# Mistakes

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One of the toughest aspects of community practice is dealing with our mistakes. In highly populated areas like southwestern Ontario, less urologists are in solo practice, but many of us practice without significant peer support. How we handle errors can define us and, in some instances, damage us along with our patients.

Think about the biggest mistake you've made. If it doesn't come to mind immediately, then think again. Most of us can remember the time we messed up as if it was yesterday. We've gone through it in our minds and replayed what we could have done differently. What we haven't done, most likely, is speak to the patient involved (if that patient is still alive). The Royal College's position on discussing mistakes with patients is, I believe, the correct way to manage our missteps. Early in my practice, I worried about errors and didn't always admit them to my patients. Yet, I always knew it was the best thing — to admit my mistakes, that is — because I have children. I remember sitting my three young boys down before they were old enough to drive and drink, and telling them that I would never punish them if they told me the truth. My oldest stretched that conversation out a number of times when I caught him intoxicated or smoking weed. "Yes, Dad, I stole your scotch and drank it with my friends." I was impressed the first few times he was straightforward with me, but it soon became his "get out of jail" card and I reinstated punishment as an option.

My biggest mistake in practice (to date) came just before my second year of practice. I decided to operate on a huge renal cell carcinoma, left-sided, and got into trouble. In retrospect, I was over-confidant and I should have enlisted a urologic colleague to assist me. I inadvertently cut the inferior mesenteric artery (IMA) and had to ask our vascular surgeon to come in and repair it. Unfortunately, a week later my patient developed ischemic bowel and died. (That's the short version.) I told the family that the surgery had been difficult and these complications occasionally occur, glossing over my mistake and subsequent repair of the arterial injury. When the patient became really sick, I had already transferred him to a tertiary centre and he died there. It remains in my mind's eye whenever I'm involved in a difficult surgery, and that was 35 years ago!!

Last month, I had a simple transurethral resection of a bladder tumour scheduled in a slightly overweight gentleman. It was a straightforward case at the end of my list. I inadvertently perforated the dome while resecting and ended up with a significant amount of extraperitoneal fluid, etc. I admitted him to the hospital and stopped by that evening to talk to him. He had had a number of straightforward TURBTs and was perplexed by why he was in hospital and a bit sore.

I explained to him that I'd cut too deeply and hadn't noticed it for 5–10 minutes. I explained what had happened with the irrigating fluid, etc. He wasn't happy, as he'd had plans that his hospitalization had interrupted. He asked me to speak to his family, who weren't very happy either. Eventually, he went home and we met again shortly thereafter to review the pathology. At that point, he was in better spirits and informed me that he was quite surprised that I had explained everything and taken responsibility. He then explained to me that he had sat on the Royal College's Committee when the matter of admitting mistakes was becoming policy; he was one of the lay members. He now routinely asks me "not to perforate my bladder" when he's in for his BTCs!

If I had told the family of my IMA escapade, would the result have been the same? I think most patients and families want (and deserve) the truth and will be reasonable with you. I've since made this policy part of my practice. I've told patients, "I should have biopsied you last year. I'm sorry," or "I probably could have removed more prostate. I'm sorry," or, now with Xiaflex, "Maybe I injected too much. That's a lot of swelling." I've learned from my son and feel liberated. I don't think I make more errors that the average urologist. Patients accept errors if they are explained and you take steps to correct them immediately. It shows them that you respect them.

What has prompted this topic for discussion? Like many older physicians, I am often asked to comment on medicolegal files. Recently, I've looked at a number of plaintiff cases and in most cases I feel an apology would have helped avoid the legal action. And even if it wouldn't, it is usually

deserved. A cut ureter during a hysterectomy with no explanation to the patient as to why or how this might happen; incontinence after a transurethral resection of the prostate with a damaged sphincter from the resection and a urologist who won't discuss it with his patient; and a vesicovaginal fistula after a hysterectomy despite a perfect operative note — not only would most of these patients, in my opinion, have welcomed an explanation, but the money we are paying CMPA lawyers is tremendous, often in cases where the patient has been injured and rightfully deserves some form of compensation… and yes, an apology.

Community physicians who read this already understand that honesty is the best policy and there's little I can say to the experienced urologist. Those of you who are just starting, a few words are in order.

You will have a major screw-up within 3–4 years of starting practice. Unless you've truly been negligent, own it and learn from it. Don't bunker up and exclude your patient. Apologize, be straightforward and, if necessary, work hard to help him/her recover. It's what you would want if you were the patient. Shipping patients to a tertiary centre isn't always the solution. And if you need some tips on how to go about apologizing, call my son Conor!

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