A Miss and a Catch

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She was a thin, bedraggled woman in her mid-60s lying on a stretcher; I was the intern assigned to evaluate her in the emergency room. Her speech was slurred and barely coherent as I struggled to obtain a history. Among the seemingly random, disjointed details, she mentioned something about tumbling down the stairs. A second-year resident stopped by her cubicle and said, "Oh, that's Mrs S. She's an alcoholic; she's always here for hepatic encephalopathy." Alcoholic? Hepatic encephalopathy? That sounded plausible. So, I wrote down "hepatic encephalopathy" as the admission diagnosis, and she was whisked upstairs to the wards. I moved on to the next patient.

The following day, I sat down to lunch in the cafeteria with members of the ward team that admitted patients the previous night. They started talking about the alcoholic woman who died overnight of a massive subdural hematoma. One of my fellow interns described seeing her pupils become dilated, one after the other, as her brain herniated. At first, I thought this could not be Mrs S. But it was. I felt as though I had been kicked so hard in the gut that I could not breathe. The team's attending physician was also present; he noticed my unease and tried to reassure me. He said that I had done a good job under the circumstances, but I knew otherwise—my miss resulted in her death.

In hindsight, I could easily reconstruct the pathophysiology. Intoxication, peripheral neuropathy, or cerebellar ataxia could have predisposed her to falling. If her cirrhosis was severe enough to cause hepatic encephalopathy, then her liver was probably not synthesizing sufficient quantities of clotting factors. Also, the alcohol could have suppressed her platelet count. In this setting, a blow to the head as might happen in a fall could rupture one of the meningeal veins, leading to uncontrolled bleeding under the skull. The expanding volume of blood would cloud her sensorium and eventually squeeze out the light within the confines of her cranium. Why had I not thought of this earlier? Because hepatic encephalopathy was such a convenient diagnosis.

I was her first line of defense, and I failed her—failed to make the right diagnosis, failed to consider all of the possibilities for her incoherence, failed to think beyond the expedient. I had encountered death before, but never one that I could have—and should have—prevented. No one blamed me, other than myself. To the larger world, she was just another chronic alcoholic who succumbed to the complications of drinking. I can still recall the sharpness of anguish and guilt I felt at that moment, even after the passage of many decades. If I could speak to my younger self, I would say to somehow accept responsibility for the mistake without being consumed by it, to draw lessons from that painful episode while not becoming paralyzed by self-doubt, to not bear the load alone and in silence. But early in the course of a medical career there are peaks and valleys, extreme highs and lows not yet tempered by long experience. The memory of Mrs S and my failure to save her weighed heavily on me for a long time.

Two years later, I was a senior resident in the emergency room when a man with dirty blond hair, perhaps in his 40s, presented for "detox clearance"; this was to certify that he was stable enough to undergo treatment to ease his withdrawal from alcohol. In the ER, there was a nonacute side for patients with minor problems such as colds, small lacerations in need of suturing, sprained ankles, and the like. Detox clearance was the least acute of the nonacute. Such patients usually received a cursory examination before being hustled off to one of the detox centers in the city.

Toward the end of the interview, I asked if there was anything else I could do for him. "Well," he said, "I have a headache." Headache? I probed further with the usual litany of questions relevant to headaches. Did he often get headaches? Was the pain constant or intermittent? When did it start? Had he sustained any head trauma? Why yes. The previous day, he fell on some steps near the city center while in a drunken haze. He was brought to the nearest hospital, a world-famous academic institution across town. They did not find anything amiss and discharged him back to the streets. His headache began then and was becoming worse.

Alerted to the fall and subsequent headache, I began my examination. There were no abrasions or ecchymoses. He was not tremulous, confused, weak, or unsteady on his feet. His pupils were not dilated or asymmetric. On inspecting his fundi with the

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ophthalmoscope (something I had not performed with Mrs S) I noticed flame-shaped hemorrhages of the retina and blurring of the optic discs, telltale signs of papilledema. No doubt a subdural hematoma incurred in the fall and was causing increased intracranial pressure. An urgent CT scan of the head soon confirmed the presence of a sizable subdural. Returning to the patient, I explained that he would not be going to detox that day; instead, he should undergo the drilling of burr holes to remove this collection of blood. As the dark fluid was drained through his skull, an old demon was exorcised from me.

Of course, in matters of life and death there are no do-overs; Mrs S was still gone, and I would always carry that burden. However, I took some solace in knowing I had learned from that tragedy and became a better physician. I was thankful to have been given the opportunity to catch this patient's subdural before he became more symptomatic.

The next morning, I tracked down the patient on the surgical wards. He was lying in bed, his head heavily bandaged. When he spotted me, he called out, "Hey doc, my headache is gone!"

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