



Systems Can be Harmful to Patients

"Every system is perfectly designed to achieve the results it gets."

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Don Berwick has stated and taught us all that every system is perfectly designed to get the results it gets. If we get bad results in system performance, it is a result of system design. If we want to achieve better results, we have to redesign the system. System design is not accidental. It is choice and intentional.

In my work I see numerous examples of poor system design and choice that lead to poor system performance. Some of the poor performance affects only the operational components of the system, while other designs also have a direct and adverse effect on patient care and clinical outcomes. Common harmful mistakes include:

1. "**Access by denial**," where practices require all patients to make appointments each day, and refuse to make any future appointments. This choice, driven by a desire to get open space on the daily schedule and a desire to reduce no-shows that are directly related to the time lapse between when an appointment is promised and when it is delivered. It also puts patients at risk for being "lost to follow-up." There is evidence that supports this. We really do need methods to track needed follow-up both for prevention needs and for patients with chronic illness. This "urgent care" model approach is designed to lose patients to follow-up, and is risky for patients.
2. Practices or providers who insist on **over-paneling** put patients at risk. Each provider has a capacity limit. Exceeding that limit means that patients will either be forced to wait or will be forced in one way or another to see another provider. The patients that are forced to wait the longest are those with the least acuity to their needs (the preventive and surveillance patients). These patients are, ironically, the ones we know we can help and influence if we see them within the recommended threshold. Making them wait past the threshold, which is inevitable if the provider is over-paneled, is risky. I would say that this is intentional. In other words, we know that we could do things differently and we choose not to.
3. Practices that choose to **ignore the value of continuity**, of linking patients to specific providers (creating the patient-provider panel), have made a choice to deliver random care. All the data and evidence demonstrates that this random care is simply not as good as continuity care. Again, this is a choice, and a bad one. And the argument can be made that since the adverse care profile is an inevitable consequence of this choice and the practice chooses this, the outcome is intentional.
4. Practices that **fail to take the opportunity** to manage all patients' potential concerns at each visit, particularly in environments where we get one shot with patients - homeless adolescents, for example - can put these patients at risk. I commonly see these behaviors in

pay-by-the-visit systems, where either the enterprise or the provider is paid or incented by the visit, and the expressed incentive or pressure is to churn visits, not to manage the patient and the panel.

These four situations are the most common instances where system design can and does adversely affect patient care. These circumstances all involve choice, and if the inevitable consequence of that choice is adverse clinical care, then my conclusion is that the outcome is a direct result of the choice and is deliberate and intentional. I do not believe that practices choose to directly harm patients (“I want to harm people”), but systems can certainly be designed that result in this inevitable outcome. System design is a choice, and if we choose systems that will harm patients, I make the argument that this is intentional because we do (or can) know better.