About the Authors

Jay Justice, JD, is Vice President and Senior Human Resources Officer, Hospital Sisters Health System in Springfield, IL; A. Kurt Kastel is a Senior Consultant with Integrated Healthcare Strategies and Kevin Van Dyke, MPP, is a Research Manager at the Health Research & Educational Trust. They can be reached at jjustice@hshs.org, Kurt.Kastel@IHStrategies.com and kvandyke@aha.org.

About the Center for Healthcare Governance

The American Hospital Association’s Center for Healthcare Governance is a community of board members, executives and thought leaders dedicated to advancing excellence, innovation and accountability in health care governance. The Center offers new and seasoned board members, executive staff and clinical leaders a host of resources designed to progressively build knowledge, skills and competencies tailored to specific leadership roles, environments and needs. For more information visit www.americangovernance.com.
Creating a Healthy Board/Medical Staff Relationship: Current Trends and Practices
Overview

In today’s rapidly changing health care environment, one of the most pronounced trends is the evolution of hospitals and health systems toward an integrated delivery model of care. An integrated delivery system implies an increasingly close relationship between doctors and health care facilities. These facilities may employ physicians directly or contract for their services. But, whatever the financial arrangements, integrated systems seek to provide a seamless continuum of patient care that requires a strong bond between physicians and hospitals.

Physicians are critical to the success of an integrated delivery model of health care because they are a key point of contact between the organization and the public. While many hospital employees also play a front-line role, no other resource will have a greater impact on a hospital’s reputation and market share than the perceived quality of its physicians.

Care delivery in a hospital or health system has characteristics similar to a theatrical production. Hospital management are like theater personnel who operate “behind-the-scenes”—writers, producers, directors, set designers, and box office staff. Physicians, however, are the actors who bring the play directly to the audience. No matter how good the scripts or sets, how the audience perceives the actors will in large measure determine the critical and commercial success of the venture. Given their “leading roles” actors will often want to have input not only about their own performance, but also about every aspect of the production that affects it. Such input may seem unrealistic, but directors disregard it at their peril.

Physicians in a hospital or system sometimes operate in a similar fashion. The challenge for executives and trustees is to address physicians’ concerns in the context of their fiduciary obligation to the organization as a whole. One of the best ways to accomplish this is to increase physician contact with the governing board.

Board/physician involvement can take a variety of forms, from discrete presentations to committee service to actual board membership. While most health care organizations have physician representation at the board level, with the chief of the medical staff serving in an ex-officio role, such representation is not automatically a
panacea for improving physician relations. Much will depend on the spirit in which the individual physician executes his or her governance responsibilities. If physician board members see their role as primarily constituent-driven, that is, as a voice for the medical staff, then they will not always govern in the best interests of achieving the organization’s community-focused mission. Board membership requires a holistic view and brings with it a responsibility to the organization as a whole and the patients it serves.

This publication presents the results of a survey of board/medical staff relationships and findings from focus groups that offered strategies health care organizations are using to improve them. It can be used as part of board orientation, as background reading for leadership retreats, and as a resource for board members and physicians participating in joint meetings and other leadership initiatives.

We hope the results of the survey and focus groups will not only shine a light on the issues and challenges facing these leaders, but will also provide new thinking and approaches that all boards and medical staffs can employ to strengthen their leadership partnership.
Introduction

The Center for Healthcare Governance and The Health Research & Educational Trust (HRET), in conjunction with Integrated Healthcare Strategies, recently conducted an online survey of health care organization board members, chief executives and chief medical officers, and a corresponding series of focus groups, to examine the current state of physician-board relations and approaches being used to improve them. The survey generated 361 responses, the largest number for our surveys of this type (see sidebar titled Characteristics of Respondents). This survey is intended to be a starting point for a continuing analysis of board-physician relationships and interaction, a topic likely to become more crucial as American health care continues to evolve.

We believe that the number of CEOs responding to the survey indicates the importance of physician-board relations as a management priority. Increasingly

<table>
<thead>
<tr>
<th>Characteristics of Respondents</th>
<th>% Responding</th>
<th># Responding</th>
</tr>
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<tbody>
<tr>
<td>CEO</td>
<td>92%</td>
<td>333</td>
</tr>
<tr>
<td>CMO</td>
<td>4%</td>
<td>14</td>
</tr>
<tr>
<td>Board Member</td>
<td>4%</td>
<td>14</td>
</tr>
<tr>
<td>Rural</td>
<td>62%</td>
<td>222</td>
</tr>
<tr>
<td>Urban</td>
<td>23%</td>
<td>82</td>
</tr>
<tr>
<td>Suburban</td>
<td>16%</td>
<td>57</td>
</tr>
<tr>
<td>Freestanding</td>
<td>61%</td>
<td>221</td>
</tr>
<tr>
<td>Subsidiary</td>
<td>25%</td>
<td>89</td>
</tr>
<tr>
<td>System</td>
<td>11%</td>
<td>40</td>
</tr>
<tr>
<td>Other</td>
<td>3%</td>
<td>11</td>
</tr>
<tr>
<td>&lt;100 Beds</td>
<td>51%</td>
<td>183</td>
</tr>
<tr>
<td>100-299 Beds</td>
<td>27%</td>
<td>99</td>
</tr>
<tr>
<td>&gt;= 300 Beds</td>
<td>22%</td>
<td>79</td>
</tr>
</tbody>
</table>
CEOs realize that getting medical staff buy-in to strategic decisions requires direct involvement with governance leaders. Interaction between board members and physicians can help address potential problems before they become acute and give physicians the confidence that trustees are aware of their concerns and perspectives.

**Board Composition**

Overall, physicians made up 18% of all board members in the organizations surveyed. The overwhelming majority (80%) of physician board members actively practiced at the institution on whose board they served (see figure above titled “Breakdown of Physician Board Member Status”). For tax-exempt health systems, practicing physicians who sit on the board represent a potential conflict with the IRS rules governing private inurement for “disqualified persons” under the Intermediate Sanctions provisions of the 1996 Taxpayer Bill of Rights, voiding the Rebuttable Presumption of Reasonableness. Since most practicing physicians would, by definition, be included as disqualified persons they could be prohibited from sitting on Compensation or Audit committees or, depending on the number of already conflicted individuals, prohibited from board service altogether.
One way to alleviate this concern, and actually take advantage of coming generational changes, would be to recruit more retired physicians to boards and their committees. As the Baby Boom population begins to retire, many will seek opportunities for service. Their experience, greater personal availability and unconflicted status are advantages that boards can increasingly leverage. Survey results indicated that only 7 percent of physician board members are currently retired, suggesting significant opportunity for growth in this potential talent resource.

**Selecting Physicians for Board Membership**

The most common criteria used to select physicians for the board were expertise in quality and patient care AND being a member of the medical staff (63%) and holding an ex-officio position on the medical staff (48%). The chart titled Physician Board Member Selection Criteria below provides more detail.

Health care systems or networks (53%) were more likely than freestanding (35%) or subsidiary (44%) hospitals to select physician board members based on holding an ex-officio position on the medical staff. A health care system or network was also
more likely to select physicians through election by the medical staff (43%) compared to freestanding (28%) or subsidiary (33%) hospitals.

As the chart above indicates, the greater the number of physicians on the board, the more likely it is that physician board members are elected by the medical staff.

Respondents from freestanding hospitals (60%) were less likely to indicate that expertise in quality, patient care, and being a member of the medical staff were the most important criteria in physician board member selection compared to health care systems (74%) and subsidiary hospitals (65%).

**Selecting Physician Board Members Not Holding an Ex-officio Position on the Medical Staff**

Knowledge of the local market, community, and patient demographics (24%), knowledge of quality and patient safety (21%), and clinical expertise (20%) were most commonly cited as the primary criteria for selecting new physician board
members who did not hold an *ex-officio* position on the medical staff. Other criteria, such as political connections, election/appointment, past experience as a board member, and participation in hospital/business arrangements, were each indicated by 7% or fewer respondents (see board selection chart above).

The survey did not explore whether physician recruitment from outside the medical staff should be promoted to secure independent directors who would not be classified as “disqualified” under IRS rules. However, this consideration was mentioned repeatedly in subsequent focus group discussions.

**Overall Board Engagement with Physicians**

Respondents were divided on most issues of board-physician engagement. Of the 10 criteria of engagement surveyed, only two were used by a high percentage of respondents: 93% of boards had engaged physicians in strategic planning and 89% had taken action in cooperation with physicians to improve patient safety or quality of care. Quality of care issues are perhaps the most obvious area for physician
participation with governance leaders. Their clinical expertise makes them natural choices to educate and even lead the board to address these issues. A high level of physician participation in strategic planning also is not surprising, particularly as the strategic focus of many organizations has expanded to make quality and patient outcomes equal priorities with finance as measures of organizational success.

A majority of respondents indicated that their boards established other ways to ensure physician leadership in quality (70%), conducted a joint retreat or meeting with physician leaders (66%), and authorized paying physicians for administrative duties (58%). On the other hand, only one-third of respondents (33%) indicated that their board approved paying physicians (beyond the chief medical officer) to monitor and ensure quality.

Around half of respondents indicated that their boards established programs for recognition of clinical quality (49%), authorized joint ventures and other business relationships with physicians (48%), approved membership on board committees for physicians who were not board members (47%), and authorized paying physicians for call coverage (46%).

**Physician Engagement in Relation to Physician Board Membership**

Overall, the number of physician members on the board was positively correlated with the level of engagement the hospital had with its physicians. For example, as the number of physicians on an organization’s board increased, the more likely it was for the board to cooperate with its physicians to improve patient safety and quality (see chart showing this relationship between physician engagement and physician board membership on page 11).

**Establishing Programs of Recognition for Clinical Quality**

A subsidiary hospital (57%) or health care system (56%) was more likely to establish programs of recognition for clinical quality than were freestanding institutions (43%). Institutions where 30% or more of board members were either actively practicing or retired physicians were more likely to establish these programs than were institutions where fewer than 30% of board members were physicians (see board composition chart on page 11).
Trend of Physician Engagement in Relation to Physician Membership on Board

Board Composition in Relation to Establishing Programs of Recognition for Quality
Authorizing Business Relationships with Physicians

A health care system or network was more likely to authorize joint ventures and other business relationships with physicians (69%) compared to freestanding (48%) and subsidiary hospitals (38%). Hospitals with less than 5% of board members who were actively practicing or retired physicians were less likely to authorize these kinds of business developments with physicians than were hospitals that had 5% or more of their board made up of physicians.

Authorizing Pay for Physicians

A health care system or network was more likely to approve physician pay for monitoring and ensuring quality and carrying out administrative duties compared to freestanding and subsidiary hospitals (see graph below). The likelihood of approving physician payment to monitor and ensure quality also increased as the number of physicians on an organization’s board increased.

While this finding seems to imply a representational model of physician service on boards, with physician trustees acting in accord with what they see as the interests
of their peers, such additional compensation may represent the wave of the future, especially when considering the generational preferences of younger physicians. The so-called generations X, Y, and Mellenials have different lifestyle expectations from their Baby Boomer parents, and vastly different expectations from their Traditional generation grandparents. While many members of these younger generations are reconciled to making less money in real terms than their predecessors and are very service-oriented, they pay close attention to the amount of time such additional responsibilities take away from their personal life. Much will depend on whether the market determines such duties are a condition of employment.

The likelihood of approving payment for physicians (other than the CMO) to monitor and ensure quality and authorizing payment to physicians for administrative duties were both directly correlated with the size of the institution in number of beds, with larger institutions being more likely to approve and authorize payment for these activities (see chart showing the relationship of hospital size to physician payment below).
Feedback from focus groups suggested that another potentially productive way to gain physician cooperation in quality oversight was to accentuate the importance of quality in achieving the hospital’s mission and to demonstrate how quality outcomes can affect the organization’s bottom line.

**Compacts Between Physicians and Health Care Organizations**

Almost half (46%) of respondents indicated that their organizations had a written compact with physicians that clarified the duties, roles, and responsibilities of both the organization and its physicians. Respondents from health care systems (56%) and subsidiary hospitals (54%) were more likely to have joint compacts with their physicians compared to freestanding hospitals (41%).

**Non-Physician Board Member Engagement with Physicians**

Non-physician board member engagement with physicians varied, according to survey results. For example, about half of respondents indicated that their non-physician board members had participated in a medical staff committee meeting (47%) or general medical staff meeting (46%) in the past 12 months.

More than half of respondents indicated that their non-physician board members participated in a board-medical staff joint planning retreat (62%) and a joint educational event with the medical staff (61%) within the past year. However, only 23% of respondents indicated that their non-physician board members participated in a board-medical staff joint assessment of redesigning medical staff structure in the past 12 months.

Respondents from a health care system or network (61%) were more likely to indicate that their non-physician board members attended medical staff meetings than those in freestanding (46%) or subsidiary hospitals (40%).

Non-physician board members of rural hospitals were less likely to engage with physicians than their urban and suburban counterparts (see chart on page 15). This result was true across all five of the categories of engagement. Focus group feedback suggested that involving physicians at the board committee level, in particular, could be a useful way to tap physician talent and share leadership responsibilities with volunteer board members. Committee service is also a frequently used method of recruiting and training future board members.
Non-physician board members engagement of physicians in the past 12 months

<table>
<thead>
<tr>
<th>Activity</th>
<th>Suburban</th>
<th>Urban</th>
<th>Rural</th>
</tr>
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<tbody>
<tr>
<td>Attended a medical staff meeting</td>
<td>63%</td>
<td>58%</td>
<td>36%</td>
</tr>
<tr>
<td>Participated in a medical staff committee meeting</td>
<td>65</td>
<td>59</td>
<td>39</td>
</tr>
<tr>
<td>Participated in a board-medical staff joint planning retreat</td>
<td>72</td>
<td>70</td>
<td>57</td>
</tr>
<tr>
<td>Participated in a board-medical staff joint assessment of the possible redesign of the medical staff structure</td>
<td>30</td>
<td>37</td>
<td>16</td>
</tr>
<tr>
<td>Participated in a joint educational event with the medical staff</td>
<td>79</td>
<td>71</td>
<td>53</td>
</tr>
</tbody>
</table>

Non-physician board members of larger institutions were more likely to engage with physicians than were non-physician board members of institutions with a fewer number of beds (see chart above). This result was directly correlated with bed size across 4 out of the 5 categories of engagement.

**Challenges and Future Trends**

Survey respondents identified current organizational challenges and future trends regarding alignment between the board and the medical staff.

- The growth of specialty hospitals and physician groups in many communities is making it difficult for existing hospitals to survive. Competing physicians provide similar outpatient services to those provided by the hospital, which makes it harder to attract and maintain a loyal patient base. Existing organizations are finding it more and more important to attract and maintain a competent medical staff in order to compete with potential market entrants.
• The payer mix is a challenge for both the board and its physicians. Declining reimbursement rates and increasing uninsured populations have added to the financial pressures that face the hospital and medical staff and have made the relationship between the two groups more tenuous.

• Recruitment of clinicians, including physicians, is increasingly more difficult for hospitals. In many cases, hospitals must compete with other hospitals on a national level to fill these positions. These shortages lead to a strain on the board’s relationship with the medical staff and are expected to get larger over the next decade.

• Recruitment of physician board members has become a challenge for organizations. Many hospitals are having trouble finding enough physicians to serve on boards who are passionate, committed, and want to make a positive difference within the community.

• Physician board members often lack financial management skills, which makes it more difficult for health care organization boards to make important strategic decisions. Many boards also are challenged to find physician members who are free from conflicts of interest.

• Communication and trust were specified as the most important elements of a successful board-medical staff relationship. Physicians and board members often find it hard to establish this rapport, and the consequences can be devastating.

• Quality improvement efforts are challenging, and some physicians find it difficult to accept necessary changes that the board mandates. Respondents indicated that quality will continue to be emphasized in the future, and better alignment is needed between the board and medical staff in this area.

• As competing time pressures increase, time management will be essential to both the board and medical staff. The success of board-medical staff relations is often dependent on how both groups effectively and efficiently manage their time.

• Many boards are taking the initiative to include physicians in the strategic planning process. This trend is helping strengthen the relationship between the board and medical staff in many institutions. On the other hand, there is growing tension between boards and physicians in organizations where boards do not inform physicians of organizational strategy.

• Boards and physicians are engaging in peer review processes more frequently. These activities help maintain competencies of board members and the medical staff.
• It is becoming increasingly important for the board and medical staff to strengthen their relationships with the community. Engaging the community in ways that build trust and respect create viable opportunities for collaboration between both groups.

Deeper Insights from Focus Group Feedback
This survey was designed to assess the state of board-medical staff relationships and then solicit additional reaction and feedback through focus groups of trustees and executives to determine current best practices in developing constructive relationships between trustees and physicians. Focus group feedback is summarized below.

Physician Involvement Beyond Board Membership
A clear theme that emerged from focus group discussions was the need to move beyond a representational paradigm where physicians were allocated “slots” on the board, to a governance and leadership model involving both physicians and trustees in initiatives that leverage their expertise and interests in strategic or quality-oriented processes and that incorporate clear metrics for success. Many board members indicated that while their boards only had one physician member, physicians were very involved in board committees and joint planning retreats. One focus group participant said that while his board only had two physician members there was considerable input from non-board member physicians. Two non-board member physicians head up safety and quality work for this board and are present at each board meeting.

Quality Focus
Focus group participants suggested that having more quality-focused board meetings was a good way to get physicians engaged in leadership and governance. Participants suggested that boards need to proactively set the agenda for their meetings and for the organization overall in ways that drive physician involvement in addressing quality-related issues. Several participants encouraged boards to make quality issues the first item on the agenda at every meeting to emphasize that “putting quality first” inherently supports mission achievement. These participants believed that boards that do not rank quality equal with finance will struggle to achieve physician engagement. Without this quality focus, physicians and other clinical staff may perceive that executives and trustees are “out of touch” with issues they believe should be organizational priorities.
Time-Efficiency and Medical Staff Realities
Focus group participants said that quality was more important than quantity in relation to how boards spend their meeting time. They said that physician board members are time-challenged and want to be certain that the issues of most importance to them are addressed efficiently. One trustee suggested that board meetings used to be shorter before they involved physicians, but admitted that the longer meetings that now occur cover more relevant subjects and those of concern to physicians. Dashboards and scorecards were seen as useful tools to facilitate discussion. Strong committees that focused their work and communication back to the board using dashboards and other performance reports also helped free time for more in-depth discussion of issues, rather than just listening to committee reports, at full board meetings.

Focus groups yielded much discussion about whether the current medical staff structure is realistic and relevant for a future dominated by Generation X and Y physicians. Feedback suggests that younger physicians have less interest in the traditional medical staff model, and that many medical staff physicians no longer practice at the hospital, even if they are hospital employees. One CEO participant said that the majority of his physicians never come to the hospital, which makes it challenging to distribute information and effectively promote integrated service delivery. Some organizations are using virtual or online meetings with physicians to overcome these barriers.

Selection
Focus group participants generally agreed that how physicians are nominated to serve on the board plays a key role in setting the proper tone for board-medical staff relations and that some organizations may need to revise provisions in their bylaws that automatically appoint certain medical staff leaders to the governing board. Several participants stressed that the selection process was important not only for physicians, but for all trustees. They also said new board members should be given detailed job descriptions and be enrolled in comprehensive orientation programs that emphasize their fiduciary duties to the organization. Focus group participants also indicated a need for competency-based selection processes to recruit new board members to fill talent or skill gaps.
Focus group discussion also revealed the differing board member selection challenges faced by rural and urban hospitals. One rural hospital CEO indicated that larger health systems tend to buy up physician practice groups, which limits the pool of potential physician board members that do not have competing interests. An urban hospital board member said that his organization faced intense competition from other health systems for board members. Generally, both rural and urban executives and trustees thought that it was easier to engage physicians in board activities in urban and suburban areas, because physicians were more likely to have financial relationships with hospitals and health systems that gave them more of a vested interest in organizational performance. Also, larger practice groups commonly found in these areas yielded a larger pool from which to recruit board members.

**Strategic Planning, Transparency, Equality**

Focus group participants generally agreed that if hospitals want excellent physician relations they need to involve physicians in strategic planning, be open and honest in sharing information, and include physicians on the board. One CEO and his board chair indicated that the turning point in their relationship with the medical staff occurred when they involved the board and physicians in a series of collaborative strategic planning sessions. These sessions resulted in vigorous discussions, cultural disagreements and concerns were aired, and both the board and medical staff forged a more cohesive relationship going forward. One board member observed that this type of collaboration is often missing in health care, as competitive issues stifle cooperation. He believed however, that the environment is changing, and that emerging financial, political and demographic realities are making collaboration with physicians essential to the survival and growth of health care organizations.

Participants also emphasized the need for a transparent flow of information to and from the medical staff. Some said they had experienced success by putting non-physician board members on medical staff committees. Although some physicians were initially skeptical about this approach, board members are now welcomed as participants because they are sensitive to physician needs and concerns and do not step outside their role. This helped create two-way communication and developed trust and mutual respect among board members and the medical staff. Some participants suggested that board member attendance at medical staff meetings was not always necessary, if the board receives a summary of meeting discussion.
The Leadership Pipeline: Continuity Planning with Physicians

Several focus group participants observed that medical staff appointment of physicians to governing boards leads to frequent turnover for physician board members. Some board members suggested that to address this issue health care organizations should have a stronger focus on continuity planning for physician leadership. Participants discussed development of a leadership institute to create a pipeline of leaders across the hospital, including not only physicians, but nurses and executives as well. Participants stressed the importance of treating physicians as equals in the leadership training process, observing that historically physicians and executives have operated at arm’s length from each other, which has often strained relationships. All participants agreed that this strategy was no longer viable. There was general agreement that board committees can play a vital role in stimulating development of a robust leadership pipeline. Participants also stated that physician leaders were very active in board committee assignments, which helps prepare them for recruitment to the full board.

The Center for Healthcare Governance and Integrated Healthcare Strategies have identified and support several strategies that can be used to help build and strengthen board/medical staff relationships. These include:

- Leadership retreats that focus on topics such as strategic planning and physician alignment, some of which may include other stakeholder representatives as well.
- Monthly reports to the medical staff.
- Communication forums, including joint board/medical staff educational sessions, newsletters and other mechanisms.
- Mentoring programs that make younger physicians aware of what governing boards do and that pair physician trustees with other physicians to make them aware of the respective leadership roles, accountabilities and authority of governance, management and the medical staff.
- A board-driven leadership culture that engages physicians and other clinicians in opportunities for ongoing communication and participation in addressing issues of mutual concern.
- Educational opportunities for interested physicians that can include pursuing business degrees and non-traditional career options.
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