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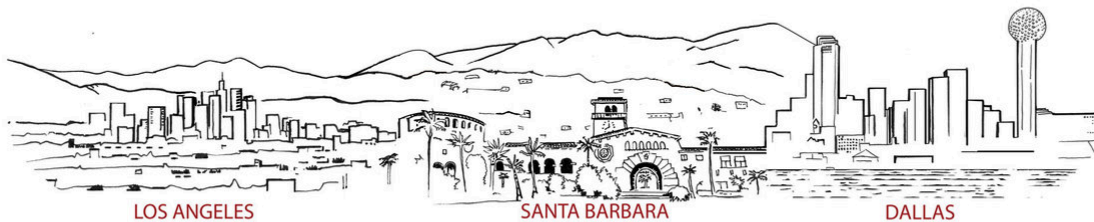

May 15, 2026

Earlier this year, **Aaron Kalin, D.O.,** posted something on LinkedIn worth expanding on. His point: the anesthesia crisis isn't fundamentally a negotiation problem. It's an operating model problem. The systems that thrive, he argues, will align governance, data, and economics on a continuous basis, not scramble every few years when the contract comes up for renewal.

He's right. And there's considerably more to say.

Although the current workforce shortage and the legislatively supercharged destruction of payment rates have significantly worsened the situation, the better approach for anesthesia and radiology groups, hospitalists, intensivists, emergency medicine, pathology, and others, has always been to align with the contracting facility on what is required for mutual success. The elements Aaron identified are some of a much longer list. This has been the case in the hundreds of negotiations between groups and facilities in which I've been involved since the 1980s.

So why do so many of these negotiations go sideways?

Because many groups, especially those who assume a winner-take-all posture, end up blowing the negotiation before it even reaches the table. Often this is driven by incorrect valuation assumptions and unfamiliarity with the wide array of issues actually in play. More fundamentally, they misunderstand what is actually being negotiated.

A prime example: the widespread, mistaken belief that fair market value is the end unto itself of the negotiation. Price is an element, of course. But what is actually delivered, and what it means to the contracting partner, that is, to the hospital or other facility, cannot be, and never has been, a commodity assessed only by price per unit consumed.

Let’s be precise about the word “commodity”. In economics, a commodity is a good with full or substantial fungibility. A gallon of gasoline. An ounce of gold. A ton of crushed granite gravel, three-quarter inch, washed. The price is the price, and the buyer reasonably doesn’t care which producer supplies it.

No professional service performed by a radiologist, an anesthesiologist, or any other hospital-based physician (or, increasingly, office-based specialist contracting with a facility) is a commodity. It simply can’t be. Anyone who says otherwise is shading the truth, whether knowingly or not, and whether they are doing it on behalf of the facility or even within the discussions among the members of the group itself.

There are two critically important dimensions to this reality.

The first is understanding value in a global sense to the facility. The anesthesia group that enables the OR to run on time, that provides subspecialty depth for a growing a cardiac or pediatric surgery program, that communicates proactively and reduces surgical cancellations, is not interchangeable with one that merely fills a schedule. The radiology group that turns reads before rounds, that drives downstream utilization, that is available for consultations, that makes referring physicians’ lives measurably easier, that is not the same as a service reading films remotely from another country. The facility knows the difference. The question is whether the group can articulate it, credibly, and with evidence, and project it in ways not actually tied to evidence.

The second dimension is inherent in the first: groups that think strategically and plan ahead can put their finger on the metaphorical scale on which they are weighed. They can actively construct the belief, optimally long before a negotiation is believed to have “commenced”, that their services are irreplaceable, and that the cost of losing them extends well beyond any number in a fair market value report.

This is what I think of as a combined arms approach. There is a plethora of legal, economic, and behavioral science tools that can be deployed to a physician group’s strategic advantage in these negotiations. Most groups ignore nearly all of them, focusing instead on price and contract language while leaving the most powerful levers untouched.

A contract is, of course, a legal document. But the word itself comes from the Latin contractus, meaning “to draw together.” The magic is in how you draw together. Not in what’s buried in Section 13 of the agreement, and not in what a valuation expert says your services are worth.

The workforce shortage and compressed payment rates have made this environment harder. They haven’t changed the fundamental dynamic. The groups that will thrive in spite of it are those that understand they are not in a commodity transaction. They are in a relationship negotiation. And relationship negotiations are won long before anyone picks up a pen.

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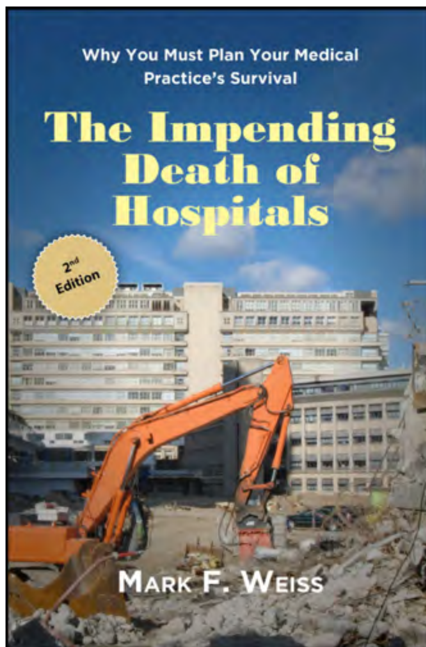

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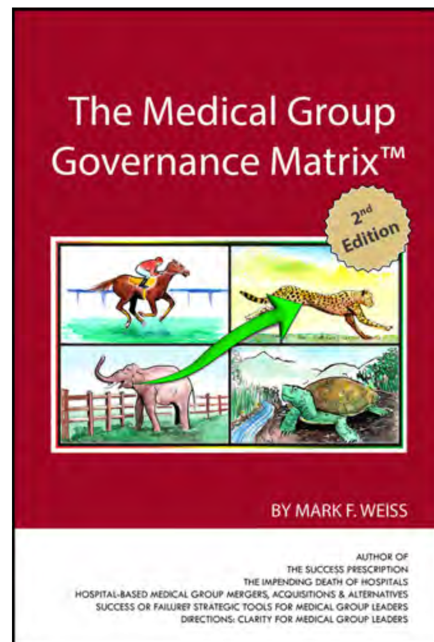

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