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

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The Scarlet "A"

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The sixth floor anesthesiology workroom is ideally located between the two primary wings of our main operating room suite. Here, a majority of our faculty members can be found in between surgical cases conferring about challenging cases, discussing near-misses or sharing major personal milestones. I was three weeks into my first assignment when I walked into a surprisingly somber workroom. The workstations to my left and my right were occupied as usual with faculty; however, the tension in the room remained palpable. "How's it going?" I said to the usually gregarious Jordan. Today, I received a barely perceptible nod and an: "Ok" in response. Perplexed, I turned back to my computer and continued to work.

Through the hospital grapevine, I later learned that Jordan had suffered an unexpected intraoperative death on his first operation of the day. Admittedly, I listened avidly as the case was discussed in the hallways, ORs, as well as in the break room that day. However, my interest succumbed to guilt as a disturbing pattern began to emerge. The overwhelming sentiment was sympathy and a fervent hope that we would never be in the same position; however no one spoke about this case directly with Jordan. Conversations ceased mid-sentence if he was in the vicinity and uncomfortable, averted glances followed his every move…shamefully, mine as well. He became an instant pariah not due to some egregious mistake or moral failing but because all anesthesiologists have an unspoken fear of death. This fear makes us believe that death itself is contagious and if acknowledged, if allowed to enter our psyche would bring it a few steps closer to our operating room.

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Nathaniel Hawthorne's literary classic *The Scarlet Letter* was set in Puritan Salem, Massachusetts. It is the story of an adulterous affair between a young wife (Hester Prynne) and her minister (Arthur Dimmesdale). The resulting pregnancy, as well as the town's banishment and mistreatment of Hester, sets a series of events in motion that culminates in the eventual demise of all involved. As a constant reminder of her sin, Hester is made to wear a scarlet letter "A" on her bodice and is cast aside by the town; living on the outskirts of her society her entire life.

While I dare say that we have come very far from Puritan times, the stigma of an intraoperative death for an anesthesiologist is ever present, like the "A" on Hester's dress. Though not worn openly, it festers like Dimmesdale's guilty conscience and its effects reverberate throughout our professional and personal lives, silently destroying us from the inside out. Intraoperative deaths are such rare events that there is no universally agreed upon incidence. Of the greater than 200 million surgical procedures that are performed on a yearly basis, anesthetic mortality has been estimated at 30 per million and continues to decline. This is why anesthesiologists routinely tell patients that anesthesia is "safer than driving a car" or "riding in an airplane." We are victims of our own successes. Therefore, not only are these events truly unexpected but when they do occur, our training does not provide us with the tools to manage this "failure" effectively.

The trauma of a patient's operative demise resonates past the day of the event, affecting our psyche as well as our personal and professional lives. Data suggests that an unexpected intraoperative death will occur at least once during our professional lifetime. Multiple surveys have established that the stress of this event is similar to the stress caused by divorce or being fired from a job. More than 70% will experience feelings of guilt, over 88% will require time off to recover emotionally from the event, 12% will consider a career change and 19% state that they have *never fully recovered*. Support from colleagues as well as departmental administration is critical for emotional recovery. At the very least, some time off for reflection and emotional "decompression" should be offered.

Despite this information, there has yet to be consistent support for anesthesiologists who experience this traumatic event. Supportive and educational activities are not available in a majority of cases in spite of literature to suggest the necessity and benefits of psychological services for staff. There is also a large gap with regards to training at all levels about dealing with adverse intraoperative events.

I regret that I did not personally ask Jordan about his patient, listen to the details of the case and validate his feelings. More than a year has passed and with it my share of near misses and close calls. In each of those situations, I have questioned everything from my career choice, training, skill set, and judgment. And after, I have said a silent prayer of thanks while vigorously suppressing that small voice in the back of my head reminding me that my time will come.