**Title:** Surgical Pause

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Many surgical specialists focus on poverty, the loss of professional liability and increasing compensation insurance premiums. More important are the factors like politicians, the media and the public seemed quality, security and transparency (Sexton, 2006). Example is anaesthesia leading to improve quality and safety. This will ultimately lead to lower insurance premiums against malpractice. It is rarely now not understood by surgeons. Perhaps it is better to return to what is good for our patients operated on today's focus on rural or city guide (Michaels, 2007, 526–32). Surgical pause practice is more complicated than ever (Makary, 2006).

Wrong-site surgery is unacceptable. The surgeon never fined in a situation in which he told his family, he just works on the body. It is embarrassing, not professional and the patient / doctor, a serious violation of the Covenant (Kwaan, 2006, 353–8).

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Kao (2008) said surgeon leaves the problem and has fully defined in the Control position. Time management and letters begin to determine the dilution procedure. There are no ultimate responsibility lies under surgeon discretion. We now have a team approach involving nurses, anaesthesia, medium-sized institutions, physicians and surgeons (Kao, 2008).

However, officials have a good idea but confused mess. Single timeout expanded and diversified. Now, for routine elective surgery, they need to see the patient in the conduct of the earth on the label (if any), signed by H&P, and answer any questions one can have. It is the standard protocol (Holtgrewe, 2001).

The process is done in bed when a patient comes. This is called Connection. At this stage, we can confirm that we have the right of patients and recommend appropriate procedures. When the patient is asleep, and official Timeout comprises repeating the same facts. There were resolved steps one and two (Hendrickson, 2009).

Gardezi (2009) discussed to take a break before the transition gallbladder from one stage to another. They cannot see a list of safe cut of the cystic duct. The truth is that as soon as you can tell the patient's name, and procedure. It meets the appropriate antibiotics, and other relevant facts. Pertinent facts are more obscure, such as reading from memory, mumbling and blind

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(Goodell, 2006). Fourth, our nation, and the procedure name of the patient, not paying attention. View all down. We are in the fog settles a false sense of security. We do our best expectations! It can be a bad thing is not possible (Gardezi, 2009).

Nobody seems to have the right to law of diminishing returns. Repeat is sometimes harmful. The surgeon may be the beginning of another patient. I do not care the team unconscious mantra is repeated 50 times. Individual evaluation is false, all time-outs and breaks. This is centred in the world and will protect the patient against evil (Clarke, 2007, 395–405).

Tasks are too complicated with my main problem that it is a distributed entity only duty too focused on large systemic solutions. Errors are ultimate responsibility in place as the primary responsibility to one person: the surgeon. If it is so weak and irresponsible as it has be a team, multi- algorithm to avoid bad deeds place (Gardezi, 2009).

We are talking about professional responsibility. Lack or responsibility occurs when surgeons do not look at notes, re- examination of patients and do not have the controls memorial. It is on the way to their privileges revoked permanently. Management should release unprofessional surgeon to prevent the consequences of neglect (Clarke, 2007, 395–405).

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Safe Surgery Saves Lives challenge objective is to define a core set of safety standards. They can be implemented in all countries art safety of surgical care. Working group of international experts set up four areas: teamwork, anaesthesia, surgical services prevention of surgical site infection in the analysis of the literature and clinical experience measuring security in the world and the practice of consensus (Charlton, 2004, 1121-1122).

They were recruited with experience in surgery, anaesthesia, nursing, infectious diseases, epidemiology, biomedical engineering, health, improve the quality and related fields, as well as patient safety. In each region they also asked physicians around the world and other stakeholders' page to enter (Backster, 2007).

In January 2007, the first consultation improves the safety of surgical difficulty and examination. The operation is defined as the place with the participation of the operations section. To cut or manipulate tissue stapling generally require deep local or general anaesthesia or sedation for pain control in any application. This is allowed in the operation, there is no single recipe that will change the security. Operation is need to safely perform a variety of tasks necessary for care, not only surgeon but and team cooperation for the benefit of patients, health care professionals (Gettman, 2009, 1289-1296).

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The first attempts to prevent surgical pause focuses on the development of redundancy mechanism to determine the right place, the procedures and the patient. For example, it includes the initiative site showing the surgeon to clearly mark the signing procedure. However, it soon becomes clear that this seemingly simple solution is problematic (Haynes, 2009).

British efforts to prevent surgical pause said that although the agreement provides propaganda to make a website to increase the use of preoperative marking, application and enforcement of agreements vary specialty surgical hospitals and many doctors have expressed concern about the unintended consequences of the agreement (Kwaan, 2006, 353–8). In some cases, even confusion, written instructions say the operations or areas that should be avoided. Frequent site approval of the Joint Committee avoids surgical pause as main components (Sexton, 2006).

Analysis of the main causes of the problem surgical pause serial connections unlocked the potential to be an important factor. Surgery before taking into account the most important aspects of the program, all participants have been developed to improve communication in the operating room, Universal Protocol surgical pause considering suspending the concept of time limit (Hendrickson, 2009). Universal Protocol also stipulated all programs before using them. Although originally developed operational procedures takes a while before invasive procedures (Goodell, 2006). Comprehensive measures improve surgical safety rules safe list surgical time-out, and these letters were presented to enhance the security of the operation and postoperative low incidence surgical pause difficult intervention action can reduce or eliminate the author surgical pause (Gettman, 2009, 1289-1296).

Gettman (2009) argued that it is interesting to note that in many cases still occur surgical pause, Universal Protocol agreement is fully respected. An error may occur and the patient may be operating milled or invalid. The stress treatment can lead to errors. Finally, the combination of preventive measures surgical pause has system solutions, strong team culture and security, individual entries (Clarke, 2007, 395–405).

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