implemented.[3,4] Although it is unquestionably valuable, it has one major drawback: its timing.

In an observation of 170 surgical procedures,[5] more than 50% of all deviations in surgical processes occurred before or after surgery. Many of these omissions and incidents can and should be corrected at an earlier stage than just before starting surgery, when it could be too late. Not checking the essentials until inside the operating room might lead to compromised safety or postponement of surgery, resulting in substantial psychological burden for the patient. Additionally, the patient is not safely home after surgery: many adverse events originate in the postoperative phase.

Therefore, we would like to plead for a checklist that covers the entire surgical pathway from admission to discharge, instead of just the perioperative phase. The surgical patient is at risk; and no less so on the ward or in the recovery room than in the operating theatre. With attitudes starting to change and a safety culture slowly emerging, we now have the opportunity to really improve patients' safety. Let's not be too easily satisfied.

We declare that we have no conflict of interest.

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Safety of surgical personnel: a global concern

Thomas Weiser and colleagues (July 12, p 139)[1] have identified high surgical complication rates and the scarcity of surgical care in low-income countries as unaddressed public-health issues of global magnitude. Their focus on the unmet needs of surgical patients is wholly justified, yet overlooks a risk group that is even more neglected: that of surgical personnel in poor countries who are at exceptionally high risk of occupational infections from HIV, hepatitis B, and hepatitis C.

A 2006 survey of surgeons from 14 sub-Saharan African countries[3] found that more than 60% were not fully vaccinated against hepatitis B. There was a near absence of availability of fluid-resistant barrier garments and 70% wore no eye protection. The percutaneous injury rate was 20 times higher than that of the average US health-care worker.[4] The population prevalence of bloodborne pathogens in the region is among the highest in the world, making every blood exposure a potentially life-threatening event.

The loss of surgical personnel has a disproportionate effect in countries where surgical resources are already scarce. Protecting their lives should be an inseparable component of any patient safety initiative. Principles of any model to protect surgical personnel from occupational infections should include the provision of surgical gloves, protective eyewear, and fluid-resistant garments; sharps protection such as blunt-tip suture needles; training in hands-free passing; and free availability of hepatitis B vaccination and HIV post-exposure prophylaxis. The cost of losing surgical personnel is far greater than the cost of protecting them.

We declare that we have no conflict of interest.

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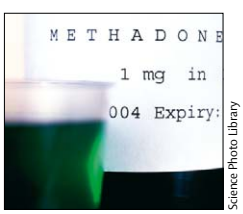
Substitution treatment in Malaysia



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Less than 6 months after Richard Schottenfeld and colleagues terminated their buprenorphine versus naltrexone study in Malaysia (June 28, p 2192),[1] the country's drug policy entered a new phase. Substitution treatment was introduced as a pilot programme in October, 2005. Methadone was prescribed through government hospitals, community clinics, and general practitioners' clinics, reaching 1241 heroin users within a year. The programme was subsequently scaled up, reaching the target of about 5000 people by the end of 2007, with a new target of 25 000 by 2010.

A survey in August, 2007, revealed that about 70% of methadone users had missed no more than two daily doses of methadone in the preceding month, indicating a high retention. Only 5% had continued to inject, and needle-sharing had become distinctly uncommon.

The effectiveness of substitution treatment with methadone or buprenorphine has been proven by a wealth of quality research. Similar efficacy studies should no longer be necessary, since the continued use of naltrexone serves moralistic rather than public-health objectives.[2] There is, however, a pressing need to expand the coverage of substitution treatment. In Malaysia, a parallel needle and syringe exchange