

Name : Prathamkumar Vaghela

Student ID : 2531876

Health Care System Organisation and Leadership

Wrong Patient Surgery at Kota Medical College Hospital

Table of Contents

1. Introduction.....	3
2. Main Body and Analysis	4
2.1 Identifying the Problem and Setting the System Context: Applying Systems Thinking and the Rich Picture	4
2.2 Centralisation or Decentralisation within the Case Study	7
2.3 Leadership Theories and Application to the Case Study	9
2.4 Improvement and Lessons Learned.....	12
3. Recommendations	14
4. Conclusion	16
Reference	17

1. Introduction

Patient safety failure is among the best indicators of healthcare organisation, governance and leadership weaknesses. A severe case of this issue is the incident at Kota Medical College Hospital in Rajasthan on 12 April 2025. Then, an old man who was waiting as his son was being operated was accidentally sent to the operating theatre, anaesthetised, and an incision was made as a dialysis fistula operation that was supposed to be done on a different patient (Singh, 2025). It was reported that the mistake was made when hospital staff referred to a name close to the name of the target patient, the elderly man, raised his hand, and the staff did not perform any serious identity checks (South China Morning Post, 2025). This incident cannot be discussed as an individual mistake. Rather, it is indicative of a larger systems failure of patient identification, perioperative communication, accountability, supervision and safety culture (World Health Organization, 2023). The Global Patient Safety Report 2024 also highlights that patient safety is not only a clinical issue, but also a leadership, governance and organisational design issue (World Health Organization, 2024). Due to this reason, Kota case can be of use in studying how system misalignment can result in preventable patient harm.

Leadership in the context of health and social care may be viewed as the process of impacting individuals and systems to facilitate the attainment of common objectives like safer care, coordinated working and continuous improvement (Harris et al., 2022). Efficient leadership is not just restricted to senior managers. It also manifests itself in the design of routines, support given to staff to speak up, and shared responsibility across professional groups (The King's Fund, 2023). This is especially relevant in surgery, where the impact of a breakdown of communication can be swift and irreparable. The case also presents a structural concern where there is centralisation and decentralisation. Centralised systems are capable of developing standardised protocols, enhanced consistency of policy and better clarity of oversight (The Joint Commission, 2025a). In comparison, decentralised structures may enable local teams to fit the context and be flexible to the clinical reality (Leask and Macleod, 2023). Nevertheless, the two methods might fail in case the leadership fails to make sure policies are translated into credible practice.

Such theories of leadership like transformational, transactional and situational leadership are thus very applicable in this case. Transactional leadership offers disciplinary and monitoring through rules, which are crucial in surgical environments (Salameh-Ayanian et al., 2025). Transformational

leadership assists in establishing a safety culture where the staff would be encouraged to safeguard patients and to question unsafe practice (Hamdan et al., 2024). The value of situational leadership occurs in situations where the context is dynamic and the leaders have to modify safeguards to align with risk (Althobaiti, 2025). This report discusses the Kota incident in four phases. It initially determines the problem through systems thinking and a rich picture. Second, it examines the presence of centralised or decentralised nature of the organisation. Third, it implements appropriate leadership theories to the incident. Fourth, it determines the enhancements and lessons learned. The report says that the incident was avoidable and that it can be improved by balancing leadership and governance and system design, instead of only trying to point the finger.

2. Main Body and Analysis

2.1 Identifying the Problem and Setting the System Context: Applying Systems Thinking and the Rich Picture

The main issue in the case was an erroneous invasive procedure resulting from a failed identity check and insufficient perioperative controls. On a superficial level, the mistake was made because the wrong individual answered when his name was called. But a closer examination reveals that a number of safeguards did not work in concert. They were failure to verify full identity, failure to cross-check procedure list, failure to verify correct patient prior to anaesthesia, and failure to have a meaningful final time-out before incision (PSNet/AHRQ, 2024). The patient was anaesthetised and incised which proves that the error went through several layers of the system and was not halted at the initial stage. Statistical data on the world reveal the reason why this case is not a mere local incident. According to the World Health Organization, every 10th patient is likely to suffer during the healthcare delivery process, and the problem is more acute in low- and middle-income nations (World Health Organization, 2023). The same estimate of 134 million adverse events per year in the hospitals of low- and middle-income countries and millions of deaths caused by these adverse events is also published in the report by the World Patient Safety Day of India itself (National Health System Resource Center, India, 2024). This puts the Kota incident in a broader global trend of avoidable damages.

Wrong-patient and wrong-site procedures are particularly severe since it is regarded as never events. They are those that are not supposed to occur in case the systems are working properly

(Taylor, Quesenberry and Yonash, 2026). These incidents can be avoided since hospitals are supposed to apply multi-layered protection as opposed to memory or verbal assessments (The Joint Commission, 2025b). In the Kota case, these safety measures were either missing, poorly executed or just seen as formalities and not as active safety nets. The systems-thinking approach to the case entails the interplay of people, processes, tools, structures and feedback loops (Thelen et al., 2023). The major players involved the father of the patient, the son, the surgeons, the nurses, the anaesthesia staff and the administrative or transport staff. The key steps included a call to the patient, transportation to the theatre, preparation to the procedure, reviewing his records, and incision. The equipment ought to have contained patient identifiers, surgical lists, medical records and an organized surgical safety checklist. These were the hierarchy of the theatre, lines of reporting and governance expectations. The system of feedback failed since the mistake was identified when the son was already operated and realized that his father was missing (Singh, 2025).

Perioperative communication is also a huge weakness revealed by the incident. Guidance on team communication in surgery emphasizes that employees should employ closed-loop communication that is structured, particularly when handing over patients and verifying information prior to an operation (Guidelines in Practice: Team Communication, 2024). In the Kota case, communication seems to be limited to the simple call of a common name. This type of informal communication is unsafe since it gives assumptions the chance to take the place of verification. Lack of accountability design was another weakness of the systems. In a safe organisation, there are a number of staff that are supposed to be responsible in stopping the process in case identity is doubtful (The Joint Commission, 2025a). This is the foundation of the Universal Protocol, which involves a series of verifications prior to the start of the surgery. In the Kota case, the responsibility seems to have been so diffused on the pathway that none of them took the responsibility to ensure that the error was stopped. This is a typical characteristic of unsafe systems, whereby all people in the system believe that someone has already inspected.

Another latent issue is related to workforce in the Indian health system. According to a recent scoping review of the problem of human-resource shortages in India, the industry is experiencing significant gaps in manpower and skill distribution, which could affect the quality and safety of the services (Mehta et al., 2024). Under these circumstances, employees might have an increased

propensity to take shortcuts or normalise risk. This is no excuse of the occurrence, but it aids in understanding why weak systems are moving towards unsafe practice.

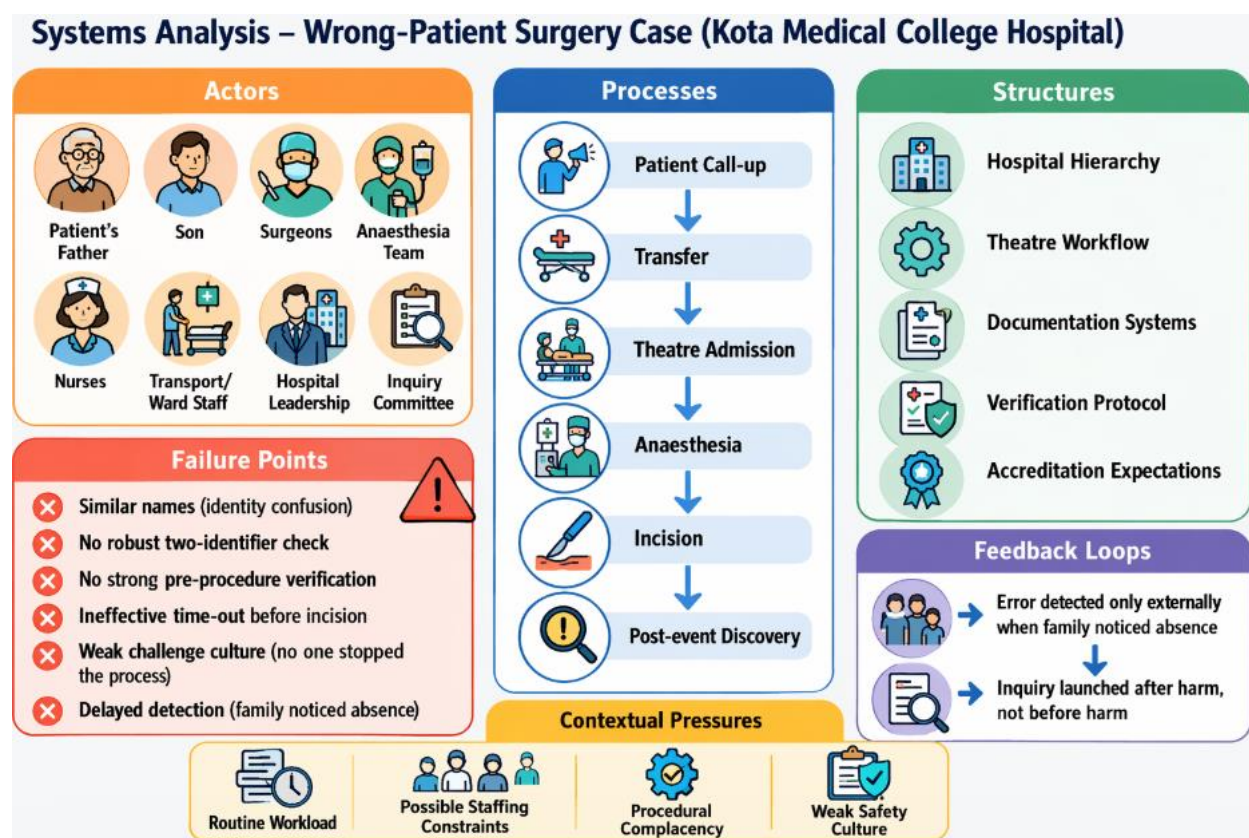


Figure 1: Rich Picture

A rich picture is also capable of visualising the case, and it can be used to clarify complexity (Barbrook-Johnson and Penn, 2022). The rich picture in this case would consist of the patient and his son, ward staff, theatre staff, anaesthesia team, surgeons, hospital management and inquiry authorities. It would also demonstrate other major processes like patient calling, transfer, documentation review, anaesthesia, incision and post-event discovery. The communication gap that is caused by similar names, as well as the failure to check identity and weak culture of challenge would be at the centre of the picture. A visual systems map would indicate that the error was a product of multiple interacting weak points and not a result of a single point.

The Kota incident, in general, is on the local governance level, as it was in a single hospital, and involved local theatre management. It also, however, creates regional and national issues as it is an indicator of the difficulty in converting patient-safety standards into a consistent practice in Indian public hospitals (National Accreditation Board for Hospitals and Healthcare Providers,

2025). The case is hence locally significant, and globally significant. A **wrong-person surgical procedure** occurred at Kota Medical College Hospital due to failure in patient identification and pre-operative verification processes.

2.2 Centralisation or Decentralisation within the Case Study

The Kota case seems to have taken place in an organisation, which is technically centralised but decentralised in terms of operations. Formally, Indian hospitals operate in accreditation standards, standard operating procedures, administrative structures, and policy anticipations pertaining to patient safety (National Accreditation Board for Hospitals and Healthcare Providers, 2025). That way, central decision making processes involve making key decisions on what needs to occur based on standards and governance systems. One of the biggest benefits of centralisation is that one set of non-negotiable rules can be applied throughout the organisation. In surgery, it involves the utilization of two identifiers, ensuring the right procedure, carrying out a time-out and escalating discrepancies (The Joint Commission, 2025a). The advantages of the centralised rule-systems are that they eliminate variation and clarify expectations. Standardisation can save lives in high-risk situations like in operating theatres. The incident at Kota Medical College Hospital highlights excessive decentralisation, where frontline staff made independent decisions without proper identity verification. Critical safety steps, such as patient confirmation and surgical checklists, lacked centralised control and enforcement. This imbalance allowed errors to occur. A safer system would combine centralised protocols for safety-critical tasks with decentralised flexibility for routine operations, ensuring both efficiency and patient safety.

But, centralisation has its flaws as well. One of them is that compliance may be performative and not meaningful. It is possible that the staff are aware of the fact that they are supposed to perform a checklist, yet they can fill it out in a mechanical way, not paying attention to the purpose of the safety (Habtie et al., 2025). This is very pertinent here under the understanding that the Kota case insinuates that though there may have been paper work procedures, it was not implemented in a manner that would have actually safeguarded the patient. This concern has been supported by recent evidence on surgical safety checklists. A systematic review has identified that the WHO Surgical Safety Checklist can deliver beneficial results when properly implemented, yet it is up to the extent to which teams practice it in reality (Alsadoun et al., 2024). Likewise a study conducted in a Level 1 trauma centre in India reported high compliance with certain checklist items and

variable compliance with others particularly in the time-out phase (Evaluating the WHO Surgical Safety Checklist Compliance at Level 1 Trauma Centre, India, 2025). This is important since it is during the time-out that the identity of the wrong patient should be detected and the procedure discontinued.

The use of checklists is also uneven in Indian regions as evidenced by Indian evidence. In one study of Tamil Nadu, there was some disparity in the use of the WHO Surgical Safety Checklist among surgeons (Use of WHO Surgical Safety Checklist among Surgeons in Tamil Nadu, 2025). An independent research by Bihar revealed that knowledge, attitudes and practices regarding the use of checklists also varied among the staff (Knowledge, Attitude and Practices Regarding Surgical Safety Checklist: A Study from Bihar, India, 2025). These results indicate that the problem of the Kota case was not whether there was a protocol or not, but whether the organisation had established the circumstances of the reliable use. Decentralisation is evident in the real-time dispersion of power to frontline workers. Small decisions made by nurses, anaesthesia staff, ward staff and surgeons determine the way safety policy is implemented (Leask and Macleod, 2023). Flexibility is the benefit of decentralisation. Employees are able to adapt rapidly to the local situation and patient requirements. But the drawback is inconsistency. When the verification process is overly relying on local customs or velocity or suppositions, then reliability is compromised.

This problem appears to be the exact case with the Kota case. The likely existence of formal standards was not able to hinder the frontline discretion which overrode verification. Unsafe practice may occur when local practices develop stronger than the central rules. The literature on collaborative leadership demonstrates that decentralised work may only be beneficial in cases when leaders establish trust, clarity and shared stewardship (The King's Fund, 2023). In the absence of those conditions, decentralisation has disjointed accountability. This problem is crucial in crisis management. Within a decentralised setting, a staff that is nearest to the patient should be empowered not only to proceed with the workflow, but also to halt it in case something appears off (Leask and Macleod, 2023). A healthy system allows a nurse or anaesthesia provider to stop the procedure in case the identity verification is doubtful. When senior figures are perceived to be the only decision-makers, the junior staffs might not even raise their voice when they perceive risk.

Simultaneously, decentralisation without effective governance brings about a diffusion of accountability. In the case of Kotas, it seems that no one person seems to have had absolute ownership of the entire verification chain. This implied that the admission staff, ward staff, theatre staff and surgeons would have thought that another individual had already done the necessary check. Such a broken accountability is perilous. Hence, the best way out is that the organisation required a hybrid structure. It needed centralised regulations on identity check and wrong-patient prevention, yet decentralised empowerment to enable any member of the team to challenge and halt dangerous action (The Joint Commission, 2025b). The Kota case demonstrates that formal hierarchy and the discretion of locals were not sufficient to save the patient.

2.3 Leadership Theories and Application to the Case Study

The theory of leadership can be used to understand why this wrong-patient incident went this far before anyone took any action. Most appropriate theories in this case are transactional leadership, transformational leadership, situational leadership and distributed leadership.

Transactional leadership

To start with, transactional leadership revolves around rules, monitoring, role compliance and clarity. This type of leadership is critical in surgery as checklists, signing-in processes, review of documentation and time-outs rely on a strict compliance with formal requirements (Salameh-Ayanian et al., 2025). The misplaced patient ought to have been halted during the initial check-up process had the transactional leadership been operating strongly at Kota. Rules were not enforced well as evidenced by the fact that the patient was taken to anaesthesia and incision. Nevertheless, transactional leadership cannot be effective on its own. A group can seem to obey but not to be safe. The literature on surgical safety is becoming more and more clear that checklists are completed not only nominally, but also meaningfully (Habtie et al., 2025). That is, effective safety performance does not necessarily exist by the presence of a rule. The Kota incident indicates that though staff may have thought that they were working by process, they were not working by process to ensure that the correct patient was the one being worked with.

Transformational leadership

Second, the transformational leadership is also very relevant as it is vision-driven, safety culture-oriented, motivational and committed to the shared goals (Hamdan et al., 2024). Rules do not often

help to avoid wrong-patient surgery. This is averted when the staff has a sense of personal responsibility in safeguarding the patient and is sure enough to question uncertainty. According to a recent systematic review, leadership style has an effect on the patient safety culture, further impacting care quality and staff behaviour (Althobaiti, 2025). A more transformational culture could have made the personnel in the Kota case doubt the belief that the man who responded to the name was the right patient.

Situational leadership

Third, situational leadership entails changing the behaviour of leadership according to the situation and the degree of risk. The same-name or similar-name situation is not an ordinary routine situation, it is a high-risk situation that needs increased attention (Does the WHO Surgical Safety Checklist Need Modification to Enhance Medical Safety in India?, 2024). A situational leader would be aware that the possibility of misidentification is enhanced by the presence of patient transfer, family separation and pressure on the theatres. This ought to have brought about more vigorous confirmation as opposed to regular advancement.

Fourth, lack of distributed leadership is evident in the Kota case. ***Distributed leadership*** refers to the fact that leadership tasks like questioning, checking and preventing harm are distributed among the team and not limited to the top (Leask and Macleod, 2023). The distributed leadership is essential in the theatre settings since no individual professional can view the entire system as a whole. A nurse can observe a discrepancy prior to the surgeon. Before cutting a physician can identify ambiguity in anaesthesia. Failure to empower these team members to act makes the system brittle.

This is supported by the ***collaborative leadership*** theory, which focuses on psychologically safe workplaces where individuals can make free contributions to a common cause (The King's Fund, 2023). That relates well to a BMJ Open Quality study that revealed that psychological safety determines the effectiveness of group use of the WHO Surgical Safety Checklist (Healthcare professionals' perception of the WHO Surgical safety checklist and psychological safety, 2024). When staff members are afraid of embarrassment or confrontation, they might not speak even when they are in doubt.

The broader safety environment can also be applied to realize leadership effectiveness. In a review of interventions to improve safety culture, the attitudes of staff and organisational learning were identified as part of safer systems (Effect of interventions to improve safety culture on healthcare workers and organisations, 2024). The other study demonstrated that wrong-patient ordering errors were linked to communication overload and disrupted digital workflow, implying that the leadership needs to address workload and cognitive load, as well (Lew et al., 2024). Though this study was on electronic orders, as opposed to surgery, the general lesson is still applicable: unsafe systems develop when both the design of communication and pressure are not well controlled. Newer studies of patient-safety also emphasize the significance of early warning and learning. Research in machine-learning has already started to find patterns that are related to wrong-site surgery, indicating that organisations can be more proactive in using data to identify new risks (Machine Learning Approach to Identifying Wrong-Site Surgeries Using Clinical Text, 2025). This is important as the case of the Kota seems to have been only spotted after the damage was already done.

What would you have done differently? Leaders ought to have initially ensured identity verification is not a ceremony but a hard stop. Second, they ought to have developed a culture of challenge where any employee could stop the process with impunity. Third, audit and incident-learning systems should have been employed to identify a vulnerability in the verification process prior to a major incident. A decade-long study of wrong-site surgery has indicated that the incidences still occur as reporting and learning is not uniform across the facilities (Taylor, Quesenberry and Yonash, 2026). The effects of mere teamwork interventions cannot be underestimated as well. A study about personalised surgical caps established that effective teamwork and communication in the operating room can be enhanced by better team identification (The Impact of Personalised Surgical Caps on Teamwork and Communication, 2025). Although these interventions are minor, they demonstrate that leadership should not only focus on the official policy but also on the real-life circumstances that facilitate safer interaction.

On the whole, the style of leadership in the case of Kota is rather reactive than proactive. The organisation appears to have looked at the workflow as a routine, instead of forecasting foreseeable safety risks. Greater leadership would have integrated transactional discipline, transformational

culture, situational vigilance and shared power. In the absence of such a combination, an avoidable mistake was turned into an actual damage.

2.4 Improvement and Lessons Learned

- The first lesson of the Kota case is that patient identification is an intervention of safety, not an administrative measure. Patient identification still remains at the center stage of safety concerns in the 2025 National Patient Safety Goals since wrong patient care is still an ongoing threat (The Joint Commission, 2025a). The concept of workflow continuity seems to be regarded more highly than that of verification reliability in this instance.
- The second lesson is that the presence of checklists does not ensure that they are effective. Surgical safety checklists are only effective when teams are proactive and sincere in their utilization (Alsadoun et al., 2024). Indian studies indicate that the compliance can appear good in certain areas and yet significantly low in the most communication sensitive stages, particularly time-out (Evaluating the WHO Surgical Safety Checklist Compliance at Level 1 Trauma Centre, India, 2025). The Kota case thus demonstrates how risky it is to believe that the presence of policies equates to the presence of safety.
- The third lesson is related to governance. The failure of governance here was not due to the lack of standards, but it was the failure to convert the standards into dependable bedside and the theatre practice (National Accreditation Board for Hospitals and Healthcare Providers, 2025). Good governance does not simply involve giving out policies. It involves audits, monitoring, obvious accountability and follow-up of leadership when poor practice is detected.
- Fourth, the fourth lesson is that safety culture and leadership go hand in hand. The leadership style influences staff challenge behaviour, openness and trust (Hamdan et al., 2024). The protocols will be more likely to take on meaning in practice where leaders facilitate speaking up and shared responsibility. In a hierarchical or passive leadership style, employees might not speak up when they are at risk (Althobaiti, 2025).
- The fifth lesson is that healthcare systems must transition away to responding to incidents to anticipating risks. The Kota case was an external, delayed detection, as the son only noticed the absence of his father after surgery (South China Morning Post, 2025). Very weak detection system. More superior organisations investigate the near misses, document

inconsistencies and discrepancy of informed consent as caution. A study of 1,166 reports of informed-consent and timing mistakes indicates that these administrative failures frequently open the door to wrong-site and wrong-patient surgeries (Risk Factors for Wrong-Site Surgery: A Study of 1,166 Reports of Informed Consent and Schedule Errors, 2024).

- Lesson Six tells that we must not rely on a single step, but design systems in a redundant way. Systems-thinking literature focuses on interdependence and adaptation over the mere linear blame (Thelen et al., 2023). This is what the Kota case shows. It was not each instance of a misplaced call of a name; the combination of habitual suppositions, culture of weak challenge, lack of verification and effective feedback.
- A last significant lesson is about the role of leadership in improvement. Health care leadership development should not be about administration and compliance. It should include communication science, human factors and systems awareness (Harris et al., 2022). Unless organisations develop such capabilities, they run the risk of repeating incidents which can be avoided even with existing policies.
- The incident at Kota Medical College Hospital provides critical insights into improving patient safety and strengthening healthcare systems. It highlights that preventable errors often arise not from individual negligence, but from weak systems lacking reliable safeguards.
- A key lesson is the importance of **strict patient identification protocols**. Hospitals must enforce the use of at least two unique identifiers, such as name and date of birth, verified against wristbands and medical records. Verbal confirmation alone is insufficient, especially in high-risk environments like operating theatres. This step should be mandatory and non-negotiable.
- Another major improvement area is the **implementation of standardized safety checklists**, such as those recommended by the World Health Organization. The Surgical Safety Checklist ensures that teams confirm the correct patient, procedure, and site before anaesthesia and incision. These checklists must not only exist but be consistently practiced and audited to ensure compliance.
- The case also underscores the need for **strong centralised control over safety-critical processes**. Introducing “hard stops” in the system—where surgery cannot proceed without proper verification—can prevent such incidents. For example, digital verification systems or barcode scanning of patient IDs can ensure accuracy and accountability.
- **Communication and teamwork** are equally vital. All members of the surgical team should feel responsible for patient safety and empowered to speak up if something seems wrong. Promoting a culture of openness reduces hierarchical barriers and encourages active participation in safety checks.

- Additionally, **clear separation between patients and attendants** must be maintained. Physical and procedural controls should prevent unauthorised individuals from entering clinical pathways, particularly pre-operative and surgical areas. Proper signage, staff training, and monitoring can support this.
- From a systems perspective, the incident demonstrates the need for **continuous training and reinforcement of protocols**. Regular drills, audits, and feedback mechanisms help ensure that safety procedures are embedded into everyday practice rather than treated as optional steps.
- Finally, the hospital must adopt a **learning-oriented approach** by conducting a thorough Root Cause Analysis (RCA). Instead of assigning blame, the focus should be on identifying system weaknesses and implementing long-term corrective actions.
- In conclusion, this case teaches that patient safety depends on **reliable systems, enforced protocols, and a strong safety culture**. By strengthening identification processes, improving communication, and ensuring accountability, healthcare institutions can significantly reduce the risk of such preventable and harmful errors
-

3. Recommendations

The actions to be undertaken next by the organisation should be realistic, supported and well connected with the failures that were observed in this analysis.

Create a hard-stop identity-verification route: The hospital is to implement a three-step compulsory way of identity verification of all invasive procedures. This must involve checking at ward handover, theatre check-in and last time-out before anaesthesia or incision (The Joint Commission, 2025b). At least two identifiers must be used at each stage and the patient must be matched with documentation and the theatre list. Scheduling systems should also be introduced with similar-name alerts (PSNet/AHRQ, 2024).

Go beyond completion of checklists to quality of checklists: The hospital must not audit the checklist as it is signed, but rather as it is spoken, shared and completed as intended (Habtie et al., 2025). External audits of observation would aid in identifying real compliance and form filling. This is significant since it has recently been discovered that the price of the checklist depends on the quality of implementation, not just on paperwork (Alsadoun et al., 2024).

Embrace an integrated leadership approach: The best leadership approach to maintain the improvement would be a blend of transactional, transformational, situational and distributed leadership. Transactional leadership is needed for rule enforcement (Salameh-Ayanian et al., 2025). Safety culture requires enhancement with the help of transformational leadership (Hamdan

et al., 2024). Situational leadership is needed to respond to high-risk contexts such as identity confusion (Althobaiti, 2025). All the staff should be provided with distributed leadership to intervene when they observe danger (Leask and Macleod, 2023).

Enforce governance and technical efficiency: Governance must involve routinely assessing identity discrepancies, near misses, incomplete time-outs and delayed reporting (World Health Organization, 2024). The organisation ought to create a safety dashboard of the theatre that monitors the checklist completion, similar cases, near miss, and response time to escalation. This would render the safety performance visible and enhance technical efficiency because it will focus the effort on the most significant risks.

Enhance allocative efficiency: The resources are to be concentrated on the areas which have the highest safety payback, such as verification of theatres, training of the staff, the use of digital tracking and organized handover practice (Mehta et al., 2024). This strategic distribution of resources would be more effective in strengthening safety than the thin distribution of resources on unrelated matters.

Create constant learning and engagement: The organisation must create a no-blame, high-accountability reporting culture in which employees can report near misses and identify discrepancies without being afraid (Effect of interventions to improve safety culture on healthcare workers and organisations, 2024). Where necessary, patients and families should also be a part of the verification as this can serve as an extra measure of protection (World Health Organization, 2023).

Redesign communication in theatre practice: The theatre process must consist of standardised read-backs, closed-loop communication and introduction of roles during time-out (Guidelines in Practice: Team Communication, 2024). Smaller interventions related to teamwork can be used to facilitate safer communication as well, such as visible team identifiers and ambiguity-reducing practices (The Impact of Personalised Surgical Caps on Teamwork and Communication, 2025).

To prevent similar incidents at Kota Medical College Hospital, strict enforcement of patient identification using at least two identifiers is essential. Hospitals should implement and audit the World Health Organization Surgical Safety Checklist at every stage. Introducing digital verification systems and “hard stops” before surgery can enhance accuracy. Staff training, clear

communication, and a culture encouraging speaking up must be promoted. Additionally, separating patients from attendants in clinical areas and conducting regular audits and Root Cause Analyses will strengthen system reliability and improve overall patient safety.

4. Conclusion

The case of wrong-patient surgery in Kota Medical College hospital was not a mere case of mix up. It was a system fault, with poor verification, feeble communication, ineffective accountability and poorly proactive leadership. Not only was an old man who had never stepped in the surgical pathway brought to the theatre, he was also anaesthetised and incised. This proves the fact that several safety barriers did not work simultaneously. Based on a systems-thinking analysis, the incident occurred as a result of the interplay of people, processes, structures, tools and organisational culture. It was not sufficient to have centralised rules since they were not implemented in the frontline in a dependable manner. Decentralised practice was inadequate since the staff do not seem to have been empowered to question uncertainty. There was too much reactive and too much procedural, not transformational, situational and distributed leadership. The most important lesson is that effective governance, leadership and operational design are essential in ensuring patient safety. It is seldom the case that one individual causes never events to occur. They are generated when systems allow ambiguity, accept routine compromises and do not learn on early warning signals. This is why to achieve meaningful improvement at Kota, hard-stop identity checks, authentic time-outs, collaborative safety culture and systems that learn before something bad happens is necessary. The incident at Kota Medical College Hospital demonstrates how system failures, rather than individual mistakes, can lead to serious patient safety events. The lack of proper identification, weak protocol enforcement, and poor communication contributed to a preventable error. Strengthening centralised safety controls, improving teamwork, and ensuring strict adherence to guidelines such as those by the World Health Organization are essential to prevent recurrence and enhance trust in healthcare systems.

Reference

- Althobaiti, F.M. (2025) The effects of leadership on patient safety culture in health care: a systematic review. BMC Nursing. Access link: <https://pmc.ncbi.nlm.nih.gov/articles/PMC12882623/>
- Alsadoun, L., Sanipini, S., Khleif, R., et al. (2024) Evaluating the Impact of the WHO Surgical Safety Checklist on Clinical Outcomes and Implementation Strategies: A Systematic Review. Cureus. Access link: <https://pmc.ncbi.nlm.nih.gov/articles/PMC11493453/>
- Barbrook-Johnson, P. and Penn, A.S. (2022) Rich Pictures. In Systems Mapping. Access link: <https://link.springer.com/book/10.1007/978-3-031-01919-7>
- Does the WHO Surgical Safety Checklist Need Modification for Improving Medical Safety in India? (2024) Access link: <https://pubmed.ncbi.nlm.nih.gov/38425830/>
- Effect of interventions to improve safety culture on healthcare workers and organisations (2024) BMJ Open Quality, 13(2), e002506. Access link: <https://bmjopenquality.bmj.com/content/13/2/e002506>
- Evaluating the WHO Surgical Safety Checklist Compliance at Level 1 Trauma Centre, India (2025) Access link: <https://link.springer.com/article/10.1007/s12262-025-04287-y>
- Guidelines in Practice: Team Communication (2024) Access link: <https://pubmed.ncbi.nlm.nih.gov/38924536/>
- Habtie, T.E., Feleke, S.F., Terefe, A.B. and Adisu, M.A. (2025) Beyond compliance: examining the completeness and determinants of WHO surgical safety checklist – a systematic review and meta-analysis. BMC Health Services Research. Access link: <https://link.springer.com/article/10.1186/s12913-025-12569-0>
- Hamdan, M., Jaaffar, A.H., Khraisat, O., Issa, M.R. and Jarrar, M.T. (2024) The Association of Transformational Leadership on Safety Practices among Nurses: The Mediating Role of Patient Safety Culture. Risk Management and Healthcare Policy. Access link: <https://www.dovepress.com/the-association-of-transformational-leadership-on-safety-practices-am-peer-reviewed-fulltext-article-RMHP>

Harris, R., Fletcher, S., Sims, S., Ross, F., Brearley, S. and Manthorpe, J. (2022) Developing programme theories of leadership for integrated health and social care teams and systems: a realist synthesis. Access link: <https://www.ncbi.nlm.nih.gov/books/NBK579233/>

Healthcare professionals' perception of the WHO Surgical Safety Checklist and psychological safety (2024) Access link: <https://bmjopenquality.bmj.com/content/13/4/e003154>

Knowledge, Attitude and Practices Regarding Surgical Safety Checklist: A Study from Bihar, India (2025) Access link: <https://pubmed.ncbi.nlm.nih.gov/40655724/>

Leask, C.F. and Macleod, S. (2023) Exploring the implementation and evaluation of a distributed leadership model within a Scottish, integrated health and care context. BMJ Leader. Access link: <https://pmc.ncbi.nlm.nih.gov/articles/PMC12038110/>

Lew, D., et al. (2024) Secure Messaging Use and Wrong-Patient Ordering Errors Among Inpatient Clinicians. JAMA Network Open. Access link: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2827227>

Machine Learning Approach to Identifying Wrong-Site Surgeries Using Clinical Text (2025) Access link: <https://pubmed.ncbi.nlm.nih.gov/39946709/>

Mehta, V., Ajmera, P., Kalra, S., et al. (2024) Human resource shortage in India's health sector: a scoping review of the current landscape. BMC Public Health. Access link: <https://link.springer.com/article/10.1186/s12889-024-18850-x>

National Accreditation Board for Hospitals & Healthcare Providers (2025 context) Access link: <https://nabh.co/>

National Health System Resource Center, India (2024) World Patient Safety Day Report 2024. Access link: https://qps.nhsrindia.org/sites/default/files/2024-10/WPSD%20Event%20Report%202024_reviewed_%20Final%20Draft_10102024.pdf

PSNet/AHRQ (2024) Wrong-Site, Wrong-Procedure, and Wrong-Patient Surgery. Access link: <https://psnet.ahrq.gov/primer/wrong-site-wrong-procedure-and-wrong-patient-surgery>

Risk Factors for Wrong-Site Surgery: A Study of 1,166 Reports of Informed Consent and Schedule Errors (2024) Access link: <https://patientsafetyj.com/article/117084-risk-factors-for-wrong-site-surgery-a-study-of-1-166-reports-of-informed-consent-and-schedule-errors>

Salameh-Ayanian, M., Lakkis, P., Jabbour Al Maalouf, N. and Makki, M. (2025) Leading through uncertainty: How transformational and transactional leadership shape employee satisfaction and performance in NGOs. Administrative Sciences. Access link: <https://www.mdpi.com/2076-3387/15/5/172>

Singh, H.K. (2025) Tale Of 2 ‘Jagdishesh’: Hospital Mix-Up Could Have Led To Unwanted Surgery. NDTV. Access link: <https://www.ndtv.com/india-news/kota-medical-college-tale-of-2-jagdishesh-hospital-mix-up-could-have-led-to-unwanted-surgery-8187530>

South China Morning Post (2025) Indian hospital probed after man mistaken and operated on while waiting for son’s surgery. Access link: <https://www.scmp.com/week-asia/health-environment/article/3307457/indian-hospital-probed-after-man-mistakenly-operated-while-waiting-sons-surgery>

Taylor, M.A., Quesenberry, M. and Yonash, R. (2026) Wrong-Site Surgery: A Study of 664 Events From 237 Facilities Across a 10-Year Period. Patient Safety. Access link: <https://patientsafetyj.com/article/156001-wrong-site-surgery-a-study-of-664-events-from-237-facilities-across-a-10-year-period>

The Joint Commission (2025a) National Patient Safety Goals Effective January 2025 for the Hospital Program. Access link: <https://digitalassets.jointcommission.org/api/public/content/9be383450fc941df806b76c5fbdd9ae6?v=3c600c3a>

The Joint Commission (2025b) All Programs 2025 National Patient Safety Goals Simplified. Access link: <https://digitalassets.jointcommission.org/api/public/content/3103ce682c16469a8d8d5425e9082df9?v=1912053f>

The King’s Fund (2023) The Practice of Collaborative Leadership: Across health and care services. Access link:

https://assets.kingsfund.org.uk/f/256914/x/1ed42745fb/the_practice_of_collaborative_leadership_2023.pdf

The Impact of Personalised Surgical Caps on Teamwork and Communication (2025) Access link: <https://pubmed.ncbi.nlm.nih.gov/40761607/>

Thelen, J., Fruchtman, C.S., Bilal, M., et al. (2023) Development of the Systems Thinking for Health Actions framework. BMJ Global Health. Access link: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10030275/>

Use of WHO Surgical Safety Checklist among Surgeons in Tamil Nadu (2025) Access link: <https://pubmed.ncbi.nlm.nih.gov/40061641/>

World Health Organization (2023) Patient safety. Access link: <https://www.who.int/news-room/fact-sheets/detail/patient-safety>

World Health Organization (2024) Global Patient Safety Report 2024. Access link: <https://www.who.int/publications/i/item/9789240095458>