The Citizen Physician: Governance Principles Make the Difference

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Until recently, medicine was one of the few areas in which an individual could practice a profession as a citizen member of the organization. However, in the last 15 years as dramatic reductions have occurred in outpatient reimbursement, physicians have moved from self-governing organizations with the rights of citizen participation to autocratic, centrally controlled organizations with little offered to physicians other than to provide high-quality manual labor. The principles of prosperity and choice espoused in The Federalist Papers are governance principles that can reestablish citizenship in medical groups no matter who owns them.

Key words: Governance; organization structure; medical group management.

For well over two decades, the evolution of the healthcare industry has resulted in new organizations for physicians. The 1990s was the first decade to see large numbers of medical practices purchased by hospitals and medical practice management companies. Both small and large practices saw their physicians give up self-governance in exchange for financial security in a time of declining reimbursement. The medical practice management roll-up model collapsed, and many of the hospital-owned groups were sold back to their original physician owners. Neither largeness nor “integration” created less-costly or better-quality care. The financial results were painful for most hospitals and medical groups.

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Recently, physician practice integration has focused on specialty groups that provide significant downstream revenue to hospitals. Whether the organization is large or small, integrated or independent, owned or managed, the most serious transformation for physicians is often in the principles by which they will be governed. As the influence of centrally controlled organizations in the practice of medicine has increased,¹ some physicians have abandoned their organization “citizenship,” either partially or completely, and their obligation to contribute to governance.

Declining reimbursement from the Centers for Medicare & Medicaid Services is the most recent cause for physicians to once again consider something other than physician-owned medical practice.² The governance principles in the new enterprises physicians are joining often move the physicians further away from their “citizen” status guaranteed in owned and self-governed medical practice.

The options many physicians are taking give them less autonomy and less opportunity to make future choices. The seductive invitation to spend no time on governance and more time practicing medicine is a siren’s call that will diminish the status of the physician and the independence with which medicine is practiced. The implementation of federalist principles of governance in medical group structures will permit physicians the same citizen decision rights they enjoyed as owners of their medical practice.

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CONSOLIDATING MARKETS

Consolidation is ancient. There have always been those who wanted to acquire their neighbor, to become bigger, to control more: Persian Empire, Soviet Empire, Columbia/HCA MedPartners of the 1990s, and more recently, hospital and health systems mergers. As they grew larger and larger, they all eventually had difficulty because of despotism, power struggles, or a center incapable of making effective decisions for its dispersed components. Empire building has always been designed to benefit the center. Britain exemplified this concept: She ruled her colonies from the center. Profits came to the center. All decisions benefited the center. That was the major objection of the colonies in North America.

There are similar analogies in other segments of healthcare that have merged. Consolidation of the home infusion therapy industry began in the mid-1980s. Company names no longer heard of (e.g., New England Critical Care, Critical Care America) were proclaimed the new “national” leaders as they consolidated. But during the consolidation, decision-making moved from local leaders to a national headquarters. Distant decisions were made either slowly or inappropriately for the local situation, profitability ratios dropped, and bankruptcy or sell-out occurred. The result was that local revenue-producing people were laid off or previously financially viable offices closed to benefit the center.

The media portrayed Columbia/HCA, growing rapidly through acquisition, as the healthcare industry’s shining star. However, a variety of complications revealed in mid-1997 resulted in the divestiture of approximately one-third of its 340 hospitals as well as ancillary healthcare businesses. Many of these hospitals linked to the center by electronic systems, financial support, and supply contracts suddenly had to fend for themselves: all to benefit the center. Britain exemplified this concept: She ruled her colonies from the center. Profits came to the center. All decisions benefited the center. That was the major objection of the colonies in North America.

A physician group sold its medical practice to this growing integrated system “looking for leadership.” However, in the four and one-half years since the practice was sold, nothing had been done. The practice was sold off with its neighboring Columbia/HCA hospital— to benefit the center.4

HCA, along with many other health systems, is once again actively buying physician practices. However, HCA may have learned something from its failed acquisition model of the last decade. The 2010 acquisition of Austin Heart by HCA is approaching a better integration model that preserves decentralized, physician governance of not only the medical practice but also the management of the Heart Hospital of Austin’s inpatient cardiac service line.

Consolidation in the healthcare industry has often resulted in increased losses.5 Centralization of decision-making, a common practice of merged organizations, results in less-informed decision-making primarily because the decision-makers are farther away from the action than they were before the merger.

PHYSICIANS’ PRACTICE TRENDS

The proportion of solo physicians in practice fell from almost 41% of all U.S. practices in 1996–97 to 33% in 2004–05.6 The number of physicians in the United States who own their practice has dropped 2% annually for the past 25 years.7 A 2009 American Hospital Association survey found that almost 40% of physicians surveyed were considering selling their practice, up from 30% the previous year.8

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Becoming part of a bigger organization is not the issue. In a hostile environment, being big can be beneficial. The question is what are the principles by which the medical group is governed in the new organization?

AUTONOMY

Should the new dynamics of healthcare require forfeiture of physician autonomy? Or in the words of the economist Ludwig von Mises, “. . . should the citizen be transformed into a subject?”9

An article on physician autonomy suggests that when a physician practice is sold to a large medical group, integrated delivery system (IDS), physician practice management company (PPMC), or physician hospital organization, the physician must relinquish some autonomy relating to personal and professional decisions and all autonomy in business decisions.10 However, there is little one can do about the first two areas once the ability to decide how money is earned, collected, and spent is relinquished. The stripping of business-decision participation from a physician moves one away from being a citizen physician to being a mere employee (i.e., subject) punching a time clock and submitting RVU production reports for the day. Within the newly recognized accountable care organization (ACO) concept that was developed in physician-governed multi-specialty IDSs (e.g., Mayo Clinic, Cleveland Clinic, etc.), physicians contribute much more to healthcare delivery than simply RVU production quotas.

INDUSTRIALIZATION OF MEDICINE

An interesting aspect of the changes in the healthcare industry is that it seems to be following the course...
taken by business as it industrialized a century ago. However, for well over two decades innovative non-healthcare businesses have been trying to rid themselves of the centralized management techniques and hierarchies that formed during that industrialization period.

As we observe the growing industrialization of medicine and its effect on physicians, we should consider the effect of the industrialization of business on workers near the turn of the 20th century. As the semi-independent foreman* was invited into the industrialized corporation as an employee (to increase “efficiency”), he realized that he not only lost autonomy and authority but over time, he lost status in the community.11 In exchange for financial security, he had to surrender decision-making authority, independence, hiring authority, and perhaps partnerships, therefore losing status and influence in the community. Today’s similar trend toward a reduction in physician autonomy, primarily through employee relationships and divestiture of practices, diminishes a physician’s status in the community as well as a physician’s self-determination. As such, the physician becomes a subject to be commanded rather than a citizen able to choose. Such an atmosphere disincentivizes independent, proactive behavior, creating instead less action, less creativity, less innovation, and less improvement, even though efficiency may actually increase. Overall, the organization becomes less effective.

In 1985, American Hospital Supply Corporation (AHS), a hospital supply distribution and manufacturing company, was merged through a desperate takeover bid by a smaller, centrally controlled rival, Baxter Travenol, and ceased to exist.12 AHS, rated among the top 100 companies to work for in the United States, was a distribution company with many semi-autonomous manufacturing divisions. These divisions were free to pursue their own destiny while supporting the AHS distribution company. American Pharmaseal was one of the largest, most profitable, and most creative divisions in AHS. However, once the merger was complete, executive management at Pharmaseal was replaced with Baxter executives, and many decisions moved from Pharmaseal in California to Baxter in Chicago. Morale plummeted in this environment, and many of the creative employees left the organization. A few years after the AHS/Baxter merger, the Pharmaseal Division ceased to exist.

The expectation of the merger between Baxter and AHS was that significant synergies would result within three years of the consolidation.12 However, under the centrally controlled organizational style of Baxter, this never materialized as expected. In 1996, in order to maximize shareholder value, Baxter completed a spin-off of a “new” company called Allegiance. Allegiance and the former AHS appear to be twins, including the corporate logo.

Throughout the 20th century, the concept of centralizing management has been acclaimed, observed, evaluated, tested, and ultimately questioned as being the most effective.

It is clear that, over a period of 10 years, centralized decision-making of the merged Baxter/AHS company did not provide the best return for investors. Hence, separation into their almost identical former corporations resulted. A centralized decision-making structure resulted in the demise of at least one of the creative, innovative, profitable, citizen-oriented divisions of AHS, as well as in less-than-adequate financial performance overall for the company’s owners.13

Throughout the 20th century the concept of centralizing management has been acclaimed, observed, evaluated, tested, and ultimately questioned as being the most effective. A study of merged corporations revealed that “Although the economics of resource sharing seem straightforward, in practice the combination of operating resources brings with it a ‘cost of compromise.’ The overall economic benefits of resource sharing need to be balanced against any loss of effectiveness in their use.”14 The authors of the study also concluded that “…the only real distinctive competence is in the ability to mobilize an organization to form new combinations of capabilities continually and to renew them.”14 It is precisely this competence that corporate America has been unable to create in its large centralized structures and hence is forsaking in favor of smaller, more autonomous subunits.

Without any U.S. Securities and Exchange Commission intervention, large companies are “de-merging.” That is, they are spinning-off companies just like Baxter did Allegiance because the inherent centralized structures are detrimental to getting things done, thereby decreasing shareholder value. AT&T spun-off Lucent Technologies (formerly Bell Laboratories). IBM spun-off Lexmark, and Kodak spun-off Eastman Chemical, among many others. GE’s strategy has changed in the last decade, and it has been going through the process of spinning-off some of its business units. A common reason for doing a spin-off is to dump a “dog.” However, newly autonomous companies typically have thrived.15

As far back as 1977, a study found that among eight different kinds of medical specialties, economies of scale were quickly reached as physicians moved from solo practice to group practice. The larger the group and more centralized its decision-making, the more inefficiency crept

*Semi-independent foreman refers to those non-employee independent businessmen who contracted with a manufacturer to produce a product. The work was typically done in the manufacturer’s facility using the manufacturer’s equipment. The semi-independent foreman hired and managed the workers. He often could negotiate a percentage of the profits as a part of the agreement.
Subject or Citizen?

Below are several questions that will help physicians discover whether the federalist principles, which ensure a citizen-led medical group, are present and steadfast in their organization’s structure.

1. Who owns the practice? If physicians are owners, how long does it take to achieve ownership? Does ownership include business decision-making rights?

2. If the physicians belong to a professional corporation, does it own its practice or simply contract to furnish provider services? Is the arrangement exclusive to one entity?

3. Do leaders in the practice serve in their positions by consent? What is the process for selection and removal of those who sit on the board of directors/trustees?

4. Are appropriate tools and resources provided to physicians so they have the means to accomplish the objectives, aims, and mission of the organization? Are there tools in place to help physicians measure how well they are meeting the organization’s objectives?

5. Is there a process for accountability to the organization’s leaders and to the physician’s peers? Does headquarters “judge” you from your reports or use them to identify resources to help you?

6. What decisions are made at the highest level of the organization? What decisions are made at the lowest level? With appropriate tools, how many of the decisions made at higher levels could be made at lower levels?

7. Does the organization offer everyone opportunities to participate as decision-makers on a committee, special task force, board, or executive committee? Are these opportunities limited to a select few? Are members of organizational committees and task forces primarily confined to headquarters personnel?

8. Do organization headquarters personnel evaluate all new opportunities and then pass down decisions for implementation? What happens to opportunities identified at lower levels of the organization?

9. Does headquarters have a major role to provide resources for teaching the overall mission of the organization and to provide the tools that facilitate its accomplishment, or does it primarily function as the central source of decision-making?

10. Are the chairman of the board and CEO different people? How are board members appointed? How is the CEO appointed? Is the CEO a voting member of the board?

11. If the practice is a member of a multisite or multidisciplinary organization, do the local mission and the headquarters mission match in actual practice? Do local leaders make the final local decisions?

12. Does the CEO or other very senior leaders visit and teach sub-units their role in accomplishing and their impact on the overall organization mission?

13. What influence do the virtues found in the Hippocratic Oath have on decisions made in the organization? Does the mission of the organization incorporate the Hippocratic Oath? Do the leaders of the organization, local and distant, personally exemplify its virtues?

Adapted from reference 34.

Siu’s description of the 1200-year-old Japanese fishing method using cormorant birds: “Observe the cormorant in the fishing fleet. You know how cormorants are used for fishing. The technique involves a man in a rowboat with about a half-dozen cormorants, each with a ring about its neck. When the bird spots a fish, it dives into the water and catches the fish in its beak. The ring prevents the larger fish from being swallowed, so the fisherman takes the fish from the cormorant, which then dives for another fish.”18 The cormorant learns well and achieves well. But such an efficient cormorant can never achieve everything it is capable of doing as a free bird. Overly intense concentration on protocols, technology, efficiency, and statistics is making physicians mere operators and mechanics rather than explorers and inventors. John Mason Brown once said, “The only true happiness comes from squandering yourselves for a purpose.” Physicians committed to the Hippocratic Oath have historically been squanderers but are voluntarily or by com-

into the organization.16 In other industries, new technology has allowed smaller corporations to thrive as equal competitors to their behemoth rivals.17 Meanwhile in healthcare, we have used technology not only to organize centrally controlled medical groups and health systems but to justify the centralized management of hundreds of healthcare providers spread across many states.

Numerous models have emerged over the last two decades to “integrate” the physician into some form of system. The model itself doesn’t necessarily determine whether a physician will be more of a subject than a citizen. However, a requirement to sell the medical practice does move a physician toward the status of subject, since the right to decide practice operations is often also sold. A physician always has influence but will not have a citizen’s right to choose if the practice is sold without a conscious effort to incorporate physician governance into the deal.

An analogy of what happens to the physician who isn’t a citizen of his or her practice can be found in Ralph
placency becoming efficient cormorants. In the process, they are giving up citizenship and becoming subjects.¹⁹

A survey from the last decade shows that physicians are skeptical about IDSs and consequently are the “most difficult aspect” of building an IDS.²⁰ I would suggest that this skepticism is rooted in the underlying instinct of physicians that their integration will result in the loss of decision-making rights that have been protected in their status as full-fledged citizens of their own medical practice.

CITIZEN COMPANIES

Physicians’ anxiety about their role in new organizations is really concern over the rights of citizenship that they will retain or surrender. However, the stress of financial stability in a dynamic and changing healthcare industry often eclipses the rights of citizenship as preeminent.

Yielding one’s decision-making rights by relinquishing citizenship status in exchange for security or so that someone can take care of you is moving toward the status of a subject or worse.

A large multispecialty medical group in the Midwest sold its practice, ancillary services, and HMO to a health system and an insurance company. The group’s board chairman gave his reasoning as, “It will generate more opportunities for growth, and over time, will provide the security that comes from affiliation with the leading provider network and managed care organizations in the area.”²¹ The group’s president stated, “Hospitals seem to have an unlimited supply of money to subsidize their physician groups.”²² A typical appeal to physicians is reflected in another medical group executive’s statement that “Physicians want to do what they’re trained to do and that’s practice medicine, not business. A way to handle that is to sell your practice to an organization that will take care of it.”²³ Yielding one’s decision-making rights by relinquishing citizenship status in exchange for “security” or so that someone can “take care of” you is moving toward the status of a subject or worse.²⁴

The principles that allow citizenship to exist in an organization require more than autonomy. Size of operating units is important. Procter & Gamble has limited the size of its manufacturing plants for three decades to help ensure employees know each other, the plant, and the goals, and can work together to make things happen quickly.²⁴ This is a common practice among the most competitive companies.

Nypro, a plastic injection molding company, which does a significant amount of work in healthcare manufacturing, has 44 facilities in 15 countries. Many plants are 50% owned by the Nypro parent company and 50% owned by local managers. Each plant has its own board and runs semi-autonomously with the assistance of corporate resources. This model has grown the company to $1.1 billion in sales. Nypro has elected to remain private in order to maintain self-determination and long-term perspective. It has provided generous profit-sharing benefits to all its employees, and in 1998 sold itself to its employees through an employee stock option plan to ensure self-determination by those who work there.²⁵

Thermo Electron was dubbed “a perpetual idea machine” by the Wall Street Journal in the late 1980s. At the end of 1997, it had 22,000 employees operating in 23 countries with annual revenues of $3.6 billion. How could such a behemoth provide an environment of citizenship for its employees? Thermo Electron uses a spin-out rather than a spin-off strategy. This strategy creates autonomy, decision-making, and reward at the lowest level. Thermo Electron’s first spin-out occurred in 1983. At the end of 1997, it had 23 public subsidiaries and more than 20 wholly owned subsidiaries. Public subsidiaries are created as soon as is reasonable. Each public subsidiary is majority-owned by Thermo Electron, which has board representation. Stock creates ownership in the subsidiary for the employees. Decision-making is left to the local executives with the assistance of centralized services at Thermo Electron. These services are provided as long as the young subsidiary needs them. They are resources that assist local subsidiary management. They do not direct local management.²⁶

A key element of Thermo Electron’s growth and profitability is its ability to capture and commercialize innovation. Its spin-out culture has created citizenship. It successfully nurtures an entrepreneurial climate that encourages employees to pursue their own ideas—and develop new businesses—while also creating long-term value. Dr. George Hatsopoulos, founder of Thermo Electron, explains: “I do not believe that you can create new businesses—while also creating long-term value. Thermo Electron was dubbed “a perpetual idea machine” by the Wall Street Journal in the late 1980s. At the end of 1997, it had 22,000 employees operating in 23 countries with annual revenues of $3.6 billion. How could such a behemoth provide an environment of citizenship for its employees? Thermo Electron uses a spin-out rather than a spin-off strategy. This strategy creates autonomy, decision-making, and reward at the lowest level. Thermo Electron’s first spin-out occurred in 1983. At the end of 1997, it had 23 public subsidiaries and more than 20 wholly owned subsidiaries. Public subsidiaries are created as soon as is reasonable. Each public subsidiary is majority-owned by Thermo Electron, which has board representation. Stock creates ownership in the subsidiary for the employees. Decision-making is left to the local executives with the assistance of centralized services at Thermo Electron. These services are provided as long as the young subsidiary needs them. They are resources that assist local subsidiary management. They do not direct local management.²⁶

CITIZEN COMMUNITIES

Physicians have traditionally practiced medicine in various “communities.” These include medical group partnerships, joint ventures, IPAs, hospital medical staffs, medical associations, and specialty societies and extend to community boards, hospital boards, and charitable organizations. It is the local leadership in each of these communities that collaborates to create a larger, prosperous, more beneficial society. Physicians have shared the leadership responsibilities in these communities. “To have community you must have people prepared to shoulder responsibility, to be accountable; otherwise, you have lots
Federalist Principles of Self-Governance

What is the structure of a citizen organization? What does one look for? Below are principles that applied and practiced in an organization will provide a physician moving from a solo or small partnership practice to a larger organization the agency, rights, and responsibilities previously enjoyed. They will also provide the new physician with a sense of autonomy and agency in the practice of medicine. These are proven principles. They are the same principles described by Madison, Jay, and Hamilton in The Federalist Papers in the 1780s. They are principles that have created greater prosperity than the world has ever known.

Subsidiarity

The most important of these principles is subsidiarity or “let them govern themselves.” It means that decisions should be made at the lowest possible point. It also involves consent. That is, decisions, especially about who should lead, should be consented to by those who are led.

It requires those who lead to provide training and tools so that physicians and others may act and decide with maximum effectiveness. Subsidiarity assumes that those up top and far away may not know better.

Interdependence

Citizenship requires participation. Physicians have traditionally passed the baton of leadership onto colleagues on a regular basis: Everyone shares the burden and opportunity that comes with sitting on or leading a committee, task force, medical staff, or board. This is important in the development of the individual so that competent leaders exist throughout the organization.

It allows new opportunities to be taken advantage of without creating permanent overhead structures.

Uniform Way of Interacting

A uniform way of measuring and accounting for stewardship responsibilities is important in an organization that provides for significant autonomy. However, this “accounting” is not to the center but within the sub-units.

It requires those at the center to teach sub-unit relationships, general policies, and overall mission so all sub-units move together in the direction of the organization’s purpose.

Separation of Powers

This principle prevents over-concentration of decision-making in one part of the group. This means there must be real authority given to the board and the CEO. And they must be separate entities. The principle of separation of powers protects decision-making at the lowest level.

Twin Citizenship

The principle of twin citizenship implies belonging to more than one entity. The challenge of an organization of numerous sub-units is that its purpose, mission, and direction must live in all the decisions made by each leader and individual throughout the organization at every level.

The principle of twin citizenship requires leaders at the center who can lead by serving, teaching, and persuading. It requires leaders who can convey the bigger picture to all the sub-units, how their role fits into that picture, and how their local decisions affect it.

Virtue

The ancient Greeks knew that the principles above could not exist for long without citizens that practiced self-mastery over personal appetites. It is both the individual and professional commitment to the virtues of the Hippocratic Oath that has allowed physicians to avoid intrusion into their medical decision-making and to continuously be considered one of the most respected professions. Selling one’s practice to an entity not voluntarily bound to the virtues of the Hippocratic Oath portends ill for the future of patients and physicians.

Organizations that protect the individual’s ability to decide and act in a fairly autonomous manner must also encourage and expect, from that individual, a self-assertive behavior that keeps the good of the patient and the whole in mind. Aristotle teaches us that, “...a citizen is one who shares in governing and being governed... (I)n the best state he is one who is able and willing to be governed and to govern with a view to the life of virtue.” It is precisely the physician’s historical “view to the life of virtue” that has permitted, in general, the business of medicine and the practice of medicine to coexist and seek temperance in the profit motive.

A lack of these minimal virtues must eventually give way to despotism in organization management.

Adapted from reference 34.
A 1953 United Nations mission studied the improvement of rural social conditions by improving community self-organization. Its findings have direct application to physicians’ quandary of giving up medical group citizenship in exchange for promised financial security.

The UN mission found that the first and most important key to success was the development of local leadership. Once the local community became self-organized, it largely abandoned its old habit of depending on others to solicit solutions/aid from government bureaucrats. Local self-organized communities created the conditions and opportunities for the rise and development of these much-needed indigenous leaders. They became citizens with local citizen-leaders capable of self-reliance.

There was evidence that problems resolved by locally developed leadership were of longer standing and that the people generally were aware of them. But until a community organizer involved them in group discussion and stimulated them to group effort, they had not realized that they could, first, do something about the problems themselves; and, second, obtain technical and material assistance from outside sources to help them help themselves. Citizens led by local leaders transformed “pleading to others” to resolve their needs into “their taking action” to fulfill their own needs.

Physicians are often sold a bill of goods with the concept that the only contribution they ought to make in a healthcare organization is efficient medical manual labor.

The UN mission found that the power and creativity of the common people is often, if not always, the greatest undeveloped natural resource of economically under-developed areas. The UN mission’s observations convinced it that it is a mistake to believe that the only contributions that unlettered peasants have to offer for community improvement is their manual labor. Yet in today’s healthcare environment, physicians are often sold a bill of goods with the concept that the only contribution they ought to make in a healthcare organization is efficient medical manual labor.

WHAT IS A CITIZEN?

Aristotle’s reflections on the meaning of citizenship in a state help us understand a citizen physician’s rights and responsibilities in a medical group: “He who has the power to take part in a deliberative or judicial administration of any state is said by us to be a citizen of that state . . .”

For this to be true for physicians, the principles of an organization must permit the physicians to be involved such that they can directly impact leadership and administration of the organization, primarily locally. A citizen is one who participates in both an organization’s decision-making process as well as in its fruits. Decision-making should occur principally at the local level. In addition, true citizenship requires time and resource commitment. Citizens must also self-govern if the organization is to continue in perpetuity.

Charles Handy defines citizenship as simply “the chance to make a difference to the place where you belong.” Belonging comes from a sense of ownership. Making a difference comes from really being a part of the decision-making process.

CONCLUSION

Physicians are in a unique position. Until the last 20 years, the majority of physicians in this country had independently exercised their economic and clinical decision-making authority. As solo practitioners, they made all the decisions. However, as they have consolidated into larger groups, some physicians have created autocratic roles for themselves by maintaining most other physicians in employee-only status. Or they have taken on physician executive roles in medical groups owned or managed by hospitals, health systems, or PPMCs. What is called a democratic group may be very much the opposite. Reflection on Dickens’ A Tale of Two Cities makes this clear. A review of the sidebar “Subject or Citizen?” will assist in the evaluation of a physician’s current situation.

Physicians have the essential credentials to join together as a citizen-led group and be successful: that is, experience in economic self-reliance, independent decision-making, and individual, voluntary commitment to the virtues of the Hippocratic Oath. The founders of a medical group in Oceanside, California, have looked beyond their own careers. Rather than sell their group as they retire, they rewrote their “constitution” to prepare their organization to perpetuate itself through a structure of self-governance for the benefit of those physicians that remain.

Physicians don’t have to wait for a hospital to acquire them and fret about their group citizenship in the new organization structure. When Olmsted Community Hospital found itself in regular financial challenges, it didn’t acquire the Olmsted Medical Group. The Olmsted Medial Group took over the hospital in 1996 and created a physician-governed IDS. The new Olmsted Medical Center has been financially viable and retained citizenship for its physicians in the community.

The Board of Directors of the Carilion Health System decided its model was not providing the high-quality, coordinated care it desired in its communities. In 2006, the health system reorganized and became the Carilion Clinic. This physician-governed model, which includes eight hospitals and 600 physicians, builds into the governance structure citizenship responsibilities for physicians.
Federalist principles of self-governance have been successfully practiced for over 300 years. These principles, shown in the sidebar “Federalist Principles of Self-Governance,” allow any organization to grow large and prosperous well beyond any other of its kind. They permit a self-perpetuating structure that allows more autonomy, more personal development, more economic self-reliance, and more opportunity to contribute than any other kind of structure: that is, they provide for and require true citizenship.

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