

The Halo

By Xi Chen

The doctors are talking. An autumnal blizzard wipes flecks of frost across the windowpane.

“Mr. M—,” the younger doctor intones, “is a 25-year-old man with a past medical history significant for chronic alcohol abuse.”

The older doctor bows his head and stands arms-crossed, feet together. The older doctor listens intently. Falling snow is a metaphor for words.

“Mr. M—,” the younger doctor continues, “presents to the N.M.I.C.U. status-post craniotomy day 10 for H.H. 2, M.F.G. 3 subarachnoid hemorrhage and C-1 fracture secondary to recurrent cranial trauma—”

The older doctor interrupts for clarification, and the younger doctor confesses to not having the information. They look at the patient to fill in the silence. I have the information, but I keep my lips sealed.

“Mr. M—,” the younger doctor continues, “his hospital course was complicated by persistent vasospasm, refractory to nimo...nimodipine prophylaxis and verapamil via D.S.A.”

Grey light from the cemetery across the street leaches through the melting frost, which is solidifying into ice. The doctors are talking in hushed, rushed cantos.

I watch with pen and paper. I watch from the entrance to the patient’s room, with half of my body in the unit, where there is security in numbers. I watch with a wrinkled pad of lined paper in my hand, not writing down a word. I exist to learn how to speak like them, to learn how to summon a snowstorm in early September.

Besides, I have heard this story before.

The rhythmic beeping of vital signs is our metric of time. The elongated gasps from the ventilator eliminate any possibility of true silence. I bore ink infinities into the paper, like a bored toddler doodling in the pews, and stare out at Mr. M. My eyelids are heavy, and I cannot maintain a steady gaze. My vision ripples with its own echoes, and a wave of nausea hits my gut.

Mr. M. lays sprawled in his hospital bed, airless and still, surrounded by the language of machines.

There are no family members present to meet with the team. There are traces of them, though: a box of tissues with the cover ripped off. The subtle imprint of a butt on the visitor's chair. A plastic radio gurgling soft jazz. Rings of water on the patient's unused food tray.

This is all a vague illusion, of course. It has been many months since visitors were allowed in the hospital.

I suddenly feel deeply ashamed of being there. For ogling. For Mr. M.'s profound boredom, having to listen to strangers ramble on about his case. This is an absurd feeling, because he is completely snowed.

A nurse replaces a bag of saline as the doctors talk. It occurs to me that Mr. M.'s eyes are just barely open. They are encrusted with dried blood, debris and ointment. His cheeks and orbits are horribly swollen, but they do not hide the whites of his sclera. They are powerful discs of light; they are powerful refutations of a decaying face.

I cannot turn away from it. There is an intense gravity in the room that only someone as naive as a medical student can sense. It radiates from the increasing entropy of Mr. M.'s body, in its various stages of healing and breakdown. I am struck with an urge to draw it in my notes: the immobile limbs, arranged at unnatural angles, held together by casts and metal rods. Several thin sheets creating their own twisted chaos. Tubes, too many tubes, simultaneously nourishing and cleansing the bloodstream. The chest, grandly exposed, strewn with EKG-leads. The scene is unabashedly sordid, but through my dewy-eyed sight it has an odd holiness. If only I could reach out and change it, tidy the bed, or cover his bare feet...but the doctors are still talking.

When the younger doctor finishes, the older doctor—a neurologist who specializes in intensive care—turns to me out of obligation and asks for my brief impressions of the case. I nod gently at Mr. M. and say that I think the case is very sad.

Everyone agrees, so I pass for the day.

There are no family members present to meet with the team, but I suppose it is better that way. The older doctor walks to the head of the bed and begins the physical exam. I'm told this is the crown jewel of Neurology, the thoroughness and utility of the physical exam. That neurologists don't rely on lab tests and imaging when they can diagnose with the sheer might of their hands. The hand, the only tool used by humans, gentle enough to cradle a baby and fierce enough to wield a war-hammer.

"Besides," the younger doctor later says to me about the physical exam, "it's free."

It's also overrated, at least in the Neuromedicine Intensive Care Unit (N.M.I.C.U.) setting. A majority of the patients already have clear-cut diagnoses, with the most common being strokes, brain hemorrhages, trauma and tumors. For the team, doing the exam is less a matter of discovery, but rather a constellation of data points to compare with prior exams. It's an additional metric of recovery, or deterioration.

The neurological exam is also a profound source of stress relief.

The older doctor prefers to start from the top and work his way down. For humans, there is nothing more top than the mind. I stand in awe as the neurologist places his face within a few inches of Mr. M.'s, and bellows the poor man's name over and over again.

For the awake and alert patient, the "mental status exam" generally involves a series of simple questions about one's identity, date of birth, location in space and time, what's this on my wrist called, can you spell the word "world" backwards, and etc. The mind is the only function of the nervous system not encased in skin or skull, and thus it can only be accessed by language.

The comatose patient presents a unique challenge, in which the tools used become increasingly more primitive, and violent.

The echoes of Mr. M.'s name fill the unit with an avalanche of sound. One's name is the single word that people will fight to respond to, when said loud enough and with excessive repetition. Against the weight of sedation and delirium, most people will at least flutter their eyes, twitch a muscle, or moan.

It dawns on me that this is medicine's essential task, and the source of its power: to bring language from the realm of the ideas to concrete flesh. When a physician is unable to achieve this lofty goal, this unique sovereignty over broken bodies, they can easily fall into causing language's polar opposite: pain.

A squall shakes the window. The older doctor shines a light into Mr. M.'s eyes. Disappointed, he begins his game of nociception. The right foot is held in one hand, and tickled with the other. When this fails to trigger spontaneous giggles, the doctor takes his thumb and slowly draws a question mark from Mr. M.'s heel up to the bottom of his big toe. We all watch for the reflexive flaring of the toes known as the plantar reflex. When there is none, he digs his thumb in harder.

In terms of medical necessity, these steps are sufficient. The neurological intensivist often goes further, however, to prove by exhaustion that everything was tried to stimulate the patient's consciousness. The match cannot be forfeited before the king is captured, or until the board falls apart.

Like a medieval knight raising a polearm, the older doctor draws his reflex hammer from the deep recesses of his white coat. The hammer has a weighted mallet for providing a solid and satisfying strike against tendons, but the neurologist instead uses the metal body of the hammer, pressing it down against the nail bed of Mr. M.'s big toe. No response. He invites me to come try, for educational purposes. Monkey see, monkey do. He warns me to be gentle, lest I be sued for breaking a nail.

There are a seemingly endless number of these mechanical, "noxious stimuli." I will list them here. After the reflex hammer is retired, the neurologist begins pinching a variety of muscles,

especially those in the legs. We take turns going up to Mr. M. and seizing hunks of his flesh in our fingers. Bruising from previous exams is evident.

Next, the excruciating “trap squeeze” in which the trapezius, a flat and triangular muscle that stretches over the shoulders like a scarf, is grabbed and tortured between the thumb and two fingers.

This is followed by the most universally known noxious stimuli, the “sternal rub,” in which a clenched fist is used to dig into the sternum, the blade of bone that defends the heart. This maneuver is sometimes performed for up to 30 seconds.

By far the most painful method, which is like a forbidden spell I have only ever learned of in lectures and books, is the application of supraorbital pressure. The supraorbital notch is a groove in the skull surrounding the eye, two finger-widths lateral to the mid-face, just underneath the eyebrow. Pushing hard on the notch compresses the nerve running through it, which should produce an intense pain localized to the eye and scalp, like a sinus headache. This is the one technique I have difficulty practicing on myself.

Thus, the older doctor traverses the terrain of Mr. M.’s body, crushing nerves and dispelling perfusion. I begin to write things down.

I can see he wants to go even further. A face mask cannot hide a scowl. Perhaps, the older doctor was considering supraorbital pressure, or even a direct blow to Mr. M.’s face.

It is shameful for a doctor to have such thoughts.

Mr. M.’s head is hardly touchable, regardless. It’s the first thing one notices when walking into the room—the ring of black metal with long rods extending from its circumference into the patient’s scalp. A veritable crown of thorns, holding Mr. M.’s head aloft and, most importantly, immobile.

A doctor should never give up, but the older doctor cannot help but sigh and slump his shoulders. The surgery had not helped. He walks out of the room. The younger doctor and I follow.

“Let’s go write notes,” the older doctor says.

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