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THE INFORMED PATIENT

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Unsnarling Traffic Jams in the O.R.

Surgeons Lose Coveted Perk In Scheduling Procedures; Faster Service for Emergencies

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Hospitals have long offered surgeons a precious perk: scheduling the bulk of their elective surgeries in the middle of the week so they can attend conferences, teach medical students -- and leave early for the weekend.

But a growing number of hospitals are starting to challenge the practice, which safety and efficiency experts say is one of the biggest impediments to a smooth-running hospital. It jams up operating rooms and overloads nurses at peak times. When last-minute surgeries pile up over the Tuesday-through-Thursday stretch, as they inevitably do, surgeons scramble to handle urgent cases -- and patients scheduled for elective surgeries get bumped for hours and even days.

For patients, hospitals' efforts to spread out surgeries throughout the week means fewer canceled elective procedures, fewer delays for emergency surgery -- and better overall safety and care. Nurses are less likely to be burned out from back-to-back procedures and overtime.

At Boston Medical Center, a leading trauma facility in New England, delays and cancellations of elective surgeries were nearly eliminated after surgeons agreed to stop block scheduling and dedicate one operating room for urgent or emergency cases. There were just three cancellations in the April-September 2004 period, compared with 334 cancellations in the year-earlier period.

"For years people have blamed the emergency room for overcrowding, but it's really a matter of how the entire organization is managed," says Dennis O'Leary, president of the Joint Commission for Accreditation of Healthcare Organizations, which accredits 4,500 hospitals accounting for 95% of all inpatient admissions.

The commission has begun requiring hospitals to develop strategies to ease "patient congestion." That means smoothing out surgery schedules as well as pressuring doctors to discharge patients in the morning when possible instead of late in the afternoon, and assigning a "bed czar" to monitor the flow of beds and ensure patient rooms are prepared for new patients immediately.

ABOUT THE INFORMED PATIENT

Laura Landro is an assistant managing editor of The Wall Street Journal, and writes frequently about health care. Her column, "The Informed Patient," runs on alternate Thursdays. The column explains how to find information and use technology to aggressively manage your health care. Laura also occasionally writes the "Finicky Traveler" column for the Weekend Journal section. Laura joined the Wall Street Journal in 1981, and spent 20 years as a reporter and editor responsible for media, entertainment and marketing coverage. Her book, "Survivor: Taking Charge of Your Fight Against Cancer," was published in October 1998 by Simon & Schuster. She received a bachelor's degree in journalism from Ohio University.

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The commission is sponsoring a meeting in Boston tomorrow, where several hospitals -- including St. John's Regional Health Center in Springfield, Mo., Boston Medical Center, and New Hampshire's Elliot Health System -- will share data from three years of experience working on surgical-flow strategies developed with the nonprofit Institute for Healthcare Improvement. Some of the successful measures include reserving one or two operating rooms for emergencies, spreading out elective surgeries more evenly during the week, and scheduling nursing staff accordingly.


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For hospitals, spreading out elective admissions can actually boost revenue and cut costs, says Eugene Litvak, director of the Program for Management of Health Care Variability at Boston University, and IHI's expert on patient-flow strategies. Institutions that have adopted the programs can increase the number of surgeries performed by 10% or more, move patients through the emergency room faster, and reduce overtime pay to nursing staff. Ambulance diversions from the emergency room to other hospitals can be by cut by 40%, Dr. Litvak's studies show.

Keith Lewis, who heads Boston Medical's anesthesiology department, says that while surgeons initially resisted the changes, they have become satisfied with the results because their patients rarely get bumped now. "We've been able to take out the variability that destroys the system," he says.

The increased efficiency can also allow surgeons to do more operations. At St. John's, urgent or emergency surgeries were bumping hundreds of elective surgeries off the schedule each year, overtaxing the nursing staff. So St. John's spread out its elective surgical schedule and designated one out of 22 operating rooms for unscheduled procedures. Its group of 11 orthopedic surgeons agreed to spread their operating-room time over five days instead of two. With the extra hours they got in the process, they were able to perform more surgeries: Operating-room overtime is the lowest in recent history, and surgeons' revenue has increased by about 5%. Scheduled cases no longer have to be bumped, so the number of surgeries that have to be performed after 3 p.m. has dropped by 45%.

"Our scheduled patients aren't getting bumped and the unscheduled ones aren't waiting," says Kenneth Larson, a trauma surgeon and director of the burn unit. "When your belly hurts or your hip is broken, it doesn't make you happy to sit around for 12 more hours."

Dr. Larson says surgeons squawked about the new schedule at St. John's at first, since many were already used to haggling with anesthesiologists over start times and blaming each other for delays. But to get both groups to work together and adhere to new schedules and start times, the hospital offered a carrot and a stick: Doctors who were more than 10 minutes late 10% of the time were fined a portion of their fee; proceeds went into a kitty to reward those who were the best on-time performers. Another penalty: revoking the coveted 7:30 a.m. start time for surgeons, which cut the number of procedures they could do in one day. In the first quarter of 2003, surgeons' late starts dropped from 16% to less than 5% and are now less than 1%.

Of course, patients pushed to Friday surgeries may have to spend time in hospitals over the weekend, when staffing levels in general are often lower. But that may be preferable to being forced to wait for a hospital bed for hours after midweek surgeries or being transferred into a unit manned by another specialty group. At St. John's, orthopedic-surgery patients sometimes ended up being transferred to the ob-gyn unit where there were no nurses skilled in their care. And at Boston Medical, before the changes, patients often had to spend the night in the recovery room because there weren't enough beds available. When flows are improved, nurses are also less likely to be burned out from back-to-back procedures and overtime requirements.

Patients should ask hospitals about surgical scheduling policies when they book procedures -- including what contingency plans surgical units have if there is no bed available when they come out of surgery. Though aimed at professionals, the www.IHI.org[1] Web site also has more information about surgical scheduling and patient-flow issues at a number of hospitals around the world.

The promised improvements have already persuaded Cincinnati Children's Hospital to begin revamping surgical schedules at its 425-bed facility, according to Frederick Ryckman, Professor of Pediatric Surgery and Surgical Director of the Liver Transplantation program.

With 21 operating rooms booked about 90% of the time in advance, "we have to get much smarter about the way we manage the flow of health care, so when everyone arrives on the scene, the patients and staff match up to deliver top quality care, which is everyone's goal," Dr. Ryckman says.

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