The sound of the absurd: Learning to listen in the Emergency Room

written by Mirko Pasquini
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It was a crowded, freezing Monday morning in late January, in the large university hospital in northern Italy where I was leading my fieldwork between 2017 to 2018. A muscular man in his late thirties rushed through the Emergency Room (ER) entrance sliding glass doors with a swoosh. He wore a leather biker jacket on one arm and lavish black tribal tattoos on the other. The man stopped in the middle of the waiting area, a large, enclosed room with eighty plastic seats, garishly lit by neon lights and painted a pale institutional green. He waved a broken glass bottle neck in his right hand, glaring across the room at the nurses' reception area, yelling: "I want to see a psychiatrist right now or I'm going to slit my wrists!"

This threat was met with jaded good humor rather than alarm. The tattooed man, a frequent ER visitor, was well known to the staff on-duty. “Go on, do it!” Nurse Giovanni – a gruff professional who that morning was seated at the reception, typing another patient’s name and symptoms into his computer – replied through the thick glass wall that divides the nurses’ reception desk from the external waiting area. “We’ll stitch you up. You know we can do it.”

The man stared at nurse Giovanni. “Fine!”, he yelled. “Then I’ll cut my chest open and stab myself in the heart!”

Nurse Giovanni laughed. “Good luck with that! If you can manage to pierce your sternum with a piece of glass, I’ll give you a round of applause (ti faccio pure l’applauso)!”

The tattooed man muttered and looked around, clearly annoyed. Then he turned and marched out through the sliding glass door with the same purpose with which he had entered (also in Pasquini 2023a).

This is what the nurses I met during my fieldwork in an ER in northern Italy between 2017 and 2018 call a “routine encounter” with a “well-known character” (un personaggio conosciuto). Even though routine, these situations are regarded as absurd by the ER staff.

Nurses and physicians recognise that people go to the emergency service due to a lack of welfare alternatives, even though the staff thinks they are in no need of urgent treatment. In the ER, competing care goals create a sensation of futility, of loss of meaning and control: a sense of the absurd amidst care (see Vohnsen 2011). Such feeling is often met with irony by the ER staff.

An analysis of the absurd illuminates how health practitioners engage with conflicts in care in an embodied manner. For instance, in the above vignette, as he shouted toward the reception area, Valerio, as I later learned the tattooed man was called, initiated a scene that changed the rules of the usual assessment performed by nurses to determine the urgency of people’s suffering (i.e., triage).

The situation could be analysed by referring to philosopher Thomas Nagel. In his short essay "The Absurd" (1971), Nagel describes absurdity as emerging from the gap between people's everyday expectations, and the practical circumstances they are living in. Valerio's shouting, for example, trumped triage procedures together with nurses' expectations to do their job (including a formal interview and a close examination), creating a context of sense-making in which a patient could bargain for urgency with the use of violence.

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Nurse Giovanni knew Valerio well enough to know he would never commit suicide in the ER. However, Valerio's shouting made nurse Giovanni step back from his usual positioning as a clinician. Sound made the nurse immediately realise that another approach was needed. Instead of trying to reason with Valerio, the nurse played along by using irony, in a new sense-making scenario that took on absurd tones. Here absurdity lies in the fact that clinical reasoning, that is, what nurses expect to be doing in delivering care, is partially bracketed out by practical circumstances requiring nurses to readapt medical practice to the chaotic environment of the ER.

The step back that nurse Giovanni took with his comment helped shift the context, introducing an appreciation of the absurd (Nagel 1971:718). In the ER such step back and reflexive attitude is often triggered by sound. One that brings new meaning to the context of interactions and that sparks the sensation of an existing gap between the daily value of everyday tasks and the practical circumstances in which nurses' work occur. Nurses feel trapped in an absurd situation because they are both doubting their everyday clinical practice, while they are also unable to completely abandon it.

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In the soundscape of triage interactions (Samuels et al. 2010), the feeling of the absurd – as the presence of conflicting goals within care – can emerge any time amid the cacophony of sounds competing for attention. Inside the ward, someone may be desperately screaming for help. At the same time, a woman may sob in a conversation over the phone in the waiting room. A boy will cry loudly in the triage area. The phone at the reception desk won't stop ringing. A tiny loudspeaker announces a patient's name, echoing across the inner aisles of the ward. The receptionist may be shouting, trying to make herself heard to incoming patients from her desk behind the thick glass wall. In the midst of all these sounds, everyone can hear the furious clacking of the nurse's keyboard typing – dull castanets clicking syncopated time (see Pasquini, under contract).

If sight signals the present – the touchable here and now – sound indicates the immediate future, what is about to happen, the emerging yet invisible. Nurses' capacity to anticipate and readapt care to the absurd comes with the crucial skill to discern particular sounds, some deemed as absurd (illogical, uncanny), like the shouting of the man with the broken bottle, others being serious and acute sounds, triggering immediate action.

Learned over years of practice, nurses contextualise their interactions with patients and their families in the ER through skilled listening. For instance, a nurse may question people's suffering by listening to the way an individual explains what happened. The way a person stutters, her accent, the way she struggles to catch her breath or rushes through words like a stream, the way she speaks plainly, motionless about her pain – all of these expressions are pieces of a story that nurses must put together on the spot. Listening reveals more than what is apparent. Whereas sight is an objectifying perception, listening is instead a powerful trigger of imagination. Sound can hit nurses' ears wherever they are and whatever they are doing. Rather than boundaries, listening evokes a widening possibility of interpretation. Thus, just like doubt, the sound of the absurd is contagious in the ER.

Sound introduced absurdity by making nurses realise that an unforeseen conflict

was under way. Shifting nurses' possibility to judge, act, or even meet urgent suffering as usual, sound is well known by nurses to have the capacity to change the context of ER interactions.

Whenever an ambulance, for example, would brake faster than usual or, worst of all, not turn off its engine while parking in front of the red code area, nurses would know – only by listening to the engine roar – that the routine division of labor no longer applied. Ambulances in a rush meant troubles and nurses would immediately put on surgical gowns, rush to the phone to call the anesthesiologist and prepare to plunge into a bloody scenario of a traumatic injury with possibly desperate outcomes.

A lurking presence in the ER, the absurd is a constantly scrutinised possibility.

Due to this capacity to change the context of interactions, nurses said that the unexpected has a specific sound in the ER. A man's hysteric laughter breaking through the loud chattering in the waiting room. The theatrical blessing of an improvised Jesus, holding patients' hands to heal them. A lurking presence in the ER, the absurd is a constantly scrutinised possibility. The nurses strive to anticipate it by listening carefully.

On the one hand, through their skilled listening, nurses perceive the feeling of the absurd hidden within their daily task in the overcrowded ER. On the other, they capitalise on sound to anticipate, and partially counter, such feeling of powerlessness.

There are only three ways for nurses to remedy the absurd, as a sensation of futility and impotence. The first is to disengage from the situation altogether. This option is not often available to nurses who have no choice but to deal with the daily care of patients even when the situation takes on absurd tones (Pasquini 2023b). Rather, like Mol, Moser, and Pols (2010) describe, caring situations need to be tinkered with, improvising with the tools at their disposal in order to make care work. Through a recursive series of attempts, of trials and errors, nurses

redefine care and change their reality according to newly emerging conditions.

This is the second way that nurses can deal with an absurd scenario, by changing the situation at hand and thus reducing the gap between practical circumstances and expectations. Of course, this move demands considerable agency, one that nurses often lack within the chaotic environment of the ER. A relevant point here is made by Catherine Trundle (2020) who highlights the limits of tinkering in context, underscoring that care can also be associated with backlash and mistakes, and does not necessarily always build up to good. Such an idea of impotence and impossibility, of the limit of improvisation and tinkering, resembles what I have witnessed in the ER, where nurses very often realise the limits of their ability to tinker with the reality they are dealing with.

A third and final way to cope with the absurd that is frequently used by nurses in the ER is to change daily expectations in order to cope with an adverse reality. A person may be able to adjust to a new circumstance by changing how they normally produce sense. This is what happened when nurse Giovanni used irony to handle the man holding the broken glass. Irony is often used by nurses to reduce the gap between their expectation and the reality they are dealing with. Shifting their registry of interactions as soon as they identified an unusual sound, nurses constantly wondered when their capacity to improvise would reach its limit while facing the competing goals of an absurd situation.

“Wait, was it the ambulance arriving again? Did it brake quickly or turn off the engine slowly?”, a nurse asked me, listening carefully for an engine roaring outside the reception area.

With a concerned look, the nurse gestured for me to follow her. As we approached the entrance to the internal ER aisle, we could hear the engine running still. Every nurse knows: this means trouble.

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