President's Message

"Medicine used to be simple and ineffective and relatively safe, but now it is complex, effective, and potentially dangerous"[1]

Chantler, cited by Baker, 2005

At the recent *Surgical Safety Saves Lives Workshop* in Vancouver, I had the privilege of representing perioperative nurses on an interdisciplinary panel. The participants included a Chief Executive Officer of an eastern hospital, two surgeons, an anesthesiologist, and a member of 'Patients for Patient Safety'. The discussion was structured by questions delivered by a facilitator: "(1) Why do you think the checklist has received so much attention; (2) Why might surgeons/anesthesiologists/nurses be opposed to using the checklist; and (3) How has using the checklist influenced or changed the way you practice?"

My response to the first question was short – "It is the right thing to do". There is strong evidence that checklists (and briefings) reduce adverse events and improve patient safety in the operating theatre.[2] The second question could be the focus of a full day conference, but in the essence of brevity I focused on the myths presented by members of the surgical team during checklist discussions within my health authority. Myth #1 "The checklist won't make a difference as we are already careful and we have never had a problem – it will just create extra work"; Myth # 2 "Staff introductions are a waste of time – we already know our team"; and Myth # 3 "We are experts – we do not need to critique our practice and we can ignore the checklist as it does not apply to us". In order to address these myths and to ensure effective implementation and sustained benefits, providing education to the surgical teams regarding the significance of the checklist is crucial.

The third question highlights the essence of the checklist beyond a piece of paper. I contend that the term "checklist" is inadequate as the importance of the usage extends beyond a document to a tool for improved team communication, collaboration, and caring. Instead, I suggest that we use the terminology "team connection".

Jane Reid, one of the seven nurses in Geneva for the initial development of the World Health Organization's Surgical Safety Checklist, coauthored a review of safer surgery progression and captured this issue under the heading "Promoting a safety culture":

> *"The real value of the checklist lies in its use as a tool, to focus everyone's attention on the critical safety points of a patient's surgery, and to create a forum for anyone in the room to question and challenge what is happening, needs to happen or to stop happening, regardless of their status or grade, thus flattening the hierarchy."*[3]

The checklist is about working differently – it will open up lines of communication between all staff present and will enhance teamwork, for the improvement of patient safety, clinical outcomes for patients, and cohesive work environments. Have a safe and happy summer!

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References

1. Baker, R. (2005). Editorial. *Healthcare Quarterly*, 8, 2.

2. Haynes AB, Weiser TG, Berry, WR, et al (2009). A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. *New England Journal of Medicine*, 360 (5), 491-497.

3. Reid, J., & Clarke, J., (2009). Progressing Safer Surgery. *Journal of Perioperative Practice*, 19 (10), p 340.

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