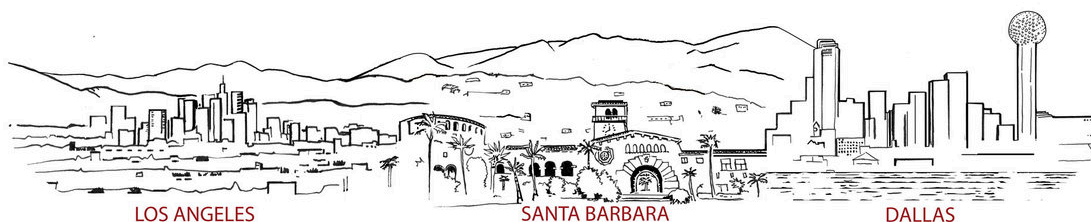


# WEISS



December 19, 2025

Dear Clients and Friends,

From time to time, I'll be using this space at the top of the newsletter to share insights reserved for subscribers, in addition to what we ordinarily publish. This is where you'll see it first.

Mark

## **SUBSCRIBER EXCLUSIVE**

### **Perception: The Strategic Asset Most Medical Groups Ignore**

#### ***A strategic blind spot in medical group governance and negotiation***

You're likely overlooking one of your medical group's most important assets. And, it's nowhere on your balance sheet.

I'm addressing the concept of perception management, something that on the governmental level is the subject of many millions to billions of dollars of coordination and effort.

In the business context, too, perception management is an extremely valuable strategic asset.

Lost on (nearly) all medical group leaders is the fact that perception itself can be deliberately managed as a strategic asset.

At the governmental level, this is obvious. Countries invest many millions to billions of dollars coordinating how populations perceive not just policies or actions, but the very concept of the country. China's Belt and Road Initiative, TikTok, and related efforts are examples of this. All major powers engage in perception management aligned with their national interests, cultural styles, and doctrines.

## **A Meta-Level Strategy**

The same logic applies to your medical group. You can, and must, manage how it is perceived, both as an organization and within the broader context in which it operates.

I'm not talking about PR. I'm not talking about vague concepts of goodwill as used in a non-balance sheet sense. And I'm not talking about marketing.

Rather, I'm talking about an overarching, meta-level strategy that works both internally and externally for the preservation of your group, the expansion of its success, and the projection of its authority, reputation, and trust.

In this context, perception management supports internal factors such as governance, morale, and structure, and external factors such as the terms of exclusive contracts, relationships with referral sources, facilities, patients, payors, and so on.

## **Context Versus Perception**

Every relationship occurs within a context, and at that level there are familiar tools such as framing, contractual control, and similar mechanisms that attempt to influence outcomes.

But what I am describing operates at a different level altogether: the management of perception itself. Because entities are run by individuals, controlling individual perception ultimately controls the perception of entities.

The implication is straightforward. You do not necessarily have to change substance if you can change the perception of substance.

## **Internal and External Consequences**

Internally, just as countries use perception management to build and focus the loyalty of their citizens, medical groups can use it to align their physicians and staff with the group's strategies and goals.

Externally, let's use the example of an existing contractual relationship, e.g., an exclusive contract, between your group and some facility, which at some point in time, will be renegotiated for another term.

Every point of messaging, whether or not in person, creates an impression, a perception, in the minds of the hospital administrators and staff, the hospital board, and third party influencers with whom you will be dealing in regard to the next negotiation. That means that you have an opportunity to manage what that perception will be over a significant period of time. This has more to do with negotiation than what most negotiation experts think negotiation is.

Failure to manage perception comes at the cost of lost leverage in negotiations and lost cohesiveness within your group.

To explore whether unmanaged perception is affecting your leverage or internal cohesion, [contact me](#).

## Hospitals and the Return of the Company Town

If you want a useful analogy for what's happened to physicians over the past few decades, skip guilds, skip unions, and skip "burnout culture."

Look instead at the company town.

In the late 19th and early 20th centuries, company towns were common in mining, railroads, and manufacturing. Employers didn't just provide jobs. They owned the housing, the stores, sometimes the schools, and occasionally the police.

Workers were often paid in scrip (that is, coupons or fake money), usable only within the company town: They paid you in fake money to work and then you paid them back in fake money back to live. If you were able to save for your fake future, it was in fake money.

No one needed to be coerced. The arrangement solved real problems. Housing was scarce. Work was unstable. Infrastructure didn't exist. The company town offered predictability and convenience.

And for a time, it worked. But then it didn't.

The problem was structural. When a single institution controlled employment, income, housing, food, and social standing, independence became nearly impossible. Leaving meant losing everything at once. Negotiation was theoretical. Loyalty became compulsory. Heck, it was the covenant not to compete on steroids.

Hospitals today are not coal companies. But the parallels are hard to miss.

Hospitals increasingly control not just where physicians work, but how they are paid, how referrals flow, what technology is used, what data is accessible, and what constitutes “acceptable” practice. Employment is marketed as support, as “relief” from billing, regulation, staffing, and capital constraints, just as company towns once were.

Most physicians didn’t “sell out.” They made rational decisions in an increasingly irrational environment

But when one institution controls your income, your schedule, your referrals, your infrastructure, your data, and your professional legitimacy, the relationship changes.

Credentialing becomes leverage. Scheduling becomes authority. Metrics become judgment. Exit becomes expensive long before it becomes impossible.

Company towns didn’t end because they collapsed overnight. They ended because alternatives emerged. Public infrastructure. Labor mobility. Independent housing. Once those existed, the monopoly no longer made sense.

Hospitals will remain essential in one form or another. That’s not the question.

The question is whether hospitals need to function as company towns for physicians.

History suggests they don’t. And when alternatives become viable, as they are now, dependence stops looking like safety and starts looking like inertia.

As difficult as it might appear, there are multiple ways out.

**Let’s talk** when you’re ready to break free.



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Your Weekly Dose of Schadenfreude: Pink Slipped

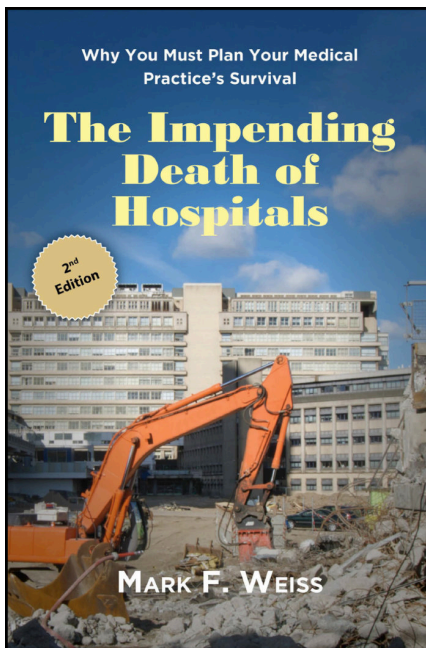


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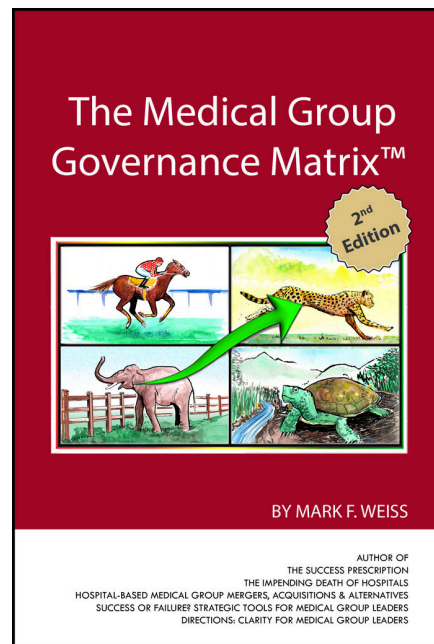
## Your favorites, updated.

Two of our most popular publications are back with current statistics and the same urgent message: You must plan for your group's continued success.



**Hospitals gorged on “aligned” physicians. Now it’s evident that integrated care delivers neither better care nor lower costs. And now, technology is mooting many of the reasons for a hospital’s existence. How can your practice survive in the post-hospital world?**

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**An inadequate governance structure can cripple your medical group’s ability to make effective decisions. Are steering your group toward disaster? The Medical Group Governance Matrix introduces a simple four-quadrant diagnostic tool to help you find out.**

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**When you're ready, here are 4 ways I can help you  
and your business:**

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