



CIRUGÍA ESPAÑOLA

www.elsevier.es/cirugia



Editorial

The power of collaboration

El poder de la colaboración



“If you want to go fast, go alone. If you want to go far, go together.” I do not know who came up with these words. It is also possible that it was a group of people rather than an individual. This also means that when you do get there, you won't be alone challenging the old aphorism that it is lonely at the top! The surest way of making the journey as well as the destination fun is by being in a group whilst simultaneously multiplying your odds of actually getting there!

One could argue I am a clinician, not a politician. Why do I need to work with people? The answer is simple. To be an effective clinician, you need to collaborate. Hopefully, in the paragraphs below I will be able to convince the sceptic amongst you of the value of networking in many roles that we assume as clinicians.

Safer clinical care

Our first and foremost job is direct patient care and there if you hadn't noticed things are changing very rapidly. Gone are the days when a senior clinician (consultant in many parts of the world) could do whatever s/he chose whether or not it was scientific or logical. Today you cannot deliver safe outcomes for your patients if you cannot work with your colleagues, nurses, dieticians, and indeed juniors. Fully expect to be challenged by somebody along the line if your decision is not sound enough. And that is no bad thing. We are all human and you may have overlooked that crucial point that only the nurses who have looked after the patient overnight are aware of. And if you don't think it is a great suggestion, you can politely point that out. The ability to take and give a contrarian opinion politely without losing face is a hallmark of collaborative working.

We all know what happens when senior clinicians work in environments¹ where nobody can challenge them; patients suffer. And these clinicians suffer too – in the long run. Teams, where all members are empowered, and own up to delivering the best collaborative care for patients, are safest. Many clinicians feel that empowering others will lead to the

loss of their authority. It should not if their practices can be justified.

Education

There is no bigger area where collaboration makes a bigger difference than teaching and learning. The value of networking is somewhat obvious when it comes to conferences but some of its other benefits with regards to education are not fully appreciated. The collaborative networks can make learning fun and remove the traditional hierarchal teacher-taught boundaries. In the new world, depending on the task at hand, we are all teachers and we are all learners.

There are also differences amongst the various available networking platforms when it comes to communication. I have found that often people find it easier to ask day-to-day real-life questions on WhatsApp® or emails rather than social media, probably because they are perceived to be more private. Similarly, social media is particularly suited for promoting good practices; sharing published research; and inviting potential collaborators.

Bigger questions

When it comes to research, it is impossible to overstate the value of collaboration. We are all familiar with single-centre studies that do not allow us to make any meaningful conclusions. Even randomised controlled trials that cannot be extrapolated to the real world are sadly not rare. Bigger multicentre/multinational networks are the only way we can answer some of the deeper questions for our patients in this day and age. Larger numbers of surgeons and patients improve confidence in findings and overcome many of the weaknesses of single surgeon/centre data.

It is especially important because we have already solved many of the puzzles that individual surgeons or hospitals could solve. What is left needs us to work together in larger

groups. This will allow us to tackle problems and collect data on a global scale.^{2,3} Simply put, when it comes to studies, the power of collaboration is an adequately powered study the findings of which will apply to real-life situations.

Developing networks

So, we can see that networking and collaboration are essential to what we as doctors do and not some unused, and therefore unnecessary skill set. How do we then go about building those networks? My journey with these started over a decade ago when I was developing a web-based publishing platform based on a post-publication peer review model. The concept did not take off but the whole project taught me many skills that I was then able to use later in life.

One of the things that I learnt during the process was that if you reach out to people and have a sound plan, many will be happy to support you. I have been able to use this to form consensus-building committees involving opinion leaders from around the world without the support of any established society or association. These committees have then gone on to publish highly regarded consensus statements.⁴⁻⁶ The independence from the influence of any society allows you to concentrate on the task at hand without any undue political influence. It also allows you to choose your team of like-minded people focussed on the task at hand. It is a crucial point as I know of projects that have had to be shelved because one person would not engage constructively with the rest of the group.

The other thing I learnt was that people generally like to belong to meaningful communities and groups. Since established societies do not usually allow members to interact freely with each other and tend to have a unidirectional flow of information, there is a need for informal channels for communication amongst professionals. What is important here is that each such channel should have a specific purpose in mind and must cater to a specific group of people. Over the last decade, I have set up google groups for One Anastomosis Gastric Bypass (OAGB) surgeons, United Kingdom (UK) Bariatric Surgeons, UK Bariatric Dieticians, UK Bariatric Nurses, Global Bariatric Research Collaborative (GBRC), and more lately The Upper Gastrointestinal Surgeons (TUGS). These groups are regularly used by professionals for informal chats, clinical dilemmas, and collaborative academic projects.

However, the most important thing that I learnt from my “failed” project was the use of social media. I became relatively adept at Twitter®, Facebook®, and LinkedIn® and was probably one of the first few bariatric surgeons worldwide to start using them regularly especially on Twitter® and LinkedIn®. This allowed me to establish groups of “The Upper Gastrointestinal Surgery Professionals” on Facebook® (which now has over 2600 members) and on LinkedIn® (with nearly 5000 members). Given that it is now almost impossible to find a surgeon or a professional who is not using social media, I can reach out to most people in the surgical community rather easily. These networks are regularly used by colleagues from around the world for a variety of purposes.

It was the same skill set that allowed me to set up a global group of surgeons to cope with the Coronavirus Disease-2019

(COVID-19) pandemic in March 2020 when we were all thrown into a situation none of us knew how to deal with. The group called “Safe Surgery During COVID-19 Times” on Facebook® reached 3000 members in a matter of days and provided immense support to surgeons from around the world during the beginning of the pandemic and also paved the way for several collaborative webinars and studies.

It is important to ensure that every group has several admins to help with the day-to-day moderating tasks. This makes the platforms self-sustainable as no single individual can have the time or the passion to do it every day and also people feel more involved when things are democratic. A little bit of oversight is often necessary with these platforms but generally, the approach should be to keep the exchange of information flowing freely.

Once you have networks and groups in place, everything else follows automatically. You can use the group’s strength to deliver educational content, a collaborative study, or just for informal support. We are always stronger together! In the words of Helen Keller – “Alone we can do so little; together we can do so much.”

REFERENCES

1. Paterson Inquiry Report. <https://www.gov.uk/government/publications/paterson-inquiry-report> [last accessed 20.12.20].
2. Adil MT, Aminian A, Bhasker AG, Rajan R, Corcelles R, Zerweck C, et al. Perioperative practices concerning sleeve gastrectomy – a survey of 863 surgeons with a cumulative experience of 520,230 procedures. *Obes Surg.* 2020;30:483–92.
3. Singhal R, Tahrani AA, Ludwig C, Mahawar K, GENEVA collaborators. Global 30-day outcomes after bariatric surgery during the COVID-19 pandemic (GENEVA): an international cohort study. *Lancet Diabetes Endocrinol.* 2021;9:7–9.
4. Mahawar KK, Himpens J, Shikora SA, Chevallier JM, Lakdawala M, De Luca M, et al. The first consensus statement on one anastomosis/mini gastric bypass (OAGB/MGB) using a modified Delphi approach. *Obes Surg.* 2018;28:303–12.
5. Mahawar KK, Himpens JM, Shikora SA, Ramos AC, Torres A, Somers S, et al. The first consensus statement on revisional bariatric surgery using a modified Delphi approach. *Surg Endosc.* 2020;34:1648–57.
6. Pouwels S, Omar I, Aggarwal S, Aminian A, Angrisani L, Balibrea JM, et al. The first modified Delphi consensus statement for resuming bariatric and metabolic surgery in the COVID-19 times. *Obes Surg.* 2020;1–6. <http://dx.doi.org/10.1007/s11695-020-04883-9> [Epub ahead of print].

Kamal Mahawar^{a,b}

^aSunderland Royal Hospital, Sunderland, United Kingdom

^bUniversity of Sunderland, Sunderland, United Kingdom

E-mail address: kmahawar@gmail.com

<https://doi.org/10.1016/j.ciresp.2021.01.001>
0009-739X/

© 2021 AEC. Published by Elsevier España, S.L.U. All rights reserved.