

Why don't my surgeries start on time?

It never fails to surprise me that when surgeons converse, invariably someone complains that the turnover time in his or her operating room is too long. The other gripes I have commonly heard are that the first patient of the day was not brought to the operating room on time, an orderly phoned in sick, the nurses are never ready on time, someone bumped me or the wrong surgical table was in my room. The reasons are a litany of grief. Health care optimization is a topic that is finally becoming important in Canada. Wait lists are now newsworthy and embarrassing to hospital administrators, at least in some provinces. We have been told that wait lists may dictate hospital resources in the future. Surgical delays are becoming more mission-critical problems. This issue of the *Canadian Journal of Surgery* presents 2 original articles that look at delays in Canadian surgical suites.

Wong and colleagues¹ took a unique look at data gathered and analyzed by 1 surgeon over a 9-year period. There seemed to be no communication of the recording of the delays to the operating room staff. Half of all cases in this study had a delay, with equipment failures and delays getting the patient into the operating room being the 2 major reasons. Wright and colleagues² looked at delays after an education process for surgical teams. The operating room staff was aware of the process and, theoretically, all personnel were attempting to optimize patient care. The most common reasons for delay were surgeon and anesthesiologist availability and a lack of preparedness of patients. The on-time starts improved with this process. However, 60% was the best on-time start rate achieved.

Certainly, many institutions have gone through this process for one reason or another. Our institution has made several attempts to examine of the flow of the operat-

ing room. These have included a 6-sigma approach, a Qmentum review and an MBA school initiative among others. Over a 5-year period, we have yet to see the final reports let alone the results from these studies. We have noted, as Wright and colleagues² reported, that a “huddle” is an effective way to engage operating room personnel. We also observed that it aggravates surgeons to have to change their morning schedules and that if a physician was not involved in at least part of the design, implementation or interpretation of the studies, the main reason for delay was “poor booking” or “surgeon not in the room.” This is in contrast with the findings of Wong and colleagues,¹ who report reasons unrelated to the surgeon for most delays.

The problems presented in these 2 articles hit home with surgeons every day. We need to be more involved in the process of gathering and analyzing data if the optimization process is to move forward. The results will be interpreted differently depending on who gathers and analyzes the data, so we need to be involved in as much of the process as possible to make the results more meaningful in day-to-day surgical experiences.

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References

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