

Liminal Personhood and Continuity of Moral Identity in Clinical Care

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Abstract

Capacity-based frameworks of personhood risk marginalizing individuals whose agency, cognition, or consciousness are diminished by illness, brain injury, or proximity to death. This article introduces the concept of *liminal personhood*, which describes the persistence of moral and relational identity even as conventional markers of personhood fade. Drawing on ethical, philosophical, and neuroethical scholarship, the paper argues that failing to recognize enduring personhood can fracture patient identity and erode clinician and caregiver moral integrity. Recognition of liminal personhood has clear clinical utility: It guides dignity-conserving care, supports relational engagement, and sustains clinicians' ethical coherence amid profound vulnerability, thus offering a practical framework for humane care at the edges of consciousness and decisional capacity.

Keywords: bioethics; clinical care; dignity; liminal personhood; moral identity; suffering

Imagine two dear friends saying goodbye. A nurse is at the bedside during their final visit. She learns that they were school classmates with the sort of relationship that led to daily morning calls over coffee, until their ritual was disrupted by a diagnosis of metastatic cancer. The daily calls were replaced by diagnostic tests and treatments, and then a sense of foreboding and loss. Ultimately, in the final month, calls were replaced by weekly plane trips and bedside visits. When her friend deteriorated and was referred to hospice, a final trip was made. She was drifting in and out of consciousness, in a liminal state between lucidity and crystalline clarity; deadening fatigue and confusion. From one moment to the next, it was unclear what would be understood or said. But the nurse observed that, despite her diminished state, their relationship endured. Amid the pauses and the silences, each was enriched by the other. The nurse bore witness to their decades of friendship and the irreplaceability of a moment that would never, ever occur again. It was a privileged space of relationality, hours that brought comfort and would inform a life-long legacy.

The poignant scene illustrates that although a patient's life was waning, flickering, coming to an end, her personhood—the amalgam of who she was, who she'd been, and what she'd

meant within the context of this loving friendship—was never in jeopardy. In clinical practice, agency, cognition, and social engagement often function as the implicit markers by which patients are recognized as persons. These capacities are fragile and finite, vulnerable to aging, illness, cognitive decline, brain injury, or proximity to death. As such, their erosion fosters the assumption that personhood itself is diminished or lost.¹ But in the fictional vignette presented above, just the opposite happened: Richness emerged out of the patient's loosening grip on life and the singularity of the moment. The patient's fragility presented a unique opportunity for relationality and connection, an opportunity that could bring comfort to the patient and ease the pain and grief of the survivor. Against this backdrop, philosophical accounts that define personhood primarily by functional capacities warrant scrutiny, particularly when clinical realities expose their shortcomings.²

This article introduces the concept of *liminal personhood* to clinical practice, holding that personhood endures across clinical thresholds where agency, cognition, or communication are altered, compromised, or in decline. It describes the state of a patient who is neither fully present in their former capacity nor fully gone, existing in a threshold of uncertain trajectory. Liminality need not be a bounded interval or

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Accepted August 18, 2026.



interregnum; it can also describe conditions in which familiar ways of recognizing and relating to a person become unsettled, while personhood persists.

Liminal personhood builds on previous scholarship on suffering,³ the moral status of the other,⁴ and dignity.⁵ Rather than relying on static assessments of a patient's current state, liminal personhood adds a temporal dimension: It captures the uncertainty of clinical trajectories in ways that terms such as "diminished capacity" cannot, holding the possibility of both recovery and decline simultaneously. Liminality helps to link these three concepts together as it captures the relationality of the suffering patient and those who attend to them and invokes dignity throughout the trajectory of illness. The term *liminal* originates in anthropological accounts of rites of passage. Rites of passage have been described as sharing three distinct phases: separation, liminality, and incorporation—allowing individuals to transition between social states.^{6,7} The first stage, separation, involves symbolic behavior that signals a detachment from the former self. Following this, liminality describes a transitional state in which individuals are *betwixt and between*—no longer who they were, but not yet who they will become. Finally, incorporation is marked by a symbolic rebirth, as the person reenters society with their newly attributed status.^{6–8}

Liminal states are marked by ambiguity and the dissolution of familiar identities, carrying both the risk of disintegration and the possibility of reconstruction and new moral insight.⁷ In health care literature, liminality has been examined with regards to experiences of living with serious illness, mental illness, brain injury, structural vulnerability, and dementia; it also sheds light on the role of family caregivers.^{9–14}

In this article, we expand understandings of liminal personhood in the context of serious illness, cognitive decline, and proximity to death that place patients in similarly liminal positions, where conventional markers of personhood are disrupted and under threat. We examine the philosophical roots of personhood and argue for the importance of attending to liminal personhood, offering moral arguments, implications for dignity and suffering, as well as clinical tools that sustain the moral integrity of patients, families, and clinicians.

Across this deeply human arc, individuals remain moral, relational, and dignified despite diminished capacities. When functional change or decline renders reciprocal engagement impossible, personhood is sustained through relationality. The patient's identity is held, preserved, and maintained by their community. Their values, history, and relationships form the basis of a continued deference to the self. For clinicians, it is essential to recognize and acknowledge these enduring threads of personhood. Within clinical encounters, this guides practice, shapes relational engagement, and sustains moral integrity. Failure to do so risks dehumanization for the patient and moral injury for the provider. Liminal personhood, therefore, functions as a clinically actionable framework for dignity-conserving care.⁵

Philosophical Foundations

Philosophical accounts of personhood have historically linked moral status to specific capacities, such as reason, consciousness, autonomy, moral agency, and articulated values.^{15–17} According to Kant, rationality matters not as a marker of intelligence, but because it enables the capacity to recognize persons as possessing intrinsic worth, which Kant defined as dignity.¹⁶ While Kantian ethics dictates that patients with diminished

cognitive capacities should be treated with the dignity they were entitled to prior to this functional change, tying personhood so tightly to rationality creates an important vulnerability in clinical practice. When illness, brain injury, or proximity to death undermine the capacities through which personhood is recognized and sanctioned, the moral status they are meant to protect becomes precarious.^{1,2}

This vulnerability is particularly evident in neurological disorders, where the long-standing association between cognition and the self has positioned cognitive function as a primary marker of personal identity.¹⁸ In clinical practice, this association between cognition and identity can result in patients being marginalized, infantilized, or excluded from decision-making when capacities wax and wane.⁸ Yet such moments are fundamentally liminal because they are marked by uncertainty. In cases of cognitive changes, brain injuries, and disorders of consciousness, clinical trajectories can be difficult to predict; while these changes may accompany decline at the end of life, they may also precede recovery. While patients who are in liminal states may lack decisional capacity and may require a surrogate decision-maker, categorical bright-line distinctions that reduce them to their legal status can preclude relational engagement that can be meaningful to the patient, family, and clinician. Hence, acknowledging liminality allows clinicians to remain open to recognizing and affirming personhood amid an unknowable future.⁸

Recognizing *moral presence*—the continued ethical and relational claim a person exerts on others even when functional capacities are altered—is therefore critical.⁴ Moral presence is the way in which moral status is encountered, experienced, and sustained relationally at the bedside. To discount personhood amid this uncertainty risks dehumanization, fosters therapeutic nihilism, and forecloses interventions that might support relationality whether patients move toward recovery or the end of life.⁸ These states exemplify personhood under threat, demanding clinical practices that recognize how moral presence persists despite profound limitations on expression, agency, or responsiveness.

Moral Integrity and Clinical Practice

Philosopher Philip Hallie observed that moral action frequently arises not from abstract concepts of obligation or heroism, but from the fundamental need to remain congruent with one's sense of self in the face of the suffering of others.¹⁹ Moral action is often internally compelled; to act against one's own values fractures the alignment between how individuals understand themselves to be and how they must act in the world.²⁰ In clinical practice, when disciplinary and institutional norms obscure a patient's personhood, they risk fracturing moral coherence for clinicians.

To understand this fracture, it is helpful to delineate three related concepts: *moral identity* refers to one's self-understanding as a moral agent; *moral integrity* denotes fidelity to that identity in action; and *moral coherence* describes the alignment between values, conduct, and self-understanding.^{1,21,22}

Caring for patients whose capacities for self-expression are diminished can exert pressure—often institutional or systemic—to shift from recognizing a person to managing an object, from moral subject to clinical task. Under conditions of sustained moral strain, clinicians often experience distress not because they lack ethical principles, but because they are prevented from acting in ways that remain faithful to who they understand themselves to be.

Recognizing liminal personhood resists this collapse. It enables clinicians to act in alignment with their values, preserve moral integrity, and remain hospitable to those at the margins.^{19,23} Acknowledging enduring personhood helps clinicians protect themselves against moral injury and burn-out, supporting ethical practice amid profound clinical and existential challenges. The responsibility of recognizing liminal personhood cannot, however, rest solely on the moral labor of individual clinicians. By cultivating environments and policies that recognize and support personhood and relational engagement, healthcare institutions contribute to moral ecologies that sustain the moral identity, integrity, and coherence of clinicians.^{1,21}

Personhood, Fractured Self, and Suffering

If denial of personhood threatens clinicians' moral coherence, it manifests for patients as a fracturing of the self.²⁴ Eric Cassell defined suffering as "the state of severe distress associated with events that threaten the intactness of the person."³ Suffering arises not only from physical pain, but from assaults on identity, meaning, and relational and narrative coherence that threaten one's future self. This aligns with Jeremy Bentham's insight that the capacity for suffering, rather than reason or speech, grounds moral consideration.²⁵ When personhood is denied—whether through neglect, dehumanization, or a failure to recognize agency—patients experience a fracturing of the self.²⁴

Moreover, this fracturing is reciprocal. Clinicians who overlook liminal personhood or are compelled to do so due to institutional or systemic norms incur a parallel moral injury.^{26,27} This injury occurs when clinicians are compelled to act in ways that conflict with their ethical commitments, generating internal conflict, self-reproach, or shame. When personhood is denied, both patient and clinician suffer a loss of coherence. Liminal personhood is therefore ethically significant not only for those in threshold states, but also for clinicians who care for them and bear witness.

Dignity-conserving care responds to both vulnerabilities. It goes beyond relieving physical and existential distress by affirming moral identity, preserving relational and narrative coherence.^{5,28} Diagnostic rigor ensures that patients in liminal states receive appropriate assessment and neuro-palliative care, thereby affirming recognition of personhood.^{29,30} By attending simultaneously to patient comfort, personhood, and their own ethical coherence, clinicians uphold both the well-being of those at the margins and the integrity of their profession.

Liminal Personhood in Clinical Practice: Continuity of the Self Through Care

Bringing liminal personhood from theory to practice requires moving beyond frameworks that tie moral value exclusively to functional capacity, autonomy, or consciousness. Recognizing liminality is enacted through relational and therapeutic practices. Interventions such as Dignity Therapy allow patients to affirm legacy and narrative integrity, and Intensive Caring emphasizes presence, attentiveness, and therapeutic humility.^{28,31–33} Even when patients are unable to communicate, caregivers sustain connection through care acts such as careful positioning, gentle touch, sensitivity to bodily privacy and boundaries, and verbal affirmation. Routine practices are transformed into relational acts of dignity when

viewed through the lens of liminal personhood: They directly acknowledge a patient's moral identity, uphold dignity, and support caregivers' moral integrity.^{5,32}

For patients who can no longer communicate verbally, the physical body becomes a locus of relational engagement; therefore, physical care is itself an ethical practice. Returning to our opening vignette, we can reflect on how holding vigil at the bedside of a dying loved one is not simply a period of waiting, but an active intervention that sustains identity and personhood. Attentive care, whether for the living, the dying, or the deceased, communicates recognition of enduring moral and relational identity, rendering care ethically sustainable. Conversely, humiliation, neglect, or desecration constitute affronts to dignity and personhood.^{24,31}

Liminal personhood applies beyond the clinical encounter, including situations of profound absence and loss. Hence, ethical responsibility also extends to postmortem care and bereavement. Biological death does not extinguish our moral obligations; the deceased remain relationally present in the memories of those who mourn them. Respectful care of deceased bodies and remains is a powerful signal of continued recognition of personhood across cultures and throughout history, serving to protect the social and moral fabric.³⁴ By supporting these practices and recognizing enduring personhood, clinicians help families navigate the liminal landscape of grief, itself a transitional space where the person remains morally significant, allowing bereaved loved ones to integrate their loss, and supporting narrative continuity.³⁵

While Turner argues that ambiguity must eventually dissolve,⁷ in clinical practice we are often confronted with instances of prolonged or permanent liminality—cognitive or physiological decline that does not have a resolution or recovery. In the absence of this final transition stage, the imperative of dignity-conserving care is to sustain personhood within uncertainty, thus maintaining moral identity, integrity, and coherence.

Conclusion: Liminality, Dignity, and Continuity

By offering this liminal view of personhood, we hope to provide clinicians an alternate way of understanding their clinical work. Liminal personhood affirms that individuals warrant moral recognition across thresholds: through illness, injury, decline, recovery, and death. Failing to recognize liminal personhood not only compromises those whose capacities are threatened but also fractures the moral integrity and coherence of those who care for them.

Personhood is continuous at the edges of being, and dignity is the moral acknowledgment of that continuity. Liminal personhood clarifies why grief is not a failure to let go, but a response grounded in enduring moral presence. It has potential therapeutic and policy implications. For clinicians, liminal personhood offers a philosophical and ethical framework for understanding and guiding compassionate, dignity-conserving care across clinical contexts. Future empirical work can examine how explicitly recognizing liminal personhood changes how clinicians relate to patients, how patients and families experience care, and how clinicians sustain moral coherence in the face of profound vulnerability. Institutions require accountability to ensure that sustaining personhood becomes solidified as an institutional commitment, rather than an individual clinician's responsibility. In this way, liminal personhood offers a humane approach to care at the limits of consciousness and our

capacity to heal, guiding clinicians and institutions to bear witness while keeping those at the margins centered in care.

Author Disclosure Statement

H.M.C. and M.S. have no conflicts of interest to declare, nor any funding to acknowledge. J.J.F. acknowledge partial support from the E. William Davis, Jr. M.D. Professorship in Medical Ethics at Weill Cornell Medicine, and report that he is the chair of the board of The Hastings Center for Bioethics.

Funding Information

No funding was received for this article.

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