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The Best Directors Ask the Hardest Questions

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Jim Conway, former Executive Vice President and COO of the Dana-Farber Cancer Institute, remembers when his colleagues would congratulate him after a board or committee meeting saying, "Great presentation, Jim! The board didn't ask a single question!" This view of a "good board meeting"—elegant presentations by staff that consume 90 percent of the allotted time, leaving no opportunity for real questions, dialog, and productive disagreement—still seems to prevail in all too many boardrooms, especially for those portions of the board agenda that deal with topics on which many lay board members are not experts (i.e., clinical care, quality, and safety). When discussions on these topics come up, lay board members tend to stay silent, and defer to the doctors and nurses in the room.

But the board is responsible for *everything* in an organization, including the quality of clinical care. How does your board spend its time on oversight of quality and safety? Listening to PowerPoint presentations or having real conversations about the important issues? To improve discussions around quality and safety board members, either at the committee or full board level, should start by asking harder questions—even if they aren't doctors. This article provides some basic clinical quality questions that anyone on the board can ask.

Smart Questions Around Quality and Safety

Has everyone read the quality report in the packet? Yes? So could we dispense with the PowerPoint presentation of what's in the packet and spend our time talking about some of the hard issues raised by this report? The first thing most boards need to do is free up time for real conversation. The best way to do this is to put good information into the board packet, expect the board to prepare in advance, and never to "re-present" that same information at the meeting itself. Note that this idea works for the *whole* board agenda, not just clinical quality and safety.

Can you translate that into the number of patients who were affected last year? Board quality reports are often expressed as a confusing table of rates and percentages, displayed as red, yellow, or green, depending on whether the various measures are meeting targets. But what does "1.9 infections per 1,000 device days" mean? Directors tend to engage much more strongly about safety performance when they understand that it means "24 people got a preventable infection in our hospital last year—an infection that doubled their risk of dying."

What does "green" mean? For this measure, if we were "green," how many patients would still be having this problem? Boards set goals, which are often linked to management incentive compensation systems. For quality and safety, if performance is on track to achieve the goal, it's displayed as "green." But how high are your goals? Could your hospital or health system be "in the green" and still be harming a lot of patients? If so, are you okay with that? This question might provoke an interesting conversation at your next board meeting.

Does every doctor on this list for reappointment to staff faithfully follow all of our safety protocols and procedures? The medical staff recommends, and the board decides, which doctors will be allowed to practice at the hospital or health system. Medical staffs generally do an excellent job of making sure that candidates presented to boards are properly credentialed and technically capable. But in the era of accountable care, with its emphasis on safety, technical competence is not enough. Boards must also be assured that the doctors being approved for staff membership are *culturally competent*—particularly in their leadership of a culture of teamwork, and in their adherence to important safety rules and standards. If you were to ask the above question the next time you are

asked to approve a list of 40 doctors' names for reappointment, you probably wouldn't get a very clear answer at the meeting. But the board could, and should, then ask the medical staff leadership to return with a plan to assure the board that each doctor being recommended for reappointment is in fact leading, rather than impairing, the organization's safety culture.

There appears to be a solid business case for purchasing this new, expensive technology. Can someone tell me that the "safety case" is equally strong? Can we do this new procedure safely? How do you know? Boards usually insist on a solid return-on-investment analysis before approving major capital expenditures such as new surgical robots. But many new procedures have a fairly significant learning curve, and require substantial experience (and sufficient volumes) to be done safely. For this reason, some hospital and health system boards insist on very strict safety standards for new procedures and technologies, and require doctors to perform many of them under expert supervision before they're allowed to do them on their own. Other boards pay little or no attention to the "safety case" for these potentially very dangerous new activities. These boards need to change the conversation, so that the board prospectively weighs the safety risks of new technologies as closely as it does the business case.

Am I the only director who doesn't understand what you just said? Healthcare is an enormously complex enterprise, with a bewildering vocabulary, and an even more bewildering set of acronyms. As a board member, you cannot meaningfully participate in important conversations and decisions if you don't understand what's being said. I have watched the faces of the board members around the table when one of their colleagues has asked the above question, and the vast majority light up with relief! Don't hesitate to ask for clarification, especially on clinical quality and safety matters. You'll be speaking for many others in the room.

The best directors know that they are responsible for everything in the organization, especially what might go wrong in quality and safety. They don't passively listen to reports, and then vote on complex issues they don't really understand. Rather, they insist on real, meaningful conversations that air out concerns, and surface controversy. *The best directors do this by asking the hardest questions.*

The Governance Institute thanks James L. Reinertsen, M.D., President, The Reinertsen Group, for contributing this article. He can be reached at jim@reinertsengroup.com.

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