



ERICA BURKHART

## The Dead Book

JANE CHURCHON

**I like to take my time** when I pronounce someone dead. The bare-minimum requirement is one minute with a stethoscope pressed to someone's chest, listening for a sound that is not there; with my fingers bearing down on the side of someone's neck, feeling for an absent pulse; with a flashlight beamed into someone's fixed and dilated pupils, waiting for the constriction that will not come. If I'm in a hurry, I can do all of these in sixty seconds, but when I have the time, I like to take a minute with each task.

I talk to the patients I'm about to pronounce, even though they're dead. "Mrs. Jones," I might say, "I'm just going to listen to your heart," before I touch the plastic stethoscope to her chest. Because I don't provide direct nursing care to patients anymore, I don't carry my own stethoscope. When I pronounce someone dead, I use one of the disposable stethoscopes designed for listening to the chests of patients with infectious illnesses. They are made of flimsy red plastic the color of cartoon blood, and I feel a little cheap when I use one to

pronounce Mrs. Jones, as if I have shown up at a dinner party in a ripped tube top. But I make sure to treat Mrs. Jones's body with the same respect that I would afford a living, breathing patient. I always imagine her soul sitting in the corner of the hospital room in one of our beige visitor chairs, invisible to the eye but listening with her large, warty ears.

Until I pronounce her, Mrs. Jones is not officially dead. Even though she's stopped breathing and her heart is silent, legally she's still alive. Sometimes I have other tasks to do, and it takes me a while to get to Mrs. Jones's room. My thinking is that Mrs. Jones, whether her soul is sitting in the corner or not, doesn't really care whether I pronounce her dead at 4:07 or 4:53. I like to believe that time doesn't matter much to dead people.

It does matter to the living, though. If Mrs. Jones's husband or children are sitting at the bedside, that will make me hurry. The dead are dead, but the bereaved want closure. Invariably the family will ask me for the time of death, as if the information makes it more real for them.

It's traditionally a doctor's duty to pronounce patients. In the hospital where I work, only a few nurses have been given the pronouncing wand — mainly the nurse supervisors, like me, who oversee the hospital's day-to-day functions and happen to be available twenty-four hours a day, seven days a week. We can pronounce only under specific conditions, however: First, the patient's doctor has to order it. This can be done after the fact — and often is, especially if the patient dies in the middle of the night. Even during the day it's kinder to the family not to make them wait for the doctor, who is often reluctant to desert his living patients in order to rush to a dead person's bedside. Second, I cannot pronounce a patient who is a coroner's case; this includes victims of violence — even if the wounds are self-inflicted — and anyone who was admitted less than twenty-four hours prior to death. And third, I cannot pronounce a patient who was on a ventilator at the time of death, although I can and often do pronounce patients who've died just a few moments after we've withdrawn the ventilator.

But if there's no tube running into the patient's lungs, and the coroner has no need to confirm the cause of death, and no doctor wants to do the pronouncing (and, really, why would they — they're busy enough with the living), then I am called to pronounce the patient dead.

Pronouncing patients is only a small part of my work. Like the doctors, I spend most of my time with people who are still breathing and whose hearts keep something at least approximating regular time. Part of my job is also to figure out how to squeeze more patients into our already crowded hospital. Hospital rooms are becoming scarcer nowadays, and this can add a scavenger aspect to the news that a patient has died. When Mrs. Jones dies, she makes room for Mrs. Smith, who's been waiting five hours for an empty bed to become available. I can't help but feel a little grateful that Mrs. Jones has finally passed. It was inevitable, and now Mrs. Smith will get the benefit of Mrs. Jones's already-cooling bed.

**All basements are creepy** places, even those without a morgue. The hospital where I work stores its bodies in the basement, where pipes painted the same pinkish beige color as the low ceiling run the length of the halls. There are many twists and turns, and the hallways all seem to lead to nowhere or to end in locked doors.

Built in the 1930s, the windowless morgue has tiles the exact putrid green color of those seen in all TV and movie morgues. The rest of the hospital has been updated with laminated wood flooring and neutral color schemes, but the morgue remains untouched by a decorator's hand. At the center of the space is the autopsy table, with its sloping steel presence and its great drain. Above it is a faucet with an enormous sprayer head attached to a flexible steel hose, like the ones used to wash dishes in a commercial kitchen. I try not to think about what happens on that table, but, of course, the more I shun the thought, the more my mind conjures it.

I once worked as a staff nurse in the neonatal intensive-care unit. Whenever a baby died, I wrapped it in a blanket, and then, around the blanket, I wound a sky blue disposable pad. I took the football-sized package — baby, blanket, and pad — down to the morgue and opened the door of the refrigerator there and placed the package on the glass shelf as gently as I could. Then I closed the door, pushing it until I heard the white seal grip, the way I might close the fridge door at home after putting away a chicken. There wasn't a way for me to close that refrigerator door with the reverence and honor the occasion deserved. This is a part of nursing that we learn early: how to do the unthinkable without falling to our knees and wailing.

The refrigerated drawers that house the larger bodies are on another wall, one above the other. The steel handle on one drawer is a little loose, and the other balks when the tray holding the deceased is moved along its rails. The dead don't mind a rickety ride.

We regularly need to move bodies from gurney to drawer and from drawer to gurney. The drawers are low, and the gurneys are waist-high, so we use a mechanical lift to protect the backs of the living who handle the dead. Usually the morgue workers operate the lift, but I occasionally help out when it's the middle of the night and only one employee is working in the morgue. I'm not sure I provide all that much assistance — I'm about as coordinated as a toddler on stilts — but if I were them, I wouldn't want to manipulate a dead body in its white plastic shroud all by myself.

The lift is constructed of sturdy steel hoops that hang from the ceiling and yellow straps with strong clips at the ends, like those in rock-climbing harnesses. After clipping the straps securely around the feet, buttocks, and shoulders of the white-shrouded body, we activate the automatic lift, and the deceased begins to rise from the gurney. The parts of the body not supported by the straps sag in the white bag. Sometimes the balance is a little off, and we quickly lower the body back down. If the balance is perfect, the body moves straight and level until we bring it gently onto the tray, which we then slide into the drawer. When everything is aligned just so, it is like seeing a white plastic bag perform ballet.

**The nursing supervisors** keep track of the dead in a large binder we call the “Dead Book,” although it bears the more dignified title “Deceased” on its spine. Paperwork is filed and moved in a complex system that tracks the whereabouts of the corpses, including bodies awaiting the family’s choice of funeral home. Some supervisors describe a body that is legally ready to leave our morgue as being “on the launching pad,” but I prefer the less dramatic “awaiting pickup.”

The hospital recently bought a shiny new set of five refrigerated body drawers to replace the two old ones. One supervisor calls it our “five-holer.” But still the morgue, like the rest of our hospital, often doesn’t have enough room for its occupants. Families sometimes are too bereft or too poor to make timely arrangements. If we have more than five bodies, the overflow goes to a private storage facility, and we pay daily rent until the families are able to provide for disposition.

At one hospital where I worked, if there were too many corpses waiting to be picked up by mortuaries, we had to rotate them in and out of the drawers on a schedule. No one body was kept outside a drawer for more than a short time, and we kept a dry-erase board on the wall to track the in and out times of the corpses, the same way one might note when personnel have left or returned to an office.

**I want to list** here all the people I’ve pronounced: the former news anchor; the lady with the beard; the chronically ill twenty-year-old; the double amputee. But the list goes on and on and would become boring after a while.

There have been so many people that I’ve started to forget them. Each one is special at that moment when I am in the room with him or her. As I flash my light into each pair of eyes and feel each pulseless neck, I think, *Who were you?* But a few months later hundreds more names have paraded through the Dead Book, and the previous ones are forgotten.

The first time I pronounced someone dead, I felt like a nervous virgin on her wedding night. I remember the patient’s family had disagreements about what we call “end-of-life issues,” which really amount to how long we should stall the inevitable. I remember that the patient’s granddaughter hugged me after I pronounced her grandmother dead. And I remember the patient’s face, frozen in a waxy pose that could never have been mistaken for the face of a person still alive.

I’d seen dead people before in my career as a nurse, and I’d thought that pronouncing someone would be only an extension of this. I hadn’t expected that I would want to linger with the body. I hadn’t expected that I would want to comfort the deceased. I hadn’t expected that I’d want to cry. And those impulses have never gone away.

The person to whom this pulseless neck and silent heart and these dilated pupils belonged is gone. Yet ten minutes ago, one minute ago, Mrs. Jones was still here, still breathing, still “Aunt Betty” to her nephew, still “Darling” to Mr. Jones. That one minute changes everything. What happens in that liminal moment? How is it that we cease to be, while our body remains, quiet and still?

And every time it is just the dead person and I alone in

the room, tears fill my eyes, and I feel as if my heart will burst through my skin. I didn’t know these people, and yet, as my hands pass over their chests, their necks, their eyes, I grieve for them. Those moments remind me that everything and everyone I love in this world will one day die: my parents, my children, our dog, the tree in our front yard. One day someone else’s hands will feel my neck and find no pulse; someone else’s eyes will look into my pupils and see no contraction; someone else’s ears will listen to my chest and hear no heartbeat. And then — I hope with reverence and grief befitting that mystery — they will pronounce me dead. ■