DR. WITHERSPOON
CHIEF OF STAFF

by J. M. MacDavid M.D.

Not Silly Anymore

Dr. Witherspoon, I feel I must relate two experiences of mine to you as you may find them useful for your series.

On the first occasion, I had a heavy schedule of knee arthroscopies. I saw each patient in the holding area and marked the proper limb according to the permit.

On about the third or fourth case, I entered the OR where the techs had prepped the right knee. I scrubbed, gowned and gloved, finished draping, put the tourniquet up then, holding the knife literally an inch from the skin, said, almost jokingly, "let's have a time out – we're doing the right knee, right?"

There was a moment's hesitation as the nurse flipped through the chart looking for the permit.

"No," she said.

"The left."

I couldn't believe it. I put the knife down, walked over to the nurse and looked over her shoulder at the chart. She was right. The patient was permitted for a left knee arthroscopy.

I yanked the drapes back and looked at the patient's left knee.

Staring back at me were my initials, drawn with a purple marker, right there on the left knee.

A few minutes and a fresh scrub and gown later, I was operating on the correct (left) knee.

On the second occasion, some years later, I was getting ready to do a total hip when the nurse ran through her time out routine. By then, the time out had been expanded to include allergies, pre-op meds, and various other details.

Barely listening, I caught the phrase: "forty milligrams of enoxaparin…"

"What did you just say?" I asked.

"The patient was given forty milligrams of enoxaparin in the holding area," she replied.

That was supposed to be a post-operative DVT prophylaxis order, not pre-op order. I looked down at the patient. She was a skinny little thing, not much more than ninety pounds, if that.

I couldn't risk a bleeding complication. I quickly discussed the situation with a colleague and we both agreed I should cancel the case. I did her surgery the next day and she did fine. I must admit, I considered the time out a little silly at first.

I'm a believer now.

Doctor Witherspoon Says:

Amen, brother.

Many doctors who have been operating for years thought the same thing, right up until it saved them at the last minute.

Couple of points.

In the first case, the doctor initiated the time out. The supervising nurse is supposed to do that. Everybody in the room should stop what they're doing and listen as the nurse makes the time out announcement. All should agree. The doctor initiating the time out is unusual. Good for him. Get involved, fellas, and don't cut until you hear that time out.

Second point. The previous surgery in that room was a right knee arthroscopy. When they turned over the room, nobody bothered to switch the knee brace to the other side of the OR table. When they wheeled the patient in, the supervising nurse allowed the techs to prep and drape the wrong knee simply because the brace was still on that side of the table. The room appeared to be set up for a right knee arthroscopy and nobody questioned it. That is a classic example of how a wrong sight surgery is generated.

Third point. Didn't anybody see that the surgical extremity was marked? The patient was lying there on the table with the doctor's initials on the left knee but they prepped the right one anyway. Not a person in the room noticed the obvious. I would have thought that nearly impossible.

One factor to consider is that this particular patient happened to be an African American. The purple markings don't stand out in such stark contrast as they do on Caucasians. Makes me concerned they may be a bit more at risk to miss the mark, so to speak. Something to think about.

The nurse in that first case needs a good talking-to. Sounds like her degree of awareness was pretty much down around floor level as was her attention to protocol. The doctor called the time out, for Pete's sake.

To the nurses who read about this episode, realize, you may be all that stands between the doctor who still thinks time outs are a nuisance and disaster. You literally have to be the responsible party. Don't give up on us. Stick to your guns, get that time out done and do it smartly.

In the second case, the doctor barely caught the word "enoxaparin" while looking at an X-ray on the computer. He nearly missed it. Dogonnit, when the nurse calls the time out, *listen* to the danged thing! Stop what you're doing and pay attention. You may hear something extremely interesting. The errant enoxaparin injection was the result of a ridiculously confusing set of pre-printed pre-op orders. The problem was quickly remedied.

Final point. As I write this, the time out is given right before the surgeon is about to start the case, after the patient has been prepped and draped. I think we should go back to doing it before the patient is put under anesthesia. If something comes to light that would prompt the surgeon to cancel the case, as occurred in the second incident, above, it would avoid an unnecessary spinal or general.

The bottom line is, folks, we need to the time out seriously. It wasn't invented just so we could make fun of it. Over time, we're finding out this thing really works! It can literally prevent disaster.