a process that itself is horrific and destructive. They are aware of how the objectifying gaze of medicine clashes with the sad experiences of the dying mother. While they are implicated in the gaze of modern medicine, or 'that business of separating the clinical everyday work from the personal implications for that person', it is clear that, for them, 'it's not that you don't know the personal implications'. In fact, this doctor is reminiscing here about one person in particular whose situation was especially tragic because *she was conscious*. This could be taken as evidence, then, of this doctor's moral involvement in and no doubt anguish about the (objectifying) choices that medicine affords and imposes. Such moral and emotional involvement, moreover, may be taken as pointing to the doctor's sensitivity to the need for compromise between medical intervention, family expectations and patient comfort.

Other commentators, too, have been keen to acknowledge medicine's moral and emotional involvement in care, attempting to go beyond traditional sociological and anthropological critiques of medicine that described it as a practice confined and committed to the gaze of technologization and objectification (Williams 2001). Good (1994) argues that statements like our doctor's in example (1) attest of how medicine is able to attend to lifeworld factors and conjoin 'the physiological and the soteriological' (Good 1994: 86).³ Again others have revisited medicine's gaze to emphasize how in many circumstances its techniques are able to alleviate suffering, not least by restoring hope and a sense of security in patients and their families (Seymour 1999). This perspective has led to the re-description of medicine as 'a cultural script that enables participants to engage in resurrec-

tive practice' (Seale 1998: 81). In our view, too, it is crucial to acknowledge that the enactment and embodiment of medicine are infinitely more complex than might be suggested by the 'biomedical caricature' (Williams 2001: 140) of scientifically trained doctors coldly and heroically subjecting patients to interventionist technologies.

By the same token, it would be unwise to gloss over how medical clinicians tend to orient to disease as ontological phenomenon:

Disease is resident in the individual body, and the goal of treatment is to understand surface phenomena with reference to a deeper ontological order, to link symptoms and signs to physiological structure or functioning and to intervene at that level. Disease has a natural course; the story of the disease is one without personalised agent. (Good 1994: 83)

In addition to this, the environment and structure of intensive care predispose clinicians, despite themselves, to particular conducts, perspectives and decisions rather than others. As Mularski and Osborne (2001: 7) put it, '[t]he intensive care unit is a major arena where technology propels and focuses the ethics of death and dying'.⁴ Given this, it may be worth exploring in greater depth how clinicians negotiate these forces and tensions. One way of doing this is to ask how people's self-projections inscribe them into this complex fabric of knowledges, technologies, anxieties and ambitions. Our attention in this regard was drawn to the ways in which specific clinicians reflect on their own extremely difficult positions. These reflections, perforce both their substance and their form, became important for throwing light on how people reflexively confront the anguish and suffering that are constantly before them.

To illustrate what we mean here, let us consider the doctor's talk in example (1) in more analytical detail. Close scrutiny reveals that there is more to this comment produced than an ethical need to balance biomedical reasoning on the one hand, and paying attention to a person's personal tragedies on the other hand. This becomes evident not only from what the doctor says but especially from *how* they say it. That is, their talk is a *performance*, and it realizes not merely a substantive viewpoint or opinion, but *self* (Butler 1996).

As performance of self, the talk manifests two features that are critical to the present argument: discursive repetition and disjunction. With regard to the first, repetition, the extract reveals that the doctor 'recycles' the dichotomy referred to above. Thus, the talk vacillates between the technical-rational character of medicine and the confronting experience of personal and familial disaster. Table 1 schematizes this vacillation.

As the tabulated text in Table 1 demonstrates, the pattern that is created in the talk resembles a swaying back and forth (five times) between two perspectives that are in tension. We could infer from this swaying

Table 1. Discursive status of recycled features in the doctor's talk

	The confronting experience of personal and familial disaster Point of departure or 'given'	The technical-rational character of medicine Point of rest or 'news'
1	I guess our decisions from society's point of view are pretty huge	but they're pretty easy.
2	It's difficult isn't it,	like we were looking at a very interesting sign
3	in a lady that was dying the other morning	and I was thinking to myself well this is very interesting
4	but she's 42 with you know, with a young baby	and we're focusing on this very interesting sign
5	and basically she's condemned to dying basically with this little baby on her and her partner next to her	and we were focusing on this very interesting classical reflex in the leg

back and forth that the doctor is unable to arbitrate between the two domains and impose 'closure'. On the other hand, the swaying may also be a semiotic resource for sustaining different and incommensurable dimensions of self.

While the going back and forth is meaningful as it sustains a level of personal complexity, the frequency of iteration schematized in Table 1 is meaningful in again a different way. To foreshadow a point to which we return below, we regard this frequency as a marker not just of the stress of having to witness dying (especially of a conscious patient), but of the intensity of moral anguish experienced by being suspended across these incommensurable domains: the medical rationalization of disease, and the sad fate of the young mother.

Towards the end of their turn, the doctor makes an attempt to resolve the dichotomy in which their talk entangles them. They speak about their situation in terms of 'this division'—a superordinate or meta-discursive term^{5, 6} that could be seen to impose order and linearity on the tensions and incommensurabilities with which they are confronted. We will analyze this further in a later section. Let us first replay how the doctor finishes their turn, and then analyze this part of their turn (example [2]) more closely:

(2) End of extract 1 (repeated)

... and you know it was like this is totally bizarre. But it's that business of separating the clinical everyday work from the personal implications for that person. And you must see that all the time you know, you see this division which is always blurring isn't it, it's like it's not that you don't know the personal implications.

The conclusion here is again as significant as the initial part of their turn analyzed in example (1), if for different reasons. First, the doctor qualifies the opposition that they are enmeshed in using interpersonal language: 'bizarre'. The word 'bizarre' relegates the issue well away from the sphere of logic, rendering the opposition between medicine and common-

sense irretrievable for a critical discussion or human intervention: it is a matter of 'fate' (Martin 2000).

Then, after qualifying his situation as 'bizarre', the doctor applies the meta-discursive descriptor 'business', in 'that business of separating the clinical everyday work from the personal implications for that person'. More ideational in orientation than 'bizarre', 'business' dissimulates in its own way the contradictory and conflictual essence of the dilemma they are speaking about. While 'bizarre' referred to the uncommon (a young, conscious person dying?), 'business' refers to the 'normal' and 'everyday': dealing with dying is the doctor's 'daily business'. The tension between 'bizarre' and 'business' continues in its own way the dichotomy portrayed in Table 1.

The tension between 'bizarre' and 'business' brings us to the second of the analytical features of the doctor's talk: disjunction. As may already be evident, disjunctions reverberate through this entire extract of talk. In Table 1, we saw how the opposition between medicine and personal experience was recycled five times. Contradictory tensions are again present in how the doctor concludes their turn at talk, not least when they counterpoint the unusualness of 'bizarre' with the commonness of 'business'. In the sentence that follows on from this, they say 'this division' 'is always blurring'. Here, elements that are divided are yet always leaching across the boundary, and while this 'division' is 'blurring', the speaker's discursive enactment suggests the tensions (and thus the boundaries) are quite persistent. Finally, they finish by specifying what is 'not' using two negatives. Here, they extricate themselves from having to state their empathy for the woman patient in positive terms, framing it as a double denial: 'it's like it's not that you don't know the personal implications'. It is in these ways that their talk *at once denies and performs* the disjunctions that confront the science and practice of medicine in end-of-life care.

The doctor shows himself to be morally and emotionally aware of the distance that obtains between the medical science that they represent and the phenomenological or experiential world of their patient. It is this very distance, too, of course, that is the guarantor for medicine's social licence to practice on

patients as it judges to be appropriate—a notion well expressed by one of Good's interviewees:

... it often seems like as medical students we kind of slide into doing these kinds of things which can have just unimaginably great consequences for patients and we just sort of do it because we've incrementally learned about the biology and the science and the pathology and the pharmacology and we kind of inch into it and suddenly there we are saying, 'I'll write the orders that such and such be done to this patient'. (Good 1994: 81)

We now turn again to the doctor's self-presentation in extract 1 (example [1]), to show that they assimilate this tension and distance into the reassuring idiom of medicine, warding off infinitely more worrisome contemplations and possibilities. They do this in two ways. First, the everyday lifeworld is referenced using 'othering' pronouns like 'she' and 'her', and medicine is spoken about in terms of 'we' and 'I', suggesting the speaker identifies with medicine (Mühlhäusler and Harré 1990). Second, in swinging back and forth between consideration for the woman patient and fascination for her disease, the doctor's talk locates the talk's 'points of rest' with the 'interesting' phenomenon of the dying patient's leg.

In framing the dilemma in these ways, the doctor manages a cyclical and perhaps inescapable logic. By replaying the tension and distance between medicine and everyday experience, they are able to express the intensity of their moral and emotional troubles, containing the reality of both medicine and the situations in which they find themselves. By the same token, this way of speaking enmeshes the doctor in a subtle discourse whose prerogative is to oppose different viewpoints, curtail conversation between these viewpoints, and privilege one in favour of the other.

These comments go some way towards outlining the complex set of discursive strategies that constitute what some have called the medical 'refuge of meaning' (Seale 1998). Central to the argument of this article, the complex nature of this 'medical refuge' has implications for how the doctor does their doctoring, as one among a number of professionals and lay people that populate the ICU. As the analysis of their talk sought to demonstrate above, the doctor's talk is full of anguish, and that anguish is at the same time and *iteratively* subsumed to the 'business' of medicine. Overall, this produces a fashion of speaking that, because of its cyclicity and its particular designation of newsworthiness, puts limits on the extent to which it will be able to engage with fashions of speaking that locate their 'points of rest' elsewhere altogether.

Before turning to nurse talk, let us look briefly at the words of another intensivist. While the doctor focused on above moves back and forth between the case of the young mother who was dying and the scientific interests of medicine, the speaker in extract 2 (example [3]) sets up a contrast between how med-

icine ('we') deals with conscious patients who are dying, and how it deals with unconscious patients close to death. The doctor here is up front about the emotional anguish that affects them when having to spell out to the conscious patients that they are dying.

(3) Extract 2: Ward interview, senior staff specialist, 11/04/02

The deaths that we have the most difficulty with are the deaths in which the patient is awake. I still have real difficulty with that. ... We do the intubated, ventilated, sedated, bad head injury—we can do that one well; but the awake patient, we don't do that well. ... It is just too daunting to go up to the patient and say 'look I'm sorry Joe but tough luck mate you've had it'; it's not easy to do that. What if Joe says, 'well stuff you; I don't want to die.' What are you going to say then? 'Tough luck, you are.'?

What medicine does well, according to this doctor, is facilitating dying for unconscious patients. By contrast, anguish takes over in cases where conscious patients refuse to accept they are dying, and perhaps insist on being given 'futile' treatment. The discussions during which prognoses and treatment options are negotiated with such patients are hugely confronting, not just because they put the doctor in the position of final arbiter about whether the patient shall live (some more) or die (they are the final arbiter often too in cases where patients are unconscious), but also presumably because such patients require them to reason about their views and decisions. Putting them right in a moral quandary, reasoning about a patient's chances means the doctor has to make explicit to themselves and potentially dissimulate for the patient's benefit the often arbitrary and uncertain nature of their views.

In the face of this dilemma, this doctor's anguish is evident both from what they say, and again from *how* they say it. Notably, in the short extract in example (3), their point about 'speaking to conscious patients being difficult' is made five times explicitly ('The deaths that we have the most difficulty with'; 'I still have real difficulty with that'; 'the awake patient, we don't do that well'; 'It is just too daunting to go up to the patient'; 'it's not easy to do that') and once implicitly ('What are you going to say then?' 'Tough luck, you are.'?). Here, and as with the doctor heard in extract 1, we are not just concerned with repetition of an interactive detail (Gee 1990: 106), simple conversational redundancy (Cameron 2001: 33) or even self-repair (Schegloff 1987), but iteration of a contradiction or a tension. This iteration was interpreted above as an indicator of the degree of emotional tension realized by the speaker. If that interpretation is correct, the second doctor's talk can also be said to manifest a high degree of emotional

Table 2. *Given and news in the intensivists' talk*

Given ('point of departure')	News ('point of rest')
We do the intubated, ventilated, sedated, bad head injury—we can do that one well;	but the awake patient, we don't do that well.

tension. If we add to that reading the second doctor's explicitly affectual and negatively coloured language ('difficulty', 'too daunting', 'not easy'; cf. Martin 2000), it becomes analytically evident how this talk suspends the speaker across two apparently incommensurable domains: scientific medicine and its technical dealings with 'futile' brain injuries and the like, and the interpersonal turmoil that springs from talking to dying patients who are awake.

Despite the similarity of the talk in example (3) to the first doctor's talk in example (1), the doctor speaking in example (3) sets up their incommensurability by positioning 'technical medicine' as point of departure of their sentences ('given') and the 'difficulties' as point of rest ('news'). Table 2 provides an example.

Instead of repeatedly bringing the tension back to the technical prerogatives of medicine as does the doctor speaking in extract 1 (example [1]), the doctor in example (3) foregrounds the challenges facing technical medicine in cases where it has to negotiate its views with conscious dying patients. This talk creates a space for the conscious dying patient (if not for the unconscious patient!): 'What if Joe says ...?' In that sense, the intensivist imagines a dialogue between medicine and the dying, with medicine this time not as initiator of the talk, but as having to answer the dying patient in their terms and in their time. As we will note in our concluding discussion, the doctor's concerns are restricted to their dealings with conscious patients, saying that they do their work with unconscious patients 'well'. This of course sets a limit on the extent to which the doctor is willing to question the dilemmas of intensive care as it is provided to unconscious patients and negotiated with other clinicians and patients' families.

3. Nursing performativity: Anguish, complicity, objection

In this section of our article we pursue an analysis similar to that developed in the previous section, now focusing on two nurses' talk in some detail. Our purpose here, as in section 2, is to use our analysis of this talk as illustration of professionally sanctioned fashions of meaning and feeling. In section 2 we referred to Seale's term 'refuge of meaning', but as with the doctors in that section, the analysis will show that nurses speak in ways that are equally heteroglossic. In that sense, their talk also defies the unifying connotation of 'refuge', and instead invites descriptions that emphasize fracture and rupture.

The extracts of talk analyzed here were produced by two nurses during a focus group discussion. Both reflect on the way patients and their families are treated, and speak about 'the system' that they work in. Just before the extract that will be the main focus of our analysis in this section, one nurse says (example [4]):

- (4) Extract 3: Nursing focus group data 31/5/01
 maybe it would just, usually take another 24 hours or so to get used to the idea that they're not going to be here but then there's the other side of it, where the doctors would like to give them an extra 24, 48 hours or whatever and so we tend to take it from that day till the next day and think oh the figures don't look so bad today so we'll give them another 24 hrs.

The nurse in example (4) raises two issues. First, there is the problem of families getting used to the idea of their loved ones 'not going to be here' in another 24 hours, and of clinicians negotiating delicate matters such as these with people. Second, they touch on how doctors' judgments of futility and nurses' views about patients' conditions are balanced, namely by the use of 'and so': 'where the doctors would like to give them an extra 24, 48 hours or whatever *and so* we tend to take it from that day till the next day'. By speaking in this manner, the nurse creates a discourse that verbalizes the interstices between the family's concerns and the doctors' decisions, modulating nursing practice in relation to both the formal concerns of medicine ('oh the figures don't look so bad today') and the soteriological disquiet on the part of patient and family ('so we'll give them another 24 hours').

The nurse speaking in extract 4 (example [5]) creates a rather more complex and uncertain picture. Here, the interstices between different stakeholders' voices are negotiated rather less confidently and consistently.

- (5) Extract 4: Nursing focus group data 31/5/01
 And that's the point it is all done in numbers and not in actual facts of what you are actually seeing and there's also, doctors are obliged to treat anything that is considered to be reversible. So even though you know that there's like may be five conditions that this one person is now exhibiting, uhm that there may be one element of that, that's reversible and they are still obliged to treat that,

Table 3. Discursive features in the nurse's talk

	The technicalizing logic of medicine Point of departure or 'given'	The sentience of nursing Point of rest or 'news'
1	and that's the point it is all done in numbers	and not in actual facts of what you are actually seeing
2	and there's also, doctors are obliged to treat anything that is considered to be reversible	so even though you know that there's like may be five conditions that this one person is now exhibiting
3	uhm that there may be one element of that, that's reversible	and they are still obliged to treat that,
4	because that one may be influencing the other	so there's this unknown quantity
5	We give them these poor, like these sad prog... negative prognoses when they first come in	but we demonstrate the opposite
6	and to me if I was the lay person,	^a I would find that very conflicting.

because that one may be influencing the other, so there's this unknown quantity. We give them these poor, like these sad prog ... negative prognoses when they first come in but we demonstrate the opposite and to me if I was the lay person, I would find that very conflicting.

This nurse recreates the disjunction between sentience and rationality encountered above in the first doctor's talk at a number of levels. The first is that between 'mere numbers' and 'actual facts': 'it is all done in numbers and not in actual facts of what you are actually seeing'. For them, medical care is a matter of acting on numbers that flash on screens, rather dealing with 'facts that you can see'. Within the context of intensive care, they imply, scientific medicine's perspective does not necessarily have access to all the answers. They elaborate on this opposition between 'seeing the whole' and 'seeing but a part of the whole' by arguing that where nurses may see five conditions exhibited in a patient, all pointing to the likelihood of dying, doctors may concentrate on only one condition that they may consider to be reversible, but that ignores the full picture.

The disjunction between 'mere numbers' and 'actual facts' is dissolved however shortly after when the nurse shifts from charging medicine with regularly ignoring 'the facts' to acknowledging the *legal* bind that doctors find themselves in (or project for ulterior reasons): 'doctors are obliged to treat anything that is considered to be reversible'. The nurse here prevaricates by first targeting medicine for treating hopelessly ill patients, and by then acknowledging that doctors are nevertheless under a legal obligation to treat all reversible conditions. Their ambivalence culminates when they jettison the certainty just established on the strength of how nurses observe 'real facts', and admit that 'there's this unknown quantity'.

A second level at which disjunction is evident in their talk is in the use of pronominals, or linguistic items such as 'you' and 'we'. The nurse starts out with 'you' to designate herself and their nursing col-

leagues (and perhaps the focus group convener): 'even though you know that there's like may be five conditions'. 'You' here appears to stand for 'one' or 'anyone' (Mühlhäusler and Harré 1990), perhaps to bestow a general validity on what they are saying or to signal inclusion to the focus group convener. The talk then shifts to 'they' to refer to the doctors, fixing the distinction between how nurses perceive these dying patients and how 'they' (doctors) treat them. Following that, however, the talk shifts to an inclusive 'we': 'We give them these poor, like these sad prog... negative prognoses when they first come in but we demonstrate the opposite'. From constructing themselves in direct opposition to medicine, then, they transform their talk towards identifying with or expressing responsibility for the judgments that medicine issues about patients.

Third, while this inclusive 'we' intimates that doctors and nurses now share a common responsibility for what happens to ICU patients, there is a tension in this 'we' that soon ruptures through the surface of the talk. When the nurse says, 'these sad prog... negative prognoses', the nurse 'self-repairs' (Schegloff 1987), switching from a patient idiom ('sad') to a medical idiom ('negative prognosis'). Their dilemma, we suggest, is well captured by the heteroglossia (Bakhtin 1981) inherent in 'We give them these poor, like these sad prog... negative prognoses': the commonsense and emotional weight of the words 'poor' and 'sad' counterpoints with the technicalizing logic of science-derived 'negative prognoses'.

This analysis seeks to demonstrate that the nurse in example (5), as were the doctors, is wedged in between scientific medicine and human suffering. Here, as with the doctors' talk, the intensity of this incommensurability between technical rationalization and empathy and the ensuing anguish appear to be registered by the frequency of its iteration. Table 3 maps these tensions, and they are quite clear in rows 1 to 4. However, from row 4 onwards the opposition initially constructed between scientific medicine and the patient's lifeworld breaks up. The table highlights

how the nurse's talk moves from first opposing medicine to patient experience (rows 1 to 4), to exposing clinical work as contradictory (row 5), only to culminate with a voice *exterior to both medicine and nursing*: 'If I was the layperson I would find that very conflicting'.

Finally, and further showing that the nurse's talk is rift with multiple tensions, their talk shifts from opposing doctors and nurses to opposing clinicians and patients. This shows that nurses are not only caught in between scientific medicine and commonsense experience, identifying first with the latter (commonsense experience; rows 1 and 2) and then with the former (scientific medicine; rows 3 and 4). In row 5 the speaker starts out with a patchwork of contesting voices: intensive care nursing ('We'), the patient ('sad'), and medicine ('negative prognoses'), only to end with a reflexive critique that exceeds each of these ('we demonstrate the opposite'):

(6) End of extract 4 (repeated)

We give them these poor, like these sad prog... negative prognoses but we demonstrate the opposite

On the one hand, this confluence and mid-sentence rupturing of voices might mean that for the nurse, the tensions and anxieties are perhaps less 'manageable' than for the doctors seen above. On the other hand, it needs to be noted too that it is the nurse who is able to distance their talk from individual patients and speak in terms of clinical processes and patients in general (unlike the doctors in section 2, who both home in on their relationship with one single patient). In their talk, the nurse constructs a meta-discourse that pinpoints the troubles affecting the ways in which clinicians deal with dying patients, not just when it comes to negotiating bad prognoses with conscious patients, but as it pertains more generally to how clinicians coordinate their modes of care ('We give them these ... negative prognoses but we demonstrate the opposite'). In saying this, the nurse does not merely imagine 'being the [dying] other' (as does the second doctor in example [3]; Elias 1982), but conceptualizes how one—as the dying other—faces not only death here but also *the vicissitudes of end-of-life ICU treatment*.

Most troublesome for these nurses, and something that is characteristic of nursing and other support professions more generally (Degeling et al. 2000), is their *limited control over any of these spheres*, in conjunction with their heightened sense of moral responsibility due to their proximity to those who suffer. What is reflected in the talk analyzed above, we argue, is how nursing is faced with both the impossibility and the necessity of having to coordinate the complex uncertainties and relationships that permeate end-of-life care (Cronqvist et al. 2001). The preceding dis-

cussion suggests that the nurses' role is less about realizing anyone's agency, than of putting up with an inevitable *contingency*, equally implicated as nurses are in executing the technical interventions of medicine, experiencing the disasters affecting patients and their families, and being the first to have to confront the needs of and conflicts between these and other stakeholders.

4. Discussion and conclusion

Our analytical intent has been to illustrate and illuminate the ways in which professionals in ICU self-present, and to suggest that their talk is illustrative of the interprofessional communication issues that affect the unit. While the doctor in extract 1 is highly conscious of the fundamental moral and emotional dimensions of late-stage illness, our analysis suggested that they construe the 'rational-technical' idiom of medical care as a point of rest that moderates the patient's suffering. They seek to limit the consequences of this contradiction by talking about the 'bizarre business of medicine', containing the ways in which medicine is implicated in making decisions about deferring and bringing on death. The talk construes an 'either/or' world; a world in which the moral payoffs made between medical competence and confidence and patients' dying, suffering and survival run the risk of being prematurely if not consistently cast in one discourse and not another.

The second doctor in example (3) positions themselves slightly differently. In contrast to the first doctor, this doctor creates a space for talking about what medicine does not do well. But, instead of extending this critical perspective to the practice of end-of-life care in general, the doctor restricts their doubts and fears to the work they do with conscious patients only; the work they do with unconscious patients goes 'well'. Here, the person's sense of what can be discursively put at risk remains delineated from within a specific set of self-descriptions and the practices that they redound with.

For their part, the nurse who speaks in extract 4 (example [5]) is clearly also perturbed, but they produce a much more fractured kind of talk. As a member of a profession that enacts and embodies patients' day-to-day (and hour-to-hour) care in a heavily technologized and depersonalizing setting, they embody not so much an agency as a 'contingency' as they cope with and work around others' decisions and indecisions, abilities and inabilities, ambitions, pains and fears. Perhaps for this reason the nurse feels the need to extract themselves from these intricacies and tensions, and go beyond established ways of being and doing. They conclude their turn in self-critical and meta-discursive terms, commenting on the contradictory aspects that define ICU clinicians' end-of-life practices seen from an outsider's perspective.

Finally, for the nurse speaking in extract 3 (example [4]) the dilemmas that people face in intensive care are clearly to do with different people espousing different understandings about what is appropriate for specific patients. Thus, the nurse acknowledges that clinicians' understandings are, ultimately, a matter of give-and-take. While the second doctor is willing to face up to the trouble that medicine has moving from curative care to comfort care in the case of conscious patients, this nurse implies that, against a background of uncertainty, the only sensible approach to end-of-life care is negotiation and compromise.

Each of the speakers surveyed here casts the incommensurabilities of ICU in a different discursive mold. While these may be emblematic of the kinds of performativities that clinicians display in intensive care, our description does not presume to be exhaustive of what clinicians (can) say and do in ICU. Rather, and referring back here to the Mol and Law (2002) quotation with which this article started, this is a case study of a field of such complexity that it makes little sense to privilege empirical scope or theoretical refinement. Against this background acknowledgement, the tenet of this article has been to explore the theme of cross-professional and professional-lay person communication in a way that acknowledges the potential role of specificities that are not evidently the principal or exclusive site into which communication-tensions are translated. By diverting the focus of our research from how people speak with one another (their interactions) to their own talk as situated performativity, we have hoped to open up an alternative perspective on how clinicians confront and (re)embody their end-of-life experiences.

That said, there are a number of lessons that we derive from our analyses. First, and in light of the high levels of stress identified in ICU doctors (Coomber et al. 2002) and ICU nurses (Cronqvist et al. 2001; Goodfellow et al. 1997), the tensions described in the previous sections are not insignificant. The importance of our analyses, we argue, is that professionals such as those heard above clearly do not embody coherent 'refuges of meaning'. Instead, these people are most likely to be themselves deeply perturbed by the positions that they find themselves in as they go about enacting their professional self/selves. The implication of this is that we are not faced with clinicians projecting and having to negotiate around reasoned, coherent and logical position-takings (Lemke 2003). On the contrary, ICUs, considerably more so than other less fraught spheres of life, bring together professionals whose self is constantly torn and challenged by dying's 'wicked problems and tragic choices', and the logic of whose interactions can only be understood against that fracturing background.

Second, these complexities, incommensurabilities and tensions, we argue, cannot continue to be dealt with in an *ad hoc* way by clinicians negotiating ways forward 'in the corridor'. However, neither is the

dynamic, fluid nature of extreme illness amenable to the use of set procedures or 'pathways' with which to rationalize or standardize end-of-life care (while specific details of such care can of course be 'protocolized'; cf. Timmermans and Berg 2003). Instead, what is needed are dynamic communication and team work strategies (Sorensen et al. to appear). These dynamic strategies should provide clinicians with a space in which to talk about or 'narrativize' their divergent understandings about and experiences of end-of-life care.

Narrativizing like this is not the same as gathering formal evidence, pooling professional knowledge, and formalizing interdisciplinary consensus. The tensions and anguish witnessed earlier would be hard to capture by restricting the talk to the domains of formal, predetermined or in-principle knowledges. Narrativizing, rather, engages all stakeholders in naming the complexities, uncertainties and fears that confront decision making around dying. Naming these complexities and uncertainties provides an important counter-point to the more formal and in-principle knowledges of clinical decision making. Naming constitutes a weave of interaction or a 'community of practice' (Bate and Robert 2003; Wenger 1998) whose very fabric provides alternative grounds for making decisions, for realizing self, and for approaching patients' families.

When these professionals next speak, they speak from within their narratively-grounded community of practice. In doing so, they obviate having to manufacture certainties out of their professional knowledges, their specialized competencies, their personal apprehensions, their misgivings about the fate of specific patients, or their in-principle stance on dying. As members of communities of practice, people rehearse the real-life considerations that they are able to bring to bear on their own experiences as well as on the plight of their patients and families.

This is at the heart of the problem that we set out from in our introduction; namely, the observed dearth of multidisciplinary negotiation and decision making among clinicians about treatment options in end-of-life care. In our introduction we cited studies that suggest that these kinds of practices are changing. Our argument here has been that clinicians need moral and emotional resources to elaborate their multidisciplinary strategies with which to face ICU's 'wicked problems and tragic choices'. They will be able to generate such resources from creating a space for and with each other where the kinds of tensions and incommensurabilities that were evident in the talk of clinicians in this article are able to be verbalized and remolded. Without doing so, it is unlikely that clinicians are going to be able to devise lasting 'formal' solutions for how to structure appropriate intensive care treatment regimes (Benner et al. 1999), conduct supportive family conferences (Curtis et al. 2001), gently break bad news (Placek and Eberhardt 1996),

and more sensitively and collectively determine the onset of dying (Christakis 1999).

Notes

1. The recent concern with 'patient-centred decision making' aims to obviate medical dominance, but appears to eschew foregrounding the performative complexity of clinicians' own conduct (Mead and Bower 2002; Epstein et al. 2002).
2. We will use 'they' ('them', 'themselves') instead of 'he' and 'she' to minimize people's identifiability.
3. 'Soteriology' is the study of suffering and salvation (Good 1994).
4. This is Porter's (1999: 692–693) description of the birth of intensive care units last century: 'With new monitoring machinery, quasi-surgical interventions and the growth of respirators and all the other technology associated with the intensive care unit, the hospital became the place, not where the patient came to die but where the apparently terminal patient might almost miraculously be rescued from death. Doctors thereby assumed control over the rituals of death: what was left of the 'good death' of the religious *ars moriendi* yielded to the priests in white coats. In the nineteenth century it had been the physician's role to minister over or administer a peaceful death; his modern successor seemed to promise to overcome death. Rendered a mark of failure, death became a taboo, something to be deferred. The management of death was subjected to medical protocols.'
5. Meta-discourse, in van Leeuwen's (1995: 91) terms, has the ability 'to reach beyond the here-and-now of the communication situation and ... represent "the then and the there" to take into account what is elsewhere, to remember the past and to imagine the future.'
6. The notion of 'point of rest' refers to different moments of the (spoken) sentence. The beginning of the sentence is its 'point of departure'; its ending is its 'point of rest'. While a point of departure tends to index (or construe) given or shared knowledge, a point of rest commonly realizes new or noteworthy knowledge (Halliday 1994; Martin 1992).

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Rick Iedema is Senior Lecturer in the Graduate Management Programs, School of Public Health and Community Medicine, and Senior Researcher at the Centre for Clinical Governance Research at the University of New South Wales. His work centres on discourse analytical and social semiotic investigations into the organization and enactment of healthcare provision, and he has published a range of articles in the areas of organizational discourse analysis. His book *Discourses of Post-Bureaucratic Organization* was published in 2003. He is currently involved in three Australian Research Council funded projects: one investigates the processes surrounding death and dying in a south-Sydney intensive care unit; a second four-year project focuses on the shift in clinical work from paper-based towards electronic information and communication media; and a third three-year project focuses on clinicians' identity change in response to health reform, captured by means of video technologies. Address for correspondence: Centre for Clinical Governance Research, University of New South Wales, Sydney NSW 2052, Australia. E-mail: r.iedema@unsw.edu.au

Ros Sorensen is senior research fellow at the Centre for Clinical Governance Research, Faculty of Medicine, University of New South Wales. She did her doctoral work on assessing the difference between the administrative and managerialist models of healthcare operation across twelve settings in seven public hospitals in New South Wales. She is a researcher on the 'Dying with Dignity' project team, and she teaches the Certificate of Clinical Governance in the Graduate Management Programs in the School of Public Health and Community Medicine at the University of New South Wales.

Jeffrey Braithwaite is Director of the Centre for Clinical Governance Research in Health, and Associate Professor in the School of Public Health and Community Medicine, Faculty of Medicine, University of New South Wales. He has published widely on health sector policy and organizational issues. He has more than twenty-five years' experience in managing, researching, teaching and consulting in healthcare settings. His major current research interests are the multidimensional, chaotic, complex, changing, deceptive, contested and politically rich organizational field we label 'the teaching hospital' and the fascinating, institutionally-emergent role within health, the

clinician-manager. He seeks to employ pluralist research strategies, bricoleur-like, to help interpret behaviour. More broadly, he is interested in various health sector policy and management issues.

Elizabeth Turnbull was a senior researcher on the 'Dying with Dignity' research project. She has a background in interdisciplinary research into the nature of self and self-transformation, death and dying, embodiment and subjectivity. With a doctoral background in sociology, she has since specialized in psychotherapy centering on death, grief and loss.