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Complications and Mishaps in Anesthesia. Edited by Mathias Hübler, M.D., Thea Koch, M.D., Karen B. Domino, M.D. Heidelberg, Germany, Springer, 2014. Pages: 365. Price: $59.99.

How do you learn best? That is not intended to be a rhetorical question but rather one aimed at fostering introspection. Let me ask a more specific question—how did you learn to manage an airway? Did you ever make a mistake? You probably read a chapter on airway management. You may have attended a lecture. You likely knew something about those three axes that had to be aligned. You may have even practiced on a simulator that seemed idealized and unrealistic even to your untrained hands.

But how did you really learn this skill? My bet is that your experience was like mine. You probably once forgot to turn the oxygen on during preoxygenation, and you experienced your own tachycardia and diaphoresis that accompanied the bass tone of the pulse oximeter in the 50s. Oh yeah…you did make the pulse oximeter audible, didn't you? You probably have taken a short cut by skimping on establishing the best sniffing position because the patient looked totally normal only to find yourself having difficulty with laryngoscopy. Your arm muscles were probably sore the next day from prolonged mask ventilation, but your pride was more injured because of how easily the anesthesiologist-in-charge rescued your airway… all she did was put a roll under the shoulders and some sheets under the head. You probably recall similar experiences when you cared for patients, and the array of emotions you experienced (frustration, anger, disgust, disappointment) only served to reinforce what you learned.

Cognitively, you were prepared for all these problems. You knew why it is important to preoxygenate. You knew to turn on your alarms. You knew that any airway could be made difficult if positioning is subpar. Despite all of this knowledge, you still made mistakes.

Everyone makes mistakes. We err because of knowledge deficits and fatigue. We err because of production pressure and information overload. The list goes on and on. As Alexander Pope (1688–1744, English poet) so aptly observed (In *An Essay of Critism,* 1711), "To err is human." Even so, as responsible physicians, we must ask ourselves… what do we do with our errors? Hopefully, we learn from them. Hopefully, we allow others to learn from them. Hopefully, we examine not only what the mistake was but also why we made the mistake.

Complications and Mishaps in Anesthesia edited by Drs. Hübler, Koch, and Domino provides a unique learning experience that can benefit trainees and attending physicians alike. Through 33 chapters based upon actual cases characterized by an array of anesthetic complications, your expertise will be challenged across a broad range of anesthetic practice. Each chapter is structured with a case introduction that engages you into the personality of the anesthesiologist performing the care. You are then given the opportunity to *consider how you would manage* each step of the case while reading through the actual course of events. Each chapter ends with a discussion of the error followed by valuable analysis of its causes and methods for prevention.

The novelty and impactful education that derives from this book comes from its general lack of "zebras" in the cases and complications described. The cases do not focus on rare events. They would not get published as case reports because their ubiquity would make them uninteresting to most editors. In fact, most would fall into that "near miss" category and may not even result in a presentation at your local morbidity and mortality conference. I ask you rhetorically—which would be more impactful for your patients today; reading another case report of a rare event that happens once in 10 million anesthetics or learning how to mitigate common errors such as those related to drug misdosing? In aggregate, this collection of cases is impactful and educational because it highlights the mechanisms of errors and complications that we see on a daily basis.

The authors unfold cases in a step-by-step manner that will engage you as you begin to project yourself into the story and onto the protagonists. Beyond cognitive learning, you will become emotionally engaged in the stories just as you do when you personally deal with misadventures that affect your patients. This engagement adds a new and unique dimension to learning. None are more powerful than Chapter 8 in which "Dr. Sharon Collins," an anesthesiologist herself, describes her experience as a patient…complicated by explicit recall during an exploratory laparotomy. Sometimes you will be screaming because you cannot believe what is being done. Sometimes you will be shocked by unexpected outcomes. Continually you will be engaged and you will learn.

I strongly recommend adding this book to your library. As medicine moves toward models that reward quality over quantity, elimination of errors is a must. This cannot be accomplished by merely focusing on the errors themselves, which by definition are retrospective in nature. We must focus on why errors are made. This book is an excellent introduction to the factors that lead to errors in anesthesia patient care. Just as you have certainly experienced in your own practice, the interjection of emotion into learning seems to only make the educational experience stronger, and emotions are never stronger than when we have made a mistake. I hope you will "take advantage of the mistakes of others," read this book, and learn.

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