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“You’re Already on Payroll” Isn’t an Incentive

Healthcare organizations inadequately account for the human endurance required to keep legacy systems running. However, labor markets inevitably correct themselves, and relying on clinical endurance to buffer legacy processes accelerates early retirements, drives multi-hyphenate talent out of clinical medicine, and worsens an already punishing staffing shortage. To increase market competitiveness, health systems must transition away from clinician fatigue as a cultural given and start leveraging operational ingenuity as a strategic asset.

Despite record adoption levels of enterprise artificial intelligence and software infrastructure as described by the American Medical Association, US clinical labor productivity has dropped roughly 1 percent over the past two decades compared to 1998 baselines; over that exact same period, worker productivity across all other US service industries grew by over 55 percent (McKinsey, 2026). Facing an impending national shortage of up to 86,000 physicians over the next decade per the American Association of Medical Colleges, health systems must realize that productivity losses cannot be solved by repeatedly buying new software or attempting to increase clinical headcount. Recent studies offer possible explanations for why healthcare talent retention and productivity are failing: data from the 2025 EY Global Generation Report reveals that 51 percent of young adults rank physical and mental health as their primary measure of future success, while the 2023 McKinsey US Physician Survey demonstrates that doctors now rate work-life balance and manageable workloads as equal in importance to their paycheck. Healthcare leaders have to acknowledge that modern clinicians are undeniably multi-hyphenate practitioners who possess fluid expertise and creativity across disciplines. To address declining productivity and clinical shortages, healthcare organizations must adopt policies that incentivize the modern clinician’s innovative spirit.

Consider the tenant farmer who fertilizes and improves land they will never own. Unable to capture returns on their contributions, the farmer is prone to underinvest their problem-solving skills and creativity as demonstrated by the hold-up problem. Healthcare organizations operate under a similar dynamic, capitalizing on a subtle leverage point. Medical organizations bet on the reality that a clinician's deep-seated commitment to human welfare will routinely override their self-preservation. A physician can be handsomely compensated for their clinical hours, highly skilled, and profoundly dedicated to their patients, yet see the full value of their problem-solving captured by an institution without any upside returned to them. In instances where an organization treats a clinician’s problem-solving as simply “part of the job”, it is comparable to weaponizing the Hippocratic Oath as requests for rewards and incentives are often framed as antithetical to the mission of healing. The resulting feedback loop wherein innovators in the clinic receive no return for their problem-solving disincentivizes innovation.

Health systems have a vital interest in protecting their continuity, managing liability, and capturing a fair return on the infrastructure and capital they risk. Confronting intense regulatory and financial contexts, healthcare organizations are entirely justified in securing the intellectual property developed through their resources; a workflow fix devised mid-shift, using hospital equipment, solving a hospital problem, is uncontroversially within business overlap claims. Roughly a dozen states, California's Labor Code 2870 among the earliest, have passed statutes narrowing the reach of business overlap language, although they primarily target patentable inventions created on an employee's own time and without employer resources. The focus isn't whether business overlap applies to a clinician's frontline innovation…it does. Rather, we must interrogate whether business overlap policies discharge institutions from their obligation to reward innovation. "You are already being paid to do your job" is not a sufficient answer; in the absence of meaningful incentives in return for innovation, clinicians are prone to suppress their problem-solving.

To build a thriving organizational culture, health systems must derail from "already on payroll" defenses and re-evaluate how they reward operational innovation. Consider a staging protocol optimization inspired by Stanford's 2004 Material Flow Committee: a surgical team might redesign visual cues and instrument tray assembly to reduce operation room turnaround times. Notably, such innovations require zero software integration, avoid sensitive patient data, and were never headed for a patent application in the first place. Validated and regulated under standard clinical safety guardrails rather than complex legal oversight, a redesigned operating room workflow carries lowered risk while directly accelerating clinical throughput. Health systems must reject the posture that unpatentable innovations carry no obligation for shared return. Even when a workflow fix cannot be patented or commercially licensed, it can still produce quantifiable financial and operational benefits for the organization: reducing expenditure, minimizing wait times, or expanding patient capacity. To promote innovation, organizations must establish gain-sharing mechanisms, budget reinvestments, administrative benefits, protected time, and professional recognition. While financial compensation is a tangible reward, it is not the only way to incentivize clinicians to innovate. Organizations can funnel operational wins back into better working conditions, investing in employees, improving scheduling, and modernizing infrastructure. Implementing deliberate reward structures around unpatentable innovation is likely to make health systems more competitive and agile, transforming them into incubators that elite clinical talent, and equally important, patients, will naturally gravitate toward.

For the hospital organization of tomorrow, building reward systems commensurate with innovation and abandoning the illusion of the clinician's noble sacrifice must become primary goals. Modern clinicians increasingly prioritize autonomy and self-preservation; healthcare

leadership must recognize that clinical ingenuity will only flourish when the rewards for innovation match the value created. The era of relying on uncompensated endurance as a subsidy has reached its structural limit.

Sources

American Medical Association (March 2026). 2026 Physician Survey on Augmented Intelligence.

Association of American Medical Colleges (2023). The Complexities of Physician Supply and Demand: Projections From 2021 to 2036.

Ernst & Young (2025). The First Global Generation: Adulthood Reimagined for a Changing World.

McKinsey & Company (2026). The Real Future of Work in Healthcare.

McKinsey & Company (2024). The Physician Shortage Isn't Going Anywhere (drawing on McKinsey's 2023 US Physician Survey).

Stanford Graduate School of Business (2004). Process Improvement in Stanford Hospital's Operating Room.

California Labor Code § 2870.