

2010

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Blum, John D. The Quagmire of Hospital Governance, 31 J. of Legal Medicine 35 (2010)

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Publisher: Taylor & Francis

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Journal of Legal Medicine

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/ulgm20>

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Available online: 24 Mar 2010

To cite this article: John D. Blum J.D. (2010): The Quagmire of Hospital Governance, Journal of Legal Medicine, 31:1, 35-57

To link to this article: <http://dx.doi.org/10.1080/01947641003598229>

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THE QUAGMIRE OF HOSPITAL GOVERNANCE FINDING MISSION IN A REVISED LICENSURE MODEL

John D. Blum, J.D.*

INTRODUCTION

Governance lies at the core of the American hospital and, together with the medical staff and administration, is one of three foundational elements of structure that is universal to all types of acute care institutions.¹ The evolution of the hospital board is tightly linked to the development, growth, and ongoing changes in medicine that frame the acute care institution over time, and is a matter of continuing interest to parties in health care delivery, management, and regulation. Although various structural models of governance populate the hospital landscape, there are considerable commonalities in overall goals and functions of boards that make generic evaluation of governance feasible. Examination of the commonalities in board structures and functions underscores a high level of ambiguity in how this critical function of institutional operations ought to be cast.

There is no paucity of ideas and suggestions related to hospital board operations, but a notable lack of foundational purpose characterizes this area. This article explores the appropriate roles of hospital governing boards during a time of great transition for health care in the United States. It initially reviews the fundamental landscape of governance, highlighting basic statutory and common-law elements that have converged to form a rather eclectic, but complex, body of law. Second, the article explores some recent events that have sparked a renewed interest in governance matters. These include controversies over institutional asset changes, the national debates on charity care and

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¹ For an interesting historical perspective on governance, see EMANUEL HYATT ET AL., *LAW OF HOSPITAL, PHYSICIAN AND PATIENT* (3d ed. 1972); GEORGE D. POZGAN, *LEGAL ASPECTS OF HEALTH CARE ADMINISTRATION* 127-57 (10th ed. 2006); Richard L. Johnson, *The HCMR Perspective: The Purpose of Hospital Governance*, 19 *HEALTHCARE MGMT. REV.* 81, 81–88 (1994); ARTHUR F. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTHCARE ADMINISTRATION* 114–30 (1998).

community benefit obligations, and the new emphasis on board oversight of medical care quality and the related concerns involving institutional patient safety.

The final section posits a model for hospital governance that departs from traditional regulatory formats. The new model would be built around principles of management and responsive regulation that are parts of a global legal reform movement, loosely referred to as “new governance.”

I. LEGAL FOUNDATIONS OF GOVERNANCE

A. A Convergence

The law *per se* may have very little to do with how a particular hospital board functions on a daily basis. Other variables such as geography, tradition, membership in a system, sponsorship, corporate member influence, local market pressures, and financing may provide far better explanations about how the roles and overall mission of a given hospital board are actualized. But ultimately the behavior of acute care governing entities, in terms of structure, operations, and overall purpose, is very much a function of law, which is the most significant core element driving the trustee role.²

The difficulty in comprehending the legal role of hospital boards is that there is no unitary body of law that encapsulates this sector. Rather, the law here is composed of a series of principles that have evolved over many years, drawn largely from state statutory and common law.³ The legal principles affecting governance represent the convergence of the threads related to institutional sponsorship, including charitable trusts, non-profit and for-profit corporations, and governmentally sponsored entities. The various principles and corporate foundations combine to form a hospital board that acts as a fiduciary, a type of overseer vested with final authority over all aspects of the hospital's operations and policies.

In attempting to flush out details concerning the role of the board, greater specificity can be found in examining three particular areas of this diverse body of law. These areas are hospital licensure and accreditation, foundational corporation law, and key court decisions on board power and obligations.

² For purposes of this article the terms “director(s),” “board of directors,” “board,” “hospital board,” and “trustees” will be used interchangeably. The term “governance” will be used generically, providing an overview concept of the entire area. For a detailed overview of legal issues affecting boards, see Robert C. McCurdy, *Governing Boards*, in ASPEN HEALTH LAW & COMPLIANCE CENTER, HEALTH LAW MANUAL 180 (2004).

³ *Id.* For an excellent overview of board law in the non-profit setting, see Thomas L. Greaney & Kathleen Boozang, *Mission, Margin & Trust in the Non-Profit Healthcare Enterprise*, 5 YALE J. HEALTH POL'Y L. & ETHICS 1 (2005).

B. Public and Private Regulation: Licensure, Accreditation, and Corporate Enabling Law

For acute care hospitals to operate, regardless of the sponsorship model, they must hold a valid state license. Licensing, a form of state police power, has existed widely since the 1950s and details a set of baseline structural and operational requirements by which hospitals can be surveyed and evaluated.⁴ Fundamental to all state licensing laws are universal requirements that acute care institutions must be overseen by a board of directors with both general and specific responsibilities delineated in law.⁵

Over time, hospital licensing requirements have been expanded to keep pace with developments in institutional functions, and they serve as a rather detailed template for discerning functions of particular parts of these operations, such as those of the governing board.⁶ For example, under West Virginia law, the hospital board is charged with overall management and control of the institution, with specific duties including hiring and evaluating an administrator, approval of medical staff credentialing, quality monitoring, infection control, regulatory compliance, and fiscal oversight.⁷ West Virginia law also includes board mandates for the development of bylaws, an organized committee structure for governance, consumer representation on the board, and a liaison with the medical staff.⁸

Related to licensure are two other sets of core regulatory requirements—the Medicare Conditions of Participation and private regulatory requirements of The Joint Commission. Both of those contain mandates for boards, and thus provide further guidance on matters of hospital governance.⁹

The majority of hospitals participate in the Medicare program, and thus must comply with federal requirements for acute care structure and operations, including those that apply to governing boards.¹⁰ Medicare delineates six areas in which boards must act: approving medical staff credentialing and bylaws; appointing the hospital chief executive officer; ensuring appropriate patient care; developing an institutional budget and operational plan; providing oversight of contracted health care services; and, if relevant, maintaining adequate emergency services. In addition to overseeing these mandates, because the

⁴ John D. Blum, *A Revisionist Model of Hospital Licensure*, 2 REG. & GOVERNANCE 148 (2008).

⁵ All 50 states and the District of Columbia have hospital licensing laws. A good example of such laws can be found in Illinois, 210 ILL. COMP. STAT. 85 (2009). A helpful list of board functions can be found in MISS. CODE ANN. § 41-13-35 (2009).

⁶ See Hospital Regulation and Approval Act, WIS. STAT. §§ 50.32-39 (1965).

⁷ See generally W. VA. CODE §§ 16-5B-1 to 16-5B-17 (2009).

⁸ *Id.* § 16-5B-6a.

⁹ Conditions of Participation for Hospitals, 42 C.F.R. § 482 (2009); THE JOINT COMMISSION, ACCREDITATION PROGRAM: HOSPITAL, CHAPTER: LEADERSHIP § LD.01.05.01 (2009).

¹⁰ MEDICARE PAYMENT ADVISORY COMMISSION, HEALTHCARE SPENDING AND THE MEDICARE PROGRAM: A DATA BOOK 73 (2009); Conditions of Participation for Hospitals, 42 C.F.R. § 482 (2009).

board has final institutional authority, it would have a general obligation to see that the hospital meets the regulatory requirements of Medicare falling under the general Conditions of Participation.¹¹

Beyond licensing laws and the Medicare Conditions of Participation, a third regulatory point of reference for determining board rules comes out of the area of private sector accreditation. Although all hospitals are licensed, the Medicare Conditions of Participation requirement for state review and certification may be partially waived because private regulators have been granted “deemed status,” thus giving certain accreditation programs quasi-governmental power.¹² The largest private accrediting body in health care is The Joint Commission (TJC). Therefore, TJC standards relevant points of reference for understanding institutional responsibilities, including governance.¹³

Under the leadership standards of the TJC, the hospital board is charged directly with ultimate responsibility for patient safety, quality of care, and treatment and services. In addition to these broad mandates, TJC standards include several targeted areas: governance responsibility, including review and approval of the scope of hospital operations; ensuring adequate resources; evaluation of hospital performance; institutional conflict resolution; and medical staff collaboration. Private accreditation standards tend to reflect current industry practices and are designed to cut across a wide spectrum of individual and system board models.¹⁴

Review of corporate laws under which hospitals are established garners another core set of insights on the roles and functions of boards. These include general corporate enabling laws, non-profit corporation acts, and laws that underpin public institutions. For example, in the Model Non-Profit Corporation Act, considerable details are provided about the roles of boards and requisite structure and process.¹⁵ The model law lists three broad standards of conduct that directors must follow: good faith; prudent person; and corporate best interest.¹⁶

Special board requirements can be found in public hospital sector laws. These may be similar to those of other types of government corporations, with requirements for election of trustees, record keeping, and open meeting policies.¹⁷ Emanating from foundational corporate laws are basic enabling

¹¹ The board of directors has the ultimate responsibility for hospital affairs, which clearly entails fulfillment of regulatory mandates. Thus, Medicare compliance falls within the ambit of board oversight.

¹² 42 U.S.C. § 1865(b)(1) (2006).

¹³ JOINT COMMISSION, *supra* note 9.

¹⁴ *Id.* §§ LD1.10-LD1.30. Section LD1.30 details the areas noted in the text.

¹⁵ REV. MODEL NONPROFIT CORP. ACT §§ 8.01-8.33 (1987).

¹⁶ *Id.* § 8.30(a).

¹⁷ *See, e.g.*, 70 ILL. COMP. STAT. 910/13-15 (2009); IOWA CODE ANN. §§ 347.13, 347.25 (2009); NEB. REV. STAT. ANN. § 23-3534-3536 (2009).

documents, articles of incorporation, and bylaws that provide specific details about individual hospital board operations. Such documents, in turn, reflect the realities of single and multi-institutional arrangements.¹⁸

C. Common-Law Directions

There is no shortage of regulatory direction concerning the structure, functions, and operational standards for hospital boards; however, such direction does not necessarily yield guidance about the manner in which directors must behave in given situations. Thus, to ascertain a more rounded picture of board behavior, it is necessary to consider how courts view specific mandates and the concepts of implied authority. The common law attests to the fact that governing boards possess adequate powers, both explicit and implicit, to fulfill the recognized mission and roles of a given institution. In determining what implied authority is present in a given situation, the courts often characterize the board as the institutional fiduciary, having considerable leeway to steer the hospital in directions that are responsive to the realities of the acute care sector.¹⁹ In the nonprofit sector, as charitable trust principles have given way to more current concepts of corporate law, such as use of the business judgment rule, directors are less constrained by strict adherence to charitable purpose and have been able to adopt a more business oriented outlook. Although exercise of implied power may provide trustees' greater freedom, boards must still recognize their legal boundaries, and misconduct may spark both individual and institutional liability.²⁰

A collective sense of common law frames the director's fiduciary role as composed of three primary duties: obedience; due care; and loyalty.²¹ In general terms, the courts have required, as a core mandate, that governing boards exercise sound business judgment in the exercise of financial affairs.²² A somewhat narrower reading of fiduciary responsibilities would also include obligations of boards to protect and preserve hospital property, ensure the

¹⁸ Historically, hospitals have been established as corporate entities. A snapshot of hospital corporate history can be found in the 1907 articles of incorporation of the Calumet Hospital, available at http://ccdlib.libraries.claremont.edu/cdm4/item_viewer.php?CISOROOT=/lsc&CISOPTR=2389 (last visited on Sept. 16, 2009).

¹⁹ SOUTHWICK, *supra* note 1, at 122–28.

²⁰ *Id.* at 128–31.

²¹ JAMES P. JOSEPH, ARNOLD & PORTER LLP, FIDUCIARY DUTIES OF A DIRECTOR AND CONFLICTS OF INTEREST, available at http://www.cof.org/files/documents/education_collaborations/difficultboards/handout1.pdf (last visited Sept. 16, 2009).

²² Dan Culica & Elizabeth Prezio, *Hospital Board Infrastructure and Functions: The Role of Governance in Financial Performance*, 6 INT'L J. ENVTL. RES. & PUB. HEALTH 862 (2009). A dispute over board malfeasance occurred recently at Tri-City Hospital in San Diego, where a hospital board dismissed a CEO and eight executives, calling into question the feasibility of the institution's governance structure. See Rebecca Vesely, *A Storm in Southern California*, MODERN HEALTHCARE, June 8, 2009, at 18.

adequacy of insurance, support risk management functions, develop collection policies to protect assets, and safeguard against director conflicts of interest.²³

The nature of board duty was explored in *The Health Alliance of Greater Cincinnati v. The Christ Hospital* (TCH), which involved a dispute over the hospital's decision to withdraw from the multi-institutional Alliance arrangement.²⁴ The TCH board sought to drop out of Alliance because of its perception of financial improprieties involving Alliance's attempts to strip the hospital of its reserved powers, and the fear that the facility would be closed or relocated. An instructive element in the TCH case is the concept of board duty, framed by the Ohio Non-Profit Corporation Act and the specific Joint Operating Agreement in question. The court noted that the TCH board was required to act with due care and had a good faith obligation to function in the interests of the institutional mission. The board's careful review of the viability of hospital operations, as demonstrated by the formation of a special board task force and the retention of an outside management consulting firm, supported evidence that the TCH directors complied with their due care and good faith obligations. Interestingly, the Ohio court in TCH found an obligation on the part of the system to behave in the best interests of its member facilities, and held that the Health Alliance had breached its fiduciary duty to the hospital.²⁵

Some of the most helpful case law in the governance area can be drawn from disputes between hospital boards and members of the medical staff in the credentialing area.²⁶ Under both common and statutory law, hospital medical staffs are independent, self-governing entities. They are delegated the tasks of appointment, reappointment, and delineation of privileges, activities collectively referred to as credentialing.²⁷ Medical staffs may operate independently, but their powers, reflected in staff bylaws, are derivative, and final decisional authority for hospital matters—including appointments and privileging—rests with the hospital board.

Mahon v. Avera St. Luke's illustrates how the courts have perceived board authority in the medical staff dispute area.²⁸ In *Mahon*, the South Dakota Supreme Court dealt with a dispute centering on the power of the board. The appellees, a physician corporation and an individual physician, alleged

²³ ROBERT D. MILLER & REBECCA C. HUTTON, *PROBLEMS IN HEALTH CARE LAW* 25-34 (8th ed. 1999). A case dealing with boards that is well known in the hospital law area is *Stern v. Lucy Webb Hayes Nat'l Training Sch. for Deaconesses and Missionaries*, 381 F. Supp. 1003 (D.D.C. 1974).

²⁴ *The Health Alliance of Greater Cincinnati v. The Christ Hosp.*, No. C-070426, 2008 WL 4394738 (Ohio Ct. App. Sept. 30, 2008).

²⁵ *Id.*

²⁶ Mark A. Kadzielski et al., *Peer Review Potpourri: New Developments in Credentialing and Privileging*, 15 *WHITTIER L. REV.* 51 (1994). There is a long history of credentialing disputes between physicians and hospitals in which medical autonomy directly clashes with board oversight duty.

²⁷ *Id.*; see also SOUTHWICK, *supra* note 1, at 585.

²⁸ *Mahon v. Avera St. Luke's*, 621 N.W.2d 150 (S.D. 2001).

that the hospital board lacked authority to restrict medical staff privileges and to close staff membership in certain specialty areas. Two central matters were the state law concerning board powers and the authority of hospital directors as specified in the institutional bylaws. Under the South Dakota Non-Profit Corporation Act, directors are charged with managing the affairs of the corporation. *Mahon* characterized the board as having a large amount of discretionary power within the limits of its legal authority and the exercise of sound business judgment.²⁹ In turn, the court reasoned that the hospital bylaws provide the board with a foundational power that enabled it to make business decisions affecting the institution's medical staff.

Mahon is often referred to as a case dealing with economic credentialing. In this contentious area, the case underscores the power of a governing entity to exercise authority in the interests of sound financial management.³⁰

II. A NEW EMPHASIS

A. Broad Reflections

As discussed above, statutory and case law combine to provide both a general and specific view of the governance role in the hospital sector. The law of boards is hardly static, but its focus has been one largely played out within the arenas of regulation, the courts, and hospital management. In recent years, several developments have occurred to spark interest in governance and, in turn, lead to changes in the scope of this function. Three major developments have triggered a broadening focus on acute care governance; they involve controversies over asset reallocation, concerns over the adequacy of non-profit hospital community benefits, and a new and expanded emphasis on hospital board oversight of clinical quality issues, including patient safety.

In general, the issue of corporate governance has been elevated in the public consciousness. In the 1990s, corporate oversight scandals resulted in major legislative changes affecting governance, leading to passage of the 2002 Corporate Oversight and Criminal Fraud Accountability Act, the so-called Sarbanes-Oxley Act (SOX).³¹ Sarbanes-Oxley imposes a number of changes on the operation of boards of publicly traded companies. Changes included greater disclosure, new conflicts of interest policies, and increased

²⁹ See S.D. COD. LAWS § 47-23-13 (2009) (illustrating how generic statutory law can be in the board area, giving boards greater discretion to fulfill their oversight roles).

³⁰ John D. Blum, *Beyond the Bylaws: Hospital-Physician Relationships, Economics, and Conflicting Agenda*, 53 BUFF. L. REV. 459 (2005); Beverly Cohen, *An Examination of the Right of Hospitals to Engage in Economic Credentialing*, 77 TEMP. L. REV. 705 (2004); see also Brad Dallet, *Economic Credentialing: Your Money or Your Life*, 4 HEALTH MATRIX 325 (1994); Nicole Huberfeld, *Tackling the "Evils" of Interlocking Directorates in Healthcare Nonprofits*, 85 NEB. L. REV. 681 (2007) (detailing some of the complex issues that arise in multi-hospital system contexts).

³¹ Sarbanes-Oxley Act of 2002, Pub. L. No. 107-204, 116 Stat. 745 (2002).

audit activities.³² Although the non-profit world is not covered by Sarbanes-Oxley, the law has acted as a broad template for outlining governance practices that all corporations, regardless of sponsorship, should consider. For example, as a result of SOX it has been suggested that boards increase the number of independent members, create ethics policies, enhance fraud detection, and conduct board training on fiscal issues.³³

The dramatic failings of major financial institutions have placed attention on the shortcomings of governing boards.³⁴ Within health care, the 1998 bankruptcy of the Allegheny Health, Education, and Research Foundation, the nation's largest non-profit failure, still stands out as a dramatic example of the ramifications of inadequate governance. It has had a strong effect in the hospital sector in sparking attention about the need for effective boards.³⁵

B. Three Developments

Of the three previously mentioned developments directing attention to hospital boards—asset allocation, community benefit, and quality of care—the first two are representative of the tensions boards face in balancing institutional mission with the realities of the health care marketplace. In its fiscal oversight role, the board must make decisions that meet the dictates of business judgment and respect the idiosyncrasy of third party payer and financial institutions. Although the majority of financial decisions made by a hospital board can be viewed as routine, it is those rarer decisions that impact the structure and operations of the institution, leading to internal and external parties that call into question board judgment.

No doubt hospital boards of every model and structural iteration struggle with fiscal challenges, but non-profit board decision making is especially difficult. Directors of such entities are caught between business and charitable imperatives. The tensions felt by non-profit directors between economics and charitable mission go beyond operational realities, but are also manifested in

³² See generally Roberta Romano, *The Sarbanes-Oxley Act and the Making of Quack Corporate Governance*, 114 YALE L.J. 1521 (2004).

³³ THE BOARD SOURCE, THE SARBANES-OXLEY ACT AND IMPLICATIONS FOR NON-PROFIT ORGANIZATIONS, available at <http://www.boardsource.org/clientfiles/sarbanes-oxley.pdf> (last visited Sept. 16, 2009); see also Joseph Mead, *Confidence in the Non-Profit Sector Through Sarbanes-Oxley Style Reforms*, 106 MICH. L. REV. 881 (2008).

³⁴ SUDHAKAR RAM, FINANCIAL MELTDOWN AND GOVERNABILITY BUSINESS STANDARD, available at <http://www.nasscom.in/Nasscom/templates/NormalPage.aspx?id=56007> (last visited Sept. 16, 2009); Ben W. Heinman Jr., *Financial Leaders Go AWOL in the Meltdown* (Nov. 4, 2008), available at http://www.law.harvard.edu/programs/plp/pdf/Financial_Leaders_Go_AWOL.pdf (last visited Sept. 16, 2009).

³⁵ See, e.g., Lawton R. Burns et al., *The Fall of the House of AHERF: The Allegheny Bankruptcy*, 19 HEALTH AFF. 7 (2000); Lisa Goldstein, *The Failure of AHERF: 5 Important Lessons*, HFM MAG., Aug. 2008, at 54.

the law.³⁶ There is a legal tension between the obligation of directors to fulfill the charitable purposes of a non-profit hospital, on one hand, that may clash with a stream of non-profit corporation law strongly requiring directors to exercise sound business judgment, on the other.

1. Challenges

A number of high profile cases have been decided in which state attorneys general have challenged the actions of individual and health system boards as not meeting the directors' fiduciary obligations to the charitable mission.³⁷ Under a type of *parens patriae* argument, state attorneys general, acting on behalf of the public interest, have challenged hospital decisions to close or relocate a facility, convert an entity from a non-profit to a for-profit, or spend sold assets in a particular way.³⁸ In one of the better known cases in this area, an attorney general's challenge was brought against the hospital directors' decision to sell the facility and use the proceeds to fund freestanding clinics.³⁹ In assessing the directors' conduct, the court found that the decision to sell the facility failed to meet the two-pronged state test for non-profit board actions; namely, the transaction was not fair and reasonable and did not advance the entity's charitable purpose.⁴⁰

Other attorneys general challenges affecting board decisions involve the uses of proceeds earned from the sale of non-profit assets. In *Banner Health System v. Long*, a non-profit health system sought to sell its facilities in North Dakota, South Dakota, and New Mexico and to use the proceeds to expand services in Colorado and Arizona.⁴¹ Banner defended its decision as a reasonable exercise of business judgment under non-profit corporation laws. The South Dakota Supreme Court ruled that use of sale assets was not only a matter to be evaluated under non-profit corporation law, but if a sale resulted

³⁶ There is an excellent body of scholarly and practice literature concerning non-profit board law. See generally, e.g., MICHAEL W. PEREGRINE & JAMES R. SCHWARTZ, THE APPLICATION OF NON-PROFIT CORPORATION LAW TO HEALTH CARE ORGANIZATIONS 40–41 (2002) (citing DANIEL KONTZ, BOARD LIABILITY: GUIDE FOR NONPROFIT DIRECTORS (1988)); Jill R. Horowitz, *Why We Need the Independent Sector: The Behavior, Law, and Ethics of Not-for-Profit Hospitals*, 50 UCLA L. REV. 1345 (2003); Greaney & Boozang, *supra* note 3; Alice M. Maples, *State Attorney General Oversight of Economic Credentialing*, 37 CUMB. L. REV. 235 (2006-07).

³⁷ Derivative actions can be brought by private parties challenging public benefit corporations, but the state attorney general must be notified. See Marion Freemont-Smith & Andras Kocaras, *Wrongdoing by Officers and Directors of Charities: A Survey of Press Reports 1995–2002*, 42 EXEMPT ORG. TAX REV. 25 (2002); see also Evelyn Brody, *Whose Public? Parochialism and Paternalism in State Charity Law Enforcement*, 79 IND. L.J. 937 (2004).

³⁸ Phil Kline & Reid Holbrook, *Protecting Charitable Assets in Hospital Conversions: An Important Role for the Attorney General*, 13 KAN. J.L. & PUB. POL'Y 351 (2004).

³⁹ *Manhattan Eye, Ear & Throat Hosp. v. Spitzer*, 715 N.Y.S.2d 575, 577 (N.Y. Sup. Ct. 1999) [hereinafter MEETH].

⁴⁰ *Id.* at 594-95.

⁴¹ 663 N.W.2d 242, 246 (S.D. 2003).

in a non-just enrichment and hurt local communities, the charitable assets in question could be characterized as an implied or constructive trust and would fall under the purview of attorney general oversight.

In another case, the hospital board was motivated by operational losses, reduction in capital, increased competition, and low reimbursement to sell assets located in Missouri and Kansas.⁴² The board had agreed with the Missouri attorney general to transfer the proceeds from the sale to a Missouri foundation, sparking a challenge from the Kansas attorney general. In the resultant litigation, the federal district court in Kansas concluded that the hospital board actions should be evaluated under the business judgment rule, but still found—independent of charitable trust doctrine—that the board of the Kansas subsidiary did not exercise sound business judgment because it failed to ensure that the charitable purpose of the organization remained intact after the sale.

The difficulty in articulating a standard for non-profit board business accountability is that the legal concept of duty is ambiguous and the judicial tests are muddled, forging a rather odd hybrid standard mixing charitable and non-profit law. Such ambiguity in non-profit board decision making hampers good faith business judgment, particularly for multi-state hospital systems.⁴³ The National Association of Attorneys General supports a Model Act for Non-Profit Health Care Conversion Transactions.⁴⁴ The model law empowers AGs to review non-profit hospital transactions involving disposition of assets and alteration of operations, as well as transfer of control or governance. Under the model act, attorneys general would review questions of fiduciary obligation, due diligence, economic soundness, and community benefit. Although adoption of the model law may result in more predictable and defined oversight, it does not alleviate the primary tensions faced by non-profit boards between economics and charitable mission, and could serve to improperly hamstring non-profit hospital decision making.

2. *Community Benefits*

Perhaps an even larger issue in the public eye affecting hospital governance concerns controversies over the community benefit obligations of non-profit hospitals. Under both federal and state laws, non-profit acute care facilities are required to offer some type of community benefit, typically (but

⁴² *Health Midwest v. Kline*, No. 02-CV-08043, 2003 WL 328845 (D. Kan. 2003); see Harold Kaplan et al., *The Charitable Trust Doctrine: Lessons and Aftermath of Banner Health*, 23 AM. BANKR. INST. J. 28 (2004).

⁴³ Brody, *supra* note 34, at 937; see also Brody, *supra* note 34, at n.121 (citing Michael W. Peregrine & James R. Schwartz, *Key Nonprofit Corporate Law Developments in 2002*, 12 HEALTH L. REP. 324, 327 (2003)).

⁴⁴ NAT'L ASS'N OF ATTORNEYS GEN., PROPOSED MODEL ACT FOR NONPROFIT HEALTHCARE CONVERSION TRANSACTIONS, available at <http://www.naag.org/naag/resolutions/res-sum98> (last visited Sept. 16, 2009).

not only) charity care, as a type of *quid pro quo* for tax exempt status. Clearly, community benefit obligations fall within board oversight duties and are mandated by regulatory requirements as well as general fiduciary duties to fulfill the institutional mission.

In recent years, controversies have emerged dealing primarily with state property tax exemptions, in which individual hospitals have been charged with failing to meet community benefit obligations.⁴⁵ Often, it is not the failure to meet non-profit tax requirements that trips controversy, but rather the aggressive posture of a facility in the billing and collection area, especially involving uninsured patients.⁴⁶ In one publicized situation, Illinois-based Provena-Covenant Hospital lost its property tax exemption for failure to meet its charitable obligations and was criticized for its handling of uninsured patient accounts. In the Illinois Court of Appeals decision resulting from Provena's challenge to the loss of its property tax exemption, it was pointed out that the hospital devoted only 0.7% of its total revenue to charity care.⁴⁷ The appellate court held that the institution failed to meet the necessary characteristics of a charitable institution under state law.⁴⁸ Individual facility controversies such as *Provena-Covenant* prompted a number of state attorneys general to develop more stringent standards.⁴⁹

⁴⁵ Fred Joseph Hellinger, *Tax-Exempt Hospitals and Community Benefits: A Review of State Reporting Requirements*, 34 J. HEALTH POLITICS, POL'Y & L. 37 (2009); Deanna Bellandi, *Bubbling Over Again: Property-Tax Issues Heat Up in Idaho, Pennsylvania*, 27 MOD. HEALTHCARE 38 (1997).

⁴⁶ Vince Galloro, *No Gouging Allowed*, 33 MOD. HEALTHCARE 8 (2003).

⁴⁷ *Provena Covenant Med. Ctr. v. Dep't of Revenue*, 894 N.E.2d 452, 456 (Ill. App. Ct. 2008).

⁴⁸ The *Provena* court first looked to the six distinctive characteristics of a charitable institution laid out in *Methodist Old Peoples Home v. Korzen*, 233 N.E.2d 537 (Ill. 1968):

- (1) the institution bestows benefits upon an indefinite number of persons for their general welfare, or the benefits in some way reduce the burden on government;
- (2) the institution has no capital, capital stock, or shareholders and does not profit from the enterprise;
- (3) the funds of the institution are derived mainly from private and public charity and are held in trust for the purposes expressed in the charter;
- (4) charity is dispensed to all who need it and apply for it;
- (5) the institution puts no obstacles in the way of those seeking the charitable benefits; and
- (6) the primary use of the property is for charitable purposes.

Provena, 894 N.E.2d at 460. The Director had found that Provena satisfied only the second characteristic and determined that not-for-profit status alone did not confer the property tax exemption. *Id.* at 461. The court considered the rest of the factors, and did not find Provena to be a gift to the public, nor to relieve burdens on the state as it still sold medical services, just as for-profit hospitals do. *Id.* at 462. As Provena derived a maximum of 3.4% of its revenue from charity, it could not be said it derived most of its funds from charity. *Id.* at 463. Regarding the final two characteristics, the court reaffirmed the understanding that medical care itself is not a charity, as selling something is not generous, and found that the Director could reasonably have found that Provena could not prove that those without money were cared for without charge, even if it were able to prove it turned no patient away. *Id.* at 469.

⁴⁹ See Press Release, Minnesota Hospital Association, Agreement Between Attorney General and Minnesota Hospitals Will Provide for Pricing to Uninsured Patients, Establish a Code of Conduct for Debt Collection Practices, available at http://www.mnhospitals.org/inc/data/pdfs/AG_agreement_press.pdf.

At the federal level, the failure of hospitals to meet community benefit obligations has sparked heightened Congressional scrutiny and threats to invoke more stringent institutional requirements for maintenance of federal income tax exemption.⁵⁰ The pressure placed on non-profit acute care facilities by ongoing Congressional oversight leads to voluntary, private sector responses. This is seen in the development of new policies by hospitals and their associations in the community benefit area. For example, the Catholic Health Association has identified a number of factors, such as improving access to health services in a given community, advancing medical knowledge, and reducing burdens on local public health authorities, as steps hospitals can take to demonstrate their adherence to a charitable mission.⁵¹

Apart from Congressional policy review, the community benefit matter is squarely rooted in non-profit tax law. Prior to 1969, the federal tax exemption provided to non-profit tax entities was based on the provision of services to “those not able to pay,” a standard drawn from traditions forged in the area of charitable trust law.⁵² A new standard for exemption was developed by the Internal Revenue Service (IRS) in 1969, which recognized promotion of health for the benefit of the community (in addition to the provision of free care) as a charitable purpose.⁵³ Over time, both the IRS and the courts have flushed out details on what constitutes hospital community benefits. Some of these elements have been incorporated into a required annual filing for exempt entities, including hospitals.⁵⁴

In the wake of charity care scandals, Congress placed pressure on the IRS to revise its annual community benefit reporting requirements.⁵⁵ The

(last visited Sept. 16, 2009); see also KAN. STAT. ANN. § 59-22a01 (West 2008) (for a reference to a state-based conversion law).

⁵⁰ John D. Colombo, *Hospital Property Tax Exemption in Illinois: Exploring the Policy Gaps*, 37 LOY. U. CHI. L.J. 493, 496 (2006).

⁵¹ *What Counts as Community Benefit*, Catholic Health Association, available at <http://www.chausa.org/Pub/MainNav/ourcommitments/CommunityBenefits/whatcounts/> (last visited Sept. 16, 2009).

⁵² Colombo, *supra* note 50, at 496.

⁵³ John D. Colombo, *Federal and State Tax Exemption Policy, Medical Debt and Healthcare for the Poor*, 51 ST. LOUIS U. L.J. 433, 437 (2006).

⁵⁴ *Id.* at 437; see also Michele R. Goodman, *Putting the Community Back in Community Benefit: Proposed State Tax Exemption Standard for Nonprofit Hospitals*, 84 IND. L.J. 713 (2009). The Goodman article reviews some of the background history of exemption and expands the discussion into state law. She is heavily influenced by Mark A. Hall & John Colombo, *The Donative Theory of the Charitable Tax Exemption*, 52 OHIO ST. L.J. 1379 (1991), as well as Mark A. Hall & John D. Colombo, *The Charitable Status of Non-Profit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307 (1991).

⁵⁵ Memorandum from Senator Charles Grassley, United States Senate Committee on Finance, to Reporters and Editors (July 19, 2007), available at <http://finance.senate.gov/press/Gpress/2007/prg071907c.pdf> (last visited Sept. 16, 2009). For a helpful insight into the nature of Congressional concerns regarding the shortcomings of tax-exempt organizations, see United States Senate Finance Committee, Staff Discussion Draft, available at <http://finance.senate.gov/hearings/testimony/2004test/062204stfdis.pdf>

present community benefit reporting mandates involve governing board matters. These include a special schedule for hospitals that mandates reports on board composition and policies, board business relationships, information on independent directors, relevant changes in enabling documents, and conflicts of interest policies.⁵⁶ The new IRS hospital board reporting obligations reflect the belief that the structure and operation of the hospital governing authority are related to the institution's ability to fulfill its charitable mission.⁵⁷ Coupled with the new reporting mandate is the IRS's governance compliance guide that provides general focal points for boards. These points include the need for due diligence, loyalty, and transparency, and highlights specific board functions such as fund raising, financial auditing, compensation review, and assurance of document retention.⁵⁸

3. *Quality, the Newest Variable*

The third development impacting hospital governance is a related emphasis on engaging boards in improving quality of care.⁵⁹ There has been a long-standing oversight responsibility on the part of boards for the quality of care provided within the facility, evident in both common and statutory law.⁶⁰ The quality obligation can be divided into four particular governance functions: compliance with specific regulatory quality mandates, such as those established by Medicare; medical staff credentialing; development of clinical improvement goals for executive compensation; and development and analyses of patient satisfaction measures in institutional performance audits.⁶¹

(last visited Sept. 16, 2009). The pressure for congressional reform in charity care persists. See Robert Pear, *Hospitals Mobilizing to Fight Proposed Charity Care Rules*, N.Y. TIMES, June 1, 2009, at A12.

⁵⁶ IRS, IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report, 149–51, available at <http://www.irs.gov/pub/irs-tege/frephospproj.pdf> (last visited Sept. 16, 2009).

⁵⁷ Nicholas Wolter, *The New IRS Form 990 and Schedule H: What Trustees Need to Know*, TRUSTEE MAG., Aug. 1, 2009.

⁵⁸ I.R.S., Governance and Related Topics—501(c)(3) Organizations, available at http://www.irs.gov/pub/irs-tege/governance_practices.pdf (last visited Sept. 16, 2009).

⁵⁹ National Quality Forum, *Hospital Governing Boards and Quality of Care: A Call to Responsibility*, Dec. 2, 2004, available at <http://www.ihl.org/NR/rdonlyres/C75264FA-1703-4DD0-99C2-0355D81DF982/0/NQFCalltoResponsibilityHospitalBoards2004.pdf> (last visited Sept. 16, 2009); see also Joe McCannon & James Conway, *A New Era for Leadership of Quality and Safety*, ModernHealthcare.com, Jan. 16, 2009, available at <http://www.modernphysician.com/article/20090116/REG/901159997/1> (last visited Sept. 16, 2009); Melanie Evans, *Raising the Bar for Boards*, Mar. 2, 2009, available at www.modernhealthcare.com/article/20090302/reg/902279962 (last visited Sept. 16, 2009).

⁶⁰ See McCurdy, *supra* note 2. Perhaps the best known case in the hospital law area acting as a catalyst for board involvement in quality was *Darling v. Charleston Community Memorial Hosp.*, 211 N.E.2d 253 (Ill. 1965).

⁶¹ There is no single way to divide up quality activities of a board. Over time, the board role concerning quality activities has expanded. For an excellent discussion of board engagement in quality, see

Of these four activities, credentialing stands out as the most established board role in the quality area. Although delegated to the medical staff, this function is ultimately controlled by the governing authority.⁶² Credentialing is illustrative of the board dilemma in quality control, because it entails judgments about medical practice that lay trustees may not be able to make, and only in cases of overt misconduct can a board exert its authority without significant medical consultation. Board questions generally are more likely grounded in financial and managerial issues, and thus boards become highly dependent on external guidance for the development and analysis of quality of care matters.⁶³

Nevertheless, trends in patient safety have prompted boards to take on greater accountability for quality assessment, and a growing appreciation has emerged about the value of lay perspectives in this area.⁶⁴ In 2007, the Department of Health and Human Services Office of Inspector General (OIG), the agency with regulatory responsibility for enforcing Medicare and Medicaid fraud and abuse laws, identified expanded quality oversight as central to the governance mandate.⁶⁵ The OIG, jointly with the American Health Lawyers Association (AHLA), characterized the board quality role as underpinned by the duty of fraud and abuse compliance and, more broadly, by the duties of due care and obedience.⁶⁶

The OIG/AHLA document does not identify any single tipping point as the catalyst prompting a new focus on board quality initiatives. Rather, such emphasis results from a combination of elements, including prevention of medical errors, the role of sound governance in fraud and abuse corporate integrity agreements, and new regulatory demands such as quality data reporting and pay-for-performance reimbursement.⁶⁷ The document details questions for directors concerning the goals of institutional quality improvement, integration of quality into corporate policies, board education, creation of metrics for quality measurement, and adequacy of human resources in the

DEP'T HEALTH AND HUMAN SERVICES, DRIVING FOR QUALITY IN ACUTE CARE: A BOARD OF DIRECTORS DASHBOARD (2009), available at <http://oig.hhs.gov/fraud/docs/complianceguidance/roundtableacute.pdf> (last visited Sept. 16, 2009); see also Karen Sandrick, *Enhancing the Board's Role in Quality: Research Examines How Boards Oversee Quality and How They Can Improve*, 60 TRUSTEE MAG. 20 (2007).

⁶² SUSAN B. TAYLOR, THE AUPITA MANUAL OF HEALTH SERVICES MANAGEMENT 172-73 (1994).

⁶³ H. Joanna Jiang et al., *Board Oversight of Quality: Any Differences in Process of Care and Mortality?*, 54 J. HEALTHCARE MGMT. 15 (2009). It also is important for boards to develop effective quality committees, wherein a higher level of expertise can be established.

⁶⁴ Sandrick, *supra* note 61 (noting that board quality oversight presents great challenges). There is no overall measure for quality, requiring boards to identify and analyze multiple measures of quality; this task requires extensive time and division of labor that may be hard to accomplish in smaller hospitals. Legal accountability is the lever that has prompted boards to be active in this area.

⁶⁵ ARIANNE N. CALLENDER ET AL., CORPORATE RESPONSIBILITY AND HEALTH CARE QUALITY: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS (2007).

⁶⁶ *Id.*

⁶⁷ *Id.*

quality area. In a subsequent report, the OIG considered ways to improve a hospital board's engagement in quality matters and supported the use of dashboards (a graphic representation) as a vehicle for analyses of complex clinical data.⁶⁸

III. GUIDANCE?

The appropriate use of assets, community benefits, and quality improvement must be viewed against the backdrop of established board mandates. The challenge for governing entities is to balance their growing set of responsibilities with the more traditional functions of hospital boards, such as financial oversight and chief executive officer evaluation. The manner in which boards cope with expanding functions will be colored by sponsorship, and the range of activities of a particular governing entity will be impacted by the corporate structure within which it functions.⁶⁹ Nevertheless, the layering of mandates that confront all types of governing authorities presents challenges that cut across the spectrum of hospitals. Considerable introspection concerning the propriety of the governance function, both within individual facilities and multi-hospital arrangements, is needed.

There is no shortage of guidance on how a board should function. The landscape of hospital management is layered with numerous reports on governance, with some written from broad, generic perspectives and others that are more narrowly oriented. For example, a report issued by the Center for Healthcare Governance (CHC) in 2007 presents detailed guidance for enhancing board effectiveness in current environments.⁷⁰ The CHC report identifies a number of steps for improving boards, including developing a positive culture for governance, setting clear priorities for boards, clarifying roles and responsibilities, and—if possible—going beyond required fiduciary functions to a higher level of institutional engagement.⁷¹

⁶⁸ *Id.* at 21–27.

⁶⁹ For a description of the role sponsorship played in one of the two Mayo Clinic hospitals, see <http://www.mayoclinic.org/saintmaryshospital/sponsorshipboard.html> (last visited Sept. 16, 2009). Also, board function is impacted by status as a whole system board, a hospital board within a system (often a very limited role beyond licensure and accreditation mandates), or a board in single acute care facility. See Jeffrey Alexander & Shouou-Yih D. Lee, *Does Governance Matter? Board Configuration and Performance in Not-for-Profit Hospitals*, 84 *MILBANK Q.* 773 (2006).

⁷⁰ CENTER FOR HEALTHCARE GOVERNANCE, *BUILDING AN EXCEPTIONAL BOARD: EFFECTIVE PRACTICES FOR HEALTH CARE GOVERNANCE* (2007); see also LINDA POWELL & CAROL TAYLOR, MOUNTAIN STATES GROUP, *HOSPITAL GOVERNING BOARD ASSESSMENT: A SELF-HELP GUIDE* (2004); FRANCES S. MARGOLIN ET AL., HEALTH RESEARCH AND EDUCATIONAL TRUST, *HOSPITAL GOVERNANCE: INITIAL SUMMARY REPORT OF 2005 SURVEY OF CEOs AND BOARD CHAIRS* (2005) (providing information on board practices based on a survey of key performance indicators); JOHN CARVER, *BOARDS THAT MAKE A DIFFERENCE* (3d ed. 2006). Carver presents the policy governance model, which has been influential across industries.

⁷¹ CENTER FOR HEALTHCARE GOVERNANCE, *supra* note 70, at 22.

The Texas Academy of Governance, an educational entity dealing with health care trustees, recommends a traditional array of board roles. In addition, it stresses the need for boards to represent community needs and confront broader health system problems.⁷² The Ontario Hospital Association recommends an effective framework for governance, including a delineation of accountabilities, identification of general board and individual directors' roles and responsibilities, development of director selection and succession guidelines, adoption of streamlined committee structures, and promotion of corporate membership that includes community engagement.⁷³

A broader perspective was taken in a Grant Thornton report that evaluated the elements of good governance in 10 high performing health systems.⁷⁴ This health system report recommended a proactive stance on governance, calling for a better understanding of a system's core roles and responsibilities, a careful consideration of board composition and size, enhancement of board development and evaluation programs, the adoption of transparent goals for community health, and an ongoing evaluation of performance benchmarks.⁷⁵

Both regulators and private organizations have attempted to engage boards in quality and patient safety initiatives. The Centers for Medicare and Medicaid Services (CMS) in 2004 launched several initiatives with partner organizations to promote the active engagement of hospital leadership in quality matters, and the agency's activities on quality reporting and patient satisfaction have direct implications for board oversight.⁷⁶ A private entity, the National Quality Forum (NQF), developed a set of principles that call on governing boards to review their role in quality and develop expertise in patient safety, clinical care, and performance measurement.⁷⁷ Boards have been challenged to take an affirmative role not only to understand quality measures as passive consumers of data, but also to develop their own case studies of hospital based injuries and evaluate how such occurrences were handled in their respective institutions.⁷⁸ It has even been suggested that boards and

⁷² Texas Healthcare Trustees Foundation, http://www.tht.org/programs/texas_academy_of_governance/why_are_trustees_important.asp (last visited Sept. 16, 2009).

⁷³ MAUREEN A. QUIGLEY & GRAHAM W.S. SCOTT, HOSPITAL GOVERNANCE AND ACCOUNTABILITY IN ONTARIO 34 (2004).

⁷⁴ LAWRENCE PRYBIL ET AL., GOVERNANCE IN HIGH-PERFORMING COMMUNITY HEALTH SYSTEMS (2009).

⁷⁵ *Id.*

⁷⁶ Thomas Vaughn et al., *Engagement of Leadership in Quality Improvement Initiatives: Executive Quality Improvement Survey Results*, 2 J. PATIENT SAFETY 2 (2006); see also Press Release, Center for Medicare & Medicaid Services, CMS Announces Guidelines for Reporting Hospital Quality Data (Jan. 28, 2004), available at <http://www.cms.hhs.gov/apps/media/press/release.asp?counter=995> (last visited Sept. 16, 2009); see also CMS, HOSPITAL QUALITY INITIATIVES CAHPS: PATIENTS' PERSPECTIVES OF CARE SURVEY, available at http://www.cms.hhs.gov/HospitalQUALITYINITS/30_HOSPITALCAHPS.ASP (last visited Sept. 16, 2009) (detailing the hospital CAHPS survey composed of 27 items, including 18 substantive items that encompass key aspects of the hospital patient experience).

⁷⁷ NATIONAL QUALITY FORUM, HOSPITAL GOVERNING BOARDS AND QUALITY OF CARE: A CALL TO RESPONSIBILITY (2004).

⁷⁸ A tool frequently mentioned in discussions of board engagement is a dashboard or scorecard that presents boards with a graphic depiction of key quality variables. It is estimated that 80% of hospitals use some

hospital CEOs actively monitor their institutions by engaging in workarounds of the facility.⁷⁹

IV. SO, WHERE ARE WE?

Governance has moved from a backwater of regulation into a focal point for public and private policy makers. No doubt, the days of boards being pro forma entities with limited ability to effect change have passed, and a wide consensus has emerged that hospital boards have untapped value that can be harnessed to overcome acute care institutional inefficiencies. Regulation in the board area, both public and private, has expanded and has thrust hospital boards into a broader array of oversight responsibilities in the three areas noted above.

Although the common law on governance remains unsettled, it is moving toward a hybrid corporate governing model, with traditional responsibilities of corporation oversight combined with fulfillment of institutional mission. Health policy groups promote the most expansive agenda for boards, and have provided detailed templates for ways in which governance can be reshaped. Redirection, however, is not easily accomplished. Beyond specific charges and the broadly cast duties of financial, managerial, and quality oversight, it is still largely a matter of institutional self-determination as to how a particular board deciphers its own roles. Governing authorities must individually face the challenge of trying to respond to this growing chorus about change amid realities of operational complexity and the practical limitations of a function that is part-time and voluntary.

Ironically, with all the attention devoted to governance, there is still a lack of clarity about what is expected from hospital boards and a sense of confusion has emerged among the growing layers of mandates. Just what the core mission of hospital governance is and how that mission can be best fostered by law remain unclear.

V. LICENSURE AS THE CAPSTONE

In grappling with the question of the core mission of a hospital governing board, a matter that has been obfuscated in the face of regulatory pluralism, there are two points of demarcation for analysis. These are a fundamental

type of dashboard or scorecard. The challenge is to select quality variables and make them relatively short and focused. See Eugene Kroch et al., *Hospital Boards and Quality Dashboards*, 2 J. PATIENT SAFETY 10 (2006).

⁷⁹ BRIEFINGS ON QUALITY IMPROVEMENT AND DATA REPORTING, BOARDS KEYED-IN TO QUALITY AT TOP PERFORMING HOSPITALS (2006), available at http://provider.thomsonhealthcare.com/uploadedfiles/qI_datareport_august_06.pdf (last visited Sept. 16, 2009).

understanding of the legal nature of the hospital and a basic awareness of the hospital trustee role.

There are many ways to depict the manner in which law frames the nature of the acute care hospital, but the most fundamental vantage point comes from licensure.⁸⁰ Hospital licensing laws not only serve to protect the public, but also articulate both broad and specific duties that are the most fundamental statement of purpose and obligation in this sector. Licensure empowers hospitals of every type as entities rooted in public purpose, and that purpose entails treating sick and injured people both individually and collectively within a given community. Thus, it is health care delivery in a community context that lies at the root of the licensure obligation, constituting a core purpose of all hospitals, regardless of type, size, or location. Community service may not be the sole variable in the hospital panoply of obligations, but it represents a primary pillar of public duty. It is that pillar that should be stressed in deciphering the mission of the hospital and that of its leaders, the board of directors.⁸¹

The sum total of general legal and specific governance obligations may form a type of community service obligation, in that elements such as financial oversight and quality audits benefit the institution and ultimately the community it serves. Even though a collectivization of board functions may

⁸⁰ N.Y. PUBLIC HEALTH LAW § 2801(10) (2009) (providing a good, generic definition of a general hospital); Huberfeld, *supra* note 30, at 706–07 (discussing two distinct missions for hospitals: licensure mission and charter mission). Huberfeld points out that charter mission concerns the specific type of corporation involved and is rooted in furtherance of fiscal trust. By contrast, Huberfeld describes licensure mission as linked to services provided to the community, and mentions that licensure mission could help guide directors in their service to the organization and its community. I agree with Huberfeld and express dependence on her analyses for my endorsement of licensure. Although recognizing the need for charter mission, it is far less central to the core purpose of the hospital, and the regulatory oversight scheme in which it resides is very tangential to health delivery. I also share Professor Huberfeld’s query about what boards are supposed to do.

⁸¹ The idea that public or private hospitals have a special obligation to community is not a new one. In 1963, the New Jersey Supreme Court in *Greisman v. Newcomb Hosp.*, 192 A.2d 817 (N.J. 1963), a medical staff dispute case, took the position that hospitals were imbued with the public purpose of serving the sick and injured and had a special community service obligation. Twenty-five years later, the Illinois Supreme Court in *Barrows v. Northwestern Memorial Hosp.*, 525 N.E.2d 50 (Ill. 1988) rejected the *Griesman* holding of reviewability of credentialing matters, but underscored the community service rationale that drove the New Jersey court and underpinned similar cases in New Mexico and Arizona. Additionally, it can be argued that certificate of need (C.O.N.) laws demonstrate the core community service component of hospitals. While C.O.N. laws may be widely discredited for their inability to control health care markets, see Aaron S. King, *Medical Market Failure in Maine: Is the Dirigo Reform Act’s Certificate of Need a Market Connection?*, 22 ME. BAR J. 156 (2007), these laws (where they still exist) focus greater attention on community service. For a current discussion of C.O.N., see ILLINOIS TASK FORCE ON HEALTH PLANNING REFORM (2009), available at <http://www.idph.state.il.us/tfhpri/reports/TFHPRFinalReport.pdf> (last visited Sept. 16, 2009). The concept of community service permeates the world of hospital operations, both externally and internally. Although this article focuses on external community service obligations, internal community service from volunteer bingo to clinical support team building also falls under the rubric of board oversight.

underscore public purpose, much of governance is internally focused and siloed in any given facility or system. A hospital board needs to approach its role from a distinct public health perspective, in tandem with—but separate from—other obligations.

The suggestion of coalescing around community service, derivative from hospital mission, may be viewed as redundant of community benefit obligations driven by non-profit tax law.⁸² But there is a twofold difficulty in focusing board obligation on tax law. First, the non-profit tax exemption does not apply to all hospitals. Second, tax law does not lie at the root of a hospital's status and obligations.

Licensure is a more appropriate vehicle for framing the hospital mission and related duties, including governance, and its underdevelopment should not be viewed as necessitating more regulators to step into a void. The fundamental role of trustees has not changed, regardless of the expanding nature of obligation.⁸³ Boards and their individual members are overseers, lay stewards, and—even factoring in legal liability and final approval power—their oversight must be guided by those with clinical and operational expertise, actualized by realistic parameters and effective committee structures.

To effectuate a better sense of mission and a realistic view of the governing function, the focus of regulation needs to shift to licensing as the core reference point for the trustees' role. For this to occur, a broad reform of licensing must take place. Licensing laws are hardly dormant, and are frequently amended to reflect changes in the industry and responses to pressure from CMS.⁸⁴ The licensure scheme, however, is not a strong one, as it is beholden to state budgets and an odd interplay with federal and private sector

⁸² Community service should not be just a matter of tax exemption law but must extend beyond a checklist to a more fundamental sense of obligation on the part of boards. As things stand, the IRS has made considerable progress in developing policies on board roles and community service mandates, but there are still ambiguities. See Letter from Marcus S. Owens, Attorney, Caplin & Drysdale, to Eric Solomon, IRS Secretary for Tax Policy (Jan. 14, 2009) (on file with author).

⁸³ A great deal has been written in the legal and health management literature about the trustee role. However, ruminations on the trustee function written 37 years ago seem as germane today as when written.

The lot of the hospital trustee is not always a happy one, especially if he believes all the misconceptions concerning his legal responsibilities. He is likened at times to the trustee of a trust fund. He is told he is the owner of the hospital property and charged with its management; that he must handle hospital funds with the same degree of care used in handling his own funds, that he is personally responsible for the quality of medical care in the hospital; that he is individually liable for negligence causing injury to a patient. Were all these opinions legally valid, few of our distinguished citizens would hazard the personal risks entailed in hospital trusteeship.

Hyatt et al., *supra* note 1, at 119.

⁸⁴ Hospital licensing laws are frequently amended and become touchstones for appreciation of new developments. See, e.g., 210 ILL. COMP. STAT. 85; 42 C.F.R. § 482.21 (2009) (exemplifying changes in hospital

standards.⁸⁵ Beyond its threefold layering, hospital licensure invites further regulatory pluralism. It is hardly viewed as a font of creativity and innovation, but rather as a sort of underfunded backwater, inviting other parties to promote alternative regulatory initiatives. Although harsh criticism of hospital licensing laws may be unwarranted, these schemes need to be improved to regain legitimacy. As they now stand, they are unlikely candidates for anchoring the governance function. Thus, the frameworks of licensing regulation should be revisited and a search for alternative models undertaken.

VI. A NEW GOVERNANCE LICENSURE MODEL

One general approach to refocusing board direction in the licensure context can be garnered from the broad and somewhat amorphous area collectively referred to as new governance.⁸⁶ New governance is a term applying to a series of theoretical and applied approaches to regulation. It carves out a middle ground between the typical administrative law command and control models of oversight, on one hand, and self-regulation, on the other. There is no single model of new governance; rather there are a series of evolving models that have been developed and tried in various industries around the globe.

For example, an alternative regulatory structure for health care can be found in the use of the ISO 9001 standards for purposes of Medicare deemed status.⁸⁷ ISO 9001 is not without detail, but it is a process that stresses quality in ways that provide institutions latitude to develop programs compatible with their individual environments.⁸⁸

Conditions of Participation); CTR. FOR IMPROVEMENT IN HEALTHCARE QUALITY, SYNOPSIS OF THE 2008 JOINT COMMISSION STANDARDS FOR ACUTE CARE HOSPITALS (illustrating that amendments are frequently made to accrediting standards of The Joint Commission and the American Osteopathic Association), available at <http://www.cihq-hacp.org/images/pdf/HACP%20Study%20Resource%20-%202008%20Joint%20Commission%20Acute%20Care%20Standards.pdf> (last visited Sept. 16, 2009). For an interesting addition to hospital governance in Ohio, where the relevant statute has been amended to encourage boards to work across hospitals to create efficiencies, see OHIO REV. CODE ANN. § 3727.21 (2009).

⁸⁵ John D. Blum, *A Revisionist Model of Hospital Licensure*, 2 REG. & GOVERNANCE 48 (2008).

⁸⁶ There is a large body of literature dwelling on new governance that cuts across borders and industries. See, e.g., David M. Trubek & Louise G. Trubek, *Narrowing the Gap? Law and New Approaches to Governance in the European Union: New Governance and Legal Regulation: Complementarity Rivalry and Transformation*, 13 COLUM. J. EUR. L. 539 (2007); Orly Lobel, *The Renew Deal: The Fall of Regulation and the Rise of Government in Contemporary Legal Thought*, 89 MINN. L. REV. 342 (2004); Kenneth W. Abbott & Duncan Sivaldi, *Strengthening Intentional Regulation Through Transnational New Governance: Overcoming the Orchestration Deficit*, 42 VAND. J. TRANSNAT'L L. 501 (2009); Louise G. Trubek, *New Governance and Soft Law in Health Care Reform*, 3 IND. HEALTH L. REV. 137 (2006).

⁸⁷ Claire Lee, *The New Hospital Accreditation: Case in Point*, 7 NURSE LEADER 30 (2009).

⁸⁸ *Id.*; see also Thomas Gnale, *Middletown, Ohio Hospital Is First in State to Get ISO Certification*, MIDDLETOWN J., Sept. 11, 2004.

Within the rather broad arena of regulatory reform, there are two particular models of new governance that can be drawn on in licensing reform: management based regulation and responsive regulation.⁸⁹ Management based regulation is oriented around planning, and calls for regulated entities to develop and comply with their own constructed solutions to particular problems.⁹⁰ Responsive regulation is based on the application of a hierarchy of government interventions that run from a hands-off approach (a type of self regulation) to a traditional direct regulatory intervention triggered by a failure of the regulated entity to meet public goals.⁹¹

A redesigned licensure model drawing on elements of management based and responsive regulation could be constructed in three primary parts. The initial phase of a new model would retain core entry requirements, namely, the baseline set of structural and operational mandates that would ensure quality and uniformity across the sector. This is not to suggest that entry requirements would remain static; on the contrary, this core needs to be frequently evaluated and updated as changes in clinical medicine and the nature of the hospital industry occur. Baseline licensing requirements are highly visible and effective mechanisms to bring change.

The second part of a revised licensing model concerns self-assessment and adoption of problem solving strategies. This would involve a bottom-up process, in which a facility (or system) would identify problem areas, analyze the etiology of a problem, collect supporting data, and craft solutions. This phase of the licensure model is heavily influenced by management based regulation, and rests on the notion that self-assessment and problem solving would improve outputs.⁹² Like core regulation, problem solving would entail regulator involvement to assist hospitals and, drawing from responsive regulation, intervene when self-regulation fails.

The third phase of new licensure entails the development of institution specific obligations that would be developed through negotiation between the regulator and the hospital. This element of licensure, unlike problem solving, is not self-directed, but rather is one that would involve the significant initial and continued involvement of public authorities and would be driven by a balance of need and cost sensitivity.

The three-part model for translating reformed licensure into governance can be illustrated by considering each element. The refocus on baseline entry

⁸⁹ Cary Coglianese & David Lazer, *Management-Based Regulation: Prescribing Private Management to Achieve Public Goals*, 37 L. & Soc'y Rev. 691 (2003); see JOHN BRAITHWAITE ET AL., THE GOVERNANCE OF HEALTH SAFETY AND QUALITY: A DISCUSSION PAPER, AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTHCARE, COMMONWEALTH OF AUSTRALIA (2005).

⁹⁰ Coglianese & Lazer, *supra* note 89.

⁹¹ Blum, *supra* note 85; see also IAN AYNES & JOHN BRAITHWAITE, RESPONSIVE REGULATION: TRANSCENDING THE DEREGULATION DEBATE (1995).

⁹² See Coglianese & Lazer, *supra* note 89.

requirements would touch all hospital parts, involving the governing board as the final institutional authority. It would require the addition of specific obligations based on fluid conditions in acute care health delivery. This part of licensure is no different than current regulation, except that it would need to be highlighted across regulatory sectors as the touchstone for changes in governance and could, in turn, be shaped by a strong sense of community mission and a realistic view of what functions lay trustees can undertake. The second part of the model—problem solving—is in sync with trends in governance that call for introspection by boards concerning their roles and active engagement in institutional matters, particularly in quality and patient safety.⁹³ A specific mandate for governing authorities to engage in problem identification and resolution could act as a guiding principle to actualize such behavior in ways that current advisory mandates cannot. State authorities may act as consultants here, and may be very valuable in decision making in areas such as quality software selection.⁹⁴

The third part of a reformed licensing program—the creation of negotiated obligations—would provide a very helpful mechanism to go beyond rote regulatory templates and accommodate board obligations to local needs. This phase could be designed to recognize that variables such as institutional size, local health market composition, and economics should be factored into the public expectations carved out for governing boards.⁹⁵ It is here that regulators may promote board engagement directed toward community service, and what one board may be charged with could in some ways be quite different than another would be. Regulators would also have the power to mandate cross-institutional planning and activities to maximize resources and meet the health needs of populations within regions.

There is no doubt the three-part licensure model suggested will call for some major changes on the part of state regulators. As such shifts in state regulatory process occur, the involvement of CMS and private accrediting authorities will also be needed.

⁹³ BRAITHWAITE ET AL., *supra* note 85.

⁹⁴ iHealthBeat, EHR Software Glitches Exposed VA Patients to Medical Errors (2009), at <http://www.ihealthbeat.org/Articles/2009/1/14/EHR-Software-Glitches-Exposed-VA-Patients-to-Medical-Errors.aspx> (last visited Sept. 16, 2009).

⁹⁵ Variation among hospitals is recognized in terms of finances, quality, and patient-mix; see DRAFT REPORT OF THE COMMISSION TO STUDY MAINE'S HOSPITALS (Dec. 22, 2004) (on file with author); see also NEW YORK STATE DEPARTMENT OF HEALTH, REPORT ON IMPLEMENTATION OF THE REPORT OF THE COMMISSION ON HEALTH CARE FACILITIES IN THE TWENTY-FIRST CENTURY (2007), available at http://www.nyhealth.gov/facilities/commission/docs/implementation_of_the_report_of_the_commission.pdf (last visited Sept. 16, 2009). A proposal developed by the American Association of Medical Colleges would utilize teaching hospitals as vehicles to coordinate health care innovation zones. Such zones would mandate that tertiary care centers coordinate health services across an array of geographic providers in particular areas, and presumably would engage hospital boards in more meaningful service coordination. See DARRELL G. KIRCH, AM. ASS'N MED. COLL., CAN MEDICAL EDUCATION "FIX" THE HEALTH CARE SYSTEM? (2009), available at <http://www.aamc.org/newsroom/reporter/sept09/word.htm> (last visited Oct. 13, 2009).

CONCLUSION

It is hard to deny that an effective board can have a beneficial impact on hospital operations, but it is difficult to appreciate the parameters of its role and even harder to identify the core mission of governance. The law in this area is deep and convoluted, drawing together threads of charitable trust and corporate doctrine in common-law and statutory contexts across the span of many years. Starting from a position of relative inattention, hospital boards have moved into a sea of directives, driven by growing numbers of public and private regulators and policy groups, and sparked recently by issues of asset allocation, community benefit, and quality.

Governance can be improved, but for that to happen, a more unified regulatory approach needs to be developed. The licensing function is the most logical regulatory process to act as a central force in channeling a new form of public oversight of governing entities. Hospital licensure is a fundamental, well established control process that exists to protect citizen health. It can act as the primary mechanism for delineating the obligations of governance.

However, as state licensing currently stands, many regulatory actors see it as a flawed process, giving it little credence and thus underscoring the need for reforming this apparatus. A reformed licensure system that takes ownership of governance questions is necessary not only to dampen regulatory pluralism, but—more importantly—to help state authorities to better frame the core community health mission of hospital boards and clarify the boundaries of the trustee role. The foundation for a revised licensing process can be drawn from the regulatory theories of new governance. The model called for in this article is a hybrid of two primary theories, management and responsive regulation, that combine to stress self-direction and active engagement between hospitals and regulators to craft programs tailored to local needs.

The core functions of governance concerning finances, executive review, and quality would not be abandoned, but should become part of an adjustable baseline, more informed by a realistic view of the board's oversight capabilities. The value added in this reformed model is a board that is encouraged to tailor its activities to local needs, protected by a regulatory scheme that encourages collaboration across institutions. Boards can become agents for change, but for that to occur, the ethic of compliance must be replaced by a more coherent and grounded vision of purpose and capacity.