How Diminishing Returns May Render The Surgical Timeout Ineffective

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Wrong site surgery is never acceptable. A surgeon ought never to find himself in a situation where he has to inform the family that he just operated on the wrong body part. It is embarrassing, unprofessional, and an egregious violation of the patient/physician covenant.

That being said, we have allowed this issue to be defined entirely in terms of "systems management". And hence the rise of the timeout and the checklist. The ultimate responsibility for identifying the proper surgical site has been diluted. No longer is it at the sole discretion of the operating surgeon. Now we have a team-based approach involving nurses, anesthesia personnel, mid level providers, and surgeons. Performance of a group timeout (of which I am actually a strong proponent) has quickly become the standard of care at most American hospitals prior to initial incision.

But the bureaucrats have taken a good idea and muddled it up in layers of unnecessary complexity. The simple timeout has been expanded and diversified. Now, for a routine elective surgery I am required to see the patient in the holding area for proper marking of the site (as applicable), to sign the H&P, and answer any questions the patient may have. This is a standard protocol. I have been doing exactly this same thing since I was a resident.

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