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Editorial

When things go bad...

The airline industry trained its pilots on a flight simulator. The trainer can take a pilot through almost all unforeseen circumstances and train a pilot in almost all conditions. The stakes are very high and you can't really blame the industry for being too careful about this. It does not finish here, the pilots come back every year and revalidate their set of skills and prove their physical and flying competence. Now let me take you through another scenario in which a young doctor recently graduated having done his final prof is asked to manage the casualty on his own or be the only doctor at night time in the ward. There has been no simulation, he has seen, watched, read a lot and maybe helped someone to a few basic things but is he now ready for an actual flight just because he carries a registration number and a prefix of Doctor. The stakes are quite high, the impact is considerable but fortunately not reported in the national dailies. Best part he does not have to revalidate his skills ever. Pilots have a flight simulator which they use very often in the learning process to develop their skills, hoteliers have mock guests to develop their skills, drivers have a mock driving tracks and doctors have actual patients. And things go wrong very often, in fact too often.

Complications, mishaps, unforeseen circumstances call it what you may but the impact on both a surgeon and patient is immense. The inability to lock a nail causing shortening and a lifelong limp, the use of a weak plate causing implant failure and subsequently 3 more operations some involving taking ½ of the pelvis away, the nerve which got damaged because of poor exposure causing deformity/weakness in the hand, there are enough opportunities in any medical field to cause problems. A surgeon and the patient unfortunately have then to deal with them. While no means belittling the patients' misery there are even enough instances of doctors totally disillusioned and giving up medicine as they were not able to take the stress and anguish around practicing medicine.

Broadly speaking complications can be divided into:

1. Surgeon related
2. Disease related
3. Patient related.

Surgeon based complications can be classified as:

Poor surgical experience including implant selection/approach/inexperience
 Poor interpretation of a case (X-rays/comorbidities).

I personally believe that 80% of all complications will be surgeon caused. A DHS which cuts through, or a nail which breaks, a hip replacement which dislocates, a standard ankle fracture fixation in an elderly which failed are all instances where the surgeon possibly has not really analyzed his patient, his patients' intellect, his socio-economic conditions, his home circumstances etc. How else can we justify things like doing a total hip replacement in a person for a fracture neck of femur in someone who only has an Indian toilet at home? A patient with dementia given cancellous screws for neck of femur fracture which fall out within 1 weeks, are all complications which have to be blamed on the surgeon. How many times we have heard "there was too much comminution", "bone was too soft", "there was bone loss", "patient was very non-compliant" "left it to my assistant who really screwed up". I will put up my hand up first to say that I have made all these excuses whenever things have gone wrong. Unfortunately all of these essentially only show a lack of pre op planning, thought process and organization. A day comes when you actually start believing so much in these excuses and that is the day that the surgeon stops his learning cycle and stagnates. He firmly starts to believe that no complication is related to him. I will also now admit that it is these excuses that stopped my knowledge progress and my surgical skills for a long time. It was always so easy to say it is was all the patients fault that I started saying it all the time. The more I observed my notable peers interacting with patients I see the ones who actually own up and take responsibility for their action are the ones who are and will be in the forefront. They are the ones who will improve, they are the ones who will avoid future complications, and they are the ones who will teach our next generation how to avoid making complications.

Possibly it's the same as when we try to teach our children for owning up for a broken glass window or losing the keys to the car, we insist that they own up and take responsibility in the hope that it will build character much like George Washington who claimed responsibility for cutting an apple tree and eventually went on to be we all know who.

I keep hearing people say that it's all right to make mistakes as that's how people learn. But I put it to you if you are always going to learn from bad experiences there will never be enough complications in your lifetime. As the ancient Chinese saying goes, "*anyone can learn from their own mistakes wise men learn from other people's mistake*". There is no

paucity of medical literature and workshops in which to learn. Though I hasten to add we don't we talk enough of our complications, we have not created an atmosphere which allows people to talk about their complications and bad results in a more constructive way. Many years ago when I started doing ACL reconstruction I had 2 consecutive cases in which I prematurely amputated my graft but what was surprising that although I kept on asking my colleagues regarding the mistakes I was making people were very reticent to actually talk about it. I was almost made to feel that I was the only one having that problem. What stops us from showing our bad results? Why are people in all the conferences showing brilliant results if the purpose of all the meetings is really education? There is no denying that all of us learn more from our complications rather than our successes. The more emotional, more thoughtful and involved we get with our complications the more likely is it that we will ponder over them, more likely that we will avoid them. I am aware of the tremendous stress and tension that we will have to take but that is the burden of the white coat that we have to bear. This cross we will need to be carried. Some people will say I am being rather harsh on surgeons but do you see the stakes here my friends. We are dealing with peoples' lives here and their family who may be relying on them for being bread earners for running the house.

Medical books/journals/workshops/conferences/internet... there is a plethora of sources available to learn from in case you are interested but the penetration factor/practice changing influence is still not all that significant. Our innate feeling based on past experiences still kicks in. I still keep hearing "I tried this in 1 case and the patient did well so I think this is the best thing to do". Our very recent past experience seems to over-ride our logical sequencing of events and current state of knowledge. Can I suggest my friends be guided by peers, good teachers and writers not by anecdotes.

A true mark of a great surgeon however is not, not having complications as they are inevitable but managing complications well and issues around it or let's call it managing inevitable fallouts. This will make you stand out as a cut above surgeon. Honesty possibly is the starting point in this and

acknowledging and discussion with colleagues is something which needs to be done.

Introspection is the key to a successful career and asking one self and his colleagues and assistants "what could I have done better? what am I going to do differently next time?" should be the thought process of every surgeon. The irony of identifying complications is evaluating other colleagues' patients. Wish we were as scrupulous with our own results as other peoples. We should be able to take it on our chin what we are ever ready to dish out.

You need to ask yourself after every case maybe even aloud "what is it that I did well and what could I do better"? If you have a complication you need to identify people with whom you can go and discuss – whom do I talk to about this? Identify your peer group who don't have an agenda and whose judgment you can rely upon. Part of managing complications is having good pre-operative discussions with the patient regarding potential complications. Complications will occur but the patient will be working with you not against you. Be self-critical and confront your worst fears. Know your capabilities and don't over reach, talk about things that go wrong and be bold enough to accept your inadequacy. If you notice things not right the patient needs to go back to OT now rather than 3 months later when there are not too many options.

Eventually a large part of our response will come down to our training and how our mentors and teachers manage things. So if the stress of the job was not enough you need to be wary of your response in front of your juniors. This journal is read by a mature qualified readership they cannot be asked to go back to medical school but walking away when the bucks are down does not show good character or upbringing.

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