Patient-Centered Operating Room Briefings to Improve Surgical Quality

To the Editor—Hicks and colleagues1 highlight several ways in which operating room briefings improve patient safety and surgical quality, citing 4 categories of outcomes in their Table 2 that are aligned with Medicare incentives to reduce 30-day readmission rates. The concept of quality, however, has grown increasingly multifactorial in measurement and application. For instance, of the 3 domains of quality in the Centers for Medicare & Medicaid Services’ Hospital Inpatient Value-Based Purchasing Program (clinical process of care, patient experience of care, and mortality outcomes), the patient experience of care counts for 30% of a hospital’s overall score.2 Whether patient satisfaction surveys are valid as an independent measure of surgical quality3 remains a subject of ongoing investigation, but the influence of the patient experience on what has been called the “trauma of hospitalization”4 merits attention, both in principle and as it applies to public reporting and hospital reimbursement.

Consistent with a patient-centered surgical culture, operating room briefings should, when possible, include personalizing details about the patient. This can be performed while identifying the patient during the time-out, and it need not be cumbersome or time-consuming. For instance, “This is Mr Jones, who had a right rotator cuff tear 6 months ago and hasn’t improved with conservative therapy. He also volunteers as a basketball coach at Central High. Today we’re going to do an arthroscopic repair so he can be ready for the upcoming season.” The addition of a few words of explanation in a few seconds of time elevates the briefing from being about Mr Jones, the rotator cuff repair case, to being about Mr Jones, the coach who needs his rotator cuff repaired.

That distinction is significant, and it benefits the patient experience. When a patient-centered briefing model was recently piloted at my institution, there was initially reluctance, akin to the implementation challenges outlined by Hicks and colleagues.5 But personalizing the briefing succinctly accomplishes 3 objectives: it introduces an unfamiliar patient to the operating room staff; it adds a human dimension to a briefing that is usually filled with technical jargon; and, importantly, it reminds all the participants of the culture of surgical safety and quality of which they are a part.

Certainly some of the improved outcomes associated with operating room briefings can be attributed to better staff communication or attention to prophylaxis. But in terms of the “supportive culture” to which Hicks and colleagues refer that sustains a commitment to surgical quality, patient-centered briefings underscore a key tenet of both perioperative teamwork and the patient experience: putting the patient first.

Kevin Koo, MD, MPH, MPhil

Author Affiliation: Department of Surgery, Dartmouth-Hitchcock Medical Center, Lebanon, New Hampshire.

Corresponding Author: Kevin Koo, MD, MPH, MPhil, Department of Surgery, Dartmouth-Hitchcock Medical Center, One Medical Center Dr, Lebanon, NH 03756 (kevin.koo@hitchcock.org).


Conflict of Interest Disclosures: None reported.


