An Intern’s Guilt

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“She’s been here for two months already. She’s very complicated; you’re going to be spending a lot of time with her and her family,” my fellow intern said as she began signing out her patients to me.

It was my first rotation in the medical intensive care unit, and I was terrified. I was in my first few months as a “real” practicing physician—a title that I still felt uncomfortable with. If a nurse called out “Doctor!” I wouldn’t respond, thinking that she couldn’t possibly be referring to me.

My fear mushroomed as my co-intern rattled off the patient’s problem list—bone-marrow transplant, shock liver, congestive heart failure, anemia, coagulopathy, sepsis, acute renal failure, ICU neuropathy, encephalopathy, ventilator-dependent…I knew what these meant, I just felt overwhelmed to see them all in a single patient.

Her name was Laura. Her story was impossibly tragic. A newly married, successful young professional, she’d visited her general practitioner two months back, complaining of weight loss and a headache, only to have blood tests reveal devastating news: leukemia.

Her first inpatient chemotherapy treatments had been followed by a bone-marrow transplant, then by complications from chemotherapy. A barrage of serious infections had landed her in the ICU.

Swollen with fluids as a result of her heart and kidney failure, Laura was thirty pounds over her normal weight. Chemotherapy had taken her hair. As her liver function worsened, her skin turned golden yellow, then bronze. Soon she developed oozing sores caused by edema and malnutrition (because her body couldn’t absorb needed nutrients). The sores became infected, turning black-green. As her blood stopped clotting effectively, her skin became mottled with blood oozing from subcutaneous capillaries.

She had tubes everywhere—to feed her and help her breathe, to monitor her blood pressure and heart function, to help her urinate—even a rectal tube to help with her near-constant diarrhea.

Perhaps mercifully, Laura had been rendered unconscious by the multiple processes that caused toxins to build up in her blood and that reduced blood flow to her brain. The neurologists called it “toxic metabolic encephalopathy.”

At first she was no more than a body and a collection of numbers to me; the machines told me what I needed to know to keep her alive. Yet, somehow, despite Laura’s enfeebled, comatose state, a sense of her personality and life crept into my awareness.

One day, with a shock, I noticed on the windowsill a picture of her, smiling—probably placed there many weeks earlier by her mother. Laura was beautiful, with shiny blonde hair, gleaming white teeth, perfect porcelain skin. I walked in one morning to find her mother filing and painting her toenails, and then one evening I found her painfully attractive husband reading to her from a David Sedaris book. I cried on the phone to my mother that night, realizing that if I were ever in Laura's crushing situation she would surely come tend to me in the same way.

I heard from the nurses that, prior to chemotherapy, Laura's biggest concern had been that she be able to freeze her eggs so that she could one day conceive a child. But once she was diagnosed, there was no time. She'd come to our hospital right away so that the leukemia could be treated.

Life with Laura was a roller-coaster. If her white count went up a tenth of a point, I ran to tell her husband and her mother. If her platelet count didn't respond to the latest transfusion, I somberly told them of the need for another one. Dutifully, I informed them when antibiotics were changed, when new consults were called and when the blood cultures indicated yet another life-threatening infection to be dealt with.

When my last night call arrived, I felt happy—happy to be leaving the next day, happy that I'd survived, and relieved that Laura would not die on my watch. The hematologists had told me to give her a platelet transfusion if her count fell under 10,000—the level below which the chances of a life-threatening bleed into the brain would increase substantially. On her evening labs, her count was 13,000. Per the instructions, I didn't transfuse her and ordered routine morning labs.

The nurse interrupted me at 5:00 in the morning as I was writing an admission note. "I think you'd better come and examine Laura. One pupil is dilated, and she's not breathing above the ventilator."

I walked to her room, my legs weak, and began to assess Laura's condition. My heart sank with each finding: one pupil "blown," wide-open and unreactive; no gag reflex; no spontaneous breaths. I called the supervising resident, then numbly listened to her directions: Order a head CT, then transfuse blood products to prevent further bleeding….

But I couldn't order the CT scan. When I sat down at the computer, my hands were shaking too much. The resident had to type the order for me.

Yet the reality of what had happened didn't sink in until the attending physician came onto the unit for morning rounds and said, "I'm so sorry, your patient is brain dead."

I had to leave the room and get away from the shocked eyes of the ICU nurses, my colleagues and the attending—mortified that I couldn't keep the tears from streaming down my face.

The attending tried to console me, assuring me that this was the best that could have happened to Laura, that it was something he had prayed for. He

also said that, had I not been caring for her, she wouldn't have lived as long as she did.

It didn't help.

I went home, relieved at not having to give Laura's family explanations or face their grief, glad to have the chance to be alone, yet churning with guilt over not having transfused her.

It's six years later, and I am now the same age as Laura was when she received her diagnosis. I've had the chance to make and learn from my mistakes as a young physician; I've spent enough time in the ICU and in oncology units to become accustomed to death's inevitability, even at times to view it dispassionately. And yet, although an autopsy showed that my decision not to transfuse Laura wasn't the sole reason for her intracranial hemorrhage, I still can't shake the strong emotions that surface when I think of her.

I wonder if these emotions are brought on by lingering guilt over not having transfused her. Or do they reflect how much, in her youth and aspirations, Laura reminded me of myself—of my own good fortune, my own mortality?

About the author:

Anna Kaltsas is currently pursuing a fellowship in infectious diseases at Montefiore Medical Center in the Bronx. She has maintained her interest in writing ever since her days as an undergraduate English literature major, and pursued it further through her ethics courses in medical school. This is her first story for *Pulse*.

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