One morning in the OR

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Last week I had what emergency doctors call a "difficult airway." An elderly man with sky-high blood pressure required urgent intubation. It took me and a colleague several attempts and almost 10 minutes to put a clear plastic tube down the man's throat and into his trachea. Just as the on-call anesthetist answered my page for assistance, my colleague got the tube in. The patient survived.

Harrowing cases like this can shake a doctor's confidence, so I decide it is time to get some practice putting in endotracheal tubes. I knew that during a single morning in the operating room I could perform this critical intervention as many times as I normally would during a year in the ER. A few days later, I ascend to the ethereal realm of the OR. The modern surgical suite is a controlled environment of imposing machinery, inhaled and intravenous anesthetics, and computerized monitors. Normally the operating theatres are pleasantly air conditioned, but on this morning staff are complaining about the heat.

A little self-conscious in my green OR costume, I follow one of the anesthetists into the pre-op area. I also work from a different script here. He introduced me to his next patient. "This is my colleague, Dr. Hanlon. He works in Emergency and he's with us this morning to brush up on some of his skills."

"The fine brush," I say with a smile, attempting to reassure the young patient, who appears a little apprehensive. Today my palette includes milky-white Propafol anesthetic — "the milk of amnesia" — yellow-brown antimicrobial skin cleaner, and 16 million colours of the computer screen that Etch-a-Sketch the patient's blood pressure, heart rate and percentage of exhaled carbon dioxide. Surprisingly little crimson is seen.

Rhythmic continuo of patient heart beeps emanates from the computer monitor. The voice of Placido Domingo sings *O Holy Night* on the cassette player beneath the clock. The television screen hovering over the patient suddenly grows a large gall bladder. Wisps of smoke dance across the screen as a pointed metal probe releases the pendulous gall bladder from the undersurface of the liver. The picture is so clear I can smell the cauterized flesh. I scan the OR list. Laparascopic cholecystectomy. Abdominal hysterectomy. Panniculectomy. Cataract excision. Body parts lose their meaning and need to be removed.

The dialogue is sparse and to the point. "Raise the bed please." "A little more head down." "Is the tube in?" Doctors and nurses work quietly over even quieter patients. I exchange brief greetings with my surgical colleagues. As one case ends, I discuss with a plastic surgeon his proposed purchase of a new espresso machine.

Salvador Dali would be impressed. The anesthetist's pager trills to life. He checks his hip and steps across to the phone. Leaning against the wall, he murmurs into the receiver. His disinterested gaze sweeps across the room, pausing momentarily on the exposed lower half of an elderly woman's body while a nurse paints her pudenda with Betadine solution. She begins at the grey mass of pubic hair and inscribes expanding circles to encompass the pale lower abdomen. Subdued lighting is pierced by the intense beams from 2 surgical spotlights. One falls on the woman's left knee. The other splashes the floor well away from her unconscious form. Garth Brooks breaks into *What Child is This*?. I realize I'm just one more detail in a surrealistic Christmas tableau of surgery at the close of the 20th century. All it lacks is Dr. Don Quixote carrying a 14-foot laparoscope. The hands of the clock appear to droop slightly.

The world of elective surgery is one of no rush and less fuss. One case follows another with monotonous regularity, to the point of almost running on schedule. I move from room to room and intubate a handful of patients without difficulty. Between cases the anesthetist quizzes me about distinctive anatomical features of neck, jaw and tongue that can make intubation more challenging.

Just before we render a middle-aged man unconscious I speak the familiar refrain: "*Take some deep breaths. In a few moments you'll be going off to sleep.*" Will he dream of a white Christmas? As he loses consciousness, I squeeze a black bag that pushes oxygen into his lungs — one part of the process called "managing the airway." I open the man's mouth and insert the curved steel arc of the laryngoscope. Despite my best efforts to be gentle with the patient's lips, teeth, tongue, head and neck, the anesthetist uses the words "a little rough" to describe my effort — the same words he used a year ago, when I last spent a wintry morning here.

Sporadic practice, in my case, does not make perfect, but it does make the procedure less intimidating. The morning has been full of good advice and practice. I thank the final anesthetist I work with, shed my surgical garb and exit through the change room. I leave feeling more confident about slipping tubes through narrow passageways. I head for the café while Leon Redbone sings *Christmas Island* on the car radio. Waiting for my small cap to arrive, I scan the room, discretely inspecting the necks of my fellow patrons, on the lookout for that difficult airway.

Vincent Hanlon is an emergency physician practising in Lethbridge, Alta. His recently published CD/book, The ABC of the ER*, is available from www.abc-er.com.*