On Failure, Trust and our Common Humanity.

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A few weeks ago, a patient came to see me. He had received a transplant from his sister in 2017 and the kidney failed in 2022. I had done the transplant. He told me that his graft never really functioned properly. According to him, this was most likely the result of how I did his surgery in 2017. Now he was coming for a second transplant – a kidney donated by his wife. He was meeting me to tell me that he didn't want me to be involved in his transplant, although he was worked up for this procedure by people in my practice and in my team.

A few months ago, I transplanted a patient with a donor kidney from a friend. The day after the transplant the patient developed a very low blood pressure and a few hours later the patient died. We were not sure what had happened – if he had a myocardial infarction, had sepsis or was bleeding. Whatever it was that happened – the outcome was dismal.

Why am I telling you these stories of failure and difficulty on an evening where you want to celebrate your new qualification and success?

The answer is that failure explicates. In other words, failure makes us analyse our life events in more detail.

The German philosopher, Peter Sloterdijk writes in the third volume of his monumental project to chart Western thought, entitled *Foams*, about how the process of explication has driven Western science in the modern era. He writes:

> *The present age does not turn things, conditions or themes over; it rolls them out. It unfolds them, it pulls them forwards, it lays them flat and takes them apart, it coerces them into manifestation, it respells them analytically and incorporates them into synthetic routines. It turns suppositions into operations; it supplies muddled expressive tensions with exact methods; it translates dreams into instruction manuals … It wants to know everything about all things in the background, folded inwards, previously unavailable and withdrawn enough, at least, to make it available for new foreground actions, unfolding and splitting,*

interventions and remouldings. It translates the monstrous into the commonplace.

Understanding the world is for Sloterdijk a process of explication, and each of us can think of how explication functions in our respective clinical fields of reference. Rolling out, turning over, lying flat and taking apart, coercing into manifestation, scrutinizing analytically, formalising into our routines, developing methods, bringing the murmuring background of the body into the foreground, intervening and remoulding, making the wonderous fact of life commonplace, slaying the monster of ignorance.

Tonight, I want to apply this process of explication not to the scientific endeavour, but to the inner worlds which all of us harbour within us. In a way, I want to focus on that phrase of Sloterdijk's, when he writes: *'it translates dreams into instruction manuals'*, and I want you to think with me about the dreams that come to us through failure, and the instruction manual that can be fashioned from it.

As a surgeon, when I walk into theatre my procedure is built on a foundation of work done by other people. My patient comes from dialysis, worked up by a physician. His immunosuppression is planned based on immunology reports and tissue typing done by a team of experts with multiple people participating in the decision making process. All our paperwork and workup is done by a nurse coordinator and social worker…and the day before the operation by nurses in the ward. CT scans map out the anatomy of the vessels and this is reported by radiologists who understands what exactly it is I need to know before I can remove a donor kidney. And when the patient arrives in theatre it is the anaesthetist who makes sure that this patient is safe and ready for the operation. All patients will die of sepsis if theatre instruments are not handled correctly and sterile by the theatre nurses …and post op we usually have a critical care team with doctors and nurses attending to the patient.

Before I make my first incision, and after I have made the last closing stitch, in a continuum of time preceding my technical intervention, and continuing after it, I operate not with my hands, but with trust.

If I cannot trust the pre-operative workup, the social worker and psychologist report that the patient is fit and ready for the transplant, the physician assessment and the lab that does the tissue typing, *it is a fact* that the patient will have a poor outcome. Similarly, I need to trust the anaesthetist and the critical care team to look after the patient intra- and post-op. My part in the

patient's care is relatively small. And all of these complex interactions are underpinned by a common understanding of trust. This is the first level of trust we need in our day to day clinical practice.

But there is a next layer of trust that is just as important in the day to day running of a successful practice. The trust we need between ourselves and our patients.

When I started the HIV positive- to- positive transplant program at GSH in 2008, we were not sure whether the outcomes of these marginal kidneys that were used for transplantation would work well. We were not sure if the second viral strain would flare up and cause rampant HIV. And in the world, there was no experience. HIV + Patients had little choice in South Africa – dialysis was not available to them, and they needed renal replacement therapy. I presented them with an option that was unsure and was perceived by some medical experts as dangerous at the time. However, from the beginning I was truthful about the fact that I did not know exactly what the outcome of these kidneys would be. And from that truthfulness I built relationships with these patients that resulted in trust. To a certain extent it was trust they had in me and the treatment modality I put on the table. But more importantly – I also needed to trust them to understand and accept the consequences of their decision. Patients are subjects with whom we have reciprocal trust relationships, not objects on which we apply scientific or technical solutions. Patients need to trust us and we need to trust them.

In the case of the patient who died after his transplant , he and I had a strong relationship of trust between us and between me and his family. However, I could also rely on my team to help me in this situation. I did not have to face this problem alone, I had the coordinator, social worker, several nurses, our physician and ICU doctor next to me when we talked to this family. And all this helped me (as well as the family) to get through this difficult time.

So what happens when trust is missing? If a patient comes to us, challenging our skills and our decision making and our abilities? Like the first patient I described above? The trust in this relationship is broken and it is best to acknowledge this upfront, even if it is very difficult. I cannot operate on this patient. And he can never trust me.

When I became a surgeon the role models in my world were mostly men. They were strong, never cried, worked long shifts and boasted about their results.

They never talked about their feelings or how vulnerable they felt when things went wrong. They were focused on factual and scientific conversations. Tonight, up to this point, you were mostly focused on your exams, on recognizing the x ray pictures or the blood results, and working out the detail of the newest evidence in the *New England Journal of Medicine and other high impact journals*. To pass your exam you needed to be obsessed with statistics and 'numbers needed to treat' and 'evidence-based medicine'. Tonight, I want to encourage you, in Sloterdijk's words, to "unfold and open" the issue of trust.

As humans we are extremely vulnerable. Not only as a GP, a nurse or a specialist, but also in our families and between our friends. And if we don't address and understand our own vulnerability there is the risk that we become hard and unreasonable and potentially emotionally unwell and even sick. Medical doctors have some of the highest suicide numbers in the population. We also have high numbers of people who are drug and alcohol dependent. Let's be honest – we are not really that hard-core and strong as our teachers and mentors pretended to be 20 years ago when I trained. We are extremely vulnerable. And vulnerability is best addressed in the context of trust.

I emphasized the importance of the team in the work up of the patient. But there is another reason why we need this team. We need each other to help us get through our days when dealing with sick and emotional patients. Relying on ourselves only in these situations can be very difficult. Therefore, we need to kindle the relationships we have with our colleagues.

Medicine is best practiced in a team. And it is best practiced in a team where you trust each other. Even in the loneliest private practice you will still rely on the people in your team, nurses and physio's and OT's – to help you deal with complex clinical and emotional problems. When we have difficult clinical outcomes, like my patient who died after a transplant, there is a need to rely on your team. So, I think it is important to value your team, explain to your team how much you need them, in good and in bad times. We might think this person is *just* an assistant, or *just* a nurse who helped to do a small part of the total procedure. However, it is when things go wrong that we often realize the enormous value this team had in the management of the patient and the family. The truth for me is that I would never have been able to handle a patient who died if it was not for this extensive team of colleagues who I could trust and who could help me in a situation where I personally felt extremely vulnerable.

But when I had a patient who questioned my abilities, told me I am not good enough for him, asked for a different surgeon, I also needed someone who understands this type of patient behaviour to help me think this through. So I phoned a friend that I trust and who also deasl with patients regularly and talked the situation through with him. That meant I could get perspective on this problem and realize that I have to turn this patient away. Perhaps it sounds like a small thing in the context of my day to day work and practice, but the conversation with this patient left me feeling very vulnerable and lonely.

I want to ask tonight: *is our unaddressed vulnerability the thing that drives long term mental health and wellness problems in our profession*?

When I was a registrar Prof Dent was in the Surgery team at UCT and whenever we presented a case or a talk he would always ask – so what is the take home message? What is the take home message for the people sitting in the audience tonight? What do I want you to remember when you walk out of here?

As specialists we are leading many of the healthcare initiatives in this country. We can do this best if we are honest about our vulnerability and acknowledge and nurture our teams and colleagues to build professional communities of trust. What healthcare needs most today - more than anything else at this moment - is compassion for ourselves, for our patients and for our common humanity.
This is my first take home message.

Never be arrogant. You can and should be confident in yourself, in your decisions, in your actions. But be aware of your own vulnerability. One day, you will be a patient too. One day, you will also make a mistake. And one day you will do everything right, but the patient will still have a bad outcome. Acknowledging your own vulnerability, *will mean that you also be kinder* with the vulnerability of your colleagues.

Mental health and wellbeing are important topics in the corporate, healthcare and university environments today. Many programs are put into place to look after staff wellbeing in many different environments. You are sitting in this audience tonight as colleagues and as friends. I still remember who was sitting in the audience with me when I got my FCS diploma in 2004, my fellow “vulnerables”, who I trust. It is your shared responsibility to look after each other, before you look after the patients who will depend on you. And then to

go out and care for patients, and the vulnerable and sick people who trust you with their lives.

You can only do so, and that is my *last take home message*, if you also share with these patients, our common humanity.

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