# Beyond the Checklist: Achieving Practice Excellence

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Over the past few years, I have certainly been a zealot when it comes to promoting the perioperative checklist. As with religion, once you "see the light," all you want to do is bask in it and encourage others to do the same. Paradoxically, this mission has been a labor of love. The majority of my colleagues, of every surgical persuasion, have not adopted checklists as earnestly as I have delivered the message. Looking back, I have heard "everything": from understandable hindrances caused by institutional barriers, to apathetic excuses immunized by the sanctum of private practice. Perhaps the only way to become a believer is to create your own operative checklist, conduct your own "controlled" experiment, and experience your own revelation: seeing is truly believing.[1]

Clearly, there can never be a level I study to otherwise prove this outcome. No one would allow for random logistical errors and chart their consequences. As I reflect on my own 15-year checklist experience, my team would be quick to point out the innumerable instances in which the checklist has prevented "near-miss" events: errors that I have called errors of *omission*.

Decidedly, my checklist has become part of a larger personal philosophy; a singular expression of an overarching goal: put simply, to get better. This should come as no surprise to plastic surgeons. It is in our DNA to strive to get better, *all the time*. This is what simultaneously drives us, haunts us, inspires us and, together, pushes our field forward. Our everyday practices are simply honing stones on which our skills should be sharpened. The key word is "should," because it is insidiously easy to establish a standard of care that is too comfortable. In fact, we have only ourselves to move the target a little farther away every time we rashly think we have reached it. Otherwise, a practice ceases to be a true "practice" and instead evolves into a mill.

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To this end, the surgeon must embed multiple prophylactic modalities, beyond my original "operating room checklist." For this purpose I now propose a more encompassing mandate: a "practice checklist."

This checklist extends the narrow scope of procedural mandates to encompass the holistic elements of managing the entire patient experience, from the design of the incision to the longevity of the outcome. This broader effort goes beyond reducing errors of omission to include those of *commission*. Notably, these errors should not only encompass the usual litany of "physical" complications. As aesthetic surgeons, we must be willing to consider our "aesthetic" complications as well.

To this end, the following list of surgical criteria and goals fittingly reads like entries within the *Guinness Book of World Records*:

- The extent of surgery: the least.
- The length of incision: the shortest.
- The character and location of scars: the best.
- The incidence of complications: the lowest.
- The duration of recovery: the fastest.
- The longevity of the outcome: the longest.
- The reproducibility of the case: the greatest.
- The quality of the *aesthetic* result: the highest.

How does one begin to address all the items on this fortified checklist? I propose—to borrow a term from Silicon Valley—a set of "change agents" to inspire and facilitate the endeavor:

1. Mentors: The moment you walk away from residency, you leave behind the last genuine method of peer review: someone who is literally looking over your shoulder. To fill this void in private practice, it is a powerful asset to harbor a mentor in your practice: a colleague, a former teacher, a partner. I call my own mentor my "secret weapon." The albeit

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honorable push to bring science to aesthetic surgery has inadvertently relegated the "expert" to the bottom floor of the evidence pyramid. To whit, Niels Bohr elucidates this best: "An expert is a person who has made all the mistakes that can be made in a very narrow field." Does that not describe the untapped resource of our own plastic surgical mentors? I would take the advice of my mentor over a published article any day.

2. Colleagues: "Exposing" yourself before your colleagues by way of presentation or publication, as uncomfortable as it may be, necessarily fosters innovation. Both intellectual honesty and collegial feedback are the true catalysts to getting "better." Otherwise the term "evidence-based research" will risk becoming just a slogan.
3. Residents: Equally so, engaging in the teaching of fresh minds can be a painless change agent to remaining fresh oneself. Residents have the uncanny ability to get to the essence of what you know and, most valuably, what you do not. However, one must be open to receiving these, albeit unpolished, pearls of wisdom.
4. Patients: Perhaps the most unsung change agent is the patient. However, to benefit from this source, the surgeon must leave his or her ego by the examination door. That is, we must be willing to actively listen and learn from our patients. As the preeminent physician Sir William Osler once admonished: "When all else fails, listen to the patient!" I can ascribe many of my best "aha" moments in practice to doing just that.
5. Surgeon: The full potential of the aforementioned change agents are dependent on the ultimate power source: the surgeon. The ability to examine oneself honestly, critically, and consistently is the essential stimulus. The most fruitful nutrient to feed such introspection is one's own complications. The path to checking off the various items on the above-noted practice checklist is paved with these critical pauses *between* operations. It is at these junctures that the surgeon can analyze these less-than-perfect results and tweak the surgical planning, techniques, and postoperative care.
6. Coaches: Both sports figures and concert musicians covet them. Why not surgeons? After all, in training, we used to have program directors, attendings, and even chief residents watching over us. As I opined above, should we not be forever "in training"? Atul Gawande, the surgeon-author, has recently proved the refreshing value of reinstalling someone to "look over one's shoulder" while operating: a second pair of eyes and ears to observe, to judge, and to guide. Thus, I challenge all of us to sublimate any reflexive queasiness about such a notion. Instead, let us inspire and harness the brain trust of our retired leaders to become perhaps the greatest untapped change agent of all: coaches.

The greater goal is to challenge oneself to go beyond the checklisted pause: to embed change agents within one's practice, which will act as pauses *between* operations. Only then can one ensure a truly consistent personal mandate to get better: the *practice checklist*.

## REFERENCE

1. Rosenfield LK, Chang DS. The error of omission: A simple checklist approach for improving operating room safety. *Plast Reconstr Surg.* 2009;123:399–402.

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