The 12 Laws of Healthcare Operations

The hidden physics of flow, capacity, and reliability — and how to design for it.

Huddle-board edition — write on it.

TIER I — THE PHYSICS OF FLOW

Laws 1–5

1. **The Invisible Work Law**
   Coordination work expands wherever visible efficiency leaves no room for it — migrating into after-hours, into memory, and ultimately into error.
2. **The Utilization Paradox**
   Past a point, higher utilization buys sharply accelerating delay. A system pushed toward 100% is not efficient; it is seizing.
3. **The Variability Cascade**
   Small, unbuffered variations compound across departments until routine delay becomes clinical risk.
4. **The Fragility Principle**
   Maximum utilization converts loose coupling into tight coupling. Ordinary disruptions become system-wide collapse.
5. **The Coordination Tax**
   Every handoff costs capacity. When information moves slower than clinical need, the system pays in delayed care.

TIER II — THE STRUCTURAL CONSTRAINTS

Laws 6–10

6. **The Team Familiarity Effect**
   Stable teams build the shared mental models that reduce friction — and, the evidence indicates, lower mortality risk.
7. **The Workforce Stability Rule**
   Reliability tracks team stability. The relationships that carry coordination dissolve faster than headcount can replace them.
8. **The Discharge Bottleneck**
   Exit velocity governs capacity. A hospital rarely runs out of beds; it runs out of discharges.
9. **The Clinic Capacity Illusion**
   A schedule booked to 100% is, for new acute need, already closed.
10. **The Measurement Error**
    Systems move toward what they measure. Manage the wrong number and you reward the behaviors that destabilize care.

TIER III — DESIGNING FOR RELIABILITY

Laws 11–12

11. **The Slack Requirement**
    A protected buffer of idle capacity is not waste. It is the infrastructure of flow, safety, and learning.
12. **The System Design Law**
    Optimizing a single part degrades the whole. Reliable organizations engineer global flow, not local productivity.

SPOT IT → FIRST MOVE

diagnose in the huddle, act this week

TIER I	Spot it: waits growing while everyone works harder	→ **First move: plot your unit's own wait-vs-utilization curve.**
TIER II	Spot it: full beds, closed schedules, strangers on every shift	→ **First move: measure exit velocity and the Stranger Ratio.**
TIER III	Spot it: every fix pops up as a new problem elsewhere	→ **First move: protect one buffer and defend it for 90 days.**

KEY METRICS — how to measure the three moves above

Log what you find in the 12-Week Huddle Guide (in the Team Kit).

- **Your own curve** — time the same routine task, same clock, on a light and a full day; report both times, not a ratio.
- **Exit velocity** — two numbers, separately: % discharges out by noon + median order-to-physically-out (ADT/EHR timestamps).
- **Stranger Ratio** — non-core shift-hours ÷ total shift-hours; core = permanently assigned here. Local proxy — trend within your unit; don't benchmark across hospitals.

Which law is your unit fighting today?

Today our friction is _____ (Law ____) Owner: _____

Scan for all 3 kits —
Operator · Team · Classroom & Policy