

WEISS



February 13, 2026

Physicians are, by training and temperament, skeptical people. You don't accept a diagnosis without evidence. You don't rely on a treatment plan that hasn't been tested. And you certainly don't confuse aspiration with reality when the stakes involve patient care.

And yet, time and again, physician group leaders, smart, experienced, and otherwise hard-nosed, regularly fall prey to a simple proposition when dealing with hospitals: "You can trust us."

Sometimes it's stated explicitly. More often, it's wrapped in a longer story about partnership, alignment, shared mission, long-term thinking, or "how we've always done things." But the substance is the same. The hospital is asking the medical group to rely on assurances that are not included in the contract.

And, too often, physicians do.

This isn't because physicians don't understand, intellectually, that trust must be earned through observed behavior, consistency, and accountability rather than mere statements. Physicians understand that perfectly well, at least in every other context.

The problem arises because physicians are conditioned to believe that "good faith" will fill in the gaps left by missing contract terms.

It won't.

There's a substantial body of psychological research showing that explicit claims of trustworthiness, e.g., "trust me," "we'll do the right thing," "we're different", and so on, are poor predictors of actual trustworthy behavior. Trust is assessed, consciously or unconsciously, based on incentives, past conduct, and enforceable commitments. In other words, people do not reliably behave better simply because they say they will.

Physicians generally know this. Hospitals know it too.

Which raises the obvious question: why do hospitals ask that medical group leaders rely on such assurances even in the most important of agreements, such as exclusive contracts for hospital-based services?

The answer is simple. Because it works.

Hospitals are sophisticated repeat players. They understand that once a deal closes, leverage shifts. They also understand that many physicians are uncomfortable pushing for detailed protections because doing so "feels" adversarial, uncollegial, or distrustful. So, the hospital offers reassurance instead of specificity and frames any insistence on contractual clarity as unnecessary, or worse, as evidence that the physicians "don't trust us."

That framing is powerful. It shouldn't be, but it is.

The result is a familiar pattern. The contract is silent or vague on key issues such as staffing levels, support services, termination triggers, governance input, growth commitments, or post-transaction economics. When problems arise (and they always do), the hospital's response is not, "Yes, you are right! We promised," but rather, "Show me where it says that."

And of course, it doesn't.

At that point, physicians often feel blindsided, betrayed, or "burned." But the reality is harsher: they relied on trust statements where only enforceable obligations could protect them. The hospital didn't breach the contract. It simply exercised it.

None of this is an argument against trust, cooperation, or long-term relationships. It is an argument against confusing personal trust with institutional incentives, and against mistaking reassuring language for legal commitment.

Hospitals qua entities do not act; people within incentive structures act. Those incentives change over time, often quickly, and often in ways that have nothing to do with the individuals who made the original promises.

If something matters to your medical group, whether economically, operationally, or professionally, it must be addressed in the contract. If it's not there, you should assume it will not happen, regardless of how many times you are told that it will.

“Trust us” is not a covenant.

“Trust us” is not consideration.

And “trust us” is certainly not a remedy.

Physicians are trained to verify. When it comes to hospital relationships, that verification must take the form of clear, specific, enforceable contract terms. Anything else is hope masquerading as strategy.

And hope, as many physician groups have learned the hard way, is a very expensive substitute for a contract.

Some Timely Takeaways For You

1. If it matters, put it in the contract. If you care about it, and it’s not in writing, assume it will not survive the first budget cycle, leadership change, or strategic pivot.
2. Reassurance is not a substitute for specificity. Statements like “we’ve never done that,” “we wouldn’t do that,” or “you know us better than that” are not protections. They are conversational tools designed to avoid putting obligations on paper.
3. Do not confuse trust with alignment of incentives. Hospitals act through incentive structures, not sentiment. People change. Priorities change. Financial pressure changes everything. Contracts are how incentives are managed when alignment disappears, which it eventually will.
4. If asking for clarity is framed as distrust, pay attention. When a hospital characterizes reasonable contractual protections as unnecessary or “adversarial,” that should tell you something important about how disputes will be handled later, when the stakes are higher and the relationship is strained.
5. Assume leverage shifts the day the deal closes. Before signing, you have leverage. After signing, you mostly don’t. Plan accordingly. Problems that can’t be fixed contractually up front are rarely fixed later through goodwill.
6. Hope is not a risk mitigation strategy. Many physician groups that feel “burned” were not misled; they were simply optimistic where discipline was required. Optimism belongs in clinical innovation. Contracts require pessimism.

As former President Ronald Reagan said, “trust but verify.” In hospital–physician arrangements, verification does not come from conversations, shared mission statements, or assurances of partnership. It comes from enforceable contract language.

Anything else is just a promise, and promises are remarkably easy to keep until they aren’t.



Your Weekly Dose of Schadenfreude: Double Stacked

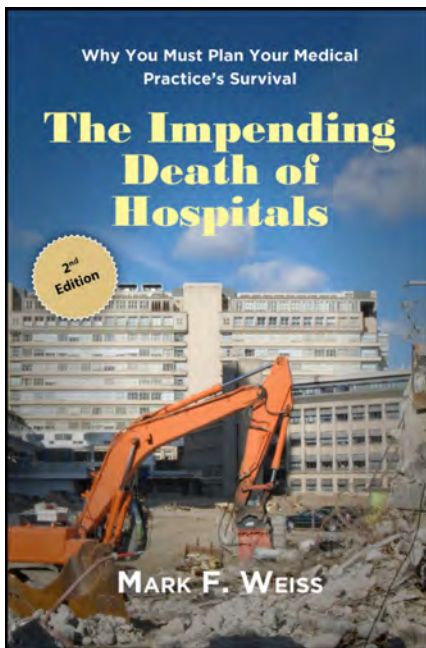


If this story made you think twice about compliance, don't wait for the next headline to find you.

Contact me to discuss protecting your reputation, your license, and your *future*.

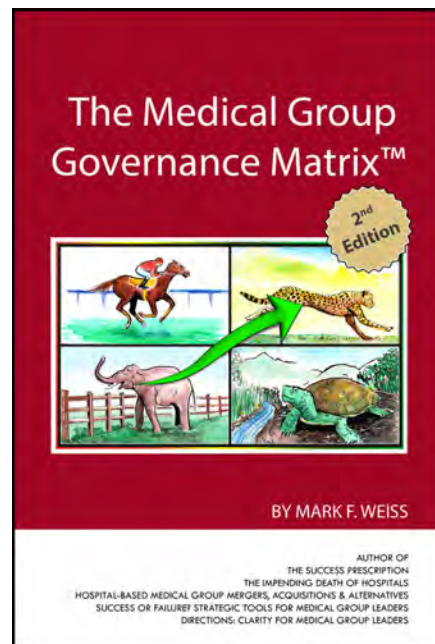
Your favorites, updated.

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?

Get your copy



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.

Get your copy

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

Download one of our books.

Our books provide you with a framework for thinking about your success. Browse our selection and take control of your future today.

Be a guest speaker on our podcast.

Passionate about sharing personal and professional achievements and lessons learned? Email me to participate in the conversation.

Book me to speak to your group or organization.

I've presented to various medical groups, organizations, universities, and privately consulted on many topics that today's healthcare professionals are facing. Let's discuss a tailored presentation to fit your group.

Engage me to represent you.

If you're interested in enhancing your profitability and effectively managing your risk, email me to discuss how we can work together to achieve your goals.

Join the conversation



Visit our website 