

# Physicians on the Board: Conflict Over Conflicts

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**T**HE VAST MAJORITY OF not-for-profit hospitals and health systems allow physicians to serve as fiduciary board members with vote (with the exception of many government-sponsored organizations). The reasons are compelling. Research has shown that having physicians on the board enhances the quality of board decisions and correlates with improved overall organizational performance, in terms of clinical quality, operational, and financial performance. Furthermore, the symbolic value of physicians playing a meaningful role in policy and strategic matters has evolved into a prerequisite for productive physician relations.

## New Pressures

Hospital boards are under intense pressure from numerous sources, including the IRS, Congress, state attorneys general, and the news media to name a few, to demonstrate that their decisions are controlled by independent community directors, not by insiders or others with significant conflicts of interest.

The pressures for board independence and transparency are colliding with the enormous increase in competition hospitals are experiencing from members of their own medical staffs, as well as an increase in “aligned physicians” who, as hospital employees or joint venture partners, may share the hospital’s goals but can’t be considered independent, outside directors. As a result, it is becoming a challenge to find physicians who are free of material conflicts of interest with the hospital. Hence, many boards are beginning to raise questions about the wisdom of having active members of the medical staff serve as voting board members.

## Important Concepts

There are a number of important concepts to consider when evaluating any person’s fitness to serve on a not-for-profit board and on certain board committees such as audit and executive compensation. These concepts apply to all board and committee candidates, including physicians.

**“Insiders.”** The IRS considers employees and most active members of the medical staff to be “insiders” and it limits the number of insiders serving on the board to no more than 49 percent. This is a non-negotiable IRS position that boards must keep in mind when selecting board members. This becomes even more important when considering who can serve on certain board committees. The IRS Section 4958 Rebuttable Presumption of Reasonableness criteria with regard to oversight of executive compensation require that the board members who serve on the committee handling this function (usually a compensation committee) are independent, which generally excludes insiders. Therefore, most hospitals that have elected to comply with the IRS criteria do not allow physicians to serve on the compensation committee.

**“Independence.”** An independent board member has no direct or indirect, *material* conflict of interest with the corporation, or has a conflict of such insignificance (*de minimis*) that it would not be perceived to exert an influence on the director’s judgment. Both

*de minimis* and material conflicts must be defined precisely and in quantifiable terms. Sarbanes-Oxley governance requirements (which have been embraced by a majority of not-for-profit hospital and health system boards) call for a majority of the board and all of the audit and executive compensation committee members to be independent. This concept applies to all board members equally.

**“Disabling Guidelines.”** These guidelines describe conflicts that are so significant that an individual should not be elected to the board, or should be asked to resign if they occur during a director’s term (e.g., investing in a direct competitor, repeated failure to disclose a conflict of interest, intentional violation of the organization’s code of conduct, and others). This concept applies to all board members but raises serious questions about the appropriateness of physicians serving on the board who are engaged in significant competition with the organization.

## Current Practices Stimulate Conflicts

In light of the concepts described above, some governance practices used today reveal a fair amount of confusion and/or lack of attention when it comes to physicians serving on the board. When a board attempts to modify these practices, physicians often react negatively and resist the changes. Some current practices that can result in conflicts with physicians include:

- Most hospital boards have not developed detailed definitions for “independence” and “disabling guidelines,” and allow physicians who are engaged in direct, material competition with the hospital to serve on the board (sometimes even in board leadership positions).
- Some boards ignore or are unaware of the fact that physicians are insiders and allow them to serve on the executive compensation committee.
- Many boards consider physicians who have clinical privileges but no direct financial relationship with the hospital to be “independent,” but in reality, any physician director who also practices in the hospital is subject to influence daily from partners and peers whose economic livelihood is affected by hospital decisions and may be able to exert undue influence over those decisions. To call an active medical staff member “independent” strains credibility. This is especially important when considering committee appointments or eligibility for a board leadership position since many boards require that board officers qualify as independent members.
- Many boards allow employed physicians to serve as voting members with little thought given to fact that these physicians are severely limited in the roles they can play on the board and that non-employed physicians do not always view them as effective representatives for their issues and needs.
- A large number of boards continue to designate the elected president (and sometimes the president-elect and past president) of the medical staff as an *ex officio*, voting board member, or allow

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the medical staff to elect board members directly as their representatives, despite the trend to move away from these practices to ensure the board's control over selecting its own members.

### For Consideration

Addressing matters related to physician board membership is politically sensitive and “one size doesn't fit all.” However, our research and experience suggests that boards should engage in education and dialogue with their physician leaders about changing requirements and consider changes in how physicians are chosen to serve on the board and/or select committees. Specifically, we recommend consideration of these practices:

1. Develop comprehensive policies concerning physicians' engagement in leadership roles and decision making, including service on the board and in medical staff positions, seeking physician input throughout the process.
2. As a matter of policy, do not allow physicians (or non-physicians) who are engaged in a form of competition that endangers the hospital's mission to serve on the board or any of its committees.
3. Determine whether employed physicians should be allowed to serve as voting board members, including a clear rationale.
4. Do not permit medical staff members and other “non-independent” directors to serve on the executive compensation committee.
5. Designate any physicians who serve in an *ex officio* capacity to be non-voting, so they have a voice but are not placed in a conflict-of-interest position.

Above all, continue to allow physicians to serve on the board. The benefits far outweigh the challenges.