

engagement of those at the clinical coalface, contrary to what proponents of the Checklist advocate, and it is being used in a way which distracts personnel during the induction of anaesthesia. To those familiar with accident analysis, this is a good example of poor process implementation by a hospital administration and its managers.

Secondly, I am concerned by the use of the study of Haynes and colleagues² to underwrite the Checklist. Results of the study would be more meaningful if the reduction rates in mortality in the hospitals in the developed countries (Canada, United States, United Kingdom and New Zealand) were separated from those in the developing countries. Or would this have shown the developed countries' reduction rate to be statistically non-significant? Are we to believe that use of the Checklist could save seven lives per 1000 procedures in Australia, or 15 000 to 21 000 lives across the three million procedures undertaken here annually? Total figures for perioperative mortality across all procedures in all operative categories remain a matter for conjecture. However, in looking at the high-risk group of cardiac surgical operations in Victorian public hospitals,³ we can see a published mortality rate of 10 per 1000 for coronary artery bypass or isolated valve surgery, only a little higher than that seen after the introduction of the Checklist across a broad surgical population.

We should be careful to see that spin does not become embedded within medicine, even where it is associated with what is probably a good idea.

Competing interests: I chair the Professional Issues Advisory Committee of the Australian Society of Anaesthetists.

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1 Merry AF, Barracough BH. The WHO Surgical Safety Checklist. *Med J Aust* 2010; 192: 631-632.

2 Haynes BA, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med* 2009; 360: 491-499.

3 Australasian Society of Cardiac and Thoracic Surgeons. ASCTS cardiac surgery database project. Annual report 2008-2009. Victoria: public report. <http://www.health.vic.gov.au/surgicalperformance/downloads/cardiac-surgery-report09.pdf> (accessed Jun 2010). □

The WHO Surgical Safety Checklist

James P Bradley

TO THE EDITOR: The World Health Organization Surgical Safety Checklist (Checklist) has recently been editorialised by Merry and Barracough.¹ We are all keen to see perioperative mortality and morbidity reduced to a minimum, and one cannot disagree with the intent of the Checklist, which was tested in a pilot study² involving almost 8000 patients in eight hospitals (in disparate developed and developing countries). The study showed a reduction in the death rate associated with surgery from 1.5% to 0.8% (or 15 per 1000 down to eight per 1000). Impressive indeed!

My concerns are firstly with process. One hospital in Brisbane has already introduced the Checklist without the constructive

Alan F Merry and Bruce H Barracough

IN REPLY: Thank you for the opportunity to respond to Bradley's letter. We agree that constructive engagement of clinicians is essential in adoption of the World Health Organization Surgical Safety Checklist (the Checklist) — that point is clearly made in our editorial.¹ Bradley's anecdotal comment about use of the Checklist causing distraction during the induction of anaesthesia is difficult to evaluate in the absence of more detail. Surely any competent anaesthetist committed to patient safety could liaise with other team members to find an acceptable time to fulfil the entirely reasonable expectation of ensuring that relevant safety checks have been done? Furthermore, the study of Haynes and colleagues² provides considerable reassurance about the possibility of unintended harm from use of the Checklist.

Justification for the Checklist does not depend on the above-mentioned study alone: the Checklist was developed by an extensive process of literature review and consultation. It reflects expert consensus, and its endorsement by the Australian and New Zealand College of Anaesthetists, the Royal Australasian College of Surgeons and many other organisations adds to this consensus. There is no suggestion that the Checklist will save any particular number of lives in any given country — rather, its use is likely to reduce the number of patients harmed during surgery, and this is surely worthwhile.

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1 Merry AF, Barraclough BH. The WHO Surgical Safety Checklist. *Med J Aust* 2010; 192: 631-632.

2 Haynes BA, Weiser TG, Berry WR, et al. A surgical safety checklist to reduce morbidity and mortality in a global population. *N Engl J Med* 2009; 360: 491-499. □