

## Should we sequence urgent cases by category?

The answer to this question depends, partly, on the meaning of a case being *urgent*. An *emergency* case can be considered one for which the patient is likely to sustain additional morbidity and or mortality unless surgical care is started in less time than needed for a team to be called in from home. By knowing the hours (days) between emergency cases, decisions can be made on the need for an in-house team. An *elective* case is one for which the patient can wait at least three days for surgery without sustaining additional morbidity (e.g., Friday to Monday). An *urgent* case is one with a priority between *emergency* and *urgent*.

[Click here](#) for derivations of urgent case sequencing, [click here](#) for further development [PDF], and [click here](#) or [PDF] and [click here](#) or [PDF] for behavioral studies. Each is based on due dates for each procedure from the evidence-based literature. [Click here](#) for a lecture used in my [course](#). Appropriate decision making on the day of surgery depends strongly on appropriate staffing for urgent cases having been chosen months in advance by using the developed statistical methods. For example, suppose that a hospital is suffering from frequent overtime. Surgeons have urgent cases that can wait safely many hours, and there is OR time available (e.g., at 1:00 PM), but many surgeons are unavailable in clinics. This is commonplace ([click here](#)). Strategically, the surgeons' focus on seeing new clinic patients is best economically ([click here](#) [PDF] and [click here](#)). Change the OR staffing.

The use of deadlines by procedure serves to reduce anesthesia groups' costs. Suppose that a hospital is considering instead the use of categories (e.g., "Urgent class 1" cases to be performed within 4 hr and "Urgent class 2" cases to be performed within 12 hr). To assure no harm to patients, deadlines for categories must be based on the briefest deadline among the procedures within the category, not the midpoint or longest due date. Thus, surgeons may negotiate for the simplicity of the use of categories, as their use will reduce surgeons' and patients' average waiting times. The fewer the numbers of categories, the briefer will be the average wait.

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