Letter to the Editor

Psychological biases and their impact on operating room efficiency

To the Editor,

Arakelian et al. [1] studied qualitatively surgical teams’ perceptions of operating room (OR) efficiency. Although they state that ‘the lack of studies of this kind rendered it difficult to compare the results with those of others’, psychological studies complement the authors’ organizational (sociological) investigations [1, 2].

OR efficiency is influenced by team members’ biases that on average cases start late [3] and take longer than scheduled [4], that rescheduling cases has negligible cost [5], and that sustained personal clinical activity is best for reducing average turnover times [6] and over-utilized OR time [7, 8]. In contrast, when decisions are made based on maximizing the efficiency of use of OR time, cases on average start early, cases most commonly take less time than scheduled, rarely does cancelling cases other than for safety purposes reduce hospital or societal costs, and targeting specific ORs is often optimal to achieve the lowest average turnover times and over-utilized OR times [3–8]. Biases can be sustained through interactions among team members and by perceptions of how team activity influences the non-value added time that lean methods aim to reduce [6, 9]. Arakelian et al’s previous study [2] provided insight into how team members’ goals and perceptions may contribute to and/or sustain biases that then influence behavior [10].

Future investigations might merge these complementary threads of investigation to improve organizational performance. Since little is known about how individuals learn the biases observed, comparisons between Sweden and the USA may also be useful. Regardless, these psychological studies [3–10] suggest that Arakelian’s study of the perceptions of efficiency [1] may somewhat overestimate the ‘importance’ of ‘understand[ing] efficiency from both team members’ and their leaders’ point of view.’

References

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Franklin Dexter1 and Danielle Masursky2

1Department of Anesthesia
University of Iowa
Iowa City, IA, USA
2Department of Anesthesiology
Upstate Medical University
750 E Adams St
Syracuse
NY 13210, USA
Tel: +1-315-464-4867
Fax: +1-315-464-4905
E-mail: masurskd@upstate.edu