CHAPTER NINE

LIMITATIONS IN DEATH: NEGOTIATING SENTIMENT AND SCIENCE IN THE CASE OF THE HOSPITAL AUTOPSY

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Preamble

It’s 11.20 am in Anatomical Pathology. I’m in a group observing the demonstration of a new tissue slicing machine. An autopsy worker appears and moves quietly behind me. He whispers in my ear, ‘We’re doing another PM [post-mortem] shortly if you want to observe. It’s just a brain’. I head off to gown up and enter the autopsy room. Shortly the trolley is retrieved from the cold room and wheeled in. As usual, the tag outside the body bag is checked first: it’s the name of a prominent politician, and wry comments are made about the possibility of the said man being within. The body bag is unzipped with a flourish, and an unknown face exposed. Of course it’s not him, and a worker dryly observes, ‘Why would a politician be in a public hospital?’ A bright white towel is neatly tucked around his neck like a scarf, the bag re-zipped, leaving only his head protruding.

The medical records indicate that the man had a medical condition which required chemotherapy. This treatment depressed his immune system, allowing some infection to take hold in his brain. He died yesterday. If the infection was what clinicians suspect, it would have been ‘a quick death’, according to one worker. The family originally consented for a full post-mortem, but then changed their mind and opted for a form of limited autopsy—a ‘brain only’ as a ‘fresh cut’. ‘This is a pain’, according to one of the workers. He explains that the brain will be removed, sections of it will be sliced, photographed and examined, and then all the brain, minus samples, will be immediately

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1 For reasons of confidentiality, I use the term ‘autopsy worker’ in this article to refer to all staff engaged in autopsy work: pathologists, registrars, mortuary scientists and mortuary technicians.
returned to the skull. In a fresh state, without the solidifying effect of formalin, the brain is much more fragile, so the task will be both more difficult and take longer. This will indeed prove to be the case. [Fieldnotes, Nov 2005]

Introduction

We all die. Most of us will die simple, obscure deaths. The majority of us will expire in a hospital or nursing home setting, and then languish in the near anonymity of a mortuary. Two of us will ‘feel’ the scalpel blade in a post-mortem. We will be farewelled in a largely private and simple fashion, and likely disposed of through cremation. Our kinfolk will create, even ritualise, a coherent story of our life and subsequent death. We will have lived complex, yet ordinary, lives, and endured (perhaps) unwanted but unremarkable deaths.

The death of others provides an opportunity for the living to contemplate our inevitable demise. The failure of so many people to register post-mortem wishes via wills, funeral plans and organ donation registries suggests we are somewhat reluctant to do so. I have been unusually absorbed by death and its mortal remains as I researched the issue of autopsies at ‘Hillside’, a Victorian public hospital. The ethnographic method I employed required my presence at a range of adult and perinatal autopsies. Being there in the mortuary demanded some reflection on both the fleshly disturbance of the body, and the grief heaped upon those who knew the deceased well.

Grief is a titanic emotion. As Graham Little once wrote, it includes ‘sadness at loss, sorrow, swelling remorse, moments of wild panic, groans of despair and sudden heaving sobs that clutch at the familiar face in a dream. "Oh no", we say. “Oh no”’. Reason is grief’s stead-

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2 In Victoria, where my fieldwork was conducted, in 2004–5, 56.6% of deaths occurred in public and private hospitals and 30.5% of deaths occurred in nursing homes. The remaining 13% died at home or in a public place. These proportions are similar to averages Australia-wide.
4 ‘Hillside Hospital’ is a pseudonym for reasons of confidentiality.