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Making visible the invisible and vice versa. Bodies and organisational arrangements in the Intensive Care Unit

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Abstract. *Background and aims:* The effectiveness of the treatments carried out in the Intensive Care Unit (ICU) is guaranteed by a socio-technical ensemble where material resources, scientific knowledge, technological artefacts, social norms, spatial dispositions, and professional practices coexist and constantly interact. This paper intends to penetrate such an ensemble for analysing the moral order produced and maintained in everyday medical practice. *Method:* The results of a case study, carried out in the ICU of a hospital in the north of Italy between 2006 and 2007 are reported. The study was performed using ethnographic methods: participant observation, ethnographic interviews, and semi-structured interviews. *Results:* I illustrate how ward organisation and professional practices of medical and nurse staff create and reproduce two dispositions of body centred on the staff's perception of the therapeutic appropriateness of patients. On one side, there are the bodies that staff expect to get better, and these bodies are exposed through a series of organisational devices and activities in order to make them immediately accessible and available for every type of treatment; on the other side, the bodies of chronic and terminal patients tend to become invisibles in the working practice of the unit. This process does not follow any guideline or protocol but is embodied in informal routine and communicative interactions. *Conclusions*: The invisibility surrounding certain patients can be seen as strategies for the management of professional conflict and bioethical issues that stem from different interpretations of the degree of severity of the patients' conditions.

Key words: organisational arrangements, medical practice, intensive care, ethnography, sociology of medicine

In the last decades, knowledge and medical practice have been undergoing important transformations due, in particular, to the enlargement of the care scene, which has given a say to usually silent interlocutors (i.e., the institutionalisation of the Tribunal of Patient Rights) or formerly inexistent ones such as the managers of local health organisations (Timmermans and Berg, 2003)[1]. The *scientification of biomedicine* (Burri and Dumit, 2007) has been another process deeply affecting medical practices. The meeting of medicine with other so-called 'life sciences' (first and foremost, molecular biology and neurosciences) and information technologies has provided medical and nursing staff with new instruments and procedures regarding diagnosis and therapeutic treatments, broadening the scope of medical intervention over life spots formerly unexplored.

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

[1] The process of transformation of public health care services in firms financed with collective funds is quite recent in Italy. It started at the beginning of the 1990s.

represented by the use of biomedical technologies in the ICU. The introduction of mechanical respirators, sophisticated systems monitoring vital levels, and the synthesis of vasoactive medicines able to support cardiac activity, have generated a new human condition in biological, psychological, and social terms, in which the survival of a patient, either for a short term or to balance chronic deficiencies, is indissolubly linked to devices and professional practice (Rodriquez, 2015).

In this paper I will show how the organisation of the ICU and medical and nursing personnel's professional practices generate and reproduce two dispositions that the *socio-technical ensemble* assumes, focused on the perception of therapeutic adequacy of the hospitalised patients: *the exposed body* and *the invisible body*. The first disposition is characterised by a high level of observability and interaction with the organisational elements while the second refers to patients who are considered by the staff to have no clinical expectation of improvement.

The Intensive Care Unit from a Sociological Point of View

Strauss and colleagues (1985) point out that ICU working practices involve issues relating to different domains: economic, political, industrial, and cultural, *in primis*. Studying routines and practices in these organisations means finding and investigating the heterogeneous human, material, and symbolic elements involved in the production and implementation of the *socio-technical ensemble* (Schubert 2007).

First of all, the types of treatments carried out in ICUs require huge amounts of economic resources. According to a recent European study, each patient per day of hospitalisation costs, on average, between €1,000 and €3,200, including the costs of the medical-nursing staff (about 60%), the pharmacological and instrumental technologies, and the hotel services connected to the hospitalisation (McLaughlin et al., 2009).

Social rules are important as well in the medical practice, and in ICUs this is particularly clear as related to the interruption, or non-activation, of life-support treatments (van der Heide et al., 2003; Bertolini et al. 210). If these aspects are related to the macro-social dimension, ICUs' medical practices embody processes related to organisational and interactional levels too, in which techno-scientific elements and professional manners are embedded (Carmel, 2013).

The technologies play a critical role in the setting up of the professional practices, in environments like ICU, in which the organizational goals are mainly rooted on biomedical devices (Bruni, Parolin, Schubert, 2015).

As Mort and colleagues (2005) point out, in anaesthesiology, a medical field that is similar to intensive care, the interaction between human beings and technological artefacts is neither a one-way relationship nor universally given as it is linked to the characteristics it assumes within the specific working setting: on the one hand, mechanical respirators substitute a physiological function of the patient and perform a 'delegated' function, so-to-speak; on the other hand, data appearing on the monitor displays the unstable general condition of the patient. Technologies, as well as other elements involved in working practices, are largely taken for granted by participants, and treated as a transparent background for the work (Svensson 2007). However, studies on collaborative work have shown that the setting of artefacts and people promotes specific integrated perspectives in the working practices (Goodwin 2007). What is commonly perceived as 'normal' in their practice and taken for granted is 'actively contrived by practitioners in order to accomplish safe and proficient practice' (p. 273).

The patient's ill body, the traditional object of medical practice, is not an immutable and universally recognisable element (Latimer and Schillmeier 2009). On the contrary, it gets different characteristics depending on professional roles, diagnostic tools, organisational cultures, and even more. As Mol (2002) states, 'in the hospital, the *body* (singular) is *multiple* (many)' (p. 84).

Bodies are multiple also in relation to biological death: the ethnographic accounts of Sudnow (1967) show that dying in hospitals involves procedural and organisational aspects that introduce a definition of death, the so-called 'social death', related to but not overlapping with the 'clinical death', or the appearance of medical evidence of death as a result of physical and

instrumental examination. Social death is all about practices set up as the patient is considered approaching death: for instance, as Sudnow observes, a patient considered to die soon is left on the stretcher on which he/she has been admitted and put in the laboratory room, or large supply room, in order to avoid messing a bed. As a result, a body still biologically alive assumes the characteristics of a dead body, from the organisation's perspective.

Spatial dispositions play an important role in producing the specific perspectives that are embodied in working practices and routines (Goodwin 2014; Timmermans and Epstein 2010). Latimer (1997) shows how patients in ICUs are categorised by professionals on the basis of the perception of potential recovery. They classify patients into seven categories, ranging from 'high dependence' a 'to resignation'. Belonging to a specific category implies a process of artefacts adaptation which leads to different spatial arrangements in the unit. Latimer describes how nursing staff move patients in different areas of the unit according to the perception that they have of patients' conditions. She points out how spatial organisation is driven by informal and non-codified rules that are 'managed to seem "natural"' (p. 170, quotation marks in original).

As I will show, the treatment of bodies in ICUs changes according to the different dispositions that the specific *socio-technical ensemble* assumes.

The Study: The Medical Practice in an ICU

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

My ethnographic study provides fieldwork in the ICU of a public hospital in the north of Italy from September 2006 to September 2007. During this period, I have observed situated practices, gathered ethnographic and semi-structured interviews of the medical and nursing staff, participated in their daily meetings (where personnel would discuss the therapeutic treatment of patients), and assisted with talks with relatives of the patients. The gathered material is as heterogeneous as follows: recorded interviews; talks and personnel meetings (transferred on a data storage device); daily ethnographic notes; and other material gathered in the ward, such as guidelines, internal reports, and medical records.

Observations, interviews, recordings of the staff meetings, and documentary materials have been analysed using a *grounded* analysis, in a three-step process: deconstruction of materials into simple units; aggregation of the analytical units into macro-categories; and validation of the macro-categories on the basis of the different types of empirical materials (Silverman, 2013).

In order to facilitate the understanding of the following paragraphs, direct quotes will be in italics, and ethnographic notes and transcriptions of teams' talks will be in narrower margins. I have also changed peoples' names in order to guarantee their privacy. For the same reason, I have removed from the plan of the ward any element that was not mere structure and that might reveal the specific organisation with which I performed my research.

Analysis: Working Practices, Technologies, and Bodies in the ICU

The process through which physicians and nurses categorise patients and perceive their conditions is embodied in working practices and organisation and produces and reproduces a *moral order* involved in distrib-

uting resources (Mackintosh, Sandall, 2015; Latimer and Schillmeier, 2009). In the following pages, I will describe how the carrying out of the moral order in an ICU generates bodies *exposed*, on one hand, and bodies *invisible* on the other.

Making the Body Exposed

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

I enter into the ward and stop at the entrance of the emergency room, where I feel there's a certain agitation. On the examination couch a middle aged woman lies intubated, her eyes closed; she's breathing very fast. On the monitor next to the couch the wave of the ECG[2] and other life parameters are displayed. A nurse is placing a drip on the support next to the couch, while another nurse is setting up a pump behind the patient. Doctor Ferrari is also in the room, filling out the medical record. I see him observing life parameters being displayed on the screen and then writing their values in the blank spaces of the medical record. On the table next to the entrance, where the doctor is writing, there are also various radiographic reports. Ferrari looks up at me and says hello. I ask him what has happened to the woman. Carla, 60 years old, felt in the morning a heavy breathing problem and a strong pain in her chest. So she went to her doctor who provided her with medicine in order to sustain cardiac activity and urged her to go immediately to the emergency unit of the local hospital. As she arrived heavily bradycardic (meaning her cardiac rhythm was slowing), with a pulse of 20 beats per minute (bpm), she's been reanimated, intubated, and transferred to the ICU. As a result of a CAT[3], it has emerged that a thrombus broke off from a vein of the left leg, climbing up to the heart and obstructing the pulmonary vein in between the two chambers of the heart. Afterwards, the patient has been treated with a strong anticoagulant which allows the thrombus to melt by stopping the blood from clotting. In fact, through the monitor, it is possible to see that the situation is becoming stable, with a pulse of 100 bpm, while the blood pressure is getting a little bit low and the oxygenation is going up to 100%. The doctor stresses how, now, having overcome the danger resulting from the thrombus, the risk is a general hemorrhage because of the anticoagulant medicine and therefore resulting in a coma. In order to avoid this consequence, it is necessary to keep the blood pressure low, around the current values, 100, no more than 110, gradually lowering the adrenaline, using one of the medicines supporting the blood circulation. He also points out that this is a typical ICU situation, in which the patient is supported in his/her life functions, respiration, circulation, temperature (*You give what is lacking and take off what is exceeding*, he says) until the overcoming of the acute event that affected the patient.

Patients like Carla represent the typical ICU situation, in which there is a temporary lack of life functions because of specific problems (traumatic or pathologic) and organisational resources are involved in order to produce and keep up the visibility of the body through its exposure. It is because of this exposure, because of the numerous parameters found through the constant monitoring of the patient as well as because of the patient's immediate availability, that the doctors can evaluate how much to reduce the medicines and how to modify the settings of respirators, adapting to the patient's respiratory capabilities.

After overcoming the acute event, as in the described episode, the main activity becomes the observation of parameters by nurses. They will note the data every hour, even more frequently in more serious cases, and will transfer the data to the medical record.

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

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

When anomalies in the expected parameters occur (for instance, the arterial pressure suddenly goes down and the cardiac frequency goes up), nurses will inform the doctor, for whom it is necessary to review the therapy on the basis of the new data. Therefore, the patient's body will keep effectively exposed, well-visible, and its internal components accessible.

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

As sociological literature points out, the spatial arrangements of organisations are producing a sense of 'normality' on which experts are basing their practices (Goodwin 2007). In the ICU that I studied, the material disposition of patients in the ward was the result of the different types of perceived bodies that medical staff were working on.

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

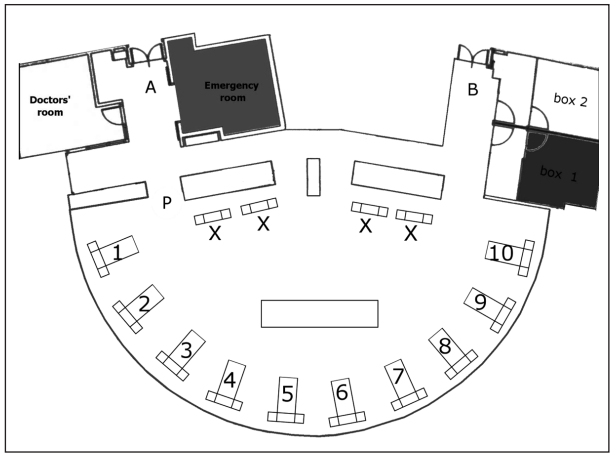

Figure 1. ICU's planimetry and main spaces

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

It's about 8 p.m. Doctor Colombo comes in the ward and stops beside the first bed, a little bit in the back, as if he wanted to stay just on the border of the room. I notice that he's observing the unit; I notice his focused gaze. So I ask him whether he will do the night shift, since I have not seen him all day long. He replies affirmatively, even though he feels he won't be particularly busy. As I ask him why, he answers: *Why? Because it is enough to give a look around for me so as to understand what is the situation, without analysing the medical records, even if I haven't been in for the last week. Half of the current situation is already clear. Afterwards, I will also start looking at the medical records and will give you the prognosis.*

In the meantime, even a nurse, Alberto, who's been working in the ICU for 15 years, listens to what we are saying and enters the conversation: *Even more than half of the situation, just by giving a look at it.*

Colombo: *Yes, sure, patients assume a certain expression and a certain, particular behavior. Then you look at the monitor…*

Therefore I ask: *Is it because they are elderly people, most of all?*

Colombo: *No, not necessarily; it's the pathology. It is the so-called 'facies', the behavior they assume, that is a main foundation of the clinical examination. It's the famous expert eye…of course you can't do everything with it, on the contrary… but it helps you, first you screen.*

In the above described episode, the doctor observes hospitalised patients from position P (in the figure), which allowed a wide view over the entire ICU. Patients' screening was done from this position so that the doctors understood how to balance their efforts, and how much attention they would presumably have to devote to the various clinical cases.

From position P, visual access concerning patients hospitalised in the first five or six beds was very good. Patients of the opposite wing, however, were not as visible because there were various obstacles to the eye, like empty beds already equipped with some devices, and the oasis in the centre, constituted by a long table surmounted by two series of shelves and a large LCD monitor.

Making the Body Invisible

Unlike the previous disposition, attracting the major part of material and professional resources of the ICU, the *invisible bodies* are more difficult to be identified in the working practices of the ward. Although the *exposed bodies* are immediately recognisable and it is easy for an outside observer to understand that every effort of physicians and nurses is aimed at improving the condition of such patients, it is important to take a closer look at the working practice regarding the *invisible bodies*.

The Organisation of Space and Activities in the Ward

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

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

The trajectory of two young lovers, in the ICU because of traumas undergone as a consequence of a road accident, is revealing of the different meanings given by the staff to the various spaces of the ward. Immediately after the accident, the young man is treated and stabilised in the emergency room, while the young woman is hospitalised in bed 1 because of the lack of a second emergency room. The young man is thereafter brought to the operative theatre because of the lesions he has suffered. When he comes back, he will occupy bed 10, as the ICU is full. The young woman, after several hours, is brought back from the operative theatre, once again to bed 1. It is particularly interesting to stress that, two days after the accident and hospitalisation, the young woman and man, partially recovered and perfectly conscious, move to beds 9 and 10, next to each other. The girl is actually moved to bed 9, which will be tilted up for about 30 degrees so as to allow the couple to talk vis-à-vis. By this time, the patients are stabilised and do not require the massive investment of resources they required at the beginning.

In this phase, doctors organise the patients' transfer to the specific ward where the therapeutic course will be completed. Indeed, during the period of greatest exposure after the hospitalisation, when the staff need to be able to check life parameters in real time so as to evaluate whether the patients are stabilising or not, doctors need to just get out and overlook the ICU to check the situation whenever they want. On the contrary, when the conditions of the two young lovers have become stabilised, and they have been able to peacefully talk together, on the opposite side of the ICU a 'confidential' space has been created, in which the patients have been able to wait for their transfer in a condition of relative privacy.

Such move highlights the significance attributed by staff to the organizational spaces: the beds closer to the doctors' room house the patients considered most relevant, while patients considered to resign or who should be dismissed are positioned on the opposite side of the department. The least exposed position in the ward is Box 1, as indicated in the picture. Here is the way the doctor on duty of the ICU describes the function of that space:

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

According to the original aims, the first of the two boxes should host infective patients, dangerous to the rest of the population in the ICU. In the ward's practice, the second box is also often destined to host chronic patients that have nothing to do with ICU

treatments, theoretically speaking. As soon as chances of improvement and therapeutic options diminish for patients, the box becomes the place to put them until their dismissal, should there be a facility able to welcome them, or until their death.

What did usually enhance this slipping to the back of the ward's activities, during my observation period, was the absence of consciousness, the comatose state of many patients with a chronic evolution in the ICU. The impossibility to set up any communication through language, verbal or not, even just through physical contact, and the patient's inability to reply, appear to result in a minor involvement of the nursing staff and to limit the resources destined for these patients. A nurse told me about her difficulties entering the box whenever there was a patient in a comatose state, unconscious: *I realise it. Today I didn't go in at all, I couldn't. For it seems I always see more important things to do rather than going there to check him out. It seems to me, I say.*

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

Slipping to the Back in Medical Discussions

This *slipping to the back* can be found also in the staff meetings of the doctors. At about 2 p.m., around four to six doctors, those who would be almost done and those who would soon start their own shifts, would meet in the doctors' room to review daily cases, the treatments already done and those still to be done, the diagnostic exams performed and those to be requested, and the medical records filled out and those not yet completed. Generally speaking, the meetings would have no pre-set list of points: the doctor assigning daily tasks would have a sheet where all the main characteristics of each case were written down. He would report them to the other doctors, who would intervene and ask for clarifications. During these meetings was common that the discussion about the patients hospitalised in the box literally loses relevance as related to other doctors' priorities. For example, during a meeting, Dr. Marino starts assessing the case of Andrea Marcolini—a 55 year-old patient who has become seriously disabled as a consequence of an accident at work, and hospitalised for over 20 days in the ICU—about whom he reports yet another unsuccessful try of making him breathe autonomously. Suddenly, another doctor stops him and introduces the situation of another patient, to whom the staff is devoting a lot of effort, as he has just been hospitalised but not yet stabilised. Finally, they start discussing the patient arriving from the ward of medicine. Such a dynamic was very frequent during the staff meetings. Simply put, some patients vanished from the accounts as soon as the picture became less 'engaging' from a clinical point of view.

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

Ferrari: *Then there's* ... [the following patient in the account]*?*

Bruno: *Rossi.*

Ferrari: *Rossi must be seen* [must be visited]*, nobody...* [visited him].

Bruno: *We said goodbye many times, but...*

Ferrari: *We tuned the TV on that show, on RAI 3*[4]*. Who saw him? Then, the same, that other one, his mate...* [they refer to another patient, whose destiny was linked to Rossi's].

[They laugh].

Ferrari: *No, those two must be seen and...*

Bruno: *Be taken care of...*

[4] They are referring to an Italian television program about looking for missing people.

Rossi and his 'mate' had been hospitalised a long time ago. The first one had been hospitalised for more than 50 days, the second for two weeks. Their clinical situation was in stall: doctors believed there was no possible chance of improvement that would allow greater therapeutic efforts and, at the same time, their survival was guaranteed by mechanical respirators compensating for their respiratory insufficiency. Therefore, they depended completely on the ward's facilities. As a consequence of the absence of clinical perspectives, like the *weaning* from the respirator, and, in Rossi's case, the rehabilitation of the swallowing capability (compromised by the ictus that affected him), these patients were considered at the edge of the daily activities of the ward, by both the medical and the nursing staff. This quote also reveals the use of humor in the management of problematic situations that can not be solved following formal procedures. As I have discussed elsewhere, the use of humor in the ICU is very frequent and it plays a role of relational coordination among professionals (Lusardi, 2015).

Conclusive Remarks

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

In the first category there are all those patients which are, numerically speaking, the majority, who pass through the ward for a short period of time, and require many resources in order to overcome a temporary acuteness so as to begin again their own therapeutic treatment in another ward. These patients have to be constantly monitored because they often risk sudden and very compromising conditions. For this reason, life condition data and specific sets of information, depending on the case, have to be immediately available. This is the only way to provide a response to a possible variation that will be quick enough so as to guarantee the survival of the patient. On the one hand, therefore, the body is exposed, nearly exhibited, so that it can be immediately accessible and available for any kind of treatment. What Svensson (2007) states about anaesthesiology is applicable to the working practices that shape this typology of body in the ICU: [they] 'are actively and prospectively engaged in reading and avoiding problems by implementing a situated and emergent organisation of patient monitoring, using a wide range of technological and material resources' (p. 19). Bowker and Star (2000) have shown how such coordination between heterogeneous elements happens mainly through the transcription of data in the medical record, wherein a patient's trajectory is 'geographically' and 'historically' reassembled. The stories of these bodies are very detailed, full of particulars and different perspectives stemming from various sources.

On the other hand, bodies of chronic and terminal patients tend to become invisible in the ward's working practices. In the management of the resources of the ICU, they slip back to moments of scarce activity, and technologies applied next to their beds diminish and become routine as the personnel perceive the chronic trajectory of the patient. These bodies do not require constant care anymore; respirators are set up and for days there can be no variation in their settings, for the relative conditions are considered stable. Even the medical record appears to be more silent as the checks become less frequent, the examinations are arranged in a bigger interval of time and medical advice vanishes.

When the trajectory of patients in the ICU cannot be concluded and the bodies do not improve despite treatment, they tend to vanish in the formal and informal organisation of the ward. These bodies are perceived as not requiring to be checked, and at the same time, the medical staff avoid their view in order not to question continuously the therapeutic adequacy and the effectiveness of the treatment. The bodies' 'social death', which Sudnow (1967) describes in his work as a set of practices that anticipate clinical and biological death, become more and more apparent. In particular, it is well distinguishable how medical staffs' perception

of patients sets up different types of organisational arrangements, to which the two dispositions of body are related. Even medicine, in spite of exponential growth in knowledge and in the effectiveness of treatments witnessed in the last decades, experiences a border beyond which its advances and techniques can do very little to heal patients (Goodwin, 2014). The organisation and the working practices of the ward are further attempts to stem such a sensation of ineffectiveness, together with the process to remove uncertainty in the medical practice, a process already started in the formal training of healthcare staff (Timmermans, Angell, 2001).

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