Patient safety in plastic surgery

Patient safety is a lot like flying on the airlines. We know accidents occur; we just hope we won't be on the plane when they happen. We trust an airline to do proper maintenance even if it is flying under bankruptcy protection. We trust pilots will do the right thing if they spot a red light in the cockpit. I once asked a pilot if he worried about the 200 people in the cabin behind him; if the responsibility sometimes became too much. He said with a laugh, "If I get into trouble, I'm only worried about one seat: the one I'm sitting in". We believe that flying is far safer than driving per passenger mile. Even so, we know some airlines and some aircraft are safer than others.

Safety in surgery is not much different than safety elsewhere. Surgery planned in an unhurried fashion is likely to be safer than surgery rushed.

Patients trust that their operations are safe and do not actually know much about what makes a safe operation. There seems to be a strong tendency to deny that there is any risk to surgery, or at least, that risk does not have to be taken into account when making a decision to have surgery. Some of this is denial; some is simply trust that the medical staff will do everything they can to ensure safe surgery.

Long operations under general anesthesia seem to be riskier than operations under local and sedation anesthesia. Perhaps patients who move even a little during surgery have a lower chance of deep venous thrombosis and pulmonary embolism. Sometimes the choice for a general anesthetic is determined when several operations are done at one time. If only one of these operations requires general anesthesia, and the others could be performed under local, it becomes necessary to do all of them under general anesthesia. Is it justified to do this for patient convenience, even if the risk is explained? If a shorter general anesthetic, followed by a second operation under local anesthetic seems safer, should elective surgery be staged?

Accrediting educational organizations are essential for surgeons who run their own clinics. The opinions developed by experience are shared, so that what is learned in one clinic can be applied to others. This is invaluable for

those surgeons starting their first surgical clinics, but membership alone does not assure safety. Safety is the mind and attitude of the surgeon operator and staff. Safety is a constant open-mindedness to new ideas and a willingness to share them. Safety is an ability to say "no" when a course of action is not necessary or riskier than a course of action that may be

less convenient. Safety is a not pushing the envelope, but even this is a paradox. Safety is pushing the envelope now and then, otherwise we would not know where the envelope is. Safety is a passion for upgrading, renewal and self-education.

When we work, we are surrounded by well-trained people. As time goes by without a problem, we sometimes lose the edge we need to act acutely in an emergency. Pilots are required to do regular simulator training; so should we. Consider the benefits of running a mock crisis without preparation. Someone could be designated to run a list of occurrences in the operating room with the staff, followed by a meeting immediately after the exercise to discuss how everyone performed. This could be done regularly until confidence rose to a level at which the drill was anticipated instead of dreaded. Operating crises are fortunately very rare, so we naturally get out of practice in dealing with them; however, survival in a crisis is directly related to the rapidity and accuracy of diagnosis and the time to treatment.

We can improve patient safety if we share ideas and make safety a significant topic for research and discussion.

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