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Physicians Fooled into the Ruse of Health System Reform (or, Cows Can't Reform a Farm Because Farmers Will Never Eat Grass)

When physicians recognize that something fundamental is wrong within a business or institution, their first instinct is often to reform it. After all, if the system is producing bad outcomes like burnout, disengagement, and inefficiency, then surely the solution is to fix it.

Health systems encourage this instinct. They invite feedback. They form task forces. They convene committees. They launch initiatives.

From the outside, this looks like responsiveness. And, from the inside, it often feels like movement.

But reform in institutional settings like modern healthcare almost always fails. That's not because the ideas are bad, but because reform is structurally constrained.

Think of it this way: Just because you're moving, don't assume you're actually going anywhere. You might just be on a treadmill.

Reform Begins After Authority is Gone

The first problem with reform is timing.

Reform efforts begin after control has already been centralized. By the time physicians are invited into redesign conversations, the core architecture is no longer negotiable.

Infrastructure ownership is fixed. Payment arrangements are locked in. Referral networks are established. Compliance systems are entrenched.

Reform is allowed only at the margins.

Physicians may be asked to redesign workflows, refine metrics, or improve communication, but they are not invited to change where authority actually resides.

This creates a predictable outcome: engagement without power.

Participation Might Be a Trophy, but it is not Authority

Most reform initiatives emphasize participation. Physicians are invited to the table. Their voices are heard. Their concerns are documented.

But participation is not authority. Decisions continue to be made upstream, constrained by financial, regulatory, and organizational imperatives that reform committees do not have the authority to touch.

Over time, physicians recognize the pattern. They are being asked to help implement decisions or, worse, to shill for them, not to shape them. Reform becomes advisory theater.

The cold, hard fact is that hospitals and health systems do not exist to maximize professional autonomy. Most simply exist to remain solvent, or solvent enough.

Reform proposals that threaten margins, introduce variability, or reduce centralized control are quietly neutralized. This is not malice. It is institutional logic and C-level self-interest.

Symbolic Concessions Replace Structural Change

When real reform is impossible, institutions offer symbolic concessions.

Titles are created. Committees and advisory boards are expanded. Town hall sessions multiply.

These gestures are not meaningless, but they are insufficient because they are simply the creation of the appearance of inclusion without with redistribution of power.

Physicians eventually sense reality and instead of the effect hoped for by administration, symbolic reform often accelerates disengagement because it highlights the limits of influence more clearly than silence ever did.

The Reform Trap

Once physicians recognize that reform cannot impact actual control points, they face several choices.

The first two choices are perceived as easy. They can either continue engaging in processes that cannot succeed or they can stop making an effort in regard to reform. Many choose the second, not out of apathy, but out of self-preservation; like a fly, one can bounce headlong into the glass only for so long before giving up.

The third is perceived as far more difficult, but that perception is not reality: It's to stop asking how to fix the system and instead to ask where else you could practice.

The Shift That Reform Cannot Deliver

Once physicians start evaluating alternatives such as independent practice, partnership structures, expense sharing arrangement, verein-like collaboration, specialty centers, direct contracting, and so on, the thought of having to reform an ossified institution loses its lock on you, and its power.

Reform assumes the institution remains central.

Exit assumes it does not.

Considering that even 60 years ago, hospitals were essentially appendages to physician practice, not the owners of it as they position themselves today, why assume the worst?

Inside the 2026 Medicare Physician Fee Schedule

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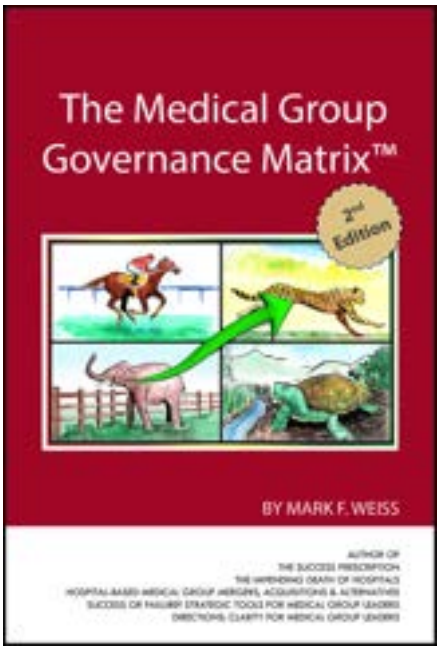

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