Journal of Visceral Surgery (2016) 153, 243—247

Available online at
ScienceDirect
www.sciencedirect.com

Elsevier Masson France
EM|consulte
www.em-consulte.com/en

POINT OF VIEW

Presidential address of Professor Denis Castaing☆

D. Castaing

CHB-hôpitaux Universitaires Paris-Sud, département Hépato-Biliaire de l'hôpital Paul-Brousse, INSERM U-785, DHU Hépatinov, 94800 Villejuif, France

Available online 15 July 2016

Looking out at all of you gathered here, I feel the measure of honor bestowed upon me by the administrative council of the French Association of Surgery (AFC) in naming me its president for this 117th Congress. Despite what my all-too-modest predecessors may have said, I had the feeling that, one year or another, especially with advancing age, I would one day stand here as president of the Congress. All the same, this remains a great surprise and an altogether agreeable moment. I am honored, very happy, and I thank you all sincerely.

One could say that I have been very lucky in my life, blessed by my loving wife, Marie, my children Raphaëlle, Grégoire and Charlotte and their children who are a real source of joy; lucky, because I had parents who always encouraged me and a father, professor of orthopedics in Tours, who did not want me to do my medical studies at his university in Tours (like a true Parisian, he sent me off to Paris); lucky, because I started my internship in Paris in the surgical service of André Monsaingeon with Henri Bismuth; lucky, because I was able to pursue my surgical career within the strong, competent and collegial team at Paul-Brousse Hospital, without whom I would have been nothing. But what does it actually mean to say that I had good luck? Has there been some quasi-divine intervention that has governed my entire live, and prevented a massive wave from capsizing my little ship or saved me from a banal road accident? I would deny the effects of good luck. I refuse to consider that the events of my life should be considered lucky or unlucky. They are what they are and that is enough. What purpose does it serve to consider how events could have pursued another course? To speak of luck simply underlines the fact that I, an opportunist, profited from my opportunities; what interest would you have in hearing about all that?

People think (or at least this is a question I have often been asked) that a surgeon remembers his first stroke of the scalpel. That was certainly not my case, and I have no such memory. However, you can be sure that my first medical error is engraved in my memory. Because a surgeon learns enormously from errors, and finally, remembers these more than all the other rites of passage, I want to talk to you about my errors, my stupidities and my thoughts that arose from them. Or, as Pierre Dac once said, ''an error can become correct, depending on whether he who committed it was mistaken or not.''

DOI of original article:http://dx.doi.org/10.1016/j.jviscsurg.2016.06.008.
☆ Opening speech of the 117th Congress of the French Association of surgery, Paris — September 30, 2015.
E-mail address: denis.castaing@aphp.fr

http://dx.doi.org/10.1016/j.jviscsurg.2016.06.009

I committed my first error when I was the on-call first-year intern and Mr. Lambert presented with abdominal pain and diarrhea. His physical exam seemed normal. I reassured him and allowed him to return home. In fact, I committed three errors simultaneously. The first was not to have considered the possibility of pseudomembranous enterocolitis, particularly since he had been on antibiotic therapy for pharyngitis for the two preceding weeks. The second was to discharge him without having first talked to my chief resident, because I did not want to appear to be an indecisive intern and I felt sufficiently confident to make such a decision without asking advice from anyone about anything. The third error was to fail to listen to that little voice whispering to me, ''You're making a mistake.'' Four days later, I was on call again and when I got to the E.R., the nurse said three words that I have learned to hate — ''Do you remember. . .?'' ''Do you remember the patient you allowed to go home? Well, he came back in shock from a perforated colon and he died.'' I felt less than worthless, ashamed, and to blame. I had never even considered this diagnosis; I hadn't taken the right approach; I was responsible for his death. I didn't dare talk to anyone about it; I was undoubtedly too proud. I told myself that I would never again make such a mistake, that this error would serve as a lesson, that I would be more attentive in future, more modest. I would like to tell you that that has been the case, but that would be false; I have continued to commit errors during and after my internship and residency. Failure to act when action is straightforward and effective, lack of clear-sightedness, distraction and fatigue, personal worries, inadequate clinical knowledge: these are all clearly contributory factors, but, in reality, most often, the principal motive is the fear of appearing to be a fool.

Why did I fail to heed that little inner voice that tried to tell me ''there's something not quite right here''? It was an alarm signal but I was deaf to it. I think it was because I had fallen into an automatic mode. A surgeon needs this automatic mode because if his attention were eternally on high alert, he would be bombarded with too many signals to choose from, he would lose the ability to select and process so much information. It is impossible to drive a car if one must incessantly pay attention to each piece of information one receives. Short-term memory is restricted in both capacity and duration. Each new piece of information will take up space and rapidly fill and saturate memory capacity. The automatic mode is a means of avoiding this. And yet, one must know how to remain attentive. Faced with this contradiction, the real difficulty is to maintain a minimum level of concentration in spite of everything, allowing one to pick out the valid alarm signals when the unexpected arrives and to stop, or redirect the routine process that has been undertaken. In the years around 1995, we were doing about 170 liver transplantations a year. It had almost become a routine process. One day, I had to do a re-transplantation and, in such cases, the portal vein anastomosis is often firmly adherent to the caval anastomosis. I knew this. I dissected around the hepatic pedicle in routine fashion, in the automatic mode. This did not strike me as the most difficult part of the procedure. As I passed a finger behind, I felt a slight resistance, an alarm signal. I didn't pay it much attention, and continued my maneuver, only to find my finger in the vena cava with a posterior laceration of the portal vein. This was, or should have been, perfectly avoidable. One can learn the circumstances that require discontinuation of procedural routine, either by apprenticeship learning, by grim experience, or by training. For a teacher, this is the most difficult lesson to impart.

The other important element in this situation is the mechanism for decision-making. While no single approach is the best, every surgeon has his own particular mode of decision-making. The mental schemas are very ingrained and difficult to change. Two principal modes can be distinguished:

- the rational mechanism is a deliberation in which one weighs the pros and cons leading to a choice. The response is intellectualized and it is relatively easy to reverse the initial decision. This is a slow process and adapts poorly to emergency situations, particularly those arising in the middle of a surgical procedure;
- the intuitive mechanism is a rapid, subconscious mental process. One decides rapidly, decisively, permanently but there is no choice.

In these two cases, one should follow certain common rules:

- the first rule is to have adequate knowledge and experience for the task in hand;
- the second rule is to understand the situation, even if, in an emergency, there is very little time to do so. One day, I was on call in the emergency room when a young 28-year old female was transferred from an outlying hospital because of hepatic trauma after a motor vehicle accident. She had been operated on at the receiving hospital, and the surgeon explained to me over the telephone that he had performed a right hepatectomy but was unable to control the bleeding. I re-operated on the patient emergently but did not make the effort to comprehend what was actually going on. I was baffled and confused by the volume of hemorrhage and pre-occupied by efforts at hemostasis, and without success. The young woman died of hemorrhage. It was only afterward that I realized that the initial surgeon had unwittingly resected the vena cava while performing the right hepatectomy and that all the retroperitoneal bleeding was due to this. I should have perceived this before the situation became irreversible. . .;
- the third rule is to avoid confusing wish with reality. One day, I saw a 25-year-old dentist in consultation for a very large hepatocellular carcinoma arising in a healthy liver; the lesion was clearly non-resectable since there was evident lymphadenopathy. Because he was young and had a kind face and had been sent to me by a dear friend who had told him of the possibility of a surgical intervention, I decided to operate, even though I knew full well that this was not a reasonable choice. During the mobilization of the liver, I broke into the tumor resulting in spillage throughout the peritoneum. In spite of this, I completed the hepatectomy. Four months later, I heard the fatal phrase from my friend, who had sent me the patient, ''Do you remember the young dentist? He just died — a miserable death with peritoneal carcinomatosis.'';
- the fourth rule is that the first solution that comes to mind is often the best one, even though this attitude may entail the risk that you will see only confirmatory rather than affirmatory information. One time, I was supposed to operate on a patient with a fairly large gallbladder cancer. From the moment we opened the abdomen, I felt that the tumor was not resectable. Because I found it hard to admit that I had misjudged the indications for surgery, I proceeded with the dissection, in hopes of being able to resect the lesion. Fortunately, I stopped before the situation became irreversible. Hypocritically, I asked my assistant for his approval.