

When Six Millimetres Is Not Enough

Type: Editorial

Received: February 23, 2026

Published: August 04, 2026

Citation:

Namrata Makkar. "When Six Millimetres Is Not Enough". PriMera Scientific Surgical Research and Practice 8.2 (2026): 01-02.

Copyright:

© 2026 Namrata Makkar.
This is an open-access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Namrata Makkar*

Assistant Professor, Dept. of Hospital Administration, All India Institute of Medical Sciences, New Delhi-110029, India

***Corresponding Author:** Namrata Makkar, Assistant Professor, Dept. of Hospital Administration, All India Institute of Medical Sciences, New Delhi-110029, India.

Recently, I found myself in an unexpectedly intense discussion — not in an operating theatre or clinical meeting, but in front of a sliding wardrobe at home.

The carpenter had completed the installation. The shutters moved. The alignment was acceptable. Technically, the job was done.

The gap between the internal shelves and the sliding shutters measured nearly 30 millimetres. The shelves sat recessed, leaving a depth that felt disproportionate — structurally harmless, yet visually excessive. The doors moved easily. There was no mechanical fault.

But the space felt wrong.

So I asked for it to be reduced.

The next day, the carpenter returned with a correction. The clearance was now 6 millimetres.

"It will move," he said confidently.

He was right.

The door slid smoothly. There was no obstruction, no friction. By mechanical standards, the problem had been solved.

Yet something about those six millimetres felt inadequate.

There was no structural flaw. No obvious defect. No immediate failure. But there was no margin either — no allowance for overfilled shelves, minor warping, seasonal expansion, or the quiet unpredictability of daily life.

We had moved from excess to minimum in a single adjustment.

But I had not asked for minimum.

I had asked for appropriate.

That distinction stayed with me.

In medicine — and especially in surgery — we are constantly negotiating margins. We speak of resection margins, perfusion thresholds, safe dosing limits, tension-free closures. We operate within measurements that are numerically precise yet biologically uncertain.

A technically negative margin may satisfy pathology. But does it satisfy physiology?

An anastomosis may appear perfect under inspection. But will it remain secure when tissues swell?

A patient may be “stable” by parameters. But will they remain stable through the night?

Minimum adequacy and functional safety are not always the same.

Engineering tolerances assume controlled environments. Medicine does not enjoy that luxury. Our “structures” are dynamic and adaptive. Edema develops. Blood pressure fluctuates. Compliance varies. Biology resists neat mathematics.

The carpenter optimized for movement. Six millimetres was enough.

But medicine teaches us to anticipate load.

Over time, clinicians develop an instinct for margins — not out of anxiety, but out of experience. We have seen how systems fail when pushed to their limits. We understand that sufficiency under ideal conditions may not endure under stress.

So we adjusted again — not back toward excess, and not toward minimalism, but toward balance. The final spacing allowed ease without strain. In the process, nearly an inch of additional usable depth was gained. The wardrobe no longer looked recessed, nor did it feel tight.

It simply felt right.

The door had moved at thirty millimetres.

It had moved at six.

But it moves differently now.

It moves without friction. Without hesitation. Without the quiet anxiety of near contact.

Perhaps that is what we seek in clinical practice as well — not merely function, not merely adequacy, but margin.

Because in medicine, six millimetres may work.

But appropriateness is what lets it endure.