

What Textbooks Taught Me - and What I Learnt Later

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ABSTRACT

Surgical education relies heavily on textbooks, yet operating room realities reveal critical gaps in practical application, decision-making, and medico-legal compliance under India's new criminal laws (BNS, BNSS, BSA 2023). This interview-based review captures reflections from an experienced surgeon on common procedures appendectomy, cholecystectomy, hernia repair, and trauma laparotomy highlighting experiential lessons in time handling, complications, and clinical bedside documentation. Emphasis falls on BNSS §183 (mandatory videography) and §176A (viscera protocols), transforming surgeons into evidentiary stewards. Comparative tables juxtapose textbook ideals against practice realities, advocating simulation-integrated curricula to minimize litigation risks and enhance outcomes. These insights equip trainees for the art-science-humanity triad of surgery. Medical education provides a strong scientific and clinical foundation; however, the realities of medical practice often reveal important gaps between what is taught during undergraduate and postgraduate training and what is required for effective, compassionate patient care in practice. Drawing on reflections from a lifetime of surgical practice in India, this article examines two broad domains of learning: aspects of medical training that later prove inadequate or incomplete, and the essential professional competencies that are rarely taught but gradually acquired through experience. These include managing atypical clinical presentations, decision-making under uncertainty, caring for patients with multiple comorbidities, effective communication, expectation management, documentation, ethical dilemmas, grievance redressal, teamwork, and emotional resilience.

Through illustrative clinical anecdotes, the interview dialogue highlights the "unwritten curriculum" of medicine that shapes doctors long after formal education ends. Recognising and integrating these lessons into medical training may help prepare future generations of Indian doctors to be not only clinically competent but also ethically grounded, communicatively skilled, and better equipped to navigate the complexities of contemporary medical practice.

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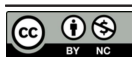
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KEYWORDS

• Medical Curriculum • Medical Education • Clinical Practice • Textbook Patient • Real Patient • Single System Disease • Counselling • Conflict Management • Art of Medical Practice • Surgical Education • Procedural Gaps • Experiential Learning • Appendectomy • Cholecystectomy • Hernia Repair • Mentorship.

INTRODUCTION

Textbooks like Schwartz's Principles of Surgery and Sabiston provide anatomical precision and stepwise protocols, forming the bedrock of surgical training. However, they often idealize "virgin" anatomies, omitting inflammation's chaos, patient variability, and medico-legal imperatives. India's 2023 criminal law overhaul Bharatiya Nyaya Sanhita (BNS), Bharatiya Nagarik Suraksha Sanhita (BNSS), and Bharatiya Sakshya Adhinyam (BSA) amplifies these gaps, mandating audio-visual records (§183) and forensic specimen handling (§176A) in invasive procedures. This interview distills 50 years of a senior surgeon's innumerable cases into teachable moments, using dialogue to humanize lessons on appendectomies (perforation surprises), cholecystectomies (Calot's pitfalls), hernias (strangulation staging), and trauma laparotomies (damage control). Comparative analyses reveal how practice refines theory, urging experiential reforms.

INTERVIEW DIALOGUE

When I entered medical college several decades ago, one of the first norms that was emphasized was "Medicine is an art and a science". It was very impressive. I adapted myself with the reverence and certainty common to most young brilliant students. Medicine appeared logical, structured, and dependable. Diseases had names, signs followed symptoms, investigations confirmed diagnoses, and treatment led to a cure. Our teachers were brilliant clinicians, textbooks were authoritative, and examinations rewarded clarity and precision. Yet, as years of surgical practice unfolded, I gradually realised that the medicine we practise bears only partial resemblance to the medicine we were taught. Many of the lessons that ultimately shaped me as a clinician were not learned during undergraduate or postgraduate training, but slowly acquired at the bedside through experience, uncertainty, and reflection.

Doctors begin developing the skills and knowledge they need in medical school and continue developing them through residency and into practice. However, there are important differences among medical students, residents, and practicing physicians, and these differences have an impact on how the individuals satisfy their concept of medical practice. Knowledge and skills learned early in a physician-in-training's medical school-through-practice trajectory must be revisited (relearned) at subsequent points in the trajectory so that what has been learned under an earlier set of expectations can be reconsidered in light of newer, more sophisticated expectations.¹

Table 1: Textbook vs. Experiential Insights for Appendectomy

Aspect	Textbook Ideal	Experiential Reality & Adaptation
Localization	McBurney's point fixed	Dynamic palpation; lap for retrocecal (40% cases)
Stump Management	Purse-string inversion	Endoloop if inflamed; check for leaks
Conversion Rate	Rare (<5%)	10-15% in perforated; prioritize drainage

Table 2: Textbook vs. Experiential Insights for Cholecystectomy

Aspect	Textbook Ideal	Experiential Reality & Adaptation
Dissection Plane	Calot's triangle, CVS	Fundus-first if fused; harmonic for bleed control
Bile Duct Risk	Clip after cholangiogram	Routine IOC; subtotal if gangrenous
Conversion Rate	<2%	5-10% in acute; bail to open early

DISCUSSION

This foundation is indispensable and has produced generations of competent doctors. However, clinical practice in India often characterised by late presentation, limited resources, heavy patient loads, and complex social dynamics quickly exposes the limitations of textbook-based learning. Over a lifetime in surgical practice, I came to understand that many essential aspects of being a doctor are

either inadequately taught or not taught at all, and are instead learned gradually, sometimes painfully, through day-to-day clinical experience.

Patients seldom presented with classical features, decisions often had to be made in the absence of diagnostic certainty, and outcomes did not always match effort or intention. With time, I realised that medical education imparts knowledge, but medical practice teaches wisdom often through mistakes, difficult conversations, and moments of self-doubt. Real-life medicine is far more ambiguous, humane, and unpredictable than what is taught in undergraduate and postgraduate curricula. Many of the lessons that ultimately shaped me as a clinician were learned not in lecture halls or examination halls, but in crowded outpatient departments, emergency rooms at odd hours, operating theatres under stress, and difficult conversations with patients' families, before & after surgery, before & after adverse events, and in conferences & workshops. This article reflects on those lessons learned beyond the formal curriculum. It divides the presentation into two categories – Teachings that were modified in clinical practice and learnings of clinical practice which were never taught.

A. Teachings that were modified in clinical practice.

Clinicians of all specialities find that the ground realities of clinical practice reveal many situations quite different from what they had learnt through their curriculum. The experience they gain allows them to unlearn some aspects and adapt the practice, which is practical and focused on patient safety and patient comfort.

The 'Textbook Patient' and the 'Real Patient.'

Textbooks excel at anatomy, steps, and evidence-based protocols, yet surgery demands intuition honed by experience and foresight against legal scrutiny. This interview explores those unspoken lessons, including medicolegal dimensions often siloed from training. During our student days, patients presented neatly, almost obligingly, according to textbook descriptions. Appendicitis had pain starting in the umbilical region, migrating to the right iliac fossa with guarding and rebound tenderness. Intestinal obstruction announced itself with classical pain, distension, vomiting, and air-fluid levels on an erect abdominal film.

Jaundice is a sign of liver dysfunction, biliary obstruction, or haemolysis through carefully separated clinical features. However, in actual practice, especially in India, patients rarely read textbooks. They do not necessarily follow what the medical students were taught. They often come with complex, mixed clinical features, quite different from what the textbooks print.

Table 3: Textbook Patient Vs Reality Check

Procedure	Textbook Ideal	Practical Reality + Reality Imperative
Appendectomy	McBurney's point, clean ligature	Perforated, pus; video narration, tip preservation
Cholecystectomy	CVS in Calot's triangle	Scarred/obese; IOC upload, risk videography
Hernia Repair	Tension-free mesh	Strangulated contents; viability photos, staged no-mesh
Trauma Laparotomy	Definitive surgical repair	DCS abbreviate; viscera video handover

Interview Discussion

As Interviewer probe Interviewee's reflections to demystify procedural art and defensive practices. Mentorship bridges theory to resilient practice.

Interviewer: The textbooks describe appendectomy as a straightforward McBurney's incision, mobilization, and stump ligation. What did they miss from your first 100 cases?

Interviewee: Textbooks assume a classic presentation RLQ pain, McBurney's point tenderness but 40% of appendices are retrocecal or pelvic, hidden by omentum or adhesions. Early on, I chased shadows, converting to laparotomy unnecessarily. Lesson one: always palpate for the "point of maximum tenderness" dynamically; it shifts with position. Use laparoscopic exploration first in equivocal cases textbooks underplay pneumoperitoneum's diagnostic value. And the stump? Inversion with purse-string is ideal, but in inflamed bowels, simple endoloop suffices to avoid leaks. I learnt to trust tactile "fullness" over visuals alone.

Interviewer: Cholecystectomy textbooks emphasize Calot's triangle dissection and critical view of safety (CVS). How did real gallbladders challenge that?

Interviewee: Gallbladders defy diagrams Mirizzi syndrome, porcelain variants, or

acute gangrene turn CVS into a nightmare. Textbooks gloss over “fundus-first” for fused Calots; I lost a common bile duct in my fifth case chasing the textbook triangle. Now, I start with fundus decompression, rolling it cephalad for exposure. Intraoperative cholangiogram? Mandatory if anatomy blurs saves lawsuits. And bleeding? Textbooks say “clip and divide”; reality demands harmonic scalpel for oozing Calots. Experience taught me: dissect in planes, not points.

Interviewer: Sir, textbooks rarely touch medicolegal aspects. What pitfalls have you faced, and how do they shape your practice?

Interviewee: Early career, I learnt the hard way textbooks list complications like bile leak or recurrence, but not documentation’s lifeblood. In a cholecystectomy suit post-bile duct injury, plaintiff claimed no consent for subtotal cholecystectomy. Reality: acute gangrene blurred anatomy; I converted safely but notes lacked “intraoperative findings: gangrenous fundus, fundus-first bailout.” Lesson: dictate intraoperative notes immediately detail rationale, alternatives discussed (e.g., MRCP deferral), patient-specific risks. Consent forms? Verbal beats paper; video-record high-risk laps if possible.

Interviewer: How about negligence claims in emergencies like perforated appendix?

Interviewee: Delay suits kill textbooks say operate within 6 hours, but weekends stretch it. I won one by logging “equivocal CT, dynamic exam shifted tenderness, lap diagnostic in 20 min.” Key: timestamp decisions, multidisciplinary notes (anesthetist corroborates urgency). For hernia enterotomy, tNumber friability from smoking wasn’t “foreseeable”? Prove it pre-op risk stratification (smoking cessation counselled 4 weeks prior). Defensive surgery: bailout early, document “frozen abdomen, abort to prevent catastrophe.” 80% suits drop with robust notes.

Interviewer: Ethical gray areas, like obesity in hernia consent?

Interviewee: Obese patients deny risks; textbooks omit psychosocial angles. I now say: “Mesh chronic pain 10-15%, higher in BMI>35; lap TEP preferred but femoral risk persists.” Photograph incisions pre/post for infection claims. Expert witness? Charts beat memory review morbidity meetings quarterly. Textbooks teach procedures; courts teach

precision.

Interviewer: For inguinal hernia repair, texts laud Lichtenstein tension-free mesh. What gaps emerge in tense, recurrent, or obese patients?

Interviewee: Mesh is king, but textbooks ignore tNumber quality. In smokers or recurrent hernias, direct defects gape despite plugs preperitoneal (TEP) laparoscopy shines here, visualizing both sides. I once ignored a “sliding” hernia with colon involvement, leading to enterotomy. **Key lesson:** always reduce the sac fully, check for femoral extensions. Fixation? Glue over tacks in lap less chronic pain. Obesity hides landmarks; use finger-guided dissection. Textbooks teach steps; OR teaches adaptation.

Interviewer: Across procedures, what overarching gaps persist in education?

Interviewee: Judgment under fatigue, complication cascades, and ethics like when to abort. Textbooks lack “bailout” algorithms. Mentorship fills this: simulate crises, debrief failures. I review every case mentally what ifs build resilience.

Table 4: Textbook vs. Experiential Insights for Inguinal Hernia Repair

Aspect	Textbook Ideal	Experiential Reality & Adaptation
Approach	Lichtenstein open mesh	TEP lap for recurrent/obese; glue fixation
Sac Handling	High ligation	Full reduction; check femoral/sliding components
Recurrence Risk	<2% with mesh	<1% lap; optimize in poor tNumber (e.g., smokers)

Textbooks emphasize steps; experience demands adaptation tNumber feel, patient factors, forensic foresight. BNSS 2023 elevates surgeons as evidence custodians: Mandatory videography for invasives, specimen protocols for suspicious cases reduce litigation. Curricula must incorporate simulation with mock documentation, mentorship debriefs, and BSA-compliant EHR drills. These gaps, once tacit, now demand explicit training for safer, defensible surgery. Future studies should audit compliance post-reforms.

I recall an elderly diabetic gentleman who presented with vague abdominal discomfort and mild breathlessness. There was no guarding, no rigidity, and no dramatic pain. Investigations were inconclusive. It was only clinical unease - rather than textbook certainty

- that prompted surgical exploration, revealing a gangrenous bowel. Had I waited for classical signs, the outcome would have been fatal. There are many such examples encountered by all surgeons in practice. Textbooks teach surgery as science; practice reveals it's art meets humanity. Feel the tNumber tension, read the patient's eyes, anticipate the bleed. Simulation labs help, but nothing beats supervised cases. To students: Scrub in early, fail small, learn ethically. The scalpel humbles you faster than any chapter.

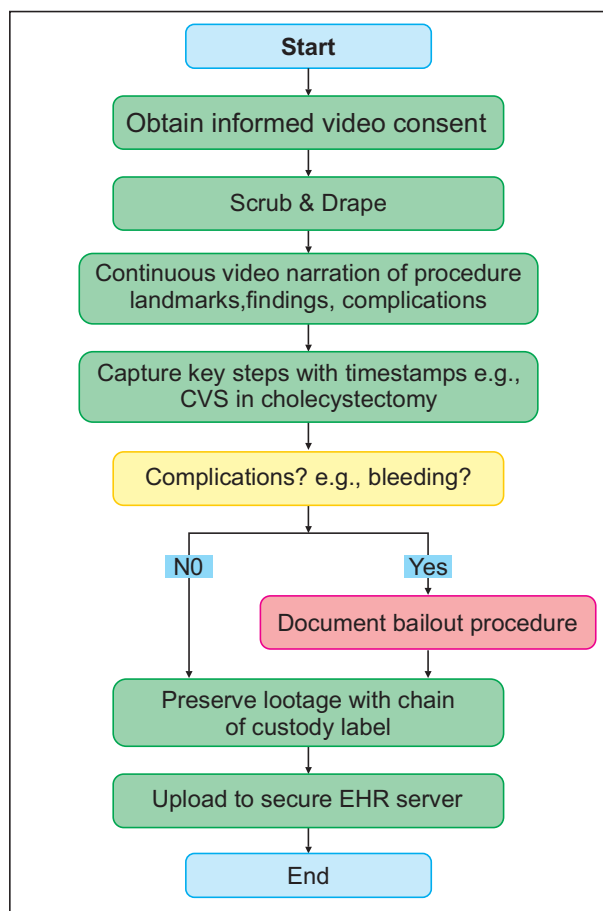


Figure 1: Flowcharts for BNSS-Compliant Surgical Documentation SOPs

1. Consent, complications, medico-legal angles textbooks list them dryly.

Consent forms are checklists; reality demands dialogue. "1% bile duct injury" becomes "I'll use the safest view, but nature can surprise." Post-op, DVT prophylaxis? Books say LMWH; here, early ambulation trumps. Wound infections skyrocket in summer teach asepsis rituals. Medicolegally, under new BSA 2023, photograph everything: pre-op vitals, intra-op findings. I lost a negligence suit early didn't photo a retained gallstone. Now?

Timestamped gallery in EMR. Intra-operative audio-video recording ensures compliance and defensibility. The surgeons follow this step-by-step process for all invasive procedures.

In the classroom, Orthopaedic conditions are presented in clean categories with step-by-step protocols. In the clinic, however, patients rarely arrive in such a neat package. Consider the patient with chronic knee pain who also works long shifts as a labourer, struggles with sleep, and harbours other health conditions. The rigid flowcharts from textbooks suddenly feel incomplete. This is the challenge new clinicians often face: bridging the gap between idealized models and the messy reality of human lives. Every patient brings individual variables that influence the plan of care. Lifestyle factors such as job demands or time constraints can dictate which interventions are realistic. Personal goals often redefine priorities entirely; for some, returning to work without discomfort matters more than perfecting mechanics. By weighing these contextual factors, frameworks can be shaped into flexible tools rather than rigid rulebooks.²

There are also variabilities of body response to various insults. Over time, one learns that absence of classical features does not exclude serious disease, particularly in the elderly, diabetics, immunocompromised patients, or those presenting late common scenarios in Indian practice. The experienced clinician attends to his patient with an open mind and trusts his 'gut feeling' in ambiguous situations. Presentation with the classical book picture of an illness does happen, but the clinical acumen of the physician is tested in ambiguous situations.

2. From Diagnosis to Decision-Making

Medical education places great emphasis on reaching the "correct diagnosis." Examinations reward diagnostic precision. However, clinical life teaches us that decision-making often precedes diagnosis, and sometimes occurs in its absence. Symptomatic treatment is valued by the patient at the first instance, pending the establishment of the diagnosis, in most cases.

In emergency surgery, especially in district hospitals or resource-limited settings, we frequently operate with incomplete information. Imaging may not be available, laboratory support may be delayed, and the patient's condition may not permit prolonged

deliberation.

I learned early that a timely, imperfect decision is often superior to a delayed, perfect one. Timely action is the essence. The “exploratory” laparotomy, often undertaken, is very satisfying most of the time. Surgeons have realized at times, the timely surgical intervention saved the patient even though the diagnosis could be established only retrospectively. Conversely, I also learned the humility of restraint knowing when not to operate, even when the diagnosis remains uncertain or even when it is established. Sometimes the diagnosis is certain, but the patient’s hemodynamic parameters are tilted against him, and the surgeon restrains himself, pending his stabilization. This balance between action and restraint is rarely taught, yet defines mature clinical judgment, out of experience.

3. The Myth of Single-System Disease

Our teaching is organ-based: gastroenterology, cardiology, nephrology, pulmonology, and so on. Patients, however, arrive as complex wholes. A typical surgical patient today may have diabetes, hypertension, ischemic heart disease, chronic kidney disease, anaemia, and malnutrition all interacting with the surgical pathology. In India, delayed presentation further complicates this picture. The mature surgeon has a broad outlook of his patient to weigh the priorities, when to operate, when not to operate, and when to wait before the patient is stabilized and considered fit to operate. He has to treat ‘the patient’, not ‘the disease’. We are trained to treat diseases; we learn later to manage patients.

This simple “disease model” generally works well for acute diseases in otherwise healthy subjects because they most often involve a single organ system and have a well-defined and short clinical course (e.g., trauma, Acute MI, infections, and many others). However, this is not the case when we consider the clinical management of chronic, noncommunicable diseases, which, today, are far more prevalent than acute diseases.³

In the presence of co-morbidities, the body’s response becomes a little more complex. I am aware of many patients whose surgical problem was straightforward, but whose postoperative course was dominated not by surgical care, but by cardiac instability and renal failure or other co-morbidities. The surgery was technically successful; the outcome, however, was determined by comorbidities and how well we

handled them.

4. Investigations: From Confirmation to Confusion

As students, investigations are presented as confirmatory tools. In practice, they frequently complicate matters.

Incidental findings, borderline abnormalities, and conflicting reports are common. Over time, one learns that investigations do not replace clinical judgment they challenge it. The physician has to be smart enough to align the investigation reports with the clinical judgment, without accepting the dominance of the reports. He realizes that he has to treat ‘patients’ and not necessarily his ‘reports’. I have seen CT scans create more confusion than clarity, and “normal” reports falsely reassure clinicians into ignoring worsening clinical signs. Learning when to trust investigations and when to trust one’s bedside assessment is a skill acquired only through experience.

B. Learnings of clinical practice which were never taught.

Physicians in general and surgeons in particular exhibit excitement when they start their independent clinical practice. They know that they have studied well and cleared their examinations with flying colours. But very soon, they realize that the ground realities in practice are quite different. They begin their practical training in the field, with some surprises. I vividly remember Dr Waryam Singh, Professor and Head of Surgery at Medical College Rohtak, when he had advised some of us when we were in the final MBBS & aspiring to become surgeons, with his pearls of wisdom. One of the advices was that ‘*after passing the MS examination, consider that your practical training has just begun and consider yourself still a trainee for at least 5 years*’. That was a sane advice whose importance we realized when we launched ourselves as independent surgeons some years later.

1. Communication: The Most Important Clinical Skill

Perhaps the greatest omission in medical education is communication. I was never formally taught how to break bad news, explain complications, provide grief counselling, or handle angry/aggressive patient relatives. These skills were acquired through trial, error, and, at times, regret. Pre-operative counselling

is another area that requires tact, besides honesty. During our residency, we were often blunt while explaining the risks of surgery before taking the patient's signature on the consent form. How casually did we even talk of the possibility of death on a pointed enquiry by the patient or his family? Over the years, we have learnt that such sensitive Numbers have to be handled with empathy & tact, explaining what we meant, without being blunt.

I distinctly remember my early years as a consultant, explaining a postoperative complication using technical language, only to realise later that the family understood nothing except that "something had gone wrong." It was only after years of practice that I learned the power of simple language, empathy, silence, and honesty. In Indian settings where families are deeply involved communication is not just a soft skill; it is a survival skill.

2. Consent and Expectations

Consent, as taught, is a form to be signed by the patient. Consent, as practised, is a process. It is a reflection of patient autonomy and patient participation in their own treatment. Most disputes arise not from negligence, but from inadequate counselling or unmet expectations. Patients and families often equate surgery with a guaranteed cure. Explaining uncertainty, risks, and possible adverse outcomes requires time and patience - both in short supply in busy Indian hospitals.

I learned that a well-conducted preoperative discussion & counselling helps to prevent dispute & conflict, better than anything else. The expectations of the patient & family become more realistic, as they involve themselves in the participative decision making

3. Documentation: The Unseen Shield

As students, we write case sheets to pass examinations. As practitioners, we learn that documentation is memory, communication, and legal protection combined. I have seen excellent clinical decisions questioned simply because they were poorly documented. Conversely, clear notes have protected doctors even when outcomes were unfavourable.

The casual & cursory mentioning of medical records in the UG & PG curriculum proves to be too inadequate in the actual medical practice. This is important for ensuring continuity of care, with multi-disciplinary care of patients,

often conducted in critical patients today. The medical records are even more important in medicolegal defence as credible evidence. The contentions of the doctors in the court need to be substantiated by documentary evidence. "If it is not written, it did not happen" is a lesson learned too late by many.

4. Grievance Redressal and Conflict Management

No doctor completes a career without facing dissatisfaction, complaints, or accusations. Unfortunately, we are never trained for this. Early in my career, I responded to complaints defensively, with facts, data, and arguments. With time, I learned that listening calmly often defuses conflict more effectively than explanation, and the explanation, if at all, has to be simply worded & easy to understand.

In the current Indian medico-legal climate, grievance redressal should be taught as an essential professional skill, not left to individual improvisation. As a matter of fact, the 'art of medical practice' or 'healthcare management' is conspicuous by its absence in the academic curriculum of medical students. The doctors in practice are left to learn these attributes through trial and error, after making mistakes, facing consequences, and maturing into complete clinicians.

5. Ethics Beyond Textbooks

Lectures on medical ethics are neat and principled. They are theoretical and often trivialized by the degree of emphasis placed on them. Real-life ethics is uncomfortable, more practical, and carries immense significance in the doctor-patient relationship. Deciding when to withdraw futile treatment, balancing financial constraints with ideal care, and navigating family wishes against patient autonomy are daily dilemmas in Indian practice. We have all provided discounts and complimentary treatments, offered medical support at medical camps, and arranged for costly medications as part of our research-related assistance to underprivileged patients. Such measures are helpful to a large number of patients who are unable to afford the high cost of treatment. These and such other charity efforts were never taught and are generally missing from the textbooks. These decisions weigh heavily on clinicians and are rarely discussed openly during training.

6. The Emotional Cost of Being a Doctor

Perhaps the most personal lesson is learning to live with failure. Complications, deaths, and missed diagnoses leave deep impressions. Successful cases fade away, but adverse outcomes linger on. Burnout, emotional fatigue, and moral injury are realities many doctors silently endure. Generally, the doctors involve themselves in the clinical practice with such dedication that they often tend to neglect their families and certainly their own selves. They forget that they have a life beyond their professional duties. Unfortunately, they were never taught such things as work-life balance, time management, self-care, hobbies, etc, during their UG or PG training. We were taught to care for patients - but never how to care for ourselves.

For the physician-as-healer, this means placing the patient's needs above the doctor's needs; for the physician-as-professional, it means supporting the medical profession more than seeking personal gain while participating in medicine's continuing dialectic with society. Later in life, the experienced physician learns how to balance these well-meaning goals of life.

7. We Treat; He cures philosophy

Doctors in general and surgeons in particular are well aware of situations where the treating team had worked very hard, day & night, on a patient for several days but ultimately lost him. The cause of death remains speculative. Or that was the will of God. Many times, the patient just dies without any rhyme or reason, a few hours before he was to undergo a simple elective surgery. On the other hand, it is also often seen that when the doctors had given up on a patient, after several days & weeks of efforts, the patient begins to improve and recovers unexpectedly. Is it magic or the resilience of body systems to heal, or God's will? The role of God the Almighty in the outcomes was never taught in medical school. We have learnt over time to align our treatment & care decisions according to the body's rhythm and hope for the best. Statistics are important, but they are meant for the populations, not for individuals. For an individual, our efforts, our hope, and our patience need the blessings of the Almighty.

Surgery, then, is never merely a technical act. It is a lived process for all involved patient,

family, operating team, and even the machines that make modern surgery possible. It is a web of decisions, relationships, emotions, and actions held together by trust and care. In this unfolding, God is not absent. Rather, the Spirit breathes through every stage of the process, working through human hands and hearts, calling forth life from fear, and guiding the ensemble toward healing. In a world that often seeks quick fixes and isolated outcomes, remembering that surgery is a process relational, dynamic, sacred can help us recover the deeper meaning of what it means to care and to be cared for.⁴

Prayer has long been recognized as a powerful source of comfort and healing in times of need. In the high-stress environment of the operating room, many surgeons, nurses, and patients have turned to prayer as a way to find solace and strength. Whether it's a quick silent prayer before a procedure or a collective prayer with the surgical team, the act of praying has been shown to have a profound impact on the mental and emotional well-being of those involved.⁵

CONCLUSION

Towards a More Complete Medical Education

This dialogue illuminates how surgical education evolves from rote textbook steps to adaptive mastery. Experiential gaps—tactile nuance, bailout strategies, and patient variability demand mentorship to forge competent surgeons. Integrating such reflections into curricula could halve early-career complications. Residents: observe, palpate, adapt; textbooks guide, experience governs. Medical education in India has produced technically competent doctors in large numbers. They specialize in their chosen field. When they launch themselves on the ground to practice what they have learnt, they often realize that technical competence alone is not enough.

If we wish to prepare future generations better than what we were prepared, we must broaden medical education to include the 'art of medical practice' or soft skills like communication, ethics, documentation, teamwork, emotional resilience, and the management of uncertainty and adverse events. These are not optional extras. They are

central to safe, compassionate, and sustainable medical practice.

As teachers, senior clinicians, and professional bodies, we owe it to our students not only to teach them medicine but to teach them how to live as complete doctors.

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