**Journal of Sound, Silence, Image and Technology**
Número 7 | Desembre 2024 | 74-88
ISSN 2604-451X | DOI: 10.60940/jossitv7n7id432132



# Patient Bodies and the Heard World of Cinematic Hospitals

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Submission date: 10th July 2024
Acceptance date: 26th November 2024
Publication date: 20th December 2024

KEYWORDS: VOICE | SOUND DESIGN | HEALTH HUMANITIES | COVID-19 | DIGITAL SOUND/NOISE.

PARAULES CLAU: VEU | DISSENY SONOR | HUMANITATS DE LA SALUT | COVID-19 | SO I SOROLL DIGITAL

**ABSTRACT**

As an extreme form of crisis where medical discourse got preoccupied with human behaviour and social distancing, the COVID-19 pandemic also created an unusual desire for community, for listening and caring amidst deep silences. Covid wards became spaces of intimate encounters between patients and caregivers, both in a state of extreme precarity. Health facilities became sonic territories, where listening had to be recalibrated to compensate for muffled voices and unintelligible utterances mediated through masks, bi-pap machines, and ventilators. How do we take into account the comatose sonic body of the patient whose breath we hear only through the machine? Drawing on a transdisciplinary approach of film studies and sound studies, I turn to two recent Indian films that give us an intimate encounter of screen bodies in a state of extreme precarity and medical distress, while being under the care and supervision of health professionals and caregivers. I consider how technological mediations rejig the relationship between sounding and listening, to pressure the idea of voice as a site of signification. Digital sound technologies and computational media play a critical role in expanding our heard world to include the sonic voice of both non-human and comatose bodies. Following Jonathan Sterne's use of the term mediate auscultation to refer to it as a listening technology, I argue that cinema in the post-digital age can pose itself as a listening technology, enabling us to listen to sounds that may not be audible to humans in the first instance.

**RESUMEN**

La pandemia del COVID-19, como una forma extrema de crisis en la que el discurso médico se preocupó por el comportamiento humano y el distanciamiento social, también suscitó un deseo inusual de comunidad, de escucha y de cuidados en medio de profundos silencios. Las salas de COVID se convirtieron en espacios para encuentros íntimos entre los pacientes y sus cuidadores, ambos en un estado de extrema precariedad. Los centros sanitarios se convirtieron en territorios sonoros en los que había que recalibrar la escucha para compensar las voces apagadas y las palabras ininteligibles mediadas por las mascarillas, los aparatos de respiración asistida y los ventiladores. ¿Cómo se puede tener en cuenta el cuerpo sonoro comatoso del paciente cuya respiración solo oímos a través de la máquina? Aplicando un enfoque transdisciplinar de los estudios cinematográficos y sonoros, la autora recurre a dos películas indias recientes que ofrecen un encuentro íntimo de cuerpos que aparecen en pantalla, en un estado de extrema precariedad y angustia médica, mientras se encuentran bajo el cuidado y la supervisión de profesionales y cuidadores sanitarios. El artículo considera cómo las mediaciones tecnológicas reajustan la relación entre el sonido y la escucha, para proponer la idea de la voz como lugar de significación. Las tecnologías de sonido digital y los medios informáticos desempeñan un papel fundamental en la ampliación de nuestro mundo sonoro al incluir la voz sonora de cuerpos no humanos y comatosos. Siguiendo el uso que Jonathan Sterne hace del concepto de "auscultación mediada" para referirse a la auscultación como tecnología de la escucha, la autora sostiene que el cine en la era posdigital se puede presentar como una tecnología de la escucha, que nos permite escuchar sonidos que pueden no ser audibles para los seres humanos en primera instancia

The COVID-19 pandemic created new inventories for listening to our auditory environment. As lockdowns shut down our cities across the globe, we started listening to our environments[1]. Bird calls, crickets, neighbour's kids or pets, we soaked into these sounds. Covid wards too became spaces of intimate encounters between patients and caregivers, both in a state of extreme precarity (Gopichandran & Sakthivel, 2021). This paper is an attempt to examine two films made in India before the pandemic that seem to pre-empt its experience, with narratives intensely located in medical facilities with critically ill patients needing respiratory support. I will argue that cinema as an audio-visual form is in a unique position to push us to think about both voicing and listening as an experience of the contemporary. By inviting the spectator into immersive sonic territories located in ER and ICU wards, cinema and new media arts nudge us to take into account both audible and inaudible bodies in a state of extreme precarity. The comatose body strapped to a ventilator in an ICU ward with amplified breathing sounds seems to question the disjunction between the interior and the exterior domains (Wegenstein, 2010, p. 25). ICU wards in these films are crafted as sonic territories carrying audible sounds of machines, voices, murmurs of patients and health workers and the silence of bodies. This framework also demands a detour toward a historical look at the sound aesthetics of Indian cinema and their transformations in the post-digital media ecology. Through a method of close listening, I disassemble the soundtracks in conjunction with the image/narrative action, to demonstrate how sonic environments inhabited by patients, and health workers, become part of a larger sensorium in a situation of crisis. I consider cinema as a visual and sonic form that is in a unique position to push us to think about voice, environmental sound and listening in a post-human context as an experience of the contemporary.

## Sound aesthetics of Indian cinema

Scholars working on auditory cultures of Indian cinema have argued that the dominance of film songs, background music and dialogues left little room for environmental sounds and ambient tones (Rajadhyaksha, 2007; Pemmaraju, 2013, Jhingan, 2022). There was an overwhelming tendency in commercial films across regional industries to rely on foley sound and loud, dramatic background scores in monoaural soundtracks[2]. Through his conversations with sound professionals working in the Bombay industry, Pemmaraju notes how filmmakers deployed sound to privilege "narrative, expressionistic and mythic values," rather than the truthfulness of experience, perspective, realism or the fidelity of tone, texture and timbre" (2013, p. 70). Technology played an important role in establishing dubbing or post-synchronised recording of dialogs (known as ADR, Automatic Dialogue Re-

1 See for example Mara Maracinescu's "Pandemic Soundscapes" – Sounds across Europe during the coronavirus pandemic, recorded during the 2020 lockdown (House of European History, 2020).

2 The four southern industries include Malayalam, Tamil, Kanada and Telugu cinema. However, as recent scholarship has established within each of these regional industries, there is a substantial diversity in terms of sub-regionality, dialects, styles and industrial and aesthetic practices.

placement) as an industrial norm, to help bypass the sound of noisy Arriflex cameras while filming (Bhattacharya, 2021a, p. 179). Intervening with his theoretical insights, Ashish Rajadhyaksha has rightly foregrounded the "curious resistance of Indian cinema to live sound," that was responsible for the failure of Indian cinema to become properly realist (2007). Let me cite an instance from *Achanak* (1973), a film that revolves around the narrative of a prisoner on death row who gets critically wounded by gunshots as he tries to escape from custody[3]. The film has been described as a medical thriller, that captures a close relationship between the medical team and a patient in a hospital setting. The film opens with the arrival of a grievously injured convict who is not expected to live beyond a few minutes. However, when this is proven wrong, the patient is taken in for an extensive surgery. What follows is a two-minute sequence capturing the procedure from several camera angles, focusing on the faces of the medical team, the patient, the tools, a small rudimentary monitor and blood transfusion machines, repeated in a pattern. Aurally, the scene is crafted with a dramatic musical score dominated by a heavy string section, clanging and beating of cymbals, the strumming of a guitar in the middle section to indicate the passage of time and a final building of tension with the introduction of low bass rhythmic drumming that is matched with the weakening of the pulse on the monitor[4]. The dominance of a non-diegetic score with variations in the sound chain points towards an attempt to hold onto the spectator/audience's interest in an event of a crisis where the images remain static and repetitive. The sound of surgical tools being picked and placed back a couple of times is a half-hearted attempt to create a fidelity to space, action and event.

*Achanak* captures various stages of the convict's sluggish yet "miraculous" recovery from the medical crisis, woven through flashback sequences that reveal the sequence of events before Major Ranjeet Khanna, a decorated Army officer, kills his wife and lover in a so called-crime of passion. Though the approach to sound is tilted towards James Lastra's telephone model, or direct sound, with exaggerated tones (1992), the film manages to create the hospital as a sentient auditory terrain. In the recovery room distinct voices of the doctors and the health workers are juxtaposed with the patient's low moans and murmurs. The parallel editing works to move back in time to carve out a past when the Army officer received audio letters from his wife, including songs that she sung for him, while he was on duty with his unit. In another scene, when we see the patient lying awake at night, the camera tilts up from a mid-shot of his face, to the window behind his bed, as the sound of a moving train fades up. This creates the trigger for another extended flashback. In a scene when

3 *Achanak* was directed by Gulzar and based on a story by K.A. Abbas. It is known to be inspired by the highly mediatised trial of K.M. Nanavati, a commander in the Indian Navy who killed his wife's lover in a so-called act of passion in 1959. This incident was heavily covered by the tabloid press and there was a huge amount of public support created for Nanavati, who was a highly decorated naval officer and represented the nation-state (Gadihoke, 2011).

4 This rhythmic drumming has been created through a mix of Indian and Western drums and is attempted to synchronize with the action or the movement of the pulse on the monitor. This technique is called *mickey-mousing* (Handzo, 1985, p. 409).

we finally see the patient fully conscious and well, he asks the nurse the number of days he has already spent in the hospital. As she informs him that it has been 41 days, we hear the off-screen sound of a whistle. The two exchange an impish smile while looking towards the window. Next, the patient demands to know the name of the young man she is romantically involved, thus drawing attention to the sound of the whistle. Once again, this scene establishes the patient being sensitive to auditory stimuli and the importance of voicing and listening in the affective relationship between the patient and the health worker. Each sound in *Achanak* is made distinct in the soundtrack and connected to its source thus establishing causal listening (Chion, 2012, pp. 25-34). The background score with its overstated expressionistic style is harnessed to "fill in" for the lack of location sound and spatial perspectives[5].

When it was released, film critics noted that despite being a commercial film, *Achanak* was a songless film, that relied heavily on the background score and an interesting use of sound. In this regard, *Achanak* seems to be influenced by New Wave films like *Bhuvan Shome* (1969), crafted with studio-based "non-naturalistic, processed and modulated use of sound", enhancing its affective modalities (Chattopadhyay, 2012, p. 71)[6]. By the mid-1970s New Wave filmmakers like Shyam Benegal, Govind Nihalani and Adoor Gopalakrishnan had started pushing the envelope by including sync-sound and field recordings to bring in a modulated use of sonic realism in their films[7]. The documentary film movement in India by the 1980s, brought into force a palpable shift towards location sound, field recordings and inscription of voices that organically carried environmental sounds and traffic noise in the background[8]. Despite these shifts in the sound aesthetics of Indian cinema, it took another two decades for sound technicians to introduce location sound recording, thereby bringing in fidelity and spatial perspective while crafting sonic territories in films in step with global practices of sound design. Digitally created audio tracks with a greater dynamic range allowed sound designers to play with a greater range of frequencies and create layered and evocative soundtracks that were more sensitive to spatial settings (Chattopadhyay, 2021a). Recently, Pavitra Sundar has insightfully brought our attention to "contemporary experiments in song, film sound and speech [that] emerge alongside, and demand, different listening practices" (2023, p. 10).

Discussions on innovative sound design in films have been skewed towards action genres,

5 Pemmaraju has also discussed lack of budgets in the production chain, where sound was given the least amount of importance by the industry, especially in the 1960s and the 70s (2013).

6 The Indian New wave cinema was inaugurated in the 1970s with the aid of a new approach developed by the Film Finance Corporation to help the film industry make more meaningful 'realist' cinema that was not driven by commercial interests (Bhaskar, 2013; Prasad, 1998).

7 In a conversation with Buddhaditya Chattopadhyay, Shyam Benegal has shared that he liked the idea of using "direct sound" as was practiced in Europe, which gave a "sense of reality" that was impossible to get in post-sync sound (Chattopadhyay, 2021b, pp. 21-22).

8 Important documentary films in this trajectory are: *The sacrifice of Babulal Bhuiya* (1981) by Manjira Datta and *Bombay, Our City* (1985), directed by Anand Patwardhan.

crime, fantasy, horror and war films, acknowledging the importance of technologies like Dolby and surround sound technologies in imagining and crafting spectacular sequences (Elsaesser & Hagener, 2015, pp. 129-148). Driven by the experience of the pandemic, I intervene to discuss two films that deploy digital technologies to create sonic environments in hospitals, where both listening and sounding get lionised through the mise-en-scène and narrative themes.

## Listening as an audile practice in medical science

Before we turn our aural attention to films that narrativize experiences of diseased bodies, enmeshed in relationship with other bodies (health workers, care givers and pathogens), it is important to historicize the deep connections between listening, medical science and human bodies. In his work on the history of sound in modernity, Jonathan Sterne has argued that "listening was one of the central modalities" through which the human body was turned into an "object of knowledge" (2003, p. 99). Sterne has foregrounded the concept of mediate auscultation that brought forward a philosophy of mediation in a medical practice of listening. The stethoscope according to Sterne was responsible for shifting the practice of audile diagnosis from inter-subjective speech between patients and doctors to the "objectification of patients' sounds" (2003, p. 117).
By using the stethoscope, he adds:

> ...doctors learned to restructure their auditory space. Mediate auscultation articulated both physical and a social distance between doctor and patient, enacting a distinctly modern sensibility about bodily presence and distance. All these factors organizing space helped create and frame a sonic event where sounds were grouped into "interior" sounds which had diagnostic meaning, and "exterior" sounds which were to be ignored (Sterne, 2003, p. 128).

While Sterne drew attention to audile-interpretive practices to discuss how the body is seen in the modern practice of medicine, I turn to cinema as a listening practice to engage with the social, technological, and environmental aspects of medical humanities. I discuss two films produced in the pre-pandemic period that deploy digital sound technologies to create sonic territories in hospital wards to rehearse a "tension between the body as object and as an agent of experience" during a period of acute medical crisis (Wegenstein, 2010, p. 21). In this regard, we have to consider the sophisticated medical technologies that have further expanded the way the body is treated as a medium for the production of knowledge. Cinema in its contemporary ecosystem is in a unique position to limn the process of embodiment where its digital apparatus (both sound and image), enters into a dynamic relationship with the medicalised body. The informatization of the body is upheld, in a speedy, dynamic relationship with the health workers and caregivers drawing attention to both "interior and exterior" sounds. Digital sound technologies and computational media play a

critical role in crafting medical wards and their surroundings as sentient territories that can give voice to both human and non-human bodies.

## The sonic body of a comatose patient

*October* (2018), directed by Shoojit Sircar, is a "quiet" film, a departure from the usual Bollywood film melodramas. Dan and Shiuli are hotel management trainees in a five-star hotel in Delhi. Dan is a confused young lad, ambling along and often struggling to keep up with the discipline that the job demands, while Shiuli is appreciated for being a good worker. In an accident at an evening party organized by the trainees, Shiuli falls from the terrace of the hotel and gets grievously injured. The doctors inform the family that Shiuli has slipped into coma and her chances of recovery are minimal. Dan, who was not present at the site of the accident, learns from his friends that Shiuli was asking about him, just before she slipped and fell from the terrace ledge. Dan starts obsessively visiting the hospital, sneaking into the Neuro ICU ward, where Shiuli lies motionless, unresponsive to any stimuli. Undeterred, Dan starts communicating with her in his own naïve way, sometimes annoying the health workers and his friends[9].

**Figure 1. Shuili lying comatose in the Neuro ICU. Screen Grab from *October*.**

The first time we see Shiuli in the ICU, the sound of her respiration through the ventilator remains persistent while the doctor explains her condition to the family. The cinematic framing: camera angles, editing of images, the sound of the medical devices, and the presence of Shiuli lying comatose highlight a performative body: a process of embodiment, in a state of extreme distress (Fig. 1). The digital apparatus of cinema brings into attention the body's entanglement with medical devices, constantly monitoring her vitals. The computational devices instance what Bernadette Wegenstein has referred to as a positioning of the media not secondary to the body, but rather as *constitutive* of bodily experiences (2010, p. 29). The construction of the ICU ward as a sonic territory draws us into the rhythms of bodies enmeshed with highly sophisticated medical devices. This connects with Chattopadhyay's argument that "digitalised sound practices enable the creation of "multi-chan-

9 In speaking about the writing of *October*, Juhi Chaturvedi has shared that Shoojit Sircar had taken care of his mother who had slipped into coma, and Chaturvedi had also been a caregiver to her ailing parents for a considerable period of time. However, in this film, the idea was to explore a relationship between these two characters who really have no relationship with each other and see how far, Dan, the caregiver can go into this relationship.

nel sound design," commensurate with spaces that are being evoked in a perceptible way (2021a, p. 24).

Can comatose patients hear us? This question remains palpable throughout the film as the soundtrack captures Dan's engagement with Shiuli's highly medicalised, sensory body. The sound of respiration creating a hissing rhythmic pattern with the machines seems to affect Dan, evoking curiosity about her condition and keeping his hopes alive. The mise-en-scène, with a non-dramatic sound design alerts us to various stages of Shiuli's embodiment. As Dan enters the ward, we hear announcements on the hospital address system. The security guard gives instructions to remove his shoes and sanitise his hands in a hushed tone. We now enter the ICU ward bathed in a sonic envelope, layered with room tones, the hum of the air conditioners and the sound of high-pitched alarms attached to various devices beeping at regular intervals[10]. Next, we see Dan walking towards Shiuli's bed from behind her bed: the sound perspective now shifts to subtly amplify ventilator-delivered breath, mixed with monitor tones indicating the reading of her vitals in a rhythmic pattern. The sequence through the sound-image synchronization seems to create an intimate space between Shiuli and Dan, pre-empting the interpersonal dynamics (Fig. 2). Slowly, over the next few scenes, we see how Shiuli's siblings start giving up on her, while Dan gets intensely involved with her somatic body. This distinction is highlighted by the extra-diegetic background score when the family members are sitting in the waiting rooms. In contrast, the film creates a more immersive sonic experience of the ICU's ambient sounds when Dan visits her at night, often speaking to her as if she can hear him and make sense of what he is trying to communicate to her.

**Figure 2. A closer look at Shiuli from Dan's point of view. Screen Grab from *October*.**

In an interesting sequence, the film captures Dan coming across Shiuli's urine bag while looking for his visiting pass, which has fallen under her bed[11]. This hypersensitization to Shiuli's bodily functions prepares us for the next important sequence. Recalling her love for the fragrant night jasmine flowers, Dan keeps some jasmine flowers next to her bed.

10 This is in complete contrast with the soundtrack in *Achanak*, where each sound was made distinct and tied to the chain of causality.

11 The night flowering jasmine or *Nyctanthes arbor-tristis* is also called *shiuli* in some Indian languages, like Bangla and Hindi, and blooms in the Autumn season.

The presence of olfactory stimuli becomes a scaffolding to connect with the other sensory phenomena. The next morning, the nurse notices the sound of amplified breathing, along with a slight movement in Shiuli's nostrils[12]. Sound becomes an extension of her sensory self, highlighting her sensitivity towards other senses. In the next sequence, Shiuli responds to the verbal instructions of the doctor, by moving her eyes and giving a sign that she can comprehend verbal communication. Momentarily, this event offers a new hope of recovery to the family. *October* nudges us to listen more closely to the breathing sounds of the patients and to the quiet silence of the ICU, where we are made privy to both spoken and unspoken communication between Dan and Shiuli.

However, in terms of narrative events, nothing much changes in the film. After Shiuli shows signs of slight improvement, she is brought home for palliative care. Nudged by her mother to focus on his own life, Dan starts working in a hotel in Manali. When he learns that Shiuli has stopped eating and is having angry outbursts directed towards her family, Dan comes back to Delhi to take care of her. In a poignant moment, when he takes her to a nearby park in a wheelchair, Shiuli uses her voice to say 'Dan.' This utterance finally gives materiality to her voice that can be inscribed on the film. The next day, Dan comes to know from her mother that Shiuli has passed away.

## Thresholds of audibility in an ER ward

*Virus* (2019), a Malayalam film directed by Aashiq Abu, follows a team of medical experts trying to tackle the crisis triggered by the outbreak of a deadly virus in a small region of Kerala. The film is based on a real event of an outbreak of a "highly pathogenic" Nipah virus in 2018 that claimed 17 lives, showing how a group of dedicated health workers, administrators and social activists managed to contain the virus[13]. Veena Hariharan has rightly pointed us towards the film's realist style, but also observes that it cannot completely do away with the tropes of melodrama. The music, according to Hariharan, "is modulated to enhance affect and elemental nature" (2024, p. 168). Described as a medical thriller by film critics on its release, the film stages a team of epidemiologists desperately trying to identify the virus, similar to the hunt for a serial killer in a typical procedural film. However, what sets the film apart is its micro-detailing of the auditory relationship between patients and the doctors in the emergency wards and isolation rooms, where silence, ambient noise, murmurs of voice and a piercing musical score guide us into various narrative ups and downs. What is noteworthy about the sound design is that the tonality or the sonority of the words seem to matter more than their intelligibility[14].

12 Patients under coma can hover between multiple layers of consciousness and unconsciousness where in some situations they can respond to olfactory sensations or sounds. However, it is difficult to ascertain whether their ability to hear also means that they can register sounds completely or comprehend those sounds. I want to thank Dr. Sumit Ray, critical sare specialist, for explaining these different layers or stages that comatose patients go through.

13 According to WHO, Nipah virus is a zoonotic virus that can be transmitted from animals to human and further human to human contact (Bina et al., 2019).

14 I draw upon Pavitra Sundar's discussion of *Satya* (1997), where she notes how words and speech in the film are used as sound (Sundar, 2023, p. 170).

Unlike *October*, whose narrative was located in the ICU of a private hospital, *Virus* takes us to Calicut Medical College, a crowded public hospital of Kerala. An extended sequence early on in the film shows crowds, security guards managing the chaos of the incoming patients with trauma injuries, and doctors, nurses, and patients jostling for space in the emergency ward. The tension gets built as a health worker dies suddenly with unexplained symptoms. Following the narrative codes of a crime thriller, the film moves between different locations, characters and micro stories to give clues to the spectators that some catastrophic events are waiting to unfold, unknown to the medical fraternity. The doctors in the ER are unaware of these parallel events. An important sequence in the film is the arrival of nurse Akhila in a state of respiratory distress: things are already chaotic by now, but Akhila tries her best to make herself heard. The unfathomability of the situation is heightened by the precarity of breath, highlighted through her stutters, and intermittent use of a low-frequency rumble sound that seems to stand at the periphery of the background score. Akhila pleads with the doctors to intubate her. The senior doctor tells her, "Don't worry, we will look after you, you are one of us," and asks for a repeat of the dengue test[15]. Struggling to breathe, Akhila tells them that she does not have dengue. As her condition deteriorates, the doctors give her an oxygen mask and decide to intubate her, while Akhila struggles to convey that she had provided care to a patient in another hospital, who had similar unexplained symptoms and had died. This is the moment in the sequence when the doctor pays his full attention to Akhila, bringing the spectators and the narrative community somewhere closer to each other through attentive listening (Fig. 3).

**Figure 3. Akhila tries to make herself heard by the Doctor in the Emergency ward. Screen Grab from *Virus*.**

In *Virus*, the emergency ward presents new challenges: the thresholds between interior and exterior sounds get complicated by the repetitive presence of a glitch sound each time a new patient falls sick to the disease. While the doctors struggle to make sense of the disease, the film pulls the spectators towards the unusual acousmatic rumble that starts getting distorted into a glitch, indexing the virus. The glitch noise disappears when

15 Dengue is a viral disease transmitted to people through the bite of infected mosquitoes. It is very common in tropical and subtropical regions. In severe cases, it can cause internal bleeding with the body going into a shock.

the haunting background score fades up and starts enveloping the image gesturing towards the imminent arrival of an uncertain crisis. The spread of the pathogen gives rise to the greater circulation of media, activating circuits of fear, amplifying the presence of news media, sirens of patient vehicles and mobile notifications. On the other side of this curtain of loudness, the film creates moments of silence, despair and longing. As the hospital tries to isolate the infected patients, we see their loved ones desperately trying to meet them, to ask for forgiveness to redeem themselves.

In the next part of the film, the camera slowly rehearses its entry into the isolation wards, with a distinct pink hue (Fig. 4). We see doctors, health workers, and pallbearers struggling to get into PPE kits and face masks that have become the new norm. The film shows how isolation wards turn into interrogation chambers as epidemiologists race against time to understand the source of the virus, by analyzing the transmission dynamics of the disease. Volunteers are hired in a control room to trace the patient's contact history and social relations. Sounding and listening are intensified not through the presence of voice but rather the foreboding presence of noise. In an important sequence, we see Dr. Anu, talking to Akhila who is now being given respiratory support through the machine[16]. The distance between the two becomes palpable as the doctor is geared up in a Level A PPE kit, completely masked. While Akhila tries to speak through her oxygen mask, the rustling sound of the PPE kit further accentuates the uneasiness in their ability to hear and be heard[17].

**Figure 4. Healthcare workers in the isolation ward. Screen Grab from *Virus*.**

The soundtrack plays a critical role in building the atmosphere of discomfort and fear. Dr. Anu who has been tasked to find the source of the virus interrogates a patient in the isolation ward. Unnikrishnan, who has had a brush with the law, looks visibly distressed

16 According to Ajayan Adat, the sound designer of the film, the actor's vocal "performance was according to whether the character is wearing a mask or not wearing a mask so all these things were taken into account in terms of sync sound. If it would have been dubbed then we would need to process it to give it that feel but it will sound slightly artificial. But here, we did sync sound recording, and if they were in a PPE kit or masked, I miked them accordingly. I added the sound of the machines/medical devices that I had recorded separately (Adat, 2024).

17 According to Ajayan Adat, he used silence and foley to enhance the sound of the PPE kit. The idea was to create a soundscape from the patient's perspective, registering the psycho-acoustic effect. Each time the doctor moves, the rustling sound gets accentuated, creating fear and discomfort (Adat, 2024).

as he struggles to breathe while responding to questions about his recent travel history (Fig. 5)[18]. When Anu pushes him to answer questions about his illegal activities, Unnikrishnan takes recourse to silence. As he breaks down, he asks Dr. Anu how a dying man can be subjected to this cruelty. Minimal use of sound plays a critical role in this scene in capturing the state of distress of the patient. The film stages a breakdown in the flow between patients and health workers and voicing and hearing, when Unnikrishnan starts getting agitated in the isolation ward, unstrapping himself from medical devices crucial for his respiration[19]. Zoning into a state of incoherence, we see him getting visions of his mother, murmuring that "he did no wrong", just before collapsing on the floor. Amidst the patient's condition of altered sensorium, impaired cognition, confusion, and breathing distress (ARDS), the film highlights the inability of the patients to articulate themselves through verbal speech. The encounter between the doctors and patients is marked by voice remaining at the threshold of audibility, through modalities like stuttering, amplified breathing, and coughing that gets further highlighted by the subtitles (Fig. 5). The image-sound complex with text on screen enhances the experience of fragmentation and a sense of isolation.


**Figure 5. The patient in breathing distress under interrogation. Screen Grab from *Virus*.**

## Pathogen as an aural glitch

Jonathan Sterne has offered a critique of the overt reliance on intelligible speech and voice as a locus of political, cultural and sonic agency (2003, p. 345). Steven Connor has highlighted the noisiness of the voice, that escapes signification (2014)[20]. In Virus, several strategies have been deployed to underline the fear of the patients amidst the foreboding presence of the pathogen. Prominent in the sound design is the use of subsonic drone sounds, combined with low-frequency distorted noise of an aural glitch, indexing the aural and material presence of the virus that escapes interrogation. This connects

18 In this scene, Unnikrishnan is shown breathing with the help of an oxygen mask and pressure-supported ventilation.

19 In this scene, Unnikrishnan is shown to be on an NIV (Non-Invasive Ventilator) support for respiration. The film thus carefully shows patients going through different stages of illness and the corresponding need for support in respiration.

20 In another work, Connor (2013) has made a distinction between speech and voice, where the latter can reach us across broken and fragmented speech.

with Michel Chion's idea of the acousmetre as an unidentified being, that hovers around the screen (1999). Further, Donnelly has argued that asynchronous sound can create a sense of foreboding or moments of textual danger (2014, p. 8). The asynchronous glitch noise is first introduced in the track in the title sequence just before 'Virus' as the title of the film appears as text on the screen in green and pink psychedelic colours. We are introduced to a disturbing rumble-like noise, which is our first encounter with the aural glitch. This mutates into distorted tones of a medical monitor that get abruptly cut off with the sound of a technical glitch. Following the codes of a crime thriller, the background score and sound design are crafted to alert the spectators to the dangers lying ahead, while also enticing them bit by bit with the suppressed 'voice' of the pathogen presented as an aural glitch. "Noise," writes David Novak "is a relational concept" (2015, p. 126). As Novak adds:

> It [noise] can only take on meaning by signifying something else, but it must remain incommensurably different from that thing that we do know and understand. Even in the fundamentally relativistic context of musical aesthetics, noise is defined by its mutual exclusion from the category of music (2015, p. 126).

The crafting of the sound design with digital technologies works to give a distinct identity to the virus, as the film tries to apprehend and inscribe its lurking presence in the environment. Technical sound recording in the age of new media, according to Miriam B. Hansen, can "inscribe frequencies outside the range of human hearing," contesting the limits of "human modes of symbolization" (2010, p. 178). However, digital technologies have been leveraged to create an aesthetic of noise that marks the sonic presence of the pathogen. In an important sequence, the glitch fades up for a few seconds, when we see Akhila losing her battle to the virus. What follows is a deathly silence, as the health workers start removing the respiratory mask, the endotracheal tube from her mouth, and the tapes from her face that have been used to secure the tubes. Next, a loud excited voice of a news anchor fades up on the track as a sonic bridge, announcing her death[21]. The image and sound complex are thus used to give weight to Akhila's silence, and her voicelessness in contrast to the media's hyperbolic aural presence. In the next shot, we see the anchor with a microphone reporting the news for a television channel. The aural glitch in *Virus* is activated to inscribe the presence of the pathogen, highlighting in the process the gaps between the medical system and patient care, and the inability to perceive voicing and listening beyond the human world.

21 Akhila's silence is related here to her respiratory condition that forces the doctors to put her on invasive ventilation because of which the patient cannot speak. In an earlier sequence, we see Akhila with Dr. Anu, where she asks her for a paper and pen so that she can write a letter to her husband. In this sequence, Akhila is seen to be on an NIV and can speak through the oxygen mask. Finally, her ultimate silence is also marked by her death.

## Conclusion

*Virus* and *October* deploy unorthodox practices to produce soundtracks that pressure the idea of human voice as a locus of signification. Struggle with voice and voicelessness are highlighted in both films through the sonic presence of patients and care providers during a medical crisis. When we compare these films with Achanak, a film made in the 1970s, we can apprehend how in the contemporary period, digital technologies have played a key role in producing immersive soundtracks that are sensitive to spatial markers and deeply enmeshed *within* the diegesis. It is important to note an emerging critique in *Virus* of producing cinematic sound as voice, music, and ambient noise only from the vantage of human experience. The aural glitch in *Virus* can be read as a technological mediation, harnessed to create an auditory presence and perception of the pathogen. In the post-pandemic world, Jonathan Sterne's use of the term mediate auscultation becomes productive in thinking about cinema and new media as listening technologies, enabling us to listen to sounds that may not be audible to humans in the first instance.

## Acknowledgements

I am grateful to Dr. Sumit Ray for sharing his experiences in handling ICU wards and helping me understand the monitoring devices and medical protocols used for critically ill patients. I want to thank Ajayan Adat, the sound designer of *Virus* for sharing his approach and aesthetic choices for the film. I am grateful to Vibhushan Subba for his careful reading and helpful comments.

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