While studies of triage in clinical medical literature tend to focus on the knowledge required to carry out sorting, this article details the spatial features of triage. It is based on participation observation of traffic-related injuries in a Mumbai hospital casualty ward. It pays close attention to movement, specifically to adjustments, which include moving bodies, changes in treatment priority, and interruptions in care. The article draws on several ethnographic cases of injury and its aftermath that gather and separate patients, kin, and bystanders, all while a triage medical authority is charged with sorting them out. I argue that attention must be paid to differences in movement, which can be overlooked if medical decision-making is taken to be a static verdict. The explanatory significance of this distinction between adjustment and adjudication is a more nuanced understanding of triage as an iterative, spatial process. [emergency medicine, triage, trauma, traffic, India]

Introduction

“Accidents happen,” Mr. Karve says to me in the hall outside the intensive care unit (ICU) of a municipal public hospital in Mumbai. It sounds distant, shell-shocked, even indifferent. Two hours ago, a car collided with the autorickshaw carrying Mr. Karve’s wife, their 10-year-old son, and the family’s bai (maid servant), a woman in her 20s named Usha. Usha is in the ICU. The wife and son are downstairs in the casualty ward, where I am conducting ongoing ethnographic research on the lived predicaments of traffic injuries. The wife and son are stable. Their bodies remained inside the rickshaw as it somersaulted across the road. They are injured, but not grievously so. The story is different for Usha. She flew out of the rickshaw on impact and hit the pavement headfirst. On her arrival to the casualty ward, it was clear that she needed resuscitation. That meant a shift elsewhere in the hospital. An orderly and an intern rolled her gurney outside into summer air, across the hospital courtyard, up a ramp into a different building, into an elevator, then down a corridor to the ICU. There, Usha lies unconscious with poor vitals and as-yet-unknown neurological damage. She requires an immediate computed tomographic (CT) scan, but the hospital does not have available CT working at this hour. Things came to an impasse, and only adjustments around it would open up Usha’s chances for recovery.
This article pays close attention to the transformations of triage in an urban Indian public hospital casualty ward. I argue that attention must be paid to adjustment—i.e., to differences in movement. This feature is otherwise overlooked in a focus only on adjudication—i.e., on differences in medical knowledge. The significance of this distinction is a more nuanced understanding of triage as an iterative, spatial process. Studies of triage in medical literature tend to focus on sorting, with optimal time and efficiency most at stake (Wiler et al. 2010). In conversations with the issue of sorting, yet also critical of it, critical scholars of science and medical anthropologists have discussed the epistemic stakes of differentiation, and how triage classifies the useful and the discardable (Bowker and Star 2000; Redfield 2013).

The ethnographic cases in this article evoke triage spatially, along with difficult decisions in moments of emergency. Sorting certainly happens, but it happens as a function of movements both arrested and unblocked. Decisions about medical practice in the ward proliferate: They move between medical authorities, patients, kin, and strangers. Often, there are multiple and even competing decision-makers. A freshly injured person might displace a previous one in terms of the center of attention, rebooting actions already in play. A patient’s relatives may jockey for some sort of resolution, opening up what may have seemed like a closed case. These adjustments between spaces of care and neglect, and between algorithms of order and disorder, require a rethinking of triage. That is this article’s central aim. Its attention to movement opens up questions of how life and death in hospitals reflect their spatial resources and constraints (Adams 2013; Ansell 2012; Livingston 2012; Lovell 2011; Street 2014). It highlights traffic as a socio–material movement that bleeds into the ward, spilling off the streets and into clinical spaces. It explores how traffic becomes a problem for medicine to solve.

Shifting Usha to the ICU was medically necessary. But that shift opened up space in the casualty ward for someone else. The bodies moving between beds are always interrelated. Ward staff half-jokingly, half-seriously, describe triage as the motion of a funnel (nasralla) that sluices patients through a crowd. Funneling is a relational practice that moves one injury in relation to another based on degrees of severity. This material metaphor calls forth the research of anthropologist Lorna Rhodes (1991), who conducted ethnography in a U.S. urban emergency psychiatric ward, which staff and patients also depict as a funnel. These appeals to movement led Rhodes to conclude that hospital staff and those they treat “experienced their relationships to [clinical] disposition as a movement among individually negotiated options” (1991, 41–42). As in that context, triage in Mumbai moves bodies through space to make decisions for care. Knowledge is part of the equation, but, like Rhodes, I found problems of movement thoroughly productive of what counts as emergency medicine and what counts as normalized and exceptional injuries of urban life. To make sense of how movement, obstruction, and medical knowledge interrelate, I pursue the shifts and adjustments that all those caught in the ward must make. This bundle of movements—traffic—is what triage both faces and produces.

Consider Usha’s shift from the casualty ward to the ICU, where the movement hits an impasse on the topic of the necessary-but-not-available-here CT scan. The doctors instruct Mr. Karve that Usha’s only option for CT lies in a private hospital several kilometers away. “Shift her,” they say to him. “Shift karo.” “Shift” here
means that Usha will go down the corridor from ICU, down the elevator, back outside, into an arranged ambulance, into the stop-and-go of Mumbai’s roads to survive. Doctors and nurses shared varying guesstimates of the time required to reach the private hospital for her CT. “Thirty minutes.” “An hour.” “If the driver knows good shortcuts, maybe forty-five.” Mr. Karve hears Usha’s treatment rendered as spasms through tangled urban infrastructures. He hears that a driver’s street smarts will determine her survival. He hears that traffic is inescapable, because for medicine to do its work, Usha must go back into the traffic from whence she came. He replies by invoking something that he feels will not budge: the obligations of patronage for families in India with domestic servants. “She is like a daughter to us,” Mr. Karve says, gesturing in her direction with a hand-wave that gathered her into the fold of domesticity that so often imprints the clinical worlds of India (Das 2015). “We know her (natal) family,” he said. “We will do anything, whatever it costs.” “Anything,” however, still had to face deadlocked traffic (see Lee 2015).

It takes motion to survive the injurious aftermath of motion. The Hindi imperative command to move a person or a thing, shift karo, captures the adjustments that follow. These might include how a person must be transferred from one area of the casualty ward to another part of the hospital; how physicians and nurses circulate and displace medical attention; and how kin animate caregiving because of limited hospital resources. These movements share several features with the complexities of vehicular movements in Mumbai that, when traffic goes morbidly awry, bring people to the casualty ward. In Mumbai, as in many megacities elsewhere, jammed roads inflect medical triage. In addition to the movements that comprise “traffic in the ward,” there is a related formation of traffic we might think of as “traffic in the world.” Traffic, then, is a fraught and moving boundary between world and ward in the context of traumatic injury.

I first detail the local context of the hospital ward and then explain the research methods employed. I then discuss concepts of triage to bridge the background and methods to two vignettes about traffic-related injuries. The first describes a motorcycle crash that injures two friends and brings them both into the ward. A decision to separate them spatially prioritizes treatment for one but causes great distress to the other. In this case, triage creates tensions that must be adjusted. The second vignette details how a bystander brings in a man injured by a bus. While the doctor in charge of the ward attempts to close the case, the bystander pries matters open again, dissatisfied with the man’s treatment. In both, triage distributes, adjudication rarely ceases, and adjustments sustain the ongoing operations of triage.

Research Context and Methods

Casualty Care in Mumbai

The traffic of cases in the municipal casualty ward is made up of kin relations, formal and informal. When a patient’s relatives are present, the traffic between spaces of home and clinic can be rescripted. Makeshift or fictive kin relations can emerge in the ward among iconic community figures such as police, extended kin, friends, and neighbors. These figures by no means stand in equal states of authority. Police have vested forms of power. Among relatives, mothers and elder siblings can
exert enormous influence, often reminding nurses that the IV drip is finished or that their charge is still waiting. Such advocacy is its own demand for motion.

Among ward staff, kin categories structure names and hierarchies of power. Male orderlies [“ward boys”] are called “mama” (elder maternal uncle); female sweepers (janitors) are called “maushi” (maternal aunt); female nurses are called “sister,” and male nurses “brother” (a colonial holdover). With the rotation of interns in the ward, often for only 12 weeks, names of these young doctors are always fleeting. The nursing and cleaning staff often simply refer to them as “intern.” The phone in the ward constantly rings, either at the desk of the casualty medical officer (CMO) or the nurse’s desk. Kin monikers are shouted to inform the correct person of the caller’s request (often a specialist physician responding to a case inquiry). Other sounds punctuate the room. For instance, there is a call buzzer that echoes throughout the ward and its surrounding area when a button is pressed on the wall: one buzz to summon the orderly; two for the sweeper; three for a “dresser” (an orderly who does bandaging, suturing, and plaster cast work); and four for a “barber” (an orderly with expertise in shaving the skin with a straight razor, especially necessary in the case of head injuries). This sonic interruption is a necessary feature of triage work. Referral and transfer cannot happen without it; communicative traffic directs a bodily traffic. Still, when they face the CMO, patients face an official sign on the wall demanding silence (shaantitaa).

These scenes unfold in a public hospital facility that is part of Mumbai’s municipal health care system. The system is funded by the Brihanmumbai Mahanagar Palika, the city’s governing body better known as the “BMC” for its earlier name as the Bombay Municipal Corporation. The BMC is the official apparatus of urban governance in Mumbai. It is involved at some level in nearly every form of public resource allocation (including road maintenance, whose failings are often blamed for traffic accidents in the first place). Health care facilities such as hospitals operate at different levels of specialty under the BMC’s Public Health Department. A midsized secondary hospital like the one described in this article operates with a current budget of 554 million rupees (US$8.34 million). A more specialized tertiary public hospital, by contrast, can operate with a budget of nearly 3 billion rupees (US$45.2 million).

Mumbai is both famous and infamous for its gridlock traffic. Intense vehicle-to-vehicle collisions are low because of slower speeds, but the number of vehicles colliding with pedestrians and motorcycles is very high. Consequently, injuries are the primary cause of death for the 15–24 age group among men in India (Mock et al. 1998; Roy et al. 2010, 2011). Traffic as gridlock relates directly to traffic as movement. Clogged streets compel many residents to take the aboveground train system, which offers faster transit times but at considerable bodily risk.

Mumbai’s municipal and suburban railway system is among the busiest globally, carrying 7.6 million passengers daily (Mumbai Railway Vikas Corporation Limited 2013). The rail line moves life through the island city and folds Mumbai into India’s broader history of colonial and postcolonial development through trains (Bear 2007). But with nearly 10 people dying each day as a result of train-related injuries and the collateral damage to bodies and families from road accidents, city residents regularly observe that one must move to live, but at mortal risk. Despite such intimate bodily connections, however, the relation between transport infrastructures
and bodies remain underexplored, in India and elsewhere (Steinberg 2012, 2013). Government (i.e., public) hospitals, where injuries of infrastructure often arrive, are an ideal site to examine how movements constitute what it takes to survive in the tenuous passages between world and ward.

Research Design and Methods

The project’s research methods draw from those detailed by Kaufman (2005), Livingston (2012), and Mulla (2014), in which the anthropologist follows one ward and may follow cases in and out of the hospital into homes and neighborhoods. My research in the ward is governed by two ethics board clearances: one from my own university, and one from the IRB of the hospital itself. Note-taking based on participant observation occurred in small moments, in corners (sometimes the only place available for me to stand, as chairs were limited). I use direct quotes for any speech I was able to write down in my field notebook as an exact, direct quotation; otherwise, I treat verbal interchanges as accurately as possible.

Over six months in 2015, and two months in 2016, I conducted participant observation during different hospital shifts (morning, afternoon, and overnight) to understand different rhythms of the ward as well as to ensure repeated, representative interactions with the ward’s staff. I regarded my own position in the ward as an enactor of small gestures: I untangled IV lines, closed doors, directed patients and relatives to varying destinations in the ward and hospital, and dispatched paper. Individual interviews conducted outside of a given shift were tape-recorded when possible, transcribed by me and by a research assistant, and analyzed for emergent concepts and connective themes as the corpus of data grew. Broader context about the municipal hospital system came from analyzing city newspaper coverage of health care, transit and traffic politics, and reporting on specific accidents. This was done using database software set to search Marathi, Hindi, and English news sources. Semi-structured interviews in Hindi, Marathi, and English elicited data on a staff member’s own educational and work experiences, memories of the first day in the ward as well as subsequent, notable/memorable cases, opinions on the ward’s functions and on more generalized opinions about the social aspects of casualty care in the city.

I was able to follow up on patients admitted to the hospital by accompanying doctors on their regular rounds. However, my primary study setting was the ward itself, and it is this space that grounds the data presented in this article. When I make a claim about the world–ward bleed of traffic, I am doing so from the consensus of patients, their kin, and the hospital staff that everyone must chug through traffic to reach the hospital in the first place, whether for work or for treatment. Then, they must navigate or be steered in and out of the ward, depending on one’s position. This social fact was the starting point of my methods, and thus attuned them to matters of adjustment to traffic.

Moving into Triage

Usha’s predicament is one of many similar cases that can arrive to the casualty ward at roughly the same time. One displaces the next, just as cars and rickshaws and
motorcycles and trucks jockey for space on the road. Movements layer on movements, like paint cast on a canvas already filled with brush strokes of many different colors and textures. Let us return to the scene of the casualty ward, moments before Mr. Karve’s wife, child, and maid Usha arrived. The room’s 12-foot by 15-foot area was filled with people. Hospital staff describe the ward in this crowded state using the Hindi term *garam*, meaning hot. The ward is either garam or not, and on that night, it was very hot. The cases filling the room edified the hospital’s admission statistics, which record an average volume of 500 visits per day to the casualty ward.

Larger public hospitals in Mumbai may have volumes of 1,000 daily casualty visits. To offer a contrast, a study of U.S. emergency rooms estimates that metropolitan hospitals have an average daily visit volume of 93.4 visits, with the average across the sample being 67.6 visits (Burt and McCaig 2006). This problem of overcrowding is a constant refrain among the ward’s staff, who work in overlapping eight-hour shifts. The staff consists of one casualty medical officer in charge (the CMO); occasionally interns just out of medical school; four nurses; a few orderlies; a security guard; and several police stationed outside the hospital who may enter the ward. It is the security guard who is ostensibly charged with crowd management. In moments of tension, the guard or the police or the CMO herself may order everyone into a single line (*line lagao* or *eki line karo*). Further riffs entail commanding the crowd that only one relative per patient is allowed in line and all others must go outside (*Baki log bahar chelo*), or that those in line should not cut in front of each other (*Beech beech me mat ke jao*).

Urban Indian casualty wards perform a combination of acute, emergency care alongside primary care, as is often the case in emergency rooms globally. The night Usha arrived, an asthmatic man received a nebulizer treatment on a machine whose roars forced doctors and nurses to shout. A baby with dull skin and slow breathing received an IV of dextrose solution as her mother held the tube carefully so the flow rate stayed constant. The casualty ward is a place of passage for a spectrum of injury, bridging the acuteness of trauma with the possibilities of chronic morbidity. Trauma in this context conveys the term’s surgical meaning: a blunt or penetrating wound that is immediately life threatening. The word trauma is used in the local operating languages of the ward to classify this kind of injury, not to refer to the broader, psychic domain of trauma that anthropologists have elaborated at length (Fassin and Rechtman 2009; James 2010). This semantic valence of trauma is notable because technically speaking, traumatic injury already has motion built in because it takes movement to inflect a trauma on the body. At times, the injured are not obvious. Tight clusters of patients and their family members entail a common question from medical staff: “Who is the patient?” (*kaun hai patient?*).

Other cases that night typified the ward’s usual roster. A teenager arrived following a motorcycle accident, bleeding profusely from his cheeks and mouth and legs. He cried repeatedly to the friend who dragged him in, “My face is ruined!” (*Mera chehra kharab hai!*). A man I later learned was the teenager’s older brother arrived a few minutes later, cursed him for crashing the motorcycle that would be expensive to repair, and before storming out, folded 1,000 rupees (~US$20) into the teen’s hand to help pay for any medicines not offered for free by the hospital. Tenderness, obligation, and castigation often knot together. “These relatives can become very violent,” a nurse said to me of the complex family dramas that unfold.
around injuries to persons and property. At this moment, Usha, Mr. Karve’s wife, and the child entered the ward. The CMO caught a glimpse of the trio through the webs of emptiness in between queued bodies that had shifted a bit.

Over the whir of the nebulizer, the CMO yelled to the orderlies and nurses to take Usha in the back area, next to the teen, out of the throng of the people in the combined entryway/queue/treatment/waiting area. The teen from the motorcycle accident turned to look at Usha, as she lay bleeding and unconscious. His yelps about his broken face ceased momentarily as orderlies shoved his trolley aside to make space for Usha. To even begin triage, space must be created, for it is certainly not given. To make space for one person often requires taking it away from another. A single movement can create different demands on multiple people.

The brief vignettes above begin to depict how people face the ward’s constant displacements. A conventional notion of triage would highlight matters of adjudication: Who goes where, for what treatment, in what order, and with what kind of urgency based on diagnosed need. Trauma care appears to be a matter of doctors sorting the injured in relative, ordinal positions. This conventional understanding of triage derives in part from a sense of battlefield medicine, where pile-sorting bodies into degrees of salvageability has, over time and across wars, become emergency medicine’s operational logic and rationale. But to emphasize the piles themselves at the expense of the work of heaping bodies would be inadequate. In a framework of pure adjudication, the casualty ward can appear like a place where a centralized power (enacted by an in-charge physician) confronts disorder, sorts it according to certain criteria (like injury severity and available resources), and sends people and bodies on different trajectories for care. This is akin to understanding the casualty ward like a busy street intersection, but from a standpoint that while attentive to space nonetheless privileges sovereign logistics more about destination than about the movements required to reach the destination. A traffic officer signals stop-and-go, the vehicles comply, and each individual car proceeds along its directed path toward a desired endpoint. However, this is simply not how traffic in Mumbai works, on the streets or in the hospital. People constantly jockey for space. They displace each other, in real-time motion, and must adjust. Transpositions enact tactics. Sudden moves shortcut authority.

To describe these movements, subtle and gross, sometimes requires slowing down the narrative pace of emergencies. This can help pinpoint how bodies are differentially exposed to injury and care. Only then can we apprehend that “accidents and injuries are social facts” and that motion underwrites the ways that “bodies are built into both social and technological systems” such as transport infrastructures (Jain 2013, 37, 171). Through adjustments, one can also understand the trajectories of blame in the aftermath of a collision, whereby, as Lamont (2012) explains: “It is clear which mobilities are king” because drivers or victims absorb claims of negligence. Lamont also notes that vehicles “are almost always exonerated and considered inert, speechless witnesses to crime” (2012, 182). It is persons and bodies that must adjust to the accident. Whether the accident is really a matter of misfortune or something more calculable is beyond the scope of my analysis here (see Jain 2004, 2006). However, it is crucial to note that adjustments concern the ways that motions before, during, and after a collision are stratified, meaning that who and what must adjust rarely sit on even footing of power and authority.
Conversations about the need for medical anthropologists to take up motion and movement as important analytics have appeared in varying contexts. In an inpatient ward in North India, for instance, Sarah Pinto examines the “choreography” of patients as they wander, iterant both physically in the ward but also in narratives that shift genres between personal accounts, dreams, films, and clinical notes (Pinto 2013, 2014, 2015). Another appeal to study movement appears in ethnographies of post-combat soldiers in the United States. This literature offers painful reminders that the lives people endure during and after an emergency are bound up in movements: of limbs, real and artificial; of labile diagnostic categories such as PTSD; and of the ebb and flow of caregiving of the injured by medical staff, colleagues, kin, friends, and strangers (MacLeish 2013; Messinger 2009, 2010; Wool 2013; Wool and Messinger 2012). Though my own research is rooted in a different place (a casualty ward in Mumbai) and in a different analytic frame (how moving through a city is deadly even as it is necessary to live), I share with these scholars an interest in how movements constitute the lived dilemmas of trauma, and how that which moves around and through an unresolved wound can easily flicker between the concrete and illusory.

The use of triage in clinical medical contexts has its own history (Edwards 2009; Iserson and Moskop 2007; Moskop and Iserson 2007; O’Meara et al. 2007). In clinical contexts, triage relies on the translated force of several semantic variants of its French derivation, among them “sorting out” or “marshaling.” Triage in medical anthropology, by contrast, has generally not been a descriptor of emergency room settings, as is the case in clinical literature. Further, ethnographic engagements with the term have triaged it, so to speak: The most prominent uses have relied on the word’s semantic property of sorting to understand practices of governance by states, non-governmental organizations, clinics, and families. For instance, Nguyen (2010, 109) defines triage as a practice “selecting those who would receive the treatments and those who would not” in the case of antiretroviral treatment programs in Côte d’Ivoire. Nguyen elaborates how triage became the operational logic of HIV treatment programs: “Triage thus linked procedures for selecting people, the ways in which people seek to transform themselves, practices of ‘telling’ the truth about the self, and the paradoxical affirmation of citizenship” (p. 109).

This rendering of triage as a mode of biological citizenship (Petryna 2002) also resonates in Biehl’s monograph Vita, in which he casts the institution Vita as “a local triage state” (Biehl 2013, 69). Triage pervades familial relations to the no-longer-useful, sick members of a family, in Biehl’s account. Like Nguyen, Biehl allows triage to stretch across institutional and individual experiences of illness and abandonment, as families reach their limits of providing care and transfer sick persons to para-state entities like NGOs and charity programs. As Clara Han points out, however, “triage is not all or nothing,” meaning that even in these optics of sorting, triage cannot be understood as a clear-cut or complete decision-making apparatus (Han 2012, 240). In the casualty ward I describe, triage and sovereignty move in and out of synch. The bearer of medical authority (such as the physician in charge of the ward) may decide to focus resources and power on one case, only to find her decisions subject to revision and realized through movement.

Triage may seem to act on one body in one moment, but often, persons linked to that body find their way into the picture, at the edges of life and death and sometimes after death has taken hold. For example, in contexts of mortality from
Ebola in Sierra Leone, Abramowitz and colleagues found that for a person who has contracted Ebola, it is the relatives and community members who do triage work and insist on the importance of this work (Abramowitz et al. 2015). As individuals are culled from families in epidemic outbreaks, triage’s movements extend well beyond the individual. Kin persist in the imagination of a body that lies dead in the arms of failed public health care efforts. It is important here to reiterate that body or person and family are often in complex sociopolitical hierarchical arrangements. This is acutely clear in hospital settings. For instance, Julie Livingston and Alice Street both point out how variables like social class and ethnicity hardly disappear upon hospital entry (Livingston 2012; Street 2014).

Stacey Langwick (2008) demonstrates that the practice of medicine itself unfolds at the threshold of a hospital, because patients may seek healing practices at its margins. Such dynamics lead hospital ethnographers to question what precisely counts as “the field” inside a hospital and what its relation to worlds outside a hospital building’s walls may be (Long et al. 2008; van der Geest and Finkler 2004; Wind 2008). Van der Geest and Finkler, for example, remark that “extant studies of hospital life suggest that is a world apart, a culture which is altogether different from the ‘real’ world or even a reversal of normal life” (2004, 1998). While that may be so in some cases, traffic and its injuries do not fully respect such exceptional spatial claims. To demonstrate this, I add to the insights of hospital ethnographers a focus on movement.

Adjustment and Adjudication: Ethnographic Examples

Making Space: Triage as Displacement

On a warm April evening, the ward was comparatively empty of critical cases. Aches and pains and a few pediatric fevers filled the queue. Suddenly, a man in his early 20s appeared in the entryway, asking for a trolley. A few minutes later, a trolley was wheeled in, holding a young man with an open knee wound. His name was Varun. Another man of a similar age, named Gautam, hobbled in a few moments later. The CMO on duty, Dr. Datta, phoned the orthopedic surgery residents to come to the ward at once. They arrived shortly, followed by the surgery resident, Dr. Diya. A rickshaw had entered the wrong lane on the road. Gautam and Varun were on a motorbike in that lane (the correct one for them) and swerved to avoid a collision. Their bike hit a concrete road divider, and Gautam (driver) and Varun (passenger) hit the road.

Gautam was laying on a bed by the door, with a laceration on his hand but otherwise alright. Varun was a different story. His left leg was a throbbing mess; his patella, femur, and tibia were fractured. The two ortho residents, Dr. Raj and Dr. Mohit, had their hands inside the torn-open skin of his lower leg. Dr. Raj washed muscle, tendon, and bone with isotonic saline, and Dr. Mohit snipped bits of torn flesh and picked out bits of asphalt as the sluice of saline clarified both Varun’s knee and Dr. Mohit’s visual field. Varun kept raising his head to watch the two residents move their hands inside his open leg. “It’s ruptured, isn’t it?” (toot gaya) he repeatedly asked. “No, no,” the residents repeated as they continued their work. Small consolation. Gautam and Varun worked together; their colleagues and
boss arrived. Varun yelled across the room to them: “Call my Mom (Mummy-ko bulao).” He had received a dose of tramadol for pain when he first arrived, but it was always a guess as to a patient’s intensity of pain. He moaned, a moan that climbed in pitch and volume anytime he looked down to his knee. “Just make me unconscious, please, and then do what you want,” he pleaded. He quietly wailed over and over, “Make me unconscious!” (Unconscious karo!). It was fine with him that certain substances interrupted his body’s regular state—painkillers, antibiotics, hydrating IV fluids, saline for taking the road out of flesh. But he wanted a total shift from the scene. Varun’s yelps quieted as the tramadol took effect.

Varun’s coworkers beckoned me over to the bed where Gautam lay, agitated. Over the ward’s noises, his boss spoke in my ear: “Please cool him down.” I was unsure if he meant bodily or otherwise. He repeated: “Cool that boy down,” and gestured to Gautam’s head. Gautam was breathless and panicking. He repeated over and over, “Varun’s ok, right? Is he ok?” I bent down, level with his bed. His line of sight did not include Varun. He continued crying. He worried that Varun would never be able to walk again, or that the injury was mortal and Varun was dying in the back room. “It’s nothing, really? Really?” he asked me again. I said, “Listen, people come in here all the time after a bike crashes. They don’t know their name. They can’t talk. Varun knows his name. He knew to call his mummy. He said, ‘Mummy-ko bulao.’” Gautam nodded. Small consolation.

Two police officers arrived to take Gautam’s statement. A motor vehicle accident is considered a medico–legal case according to the law. A statement (jawaab) written in Marathi is required of all parties involved. Police do a form of triage of their own. First, the doctors, then the coworkers, and now the police asked Gautam to reconstruct the accident, to imagine himself at the moment of collision. In Usha’s case, her body had to go back into traffic for medical imaging; in Gautam’s case, the law demanded he displace himself back in traffic, back in time, to find out the facets of injury most germane to police work on the case. One police officer wrote down the narrative. The other sketched the crash, with arrows representing vectors of skidding and impact, circles and squares representing motorcycle and rickshaw, and Xs representing Varun and Gautam’s bodies. Displacements had to be recalled and reported for the official record. Regulators of the road easily move into the clinic, because movements make evidence in both domains. And after the crash, movements still create tensions that must be adjusted. Gautam and Varun are together on the bike. The crash sends them flying apart. They are rejoined in the ward. But then, with Gautam in the front and Varun in the back, they are sundered. Gautam’s inability to see Varun—the result of a spatial adjustment—was the source of his panic and his vision that the next place Varun would go would be the morgue.

Moving paper de-dramatized and slowed things down, as is often the case with bureaucratic work. At the nurse’s desk, Varun’s case notes piled up with three residents writing. Dr. Diya was exhausted. She had been on call for a full day, and, as she gathered a fresh sheet of paper for a continuation of Varun’s notes, she told me her own notes in the hospital inpatient surgery ward were piling up. Attending to Varun meant that she was not attending to patients assigned to her there. Triage moved staff, staff moved papers, and both were in economies of relative motion: more movement for some came at the expense of less for others. As the drugs took hold, Varun became more restful but then became agitated when his mother
and uncle arrived, accompanied by the orthopedic resident Dr. Raj. Caressing his head, his mother scolded him for being careless with driving. “Don’t get worried” (mat cinta karo), Dr. Raj said to her in a tone that combined respect for an elder woman but also a firm instruction: Her burst of emotion might stress Varun. “It will increase his tension,” Dr. Raj explained. Varun’s mother took a breath and set about cleaning: “Give me more of this,” she ordered me, pointing to a white puff of surgical gauze. I handed it over. She wiped Varun’s face of blood and tears.

In Varun and Gautam’s case, one form of movement (a motorbike crash) impelled numerous others (movements of family, friends, drugs, hands, police investigations, memories, imaginations of different endings). In the end, triage took hold across several parties. But triage does not always stick, as the next section illustrates. Sometimes, what seems like a closed case can be pried right back open.

**Impasse: Making the Adjudicator Adjust**

On a weekday evening, I sat at the desk for nurses during a moment of relative downtime. They caught up on paperwork or text messaged family members on issues ranging from child care to food shopping to mobile phone updates on railway timing. It was a relatively “cool” time in the ward, with just coughs and冷s and fevers, IVs to place, injections to give. Amid this downtime, the rhythm changed. An old man entered the ward. He was propped up by two men in their 20s. A smartly dressed woman clutching a Blackberry phone followed them. The man’s shirt was bloody and he had a handkerchief applied to the back of his head.

The woman, Padma, was uninjured. She marched past the queue. This was rather unprecedented. There was a tacit understanding among those in the line that a parent rushing in with an infant in his arms needed to go to the front of the line, as did anyone gasping for breath or with an apparent cardiac arrest. Traffic in the ward could make space for exceptional bodies. But otherwise the doctor moved someone to the front of the line. Yet, Padma still approached the desk of the CMO, Dr. Tambe, with the intent to do some adjustments of her own design. She explained that the older man fell from a moving bus, and was bleeding from the back of his head. The two young men were bystanders. She was on the way to see a film with her mother when she too witnessed the accident. She conscripted the two young men to grab the older man. They were four blocks from the hospital when this occurred. The two young men acted as a vehicle, supporting the injured man, collectively limping toward the hospital instead of pursuing the impossible task of hailing a rickshaw and then creeping inch by inch to the casualty ward in rush hour traffic. It was simply faster to limp than to venture in a vehicle.

Dr. Tambe examined the old man. The man’s head had a shaven circle in the back. This was a telltale sign of the work of the ward’s barbers. Dr. Tambe took a quick glance and returned to his desk. He informed Padma that the man must have already been in the ward earlier in the afternoon. He came in, moved through, moved out, and was back again (vapas aa gaya hai). The nurses and the orderlies confirmed this. The man was drunk earlier, they said, but they still bandaged his wound. Someone muttered: “He’s probably still drunk now.” The injury couldn’t have been caused by the fall from the bus, Dr. Tambe said. At least, not the fall that
Padma witnessed. Maybe an earlier one. People in the queue became agitated. Their shuffling in place intensified. Padma seemed to ignore this. She spoke in English to the doctor, a signal of higher social class in a space that otherwise is almost entirely Marathi- and Hindi-speaking. Dr. Tambe succinctly addressed her protests and said: “This man is an alcoholic.” Padma raised her voice: “He is also a human being. And he’s bleeding. What this man needs is medical attention.” To withhold movement was to neglect humanity and inflict medical negligence.

Dr. Tambe sighed and said that Padma would need to prepare an admission paper to (re-)start things. Padma did so and returned; the line had chugged onward. She held out the admission paper. Taking it, Dr. Tambe wondered if the old man possibly passed out due to blood sugar fluctuations from alcohol intake. They would test his blood glucose, Dr. Tambe decided. But there were no test strips in the ward. He instructed Padma that she must buy it from the pharmacy across the street. She dispatched one of the two young men to do so. Orders bounced.

Dr. Tambe and the staff adjudicated the man’s situation. They sutured his scalp, he is an alcoholic, case closed. But Padma did not accept this. She demanded that they adjust. Dr. Tambe reluctantly went along with this, but not without throwing some roadblocks in the path such that Padma had to fill out paperwork and buy a glucose test strip. Still wielding the power of her class and age position, Padma simply offloaded the tasks onto the two young men. “These doctors,” she said to me, sighing. “They’re going to give that man the runaround.” From her perspective, all the movements of the ward would add up to nothing for the man’s sake. But things did shift. An intern kneeled by the old man’s side for the blood glucose test. I spoke with the two young men who came in with Padma. They had been on the street, ready to jump onto the moving bus as it approached the bus stop—the required motion in order to get home during rush hour—when Padma called out for their help. “Why did you stop?” I asked. They explained that the man seemed alone, with no family, and therefore no one to move him. There is no guarantee that one can move alone.

The old man had not and would not yet tell his name. Padma asked him for a mobile phone number of a relative. He haltingly offered a string of numerals. One of the young men wrote each one down, until a proper 10-digit mobile phone number was reached. He took his own phone out and called the number. The person answering it had no idea what the young man was inquiring about; it was a wrong number (galat). They were back to square one. Padma said to the injured man that she wanted to help him. The old man looked at Padma. “Who are you, anyway?” he asked. She repeated that she was a helper. This had no effect. She tried a different approach. “I’m your elder sister (didi),” she said to him. He paused.

“Are you married?” Padma sighed. “Yes,” she told him. “I’m married.” The man was silent for a moment. “You don’t look elder to me,” he observed. “I don’t look that old, but I’m elder. Can you tell us your phone number?” He considered that. And then: “Why did the police hit me?” “Police?” “Well . . . why do police hit people? If they commit a crime, for example, or—”
“—No,” he interrupted her. “They beat up the poor.”
“Did the police hit you? (Police ne mara?)” she asked. He didn’t respond.

At this moment, six people wheeled in a trolley, carrying in a convulsing teenager. The friends who brought him in reported that he drank phenyl, in a suicide attempt. Dr. Tambe strode towards the trolley. “Love matter,” the two young men accompanying Padma whispered to me—an English-derived Hindi term to suggest suicide out of a broken heart. An intern wrapped a blood pressure cuff on one arm of the teen and clamped a pulse oximeter on his fingertip. An orderly dragged an oxygen tank over. Dr. Tambe turned his attention to the teen on the trolley, with his back to the old man and Padma, brushing up next to them because the trolley could barely fit into the door on account of the crowd. Padma, still with no luck moving past the impasse of learning more about her charge, took it on herself to direct traffic. She yelled at the teens that they must fill out the proper admission papers if they wanted good care for their friend. She scolded them that they were wasting precious time by not moving (aap log time-waste karte karte hain). Here, the problems of no movement constituted triage as much as problems of excessive movement. Padma, who found herself stuck on the cot waiting, angled things in a new direction, toward the newest addition to the ward lying on the trolley. She moved the old man into the room for immediate care, but even after medicine declared itself done, things were at an impasse. Where would the man move next? She, like others in the room, would triage the triaged.

Discussion

In this article, I have argued for closer attention to the adjustments that triage demands. Multiple and at times competing forces move a body in the aftermath of an injury. In scenes of triage, care is fractured and distributed. Kin, police, and even perfect strangers attach themselves to a case and nudge it in both expected and unexpected directions. All the while, the work of the casualty medical officer proceeds apace, continually interrupted and readjusted. And all the while, the patients themselves in the ward are readjusted, whether that entails movement to a different place entirely (as in Usha’s example) or just a few feet away (as in Gautam’s example). Across these cases, movement is key. Its inflection as triage is an inflection of traffic between world and ward.

The case of Varun and Gautam illustrates the ways that the sovereign, centralized power of the person in charge of triage—the CMO—is in actuality quite fractured. However, as the case of the old man with Padma shows, a concluding note of fracture or dispersal is not really the end of the story. Rather, we see that the adjudicator (the CMO) must adjust, as Padma repeatedly impels him to do. Further, sometimes adjustments don’t add up to a resolution, and an impasse reemerges. The force of social class, in Padma’s case, calls into question the very model of centralized medical adjudication as a way of knowing and doing triage work. Adjudication as a binding way of decision-making fails to describe the contingencies of the ward, both frozen and fleeting. This article has posed adjustment as an alternative framework to understand how movement and triage mutually constitute each other.
Across both adjudication and adjustment, patients, families, and hospital staff constantly face problems of movement. Medicine must address moving damages wrought by mortal body–city displacements, such as a road accident. While often understood as a matter of infrastructure and logistics for vehicles, I have demonstrated that traffic also has a somatic dimension that moves through hospital walls and doors. Bodies shift from roads to the hospital and then shift inside and back out again, all in relative motion even after a crash brings things (momentarily) to a halt.

Notes

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1. All names used are pseudonyms.
2. My use of “impasse” here refers to scenes that can feel unmoving, yet are also built around physiologically dynamic injuries. Feeling stuck and bleeding out happen simultaneously. The line to see the doctor may be at a standstill, but those waiting (injured and relatives both) register blood pressure changes. A person may lie on a cot, reporting the indignity of being ignored, yet the IV in his arm changes his hemodynamics. In a broad sense, at a deadlock are ways of knowing the clinical as a matter of both the senses and biology. For different applications of the impasse, see, for example, Berlant (2011) and Pandolfo (1997).

References Cited


