The Avera Marshall Decision

What the Supreme Court’s ruling means for hospitals and physicians

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On December 31, 2014, the Minnesota Supreme Court issued an important ruling relating to physician autonomy and medical practice in hospitals in the state. The ruling was made in a case that began in 2012, when the medical staff of Avera Marshall Regional Medical Center, its chief of staff and chief of staff-elect sued the hospital over its failure to comply with certain provisions in the medical staff bylaws relating to quality of care and medical staff self-governance.

Within days after the lawsuit was filed, the hospital’s board adopted extensive and controversial amendments to the bylaws. These amendments shifted significant responsibility for matters relating to quality of care away from the medical staff’s executive committee and officers and onto hospital employees, including a nonphysician administrator. They also stripped the medical staff of its right to self-govern. A significant majority of the medical staff voted to reject the changes. Nevertheless, the hospital unilaterally rescinded the existing bylaws and imposed the revised bylaws.

In the lawsuit, the hospital argued that it had the right to unilaterally change the bylaws, that bylaws were not a contract and that the medical staff did not have legal capacity to sue the hospital. The hospital prevailed in the lower courts.

In 2013, the medical staff asked the Supreme Court to consider several issues, including—Was a medical staff permitted by law to commence a lawsuit? And did medical staff bylaws constitute a contract? The Supreme Court ruled that the individual members of the medical staff did indeed have a contractual relationship with the hospital and that the medical staff could sue the hospital. Although the Supreme Court ruling did not fully resolve the dispute between Avera Marshall Regional Medical Center and its medical staff, it was a positive decision for physicians and their patients.

The Supreme Court’s ruling

In making its ruling, the Minnesota Supreme Court reversed two lower courts’ decisions and held that medical staff bylaws were an enforceable contract between Avera Marshall Regional Medical Center and the members of its medical staff. The Court determined that the legal requirements for the existence of a contract were met when a physician, as part of the application process, agreed to abide by the medical staff bylaws and the hospital board appointed the physician to the medical staff. Under well-established general contract law, this meant the bylaws were an enforceable contract.

The Court also held that the medical staff was an unincorporated association that had the capacity to sue and be sued under Minn. Stat. 554.151. It stated: “we can only conclude that when the Legislature used the words ‘[w]hen two or more persons associate and act … under the common name …, they may sue in or be sued by such common name,’ it intended to give such associated persons the legal capacity to sue.” The Court found that the Avera Marshall medical staff satisfied this definition because it “is composed of two or more physicians who associate and act together for the purpose of ensuring proper patient care at the hospital under the common name ’Medical Staff.’”

Duties and rights of a medical staff

A medical staff is the group of medical professionals (physicians and sometimes advanced practice registered nurses or physician assistants) who treat patients at a hospital. Each hospital has a medical staff, and all medical professionals who admit patients to a given hospital are required to be members of the medical staff. A medical professional may only provide services at a hospital when the hospital grants them privileges to do so.
Although the duties and rights of medical staffs may vary somewhat from hospital to hospital, there is guidance on their role. The Joint Commission, in its Hospital Accreditation Standards, has described the duties of medical staffs as follows:

The self-governing medical staff provides oversight of the quality of care, treatment and services delivered by practitioners who are credentialed and privileged through the medical staff process. The organized medical staff is also responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization. In addition, The Joint Commission states that “the primary function of the organized medical staff is to approve and amend medical staff bylaws and to provide oversight for the quality of care, treatment and services provided by practitioners with privileges.” These concepts appear in Minnesota’s administrative rules for hospital licensure as well: “the medical staff shall be responsible to the governing body of the hospital for the clinical and scientific work of the hospital. It shall be called upon to advise regarding professional problems and policies.” Further, under Minnesota rules: “the medical staff shall be an organized group which shall formulate and, with the approval of the governing body, adopt bylaws, rules, regulations and policies for the proper conduct of its work.”

The Conditions of Participation for Hospitals, federal regulations promulgated by the Centers for Medicare and Medicaid Services, require hospitals’ governing bodies to “assure that the medical staff has bylaws.” They also provide that the “medical staff must adopt and enforce bylaws to carry out its responsibilities,” which bylaws must also be approved by the governing body.

The role of the medical staff bylaws

Medical staff bylaws, as defined by The Joint Commission, “create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.” As such, they typically describe in detail a) how the medical staff will perform its duties; b) the rights and obligations of the medical staff, as a whole and as individual members, under various circumstances (eg, appointment, reappointment and other peer-review procedures); and c) the rules for the medical staff’s self-governance (eg, selection of leaders, medical staff committee structure and appointments and organization into departments or clinical services). Bylaws also outline a process for amendment that, at least in Joint Commission-accredited hospitals, requires approval of both the medical staff and the hospital governing board: “Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.”

In addition, medical staff bylaws impose a framework for physician-to-physician interactions. Particularly at large hospitals, the medical staff may be composed of physicians from myriad backgrounds, who have various employment arrangements and practice in a variety of settings. Only the bylaws establish the rules for physician interaction and dispute resolution. Therefore, it is important that the rules for inter-physician relationships in the bylaws reflect the collective agreement of the medical staff.

Importance of medical staff autonomy

The various requirements for a medical staff are an acknowledgment that the physicians caring for patients in hospitals and the board and administrators responsible for running the business operations have parallel, yet distinct, perspectives and roles. Although all can agree that many of the goals, obligations and decisions made by the two groups might be in sync much of the time, there will be times when their opinions diverge. As a discrete group of medical professionals dedicated solely to the interests of patient care that makes recommendations to the board and administration based on their collective professional judgment, a medical staff creates an internal check against the fiscal demands of the hospital.

Moreover, a medical staff creates a safe environment in which physicians can address quality and patient care issues without outside financial pressures. This is important for all physicians, but it is arguably most important for employed physicians, who may otherwise face implicit pressure from their hospital employers. The existence of an autonomous medical staff allows all medical staff members—those who are employed by the hospital as well as those who are not—an equal opportunity to participate freely in expressing their professional opinions with respect to quality improvement and other patient care oversight activities. For the benefit of patient care, this freedom and associated protection should not be undermined.

The emphasis on a self-governing medical staff and duly established bylaws reflects a balance between a hospital’s ultimate responsibility for its operations and the quality of care it provides and the crucial professional input reserved to and required of the medical staff. Loss of medical staff autonomy undermines that fundamental and long-effective balance.

As a part of the mandate for quality care, medical staffs are authorized to conduct peer review. This may involve coaching members, improving system quality, proposing policies and making thoughtful recommendations on privileges. Peer review can only exist, both practically and legally, within the confines of medical staff peer review privilege and confidentiality. Peer review may become an extension of hospital human resources departments, rather than an independent peer assessment.

In its amended complaint seeking declaratory relief and judgment dated January 27, 2012, the plaintiffs alleged, among other things, that the hospital improperly precluded the medical executive committee from exercising its authority under the bylaws and related policies to appoint phy-
sician members to a Medical Staff Quality Improvement Committee (a medical staff peer-review committee) and instead substituted nonphysician hospital board members for physician members.¹⁵

**Implications for medical staffs and their members**

Although the Court’s ruling that the medical staff bylaws were an enforceable contract and that the medical staff was an unincorporated association with the capacity to sue and be sued was limited to the facts at Avera Marshall, the decision has generated much discussion among physicians and hospital administrators regarding the following:

**Bylaws as an enforceable contract**

The Supreme Court compared its decision on the medical staff bylaws in the Avera Marshall case with its decision in a 1983 case in which the Court determined that an employee handbook was an enforceable contract.¹⁶ Accordingly, some hospitals may try to attach disclaimers to medical staff bylaws, as employers have done with handbooks, disclaiming that they are a contract. This may not be effective (except in a new hospital or a hospital whose medical staff bylaws already have a validly adopted provision that the bylaws are not a contract) because individual medical staff members will continue to have contractual rights. There may be additional reasons why such a disclaimer may not be effective. The Avera Marshall decision highlighted the inconsistency of a hospital being legally required to have medical staff bylaws while having no intent to be bound by them: “It is unclear how, on the one hand, Avera Marshall can be obligated to have such bylaws, yet at the same time have no intention to follow them.”¹⁷

Hospitals also may seek to alter appointment and re-appointment applications in a way that requires physicians at the time of appointment or reappointment to agree that medical staff bylaws are not a contract, or that they can be unilaterally amended by the board. Doing so may be ineffective if it conflicts with other amendment procedures in the bylaws. Further, it would certainly conflict with the prohibition against unilateral amendments by either the organized medical staff or the governing body contained in MS.01.01.03 and may conflict with some of the regulatory requirements discussed earlier.

Because most hospitals will want at least some provisions of medical staff bylaws to be enforceable against physicians, they may propose amendments that clearly state that certain provisions are enforceable and others are not. This may be unfair and possibly unworkable.

Physicians should carefully read and consider any proposed changes to bylaws and seek counsel—separate from hospital counsel—about whether those changes are in their best interests.

**Capacity to sue and be sued**

This holding is likely to affect most medical staffs because of their nature and activities. It is also likely to affect other groups of people who come together and act under a common name such as various types of special interest groups or clubs that are not organized as corporations or other legal entities.

The necessary corollary to concluding that the medical staff had the capacity to bring the lawsuit under Minn. Stat. §540.151 is that the medical staff could also be sued in the name of the medical staff, rather than as individual members. A valid cause of action (eg, negligence) would still be required. Some have suggested that claims might be brought under a negligent credentialing cause of action, but it is unclear whether such a claim against a medical staff making recommendations to a hospital board would be viable.

Also, the statute contains language that appears to indicate that only the assets of the medical staff—and not the assets of individual members—are at risk: “The judgment in such cases shall accrue to the joint or common benefit of and bind the joint or common property of the associates, the same as though all had been named as parties.”¹⁸ Some have suggested that the statute is not as clear as it could be in this regard.

Because the medical staff may need its own counsel, especially if sued, consideration will need to be given to how this should be arranged and paid for. If the hospital and its medical staff have adverse interests as parties to a contract (ie, bylaws), counsel will need to be someone other than the hospital counsel.

Many medical staff bylaws provide for indemnification by the hospital of physicians engaged in peer review. Medical staff bylaws will need to be reviewed to see if existing provisions are adequate. Finally, hospitals and medical staffs may wish to explore what insurance coverage may be available to provide defense, and perhaps indemnification, in the event of a lawsuit brought against the medical staff.

All of these are important issues requiring informed consideration by medical staffs and hospitals and their respective counsel.

**Conclusion**

The Supreme Court’s ruling reinforces the notion that medical staffs have an important role to play in promoting quality patient care. Physicians should be vigilant in assuring that medical staff bylaws protect this role and their individual rights. MM

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**References**

1. Medical Staff of Avera Marshall Regional Medical Center et al., v. Avera Marshall, et al., 857 N.W.2d 695 (Minn. 2014).
2. Id. at 703.
3. Id. at 700.
4. Id.
5. Hospital Accreditation Standards 2014, Medical Staff Standards (“Medical Staff Standards”), MS-1.
6. Id. at MS-2.
7. Minn. R. 4640.0800, subp.1.
8. Minn. R. 4640.0800, subp.2.
9. 42 C.F.R. §482.12(a)(3).
10. 42 C.F.R. §482.22(c).
11. 42 C.F.R. §482.22(c)(1).
12. Medical Staff Standards, MS-1.
13. Id. at MS-2.
14. Id., Standard MS.01.01.03.
17. Id., at 705 n.4. See Minn. R. 4640.0800, subp.2.