



Commentary

Commentary on: 'The WHO safer surgery checklist time out procedure revisited: Strategies to optimise compliance and safety'

The review 'The WHO safer surgery checklist time out procedure revisited: strategies to optimise compliance and safety' is a thought-provoking overview of a simple yet under-utilized tactic to obviate operation room mishaps [1]. The 'surgical time-out', a pause to re-confirm and re-assess in terms of a checklist, is an expedient, efficient and common-sense safeguard, and I am sure this article will spark constructive introspection among surgical teams worldwide and inspire its wider implementation.

The authors identify lack of awareness of the importance as the major cause of low compliance. I would add complacency as a factor that could outweigh ignorance, and even override awareness. There is considerably greater awareness of the time-out than its low prevalence would suggest [2]. Most surgeons acknowledge the benefits of checklists (in surgery, as in life); equally, most do not time-out while operating, unless mandated by workplace protocol. The barriers to time-out adoption are often egotistical and subjective. Checklists are disdained as being akin to instruction manuals for novices, – new-fangled, time-wasting, amateurish, unnecessary or mere eyewash. Failing education, the only way past this impediment is legislation: mandating explicit check-listing in the form of a documented time-out, preferably on audio-visual record.

Other factors weighing against greater adoption of the time-out are socio-cultural sensitivities [3]. Some operation rooms are like a tribal fiefdom where no one dare question the chief. Hierarchical and interpersonal dynamics between surgeons, assistants, nurses and anaesthetists also vary between cultures and tradition. Only if senior personnel enthusiastically champion the time-out will juniors have the courage to speak up or raise questions. (Ironically, one disaster averted by this simple procedure is enough to convert the entire surgical team into ardent life-long proponents.)

The authors rightly recommend patient involvement where feasible. After all, no surgical procedure is routine to the patient; an informed and well-briefed patient can be an asset to surgical safety - one with a very personal interest.

Paradoxically, compliance can breed hazardous complacency. The time-out is eagerly adopted when first introduced, but soon becomes as routine as the procedures it is intended to check. This may result in perfunctory time-outs lacking in spirit that perilously raising complacency while eroding innate caution, like the wobbly balustrade on an elevated balcony.

Again, the best checklists are those home-grown from standard guidelines; this encourages ownership while ensuring that the time-out protocol has real-world applicability rather than abstract idealism. Modifications should reflect the local situation. For example, introducing all members of a surgical team would be farcical in, say, a rural hospital with a four-member staff. Instead, this step could be a re-defining of functional roles (as tasks tend to informally overlap in such teams). Again, a time-out need not be called once, only at incision; indeed, a pause to re-assess may be advantageous at any critical juncture during the procedure. In teaching hospitals particularly, this would be instructive to trainees, while fostering a culture of time-out check-listing by future safer surgeons.

References

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