

Block Scheduling Isn't a Calendar Problem: It's a Trust Problem

By Pat Mews

Block scheduling breaks for one reason above all others: nobody trusts the numbers enough to act on them. Fix that, and the calendar takes care of itself.

Start with why it matters. When a recruiter calls a prospective surgeon, the first question is almost always, “How much block time will I get?” Directors who schedule every hour at full capacity cannot answer. That is why open time should be built into the schedule intentionally. It is the “only level” for recruiting a high-volume surgeon or accommodating a new surgeon who has not yet earned a full block.

The dysfunction that follows is rarely about scheduling; it is about governance. A tenured surgeon keeps time they no longer fill, others grow frustrated, and no one trusts the data enough to resolve it. The solution is a dedicated scheduling committee, separate from the OR steering committee, so scheduling does not dominate every agenda. Include a tenured surgeon, a newer surgeon, anesthesia, the director, the surgery scheduler, a trusted data owner, and a scheduler from the busiest surgeon's office. Anesthesia should review the numbers before they go to the steering committee, and a physician should present the report. The same data carries more weight when it comes from a peer than when it comes from the director.

None of this works without standard definitions. The same procedure may have five different names across five offices—GYN is often the worst offender, so build the schedule around CPT codes. Surgeons already trust that language because it is how they bill. Define the clock in writing as well: first case start, release time, and turnover. Post those definitions where staff and surgeons will see them. One minute past 7:30 is late, with no exceptions. Grace periods do not stay at five minutes; they become ten.

Measure minutes, not just case counts, and involve the CFO to connect utilization with contribution margin. A surgeon can run a full day of cases and still lose money for the hospital. When that happens, the answer is operational support—implants, staffing, or help for a slow-closing PA—not a lecture. Release blocks proactively when a surgeon cancels or travels, rather than waiting for the phone to ring. Require new block requests in writing so the committee, not the director alone, makes the decision.

Publish performance data but protect people in the process. Rank surgeons by letter, not name, and take the information to the steering committee before sharing it more broadly. Questions about who “Surgeon C” is should be handled one-on-one, never in a meeting.

This is not about the director's authority. It is about earning trust through clean data, clear definitions, a shared language, and consistent governance. Then, using that trust to create the flexibility to say yes when opportunity comes through the door.