

## Too Much Calm in the Storm?

### In the Operating Room

In the course of one's training, one often learns information that is seldom put into practice, but is, nevertheless, of vital importance. For example, when a patient is given succinylcholine, a depolarizing muscle relaxant that is the anesthesiologists' drug of choice for rapid muscle relaxation for intubation, the serum potassium levels rise, on average, 0.3 to 0.5 mEq/L. However, every anesthesia resident should know that in chronically immobile patients, the serum potassium level may rise much higher, resulting in marked hyperkalemia, cardiac arrhythmia, and even cardiac arrest.<sup>1</sup>

When teaching anesthesiology residents, I emphasize the importance of communication with the surgical and nursing teams. I explain that, in the operating room (OR) environment, anesthesiologists usually are the best trained to manage a code situation. I also go to great lengths to teach residents always to maintain a calm exterior no matter how much anxiety exists inwardly, believing that if the anesthesia provider starts panicking, the rest of the OR is going to follow suit, usually with less than desired results! One of the "rules" listed in *The House of God*, the classic novel of medical training by Samuel Shem, states (paraphrased), "The first thing one should do in a code situation is take one's own pulse."<sup>2</sup>

Recently, I was challenged to put my own teaching into practice. The patient of the day was a 23-year-old man who had sustained a closed head injury several months previously and was now undergoing placement of a gastrostomy tube because of poor feeding. He had been bed-ridden for the past 2 months, his only activity provided by daily physiotherapy.

The junior anesthesia resident had dutifully drawn up succinylcholine as well as a nondepolarizing muscle relaxant, happily explaining that he had read up on the information described above. Although I knew that the patient was at risk for hyperkalemia, I still suggested use of the depolarizing agent, arguing that the other muscle relaxant would have far too long an effect for the proposed 5-minute surgical procedure. Not being one to challenge his mentor, the resident raised no objection. Honestly, I also wanted to test the theory that textbooks are written by people too busy writing to actually practice clinical medicine.

Monitors were applied, the patient was denitrogenated with 100% oxygen administered via facemask, and drugs were injected into the intravenous line. After the muscle fasciculations of succinylcholine were

seen, the resident had some difficulty intubating the patient, so attention was directed towards the airway. As the tube was successfully passed, I looked up at the electrocardiogram (EKG) monitor and observed a straight line traversing the screen.

Knowing instantly that this was not a disconnected EKG cable, I sighed, and, practicing what I had preached, I very calmly directed the resident to administer calcium, exactly as the textbooks suggested, while I began mechanical cardiopulmonary resuscitation. Having commenced chest compressions and surprisingly impressed with my calm demeanor in my first iatrogenic code, I asked the circulating nurse to summon help. She was filling in some paperwork with her back to me and asked me to repeat what I had said. Again, in a measured tone, I repeated my request. This time, she looked up, digested the situation, and immediately panicked! "Anesthesia stat to OR 14!" boomed over the public address system. This call, in a teaching hospital such as ours, results in a herd of anesthesia elephants descending on the room, since fixing someone else's mistake is the great equalizer, a sort of academic one-upmanship!

The first person to arrive was the OR director, a fellow cardiac anesthesiologist. He took one look at me and said, "Oh, it's you," and promptly turned to leave the room, assuming that I was taking care of someone else's dilemma. At this point, teaching aside, I confess that I did raise my voice a little: "No, really, I actually *do* need help!"

Fortunately, the patient was rapidly and appropriately resuscitated (his rhythm had returned by the time help had arrived). Everyone left, and back to my calm demeanor, I nonchalantly directed the surgeon to continue. He would have nothing of it and cancelled the case immediately!

I learned several important lessons that day—notably, that those guys writing the textbooks may, in fact, have something relevant written there, and that being too calm has its detractions as well!

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#### REFERENCES

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2. Shem S. The house of God. New York: Dell; 1981.

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