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Stable condition: Traumatic injury, coma, and vital traffic in a Mumbai hospital ward

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Abstract

Based on five years of research in a public-hospital trauma ward in Mumbai, this article examines the fraught case study of comatose states that result from traffic-accident injuries. It focuses on a relationship between two brothers, one injured in a motorcycle accident and in a coma, and the other caring for him. The article asks: How do people navigate life-and-death situations through both stillness and motion? Addressing this question requires recasting traumatic injury from a wound that lodges in a single body to an intersubjective problem of discontinuous and relational traffic. In moments of transfer to the hospital, prognosis about vital signs, and reflections on death, the embodiment of and care for traumatic injury materializes through uneven relationships of intermittent motion. The article develops the analytic of *vital traffic* to describe these relationships and analyzes the temporal and spatial discontinuities that shape and undermine stability after injury occurs. Differences in vital traffic matter to patients, families, providers, and to the very possibility of survival. The implication of this finding is a better understanding of the sociality of injury and its care. Beyond the case of medicine, attention to vital traffic can illuminate the flux of ethnography itself.

KEYWORDS
coma, injury, hospital, medical anthropology, movement, traffic, trauma, India

Resumen

Basado en cinco años de investigación en una sala de trauma de un hospital público en Mumbai, este artículo examina un estudio de caso difícil de estado comatoso que resultó de las lesiones de un accidente de tránsito. Se enfoca en una relación entre dos hermanos, uno lesionado en un accidente de motocicleta y en coma, y el otro cuidando de él. El artículo pregunta: ¿Cómo las personas se mueven en situaciones de vida y muerte a través de la quietud y el movimiento? Abordar esta pregunta requiere remodelar la lesión traumática de una herida que está en un sólo cuerpo a un problema intersubjetivo de tráfico discontinuo y relacional. En momentos de traslado al hospital, pronóstico de los signos vitales, y reflexiones sobre la muerte, la corporeidad y el cuidado de la lesión traumática se materializan a través de relaciones desiguales de movimiento intermitente. El artículo desarrolla el análisis del *tráfico vital* para describir estas relaciones y analiza las discontinuidades temporales y espaciales que determinan

y socavan la estabilidad después que la lesión ocurre. Las diferencias en el tráfico vital importan a los pacientes, las familias, los proveedores de servicios, y a la posibilidad misma de supervivencia. La implicación de este hallazgo es un mejor entendimiento de la socialización de la lesión y su cuidado. Más allá del caso de la medicina, la atención al tráfico vital puede iluminar el flujo de la etnografía en sí misma.[coma, lesión, hospital, antropología médica, movimiento, tráfico, trauma, India]

Stasis is a deep wound in the body of the city.

—Loraux (2002, 24)

INTRODUCTION

"He's in a very deep coma," Maanav observes about his brother, Abhi. Abhi is the last of all the intensive care unit's (ICU) patients to be transferred down the hall. "Is my brother the last to go?" he asks the nurse. She nods. Abhi's condition is the most severe in the unit.

Abhi has extensive brain trauma from a motorcycle accident. He rode pillion without a helmet, and his head hit the pavement when the motorcycle crashed. He lies in the ICU of the trauma ward at Mumbai's largest municipal public hospital, at a medical center I call Central Hospital. Central's trauma ward cares specifically for traffic accidents, such as road and railway injuries, and in this ward, "trauma" refers to the term's surgical definition of a blunt or penetrating wound that is immediately life-threatening. From 2015 to 2020, I carried out ethnographic research on the social dimensions of injury from traffic accidents at Central (Solomon 2022). I followed cases through their entry into the emergency room, into Central's dedicated trauma ward, and through periods of surgery, ICU stays, discharge for some, and death for others. Traumatic brain injuries (TBIs) such as Abhi's are common, and they frequently generate comatose states in patients.

Injuries, as well as comatose states that may follow, are relational. They distribute among family members and healthcare workers. As Maanav stands by Abhi's bed, he asks for updates from ward staff. Today, the ward will shift from a temporary space back to its original location, which has undergone months of renovation. Some of the workers are excited to return to this supposedly improved space; others feel too distracted as they transfer the materials and bodies of an entire unit. The nurses pile paperwork for keeping and tossing. An orderly stacks colored buckets for bodily fluid collection, a rainbow of biohazards. Abhi's transfer commences. An anesthesiology resident disconnects Abhi from the ventilator and squeezes an Ambu-bag, a handheld device that can manually oxygenate a patient. The orderly pushes Abhi's gurney slowly enough for the doctor to squeeze while walking and supporting Abhi's breathing, all while navigating around diagnostic equipment. The travel distance is a single hallway. But even in that short distance, Abhi's care involves a necessary but precarious flux of stability, concretized through speedups and slowdowns across time and space.

In this article, I address intermittent and uneven relationships of movement involved in trauma care. I turn to comatose states as a case study. I examine how these relationships connect patients, their relatives, healthcare providers, and the ethnographer. I use the term *vital traffic* to describe this set of relations. Vital traffic entails temporal and spatial discontinuities that shape survival after injury occurs. Quests for stability become complicated by an injured body's volatility, and in turn, medically necessary bodily movements must be conducted in ways that do not further already-existing harms. All of these motions and decisions about motion are relational: they extend beyond one patient's body. The concept of vital traffic, then, can help illuminate the unstable and moving yet necessary relationships to trauma that make its care possible.

I am guided by Maanav's twinned observation and question: Abhi lies fixed in a comatose state ("He's in a very deep coma"), and yet Abhi also must be moved ("Is my brother the last to go?"). Maanav is drawing attention to an uncertain but crucial cooccurrence of stasis and kinesis. His observations of Abhi's dilemma inform the questions at the heart of this article: How do you move someone to keep them alive, even as moving them can also be lethal? And at the same time, what does it take to achieve stability, when it is so difficult to attain? To address this double bind, I make two related claims. First, traumatic injuries—and the comatose states that such injuries can generate—constitute dilemmas of discontinuous and relational movements that I describe as "traffic." Second, traffic is intersubjective because traumatic injury may lodge in a single body, but it often operates relationally. Together, these claims create an analysis of trauma as traffic, one that can illuminate the ways that trauma patients get accelerated and decelerated and how they may also appear to others around them to be in varied forms of movement and stasis. Injury's socialities, medicine's powers, and ethnography's potential to address both are matters of vital traffic in this light.

Central's trauma ward offers a generative case study to understand this vital traffic. Ambulances must deliver the injured to the hospital. Triage doctors in the emergency room move people in and out of lines of treatment priority. Machines get spun around and drugs drip into bodies lying in

beds. Families arrive, sit waiting, and shuffle in and out of the ward during visiting hours. Surgery on chest, brain, and limb trauma shifts patients' bodies into particular shapes to restore their mobility potentials. Patients who do not survive get shifted to the hospital's morgue; those who do are discharged back home. None of these shifts occur without friction or pause, even if they head in roughly the same direction. Trauma and trauma care emerge as discontinuous traffic, which pluralizes and animates injury.

Elsewhere, I have argued that traffic constitutes a social field, a process of embodiment, and a clinical infrastructure (Solomon 2022). Here, I focus on one aspect of this phenomenon: the problem of achieving stability in the face of coma, and how this problem organizes different forms of traffic. Coma is one of many possible sequelae of traumatic injury, but coma's often-elongated timeframe usefully illustrates the microdynamics of stillness and movement involved in vital traffic. In particular, coma following traumatic injury exemplifies how stability is an elusive yet critical balance point required for survival.

As a surgical specialty, trauma medicine requires hemodynamic stability before it makes major movement interventions on or to a body. A patient with low blood pressure may not be ready for surgery; a patient recovering from surgery may not be ready to be discharged from the ICU. Clinical decision-making operates in its own points and counterpoints, inroads and exit paths on which life or death might lie ahead. Care and the experience of clinical space entail speedups, slowdowns, recursive loops, and desires to shift out of bureaucratic regimes of waiting (Desjarlais, 1994; Hage, 2009). A binary framework opposing absolute flow to absolute stuckedness risks missing the intermediate power relations of this ongoing injured present (Berlant, 2011) and moving aftermath of injured life (Wool, 2015). A framework premised on the discontinuous differences of vital traffic may better address how stability and transition matter for survival.

I detail three connected aspects of vital traffic. Vital traffic is *structural*: movements and holds in the trauma ward derive from, echo, and recast the socioeconomic difference of urban Indian lifeworlds and the inequalities of public hospital medicine. Second, vital traffic is *relational*: due to the epidemiology of traumatic injury by which men are most affected, intersubjective relations between men (pairs of brothers, fathers and sons, and friends) can reveal trauma care's obligations and intimacies. Third, vital traffic is *narrative*: the forms of uncertain movement in the trauma ward are illustrative of a broader challenge for ethnographic inquiry, regardless of site or object of attention. Because lives are in motion, the words crafted to describe such lives must themselves remain open to flux. When stability is hard-won, what stories can be told about the moving interface between injury and care?

THE TRAFFIC OF TRAUMA

Injury is materially and socially generative precisely because it is structural, relational, and unequally distributed through medicine (Jain, 2006). Anthropologists have detailed how moving compromised bodies crystallizes medicine's powers (Kaufman, 2005; Pinto, 2014; Rhodes, 1991). Ethnographies of combat-veteran life describe stuttered movements of the injured by medical staff, colleagues, kin, friends, and strangers (MacLeish, 2013; Messinger, 2009; Wool, 2013). Debilitative and disabling movements can mark bodily differences and the unequal ability to make claims on those differences (Addlakha, 2018; Das and Addlakha, 2001; Kafer, 2019).

These conversations about the politics of restoring bodily motion connect to long-standing discussions in anthropology about traffic as a mode of exchange, kinship, gender, and political economy, such as Rubin's (2011) landmark work on how who moves and who gets moved can shape conditions of subjecthood and objecthood. In urban studies, traffic has been a site to better understand cities in terms of critical bottlenecks (Melly, 2017; Solomon, 2021), how unexpected relations can form at roadblocks (De Boeck and Baloji, 2016), and how traffic accidents crystallize state politics (Lamont, 2012). Traffic also concretizes connections between private vehicle ownership, corporate manufacture, import/export politics, and human movement (Chalfin, 2008; Dalakaglou and Harvey, 2012; Harvey and Knox, 2015). As Lawrence Cohen (2013) details, mobility is also a problem that both constitutes the clinic and marks out its dilemmas.

Traffic can feel "absolute" in global metropoles such as Mumbai, yet accompanying interlocutors through traffic can reveal journeys of invention and creativity (Lee, 2015). In discussions about global humanitarianism, the stop-and-go of "vital mobility" (Redfield, 2013) illustrates the limits of achieving flows of essential aid. The power of movement here is both aesthetic and political, a way of thinking I learned from scholarship on dance and gesture (Dunham, 1994; Manning, 2016; Meintjes, 2017; Pinto, 2013). With these conversations in mind, but also with an emphasis on embodied intersubjectivity in life-and-death moments, I describe traffic that scales down to relations between potential and actual individual movements and that scales up to an aggregate of care that intermittently shifts.

Clinical care and urban conditions are thus continuous in particular ways (McKay, 2018), and locally, traffic's multiscalar dimensions connect the uneven motions of medicine in Central's trauma ward to the uncertainties of mobility patterns in urban South Asia (Amrute, 2015; Bedi, 2022; Phadke, Khan, and Ranade, 2011; Sadana, 2021). Through rhythms and breaks, bodily displacements of coma patients in the trauma ward can reflect (although may not reproduce) inequalities in Mumbai's transit infrastructures, as well as the uneven access politics of India's public and privatized healthcare systems (Sunder Rajan, 2017). In a megacity like Mumbai charged with the fantasy of the "maximum city"—a megalopolis always moving and working—traffic accidents might suggest a sudden halt to the hypermobilities of urban centers in the Global South, and a crash might suggest a tragic cutoff to the flow of city life. However, that is simply not how trauma medicine nor mobility operate. Traffic emerges *between* and *across* states

of stasis. It is transitional and thus provisional. Comatose states from traumatic injury are an acute and illustrative site where this provisionality occurs.

THE TRAFFIC OF COMA

Abhi's coma continued to trouble me after I completed my research in Central's trauma ward. His coma, and that of many other patients like him, was not an example of clear-cut kinesis or stasis. So much of the story was about struggles to hold steady amid the tumult. It also was a story about struggling to achieve an exit alive out of the trauma ward. Maanav watched for signs of recovery, even as Abhi lay in the hospital bed, praying for a twitch or a wiggle of a limb, anything that might predict a survival offramp. As I observed other comatose patients, clinical assessments of them, and family experiences of both, it seemed like Abhi's was one of many versions of coma that were jockeying with each other in the ward for the right of way.

Ethnographic representation of this traffic mattered. I did not feel that "traffic" was merely an applied metaphor but more an in-situ ethnographic genre that I belonged to as well. What would a traffic-oriented description of stasis in the trauma ward be? How might one navigate words that risked either freezing one's object of attention in place or assuming its unobstructed motion? For example, my ethnographic account of Abhi's case could easily shift emphasis depending on which temporal horizon of coma I chose to grapple with (Lovell, 2011). The narrative I attempted to craft in my own fieldnotes when I left the hospital and the common sense this account solidified could both look different depending on whether I was thinking about Abhi as stuck close to death or stuck close to living. It mattered which terminus of movement I highlighted. Was Abhi a case of near-to-death, which could lead me to think about end-of-life bioethics (Kaufman, 2000; Stonington, 2020)? Or was he near-to-life, just an awakening away from exiting the scene, which might lead the narrative elsewhere? Was his stasis what mattered, illustrating bureaucracy's structural violence, or were the gendered forms of his freedom to move most at stake? Regardless of the narrative decisions that would ultimately shape this story on the page, one thing was certain: his stuckedness and mobility were in complex relation to the movements of those around him, including me. I could not learn what was happening from Abhi's point of view. I could learn about Maanav's obligations to care for Abhi and about how healthcare workers in the trauma ward understood their obligations. Across these forms of knowing, a tension between stillness and motion, never just one or the other, seemed to exemplify coma and the ethnography of comatose states.

I found it instructive to regard coma as distributed, even as coma is certainly one person's dangerous and potentially deadly problem. I learned to think about the distribution of injury from Laurence Ralph's (2014) study of how gun violence shapes disabled life in Chicago, from Omar Dewachi's (2020) study of war injuries in Iraq, and from scholars writing about a broad range of disabilities (Addlakha, 2018; Das and Addlakha, 2001; Friedner, 2022; Jain, 2006; Kohrman, 2005; Livingston, 2005; Wool, 2015). In a framework where injury or debility is distributed, the effects and experiences of violence may not be wholly isolatable in the bodily capacities of the wounded person. Instead, they are intersubjective, and this intersubjectivity accords them social force.

One form of coma's distribution involves terminology and language use. Doctors at Central vary in their use of the term "coma," importing it into both Hindi and Marathi (the operative languages of the ward). On one hand, some say, "coma" is a technical term that families with often little formal educational backgrounds may not be familiar with. In a public hospital setting like Central that caters to the city's poorest residents, and in a hospital ward that treats injuries that mostly affect the poor, the ward's workers use words carefully in a context of presumed low literacy. But, healthcare workers attest, the very reason some patients' kin are familiar with the term "coma" is itself reason enough *not* to employ the term. Some workers believe that kin are familiar with coma, but only its Bollywood film version (through films such as *Piku* and *Staying Alive*). In these comas of the big screen, a comatose person in bed eventually wakes up. And, as a consequence, they do not die. This version of coma is long enough for those who are conscious (usually, family members) to express truths about their relationship to the unconscious person in the hospital bed, such as love or regret. And then the person in the bed wakes up to resolve the scene. The intersubjectivity of medical crisis holds the conscious and the comatose together, and also, the comatose patient wakes up. The problem, Central's trauma ward workers say, is that this version of coma does not always hold for injury patients.

A dramatized version of coma also fails to account for the ways it can move the ethnographer. Coma renders injured subjects temporarily and sometimes permanently silent, and thus, as an ethnographer, I cannot listen to Abhi's account of his injury and his coma "experience," because Abhi never speaks.[1] For the comatose patients in Central's trauma ward, people speak for them as proxies. They talk around them and make decisions for them. Ethnography cannot access what coma's distribution might mean from the very person who makes the story possible in the first place. Nor should it, necessarily. There is an ethical limit here: Even if patients "woke up" in the trauma ward, at no point did I make an effort to speak to them until they were ready for transfer or discharge. The effects of pharmaceutical sedation on comatose patients are manifold, and "awake" does not mean "ready to talk." I want the people who make this ethnographic study of a trauma ward possible to leave the trauma ward as soon as possible, alive. This exit premised on stability became a matter of research ethics. I found myself moving through a timespace premised on fixing problems that began elsewhere and in other moments, even as the emergency continued. "The field" as such was neither origin nor destination, but a moving middle of traffic.

THE TRAFFIC OF TRANSFER

It was the dog that barked. Abhi had finished his work as a bartender at a restaurant near Mumbai's international airport around 2 a.m. Abhi climbed on the back of his friend's motorbike and headed home. They passed a dog, whose bark jolted the driver, and the bike fell. The driver was unhurt, but Abhi fell from the bike without a helmet on, hit the back of his head on the pavement, and lost consciousness. The driver called another friend, and through the chain of calls, Maanav got the news.

Maanav now stands by Abhi's bed. Several doctors look at Abhi's CT plates, seeing their details by holding them to fluorescent tube lights on the ceiling, plastic-glossed images flopping around. The neurosurgery residents decide that they will not operate on Abhi. The size of his hematoma and the size of the brain's midline shift are borderline indicators for surgical intervention. This means moving Abhi into neurosurgery is potentially indicated, but surgery is risky on someone with blood pressure as low as his. The doctors decide holding steady is the best course of action and will manage him medically with drugs to elevate his blood pressure. They will wait and watch, they say. Maanav asks for updates on his brother; the surgeon tells him they will wait and watch. It took a week of waiting and watching before Abhi died.

Maanav had initially brought Abhi to a private hospital close to the accident scene, the ideal type of transfer because it was the fastest route to care. Yet, the family couldn't afford the cost of treatment. The response to this blockage of access was an attempt to create a path toward another option. Maanav paid out of pocket for an ambulance to shift Abhi to Central—a municipal public hospital—for its lower-cost care. This traffic between different healthcare systems complicates policy assumptions that public and private healthcare systems are easily separable domains. It demonstrates how people in precarious economic conditions often turn to private healthcare first, knowing that the care is better, only to struggle with the attendant costs and to eventually move loved ones elsewhere (Das, 2015). Moving through vital traffic bears critical costs well before treatment begins.

Taking into account the variation of rural areas less defined by traffic congestion, nearly four hundred people die each day in India as a result of road-traffic injuries. This makes India the source of over 20 percent of global road-traffic deaths (World Health Organization, 2014). Each year, nearly one million people in India die from trauma (India State-Level Disease Burden Initiative Road Injury Collaborators, 2017), and many more are hospitalized. Traumatic injuries mainly affect the poor, and government hospitals with mostly free treatment, such as Central, are key nodes for treating those affected. This is because traffic is always a matter of social class, such that people in the protective cages of cars or first-class public transit train carriages are in different relationships of exposure to violence than those on the street or more-crowded train carriages with less-expensive fares.

Injuries and care for injuries also stratify by gender. Road injuries have been the primary cause of death among men aged 15 to 39 in India in several studies (Bhandarkar et al., 2020; Roy et al., 2010; World Health Organization, 2014). This means, in effect, that most of the patients in Central's trauma ward are often men, and "care" by families often means "care of male relatives." Maanav and Abhi concretize this, as filial obligations in the face of life or death come to define the stakes of survival. Given that the epidemiology of traumatic injuries skews toward men as most affected by traffic-accident-related injuries, the disabilities and deaths from trauma can shift gendered and socially classed household wage-earning structures and care economies. The hospital ward itself is a site to see gendered care differences play out, too, as male relatives of the injured are often tasked with coordinating care responsibilities.

The uneven velocities that follow traffic accidents in urban India are prefigured in transit inequalities. Thick vehicular traffic on Mumbai's roads means vehicle-to-vehicle collisions can be low at rush hour, but the intervals between speedup and slowdown in traffic gaps make the number of accidents between cars, pedestrians, motorcycles, and trucks high. On the city's railway system, where 10 people die each day in accidents, those who can afford tickets for the less-crowded, more-expensive train compartments experience exposure to risk differently than commuters in more-crowded, less-expensive train compartments. The train's open doors that accommodate rush-hour densities amplify the danger. Furthermore, accidents can be talked about in terms of misfortune, but randomness does not fully dictate their occurrence. The unequal somatic propulsions, inertias, and repulsions that derive from gender, caste, class, and community of origin shape the conditions of injury and its aftermath.

Abhi's body and the bodies of those around him reflect these histories and continuities of intermittent motion. There was Abhi's transfer from an expensive but presumably "better" hospital due to inability to pay, and there are now Maanav's intermittent comings and goings from the ward, both conditioned by security guards and nurses who regulate visiting hours. There is the circulation of care among doctors, nurses, and orderlies who move between the ward's beds. These itineraries begin with, but do not end with, the traffic accident's cause of injury. The comatose patients seem to slumber, but their visiting kin are instructed to massage and flex their limbs. Nurses and orderlies flip their bodies to sponge and powder skin to prevent pressure wounds and bedsores. Orderlies begin to transfer patients to radiology for imaging. At different bodily scales, intermittent traffic suffuses care with halting momentum, and moments of critical decision-making can be especially fraught.

THE TRAFFIC OF PROGNOSIS

As Maanav waits for updates on Abhi's condition, he reflects on prior deferrals. At the first destination, the high-end private hospital, the staff told Maanav it would be more than ten thousand rupees daily ($150) just for Abhi to have access to a ventilator in that hospital's ICU. This did not include

the cost of surgery and other treatment. Even with savings from an entry-level office job, Maanav couldn't afford this. His father is a rickshaw driver, and his mother is a housewife, and the family relied on Maanav's work as its primary source of income. Maanav dispatched a friend to Central to check if there were available ventilators in the trauma ward ICU. There were, he learned, and so he paid an ambulance to shift Abhi to Central. Thus, as Maanav waits for updates, he is also waiting in part on the consequences of a choice that wasn't really a choice. He learns how communication can be a form of vital traffic, one that ensnares families.

Patients' relatives know all too well about the gumminess of bureaucracy and the political economy of public hospitals, and so they can feel stuck in this transitional biopolitical middle as they wait for news in the open-air waiting area outside the ward. Maanav tells me how he slept on the waiting area's benches, waiting for news on Abhi's condition and hurrying into the ward anytime Abhi's name was called over the loudspeaker, only to learn that he had to help run lab tests or referrals.

Maanav gets wrapped into the clinical practice of incremental truth-telling integral to the daily work of a hospital ward with high mortality rates. For patients who die, a doctor might deliver news to a relative by saying "He is no more" (*abhi toh nahin hai*) or "He expired" (*expired ho gaya hai*). Relatives might ask if there were still chances or if something else could be done, if the coma might subside, and if there was awakening on the horizon. This would occur even as the doctor asserted death's presence by the person's bed and even as everyone watched the flatline on the ECG monitor.

It's disbelief, sometimes, but it's also confusion. Coma can be so protracted. Dying can be, as well. There are also reasonable expectations that medicine should be able to fix things, and so there are multiple opportunities for mixed or incomplete messages (Banerjee, 2020, 2022; van Hollen, 2018). A comatose body already presents a distressing timeframe in which someone seems neither fully alive nor fully dead. And then, if the person does die, family members get shifted into another linear frame in which death becomes a fact.

These protracted forms of news and their overlapping temporal frames struck me as potentially different from the sudden shocking thump of hearing that one's family member is dead. In one of his essays about his childhood in Berlin, critical theorist Walter Benjamin (2006) recounts how at about the age of five, his father came into his room, "presumably to say good night." His father told Benjamin the news of a cousin's death. Reflecting on this moment, Benjamin writes of the ways that news of death "makes us pull up short." It is a reminder of something in the room that might have been otherwise forgotten, what Benjamin calls "a stranger who was on the premises" (130). A chronicler of modernity's ruptures, Benjamin appeals here to shock's suddenness.

In the trauma ward, however, there are also slowdowns and speedups that characterize death's news. For example, the trauma ward prepares relatives to be pulled up short by asking them to sign a document called "the poor prognosis consent." In the register of informed consent, it is a legalistic document that simultaneously ratifies the likelihood of a patient's death while indemnifying the hospital against responsibility for adverse outcomes.[2] Maanav signs a form stating that he is aware that his brother's condition is "very critical," that Abhi has "poor chances of survival," that the hospital is providing "the best possible Rx," and that Maanav will not hold the doctors, the hospital, or the municipality responsible for any outcome.

Prognosis works on several fronts here. It is medicine's way of attempting to minimize damage to a story by propelling families forward. The poor prognosis conveys uncertain continuity: medicine has some expectations of the path but isn't certain about the destination. As Maanav signs the consent form, the anesthetist reminds him that "the medicines are working" (*treatment chalu hai*) and that since Abhi is on a ventilator, that "the machine is working too" (*machine chalu hai*). Does this appeal to flow strike him as noteworthy, or another swirl of bureaucracy? I do not ask, as the moment does not feel like it should invite this inquiry. The confluence of writing and speaking here allows doctors to assert that the hospital is doing hospital-y things: giving drugs, intervening, trying things that in speech connect to the present tense. And indeed, it is difficult to pin down the time of dying, a relationship between temporality and mortality that can shape the ideology of healthcare (Kaufman, 2005).

Propulsive clinical ideologies can also be existentially violent as they move family members into different temporal lanes. The poor prognosis takes Maanav out of one temporal path that can feel suspended and circular. It then shifts him into a second pathway in which the experts are saying that a person he loves is barreling toward death. To be abundantly clear: I do not question the importance of this process. It can be bureaucratic and punitive, but also, its absence can be dangerous and misleading. Traumatic injury and comatose states are highly volatile and often unpredictable clinical conditions. Doctors and nurses rely on certain predictive factors, such as blood pressure, to gain a sense of where a patient is headed, but surprises are also possible.

At the interface between clinical action, clinical ethics, and life itself, communicating coma and its severity offers doctors the terms of vital traffic that underlie the poor prognosis.

Instead of asserting "coma" as such, doctors tend to communicate about it with families by describing a patient's condition as "serious," by reiterating the severity of the wounds, and by pointing to life-support technologies as signs of brittle reality. For instance, a surgeon faces the father of another patient who is in a comatose state following a traffic accident. The father wishes to know what his son's chances are. The surgeon speaks to the father from across the patient's bed. "Sir, he's got deep chest wounds, and he's on the machine [ventilator]. His condition is very serious. His BP, his pulse … his condition is very serious" (*Sir, aur chhati mein gehri chot hai, machine peh hai, condition kaafi serious hai. BP, pulse … condition kaafi serious hai*). The father responds immediately with a question about money. How much money should the family pay to change this situation? They can find it, somewhere. The doctor attempts to correct him, gently. No, no money is necessary, he explains, because this is a public hospital, and the treatment is mostly free. Treatment will continue, and that is what is important. Whatever treatment is necessary, the doctors will take care of it

(*unka treatment chalu hai; paisa ka kuch nahin. Jo bhi hai hum yahan se karenge*). The traffic of gendered monetary obligations underlies this moment of uncertainty, too, with a father willing to pay out of pocket for a son's care.

In this setting of serious resource limits, a medical labor force composed primarily of junior/resident physicians still learning, and a high volume of patients in critical condition, there is a sense that injury severity and volume will not dampen due to the ever-present traffic accidents outside the walls of the hospital. What this means is that while providers often want to update families, it is sometimes only when bureaucratic requirements like the poor prognosis consent must be signed that certain conversations happen. The poor prognosis becomes akin to a stoplight that temporarily realigns the proximity of two entities—doctors and families—who otherwise are moving on their own trajectories and temporalities around the comatose patient. This moment may not be palliative, yet it also marks how institutions exert blockades or detours that continue coma's relationality and injury's distribution. It also marks hierarchies of knowledge, expertise, and labor within one site, as junior physicians, nurses, and orderlies often bear the responsibility of moving care and setting the pace of actions that follow clinical decisions.

Time and temporality come to matter for vital traffic in the context of prognosis. Given coma's uncertainties, doctors often say "we'll see" (*dekhte hai*) to describe the uncertainty of outcomes, or they may insist that a patient's condition is "very serious" (*kaafi serious*). When I ask doctors how they employ the poor prognosis, several reply that it is a stretched-out form of honesty. They try to pace it with the time families need to gather resources, and the time patients need to die or recover. Straightforward updates are something that everyone deserves, they say. Whether or not the updates are understood, good medical practice requires one to be frank about uncertainty. Good doctoring means creating a series of information waystations and leading families bit by bit through the jam. Through prognosis, traffic differentiates who can know what information, and when.

Two junior doctors call Maanav in from the waiting area. They tell Maanav that Abhi's condition is "very bad" (*kharab*), that his chances for living are very slim. They ask Maanav to return to the waiting area outside. They tell me that Abhi is "nonoperable" and that his neurological scores are the lowest possible. "He's not there," another resident reflects about Abhi; she says they expect his vital signs to flatline soon. "It will take a miracle," another doctor says. "Basically, he's brain stem dead." This doctor is frustrated with the constant shifting-work that's happening to Maanav, summoning him inside the ward only to dismiss him later. She thinks this is a terrible thing to do to families. "Why put *them* through so much trauma?" the doctor reflects. All this traffic for the family, so much moving around, most of it unnecessary and even harmful. I am unsure if she envisions stasis as an antidote, and if so, whether Maanav should be allowed to stay by Abhi's bed.

I shift myself outside and sit with Maanav. He says that he is confronting a similar dilemma of how to mete out news. He chooses his words about Abhi's condition carefully when he phones his family with updates. As the person always at the hospital, a role he absorbs in accordance with being the eldest male child in the family, he is invested with truth-telling and prognostication. He also tells his family partial truths. He tells them that Abhi's situation is "serious," but not much more, letting the word do its work. I wonder what it was for Maanav not only to hear the news of Abhi's impending demise but also to instantly transform from being the told to being the teller. I return to the trauma ward and chat with the anesthetist. She checks the blood pressure monitor. Abhi's systolic blood pressure is dropping perilously low, and he remains unstable. He had improved with some calcium, but then his platelet counts dropped. These indicators of vital instability and organ failure also mean that if he were to die, organ donation would not be possible. "He was really young," she says, displacing him into the past tense.

THE TRAFFIC OF CLOSURE

Abhi dies days later. His case, like all cases of road and railway accidents in the trauma ward, is considered a medicolegal case according to state law. This means that in the event of death, a medicolegal postmortem must occur. Forensic doctors must determine the cause of death, and this evidence will anchor any juridical pursuits by the family of the deceased, such as pursuits for compensation. While I also conducted observations in the morgue, I am not there on the day of Abhi's autopsy. Weeks later, I am observing the work of the morgue. At a break between autopsies, it becomes my turn to get treats for the forensics team from the hospital snack bar. Samosas and chai get everyone through the long days. As I enter the hospital cafe, a young man approaches: "Hey, remember me?" I squint in the fluorescent light reflecting off the floor tile: it is Maanav. Since Abhi's death and his autopsy, the family conducted proper funerary rituals and cremated him. But Maanav still needs the final death certificate the hospital produces. This can take time to produce, even after a body is released from the morgue.

I am struck by the recursion: Maanav has already returned to the hospital after Abhi's death, to collect his body from the morgue. And now he is back again, to collect paperwork from the morgue's small office. Then Maanav must go to the city's vital records office, to record Abhi's death in the city's registers. Maanav and the family must engage in traffic mechanics of their own to make Abhi's death official, moving its certification from the hospital to the city. Vital traffic continues through agentive displacements, even after death occurs.

Some of Maanav's relatives want to lodge a police case against the motorcycle driver. This could be a possible move, one that would ensnare the young driver in a complex choreography of compensation claims, settlement procedures, lawyers, perhaps a court, and insurance company machinations. But Maanav has stopped this momentum in its tracks and forced a procedural stasis. Both police officers and insurance agents have repeatedly come to his house to inquire about this course of action. He told them to leave him and his family alone. "The guy is 19," he says of the driver. "Why ruin his life? He'll be tried as an adult. It will ruin his career. It was an accident. Leave it be." There has been enough stasis already; fomenting more traffic jams is not what Maanav wants. Refraining from doing so marks out his own ethics relative to all the movements in play.

After all, Maanav says, the family is grieving. More stuckedness will make things worse, he suggests. They will deal with money later. He wants to change the shape of this traffic from within.

Maanav and I sit for a while. We drink tea and eat some sesame seed candy in a lounge plastered with ads for cram courses for the board certification exam. Things at home are hard, Maanav says. His mother is still very much "in tension." The other day, he had discovered a USB drive in Abhi's room, and it contained videos of Abhi at work. He transferred them to his phone so he could look at them anytime he wanted to connect to Abhi. The directions of traffic can go in reverse.

Maanav takes out his phone and plays some of the videos. One is of Abhi bartending at the restaurant he worked at. He's making fancy cocktails. In another video, Abhi stacks some tall glasses filled with beer and puts shot glasses on top like a pyramid. "Watch this," Abhi says to whoever is taking the video. He pours Jägermeister into the shot glasses and swipes the shot glasses, which spill into the beer without a drop wasted: Jägerbombs. And in another video, Abhi pours cocktails directly into the mouths of dancing partygoers. He grooves to the music. "He was a great dancer," Maanav says as he watches the phone screen. It is eerie, and it is mournful, and Maanav is smiling, too, just some of many responses that anyone might experience during tragedy.

Maybe this is what exiting the traffic of trauma can look like: an attempt to inhabit the space of memory, to find alternative timelines when a loved one who died is still alive. And moreover, in refusing to press charges against Abhi's friend, Maanav affirms that his own survival is not predicated on throwing a block to someone else's life. He is yielding so that he can eventually move on.

Maanav has some new job prospects; a second job might help with the loss of family income that came with Abhi's death. In the meantime, he must keep returning to the hospital for paperwork, although today will probably be the last time. We walk on the hospital campus, past the trauma ward. He saw so much in that ward, he says. People burned all over their bodies. People with severe injuries, amputations. He watched people emerge from ambulances, he saw them inside the ward, and he saw their relatives in the waiting area. Trauma care's traffic is public in this way. It distributes.

We walk toward the hospital gate. It's almost 2 p.m., and I am due at a trauma mortality meeting inside the surgery department. The trauma surgeons are keen about research, and about doing better, and verbal autopsy is integral to this. Assessing deaths is critical to improving systems for the patients yet to come. I will join the physicians in reviewing clinical data on all deaths in the trauma ward during the last three weeks, including Abhi's. These deaths will be rendered as a blizzard of PowerPoint slides, each death telling its own failure story, and each one concluding with a vote of the meeting's attendees: Was death preventable or not? This is the basis of verbal autopsy. The question of preventability is often one of acceleration and deceleration: What did and did not happen quickly enough? Did the transfer from another hospital to Central underlie the patient's cause of death? Each case is unique, but there are still patterns: delays in care tend to underlie many of them. As each death is imagined as a counterfactual—What if the person did not die?—the meeting becomes a space to imagine trauma care systems differently. It is a way of introducing other possible interventions, other possible displacements, which in theory could have led to destinations different from the one we look at on the screen: Abhi's death.

I'm not sure how much of this would matter to Maanav, for whom Abhi's loss was preventable but irreversible. "I never wanted to come back here," Maanav says as we walk by the trauma ward again. Inside the ward, things are settling in after the unit's move. And here Maanav is, in a U-turn, headed past the stone benches where he slept, where others in similar situations now sleep. The event of Abhi's crash, his time in Central's trauma ward, and his death all were now in the rearview mirror, and still, Maanav is being rerouted.

CONCLUSION

Deadly traffic on the road brings Abhi to the hospital, and vital traffic after the accident sets the terms for what follows. In the context of India's high rates of death from traffic-accident-related traumatic injuries, it is one thing to affirm mortality rates, which is a critical task that epidemiologists face not only in terms of empirical accuracy but also in terms of how they might translate data for policymakers. It is a complementary aim, one I have taken up here, to question how injury puts families and institutions into unequal moving relations in a hospital. Medical care can be understood as a politics of what is moving, even though it is often understood as a politics of what is known. Medicine is a problem of what to move and what to stabilize, all with different costs. Medicine, then, is a process of vital traffic.

In the cases detailed here, trauma and coma spill out of an injured person's singularity and become intersubjective through unequal relational displacements. Stuckedness and motion both operate, but one cannot assume that moving is reparative and stuckedness is dangerous. Stasis in the trauma ICU can be healing, and mobility between institutions can be deadly. Traffic can also be a multiscalar analytic. One might regard traffic in the aggregate, as traffic science does, but one might also focus on the micro-level interactions between individual bodies, like one vehicle shifting so that another might advance. Traffic as an ethnographic framework opens up the possibility to see multiscale and intersubjective patterns in care's flows and constrictions. This framework also highlights the power of easing and blocking critical transits. To be subject to care within and beyond medicine, and indeed to survive threats to life, involves a power relation of moving and being moved.

Narrating vital traffic involves its own instabilities, a flux of ethnographic writing. I could have told Abhi's story in a different order of events. I could have shaped it to be a tragedy about freeze, anchored solely by Abhi in his bed, dying, and Maanav standing by his side. It could also have been a story of unfettered movements: the shuffling around of care, with the sense of chaos that may have implied. I have chosen to write differently, in

an ethnographic mode of traffic to describe the drives, recursions, and setbacks of life at the edge of death. Traffic is transformative, even as it may feel like there is little progression. That transformation can be palliative, and it can also be dangerous. Traffic is a moving middle, and medicine is one of many possible domains to detail how life in that moving middle comes to matter.

Clarifying vital traffic thus has implications that extend beyond the case study of traumatic injury and coma presented here. One is a reflection point for anthropology: What are the conditions and limits of stability in ethnography? How might ethnography itself be a mode of traffic—that is, a mode of actively displacing forces? The ethics of fixing people in narrative place has been an important site for anthropology's methodological commitments (Hurston, 2018), and something that often surfaces as a dilemma of anthropological location (Gupta and Ferguson, 1997). But more than obsessions over location, anthropology's conversations about itself also reflect attachments to stasis: finding a place of fleeting stillness amid dynamism. These conversations might be framed through discussions of what it takes to make a situation stable enough to describe, which would also open up questions of what unequal moving forces still may be in play for interlocutors, and for ethnographers, too. Ethnography *is* disturbance, a mode of knowing premised on and subject to kinetics. Ethnography as theory and praxis produces, reproduces, and observes traffic. The discipline's genealogies might be reimagined in terms of different scholarly commitments to embodied movement in scenes of transition.

Comatose states like Abhi's can mark a limit test for ethnographic knowing and communication. Frameworks attentive to practices, desires, and aversions of traffic can address bioethics, embodied political economy, and mobility differently if injury is understood as more than mere stasis. There is often a hunger in ethnography, indeed in narrative itself, for a story's final destination. For instance, the end-of-life issues that permeate ICUs like Central's might lead the anthropologist to act on this attachment to endpoints. However, my aim here has been different. It has been to move with traffic and to amplify how ethical and existential gray zones derive from often-unresolved stops and starts. For it is in this dynamic middle between fixity and flow that one might grapple with vital traffic: what it means to be moved to life.

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ENDNOTES

[1] The matter of subjects who do not or cannot speak, as well as the relative primacy of speech to the ethnographic encounter, is one shared by scholars of dementia and disability (Pols et al., 2018; Taylor, 2008).

[2] It remains unclear to me the relative weight of such a document in court.

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