Personal Narrative

Responsibility without error

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We remember some patients more clearly than others.

Many of us assume that the cases which remain in memory are the dramatic ones: the difficult surgeries, the rare diseases, or the long operations that test our technical skills. Sometimes that is true. More often, however, the patients who stay with us are the ones who quietly change the way we think.

Neurosurgery is often seen as a discipline of precision. Advances in imaging, microsurgical techniques, intraoperative monitoring, and critical care have transformed the way we care for our patients. They have reduced uncertainty, but they have not eliminated it. Uncertainty remains present in every diagnosis, every recommendation, and every operation. Experience changes how we respond to it, but it rarely removes it.

Early in our careers, we believed that experience would gradually replace uncertainty with confidence. The more patients we saw and the more operations we performed, the more certain we felt of our decisions. Families seemed reassured by that confidence. We were reassured by it too. As our technical skills improved, operations that had once felt intimidating became familiar. We learned to manage complications, navigate difficult anatomy, and make decisions under pressure. Like many surgeons, we assumed that maturity came from mastering complexity. Over time, however, we realized that confidence and certainty are not the same thing.

One of the patients who taught us that lesson was a young construction worker who had suffered a severe traumatic brain injury. When we first met him, survival itself was uncertain. He underwent a decompressive craniectomy and spent weeks recovering while his family lived through the slow, exhausting process of waiting for signs of improvement. They celebrated victories that most people would never think twice about - a movement, a word, a few steps. By the time he returned to our clinic months later, he was walking, talking, and beginning to think about returning to work. The atmosphere in the clinic had changed completely. Fear had gradually given way to hope. It felt as though the hardest part of the journey was behind him.

What we remember most from that visit is not the patient but his mother. As a construction worker, the young man hoped to return to an environment where another injury could undo

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everything he had fought to regain. To reduce the risk, he needed a surgery, called a “cranioplasty” to repair the defect in his skull from the previous trauma and surgeries. But his mother was worried about another operation.

Looking back, we realise that her concern was entirely reasonable. She had already watched her son survive something that should have killed him. She had seen him emerge from coma, regain his independence, and slowly reclaim a life that had seemed lost. To her, another operation was not simply another procedure; it was another chance to lose him.

In the moment, though, we saw the situation differently. We saw a young man eager to return to work, a skull defect that left him vulnerable to another injury, and a procedure that felt like the final step in an otherwise remarkable recovery. So, we encouraged them to move forward. We explained why cranioplasty mattered: it was protection, rehabilitation, confidence, and the possibility of returning to work.

We discussed the risks as surgeons do. We answered questions, explained probabilities, and genuinely believed we were helping him make the best decision for his future. We had performed many cranioplasties before, and familiarity gave us confidence. The exact words we used have long since faded from memory, but we do remember the long pauses in the conversation. The mother’s questions were never really about the operation itself. They were about whether her son - after everything he had survived - needed to face another risk. We answered the questions we heard at the time. Looking back, we wonder if we missed the question she was really asking.

The operation itself was uneventful. There were no technical difficulties, no moments of concern, and nothing to suggest what would follow. Shortly afterwards, he deteriorated and, despite every effort, he died. Even now, years later, it is difficult to reconcile those two facts. A young man who had survived a devastating brain injury died after a procedure that we considered routine.

For a long time, we searched for an explanation. We reviewed records, revisited decisions, reconstructed events, and looked for mistakes. Doctors are trained to do that. If there is an error, there is a lesson. If there is a lesson, there is a path forward. Yet we never found an answer that satisfied us.

For months afterwards, we thought of that case as an exception - an unexpected tragedy attached to an otherwise familiar operation. We continued operating, continued gaining experience, and continued becoming more comfortable with procedures that had once seemed intimidating. The case made us more cautious, but we still believed that experience and preparation would allow us to anticipate most problems.

The case gradually disappeared from departmental discussions as new patients arrived and new emergencies demanded attention. That is the rhythm of clinical practice. Life moved on, as it always does in a busy neurosurgical service. Yet the patient never entirely disappeared.

Every cranioplasty still brings him back. Not the operation itself, but the conversation before it. Whenever a family asks whether the procedure is safe, there is a brief moment before we answer when we remember another family sitting in another clinic room many years ago. We remember a mother who was hesitant. We remember ourselves reassuring her. Most of all, we remember how certain we felt while doing so.

Before we had fully made peace with that loss, another patient arrived who challenged those assumptions again.

The second patient was a young man with neurofibromatosis. He had bilateral vestibular schwannomas (tumors on the nerves of the

inner ear) that had already been treated with radiosurgery. He also had several spinal tumours, one of which was large enough to concern us. He was newly married, managing well, and living an otherwise normal life. His symptoms were mild. Most of our discussions centred not on how he was, but on what the tumour might eventually do if left untreated. We worried about future disability and believed that surgery offered the best chance of preventing it. We had performed many similar operations before. The scans were reassuring, the anatomy appeared favourable, and the operation looked straightforward. We expected a good outcome.

The surgery itself seemed to justify that confidence. The dissection was clean, the tumour planes were good, and everything unfolded as expected. Then, near the end of the procedure, the monitoring signals disappeared. There was no dramatic event, no obvious injury, and no moment that clearly explained what had happened. When he woke up, he was paraplegic. He also lost bowel and bladder control. The operation that was intended to preserve his future had changed it completely.

Once again, we searched for answers. We reviewed the imaging, revisited the operation, and discussed possible explanations. Once again, certainty remained out of our reach.

What we remember most about that patient is not the operation. It is the clinic visit a year later. Before surgery, he had walked into our clinic as a strong young man at the beginning of married life. A year later, he returned in a wheelchair.

We remember the wheelchair before we remember the conversation. The family had every reason to be angry. They were not. Nobody raised their voice. Nobody accused us of anything. Nobody demanded explanations that we could not provide. Their silence was harder to face than anger might have been. We remember sitting across from him and finding it difficult to look him in the eye.

We had spent months examining the case and still could not identify a clear explanation. Yet the unease remained. Perhaps it was because we could not stop comparing the young man sitting before us with the young man who had first walked into our clinic. Perhaps it was because we remembered how confident we had been when recommending surgery. Or perhaps it was simply because we knew that we had genuinely believed we were protecting his future.

As surgeons, we often discuss complications in percentages. We quote risks, describe probabilities, and reassure families that serious complications are uncommon. That is how medicine teaches us to think. Yet some complications eventually stop being statistics. They acquire a face, a family, and a memory. After that, they are no longer numbers. They become part of us.

These two patients changed the way we speak to families. They have not made us avoid surgery, and they have not made us stop recommending operations when we believe they are necessary. What they changed was something more subtle. They taught us to listen more carefully. They reminded us that families are often asking questions that extend beyond the operation itself. Beneath discussions about risks and benefits are questions about hopes, fears, and the future they are trying to protect. Those questions deserve as much attention as the operation we recommend.

Looking back, we spent a great deal of time explaining our reasoning to the young construction worker's family. We spent less time understanding the fear that his mother carried into the room. She was not predicting what would happen. She was simply responding to the possibility of losing something she had only recently regained. We understood the operation better than she did. She understood the stakes better than we did. Those experiences reminded us that the conversations before surgery are not only about explaining risks and benefits. They are

also about understanding what patients and families are trying to protect.

The young man with neurofibromatosis taught us something different. He reminded us that operations may become familiar to surgeons, but they are never routine to patients and families. Experience may make procedures familiar to us. Familiarity, however, is not the same thing as simplicity. Cranioplasties became familiar. Intradural tumour resections became familiar. Yet these patients reminded us that every operation remains an act of uncertainty for the person lying on the operating table and for the family waiting outside. The older we become as surgeons, the less comfortable we are with the word “routine”.

Perhaps this is how surgeons truly mature. Not simply by becoming more technically proficient, but by developing a different relationship with uncertainty. Early in our careers, confidence grew with experience. Later, humility grew alongside confidence.