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I. INTRODUCTION

Asking a medical staff attorney to respond to the question posed by the Loyola Health Law Annual Colloquium, "What exactly has to change in the hospital-medical staff relationship for quality to be improved?" is an invitation to familiarize colleagues with a problem that Minnesota's great Supreme Court Justice, Harry Blackmun, also faced as a physician advocate.[1] In less eloquent words than his, the solution must be that, despite what most health care lawyers strive to convince judges of on behalf of their managed care hospital and health system clients, physicians must control clinical decision-making. It is appropriate – it is vital – to entrust clinical care not to administrators, accountants, or actuaries, but to doctors.

Instead of going to great lengths and costs to circumvent the medical staff, the change that can and should be made is to ensure physician control over patient care. Changing medical staff bylaws towards clinical control by clinicians and complying with the medical staff bylaws would truly produce a quality change.

One must take advantage of the considerable thought, analysis, drafting, and scholarship made evident in model medical staff bylaws that have been

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1. I have always been surprised and disturbed by the lack of sympathy that judges often have for the problems that confront the medical profession. There seems almost to be an element of distrust that is present. I have heard the comment, "Who do these doctors think they are?" Is it fear or ignorance? I have noticed this even at conferences of our Court. I have done my best to alleviate the feeling, but I have not been successful. It might be a rewarding day if every lawyer was compelled to represent physicians for a time. His mind would be broadened and his sympathies would be extended.

Harry A. Blackmun, *Remarks*, 15 LAW, MED., & HEALTH CARE 175, 176 (1987).

published by state medical associations[2] in meeting the charge, "What specific provisions in the medical staff bylaws must change?" As with all models, tailoring to the particular situation faced by the particular medical staff and hospital is crucial to the success of the final document. State medical society models are drafted to meet the peculiarities of that specific jurisdiction. This degree of specificity is invaluable for medical staffs and hospitals in that state, but must be carefully screened by medical staffs and hospitals of other states due to the difference in statute, regulation, and case law governing medical staffs. Model language is nonetheless a helpful start, particularly given the influence of federal law and accreditation standards. Furthermore, many models are annotated, providing the rationale for what is necessarily detailed wording for the many rights and responsibilities medical staff bylaws must address.

II. ACKNOWLEDGE THE BINDING NATURE OF MEDICAL STAFF BYLAWS

There is no logic in detailing specific changes in medical staff bylaws to effect changes in the hospital-medical staff relationship and improve the quality of care, if the bylaws are not recognized as binding upon the parties and not subject to unilateral amendment. Yet, this basic premise has a history of being, and still remains, a controversy between hospital and physician advocates.[3]

Rights described in medical staff bylaws have been found to be contractual by courts in the United States dating back to 1958.[4] The acknowledgement that medical staff bylaws were contractual in nature took root in *St. John's Hospital Medical Staff v. St. John Regional Medical Center*.[5] This seminal case was brought by a South Dakota Medical Staff against its hospital, which successfully challenged the hospital board's unilateral amendment of the medical staff bylaws. Sufficient numbers of subsequent cases[6] have categorized medical staff bylaws as a contract, which supported the holding in *Islam v. Covenant Medical Center, Inc.*, that

2. For a current listing of state medical societies from which model medical staff bylaws are available, see AM. MED. ASS'N, PHYSICIANS' GUIDE TO MEDICAL STAFF ORGANIZATION BYLAWS, APP. B (2d ed. 2002).

3. *See, e.g.*, Theodore C. Falk, *Delegated Power to Amend Medical Staff Bylaws*, 21 WILLAMETTE L. REV. 1 (1985) (questioning the position that hospital board must have authority to amend medical staff bylaws unilaterally, as described by JOHN HORTY, HOSP. LAW, MED. STAFF, ch. 6 (1982)).

4. *See* Joseph v. Passaic Hosp. Ass'n, 141 A.2d 18 (N.J. 1958).

5. St. John's Hosp. Med. Staff v. St. John Reg'l Med. Ctr., 245 N.W.2d 472 (S.D. 1976).

6. Lawler v. Eugene Wuesthoff Mem. Hosp. Ass'n, 497 So. 2d 1261, 1264 (Fla. Dist. Ct. App. 1986); Lewisburg Cmty. Hosp. v. Alfredson, 805 S.W.2d 756, 759 (Tenn. 1991); Bass v. Ambrosius, 520 N.W.2d 625, 627-28 (Wis. Ct. App. 1994).

the "majority view" is that medical staff bylaws are contractual.[7] Typically, the cases were brought by individual physicians whose practices at the defendant hospital were disrupted without full adherence to hearing rights detailed in the medical staff bylaws.[8] Some, however, were brought by medical staffs in attempts to defend the rights of the medical staff organization against usurpation by the hospital.[9]

Despite the plurality of findings to the contrary, there are jurisdictions that have concluded that the medical staff bylaws cannot be contracts, holding that essential elements of a contract are lacking. These include Missouri,[10] and more recently, California.[11] Interestingly, in a subsequent Missouri case, *Goldman v. Truman Medical Center*,[12] the court opined that "[a]lthough Medical-Dental Staff Bylaws do not constitute a contract [under *Zipper*], a hospital has a 'duty to obey its bylaws.'"[13] It must be noted that the California court similarly opined that the bylaws are binding, albeit not a contract.

While some courts have concluded that bylaws are not technically a contract, those courts nonetheless held that bylaws are binding on the parties.[14] In New York, a court ruled that medical staff bylaws must be considered binding based not only on contract and association law theories, but also on "concepts of fundamental fairness."[15]

The Ohio courts have based bylaws-as-contract decisions on whether or not intent to be bound is actually stated in the medical staff bylaws themselves.[16] Medical staff bylaws, not only in Ohio, but in all jurisdictions, can and should obviate the issue, as the following sample language does: "These Bylaws, as adopted or amended, create a binding system of mutual rights and responsibilities or contract by and between *medical staff* members, and the Hospital. Thus, these Bylaws may not be

7. Islam v. Covenant Med. Ctr., Inc., 822 F. Supp. 1361, 1370 (N.D. Iowa 1992).

8. *See Alfredson*, 805 S.W.2d at 757-58 (describing defendant hospital's termination procedure).

9. *See generally St. John's Hosp. Med. Staff*, 245 N.W.2d at 472 (presenting a situation where a medical staff sued on its rights).

10. Zipper v. Health Midwest, 978 S.W.2d 398, 416 (Mo. Ct. App. 1998).

11. O'Byrne v. Santa Monica-UCLA Med. Ctr., 114 Cal. Rptr. 2d 575, 584 (Ct. App. 2001).

12. Goldman v. Truman Med. Ctr., No. CV97-31606 (Div. 16, Jackson County Cir. Ct., Mo. Apr. 13, 1999), http://www.aapsonline.org/judicial/truman.htm.

13. *Id.* at 4.

14. *See, e.g.*, Robles v. Humana Hosp. Cartersville, 785 F. Supp. 989, 1000 (N.D. Ga. 1992); Balkissoon v. Capitol Hill Hosp., 558 A.2d 304, 308 (D.C. 1989).

15. Murphy v. St. Agnes Hosp., 484 N.Y.S.2d 40, 43 (App. Div. 1985).

16. *See, e.g.*, Munoz v. Flower Hosp., 507 N.E.2d 360, 365 (Ohio Ct. App. 1985).

unilaterally amended by either party."[17]

III. PRESERVE THE BAN ON UNILATERAL AMENDMENT

The Illinois State Medical Society Model Medical Staff Bylaw language quoted above includes a prohibition against unilateral amendment of the document by either party. Such a statement may seem self-evident, if not oxymoronic, in any discussion of contract law. However, as with the issue of the status of the bylaws as a contract, mutuality of agreement and commitment in medical staff bylaws is not uniformly recognized. Some hospital advocates differ as to whether the hospital can amend the medical staff bylaws without the medical staff's consent. Obviously, such a position undermines the effectiveness of the bylaws as the governing document of the medical staff.

The Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO"),[18] which accredits hospitals based on a range of patient quality standards, includes as its Medical Staff Standard ("MS") 2.1 in its Medical Staff chapter of standards the following: "Medical staff bylaws and rules and regulations are adopted by the medical staff and approved by the governing body before becoming effective. Neither body may unilaterally amend the medical staff bylaws or the rules and regulations."[19] JCAHO standards can be abstruse and are subject to elaboration and explanation in related Intent Statements in its Comprehensive Manual for Hospitals. The Intent Statement for MS 2.1, however, reads, "The intent of this standard is self-evident."[20] To improve quality of patient care, medical staff bylaws cannot be unilaterally amended.

Nonetheless, some hospital advocates propose going to great lengths to avoid allowing the medical staff to be included in the amendment process governing its own bylaws, to wit:

> [M]edical staff approval is *required* before any amendments to the medical staff bylaws or rules and regulations can be effective. However, if other documents, such as the Fair Hearing Procedure, are structured as

17. ILL. STATE MED. SOC'Y, MODEL MED. STAFF BYLAWS 1 (2000).

18. "The mission of the Joint Commission on the Accreditation of Healthcare Organizations is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations." JCAHO, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK ii (2002) [hereinafter JCAHO]. Accreditation by JCAHO is more than voluntary recognition, however, as it is recognized in most states as certification for Medicare participation under 42 U.S.C. § 1395bb (2000).

19. *Id.*, MS2.1 at MS-3.

20. *Id.*

> procedures of the governing body, an argument can be made that specific medical staff approval of amendments to these other documents is not required under the JCAHO standards. Although in most cases making any amendments that might have an impact on the medical staff should occur only with the approval of the medical staff, by separating some of the governance mechanism into governing body policies and procedures, the ability to amend such documents on short notice and without medical staff involvement is achieved.[21]

In essence, gutting the medical staff bylaws of key elements, such as fair hearing processes, is advocated in order to avoid action by the medical staff on those critical processes and circumvent the prohibition on unilateral amendment.

IV. PROTECT THE INDEPENDENCE OF THE MEDICAL STAFF

To enable the medical staff to carry out its responsibilities for quality assurance, the leadership and organization, not only the documents of the medical staff, must be protected from hospital control and manipulation. Medical staff self-governance is mandated by regulation in some states.[22] More broadly, JCAHO standard MS.1 looks for "[o]ne or more organized, self-governing medical staffs [to] have overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body."[23] The medical staff cannot provide an independent accounting of patient care quality to the governing body if it is controlled by the governing body, communicating through leadership selected or approved by the governing body, pursuant to documents unilaterally adopted or amended by the governing body. Recent U.S. economic history is replete with examples of the importance of independent accounting, of which Enron/Arthur Anderson may be the most notorious. Quality patient care is not served by preventing medical staff self-governance. Yet, medical staff self-governance is institutionally diminished almost routinely.

The typical means of hospital control over medical staff self-governance is through determining who can and cannot serve as a medical staff officer or department head, by subjecting nominees or election results to approval by the hospital board, or by purporting to remove duly elected officers.

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21. KAREN S. RIEGER & ERIC S. FISHER, HEALTHCARE ENTITY BYLAWS & RELATED DOCUMENTS: NAVIGATING THE MEDICAL STAFF/HEALTHCARE ENTITY RELATIONSHIP 40 (2000).

22. *See, e.g.*, MO. CODE ANN. tit. 19, § 30-20.021 (2002); CAL. CODE REGS. tit. 22, § 70701(a)(1)(F) (2002).

23. JCAHO, *supra* note 18, at MS-3 (definition of "clinical privileges" omitted).

Such manipulation of leadership cannot be self-governance, as noted by the court in *Goldman*.[24]

Other hospitals take the tactic of "investigating," or otherwise threatening a leader's clinical privileges for failure to fully comply with hospital demands regarding medical staff organization issues. This practice has led to the adoption by the American Medical Association ("AMA") of a formal policy statement,[25] condemning hospitals for manipulating peer review to undercut self-governance.

V. ELIMINATE GAG CLAUSES

Quality improvement cannot result from silencing physicians and other professionals who would identify shortcomings in patient care. "Codes of Conduct," "Disruptive Behavior Policies," and other rules often handed down as hospital policy or other extra-bylaws imposed on the medical staff typically include a prohibition against statements by members of the medical staff and impugn the quality of patient care provided at the hospital. The horrifying result of such overbroad attempts to squelch any acknowledgement, much less discussion, of patient care problems leads to the inevitable and life-threatening result of increasing and intensifying them. Further, such policies and codes frequently deem any perpetrator as barred from hospital property, without the hearing and appeal procedures afforded under the medical staff bylaws.

The recent Ninth Circuit decision in *Ulrich v. San Francisco*,[26] remanding to the district court a physician's claim that the hospital initiated a peer review investigation due to the physician's protests against staffing reductions, points out the dangers in hospital persecution of physicians who come forward with patient care concerns. First amendment rights and patient care are threatened by such extreme actions.

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24. *Goldman*, *supra* note 12 (noting, "[i]t is inconsistent with principles of medical staff self-governance to hold, as Defendant argues, that TMC [the hospital] is free to disregard the input of the Medical Staff in deciding to remove Department Chairs and to remove such Chairs unilaterally.").

25. The AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw or otherwise prevent a physician from exercising professional privileges because of medical staff advocacy activities unrelated to professional competence, conduct or ethics.

AM. MED. ASS'N, POLICY COMPENDIUM, H-230.965, IMMUNITY FROM RETALIATION AGAINST MED. STAFF REPRESENTATIVES BY HOSP. ADM'R (2002).

26. Ulrich v. San Francisco, 308 F.3d 968 (9th Cir. 2002).

VI. MAKE USE OF NATIVE CLINICAL ACUMEN

Simply following the medical staff bylaws should lead the hospital to have the benefit of the medical staff's professional opinions on clinical issues. At a minimum, JCAHO calls for the executive committee to make medical staff recommendations to the governing body on clinical privileges and medical staff membership for those providing services at a hospital.[27] The governing body has approved this group of local professionals as qualified, yet often the medical staff's recommendations are either disregarded or not considered. Medical staff bylaws should ensure that hospital practice meets the intent of the JCAHO standard by including specific language, such as the following: "If the medical executive committee issues a favorable recommendation, the board of [trustees/directors] . . . shall affirm the recommendation of the medical executive committee if the medical executive committee's decision is supported by substantial evidence."[28]

In other clinical decision-making, such as determining which medical services will be offered to the community according to what professional standards, hospital administrators argue that obtaining medical staff review consumes valuable time, resulting in lost opportunity costs. Where well-written bylaws require medical staff involvement, the delay incurred in obtaining clinical insight does not justify unilateral administrative action. In *Austin v. Mercy Health System Corp.*,[29] brought by physicians who lost Cardiac Care Unit and Intensive Care Unit privileges when the hospital adopted a policy limiting intensive care privileges to different specialists, the court opined that the hospital's unilateral action "usurped" medical staff committee functions established in the bylaws, such as establishing the credentials criteria for intensive care.[30] The hospital conceded that the policy was implemented due to its impression that review by medical staff committees, as required by the medical staff bylaws, would cause delays.[31]

A decision to award an exclusive contract can be a source of friction in the hospital-medical staff relationship. Exclusive contracts restrict those who can provide a certain service to those who have signed the contract, thus aggravating those with the same skills who do not, or commonly cannot, sign on. Other medical staff members are also affected by the change, when in their treatment of patients, they are suddenly replaced by

27. *See* JCAHO, *supra* note 18, MS 3.1.6 at MS-5.

28. CAL. MED. ASS'N, MODEL MED. STAFF BYLAWS § 4.5-8(a) (2001).

29. Austin v. Mercy Health Sys. Corp., 541 N.W.2d 838 (Wis. Ct. App. 1995) (unpublished table opinion).

30. *Id.*

31. *Id.* at n.1.

others whose approaches, demeanor, and even skill level are not equal. There can be no disagreement that the imposition of an exclusive contract affects the quality of patient care; consequently, a JCAHO standard calls for medical staff approval of patient care sources provided through contractual arrangements.[32]

Although hospital administrators are reluctant, courts have recognized the usefulness of medical staff participation in exclusive contract decision-making to establish the effect on patient care quality.[33] In their Joint Task Force Report on Hospital-Medical Staff Relationships, the principal professional and industry representatives, the American Hospital Association and the AMA advocated medical staff involvement in exclusive contracting decisions.[34]

Nonetheless, hospitals rarely include the medical staff via any organized process in the decision as to whether an exclusive contract should be introduced, continued, or terminated in a particular service or department of the medical staff. Medical staff notice-and-comment type hearings can be a very effective process for gathering information from all stakeholders and potential stakeholders, and for achieving consensus among those whose patient care will be regularly affected by the outcome of an exclusive contract evaluation. Detailed procedures such as the following are available

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32. JCAHO, *supra* note 18, LD.1.3.4.2 at LD-5. The Intent Statement for this standard is informative. It states:

> Through the planning process, leaders determine, first, what diagnostic, therapeutic, rehabilitative and other services are essential to the community; second, which of those services the hospital will provide directly and which through referral, consultation, contractual arrangements or other agreements; and third, timeframes for providing care. Essential services include at least the following: Diagnostic radiology; Dietetic; Emergency; Nuclear Medicine; Nursing care; Pathology and clinical laboratory; Pharmaceutical; Physical rehabilitation; Respiratory care; and Social work.

Id. at LD-11 (footnotes omitted).

33. *See* Lewin v. St. Joseph Hosp. of Orange, 146 Cal. Rptr. 892 (Ct. App. 1978) (finding that the medical staff's hearing yielded information that supported an exclusive contract for hemodialysis services, unsuccessfully challenged by a nephrologist whose privileges were terminated as a result of the exclusive contract).

34. Because such arrangements relate to the quality of care and the manner of its delivery, the medical staff has a legitimate interest in the selection of physician or groups of physicians entering into contractual arrangement or salaried positions on the medical staff. In a prudently-managed hospital, responsibility during the selection process is generally "shared" with the medical staff because unilateral decision by the governing board/administration made with out medical staff involvement can have an unnecessarily disruptive impact, particularly when the decision concerns key positions within the medical staff, such as department heads.

AM. HOSP. ASS'N-AM. MED. ASS'N, REPORT OF THE JOINT TASK FORCE ON HOSP.-MED. STAFF RELATIONSHIPS 40 (1985).

in models bylaws and have been implemented in medical staff bylaws:

ARTICLE XII: F. Exceptions to Hearing Rights

1. Appropriateness of Exclusive Contracts

Privileges can be adversely affected reduced or terminated as a result of a decision to close or continue closure of a department/service pursuant to an exclusive contract, or to transfer an existing exclusive contract, only following review by the *Medical Staff* pursuant to Article XV(D) and a determination of appropriateness of the closure, continued closure, or transfer as set forth below. The *Board* decision shall uphold the *Medical Staff's* determination unless the *Board* makes specific written findings that the *Medical Staff's* determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

a) The *Medical Staff* shall determine the need to close or continue closure of a department/service pursuant to an exclusive contract to be appropriate where:
   (i) a failure to provide full coverage of a needed service cannot be remedied by less extreme measures, such as mandated call schedules; or
   (ii) irreconcilable differences within an existing department/service adversely affecting quality of care have not been resolved by less extreme measures; or
   (iii) demonstrable efficiencies would result, producing significant improvement in the ability of the *Medical Staff* to dispense quality care, which have not been accomplished through less extreme measures.

A determination to close a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment. A determination to continue closure of a department/service pursuant to an exclusive contract must be based upon the preponderance of the evidence presented by members of the *Medical Staff*, following notice and opportunity for comment.

b) The *Medical Staff* shall determine the transfer of an existing exclusive contract to be appropriate only when:
   (i) continued closure of the department/service pursuant to an existing contract is found appropriate pursuant to (a) above, and
   (ii) quality of care is significantly improved by the transfer.

c) The *Medical Staff* shall make a recommendation regarding the continuation of *Medical Staff* membership and privileges for those *members* whose membership and privileges may be affected by

the granting or transfer of an exclusive contract.

d) The *Medical Staff* member(s) whose privileges may be adversely affected by the *Medical Staff's* determination of appropriateness of the closure or continued closure of a department/service pursuant to an exclusive contract, or transfer of an exclusive contract, may request a hearing before the hearing panel. Such a hearing will be governed by the provisions of Article XII,

e) All requests for such a hearing may be consolidated. Should an affected *Medical Staff* member request a hearing under this subsection, the *Medical Staff's* recommendation regarding the exclusive contract will be deferred, pending the outcome of the hearing panel hearing.

f) Any *Medical Staff* member providing professional services under a contract with the hospital, which requires membership and clinical privileges on the *Medical Staff*, shall not have his/her *Medical Staff* privileges terminated without the same rights of hearing and appeal as are available to all members of the *Medical Staff*. The hearing and appeal rights included herein may not be waived or limited by any provisions in an exclusive contract that are inconsistent with these bylaws, except if the exclusive contract is signed by a representative of a group of physicians (with authority to bind the group members, a waiver contained in the contract shall apply to all members of the group unless stated otherwise in the contract.

g) Except in cases of contemporaneous transfer of an existing exclusive contract determined to be appropriate by the *Medical Staff*, a decision to terminate an exclusive contract shall not affect the privileges of *Medical Staff* members who were performing services pursuant to that contract, except that their privileges shall no longer be exclusive.[35]

These same models set forth a general description of the role of the medical staff in exclusive contracting, to wit:

Article XV: D. Medical Staff Role in Exclusive Contracting

The *Medical Staff*, through the *Medical Executive Committee*, with medical staff approval, shall review and make recommendations to the *Board* regarding issues related to the exclusive arrangements for physician and/or professional services, prior to any decision being made, in the

35. ILL. STATE MED. SOC'Y, *supra* note 17, at 134-37 (citations omitted); *see also* CAL. MED. ASS'N, *supra* note 28, § 7.6-1.

following situations:

1) the decision to execute an exclusive contract in a previously open department or service;
2) the decision to renew or modify an exclusive contract in a particular department or service;
3) the decision to terminate an exclusive contract in a particular department or service. [36]

At a minimum, medical staff bylaws should include among the duties of the medical executive committee the review of proposals to limit privileges or services by exclusive contracts, stipulating that the review must be received and considered prior to contract implementation.

VII. CONCLUSION

Hospitals cannot function successfully without being informed by professionals as to the quality of patient care. Statutes, regulations, and standards all point to the need for hospitals to recognize and follow the recommendations of the medical staff in all clinical matters.[37]

36. ILL. STATE MED. SOC'Y, *supra* note 17, at 146-47 (citations omitted); *see also* CAL. MED. ASS'N, *supra* note 28, § 13.9.

37. Portions of these materials have been or may be used in other materials prepared by the author. These materials highlight and briefly summarize current law. They are not intended to serve as legal advice to any person. I strongly recommend that anyone who has questions about this area of law consult with a knowledgeable medical staff attorney.