Surgical Checklists: Prevention Is Better Than Cure

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Dear Editor,

We are writing in response to the article “Effects of Implementation of W.H.O Surgical Safety Check List: Our Institutional Analysis” by Haridarshan et al. published in the April 2017 edition of the Indian Journal of Surgery [1]. Since the introduction of the Surgical Checklists by W.H.O, its use has been mandated in operating rooms in over 4130 hospitals across 122 countries. It has led to an improvement in operative communication, minimization of distractions and interruptions in the operating room. This verbal confirmation of critical steps of identifying the key aspects of a procedure have led to a noticeable decrease in the avoidable perioperative mistakes and the potential for human error. We would like to congratulate the author for their acceptance of the concept of these checklists at their institution and publishing their experiences.

Surgical complications have always been recognized as a significant contributor to the morbidity and mortality and a high percentage of such errors are avoidable. Arriaga et al. expressed that checklists dramatically improved adherence to critical processes of care in simulated scenarios of surgical crisis [2]. Observations by Gillespie et al. are also worth mentioning; they proposed that checklist protocols which are prospectively tailored to the context are more likely to be used and subsequently sustained in actual practice with an increased fidelity and sustainability when integrated into

daily surgical practice. These statements were in sync with the authors’ data of a significant reduction in the intraoperative and post-operative surgical and anesthetic complications with a fall in intraoperative mortality from 1.4 to 0.4% [1].

Different institutions react differently to such checklists and the response is highly subjective. However, strict implementation of such protocols lead to a Hawthorne effect where individual display an improvement in performance secondary to the subjects knowledge of being observed. And this in turn helps in controlling preventable errors both intra- and pre-operatively.

Although recent literature has praised the role of intraoperative W.H.O Safety checklist, 53–70% of surgical errors occur outside the operating room [3]. The SURPASS or the Surgical Patient Safety System was formed to address all errors by monitoring patient care between admission and discharge [3].

Even though the concept of surgical checklists is facing certain barriers in the form of non-compliance secondary to pragmatic issues like extra time and emergency procedures, it still remains to be an evolving and effective strategy in dealing with surgical complications. There is a constant need for surgical checklist training worldwide to standardize the nature of care provided to patients and continue minimizing the risks and augment the benefits of surgery.

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Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflict of interest.

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