Elements of GOVERNANCE®

Providing CEOs, board chairs, directors, and support staff with the fundamentals of healthcare governance

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PHYSICIANS ON THE BOARD

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Elements of Governance®

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Elements of Governance® is designed to provide CEOs, board chairs, directors, and support staff with the fundamentals of not-for-profit governance. These comprehensive and concise governance guides offer quick answers, guidelines, and templates that can be adapted to meet your board's individual needs. Whether you are a new or experienced leader, the *Elements of Governance*® series will help supply you and your board with a solid foundation for quality board work.

About This Publication

This publication includes information from a *BoardRoom Press* article by Todd Sagin, M.D., J.D., national medical director of Sagin Healthcare Consulting, as well as multiple articles from The Governance Institute's advisors. See bibliography for a complete list of all publications cited in this report. The Governance Institute also thanks Pamela R. Knecht, president of **ACCORD** LIMITED and Governance Institute advisor, for reviewing and contributing to this publication.

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Introduction

Due to current challenges in healthcare, hospital and health system boards are reassessing their composition to determine the kinds of directors that will be the best fit to successfully lead their organization into the future.

AS HEALTHCARE ORGANIZATIONS FACE INTENSE PRESSURE to improve the quality of healthcare and lower the cost, it is becoming increasingly valuable to have physicians jump into leadership roles. While opinion has varied over the years about whether physicians should be board members of hospitals and health systems—hesitation that was mostly due to conflict-of-interest concerns—over the past several decades, many more boards have decided to increase the number of physicians sitting as directors. The passage of healthcare reform will only advance this trend; it is now clear that boards and senior leadership teams must involve physicians and other clinicians in discussions of policy and strategy regarding clinical care delivery and process redesign.

The reasons to have physicians on the board (or, at the least, involved in leadership activities) are plentiful. Physicians bring numerous strengths to a hospital board, including clinical expertise, an insider's view of the organization, and operational experience—all traits that will be helpful as leaders look to increase hospital–physician integration and improve patient safety and quality efforts. 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. Because of these known benefits, healthcare leaders are working to develop effective physician leaders and integrate them appropriately into governance roles.

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. This *Elements of Governance*® explores the benefits of having physicians on the board, considerations for choosing which physicians will be best as board members, possible barriers, and alternatives to increasing physician board membership.

The Value in Adding Physician Expertise

The 21st century healthcare arena is putting new demands on the governing board forcing boards to reassess the expertise and skills needed to successfully lead their organization. Many healthcare organizations see physicians as critical players in the changing healthcare landscape.

AS DEMANDS FOR GREATER VALUE PRESSURE HOSPITALS AND health systems to enhance their use of electronic health records, better integrate services, and improve quality performance, patient safety, and patient experience—and as reimbursement is increasingly tied to achievement in these areas—it is becoming clear that physicians have a lot to offer as members of the board.

While The Joint Commission does not prescribe that any number or percentage of board members must be elected by or from the medical staff, the presence of physician board members can definitely be beneficial. Boards should take time to discuss what percentage they feel most comfortable with, given the multiple needs to:

- Increase physician engagement in governance.
- Allow enough seats on the board for all of the perspectives that are needed.
- Ensure at least 51 percent of the board is independent to retain tax-exempt status.

According to The Governance Institute's 2011 biennial survey of hospitals and healthcare systems, the median hospital board has 13 members, including two medical staff members (this number is typically higher for system boards).[1] 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. The three main areas where physicians are exceptionally valuable are quality oversight, strategic planning, and hospital–physician alignment efforts.

Helping Improve Quality

Improving quality and patient safety is one of the most urgent issues in healthcare today. The Patient Protection and Affordable Care Act (PPACA) is full of provisions to encourage improved quality across the continuum of care. Medicare has begun to tie financial incentives to both quality of care and patient satisfaction, and regulators are expecting significant governance attention to be applied to quality-of-care issues across a broad spectrum of the board's agenda. Plus, the board has a moral and ethical obligation to guarantee that the organization is doing everything it can to keep patients safe and provide them with the highest-quality care.

While many board members understand the critical need for quality oversight and improved performance, they often lack the expertise to set meaningful quality goals or to evaluate the effectiveness of the medical staff and management in meeting these goals. Physician board members, especially those with additional training in quality improvement and peer review, are more knowledgeable than the average layperson 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. Physicians bring a know-how of the clinical side of the industry as well as in-field experience, giving them a valuable perspective on quality oversight—a critical responsibility of the board.

By including physicians in a meaningful way at the governance level, organizations set the message from the top that quality of care is a top priority. Physician board members can help with quality efforts in a number of ways, including:

- Sharing knowledge about the clinical side of care
- Helping the board to select quality metrics and set attainable targets
- Providing a greater understanding of how to use technology to improve quality
- Holding a position on the quality committee
- Getting other physicians on board with quality efforts
- Enhancing alignment and integration of physicians with the organization

Strategic Planning Insight

Physician participation is key to a successful, thoughtful strategic plan. Having physicians involved in identifying critical issues, developing a vision, and coming up with strategies to accomplish that vision ensures that physicians buy-in to the plan and advocate for its effectiveness. Strategic plans often have an impact on them, as well as their patients, so enabling physicians to have a voice in these major decisions is beneficial.

1 *Dynamic Governance: An Analysis of Board Structure and Practices in a Shifting Industry,* The Governance Institute's 2011 Biennial Survey of Hospitals and Healthcare Systems.

Physician participation in strategic planning has become increasingly needed as the pace of technological change in medical practice has accelerated. Physicians can help provide the rest of the board with an understanding of and "real-world" perspective on clinical issues and help in the development of effective new programs and patient services. No hospital wants to make multimillion dollar investments in support of programs that might be obsolete in a short window of time. This makes physicians valuable not just in strategic planning, but in financial planning decisions as well. 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.

As hospitals and health systems move toward customer-centered, cost-effective care, clinical expertise should always be taken into account. Physicians are closest to the patient experience and care processes, and have a lot to contribute to strategic plans that will impact the future of the organization.

Hospital–Physician Alignment

The business model for healthcare in the U.S. 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. 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.

One tactic for overcoming physician mistrust and skepticism regarding hospital intentions is to increase physician representation on the board and its committees. 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. Most professional medical communities have greater confidence in a hospital board when they know physician perspectives are consistently discussed 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.

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 both physicians in private practice and those who are employed by the hospital or health system.

Fostering Hospital–Physician Integration

Adding physicians to the board helps:

- Build trust between physicians, executives, and the board.
- Ensure physician concerns are discussed and considered.
- Increase physician confidence in board decisions.
- Align organizational goals with physician interests.

Choosing Which Physicians Belong on the Board

Determining who should be a member of the governing board is one of the key decisions the board makes. If the board does decide to add physicians to its membership, they need to think strategically about who is best for the position.

PHYSICIAN BOARD MEMBERS SHOULD—LIKE ANY OTHER board member—be fully committed to the organization's success and performance of their fiduciary duties, demonstrate integrity, think strategically, and be able to work collaboratively with others. They need to 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.

It is also smart to develop guidelines and policies around physician membership. There is no one-size-fits-all structure for this. Each hospital or health system is different and needs to take into consideration the unique factors at the hospital(s) and the current relationship between the hospital(s) and physicians. The board should also adopt "disabling guidelines" that bar or allow removal of directors for specific reasons (for example, they are direct competitors to the hospital or have violated confidentiality). Below are some examples of how to find the right physician leaders and the benefits and complications of each physician group.

When considering physician board membership, several questions need to be considered, such as:

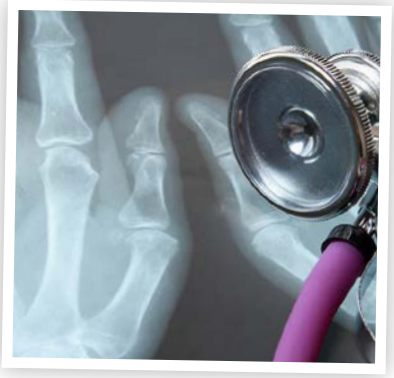
- What role are physician board members expected to play, and how many are needed to fill that role?
- What are the qualifications for physicians to be selected for the board? Are there any characteristics or business relationships that would disqualify a physician from board membership?
- What is the organizational structure that will best enable the medical staff, board, and senior leadership to collaboratively pursue the organization's goals (is it through physician board membership, a different physician leadership structure, or other methods of involving physicians in governance)?

How to Find the Right Physicians for the Role

Medical Staff Leadership

Historically, it has been common to have the president of the medical staff (or equivalent) be an *ex officio*[2] board member with or without voting privileges. Giving this individual voting privilege is often seen as prudent to send a message to the clinical community that its representative is not a "second class" member. However, it often creates confusion for the medical staff president who struggles to balance the conflicting roles of an elected medical staff representative and a fiduciary board member. For this reason, it may be better in certain circumstances to have medical staff officers attend board meetings as standing guests. In this way, they can serve as an advocate for physician interests unencumbered by the responsibility of a fiduciary who must put the interests of the hospital or health system first.

Regardless of voting status, the value of having one or two officers from the organized medical staff serve on the board is diminishing. 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, ethnicity, and 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. Furthermore, since most 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.



Retired Doctors

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. They also bring both expertise and independence since they are not active members of the staff. On the other hand, they can be seen by their

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

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.

Practicing Community Physicians

Many boards add practicing community physicians to their membership. Such individuals can provide the board the insights of someone actively negotiating the challenges of 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. The board and senior leadership should consider whether physician board members should be drawn from those who are hospital-based or from the growing cadre of doctors whose professional activities are largely in the community? Consideration should include aspects of clinical knowledge and experience the board is currently lacking; selecting a board member from the two different physician groups could provide a balanced perspective in this regard.

Employed Physicians

Perhaps the most sensitive of these questions has to do with the placement of employed physicians on the board. Internal Revenue Code permits the service of employed physicians on the boards of not-for-profit, tax-exempt health systems in virtually all states in the U.S. (except as prohibited by state code as in the state of Washington). As a result of being employees, employed physicians do have a conflict of interest that must be disclosed and addressed in accordance with the hospital or health system's conflict-of-interest guidelines, but they also have skills and insights that are valuable to the board. Hospital employment should not prohibit 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 of the board members (including all active medical staff members) meet the IRS's definition of "independence" for tax-exemption purposes.[3]

The percentage of hospital-employed physicians on the typical medical staff is rising exponentially in most parts of the country. As the baby boomer 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.[4] 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.

Outside Physicians

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 publication, 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.

3 Note: All physicians serving as active medical staff are considered by the IRS to be insiders/non-independent board members, regardless of whether they are employed by the hospital/system or in private practice.

4 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. Todd Sagin, "The Changing Face of Physicians on the Hospital Governing Board: Tactics for Promoting Board–Physician Understanding," *BoardRoom Press*, The Governance Institute, February 2011.

Identifying New Physician Leaders

In the current healthcare world, hospitals and health systems should spend time identifying physician leaders and preparing the most engaged, knowledgeable physicians for a role in governance. Those physicians who aspire to be in governance can begin to learn leadership skills that enhance both management and the ability to guide other physicians, clinicians, and medical staff toward clinical and financial benchmarks and drive them toward future success. Physician leadership development is much more accessible now through education and training, and physicians can take advantage of these programs in order to prepare for participation in leadership and governance roles.

As the board considers the idea of having physicians on the board or expanding their physician board membership, it should reflect on what characteristics make an effective physician leader and whether those skills translate to the world of governance. Some skills and qualities that the board can look for in future physician leaders include:[5]

1. **Collaboration and cooperation.** These are both mandatory traits. Finding compromises, welcoming new ideas, and often meeting in the middle are necessary attributes in leadership roles. Building new teams across the care continuum requires an open mind and a willingness to accept different ideas and change.
2. **Strong listening skills.** The collaboration and teamwork requires good listening skills. Good listeners hear the true message conveyed—not just the words. The ability to listen to conflict and disagreement while working towards cooperation must be developed.
3. **Communication skills.** Both verbal and written communication skills are critical. Clarity, precision of message, and the ability to be consistent and be heard are necessary to deliver a message of change. The ability to present and tell a story with listeners engaged and understanding the message is critical.
4. **Self-confidence and mental resilience.** Both are necessary for a change agent. Not all may welcome the changes in healthcare, and the agent of change at times needs to have tough skin.
5. **Humility.** Humility and the ability to accept the missteps and mistakes that will occur at times are essential. While this seems in conflict with the characteristic of self-confidence above, it is the balance of self-confidence and humbleness that will serve physician leaders very well in being effective at every level of governance and leadership.
6. **Lack of arrogance.** A lack of arrogance in giving direction and guidance is necessary. Transforming healthcare requires team-building as well as giving direction. However, the direction needs to invoke a collaborative and participatory environment—not one of "I say; you do."
7. **Appreciation for others.** An appreciation for others' thoughts, ideas, and input is vital. A team culture will only materialize when its members believe their voices are heard, their contributions matter, and their ideas are considered. People will defend and take ownership of decisions they have helped to make.
8. **Mentoring.** Mentoring team members must be in the skill set, and if it is not, then it must be developed. The skills to allow professional development of other physicians, clinical staff, and administrators may take time and effort but promotes successful, self-sustaining teams.
9. **Vision.** The vision to see beyond the short-term and stay the course toward the future is needed. True physician leaders have the vision to look to the future and navigate the system, physicians, and teams through the challenges of healthcare transformation to the next level and beyond.

The physician perspective is valuable in the boardroom and in senior leadership positions. Begin now to identify physicians with leadership potential and support their education, training, and coaching efforts consistently.

5 Graham A. Brown, et al., *Payment Reform, Care Redesign, and the "New" Healthcare Delivery Organization,* The Governance Institute, 2012 Signature Publication.

Barriers to Having Physicians 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. As discussed below, there are a number of legal issues that should be considered when choosing physician board members.

Legal issues can arise with regard to any of the following:

- Compliance with fiduciary duties of loyalty and 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

Legal Issues to Consider

Putting Fiduciary Duties First

Once elected, all board members are legally mandated to fulfill their fiduciary duties. Among these is the duty of loyalty, which requires board members to candidly discharge their duties in a manner designed to benefit only the corporate enterprise, not the individual interests of the board member. This is often a challenging concept for new physician board members to embrace. Doctors frequently come to the board perceiving themselves as spokespeople for 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 elected officer or leader of the hospital medical staff.

While physician board members can facilitate communications and working relationships amongst leadership groups, they are not there to formally represent the views of the general medical staff. The clearest way of viewing physicians on the board is to think of them as citizens who happen to be physicians. For example, bankers and lawyers on the hospital board are not expected to represent banking or legal professional interests, but rather to represent the community at large. The physician's fiduciary duty is to subordinate their personal and professional interests *and* those of the group they represent to the interests and mission 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

Ensuring that physician board members do not have a conflict of interest during a transaction can be complicated. Because they work in and around the hospital, there are opportunities for their decisions as board members to affect their—or their colleagues'—income and practices of medicine. Too often physician board members are asked to vote to approve new equipment, new programs, real estate purchases, and other issues that could affect their own income or that of their colleagues and referral partners, without sorting out where the various conflicts may lie.

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." Whenever an officer or director stands to gain materially, either directly or indirectly, from a specific transaction involving the organization, there is a potential conflict. Directors with real or potential conflicts *must* disclose them and they and the board must then act carefully to ensure 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 with the conflict-of-interest policy.

Another fiduciary duty that should be emphasized to physician board members is the duty of care. All board members are required to fulfill a duty of care to the organization by acting in good faith, in a manner he or she believes to be in the best interest of the corporation, and 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.

Physician board members, as well as other board members, should always be educated on their fiduciary duties during board orientation and reminded of them long after. Ensuring that board members understand the implications of their fiduciary duties and the obligations they have to the hospital or health system, will help board members steer clear of conflicts and other legal complications.

IRS and Tax Status Considerations

Hospital boards are under pressure from numerous sources, including the IRS, to demonstrate that their decisions are controlled by independent community directors, not by "insiders" or others with significant conflicts of interest. A non-profit hospital or healthcare system will be unable to maintain its tax-exempt status if it is considered to be controlled by "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. The IRS now requires that healthcare organizations show that:

- The board broadly represents the community.
- The majority of its members are independent of the organization.
- The board has adopted and operates under a conflict-of-interest policy.
- All components of the organization conduct periodic activity reviews to ensure the organization operates in a charitable manner.[6]

The IRS is increasingly interested in the independence of the not-for-profit hospital board. Employed and most other compensated physicians are not considered independent because of their close and continuing connection with the hospital when evaluating an organization's tax-exempt status. The IRS considers any member of the active medical staff to be an "insider."

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.

Antitrust Concerns

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
- 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. 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 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 anti-kickback statute:** 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.

6 Lawrence M. Brauer and Charles F. Kaiser, "Tax-Exempt Health Care Organizations Community Board and Conflicts of Interest Policy," 1997.

- **The Stark law:** 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.

An increasing number of states have enacted their own fraud and abuse statute as well. 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. 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.

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 ensure 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.[7]

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

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.

Other Options for Physician Engagement

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 advantages of such advisory bodies are the:

- Opportunity to include broad representation from the medical community
- Avoidance of legal and regulatory complications
- 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. The use of an advisory council allows input from diverse perspectives and it can ensure that the board hears from key physician stakeholders even when they are not holding leadership positions on the medical staff or board. The council can include physicians with multiple perspectives (employed, independent, primary care, specialty care, acute care, ambulatory, etc.).

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 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.

Get Physicians Involved

Physician leaders bring great value to a healthcare organization. Other ways to get them involved, besides board membership, include:

- Physician advisory councils
- Involvement in board retreats
- Participation on board subcommittees
- Education opportunities
- Membership on subsidiary boards

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 committee:** Given the growing pressure on boards to increase their oversight and leadership regarding quality, safety, and patient satisfaction, 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.

- **Governance committee:** A committee responsible for all matters related to board development (education, recruitment, self-assessment, etc.).

Other possible committees include those focused on legal and regulatory compliance, fundraising, 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 and audit committees, 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 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.

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.[8] 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.

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.

Physicians can and should also serve on other subsidiary boards within health systems. Often, subsidiary hospital boards choose to have a higher percentage of physician board members than the system board, which needs to be seen as highly objective. For instance, the system board may decide that two-thirds of its members will be independent (see the Panel on the Nonprofit Sector's recommendation), but that the hospital subsidiary will have 49 percent independent members. This allows for a higher percentage of the hospital board to be physicians. Physicians are also valuable members of the boards of other subsidiaries such as long-term acute care entities and health plans.

8 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, 2009.

Conclusion

Adding physicians to the board has become much more necessary in the last few years as the governance of healthcare organizations has become ever more complex. Currently, there are many advantages to having physicians serve as members of a hospital or health system board.

HAVING PHYSICIAN BOARD MEMBERS WILL NOT ONLY HELP achieve quality and financial goals, but will also help achieve clinical integration and improve the patient experience. While some may still be skeptical about physician board membership, the majority of hospital leaders see the benefits as outweighing the risks.

As boards move ahead to add physicians, they will need to be smart about choosing the *right* physicians for the board. Physician board members should be creative, strategic thinkers who bring a mix of needed skills to the table. The board should also recognize potential concerns raised by the unique relationship between the hospital and doctors, the myriad laws regulating healthcare, and the need to put fiduciary duties first. Helping physicians clarify their roles as board members, as well as clarifying their roles in the minds of the lay board members, is a key step in the process of shared leadership. Physicians are essential to the success of each and every health system and putting them in leadership positions helps ensure they have a voice. The physician perspective will only grow more essential to defining and executing effective board and senior leadership team activities in an era of value-based, affordable care.

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