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Prescriptions for Excellence in
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The Future of Boards: White Water Ahead

By Gary Filerman, PhD

As previous articles in this newsletter have shown, there are clear indications that turbulence lies ahead on the governance path. Although the signs warn us to heed them and act accordingly, health care boards are slow to adapt, and providers who serve on boards are not known for their willingness to lead change. To survive and prosper in a constantly changing environment, health care delivery organizations must be adaptive systems. This requires leadership from the top – the board level – and there has never been a time when provider board members have had a more critical role to play… *if* they are well prepared.

Can it get more turbulent? Yes, because of the diverse pressures that buffet organizations, including:

- Tensions over appropriate medical staff representation in governance
- Misaligned economic interests between the hospital and some physicians – or among different physician groups
- Increasing understanding of the determinants of quality of care that mandates hands-on board involvement and response

Other changes also impinge on the future of boards; for example:

- Medical work. Tasks and competencies are being redistributed within the medical profession and among health care workers.
- Workforce organizations. The traditional adversarial relationship between management and workers will dissipate as unionization expands and everybody joins the patient-centered team.
- Transparency. It may be a private organization, but tax exemption will bring the same kind of accountabilities (ie, rules) that the Sarbanes-Oxely Act of 2002 brought to publicly traded companies.

Physician membership on boards has been increasing in recent years. I say "membership" rather than "representation" because members of the board have a primary responsibility to the interests of the organization. It is a confusing picture that will be sorted out – hopefully by the boards themselves, but more likely by regulation.

Medical Staff Representation in Governance: The relevant questions include: 1) how autonomous is the hospital medical staff, and 2) what is effective medical staff representation on the board? Interests, responsibilities, and relationships keep changing and the structure of the organization must adapt to the changes. It was relatively simple when most of the doctors were independent users of the facility whose interests were managed through the medical staff organization that they controlled. Now there is a substantial subset of physicians whose financial ties to the institution differentiate them from those who maintain the traditional relationship. The real or perceived differences in interests may lead to conflict.

The ramifications of the quality of care revolution on all aspects of health professions practice have just begun to be felt. It is hard for some organizations and practitioners to imagine greater impact, or intrusion, depending on the perspective. Outcomes assessment-driven research continues to reveal more ways in which the system must change, and increases the onus on governance to craft and enforce the changes. In simple terms, this means changing provider behavior, for which the board carries unequivocal responsibility. There may be a "partnership" with the medical staff but, in the eyes of the law and the patient, it is an unequal partnership. The physician on the board shares responsibility with the other members to support a culture of quality, to ensure that the by-laws adequately

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address quality, and to enforce the by-laws by putting the interests of the patient first.

Medical Work: There are profound changes under way in how medical work gets done. Outcomes research is an important factor, but so are the shortages of professionals – particularly primary care providers – and the increases in the burden of chronic disease and the elderly population. There is no prospect that expanding the number of doctors, nurses, and other providers while following the present work rules (commonly called scope-of-practice) will meet the need.

It is clear that tasks will have to be redistributed among providers according to the needs of the patient and the competencies of providers, and not according to the economic interests of the professions. How well it works will be assessed in terms of patient safety, outcomes, and cost-effectiveness – not by conformity with outmoded licensure laws.

The Workforce: The expansion of organized labor in health care is an important trend with implications for the board. Unions are becoming more sophisticated in their appeal to health workers and have raised moral questions about wages and benefits in the not unsympathetic public arena.

It is also important to recognize that all of the health professions are turning to collective negotiation for economic leverage. Unions clearly have a stake in quality of care and the strength of the institution. Looking forward – a key role of the board – a new social compact is likely to emerge that goes beyond traditional relationships. The challenge lies in getting there.

Transparency: Demands for the release of "inside" information about quality of care, charges, and costs are becoming more insistent and duplicative. This "production transparency" will continue as pay for performance becomes the general pattern and the number and scope of quality measures continues to expand. Governance transparency is another matter.

Both for-profit and nonprofit hospitals are being swept into the growing regulation of the governance function. The rationales are different but the results are the same. Shareholders' rights are the issue in publicly traded systems and the public's rights are the issue in tax exemption. Abuses, rising costs, and issues of access and quality of care all converge to encourage regulators to press for more transparent and predictable governance processes.

More regulation, not less: The mandate will be for boards to proactively meet the public policy objectives of greater accountability and transparency. Boards will have less privacy as they wrestle with the tensions of interprofessional economics and with how to achieve greater clarity of responsibility for provider competence.

Boards, especially tax-exempt boards, are entrusted with the stewardship of resources in the service of the mission, whether on behalf of stockholders or patients. It is a social compact built on trust that has diminished. The emerging social compact will depend much more on regulatory processes. The sources will probably be a mix of federal, state, local, and even "voluntary" agencies (eg, the Joint Commission).

Mandated transparency will be but one aspect of greater public accountability. Increasingly, boards will be required to define their own operating rules and held accountable for playing by those rules. This trend has serious implications for physician board members whose representative function and participation will come under scrutiny. Boards must be very sensitive to this trend and proactive in addressing all identifiable questions of real or apparent conflict of interest. Steering through the coming white water demands the deliberate, proactive attention of boards. In particular, clinician board members will be expected to clarify their roles and provide expert guidance as the board engages the rapids.

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