

Physicians in the Boardroom: Contemporary Considerations for a Common Practice

By Todd Sagin, M.D., J.D., Sagin Healthcare Consulting

Over the past decade there has been growing recognition of the importance of physician leadership in our nation's hospitals and health systems. As these institutions struggle to transform to meet contemporary demands for quality, safety, and cost efficiency, it has become increasingly apparent that physician insight and buy-in are essential factors. Healthcare boards are recognizing this need to enhance physician engagement by exploring new tactics for doctors to participate in and impact the governance of their organizations.

In recent years, more and more boards have decided to increase the number of physicians sitting as directors. Adding clinicians 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/frontline experience. Nevertheless, there are many considerations that should be weighed when governing bodies seek greater participation of physicians in their work. This special section will explore these considerations, various tactics for physician engagement in governance, and the potential political, legal, and financial ramifications of the decisions made.

A Brief History of Physician Involvement in Governance

In the 20th century, there was wide variance in physician presence on hospital governing boards. At most institutions, it was common for the President of the Medical Staff (or Chief of Staff) to be present at board meetings to report on credentialing recommendations and represent the voice of the physician community. These medical staff officers might be at these meetings as a guest, a non-voting board member, or a full voting director. Since the board is charged with oversight of the medical staff, such representation

at the table made good sense. It was also common to find a retired doctor serving as a full board member—in most cases someone who had previously practiced locally and was well-regarded in the professional community.

In non-profit institutions, physician board participation has typically been limited by tax rules that require boards of such organizations to minimize the number of "insiders" serving in governance. "Insiders" are those whom the IRS sees as financially tied to the hospital (e.g., through direct employment, contracts for services, or use of the institution's facilities to generate income) and therefore motivated by their private economic interests.



In past decades, the IRS provided a "safe harbor" from enforcement action if physicians (or other insiders) comprised no more than 20 percent of the governing board's voting membership. Thus, it was rare to see more than one or two doctors on the typical board of a non-profit hospital.

Until recently, hospitals and physicians had a sometimes contentious working relationship, which also limited many boards' willingness to include physicians. In the 1980s and 1990s, managed care frequently undermined formerly collegial relations between doctors and hospitals. In later decades, hospitals and doctors found themselves competing with one another as physician-owned surgical and diagnostic centers multiplied and hospitals moved more aggressively into ambulatory services. Boards often were not willing to let potentially competing physicians into their strategic planning sessions.

The healthcare environment has continued to evolve dramatically as the needs of doctors and hospitals have once again grown more symbiotic with the rise of physician employment. The shift toward value-based purchasing and heightened public concerns

Key Board Takeaways: Discussion Questions

Should there be more physicians serving as board members? If so:

- What is the right number or percentage of doctors?
- How should they be selected? What qualifications should they possess?
- Should they be voting or non-voting board members?
- Should they be *ex officio* members (e.g., Chief of Staff, CMO, VPMA, or President of the employed physician group)?

Should more physicians be standing guests at board meetings? If so, should they be:

- Medical staff officers?
- Physician executives?
- Representative of employed physician group?
- Physician representatives elected at large?

Should more physicians sit on board subcommittees? If so:

- Which committees (e.g., professional affairs, strategy, quality)?
- How many spots on these committees should be held for physicians?

What alternatives to board membership should be considered that can bring physicians and board members together? For example, should board members participate in a standing joint council that periodically brings together key physician stakeholders, senior management, and trustees/directors?

Should some board members attend medical staff assemblies or standing committee meetings to build social capital with physicians and inform board oversight of the medical staff?

about quality and safety has required hospitals and doctors to increase their collaboration. Hospitals have moved into new territory with the assumption of financial risk through ACOs and clinically integrated networks (CINs). Healthcare organizations are challenged to engage in population health management and expand their footprint outside the traditional walls of their hospitals. To be successful in these changes, hospitals and physicians have needed to partner with greater synergy, forcing governing bodies to be more cognizant of the perspectives and needs of their practitioner communities.

Several other changes have pushed consideration of physician board membership into greater prominence. Enormous consolidation has taken place throughout the industry with ever-greater numbers of hospitals merging into multi-campus health systems. Where historical local hospital boards have been merged into a system governing body, the involvement of medical staff leaders has become more problematic. Furthermore, system board members are less likely to have regular contact with the physicians practicing in their facilities and risk becoming more remote and detached from the perspectives of the medical community. One result has been a push for more physician board members. This has been facilitated by the tax authority's more relaxed posture regarding the number of insiders on the board, which now states that at a minimum, a non-profit hospital or health system 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 has allowed more space to appoint physician board members than in the past.

The pressures of recent years have also caused many boards to become more rigorous in their own self-management. It is common for boards to create a grid of needed competencies to inform the selection of future board members or drive a needed expansion of board seats. In particular, the need to

Why Physicians on the Board?

Promotion of quality: Many boards struggle to improve quality and safety in their hospitals. While board members understand the importance of driving the quality agenda, they often feel they lack the expertise to set meaningful quality goals or to evaluate the effectiveness of the medical staff and management in meeting those goals. Physician board members, especially those with extra training in quality improvement and peer review, bring a critical dimension.

Promotion of hospital-physician alignment: Ongoing hospital success in a transforming healthcare environment will depend on strong physician integration and collaboration. Having physicians on the board can serve to reassure medical colleagues that physicians' interests will be addressed at the highest levels in the organization. This becomes increasingly important as doctors are asked to relinquish more of their historical autonomy and become part of integrated teams focused on the hospital's mission. Physician board members provide legitimacy to the board in the eyes of the medical community, and provide insight regarding which strategies for physician alignment and engagement are likely to succeed.

Insight into the institution's frontline challenges: Because physician board members are often practicing within the hospital, they become important sources of feedback regarding how the institution is functioning on the frontlines. This provides a source other than management to inform board members about issues such as workforce morale, adequacy of staffing and support services, patient perceptions of care, and more.

focus more on quality has driven many boards to bring more physicians into their deliberations.

Boards are anticipating growing problems with physician recruitment and retention, caused by the rise of physician employment by insurers, private equity groups, and large contract single-specialty companies, along with retiring baby boomers creating an acute shortage. At the same time, the retreat from a private practice model to employment has made many doctors

more mobile and transient in their work commitments. An indicator of a health system's attractiveness as a good professional home may be whether it provides an adequate presence of physicians on the board.

Expanding Physician Presence on the Governing Board

The case for adding physicians to the board is becoming increasingly compelling. Physicians are critical players in driving and sustaining any significant transformation in healthcare structures, processes, and results. The knowledge, insights, and support of doctors are critical to the effective redesign of healthcare delivery systems. Physician leadership in our healthcare institutions has grown exponentially as manifest in an increased number of physicians in executive roles (VPMA, CMO, CMIO, CCO, CCOO, etc.),¹ serving management roles in hospital-employed physician groups, acting as medical directors of hospital service lines, and providing governance to ACOs and CINs.

The upsides of physician boardroom participation are fairly clear. Doctors bring clinical knowledge and a sense of the direction medical science is leading the field; have insider insights into struggles on the frontlines; are acutely tuned to the concerns and complaints



1 These abbreviations respectively stand for Vice President of Medical Affairs, Chief Medical Officer, Chief Medical Informatics Officer, Chief Quality Officer, and Chief Clinical Operating Officer.

of patients; bring familiarity with tactics to improve the quality of care; can communicate the worries of the medical community; are especially helpful when performing medical staff oversight; and can foster engagement of their peers in the important strategic efforts undertaken at the institution.

However, there are downsides to increased physician board presence. Physicians can be intimidating to lay board members who may be reticent to voice questions and opinions at variance with those of the medical experts in the room. Because physicians on the board are frequently still in practice, they tend to draw board discussion into the weeds where their personal concerns and experiences can be addressed. Adding physician spots on the board may push out opportunities for others or it may increase board size to a point beyond the ideal. Physicians often see their board service as representing the interests of the practitioner community and fail to understand their fiduciary role as a board member. Furthermore, adding physicians to the board can trigger concerns by the IRS that can jeopardize non-profit status.

Which Physicians Should Serve in Dedicated Board Seats?

Once a board has decided to add physicians to its membership, a key question is, "Which physicians?"

Medical Staff Officers on the Board

Historically it has been common to have the President of the Medical Staff (or equivalent) attend board meetings. However, there is considerable variation in how this is done. Some boards give these individuals full voting membership, while others choose to grant *ex officio* board status without a vote. Still others make the Medical Staff President a standing guest at board meetings. There are advantages and disadvantages to each approach. Giving a medical staff officer membership without a vote can bind that individual to the fiduciary responsibilities tied to governance but preserve more seats for additional insiders who might be desirable as board members. It can also allay the worries of some lay board members that physician self-interest might bias critical board decision making. However, denying the vote may appear as a diminution of status in



the eyes of the medical community and undermine efforts to make physicians feel like true partners at the leadership table.

Giving the President status as a voting board member makes a statement that the input of clinicians is considered a priority, but it does have downsides. Since medical staff officers typically turn over after one or two years in office, their board membership is relatively fleeting. This means they rarely have the opportunity to build social capital and relationships of trust that enable a board to challenge itself with hard questions and decision making. Furthermore, serving as a full voting board member can create role confusion for an elected medical staff officer who may be torn between a fiduciary duty as a board member to put institutional interests first and his/her responsibility to advocate for the practitioner community that elected him/her to office.

Many boards choose to have the Medical Staff President serve as a standing guest. This eliminates the role confusion and everyone is clear that a medical staff officer sits in the boardroom to represent the voice of the physician community and advocate for practitioner interests. At the same time, it facilitates communication between the medical staff and the board, promotes transparency between these parties, and ensures physician concerns will be heard and considered in critical strategic planning and decision making.

Creating an *ex officio* position on the board for a medical staff leader is

also problematic as more and more hospitals are folded into health systems with a common governing body. Systems with multiple medical staffs need to determine which medical staff officers should attend board meetings. It is neither practical nor wise to have every medical staff represented at the table once more than two or three hospitals comprise the system.

Other Physician Leaders as Board Members

In contemporary hospitals and health systems, it is common to have physician leaders beyond just those in elected medical staff positions. Boards sometimes look to these clinicians to bring valuable perspectives and expertise to their member ranks. The most common of these leaders are CMOs and Presidents of hospital-employed physician groups. The former is valuable because he or she brings both clinical and executive skills and often works with multiple medical staffs in a multi-hospital system. The latter may be valuable because as more and more physicians become hospital employees organized into a multidisciplinary group practice structure, the health system has a critical interest in the effective functioning of this entity.

Physician Board Members in Multi-Hospital Health Systems

In multi-hospital health systems, the issue sometimes arises whether each institution needs a physician seat at the system governing body. As already mentioned, this can be impractical when inviting chiefs of staff to attend

board meetings. In most cases, a system board is unlikely to have enough member seats dedicated to physicians to allow someone from each hospital medical community. When creating dedicated physician seats or expanding their number, it is important for the board to communicate that its selections to fill the spots will be based on needed competencies and not geography. In most cases it is inadvisable to let an expectation take hold that each hospital will have a physician “representative” on the system board.

Of course, physicians can be appointed to local or regional hospital boards if these have been maintained in the health system. This makes good sense when such subsidiary boards are carrying out tasks delegated from the system board (e.g., credentialing and privileging).

Competency-Based Selection of Physician Board Members

Once the board moves beyond *ex officio* spots for physicians, it should fill any additional physician seats as it does any other board vacancy. A best practice is for the board to create a grid of needed competencies and then see where deficits exist in the skill set of the current board complement. It is important to remember that medical

school training alone does not provide doctors with the competencies for which they are often sought. For example, the typical clinician does not have expertise in quality improvement techniques, performance data management, population health, practitioner competency assessment, or other areas where the board members tend to turn to doctors for insight. The selection process for physician board members should be rigorous to ensure that the board’s effectiveness will be enhanced by their addition. In the past it was common for a board to seek out a well-respected, newly retired practitioner to fill an empty board seat. Historic service in the community or high regard for clinical acumen are no longer sufficient attributes alone to justify a seat on most boards. Retired doctors may not be familiar with the challenges that physicians face today in their private offices or in their new settings as employed practitioners. Boards may be better served looking to the ranks of mid-career physicians who have sought out additional management training, had experience in administrative roles, and have demonstrated leadership capabilities. In selecting a physician board member, the board should communicate clearly that it is seeking specific abilities in the individual it chooses. This may

help reduce potential political fallout in various physician constituencies who will be disappointed that their favored candidate was not selected.

Should Physician Board Members Be Sourced from Inside or Outside the Community?

Many boards add practicing community physicians to their membership. Such individuals can provide the board with 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 physician should sit on the board can prove politically sensitive. Should such doctors only be chosen from the ranks of private practitioners? Given that most physicians in private practice are both collaborators *and* competitors with their local hospital, appointing one of their own can assure this group that the board wants “collaboration” to prevail.

Should new appointees to the board be drawn from the growing ranks of hospital-employed doctors? Some argue that such doctors can never serve objectively because their paychecks come from hospital management. On the other hand, excluding this group deprives the board of participation from a physician whose interests are fully aligned with the institution and whose input is not compromised by competing self-interest.

Should physician board members be drawn from influential large practices or from small or solo practices whose voices are less likely to reach the ears of board members? As hospitals focus increasingly on the outpatient setting, should physician board members be drawn from those who are hospital-based or from the expanding cadre of physicians whose professional activities are largely based outside the hospital’s walls? While these are all relevant considerations, a board will be best served by looking to its needed competencies and selecting the physician who can best provide them.

When should a board consider going outside its community to seek board candidates? In some locales it may be difficult to find a physician with the desired competencies to fill an open board seat. Going outside the community lets the board seek out strong options from a national pool



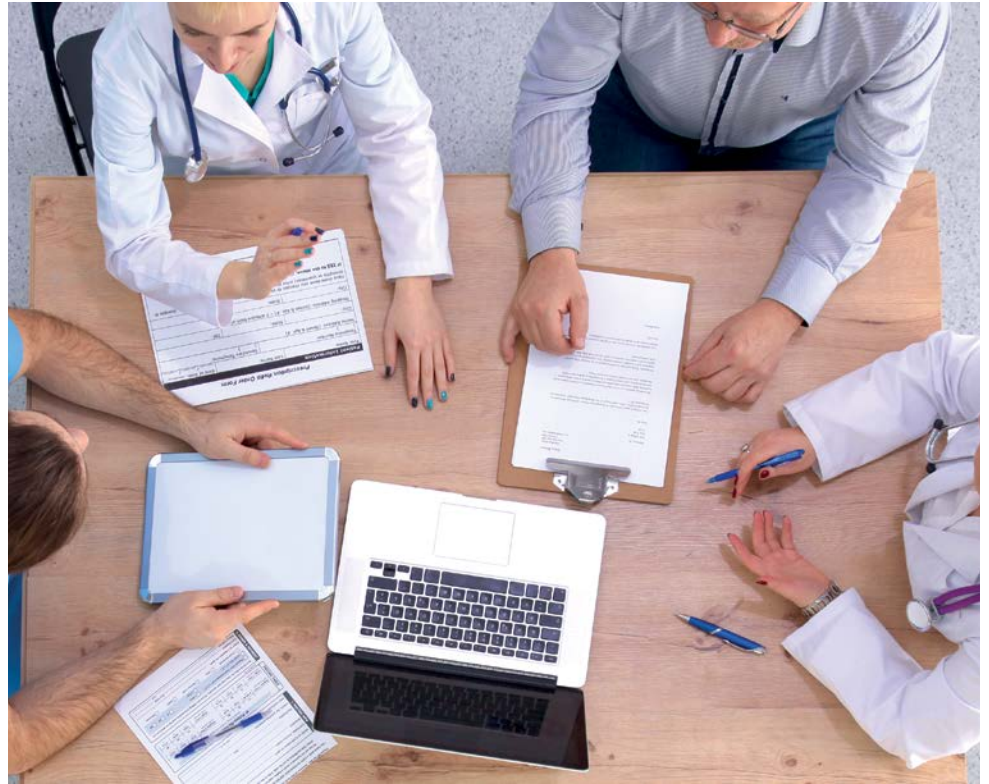
of candidates. For example, the board might seek out a national expert in quality and patient safety or a respected physician executive with deep knowledge regarding the handling of professional affairs. Bringing external experts onto the board is a common practice in many corporate boardrooms outside of healthcare. However, there are some clear downsides to going this route. Such individuals may wish to participate virtually in board meetings to avoid extensive travel. This creates a board member who has less ability to build valuable relationships with board colleagues and fully participate in board discussions. An external or outside candidate may have less credibility with local physicians. In addition, it is sometimes necessary to pay these practitioners for their time and reimburse them for travel expenses. Large health systems may find the cost of an outside board member insignificant relative to the advantages. Smaller hospitals may find it an essential expense because the expertise their boards require is simply not available in their own communities. Of course, paying some board members for their time and not others can create its own problems. Many board members give extraordinary amounts of time and dedication to their institutions and would likely feel affronted by a decision to pay an outsider for their periodic appearances at board meetings.

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

A board will be best served by looking to its needed competencies and selecting the physician who can best provide them.

Physician Participation on Board Subcommittees

Board subcommittees are often comprised of a mix of board members and non-board members. This provides an opportunity to involve more physicians in governance activities than a



limited number of physician-designated board seats would otherwise permit. These committees also provide an important setting for physicians and board members to interact, communicate, and build working relationships. This familiarity in turn builds social capital and trust that can pay off when controversial issues raise friction between the board and the medical community.

Some subcommittees are better choices than others for physician participation. Obvious candidates are professional affairs committees (commonly focused on medical staff oversight including credentialing, peer review, and corrective actions) and quality and patient safety committees. When boards establish special or *ad hoc* committees to explore strategic options including possible affiliations or mergers, physician involvement should be robust.

Each board subcommittee chair must be sensitive to potential conflicts of interest that may involve physician members. It is also important for the chair to ensure that physicians do not dominate discussion. As clinicians whose livelihood is directly impacted by board work, doctors frequently attend these meetings with passion and strong predilections. These feelings should be

harnessed constructively but need to be kept in perspective by lay members of the committee.

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

Increasing physician participation in governance implicates a number of legal and tax issues with important ramifications for non-profit healthcare organizations. Serving on the board often puts these physicians in a position where they may contribute to decisions that have an impact on their own incomes or those of community physicians with whom they compete. Legal and tax issues that can arise include the following:

- Has the physician board member complied with fiduciary duties of loyalty and duty of care?
- Do the number of physicians on the board create a concern about “insider control” that could jeopardize the organization’s tax-exempt status?
- Is there an issue of “private inurement” or “private benefit” that could jeopardize tax exemption or subject the organization or its physician leaders under the IRS’s “intermediate sanctions” rules?
- Could an outside party claim that physician participation creates an

anti-competitive conspiracy in violation of federal or state antitrust rules?

- Is there a possibility that physician decision making at the governance level will implicate fraud and abuse statutes or regulations?

A complete discussion of these issues is beyond the scope of this article. Boards should always engage knowledgeable legal counsel when making decisions regarding physician participation in governance and whenever confronted with any of these issues.²

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 Act³ 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 can be 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 he/she holds as an officer or leader of the hospital medical staff, ACO/CIN, or an employed physician group practice. The physician's fiduciary duty is to subordinate their personal interests *and* those of the group he/she represents to the interests of the hospital or health system.

This duty of loyalty has the 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:

- Competition between the hospital and private medical practices or other ambulatory business ventures
- Physician compensation
- Medical staff membership and privileging concerns

- Physician recruitment and retention agreements
- Medical staff development planning
- Network and compensation arrangements with third-party 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 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.

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.

IRS and Tax-Exempt Considerations

How many physicians can sit on a hospital board?⁴ This question is often asked as physicians push for greater representation in governance. 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. Specifically, a non-profit hospital or health 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 physicians on

hospital boards and with the growth of complicated integrated delivery systems, the IRS has taken a more relaxed approach in recent years.

At a minimum, a non-profit 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, even if not directly employed, 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 applies not only to physicians but also other hospital employees such as the CEO, CNO, or physician executives such as a VPMA or CMO. On the other hand, this concern might not exist where a physician from outside the community is brought in to provide the board with unique expertise.



² 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 discussed in this publication.

³ 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.

⁴ ACO boards structured according to the CMS guidelines for the Medicare Shared Savings Program (MSSP) have different requirements regarding the number of physicians on the board. For more information, see, e.g., <http://bit.ly/2xmTACq>.

Case Example: Scripps Health

Scripps Health has undergone a dramatic transformation from a struggling health system losing \$15 million a year in 1999 to a \$2.9 billion enterprise (2.3 percent margin) in 2017. The health system has been named to Fortune's "100 Best Companies to Work For" 11 consecutive years.

Unlike many other non-profit health systems, Scripps has opted not to include physicians on its board. Its 16 members represent a variety of industries and eight members are retirees. Despite the lack of physician representation on the board, the importance of physician engagement in decision making is critical at Scripps.

Chris Van Gorder, President and CEO, credits much of Scripps' success during his tenure with the formation of a Physician Leadership Cabinet (PLC), which acts as an advisory committee to hospital leadership and the board. The PLC has significantly enhanced trust and collaboration between medical staff and administration. Physician leaders' voices are consistently heard and acted upon, as demonstrated by the fact that 100 percent of PLC recommendations have been adopted during the 18 years since the PLC's existence.

Physician leaders have also been elevated in the recent restructuring of health system operational leadership. Scripps eliminated the CEO position at each of its regional hospitals and has adopted an operational model by which each hospital is jointly led by a non-physician chief operations officer and a physician operations executive. The restructuring provides more balance to local leadership between administrators and medical staff and is also expected to reduce costs.

Many lawyers advise governing boards to limit "insiders" on the board, including physicians, to no more than 30–40 percent of the board's complement of voting members. They also recommend that in light of the IRS's rules against "private inurement" and "private benefit,"⁵ a non-profit hospital should exclude from participation on any compensation committee, practicing physicians who receive (directly or indirectly) compensation from

the organization for services as employees or as independent contractors.

Antitrust Concerns Relating to Physician Board Participation

Physicians serving on the board 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 specific 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. 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

Hospital and health system decisions regarding physicians always have potential to run afoul of federal and state efforts to prevent fraud and abuse. Any payment to physician board members should be carefully reviewed by counsel to ensure that fraud and abuse laws are not implicated. A board with strong physician presence must always take care that physician preferences don't push the board into making decisions that could create liability under these laws. A further discussion of this topic is beyond the scope of this article, but resources for further information abound.

Physician participation at the governance level can be increased by allowing more physicians to attend board meetings as invited standing guests and recognizing that they come to represent a specific constituency. This approach avoids problematic growth in board size, inadvisable numbers of insiders on the board, and role confusion on the part of doctors who attend board meetings.

Preparing Physicians for Board Service

Physicians face some unique challenges when they assume board roles. As already mentioned, they often become confused and conflicted around the tension between their fiduciary duty of loyalty and their desire to represent the hospital medical community. Doctors also tend to be hands on problem-solvers and lack a good understanding of the difference between governance and management. For this reason, they often want to get into the weeds rather

⁵ 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 intermediate sanctions rules. 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.

than focus on larger strategic issues and institutional vision. Physicians are also typically self-confident and are sometimes hesitant to reveal their lack of knowledge about issues being discussed in the boardroom.

Physicians should be given a thorough orientation to board service just as any other new board member will receive. However, some customization may be warranted to address the concerns above. It can also be particularly helpful for new physician board members to be paired with an experienced member as a mentor. Regular discussion with a mentor can reinforce the messages communicated in orientation and provide the new physician with both feedback and a role model.

Alternatives to Increased Physician Board Membership

Placing a large number of physicians on the 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 make available to the board 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 their medical communities.

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 ensure 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 and 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 communicated to the medical community is that the board values its input and is interested in hearing firsthand about their concerns, without them first being



filtered through intermediaries such as the hospital CEO. This structure 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 above, the elected medical staff leader attending board meetings 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. Advisory councils allow for input from diverse physician perspectives and can ensure that the board hears from key physician stakeholders even when they are not holding leadership positions on the medical staff. Such councils also make it easier to include the voices of non-physician practitioners, a growing cohort of clinicians at most hospitals.

Physician Participation in Board Retreats

Another tactic for enhancing communication with doctors is to invite a significant number of formal and informal physician leaders to board retreats. 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 hospital or 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. These retreats are also an occasion for building social capital between board members and doctors. If tensions have historically 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.

Conclusion

The primary reasons for including physicians in governance are: 1) having access to critical medical expertise for the purposes of quality and patient safety improvement and medical staff privileging and credentialing; and 2) to maintain and/or improve relations between the hospital/system and physicians. Whether the physicians are voting or non-voting board members, or engaged via an advisory council, boards must ensure that physicians contribute significantly to strategic-level and quality-related leadership decisions affecting patients and the community. There are many options, as discussed in this special section, that accomplish these goals while appropriately addressing conflicts of interest, representational issues, and other concerns. Boards that do not have sufficient engagement of physicians in governance are putting their organizations in a poorer position to meet today’s increasingly high expectations of survival in a dynamic healthcare industry. ●

The Governance Institute thanks Todd Sagin, M.D., J.D., President and National Medical Director of Sagin Healthcare Consulting and Governance Institute Advisor, for contributing this article, and Brian J. Silverstein, M.D., Director, The Chartis Group, and Governance Institute Advisor, for contributing the case example on Scripps Health. Dr. Sagin can be reached at tsagin@saginhealthcare.com.