Q&A: Physicians on Hospital Boards: Prepare to Challenge Traditional Wisdom

by Mary K. Totten

Editor’s note: Relationships are changing between hospitals and physicians as they work more closely together to implement new models of care delivery and lead value-driven, integrated care systems. These changes also will affect physician board members, as traditional approaches to their selection and role are likely to migrate beyond ex-officio representation of medical staff needs and views toward broader competency-based, mission- and vision-focused participation. However, change rarely occurs without challenge. To help sort through some of these challenges, Great Boards asked John Combes, MD, President and Chief Operating Officer of the AHA’s Center for Healthcare Governance, and Barry S. Bader, governance consultant and contributing editor to this newsletter, to share their views on the implications of health care transformation for physicians on boards.

Great Boards: What are the traditional roles physicians have played on hospital boards, and how have physicians come to serve on the board?

Bader: Physicians have been and should continue to be valued for bringing clinical knowledge to help the board understand patient care, and for their connection to the medical staff’s perspective on hospital matters. Imagine planning an ambulatory care center or approving a quality improvement plan without clinical expertise, and the value that physicians could bring is clear. Many physician trustees I’ve met are smart, collegial and committed to the hospital. They make boards more effective in numerous ways.

On the other hand, some medical staffs traditionally viewed physician trustees as their “representatives” on the board, an outdated perspective that contradicts the fiduciary duty all trustees have to act in the best interest of the entire organization, not a single stakeholder. One traditional means of selecting physician trustees — ex-officio seats for medical staff officers such as the medical staff president, president elect and past president — perpetuate the notion that physician trustees are there to represent doctors.

Combes: As the workload for boards increases, finding the time to prepare and participate effectively is a challenge, not only for physicians on boards, but for all trustees. Financial relationships between hospitals and physicians are becoming more varied and complex, which will make it more difficult to find physicians who can serve as truly independent, stakeholder- and mission-focused board members. Few boards are conflict-free, and boards have processes for managing conflicts. However, some boards are seeking physicians who are retired, or who work in industry or for non-competing health care organizations to avoid the conflicts that exist when physicians have a financial relationship with the hospital.

Bader: Board service today obviously is time-consuming, and that’s challenging for busy physicians. The requirements for board independence and objectivity also run counter to allocating “representation seats” for single stakeholders such as the medical staff.

More important, though, the fundamental relationship between the hospital and its medical staff is changing. The medical staff once was a quasi-independent, self-governing entity of private practitioners who used the hospital’s facilities as a workshop.

Today, hospitals need physicians to function as full care team partners in order to become integrated...
delivery systems that are accountable for their costs and quality. As such, they are employing physicians, operating medical practices and engaging in interdependent economic ventures with doctors more than ever. These physicians are aligned with the hospital's clinical and economic goals and are integral to its success. They are moving into clinical leadership positions and logically, they are precisely the doctors to whom the board looks for expert guidance. Meanwhile, some private practitioners feel threatened by hospital competition and oppose some hospital strategies such as buying practices.

This dynamic puts boards in a quandary over physician trustees. On the one hand, employed and other economically aligned physicians should make great trustees because they share the hospital's goals. However, these doctors are not independent, according to IRS rules—they are “insiders” and have a per se, potential conflict of interest as employees, joint venture partners, or exclusive contractors. For example, will they really offer constructive challenge to a CEO who they work for? On the other hand, private practitioners may or may not share the hospital's vision, but they sometimes become trustees when the medical staff elects them to “protect their interests” as leaders who have ex-officio board positions. So, bringing physicians on to the board is not a simple proposition.

**Great Boards:** As hospitals move toward a “value-based” model of health care delivery with stronger alignment between hospitals and physicians how, if at all, will the role or function of physician trustees on hospital boards change, and will selection methods change too?

**Bader:** Change will occur in different ways and at different paces among different organizations.

Some boards, particularly of community-based hospitals and health systems, will continue to have physician trustees, but will select them using the same competencies as other trustees. Some hospitals will take a collaborative approach, for example, communicating the selection criteria to the medical executive committee and asking for nominees, but retaining final approval over board selection. No voting board seats will be ex-officio, but the medical staff president will be either a non-voting member or an invited guest, to continue giving the medical staff a “voice” at the board room table.

Boards will conscientiously apply conflict of interest policies to all their members to fulfill their fiduciary duty of loyalty. Physician trustees, whether they are employees or private practitioners, will have to excuse themselves from matters in which they have a material economic interest and should not serve on the oversight committees for audit or executive compensation. On occasion, they may have to be excused from executive sessions convened to discuss strategies or transactions in which they have a material interest.

The sweet spot for the physician’s voice may well not be the board, but rather other clinical leadership roles. As hospitals transform themselves into integrated care systems, the locus of physician engagement in leadership decision making will expand to new leadership positions closer to the patient. For example, dyads of a physician and administrator, or a physician and nurse executive, will co-manage clinical service lines. Physicians will serve on boards of group practices, clinically integrated physician hospital organizations (PHOs), joint venture clinical institutes, and hospital-wide operations councils composed of physician, executive and nursing leaders.

Boards will also look outside their medical staffs (and obviously not to staffs of competing hospitals) to find independent physicians to serve on the board. Examples are retired physicians, corporate medical directors, and physician leaders from other communities and other hospitals in a multi-hospital system.

Some boards will go 100 percent independent except for the CEO, but they’ll get expertise from active staff physicians on board committees, subsidiary boards, and advisory bodies.

**Combes:** In a value-based model of care delivery, the role of the physician board member will be enhanced, as physicians bring their clinical expertise to answer the question, “What adds value to health care delivery and what does not?”

Physicians can help health care organizations determine which interventions are appropriate and which tests or procedures add cost but do not add value. They also can help their organizations invest in technologies that have the most positive impact on patient outcomes or the ability to support diagnostic speed and efficacy to identify patients most in need of treatment. Health care organization boards should look for physicians who have these competencies and want to apply them to improve community health, rather than selecting physicians who are the biggest admirers or who are well-connected with the medical staff. Boards will need physician trustees who can participate in strategic discussions to advance the mission, rather than their own goals or even the hospital itself. Physicians identify more strongly with advancing the mission of the organization, which focuses on the health of patients and communities, rather than on advancing the needs of the organization. Hospitals and physicians will often find more common ground when they focus on developing partnerships around improving patient care.

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**Figure 1 - Profession**

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2011 AHA Health Care Governance Survey Report, Kevin Van Dyke, MPP, John Combes, MD, Maulik Joshi, Dr.PH, pg. 13.
Great Boards: Do physicians on the active medical staff have a conflict of interest as trustees?

Combes: Absolutely. There is no question that active medical staff physicians should not participate on the board’s Audit, Executive Compensation and Nominating Committees. They do, however, have an important role to play on other board committees, such as Quality, Finance and Strategic Planning, and when conflicts arise, they should be managed in the same way for all board members.

I also think that active medical staff physicians should not hold the position of board chair. The relationship between the board chair and CEO is a special one that places the board chair in the role of mentor and sounding board. A board chair who is also a member of the active medical staff would be in a strong position to advise the CEO on issues such as allocation of resources that he or she may benefit from directly and would therefore not be able to be independent enough to serve in this role.

Bader: A potential conflict of interest exists when any individual has an economic, personal or professional relationship with the organization that could reasonably be perceived as affecting their actions on the board. Conflicts can be actual or potential.

Active staff physicians who are employees or perform services under contract obviously meet the definition: the hospital pays them. In addition, even private practitioners who have no hospital contracts for services derive economic value from their hospital relationships. They may use hospital inpatient and outpatient services. They may get referrals from the emergency department and from other physicians, and their practices are affected if the hospital recruits doctors or operates services in their specialties.

So yes, they have a potential conflict of interest. If active staff physicians serve on the board, they must follow the conflict of interest policies and refrain from voting on or otherwise participating in decisions in which they have a material interest.

I agree with John that active staff physicians shouldn’t serve on the audit or executive compensation committees or as Board Chair, but I’d consider membership on a governance or nominating committee a little more liberally, on a case-by-case basis, because I think a physician’s input on board development and succession planning can be useful.

Great Boards: Should physicians employed by the hospital serve on the governing board? In your view, is this practice likely to become more common?

Bader: Theoretically, the principle of independent governance suggests the only employee on the board should be the CEO, who reports directly to the board and is excused when his or her performance is under discussion. But the fact is that employed physicians are often the doctors with the best mix of commitment, visionary outlook and willingness to serve. That’s especially true in smaller hospitals.

So yes, I think it’s inevitable some hospitals’ employed physicians will become trustees, and the board will need to manage their relationship with the CEO and CMO very carefully. There can only be one person running the hospital, and that’s the CEO.

Combes: As a general rule I don’t think physicians who are employed by the hospital should serve on the board. Exceptions might include smaller organizations that have employed all of their physicians or that don’t have access to physicians who are outside of the organization, but this approach should be used as a last resort. Having a clinical voice on the board is important and can be provided in a number of ways—by physicians who work at non-competing hospitals or state-level physician organizations, for example, or by nurses or pharmacists who also are not employees.

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Great Boards: Should physician board members be chosen based on the same criteria as any other trustee, or should different benchmarks be used?

Combes: Boards should use the same criteria when selecting all trustees. They will want to consider what expertise and competencies a potential board member can add to better address community needs or what missing voice around the board table a particular candidate can contribute. Boards should look to all of their members, and perhaps especially physicians, to be the voice of the organization’s stakeholders and a resource to help the organization accomplish its mission.

Bader: The same criteria should apply, but be viewed with a critical eye based on a physician’s background. Does their past record of service, on the medical staff or with their group practice, suggest they can separate their practice concerns from board deliberations? Do they think in visionary and global terms about health care? Do they work well in teams? Can they communicate clearly to share their knowledge and perspective with other trustees? Will they devote the time required? Ask those questions about any prospective trustee and the board will be better off.

Great Boards: Are there any best practices emerging related to physician members of the hospital board?

Bader: The best practices aren’t restricted to physician members. Things like orientation and mentoring for new trustees, a clear statement of roles and responsibilities, board education, use of board portals and teleconferences, and individual assessment are all good tools. I also think that participation in off-site education conferences is very beneficial, providing a global perspective and the opportunity to meet and share experiences with other trustees, including other physicians. Conferences also are a good way for physician trustees who lack management backgrounds to pick up boardroom skills in such areas as strategic planning, team-building, and corporate compliance.

Combes: While some best practices are in early stages of development, it is clear that physicians on boards need an orientation to their role, including their obligation to act as a fiduciary of the organization and not for their own self-interest. Physicians...
on boards also can benefit from mentoring by non-physician trustees. The mentoring process should emphasize what it means to be a trustee and how physician trustees should relate to the medical staff. After a year of board service, physician trustees should participate in individual performance assessment that includes both self-reflection and evaluation by their board member peers. The assessment should include a conversation with a board officer about the challenges they have experienced as a trustee and how to overcome them.

**Great Boards:** What are the most common mistakes you see hospitals and medical staffs making as they go about changing the traditional roles and physician makeup of the hospital board?

**Combes:** Probably the biggest mistake is to exclude the organized medical staff from the change process. It is crucial that clear communication occurs between the board and the medical executive committee about why these changes are being made to further good governance practice and how medical staff interests will get in front of the board with this new process. The elected medical staff leadership should continue to serve on the board in a representative role which is clearly defined and differentiated from the role of the physician trustee who is the fiduciary for all stakeholders, not just physicians.

**Bader:** I agree. For example, boards run into trouble when they try to change the bylaws to eliminate ex-officio seats for voting physician trustees without a careful process of engaging medical staff leaders to understand the rationale for the change and to seek their input on alternative means for physician engagement in decision making. Taking away board representation is a bigger deal to doctors than some CEOs and boards seem to appreciate. How could physicians already wary of hospital expansionism not view that as a power grab? Failure to communicate and engage is a big mistake.

**Great Boards:** How well do you think physicians are typically prepared by the hospital board to assume and continue to effectively fulfill their board role? How

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### Physician Trustee Relationships with Independent and Employed Physicians: “Dos and “Don’ts”

**Do:**

- Encourage physician board members to communicate with the medical staff about the rationale for board decisions and how those decisions will advance the mission.
- Expect physician trustees to use their clinical expertise to raise questions about how care is being delivered and what could be done to improve it in the context of achieving the mission and better meeting stakeholder needs.
- Remember that independent physicians may feel threatened economically by a variety of forces, including the hospital and its employed physicians.
- Remember that employment and alignment are not synonymous: building a shared culture takes work and time.
- Share your vision for patient-centered, hospital-physician alignment and integration with all physicians, and keep lines of communications open. Today’s independent physician could be tomorrow’s employed physician, exclusive contractor or even physician executive.
- Encourage the medical staff to choose leaders based on objective competencies and a collaborative work ethic, whether they are employed or independent.
- Remember that most hospitals will have both employed and independent physicians for some time, perhaps always, and they will need to work together in a patient-centered system of care. So, adopt objective competencies for clinical leadership positions and choose physicians from the private or employed staffs who meet the requirements.

**Don’t:**

- Undermine the board’s decision-making process or be an apologist for the board with other physicians.
- Be a know-it-all at board meetings. Remember that other perspectives are valuable and that good decisions weigh all points of view and alternative solutions.
- Lose focus on the vision and allow a minority of vocal physicians protecting their economic franchise and traditional autonomy to outweigh decisions that are in the best long-term interests of patients and the community.
- By all means, don’t abandon your CEO if the going gets tough.
- Just talk—listen!

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*continued on page 5*
could physician preparation and ongoing development for board service be improved?

Bader: It varies, but both board education and physician leadership development generally have been insufficient in the past. On the board, new trustee orientation should be sufficiently individualized so that a physician trustee fills in knowledge and skills gaps he or she may have for – at risk of generalizing – understanding budgets or strategic planning, skills that trustees with a business background would have.

Increasingly, hospitals are investing in development for physician executives and other leaders. They also need to educate physicians on the boards of hospital-owned or co-owned medical group practices, ACOs, PHOs, joint ventures, clinical institutes and so on about how to be an effective board member. It’s “Governance 101” for physicians who need to understand a board’s fiduciary duties and the best practices for carrying out their responsibilities for quality, finance, strategic planning and so on with a governance rather than an operations hat.

Combes: I think that many boards don’t adequately prepare or further develop their physician members. When boards appoint physicians, other than the Chief of Staff, to the board, they often fail to think about what the transition to board service will be like for those physicians. Many times physician board members who also are on the hospital medical staff get pressure from other medical staff members to bring their issues and concerns to the board and don’t understand that the Chief of Staff serves on the board in that role. Physician board members, excluding the Chief of Staff, should view their ongoing relationship with medical staff physicians as one of communication. They should be prepared to discuss with medical staff physicians the rationale for board decisions and why the organization is moving in a given direction. The Chief of Staff, on the other hand, has the duty to carry medical staff views and concerns back to the board. It’s also important for all physician board members to understand that once the board makes a decision, all board members must support it.

Great Boards: How can boards best engage their physician members to maximize their contribution to board service?

Combes: When I attend hospital board meetings I often observe an interesting phenomenon: physician trustees are very quiet. They will sometimes speak about medical practice or quality issues, but I think they hold back because they know that others view physicians as having strong personalities, so they only address issues that relate to their own expertise.

When this occurs, the board chair should ask physician trustees to share their views. This can be done in a number of ways, for example, the chair can go around the board table and ask everyone to weigh in on an issue or the chair can assign agenda items in advance to various trustees, including physician board members, who should be prepared to tee-up the issues as a first responder at the next board meeting. In this way boards can benefit from physicians’ input and learn more about their perspectives on a broader range of issues, not just those that reflect physicians’ strengths or interests. It’s often on issues where physicians are silent that their views are needed the most.

Bader: Three things: First, value their input. Nothing engages someone like seeing that their ideas are appreciated and applied.

Second, give them work to do. Just having a doctor come to meetings is not engagement: giving them tasks such as chairing committees, leading task forces and making expert presentations fully taps their skills and connectedness.

Third, give physicians and all trustees a larger strategic context in which to make the difficult choices confronting many boards, such as “should we employ more doctors or engage in more joint ventures, merge the practices we already own, build more outpatient centers, employ more physician extenders in physician-shortage areas, and merge with another hospital?” Viewing each of these individually misses the benefits of the long view. Engage physicians in discussions of the vision of the hospital as an integrated care system and about the desired future culture of patient-centered medical care.

Physician trustees and other physician leaders are at the leading edge, or maybe the bleeding edge of a transformational change in health care . . . The physicians to select for the board are those who want to help shape that future, not be passive bystanders.

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