

Five Questions for Atul Gawande, M.D.

An interview by David Cameron, Director of Media Relations, Office of Communications and External Relations, Harvard Medical School



Courtesy of Picker Institute

Atul Gawande, M.D., MPH, is a surgeon at Brigham and Women’s Hospital; Associate Professor of Surgery, Harvard Medical School; and Associate Professor in Health Policy and Management, Harvard School of Public Health—all in Boston, Mass. He received his B.A.S. from Stanford University, an M.A. in politics, philosophy and economics from Oxford University, his M.D. from Harvard Medical School, and an MPH from the Harvard School of Public Health. He is director of the Global Challenge for Safer Surgical Care of the World Health Organization. A staff writer for *The New Yorker* magazine since 1998, he recently published “The Checklist Manifesto: How to Get Things Right” (Picador, 2011).

David Cameron: Your latest book, “The Checklist Manifesto,” examines the role of the checklist in the operating room. Can a humble checklist really save lives?

Atul Gawande: Though it seems almost ridiculous in its simplicity, we’ve found that a checklist can save lives. And two recent studies—in the Veterans Administration system and in the Netherlands—have confirmed the substantial mortality reductions we observed when teams are trained in the principles the checklist embodies. What’s intriguing are those principles. Checklists are memory aids. But, designed well, they also foster teamwork. Doctors don’t love to use them at first. I know I didn’t, and I was running the World Health Organization’s program that was testing them. But no matter how routine an operation is, the patient never seems to be. The checklist made our team discuss each patient’s medical and surgical issues before starting. And in the first month, that conversation alone saved a patient’s life. We’ve since caught unrecognized drug allergies, confusion about medications, errors on biopsy specimen labels, and equipment failures.

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The evidence is: any hospital or surgical staff that operates on patients without a team checklist is endangering them.

DC: What’s the most daunting part of being a surgeon?

Five Questions (cont'd)

AG: The complexity. Although there are procedures that we do over and over again, we perform many types of operations only a few times a year. Surgeons need to be able to handle both the routine and the anomalous. Beyond surgery, medicine as a whole has become extremely complex. Science has enumerated more than 13,000 diagnoses—ways the human body can fail—and found ways to help with nearly all. But these involve more than 6,000 drugs and 4,000 medical and surgical procedures, and those numbers are growing. The volume and complexity of knowledge has exceeded our capacities as individual clinicians.

DC: How can medical professionals cope with such complexity?

AG: You probably think I will say: checklists! But it's deeper than that. What fascinates me about checklists are the values the best ones implicitly contain—humility, discipline, teamwork. Medicine's traditional answer for how professionals should cope with complexity is through training and technology. But we also need the humility to acknowledge that we as individuals will fail at our tasks no matter how smart or experienced we are. We need to believe that discipline in our processes is one way to overcome such failures. And we need to understand that our colleagues, no matter their station or experience, are key assets for helping us maintain vigilance and caring, identify problems, and solve them.

DC: What was the most telling lesson you learned through your research?

AG: Even as they groaned about—or even opposed—having to incorporate the basic checklist into their routine, 93 percent of the surgical staff members we surveyed said they would want their surgeons to use it.

DC: What's next on your checklist?

AG: It's getting long. By the end of 2010, about 30 percent of U.S. hospitals will have adopted the surgical checklist, and we're working to bring it to the rest and to improve the effectiveness of adoption around the world. The stakes are high: Globally, more than 7 million people a year are left dead or disabled following surgery, about 500,000 in our country alone.

We're now testing crisis checklists for the operating room and, in South India, a WHO Safe Childbirth Checklist. We've also worked with a Boeing safety engineer to design a Checklist for Checklists—which we've posted at www.projectcheck.org—to help others effectively design their own checklists. And there's much more work to be done. The knowledge exists about what great care requires. It's a matter of putting it into practice.