Physicians and Conflict of Interest

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An Interview with Edward A. Kazemek, Chairman & CEO, **ACCORD** LIMITED

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Charles M. Ewell, Ph.D.: My guest today is Ed Kazemek, chairman and CEO of **ACCORD** LIMITED, a Chicago-based advisory firm specializing in helping boards become more effective. Ed's firm conducts governance assessments, board education programs, and annual retreats. He has served as a faculty member for The Governance Institute for the past 11 years, and he recently coauthored a thought-provoking white paper for us on the topic of institutional integrity. The paper addressed a number of issues pertaining to board member conflicts of interest, especially physicians who serve on the board.

Ed, welcome!

Edward A. Kazemek: Thank you.

Ewell: If the average size of the hospital or health system board is still around 14 or 15 people, how many chairs are occupied by physicians these days, typically?

Kazemek: Well, typically it stays around 20 to 25 percent, somewhere in that range.

Ewell: …two or three people.

Kazemek: Yes—it's been like this for years.

Ewell: And one of those is the chief of staff?

Kazemek: Typically, the president of the medical staff (the chief of staff) often is a board member.

Ewell: With the frequently discussed competition by physicians with hospitals and with systems, and with some conflict of interest issues as you've written about, what seem to be the trends as far as physicians serving on boards with a vote?

Kazemek: Well, there is a lot of concern growing out there. On the one hand, hospitals are really trying to rachet up the degree of ethical performance on the part of the board by looking at their conflict of interest policies and procedures, trying to go beyond mere compliance with state statute or federal regulations, and at the same time, physicians continue to enter into complex business deals among themselves and with the institution, and as a result, it is becoming increasingly difficult to find good physicians or physicians who are qualified to serve on the board without serious conflicts of interest. Interestingly though, the latest survey done by The Governance Institute still supports the vast majority of non-governmental hospitals continue to have physicians on the board—in fact the number is still around 85 percent who have physicians on the board, with vote, as fiduciary board members.

Ewell: Does the chief of staff typically have a vote or not have a vote?

Kazemek: Well, it's changing. Historically, the president of the medical staff/chief of staff usually was a voting board member, *ex officio*, because of his or her position. We basically view it as an antiquated practice that should be abandoned simply because the chief of staff has an irresolvable conflict between his loyalty to the medical staff that elected him or her to the position and the duty of loyalty to the institution which is one of the board's member's fiduciary duties. So we think it's an irresolvable conflict; therefore, we're recommending that the chief of staff or president of the medical staff become an *ex officio* non-voting member of the board.

Ewell: I remember one conversation we had in a boardroom where we were discussing this very thing of voting and we asked the physicians around the table if they had a vote or not a vote and one man said, "You know, I don't know whether I do or not but I always hope!" They may vote when they're not supposed to!

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Kazemek: That's true and not unusual.

Ewell: The IRS views physicians as insiders or interested persons in the larger consideration of their role, but how does affect their role in the hospital?

Kazemek: This is an area of confusion I think. It is true the IRS deems physicians—active medical staff physicians—to be insiders, but [being an] insider is not synonymous with [having a] conflict of interest. Many people think it is. The reality is that insider means simply that there are certain limitations on what you're able to do on the board. An insider cannot be deemed to be an independent board member and if the board chooses not to have non-independent board members serve, for example, on the compensation or audit committee, that means those physicians cannot serve on those committees. Other than that, though, they are board members like anybody else and are free to serve on the strategic planning committee, the finance committee, the quality committee, what have you, just like any other board member.

Ewell: Are you finding any hospitals selecting, or recruiting and appointing, physicians to their board who do not practice at that hospital or perhaps live in a different neighborhood or service area or even a different town?

Kazemek: You know, that sounds good on paper but it doesn't work as well as it sounds. Some of my clients have tried that and I have talked to other people who have tried it and essentially you lose the connectivity to the medical staff. You lose the unique perspective that physicians bring on the operations of your hospital as opposed to somebody else's hospital. And at the end of the day, the active medical staff does not view a retired physician or a physician from outside the community, regardless of their reputation, as one of their own. And so you lose that some of that symbolic connection to the institution.

Ewell: That sounds like it relates to the notion that this is a delegate that they are sending to the board to represent their best interest.

Kazemek: I basically tell my clients not to rely on that technique alone. That will not satisfy the medical staff's desire to be part of the decision-making process.

Ewell: The notion of whether the chief of staff should be voting or non-voting—if you recommend as you increasingly are that they be non-voting. Does that upset the medical staff members that it's not a "full service citizen?"

Kazemek: It can if it's not handled skillfully. This is an area where we have done a pretty poor job in educating physicians on what it means to be a fiduciary board member. Most physicians don't realize the legal requirements that they are accepting when they agree to serve on the board. My experience has been that if you do a thorough job of educating physicians on what it means to be a fiduciary board member, often the chief of the medical staff will say, "I'd rather not be a voting board member; I just want to be in the room, and I want to be able to participate, and that way I'm free to champion the cause of the medical staff, freely, without worrying about violating my fiduciary duty of loyalty."

Ewell: It doesn't seem to be a problem with attorneys on the board—they know they're not representing the legal community, or an architect representing the architectural community, or the banker and the banking community. It seems to be more complicated because that physician who should represent the community at large thinks more like a doctor in the medical center.

Kazemek: That goes way beyond my time, but physicians, it's a tight brotherhood or sisterhood as the case may be and I don't think they're likely to change that. But I think there are ways you can still have physicians on the board and work around that and not let it become an obstacle to good governance.

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Ewell: Ed, talk for a minute about the notion of competition by physicians with the hospital and even when they're a member of the board or a voting member of the board but actually involved in competitive effort at one time or another.

Kazemek: It's probably the most controversial issue out there today in terms of physicians serving on the board, which is why many organizations have questioned whether they should have any physicians on the board. The reality is that you have to look at each situation separately. If a physician is moving some minor procedures or x-ray machine into his or her office or a small laboratory, I don't think that's the kind of competition that would exclude a physician from serving on the board. It's not material competition—it doesn't jeopardize the mission of the hospital. On the other hand, if a physician is investing in a specialty hospital for heart care, cancer, or orthopedics, or investing in an ambulatory surgery center in which the hospital is not an investor, that rises to the level of material competition that could jeopardize the mission of the organization which, at the end of the day, the board is responsible for ensuring. So we do recommend to hospital boards to do the difficult work of establishing clear policies—rules of the road—on what kind of competition they will countenance, which type of competition rises to the level where those physicians are "disabled" and are no longer welcome to serve on the board.

Ewell: I know there have been some bloody battles on this subject. Ed, we're about out of time but thanks for this. This subject will not go away and you will have a lot of business, I can guarantee, for a long time. Thanks for 11 years of collaboration with The Governance Institute.

Kazemek: Thank you.

Ewell: Until next time, for The Governance Institute, I'm Charlie Ewell.