

The Sisyphean tasks of avoiding case cancellation

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The short-term cancellation of an elective procedure is an extraordinary challenge for process quality in surgical medicine. According to current literature, 5% to 20% of all elective surgery cases are cancelled the day of surgery.¹⁻⁷ Cancelling or postponing an operation poses considerable emotional distress on the patient⁸ and leads to long and repetitive episodes of starving with relevant negative physiological effects.⁹ Furthermore, the patient and, in some cases, health insurance companies have to carry extra costs for the prolonged duration of treatment.

Case cancellations are also a big problem for hospitals. The final operating room (OR) plan aims to optimize the use of the very expensive OR resources. If cases are cancelled on short notice, it is unlikely that this goal can be reached.¹⁰ In addition, the cancelled patient has to be rescheduled; in most cases, this requires extra time and effort. For inpatients the hospital stay is prolonged; for the surgeon and anesthesiologist, the case has to fit in their usually tight schedule within the next days, which leads to even more administrative and procedural problems.^{11,12}

Case cancellation has been reported by almost all surgical disciplines¹⁻⁷ and a huge variety of reasons have been reported, including medical, OR-organization based or administrative reasons.

In the study presented in this issue of *CUAJ*, Leslie and colleagues looked at the specific situation in urology in an academic institution.¹³ They found a cancellation rate over the total 5-year study period of 9.5%, which is well in the area described in previous studies. Interestingly they found a much higher cancellation rate in non-oncological cases. Additionally they took the effort to interview 29 of the 50 patients cancelled in the 2009 calendar year. Most patients interviewed said they were notified of the cancellation shortly before the surgery, some even less than an hour before the scheduled time of the operation. Most of the patients did not assume that postponing their surgical procedure had any negative impact on their health and over 60% agreed that the issue was handled appropriately. However, the patients

did report a modest amount of additional emotional stress because of the cancellation.

The study sheds further light on the patients' perspective of cancellation. This is of great importance, because all too often medical institutions do not focus enough on this issue.

In a recent large multicentre study, I and my fellow colleagues found considerable differences in the case cancellation rate, not only among different disciplines, but also among hospitals of different sizes and academic status.⁷ University hospitals, especially, seem to face many challenges in organizing their OR-processes. Even within university hospitals, there are big differences in the case cancellation rate – a fact that cannot be explained by the type of surgery performed or the patients served in the specific institution.

We, therefore, must accept that it is largely in the hand of the single institution and its personnel: is the OR plan realistic or overbooked? Was the patient work up sufficient? Are the implicated physicians communicating well with each other? The driving force behind this is this question: How much do we care about it? Every institution should consider such a rigorous approach described in the study by Leslie and colleagues: measure the cancellation rate by predefined categories and ask the patient about their perspective.¹³ It might sound like a Sisyphean task, but it would benefit all of us.

Competing interests: None declared.

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