intima
a journal of narrative medicine

NON-FICTION | FALL 2023

Body of Work

By Anna Dovre

The cadaver is so small that my first thought, glimpsing her frame through the thin white blanket, is that she's been dismembered from the chest down. All I can discern is the rounded skull, the hint of a nose, two knobs of shoulder.

On the wall behind me, daylight seeps in through tall frosted windows. The conditioned air bounces off stainless steel cabinets and porcelain sinks. On the back of the door, a whiteboard proclaims in a large, curling script, "Be like a sponge: absorb knowledge!" We are third- and fourth-year medical students, here to practice emergency skills on a cadaver. I wear a loaner set of scrubs in mismatched shades of green, and the cloth is stiff against my goose-bump-covered skin. I wonder who wore them last.

For our first exercise, we will learn about airway management. The tools sit on a wheeled stand next to the cadaver table, various tubes and blades and syringes in orderly rows. Our instructor pulls down the blanket far enough to reveal a head wrapped in cloth and gauze, with only the mouth uncovered. Her jaw is slackened, her cheeks hollow and her mouth—empty of teeth—gapes open in a perfect, shadowed *O*. I want to place my warm hands along those cheeks, to peel the bandages off her eyes, to cradle that tiny head in the crook of my arm. And I also want to run away.

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The point here seems simple: corpse as proxy for one's own mortality. But looking at a cadaver doesn't remind me of death; rather, illness, decay and the separation of the body into its constituent parts—skin, muscle, bone, fat. There's no mystery in a cadaver, because dissection is the procedural excision of mystery. A more apt metaphor for death would be something akin to a black hole, the event horizon, the point from which there is quite literally no return.

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I stand at the head of the bed, preparing for intubation. The dull metal instrument in my left hand catches the light, curved like a scythe. I place my right palm over the cadaver's covered forehead, press gently, and her head tilts back. There's debris in her mouth, on the back of her tongue, flecks of dried blood and something else, which coats the surface of my gloved thumb as I grasp her jaw and pull forward. Once I find her vocal cords—those pearly gates—the tube goes in easily. Next to me, a classmate squeezes on a firm plastic balloon, puffing artificial breaths into stiff lungs. I watch the rise and fall of her chest, a miraculous puppetry. Our instructor nods, once. The breaths cease, the tube is removed, and we rotate around the table to do it all again.

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In my early twenties, I volunteered in a hospice program. Among the list of available duties—errands, clerical work, selling plush toys at the gift store—I chose to be a "companionship" volunteer. At the time, death held a comfortably abstract role in my life, a gritty concept to be mused over in basement apartments and sprinkled into essays on Samuel Beckett. I sought a first-hand, transcendental experience; only in retrospect do I see this for the privilege it was. After a few training sessions held in an office building on the outskirts of town, my phone number was added to a spreadsheet and I was deemed ready: a capable companion for the dying.

When the first call came, I drove to the nursing home with my stomach in knots. I had a name, a room number, and a folder full of pamphlets telling me what death ought to look like. The room was warm, sparsely decorated, the twin bed pushed up against the window. There was a bottle of Eucerin on the bedside table, and a Bible. I introduced myself to her, told her I'd stay awhile, though she appeared to be sleeping or comatose or otherwise, in some fundamental way, elsewhere. (Even as we lose our senses, the pamphlets say, hearing remains. How they know this I cannot say.) I rubbed lotion into the tissue-paper-skin of her knuckles and counted her irregular, rasping breaths until my shift was over. She was "actively dying."

This is what I remember most from our hospice training class: that there are different ways to die. To die actively means the pauses between breaths lengthen and stutter; the mind slips into unconsciousness; the skin begins to mottle into starbursts of purple and blue. To die inactively—well, that becomes a question of semantics, of philosophy. Years later, a palliative care doctor would tell me "There's a difference between living longer and dying slowly." As though that difference should be obvious.

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We learn a lot from our cadaver: after intubation come chest tubes, intraosseous lines, surgical airways. The chest tube is the most technically challenging, leveraging a thick plastic tube up and over the rib into the lung space. By the time it's my turn, she already has several holes in her side, and so I follow the paths left behind.

At some point, standing at the foot of the table, taking stock of all the places we've poked and sliced and drilled and sewn her, a snippet of song drifts into my mind: *Your body is a wonderland.* I wonder who to tell this to. And then I wonder at myself: the way my nausea has ebbed, my body looser, at ease. If anything, the scene on the table has become more gruesome, but perhaps that has rendered her less real, less human to me.

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I witnessed my first death in a bustling emergency department on the edge of the Great Plains, where snowshoe hares would graze at the edge of the parking lot. It was my second week on the job; in the trauma bay, a man was strapped under a CPR machine, which pumped his chest

with a relentless metallic fervor. The sound this made was like the pressing in and out of a freshness seal on a bottle cap. One of his arms hung off the edge of the bed and shook in concert with the machinated compressions.

At some point there was a pause, a checking of the pulse, a decision made in a series of glances. Then the machine was unhooked, the IV lines removed, the blanket pulled up over the body. The hospital chaplain arrived: I remember her knitted white cardigan, worn over a canary-yellow shirt with embroidered lapels. She recited a prayer with her palms spread open, as if to catch rain. At the end, she said, "May all in this room know that the place between life and death is a holy one."

We slipped one by one out of that holy room. Someone taped a paper image of a dove onto the doorframe, and we went on with our work. He went downstairs to the morgue. On the electronic patient list, his icon turned a maroon color, the word "expired" materializing in the comment section like an omen. I felt unchanged.

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In medicine, the concept of "mortality" carries a specific, epidemiological meaning, being often uttered alongside—and in conversation with—the concept of "morbidity." These terms live in symbiosis, affectionately referred to as M&M: Morbidity, the state of illness, and Mortality its terminus. When I first heard of an "M&M conference," I was disappointed to learn its purpose: that of reviewing adverse patient outcomes, the unexpected accrual of death and disease. On close review, such misfortunes (a patient falling ill, experiencing an unexpected complication, or indeed dying) may in some cases belie an error in medical practice. The goal, then, is to identify the error and prevent it from happening again. Morbid as the human condition is, many of these cases are found to be unavoidable—a reminder that what's mortal is destined to be so.

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When I return home from the cadaver lab, I shower and let the water run 'til it turns cold. Afterward, I stand in front of the mirror, the fluorescent light abuzz. Along the shadowed column of my neck, I trace the knobs of my trachea, find the thyroid and cricoid cartilages and the ribbon of membrane spanning them. I turn to the side and lift one arm, running my hand along the imaginary line from armpit to hip. We look so different, the cadaver and me. Perhaps I am trying to understand death through comparison. Her fat and muscle had melted away, her skin pulled taut across the scaffolding of her ribcage. On my own chest, subcutaneous tissue obscures the outlines of bone, so I have to find each rib by touch, feeling them lift into my palm with every breath. I pause below my fifth rib, testing the skin, trying to work my finger into the space between the bones. I picture a scalpel making that first incision: dark blood welling in its wake, the pop of punctured pleura, a length of tube sliding in deep, snaking up through my chest, and at last coming to rest in a dark, soft corner, close to my heart.

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There's a planetarium half a mile away from my home, where a man named Thaddeus holds court among the stars. On a cold day in early December, two months after the cadaver lab, I walk to the planetarium along streets bleached bone-white with salt. About a dozen of us claim seats under the darkened dome, necks craned back against cushioned headrests, as Thaddeus takes us five million years into the future: the day when the Milky Way galaxy will collide with our nearest neighbor, Andromeda. He shows us the collision, slowed-down and projected onto the concave screen: two swirls of sparkling dust, catching one another's outstretched arms like partners in a dance. In the heat and gravitational pressure of their joining, Thaddeus says, new stars will be born. "Maybe we'll be able to move to one of them," he says.

I admire his intergalactic optimism, his belief in a collective immortality spanning eons, light-years of humanity stretched over an impossible horizon. I do not agree with Thaddeus. The finitude of my existence, and of our species, is one of the few things of which I am certain. Here is the scale, I think, at which death is its most comforting: a glorious doomsday of staggering scope, so far in the distance that it might as well be fiction. I imagine a dust-strewn dawn, the scattered and flighty particles of my long-dead body caught in orbital eddies, burning and gold-limned by the light of a thousand new stars. And it doesn't scare me at all.

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