

Philosophy 110
Extra Credit Assignment (up to 10 Points)
Spring 2019

Due date: Sunday, 6/9/19, by 11:59 pm.

Instructions: Read the following article and answer the questions at the end of the reading.

An Unreasonable Sleep
by
Elizabeth Rosenthal

The emergency room was unusually quiet early that Thursday morning, and rounds promised to be brief. You have only one patient, said the doctor I was relieving. He's a real winner, though. He's basically unresponsive, but I can't find anything wrong.

Well, you know, I said dryly, when a patient's in a coma, there is usually a problem.

Look, I know it sounds weird, but all the tests are coming back normal. I'm beginning to think the guy's faking. Well, not faking exactly. But I'm beginning to think the problem's psychiatric. Hey, if you find something else, more power to you--you're a better doc than I am. And with that, he was out the door.

When I stopped by Mr. Gerard's room, I found a handsome blond man in his early thirties lying motionless in bed. His eyes were closed and perfectly still; his arms lay crooked at his sides. When I pulled down his sheet I was slightly surprised to find his feet crossed at the ankles. Maybe the nurse's aide had left him that way when she had put on his hospital gown.

He looked so perfectly peaceful, so perfectly asleep, that I suspected this coma business was some kind of practical joke. I tapped his arm and whispered to try to wake him up.

Mr. Gerard.

No stirring.

Mr. Gerard! -- this time with a little nudge.

No reply.

MR. GERARD!! I took both his shoulders and shook as hard as I could. But again, no response. When I let go of his torso, he slumped back on the pillow. The only movement I could detect was the perfectly rhythmic rise and fall of his chest 12 times a minute, the most normal of normal respiratory rates.

The chart at the foot of the bed recorded 14 hours of the most stable vital signs an ER doctor could ever hope to see. And my brief neurological exam suggested that every major brain pathway was intact: With his eyelids propped open, his pupils reacted normally to light. When I tapped on his knees and tickled his feet, his reflexes performed on cue. A man so profoundly unresponsive, with nothing obviously wrong? I retreated to the nurses' station to pore over his chart.

Mr. Gerard had been brought in the previous evening by an ambulance his sister had summoned. He was a well-respected estate lawyer in a large city halfway across the country, she said, and had just made partner two years before. He had no real medical problems and, as far as she knew, had never seen a

psychiatrist or had any mental illness. She was fairly certain that he didn't drink or take drugs. But she confessed to the social worker that she and her brother had become close only in the past year, during his tumultuous breakup with a longtime girlfriend; before that they had done little more than exchange birthday cards.

Mr. Gerard had finished a major project the week before and had called her Friday night saying he had no plans for the Fourth of July and might he join her family for the week? He seemed fine for the first three days of his visit, even organizing a picnic in the park and a trip to a ball game, she said. But on Wednesday he seemed depressed, and he retired to his room early because he didn't feel well. On Thursday he hadn't emerged by the time she left for work. When she got home at 6 P.M. the door was still closed, so she went in and found him, as she put it, looking dead. She called an ambulance and frantically searched her brother's suitcase for clues. All she found were books and clothes--no pill bottles, liquor, or drug paraphernalia.

En route to the ER, Mr. Gerard had received the standard treatment for patients who are unresponsive. First the paramedics gave him a shot of Narcan--which reverses the effects of heroin and other narcotics by blocking opiate receptors in the brain. Then they gave him a shot of dextrose, which brings around patients who are comatose because of low blood sugar. But neither had helped. The ER staff was faced with a man who appeared absolutely healthy yet profoundly unresponsive.

There are only a handful of reasons for a coma in a young person: a drug overdose or poisoning, a massive hemorrhage in the head because of trauma or a premature stroke, a seizure, a metabolic abnormality, a brain tumor or abscess, or a rare overwhelming infection. By the time I arrived, the night staff had methodically tested Mr. Gerard and found no trace of these conditions.

Although overdoses are the most common cause of comas in young people, they almost always produce some other symptoms. With heroin, the pupils shrink. With Valium, the respiratory rate dips slightly. With many antidepressants, the heart races. But aside from Mr. Gerard's absolute failure to respond to voices or even pain, his exam showed nothing wrong.

Just to be sure, the night doctors had put a tube down his throat and pumped out his stomach looking for pills. They had drawn blood to test for poisons and drugs. They had sent Mr. Gerard up for an emergency CT scan of the brain to rule out hemorrhage or a stroke. Still, they had come up empty-handed. At 5 A.M. they called a neurologist to see if she had any ideas.

Dr. Green wasn't too pleased about being dragged out of bed, and she was immediately suspicious of this motionless body with an apparently normal neurological exam. She began a series of standard neurological tests designed to elicit signs of consciousness.

She started by shaking his shoulders but quickly adopted more aggressive tactics to see if she could get him to react. She pressed the handle of her reflex hammer against his toenail with all her might. No response. She then pushed down hard on his breastbone. This move, the so-called sternal rub, is so unpleasant that it evokes at least a grimace from patients in pretty deep comas. But there was not a twitch from Mr. Gerard.

She even went so far as to squirt ice water into his ear, a technique neurologists use to find out if the brain stem--the primitive region of the brain that regulates basic brain function--is working. If it is intact, the eyes jiggle reflexively. And if the patient is conscious, he becomes dizzy and sick to his stomach. Dr. Green saw Mr. Gerard's eyes jiggle. And she thought she saw him begin to retch. Her hunch was that he was awake.

She then tried to find out whether Mr. Gerard was capable of voluntary movement. Without giving any warning, she sprinkled ice water on his face. He seemed to wince slightly and sink back into his trance. She resorted to a neurologist's ploy to distinguish the conscious from the comatose: she took his limp arm by the hand and raised it a foot above his face, then let it drop. Patients in true comas have no choice but to smack themselves, hard, in the face or chest. Every time she tried this, however, Mr. Gerard's hand somehow veered right and glanced off his cheek.

Based on her observations and Mr. Gerard's normal CT scan, Dr. Green pronounced that there was nothing neurologically wrong with the patient. Her note concluded: Catatonia, of psychiatric origin. No evidence of neurological dysfunction.

I agreed with her, but I had to admit the diagnosis made me nervous. True, catatonia can befall patients with psychiatric illnesses, producing movements that are frenzied, bizarre, or slowed to the point of complete stupor. And if left untreated, the stupor can be deadly because the patient cannot eat or drink. But catatonia in someone with no previous psychiatric history was extremely rare--yet what else could explain this condition?

I called the psychiatrist at the mental hospital to which we would refer Mr. Gerard, described the case, and tentatively suggested that he be admitted. The doctor, as I suspected, wouldn't readily agree.

I don't know if we can take him, he began, and then he proceeded to echo my own worst fears. Are you sure he's not an overdose? Maybe he's taken something weird that's not on our drug screen. Can you guarantee he's not seizing? You know not all seizures involve obvious twitching. Will you write on the record that you're positive he hasn't had a stroke? They don't always show up on the scan right away.

Look, I can't promise you anything right now--come see him and we'll talk. But it would be weird for a guy with an overdose or a stroke or a seizure to be so rock stable for over 12 hours.

Within 20 minutes the psychiatrist was in the ER. He spent some time talking with Mr. Gerard's relatives--some at the hospital, and some at their homes--and unearthed still more clues. What they had dismissed as eccentricity began to seem more like serious mental illness.

When he called Mr. Gerard's mother, who lived on the opposite coast, she told him that her son's behavior had been so erratic that she had been urging him to see a therapist for several years. In the past six months, however, she had stopped because her son had started accusing her of tapping his phone conversations and monitoring his mail--and she worried about feeding his escalating paranoia. A younger brother said he had been called to pick up Mr. Gerard at a hospital three months before. He had been brought there by the police after a security guard had found him in his office at 5 A.M. dressed in swim trunks. Although the ER doctors had thought he needed psychiatric help, Mr. Gerard had insisted on leaving without any care.

I'm beginning to think he is a little nuts, the psychiatrist said, as he relayed his new findings. But I'm still not sure. You can torture the guy and he doesn't react. How about a rush order on the drug tests that haven't come back yet? And maybe an EEG and a better CT scan.

Inside I groaned. That would be another six hours' worth of tests and another \$2,000. I called to arrange for an EEG to monitor the electrical patterns deep in his brain, which would guarantee 1,000 percent that he was not having a seizure. I also asked for a CT scan enhanced with a dye that might reveal some odd tumor or infection. And I left a message at the toxicology lab begging for the remaining results as soon as possible.

After much coaxing and cajoling, Mr. Gerard got his EEG and second CT scan. As I suspected, both tests were normal. But when the chief lab technician returned my call, it was bad news. No way for today, he said. We sent the screen out to another state.

By now, though, the evidence was all pointing in one direction. When I looked in on Mr. Gerard one last time, his feet were again crossed-- and hadn't they been crossed the other way before?

I called the psychiatrist. He's yours, I began, mentioning the latest results to assuage his fears. The tox screen won't be back until tomorrow, but he's been lying here rock stable for almost 24 hours and there's no overdose that can explain it.

My colleague started in with another round of questions. His temperature? Normal. His chest X-ray? Totally clear. His blood counts? Perfect. Had they been repeated? Yes, perfect again. His urine output?

I faltered. I tried to picture Mr. Gerard's bed. I didn't recall a urine bag hanging by its side, and he certainly hadn't gotten up to use the men's room. I'll have to check.

I rummaged through the nursing charts trying to calculate how much fluid Mr. Gerard had gotten through his IV line--and how much he'd put out. With renewed trepidation I realized that there was no sign that he'd urinated at all. I looked around his stretcher for a urine bag that had not been emptied. Nothing there.

Evidently Mr. Gerard had gone almost 24 hours without urinating. How could I have missed this potentially critical clue? Were his kidneys failing? Was his bladder paralyzed by an unusual overdose that had left him in a coma? Or was he holding back voluntarily? I drew down his sheet to see if I could feel the outline of a bloated bladder under his skin--indeed, I thought I could. But as I pressed, there it was again: that slight grimace of a man who is awake and feeling pain.

Clearly, we needed one more test. I asked the nurse to accompany me, explaining, Let's stick a catheter in his bladder to see what's in there.

Working in an ER, you get in the habit of talking to unconscious patients because you never know what they may feel or understand. So as the nurse draped a sterile sheet across his pelvis, she said exactly what she would say to any patient:

Mr. Gerard, you haven't urinated in a while, so I'm going to put a tube in through your penis and up into your bladder to see if there's any backup there. By now she had cleansed the area with disinfectant, put on sterile gloves, and unwrapped the thin rubber catheter connected to a urine collection bag.

Okay, Mr. Gerard, she said, picking up the catheter and taking aim. It's going in. As if those three small words had broken some deep trance, suddenly the sheets began to stir and the carefully cleaned equipment tumbled to the floor.

The nurse and I were speechless as Mr. Gerard sat bolt upright and said, Excuse me, if you give me a urinal and close the curtains, I can handle this myself. Stunned, not knowing what else to do or say, we granted his request and left.

What a way to clinch a diagnosis. We were finally certain that Mr. Gerard's problem was not caused by some undetected neurological injury. I should have known, I said to the nurse, that to a man, the threat of a catheter is the most noxious stimulus of all.

When we returned to the room several minutes later, Mr. Gerard was once again lying on his stretcher, limp and silent, unresponsive to commands. But now we all agreed where he should spend the night.

Over the next week, as Mr. Gerard went in and out of his stupor, doctors at the psychiatric hospital garnered a bit more information from him. Mr. Gerard was basically lucid, they said, but paranoid, and his thought patterns did not always follow normal logic. They suspected that he had a mild form of schizophrenia and started him on a low dose of an antipsychotic drug to treat that disease.

As the drug brought Mr. Gerard's symptoms under control, however, a clearer picture of his condition began to emerge. In retrospect, it was obvious that Mr. Gerard had been suffering for months from mood swings, and his odd behavior more closely matched the symptoms of bipolar disorder, or what used to be called manic-depressive illness. Patients with this psychiatric disorder, which tends to run in families, suffer bouts of hyperactivity and depression.

It had taken a catatonic episode to force Mr. Gerard into treatment for his illness, but his prognosis was good. Fortunately, treatment with lithium can prevent the destructive mood swings and permit the patient to lead a normal life. Not long after he was admitted, Mr. Gerard was walking, talking--even gregarious, the psychiatrists said. Just two weeks later he was able to return home and resume his law practice.

Questions:

1. What is the mystery in this story that the doctors are trying to solve?
2. Identify at least 5 possible causes for the patient's condition that were mentioned in the article.
3. What are all of the pieces of evidence that go against the idea that this is a case of a drug overdose?
4. What are all of the pieces of evidence that go against the idea that the patient is actually comatose?
5. What are the pieces of evidence that support the idea that the man has a serious psychiatric disorder?