STUDENTS' CORNER
LETTER TO THE EDITOR

A crucial step towards a safer healthcare system: Embracing the WHO surgery checklist in Pakistan

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Dear Madam, Mistakes happen. We all make mistakes that makes us human. But when a surgeon makes a mistake, it costs lives. Being a surgeon, a little negligence can cause catastrophic complications. An unintentionally retained needle in the abdominal cavity or surgery of a normal limb instead of faulty gall bladder can have serious consequences not only for the patient and the patient-physician relationship but also for the healthcare system. Such negligence events have become common in Pakistan. In Faisalabad, it was reported that a patient with gall stones was mixed up with a patient of limb surgery having the same name that led to inappropriate surgical procedures performed on both.[1] In Abbottabad, an incident was reported where the patient had to undergo an arm surgery but an eye surgery was performed in a private hospital.[2] Everyone blamed the surgeon and the health care system but no one dared to dig into the cause. Why are such childish mistakes being encountered? And if it happened once how is it being repeated? How could a surgeon, an experienced doctor, make such careless mistakes. The answer to all these questions lies in the WHO Surgical Safety Checklist.

"Safe Surgery Save Lives" was initiated by the World Health Organization (WHO) in 2007 in order to alleviate the number of such unwanted events encountered in the surgical procedures. For the purpose of improving patient safety with least of the resource utilization, WHO came on board with safety checklist in 2008.[3] The WHO 19-item checklist is based on advocating safety checks and a good communication among surgery team members during perioperative periods. It also contains a time-out procedure. In Pakistan, in spite of the great effectiveness, the time-out is either not practiced or is done by some junior, and not by the operating surgeon at the preoperative time. A time-out is a short interval before incision during which it is confirmed that the patient on the surgery bed is the correct one, the procedure to be performed on it is exact and at the required part of body either marked or unmarked.[4] The surgeon should be present at the time-out and all members should guarantee the correct patient, procedure and site. Patient participation in the time-out process is also advised. Majority of the patients show great compliance and satisfaction for participating in the time-out procedure. A sign-in briefing has to be performed preoperatively, and a briefing after closure of the skin- the sign-out.

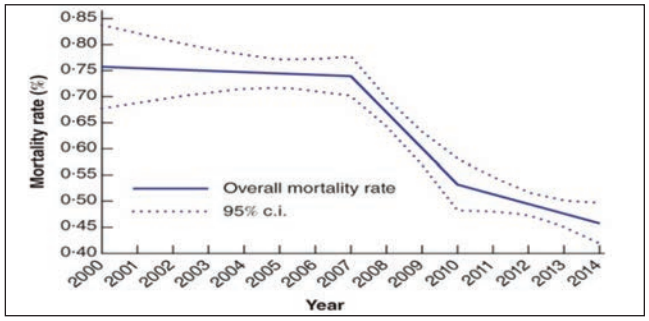

Figure: The mortality rates in pre-implementation, implementation, and post-implementation periods of safe surgery checklist in Scotland.

The WHO checklist was implemented in Scotland between 2008 -2010. Its use was uniform throughout the country by 2010. The nationwide population-based cohort study proved there was a marked decrease in mortality rates in patients undergoing surgical procedures. Figure shows the mortality rates in pre-implementation, implementation, and post-implementation periods.[5] No such alterations were seen in the non-surgical patients. It can thus be summarized that the decrease in the mortality rate was in part due to the WHO checklist implementation. On contrary, the procedure has not been implemented uniformly in Pakistan till now. A study was conducted in Karachi, Pakistan and a total of 103 patients were taken into consideration. Results that came out were terrifying, site for surgery was not marked in 10.7% cases, during time-out in 88.3% cases staff did not introduce themselves to the patient, during sign-out name of procedure performed was not recorded in 33% cases, instruments were not counted in 20.4% cases, specimens taken were marked

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with patients' identity in only 9.7% cases.[6] Another common factor is to fill out the checklist form without involving the patient and is mostly done by juniors on call. Surgeons don't even bother to confirm all the marked information. In such circumstances, the patient's life would always be under great safety risks.

There are clear instances demonstrating that we need to implement the WHO checklist and the time-out procedure over quick notice. Awareness should be given to the patients and surgeons to take checklist into serious consideration otherwise this little negligence could cost someone their life. It can be done by adopting the Tick-Box culture, and offering workshops at various levels. All the staff members and especially the surgeons must be taught about the importance of WHO checklist and they must ensure the proper implementation of the safety checklist in all the procedures performed under their lead. No exceptional education is required to perform this procedure. Only the necessity should be in one's mind. This would be at least a small step leading towards a better health system.

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