



## Letter to the Editor

## A commentary on “The WHO safer surgery checklist time out procedure revisited: Strategies to optimise compliance and safety” [International Journal of Surgery 69 (2019) 19–22]



## ARTICLE INFO

## Keywords:

Time-out

Safer surgery

Never-events

Surgical environment

We took substantial interest in reading the article by Papadakis et al. [1] entitled ‘The WHO safer surgery checklist time out procedure revisited: Strategies to optimise compliance and safety’.

The article presents patterns of incorrectly implemented time-out procedures and suggests strategies to increase compliance of such procedures.

We agree, the original purpose of the surgical-time out was to reduce the rate of avoidable events caused by human error, through the implementation of robust and repeatable peri-operative processes [2].

As mentioned in the original article by Papadakis et al., the checklist can be triggered by any member of the wider surgical team. We feel this demonstrates an integral secondary function; to deconstruct the underlying hierarchy that permeates operating theatres worldwide and promote a more cohesive working environment [3]. In recognition of this secondary function, we feel a lack of compliance with time-out procedures masks a more pervasive issue surrounding the peri-operative environment. As discussed by McConnell et al., the progress of an operative procedure can be attributed to distinct individuals, with the operating surgeon often dictating the pace of the procedure. The time-out democratises the operating theatre and attributes operating progress equally amongst the wider surgical team, with its completion facilitating further progress. Poor compliance with time-out procedures need not only be attributed to a lack of awareness, but also critically to hierarchical constructs that dynamically affect the operative environment.

Papadakis et al. discusses the idea that academic centres demonstrate poorer compliance with time-out procedures than teaching hospitals. A theoretical mechanism for this discrepancy is not offered. We believe different surgical environments offer subtle hierarchical and human factor variation which could impact on uptake of time-out procedures, with further primary research required in order to investigate this discrepancy further.

As evidenced by the work of Berlinger et al. [4], when surgical leaders question the value of the time out checklist, they attempt to bypass the checklist in favour of individual methods. Russ et al. demonstrated that resistance from senior clinicians prevented wider implementation of time out procedures [5]. We feel there is a possibility that the compliance variation in time-out uptake could reflect deeper

human factor variation in differing surgical environments.

In order to increase compliance of time out procedures, we note that Papadakis et al. encourage the use of novel methods, such as an audio or electronic based timeout process. We disagree with the feasibility of these methods on a global scale. The original premise of the surgical time-out was to produce a robust procedure across the entire spectrum of surgical environments [2]. Surgical teams operating in resource-deficient areas cannot afford the luxury of costly adjuncts in order to increase compliance.

We strongly believe that increasing compliance is dependent on education of surgical teams, with operating surgeons and key stakeholders being involved in all aspects of this process. By explaining and reinforcing the original motivation for the introduction of the checklist, and disseminating this widely, we feel surgical teams will respond positively.

**Ethical approval**

Not applicable.

**Sources of funding**

None.

**Author contribution**

HK: Conception, Literature search, Writing.

MP: Literature search, Writing.

**Trial registry number**

Not applicable.

**Guarantor**

Harman Khatkar.

<https://doi.org/10.1016/j.ijss.2019.10.051>

Received 27 October 2019; Accepted 31 October 2019

Available online 09 November 2019

1743-9191/ © 2019 IJS Publishing Group Ltd. Published by Elsevier Ltd. All rights reserved.

**Provenance and peer review**

Not Commissioned, internally reviewed.

**Data statement**

Not applicable.

**Declaration of competing interest**

Not applicable.

**References**

- [1] M. Papadakis, A. Meiwandi, A. Grzybowski, The WHO safer surgery checklist time out procedure revisited: strategies to optimise compliance and safety, *Int. J. Surg.* 69 (2019 Sep) 19–22.
- [2] A.B. Haynes, T.G. Weiser, W.R. Berry, et al., A surgical safety checklist to reduce morbidity and mortality in a global population, *N. Engl. J. Med.* 360 (5) (2009 Jan 29) 491–499.

- [3] D.J. McConnell, K.M. Fargen, J. Mocco, Surgical checklists: a detailed review of their emergence, development, and relevance to neurosurgical practice, *Surg. Neurol. Int.* 3 (2012) 2.
- [4] N. Berlinger, E. Dietz, Time-out: the professional and organizational ethics of speaking up in the OR, *AMA J. Ethics* 18 (9) (2016) 925–932.
- [5] S.J. Russ, N. Sevdalis, K. Moorthy, et al., A qualitative evaluation of the barriers and facilitators toward implementation of the WHO surgical safety checklist across hospitals in England: lessons from the “surgical checklist implementation project”, *Ann. Surg.* 261 (1) (2015) 81–91.

Harman Khatkar\*

*Oxford University Hospitals NHS Trust, Headley Way, Headington, Oxford,  
OX3 9DU, United Kingdom*

*E-mail addresses:* [harmankhatkar@yahoo.co.uk](mailto:harmankhatkar@yahoo.co.uk),  
[Harman.Khatkar@ouh.nhs.uk](mailto:Harman.Khatkar@ouh.nhs.uk).

Max Prokopenko

*Oxford University Hospitals NHS Trust, Headley Way, Headington, Oxford,  
OX3 9DU, United Kingdom*

*E-mail addresses:* [maxprokopenko@hotmail.co.uk](mailto:maxprokopenko@hotmail.co.uk),  
[Max.Prokopenko@ouh.nhs.uk](mailto:Max.Prokopenko@ouh.nhs.uk).

---

\* Corresponding author.