Operating Room Planning

Agent based system analysis and design

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**Abstract**

Für Interessierte, die sich innerhalb kurzer Zeit einen Überblick über den Inhalt eines Berichts verschaffen wollen, ist das Summary (eine halbe bis anderthalb A4-Seiten das geeignete Mittel. Die Zusammenfassung soll die folgenden fünf Aspekte beleuchten: Problemstellung, Problemlösungen, allenfalls mit Varianten, Hauptergebnisse, Schlussfolgerungen und Vorschläge für das weitere Vorgehen. Die Zusammenfassung entscheidet – zusammen mit dem Inhaltsverzeichnis – ob die Leserin, der Leser den Text eingehend studiert oder gleich beiseitelegt.

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# Introduction

The aim of this report is to present analysis and design of an agent based system which is capable of handling the “Operating room planning” problem.

# Purpose of Agent System

The Operating Room Planning (ORP) problem describes a dynamic environment in which clients in general share a common goal: getting well as soon as possible. Survival is one of the strongest instincts of a human which means that a client, who finds himself trapped in an environment such as the ORP describes, his desires are pretty straightforward and normally don’t change. In contrast, his believes and intentions may change. Unfortunately, once a client falls into the custody of a hospital, his believes and intentions become irrelevant.

The problem of the ORP which has to be solved is therefore not managing the individual wishes or handle the clients differently because of their distinction in believe. It is about live and death and how latest can be minimalized, which becomes more and more difficult due to increasing surgery demand. Health care is a huge building which requires several administrative instances and since there are numerous clients and just limited resources a clever client management system is inevitable.

Each client has its own health status and his own path of welfare it has to go through. In order to achieve the ORP goal, maximize the success rate of surgeries and minimalize the cost, a very simple but effective method has to be applied: Prioritization. Unfortunately the prioritization alone does not solve the problem hospitals are confronted with. The most difficult part it to manage a plan which allows increasing efficiency, flattening out peak demands and save costs. The ORP is therefore an optimization problem.

In this paper we discuss a multi agent system approach in order to fulfill the systems requirements and produce a plan which achieves the design objectives. The facts that the client status may change at any time and the health of a human, as well as the applied medical measurements are everything else than predictable, make the environment dynamic and complex. Both characteristics which fit an agent solution approach. We identified different instances, i.e. departments, which have common interests and different kind of resources which have to be allocated. These circumstances lead us to declare the departments as agents which are able to state their desires and communicate. The purpose of the agents is therefore to interact with each other in a dynamic environment in order to achieve a local as well as global optimum.

# Agent Architecture

## General Agent System Architecture

The Operating-Room-Planning problem consists of two major challenges: Creating a successful schedule, but also be able to react in emergency cases.

The Agent-System has to handle the general patient cases, referred as long term planning, where an optimal schedule is the resulting artifact. Emergency cases, referred as short term planning, must also be handled, and are always in a higher priority than the general patient cases.

Due to the dynamic nature of patient cases (e.g. a general case can always become an emergency case), the Agent-System needs a reactive part for handling emergency cases yet the overall problem solving must be handled by a pro-active part for long term planning.

Therefore, the approach is to design the Agent as a Hybrid Agent [1; *Wooldridge, An Introduction to Multi Agent Systems* ] includes both – reactive event handling as well as proactive planning.

This leads to layer architecture for the Agent, where the layers are organized hierarchically; the most basic reactive behaviors are in the top layers, the long term planning in the bottom ones.

The primary layers are identified as a reactive layer for handling environment changes and a planning layer for the long term planning. The reactive layer may affect the planning layer, as the emergency case handling may result in a reprioritization of the overall situation.

## An Agent who can learn and modify itself

So far, talked not about a learning machine; that is, the some Agents in the MAS may contain an AI (artificial intelligence) based upon a learning system. A learning system can be designed in several ways which overall define its autonomy as well as its potential to change itself.

Making decisions, based upon analysis of the history, is a simple learning system. Still, the programmer can control the behavior very precisely and predict its behavior. However, such approaches are not really dynamic and adaptive by design. (If the programmer can predict the behavior of the system exactly, it is not very adaptive.)

We will now analyze the possibility of applying genetic programming to our Agent System.

### Genetic Programming

More advanced approaches of a learning AI use genetic programming, also known as evolutionary algorithms. They work basically with an initial set of solutions (a population) and are able to modify the given set of solutions by either mutate a existing solution or recombine them into new ones. Now the population is tested against a utility method and then the score of each solution is used to determine a prioritization. All of this is done as fast as possible and repeated thousands or millions of time.

That means, that we need to be able to simulate the outcome of a given solution in a short amount of time to sample a lot of solutions, otherwise we cannot use this approach.

A solution can be a simple entity, holding some parameters, which then are changed. But a solution can also be a part of the Agents own Code, which can be changed by the Agent himself. The later is what we will talk about now.

In order to use genetic programming to modify code, we have to define the “Genes” as pieces of Code.

The Agent has a set of predefined Methods given as well as some control-statements – those are the genes. Those genes can now be assembled and ordered in nearly unlimited ways. The agent modifies the code by reordering, adding and modifying the given statements and runs the new Code against its utility simulation method, to compare the strength of the new Code.

The only way to “control” such a system is to limit the available Methods (Genes) to the evolutionary algorithm. It should be clear, that it is not possible to prove that the real behavior of the AI as well the development of it follows a strict pattern.

### Artificial neural networks

Artificial neural networks are yet another approach creating an AI, which is capable of learning. It is a simulation how our brain works, using the current knowledge in this field. The neural network models a network with nodes (Neurons) connected to each other by different weighted paths, sort of a weighted Graph. In the process of learning, some connections become stronger other weaker, building better paths.

A trained neural network becomes something, which can no longer be understood by a human. It is just not readable but a bunch of floats, representing some strength of a path.

Key point is of the unpredictability of both of the approaches (evolutionary algorithms as well as artificial neural networks). A system, which is able to modify itself to a certain grade, becomes unpredictable. At least, it is not more predictable than a human.

### The ethic issue when machines decide over live

The autonomous agents may run into dilemma situations where all decisions may result in loosing one or more lives. Consider the following situation:

### The ethic schedule dilemma

Lets assume the following hypothetical situation in a hospital, running an Agent system for scheduling operations.

The current waiting list has 4 emergency cases of patients {A, B, C, D} at the top. All 4 patients need to get their operation within 3 hours – or they might die. There is only one operating room left, the others are not available for whatever reasons. The estimated operating time for each patient shall be defined as {A(4h), B(1h), C(1h), D(1h)}.

|  |  |
| --- | --- |
| Patient | Estimated surgery duration |
| A | 4h |
| B | 1h |
| C | 1h |
| D | 1h |

A rational decision is made easy. If we operate patient “A” first, all the other patients are likely to die. If we move “A” to the bottom of the queue, it is very likely to save all but A. So we have one live versus three. The Agent system may therefore decide that patient A will die for the sake of a better global optimum.

It is a sad situation, but you might agree with the decision of the Agent nonetheless.

Lets now identify our patients given by the following table. We introduce moral factors.

|  |  |
| --- | --- |
| Patient | Identity |
| A | Lucy, 11 years. |
| B | Marcel, 48 years, Father of Lucy |
| C | Petra, 89 years |
| D | Rob, 82 years |

Is the decision still that clear? Is a young live more worth than an old one? Is the wish of one person (a Father is likely to die for his child) less worth than the rational decision?

A human hardly can answer those questions. How can we think of an Agent to answer them? And, if a Agent system answers those questions, which acceptance will they have?

### Conclusion of Agents capable of learning

In the above example, you might argue that the situation is very hard, but there might be rules at some point to guarantee a given protocol. So, some parameters like live expectancies might influence the decision (which is off course highly questionable). Either way, the problem exists with or without having a learning system.

But it gets even worse with a machine which can learn is responsible for such decisions. If we bring the genetic programming approach and such dilemma situations together, we exactly run into this kind of situation.

In the end, the machine decides based upon its learning experience and passed evolution what should happen. Also note, the Agents behavior will not be predictable because the system is able to modify itself. Even if the decision of the Agent is 100% rational and correct, it is a decision of a machine, which judges about life. We do not even talk about errors in software – which are very likely to occur in such complex systems.

Would a hospital trust the decisions of such an Agent system, which is able to learn and modify itself? Would you trust in a computer program that constantly modifies itself?

Albeit this technology seems to be very interesting, the lack social acceptance of such technology will be a deal breaker.

Therefore, in such a social high sensible environment like a hospital, a system, which can change itself, seems to be the wrong place to put such experimental technologies into action.

# GAIA Methodology

## Introduction

Regarding the GAIA Methodology we consider the following steps as most relevant:

* Subdivision of System
* Environmental Model
* Organizational Rules
* Role Model
* Interaction Model

We wanted to make sure that we have selected steps of both analysis and design. Since the artifacts “Agent Model” as well as “Services Model” are very time consuming because of their high degree of detail and due to the fact that the Agent Model pretty much matches our Role Model, we left these two steps out.

However, in the following paragraphs we will discuss the Operation Room Planning problem within the above defined topics of the GAIA Methodology. In addition, we will first describe the requirements of the system. Although the requirement elaboration and elicitation process is not included in GAIA it is essential to have solid knowledge about them.

## Vision

The vision of approaching the Operating Room Planning problem with an agent based system is to optimize surgery scheduling in order to improve surgery efficiency, minimize peak demands and save costs.

## Requirements

* The system needs to be able to do long term planning
* The system needs to be able to do short term planning
* The system has to adjust the planning in case of sudden changes of patients state

## Subdivision of System into Sub-Organizations

We separated our system into the following sub-organizations:

* Patient Manager
* Patient Departments (including Surgery Waiting List System)
* Operation Room Provider
* Surgeon Teams Provider
* Postoperative Provider
* Operating Room Planner

### Patient Manager

We consider patients as entities. The Patient Manager holds all the patients and assigns them to the corresponding departments based on their medical issues. Emergency cases will be assigned to the emergency department.

### Patient Departments

We consider each department as an individual agent with its own desires, believes and intentions. The desire of a department is to heal its patients. Each patient has its own health status and its own path of welfare it has to go through. The path itself is the product of a patient’s health status and several rules within the ORP (see Organizational rules). The patient’s may intent to skip steps of his path in order to shorten his healing process. However, the system does not allow such behavior. A patient’s path can only be shortened by the system due to negative changes of a patient’s health status.

Each department has its own patients based on its field of medical expertise. Each department contains a surgery waiting list system consisting of 2 separate waiting lists; one list for surgeon appointments and another for surgery appointments. Each department is responsible for its own waiting list and therefore defines the prioritization of the patients based on department-related indicators.

### Surgeon Team Provider

In order to allow an adequate level of abstractness we do not consider individual surgeons but rather whole surgeon teams. Each surgeon team consists of a set of employees which is defined by the system rules (see Organizational rules). Every team is identified by their field of expertise which defines in which field of surgery the team is specialized. The Surgeon Team provider has an overview of the team’s availability.

### Operating Room Provider

The Operating Room Manager holds all information about the individual operating rooms. It knows which operating room is able to handle which kind of surgeries based on the room equipment and has an overview of the room’s availability.

### Postoperative Provider

There are postoperative resources within the hospital care such as wards and the ICU (Intensive Care Unit). Each ward as well as the ICU contains a certain available space to offer. The Postoperative Manager is responsible for all these units and is therefore able to provide information about the availability of them.

### Operating Room Planner

The Operating Room Planner has several input sources. On the one hand it receives requests from the different departments, which provides the planner with information about what kind of operations are next. With the gathered information the planner knows what kind of resources it needs in order to fulfill the surgery demand. On the other hand the planner has different input sources, i.e. the surgeon teams and the operating rooms. Based on the requests and the resources the planner is able to generate an always up to date output, which would be a plan of all the surgeries defining which operation should be carried out when, where and with which team.

## Environmental Model

The environmental model of the ORP consists of an information system containing different types of entities and agents. Patients as entities build the input of the system. The output is an always up-to-date plan of surgery procedures. The core attribute of a patient is its health status which is the base for the patient’s periodization within the system. Furthermore, patients get assigned to departments based on their medical issues. The fact that a patient’s health status may change at every time makes the environment dynamic.

In order to achieve the system objectives the departments can communicate with each other and are able to bid for resources, i.e. operating rooms, surgery teams and post-operative measurements. We will present more information about the interaction in the section “Agent Interaction”.

## Organizational Rules

* A patient has to follow its assigned path of welfare which means he has to fulfill the following preconditions in order to proceed:

|  |  |
| --- | --- |
| Step | Precondition |
| Appointment waiting list | Referred from primary care |
| Outpatient appointment | Passed appointment waiting list |
| Surgery waiting list | Passed outpatient appointment |
| Surgery | Passed surgery waiting list |
| Use postoperative resources | Passed surgery |
| Discharged | Passed postoperative ward or ICU |

This rules only has effect as long as a patient’s status is not declared as an emergency case

* Each surgeon team consist of a specified allocation of employees
* An emergency case has always a higher priority as a non-emergency case
* The following artifacts must be available in order to proceed a surgery:
  + 1 operating room, which matches the required equipment
  + 1 operating team, which matches the required field of expertise
  + Post-operative measurements (available resources in ward or ICU)

## Role Model

In the following section we defined the most important roles according to the GAIA concept. [1]

**DpApWlHandling (Department Appointment Waiting List Handling)**

Description This role is responsible for managing the appointment waiting list of a department

Permissions

Read healthStatus //health status of incoming patient

Read ApWaitingListStatus //read status of appointment waiting list

Change ApWaitingList //put patient on appointment waiting list

Responsibilities

Liveness: DpApWlHandling = (HandlePatient, InformSurgeonTeamProvider)

Safety: ApWaitingListStatus != empty as long patients are requesting

**DpSyWlHandling (Department Surgery Waiting List Handling)**

Description This Role is responsible for managing the surgery waiting list of a department

Permissions

Read healthStatus //health status of patient

Read SyWaitingListStatus //read status of surgery waiting list

Change ApWaitingList //put patient on surgery waiting list

Responsibilities

Liveness: DPPatientHandling = (HandlePatient)

Safety: ApWaitingListStatus != empty as long patients are requesting

**DpGoodsRequest**

Description This role handles the bidding for the needed goods

Permissions

Read healthStatus //health status of incoming patient

Read SyWaitingListStatus //read status of surgery waiting list

Request Goods //bid for needed goods

Responsibilities

Liveness: DpGoodsRequest = (AnalyzePatient, RequestGoods)

Safety: RequestGoods as long surgery package is not feasible

**DpProposalCall**

Description This role is responsible for sending calls for proposals to other departments

Permissions

Read packageInormation //To find out which goods are missing

Send call for proposals //send task (problem) to solve to other departments

Responsibilities

Liveness: DpProposalCall= (AnalyzePackages, CallingProposals)

Safety: CallingProposals as long surgery package is not feasible

**DpAnswerCall**

Description This role is responsible for answering proposal calls from other departments

Permissions

Listen Proposal calls //listen to eventual calls for proposals

Send proposal //send proposal for the received task

Responsibilities

Liveness: DpProposalCall= (ListenForProposalCalls, SendProposal)w

Safety: always ListenForProposalCalls

## Interaction Model

In the following section we defined the most important protocols according to the GAIA concept. [1]

**InformSurgeonTeamProvider**

Purpose inform the surgeon team provider that appointment has been made

Initiator DpApWlHandling

Responder SurgeonTeamProvider

Inputs Appointment

Outputs Confirmation

**RequestGoods**

Purpose Bid for the needed goods in the corresponding auctions

Initiator DpGoodsRequest

Responder operatingRoomProvider, postoperative provider, surgeon teams provider

Inputs Surgery waiting list, patient’s health status

Outputs Requested goods || reject information

**CallingProposals**

Purpose Send calls for proposals in order to solve the given task (problem)

Initiator DpProposalCall

Responder DpAnswerCall

Inputs The task which has to be solved (missing goods)

Outputs proposal || requested good || nothing

**SendProposal**

Purpose Send answer for proposal call

Initiator DpAnswerCall

Responder **DpProposalCall**

Inputs The tasks (problem) solution: missing goods

Outputs confirmation by initiator

# Agent Interaction

## Introduction

We made ourselves several thoughts about how to approach the interaction handing. We consider both, the CNP and the Auctions approach, as very interesting and both of them have characteristics that fit our architecture as well as some that don’t. An auction approach fits due to the fact that we have several individual agent with own desires and resources to fulfill them. The CNP approach fits because we have several instances which need to solve a task which they can’t on their own. Once we analyzed these characteristic and realized the above mentioned facts, we concluded it makes sense to make use of both approaches to build our interaction model.

## Interaction Model

The main interaction in our ORP system happens between the different departments and the resources. Each department is self-interested to a certain degree and tries to achieve its own goal, which would be to get all the resources it needs to put its patients into surgery. Therefore, departments are surgery agents which “protect” their own patients. We consider the resources as goods, i.e. surgeon teams, operating rooms and postoperative measurements such as beds in a postoperative ward or in the ICU. For each type of resources there are one-sided auctions for which departments are allowed to bid. The sellers offer teams, rooms and beds for periods which are not yet reserved. Bidders submit bids for the wanted goods. The price they offer to “pay” is the health status of their next patients represented by a calculated value. Of course the departments do not really pay but the value is needed in order for the seller to determine which department, more precisely which patient will receive the goods. If a bidder wins it will receive confirmation about it. As soon as surgery package is feasible, the surgery appointment for the corresponding patient is fixed. Furthermore, departments are able to interact with other departments in means of solving tasks (CNP). These tasks represent the needed surgeries. For example: If a department was not able to “buy” an operating room for a given time span, it can initiate a task which would be to make this specific surgery package feasible. Different departments which may have a room at the given time but still miss another resource may be willing to help. This is why departments are just self-interested to a certain degree.

The emergency department is the only one which does not bid, since it immediately needs resources rather than planning a surgery. Some resources are always put on hold for emergency cases.

## Prisoners Dilemma

# Agent Communication

Consider the following diagram, showing the defined subsystems and Agents, and the interaction paths between them:

Resource Managers

OP-Room-Provider

Team-Provider

Post-OP-Provider

Emergency Department

Some Department

Some Department

Patient Departments

# Register of Illustrations

[Abbildung 1: Logo FHNW (Quelle) **Fehler Textmarke nicht definiert.**](#_Toc305602880)

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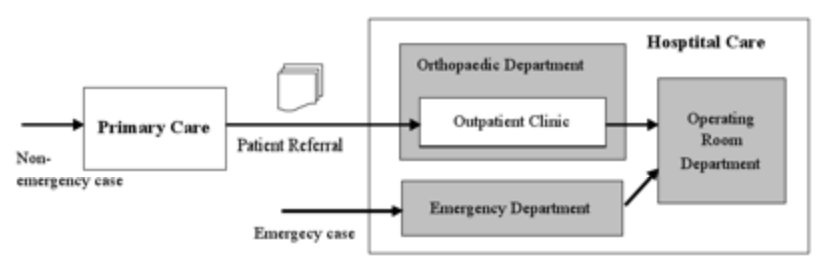
# Appendix 1 – Operating Room Planning

## Introduction

Most countries today, try to adjust to increasing demand and cost for healthcare services. One of the most expensive areas in healthcare is surgery, which necessitates many expensive resources in terms of staff, equipment, and medical resources. Generally, these resources have to be managed and divided between several departments within the hospital, e.g., orthopaedics, gynaecology and general surgery, in order to meet the total surgery demand.

## Operating Room Planning

The operating room planning includes both short term planning and long term planning, i.e., emergency cases and non-emergency cases. Non-emergency cases are described as elective cases and are commonly referred from primary care to a specified department within the hospital care. Before surgery is decided, the patient generally meets the surgeon at the outpatient clinic, i.e., the hospital care. Emergency cases commonly enter the Operating room department passing through the Emergency department as illustrated in Figure 2. However, there are exceptions to this rule; for instance, an elective patient admitted to an inpatient ward can suddenly become an emergency surgery case due to unexpected complications.



In general, the elective surgery process starts at primary care. The patient is then referred to specialist care for an outpatient appointment. If surgery is decided, the patient is then put on hold for surgery. In reality, the *surgery waiting list* system consists of two waiting lists; one, waiting to meet the surgeon specialist at the outpatient appointment, and one, waiting to be scheduled for surgery after the appointment. Moreover, there is one surgery waiting list system representing each of the operating departments and which are separately managed, i.e., one waiting list system at the Department of Orthopaedics (as depicted in Figure 2), another one at the Department of General Surgery and at the Department of Gynaecology, and so on. Consequently, the allocation of operating room resources affects every surgery waiting list system. In addition, the Operating room department also has to consider a variety of postoperative resources when planning. After surgery, the patients are monitored in a postoperative ward for circulation and respiration, but also for assistance with analgesic before being transferred to the ward or directly discharged. In addition, some patients will need postoperative intensive care and consequently have to be transferred to the Intensive care unit, (ICU) after surgery.