

Message to surgeons: Cut it out

by Editorial Board, The Oregonian

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New research shows that it's remarkably easy to reduce errors during surgery by using a checklist

Research suggests it can take as long as 17 years for a medical innovation to become standard practice. Here's one, though, that should penetrate the thickest barriers -- and skulls -- overnight.

It costs nothing. It involves no high-tech equipment. Of the 58 hospitals in Oregon, 54 do surgery, and they could make this change immediately. They could begin using a cockpit-style checklist to prevent grief, glitches, misunderstandings, malpractice suits, save medical careers and save lives.

A study published last week in the New England Journal of Medicine shows hospitals can't afford not to. If surgical teams started using the 19-point checklist immediately, U.S. hospitals could save from \$15 billion to \$25 billion a year.

The study tracked results at eight hospitals around the globe. By following a 19-step checklist, surgical teams reduced complications by 36 percent, and deaths by 40 percent. Results that dramatic would be deemed miraculous if they involved a new therapy, high-tech device or drug. But the checklist is much more basic and simple. The resistance the idea encounters is of the skull variety: Most of us think we're smarter than we are.

Most surgeons and surgical teams think so, too. They think they don't need a list. They'll tell you they're already doing everything on it.

We don't want to beat up on surgeons here. They have such amazing skill and training that they can be forgiven for occasionally confusing themselves with prima donnas, or relegating everyone else in the operating theater to the tech crew.

But there really is a hierarchy in medicine, or at least a residual one. The checklist sharpens the attention and focus of a surgical team. Something as simple as requiring each person to introduce himself or herself (as the checklist requires) can cut down on misunderstandings.

"It sounds almost silly, but it reinforces that there's a team here," says Jim Dameron of the Oregon Patient Safety Commission. Once people have identified themselves, they're much more likely to speak up if they notice something wrong.

The team also ensures that equipment has been sterilized, doublechecks the patient's name and allergies, analyzes the antibiotic regimen and the need for extra blood.

After the surgery, the team checks to ensure utensils have been removed from the patient. (Think this always happens now? Read the Oregon Patient Safety Commission's confidential reports on hospital errors.) The commission is part of a network of six agencies affiliated with the Institute for Healthcare Improvement.

By April 1, the Institute is asking every hospital in the nation to test the checklist. To meet the requirement, the hospitals just need to ask one surgical team to conduct one surgery, using the list. It's a realistic deadline. In fact, it's almost too modest and humble of a request.

There's no reason hospitals in Oregon can't go further, and they need not wait until April Fool's Day to do so. They ought to use the checklist starting with their first surgery.

Today.