Editorial | Journal of Orthopaedic Case Reports 2025 January:15(1):Page 1-3

Safe Surgery is Everyone's Responsibility

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Introduction

Surgeons must exercise extreme caution whenever they wield a knife, as aptly put by Emily Dickinson., "Scattered Culprit Life Rage Beneath Their Fine Incisions!" The probability of dying while flying is one in 3 million, according to estimates. There is an estimated one in 300 chance that a patient will die as a result of a preventable medical accident while receiving treatment [1]. This demonstrates that patient harm occurs in 10% of all hospitalized patients. More than 1 million people die each year as a result of surgical complications, according to the World Health Organization (WHO) [2]. The volume of surgeries is rising, and the complexity and variety of surgical procedures are also on the rise. Providing care to a patient who is unconscious from anesthesia requires a multidisciplinary team that routinely interacts with one another in operating rooms (OR). Although the main goal of surgery is to prolong or enhance patients' lives, many avoidable complications arise when things do not go according to plan. Health-care providers must become experts in gathering evidence to enhance patient safety and mitigate the likelihood of adverse events. Having a firm grasp on what standards and procedures entail is the first step toward accomplishing this objective. A large number of trauma and emergency cases are handled by orthopedics specifically. The high-stakes nature of these procedures makes errors a major concern in emergency ORs. OR surgical safety checklists, standard protocols, error reporting systems, and ongoing education and training are some of the methods that have been used.

The Need to Understand Guidelines Before Improving Safety

The WHO has launched multiple regional and international programs to improve surgical safety. The Second Global Patient Safety Challenge "Safe Surgery Saves Lives" was a major inspiration for a lot of this work [1]. Safe Surgery Saves Lives is an initiative to establish universally applicable safety standards for surgical procedures. The 10 goals for safe surgery established by the WHO are [2] –

1. The right patient will be operated on at the right site by the right team
2. To protect the patient from pain, the team will employ methods that are known to prevent harm from the administration of anesthetics
3. Third, in the event of a potentially fatal airway or respiratory function loss, the team will know what to do and be ready
4. The squad will find out if there is a chance of a lot of blood loss and plan accordingly
5. If there is a high probability that the patient could have an allergic reaction or other negative drug reaction, the team will take precautions to avoid doing so
6. To reduce the likelihood of surgical site infections, the team will always employ proven methods

Access this article online

Website: www.jocr.co.in

DOI: https://doi.org/10.13107/jocr.2025.v15.i015100.

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Submitted: 04/10/2024; Review: 10/11/2024; Accepted: December 2024; Published: January 2025

DOI: https://doi.org/10.13107/jocr.2025.v15.i01.5100

7. The group will take measures to ensure that surgical incisions do not become stuck with instruments or sponges

8. All surgical specimens will be properly identified and stored by the team

9. The team will ensure the operation runs smoothly by communicating and exchanging important information

10. Surgical capacity, volume, and results will be routinely monitored by hospitals and public health systems.

Extensive consultation was conducted to develop the WHO surgical safety checklist, which aims to enhance patient safety by decreasing errors and adverse events and increasing teamwork and communication during surgery. A worldwide trend toward using the 19-item checklist – with some regional tweaks here and there – has been a marked decline in mortality and morbidity.

Every member of the OR team is responsible for reviewing the surgical safety checklist to make sure every patient is safe. Using three pauses, it is a verbal checklist of dos and confirms. The surgical safety checklist consists of three parts: The sign-in, the time-out, and the sign-out.

Surgeons, anesthesiologists, nurses, and support staff should all work together to make the ORs a safe place by following the surgical safety checklist to the letter.

Human Errors and Patient Safety

While other industries may simply issue an apology or compensate victims, medical mistakes can have lasting effects on patients and their families, making them the most stressful experience a doctor can have in clinical practice. In particular, surgeons are vulnerable to the full spectrum of human emotions when problems arise that they attribute to themselves, including feelings of guilt and even a loss of faith in their ability to continue operating. Surgeons avoid taking risks with patient management because of this, which could hurt patients. Taking care of the victim and their loved ones comes first in any major emergency. Although some actions and behaviors warrant sanctions and actions, the second priority should be supporting colleagues and not hastily blaming or condemning those who make significant mistakes. They and the patients they will care for in the future require the backing of their organizations and coworkers. To improve patient safety and decrease human error, undergraduate and graduate curricula should include human factors that cause treatment errors.

Patients for Patient Safety

It is crucial that all patients who have experienced adverse events are given the chance to work together to find solutions for patient safety. People who have been through bad things can point out where safety and quality are lacking and provide information, anecdotes, and wisdom that cannot be found elsewhere. All of these areas – research design, medical education, policymaking, and health-care organization quality improvement – should work together to make patients safer.

The Vision for the Future

Zero harm is a future-oriented goal that reflects our commitment to patient safety. Achieving complete safety is often a mirage, according to some. Despite being completely impossible to achieve, the ideal of zero harm should be our goal [3]. To make zero harm a reality, we must rethink our care systems through collaboration and coproduction, while also tackling the obstacles posed by social determinants, hierarchical cultures, and technological advancements. Norm Kerth aptly remarked – "Regardless of what we discover, we understand and truly believe that everyone did the best job they could, given what they knew at the time, their skills and abilities, the resources available, and the situation at hand."

Conclusion

A commitment to safe surgery is a shared responsibility, and each person plays an important part in ensuring that the best possible outcomes are achieved. Every patient and every surgery should be should be safe and this can be possible by maintaining vigilance and working organised as a team.

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Conflict of Interest: Nil
Source of Support: Nil

Consent: The authors confirm that informed consent was obtained from the patient for publication of this case report

How to Cite this Article

Jain M, Sakale H, Shyam A. Safe Surgery is Everyone's Responsibility. Journal of Orthopaedic Case Reports 2025 January;15(1):01-03.