The Pros and Cons of Physician Participation

Organizations have much to consider regarding physician board participation.

Determining who should comprise the members of a governing board has become increasingly important to ensure this body has the competencies it requires. In this regard, physicians are frequently sought for board participation because they possess insights into clinical strategic planning, a familiarity with the underpinnings of quality and safety, firsthand knowledge of front-line hospital operations and an understanding of the growing difficulties of practitioner recruitment and retention. But, despite the strengths physicians bring to board membership, many governing bodies have minimal physician presence among their trustees.

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Several factors may be influencing healthcare organizations' hesitance to increase physician representation on their boards. Among those factors are legal concerns about "insiders" on the board, worry about political fallout when choosing which physicians receive coveted board positions, lay board member apprehension of having physicians dominate discussions and historically strained working relationships between physicians and administrators.

The Growing Case for Physician Participation

For hospitals and health systems to provide care that is higher quality, safer, more cost-effective and patient-centered, it is necessary to redesign the way care is fundamentally organized and delivered. Increasingly, physician insight and buy-in is seen as a linchpin in such endeavors. When physicians are not integrated into strategic planning at the highest level, care transformation is often poorly designed and fails to engage the practicing medical community. A physician presence brings crucial insight during board strategic discussions from those who actually deliver care.

Many boards struggle to provide aggressive oversight of organizational quality. Physician board members can bring a critical dimension of expertise to this board responsibility. However, boards should be careful not to assume that possession of a medical degree provides an individual knowledge of quality-improvement science. Board nominating committees should recruit physicians who have competencies in performance metrics and data management, are familiar with tactics to advance a high-reliability culture and have studied or directly engaged in sophisticated quality improvement initiatives such as Six Sigma.

One of the most valuable reasons to place physicians on the governing board is to promote hospital–physician alignment. Many hospitals and health systems today struggle to improve physician engagement among both employed and private practice medical staff. The presence of physicians on the board can reassure colleagues that their interests will be addressed at the highest level in the organization.

Which Physicians on the Board?

From multihospital systems to small community hospitals, healthcare organizations have much to consider regarding physician board participation depending on the type of facility.

Standalone hospitals. Often, the chief of the medical staff serves on governing boards. Whether such ex officio members are voting or

nonvoting board members is a matter of considerable variance. Many medical staffs prefer their chief to be an invited guest who can participate in board meetings as an advocate for medical staff interests. Because board members do not represent constituencies (i.e., they are fiduciaries for the interests of the institution), a medical staff chief elected to represent her or his colleagues often encounters role confusion when sitting as an ex officio member of the board. Nevertheless, some in the medical community will inevitably perceive the failure to give a medical staff chief a vote on the board as a "slight" by the governing body.

Multihospital systems. The trend for hospitals to join health systems has complicated ex officio participation of the medical staff chief on a governance board, as several questions are likely to arise. If a system board oversees multiple medical staffs, which chiefs get to attend system board meetings? Do they all get a vote as a board member, do none vote, or are they all standing guests? If the board limits the participation of chiefs of staff, are they all treated the same or are there criteria (e.g. medical staff size) that determine their relative involvement? Do they rotate board attendance, or should they be encouraged to unify their medical staffs under a single chief who can be a regular board attendee?

Large institutions such as teaching hospitals. Beyond medical staff officers, there is a growing body of physician leaders connected to contemporary health systems whose presence at the board table might be

considered equally important to that of medical staff officers. These include leaders from one or more of the following: the hospital or health system's employed physician group(s); an affiliated accountable care organization or clinically integrated network; an expanding group of physician executives (CMO, vice president of medical affairs, chief clinical operating officer, chief quality officer); an associated academic enterprise (medical school dean); or another affiliated healthcare enterprise (a large independent practice association).

Organizations with a hybrid of private and employed physicians. In health systems where the medical staff contains a significant portion of physicians in private practice in addition to those the hospital employs, private practitioners often contend that one of their cohort must be on the board to assure the board is knowledgeable about the concerns of this constituency. This group of physicians feels increasingly marginalized in today's healthcare environment. Increasingly, they demand a seat at the table.

Small hospitals. Some boards of small hospitals go outside their immediate community to include physicians with skills or expertise not readily found locally. This approach can be seen with smaller medical staffs that may not, for instance, have individuals with a national perspective on healthcare trends, experience or facility in the use of safety and performance improvement techniques, or possess a familiarity with the role of a fiduciary in governance. There are drawbacks, however, to bringing in experts from outside the community. Such individuals may lack insight into local community needs and politics, they may be unavailable to participate regularly in face-to-face board meetings, and they may charge for their services and incur travel expenses.

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In recent years, many health systems have seen their medical communities expand significantly with growing numbers of advanced practice professionals. Whether APPs should be considered for membership or participation at the board level is a question a greater number of governing bodies will be asking in the years ahead.

To accommodate the growing number of practitioners interested in governance work versus the limited availability of board seats, many organizations are placing physicians on working subcommittees to access their expertise and provide for their participation. It has become increasingly common to place significant numbers of physicians on board professional affairs committees, quality and safety committees and strategic planning work groups.

Legal Considerations

Having physicians on the board can raise a host of legal and ethical considerations, requiring consultation with knowledgeable legal counsel to address these concerns. For example, as physicians push for greater board representation, the number of physicians that may serve on the governing body is an important consideration. It is generally advised that healthcare organizations ensure that a majority of voting members on the board are community leaders who have no personal economic stake in the organization's strategic and financial decision making.

When physicians serve on the board, the chairman must be particularly careful regarding conflicts of interest. Antitrust concerns arise when physicians are involved in decisions affecting the business of their competitors in the community; improper private inurement can occur if physicians receive payments or other compensation for work driven by their participation in board decisions; and fraud and abuse concerns can arise where the board approves financial arrangements with community practitioners.

As our health systems evolve, so do our governing boards. Health systems are continuing to push for greater physician engagement from their rank-and-file practitioners. While doing so, they also need to consider the value of increased physician participation in organizational governance. ▲

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