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"Due Care" and the Relationship of a Governing Board, the CEO, and the Medical Staff

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Governance, Management, and Operational Performance of a Licensed Hospital

Governing boards of community hospitals in the U.S. have a duty of "due care" as it relates to the organization's operations and performance. This duty derives from the description of the responsibilities of a "fiduciary" and means that a director must exercise appropriate diligence—doing what a reasonable person would do in the same situation with the same information—in making decisions for the organization when overseeing its management.[1] The duties and responsibilities of the board as a fiduciary body extend to the CEO and all members of the medical staff, whether operating as independent members of the hospital medical staff, employees, or contract providers of professional services within the health system.

Confusion at the governance level frequently occurs as it relates to the complexity of the relationships between the board, CEO, senior leadership team, independent members of the hospital medical staff, and employed and contracted physicians (i.e., "Who is accountable for whom, what, when, and how?"). This confusion led to multiple legal cases including those involving patient care and related harm.[2]

This article addresses the duty of "due care" in practice, with special attention paid to the CEO's role and the relationship between the community hospital/health system board and the identified "medical staff" in all of its forms. It provides direction to boards as they face an increasingly complex array of organizational designs, business relationships, and decisions made within the context of systems, processes, and leadership constructs of today's hospitals and health systems.

Key Board Takeaways

When considering the roles and relationship of the board, CEO, and medical staff, it is important for board members to:

1. Ensure they understand the requirements of a "fiduciary" as they apply. Boards of licensed hospitals and health systems are not "advisory." They are deemed to be "fiduciaries" and in charge of the management and performance of the organization.
2. Always exercise "due care," including for matters relating to the function of the formal medical staff and its role as "agent advisor" to the board. The executive structure of the formal medical staff must have a direct reporting relationship to the board. Executive management facilitates the ongoing functionality of the relationship but does not control or direct the relationship.
3. Fully understand the nature of employed physicians' relationship with the medical staff, the organization, and the board, including aspects relating to physician employment agreements. While physicians employed by the hospital or health system may be members of the formal medical staff, this body is not responsible for the performance of physicians as employees. The employer remains "primary" as it relates to the actions of physicians as employees.

Due Care and the Board's Relationship with the Medical Staff

The relationship between the medical staff and the board is the subject

1 Daniel Zismer and Kevin Egan, "The Board's Accountability for Complex Healthcare Strategies: Exercising 'Due Care' in the Face of Unfamiliar Organizational Strategy and Strategy in Action," *BoardRoom Press*, The Governance Institute, August 2016.

2 See e.g., *Mitchell County Hospital Authority v. Joiner*, 189 S.E. 2d 412 (Ga. 1972) and *Darling v. Charleston Community Memorial Hospital*, 211 N.E. 2d 253 (Ill. 1965, cert. denied, 383 U.S. 946, 1966); see also *Gilbert v. Sycamore Municipal Hospital*, 156 Ill. 2d 511, 622 N.E. 2d 788 (1993).

Connecting the Board to Hospital Licensing and Control

For review, the existence of a licensed hospital derives from its incorporation in the state within which it operates. The articles of incorporation and/or corporate bylaws provide for the purpose of its existence. Upon incorporation, and for the full life of its existence, it possesses a board of directors (sometimes referred to as a board of trustees). The board derives its authority from state law (the state in which the hospital is incorporated) and the corporation's resultant articles of incorporation (and related bylaws), which together align the mission, responsibilities, and accountabilities of the hospital with state statute and state licensing requirements.

The board may not abdicate or delegate its final decision-making authority and it retains supremacy in all decisions, actions, responsibilities, and accountabilities as they relate to operations and performance of the institution that it governs. Governing boards are not "advisory" but are rather controlling in nature.

of occasional and intense debate in the nation's courts. Some courts recognize the independent existence of a medical staff, as was done by the Minnesota Supreme Court in the case of *Medical Staff of Avera Marshall Regional Medical Center v. Avera Marshall*.[3] Other courts do not, as was noted distinctly in the dissent in *Avera Marshall*.[4]

The majority in *Avera Marshall* concluded that the Avera medical staff was capable of suing and being sued independently and further decided that the hospital's medical staff bylaws formed a binding contractual relationship between the two. This decision thus increased the medical staff's status as being something more than merely a department of the hospital and a creature of the hospital's board.

Rather confusingly, the Supreme Court ordered the case remanded to the lower court for further proceedings "consistent with this opinion." When the case returned to the lower court, that court considered the matter further and concluded that the board did indeed possess ultimate authority over the hospital's medical staff. Further, the court held that the medical staff and its member physicians served only in an advisory capacity to the board and had no power to veto any board decisions. Thus, in a roundabout way, this litigation confirmed the supremacy of not-for-profit boards over their medical staffs.

The ultimate conclusion of the *Avera Marshall* litigation tells us that a medical staff of a hospital is considered to be "agent advisor" to the hospital or health system board. That is, a medical staff exists to advise the board in many areas including:

- Medical policies
- The qualifications and competencies of medical staff members
- The identification and management of problems relating to the care of patients by the hospital and affiliated members of the medical staff, as well as the establishment of standards of care
- The scope of practice of clinical professionals treating patients in the hospital

As is the case with other professional advisors to the board, directors are not required to possess the knowledge of medicine, nursing, or that of other licensed healthcare professions to carry out its appointed duties. Instead, it must rely upon the advisory function of its affiliated medical staff just as it does with other professionals in advisory roles such as legal and tax advisors. As noted above, a governing board is required to take "due care" in managing the often-delicate relationship between the board itself and the formal medical staff.

The advisory functions and responsibilities of the medical staff are most always provided for in the written medical staff bylaws of a licensed hospital. These bylaws delineate the responsibilities of the formal medical staff as they relate to the board and typically describe the specific activities and actions required of the medical staff as it discharges its responsibilities on behalf of the board.

Because of this unique advisory relationship between the medical staff and the board, there is conflict among various states regarding the independence of a medical staff and its separate existence from a hospital. However, it would seem that the ultimate disposition of *Avera Marshall* by the lower court seems to carry the day from an operational perspective. Accordingly, we should accept the following key terms as governing a board–medical staff relationship:

3 *Medical Staff of Avera Marshall Regional Medical Center v. Avera Marshall*, 857 N.W 2d 695 (2014).

4 The forceful dissent went the opposite direction, concluding that the medical staff was controlled by the corporate bylaws of the hospital and accordingly lacked the power to overturn any valid business decision made by the board. Citing cases from several other jurisdictions, the dissent argued that a hospital board and its bylaws controlled the relationship between the hospital and its medical staff. See *Mahan v. Avera St. Luke's*, 621 N.W.2d 150 (SD 2001); *Radiation Therapy Oncology, P.C. v. Providence Hospital*, 906 So. 2d 904 (Ala. 2005); and *Bartley v. Eastern Maine Medical Center*, 617 2d 1020 (Me. 1992).

- The medical staff exists as a constituent part of the hospital/system. It has no purpose or standing as a legal entity nor has it the capacity to bargain with the hospital boards.
- It is advisory with its scope of activity and responsibilities in this regard, which is delineated in the medical staff bylaws.
- It recommends actions to the board often through a medical executive committee (MEC), a formal, functioning subcommittee of the medical staff.
- It is typically the case that authorities regarding changes or amendments to the medical staff bylaws remain unilaterally with the board, as the medical staff is a product of the bylaws of the organization and does not exist independently.
- While the medical staff is functionally "self-governing," it operates in accordance with bylaws approved by the hospital board. The medical staff's role is one of support to the responsibilities and accountabilities of the board and accordingly exists as an agent of the board.

With this in mind, it is important to remember that the medical staff, due to the special nature of its collective base of knowledge and experience, is relied upon by the board to carry out its purpose and function as designated, which requires it to have a direct line of report to the board.

The nature of the advisory role of the medical staff enables the board, and its constituent members, to partially fulfill its legal and ethical "duty of care":

> "The duty of care requires that directors (trustees) exercise independent judgment in the exercise of their responsibilities on behalf of the organization and that they be reasonably well informed. The duty of care suggests that directors take the time needed to study, understand, and discuss matters that are brought to their attention. Directors are required to act in good faith and to exercise sound and informed judgment in making organizational decisions."[5]

There is no legal bright-line test of "due care"; cases involving issues of due care are decided by a judge or jury based upon the evidence produced at trial and each factual pattern is different.

In summary, the board ultimately controls all aspects of the mission and operation of the organization and is responsible and accountable for its performance by both law and regulation. Management and the medical staff exist as instruments of the board to effectively carry out its assigned responsibilities and authorities.

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Employed Physicians, Due Care, and Governing Boards of a Health System

Boards should expect that the health systems they govern will employ physicians at accelerating rates. Employed physicians are typically contract employees of health systems meaning their employment is governed by a written employment agreement between the organization and employed physicians. Employed physicians are typically members of the formal medical staff of the hospital(s) controlled by the health system.

While employed physicians are subject to all requirements of the governing bylaws of the formal hospital medical staff, the hospital medical staff is not primarily responsible for the behaviors and performance of employed physicians, as specified in their employment agreements.

Board members of health systems do hold a responsibility of due care as it relates to the physicians employed within the health system. Governing boards are responsible to know and understand how physicians employed by the organization are accountable to the organization under the terms and conditions of their employment agreements, and are responsible to know and understand the means, methods, structures, and individuals responsible for the performance of the physicians employed by the organization. The proper exercising of "due care" as a board member, in this regard, extends beyond the knowledge that employment agreements, and related compensation plans, meet legal, regulatory, and fair market tests. Likewise, the health system, the governing board, and by extension, senior leadership, are responsible and accountable for the medical care delivered by physicians within their employ. Employed physicians operate as "agents" of the health system.

"Due Care" as It Relates to Hospital Administrators

As cited, management exists to carry out the healthcare organization's mission, vision, strategic plan, clinical services plan, and operating and capital budgets as approved and directed by the governing board.

The functions of hospital management are generally the acquisition, organization, deployment, management, and evaluation of human resources,

5 Gary Filerman, Ann Mills, and Paul Schyve, *Managerial Ethics in Healthcare: A New Perspective*, 2013.

capital assets, financial assets, and related and required third-party arrangements needed to achieve the vision, mission, and plans of the hospital as directed and overseen by the board, which operate as the ultimate authority of the organization. Hospital management operates within and through governance and an organizational structure provided at the approval of the board (see **Exhibit 1**). This structure identifies, organizes, and links together the programs, services, and functions provided to care for patients.

Hospital management serves as a facilitating link between the formal medical staff body and the board. Since the formal medical staff does not report to or through hospital management, typically the chair of the MEC and the CEO will collaborate to ensure that the board is well-served by the operations of the formal medical staff.

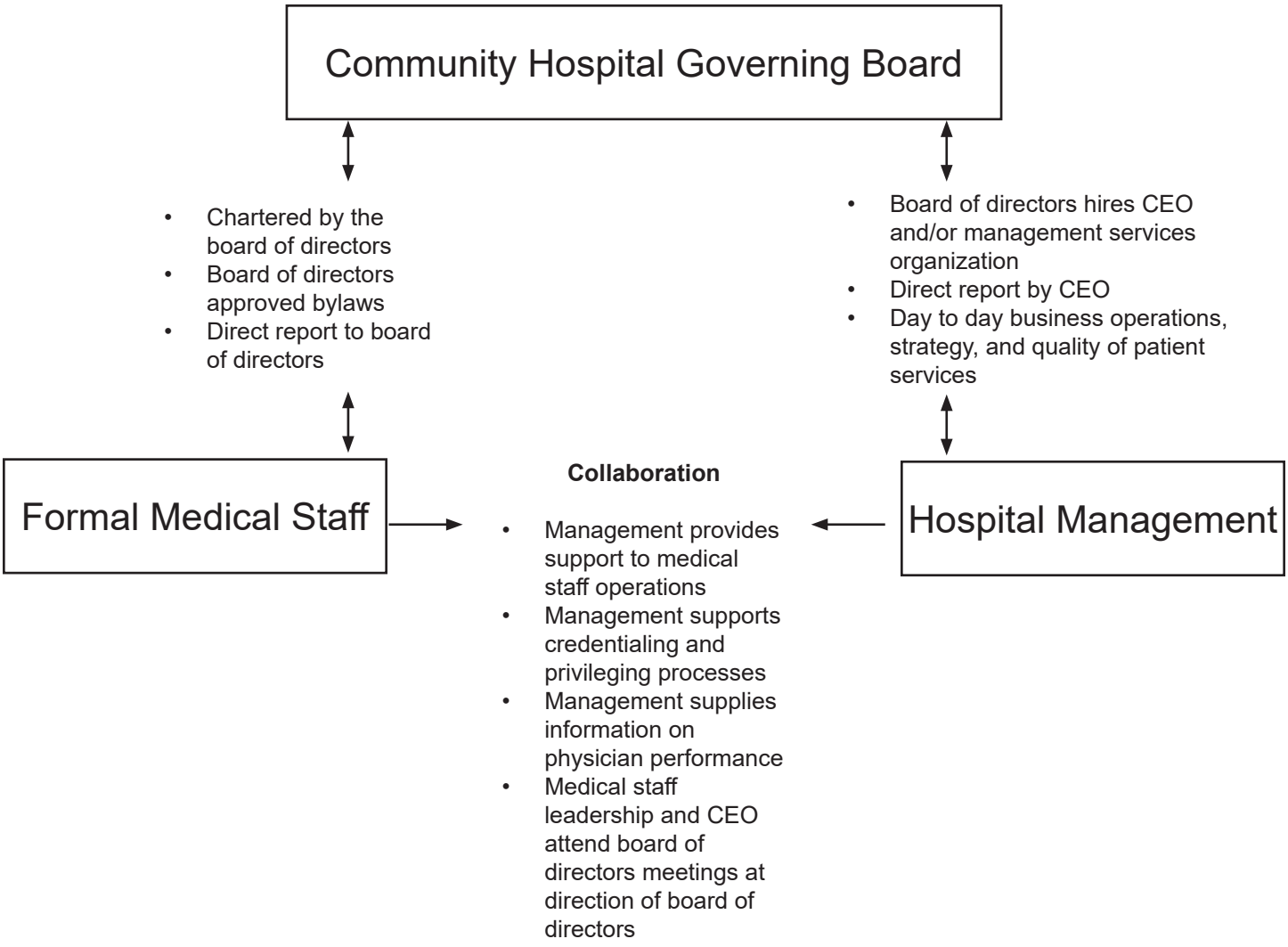
It has been demonstrated in legal proceedings that hospital leadership does bear some responsibility and accountability for informing the board of matters that fall within the purview of the formal medical staff that are left unattended by medical staff proceedings for any reason.

Are Quality and Safety the Responsibility of Hospital Administration?

The quality of care and safety of patients are the most important tasks of all who work in a hospital or health system. The board, medical staff, hospital administration, and all employees and affiliates play an important role.

All in positions of authority, including administrators, licensed professionals, affiliated physicians, and the medical staff, bear responsibility to raise observations and issues of concern

Exhibit 1: The Relationship between the Board of a Standalone Community Hospital, Its Medical Staff, and Hospital Management



to the authoritative bodies within the hospital, including hospital administration, the medical staff, and the board. The CEO and subordinate officers bear responsibility to raise concerns regarding the clinical practice of physicians (whether employed by the hospital or working independently) to the medical staff and hospital board.

In rare instances where an administrative officer of the hospital has foreknowledge of circumstances where a patient may be harmed by the acts of a member of the medical staff (e.g., the hospital officer has reason to believe the physician in question is impaired or intends to perform a non-emergent procedure for which that physician is not privileged to perform) the ranking hospital officer on duty has the obligation to: a) ensure that no patient is subjected to potential harm or unauthorized care; b) confirm that the leader of the medical staff is notified of the issue and action is taken as soon as is practicable; c) make certain that the hospital board chair or designee is informed of the issue and action is taken as soon as is practicable, unless the leader of medical staff accepts responsibility for notice; and d) ensure that the proper and assigned hospital staff member remains involved with follow-up processes and actions of the medical staff, including actions related to the ongoing privileges of the physician.

To set these processes and requirements within the framework of "due care" for hospital administration, when hospital administration becomes aware of the possibility of a member of the medical staff exceeding his/her approved clinical privileging, a notice should be made available up the hospital administration chain of command. Senior leadership has a first duty of notice of the medical executive committee, so long as there is no need to intervene immediately to ensure patient safety and welfare. Senior hospital administrators are then responsible to ensure the medical staff leadership pursues due process according to approved medical staff bylaws, including final disposition and report, and possible involvement of the hospital board.

In conclusion, members of the governing board of a community hospital (or an affiliated health system) should assume that all that occurs with the operation of the entity is the responsibility of the board. While the courts, judges, and juries recognize that community boards cannot know all that is required to properly deliver complex medical care to patients, boards can be and are expected to exercise "due care" in the discharge of their duties. "Due care" in this regard has been extended by the courts to matters that have involved the effects of the management of the relationships between the board, the hospital medical staff, and the management of employed and contracted physicians, all as it relates to the role of the hospital (or community health system), the CEO, and the senior leadership team.

Of special importance is the functioning and direct reporting of the officers of the hospital medical staff to the governing board, especially as it relates to the scope of practice and patient care outcomes for independent and employed physicians. For employed physicians, boards should be clear regarding those areas of physician performance that will be addressed within the scope of the functions of the hospital medical staff and those to be addressed solely within the scope of the employment arrangement.

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