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ETHICS AND TRUSTEESHIP FOR HEALTH CARE



Hospital Board Service in Turbulent Times

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ospitals are complex and imposing institutions. They are vital to the communities they serve and to society as a whole. They are places of joy and sorrow, rescue and loss, recovery and death. They command enormous capital investment, expensive high technology, and often the largest payrolls of any organization in their community. They are monuments to governmental and philanthropic largess. Most are now integrated health systems offering multiple health services and countless activities under the headings of counseling, education, health promotion, and community service. They employ and support the practice of some of the most highly trained, intelligent, and capable professionals in the nation; their hallways are thick with titles, academic honors, and advanced degrees.

Over half of the nation's hospitals today are not-for-profit organizations, traditionally called "voluntary" because, while they are *managed* by specialized professionals, they are *governed* and supported by volunteers—philanthropists, community leaders, business people, clergy, and others with a civic orientation of service. These are not-for-profit hospital trustees, men and women who serve without pay and who are entrusted with the oversight, mission, and strategic operations of these expensive and vital institutions.¹

It is important to all of us that not-for-profit hospitals be governed well and trustees do their job well. Hospitals deal with the most fundamental matters of human well-being; their services are not just another commodity in the marketplace. By providing health care services of high quality, a hospital is an important community resource. Those who run not-for-profit organizations owe a fiduciary duty to the founders, benefactors, and donors who support the institution with an expectation that their money will be used in certain ways and for certain purposes. Not-for-profit hospitals also enjoy tax exempt status in return for fulfilling certain public purposes, and thus those who govern these institutions have a responsibility to all citizens and taxpayers to ensure that these public purposes are realized. There is much with which trustees have been entrusted. These public and private fiduciary promises, implicit in each trustee's acceptance of appointment to the board, lay the foundation for a set of more specific ethical and legal duties that not-for-profit hospital trustees assume.

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This report is a discussion of the roles and responsibilities of those who serve on not-for-profit hospital boards. It is about the ethics of being a trustee.² It is about how ethics can be used to assist, facilitate, and enable already virtuous people to make hard choices. It is not about one right answer but about striving to do the right thing for the right reasons.

In a legal sense, not-for-profit trustees are not as highly regulated or as accountable as the directors of for-profit corporations, who are formally accountable to the shareholders who elect them. State attorneys general oversee the conduct of not-for-profit trustees, and they rarely use their regulatory power to interfere with board actions, except in cases of the most blatant misconduct and abuse of trust.³ The law trusts trustees and provides a set of general guidelines for conscientious service. The legal obligations of hospital trustees can be summarized as a duty of care, a duty of obedience, and a duty of loyalty.⁴ The trustee must attend meetings and become informed enough to make reasonable, prudent decisions. A trustee must adhere to the mission of the hospital. A trustee must pursue the best interest of the hospital and not misuse his or her position to advance personal interests. The trustee must avoid conflicts of interest, engage in open decisionmaking, and act with an independent mind and in a fiduciary spirit.

This emphasis in the law of trusts and trusteeship on personal, conscientious goodwill and ethical motivation comports well with the perspective of ethics. Together, legal and ethical traditions provide guidance and high expectations for trustees. Trustees must face many dilemmas and hard decisions in the governance of a hospital. Yet they do not face those tough choices without a tradition of values and purposes to guide them. The ethical heritage of hospital trusteeship is an anchor in troubled waters.

Turbulent times are not new for hospitals. The history of the Ameri-

can hospital is a history of transformation and adjustment to shifting conditions of science, economics, and social mores.⁵ Yet in the last twenty years, American not-for-profit hospitals have been challenged by an unusual convergence of forces. Changes in medical science and practice have changed the way hospitals are used and function in the health care system, with marked trends toward shorter lengths of stay. Changes in large-scale public and private health care financing systems, in particular toward prospective payment arrangements and contractually negotiated prices, have put new pressures for efficiency and cost-containment on many hospitals, and placed them in a more competitive environment than before.⁶ Managed care systems have put hospitals into new relationships with physicians. Finally, the presence of for-profit hospitals owned by investor-owned companies has presented competitive challenges

(and in some cases potential buyers) for not-for-profit hospitals.⁷

Each of these factors, and others, calls for new ways of thinking and managing among hospital executives and for new perspectives and talents among trustees. This changing environment manifests itself differently in different regions, states, and communities. Overall, the developments of the past twenty years have made the job of trustee ethically harder. The legal duties of care, obedience, and loyalty provide only the beginnings of a framework with which to analyze the trustee's ethical responsibilities. Consider the following scenarios, which are derived from our interviews with trustees:

♦ To sell or not to sell?

Mergers involving major competing hospitals led the trustees of Metropolitan Hospital to hire a consultant to do an environmental scan and advise the board about strategic alterna-

Cover illustration, *Hospital Management*, February 1920.



tives. Although the hospital was showing a positive bottom line, the trustees were worried because the hospital's once middle-class neighborhood had changed and the hospital was increasingly subsidizing the care of a substantial uninsured population through revenues generated from other sources, including the hospital's endowment and some declining charitable support.

The consultant reported that managed care was causing hospitals to rapidly reduce prices for a shrinking pool of insured patients. He believed that the hospital would face ever-growing losses within the next three to five years. Mergers with the local not-for-profit systems were discussed, but none of those systems was interested in expanding into Metropolitan's neighborhood. The consultant believed, however, that a for-profit company that was seeking entry into their market area might purchase the hospital.

After much discussion, the board concluded that the dilemma they faced was between using their charitable assets to provide hospital services until those assets were exhausted, and selling the hospital and putting the resulting funds (along with the hospital's endowment) into a grant-making foundation that could address community needs. They disagreed about whether they could responsibly abandon their hospital's historical mission so long as they were capable of pursuing it.

♦ Responding to medical error.

A patient died unexpectedly in the hospital after a routine examination and treatment in the emergency room. When her body was removed from the treatment room, an empty medication vial was discovered in the bed, and it was thought that administration of the wrong medication might have contributed to the patient's death. Post-mortem tests reassured the hospital's medical director that this was not the case, and the county medical examiner chose not to investigate. The hospital's chief execu-

tive officer presented these facts to the board and told them of his decision not to tell the deceased patient's family about the discovery of the empty vial.

♦ Allocation of scarce financial resources.

The end-of-year financial report showed that the hospital had lost money for the first time in anyone's memory, and the board asked the CEO for an explanation and a plan of action. She was made to understand that her job was on the line.

In her report at the next meeting, she reported that reducing costs was more feasible than increasing revenue, since the hospital's occupancy was declining. The most reasonable cost-reducing alternatives were all unappealing—to defer maintenance on the building, to reduce patient care staffing levels (perhaps jeopardizing quality and creating labor relations problems), or to close some outpatient clinics that were losing a lot of money because they were the main source of care for the community's uninsured population.

She recommended closing the clinics, since the benefits of doing so would be felt throughout the institution, just as would the costs of keeping them open. The board argued about whether the care provided at those clinics was an essential part of the hospital's mission or whether it was an activity that they could no longer afford.

♦ Serving a changing community.

Eastlake Hospital is located in a suburban community that over the last twenty years shifted from middle-income white to working class African-American. The hospital, with a self-perpetuating board that served without term limits, never added new members in response to the shift in the population and ignored the changing needs of its surrounding community, whose members increasingly used hospitals in adjacent suburbs.

After a financial crisis that elicited intervention from the state, a new CEO was brought in to revive the hospital by improving relations with and service to the community and by strengthening the medical staff. He began by recommending diversifying the board and enticing new physicians to the staff. The doctors who could be attracted, however, were not necessarily of high quality, and attracting them proved to be expensive, particularly for a financially distressed hospital that was laying off low-income employees and was already unable to provide programs and services that the board saw as necessary. Expending resources to attract marginal doctors while laying off conscientious employees struck some trustees as a dubious tradeoff, but they found alternatives in short supply.

♦ Closing a facility.

Hillview Medical Center is the product of a hospital merger that was intended to ameliorate the financial difficulties of two hospitals but instead exacerbated them. Five years after the merger took place, the medical center was losing millions of dollars each year. Hillview's uptown facility was located in a low-income community, with no other acute care hospitals nearby. The physical plant was antiquated and inefficient and needed significant capital investments to stay fully functioning. Financially, the soundest option was to close the uptown campus. Some trustees saw this as a betrayal of the institution's community service mission, and community members advocated strongly for keeping the facility open. Some trustees felt they should be responsive to community wishes and needs, while others felt that keeping the uptown facility open would jeopardize the survival of the institution as a whole.

♦ Conversion from not-for-profit to for-profit status.

Valley Hospital had a long history as a community hospital, but health system change combined with debt from

a major renovation a decade ago left the hospital in increasingly bad financial condition. The practices of many of its physicians had been purchased by a not-for-profit health system based in the nearby city, and the remaining doctors competed vigorously with doctors in adjacent towns that had their own hospitals. With a crisis looming regarding interest payments on the debt, and after meeting with several consultants, the board concluded that the hospital's existence as an independent institution would have to end. After soliciting and evaluating a handful of offers regarding merger and purchase, the board narrowed its options to two: to merge with a neighboring not-for-profit hospital or to sell to a national investor-owned hospital company, creating a grant-making foundation with the proceeds.

From a financial point of view, the sale option was preferable, and it was believed that the size of the investment would ensure the purchaser's commitment to maintaining the hospital and keeping it open. The medical staff and hospital employees also endorsed the sale option, mistrusting the neighboring hospital (and its doctors) and fearing that they would close Valley down if given the chance—a fear shared by many trustees. At a public meeting, however, the most vocal community members spoke strongly against the for-profit sale, and some trustees felt that the board should respect the community's preferences.



Why bring an ethical perspective to bear on the conduct of trustees? To be entrusted with the governance authority of a modern hospital is to be placed in a position of significant power and responsibility. The study of ethics has to do with how such power should be used, how human beings should live together for mutual assistance and mutual advantage, and the boundaries people should not transgress in their rela-

tionships with one another. Ethics provides standards and rules for conduct; it interprets and clarifies fundamental values, virtues, and principles that have proven themselves over the centuries to be reasonable and beneficial to humankind.

This is generally how philosophers view ethics. In ordinary usage, the terms “ethics” and “ethical issue” often carry negative connotations. They conjure up images of scandal, abuse of power and office, misconduct, and the like. But scandal and wrongdoing are not the topics with which to begin a productive conversation about hospital trustee ethics. We want to promote ethical analysis of the world of trustees because we believe it is encouraging and helpful

course of action, the decisionmaker is challenged to articulate more than just a visceral feeling or a simple financial analysis. The decision must be supported with clear and cogent arguments consistent with institutional and personal goals and values.

To focus on trustees as individuals is to identify only one side of the subject of trustee ethics. The most important decisions that trustees make are not made alone, but collectively, by boards of trustees acting in a corporate capacity. Trustee ethics therefore requires attention both to individuals who occupy the role and discharge the responsibilities of that role and to the way these individuals operate collectively as governing boards. Properly organized and functioning,

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to trustees, not threatening. From time to time, scandals do occur and must be dealt with in not-for-profit institutions and hospitals, but they are not what we address in this report.

Ethics is the study of how to make hard choices in the face of conflicting values. It offers a rational approach to making better judgments and solving real problems. Ethical arguments are grounded in principles, contracts, or foreseeable consequences. Principles are rules that guide actions; contracts are promises of future actions; and consequences are the risks and benefits that may be arrayed to guide actions in order to result in the most benefit and the least harm. When making an ethical argument about a

a board can enable trustees together to accomplish things that no one trustee acting alone could hope to accomplish, and that no mere collection of individuals, if they were not properly organized, could accomplish.

It follows that paying attention to how boards are organized and function, and how trustees make collective decisions, is of the utmost importance. If hospital governance is to fulfill high standards of ethical conduct and to honor the trust that has been placed in it, then it is not enough to appeal to the ethical standards and conscience of individual trustees alone. For even conscientious individuals may find it difficult or impossible to perform well in an unsup-

portive environment. It is also necessary to examine how boards should function so that individual trustees can be and do what they should.

Although trusteeship is not strictly speaking a profession—indeed, it is one of the most significant bastions of civic volunteerism and amateurism remaining in our highly specialized society—the ethics of the hospital trustee has an affinity in many important ways with the ethics of professionals’ roles. A “role” is a set of norms, social expectations, and values as well as a set of particular skills, functions, and competencies.

We analyze how trustees ought to act, without losing sight of the actual constraints and circumstances that affect their actions in the real world. Our aim is to be prescriptive, but only at a level of generality that is compatible with the actual variety and diversity of boards, hospitals, communities, and cases. There is no single best way to govern a hospital, and there is no single right way to be a trustee. For this reason we have chosen to speak at length about general principles, and less about specific duties or specific actions trustees ought to perform. Principles are like large area maps. They tell you the direction you must go to reach your destination, but they do not show all the roads you might follow. Several paths could lead to where principles tell you to go. So it is with our discussion here. We aim to challenge trustees with a high ethical standard,

but we do not—and could not—dictate exactly how they must act to meet that standard.

A study of trustee ethics should start by examining the power and authority of trustees. In general, special power entails special moral responsibilities, and this is no less true for trustees than for other professions, occupations, or significant social roles. Conversely, if the powers and authority of trustees are ambiguous, shifting, and inconsistently applied, that can be a recipe for irresponsible conduct and a lack of ethical accountability.

Through the work of our project task force, staff research, and our interview study with trustees and hospital executives, we have sought first to define and specify the interests and needs served by the trustee in a not-for-profit institution and to explain the nature of the power, authority, and expertise invested in the trustee role. This includes an appreciation of the human as well as the financial interests involved, the special moral significance of health care services, and the special social functions and importance of not-for-profit organizations in health care.

Second, reasoning from the power and interests inherent in trusteeship, we have formulated ethical principles that should (and often implicitly do) govern the conduct of those individuals who occupy that role. These prescriptive principles can be compared with the responsibilities that are asso-

ciated with the trustee’s role by law, custom, and tradition. We have found that our recommended principles are very similar in substance to those already widely accepted in the trustee world, although the terminology we use may be unfamiliar, and the way we apply these principles in practice may offer new food for thought to many in the field.

Third, in light of these general principles, we turned our attention to practice and sought to offer more specific guidance and commentary about the actions of trustees in several different kinds of situations, and about the internal workings of the board and governance system in the hospital. If the board’s systems and processes are working poorly, individual trustees will find it hard to be responsible and effective.

Armed with a sense of the trustee’s power and the interests that are at stake, it is possible to construct a framework of ethical principles that flow from the role, the functions, and the cultural expectations that define the trustee in our society.

In the past, trustee ethics have been largely tacit. But these tacit understandings are being unraveled by the current health care marketplace and cannot be taken for granted. Insofar as this trend cannot be simply reversed, it is all the more necessary to re-establish and revivify a sense of ethical mission and obligation for hospital trustees on an explicit ethical footing.

THE HOSPITAL TRUSTEE TODAY

Private, not-for-profit organizations are the predominant form through which hospital services have been provided in the United States. Deeply embedded in the geographic and cultural community, and with historical roots in religious and other philanthropic institutions, not-for-profit hospitals seek to promote social welfare and public good through civic betterment and long-term commit-

ment to the community. Through these institutions, society attempts to meet the needs of those in the community and in special populations who are unlikely to receive effective care through for-profit health care delivery.⁸

In recent decades, the economic values of the marketplace have become increasingly prominent in the hospital industry and the minds of

those responsible for decisionmaking. Cost containment and efficiency have become more pressing concerns, and hospitals have experienced enormous organizational change involving mergers, joint ventures, creation of for-profit subsidiaries, acquisitions, network development, and conversion from not-for-profit to for-profit status through sales or reorganization. The not-for-profit hospital still pre-

dominates among American hospitals and will likely continue to play a central and vital role in the American health care system for the foreseeable future.⁹ But commentators are asking questions about what makes not-for-profit hospitals distinctive and about the nature of their community obligations as tax exempt organizations. As market-driven but charitable organizations, hospitals face difficult conflicting pressures that ultimately must be faced by their boards.¹⁰

Pressures in the Health Care Environment

In the past, boards of trustees focused primarily on selecting hospital executives and on fundraising. Now, trustees of not-for-profit hospitals are being asked to make critical decisions that relate to their institution's core values, and sometimes to its very existence. In recent decades there have been several developments of great importance to the governance structure.

First, investor-owned hospital companies have entered the field, demonstrating that hospitals can be run profitably, bringing new operating styles and methods, and raising doubts about the justification of state tax exemptions for not-for-profit entities. These companies have also become potential purchasers of not-for-profit hospitals. In addition, cost-containment in federal programs and the rise of managed care on the private side have introduced pressures that threaten the ability of hospitals to pursue mission-related activities that are subsidized by revenues from paying patients. Moreover, an oversupply of beds in some areas and reduced lengths of stay have led to concerns about the economic viability of some hospitals. Finally, hospitals have become the site of many complex moral choices involving life, death, and health care decisionmaking. (Interestingly, most of the trustees we interviewed did not at first blush view medical decisionmaking about life-

In virtually every case, we were told about efforts either to assure the hospital's continued presence in the community, the continuation of key aspects of the hospital's mission, or the continuation of the board's voice after the transaction was completed.

sustaining treatment as a governance or policy issue.)¹¹

These factors suggest that the governance structures of not-for-profit hospitals face several challenges, including difficult resource allocation decisions and perhaps even more difficult structural and control decisions—concerning mergers, acquisitions, closure, sale to other institutions (for-profit or not-for-profit), or reorganization to serve a new mission. How well prepared are boards to deal with such crucial issues? What tools have they to work with? Boards are collections of powerful and important people who are generally honest and concerned about their institutions. But have they the time to reflect on their duties and responsibilities and on the values that ought to underlie critical decisions? What do trustees think of these questions:

- What are the responsibilities and duties of a not-for-profit hospital trustee?
- What values ought to be considered in board deliberations?
- How can trustees address and resolve conflicts among their duties?
- How can trustees continue to promote the commitment of the not-for-profit hospital to social welfare and public good?

Hospital Trustee Survey Findings

We explored these matters in interviews with ninety-eight

trustees and hospital CEOs about their experiences and perceptions at a sample of fifteen hospitals in the greater New York area and six hospitals elsewhere that had considered sale or conversion to a for-profit.¹²

When asked to describe trustees' responsibilities at their institution, our respondents provided a varied list regarding oversight, policymaking, board-CEO relations, and mission. The most common responses pertained to financial oversight, meeting community needs, assuring quality of care, selecting and monitoring the performance of the CEO, assuring adherence to mission, policymaking, and, more rarely, fundraising and advocacy for the institution. Almost no trustees used the language of ethics to describe their responsibilities, although ethical issues were implicit in many of their responses—particularly those pertaining to mission and community needs.

Ethical issues were closer to the surface when we asked trustees to identify the major issues that had engaged their board over the previous year and to describe the considerations that had been involved. The issues fell into eight broad categories, presented here in order of frequency. The categories inevitably overlap to some extent.

Institutional autonomy. Most of the boards at our sample of hospitals had dealt with questions regarding a merger affiliation with, or a sale to, another hospital or hospital system. Many different arrangements had been considered. In virtually every case, however, we were told about efforts either to assure the hospital's

continued presence in the community, the continuation of key aspects of the hospital's mission, or the continuation of the board's voice after the transaction was completed. Virtually no one described his or her board's primary goal in revenue maximizing terms.

Financial issues. Financial issues were prominent considerations for our conversion sample, and for a majority of institutions in the New York area sample, financial issues had been among the two most important in the previous year. In virtually every case, the key problem was the need to reduce costs. Our respondents almost always identified tradeoffs that the board had been reluctant to make—laying off staff in their low-income neighborhood, “becoming the K-

Mart of health care,” reducing quality, closing a clinic on which poor people depended. As one chair put it, whereas a business can “look at the bottom line of every department and say ‘Get rid of everything that loses money,’ we have to remind ourselves that we have a mission, a Catholic mission, that has to be fulfilled.”

Positioning the hospital. In addition to issues involved with mergers and sales, almost half of the New York area sample mentioned that their board had dealt with fundamental issues regarding how the hospital should respond to turbulence in the health system. Issues mentioned were mostly described in rather general terms: “getting our hands around managed care,” responding to competition from the networks of “big

city hospitals,” “becoming a significant provider in the Northeast U.S.,” shifting toward ambulatory care, becoming more flexible and responsive to health system change.

Facility enhancement. For many institutions—more than one third of the New York sample—questions about enhancing or altering facilities had been major board issues in the previous year. These issues were almost always presented in terms of enhancing quality, meeting unmet needs, and finding the needed capital. The decisions could be very difficult. A trustee at a financially struggling institution described the options underlying the board's decision to spend \$3 million on MRI equipment. The expense “would probably bankrupt the hospital, but not buy-

An Overview of the Project

Taking trustee ethics seriously does not require that all trustees always agree. There is room within the scope of conscientious, ethical board service for a broad range of disagreement over

many financial, institutional, and public policy issues that affect hospital operations today. Nonetheless, precisely because of the conflicting forces that buffet trustees, many are seeking to give their debates and policy disputes some ethical context and perspective.

It was with this goal in mind that The Hastings Center and The New York Academy of Medicine began in 1997 a two-year research project on the ethical responsibilities of not-for-profit hospital trustees. The project was supported by the Greenwall Foundation.

Our research was built around two activities. We conducted a series of lengthy in-person interviews with ninety-eight trustees and chief executive officers from fifteen not-for-profit hospitals of different sizes and types located in the greater New York metropolitan area. We also convened a project task force chaired by Dr. William Hubbard, former dean of the University of Michigan School of Medicine and former chief executive officer of Upjohn, and comprised of hospital trustees, executives, physicians, philosophers, social scientists, and

representatives of leading professional associations representing hospitals and hospital leadership.

The task force met six times over two years to discuss and debate the current state of hospital governance, the pressures that not-for-profit hospital trustees face, and the hard choices they must often make. The task force also considered the values, cultural expectations, and historical traditions that inform the trustee role as background for developing a typology of ethical issues in hospital trusteeship and a set of principles and norms to address them.

In September 1999 a final public meeting, attended by trustees and other interested persons from hospitals in the New York metropolitan area, was held at the New York Academy of Medicine. The work of the Task Force was presented at that conference and a model educational workshop designed for trustees was tested on a pilot basis.

The report presented in these pages grows out of the project's work. It draws on the findings of the interview study and the deliberations of the task force, together with other research conducted by project staff. While the arguments made and the views expressed in this paper are those of the authors, we have tried to adhere to what we understood to be the recommendations, conclusions, and thinking of the members of the task force. Their lively debate and broad-ranging expertise and experience created a stimulating setting that generated not only this report, but also a collection of commissioned papers that were presented to the task force and will be published during the coming year.

ing it would certainly bankrupt the hospital, because doctors would not want to work here. So, we are buying it.”

Physician relations. Managing the hospital’s relationships with physicians is another common problem with which trustees must grapple. Issues include responding to physician-related quality problems, deciding whether requested investments would benefit primarily the doctors, making tradeoffs between expenditures and the risk that doctors would take patients elsewhere, and arguing about fairness in hospital-physician joint ventures.

Managerial issues. Issues mentioned here included strengthening the management team, improving the board itself, and keeping the hos-

pital functioning during a labor dispute.

Quality of services. A handful of interview respondents mentioned quality as a major issue of the previous year, either in vague terms (“monitoring quality”) or concretely (using an accreditation visit to improve quality, seeking ways to improve patient satisfaction, or getting the board more meaningfully involved with quality, for example).

Community role. Issues mentioned here included deciding whether and how to help a neighboring hospital that was in trouble and considering “how to bring together all the diverse interests—doctors, communities, and the board—to work together” to meet community needs.

Trustees’ Views on Ethical Issues

Although there are clearly conflicting value dimensions involved in many issues with which trustees are dealing, few trustees that we interviewed think of themselves as being engaged in ethical decision-making. Indeed, when asked early in our interviews whether their board had dealt in the past year or so with any matters that they think of as ethical issues, their typical initial response was a very long pause. Responses thereafter ranged from a handful of comments that the board had encountered no ethical issues to a handful that every board decision had an ethical component. Some trustees assumed that we were talking

Our goal in this report is to show that the decisions made by hospital trustees and the actions of hospital boards raise important ethical issues and that the ethical dimensions of trustee service should be more explicitly recognized and discussed. We hope to provoke and to contribute to such a discussion and to facilitate an ongoing interest in the topic of trustee ethics, both within the trustee community and in the broader discussion of medicine and health care in our society today. We aim in particular to clarify the ethical concepts and principles pertinent to the activities of both individual trustees and boards.

These concepts and principles do not arise in a historical or cultural vacuum; the “practice” of trusteeship has a history and a tradition. It has a social meaning and normative rules. It can be done well or badly, responsibly or irresponsibly, beneficially or harmfully, conscientiously or carelessly. Being a hospital trustee is a voluntary service with heavy demands, and persons who give of their time and talents in this service should be esteemed. It is also a service that should never be undertaken lightly or in a pro forma manner. Organizations, including hospitals, sometimes find it difficult to recruit qualified candidates to serve on their boards. But the importance and responsibilities of this role should never be underestimated.

Some may worry that raising trustees’ awareness ethical issues will lead them to seek more influence in the governance of their organizations at the expense of management. Again, the ethical perspective we offer does not stipulate any particular style or arrangement in the governance and management of hospitals. There is a spec-

trum of different working arrangements that permit board members and executives to fulfill their functions responsibly and to discharge the ethical obligations of their respective roles. The vision of ethics we offer here calls for a thoughtful, well-informed trustee, one who is not intrusive or overbearing in dealing with management, but who works as an effective partner with management and strives to exercise the board’s responsibilities effectively and with sound reasoning and judgment. Careful discussion of ethics among trustees can assist in that regard, and in this way will also be beneficial to hospital management.

We would like to thank Dr. Hubbard for his steady hand as chair of the task force and for his invaluable advice and support. We also wish to acknowledge gratefully the support and encouragement provided by William Stubing and the Greenwall Foundation. Strachan Donnelly of The Hastings Center had the original idea for a collaboration between Hastings and The New York Academy of Medicine, and Dr. Jeremiah Barondess, president of the Academy, has been very supportive of the project.

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—Bruce Jennings and Alan R. Fleischman
Project Co-directors

about conflicts of interest among trustees, which had been a significant problem in a few institutions.

Some trustees mentioned patient-related bioethical issues about which the board had been briefed, such as hospital policies regarding end of life decisions. In mentioning these topics, respondents generally indicated that their institution had policies and mechanisms for dealing with bioethical issues, and few indicated that their institution treated bioethical issues in patient care as one of the board's direct concerns. Catholic hospitals were an exception, particularly if they had been thinking about mergers.

A significant minority of our respondents mentioned issues pertaining to mission, or tensions between mission and business considerations, when asked about whether their board had dealt with ethical issues. These issues mostly pertained to financing money-losing services or meeting community needs, often in the context of possible mergers, sales, or affiliations.

Examples of mission-related issues that the trustees and CEOs identified as "ethical" included:

- deciding whether to stay in the city or re-locate the hospital,
 - deciding whether to invest in or maintain unprofitable specialized services to meet community needs,
 - deciding whether to help a struggling health care institution nearby,
 - deciding whether to permit two standards of care—for the rich and poor—within the hospital,
 - ensuring that the hospital does not turn away patients in need,
 - coping with tensions between commitment to the hospital versus commitment to the community in trying to assure the institution's financial soundness,
 - trying to represent fairly the hospital's different constituencies (medical staff, employees, and the populations of different communities served by the hospital) regardless of the trustee's own bias or connections,
 - deciding whether to close facilities that were losing money or in need of major capital infusions,
 - deciding whether to sell the hospital to a for-profit purchaser, and
 - making resource allocation decisions, either in ordinary situations or regarding the use of proceeds from selling the hospital.
- Another group of value-laden issues identified by respondents in our survey were presented solely as business issues. Examples included:
- the dangers to the institution of taking on additional debt,
 - how the admissions office in a rehabilitation facility should handle patients who arrive without a proper referral from a physician,
 - how to handle downsizing and layoffs,
 - the extent of salary differences from top to bottom of the institution, and
 - issues regarding the corporate compliance program.
- A third set of responses pertained to medical staff issues—a doctor with a drug problem, unspecified "unethical behavior" by a physician, problems with physicians who have lost their licenses, issues in disciplining and occasionally removing a doctor from the staff, misbehavior by "doctors" in the performance of their duty, dealing with a "very contentious doctor" who the CEO feared would physically attack him, dealing with a staff member who had engaged in fraudulent behavior outside

of the hospital, fraud and abuse concerns in contracting arrangements between the hospital and physicians, credentialing and quality issues, and how physicians handle cases with poor outcomes.

Clearly a wide variety of issues come to mind when trustees and CEOs are asked about ethical issues with which their board has grappled. Most of these issues are quite different from those that have traditionally engaged the field of bioethics. And although some are similar to those of ordinary business ethics, many flow from hospitals' responsibilities either as patient care organizations or as not-for-profit organizations.

Issues and Ambiguities in the Trustee Role

In our interviews with trustees and CEOs, several difficult issues surfaced regarding different aspects or dimensions of the trustees' role. Again, our topics overlap to some extent.

Trustees as representatives. Unlike members of political bodies, corporate boards, or boards of membership organizations, hospital trustees are generally not elected or responsible to specific constituencies who elected them. Most of the trustees we interviewed had been appointed by their own board and did not view themselves as the representative of any particular interest. They said either that they did not see themselves as serving in a representative capacity at all or that they represented the entire community. Some spoke of the trustee role as mediating among the conflicting interests of the hospital's different stakeholders—patients, management, doctors, nurses, other employees, and the community at large.¹³

We encountered three issues regarding the "representative" role of trustees. The first arose when a board decided that in recruiting and selecting new members it should seek to reflect the ethnic composition of the population served by the hospital.



Walk-in Clinic
by May H. Lesser, ©1989 Tulane
University Medical Center

This raised the question whether these new trustees ideally speak for the population that they “represent.” Several women and minority-group trustees whom we interviewed objected to being viewed as “speaking for” the groups from which they were drawn, even as some of them observed that their own presence on the board was making it more sensitive to those very groups.

The second issue arises from the appointment of members of the medical staff to the board. We found that such trustees were more likely than most trustees to view themselves (and to be viewed by other trustees) as speaking for a constituency—in this case, the medical staff or the patients. This may be appropriate, particularly when the board has been composed with an eye to representing and balancing different constituencies (as is often true of system boards made up of representatives from component institutions). Researchers report that inclusion of physicians on hospital boards is increasing. However, having trustees who represent constituencies raises a fundamental question about whether their first loyalty should be to their constituency or to the hospital and/or its mission.

There is an expectation, established by tradition and as a condition of federal tax exempt status, that not-for-profit hospitals engage in “community benefit” activities—care for the uninsured, involvement in educational and research activities, assessment of community needs, and collaborating with other organizations to address unmet needs.

The third issue arose among trustees at a hospital that had weighed the merits of sale to a for-profit company versus merger with a local not-for-profit health care system. In this particular case, after weighing the alternatives carefully, most trustees concluded that the relative advantages of the sale were clearly greater, given the purchaser’s track record elsewhere, its commitment to the future of the hospital, and a purchase price that would allow creation of a local foundation. They feared that the local system into which their assets would be merged in a non-cash transaction would eventually close the hospital. Even so, they decided

against the for-profit sale option because there was significant opposition from a community group. This example raises the question whether trustees should use their best personal judgment in making decisions regarding the institution, or make decisions that they believe will be most acceptable in the community. The latter may be appropriate (assuming that trustees really know what the “community” wants) if trustees are deemed to be serving in a “representative” capacity. But is that how they should be viewed?

The board’s value-mediation role. Unlike for-profit organizations, in which the decisions of boards and

managers are legitimately evaluated primarily from the perspective of enhancing the value of stockholders' investments, the goals of not-for-profit organizations tend to be ambiguous, their stakeholders multiple, and their performance seldom measured solely or even primarily in terms of whether the value of the assets is increasing. Not-for-profit hospital trustees must not only mediate among the interests of multiple stakeholders, but they must do so knowing that an analysis of the economic effects of the decision does not necessarily provide the criteria by which to choose among alternative strategic decisions. The not-for-profit board has the difficult task of assuring that the organization's policies and activities contribute to its mission, and of finding the necessary resources with which to pursue that mission—including aspects of mission that cannot be rendered profitably. Moreover, the stakeholders whose interests the hospital board may consider, and who may not be present when decisions are made, comprise a lengthy list—patients, physicians, employees, benefactors, purchasers of service, regulators, and policymakers. Teaching hospitals have additional stakeholders and face commensurately increased complexity. The board may also consider the needs and interests of the community, which (unlike other stakeholders) might have no voice except through the trustees.

Community benefit. Closely related to these first two topics is the expectation, established by tradition and as a condition of federal tax exempt status, that not-for-profit hospitals engage in “community benefit” activities. As analyzed by scholars and policymakers, community benefit can take many forms—care for the uninsured, involvement in educational and research activities, assessment of community needs, and collaborating with other organizations to address unmet needs. For hospitals located in small towns, the meaning of “community” is relatively clear, and trustees have various informal

ways to learn how community members define their needs. However, for hospitals located in large urban areas and nearby suburbs, the identity of the community may be much less straightforward, and likewise the ways that trustees can come to understand the community's needs.¹⁴

The trustees we interviewed had little difficulty in defining the community or the communities served by their hospital, although trustees from large urban teaching hospitals sometimes indicated that their service area differed according to the type of service in question. However, trustees at only a handful of institutions indicated that issues pertaining to tax exemption had been discussed in the previous year. One institution had defined community benefit goals in terms of the estimated value of its tax exemption and had prepared a report to the community on its performance in achieving that goal.

A practical complication regarding the board's role in assuring that their hospital meets community needs is that boards often contain members who do not live in the community. They may work but not live nearby, or, in a city like New York, they may have been selected because of their national prominence, even though they have little geographic connection to the hospital. In addition, ever more hospitals are governed by health care systems that have hospitals in multiple communities. The boards of these systems may include few or no members from some communities. Reconciling a hospital's community service obligations with governance by “outsiders” is a challenge that is becoming commonplace as hospitals consolidate into systems. If place of residence or everyday ties no longer suffice, then the value of local community benefit activities must be made an explicit part of board deliberations.

Delegation of responsibility. The board of trustees is the highest authority in a not-for-profit organization, with power to hire and fire the CEO and legal responsibility for all

aspects of the organization's activities. Yet boards of trustees are voluntary bodies that meet only periodically, so there are limits to the matters in which boards can take an active role. As a practical matter, boards delegate to management and often to small executive committees.

In questioning trustees and CEOs about the responsibilities of trustees at their institution, we found that about a third of the trustees and almost all of the CEOs defined trustees' responsibilities in terms of their relationship with management. More respondents defined trustees' responsibilities by relationship to management than by relationship to the community and its needs, the hospital's mission, or patients. Such CEOs and trustees almost always talked about the division of labor between board and management—with the board depicted as providing oversight of management, setting out policies that management carries out, hiring and firing management, or supporting or providing a “sounding board” for management.

However, most respondents indicated that important initiatives at their institution were either developed jointly by management and the board (or board leadership) or by management itself. As trustees characterized their responsibilities, they appear to be more reactive than proactive (though we did not use those terms): trustees are much more likely to describe their job as oversight rather than as policymaking.

Many boards also delegate substantial authority to subcommittees. Depending on the board's traditions and bylaws, subcommittees—including executive committees—effectively become the decisionmaking bodies either in specialized areas or, in some cases, for the entire institution.

The common practice of delegating authority reaches ethical limits when it no longer serves to reinforce responsible and competent governance. At its extreme, the practice can come to exclude some board members, to the point where they are

unable to discharge their duties and become mere token trustees.

Conflicting responsibilities. Trustees commonly frame their responsibility as making sure that the hospital meets the needs of the community it serves. Phrased this way, there appears to be no tension between the trustee's responsibilities to the institution (or its mission) and the community. Frequently, however, circumstances arise in which this comfortable formulation of responsibilities does not work. For example, many decisions that may be good for the community (or segments thereof) may be costly to the institution.

In our survey, some trustees defined their responsibilities in terms of assuring the well-being of the institution, while others focused more on furthering the institution's purpose, which was usually defined in terms of meeting patients' or the community's needs. Tensions between these perspectives can arise in ordinary budget situations—such as deciding whether to close the money-losing clinic that serves a low-income population. Situations in which the institution's continued economic viability comes into question can throw the tensions between perspectives into particularly high relief. In those cases, institutional preservation may have to be weighed against the continued availability of services in the community, as when a merger may preserve services at the cost of institutional identity.

The economic decline of a hospital raises another conflict regarding trustee responsibilities. If a board believes that it will be unable to assure the future viability of its hospital, when should it shift its attention from overseeing the hospital to protecting the value of its assets? Trustees who had considered the sale of their institutions told us that they had come to believe that their institution was on a path toward economic ruin because of debt, capital needs, and occupancy problems, and that it would be worth progressively less each year. Trustees who define their responsibility as preserving their institution may be less likely to act on such a belief—or even to accept that their hospital is in such a crisis—than are trustees who view themselves as responsible for maintaining or increasing the value of the assets with which they have been entrusted.

Social versus economic values. Many trustees we interviewed experienced a tension between social and economic values in decisions regarding the hospital. This tension was highlighted in their responses to our question whether their board had made any decisions in the past year “that could not be justified in terms of the economic interests of their hospital.”

Some trustees seemed to feel that they would be confessing to irresponsibility if they answered affirmatively. As one trustee said, “We try not to, but it happens.” On the other hand,

some respondents seemed to think that an affirmative answer was correct.

In most institutions, some respondents indicated that their board had not made any decisions in the previous year that could not be justified in terms of the institution's economic interests, but other trustees from the same institutions gave us examples of just such decisions. Most examples pertained to decisions to maintain the hospital's commitment to providing uncompensated care to the uninsured, decisions to establish or maintain money-losing services that were either used by low-income populations or were necessary (though unprofitable) to maintain the hospital's excellence, or decisions to maintain the commitment to research and training.

Finally, several respondents were ambiguous. They indicated that their board had made a decision that could not be justified in economic terms, but when asked for an example, they either could not think of any or they described a decision that they then justified in business terms. For example, one trustee cited the decision to merge with a money-losing hospital, but then said that while it might appear that this merger was against the hospital's economic interest, the real purpose was to strengthen the hospital's economic position in the long term.

THE ETHICS OF HOSPITAL TRUSTEESHIP

Some insight into the nature of a trustee's ethical responsibilities comes directly from the preceding discussion of the kinds of pressures trustees are under and the kinds of decisions they have to make. Our interviews with trustees, CEOs, and other senior managers also indicate that, in effect, ethical duties often weigh significantly in their everyday thinking and action, even though the

term “ethics” itself is not generally used as a label to describe what the trustees are experiencing.

It is also possible to think about the ethical responsibilities of hospital trustees by inference from the ethical responsibilities of the trustee role in any not-for-profit setting. It is important not to lose sight of the fact that trustees both inside and outside health care regularly make decisions

that affect the lives and well-being of a large number of people who are relatively powerless, relatively vulnerable, and in need of services or assistance. Such people have a stake in hospital governance, but no voice in it. They have a stake not only because the hospital care is a vital community service, but also because the hospital received civic support in the form of its tax exemption.

Moreover, a sense of the ethical importance of trusteeship is suggested by the word “trust” itself. Trustees have been entrusted with responsibility for a set of assets and a mission. Those assets have been created by private donation and public action, and trustees are responsible for seeing that those assets are used to serve the public interest in accord with the organization’s mission. Furthermore, trusteeship is specific: it is always attached to a mission and an institution that has a history, a moral identity, and a community presence. These elements should be respected and factored into any ethically responsible decisions by trustees.¹⁵

The generic mission of the not-for-profit hospital is comprised of three objectives: to promote the health and well-being of patients, to be a civic and health resource for the community, and to be a place of respectful, well-managed, and competent health care provision.

Each of the roles and occupations that exist in a society can be looked at from two complementary points of view. They can be considered both in terms of the social functions they perform and in terms of the ethical or cultural norms and values they embody. The ethics of trusteeship is a framework of normative expectations that constitute the role of trustee, much as physician ethics sets forth in a systematic way the normative expectations that society invests in its doctors, or as professional legal ethics contains the norms that society holds for its lawyers.

Like the professions, trustees are expected to adhere to ethical standards over and above what is called for by ordinary morality, and in return granted significant power and prerogatives. The problem is to organize the normative expectations and demands placed on trustees into a co-

herent and systematic framework. We offer below one such framework, organized around four general principles. The first of these is called “primary” because it lays the foundation for the other principles, but all four principles are essential in giving trustees the proper ethical orientation and in doing justice to the ethical significance of the trustee’s role.

Principles of Ethical Trusteeship

Fidelity to mission. The primary principle of the ethics of trusteeship can be stated as follows: *Trustees should use their authority and best efforts justly to promote the mission of the*

not-for-profit organization, and to keep that mission alive by interpreting its meaning over time in light of changing circumstances.

The mission of the organization governed by trustees is central to the ethics of the trustee role because it is the cornerstone of all of the trustee’s other responsibilities. The board exists to direct the organization, but the organization exists to pursue and fulfill a mission, a moral and social objective. Without the mission, there would be no trustee role in the first place.

It is important to interpret this principle broadly. Fidelity to mission should not be interpreted to mean that the exclusive role of the trustee is to perpetuate the past or to resist change. The “mission” is not necessarily the document that the organization refers to as its “mission statement.” The true mission of an insti-

tution is rooted in the past and in the tradition of the institution, but it also points toward the future. A mission is a dynamic thing, an overriding purpose that changes with changing environment and circumstances, and trustees are faithful to it when they adopt an open-minded orientation. A mission does not interpret itself any more than it implements itself. It is in need of ongoing interpretation and reflection, much as is the Declaration of Independence in American political theory or the Constitution in American law.

Fidelity to mission must also be understood so that it is compatible with the demands of ordinary morality. Even a narrow mission would not give a trustee carte blanche to ignore either the law or the requirements of general morality. If one were a trustee of an organization whose traditional mission was written in terms that once implied racial or religious discrimination, then in light of today’s moral norms and laws, the mission should be reinterpreted in such a way that such discrimination was neither implied nor tolerated. Hospitals, like virtually all other institutions, used to be racially segregated in America; trustees apparently once thought that their duty to the hospital’s patients (at least its white patients) required segregated wards. But today, fidelity to mission is perfectly compatible with—indeed would be seen as requiring—racially integrated patient care settings.

When we apply this primary principle to the setting of the not-for-profit hospital, three aspects of mission come to the fore and suggest more specific principles of trustee ethics. The generic mission of the not-for-profit hospital is comprised of three objectives: to promote the health and well-being of patients, to be a civic and health resource for the community, and to be a place of respectful, well-managed, and competent health care provision. Thus in addition to the principle of fidelity to mission, trustee ethics in the hospital includes three principles of *service*:

service to patients by providing medical, nursing, and allied health care; service to community by, among other things, promoting health; and service to the hospital through stewardship on behalf of that uniquely valuable social institution.

Service to patients. Fidelity to the hospital mission calls for trustees to adhere to a principle of service to patients and to their health needs: *Trustees should ensure that high quality health care is provided to patients in an effective and ethically appropriate manner.*

This principle is a requirement of diligent oversight of management and of the hospital's performance. It also calls upon trustees to support the promotion of health in manifold ways, including by mobilizing resources for professional medical, nursing, and allied health services, by participating in professional education and biomedical research, by providing chronic and palliative care, and by sustaining a meaningful and dignified quality of life for patients.

It requires that trustees protect and promote the rights and interests of patients by maintaining hospital policies and procedures in support of patient autonomy, informed consent, respect for privacy and confidentiality, and the like. Trustees should ensure that hospital practice includes the patient, and when appropriate the family, as a partner in decisionmaking about health care and medical treatment.

This principle enjoins trustees to take steps to ensure that limited hospital resources and services are utilized efficiently and effectively. When difficult distributive decisions must be made, they should be handled in a just and equitable fashion so that quality of care is not substantially compromised and so that the effects of such decisions do not fall unfairly or disproportionately on the most vulnerable or the poorest patients.

Service to the community. Throughout American history, hospitals have been understood as civic institutions. They are not only places

where individuals receive care or high-quality professional medicine is practiced; they are also resources dedicated to improving the public health and quality of civic life of the community as a whole. The health services hospitals provide are integral components of a community's identity and traditions. Trustees do well when they bear that in mind and understand the interconnection between what goes on inside the hospital and what occurs in the community outside.

The principle of service to the community recognizes this dimension of the trustee's role and the hos-

problems that are at root civic and systemic in nature.

Hospitals alone cannot cure civic or community problems, and in today's health economy they are sometimes hard pressed to attend even to the acute and emergency care responsibilities. But ethically responsible trusteeship requires a willingness to participate with other civic leaders in the search for broader community enhancement and civic renewal efforts.

A hospital, least of all a not-for-profit hospital, is not simply a business that sells something to the community out of self-interest. Neither is

A hospital may sometimes function like a business, and sometimes it will be called upon to be a charity, but above all it is a civic institution. It takes cognizance of the quality of civic life in the broader community.

pital's mission: *Trustees should govern hospital policy and deploy hospital resources in ways that enhance the health and quality of life in the broader community that the hospital serves.*

The mission of the hospital cannot be successfully pursued in isolation from the nature and quality of the surrounding community. Service to patients and families neither begins when the patient enters the hospital nor ends when she is discharged.¹⁶ This is one area where the scope of ethical responsibility is considerably broader than that of legal responsibility or liability.

Emergency rescue and acute stabilization are only the tips of the iceberg of health care needs in today's society. Chronic illness and disability, behaviorally related health risks, community mental health services, and the provision of adequate housing, nutrition, and support systems, both familial and professional, are the keys to serving the needs and rights of patients in the broader context of their lives. It makes little sense to repeatedly treat the individual symptoms of

a hospital designed to give something to the community out of voluntary charity—even if it is a not-for-profit hospital. A hospital may indeed sometimes function like a business, and sometimes it will be called upon to be a charity, but above all it is a civic institution.¹⁷ It takes cognizance of the quality of civic life in the broader community because its very essence as an institution is at stake in efforts to promote public health and its participation with other community institutions in the ongoing task of civic preservation and renewal.

Institutional stewardship. Judging by the interviews we conducted with trustees and CEOs, nearly all trustees would agree with the emphasis we have placed on patient service and service to the broader community. They might not call these issues matters of "ethics," but they do acknowledge the norm and the sense of responsibility nonetheless. They recognize even more readily, however, their role in hospital governance and institutional stewardship, responsibility and leadership.

Hence the principle of institutional stewardship: *Trustees should sustain and enhance the integrity of the hospital as an institution, as an effective organization for the delivery of high quality health care services, and as a moral community of caregiving.*

Trustees are entrusted with the hospital's mission, but in practical terms that translates into working with the executive management of the facility to ensure that it is well run, fiscally sound, and professionally competent. In short, trustees must protect the interests of all parties who rely on the hospital or are significantly affected by its activities, in addition to protecting the hospital's financial assets and its license and accreditation.

Each of these duties is vital and ethically significant, and they form a part of what is meant by institutional stewardship. But the principle we formulate here is intended to go beyond these standard and well-recognized fiduciary obligations and to encompass the notion that ethical trusteeship is responsible for the maintenance and flourishing of the hospital's

ethical integrity as an institution. Trustees are not entrusted simply with the governance of the hospital as an "asset," as a property with a certain market value. They are also—and no less significantly—entrusted with the care of the hospital as a vibrant and viable social and cultural system, a moral community comprised of many individuals from varied backgrounds with diverse needs, skills, and contributions to make to the whole.¹⁸

Of course, this does not mean that a hospital should never be closed and its monetary value liquidated or converted to another socially beneficial use. Some hospitals have outlived their mission and their usefulness in a particular community; others, through mismanagement, the departure of key personnel, or lack of resources have lost the ability to provide an adequate and competent level of service to their patients and the community. The responsibility of trustees to perceive when a hospital is no longer viable is as important as the responsibility to fight to ensure the hospital's viability and survival.

Fulfilling the duties of this principle requires certain kinds of conduct by individual trustees, certain kinds of conduct by the board of trustees collectively, and support for certain kinds of governance, administrative, and clinical policies and practices throughout the hospital. Here the general orientation offered by principles meets the more specific duties that trustees should fulfill when making particular decisions and taking action. And the duties of trustees as individuals meet the issue of the proper organization and functioning of the board as a collective decisionmaking system through which individual trustees exercise their own ethical responsibilities. The principle of institutional stewardship closes the circle on this relationship, so to speak. It reminds trustees that, even as the proper functioning of the board (and of the hospital as a whole) enables them to fulfill their duties, so too each individual trustee has a duty to help create and sustain a well-functioning board.

TRUSTEE ETHICS IN PRACTICE

The principles of fidelity to mission, service to patients, service to community, and institutional stewardship provide only the proper grounding and orientation for individual trustees and for boards; they represent the first, not the last, step in assessing the ethical quality of specific policies or decisions, by individual trustees and boards, in particular hospitals.

The next step, which leads into the domain of ethical decisionmaking in practice, requires attention to two broad topics. The first is the conduct, reasoning, judgment, and motivation of trustees as individuals. The second is the condition of the "system" or environment within which individual trustees receive information, make

judgments, come to conclusions, and make decisions. The system can be as large as the hospital, even the community as a whole. But the most immediate and important system that affects ethics in the practice of trusteeship is the functional organization of the board itself.¹⁹ By this we mean the relationships among the trustees and with the chair. It also includes the nature of the relationship between the board (and especially the chair) and the CEO, senior hospital administration, hospital medical staff, nursing staff, and other constituencies in the hospital.²⁰ Finally, beyond the boardroom, one must consider the relationships between the trustees and important stakeholders outside the hospital.

Conflict of Interest

The phrase "ethical issues in hospital trusteeship" often calls to mind problems related to conflicts of interest. A conflict of interest can produce a violation of any or all of the ethical principles we have described.

A conflict of interest arises when a trustee might personally benefit from his or her official actions or influence and when the expectation or pursuit of personal interest can bias decisions that are made by the trustee in his or her official capacity. The potential for personal gain may influence decision-making indirectly (the trustee may vote a certain way to win favor with a potential colleague) or the influence

may be direct and overt (the trustee may vote for a particular construction project with the guarantee that the bid will go to his construction company).

Conflicts of interests can be handled by such means as financial divestment, open competitive bidding requirements, recusal from involvement in certain board activities or decisions, and by public disclosure of assets and interests so that others can be alerted to a potential conflict in the trustee's situation. Not all of these steps are equally necessary or feasible in every situation. Boards should have general policies for disclosure, recusal, and prohibited activities. When special circumstances arise, trustees will have to decide on the right course of action for themselves on a case-by-case basis. Individual members ought not be the sole arbiter of whether there are, or appear to be, conflicts of interest for themselves. From an ethical point of view, the most important rule is that, however it is to be accomplished, trustees must be free from improper influences that might skew or taint their independent judgment. Trustees should never use their position with the hospital primarily for the purposes of personal or familial financial gain. To sustain the trust that the broader community has in the hospital, trustees should also avoid the appearance of a conflict of interest, and when such an appearance exists, should act cautiously so as to minimize it.

These questions become more difficult in a health care economy that is producing many unprecedented and complex financial and business dealings for hospitals and physicians. In fact, conflict of interest is a very subtle and difficult question in health care, and it is not always obvious what the evil is to be avoided or that the remedies are not worse than the disease.

It seems draconian to require volunteer trustees to divest themselves of all holdings that might be affected by the hospital or even to set up blind

trusts during their period of service. As members of small communities, trustees will routinely have business interests that intertwine with hospital business and could set up at least the appearance of a conflict of interest. Perhaps even public disclosure requirements would be a significant deterrent to volunteer board service. This is even more complex in today's climate, which has prompted a number of boards to open their membership to practicing physicians, despite the inherent conflict of interest such trustees have. Yet even as these questions become more complex and nuanced, they also become more urgent. Public suspicion of the motivations of health care institutions and

Several components of board organization and functioning play a key role in contributing to effective, ethically responsible decisionmaking by trustees. These include a clear understanding of the institution's mission and functioning, timely and accurate information, a process for thorough deliberation and consensus-building, and mechanisms for periodic review of CEO performance and board performance. This is not the place to discuss these components in detail.²¹ Here we offer only a brief overview, highlighting points that are particularly salient to trustees' ethical decisionmaking and to fulfilling the ethical principles of trustee service.

When fundamental values and principles come into conflict, *how* the board decides can be as important as what the board decides. When questions of mission, service, quality, or justice are at stake, boards should ensure that all points of view are heard and taken seriously, that reasonable compromise is explored, and that consensus has time to form.

practitioners is on the rise, and hospitals risk losing one of the most valuable of their assets, if not the most valuable—the trust of their patients and of the public at large.

Board Structure and Functions

Trustees have a responsibility to assure the soundness of the board's structure and functioning, although many of the operational duties will fall to management. Periodically, boards should review the hospital's mission (perhaps also the official mission statement), the composition of the board, and its operating procedures, committee structure, and the like.

Information. The information needed for good board deliberation comes from both inside and outside the institution.²² The board should ask: What information do we need to make our decisions? What are and what should be the sources of our information? Is the information that we have sufficient? Is there a need for special methods or formats the board should use to review complex information? Do we need to obtain information from outside the institution by means of a survey or some other mechanism? As individuals, trustees can exercise responsible institutional stewardship only if they have a basis for independent decisionmaking and judgment. They must insist that management provide them with

whatever information is necessary to make decisions wisely, prudently, and in the best interest of the hospital's integrity. It is essential for trustees to do their homework and to keep themselves well informed about the hospital's various activities and services. To make this goal manageable, trustees and CEOs should work together to support various mechanisms for reporting and cooperating with hospital management and various approaches to board organization, such as specialized committees responsible for different areas.

Board composition and deliberation. Trustees should ask: Is the composition of the board appropriate? Do we have appropriate term limits for trustees? Do we have a procedure for assessing the disclosure statements of trustees? Is the role of trustees to represent or advocate for particular constituencies?

Regarding the quality of the board's deliberations, trustees should ask: Do we have an open deliberative process? Do we allow all voices to be heard? Have we deliberated on the basis of a clear understanding of our mission? Have we made explicit the principles on which our deliberations are based? When principles come into tension or conflict, have we weighed the merits of each? Do we have a clear justification for balancing them in a particular way? Do we have an appropriate procedure for determining the consensus?

In engaging complex questions, the board should have an open deliberative process, one based on all pertinent information and all pertinent values relevant to the hospital's mission. No trustee should dominate the discussion or suppress discussion of pertinent values. At times it will be necessary for trustees to explicitly justify their positions on the basis of ethical values, and the discussion should allow for the identification of tensions or conflicts between values and other objectives or interests. Although it will often be necessary to weigh competing values, there is no mathematical formula for doing so.

At best, the board should be able to offer a clear justification and rationale for giving greater weight to one value than another—for valuing indigent care more than profitability, for example.

Regarding the process of decision-making, the board must operate on the basis of fair and democratic rules, although the board chair and committee chairs obviously will wield considerable influence. Volunteer trustees with limited time to devote to their board work will rightly defer to those who have studied an issue longer or bring greater experience or expertise to it. Nonetheless, each trustee should have an opportunity to participate fully in board deliberations. Sometimes, too, it is necessary and appropriate for individual trustees to openly state their disagreements and voice alternative points of view. A strong and effective chair will not stifle debate or force agreement, but will utilize the trustees' diverse talents and opinions to further the goals of wise counsel and good decisionmaking.

When fundamental values and principles come into conflict, *how* the board decides can be as important as what the board decides. In routine day-to-day decisionmaking, boards operate well by following majority rule, sometimes even by deferring to individual trustees who have special expertise or particularly intense interest in the issue. But when fundamental questions of mission, service, quality, or justice are at stake, boards should take extra time to make certain that each trustee understands the issue and the alternatives. It should ensure that all points of view are heard and taken seriously, that reasonable compromise is explored, and that consensus has time to form. The rule of unanimity is usually impractical, but the spirit of compromise, mutual respect, and consensus is the best soil from which sound ethical decisions spring. It is also the spirit that keeps boards operating after the tough decisions have been made and the losers must go

home disappointed to return another day.

An ordinary part of the responsibilities of most boards, in collaboration with the hospital administration, is not only setting or approving new policy, but also periodically reviewing previous policies. Here too, mechanisms of evaluation and deliberation are important. Trustees should make sure that those mechanisms provide the timely and accurate information necessary for responsible decisionmaking at the board level. One particularly important aspect of this is to ask whether feedback loops are in place to inform the board about how policies are affecting patients, families, and staff, the community, and other stakeholders of the hospital.

Engaging in constructive self-assessment about board functioning and other institutional processes can lay the groundwork for good ethical decisionmaking. In addition, such a reflective process can contribute to an institution's organizational ethics by explicitly addressing institutional obligations at the highest level of the organization.

Shared or Federated Governance

Today, many hospitals are part of larger systems or networks and hospital boards may be subsidiary to the decisional board of the parent system. This trend raises two unique ethical issues.

Allocation decisions by the parent board. The board of an individual hospital must make allocation decisions between services. Likewise, the board of a hospital system—the decisional board—must make allocation decisions regarding its subsidiary hospitals. In both cases, values such as justice, equity, efficiency, and community well-being should guide decisionmaking. It is not enough, for example, to decide that a subsidiary hospital will be closed or experience cut-backs because it is inefficient. The inefficiency must be explained.

Is the hospital inefficient because community demand has declined? Because it serves a sicker population than other network hospitals? These considerations are central to the service mission of the hospital system and to the demands of ethical deliberation. Decisions that are made solely on the basis of short-term return on investment do not sufficiently engage the important noneconomic values at stake in these decisions.

Trusteeship on subsidiary boards. The relationship between a decisional and subsidiary board may take a variety of forms, each reflecting the degree of discretion granted to the subsidiary. In the worst case, the subsidiary board could find that acting morally is impossible because the board has no power or discretion.

When a subsidiary board is forced to comply with a directive with which it strongly disagrees, the subsidiary is faced with the classic problem of complicity. Should the board “go along to get along,” resign, or continue, attempting to mitigate harms that it believes will follow from the directive? In the face of moral objection, “going along to get along” is unacceptable. It degrades the board’s moral integrity. A sitting board still has an obligation to serve the mission of the hospital. Resigning would de facto remove that obligation, but it would also remove the board’s moral authority, which in situations such as these may be the board’s only authority. Remaining as a sitting board and attempting to influence policy in the interests of the institution is the most difficult choice, but it is likely to be one that best conforms to the board’s ethical obligations. The answer to this question will depend on the cohesiveness of the subsidiary board as well as the prospect of success.

This is admittedly a worst-case scenario. Ideally, the relationship between the decisional board and the subsidiary board would be respectful and mutually supporting. Open deliberation using ethical principles and commitment to mission as guides

should in most cases allow two boards to come to agreement.

Relations between Trustees and the Hospital Administration

When discussing the institutional system or environment within which trustees work, it is appropriate to give special attention to the relationship between trustees and the hospital administration, particularly the hospital CEO. The principal responsibility of all trustees is to select, support, and monitor the performance of the hospital’s CEO. And it is through the medium of providing the hospital with a qualified and effective managerial leader that trustees indirectly act in service of the principles of fidelity to mission, and service to patients, community, and institution. Without the foundation of a good CEO and a good relationship between the CEO and the board, it becomes much more difficult for individual trustees to perform their duties well.

Diligence in the selection and periodic evaluation of the CEO is a paramount responsibility. Ongoing working relations and regular, timely communication are no less important. Trustees must often rely on the hospital administration for the information upon which they base board decisions, and therefore a climate of trust and mutual respect is essential to effective board functioning and trustee performance. Mutual respect is the key. Trustees should not be overly intrusive in their governance; they should allow their CEO to lead and to manage, and should not undermine his or her authority or encroach on expertise. At the same time, CEOs should respect their trustees and the legitimate, independent role they play in the governance and oversight of the institution. Trustees and CEOs are most effective when they assist each other.

Relations between Trustees and Hospital Staff

Trustees, individually but especially collectively, should safeguard internal policies and practices that are vital to the institutional integrity of the hospital as a place of competence and efficiency *and* as a place of moral community, mutual respect, and humane care. Three types of policies and procedures are noteworthy here, although many more could be added.

One pertains to quality of care. This includes the mechanisms of continuous quality improvement, quality assurance, the reduction of medical mishaps and mistakes, the prevention and control of nosocomial infection, and the mechanisms of hiring staff and granting practice privileges to physicians.²³

Another area involves clinical decisionmaking and patient care, including the functions of hospital ethics committees, policies regarding life-sustaining treatment such as artificial nutrition and hydration, advance directives, family or surrogate decisionmaking when patients lack decisionmaking capacity, and protocols for palliative care.²⁴

A third area that is key to institutional integrity and should be monitored by attentive trustees involves nondiscrimination and civil rights policies governing employee relations and benefits, and the interaction among hospital staff and between staff and patients.

We mention these matters of internal policy and practice not to recommend that trustees become micro-managers. But far short of micro-managing, trustees do have an obligation to maintain the accountability of management and to keep themselves informed about the patterns of internal hospital life. These are not areas where trustees and CEOs ought to be at odds; on the contrary, their roles should be complementary and symbiotic. Trustees can and should maintain a breadth of vision about the nature of the hospital as an institution and its moral integrity. Trustees are in

a favorable position to do this precisely because they are neither managers nor health care professionals. Their distance from the day-to-day problems of hospital management and from the exigencies of clinical medical or nursing practice can work to their advantage in fulfilling the principle of institutional stewardship.

Benefiting patients is a defining obligation of the health professions. What we have called the principle of

patient service calls trustees into that vital duty as well. Ideally, therefore, the common goal of providing high-quality care to patients will provide common ground for clinical staff and trustees. This ideal is not translated into practice at many hospitals. Yet the history of the relationship between trustees and medical staff, as well as that between the trustees and the hospital administration, is rife with shifts in power and authority.

The issue of control and decisional autonomy is ever present in the organizational life of the hospital. Personality and openness to dialogue are often key aspects of working relationships and the basis on which they may succeed or fail. Thus trustees should take steps to ensure that lines of communication are kept open between the board, the administration, and the medical staff.

HARD CHOICES

In order to illustrate how the ethical perspective offered in this paper can illuminate the dilemmas and hard choices hospital trustees face, we

tions on economic restructuring may involve eliminating a hospital service such as pediatrics or the emergency department because it is no longer a

The ethical limit on the board's responsibility to constituencies and overseeing bodies is its responsibility for the goods articulated in the mission. To the extent that the interests of oversight bodies or constituencies are at odds with the mission, the board has a responsibility to decide on the basis of its obligation to the mission.

close by considering three difficult kinds of problems confronting not-for-profit hospitals and boards of trustees.

Decisions to close a hospital or clinic. The decision to close a hospital or a clinic or department is one of the most difficult a board addresses, but it is also one that can be effectively guided by the principles of fidelity to mission, service to patients and the community, and stewardship of the institution.

In this era of cost containment and consolidation in health care, small hospitals often find that they must affiliate with former competitors in order to survive. The negotia-

“revenue stream.” A board's decision regarding the possible closure of a clinic should focus not only on the financial considerations but also on the impact that such a decision will have on the community and its access to services. Likewise, trustees should explicitly discuss whether the decision is compatible with the hospital's stated mission.

The principle of stewardship requires that the resources governed by a board be used wisely. “Wisely” means in a manner consistent with the moral aims of the institution. In the case of faith-based health care institutions that have a broad mission of service to the poor, the principle of

stewardship enjoins the duplication of resources and services that may characterize a competitive health care market where hospitals are vying for patients. Under some circumstances, therefore, the principle of stewardship may justify a decision to close a service, even the hospital itself, if doing so serves the broader mission of more efficient and accessible care.

In secular hospitals, the principle of stewardship is also tied to institutional mission. Deliberating about the most cost-effective way to advance the mission will again depend on the demands of the mission and the community impact. If a board decides that stewardship requires cutting back on service, responsibility to the community entails informing the community and assisting in the development of a plan to accommodate the community services lost in the closure.

The issue of clinic or hospital closure points to two important board responsibilities. The first is that the board be proactive in monitoring the institution for signs of financial distress and respond to these signs before the closure decision is imminent. The second is that the board look for alternative scenarios to closure. Exploring alternatives is a requirement of stewardship and a necessary component of board deliberation. Our research suggests that conflicts of interest on the board are likely to adversely affect decisions regarding the fate



*Emergency Pediatric
Waiting Room*

by May H. Lesser, ©1989 Tulane
University Medical Center

of an institution and undercut the legitimacy of whatever decisions are made. Thus boards should be especially alert to the ways in which vested interests may hamper efforts to remedy financial distress or to limit alternative scenarios.

Affiliations and conversions. Among the trustees we interviewed, the question of affiliation (through merger, partnership, or conversion, for example) was identified as the most important issue that had occupied boards at the end of the 1990s. Affiliation raises a number of ethical considerations that boards should explicitly address. These include the trustee's obligation to preserve the hospital mission and the obligation to prudently manage the hospital as an "asset." Ordinarily, a high burden of evidence should be required before trustees decide to abandon the historical mission of a charitable institution. It is never a decision to be taken lightly. In some cases these two obligations will be compatible, even mutually supporting. In other cases they may conflict, and the board will need to weigh and balance conflicting objectives in light of the values and

stakeholder interests that trustees should serve.

Deliberation about these matters requires explicit consideration of two additional ethical questions. First, whether and how should the board solicit community values to inform its decision? The board has an obligation to listen to community viewpoints and to share its reasoning with the community. Second, if the hospital in question is part of a larger system, how should the boards both of the hospital and of the system weigh the interests of the system, the hospital itself, and the community of which it is a part?

The first of these questions touches on a feature of all trustee-governed activities, namely the problem of paternalism. There are good reasons why a board should not presume to know the best interests of the community it serves. Above all, the board may simply be wrong. It may be too parochial, for example. The hospital's mission, therefore, and fidelity to that mission is authenticated by the community, through needs assessments, surveys, public hearings, and community representation on boards or reporting committees of the hospital.

Not only the principle of fidelity but also that of service to the community (civic responsibility) supports this view. The existence of not-for-profit hospitals depends on significant tax advantages, patient stream, and community support. Reciprocity thus requires the hospital to serve the community in a way that is responsive to its particular needs.

The second question, regarding consideration of the interests of the community, the particular hospital, and the hospital system of which it may be a part, raises the important issue of negotiating responsibility. On the one hand is the board's accountability—that is, its "responsibility to" its constituencies and overseeing bodies. On the other hand, the board also bears a "responsibility *for*": it is responsible for preserving and effectuating the stated mission of the institution. The notions of independent judgment and accountability require that board decisions be sensitive to—but not determined by—these pertinent interests. Thus the ethical limit on the board's responsibility to constituencies and overseeing bodies is its responsibility *for* the goods articulated in the mission. To the extent that

the interests of oversight bodies or constituencies are at odds with the mission, the board has a responsibility to decide on the basis of its obligation to the mission.

At times, however, the mission itself will be ambiguous. Appeal to mission alone will not settle the quandary. This as well as the potential conflicts between a board's various obligations points to some of the most difficult aspects of the role of the board as an arbiter of community and institutional values.

In deliberating about the sale, merger, and ultimate control of the hospital, therefore, trustees must follow a decision procedure that explicitly considers the financial value of the hospital and the interests of stakeholders relative to the mission itself.

Embedded in the question of affiliation or merger is the issue of a board's deciding to give up its status as a decisional body to become a subsidiary to a parent board. The ideal outcome in such a situation is maximization of the resources supporting the institution's mission and minimization of the loss of autonomy. Tradeoffs between these two goals are likely, however, as the institution is no longer self-sovereign. In deliberating about tradeoffs, the board should consider not just the financial dimen-

sions of such a shift but also the interests of the community and the patients and the ethos of the institution.

The decision to convert from not-for-profit to for-profit status, once made, is the last opportunity the sitting board will have to negotiate on the basis of the institution's historical mission. Conversion from not-for-profit to for-profit status shifts the legal responsibility of the institution from community stakeholders to shareholders. Inevitably, this shift narrows the new institution's perceived ethical obligations. As a not-for-profit board considers conversion, it should explore the possibilities for preserving features of its mission that might otherwise be lost. These possibilities include the provision of uncompensated care, the involvement of community members on the new board, and the provision of particular services to patients and communities. If a hospital's financial situation is dire, it will clearly have little negotiating power. For this reason, it is essential for the board to actively monitor the institution for signs of financial distress and to act before it completely collapses.

Money losing services. At times, the board of a not-for-profit hospital may need to consider the limit of its ability to provide money-losing ser-

vices, and uncompensated care in particular. The values conflict at issue here is often colloquially referred to as "margin versus mission."

The starting point for approaching this conflict is recognition that the institution's not-for-profit status imposes certain obligations that the institution will, through its mission, serve stakeholders. One of these is the community. Thus the not-for-profit hospital, as a civic institution, has an obligation to serve the sick who cannot pay for their care. This obligation should remain in the forefront of board fundraising efforts as well as budgetary considerations. When the board faces a decision about the goals to set for uncompensated care, it should keep in mind the community's needs and the institution's record on charity care. The institution's financial health is also pertinent to these deliberations, but if charity care is continually threatened because of fiscal priorities, this is an indication of financial distress in the institution and should be considered a signal in the board's overall monitoring.

If deliberation about uncompensated care is prompted by the needs of a particular patient, the board must be guided by values of equity and nondiscrimination in its deliberation.

CARRYING ON WITH THE CONVERSATION

We hope to have gone some way toward setting an agenda of topics and ideas for an increasingly energized and widespread conversation about trustee ethics, both within various hospital boards and the trustee community across the country, and between trustees and the various stakeholder groups concerned with the functioning of American hospitals. That would be virtually all of us.

To further this goal, The Hastings Center and The New York Academy of Medicine Task Force on the Ethics

of Not-for-profit Hospital Trustees developed a curriculum for a model workshop on trustee ethics designed primarily for trustees and other hospital leaders and professionals. The design of the workshop and cases prepared for use in it are printed with this report (pp. 522-523).

If a richer discussion of trustee ethics is to develop and if trustees are to be assisted in clarifying concepts and applying ethical principles in practical decisionmaking, then the support and initiative of other organizations will be needed. We offer the

following recommendations to promote these goals.

Recommendation 1:

National, state, and local trustee organizations should give higher priority to trustee ethics in their educational and service programs.

One difficulty in reaching hospital trustees is that few activities, except board meetings and other hospital function themselves, are organized around this facet of their lives. When they do come together under the aus-

pices of their role as trustees it is often in conjunction with periodic meetings or conferences sponsored by hospital or trustee associations. That is when presentations, panels, or workshops relating to trustee ethics would have the greatest chance of making and impact.

Recommendation 2:

A body of literature needs to be developed to support discussions of trustee ethics, and ethics-related articles should be included in various publications designed for a trustee audience.

The field of bioethics, and cognate disciplines such as medical sociology, health services research, and management studies, have not given trustee ethics the attention it deserves. Editors of bioethics and academic journals should encourage publications on this topic, and researchers should develop studies along these lines or build ethics issues into multidisciplinary projects. These publications may not be read regularly by many individuals who serve as trustees, but if first-rate articles are once published, they be reprinted and used in educational programs for trustees. Trustee attention can also be called to ethical issues directly via publication in magazines or other publications that are directed toward trustees, such as the American Hospital Association's publication, *Trustee*.

Recommendation 3:

Financial support for research and education on the ethical issues facing hospital trustees and executives should be developed to encourage excellent work in this field.

Foundations and government agencies concerned with health services and administration issues, quality of care, patient's rights, and the like should devote more attention and resources to the topic of hospital trustees and trustee ethics.

Recommendation 4:

Hospitals and health systems should de-

vote attention to ethical issues for their trustees.

Probably the best way to reach trustees is through the hospitals they serve. Various programs to assist and inform board members already exist and provide an infrastructure for paying more explicit attention to ethics. These programs include board retreats, continuing education programs in hospitals that trustees can attend, and hospitals' distribution of materials to their trustees.

References

1. Although the results of our research will be generically applicable to some extent, we have chosen to focus on the special circumstances of the trustee in a not-for-profit setting because of the distinctive moral and legal responsibilities that obtain in that setting. Trustees or directors of for-profit hospitals will also benefit from the ideas discussed in this report, but they will not be its focus. Papers commissioned for the project, some of which are cited below, can be found in Bruce Jennings, Virginia Ashby Sharpe, Bradford H. Gray, and Alan R. Fleischman, eds. *The Ethics of Hospital Trusteeship: Responsible Governance of the Not-for Profit Hospital* (Washington, D.C.: Georgetown University Press, forthcoming 2003).
2. We follow conventional usage in referring to the members of the governing board of not-for-profit organizations as "trustees" instead of "directors," which is used in the for-profit sector. Moreover, when we use the term "trustee" in this report we refer not to trustees of not-for-profit organizations in general but specifically to a trustee of a not-for-profit hospital.
3. See H.J. Goldschmid, "The Fiduciary Duties of Nonprofit Directors and Officers: Paradoxes, Problems, and Proposed Reforms," *The Journal of Corporation Law* 23, no. 4 (1998): 631-53; reprinted in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.
4. On legal responsibilities of not-for-profit boards, see D. Seay, "The Legal Responsibilities of Voluntary Hospital Trustees," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.
5. R. Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).
6. B.H. Gray, "The Changing Face of Health Care," in *Philanthropy and the Non-profit Sector in a Changing America*, ed. C.T. Clotfelter and T. Erlich (Bloomington: Indiana University Press, 1999), 364-84.

7. F.A. Sloan, "Commercialism in Non-profit Hospitals," in *To Profit or Not to Profit: The Commercial Transformation of the Nonprofit Sector*, ed. B.A. Weisbrod (Cambridge: Cambridge University Press, 1998), 151-68.

8. Stevens, *In Sickness and in Wealth*; D. Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885-1915*, (New York: Cambridge University Press, 1982); M.J. Vogel, *The Invention of the Modern Hospital: Boston 1870-1930*, (Chicago, Ill.: University of Chicago Press, 1980); and S. Opdyche, *No One Was Turned Away: The Role of Public Hospitals in New York City since 1900* (New York: Oxford University Press, 1999).

9. L.M. Salamon, *America's Nonprofit Sector* (New York: The Foundation Center, no date), 57-70.

10. S.M. Shortell, R.R. Gilies, and K.J. Devers, "Reinventing the American Hospital," *Milbank Quarterly* 73, no. 2 (1995): 131-60.

11. J.A. Alexander, "Hospital Trusteeship in an Era of Institutional Transition: What Can We Learn from Governance Research?" in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

12. The discussion in the following pages draws upon B.H. Gray and L. Weiss, "The Role of Trustees and the Ethics of Trusteeship: Findings from an Empirical Study," and L. Weiss and B.H. Gray, "Hospital Partnering, Sale and For-Profit Conversion: Trustees' Responsibility and Perceptions in a Time of Change," both in *The Ethics of Hospital Trusteeship*, ed. Jennings et al. See these chapters for further discussion about the methods and findings of this study.

13. B. Jennings, "Hospital Trusteeship and the Ethics of Representation," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

14. R.H. Wynia, F. Margolin, and M.A. Pittman, "The Role of Hospitals in the Community," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

15. D. Smith, *Entrusted: The Moral Responsibilities of Trusteeship* (Bloomington: Indiana University Press, 1995). See also D. Smith, "Trustees and the Moral Identity of the Hospital," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

16. See E. Robilotti and D. Rosner, "The Trustees' Dilemma: Hospitals as Benevolence or Business—Looking Back a Century," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al. Compare M. Schlesinger and B.H. Gray, "A Broader Vision for Managed Care, Part 1: Measuring the Benefit to Communities," *Health Affairs* 17, no. 3 (1998): 152-68; and "A Broader Vision for Managed Care, Part 2: A Typology of Com-

munity Benefits," *Health Affairs* 17, no. 5 (1998): 26-49.

17. W.F. May, "The Trustees of Non-Profit Hospitals: Dealing with Money, Mission, and Medicine," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

18. This point may be most obvious when a hospital is affiliated with a particular religious tradition, but it is valid for hospitals with a secular history and mission as well. See C.J. Dougherty, "Ethical Dimensions of Trusteeship on Boards of Catholic Hospitals and Systems," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

19. D.D. Pointer and J.E. Orlikoff, *Board Work: Governing Health Care Organizations* (San Francisco: Jossey-Bass, 1999).

20. A.J. Riddell and S. Hanson, "Inherent Tensions: Administration Versus Not-for-Profit Governance," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

21. See T.P. Holland, R.A. Ritvo, and A.R. Kovner, *Improving Board Effectiveness: Practical Lessons for Nonprofit Health Care Organizations* (Chicago, Ill.: American Hospital Publishing, 1997).

22. A.R. Kovner, "Fitting Board Information to Board Function," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

23. V.A. Sharpe, "Patient Safety and the Role of Hospital Boards," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

24. J.J. Fins, "What Hospital Trustees Can Learn from Ethics Committees: An Essay on Pragmatism, Ethics, and the Governance of Health Care Organizations," in *The Ethics of Hospital Trusteeship*, ed. Jennings et al.

A Model Workshop on Ethical Issues in Not-for-Profit Hospital Trusteeship

This is a design for a four-hour workshop intended for those who serve as hospital trustees, hospital executives, and health care professionals with an interest in ethics and contemporary problems of health care governance and management.

Its presentational format alternates between plenary sessions and smaller break-out sessions. Both types of sessions feature faculty-participant interaction and discussion. One break-out session is devoted to the discussion of a case hypothetical (based on actual cases) that raises ethical issues for board members. The workshop is designed both to convey information concerning expert thinking about ethical and legal standards for not-for-profit hospital trustees and to permit trustees and others to share their own perspectives and experience. Its goal is to encourage and enable trustees and hospital executives to discern more clearly the ethical dimensions of their policy-making and decisionmaking and to conduct board operations and board business in a way that is attentive to the ethical responsibilities attached to the role of trustee.

Resource Materials

The workshop is built around the analysis and ethical framework presented in "Ethics and Trusteeship for Health Care: Hospital Board Service in Turbulent Times," *Hastings Center Report Special Supplement*, July-August 2002. Reprints of this document may be photocopied or obtained from The Hastings Center and either distributed at the workshop or mailed to registrants prior to the workshop. In addition, a PowerPoint presentation is available from The Hastings Center that contains slides pertaining to each of the plenary presentations in the model workshop.

Optimal faculty requirements are four people: (1) a moderator who can provide an overview of the issues, (2) someone knowledgeable about current academic research on hospital boards and trustee behavior, (3) someone knowledgeable about the ethical issues in trusteeship and management and able to discuss the ethical framework presented in the article mentioned above and in other literature on the ethics of trusteeship, and (4) a current or former not-for-profit hospital trustee who can lead a plenary discussion of trustee views and attitudes.

Agenda

Registration and Coffee

Introduction—Workshop Moderator

(plenary session, 20 minutes)

Define the problem, "Board service and trusteeship in turbulent times," explain the objectives of the workshop, give overview of program and process, introduce speakers

Trusteeship in turbulent times—Expert on boards of trustees and issues facing the health care system generally

(plenary session, 50 minutes including discussion from the floor)

Review the present state of not-for-profit hospitals and the issues and pressures facing trustees

Small group discussion of trustee experiences and perspectives

(break-out session of no more than ten people, led by a facilitator; 40 minutes)

Trustees' views—Present or former trustee

(plenary session, 40 minutes including discussion from the floor)

Begin with brief reports from each break-out session concerning the issues they identified *(15 minutes)*

Speaker to present findings of an empirical study of trustee and CEO attitudes and opinions of trustee duties, responsibility and functioning.¹ These findings can be used as a point of comparison with the ideas that surface in the break-out groups

Ethical principles for hospital trusteeship—Expert on ethics

(plenary session, 40 minutes including discussion from the floor)

Describe the principles and framework for ethical trusteeship and board functioning

Small group discussion of an ethics case for trustees

(break-out session with groups of no more than ten people each, led by a facilitator; 40 minutes)

An alternate approach to this session is to have a panel of three or four trustees discuss the case in a plenary session and then open up the discussion of the case to the audience

Concluding session *(plenary session, 20 minutes)*

Brief reports from the small groups on highlights of their discussions of the case

Closing comments by workshop moderator

1. B. Gray and L. Weiss, "The Role of Trustees and the Ethics of Trusteeship: Findings from an Empirical Study," in *The Ethics of Hospital Trusteeship: Responsible Governance of the Not-for Profit Hospital*, ed. B. Jennings, V.A. Sharpe, B.H. Gray, and A.R. Fleischman (Washington, D.C.: Georgetown University Press, forthcoming 2003).

A Case Hypothetical for the Workshop

Community General Hospital is a 300-bed urban hospital in a community that has changed dramatically in the last twenty-five years. Created after World War II to meet the health care needs of a white middle-class population, Community General today serves a multicultural community of working poor minorities and uninsured recent immigrants.

Community General has a proud history of service to its community, but its physical plant is old and in need of significant renovation. The hospital also has a proud tradition of affiliation with a regional medical school, provides sites for education of students, and has two accredited graduate medical education training programs in internal medicine and surgery. In recent years these residencies have been able to attract only international medical graduates.

The chief executive of Community General will reveal at the board meeting today that in the first quarter of this fiscal year there is a three-million dollar deficit and she predicts a fifteen-million dollar shortfall for the year.

As a board member:

- Are you surprised by this revelation, given a re-engineering and downsizing exercise last year that reduced personnel by 15 percent?
- What information do you need to begin to address this issue?
- What has been the impact of previous cost cutting measures on quality of care? Staff morale? Community response?
- Can you articulate the “mission” of Community General?
- Do you see this as an ethical dilemma or only as a fiscal matter?

The CEO suggests three potential options to address the problem: close two money-losing primary care clinics, each several blocks from the hospital; close the pediatric inpatient service, which has a decreasing occupancy; or attract a group of three interventional cardiologists away from a neighboring hospital by creating a new catheterization laboratory which will cost two million dollars.

As a board member:

- How do the views of the community affect your decision?
- Will you consider either merging with another institution or closing?
- How do you interpret your duty to:
 - fidelity to mission
 - service to patients
 - service to community
 - stewardship of the institution

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The New York Academy of Medicine, founded in 1847, is an independent nonprofit institution committed to enhancing the health of the public with a particular emphasis on disadvantaged urban populations. This mission is fulfilled through research, education, and advocacy focused on understanding and eliminating the root causes of poor health. The research agenda includes epidemiologic, health policy, and public health studies of all the major contributors to the poor health status of underserved populations. In the area of education, the Academy convenes an array of conferences and symposia on health issues, offers continuing medical education opportunities for professionals, and provides health education training for teachers. The landmark Academy building contains one of the world's largest privately owned medical libraries, which is open to the public. As a unique academic forum in which all constituencies of the medical and health care community can convene and collaborate as equal partners, the New York Academy of Medicine attracts renowned scholars, analysts, physical and social scientists, medical practitioners, and community leaders from around the world. These collaborations seek to enhance knowledge, strengthen public health organizations, advance clinical practice, and promote scholarship in medical and health affairs.