

1

Autopsy

A Context

Mortui Vivis Praecipiant

In *Medicolegal Investigation of Death*, Ramsey Clark, former U.S. Attorney General, laments the fact that an autopsy was not performed on old King Hamlet. Had an autopsy been obtained, “Shakespeare’s play might have turned from tragical to historical” (ix). Perhaps. Yet even today, an autopsy does not ensure the solvability of a murder. What we can feel certain about, though, is the response of Shakespeare’s public to the entrance of a human dissector in *Hamlet*—a mixture of fascination and loathing. Since human dissection was a public spectacle in Shakespeare’s day—it had not yet retreated behind the closed doors of medical and legal authority—the appearance of an anatomist on the stage would not have been too surprising. But threatening? Yes! And so much more threatening than the manifestation of a mere Renaissance ghost.

While the actual purpose and practice of autopsy has changed little from Shakespeare to Clark, the social history has been a roller coaster, careening over a complex, even vexed, terrain of social relations in modern Western culture. On the one hand, it represented brilliant science, intellectual endeavor, hard and dangerous work, humanist dedication; on the other hand, public humiliation, criminality, execution, morbid infection, body mutilation. What follows in this chapter is a brief narrative of autopsy. I hesitate to call it a history, since my goal is modest—simply to provide a ground for the discussions of autopsy following in the rest of

the book. As such, I hit only the peaks and valleys.¹ And at the end of the chapter, I describe what it is like to go behind the closed doors of the autopsy suite today.

BEFORE CLOSED DOORS

The genealogy of modern autopsy may begin at the Renaissance, but its practice actually goes back a very long way in Western culture—at least to early Greek and Roman civilization, despite widespread taboos in those societies against human dissection. We can even push the narrative back to ancient Egypt, where embalmers and artists practiced autopsies to gather and teach knowledge of human anatomy for burial preparation. After 300 BC, the Greek states did permit a limited practice of human dissection, but only on the bodies of criminals. But for Galen, the second-century Greek anatomist of Rome, human dissection was strictly forbidden. Despite the fact that his work became the authoritative source of human anatomy throughout medieval Europe, Galen was only able to extrapolate human anatomy from the dissection of animals and treatment of premortem injuries in humans. As one might expect, his model of the human body was often oddly skewed: For instance, he wrongly attributed five lobes to the human liver, gave the uterus horns, and speculated on a unidirectional blood movement system that had blood departing from the liver and arriving at the periphery of the body through both the veins and arteries, a model that did not change until William Harvey published *On the Motion of the Heart* in 1628 (Ackerknecht 76–77).

Nevertheless, the taboo against human dissection did not prevent external, postmortem examination of the cadaver, a practice both the early Greeks and the Romans relied upon mainly for medicolegal purposes. For a number of reasons, it could be important to ascertain the exact cause of death and distinguish between those that occurred naturally and unnaturally: Manner of death would determine such issues as burial privileges and inheritance, as well as criminal liability. Autopsy in this sense can be practiced without ever opening the body. Indeed, after externally examining the twenty-three stab wounds on the body of Julius Caesar, the Roman physician Antistius was able to conclude that the ultimate cause of death was one particular wound in the chest (Fisher 3).

By the thirteenth century in Europe, though, pressure from the medical and legal communities had increased. Christian tradition was beginning to change: The doctrine that the soul is resurrected within an

intact body, which creates a real problem for canonical acceptance of human dissection, was slowly giving way to a separation concept, complete by the time of Descartes, of the mind or soul from the body. The church would eventually decide that studying the body's interior was a way of celebrating God. In fact, the administration of Pope Sixtus IV in the mid-fifteenth century allowed medical students to open the cadavers of plague victims in an effort to determine what was causing the disease (Iserson 115).

Perhaps surprisingly to us today, it was actually the College of Physicians that stood solidly in the way of advancements in human dissection. In medieval Europe, physicians did not touch the body, whether living or dead; that lowly charge was left to the surgeons. Pedagogical autopsies were conducted with the physician standing at a podium, Galen's book of anatomy open before him, and the surgeon at a table below making the actual incisions in the cadaver. In this text-based culture, Galen's words, not the evidentiary body, were the reigning authority. Galen was assumed to be "true," and any variation between the cadaver's anatomy and Galen's book was attributed to idiosyncratic anomaly. Given the nonhuman ground of the Galenic medical text, one can easily surmise that the suppression of a vast number of deviations would not be particularly conducive to human anatomical research, pedagogy, or treatment. It would take the onset of empiricism to effect a new episteme and epistemology.

As Jacalyn Duffin writes in the *History of Medicine*, the method of inquiry was about to change from a theory of purpose as practiced by the ancients and their medieval followers to a strategy of "non-theoretical" observation, from teleology to empiricism (42). Assisted by contemporaneous Cartesian mind/body dualism, medical science was becoming able to posit the (dead) body as a field of study, as a group of functions (physiology) and as a structure (anatomy). This development would soon give rise to mechanistic theories which likened the body to metaphors of "pumps, levers, springs, and pulleys," hence Descartes's comparison of a sick man to a poorly made clock (Duffin 48–49). In fact, Rembrandt's painting *The Anatomy Lecture of Dr. Nicolaes Tulp* (1632) has the good doctor manipulating the forearm muscles of a cadaver to demonstrate how the hand is mechanically leveraged.

Artists like Rembrandt and da Vinci were among the first Renaissance men to recognize the significance of empirical observation of the opened cadaver. Human dissection gave rise to a burgeoning theory of art based on an understanding of human anatomy, right down to the skeleton.

A modern sense of interiority appeared at the same moment artists began the practice of drawing the body from the inside out: first bones, then muscles, then skin. Yet to the medical profession, human dissection was viewed as a trivial, if not useless, academic exercise. After all, if lesions in the cadaver could not be correlated to symptoms of disease in the living body, performing a research-oriented autopsy would be a waste of time. In early modern Europe, it was actually easier to advocate autopsy for medicolegal purposes than for research or pedagogy. As Michael Sappol points out, medicolegal autopsies were not considered as humiliating as anatomies, in part because the bodies were victims rather than criminals (103). In fact, Andreas Vesalius, the great Renaissance anatomist and physician, laments the fact that he had to obtain much of his information on human anatomy from corpses autopsied for medicolegal purposes (in Saunders 170). Ideally, he would have wanted healthier specimens.

Nevertheless, Vesalius is responsible for giving the acceptance of human dissection in medical science a big push. Unlike other physicians, Vesalius was willing to come down from the Galenic pulpit to dissect the body himself and to propose an innovative model of human anatomy based on empirical observation rather than deductive speculation. His extraordinary book, *De Humani Corporis Fabrica* (1543), not only proposed a positivist basis for representing human anatomy, but did so by subtly combining the arguments, both artistic and medicolegal, that could best advocate the practice of human dissection. The series of plates affectionately nicknamed “the muscle men,” for instance, shows the human form flayed to the muscles but enlivened in lifelike poses and set in a naturalistic landscape. Vesalius states in the text of the *Fabrica* that the muscle men, especially the second, third, and ninth plates, are designed to be particularly useful to artists, “such as only painters and sculptors are wont to consider” (in Saunders 92). Of course, they also illustrate for physicians the arrangement of the muscles.

The title page woodcut to the *Fabrica* cleverly combines the artistic and medicolegal arguments for the value of autopsy and the empirical study of human anatomy (Figure 1.1). The unknown artist has recorded Vesalius in the middle of an actual postmortem examination of a female cadaver to demonstrate anatomy to an audience comprised of medical men, students, and the curious public in a temporary outdoor theater. Critics such as Jonathan Sawday and Luke Wilson have analyzed the breathtaking aesthetics of this scene: its drama, theatricality, performativity, visual focus, and perspective.² Indeed, the woodcut records how much human dissection had become a public spectacle by the time of the

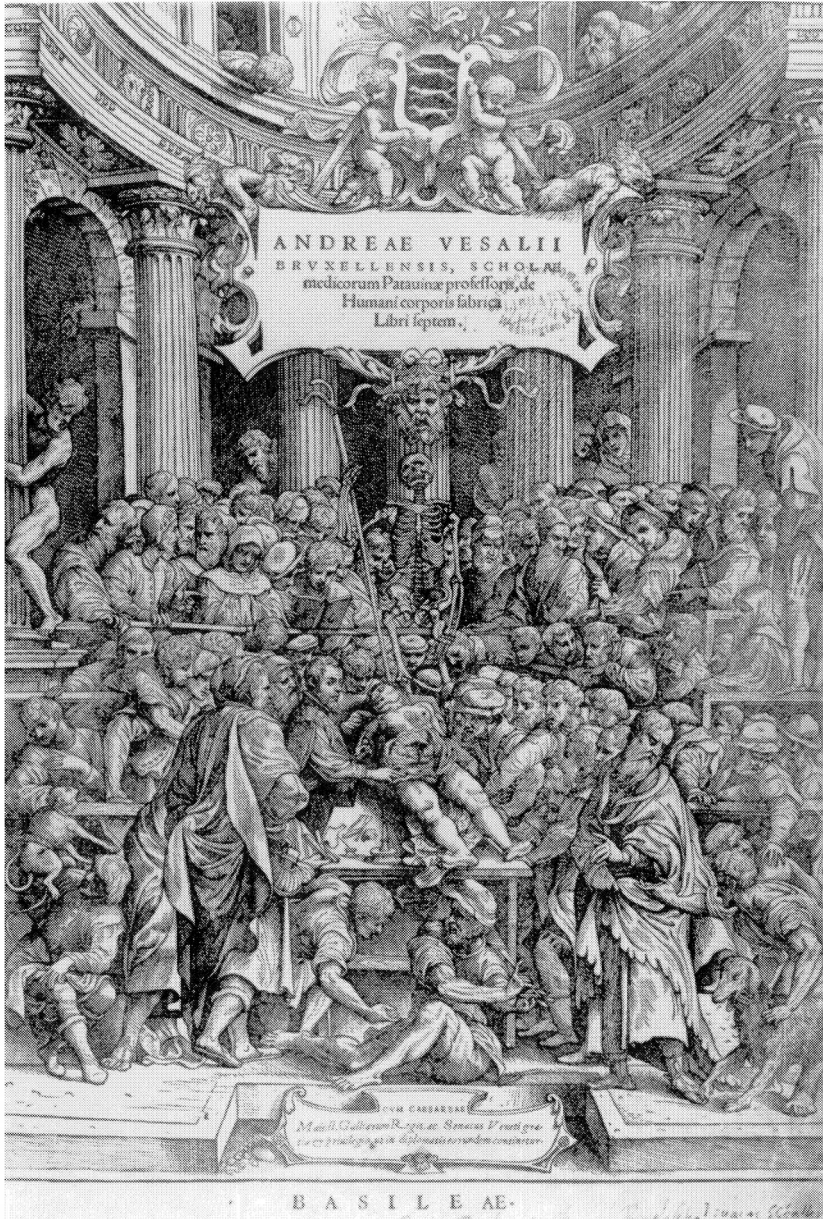


FIGURE 1.1. Andreas Vesalius, Title Page to *De Humani Corporis Fabrica*. U.S. National Library of Medicine.

Renaissance, available to the prurient and voyeuristic as well as the learned, a feature which it has retained to this day if the number of autopsy depictions on television is any indication. Of course, the parallels between the anatomy theater and the playhouse are striking in the woodcut, and clearly evidence the interdisciplinary tropology of “autopsy.” In both venues, the audience is invited to observe the performance, to spindle the onstage bodies with its own eyes for the purpose of constructing meaning and knowledge. And certainly, this particular performance of an anato-autopsy, the title page would seem to proclaim, is grounding the artistry of the woodcut itself.

The medicolegal argument for the value of autopsy is also apparent in the woodcut and turns on the question of whether the female specimen was pregnant at the time of her execution. Claiming pregnancy was a common way of gaining a stay of execution, which this woman had hoped to obtain. After midwives examined her and found no signs of pregnancy, the prisoner was summarily hanged. But only by opening the body postmortem would the medicolegal point be proved one way or the other. In the woodcut, Vesalius has incised the abdomen and pushed aside the intestines in order to display the uterus, which is indeed without child. More significant to the historical narrative of autopsy, though, the medicolegal dispute has also provided Vesalius with the opportunity to justify the work of the anatomist, here applied to the unknown territory of the female. Since female specimens were rare at the time—most of the cadavers being male criminals provided by the hangman—knowledge of the anatomy of women was terribly misunderstood. The second edition of Vesalius’s own *Fabrica*, for instance, naively pictures the vagina and vulva as a hollow penis. But here in the woodcut, Vesalius’s triumphant gaze invites the viewer to agree that a more research-oriented, empirical knowledge is essential to progress in medicine. He is demonstrating the placement of the uterus, its appearance, its relation to the other organs, and so on (O’Malley 143). And he is presenting the claim that only by understanding the dead body can we hope to understand the living.

The sixteenth century in Europe witnessed an increasing regularity in the postmortem dissection of humans, giving rise to what Jonathan Sawday calls a “culture of dissection” (ix), which manifested itself across disciplinary lines and spoke to the desire to partition (the things of) the world. Certainly, advances in the epistemological paradigm enabled the use of anatomical and pathological knowledge of the body for treatment and pedagogy. To a surgeon like Ambroise Paré, a contemporary of Vesalius, practicing autopsy on deceased patients became a customary pursuit.

Paré recorded the autopsies he performed together with his case histories, and the collection gathered by Wallace B. Hamby, MD, provides a priceless documentary of Western, early modern, research-oriented autopsy. In one case, the autopsy revealed cause of death to be an aneurysm of the pulmonary artery. After describing the condition of the thorax and the artery itself, which was “dilated to admit a fist and its inner coat was bony” (18), Paré attempts to correlate his postmortem findings to the patient’s clinical history and treatment. He also describes how he dissected the artery at the Medical School to the gratifying admiration of observers. Out of this one autopsy, Paré manages to make a diagnosis, reconsider the patient’s symptoms and treatment, and teach.

Interestingly, Paré and Vesalius collaborated on at least one autopsy of which their reports are extant. The case is pivotal in its own right, for it demonstrates the effort to confirm the anatomical effect of trauma, specifically the *contra-coup* brain injury. In fact, in Hamby’s collection, there are three different cases where Paré considers the dual question of whether the side of the brain opposite a blow can be injured without a fracture to the skull. The first involves a serving man who was hit on the right parietal bone by a rock. Only a small cut was visible. Yet upon autopsy the opposite side of the skull was seen to be fractured with a large amount of bloody pus in the dura mater (24–25). The second case concerns a soldier who sustained a gunshot wound to the head. Although the helmet was dented, there was no external injury to the skull. During autopsy, Paré discovered that the inner table of the skull was fractured and splinters of bone had been forced into the brain. While not a *contra-coup* injury, this case still proved that the brain could be injured without external trauma to the skull—just as in JonBenét Ramsey’s case. Paré would use the postmortem knowledge gained from both of these types of brain injury to speculate on the deathbed condition of Henri II, whom Paré and Vesalius both attended and examined postmortem.

During a tournament, Henri II suffered a blow from a tilting lance just above the right eye. Although the external injury appeared to be quite superficial, the king worsened and died eleven days later. Recognizing pre-mortem complications similar to those in the soldier described above, Paré suspected that the king’s brain must have sustained massive trauma. The autopsy would be extremely important in this case for two reasons: It would not only determine cause of the king’s death, but would also prove whether the brain could be injured *contra-coup* without a fracture of the skull. Although Vesalius and Paré produced separate autopsy reports, they recorded the same information: A section of the brain opposite the blow

had been injured and had putrefied. Paré thus writes: “After his death a quantity of blood was found collected between the dura and the pia mater in the area opposite the blow. . . . Here putrefaction was beginning, which was sufficient cause for death of the Lord, and not the eye wound” (26–27). And Vesalius: “Thus the putrid condition [of the brain] gave proof that the brain had collided with the skull and had been concussed and shocked by it, and not that the condition had been caused by an injury to the skull” (O’Malley 397). Vesalius and Paré emphasize that cause of death was not the eye wound, but an internal collision of the brain *contra-coup* with the skull. The king suffered the same kind of injury we see in boxers today.

Meanwhile, throughout the early history of medicine in Europe, medicolegal autopsies continued apace. According to Russell S. Fisher, MD, as early as the fourteenth century physicians performed autopsies for the courts to determine whether manner of death was “infanticide, homicide, abortion, or poisoning.” Complete dissections were not usually practiced before the Renaissance, but wounds on the body were opened and probed. In fact, Paré made a number of medicolegal autopsies and reported on cases of infant smothering and sexual assault (4). One interesting case in Hamby’s collection describes the instance of a monk who had died rapidly and with extreme symptoms. Suspecting murder, the governors of the Hôtel-Dieu asked Paré to perform an autopsy. Upon seeing evidence of burning in the stomach, Paré determined initially that cause of death was poisoning, which pointed to homicide. But after considering the color of the flesh under the skin and the generalized lividity of the body, Paré decided that the monk had died of a ruptured plague carbuncle in the stomach (140–41). Case closed.

By early-seventeenth-century New England, medicolegal autopsies were being performed regularly. Iserson reports that one of the first examples was an investigation into the death of a young apprentice in Massachusetts. Physicians determined that he had died of a skull fracture and subsequently charged his master with the crime (140). Another example occurred in Hartford, Connecticut, in 1662. A young girl was autopsied as a suspected victim of witchcraft. Physicians found that “the gullet or swallow was contracted like a hard fish bone that hardly a large pease could be forced through” (Rossiter in Iserson 116). Today, the interpretation would be something like “upper airway obstruction, probably caused by diphtheria or epiglottitis” (116). However, given the episteme of colonial America, it is not surprising that the suspected “witch” departed Hartford in a big hurry. By the mid-eighteenth century, medicolegal

autopsy findings were regularly introduced into trials in Europe, Britain, and the United States as part of the Coroner system.

Indeed, the “Jack the Ripper” inquests of 1888 accepted into the record the results from autopsies of the victims, which provided information not only about cause of death but also about social conditions, lifestyle, and disease. Sadly, the autopsy of Annie Chapman, the second victim, determined that she was already dying of malnutrition as well as chronic lung and brain disease when she was eviscerated by the Ripper (Douglas 20). At the time, the autopsy records of the Ripper victims were also analyzed for possible clues about the murderer’s identity—the body mutilations were thought to indicate he had some medical or anatomical training. And in the ongoing quest to identify the Ripper, the autopsy records still function as one of the major pieces of victimology for developing a behavioral profile, if not a suspect. According to John Douglas in *The Cases That Haunt Us*, the Ripper inscribed enough of a *signature* on the bodies to suggest a disorganized, asocial, blitz-style, lust predator. But this type of behavioral analysis, as well as the institution of the medical examiner so beloved of popular novels and television dramas today, was not introduced until well into the twentieth century.

In the eighteenth century, an enormous boon to the medical and medicolegal fields was provided by Giovanni Batista Morgagni’s book on anatomic pathology, *The Seats and Causes of Diseases Investigated by Anatomy* (1761). In this text, Morgagni correlates autopsy findings to clinical symptoms based on the dissection of about seven hundred cadavers (Ackerknecht 135–36). Medical science had begun to codify disease predicated on abnormalities of the organs rather than the traditional humors, which paved the way for the radical, epistemic break in the late nineteenth century upon which Foucault builds his discussion in *The Birth of the Clinic*: “The age of Bichat has arrived” (122). Associated primarily with Marie François Xavier Bichat, the lesion-based concept of disease looked to changes in the tissue rather than in the organ, an advancement which, to Foucault, occurred not coincidentally at the time of a great shift in Western epistemology and the gaze of the medical profession.

The epistemic change is described by Foucault as a transformation in the reciprocity of the knowing subject and the object-to-be-known. While Foucault concedes that with the introduction of auscultation and percussion, the subject-physician and object-patient drew closer together, the physician actually touching the patient in an attempt to interpret the signs of the body’s interior, the crucial shift lay in the way ailment would

be known: as a *seat* of disease rather than as a *class* of symptoms. The imprint left on the body's interior (postmortem) would point to the originary locus of the disease, and thereby organize the range of secondary symptoms (*Clinic* 136–40.) Even the names of diseases changed at this time—for example, from consumption to tuberculosis.

The clinical gaze of Bichat's predecessors may have observed the (dead) body, but it did so as a one-dimensional, historical function, "linking up symptoms and grasping their language" (*Clinic* 126). As a limited form of medical observation, the clinical gaze still could not quite deliver to the medical community and the public the value of autopsy for clinical analysis and treatment of the patient. The medical gaze introduced at the time of Bichat, on the other hand, was based on a sense of geographic spatiality rather than historic temporality, of lesion in the dead rather than symptom in the living. The medical gaze would be able to recognize the body as a vertical and horizontal terrain as it "plunges," "penetrates," "advances," and "descends" (Foucault's verbs) into ever deeper and stratified space (136).³ To Foucault, the onset of the medical gaze should not be seen as part of an *inevitable* development in the history of medicine, and neither, I would add, should the sort of autopsy introduced at this time. After all, as I have shown, by Bichat's era autopsy had had a long track record. To Foucault, the relevance of Bichat lies in the epistemological break; the medical gaze "was the result of a recasting at the level of epistemic knowledge (*savoir*) itself, and not at the level of accumulated, refined, deepened, adjusted knowledge" (137). The dissected cadaver had become the ground for a magnificent medicine of lesions.

At least, that is, to the medical profession. But to much of the public, human dissection, even after acceptance by the Church in the fifteenth century, continued to be seen as the ground for an indecent and appalling practice and, to many people, remains so today. In a 2001 article in *The New Yorker* entitled "Final Cut," Atul Gawande, MD, describes a typical response from family members to the request for permission to do an autopsy: "'An *autopsy*?' a nephew said, horrified. . . . 'Hasn't she been through enough?'" (94). Such a response captures a number of reasons the idea of human dissection has so profoundly vexed the living. To this nephew, in some manner the corpse is still capable of physical and emotional feeling, as if the remnant of the body in continuing to occupy space/time continues to suffer in space/time. Somehow, the still-living are reluctant to yield the subjecthood of the other-dead to object status. It is not so easy suddenly to see Auntie as nothing more than a laboratory specimen. After all, if the other is necessary to the sense

of coherence and identity of the self, as Western theories of subjectivity maintain, how does the subject reconstruct itself when the other dies? I examine this question of subjectivity with respect to the dead body in greater depth in chapter 3.

Another reason is that human dissection appears as some sort of violation of the body, a desecration of the dead, indeed, a necrophiliac “rape” of the completely vulnerable. And, in many ways, this belief has merit. Performing an autopsy in the modern era of the West has meant surgical mutilation, penetration to the interior’s most private parts by cleaving phallic instruments, combining *ana-tomē* (to cut up) and *auto-opsis* (to see with one’s own eyes) to produce a “piercing gaze” in the service of medical science or the courts. (Note how Foucault above uses aggressive, penetrating verbs to describe the medical gaze.) Despite its evidently pedagogical purpose, the public performance of human dissection from the fifteenth to the nineteenth centuries, recorded in such art works as Vesalius’s title page to the *Fabrica* and Rembrandt’s *Anatomy Lecture*, suggests a furtive voyeuristic pleasure, especially among the upper or bourgeois classes, in reducing the dead, usually criminal, body to the status of a sideshow freak, a dubious entertainment that smacks of indecency and seems still suspiciously active today in depictions of autopsies in the visual media. Sawday notes that horror and fascination were a significant aspect of metropolitan culture in early modern Europe; playwrights who referenced penal dissection, for instance, knew only too well how “morbid fears . . . could easily be transformed into a set of barely suppressed desires” (49). Moreover, the fashionable study of anatomy among Europe’s elite amateurs in the nineteenth century only played into lower-class perceptions that any interest in the dead body must be unhealthy, scopophilic, even lascivious. Perhaps autopsy is one more insult the bourgeoisie, medical profession, disease, or sadism can render upon the poor person who has suffered so much. Despite mind/body dualism, folk superstitions, going all the way back to the Greeks regarding the importance of an intact body for the afterlife, endure to this day, which present a real obstacle to organ donation as well. Let Auntie go out the way she came in.

But there have been other reasons as well for public disapproval of human dissection, some of which undoubtedly linger in the Western cultural Imaginary if no longer in our frontal lobes. One good way to spread disease is to handle corpses. Even before the advent of bacteriology, dead bodies were recognized as dangerous to the living and were quickly removed and disposed of. To many ordinary folk in the early history of

anato-autopsy, digging into the interior of a cadaver must have seemed like a profoundly bad idea, and it is true that even today pathologists have one of the most dangerous, and unhygienic, jobs in the medical profession. In the early modern period, anatomy also became associated with criminality in two ways, a predicament that lasted into the twentieth century. Both of these associations deeply prejudiced the public against the practice of human dissection.

One, because subject bodies were supplied by the executioner, anatomists quickly became associated with the punishing arm of the state. During the Renaissance, it was not uncommon to see an anatomist, even the distinguished Vesalius, fighting with family members over a corpse at the foot of the gallows. Edward Ravenscroft's play, *The Anatomist* (1696), makes clear the similarity, in the public's eye, of the executioner and the anatomist: "A Physitian cuts up a man with as little remorse, as a Hangman carves a Traytor" (114). Two, dissection, and most particularly public dissection, actually became attached to capital punishment in some European countries, and was treated as part of the huge spectacle surrounding execution. In England, for instance, the Murder Act of 1752 added public dissection to the death sentence as a means of inflicting "further Terror" (in Marshall 21), a decision that, in a Foucauldian sense, continued to inscribe discipline on the body after death. The Murder Act was also an effort to provide medical schools with more cadavers, which backfired in terms of public opinion. What could possibly be more humiliating, at least for the survivors if not for the decedent, than to be publicly dissected?

In an effort to legitimize human dissection in the eyes of the public and to pass England's Anatomy Act of 1832, Jeremy Bentham, humanitarian philosopher and founder of the modern panopticon penitentiary, willed his body in 1832 to an anatomy school in London for public dissection. In fact, Bentham's body is still on display at University College in the form of the strange auto-icon, his legacy to medical science. The auto-icon was built according to Bentham's specifications and consists of wax-works formed over what was left of his body after dissection, essentially, the skeleton. Although the auto-icon bears a wax head, it was originally topped with Bentham's preserved head, which now rests on a stool beside the seated figure as if it were the master's favorite hound (Marshall 10). The auto-icon is an attempt on Bentham's part to eradicate the space between oneself and the image of oneself by making the subject, or at least the subject's remains, an essential ingredient in the representation of the subject. And, of course, as long as the auto-icon exists, Bentham's remains

exist. Will your body to medical science and you, too, can become a monument unto yourself! And herein lies one of the most important rhetorical functions of Bentham's auto-icon: It demonstrates an "intact" body after dissection.

But the auto-icon appeared after a long period in which grave-robbing, bribery, and even murder were the chief means of supplying cadavers to the medical community. Once human anatomy and autopsy became an essential part of medical training and research, thousands of cadavers were needed by the medical schools each year. From the seventeenth through the nineteenth centuries in Europe and continuing into the twentieth in the United States, medical students and professors were reduced to bribery and thievery, obtaining bodies against the wishes of the deceased and often stealing them from graveyards in such numbers that families had to station guards throughout the night, thus coining the phrase "graveyard shift" (Gawande 96). In the 1998 novel *The Giant, O'Brien*, Hillary Mantel tells the true story of the giant Irishman Charles Byrne and John Hunter, the "father of modern anatomy," in eighteenth-century London. Pursued relentlessly by Hunter, who, like other anatomists such as Paré, was fascinated by "monsters," Byrne arranged to have his body buried at sea. A round of bribes, however, ensured that his body was delivered to Hunter's surgery and subsequently dissected at the Royal College of Surgeons, where the skeleton remains on display to this day. This is a truly terrifying abuse of the public trust, particularly of someone's faith in the requirement of an intact body at resurrection, at least to the Byrne of Mantel's narrative. Not only depicting the rise of empirical science—the "humble cast of mind" (63) necessary to doing experimental research—as well as the acutely vexed relation of medical science to the public, Mantel deploys the act of human dissection as a means to tropologize a brutal class and colonial system.

As the public grew increasingly angry at the sort of blatant exploitation so frankly recorded in *The Giant, O'Brien*, riots became common at the medical schools, and were so threatening as to drive medical schools out of town in both Britain and the United States. Columbia Medical School, for instance, was ransacked by an angry mob in 1788 when the public learned of a rash of body-snatching. In this grisly demand-side economics, the next logical step from grave-robbing would be murder. Indeed, the Burke and Hare case of Edinburgh in 1828 solidified public perception that "murdering to dissect," to borrow the title of Marshall's book, or "burking" as the public called it, was running rampant. Burke and Hare represented only a few of the many "resurrection men" who

were ever caught and charged with the murder and delivery of victims to the back door of the surgery (Marshall 1). In a fascinating irony, autopsy testimony by a surgeon-pathologist was given at the London trial of the resurrectionists Bishop, Williams, and May that helped convict them of the “burking” of a young boy. The autopsy record reads in part: “Some coagulated blood was found laying in the [spinal] cavity opposite the blood found in the muscles of the neck. . . . I think a blow from a stick on the back of the neck would have caused those appearances” (in Iserson 140). Burke, Bishop, and Williams were all convicted, hanged and dissected. Burke’s anatomized body was publically displayed to an audience of 30,000 (Iserson 344).

“Burkophobia” did end up assisting passage of anatomy legislation designed to detach human dissection and medical science from the taint of murder—either murder as punishment or as supply-line. Beginning with Massachusetts in 1831 (Sappol 4), anatomy legislation throughout Europe and America severed public dissection from the death sentence and gave surgeons access to unclaimed bodies. However, the class consequences of these anatomy acts were enormous. As Marshall points out, England’s 1832 Anatomy Act officially transferred the burden of human dissection from the gallows to the workhouse, which hardly appeased the poor. The year the Anatomy Act passed in England saw 74 percent of cadavers obtained for dissection coming from the workhouse. By 1914, this number was only rivaled by 43 percent from the asylums. By the mid-nineteenth century in America, a disproportionate representation of cadavers had come to be poor black people. In fact, if they were at all conscious, black patients would refuse to be admitted to the University of Maryland Hospital. The supervisors of the poorhouse in Philadelphia supplied so many bodies to the Colleges that they earned the nickname “Board of Buzzards” (Iserson 84, 338–39).

Nevertheless, anatomy legislation marked the onset of changes in social attitude toward human dissection by both the public and the medical profession. Slowly retreating behind the closed doors of the morgue and laboratory, human dissection was no longer offered as a public spectacle and humiliation, and became linked, by acts like Bentham’s, to altruism rather than criminality. Medicine embarked on a vigorous program to disassociate itself from punishment. By 1949, when methods of execution such as lethal injection were replacing hanging, both the British Medical Association and the American Medical Association strongly opposed the participation of any medical personnel in executions (Sawday 78–79). While a few unclaimed cadavers still end up in the medical schools today,

most are acquired by donation, and medical students acknowledge their indebtedness to the benefactor by performing funerary services at the end of the anatomy course. Marshall Goldberg's novel *The Anatomy Lesson*, which I discuss at greater length in chapter 4, contains such an exemplary grave-side ceremony. In most Western countries today, permission for a medical autopsy must be given by the family, as Dr. Gawande's anecdote demonstrates above. In medicolegal cases, the state has jurisdiction.

During the first half of the twentieth century, medical autopsies performed in Britain and the United States reached an unprecedented number, at times as high as 90 percent of hospital deaths, and contributed enormously to major advances in medical knowledge. By the turn of the twenty-first century, though, this number has dropped precipitously, a fact that concerns the medical community and gives rise to rhetorical articles, like Dr. Gawande's, advocating the value of autopsy in the public sphere. Interestingly, the history of autopsy seems to have come full circle, with physicians and the public again caught in a most conflicted attitude toward autopsy. Once again, physicians are standing in the way, whether for reasons of expense, malpractice, over-sensitivity to the family, or a belief in their own diagnostic infallibility. And the public is still caught between horror and fascination, reluctant to give permission for autopsies *and at the same time* salaciously enthralled at their depiction on television and in the movies. Recall the public's desire to see the Brown and Goldman autopsy photos during the O. J. Simpson televised murder trial of 1995. Or, more recently, the controversy over releasing the autopsy photos of race-car driver Dale Earnhardt to the Internet. Like Vesalius's public, we seem to harbor both an attraction to and a revulsion for beholding the opened, spectacular body. If the dissection of Hamlet's father were to take place in a production of *Hamlet* today, I'm sure we would be more surprised than our Renaissance predecessors, but we would feel no less threatened.

BEHIND CLOSED DOORS

For me, at any rate, the emotions of anticipation and revulsion were surely colliding the day I showed up at the hospital to observe an autopsy. Attending an autopsy had never been at the top of my list of things to do—that is, until I started this research project. I soon realized that an autopsy was something I was going to have to see with my own eyes. At the very least, I recognized the need to establish a ground from which to

assess the various forms of autopsy I would be discussing in this book. But I also realized there was a danger of universalizing my experiences at the autopsy to assume a ground for everyone else. This is both a theoretical and a practical problem. How to write about viewing a performance of any kind without seizing the mantle of ideal spectator? I have tried to negotiate this crux by combining two strategies: one, a recognition of my own agency and the perspectives and choices that it would give rise to, what Bourdieu terms a *habitus*—that is, how my personality is informed by my particular individual and social position in the cultural field as a white, female, middle-class, middle-aged, Western academic, if I may be so long-winded; and two, a recognition of how this *habitus* may inform a style of writing. My position in the following pages functions, therefore, both as personal reflection *and* as representative of a certain way of analyzing the world. I have attempted to let the narrative reflect this dual condition.⁴

With that said, let me describe the event. On a lovely April afternoon in the year 2001, my graduate student Cammie Sublette and I walked past a series of doors in the hospital, actually empowered to obey the “Authorized Personnel Only” signs, and into taboo country indeed—the autopsy suite. We had little idea of what to expect. About the patient: Would it be male or female? Old or young? Thin or obese? Covered or naked? Would it smell? About the protocol: Where would we stand? Sit? How far back? Would we be behind glass? In a lecture theater? About our reactions: I could easily see myself behaving in one of two opposing ways—rational and calm or faint and queasy. The only thing we knew for certain was that the autopsy would be medical. The public is not allowed to view medicolegal procedures.

Of course, I also went with a series of more research-oriented questions. Would the procedure, purpose, and atmosphere of the autopsy correspond to what I had read? Would the autopsy be a quest for truth in the finest tradition of Western epistemology? What would be the import of seeing, especially given the embodiment of “seeing” in the word “autopsy?” Would the gaze of autopsy be spindling and penetrating, rendering the human body to the status of mere object? Would any other ways of seeing be available? What would it be like to cut into and take apart the human body? To what extent would objectifying the corpse be necessary in order to perform the procedure at all? How “intrinsic” or how “constructed” would the dead body seem, and what of its relation to the models of Western medical science? And what would all this do to my subjectivity?

Some of the questions were answered the instant we walked through the door. On a stainless steel table not more than two feet away lay the body—an older man, completely nude, and all ready to go. I quickly turned around and faced the wall. Which was more shocking? The genitals so frankly exposed? Or the face? I must have expected the body to be decently covered—after all, it always is on television. Even Rembrandt's *Anatomy Lecture* has the genitals discretely swathed. As Cammie observed later, never before had any body to her looked so naked. And yet, even though constituting the most important “person” (or “object,” I scarcely know which) in the room, the cadaver clearly did not have the same status as the living subjects. Introductions were made all around—except, of course, to the cadaver. Oddly enough, this exclusion seemed like a social faux pax, as if the cadaver had been rudely overlooked like a child amid a crush of adults.

And, in fact, the room seemed crowded. In a very small space, about twelve by twenty-five feet, were assembled ten people plus the cadaver: the pathologist, two medical technicians, five medical students, and we two observers. I retreated to an area just behind the cadaver's head, which allowed me to see the body partially without seeming to look directly at it. Interestingly, I had been developing a theory, which I go into further in chapter 3, that the notion of autopsy as simply an objectifying and spindling gaze is too reductive. Perhaps the dead body has a glare of its own, a “power of horror” to borrow from Julia Kristeva (*Powers of Horror*), that collides with and disrupts the subject's eye. Perhaps, indeed, the autopsy itself would be less a function of a gaze than a glance, a means of enabling the living to look at the dead without really seeing them. I was certainly finding ways to mediate the corpse, even peering around my notepad as if it were a curtain. I was beginning to feel quite pleased with my vantage point: I could watch the autopsy as I would a play, observing the performance not only of the actual procedure but of the medical staff and students. But I was also standing right beside the body refrigerator, which bore a sign reading “Bio-hazard: Do Not Store Food or Beverages”! There was to be no outside to this set.

The inclusion of the medical students meant that this would be a pedagogical as well as a diagnostic autopsy. Dr. Q, as I shall call her, began by going over the clinical history. The deceased was a sixty-two-year-old white male who had undergone surgery five days earlier to remove a cancerous kidney. His recovery had been uneventful, but the evening before he was scheduled to go home, he began “coding” and died. The family and attending physician requested an autopsy. Dr. Q expected to find a

pulmonary embolism (blood clot in the lung), or, failing that, a myocardial infarct (heart attack). As such, this autopsy would be limited to the chest and abdomen. The course of the autopsy, including the written report, would follow the basic procedure developed by Rudolph Virchow in the mid-nineteenth century.

Dr. Q began by making the Y-shaped incision, cutting swiftly from the shoulders to the middle of the chest and then down to the pubis. Similar to many medical terms such as the “DNA misspellings,” the Y-incision contains a fascinating pun on language. Of course, tracing the form of a “Y” on the body is the most efficient way to enter the torso, but it also etches the very point of the autopsy on the outer surface, enculturating the body as text, to borrow language from de Certeau. The Y-incision opens the book, authorizing the readability of an interior structure available to the pathologist as the discourse of (Western) disease. Today, as it did for Vesalius and Paré, it opens an epistemological quest.

After reflecting the skin and muscles of the chest, the technicians sheared through the rib cage and lifted the breast plate off. The procedure up to this point would turn out to be the most harrowing part for me, and I found out later for Cammie as well, of the entire autopsy. It was hard enough to see the dead body upon first stumbling into the room; it was harder still to watch it lose coherence, even positioned as I was to take full advantage of “glancing.” To anyone with a Lacanian bent of mind, what was happening would definitely seem to justify the theory of the mirror stage, or at least the mirror stage in reverse. As Charles W. Bonner points out, most interpreters of Lacan have not paid much attention to the significance of the body in his work, preferring to focus on the linguistic side or, I would add, the Orders and the gaze (232). Yet Lacan’s earlier works establish the importance of the body to the construction of the subject. Experienced initially as a heap of disparate parts, the body is *straightened out* or made “orthopaedic” by the subject’s desire (*Écrits* 4). But, of course, an autopsy takes the body back apart, puncturing its surface manifestation along with the subject’s desire; now we desire to dismember the body. The skin will no longer disguise the body as one seamless fabric, the muscles as one harmonious kinesis, the bones as one symmetrical posture. I realized that as I was looking into the body’s inchoate parts, I was witnessing the subject’s undoing. And as the autopsy proceeded, the body would, of course, lose more and more of its integrity. Indeed, at the end of an anatomy lab, the body is reduced to a few scraps. Looking at the cadaver, and especially looking *into* the cadaver, did seem to raise the specter of my own subjectivity, but *not*, it

seemed to me, in the old tradition of *memento mori*. I didn't think, "this is what I am," so much as "this is what I *am not*."

Nevertheless, illogical as it would seem, I found it easier to tolerate the dissection as the autopsy went on. The more the body was taken apart, the less my sense of subjecthood was involved. Was I becoming inured to this ruthless assault on the body? In fact, I was already beginning to strike the attitude of the medical students who were among the most attentive, rapt, and fascinated groups of people I had ever seen. We could have been watching a cooking demonstration. By the time Dr. Q was drawing out and examining the organs, it was clear that two important processes had been going on: objectifying and mapping. Perhaps because the organs are so well secreted within the body, they don't really appear to belong to the body—they do indeed seem like objects. And once they can be discretely separated as objects, we can map them according to the Western model of anatomy. So even though the body is losing coherence in one way, it is recovering it in another. Here's the lung. Here's the heart.

I certainly would hesitate to claim that "getting used to" human dissection is a feature of human nature, or that it is universal. I can imagine someone else finding the entire autopsy utterly sickening. But I would suggest that such inurement is connected to training in Western epistemology, even for those of us in the humanities rather than the sciences. Especially when it comes to real-world knowledge, Western epistemology is still inductive and positivist, despite the critique of these empirical strategies by phenomenologists such as Drew Leder, who sees the Cartesian mechanistic model of the body as still a problematic episteme in Western medicine (which I will discuss shortly). Certainly since the advent of dualism in the Renaissance, it has been possible for the Western academy to teach objectification, to train the subject to imagine the object apart from oneself, to set the object "over there" as a field of study and to exert a topography on it. And this learning curve might develop slowly over time. Arguably, advances in medical science could not have taken place without this particular frame of mind, an attitude that works to limit the impact of the object on the subject. We can objectify if it is really essential to do so.

And autopsy is one procedure demanding a high degree of objectification if its epistemological goal is to be reached. As I mentioned above, the clinical history suggested the patient's cause of death would most likely be a pulmonary embolism. However, when Dr. Q dissected the lungs she found no evidence of clotting, although the lungs were well

oversized. One lung weighed 1000 grams more than it should have. After inspection, the lungs went into an orange garbage bag by the cadaver's feet. "Do you ever do an autopsy and not discover cause of death?" asked a student. "Of course, but here we still have the heart." As Dr. Q removed and weighed the heart, she commented that it was also oversized. Once the heart dissection began, she noticed large areas of grey tissue—here was evidence of massive infarct. Everyone craned forward to get a good look at the heart. *I* craned forward to get a good look at the heart! How old was the infarct? Some of it could have happened a while ago (the silent heart attack); some of it could have happened during surgery. After taking tissue samples—Dr. Q would be able to date the infarct under a microscope—the heart also went into the garbage bag. As a last pedagogical gesture, she resected the adrenal gland, and showed it to the students as "something a little extra."

Although Dr. Q found no signs of clotting in the abdomen contributing to death, she observed that the liver was also enlarged and the entire torso full of fluid. Together with the size of the heart and lungs, these conditions suggested congestive heart failure. In interpreting such signs of the postmortem body, Dr. Q correlated them to Western models of disease, in this case heart disease. With all of her training in Western medicine at her fingertips, Dr. Q was able to determine at this point in the autopsy that cause of death was myocardial infarct with congestive heart disease contributing. Interestingly, this autopsy turned out to be one of the 50 percent in which postmortem lesions show that the initial diagnosis—here, the pulmonary embolism—made by the attending physician was wrong, and a classic argument for the importance of continuing to perform medical autopsies (Iserson 118).

Jacalyn Duffin, an MD and medical historian, defines disease "as a theory constructed to explain the illness," and illness as the word used to "designate individual suffering." What Duffin calls "[d]isease concepts" in Western medicine are built structures determined by countless observations of similar symptoms of illness in patients and, I would add, similar postmortem lesions (66). This type of body criticism does not deny the intrinsic materiality or physicality of the body. Medical professionals know only too well that the body has some sort of "volition" of its own outside social constructivism—after all, it always eventually dies no matter what the social or cultural fabrications. Nevertheless, the *understanding* of the body is recognized as culturally constructed. In this view, I would argue that the medical history of the body in the West has been a history of models—from the humors to anatomical structure and physi-

ological function to organ, tissue, and cellular processes, and now to genetic coding. But much of the discourse of medicine is still founded on the metaphor of “the frontier”; we have all undoubtedly heard about Harvey’s “discovery” of the circulation of the blood, as if the body were some uncharted and unknown new world. Body criticism would rather recognize Harvey’s contribution as a highly significant *model*, a model much better and more accurate in its descriptive power and application than any that came before. Certainly, it seems to me, we have to admit that some models are better than others—Harvey’s is better than Galen’s, for instance—if we are to explain the enormous difference in success rates of treatment between medieval and contemporary Western medicine. But this does not mean that other models would not work as well as or better than the models we have in the West today.

Currently, the debate in body criticism circles seems to be over how constructed or how intrinsic we ought to consider the body, a discussion I will return to at length in chapter 2. The two major schools of thought hang on the question of how to accommodate the biophysical, fleshy matter of the body to the enculturated body of the West, to put it in the terms of Judith Butler, the body whose sex is constructed as much as its gender. On the one hand, de Certeau draws a useful distinction between the flesh and the body in *The Practice of Everyday Life*: The flesh is the biophysical matter that intextuation transforms into a body (145). But this distinction between the flesh and the body is exactly what Butler critiques as a mistaken Western binary, in which a prediscursive body is seen as ontologically existing before the law, before writing, before culture. In fact, in her essay “Foucault and the Paradox of Bodily Inscriptions,” Butler claims that even Foucault defeats his own project by unconsciously reinscribing a prediscursive body before the relations of power and language (308).

On the other hand, Butler’s work has been criticized by Carol Bigwood for reducing the body to nothing more than cultural determinants (102), a sort of postmodern Idealism. To Bigwood, this position is of real concern, for in the act of ignoring the body’s intrinsic physicality we court the reinscription of an anthropocentric view of the world. Similarly, Evelyn Fox Keller notes that the extreme edge of cultural constructivism in science studies has claimed that any gesture to an intrinsic world is “an ideological phantasm.” Keller would rather retain the idea of a world of “nature,” even though “nature” is a highly problematic term, because at least it acknowledges an existing world outside human construction (3–4). Indeed, the desire to put human culture at the center of things reminds me of Steven Jay Gould’s quarrel in *Full House* with the most

popular metaphor of evolutionary progress, the “ladder-concept.” Gould criticizes the ladder-concept for its anthropocentric bias toward modern human beings as occupying the highest evolutionary rung on earth. Yet in terms of the “full house” model, which favors variation and diversity, bacteria are far superior to humans.

Bigwood comes up with an intriguing insight: that the logical extension of cultural determinism is a “disembodied body” (104). This insight seems close to Susan Bordo’s idea of the postmodern plastic body, which she critiques for its denial of “the historicity, the mortality, and, indeed, the very materiality of the body” (45). In this paradigm, according to Bordo, God as the prime constructor has been replaced by ourselves (45). Despite their differences, Bigwood and Bordo are pointing critically to the assumption made by some (Butlerian) body critics that postmodern subjects are empowered to ignore issues of biological and intrinsic facticity either through medical interventions (usually plastic surgery) or performance. I would add that the radical edge of social constructivism seems to ratify the privileging of the mind in the same old Cartesian mind-body split. The disembodied or postmodern plastic body certainly does not hold up very well in the face of the dead body.

Indeed, before I began this research project I was much more of a pure cultural constructivist in the Butlerian mode. But after studying autopsy and the dead body, I have had to come to a position that concedes a degree of “realness” to the body outside or beyond social constructions. Today, I consider myself something of a *constructivist Realist*, a position I develop at length in the next chapter. Suffice it to say for now that I combine the philosophical theory of Realism, which admits to a real world (however one may end up defining it), with a theory of cultural models (social constructs). In the course of my work, I have found that the dead body, particularly at autopsy, is just too raw, too overpowering in its own right, to be simply seen as a cultural object. For instance, we may interpret its odor as the construct “odor of a cadaver,” but surely we must accept that it really is producing the smell!

The material facticity of the cadaver was, to be sure, something that struck me deeply at the autopsy I attended. This man died at the age of sixty-two in the hospital under full resuscitate orders. We can rest assured that all medical interventions would have been attempted, but for some reason his body still succumbed. Wayward, contrary, insubordinate: Here was a graphic lesson on how the body has some sort of power to compel all its own, a power that can come into play at any moment at whatever level we want to call it—anatomic, organic, or cellular—regardless of,

indeed despite, our social and cultural constructions. Nevertheless, I am not advocating what Donn Welton terms biologism (2), even though the certainty of death seems to confirm that the body, with all its cultural manifestations, must live in the world as a biophysical entity. More specifically, I am also not promoting the (dead) body as simply a “physical thing,” a *Körper*, for the dead body is also the fruit of lived experience.

In “A Tale of Two Bodies,” Drew Leder employs a useful term, the “lived body,” drawn from the work of Maurice Merleau-Ponty and other phenomenologists, to explain the way living bodies exist in the world that takes into account extrabiological phenomena such as time and space (123). The lived body consists of the “intended” plus the biophysical: “It is a being in relationship to that which is other: other people, other things, an environment” (123). In Leder’s model, as in Duffin’s, the body and the world exist as material, other, or more than a conflation with cultural and social constructions. In fact, this mind-set is noticeable throughout Leder’s essay by the way he positions the body in the world: When illness strikes the body, medicine intervenes (121)—this example indicates an acceptance on his part of the biophysical entity, the “body-object, [or] material thing” (125).

However, I would not agree with Leder’s evaluation of the body paradigm in Western medicine, which he argues is based to this day on the Cartesian model of the inanimate, corpse-like, mechanistic body. A better principle, Leder suggests, would be the lived body, a patient body that is based not only on the biophysical object, but also on the human subject in space, time, and an environment. Surely no one would disagree with this proposal. Yet the problem with Leder’s analysis is the articulation of an extremist, possibly strawman, fallacy for the way Western medicine models the body. While it is accurate to say that the analysis of the human cadaver has been fundamental to the development of Western medicine since Vesalius, human dissection has always been a way of *looking back* at the lived body, as Morgagni, for instance, looked back at patient symptoms from postmortem signs. In fact, one of the most disconcerting aspects of Vesalius’s illustrations to the *Fabrica* is the pose of the dissected cadavers as enlivened subjects. Moreover, the title page to the *Fabrica* demonstrates that in the social sphere the benefits obtained for the living body are *the only way* postmortem dissection can be genuinely justified. As Foucault deftly puts it, the medical gaze at the time of Bichat becomes “the gaze of an eye that has seen death—a great white eye that *unties the knot of life*” (144, my italics). Despite the importance of the cadaver to medical epistemology, I would suggest that Western medicine

has always been primarily concerned with the lived body. Given her definition of disease as a taxonomy of similar symptoms in live patients, I suspect Duffin would agree.

Moreover, some of Leder's examples seem stretched. For instance, the routine medical exam is used as evidence for the primacy of the mechanistic model, because the patient becomes dehumanized, taking a "corpse-like pose, flat, passive, naked, mute" (121). But this description does not seem quite fair, especially when we take into consideration William Monroe's observation that doctors and patients are developing a performative relationship in which the patient is expected to take an active role. Of course, patients do lie flat at times. Some medical exams such as the breast palpation simply work best when the patient is flat on her back, allowing the breast tissue to spread out over the chest wall. And what of surgery? Some brain surgeries are actually performed with the patient awake, because the verbal responses of the patient are critical indicators of the operation's progress. Moreover, to the other lived bodies in the operating room—given the upright posture of humans, the way we work with our hands, our eyes situated above—expedient access to the patient's body in the environment would seem to be eminently important. When a surgical team has to crowd around a patient, is it not wise to have that patient taking, what seems to me, a *sleep-like pose*? Imagine how difficult heart surgery would be with the patient in any other position.

In recounting his experiences as a surgeon, Sherwin B. Nuland, author of several books on Western medicine, would seem to counter in practice Leder's mechanistic paradigm. Nuland seems only too well aware of the fact of the patient's lived body—and of what happens if he can't be successful in the operating room. In the following scene, Nuland describes a truly desperate moment while attempting emergency surgery on a woman with a severely lacerated liver, sustained in a car crash:

Faced with the impossibility of repairing the enormous hepatic injury with sutures, and the minimal likelihood that packing would succeed, I was promptly engulfed by unaccustomed pessimism. There seemed no way to proceed. Though our patient was still alive—with blood pressure and pulse responding, in fact, to the blood being pumped into her—I felt myself without options. I could think of no way to save the young woman whose life was in my frustrated hands. (98)

Even though some of Nuland's discourse retains the legacy of seventeenth-century medicine—the pump, for example—the patient body is

far from being viewed mechanistically. To him, “the young woman” is undoubtedly a live subject. Significantly, instead of using the word “liver,” which would fit the mechanistic model—and he’s actually grasping her liver—he uses the word “life,” as in her *life* was in his hands. Indeed, Nuland’s choice of words goes back to ancient times, well before the seventeenth century, when the liver was considered the seat of life (112).⁵

To apply Occam’s razor to one last point in Leder’s claim of the mechanistic model. The cadaver has assumed such importance to Western medicine, I think, not so much because of a fancy for mechanical functions, but because it has been available. To make such anato-pathological examinations—autopsies—on the lived body would have to mean something like human vivisection, not that some practitioners in the history of Western medicine would not have been up to the task. In fact, Harvey’s model of blood circulation was, in part, based on animal vivisections. But I think Leder, who is himself a medical doctor, must fathom some of these problems with his discussion, for he qualifies his argument throughout the essay. He even qualifies his comments on Descartes, founder of the mechanistic model, by allowing that Descartes, when he was at home, believed in a holistic form of medicine and advocated, as my own doctor does, the value of a good lifestyle (n129). Certainly, I agree with Leder that some health-care institutions do dehumanize the patient, reducing *it* to little more than *Körper* or “a piece of meat” (122). But I submit that this inclination is due more to the ideology of the Western, politico-economic system, or, more crudely put, “the bottom line,” than a mechanistic paradigm of the body.

Certainly at the autopsy I observed, something other than a mechanistic paradigm seemed to be engaged, although it is difficult to say exactly what it was. Contradictory as it may seem, perhaps more accurately the dead body at autopsy is less a *Körper* than a *once-lived body*. To me, the cadaver never seemed quite to attain the status of simply object, a laboratory specimen, possibly because of the “othering” impact *he* made to subjectivity—even though, as I argue above, objectification is a demeanor that seems necessary to performing the procedure. I also observed, though, that he retained a form of “lived-ness” to the medical staff. Dr. Q used the personal pronoun throughout the procedure, as in *his* clinical history. A student asked if he had smoked cigarettes, a question that surely acknowledges the relation of the lived body and its disease manifestations to lifestyle and a socio-environment. And, most importantly in terms of the epistemological project of the autopsy, Dr. Q was trying *to see with her own eyes* what had happened during this man’s life to bring about his death.

Which brings us back to the question of the gaze of autopsy. At first glance, *auto-opsis* would seem to be a prime example of the sort of penetrating and mutilating gaze associated with vision in Western culture—the male gaze of feminist film theory is another—in which a masterful looker exerts power over an exposed and vulnerable looked-at. And, to be sure, there was a powerful sense of voyeurism with its attendant uneasiness that I experienced upon first catching sight of the cadaver. The autopsy would be not only a voyeurism of the naked body, but a voyeurism of the *internal* naked body. Yet the sense of uneasiness was the first clue that the position of voyeur would be problematic. As Jean-Paul Sartre describes in *Being and Nothingness*, the “shame” of the voyeur only comes about when the voyeur is caught watching (347–52). And so, at the autopsy, who was doing the catching?

In the novel *The Anatomy Lesson* by Goldberg, the anatomy professor quotes Nietzsche: “Gaze not into the abyss, lest the abyss gaze into thee” (171). To the first-year medical student, anatomy lab can be a perilous misadventure, if the student takes the cadaver too personally and allows it to reflect his or her subjectivity. Based on my experience at the autopsy, the professor’s advice seems pretty good. Something coming from the cadaver, something like a glare or a power of horror, provoked in me a constant state of subjective renegotiation, right down to a navigation of space. In fact, it was only until the body had fragmented into a geography of objects that I could attain anything approaching the stance of Western epistemology—perceiving the cadaver as a field of study—and exercise anything like an inquiring gaze. But if I even momentarily cast an eye back from the heart or lungs on the dissection table to the body with its opened chest, I was caught once again by the body’s shadowy subjecthood, its once-lived-ness, its disintegrating hold on coherence. The objectifying gaze of autopsy with its “imperial” subject position seemed nothing more than a way of navigating the abyss, of looking askance, of mediating the corpse, of figuring it out *and* avoiding it at the same time. Kenneth Burke had never seemed so accurate: “A way of seeing is also a way of not seeing” (49). Indeed, I could detect that everyone in the autopsy suite was involved in this *performing* of an autopsy, although some were better practiced at it than others, for such an enabling gaze demands from all of us a certain posture and a certain way of acting.

And then, suddenly, after forty-five minutes it was over. The orange garbage bag with its collection of resected organs was tied up with a suture, the excess tail cut off, and placed in the chest cavity. The breast plate was balanced on top of the garbage bag, and the reflected skin and

muscle pulled up over the whole thing like a tight vest. The technicians sutured the body closed. Indeed, the body would be released to the family “intact,” at least in a loose sense of the word. After thanking Dr. Q—who, by the way, was curious as to why an English professor and graduate student would want to observe an autopsy—for permitting us to attend, Cammie and I left, grateful that we were not allowed to witness the next one: a four-year old boy who had been killed by a dog.

As one might imagine, I have had lots of friends and colleagues ask me questions about this autopsy, questions that it would take pages to answer, such as: Did it smell? Did it change my view of life? The short answers are, respectively, yes and no. But the one question that I can give a simple answer to is: What was it like to attend an autopsy? It was a privilege.