The Changing Face of Physicians on the Hospital Governing Board: *Tactics for Promoting Board–Physician Understanding*

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Determining who should comprise the members of a hospital or health system governing board is one of the linchpin decisions made by an institution's governing body.

PERIODICALLY THE BOARD MUST ASSess its makeup and determine if it has the right members to adequately perform its oversight and leadership tasks. Over the past several decades, more and more boards have decided to increase the number of physicians sitting as directors. Adding physicians has generally been perceived as a practical necessity as the governance of healthcare entities has become ever more complex. Physicians bring numerous strengths to a hospital board, including clinical expertise, an insider's view of the organization, and operational experience. This trend has also been a response to rising demands by physicians that they have greater input into their practice environments.

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In the months and years ahead, many healthcare organizations will be reassessing the role of physicians in the boardroom in light of dramatic changes taking place across the healthcare industry. Such changes include a mushrooming national shortage of physicians, the implosion of the private practice of medicine and increasing employment of doctors by hospitals, growing frustration with poor hospital quality and safety performance, and a shift in healthcare payments from fee-for-service to value-based reimbursement models. This article explores how these changes impact decisions to place doctors on the board; whether physician representation should be increased or decreased; the growing conflicts of interest that impact physician board members; and it provides some guidance for boards currently under pressure to increase physician representation.

Healthcare Changes That Compel Reassessment of Board Composition

The days when the board of a not-for-profit community hospital was simply an excuse for a quarterly "meet and eat" are long behind us. Hospital boards today are being challenged with enormously complex issues ranging from the financial, organizational, and legal to those regulatory and ethical. Now that healthcare costs have risen to 17 percent of the country's gross domestic product (GDP), various constituencies are demanding greater value from our healthcare institutions. This in turn means that boards have to move their organizations towards better quality performance, improved patient safety records, better integration of services, enhanced use of electronic health records, and greater levels of patient satisfaction. As reimbursement is increasingly tied to achievement in these areas, only hospitals that see real improvement in all of these dimensions will remain economically viable and competitive. Such improvements will require significant redesign of historic ways of delivering care.

The Value of Physician Participation on the Governing Board

Many healthcare organizations see physicians as the critical players to lead the needed transformation of our healthcare enterprises. The knowledge, insights, and support of doctors are perceived as critical to the effective redesign of health systems. This belief is manifested in tactics ranging from the revival of dormant physician–hospital organizations (PHOs), the engagement of physicians in leadership roles for the development of accountable care organizations (ACOs), enhanced efforts to provide physicians with leadership skills through hospital sponsorship of leadership academies, the formation of physician advisory cabinets to assist management, and, of course, increased physician representation on hospital boards.

Physicians contribute two particular assets through their presence on hospital/health system boards. The most traditional is their familiarity with medical practice and the insights it brings to the activities of strategic planning and quality oversight. Physician participation in strategic planning has become increasingly necessary as the pace of technological change in medical practice has accelerated. No hospital wants to make multi-million dollar investments in support of programs that might be obsolete in a short window of time. Physician knowledge of advances and changes in the field of medicine makes them critical participants in any long-term planning process. They also possess insights into the resources it will take to deliver clinical services adequately and whether or not community physicians are likely to support new initiatives with referrals.

> A significant gulf in trust exists between many hospital boards and the physician community on which their organizations depend.

Physicians also are more knowledgeable than the average lay person when it comes to setting the institution's quality agenda. The field of quality improvement is overflowing with initiatives, activities, advocacy organizations, regulators, suggested projects, and recommended benchmarks and targets. In the midst of all the commotion around performance improvement it can be hard for board members to separate the "wheat" from the "chaff" and create an effective quality agenda for their institution. Expertise to accomplish this can be obtained by adding individuals with facility in quality improvement to the board—frequently this means adding physicians.

If improved strategic planning and enhanced quality oversight have been long-standing rationales for physician membership on the board, the 21st century has brought an

1 Dr. Sagin gratefully acknowledges the input and assistance of Robin Locke Nagele from the law firm Post & Schell in Philadelphia, PA.

even more compelling motivation. The business model for healthcare in the United States is undergoing a significant transformation from a fragmented and balkanized delivery system to one with ever increasing degrees of integration. This means that hospitals and doctors will need to collaborate to a much greater degree than they have in the past. Hospitals and health systems that fail to align their interests and those of physicians in their communities will simply not succeed under changing reimbursement models and the demands for more patient-centered care. However, a significant gulf in trust exists between many hospital boards and the physician community on which their organizations depend. This mistrust may be baggage from previous collaborative efforts that failed. For example, many PHOs created in response to the managed care movements of past decades have proven unsuccessful and have not been sustained. Such failures leave doctors suspicious and dismissive of such collaborations. The growing business competition between doctors and hospitals over the past 10 years has also created frictions between these parties. Inevitably, traditionally poor communication between hospital boards and their physician communities exacerbates any frictions that exist. One tactic for overcoming physician mistrust and skepticism regarding hospital intentions is to increase physician representation on the board. Most professional medical communities have greater confidence in a hospital board when they know physician perspectives are consistently represented and physician expertise contributes to decisions made at the board level. It is currently this rationale, more than any other, that has boards across the nation contemplating the expansion of physician directors.

Which Physicians on the Board?

Once a board has decided to add physicians to its membership, a key question is, "which physicians?" Historically it has been common to have the p*resident of the medical staff* (or equivalent) attend board meetings as an *ex officio*[2] member with or without voting privileges. Giving this individual voting privilege is often seen as prudent to send a message to the medical community that its representative is not a "second class" member. However, it often creates confusion for the medical staff president who struggles to differentiate his or her role as medical staff voice and advocate from that of a fiduciary board member. For this reason it is often best to have medical staff officers attend board meetings either as standing guests or non-voting board members. In this way the medical staff officer can serve as an advocate for physician interests unencumbered by the responsibility of a fiduciary to put the interests of the hospital first.

Regardless of voting status, the value of having one or two officers from the organized medical staff serve on the board is diminishing as the traditional 20th century medical staff structure becomes less and less relevant to medicine as practiced in the 21st century. Boards that depend on such individuals to serve as the sole "voice of the medical staff" do so at their peril. Today's medical staffs are increasingly diverse. They are divided across multiple generations that view their professional roles differently. They are also increasingly divided by gender, by ethnicity, and by practice status (private practice vs. employment by the hospital). Within a single medical staff some physicians may be strongly aligned with the hospital while others are significant competitors with the organization. One or two medical staff officers can rarely adequately represent all of the diverse interests that comprise this varied group of professionals. Furthermore, since most such officers rotate out of office in one or two years, their tenure on the board is short and their value and contributions are consequently truncated. During their brief time of service they rarely have the opportunity to adapt to the culture of the board or to build strong working relationships with other board members.

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Another source of physicians for board positions is to recruit from the pool of *retired doctors* in the community. Such individuals often have a great deal of institutional memory and a wealth of experience with the politics of the medical community. On the other hand, they can be seen by their practicing colleagues as less credible choices to represent the medical community. Retired doctors may not be familiar with the contemporary challenges that face physicians in their offices or in their new settings as employed practitioners. This lack of contemporary practice experience also makes them less valuable to a board that is specifically seeking such knowledge through the addition of doctors to its ranks.

Many boards add *practicing community physicians* to their membership. Such individuals can provide the board the insights of someone actively negotiating the challenges of

Docs on Board: Compelling Rationales for Physician Expertise on the Board

Promotion of Quality

Many boards struggle with growing pressure to improve the quality and safety of healthcare in their hospitals. They understand the critical need for oversight of these dimensions of performance, but board members often lack the expertise to set meaningful quality goals or to evaluate the effectiveness of the medical staff and management in meeting whatever goals the board establishes. Physician board members, especially those with additional training in quality improvement and peer review, bring a critical dimension of know-how to this critical board oversight function.

Promotion of Hospital–Physician Alignment

In an era demanding new levels of hospital–physician integration and collaboration, the presence of doctors on the governing board serves several valuable purposes. Physician board members can reassure their colleagues that the interests of physicians will be addressed at the highest levels of newly integrated health systems. Such reassurance becomes increasingly important as doctors are asked to relinquish more and more of their historical autonomy and become part of integrated teams serving the mission of the hospital. Many doctors feel burned by past efforts at hospital–physician collaboration that were common during the managed care era of the 1990s. They are skeptical of the renewed efforts to bring the activities of doctors and hospitals into closer alignment and suspicious of the motives of health system management. Physician board members not only provide legitimacy to the board in the eyes of the medical community, but they also provide insight regarding which strategies for alignment are likely to succeed given the specific players on the medical staff and the business realities facing physicians in private practice.

2 An *ex officio* board member refers to someone who serves on the board by virtue of some official position they hold, such as chief medical officer or president of the medical staff. *Ex officio* members can be on the board with voting privileges or without voting privileges.

modern clinical practice and the perceptions of someone who regularly uses the services of the hospital. However, choosing which practicing physicians should sit on the board can prove politically sensitive. Should such doctors only be chosen from the ranks of those in private practice? Should they be drawn from the rising ranks of hospital-employed doctors? Should such members be drawn from influential large practices or from small or solo practices whose voices are less likely to reach the ears of the board? Many health systems are increasing their outpatient presence and community footprint, as medicine becomes less hospital-centric. Should physician board members be drawn from those who are hospital-based or from the growing cadre of doctors whose professional activities are largely in the community?

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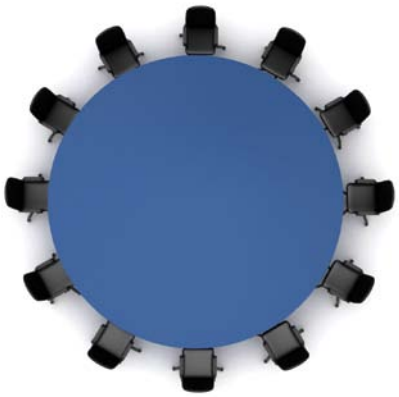
Perhaps the most sensitive of these questions has to do with the placement of *employed physicians* on the board. The percentage of hospital-employed physicians on the typical medical staff is rising exponentially in most parts of the country. As the baby boom generation of physicians begins to retire over the coming decade, it is likely that only a small percentage of medical staff members will remain in private practice.[3] Practicing physicians argue that it is essential for boards to have "independent" (i.e., non-employed) doctors as members. It is often their belief that employed physicians on a board will inevitably endorse the perspective of hospital management in order to protect their jobs. This deprives the board of the perspective of those who are supportive of the hospital but not on its payroll. Employed doctors retort that it is they who are fully aligned with the interests of the hospital and therefore can provide the board with input that is not compromised by competing self-interest. While both arguments have some merit, board appointment of physician members is often swayed by how essential the private practice referral business is to the fiscal health of the hospital. Given that most physicians in private practice are both collaborators *and* competitors with their local hospital, appointment to the hospital governing body can provide assurances to this group that the board wants "collaboration" to prevail. Some boards reach outside of their communities to find physician members. This tactic has several advantages. It can circumvent the tricky politics of selecting a local community doctor. It allows the board to seek out focused expertise from a national pool of candidates. For example, the board might add someone who has great experience in quality and patient safety matters or who is a highly respected physician executive with deep knowledge regarding the handling of professional affairs. However, there are downsides to going this route. An outsider may have less credibility with local physicians. In addition, it is often necessary to pay such individuals for their time and reimburse them for their related travel expenses. Large health systems may find the cost of an outside board member insignificant relative to the advantages. Smaller hospitals may find it is an essential expense because the expertise their boards require is simply not available in their own communities.



As discussed further in this article, from wherever physician members are drawn, issues arise relating to conflicts of interest, potential impact on the hospital's tax status, and compliance with the many laws addressing healthcare fraud and abuse.

Alternatives to Increased Physician Board Membership

Placing a large number of physicians on the governing board of a hospital or health system is not the only tactic for strengthening trust and alignment with community doctors. Nor is it the only approach to present the board with the expertise and insights of medical professionals. Hospitals and health systems across the nation utilize a variety of mechanisms for increasing their working relationships with the medical community.

Physician Advisory Councils

One such approach is the use of an advisory body of physician leaders who meet periodically throughout the year with members of the board. Many hospital CEOs have done something similar by establishing their own "physician cabinets" to assure effective communication with the medical staff. For the board, the advantage of such advisory bodies is the opportunity to include broad representation from the medical community, the avoidance of legal and regulatory complications, and the ability to keep the advisory council flexible and informal so its membership or functioning can be quickly adapted to any current crisis. Such bodies might meet quarterly with the board or more often if circumstances warrant. The message to the medical community is that the board values its input and the assurance to doctors is that their concerns can reach the board without being filtered through intermediaries such as the hospital CEO. It also allows the board to hear from physicians other than the officers of the medical staff who traditionally report to the board on physician concerns. As noted elsewhere in this article, the elected medical staff leader serving on the board in any particular year may or may not be an effective communicator or someone who can represent the full diversity of views held by the medical community. The use of an advisory council allows input from diverse perspectives and it can assure that the board hears from key physician stakeholders even when they are not holding leadership positions on the medical staff.

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Physician Participation in Board Retreats

A similar tactic for enhancing communication with doctors is to invite a significant number of formal and informal physician leaders to any periodic strategic retreats the board holds for its members. This might be an annual or semi-annual event and it can be a topical retreat or simply an opportunity to foster intense dialogue about the directions in which the board is leading the health system. As with advisory councils, this approach enhances critical dialogue between the board and physicians and assures doctors that they have the attention of board members even if they do not hold large numbers of board seats. If tensions have traditionally been high between doctors and hospital leadership, these retreats can be

3 Nearly 40 percent of currently practicing physicians are 50 or older. The younger generations of physicians and newly graduating medical residents who will replace those who retire demonstrate a clear preference for hospital employment over the burdens and uncertainties of the private practice of medicine.

facilitated by an outside expert to take full advantage of this opportunity to break down barriers and find common ground for collaboration. If nothing else is accomplished, there is value in simply providing a social activity in which board members and doctors can get to know one another as individuals.

Adding physicians to subcommittees allows a greater number of doctors to interact and get to know board members.

Physician Participation on Board Subcommittees

Many hospital boards have organized subcommittees to focus on particular responsibilities of the governing body. Subcommittees report to the full board and many of their actions can only take effect when ratified by the entire governing body. The following are common examples of board committees:

Professional affairs committee: A committee that deals with matters of credentialing and privileging medical staff members, provides oversight to episodes of corrective action or disciplinary measures, and addresses the complexities of medical staff development planning.

Quality and safety committee: Given the growing pressure on boards to increase their oversight and leadership regarding quality, an increasing number of boards are using such committees to bring greater intensity and expertise to this area of responsibility.

Finance committee: This is the most traditional of board subcommittees, designed to provide oversight to the organizations' financial affairs.

Compensation committee: This committee has grown more important as hospitals employ not just traditional senior managers, but more and more highly paid physicians. In addition to setting salaries and bonuses, the challenge of designing effective compensation models for employed physicians may fall to this subcommittee.

Other possible committees include those focused on legal and regulatory compliance, fund-raising, or *ad hoc* committees to look at potential affiliations or mergers.

Membership on these committees need not be restricted solely to governing board members. With the exception of the compensation committee, each could benefit from the appointment of physicians who can enhance the credibility of the committee's work with their unique perspectives and their specialized knowledge and skills. Adding physicians to these committees allows a greater number of doctors to interact and get to know board members. This familiarity in turn builds social connections and trust that can pay off when controversial issues raise friction between the board and doctors.

The chair of each board subcommittee must be sensitive to potential conflicts of interest that may involve physician members when specific matters are discussed. It is the chair's job to police such conflicts by inquiring or probing for adequate disclosures and when real or potential conflicts are identified, determine when a physician committee member should refrain from participating in a discussion or vote. This decision by the chair will always depend on the specific facts and circumstances at play. Because conflicts are always present and for additional practical and legal reasons, the compensation committee should always have a membership limited to lay community board members.

The Use of Leadership Academies

Several hospitals and health systems have undertaken efforts to enhance the non-clinical leadership skills of their physician staff members. This may entail sending doctors away to educational programs where they learn specific skills such as the effective performance of credentialing or peer review. Some hospitals bring speakers onsite to reach a broader physician audience. A considerable number have developed regular curriculums covering broad topic areas ranging from running meetings well to managing conflict, understanding new reimbursement models, or handling interpersonal disputes.[4]

At the same time, governing bodies have a responsibility to regularly educate their own membership on issues ranging from fiduciary responsibilities and strategic planning to compliance requirements and coming changes in the healthcare industry. Board education can be carried out through membership in organizations like The Governance Institute, by bringing speakers to board meetings, or through the use of periodic educational retreats.

There is considerable overlap in the educational needs of board members and physicians and curriculums can be developed that are germane to both groups. A combined leadership academy can be more efficient in the use of health system resources, promoting common knowledge on important issues, facilitating communication and understanding between doctors and board members, and providing common background for challenges requiring collaborative problem solving. The curriculum content of a combined leadership academy can be general in nature (e.g., trends in healthcare finance or "how to read a balance sheet") or it can be customized to address specific challenges (e.g., how to form an accountable care organization).

The Use of Subsidiary Boards

Many hospitals give careful thought to how best to organize their growing ranks of employed physicians. Eager to avoid the past failures that characterized hospital employment of doctors, many are forming multispecialty group practices as divisions within the health system or as legal subsidiaries.[5] Such arrangements provide a structure by which the employed physicians can maintain considerable autonomy and authority over their professional affairs. They remain accountable to the health system board and the institutional mission, but they don't feel powerless (and therefore indifferent) to affect the direction of events around them.

4 A sample curriculum or extensive list of topics that often comprise leadership curriculums is available from the author at ToddSagin@Gmail.com.

5 Eric Lister, M.D., and Todd Sagin, M.D., J.D. *Creating the Hospital Group Practice: The Advantages of Employing or Affiliating with Physicians.* Health Administration Press.

If the group practice is organized as a legal subsidiary of the health system, it may have its own governing board. This gives physicians a new arena in which to learn and hone the skills of serving as a fiduciary. The chair of the physician group's board may serve as a member of the health system board in an *ex officio* (voting or non-voting) capacity. This role is akin to that of the medical staff president who may hold a similar *ex officio* position on a hospital board. In both cases, the goal is to bring the voice of important physician constituencies to the deliberations of the hospital or health system governing body.

The physician's fiduciary duty is to subordinate their personal interests *and* those of the group they represent to the interests of the hospital or health system.

Legal, Financial, Regulatory, and Ethical Constraints to Physician Membership on the Board

Increasing physician representation on the corporate governing board may be a beneficial strategy for hospitals and integrated health systems. Nevertheless, it implicates a number of legal and tax issues with important potential ramifications for not-for-profit healthcare organizations. This is especially true if physician board members are asked to participate in decisions that can affect their own incomes or those of community physicians with whom they compete. Legal issues can arise with regard to any of the following:

- Compliance with fiduciary duties of loyalty and duty of care
- Avoiding "insider control" that could jeopardize the organization's tax-exempt status
- Avoiding "private inurement" or "private benefit" that could jeopardize tax exemption or subject the entity or its physician leaders to sanctions under the IRS's "intermediate sanctions" rules
- Antitrust laws
- Fraud and abuse statutes and regulations

A full discussion of these issues is beyond the scope of this article. It is always prudent to engage knowledgeable legal counsel when confronted with any of these issues.[6]

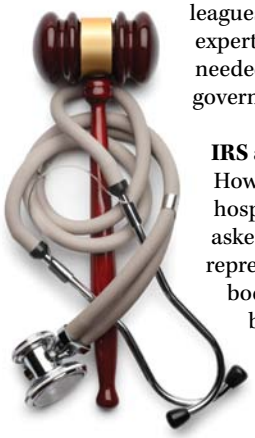
6 This article has been written to provide general information and is not intended to provide specific legal advice on the matters covered. Readers are recommended to obtain competent legal counsel to fully explore the issues outlined above.

Fiduciary Duties of Physician Board Members

All members of a hospital board have fiduciary duties as members. Primary among these is the duty of loyalty, expressed in the Model Nonprofit Corporation Act[7] as: "A director shall discharge his or her duties as a director, including his or her duties as a member of a committee, in a manner the director reasonably believes to be in the best interest of the corporation." This is often a challenging concept for new physician board members to embrace. Doctors frequently come to the board perceiving themselves as champions on behalf of the physician community. This is especially true if the physician sits on the board as an *ex officio* member because of a position they hold as an officer or leader of the hospital medical staff, an IPA[8] or PHO, an ACO, or an employed physician group practice. The physician's fiduciary duty is to subordinate their personal interests *and* those of the group they represent to the interests of the hospital or health system.

This duty of loyalty has potential to be compromised when a transaction being considered or undertaken by the board poses a real or potential conflict of interest for one or more physician board members. Examples include:

- Circumstances where competition exists between the hospital and private medical practices or other ambulatory business ventures
- Matters of physician compensation
- Medical staff membership and privileging issues
- Physician recruitment and retention agreements
- Medical staff development planning
- Network and compensation arrangements with managed care payers



A conflict-of-interest transaction is defined by the Model Nonprofit Corporation Act as, "a transaction with the corporation in which a director of the corporation has a direct or indirect interest." A board with diverse physician representatives in its makeup is more likely to find one or more of these members with a conflict on any number of the issues the governing body tackles. Of course, the mere presence of a conflict of interest does not violate the duty of loyalty. But directors with real or potential conflicts *must* disclose them and they and the board must then act carefully to assure the transactions they undertake are fair and appropriate. Boards that have a significant number of physician members should be especially careful to adopt rigorous disclosure policies and educate all board members in the importance of compliance.

Another fiduciary issue that must be contemplated when boards add physician members is the duty of care. All board members are required to fulfill a duty of care to the organization by acting (1) in good faith; (2) in a manner he or she believes to be in the best interest of the corporation; and (3) with the care an ordinarily prudent person *in a like position* would exercise under similar circumstances.

In looking at this last requirement, courts may take into consideration the special background and qualifications of the individual director. The duty of care compels board members with special expertise or knowledge to use it on behalf of the organization. Therefore, a court might hold a physician board member to a higher standard of care than a lay board member when applying the duty of care to a transaction involving a medical matter. Furthermore, lay board members are entitled to rely more heavily on their board colleagues who possess specialized medical expertise when such knowledge is needed to evaluate a matter before the governing body.

IRS and Tax Status Considerations

How many physicians can sit on a hospital board? This question is often asked as physicians push for greater representation on hospital governing bodies. The number is of concern because of long-standing worries by tax authorities regarding undue "insider" influence on the decision making of tax-exempt hospitals or healthcare institutions. Specifically, a non-profit hospital or healthcare system will be unable to maintain its tax-exempt status if it is controlled by physicians or other "insiders" whom the IRS regards as being motivated by their own private economic interests. In decades past, the IRS provided a "safe harbor" from enforcement action if physicians comprised no more than 20 percent of the governing board's voting membership. However, in concert with the trend to place more doctors on hospital boards and with the growth of complex integrated delivery systems, the IRS has taken a somewhat more relaxed approach in recent years. At a minimum, a non-profit

7 The Model Nonprofit Corporation Act, Third Edition, was adopted by the American Bar Association in 1987 with a third edition released in 2008. More than half of the states have adopted it in whole or in part to govern non-profit corporations under state law.

8 IPA stands for Independent Practice Association. An IPA is an organizational framework through which practicing physicians can collaborate to meet limited business goals.

hospital should ensure that a majority of voting members of the board are "independent community leaders" who have no personal economic stake in the hospital's strategic decision making. This requirement applies to corporate committees with board-delegated powers as well. Practicing physicians affiliated with a hospital are not considered "independent" because of their "close and continuing connection with the hospital" at a professional level. It is important to note that the prohibition against insider control includes not only physicians but also other hospital employees such as the CEO or hospital CMO who may serve on the board. Robin Locke Nagele, a healthcare attorney with the firm Post & Schell in Philadelphia, suggests having no more than 30–40 percent of the board comprised of physicians and other insiders in order to give the organization a margin of comfort. She also notes that in light of the IRS's rules against "private inurement" and "private benefit" (discussed below), a non-profit hospital should exclude from participation on a compensation committee, "practicing physicians who receive, 'directly or indirectly,' compensation from the organization for services as employees or as independent contractors."

In addition to the general protections against insider control, non-profit hospitals also must take special precautions to avoid financial arrangements with physicians that could be regarded by the IRS as "private inurement" or "private benefit" (i.e., diverting tax-exempt funds for the enrichment of private individuals or entities). The IRS developed intermediate sanctions rules in 1996 to allow the IRS to penalize "insiders" who improperly benefit from dealings with 501(c)(3) or (c)(4) public charities (which includes most tax-exempt hospitals). These provisions impose sanctions on disqualified persons ("insiders") who receive benefit from the not-for-profit hospital that exceeds fair market value. Sanctions can also be applied to "organizational managers," such as board members, who knowingly approve such transactions. Physicians serving on a hospital board are generally considered "insiders" for purposes of the intermediate sanctions rules.[9] Not all physicians affiliated with a hospital are considered "insiders" who are defined as individuals who can wield "substantial influence" over the affairs of the institution. But once a physician joins the hospital board, he or she most certainly will be regarded as an "insider" and become subject to the provisions of the intermediate sanctions law.

> Physician board members should recuse themselves from discussion and decision making that can give even the appearance of unlawful anticompetitive behavior.

Antitrust Concerns Relating to Physician Board Participation

Physicians serving on a hospital governing body are in a position to undermine the business success of competitors on the medical staff. Decisions that can suggest anticompetitive behavior include (but are not limited to): determinations regarding medical staff membership and privileges; the opening or closing of clinical services; the selection of other physicians to serve on the board; and decisions about adverse actions or disciplinary measures against other medical staff members. In addition, access by a physician board member to competitively sensitive information about a competing physician can raise concern under antitrust laws. Nagele points out that when financially interested physicians influence decisions that may negatively impact their competitors, this can not only create antitrust exposure *vis-á-vis* the federal government (FTC and Department of Justice) but, more often, can lead to costly and expensive litigation against the hospital and its insider physicians by the negatively impacted competitors. As a prudent practice, physician board members should recuse themselves from discussion and decision making that can give even the appearance of unlawful anticompetitive behavior.

Fraud and Abuse Statutes and Regulations

The federal government and the states have passed a maze of complex laws to reduce fraud and abuse in the two and a half trillion dollar healthcare industry. These laws often come into play when there are dealings of any kind between a hospital and physicians. The two major healthcare fraud and abuse laws are the federal anti-kickback statute, which makes it a crime for individuals and entities to knowingly solicit, receive, offer, or confer illegal financial inducements for referrals of federal healthcare program business,[10] and the federal Stark law, which prohibits physicians and healthcare entities with which those physicians have improper financial relationships from billing the Medicare program for any business referred by the involved physicians to the healthcare entities.[11] In addition, an increasing number of states have enacted their own fraud and abuse statute. Moreover, violations of either the Stark law or anti-kickback statute can create further significant legal exposure under the federal False Claims Act, which prohibits healthcare entities from submitting claims for payment to federal healthcare programs that have been "tainted" by violations of the federal fraud and abuse laws.[12] Nagele points out that the touchstone of all of these provisions are that financial relationships with physicians (and others) must be structured in a manner that is transparent and commercially reasonable, and that do not contain improper financial incentives that could lead to over-utilization of healthcare services or skewed medical judgment. As more doctors are added to hospital and health system boards, it will become even more incumbent upon board members to assure that undue deference to physician wishes does not lead their hospitals into suspect transactions under these various anti-fraud measures.

9 See Internal Revenue Code, Section 4958. Under the Code, intermediate sanctions may be used as an alternative to revocation of the tax-exempt status of an organization when private persons improperly benefit from transactions with the organization. The sanctions include paying back any "excess" payments that took place, plus stiff penalties.

10 42 U.S.C. § 1320a-7b(b).

11 42 U.S.C.A. § 1395nn.

12 31 U.S.C.A. § 3729.

Proactive Management of Conflicts of Interest

One of the most effective tools for avoiding trouble at the board level with violations of all of these laws is to have in place strong conflict-of-interest policies. These policies should be reviewed annually in conjunction with hospital legal counsel to assure they remain adequate in the face of changing legal interpretations and regulations. Board members should be encouraged to disclose anything they recognize as potentially raising a conflict of interest under these policies. Once a disclosure is made, there should be discussion regarding the significance of the conflict and whether it will require a board member to recuse himself from any discussions or votes on matters connected to the conflict. Such proactive management of conflicts will minimize potential future controversy and liability. Meeting minutes should reflect disclosures and how the board (or its leaders) determined the conflict should be managed.

Conclusion

There are many advantages to having physicians serve as voting or non-voting members of hospital and health system governing bodies. In particular, many healthcare institutions are seeking greater physician leadership to help them achieve financial and quality goals that have been elusive to date. Physicians are most likely to step up and be drivers of health system success when they feel they have influence at the highest levels of the organization. Nevertheless, many lay board members perceive physicians as too self-serving to be effective fiduciaries for their community institutions. As a consequence they resist the growing pressure to add to the complement of physicians on their boards. Rather than rejecting any additional doctors on the board, the better approach may be to find the *right* physicians to contribute to board activities. Such physicians will be aligned with the interests of the hospital, educated regarding their fiduciary responsibilities, knowledgeable in areas in which the board is seeking expertise, and have collaborative personalities that will not overwhelm those members of the board not steeped in the day-to-day activities of the healthcare community.

The traditional practice of drawing such physicians largely from the private practice community will need to be challenged in the coming years as employed physicians become growing majorities on hospital medical staffs. It will not be in the interests of a hospital to have their employed doctors feel like "second class" citizens who are taken for granted. A hospital-employed physician group practice that feels empowered to lead the constructive transformation of a health system will

be a strong recruitment asset as the national physician shortage worsens. Having employed doctors on the hospital board may raise tricky conflict-of-interest concerns that will need to be to be carefully monitored, but strongly engaging these doctors at the board level may be well worth the extra diligence involved.

In the years ahead, hospital/health system boards seeking physician input will need to reach beyond the tradition of appointing medical staff officers to the governing body and seek out physician representatives from a wide range of organizations, including large group practices, physician organizations (POs), ACOs, IPAs, employed physicians, and other critical community stakeholders. One way to do this is to create positions on the hospital or health system board for officers from these other entities (e.g. the president of the ACO, the chair of the employed physician group practice subsidiary, the medical director of the physician–hospital association). These are referred to as *ex officio* board positions since an individual holds a board seat by virtue of his official position in some organization within or outside of the health system. Hospital boards should be cautious not to create too many *ex officio* board positions for physicians. Doing so will diminish board control over who actually sits on the hospital board, since the *ex officio* appointments will go to individuals chosen in turn by their own respective organizations. This reduces board control over its membership and may cede too much control over hospital board membership to physicians.

Yet another concern is whether adding more physicians to the boards of healthcare organizations will create governing bodies that have too many members to operate efficiently? That is certainly likely if the total number of board positions is significantly increased to accommodate a larger cadre of physicians. The average hospital board is composed of around 13 members,[13] with many authorities suggesting that a board's efficacy diminishes once it reaches 20 or more members. The prudent action for most governing bodies seeking additional physician representation would be to have the new physician board members replace some existing non-physician board members. This can quickly become a politically sensitive maneuver unless current board members have been champions of increased physician participation and are willing to step aside to see the goal achieved. For this reason, many boards will want to consider the alternatives mentioned in this article, which increase physician input and communication with the board but do not necessarily assign them coveted board seats.

Those boards moving ahead to add physicians will need to recognize the potential concerns raised by the unique relationship between hospitals and doctors, the myriad laws regulating healthcare, and the high standards of fiduciary duty imposed on the board members of not-for-profit hospitals. But as our healthcare world transforms to adopt new 21st century models, it will be prudent for the composition of health system governing boards to adapt as well. As Albert Einstein so aptly expressed it: "Insanity is doing the same thing over and over again and expecting different results." Boards across the nation are expecting the organizations they lead to make significant changes to become stronger entities. Should boards expect any less from themselves?

The Governance Institute thanks Todd Sagin, M.D., J.D., for contributing this special section. He can be reached at ToddSagin@Gmail.com.

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