I really got to know my patient—in the morgue

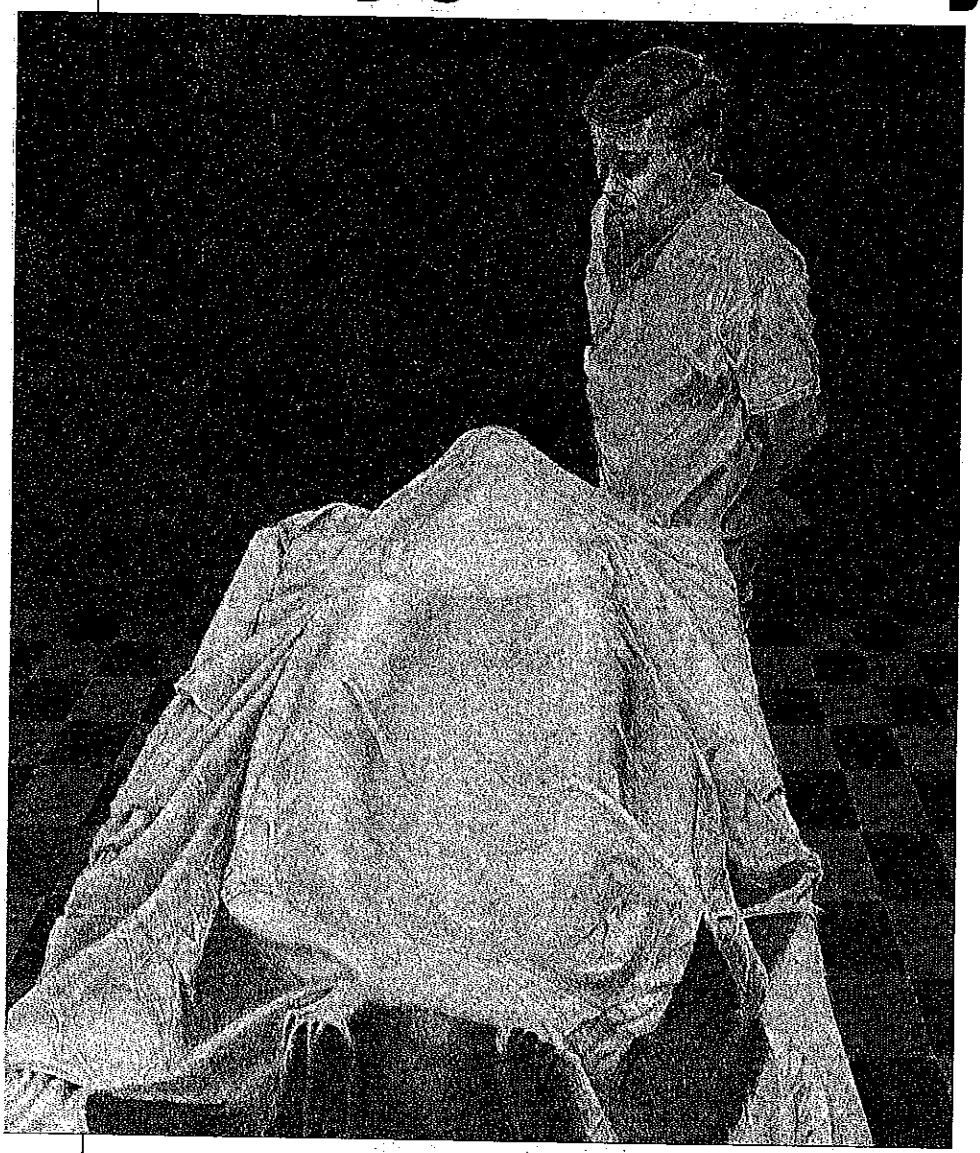

Illustration by Ron Zawistowski

The author had treated the paralyzed man for over a year, but the most memorable encounter occurred during the autopsy.

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The sign on the door said "No Admittance." I guessed correctly that I'd arrived at the morgue. The pathologist had said he'd try to join me, but I should go ahead. So I turned the key and entered a small locker room. A pair of grimy, stained shoes lay under each of six tall lockers. My white sneakers would have to do. I hung my clothes in a locker and slipped on surgical scrub pants and a shirt.

Usually, I wear slacks, a long-sleeved shirt, a tie, and a white lab coat to work. I felt strangely undressed in the short sleeves and deep V-neck. In fact, I felt generally strange: I'm a physiatrist—a rehab specialist. I deal with people who are alive, and awake. No knives. Since medical school, I'd had no reason to wear surgical garb.

I looked briefly for a paper cap, then stopped. This wasn't surgery. Brad wouldn't care if my hair infected his wounds.

At the other end of the locker room was a set of double doors with frosted glass windows. I pulled on the door handle, but my hand slipped. Greasy; well, it's not a clean business. The pathologists probably wear gloves at this point.

Brad had wanted me to do this, I reminded myself. I pulled again. Inside, the lights were off. I felt for the switch, and then illuminated a wall of big tools: thick knives two feet long, pliers, an electric drill, tin snips, and an ugly-looking crosscut saw with a stainless-steel handle. A box of double-strength rubber gloves was on a shelf next to the door. I rummaged for a pair of 7½s.

Against the far wall were five

wheeled gurneys, three occupied: human forms, draped in white cloth. I could tell Brad was on the farthest gurney. Knees were tented up, hips flexed. It wasn't rigor mortis; it was the shape of his wheelchair. He'd been in that position ever since we'd lost the battle to get Medicare approval for ongoing physical therapy.

The room was small. I had to shuffle the gurneys around each other. Finally I was alone with Brad's cart, under the bright overhead light. I didn't want to pull the cover off.

His face was pale and distorted. I'd never known it to be otherwise. His right eye was closed, the left eyebrow contracted up. At one time he'd been able to move that eyelid. A bonus. Most patients with his kind of brain damage—locked-in syndrome—can't move much of anything. They can look up and down with their eyeballs. Up means Yes, down means No. That's it.

For Brad, the eyelid was exclamation point and question mark. He used it often. Like when Marie, the incompetent aide, suctioned his tracheostomy, or when I tried to turn off the TV during Star Trek. Today his eyes didn't follow me.

They hadn't that first night after Brad's auto accident, either. He'd looked straight ahead, his pupils dilated in terror. Occasionally, they'd glanced at my face for a split second. But mostly they were fixed on the ceiling in panic.

Over time, Brad had come to realize that his stare could somehow compel my attention—and require me to pull out the letter board, for a 20-minute guessing game in the middle of morning rounds. Some rule in my head, but not on my schedule, said Brad deserved to ask his doctor questions, just like the other patients. But sometimes, when rounds were busy, I'd avoid his eyebrow. Then I'd feel so guilty that I'd invariably return after clinic, usually after 6:30 or so. I'd head home half an hour later feeling better about Brad, but hungry, tired, and wondering whether my preschool daughter had the same right to my time as Brad.

In my talks with him, I always looked for something deep and philosophical, but I didn't find much. He really began to bug me. Who was this guy? I wondered. He was completely cut off from the world. Powerless to do anything other than think—to meditate on his being for days at a time. An existence with no purpose except to absorb what the senses brought in.

It felt strange, putting on scrubs to prepare for the autopsy. I'm a physiatrist—a rehab specialist. I deal with people who are alive, and awake. No knives, not since medical school.

Before the accident he'd been a foundry worker, his wife said. A father, a fisherman on the weekends. But he'd been forced into the role of a monk, I thought. Or somewhere between a hermit and a leper. Or a Buddhist philosopher. The wise one who silently suffered alone, wearing sackcloth, peering out at the world from his unreachable cave at the top of the mountain. And yet, he'd told me he wanted to continue living.

Cases like his were at the center of a controversy. The year of his accident, 1994, The New England Journal of Medicine had published the report on Karen Ann Quinlan, the famous coma victim. A great national debate was raging about whether life was worth living for a person caught within a useless body. The question was tougher, of course, with cases involving patients who were clearly conscious. Like Brad.

I'd jumped into this controversy with a

very public stance that able-bodied people were clueless, and they had no right to pass judgment. We should find out what to do from patients who'd lived through such experiences, I insisted. Brad was one of them. And he could communicate. But he was more interested in complaining about Marie or ensuring that his wife brought a Budweiser, not a Bud Light, to swish around in his mouth.

Paralyzed, Brad would answer with his eyes (up for Yes, down for No). He wasn't glad to be alive, yet he didn't seek death. I'd inquire more, but he'd raise his one moveable eyelid: Stupid question, Doc.

Still, I would ask him, frequently, "Brad, are you glad you're alive?"

Eyes down. Nope.

"Do you wish you were dead?"

Nope.

"Tell me what you're thinking, Brad. Why do you feel that way?"

The eyebrow would raise slowly and sarcastically. Stupid question, Doc.

But why was it so stupid? I wondered. I tried to sneak the question in a few other times and always got the same response. I never got him to the point where he felt like spelling anything out on the board. Even later, when he got weaker and seemed to withdraw from the world, he consistently said that he wanted to live. I couldn't see why. He wasn't all that friendly to the nurses and he hardly signaled when his wife and kids visited the nursing home. Curiously, he would blow an ulcer (literally) if he missed Star Trek. Surely he wasn't living for Captain Kirk?

After a year or so, he conceded that he'd rather not be treated with antibiotics if a pneumonia came along. He wasn't depressed, though. I'd seen him depressed before—quiet, slow eye movements, no eye contact. But had he given up on life? I asked him. No. What had changed? I asked. He gave me the eyebrow again.

I found a scalpel, attached a fresh blade, and turned back towards the body. That eyebrow.

Stupid question, Doc. Of course you're supposed to saw my skull off.

I stepped away. Should I go to the funeral? I wondered. Maybe I should close his eye so the blood doesn't drip into it, I thought. I told myself again that Brad had wanted this. His wife had, too. She'd called me that Sunday morning to be sure I got Brad's brain, to donate it to science. But would she flip out when she saw the large stitches across his forehead? Did she plan an open casket?

I covered his face and put down the scalpel. My stomach felt tight. I braced myself against the metal sink, overcome with nausea. To hell with it. Brad's keeping me away from my kid again. Enough. I turned to the door, but noticed a shadow in the frosted glass. Someone was changing clothes. A big bald guy wearing camouflage poked his head into the room.

"You Doc Haig?" I covered up my nausea with a brief smile and a nod. I turned back to the sink, pretending to wash the scalpel.

"John Piotrowski. I'm the diener on call. Doc Milanovich said to tell you he couldn't make it."

"Sorry we pulled you away from the Packers game," I said. It seemed a safe assumption.

I was right. "No problem, there's a radio," he replied. He tuned it to AM 620, and Jim Irwin's cheerful voice soon boomed through the morgue. He was talk-

ing to his co-anchor, Max McGee.

"Well, Max, up to now this game sure hasn't been one of Favre's best."

"Yeah, Jim, the offensive line was really dead out there. Without better protection, he might just get his head ripped off in this final stretch. We'll be back to find out, after this short break . . ."

John looked at me. "Perfect timing, eh, Doc?" He walked over to the gurney, smiling. "How far'd you get?"

This guy likes the job too much. Preparing dead bodies for autopsy. What the hell makes someone want to be a diener? I wondered. Maybe he's a frustrated anatomist. "Thanks for coming," I said. "This man was a patient of mine for over a year. He's got a rare vagus nerve lesion. Worth writing up in the journals, if it pans out."

"Doc Milanovich said we were doing the brain. Is the vagus around there?"

Well, so much for the frustrated anatomist theory, I thought. He just likes to cut dead bodies. "Yeah, the brain," I replied.

"Give me a hand?" John asked. He'd whipped the sheet off, exposing my patient's entire naked body. I grabbed the hips, and we turned Brad over on his belly. Well, not really his belly. He stayed in the seated position, his knees and forehead pressing into the gurney, the feeding tube dangling from a hole in his belly. I helped John put a wooden block under Brad's chest so that his forehead was off the table. I covered his body again.

"Done many autopsies, Doc?" He pulled off the sheet.

"I'm a physiatrist." He gave me a quizzical look. "A rehab doctor. My patients aren't supposed to die." I evaded his question. "How'd you get into this business?"

He grabbed a scalpel. "Learned taxidermy when I was a kid. Two tours as a corpsman in 'Nam. Great experience. This job was a natural to me." He replaced my blade with one twice as big. My mind tried to shut out the image of a corpsman/taxidermist enjoying a tour of duty in Vietnam.

"I was worried about cutting up the face. The funeral," I said.

"There's a trick." He made a deep slash from one ear clear around the back of the skull to the other ear. As if he were peeling an orange, he thumbed the edge of the cut until he could get a grip. Violently, he jerked and pulled until the scalp peeled up and over the top around to the front, eventually exposing the whole top of the skull bone. The hair and scalp now flopped down over Brad's face. I felt hot.

After he died, his wife called, reminding me to take his brain for science. But would she flip out when she saw the large stitches across his forehead? Did she plan an open casket?

"Let's stop," I said under my breath.

"Yeah, there's a TV here. I'll get it out."

As the diener opened the door with his greasy glove and stepped into the locker room, Jim Irwin announced on the radio, "Third and six. With only two minutes left, the Packers are under plenty of pressure, Max."

"Yeah, now we're going to see what they're really made of, Jim."

I found myself staring at Brad's exposed skull all through the two-minute warning. When I glanced away, I noticed that

John had lifted a 12-inch TV from a cabinet and turned it on, without sound, so he could watch while still listening to the radio. He was lounging on an empty gurney pushed against the wall. Can't we get it over with? I wondered. John looked up at me and motioned toward another cart. I nodded, but glanced over at Brad. I covered his head with the sheet and joined John among the other bodies. I actually started following the game a bit. But then they mentioned sudden-death overtime. I began to hope for it. As the last seconds of the game ticked away, I felt a pit in my stomach grow. The Packers lost. We had to finish up.

"Damn," John said. He flicked off the TV and radio and pulled the sheet completely off Brad. "Got the saw?" He pointed to the wall, oblivious to my whitened lips.

I closed my eyes. All right, the damage is done, I thought. I picked up the saw and plugged it in. It made a high-pitched whir as the round blade vibrated back and forth. I handed it to John.

He raised his hand. "You go ahead. I don't want to be responsible for wrecking your brain."

Too late, John. I touched the saw to the bone. It sent dust and smoke and small chips of bone into the air as it cut. There was the odor you smell when the dentist drills your teeth. Burning bone. I worked the saw around the right to the front, then came to the back again and cut on the left side. The skull cap clunked onto the table.

Suddenly I felt calmer. For more than a minute I looked at the exposed brain sitting in the base of the skull. There they were—the damaged vagus nerve, the atrophied, shrunken brainstem. For the longest time, I peered into the corners and crevices of the anatomical specimen, as if looking for other pathology. I had thought Brad was in there. This was his brain. His personality. A voice I'd never heard. A baseball swing, a penmanship style. A mood, a worry, some math skills, memories of a grandmother. The Buddhist monk. Some illogical, unscientific part of me had expected more. I couldn't tell this brain from my own.

Then I reached down into the base of the skull to the spinal cord, snipped, and placed the brain in a bucket. John replaced the skullcap, pulled the skin and hair over the top of Brad's head. And Brad, brainless, raised his eyebrow at me. ■

Haig AJ, Ho, KC, Ludwig G Clinical, physiologic, and pathologic evidence for vagus dysfunction in a case of traumatic brain injury. J Trauma 1996 Mar; 40(3)441-444.

ABSTRACT: A 39-year-old male with traumatic locked-in syndrome demonstrated decreased bowel sounds, intact response to suppository and elevated, but unchanging pulse. Absent cardiac response to tracheal suctioning, high gastric residual volumes, and pulmonary edema in response to a urecholine challenge demonstrated dysfunction in the autonomic system. Symptoms persisted for 2½ years until death. At autopsy asymmetric bilateral involvement of the dorsal motor nucleus of the vagus and of the nerve tract in the medulla were demonstrated. We conclude that when delayed gastric emptying is noted in a head trauma patient, measurement of the heart rate response to deep suctioning may lead to the diagnosis of this previously unreported vagus disruption syndrome.