Physician Participation on the Hospital Board: A Moving Target

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Most hospitals and healthcare systems recognize the value physicians bring to the governing body, by enhancing the board's knowledge of clinical matters and by fostering communications and trust with the medical staff. In turn, many medical staffs believe it is essential for boards to include physicians who can ensure the board is aware of and responsive to patient care and medical staff issues.

However, as hospitals seek greater integration with physicians in order to manage costs and quality, medical staffs are resisting what they see as potential threats to patient care, professional autonomy, and their economic welfare. Several factors are provoking questions about the role, proportion, and selection of physicians on hospital governing boards.

Declining Importance of Formal Medical Staff

A medical staff's primary role is to engage physician leaders in oversight and improvement of clinical quality, patient safety, and credentialing. The medical staff organization's elected chief of staff and medical executive committee are supposed to provide leadership and promote communication among the hospital administration, board, and physicians.

In reality, many medical staffs are a loose confederation of physicians who are variously dependent on, interdependent with, or barely affected by what the hospital does. Some are actually competitors or are affiliated with competitors in key clinical services. Most physicians have little interest in medical staff leadership and serve their time out of obligation. Medical staffs can be reluctant to take adverse action against peers unless the danger to patient care is compelling. Decisions are often slowed by Balkan-like structures burdened by too many committees, departments, and specialty sections, and by poorly organized or attended meetings. Formal communications from the hospital and the staff's own leaders are routinely ignored.

Attorney and Governance Institute faculty member Brian Peters recently called the traditional medical staff "…outdated and fundamentally dysfunctional…" (open letter to The Joint Commission, October 2009). In short, the typical medical staff is the antithesis of a highly effective organization.

Thus, it's hardly surprising that as hospitals seek partners to manage costs and quality and to grow services, the traditional medical staff organization is becoming less relevant. Key physician leaders are increasingly likely to be employed by (or otherwise economically aligned with) the hospital, and are not necessarily the staff's elected leaders. Hospitals seeking policy advice and recommendations on clinical matters increasingly look to full-time and part-time chief medical officers, chief quality officers, clinical department chairpersons, service-line chiefs, physician cabinets, medical quality councils, and medical group governing bodies, all populated by employed and other aligned physicians.

The Governance Institute's 2009 biennial survey[1] suggests a decline in importance of formal medical staff leaders in some hospitals. The hospital's chief of staff is now a voting member of just 37.5 percent of boards (compared with 43 percent in 2007), and is a non-voting board member on 13 percent of boards (up from 11 percent in 2007). Conversely, the chief of staff is a not a board member but regularly attends meetings for 36.8 percent of boards (up 1 percent since 2007), and is a non-member who does not attend board meetings for 12.7 percent of boards (up 2.4 percent since 2007).

Employed physicians are beginning to crack the boardroom door despite concerns about their independence from management. According to the survey, the typical, non-government hospital or health system board has between 14 and 17 board members, of whom about two are physicians *not* employed by the organization, and 0.4 of whom *are* physician employees. (The survey broke down employed and non-employed physician board members for the first time in 2009.)

Hospital–Physician Competition

Hospitals are in competition increasingly with physician-owned or co-owned outpatient facilities and specialty hospitals. Some physicians on the medical staff treat a sizable number of financially lucrative patients in these facilities while relying on the hospital for emergencies and sicker or poorer patients. In some cases, physician competitors may dominate a major specialty or subspecialty.

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1 *Governance Structure and Practices: Results, Analysis, and Evaluation,* 2009 Biennial Survey of Hospitals and Healthcare Systems, The Governance Institute.

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The uptick in physician competition introduces the anomalous situation of a physician competitor being elected as a medical staff officer, a member of the board, or even the chief of staff, who then holds an *ex officio*, voting board seat. If that doesn't sound problematic, think of Microsoft not only allowing its top software designers to enter into business ventures with Google, but also giving designers with split loyalties a vote on the Microsoft board! Healthcare is the only major industry we know of that allows such conduct—but its roots lie deep in traditional medical staff self-governance and the protection of the physician–patient relationship, and these principles are not easily abandoned.

New Joint Commission Standards

As Paul M. Schyve, M.D., senior vice president of The Joint Commission wrote in a white paper for The Governance Institute last year, "The governing body, the chief executive and other senior managers, and the leaders of the medical staff must collaborate to achieve [the hospital's] goals,"[2] including patient safety, financial sustainability, community service, and ethical behavior. The Joint Commission does not prescribe that any number or percentage of board members must be elected by or from the medical staff, but clearly, the presence of physician board members can contribute to a culture of collaboration.

The Joint Commission has been laboring since 2007 on revised medical staff standards. One area of contention is whether the board can look to the medical executive committee as the clear, ultimate authority of the medical staff, or whether the general medical staff electorate is entitled to circumvent its leadership and go directly to the board. This controversy illustrates many doctors' fear that hospital-employed and other economically aligned physicians will gain control of the MEC and can take actions that disadvantage private practitioners. The same concern is likely to arise if a board considers reducing the medical staff's position on the board.

IRS Perspective on Physician Board Members

As we wrote in the December 2009 advisors' column in *Boardroom Press*, the Internal Revenue Service is increasingly interested in the independence of the not-for-profit hospital board. Clearly, when physicians are employed by a hospital, are active practitioners on the medical staff, or both, reasonable questions arise about their independence. IRS policy is somewhat ambiguous, however. Employed and most other compensated physicians are not considered independent; private practitioners are counted as independent on the Form 990 but are not so considered when evaluating an organization's tax-exempt status.

Guidance for Boards

Amidst these shifting sands, we do not believe a single set of guidelines regarding physician membership on the board can apply to all hospitals and healthcare systems. We also believe that any changes to a board's current policies and practices with regard to physicians on the board should be made after a genuine consultative process with medical staff leaders and communication with the broader medical staff. Much effort has gone into improving hospital–medical staff communications and relationships; hasty changes can quickly undo trust and reignite latent suspicions.

Framing the right questions is a precursor to a constructive dialogue. The wrong questions can mire leaders in the past; the right questions can point them toward developing the medical staff and hospital of the future.

We recommend a new set of questions for discussion among board, senior management, and physician leaders, beginning with the following:

Old question 1: Should the elected chief of staff, chief-elect, and/or past chief be *ex officio*, voting board members, in order to represent the medical staff and the MEC?

New question: What is the organizational structure that will best enable the medical staff, board, and senior management to collaboratively pursue the hospital's goals—and how should the leaders in this structure have access to the board?

For example, who should constitute the primary medical leadership body that is accountable to the board? Is it the medical executive committee, or full- or part-time clinical department chairs and service line chiefs, or a "physician leadership cabinet" of some sort, chosen based on objective competencies and including both employed and private, aligned, and active physicians? If the MEC is to remain the primary leadership entity, how will its leaders be chosen and held accountable for performance? If the hospital owns a physician group, will it have a governing council, and if so, what is its role and relationship to the MEC or physician cabinet?

For many hospitals, these are vision questions as they transition from largely volunteer medical staffs to employing some, most, or all their physicians and physician leaders. Although some hospitals will continue to rely primarily on private practitioners, many will have a pluralistic and hopefully symbiotic relationship between and among private practice, employed, and other economically aligned physicians. The right structure should facilitate achievement of the hospital's vision with its physician partners.

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2 Paul M. Schyve, M.D., *Leadership in Healthcare Organizations: A Guide to Joint Commission Leadership Standards* (white paper), The Governance Institute, 2009.

The discussion of leadership structures must precede questions about voting physician board members because the formal medical staff's role is changing. As governance advisors, we cannot endorse *ex officio*, voting seats for the chief of the medical staff or for any stakeholder group. However, if physicians enjoy this prerogative today, it should not be withdrawn cavalierly, without careful consideration of the other structures through which physicians are involved in leadership decisions affecting clinical quality and their practices.

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Old question 2: Should a minimum number of physicians serve on the board?

New question: What role are physician members of the board expected to play, and therefore, how many individuals are needed to fill that role?

This question must precede any determination of how many physicians are needed. On most boards, a physician's primary contribution is to provide clinical expertise and real-world insights to help the board discharge its oversight and decision making with regard to clinical quality and patient safety, as well as matters of finance, strategy, community service, and ethics.

However, are physicians also expected to "represent" the views of the general medical staff? No. We believe physician board members who serve on the active staff can facilitate communications and working relationships amongst leadership groups, but board service must not constitute "formal medical staff representation." We would strike the phase "represent the medical staff" from the lexicon.

Every voting board member, no matter how selected, must fulfill the fiduciary duty of loyalty and act objectively and independently to protect and promote the hospital's mission. There is a place for recognition of stakeholder views, not but representation in the boardroom.

Old question 3: Should the medical staff be able to elect or nominate physicians to serve on the board?

New question: What are the qualifications for physicians to be elected to the board, and conversely, are there any characteristics that would disqualify a physician from board membership?

We believe that physician board members should—like any other board member—be fully committed to the hospital's success and performance of their fiduciary duties, demonstrate integrity, think strategically, and be able to work collaboratively with others. They should be able to put in the time required to do the job. On a self-perpetuating board, the same criteria-based competencies used by the board or governance committee for lay members should apply to physicians.

The board also should adopt "disabling guidelines" that bar or allow removal of trustees who are direct competitors to the hospital or who violate confidentiality.

Should employed and other economically aligned physicians be allowed to serve on the board? We do not think that employment by or alignment with the hospital or a related organization should automatically bar an otherwise qualified physician from board membership. However, employed physicians and other active medical staff members should *not* be considered independent for purposes of populating the committees responsible for executive compensation, audit, and corporate compliance. Also, care should be taken to ensure that a majority or, better yet, two-thirds of the board members meet the IRS' definition of independence for tax-exemption purposes. Additionally, the nomination process for board members should be in the hands of independent directors, but there is no reason why a governance committee cannot welcome and give significant weight to input from the medical executive committee or from other formal or informal physician leadership groups.

We also think that more hospital boards should look for physicians who are not members of the active staff, such as retired physicians, corporate medical directors, and physician leaders from health systems in other communities. They bring both expertise and independence.

The Bottom Line

At the end of the day, a board's membership should include independent, creative, strategic thinkers who bring a broad mix of relevant skills to the table. It is difficult to imagine those skills excluding medicine. It is also difficult to imagine that employed and other economically aligned physicians who are becoming the core clinical leaders of the medical staff would be barred from the boardroom while non-aligned private practitioners remain because they are elected to office. Employed physicians do have a conflict of interest that must be disclosed and addressed in accordance with the organization's conflict-of-interest guidelines, but they also have skills and insights that are valuable to the board. Physicians should be evaluated according to the same criteria for judging independence, competence, and overall fitness to serve as any other trustee. Some physicians will make the cut; others won't.

Addressing matters of physician membership on the board may not be comfortable. The timing must be right (are reasonable leaders and a trusting relationship in place?). However, waiting too long can be dangerous, inviting the elevation of competitive or combative physicians to leadership positions. The time to raise difficult questions about physicians on the board is *before* serious problems arise. ■