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## **THE CRITICAL DECISION FOR A CRITICAL PATIENT IN A CRITICAL TIME**

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**P**rogress in surgery is measured by the diagnostic and therapeutic advances which lead to improved treatment of patient. Such advances may come through new technology or through better application of existing technology.

They may come through original inventions, experience gained by trial and error, financial necessity or even because of religious pressures<sup>1</sup>.

The standard surgical rules should be obeyed, as far as it is a documented fact which stands the test of time.

But we have to believe that changing or shifting from those documented facts are mandatory on so many occasions.

We have to avoid the half way surgery as much as possible, but sometimes we are really obliged to do it, if the patient's general condition did not allow us to complete the road of cure for our dear patients.

A real fact we have to strongly believe in, is that before submitting the patient for surgery we have to make a critical balance between the patient's general condition and the site of his pathology, in mind the injured abdomen or limbs is connected and related to the body as a whole, and the local pathology may lead or reflects on the body as a whole. Another point that should be considered is the critical balance between unnecessary haste and the unreasonable delay.

However, the critically ill patient because of trauma or serious acute pathology in need for a critical decision probably in no time to save his life which comes on the top of every priority. But the situation certainly becomes much more complicated when the environment is critical too; the good example is the war environment. I can say confidently nothing worse than a dogmatic brain which always insists on performing the standard rule. Irrespective of other parameter modification in the line of treatment or in the technique is necessary for the critical patient; you may have to sacrifice one million for the sake of gaining or at least not losing hundred millions.

Time is very vital for both a seriously ill patient and we have to gain it, prolonged anaesthesia and surgery carries a definite risk for such critical patient, adds more weight to both morbidity and mortality.

So a critical decision may be required to cut a limb rather than to preserve it, to modify the type of bone fixation, to the simplest and the quickest, to do only a life

saving measure and to the postpone the definitive procedure to a second or even a third session, to take an aggressive action of scarifying a vital part for the sake of preserving the life as in ligating the femoral, or even iliac artery to control sever uncontrollable hemorrhage by other means, performing gastrectomy, nephrectomy or splentomy so that you will shorten the time required for surgery and anaesthesia to the possible minimum. By doing these efforts, survival should continue to increase and morbidity should continue to decrease. Hopefully this policy is acceptable but what is not digestible is that you have to modify the standard line of treatment because of shortage in facilities or a long queue of patients waiting for surgery and you have to be wise in giving each his right, other wise you may loose some of them because of the delay. We have faced this painful fact during the repeated war environment in our miserable locality.

Another vital point in war surgery is the triage decision which should be done in the waiting room; we have to decide which patient should have surgery first.

However, serious consideration must be given to which patients are not the candidates for this enormous investment of resources. These measures are not intended to give the surgeon something to do for the unsalvageable patient.

The surgeon must make difficult and often final decision in this patient population. Additionally the good of the many versus the good of few must be considered.

Resources should not be wasted on patients who will never survive under any condition. The surgeon must realize the limitations of his team, the theater facilities and the level of support on which he stand. Hopefully the deviation from the standard should not be considered as a routine, so that the surgeon can please himself by doing little effort for his patient under the cover of critical patient or critical environment.

There must be a real definition for a critically ill patient which depends on the surgeon's experience. It is well known that the physiological envelop of critically injured patient is defined as the onset of hypotheramia, coagulopathy and acidosis, no good quantitative definition has been developed of the point beyond which this fragile envelop is breached.

Finally the decision to take a critical action for a critical patient, amidst a critical situation is probably one of the most difficult jobs a surgeon does, in his career. This can only be eased by experience and consultation. Also we have to remember that we should not be penny wise and pound foolish., and there is no room for procrastination when the situation from all aspect is critical.

## Reference

1. Neal C. Small. Office-operative arthroscopy forward IX- Raven Press, 1994.