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New Governance Norms and Quality of Care in Nonprofit Hospitals

Thomas L. Greaney*

Managers and boards of nonprofit hospitals understandably feel themselves under siege today. The forces circling their citadel are both numerous and heavily armed. The Internal Revenue Service, state attorneys general and charity regulators, the plaintiff's bar, and Congress are all poised to take actions that may profoundly affect the governance of nonprofit institutions, especially acute care hospitals. Not only are these forces likely to recast the formal legal duties of nonprofit fiduciaries and alter the composition of hospital boards, but perhaps equally significant is their potential to influence the norms that govern the conduct of managers and directors. It seems quite likely, for example, that directors will internalize a new conception of their responsibilities, although the institutional response will vary considerably among nonprofit systems of different size, sophistication, and mission.

What all this fomentation portends for quality of care is far from clear, however. The landmark case that provides the theme of this symposium, Darling v. Charleston Community Memorial Hospital,1 began an evolution that energized and legitimated centralization of authority within hospitals. For those foreseeing a need for enhanced efficiency in business practices and decision-making by nonprofit hospitals facing the onset of competitive health care markets, the infusion of corporate management structures seemed both inevitable and desirable. Particularly important was the need to better coordinate the business and clinical aspects of the hospital. Discarding prior common law interpretations of the role of managers of nonprofit hospitals, Darling established an affirmative duty to monitor the quality of care in their institutions. Though relying on particular licensure, regulation, and internal bylaws to support this conclusion, the decision strongly influenced the subsequent path of governmental and private ordering of responsibilities.2 Moreover, in recognizing that business

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1. 211 N.E.2d 253 (Ill. 1965).

2. John D. Blum, Feng Shui and the Restructuring of the Hospital Corporation: A Call
considerations were ineluctably linked with clinical judgments. Darling seemed to supply the impetus for uniting the parts of the so-called “three legged stool” of nonprofit hospital governance—the board of directors, the physician staff, and management—that has long operated to allocate responsibilities regarding quality.

Yet, the more thorough integration of the decision-making apparatus of hospitals has largely not come to pass, though it has been anticipated. Professor John Blum argues that the three components of the hospital triad remain alienated from one another and fail to achieve the coordination necessary to promote quality assurance in hospitals. Contributing to the institutional dissonance is the hospital legal structure, which he finds “has fueled a sense of independence of the medical staff from the operation, and fostered the concept of self-governance.” Others have characterized the impact of the governance structure of the nonprofit hospital as establishing “silos” of authority that insulate medical staffs from administration with particularly deleterious effect in the area of monitoring quality of care. Of course, one must be careful not to attribute current deficiencies to organizational structure or to legal incentives alone. Powerful economic forces motivate all actors and it is impossible to separate the choice of legal structures from the financial and economic incentives that prompt managers to adopt them. Regardless of the strength of the causal connection between structure and safety, the thesis that contemporary governance rules are not well-designed to deal efficiently with the challenges presented by the quality crisis facing hospitals today finds support in the lessons of the patient safety movement’s inauspicious progress in recent years.

This essay extends the inquiry into the disconnect between the structure of governance in nonprofit hospitals and the goal of assuring quality by

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3. See Nicolas P. Terry, When The “Machine that Goes ‘Ping’” Causes Harm, 46 St. Louis U. L.J. 37, 46 (2002) ("Darling and the more faithful of its followers have long urged that the business realities of health care delivery are the most potent arguments in favor of institutional duty. Such arguments are premised on the shift in the center of gravity of health care from individuals to institutions from the perspective of both the business relationships and the expectations of consumers. The new reality of technologically-mediated health care is that it can only exist at the institutional level").

4. Blum, supra note 2, at 24; see also John P. Marren et al., Hospital Boards at Risk and the Need to Restructure the Relationship with the Medical Staff: Bylaws, Peer Review and Related Solutions, 12 ANNALS HEALTH L. 179, 207-12 (2003).

5. Blum, supra note 2, at 24.

6. See Marren, supra note 4, at 207-08 (citing Dr. Martin Merry and tracing the effects of cultural, informational and organizational insulation on quality monitoring in hospitals).
evaluating the likely impact of the new regime of governance rules and norms emanating from various legal and regulatory sources. It then appraises the new paradigm's relationship to quality of care. Given the strong consensus that managers and boards should place quality concerns at the forefront, one might expect governance reform to directly address that subject. Instead, this essay finds the new paradigm riddled with cross currents that will impede, rather than facilitate, the promotion of quality in nonprofit hospitals.

I. FORCES OF CHANGE IN CORPORATE GOVERNANCE

After many years of benign neglect, regulators and courts have suddenly begun to focus close attention on the governance of nonprofit hospitals and their charitable missions. This newfound interest can be traced to a variety of factors, including financial and management scandals in both the for-profit and nonprofit sectors, the increased need for charity care in the wake of governmental cutbacks, and the changing economics of health care. Together these factors have caused nonprofits to mimic in many respects the emerging management models of their for-profit rivals. This section briefly canvasses these changes and the next offers some observations about their potential impact on the dynamics of governing the nonprofit hospital.

A. “Activism” by State Attorneys General

One of the most striking developments in the last five years has been the heightened degree of supervision and extensive litigation by state attorneys concerning the conduct of nonprofit health care institutions. States have challenged a wide variety of structural transactions, including conversions and sales by nonprofit entities, shifting from acute care to outpatient services, relocating or closing a hospital facility, affiliating with

7. Although prestigious institutions studying quality and safety in American hospitals, such as the Institute of Medicine, have described the current state of affairs as a public health crisis, see infra notes 46-47 and accompanying text, hospital boards have been slow to respond. See Barry Bader, Commentary: Quality Begins in the Boardroom, MOD. HEALTHCARE, Jan. 17, 2000, at 26 (analyzing reasons for hospital quality deficits, concluding “the agendas of many hospitals and health system boards devote the majority of time to economic issues and comparatively little to quality”).
multi-state systems,\textsuperscript{11} and joint ventures with for-profit entities or with religious groups that require changes in services.\textsuperscript{12} Attorneys general have also questioned board and managerial decisions on matters of administrative overhead, executive compensation and personal expenditures, alleging conflicts of interest, self-dealing, or "waste."\textsuperscript{13} In addition, several attorneys general have sought to block movement across state lines of charitable assets owned by multi-hospital systems.\textsuperscript{14}

Also notable about these cases is their potential to change norms and behavior of nonprofit executives and boards, even in the absence of definitive judicial acceptance of the states' claims. Indeed, a number of commentators have questioned the doctrinal underpinnings of these challenges, noting, for example, the questionable charitable trust theories advanced to limit the board discretion and advance a heightened fiduciary responsibility and suggesting that a certain degree of "parochialism" may motivate attorney general activism in this area.\textsuperscript{15} However, nonprofit boards are notoriously risk averse and attorneys general hold considerable leverage in their negotiations with them. In sum, directors have become acutely aware that their decisions are being closely scrutinized by attorneys general and other charity regulators and are therefore likely to conform to explicit or implicit standards arising from such oversight.

\textbf{B. Sarbanes-Oxley and Proposed State and Federal Legislation}

Congress responded to the serious deficits in monitoring corporate finances and governance exposed by the Enron, WorldCom, Tyco, and

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\textsuperscript{11} See Banner Health Sys. v. Long, 663 N.W.2d 242, 245–46 (S.D. 2003).
\textsuperscript{12} See Nathan Littaauer Hosp. Ass'n v. Spitzer, 734 N.Y.S.2d 671, 673 (2001); see generally NEW HAMPSHIRE ATTORNEY GENERAL'S REPORT ON OPTIMA HEALTH, supra note 10.
\textsuperscript{13} A notorious example was the Attorney General of Minnesota's business compliance reviews of the Allina Health System. \textit{See} Press Release, Minnesota Attorney General's Office (Sept. 24, 2001), available at http://www.ag.state.mn.us/consumer/PR/pr_allina_mou_92401.htm (challenging Allina's expenditures of $56 million on consultants over three-year period and questionable expenditures on executive training and perks).
\textsuperscript{14} In 2001, Banner Health System, a multi-state health care system, sold its holdings in several states in order to concentrate its operations in and around Colorado and Arizona. The attorneys general in New Mexico, North Dakota and South Dakota sought to block Banner Health System from removing the proceeds of its liquidation of its assets in their respective states. \textit{See} Thomas L. Greaney & Kathleen Boozang, \textit{Mission, Margin and Trust in the Nonprofit Health Care Enterprise}, 5 YALE J. HEALTH POL'Y, L. & ETHICS 1, 26-28 (2005).
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other, scandals with the landmark Sarbanes-Oxley law, enacted in 2003.\(^{16}\)

Its provisions affecting the structure of corporate decision-making and transparency of financial and accounting matters has had important repercussions affecting the duties of officers and boards.\(^{17}\) Although the law does not apply to nonprofit corporations, its impact on the nonprofit sector has been considerable. For example, nonprofits are routinely advised to comply with Sarbanes’ mandate that audit committees be comprised of independent directors and take other steps to enhance board oversight of financial matters.\(^{18}\) Also casting a shadow over directors’ activities is proposed legislation. Several attorneys general have proposed wide-ranging state statutes modeled closely after Sarbanes-Oxley (although recently some have had second thoughts)\(^{19}\) and several aspects of the federal law, such as those requiring greater disclosures and transparency, which have already been adopted in some states.\(^{20}\) Finally, federal legislation that will significantly impact governance law of nonprofits is also under consideration.

The Senate Finance Committee has recently published a white paper and


\(^{17}\) Although much of the law deals with enhancing the reliability of financial reporting, Sarbanes-Oxley contains a number of provisions that affect the fiduciary duties of corporate directors. For example, section 301 requires that audit committee members be independent; section 402 forbids loans to directors and executive officers; section 407 mandates rules requiring public companies to disclose whether the audit committee is comprised of at least one member who is a financial expert. See Lyman Johnson & Mark Sides, The Sarbanes-Oxley Act and Fiduciary Duties, 30 WM. MITCHELL L. REV. 1149, 1155-56, 1175, 1177 (2004).


\(^{20}\) California has recently passed a law that requires nonprofits to file reports with the California attorney general and “requires that the nonprofit’s board of directors . . . review and approve the compensation of the chief executive officer and chief financial officer, to assure that the compensation is ‘just and reasonable.’” Tom Gilroy, Governor Signs Bill Requiring Charities to File Audit, Review Executive Compensation, 13 HEALTH L. REP. (BNA), Oct. 14, 2004, at 1477. However, the law largely exempts acute care hospitals from these requirements.
held hearings that would, among other things, federalize the fiduciary duties of boards, limit the size of boards (to a maximum of fifteen members), require that at least one-fifth of the board be independent, empower the IRS to remove directors or officers, and impose various requirements regarding audit practices. Perhaps seeing the handwriting on the wall, nonprofit hospitals are unmistakably moving to conform their governance structures to comply with much of the post-Enron law affecting for-profit corporations. Thus, even without sweeping legislative imprimatur, nonprofit governance practices are following the path of their for-profit counterparts.

C. IRS Oversight and the Evolving Meaning of “Charity”

The IRS has long served as a de facto monitor of corporate governance in the nonprofit sector. The commands of Internal Revenue Code 501(c)(3) that only entities “organized and operated for . . . charitable [and other enumerated] purposes” and only where “no part of [its] net earning . . . inures to the benefit of any private shareholder or individual”22 have provided the basis for detailed regulatory oversight designed to assure that those governing those institutions pay close attention to the charitable purposes of such organizations and not permit any siphoning of their assets to private parties. When enforcement of the latter (anti-inurement) prohibition proved not entirely satisfactory, Congress enhanced IRS enforcement authority by authorizing imposition of “intermediate sanctions” for certain excess benefit transactions.23 Notably, this law brings the IRS into detailed regulatory oversight of the monitoring practices of nonprofit boards by specifying practices that will allow them to enjoy a “rebuttable presumption of reasonableness” for their reviews of interested transactions.24 Moreover, concerns about abuses have led the IRS to undertake a new enforcement effort to examine executive compensation practices and procedures.25

Beyond the increased regulatory oversight on inurement and private benefit, the IRS may also be moving (or perhaps is being pushed) to

23. I.R.C. § 4958. Though not many enforcement actions have been brought under this act, in one important health care case, the IRS successfully sought sanctions involving an insider conversion of a facility for less than fair market value. Caracci v. Comm’r of Internal Revenue, 118 T.C. 379, 379-80, 421 (2002).
exercise closer review of whether hospitals are satisfying their charitable missions under the IRC. One of the most remarkable aspects of federal tax-exempt organization law is the absence of any specific requirement of charity care in IRS enforcement in the hospital sector. In recent years, the IRS has closely examined and tightened the requirements for tax exemption as a charitable organization in certain health care sectors such as HMOs and integrated delivery organizations. Although it has since 1969 applied a broad “community benefit” standard to test whether hospitals satisfied their “charitable” obligations, some recent pronouncements suggest greater attention to quantitative measure of supplying care to those who cannot afford to pay. In 2004, the House Ways and Means Committee added some fuel to the fire, holding hearings that, in part, questioned the wisdom of the community benefit standard.

D. Class Action Lawsuits

The most recent assault on nonprofit hospitals is perhaps the most highly publicized. With over seventy lawsuits filed against hundreds of hospital systems, the plaintiff’s bar, led by renowned plaintiffs’ attorney Richard Scruggs, has charged that the hospitals’ failure to provide “mutually affordable medical care” violates a host of laws, including federal and state tax exemption standards, the Emergency Medical Treatment and Active Labor Act (EMTALA), charitable trust law, state consumer protection law, and implied contractual obligations to uninsured patients not to bill more than a “fair and reasonable charge.” The relief requested in these cases includes injunctions requiring hospitals change their billing and collection practices, and imposing a constructive trust on hospitals’ savings from tax exempt status, profits, and assets, so as to assure “mutually affordable medical care.” To say the least, the allegations in these cases are


27. See INTERNAL REVENUE SERVICE, FIELD SERV. ADVISORY 2001-2003 (Mar. 9, 2001) (field service advisory stating that “a hospital’s mere assertion that it has a policy to provide health care services to the indigent is not sufficient” to meet its charity care requirements under the Code and instead “must show that it actually provided significant health care services to the indigent”).


Regardless of their chances for success in litigation, these cases have focused the attention of the regulators, legislatures, and the public on the quantity of charity care provided and the billing and collection practices of nonprofit hospitals. Together with the mechanisms of explicit government oversight previously discussed, these lawsuits have galvanized boards and placed the quantity of charity care at the top of their agendas in monitoring management.

II. CHANGES AND UNINTENDED CONSEQUENCES

The initiatives discussed above have diverse objectives that will impose various new obligations on nonprofit hospitals and their managers. While it is far from certain that all will come to fruition, a reasonable prognostication is that, collectively, they have inaugurated a revolution in the governance of nonprofit organizations. The following section hazards a few predictions (and some caveats) on the likely directions in which this revolution will take the nonprofit sector.

A. Structural Changes: Board Composition and Compensation

One important implication of Sarbanes-Oxley and the cases raising issues of fiduciary responsibility is that boards must assume greater responsibility for oversight of management. Correlative to this objective is the desire for enhanced board independence and expertise. To accomplish these goals, many predict the downsizing of nonprofit boards and, in some cases, the possibility that remuneration will be necessary in order to attract individuals with sufficient financial acumen. Further, boards are likely to internalize stricter adherence to certain norms of good governance, often labeled in the management literature as “best practices.”

While many believe the impact of these changes on decision-making in the nonprofit sector will be significant, it is impossible to predict confidently whether it will be for good or ill. Far from clear, for example, is the extent to which the presence of independent directors on boards
improves the business performance of for-profit corporations.\textsuperscript{34} Though outside directors may initially appear to be a sensible antidote to problems associated with imperfect information, self-dealing by inside directors, and agency problems in general, the case for a blanket rule commanding that boards consist entirely or predominantly of outside directors is less than compelling.\textsuperscript{35} Although some studies find that director independence correlates with firm profitability or share value, others find no relationship or, in some cases, a negative relationship.\textsuperscript{36} Professor Bainbridge's lucid analysis of the issue concludes that the empirical record can only be said to demonstrate that "one size does not fit all," i.e., different firms have varying needs for internal and external monitoring and management and other expertise is likewise highly variable.\textsuperscript{37} Thus, although the adoption of corporate mechanisms of oversight – including Sarbanes-Oxley reforms – may at first blush seem likely to improve "efficient" (i.e., bottom line) decision-making, such is not always the case, even in the for-profit sector. When one turns to the question of whether increasing the proportion of independent board members will enhance the nonprofit firms' focus on mission, answers become even more speculative. Part of the reason for uncertainty is that it is unclear who will be chosen to serve as independent board members. One may see a variety of candidates serving different constituencies: public interest advocates, community leaders, businessmen and women with financial expertise, and physicians.\textsuperscript{38} Each group is likely to interpret the mission somewhat differently and is likely to balance

\textsuperscript{34} The New York Stock Exchange has proposed new listing standards requiring that independent directors comprise a majority of any listed corporation's board of directors. See \textit{NYSE, REPORT OF THE NEW YORK STOCK EXCHANGE CORPORATE ACCOUNTABILITY AND LISTING STANDARDS COMMITTEE} 6 (June 6, 2002), available at http://www.nyse.com/pdfs/corp_govreport.pdf.


\textsuperscript{36} For empirical studies which demonstrate some positive gains for shareholders associated with increasing the proportion of outside directors, see James F. Cotter et al., \textit{Do Independent Directors Enhance Target Shareholder Wealth During Tender Offers?}, 43 J. FIN. ECON. 195 (1997); Bernard S. Black, \textit{The Value of Institutional Investor Monitoring: The Empirical Evidence}, 39 UCLA L. REV. 895, 900 (1992). However, the record is far from one-sided. Meta analyses of the literature suggest mixed results and that a moderate percentage of inside directors improves performance. See Sanjai Bhagat & Bernard Black, \textit{The Uncertain Relationship Between Board Composition and Firm Performance}, 54 BUS. LAW. 921 (1999); Dan R. Dalton et al., \textit{Meta-Analytic Reviews of Board Composition, Leadership Structure, and Financial Performance}, 19 STRATEGIC MGMT. J. 269 (1998). For a review of the literature concluding, "the empirical evidence on the merits of board independence is mixed (at best)," see Bainbridge, \textit{supra} note 35, at 17.

\textsuperscript{37} Bainbridge, \textit{supra} note 35, at 23.

mission and margin using its own scale.

B. Mission and Norms

The legal developments previously described reveal that regulators and courts will exert increased pressures to assure that nonprofits improve delivery of charity care and fulfillment of mission objectives. The imposition of external pressures to consider mission in all business contexts may prove problematic for several reasons. First, it is likely that the increased second-guessing by attorneys general will prompt boards to closely consider the government’s position – and perhaps give it excessive deference.39 Hence, mission-sensitive decisions made in the shadow of government supervision may lack some of the benefits of independent judgment and risk-taking associated with the corporate board model of governance.

Second, the influence of newly added legal commands may have the effect of actually impairing directors’ capacity to function as trustees of the nonprofits’ missions. Social scientists have long understood what legal scholars were slow to appreciate: social norms play an important role in prompting individuals to act in conformance with law.40 In this sense, the legal fiduciary duties that command directors to act in certain ways function best when they reinforce social norms to behave in certain ways.41 Yet, law may sometimes undermine norm-induced trustworthy behavior. The growing scholarship on the functions of “trust” in corporate agency relationships suggests that law or regulation may also stifle boards’ willingness to fully assert responsibility to act on behalf of their principals.42

C. Unintended Consequences

As is often the case with sweeping changes in legal doctrine, unintended consequences may result. Several salutary aspects of the Sarbanes Oxley

41. See Margaret M. Blair & Lynn A. Stout, Trust, Trustworthiness and the Behavioral Foundations of Corporate Law, 149 U. PA. L. REV. 1735, 1737 (2001) (contending that corporate participants cooperate with each other not just because of external constraints, but because of internal ones and that “the behavioral phenomena of internalized trust and trustworthiness play important roles in discouraging opportunistic behavior among corporate participants”).
law may have such effects. For example, empowering an independent audit committee may create a power center within corporations that undermines effective management or information flows. Likewise, the impact of enhanced regulatory oversight might have the effect of creating an environment of risk aversion that is inimical to business planning and implementation of corporate strategies. Further, the proliferation of legal authorities exercising regulatory oversight poses the risk that they will send conflicting signals to nonprofit boards, perhaps creating dissonance in decision-making.

III. IMPLICATIONS OF THE NEW GOVERNANCE PARADIGM FOR IMPROVEMENTS IN QUALITY OF CARE

What, then, are implications of the evolving governance environment for quality of care in nonprofit hospitals? As discussed above, corporate liability, ushered in by Darling, held out the promise that hospitals would be incentivized to monitor and coordinate staffs, physicians, and technology to assure maximum patient safety. As discussed above, however, the three-legged stool has proved a wobbly platform for promoting quality. In more dysfunctional settings, health management literature finds that physicians and management are alienated from each other and operate at cross-purposes on issues of detection and sanctions. Where accommodative understandings have been reached, each party contents itself to operate within its own “silo”—physicians handling credentialing, management overseeing risk-management. In addition, health care financing has evolved in a manner that is less conducive to assuring vigorous quality monitoring by hospitals than was once hoped. In the early days of managed care, it was thought that financial incentives provided by capitation and selective


45. For example, one can easily foresee settlements in class action lawsuits imposing quantitatively and qualitatively different standards regarding charity care than may emanate from state attorneys general or the IRS.

46. See Emsley, infra note 58, at 345 and accompanying text.
contracting would drive hospitals and their staff physicians closer together. The byproduct of financial integration would be to force cooperation and spur the evolution of hierarchical organizational structures.\textsuperscript{47} However, the unraveling of managed care was accompanied by the disintegration of many systems and the expected organizational evolution has not occurred. Indeed, in today’s market, one sees the threat of competition between medical staffs and hospitals creating an adversarial atmosphere that chills desirable physician-hospital cooperation.\textsuperscript{48}

Despite the enormous academic interest concerning the crisis of quality in American hospitals generated by the Institute of Medicine Report ("Report") and other studies, efforts to fix quality problems have made at best moderate progress. Recent retrospective analyses of the effect of the Report suggest that the technological and administrative infrastructure necessary to correct the quality problems in acute care hospitals has not developed.\textsuperscript{49} Those decrying the lack of progress often note that

\textsuperscript{47} See generally JAMES C. ROBINSON, THE CORPORATE PRACTICE OF MEDICINE (1999).

\textsuperscript{48} For example, the growth of physician owned single specialty hospitals, ambulatory surgery centers, and diagnostic facilities has caused increased friction among many hospital staffs. See generally, John K. Iglehart, The Emergence of Physician-Owned Specialty Hospitals, 352 NEW ENGL. J. MED. 1, 78-80 (2005). In one notorious case involving Community Hospital of San Buenaventura, the hospital administration attempted to limit its medical staff’s self-governance powers in response to its doctors having acquired an ownership interest in a competing facility. See Medical Staff of Cmty. Mem'l Hosp. of San Buenaventura v. Cmty. Mem'l Hosp. of San Buenaventura, No. CIV 219107 (Cal. Super. Ct. 2004); Tom Gilroy & Susan Webster, Governor Signs Bill Spelling Out Medical Staff Self-Governance Rights, 13 HEALTH L. REP. (BNA), Sept. 30, 2004, at 1397 (discussing terms of the settlement agreement between the hospital and the medical staff including: the addition of a conflict of interest policy in medical staff bylaws; specifications for the handling of medical staff finances; direction for how the hospital has to consult with the medical staff in exclusive contracting matters; and a process for allowing the hospital to request amendments to the medical staff bylaws). This episode spurred the passage of a new law, S.B. 1325, which establishes medical staffs in California as entities independent of the hospital with rights of self-governance and the right to sue in their own names. S.B. 1325, Gen. Assem., Reg. Sess. (Cal. 2004), available at http://www.leginfo.ca.gov/pub/03-04//bill/sen/sb_1301-1350/sb_1325_bill_20040922_chaptered.pdf (preserving the hospital governing board as the final authority, and stating that hospitals and medical staffs are jointly responsible for providing quality medical care and that the board must not take unilateral action unless it has "a reasonable and good faith belief that the medical staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care"). Hospitals have responded to various forms of competition from doctors by limiting or denying staff privileges - a phenomenon sometimes referred to as “economic credentialing.” See Elizabeth A. Weeks, The New Economic Credentialing: Protecting Hospitals from Competition by Medical Staff Members, 36 J. HEALTH L. 247, 247-49 (2003).

\textsuperscript{49} Lucian Leape & Robert Wachter, leading experts on quality and co-authors of the Institute of Medicine’s (IOM) “To Err is Human” report, recently concluded that little progress has been realized in the wake of the Report. See Donna Young, Five Years After IOM Report, Experts Gauge Progress on Patient Safety, ASHP NEWS, Jan. 1, 2005, available at http://www.ashp.org/news/ShowArticle.cfm?id=9014; see also, Todd Zwillich,
coordination and systems approaches to dealing with medical error are still lacking.\(^\text{50}\)

An important question raised by Professor Blum and others is whether the legal standards affecting governance structures need to be reconsidered in order to promote more effective coordination and closer attention to quality of care.\(^\text{51}\) How much responsibility for quality of care deficits one can ascribe to law and regulation affecting hospital governance is a matter of speculation. Nevertheless, a salient question is whether the 'new' model of nonprofit governance discussed in this article will serve to make management more attuned to quality concerns. This is doubtful, for the reasons elaborated below.

First, the thrust of the new nonprofit governance paradigm is directed at remedying problems other than those associated with quality of care. The central themes of the new model focus on the following issues, none of which explicitly or implicitly address quality of care: the quantity of charity care, financial accountability, mission focus, board independence and diligence, avoidance of conflicts of interest, and other breaches of fiduciary duty. Further, there has been an almost knee-jerk reaction among policymakers and consultants who assume the Sarbanes-Oxley-style reforms are necessary for the nonprofit sector despite the absence of compelling evidence of systemic financial irregularities or self-interested behavior. To the extent that scarce managerial (and real) capital will be spent on reform, it is likely to follow the path recommended by legal mandates and consultants' interpretations thereof. With no obvious linkage between the various corrective measures and enhanced attention to quality of care, one can expect that board agendas are unlikely to reverse the historic pattern of placing quality behind economic issues in setting the agenda for management.\(^\text{52}\)

Second, some of these new developments may work against focusing greater attention on quality of care. The key to understanding the

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\(\text{50. See Young, supra note 49; see also Drew Altman et al., Improving Patient Safety—Five Years After the IOM Report, 351 NEW ENG. J. MED. 20 (2004).}\)

\(\text{51. Professor Blum's suggestions range from contractual adjustments to internal balance of power to statutory overhaul of the physician-hospital relationships. See Blum, supra note 2, at 28–30 (proposing a menu of possible solutions: redrafting hospital and staff bylaws to more clearly specify the respective roles of the parties; creation of a total quality committee that would serve as a bridge between the board and the medical staff executive committee; establishing a slotted board with designated positions for those with experts in law, medicine and business; ending the special self-governing status of the medical staff; recasting the non-employee physician as an agent of the hospital; and giving the medical staff control of the board and hence hospital operations).}\)

\(\text{52. See Bader, supra note 7.}\)
impediments to quality improvement is found in the economics of health financing and delivery. Business commentators refer to the underlying dilemma as a lack of a "business case" for quality improvement,\(^\text{53}\) i.e., payment systems rarely pay for quality improvement and employers rarely demand it. Moreover, it is often the case that neither provider can recapture investments in quality because benefits are too remote in time and beneficiaries are unable to perceive quality benefits.\(^\text{54}\) The costs of elements key to improving quality—especially enhanced information collection, storage and retrieval capabilities—can be daunting. It should also be remembered that some quality problems are associated with overuse (as distinguished from underuse and misuse) of services; in these circumstances, improving quality may reduce hospital revenues. With the thrust of many of the changes heralded by the new nonprofit governance paradigm to shift board attention to the bottom line and to the performance of mission objectives, it is likely that costly quality improvements will be placed on the back burner. As long as quality enhancement remains a dubious business proposition, the tendency of nonprofits to import for-profit corporation governance structures and to mimic their focus on margin will likely undermine reforms directed at enhancing patient safety.

Finally, the insistence on greater attention to mission may, paradoxically, interfere with quality enhancement efforts. In particular, implementation of quantitative standards for charity care has the potential to work at cross-purposes with efforts to improve quality. Fixing minimal levels of free care might pressure providers to cut some corners in order to maximize the quantity of charity care supplied. Lessons from the mandate of EMTALA suggest that unfunded obligations to provide charity care may cause some hospitals to scrimp on the quality of services they provide.\(^\text{55}\) Furthermore,


\(^{54}\) The nascent "pay for performance" movement may portend the beginning of change in this regard, but it is far from established and faces its own internal contradictions. See generally Jim Bellows & Michael P. Sullivan, Background Paper: Could a Quality Index Help Us Navigate the Chasm (Apr. 2004), available at http://www.kpihp.org/areas/Quality/background%20final.pdf.

even where managers and boards desire to improve quality of care, they face significant tradeoffs against other fiduciary and mission objectives.\textsuperscript{56} One problem results from nonprofits having broad mission objectives but lacking clear strategies to prioritize their goals and implement their plans.\textsuperscript{57} In addition, imperfect information, bounded rationality and other behavioral impediments to effective reasoning under uncertainty make such decisions unpredictable at best.\textsuperscript{58} Research on managerial decision-making indicates that a multiplicity of goals tends to cause performance to deteriorate and increases the risks of sub-optimal decisions.\textsuperscript{59} Where goals are given equal or unspecified weights, the attendant uncertainty also impairs effective decision-making and job performance.\textsuperscript{60}

IV. CONCLUSION

Powerful changes are afoot affecting governance in nonprofit hospitals. In broad brush, they point toward structures that emulate those recently adopted by their for-profit counterparts. Likewise, they embrace similar objective functions for management of the “business side” of hospitals: increased emphasis on the bottom line, accountability, and transparency. At the same time, class action lawsuits and regulatory oversight have focused a spotlight on charity care. When these important changes are evaluated against the many pre-existing obstacles to dealing with the quality of care crisis in American hospitals, the patient safety movement may find little reason for optimism. Increased focus on financial accountability and charitable mission may work to divert managerial attention and resources from quality enhancement. Moreover, dealing with quality of care issues poses special problems in the nonprofit context. The economics of dealing with physicians (who supply both input and customers to hospitals) and the effects of a highly competitive marketplace constrain managers’ abilities to enhance quality while simultaneously preserving both mission and margin.


\textsuperscript{57} See V. Kasturi Rangan, \textit{Lofty Missions, Down-to-Earth Plans}, \textit{HARV. BUS. REV.} 112 (March, 2004).

\textsuperscript{58} See generally \textit{JONATHAN BARON, THINKING AND DECIDING} (2001).


\textsuperscript{60} Emsley, \textit{supra} note 59, at 348.
Further affecting discretion is the conundrum of balancing incommensurable commands of regulators and patrons (donors, community leaders, and sponsors). In an era of evaporating public monies for charity care, all this portends a daunting task for hospital management.