

GREAT BOARDS

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Physicians on Hospital Boards: Time for New Approaches

It's "rule one" of good governance: All members of a not-for-profit governing board have a fiduciary responsibility to act in the best interests of the organization and its mission, not in their personal, professional, or stakeholder group's interests. The board must be independent, objective, and accountable.

Rule one notwithstanding, medical staff representation on hospital boards, in the form of an ex-officio (by virtue of office) board seat for the medical staff president and other physicians as well, has been common. It's even viewed as a good governance practice to strengthen hospital-physician communications and bring clinical expertise to the board. Thus, a potential conflict of interest for physician board members has long been hard-wired into the composition of hospital boards.

Today, as hospitals develop more closely aligned economic relationships with some or all members of the staff, the fiduciary duties of the governing board and the traditional, representational approach to selecting physician board members are coming into irreconcilable conflict. It is time to revisit the underlying principles and mechanisms for physician membership on hospital and health system boards.

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Why New Approaches Are Needed

Traditionally, physician participation in governance and medical staff representation on the board have been synonymous.

Medical staff representation on hospital boards is embodied in hospital accreditation requirements. The current Joint Commission standards on leadership call for the governing body to provide the medical staff with the “opportunity to participate in governance” and “to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.” The Joint Commission requires that medical staff members be “eligible for full membership” on the hospital board—but does not mandate that any medical staff officer or other physician be a voting or nonvoting board member.

Governance experts caution against “representational governance” and advise instead that physician directors be chosen like any other board members, based on objective qualifications. Now, their arguments are bolstered by external mandates for board independence and by changes in the hospital-medical staff relationship.

Board independence. Boards of not-for-profit hospitals face increased external demands as fiduciaries to demonstrate their accountability, independence, integrity, and effectiveness.

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The Internal Revenue Service requires that a not-for-profit, tax-exempt hospital have at least a majority of “independent” directors on its board. To be counted an independent director, a physician must not be compensated by the organization as an employee (in any amount), compensated more than \$10,000 as an independent contractor, and have no reportable, direct, or indirect business transaction with the organization. Determining reportable transactions is tricky, but these might include, for example, a private physician whose partner in a two-person practice serves as the hospital’s chief of medicine for more than \$10,000 a year, or a physician whose spouse is paid more than \$10,000 a year to provide on-call coverage in the emergency department.

Independence is not the sole attribute for effective fiduciary governance. Boards need members to be accomplished professionally and able to exercise oversight over financial, clinical, and regulatory matters with diligence and objectivity. Board members should think strategically and understand complex organizational systems and medical economics.

Board members need to be focused on where hospital and medical practice are going—toward accountable, patient-centered care and evidence-based medicine—and not on their fragmented, “separate but equal” past.

Medical staff changes. Traditionally, hospital boards and administration relied on the formal medical staff organization

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and its leaders for communications and consultation with physicians. These days, the medical staff is too fragmented for this role. The typical medical staff is segmented into various groupings of physicians with differing interests and degrees of alignment with the hospital, including:

- **Employed or exclusively aligned physicians.** A growing number of doctors are closely tied to the hospital through employment by the hospital or a hospital-owned group. In states where employing physicians is prohibited, such as California, exclusive contracts with the medical group that employs the physician serve a similar purpose. Considered together, these employed or exclusively aligned doctors share economic goals and other interests with the hospital—but they are also “inside” directors and could bring biases to such governance responsibilities as CEO evaluation or the physician compensation policy.
- **Aligned independent physicians.** These physicians are employed by private medical groups, universities, and other enterprises, but are aligned with the hospital through vehicles such as accountable care organizations; clinically integrated, physician-hospital organizations; and contracts for professional services. These physicians share many economic and quality goals with the hospital, and may be quite loyal, but as independent contractors are tied less tightly to the hospital than employed physicians.

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- **Competitive physicians.** Some doctors are aligned with competing hospitals, or they own practices and outpatient centers that compete directly with the hospital. Including these doctors in strategic planning discussions and other confidential matters is problematic because of their per se conflict of interest.
- **Non-aligned active physicians.** These physicians are active clinically, but they are not formally aligned with any hospital, so their economic interests are more connected to their private practices rather than the hospital.
- **Minimally connected physicians.** Some doctors neither compete with the hospital nor rely much on its services. They often have little stake or interest in hospital-medical staff affairs. Sometimes they get involved in medical staff politics for personal reasons, such as an ax to grind with the CEO or protect a spouse in an active independent medical practice.

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Medical staffs are a changing mix of these segments. As hospitals evolve into more integrated enterprises that accept accountability for costs and quality, and share financial incentives and risks with physicians, they are growing their ranks of aligned physicians. Hospitals also are engaging aligned physicians in clinical leadership roles such as chairing departments and co-managing service lines and performance improvement initiatives.

Conflicts during the transition. Down the road, aligned physicians will increasingly be elected to formal medical staff leadership positions because they will represent an increasing proportion of the medical staff and they will share the hospital's quality and economic goals and values. Currently, though, it is common that the medical staff's elected officers and other physician directors are from the non-aligned active physicians, competitors, and minimally connected segments as well as aligned physicians, and that's the rub. Some physician board members, especially those in ex-officio roles, bring inherent conflicts of interest involving some hospital board decisions.

Several real scenarios illustrate how choosing physician board members as medical staff representatives can be inconsistent with the requirement for objective and independent governance.

- At Hospital A, the elected medical staff president is a voting ex-officio board member and is suing the hospital over alleged competition with his practice.
- At Hospital B, several physician board members are employed by the hospital-owned medical group. When the group decides not to renew the contract of a 70-year-old gastroenterologist with out-of-date skills and poor interpersonal relationships, these doctors protest and convince the board to order management to reconsider the physician's termination.
- At Hospital C, the management team is reluctant to discuss strategic clinical services plans in their

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formative stages with the board because the elected staff president and some physician board members have economic relationships with competing medical groups and hospitals.

- At Hospital D, several physician board members who are employed by a hospital-owned medical group are reluctant to criticize administration's handling of the strategic plan because they fear retribution.
- At Hospital E, the president of the hospital-owned medical group of several hundred employed physicians attends board meetings as an invited guest and seldom joins discussions. Meanwhile, the elected medical staff president, a surgeon in private practice who opposes the hospital's physician recruitment, has a vote and participates actively as an ex-officio director.

As these not uncommon cases show, traditional models of medical staff representation on the hospital board are past their prime. They don't build bridges of communications—they create tension and inhibit cohesive, effective governance. Change is needed in how hospital boards choose physician members.

Engage Physicians to Define New Approaches

Effective boards need to be proactive and redesign their approaches to physician participation in governance to reflect

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current realities. A delicate touch is required to accomplish this transition, however. Sometimes non-physician directors and CEOs want to simply change the hospital bylaws to eliminate ex-officio seats or other guaranteed representation for the medical staff. They should recognize that in most cases these are fighting words that can trigger a hostile reaction and reduce the likelihood of success if undertaken in a unilateral fashion.

The symbolic value of medical staff representation on the governing body cannot be overestimated. It shows the board's willingness to listen and be responsive to physicians. Attempts to reduce or change the traditional proportion of physicians on the board or the medical staff's role in selecting them, regardless of the merits, will likely be greeted with suspicion and concern that the hospital is attempting to "control" the doctors.

Instead, governing boards and CEOs should engage in a dialogue with physician leaders to seek agreement on new approaches to physician participation in governance. One model will not fit all. Just as hospitals will adopt different models for hospital-physician integration, so too will they differ in their approach to physician participation in governance. A dialogue over physician participation in governance should revolve around three questions:

1. What should be the guiding principles for physician participation in governance? Illustrative principles (for discussion, not one size fits all) include:

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- **Fiduciary duty:** All directors, no matter how they are chosen, have a fiduciary responsibility to act in the best interests of the organization and its mission. As simplistic as it sounds, every board member – physician or not – must be willing to acknowledge that the organization’s interests alone must come first during all board deliberations and decisions and outside interactions.
- **Objective selection:** All members of the board should be chosen based on the competencies and personal leadership qualities needed for effective governance.
- **Conflicts evaluated:** Physicians on the active medical staff are eligible to serve on the board, but their economic relationships with the organization and competitors (including employment and contracts) must be disclosed and considered by the Governance Committee before they are elected to the board. Physicians with a material relationship with a competitor should not be elected to the board.
- **Independent directors:** Physicians who are active members of the medical staff, whether employed or not, per se, do not meet the definition of an “independent director” and therefore should not serve as the board chair or on the board’s oversight committees for audit, executive evaluation and compensation, and physician compensation.

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2. What is the hospital’s future vision for hospital-physician alignment? Think about the hospital’s medical staff not as a monolith but as a mix of various segments. What percentage of the active medical staff is tightly aligned with the hospital today, and what is the desired alignment goal in 5-10 years? The answer will inform thoughtful decisions about physician participation.

If the hospital's vision is to be financially and clinically accountable for the value and quality of the care it provides, then the hospital will require a closely integrated relationship with its medical staff. The voice and expertise of aligned physicians should make their way into the boardroom. The vision of integration should be reflected in the model for physician participation in governance and leadership as well as in the medical staff's bylaws and leadership structure.

3. What is the model for physician involvement in governance that will facilitate movement toward the desired vision?

Essentially, when it comes to hospital-physician alignment in the future, hospitals and physicians have two models to choose from:

- A. **Enhanced traditional model.** If the vision calls for a pluralistic mix of aligned employed (employed and contract), non-aligned, competitive, and minimally connected physicians, the hospital may want to choose an updated version of the traditional medical staff representation model. Illustrative principles and practices for this model include:
- **Objective selection:** Make active medical staff members *eligible* to serve on the board, but select all physician board members using the same process and objective criteria as are used for selecting all other directors. These criteria might include commitment to the mission, objectivity, integrity, strategic thinking, a collegial working style, sufficient time to devote to governance work, and absence of significant, material conflicts of interest.
 - **Outside expertise:** Recognizing that clinical knowledge is not limited to medical staff members, also recruit physicians from other settings, such as corporate medical directors and

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chief medical officers from noncompeting institutions. Seek outside board members from other healthcare fields as well, such as nursing, medical informatics, genetics, hospital management, and public health.

- **Non-voting medical staff voice:** Retain a medical staff voice by making the medical staff president (and if desired, the past president or president-elect) an ex-officio but nonvoting member or invited guest to all board meetings.
- **Executive sessions:** Excuse non-voting physician members from executive sessions when personnel matters such as CEO evaluation and strategic matters affecting competitors may be discussed.
- **Physician input:** The board should not be the sole avenue for physician input into leadership decisions. Consider forming a "Physician Cabinet" or "Clinical Advisory Council" composed of active, aligned physicians in key clinical services lines to serve as a sounding board and idea generator. Provide a line of communications between this body and the board.
- **Physician leadership investment:** Develop physicians' leadership skills and engage physicians as leaders or co-leaders of clinical service lines, clinical departments, and performance improvement councils.

B. Integrated, Accountable Care Model

If the vision calls for a highly integrated medical staff composed of virtually all aligned physicians, then the Integrated Accountable Care Model is a better starting point for redesigning physician engagement in governance. All the principles and practices in the enhanced model apply, plus these additional practices:

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- **Medical Group or PHO Board(s):** Create an effective physician leadership structure in the aligned Physician Enterprise (e.g., medical group board, PHO board) and provide a line of accountability and communications with the board.
- **Board voice for aligned physician group:** Consider making the CMO or chairperson of the aligned physician entity an ex-officio hospital board member, voting or non-voting. If allowing a board seat, the principles of excusing him or her as an “inside director” would still apply.
- **Senior Clinical Operations Council:** Create a senior level “hospital operations council” comprised 50/50 of senior executives (e.g., CEO, COO, CFO, CNO) and physician executives (hospital CMO, chiefs of medicine and surgery, chief of hospital’s Medical Group), to oversee quality and clinical operations, reporting to the board of directors.
- **Clinical co-management:** Create full-time or part-time, employed positions for clinical department chiefs and clinical service line co-directors, and elect one or more to the board.
- **Medical staff bylaws revision:** Revise the medical staff bylaws to establish the medical executive committee as an effective body to oversee medical staff activities of peer review, credentialing, and quality improvement. Eliminate unnecessary committees and staff categories. Only active physicians who increasingly will be aligned physicians, should have a right to vote and hold medical staff office.
- **Culture of inclusion.** Invite key aligned physician leaders—for example, the president of the medical staff, CMO or president of the affiliated medical group, chiefs of clinical departments and major services, etc.—to attend board retreats and educational events and to participate in board

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meetings when an appropriate topic arises needing their expertise or perspective.

Final Thoughts

Implement new approaches over time, reevaluate, and adjust the chosen model. The environment is changing quickly and will continue to do so. Organizational models must be flexible. Keep the lines of communications with physicians open and periodically reassess the model of physician participation in governance and other forms of organizational leadership against the principles.

Even more important than the specific model adopted for physician participation in governance, successful organizations will invest in physician leadership development and relationship building. In the final analysis, hospitals will thrive or falter based on physician relationships, not employment their status or contract provisions.

Both the enhanced traditional and accountable care models focus on the *hospital* board, or a care system board that governs multiple hospitals and various related patient care services. Many hospitals are now part of larger health systems, raising the question of physician participation on the health system or parent board. Therefore, the same three step-thinking process—principles, vision, and participation models—needs to be applied to the parent board. Particular questions related to physician participation on parent health system boards include:

- Should physicians be permitted to serve on both the parent board and a subsidiary hospital board as a voting member at the same time? (usually not)

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- Would recruitment of outstanding physicians from other, noncompeting health systems help the parent board avoid becoming too inner-focused? (usually yes)
- Do we need separate parent and subsidiary boards? (sometimes yes, sometimes no)

Implementation of changes to address the Patient Protection Act and other economic forces are creating alignments and unleashing potential conflicts of interest that could produce a “division of the house.” Questions about conflicts of interest involving physicians on the board will intensify. It is far better to address these issues prospectively and redesign the board’s approach to physician participation so that principles rather than personalities prevail.

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