The exposition and invisibily of bodies in Intensive Care Unit's working practice

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Introduction

In the last decades, knowledge and medical practice have been undergoing important transformations, due, in particular, to the *enlargement of the care scene* (Manghi, 2005), which has given a say to usually silent interlocutors (i.e. the institutionalization of the Tribunal of Patient Rights) or formerly inexistent ones such as the managers of the local health organizations[1]. *Scientification of biomedicine* (Burri, Dummit, 2007) has been another process deeply affecting medical practices. The meeting of medicine with other so called "life sciences" (first and foremost molecular biology and neurosciences) and information technologies has provided the medical and nursing staff with new instruments and procedures regarding the diagnosis and the therapeutic treatments, broadening the scope of intervention of medicine over life spots formerly unexplored.

Medical practices' contexts have been evolving as *socio-technical ensembles*, where physical resources, technological artefacts, social norms, spatial dispositions and professional practices live and interact constantly (Schubert, 2007).

A clear example is indeed represented by the use of biomedical technologies in intensive care units (ICU). The introduction of mechanical respirators, sophisticated systems monitoring the vital levels, and the synthesis of the vasoactive medicines, able to support the cardiac activity, has generated a new human condition in biological, psychological and social terms (Seymour, 2001), in which the survival of a patient, either for a short term or to balance chronic deficiencies of the organism, is indissolubly linked to an equipment.

In this paper I will show how the organization of the ICU and the medical and nursing personnel's professional practices generate and reproduce two models of *body*, focused on the perception of the level of therapeutic adequacy of the hospitalized patients: the *exposed body and the invisible body.* The first model is characterized by a high level of observability and interaction with the organizational elements while the second one refers to patients who are considered by the staff to have no clinical expectation of improvement.

The Intensive Care Unit (from a sociological point of view)

Strauss and colleagues, in 1985, pointed out that in ICU's working practices issues related to different domains are involved: economic, political, industrial and cultural, *in primis.* Studying routines and practices in these organizations means to find and investigate the

[1] The process of transformation of public health care services in firms financed with collective funds is quite recent in Italy. It started at the beginning of the 90's.

heterogeneous human, material and symbolic elements involved in the production and carrying out/implementation of the *socio-technical ensemble.*

First of all, the typology of treatments carried out in Intensive Care Units (ICUs) mobilizes huge amounts of money. According to an English study, each patient per each day of hospitalization costs averagely between 1,000 and 1,800 pounds, including the costs of the medical-nursing staff (weighing upon about 60%), of the pharmacological and instrumental technologies, of the hotel services connected to the hospitalization, and so on and so forth (Bennt, Bion, 1999).

Social rules are important as well in the medical practice, and in the ICUs this is particularly clear as related to the interruption or non activation of the life-support treatments. A cross-cultural study analyzing this type of decision has stressed out a very high variability at the European level, ranging from Switzerland, characterized by a declared attitude (more than 50% of the assessed cases) towards intervention by interrupting or not activating reviving treatments, to Italy where the same figure goes down to 23% (van der Heide, Deliens *et al*, 2003). A possible explanation refers to the deeply different socio-cultural context, as settled within the legal rules: on the one hand, Swiss legislation is well stated and very liberal as related to the will of the patients/relatives, providing the medically assisted suicide among the possible options. On the other hand, the Italian Criminal Law provides the charges of second-degree murder (art. 575 penal code), murder of the consentient (art. 579 penal code) and instigation or help to suicide (art. 580 penal code), all subject to penalty, for whoever causes the death of an individual, regardless the reasons of the agent (Barni, 1999).

If these aspects are related to the macro-social dimension, ICUs' medical practice embodies processes related to the meso- and meso-social level too.

The huge presence of technologies, for example, concurs to the setting up of the professional practices. As Mort and colleagues (2005) have pointed out, studying anesthesia, a medical field that is similar to intensive care, the interaction between human beings and technological artifacts is neither a one-way relationship nor universally given as it is linked to the characteristics it assumes within the located setting: if, on the one hand, mechanical respirators substitute a physiological function of the patient and perform a so to speak "delegated" function, on the other hand data appearing on the monitor constitute the telling of the unstable general condition of the patient.

Technologies, as well as other elements involved in working practices, are largely taken for granted by participants, and treated as a transparent background for the work. However, studies on collaborative work have shown that the setting of artifacts and

people promotes specific integrated perspectives in the working practices (Goodwin, 2007). What is commonly perceived by people as "normal" in their practice and taken for granted, is "actively contrived by practitioners in order to accomplish safe and proficient practice" (p. 273).

Spatial dispositions play an important role in producing the specific perspectives that are embodied in working practices and routines. Studying medical practice, Reneé Anspach (1993) has proved how visual proximity of patients in intensive care actually modifies medical personnel's perception of the conditions of the patient. On the basis of data gathered in two American neonatal ICUs, Anspach describes how medical staff and nursing staff performed different prognostic evaluations in relation to the fact that doctors tended to see patients only for short moments during the day and to ground their prognostic inferences on the basis of information deduced from clinical data and diagnostic reports. As a consequence, Anspach finds in the medical staff a greater attitude towards prognostic pessimism as compared to nurses, who, on the contrary, devoting themselves to specific patients throughout their entire working shift, used to evaluate their conditions according to *perceptive indications* stemming from the visual contact with newborn babies.

The patient's ill body, the traditional object of medical practice, is not an immutable and universally recognizable element. On the contrary, it gets different characteristics depending on professional roles, diagnostic tools, organizational cultures and even more. As Mol (2002, p. 84) writes: "in the hospital, the *body* (singular) is *multiple* (many)".

Bodies are multiple also in relation to biological death: the ethnographic accounts of Sudnow (1967) show that dying in hospital involves procedural and organizational aspects that introduce a definition of death, the so-called "social death", related to but not overlapping with the "clinical death", that is, the appearance of medical evidence of death as a result of physical and instrumental examination. Social death is all about practices set up as the patient is considered approaching death: for instance, as Sudnow observed, it happens that a patient is left on the stretcher on which he/she has been admitted and put in the laboratory room, or large supply room, in order to avoid to mess a bed up since the patient is considered to be dying soon. As a result, a body still biologically alive assumes the characteristics of a dead body from the organization's perspective.

As I will further show, even bodys' treatment in ICUs are not unique, as they change according to the different dispositions that the specific *socio-technical ensemble* assumes.

The study: the medical practice in ICU

The empirical materials that I present in this study are part of a broader ethnographic assessment whose aim is the study of the ICU's medical practice from the epistemological perspective of "the practice of the medical technology" (Timmermans, Berg, 2003). According to this approach, stemming from the encounter between Anthropology, Medical Sociology and the Science and Technology Studies (STS), assessing the medical practice in technologically highly dense environments requires the observer to be located at the level of the daily interactions within the working setting. Borrowing from the *workplace studies* the interest for the local organization of the working practices, the researcher focuses his attention on procedures, routines, communicative flows and technologies (Hindmarsh, Jenkings, Rapley, 2007). In order to do so, it is necessary to assume a symmetrical perspective (Latour, 1995), according to whom "technology is viewed as one actor among many in changing configurations of social and technical elements" (Timmemans, Berg, 2003, p. 104).

My ethnographic study has provided a twelve months period of fieldwork in an Intensive Care Unit of a public hospital in the north of Italy. During this period, I have observed situated practices, gathered ethnographic and semi-structured interviews of the medical and nursing staff, participated in their daily meetings (where personnel discuss the therapeutic treatment of patients) and assisted with the talks with relatives of the patients. The gathered material is as heterogeneous as it follows: recorded interviews; talks and personnel meetings (transferred on data storage device); daily ethnographic notes; other material gathered in the ward as guidelines, internal reports and medical records, etc.

Observations, interviews, recordings of the staff meetings, and documentary materials have been analyzed using a *grounded* analysis, in a three steps process: deconstruction of materials in simple units; aggregation of the analytical units in macro-categories; validation of the macro-categories on the basis of the different types of empirical materials (Hammersley, Atkinson, 1995)[2].

In order to facilitate the understanding of the following paragraph, direct talks will be in italics; ethnographic notes and transcriptions of teams' talks will be in narrower margins. I have also changed the names of the people in order to guarantee their privacy. For the same reason, I have removed from the plan of the ward any element that was not mere

[2] For more information regarding the design of research, the empirical material and the analysis of data, see Lusardi, 2009.

structure and that might have led to the specific organization in which I performed my research.

Analysis: Working practices, technologies and bodies in ICU

The process of categorization of patients and the perception of their conditions by physicians and nurses are embodied in working practices and organisation disposals and they contribute to produce and reproduce a *moral order,* involved in the accomplishment of the distribution of resources (Latimer, 1997; Lusardi, 2009). In the following pages I'll describe how the carrying out of the moral order in ICU generates the bodies *exposed*, from one hand, and the ones *invisibile*, from the other.

Making the body exposed

The whole organization of ICU contributes to the production of the *exposed body*, involving other units of the hospital as well. The aim is monitoring life functions in real time and acquiring detailed information about the conditions of the internal organs and even more careful information about the specific seat of the possible cause that eventually resulted in the hospitalization. In the following episode, based on my ethnographic notes, it emerges how relevant the access to these data is for the effectiveness of the treatment:

> I enter into the ward and stop at the entrance of the emergency room, where I feel there's a certain agitation. On the examination couch a middle age woman lies, intubated, her eyes closed, she's breathing very fast. On the monitor next to the couch the wave of the ECG[3] and other life parameters are displayed. A nurse is placing a drip on the support next to the couch, while an other nurse is setting up a pump behind the patient. Doctor Ferrari is also in the room, he is filling out the medical record. I see him observing life parameters being displayed on the screen and then writing their values in the blank spaces of the medical record. On the table next to the entrance, where the doctor is writing, there are also various radiographic reports. Ferrari looks up at me and says hello. I ask him what has happened to the woman: Carla, 60 years old, felt in the morning a heavy breathing problem and a strong pain to her chest. So she went to her doctor who provided her with medicine in order to sustain cardiac

[3] ECG, or electrocardiogram, is the result of the recording of the electrical activity of the heart over time by the use of electrocardiographs or specific monitors.

activity and urged her to go immediately to the Emergency Unit of the local hospital. As she arrived heavily bradycardic (slowing down of the cardiac rhythm), with a pulse of 20 beats per minutes (bpm), she's been reanimated, intubated and transferred in the ICU. As a result of a CAT[4], it has emerged that a thrombus broke off from a vein of the left leg, climbing up to the heart and obstructing the pulmonary vein in between the two chambers of the heart. Afterwards, the patient has been treated with a strong anticoagulant which allows the thrombus to melt by stopping the blood from clotting. In fact, through the monitor, it is possible to see that the situation is becoming stable, with a pulse of 100 bpm, while the blood pressure is getting a little bit low and the oxygenation is going up to 100%. The doctor stresses how, now, once overcome the danger resulting from the thrombus, the risk is a general hemorrhage because of the anticoagulant medicine and therefore a coma. In order to avoid this consequence, it is necessary to keep the blood pressure low, around the current values, 100, no more than 110, gradually lowering the adrenaline, using one of the medicines supporting the blood circulation. He also points out that this is the typical ICU's situation, in which the patient is supported in his/her life functions, respiration, circulation, temperature (*you give what is lacking and take off what is exceeding*) until the overcoming of the acute event that affected the patient. So he says to me with some satisfaction that things are running smoothly now and that every once in a while it's nice to feel some professional fulfillment and that he *is sick of working for friars*. After telling me about the situation, Ferrari goes back to the doctors' room with the medical record. He sits down and while he's finishing filling out the medical record I see him raising his eyes towards the emergency room so as to be sure there are no signs or anomalies. A nurse ends tidying up some unused devices.

Carla needs a constant attention in order to check the effects of the anticoagulant medicines, even in their interaction with other medicines, like adrenaline. The plain administering, as it could happen in an ordinary ward, would damage the very same survival of the patient. For patients like this, representing, in doctor Ferrari's words, the typical ICU's situation, in which there's a temporary lack of the life functions because of a specific problem, a huge amount of organizational resources is involved in order to produce and keep up the visibility of the body through its exposure. It is because of this exposure, because of the numerous parameters found through the constant monitoring

[4] CAT stands for *computed axial tomography,* a diagnostic device of medical imaging.

of the patient as well as because of their immediate availability that the doctors can evaluate how much to reduce the medicines and how to modify the settings of respirators, adapting them to the patient's respiratory capabilities.

Once overcome the acute event, as in the described episode, in which the patient is treated with the anticoagulant medicines that will melt the thrombus causing the bradycardia, the main activity becomes the observation of parameters by nurses. They will note the data every hour, even more frequently in more serious cases, and will transfer them to the medical record. When anomalies in the expected parameters occur (for instance, the arterial pressure suddenly goes down and the cardiac frequency goes up), nurses inform the doctor for it is necessary to review the therapy on the basis of the new data. Therefore, patient's body has to be effectively exposed, well visible and its internal components accessible.

This exposition is essential in order to make the patient compatible with the technological infrastructure that the in-ward treatment mobilizes (Lindemann, 2007). Certain values of saturation and respiratory frequency coming up in the monitor require the adjustment of the settings of the mechanical respirator, so that the patient can benefit from the respiratory treatment. It is particularly necessary that monitor, mechanical respirator and the patient's physiological conditions are aligned on the basis of an ecology of signs and indicators and that they are kept aligned through the constant monitoring of variations.

Even in the case of potential donors of organs, following the declaration of brain death, the level of exposure is kept high. This is a peculiar typology of patients, since, in spite of the fact that the patient's trajectory will end up with death, it is fundamental to keep the organs in perfect condition in order to make the removing (and the following transplantation) possible. This requires a lot of effort, as a nurse points out, telling me about: *for sure, when you follow a donor, you put in a lot of effort, you do whatever is possible, trying to maintain a good frequency, a good saturation, this good, that good, just because of the body*.

Brain death is declared only as a result of the acknowledgment of the contemporary presence of various clinical conditions, among which is the absence of brain activity verified through an electroencephalogram (EEG). Another absolutely necessary condition so as to ascertain brain death is the absence of spontaneous breathing that has to be completely substituted indeed by the mechanical respirator. Thus, it is essential to monitor the state of oxygenation of tissues, visualized on the monitors through the parameter of saturation, constantly kept at 100%. Variations of saturation, because of the obstruction of the tube putting air in the person's trachea or because of the

thickening of mucus in bronchus, can irreversibly damage tissues and organs to be removed. During my observation period I witnessed two procedures of brain death declaration, one concerning a patient from whom many organs were removed. In that case, the patient occupied the first bed in ICU and the room all around his couch had been delimited with a red-and-white plastic tape in order to reduce possible vibrations that could have altered the EEG waves.

As the sociological literature points out, even the spatial arrangements of the organizations are taking part in the production of a sense of "normality" on which are based experts' practices (Goodwin, 2007). In the ICU that I have studied, the material disposition of patients in the ward is the result of the different types of perceived body that health care professionals are working on.

In fig. 1 I have represented the ward's plan, so as to identify the organizational spaces I have been describing above: the emergency room, located next to the main doorway of the ward (A) and, right in front of it, the doctors' room and the ward, with the beds.

In both the described cases, the woman coming from the Emergency Unit and the declaration of brain death of a potential donor, the bodies are located where they can be the most visible, by the nursing staff and, above all, by the doctors: the emergency room and the first beds in the ward. In fact, the medical personnel main activities' place is the doctors' room, where doctors retire to fill out medical records, analyze x-ray radiographies and CATs, discuss about clinical cases, arrange staff meetings, or simply rest.

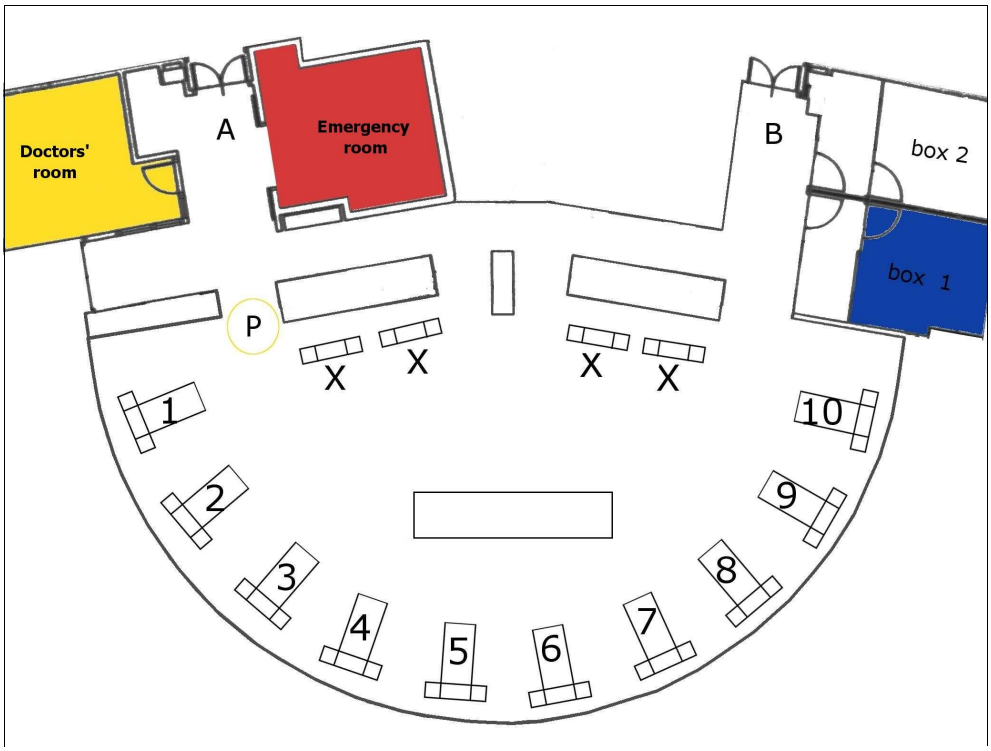

Fig. 1 – *ICU's planimetry and main spaces*

The following episode describes the entering of a doctor in to the ward, at the beginning of the shift:

> It's about 8 pm, doctor Colombo comes in the ward and stops beside the first bed, a little bit in the back, as if he wanted to stay just on the border of the room. I notice that he's observing the unit, I notice his focused gaze. So I ask him whether he will do the night shift, since I had not seen him all day long. He replies affirmatively, even though he feels he won't be particularly busy. As I ask him why, he answers: *Why? Because it is enough to give a look around for me so as to understand what is the situation, without analyzing the medical records, even if I haven't been in for the last week. Half of the current situation is already clear. Afterwards, I will also start looking at the medical records and will give you the prognosis*. In the meantime, even a nurse, Alberto, who's been working in the ICU for 15 years, listens to what we are saying and enters the conversation: *even more than half of the situation, just by giving a look at it.* Colombo: *Yes, sure, patients assume a certain expression and a certain, particular behavior. Then you look at the monitor…* Therefore I ask: *Is it because they are elderly people, most of all?* Colombo: *No, not necessarily, it's the pathology. It is the so called facies, the behavior they assume, that is a main foundation of the clinical examination. It's the famous expert eye…of course you can't do everything with it, on the contrary… but it helps you, first you screen. I remember the first time I went to* [a hospital in a small town in the province] *in an ICU with just six beds that I had never seen before, I came in at 8 pm, and somebody was waiting for me. Hello, Hi, I am the doctor of* [the main hospital], *oh, all right, all right, well, we introduce ourselves, then he says to me, "ok, let's see the patients in the ICU". I looked and said "That is a post* [post-operative], *well, there was a traumatized person, and that was easy to understand, there was another one… a respiratory insufficiency, and then…" He says to me: "But, did you see the medical records?" "No, but this is not the first one I see like this"* [*I replied*].

In the above described episode, the doctor is observing hospitalized patients from position P (in the figure), that allows a wide view over all the ICU. Patients of the opposite wing, however, are not visible as well, because there are various obstacles to the eye, like empty beds, still not usable, yet already equipped with some devices, and the oasis in the center, constituted by a long table surmounted by two series of shelves

and a large LCD monitor[5]. From position P, visual access concerning patients hospitalized in the first 5, 6 beds is very good, while the other patients remain partially hidden. I have often witnessed the change of the doctors on duty, at the beginning of the night shift, when usually there was just one doctor on duty and the one who would start working after 8 pm. It used to happen in this position, patiens' "screening" is done from this position, on the basis of which the doctor understands the way he will have to balance his efforts, and how much attention he will presumably have to devote to the various clinical cases.

Making the body invisible

Unlike the previous model of body, attracting the major part of material and professional resources of the ICU, the *invisible bodies* are more difficult to be identified for their specific integration in the working practices of the ward. If the *exposed bodies* are immediately recognizable and it's easy to understand, even for an outside observer, that every effort of physicians and nurses is aimed at improving the condition of the patient, the *invisible bodies* need a closer look by the working practice in order to analyze their situation.

The organization of space and activities in the ward

The second model of body already emerges from the assignment of the beds, as a nurse tells me and explains the informal criteria used by the personnel:

> *If the ward is empty, they all stay here* [she points from bed 1 to bed 5 on a drawing of the ICU I made so as to explain to her my observations regarding the placing of patients] *although, when the ward is full you place them there* [she points to beds from 6 to 10] *even the one you feel is less interesting to observe, because you know that even if you can see him, you won't see anything new. Therefore…*

However, the visibility criterion is not explicit, and not shared at all by the nursing staff, as it has been confirmed by other nurses: formally speaking, the assignment of beds

[5] The architectonic structure of the ICU from close up is reflective of the model of Bentham's panopticon, assessed by Foucault (1975) as an effective instrument of control of human beings and bodies . As well as in the Bentham model, even the ICU plan a privileged place of observation that should be in the central position, from where it is possible to have visual access to all the beds and where the LCD monitor has been placed displaying the life parameters of all the patients. According to the designer of the ICU, that space should represent the ward's crucial point, from which to master the clinical medicine of all the hospitalized people. In the ward's daily practice, its centrality, however, is disregarded. During my observation period, central position was often "disabled", or just conceived of as a passage point, to make phone calls, send faxes out, or for nurses' use only, for they didn't have their own place in the ward, and during the change of the shift, they had the chance to sit down as it was provided with 4 or 5 chairs.

should be random, except for those beds that are provided with particular technical functions.

The trajectory of two young lovers, in ICU because of traumas undergone as a consequence of a road accident, is however revealing of the different meaning given by the staff to the various spaces of the ward. In fact, immediately after the accident, the guy is treated and stabilized in the emergency room, while the girl is hospitalized in bed 1, because of the lack of a second emergency room. The guy is thereafter brought to the operative theater because of the lesions he has suffered. When he comes back, he will occupy bed 10 as the ICU is full. Even the girl, after several hours, is brought back from the operative theater, once again to bed 1. It is particularly interesting to stress that, two days after the accident and hospitalization, the girl and the guy, partially recovered and perfectly conscious, move to beds 9 and 10, next to each other. The girl is actually moved to bed 9, which will be tilted up for about 30 degrees so as to allow the couple to talk vis-à-vis. By this time, the patients are stabilized and do not require the massive investment of resources they required at the beginning. In this phase, doctors are organizing their transfer in the specific ward where the therapeutic course will be completed. Indeed, during the period of greatest exposure after the hospitalization, when the staff needed to be able to check life parameters in real time so as to evaluate whether the patients were stabilizing or not, doctors had just to get out and overlook the ICU to check the situation whenever they wanted. On the contrary, when the conditions of the two guys have become stabilized, and they have been able to peacefully talk together, on the opposite side of the ICU a "confidential" space has been created, in which the patients have been able to wait for their transfer in a condition of relative privacy.

This hypothetical scale of relevance of the positions within the ward ends with the first box, blue-colored in fig.1. Here is the way the doctor on duty of the ICU describes the function of that space:

> *A patient is definitely represented by numbers. Except this room over here* [he points to box 1; we are talking together in box 2, that is currently empty] *wherein nobody comes to check. Why it is that? Because you cannot do anything, therefore, well, I wouldn't say we feel it is like a defeat, but it is something you don't know how to work with, thus you pretend you don't see it. I can tell. Look at the people who come to see these beds over here. Just a few, indeed… Ricci* [another doctor of the ICU] *this* [Andrea Marcolini, the patient hospitalized in box 1 I will talk about afterwards] *well, he does not even consider him. There's nothing new. And you*

don't know what to do about it, there's nothing to do about it any more. Theoretically speaking, these should not even be our patients at all.

The first of the two boxes, that should host, according to who designed the ward, infective patients, therefore dangerous for the rest of the population in the ICU, as well as the second, in the ward's practice are often destined to host chronic patients that have nothing to do with ICU treatments, theoretically speaking. As soon as the trajectory of the patients appear to be in a stalemate situation, as both chances of improvement and therapeutic options diminish, the box becomes the place where to put these patients up untill their dismissal, should there be a facility able to welcome them, or their death[6].

Even the subdivision of duties among the nursing staff contributes to enhance the differentiation between patients who require a continuous exposure and those who become less visible. Every morning, at the beginning of the early shift, the head nurse or, in her/his absence, one of the older nurses in order of seniority, used to share the patients on the basis of the amount of work to be done. Each nurse is assigned to take care of two patients, dealing with their assistance and therapy, during the entire shift. Two nurses, instead, are assigned one patient only and any emergency. These will be the people who will support the doctor in the treatment of the patients coming from the Emergency ward, or from other hospital wards, devoting to them their constant presence and a relevant commitment. It is for this reason that, in order to balance the efforts put in the emergencies, the two nurses are assigned just one patient who is not very demanding. One will usually be the patient in the box. The other one will generally be a patient hospitalized for more than a week, who is perceived as needing less care as a result of the chronic evolution of his clinical conditions and with few or no chances of recovery. Thus, there could be beds around in nothing would happen, during the day: except for the morning wash, the meals served by health care operators and some quick look by the ICU staff, chronic patients, and, especially, the patient hospitalized in the box, receive just a little attention by the medical and nursing staff. These patients simply become less important as compared to the priorities of the ward, in other words, as compared to those patients who are possibly susceptible to improvements. What did

[6] There are many reasons why patients' trajectories in ICU cannot be concluded. For the sake of this paper I cannot address the topic now. Yet, I just would like to note how hospital organization, and therefore the interaction between the wards, and the consistency of the trajectories of the patients cannot taken for granted at all. The transfer of a patient is often the result of numerous talks, formal and informal, between head wards, of negotiations of beds (*I take one of your beds, you take one of mine*), of recurrence in the degree of occupation of the available beds, and so on. Sudnow (1967) has described effectively this hidden universe of relationships characterizing the management of bodies in two important American hospitals. Regarding the implications for the ICU personnel doing, respectively, end-of-life decision and house treatment of chronic patients, see Anspach (1993) and Steffen, Heimer (1998).

usually enhance this slipping to the back of the ward's activities, during my observation period, was the absence of consciousness, the comatose state of many patients with a chronic evolution in ICU. The impossibility to set up any communication through language, verbal or not, even just through a physical contact, and the patient's inability to reply appear to imply a minor involvement of the nursing staff and limit the resources to be destined to these patients. A nurse tells me about her difficulties to enter into the box, whenever there's a patient in comatose state, unconscious:

> *I realize it. Today I didn't go in at all, I couldn't. For, it seems I always see more important things to do rather than going there to check him out. It seems to me, I say. I said "Hi!" to the wife, I talked to the daughters out here, because in any case I understand I cannot interact with him a lot, that so isn't it? If the relatives are not inside, I don't go in. Not at all.*

Even for nurses, as well as for the medical personnel, the bodies in the box lose visibility. They slip to the back of the ward's practice and become objects of quick looks, silent and mechanical checks.

Slipping to the back in medical discussions

This *slipping to the back* can be found also in the staff meetings of the doctors, who used to meet up to discuss about the cases of the day, during the change of the afternoon shift. At about 2 pm, doctors who are almost done and their colleagues who start their own shift meet up in the doctors' room, usually four to six people, according to the day and the shift, reviewing daily cases, the treatments already done and those still to be done, diagnostic exams performed and those to be requested, medical records already filled out and those not completed yet. Generally speaking, the account has no pre-set list of points: the doctor assigning daily tasks has a sheet where all the main characteristics of each case are written down. He reports them to the other doctors who intervene and ask for clarifications. In the following excerpt of a recorded meeting, it emerges how the discussion about the patients hospitalized in the box literally lose relevance as related to doctors' priorities set up during the meeting. Four doctors participate to the meeting, doctors Marino and Rossi, who are describing the current situation to doctors Gallo and Colombo:

> Rossi: *Well, 1 2 3 4 5 6 7 8...* [he is counting the patients on the sheet where he wrote down his notes].
> Marino: *Then, there is the one in the box…*

Gallo: *What's his name? Marco…*

Rossi, Marino: *Andrea Marcolini.*

Marino: *Yesterday evening, afterwards he's been reconnected* [to the mechanical respirator].

Colombo: *Yes, he was tired.*

Marino: *And they applied a bronchoscopy to him, as he was completely blocked to the left. He tends to stop to the left. It would be good to talk to the physiotherapists in order for him to try to do some physiotherapy, the pressures, those types of things…*

Colombo: *Listen, has Bellini* [a patient hospitalized the day before because of a serious cardiac attack] *got all his things still set up?*

Marino: *He has the FIO2 at 70, nitric oxide at 10, but thereafter I didn't see how is it, no more. Then it comes a lung, it should already be there, in the other box* [the box for infective patients]. *I went to take it, a sir who had a high temperature since the last week, 38 degrees, somebody who has always been ok, never had anything and at the end… He's been treated first with tachipirina, then a bit of Citorlarsone, during the first days. Then, yesterday he's come in, somebody must have seen him at the Emergency Unit…*

Rossi: *No*

Marino: *Sent upstairs in medicine, a right lower lumbar pneumonia, he has been sent upstairs in medicine. When he has gone upstairs, he had 60 of pho2, today he was saying he was worsening I came up to see him. He had 57 of FIO2 with the 60%, he wasn't particularly* [...]*, he was doing pretty well…*

The discussion carries on about the better ventilation system to be applied to this patient. Afterwards, doctors get up and go out from the room.

Regardless of the "esoteric" subjects of this passage, given the highly cut and specialized medical language (Del Vecchio, Good, Good, 1993), whose explanation would require too much room, it is interesting to stress the communicative dynamics: as soon as Marino starts assessing the case of Andrea Marcolini - 55 years old patient who has become seriously disabled as a consequence of an accident at work, and hospitalized for over 20 days in ICU – about whom he reports the umpteenth unsuccessful try of making him breathe autonomously, a doctor introduces the situation of another patient, to whom the staff is devoting a lot of effort to as he has just been hospitalized but not stabilized yet. Finally, they start discussing the patient arriving from the ward of Medicine. Such a dynamic was very frequent during the staff meetings. Simply put, some patients vanished

from the accounts as soon as the picture became less "engaging" from a clinical point of view.

Such invisibility was reflected also in the daily practice. Although the doctors on duty, at the beginning of their morning rounds, used to share their work starting from the opposite wings of the ICU, it happened very often that the order of the beds was not followed and that some patients weren't examined but once again slipped to the back as compared to the priorities given to other patients. Many times it was because of the arrival of a consultant for a diagnostic examination, or a visit to a patient, so that the doctor on duty was distracted from the natural order of the beds and led to reserve more attention for a specific patient. Thus, it happened that at the end of the shift some patients hadn't been examined yet, as doctors confirm in the following passage. Ferrari and his colleague, Bruno (a female doctor), are the doctors on duty during the early shift, giving updated information to the two doctors who will occupy the ward during the afternoon shift:

> Ferrari: *Then there's ...* [following patient in the account]*?*
> Bruno: *Rossi.*
> Ferrari: *Rossi must be seen* [must be visited]*, nobody...* [visited him]
> Bruno: *We said goodbye many times, but...*
> Ferrari: *We tuned the TV on that show, on RAI 3*[7]*, Who saw him? Then, the same, that other one, his mate...* [they refer to another patient, whose destiny was linked to Rossi's one].
> [They laugh]
> Ferrari: *No, those two must be seen and...*
> Bruno: *be taken care of...*

Rossi and his 'mate' have been hospitalized a long time ago, the first one has been hospitalized for more than 50 days, the second for two weeks. Their clinical situation is in stall: doctors believe there is no possible chance of improvement of their condition that would allow greater therapeutic efforts and, at the same time, their survival is guaranteed by mechanical respirators compensating their respiratory insufficiency. Therefore, they depend completely on the ward's facilities. As a consequence of the absence of clinical perspectives, like the *weaning* from the respirator, and, in Rossi's case, the rehabilitation of the swallowing capability (compromised by the ictus that affected him), these patients are considered at the edge of the daily activities of the ward, both for the medical and the nursing staff.

[7] They are refering to an Italian television program which looks for missing people.

Conclusive remarks

If the operative effectiveness of the ICU, on the one hand, allows to provide the necessary support, for instance, in case of a surgical operation during general anesthesia, or in case of an acute traumatic or pathologic event, on the other hand, it runs the risk to become just an instrument to extend the suffering resulting from terminal diseases, as in the case of oncological pathologies, which are assuming connotations increasingly which are chronic-degenerative. The personnel evaluate, case by case, treatments' adequacy and the amount of resources that each patient requires. In the ward's working practices this leads to the definition of two typologies of bodies: *the exposed body* and *the invisible body*.

In the first category there are all those patients, which are numerically speaking the majority, who pass through the ward for a short period of time, require many resources in order to overcome a temporary acuteness so as to begin again their own therapeutic treatment in an other ward. These patients have to be constantly monitored because they often risk sudden and very compromising conditions. For this reason, life condition data and specific sets of information, according to the case, have to be immediately available. This is the only way to provide a response to a possible variation that will be quick enough so as to guarantee the survival of the patient. On the one hand, therefore, the body is exposed, nearly exhibited, so that it can be immediately accessible and available for any kind of treatment. What Svensson (2007) states about the anesthesiology is applicable to the working practices that shape this typology of body in ICU: [they] "are actively and prospectively engaged in reading and avoiding problems by implementing a situated and emergent organization of patient monitoring, using a wide range of technological and material resources" (p. 19). Berg e Browker (1997) have shown how such overlapping (alignment, coordination) between heterogeneous elements happen mainly through the transcription of data in the medical record, wherein a patient's trajectory is "geographically" and "historically" reassembled. The story of these bodies is very detailed, full of particulars and different perspectives stemming from various sources.

On the other hand, bodies of chronic and terminal patients tend to become invisible in the ward's working practices. In the management of the resources of the ICU, they slip back to moments of scarce activity, technologies applied next to their beds diminish and become routine as the personnel perceive the chronic path of the trajectory of the patient and goes away from it. These bodies do not require constant care any more, respirators are set up and for days there can be no variation in their settings, for the relative

conditions are considered stable. Even the medical record appears to be more silent as the checks become less frequent, the examinations arranged in a bigger space of time and medical advice vanishes.

When the trajectory in ICU cannot be concluded and the bodies don't improve despite the treatment, they tend to vanish in the formal and informal organization of the ward. These bodies are perceived as not requiring to be checked and at the same time the medical staff avoids their view, in order not to question continuously the therapeutic adequacy and the effectiveness of the treatment. Their "social death", that Sudnow (1967) described in his work as a set of practices that anticipate clinical and biological death, become more and more apparent.

In particular, it's well distinguishable how the perception of clinical relevance by physicians and nurses set up different types of organizational arrangement, to which the two models of body are related.

Accordingly, a further meaning of "clinical death" comes out: it's not only the instrumental recording of biological death, as it has been described by Sudnow; "clinical death" can acquire a new symbolic meaning when the personnel perceive that the recovery expectations are getting lower, until they disappear completely in the cases of patients with chronic pathologies. Sudnow's meaning of clinical death brings back to its "technical" definition, based on blood results, monitoring evidence and investigation, identified by Seymour (2000) as alternative to a "bodily" definition, based on sense perception and on clinical experience. From my analysis, "clinical death" is more related to the absence of evidence of improvements and to the perception the health care professionals have. "Social death" just follows as a consequence.

Even the Medicine, in spite of the exponential growth of knowledge and effectiveness of treatments witnessed in the last decades, experiences a border beyond which its know how and techniques can do very little in terms of therapeutic treatment aimed at the recovery of the patients. The organization and the working practices of the ward is a further attempt to stem such a sensation of ineffectiveness, together with the process to remove uncertainty in the medical practice, a process already started in the formative course of the sanitary staff (Fox, 2000).

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