

MIND TO MIND

Creative writing that explores the abstract side of our profession and our lives

Blame it on ... Anesthesia?

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In the heady aftermath of the code, I felt as though I were merely rolling mindlessly through the hospital corridors, an empty vessel. After providing our report to the intensive care unit and plodding down the linoleum corridor to the stairs, a familiar unease was burrowing in my chest. I always felt it anytime there was a delay in my patient waking up. Despite the successful code execution and our patient returned to us, the foxtrot with death left me feeling like a part of me had fallen into a spiritual sinkhole. And yet, nothing prepared me for what happened next.

The moment I returned to the operating room, the circulating nurse approached me with a troubled expression. “Doctor, um, I have to tell you something. That vial that was handed to the surgeon was not local with epi. Um, um, it was epinephrine—pure epinephrine. I’m sorry. I’m so sorry.” She leaned in to hug me, and everything suddenly became clear.

Our patient was a healthy, 12-year-old boy who presented for endoscopic sinus surgery. He had tolerated induction and intubation well, as expected. His cardiac instability came abruptly. Following the surgeon’s injection of “1% lidocaine with epi” his heart raced until it evolved into ventricular fibrillation. Chest compressions ensued until the code cart arrived. Then, a single defibrillating shock converted his rhythm into pulseless electrical activity. A swift dose of epinephrine restored normal sinus rhythm and a pulse almost immediately, as if nothing had happened. The sound of regular rhythm in the stone-cold silence of the muted operating room re-established a sense of order to the frenzied room.

What remained unsettling, however, was the absence of a known etiology behind the arrhythmia. We therefore consulted the cardiologist and intensivist intraoperatively. The echocardiogram revealed excellent function with no structural defects or pathology. The surgery was postponed, and we decided to keep him sedated and intubated for transfer to the intensive care unit. The boy underwent a cardiac MRI the next

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morning and was extubated shortly thereafter. Later that afternoon, I sat with him and explained what had happened while he was in the operating room. It was so good to hear his voice and feel the unease lift.

An unlabeled vial. Someone on our operating team had made a grave mistake, but no matter who it was or what it was, the responsibility of leading the effort to stabilize the patient lay on one person: the anesthesiologist.

I suppose we all know that on a superficial level. We all know that if the surgeon severs a major vessel, the anesthesia team will need to detect the bleeding and immediately intervene—I didn't often think of anyone else placing the patient in peril. After the nurse revealed the error, the full weight bore through me like a 5-ton elephant. While any number of events could endanger my patient's life, it was up to me to detect and resolve the threat.

The gravitas of that responsibility loomed over me for weeks. While we are all considered equal in the operating room, we are not equal in responsibility. In 19 years of clinical practice, no one has ever attempted to take over a code I've led. And yet, for some unknown reason, we ourselves laugh along with the thread-bare joke of "You can always blame anesthesia."

Not long after this code, a nurse who helped on that very code uttered this "joke" to me. This time, it felt like a bucket of ice-cold water had been thrown at me. I stared blankly at him, stunned. Behind my mask, I wondered, "Why did you say that to me? Did you not witness how I suffered? Don't you realize I was in anguish, too? Did you not see my own heart breaking with worry?"

Why do we perpetuate such a thinly veiled disparaging remark? Is it because we're all afraid of the nurses? And what is the appropriate response to a "joke" that has lost all sense of humor?

Maybe the history of how anesthesia developed as a profession provides some insight? In the 1940s, for example, women were strongly discouraged from becoming surgeons. Such a barring from a specialty resulted in Virginia Apgar becoming an obstetrical anesthesiologist instead of a surgeon. At that time, anesthesia was perceived as a lesser, lower paid specialty than surgery. Furthermore, anesthesia was often provided by nurses. It has since developed with both medical doctors and certified nurse anesthetists providing care. This history makes anesthesia a little unique as a specialty. I suppose our specialty has always born a kind of "mark of inferiority," particularly within the hierarchical cosmos of the operating room. But does it have to remain this way?

Given the essential nature of this field of medicine—and the fact that without it, advances in some surgeries would not be possible—perhaps it is time to move the running joke into the medical museum. The use of dexmedetomidine to enable awake craniotomies, the anesthetic care of the fetus in the *ex-utero* intrapartum treatment procedure, and the harnessing of regional anesthetic techniques to enable cardiac patients to undergo surgery without risking exposure to the myocardial depressant effects of volatile agents are but a few examples of advances in modern anesthetic care.

In an era in which we are losing medical doctors to retirement, burnout, and the lure of nonclinical professions, is it in the best interest of patients to perpetuate a sentiment that devalues our profession? How do such remarks affect the well-being of these clinicians in their day-to-day work lives?

Perhaps remarks like, “You can always blame anesthesia,” should be displayed next to the copper kettle, properly curated as relics of our past. Perhaps, just as our skills with ultrasound-guided regional blocks have evolved, so too can our language.