

LETTER TO THE EDITOR

Surgical safety checklist: fact or fake?

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Dear Editor,

In 2008, the World Health Organization (WHO) launched the Surgical Safety Checklist as part of the Global Patient Safety Challenge to reduce surgical morbidity and mortality worldwide. The list comprises three stages: before induction of anesthesia (sign in), before skin incision (timeout), and before patient leaves operating room (sign out), which consider the regular flow of surgical procedures.⁽¹⁾

The checklist is a simple and cheap intervention that may avoid half of postoperative deaths.⁽²⁾ If the implementation is carefully performed and all those involved understand the working process in the operating room, it may result in improvements. However, despite favorable evidence, the generalized adoption of the Surgical Safety Checklist has been inconsistent.⁽³⁾

Like any tools or processes aimed to improve safety, an ineffective implementation would reduce the expected benefits.⁽⁴⁾ This fact was shown in an article published in 2021, in the British Medical Journal (BMJ) entitled “Timeout procedure in paediatric surgery: effective tool or lip service? A randomised prospective observational study.”⁽⁵⁾ Errors were randomly introduced into 120 surgical procedures in the timeout routine of elective pediatric procedures. Selected errors included patient’s wrong name, incorrect procedure, wrong side, allergy, among others. In general, 54% of errors were reported loudly during the timeout process, and the remainder were not noticed. Thus, almost half of the errors introduced in the timeout routine were not reported by the team in that study. Wrong data were pointed out more frequently by anaesthesiologists (64%), followed by the nursing team (28%), residents (6%), and undergraduate medical students (1%). Several factors may diminish the efficacy of Surgical Safety Checklists. Stress and work process specificities in the surgical scenario, together with the hierarchical structure prevalent in operating rooms, may lead to omission of relevant data.^(5,6)

Based on this scenario, the Surgical Safety Checklist seems not simple to be implemented. Repeating its items in an operating room and demanding its use are not enough.^(3,5) This instrument may easily become a passive exercise, instead of a tool of active safety.⁽⁵⁾

A checklist itself is not enough to achieve the ideal outcomes.⁽⁴⁾ The apparent simplicity of this tool does not ensure the quality and safety of its practice in the operating room.⁽³⁻⁵⁾

An important mechanism of action of the checklist is encouraging change in behavior at the operating room to create an atmosphere of effective communication and a culture of safety.⁽³⁾ If properly used, the list may indeed help changing communication patterns and working processes at the operating room. A well-consolidated Surgical Safety Checklist will depend on good

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communication and team work, which is not always the situation observed in several organizations.⁽⁶⁾

The Surgical Safety Checklist might have been neglected by health professionals in hospitals all over Brazil. Hence, acknowledging this fact could be the kickoff for an urgent and necessary reflection, even if it reveals inconsistencies regarding the working processes in the operating room. This is our hint!

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