NO. A12-2117

State of Minnesota
In Court of Appeals

Medical Staff of Avera Marshall Regional Medical Center on Its Own Behalf and in Its Representative Capacity for Its Members; Chief of Staff Steven T. Meister, M.D.; Chief of Staff-Elect Jane Willett, D.O.; and John Does and Jane Does,

Appellants,

vs.

Avera Marshall
d/b/a Avera Marshall Regional Medical Center,

Respondents.

AMICUS CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION, MINNESOTA MEDICAL ASSOCIATION, AMERICAN ACADEMY OF FAMILY PHYSICIANS, AMERICAN OSTEOPATHIC ASSOCIATION, AND MINNESOTA ACADEMY OF FAMILY PHYSICIANS

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2013 – BACHMAN LEGAL PRINTING – FAX (612) 337-8053 – PHONE (612) 339-9518 or 1-800-715-3582

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IDENTIFICATION OF *AMICI*

The American Medical Association ("AMA"), Minnesota Medical Association, American Academy of Family Physicians, American Osteopathic Association, and Minnesota Academy of Family Physicians were identified in their Request to Participate as *Amici Curiae* and to File Joint Brief, which was filed herein on December 5, 2012.[1, 2]

ISSUES ADDRESSED IN THIS BRIEF

The issues addressed in this brief are as follows:

1. Does the Medical Staff of the Avera Marshall Regional Medical Center, either in its own name or through its officers acting in their designated official capacities, have the legal capacity and standing to bring this lawsuit?

2. Are the Medical Staff Bylaws of Avera Marshall Regional Medical Center an enforceable contract, not subject to unilateral amendment without good cause?

RELEVANT PROCEEDINGS

The Medical Staff of Avera Marshall Regional Medical Center and various officers of the Medical Staff, acting in their capacities as officers and as individuals, filed a lawsuit against Avera Marshall Regional Medical Center (the "Hospital"), seeking, *inter alia*, declarations that the Medical Staff has capacity and standing, as an unincorporated association, to sue the Hospital (AA38); that the Medical Staff Bylaws

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[1] This brief was not authored in whole or in part by counsel for any party. The only entity that made a monetary contribution to the preparation or submission of this brief is the Litigation Center of the AMA and the State Medical Societies.

[2] The Minnesota Chapter of the American Academy of Pediatrics has filed a separate motion requesting leave to join in this brief.

are a contract or enforceable obligation between the Medical Staff, its members, and the Hospital (AA38); and that the Hospital may not unilaterally amend the Medical Staff Bylaws (AA45).

The Medical Staff Bylaws, which the Hospital Board of Directors approved in 1995, set forth various conditions of organization and self-governance for the Medical Staff, subject to the ultimate authority and approval of the Hospital Board of Directors. (*See generally* AA50-116 (Original Medical Staff Bylaws).) In addition to establishing rules and policies for internal governance, the Medical Staff Bylaws "provide a means whereby issues concerning the Medical Staff and the [Hospital] may be directly discussed by the Medical Staff with the Board of Directors and the [Hospital] Administration." (AA58.) Although the Hospital can recommend amendments to the Medical Staff Bylaws, their adoption requires approval from two-thirds of the Medical Staff. (AA115-116.)

On July 6, 2012, the trial court ruled that the Medical Staff was not an unincorporated association with the capacity to sue the Hospital, either directly in its own name or indirectly through its representatives acting in their official capacities. (A.Add.63-81.) The trial court concluded that the Medical Staff lacked capacity, primarily because it was "not voluntary or mutually consented to" and was "not a legal entity having existence apart from the [Hospital]" and granted the Hospital's motion for summary judgment on Count I of the amended complaint. (A.Add.78.)

The individual plaintiffs pursued the remaining counts in the amended complaint. On September 24, 2012, the trial court held that the Medical Staff Bylaws were not a

contract between the individual members of the Medical Staff and the Hospital and entered summary judgment on Count II. (A.Add.82-83.) Moreover, the court ruled that the Hospital could unilaterally amend the Medical Staff Bylaws, so long as it gave the members of the Medical Staff prior notice of and an opportunity to comment on such amendments. (A.Add123; *see also* AA115-116 (amendment procedures in the Original Medical Staff Bylaws).) The trial court therefore granted summary judgment in favor of the Hospital on Count VII of the amended complaint. (A.Add.82-83.)

ARGUMENT

I. Based on the Language and Manifest Purpose of the Relevant Statutes, the Legislature Intended that Medical Staffs Should Have the Capacity and Standing to Sue as Unincorporated Associations.

The issue of legal capacity is governed by the plain language of the applicable Minnesota statutes and the intent of the Legislature. Here, the plain language and intent of Minnesota law is that a medical staff is an unincorporated association that has the capacity to sue a hospital to rectify the hospital's breaches of its medical staff bylaws.

To ascertain the legislative intent, one looks first at the specific statutory language, with all parts of the law to be considered. If the intent is clear from the language of the law, then it must be followed as stated. However, if the intent is not clearly discernable from the language, then the court should consider such factors as the objects of and necessity for the law, the consequences of the various possible interpretations, and "the mischief to be remedied." Minn. Stat. § 645.16 (2012); *Hersh Prop's, LLC v. McDonald's Corp.*, 588 N.W.2d 728, 736 (Minn. 1999). Both the language of the statutes at issue here and the secondary indicia of intent lead to the same conclusion:

medical staffs, including the Avera Marshall Medical Staff, have the legal capacity to sue the Hospital

A. The Legislative Intent Can be Discerned from the Plain Language of the Relevant Statutes.

Several Minnesota statutes address the question of an unincorporated association's right to sue. First, Minnesota Statutes § 540.151 grants one or more persons the right to sue under a common name; it states as follows:

> When two or more persons associate and act, whether for profit or not, under the common name, ... they may sue in ... such common name. The judgment in such cases shall accrue to the joint or common benefit of ... the associates.

Appellants discussed Section 540.151 in depth (App. Br. at 17-34) and *Amici* will not repeat those arguments, but incorporate them herein by reference.

Several sections of Minnesota's enactment of the Uniform Declaratory Judgments Act ("DJA") further establishes the capacity of the Medical Staff to sue. Minn. Stat. §§ 555.01, *et seq.* (2012). Section 555.01 sets forth the basic purpose of the DJA:

> Courts of record ... shall have power to declare rights, status, and other legal relations.

And Section 555.02 goes on to state:

> Any person interested under a ... written contract, or other writings constituting a contract, or whose rights, status, or other legal relations are affected by a ... contract, or franchise may have determined any question of construction or validity arising under the instrument, contract, or franchise and obtain a declaration of rights, status, or other legal relations thereunder.

Regarding the use of the term "person" in Section 555.02, a later provision of the DJA, Section 555.13 makes it clear that "person" includes an "unincorporated association ... of any character."

If Sections 555.02 and 555.13 were read in isolation, then, conceivably, there might have been some basis for the trial court's attempt to distinguish between voluntary and involuntary associations or between associations that bear some indicia of being a division of another entity as opposed to associations that are unambiguously free-standing. However, the DJA is intended to be read liberally. Thus, Section 555.05 states:

> The enumeration in [Section 555.02] does not limit or restrict the exercise of the general powers conferred in [Section 555.01].

and Section 555.12 states:

> This chapter is declared to be remedial; its purpose is to settle and to afford relief from uucertainty and insecurity with respect to rights, status, and other legal relatious; it is to be liberally construed and administered.

Read in harmony, these latter sections mean that if the dispute in this case was genuine, which it was, and it was of a type that lent itself to declaratory relief, which it also was, then the trial court should have focused on factors that lent themselves to providing declaratory relief to the Medical Staff. Instead, the trial court concluded that its ability to provide relief was restricted, contrary to the remedial purpose of the DJA.

Nothing in the DJA suggests a distinction between "voluntary" or "involuntary" associations. In fact, the Prefatory Note to the Unincorporated Nonprofit Association Act (1996) (U.L.A.) observes that "[t]here is no principled basis" for deeming one nonprofit association to be less of a legal entity than any other nonprofit association. Moreover, the

voluntariness of membership in the Medical Staff is a result of the members' desire for economic and professional advantage, rather than, say, legal compulsion or exceptional duress. An action taken to secure such advantage is deemed voluntary, even if taken under pressure. *Production Credit Assoc. v. Farm Credit Bank*, 781 F. Supp. 595, n.7 (D. Minn. 1991).

Similarly, while the Medical Staff bears certain marks of integration within the Hospital, it also bears indicia of separateness. Although some Medical Staff members are Hospital employees, some are not. The Medical Staff Bylaws are in writing and can be amended only according to an established protocol. (AA115-116.) While the Hospital Board of Directors retains the general authority to run the Hospital, the Medical Staff Bylaws do *not* state (and it should not be implied) that such authority extends to unilateral amendments of those Bylaws, purely at the whim of the Hospital Board of Directors. (*See* AA58.) If the parties intended to allow unilateral amendments by the Hospital Board of Directors, the Medical Staff Bylaws would not include a requirement of two-thirds approval from the Medical Staff. (AA115-116.)

Further, one of the stated purposes of the Medical Staff Bylaws is to provide for "the internal governance of the Medical Staff," another sign of distinction from the Hospital itself. (AA58.) Moreover, the Minnesota Hospital Regulations require all medical staffs of two or more persons to be "an organized group," with bylaws, rules, regulations, and policies, a chief of staff, and with regular, formal meetings. Minn. R. 4640.0800, subp. 2 (2011).

All of these are reasons why the Medical Staff qualified as an unincorporated association under the DJA. *Amici* believe that the mandates of Sections 555.05 and, especially, 555.12 removed any ambiguity about whether the Medical Staff, either in its own name, or in the names of its officers, could bring suit. However, if this Court does find ambiguity, then it would be appropriate to consider the intent of the law and not just its plain language. If this further step is taken, then the argument becomes even more compelling.

Contrary to the directive of the DJA, the trial court rejected a straightforward definition of the term "unincorporated association," and in so doing the trial court violated the requirement of Section 645.16, which states that "the letter of the law shall not be disregarded under the pretext of pursuing the spirit." Appellants also readily distinguished *George v. Univ. of Minn. Athletic Ass'n.*, 107 Minn. 424, 120 N.W. 750 (1909), and *Hyatt v. Anoka Police Dep't*, 700 N.W.2d 502 (Minn. Ct. App. 2005), which the trial court had relied upon, but are inapplicable. (App. Br. at 29-30.)

B. The Rulings Below Opened a Pandora's Box of Mischief.

As discussed, the purpose of the DJA is "to settle and to afford relief from uncertainty and insecurity with respect to rights, status, and other legal relations" through a judicial declaration. § 555.12. By ruling that the Medical Staff was not a proper party, the trial court here did just the opposite.

Under the common law, unincorporated associations were not considered legal entities and are incapable of bringing suit. Hence, at common law each member of such an association must be sued individually in order to secure jurisdiction over and make the

court's judgment binding on that person. *Zak v. Gypsy*, 279 N.W.2d 60, 65 (Minn. 1979); *Bloom v. American Express Co.*, 222 Minn. 249, 252-53, 23 N.W.2d 570, 573 (1946). This can be an expensive and disruptive proceeding for the individuals involved and can place unnecessary burdens on the judicial system. Statutes such as Section 540.151, and Sections 555.02 and 555.13 of the DJA, which authorize suits by or against unincorporated associations, were enacted to alleviate such waste and inconvenience. *See* Prefatory Note to Unincorporated Nonprofit Association Act (1996) (U.L.A.) (explaining rationales for creating legal personage in unincorporated associations).

In this case, nothing practical would have been gained by serving process on each member of the Medical Staff. Once the Medical Staff was dismissed from the case, the suit proceeded with two individual members of the Medical Staff as litigants and the trial court proceeded to declare their rights. Yet, the two remaining litigants had no greater or lesser legal interest in the outcome of the lawsuit than any other member of the Medical Staff. It would have made far more sense—practical and legal—to have had the Medical Staff bring suit as one entity, rather than on a physician-by-physician basis.

In fact, Section 555.11 of the DJA requires: "When declaratory relief is sought, all persons shall be made parties who have or claim any interest which would be affected by the declaration." *See also* Minn. R. Civ. P. 19.01 (setting forth the standards regarding joinder of parties). These procedural rules were not followed. As a result, other members of the Medical Staff, who may be dissatisfied with the outcome, may not be bound by the judgment. If they so choose, they can sue the Hospital for similar relief. Maybe such litigants will secure the same result as the Appellants here, but maybe the

case will be assigned to a different judge who will rule differently. The legal complexities and difficulties would be even greater than they were before this suit was filed.

Additionally, by denying the Medical Staff the capacity to sue and refusing to recognize the Medical Staff officers capacity to undertake the suit, the trial court undercut the expectations of all parties. As memorialized in the Medical Staff Bylaws, *e.g.*, the Chief of Staff is to enforce the Medical Staff Bylaws (AA81 at ¶ 7.2-1(a)) and represent the views and policies of the Medical Staff (*Id.* at 7.2-1(g)). In the experience of *Amici*, such provisions are typical for medical staff bylaws generally (in Minnesota and elsewhere).

Thus, the lower court ruling, if upheld, creates the following results, all without a countervailing purpose, in those cases in which a medical staff brings a declaratory judgment action against a hospital administration: it will add to litigation expense, delay, and complexity; it will increase the likelihood that members of the medical staff become individual litigants; it will result in an incomplete and uncertain resolution of legal rights; it will open the door to multiple lawsuits on the same issue, with possibly inconsistent results; and it will defeat the parties' pre-litigation understanding as to how their disputes should best be resolved. All of these "mischiefs" can be avoided if this Court concludes that medical staffs are unincorporated associations, empowered to bring suit for the common interest of their members.

II. Medical Staff Bylaws Create an Enforceable Contract Between The Medical Staff, Members of the Medical Staff, and the Hospital, Which the Hospital Should not be Allowed to Amend Unilaterally.

In ruling on Count II, the trial court held that although the Medical Staff Bylaws should in some respects be enforceable, they should not be deemed contracts. In Count VII, the trial court held that the Hospital Board of Directors could amend the Medical Staff Bylaws unilaterally—without the two-thirds approval set forth in the Medical Staff Bylaws—as long as the Hospital preceded the amendment with adequate notice to the Medical Staff and an opportunity for the Medical Staff to comment. (*See* A.Add.123.) These rulings were premised in large part on the trial court's concern that the Medical Staff not unduly interfere with the operations of the Hospital. The trial court also acknowledged that Minnesota case law was sparse on these issues, and her rulings would be based on what she deemed to be most in accord with sound public policy regarding hospital administratiou.

Amici acknowledge that the Hospital Board of Directors is legally responsible for and must necessarily be empowered to manage the affairs of the Hospital. *Amici* further acknowledge that the Medical Staff or Medical Staff Bylaws ought not to prevent the Hospital Board of Directors from fulfilling its responsibilities. Finally, *Amici* acknowledge that both sides in this dispute sincerely believe that their actions were taken to enhance the care of patients within the Hospital.

But, *Amici* also assert that the Medical Staff Bylaws, properly interpreted, do not prevent the Hospital Board of Directors from fulfilling its responsibilities. The trial court erred in concluding that they did. The Medical Staff Bylaws serve an important function

in protecting patient care, which represents a balance between the needs of individual patients and the imperatives of the institution. This balance was struck by hospitals and physicians generally within the industry, long before this dispute arose, and it was reflected in the Medical Staff Bylaws in this case. By its rulings, the trial court upset this balance.

In health care, physicians are subject to conflicts of interest, and so, too, are administrators of eleemosynary hospitals owned by religious orders. When a physician considers whether to recommend an extra day of hospitalization, or an additional round of invasive tests, or a surgeon not on a hospital's medical staff, there are financial consequences for the physician and for the hospital. The physician's decision should be based on the interests of the patient, not on those financial consequences. *See* AMA Principle of Medical Ethics VIII ("A physician shall, while caring for a patient, regard responsibility to the patient as paramount."), available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page. Of course, a hospital is also required, legally and morally, to consider the patient's medical needs as paramount.

Notwithstanding the parallel moral and legal obligations of the physician and the hospital, there is a profound practical difference. The physician sees the patient, she talks to him, she touches him, and perhaps she meets his family. It is she who provides the professional care, and it is she who writes the orders for treatment and medication. Minn. R. 4640.0800, subps. 3, 4. The hospital can do none of these things. So, in the process of

keeping the medical needs of the patient paramount over financial considerations, the physician may view the situation differently than the hospital.

The ramifications of this potentially differing viewpoint can be far-reaching. The physician may be an employee of the hospital and on that basis alone will have a powerful reason to keep the hospital happy. Even if not an employee, she will depend on the hospital for her medical staff privileges. Per footnote 17 of the order of July 6, 2012, a loss of such privileges could severely affect her medical practice. (A.Add.77.) Hence, physicians may be squeezed between their professional obligations to their patients and their hospital's desire for revenue.

The Minnesota Supreme Court has long recognized the dangers that can arise when institutions or laypersons can influence medical decisions. Thus, *Granger v. Adson*, 190 Minn. 23, 27, 250 N.W. 722, 723 (1933), states the following:

> What the law intends is that the patient shall be the patient of the licensed physician not of a corporation or layman. The obligations and duties of the physician demand no less. There is no place for a middleman.

In *Isles Wellness, Inc. v. Progressive Northern Ins. Co.*, 725 N.W.2d 90, 93 (Minn. 2006), the supreme court reiterated its adherence to the doctrine prohibiting the "corporate practice of medicine."

At the same time, physicians and hospitals are interdependent. Moreover, the ability of external agents, such as a court, to alleviate the potential pressures hospitals can exert on physicians is (and should be) limited. Hospitals require latitude to run their own affairs.

To resolve this dilemma, in 1951 the AMA, the American Hospital Association, the American College of Physicians, and the Canadian Medical Association established the Joint Commission on the Accreditation of Hospitals (the "Joint Commission").[3] A principal motivation behind the establishment of the Joint Commission was to formulate objective standards for patient care. Those standards have always endorsed a self-governing medical staff, which would enable physicians to exercise independent professional judgment for their patients, while still allowing the hospital administration to run the hospital effectively.

In essence, those standards, as they apply to this case,[4] are summarized as follows:

- The medical staff should perform its duties under written bylaws, binding on the members of the medical staff and on the hospital.
- The members of the medical staff should designate their own leaders.
- Members of the medical staff should be allowed to retain their hospital privileges except when a peer review committee, acting under the authority of the medical staff leadership and adhering to requirements of due process,

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[3] The Joint Commission is a not-for-profit corporation that accredits and certifies more than 19,000 health care organizations and programs in the United States. *See* http://www.jointcommission.org/about_us/about_the_joint_commission_main.aspx. Joint Commission accreditation standards are recognized by the Centers for Medicare and Medicaid Services, and institutions maintaining Joint Commission accreditation may be eligible to forego government inspections. The current composition of the Joint Commissioners is at http://www.jointcommission.org/assets/1/18/Facts_about_Board_of_Commissioners.pdf Minnesota recommends that the rules of Joint Commission be adopted by hospitals. Minn. R. 4640.0700, subp. 1 (2011).

[4] Relevant provisions of the Joint Commission standards and commentaries are included in the Appendix.

determines otherwise, based on considerations of professional competence and abilities.

- The leaders of the medical staff are to represent the medical staff as a whole before the hospital administration.
- The medical staff bylaws can be amended only with the consent of both the medical staff and the hospital.

The Joint Commission standards also make clear that the governing body of the hospital is to have ultimate responsibility for the hospital. While the Joint Commission does not state how the medical staff rights under bylaws are to be reconciled with the reservation of ultimate responsibility in the hospital governing body, the only meaningful way to achieve such reconciliation would be through an implicit requirement that the governing body can only overrule the medical staff for objectively valid reasons. Quite simply, there would be little point in having bylaws that curtail the hospital's administrative powers if a hospital could arbitrarily violate or modify those bylaws.

Likewise, the federal and state laws that require hospitals to maintain medical staff bylaws, which by their nature limit hospital power in areas of medical staff governance, would have little purpose if the hospital could so readily circumvent those limitations. *See, e.g.,* 42 U.S.C. § 1395x(e)(3) (requiring all hospitals that participate in the Medicare Program to have "bylaws in effect with respect to its staff of physicians") and Minn. R. 4640.0800, subp. 2. (also requiring medical staff bylaws). Yet, the trial court ruling in this case allows exactly such circumvention.

Thus, the health care industry has recognized the need for an organized medical staff to buffer the pressures a hospital might potentially exert on a physician's medical decisions, even though the medical staff will act under bylaws that somewhat constrain a hospital's exercise of discretion, but not its ultimate authority. If those bylaws are deemed to be empty shells, however, the protective function of the medical staff will fail. Moreover, if the hospital is allowed to erode the medical staff bylaws, then that is the first step toward erosion of the rights that the medical staff bylaws are designed to safeguard, including the right (and obligation) of a member of the medical staff to exercise her best clinical judgment in caring for her patients.

While *Amici* cannot predict exactly what the Hospital will say in its brief, it is near certain that it will reject any possibility that it would *ever* act in contravention of patient care. In fact, it may well be that the Hospital in this case never would take such an action and that the actions of the Hospital that led to this lawsuit were taken for the purest of altruistic motives. Nevertheless, the organizations that establish policy for the Joint Commission (which include the American Hospital Association, the national counterpart of *amicus curiae* Minnesota Hospital Association) have for decades adhered to the belief that, while a hospital governing body has the right and the obligation to manage the affairs of the hospital, in areas of medical staff governance, as expressed in board-approved medical staff bylaws, the governing body should defer to the decisions of the medical staff itself, unless there is a valid reason why it should not.

The Medical Staff Bylaws at issue in this case are typical.[5] They delineate rights of self-governance, and they require approval from both the Hospital Board of Directors and the Medical Staff itself to authorize an amendment. Also, they make clear that the Board of Directors retains ultimate authority over the Medical Staff and the administration of the Hospital as a whole.

When construing a written instrument, all of its provisions should be given effect. *Motorsports Racing Plus, Inc. v. Arctic Cat Sales, Inc.*, 666 N.W.2d 320, 324 (Minn. 2003). Thus, the Medical Staff Bylaws' reservation of power in the Hospital Board of Directors should not trump the remainder of the document. Rather, the power of the Board of Directors should be tempered by its agreed-upon obligation to act reasonably and consistently with the specific rights granted to the Medical Staff, including the right to approve changes to the Medical Staff Bylaws. *Advantage Consulting Group, Ltd. v. ADT Security Sys., Inc.*, 306 F.3d 582, 586 (8th Cir. 2002); *Stellar v. Thomas*, 232 Minn. 275, 283, 45 N.W.2d 537, 542 (1951). Those rights of the Medical Staff include a right to disapprove an arbitrary or one-sided amendment to the Medical Staff Bylaws, not simply a right to receive prior notice of and comment on such an amendment.

Minnesota Rule 4640.0800, subpart 2 requires that the medical staff "formulate" and "adopt" its bylaws. If the regulation had intended that a hospital board of directors could unilaterally determine the content of the medical staff bylaws, it would have said so

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[5] While *Amici* have not made a detailed comparison between the two, it appears that the Medical Staff Bylaws at issue adhere to the applicable Joint Commission standards and were probably drafted with those standards specifically in mind.

and would not have used the quoted language. The requirement of governing body approval cannot fairly be construed as a license to amend the bylaws arbitrarily and without consent from the medical staff. *See also* Centers for Medicare and Medicaid Services (CMS) *State Operations Manual, Appendix A-Survey Protocol, Regulations and Interpretive Guidelines for Hospitals: Survey Procedures*: Guideline for § 482.12(a)(4)—"Verify that any revision or modifications in the medical staff bylaws, rules and policies have been approved by the medical staff and the governing body." *Available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_a_hospitals.pdf*, at 47.

At least one court has recognized the potential danger that can arise when hospitals have unchecked power over their medical staffs. *Berlin v. Sarah Bush Lincoln Health Center*, 688 N.E.2d 106 (Ill. 1997), considered the legality of hospitals employing physicians. That court held that such employment was legal, in part because an organized medical staff should have sufficient independence to countervail the hospital's administrative authority.

> [W]e find the public policy concerns which support the corporate practice [of medicine] doctrine inapplicable to a licensed hospital in the modern health care industry. The concern for lay control over professional judgment is alleviated in a licensed hospital, where generally a separate professional medical staff is responsible for the quality of medical services rendered in the facility.

688 N.E.2d at 113-114.

Here, the trial court was concerned, and properly so, that if monetary damages were to be allowed to physicians to compensate them for an improper termination of their

medical staff privileges, this would chill the ability of the hospital to protect the public from incompetent physicians. However, the court did not consider that both Congress and the Minnesota Legislature have enacted laws that determine when such damages are or are not appropriate. *See* 42 U.S.C. § 11111 and Minn. Stat. § 145.63. Thus, the trial court took upon itself what is a legislative prerogative, and reached a contrary decision.

Also, the trial court analyzed numerous cases, mostly from states other than Minnesota, while trying to ascertain a principled policy basis for her decision. *But see Campbell v. St. Mary's Hospital*, 252 N.W.2d 581, 587 (Minn. 1977) (noting that bylaws created contractual rights that may be enforced by individuals against the hospital). Some of those cases hold that medical staff bylaws should be enforced against hospitals under the law of contracts; some hold they should not. The court deemed some of these cases to be well reasoned; some she deemed not. These decisions, however, were not made by people who work in or regulate hospitals.

The Joint Commission standards and the Medical Staff Bylaws at issue in this case were written by people who do work in hospitals, and the Minnesota Commissioner of Health regulation and CMS *State Operations Manual* were written by hospital regulators. Those people formulated policies based on their own experience, not on abstractions, and those policies require medical staff approval of amendments to the medical staff bylaws—not just "substantial compliance" with some parts of the amendment procedure. While *Amici* do not remotely suggest that this Court should disregard judicial precedent in this area, *Amici* do believe that this Court should give appropriate deference to the wisdom and experience of that class of persons most affected by a decision in this case.

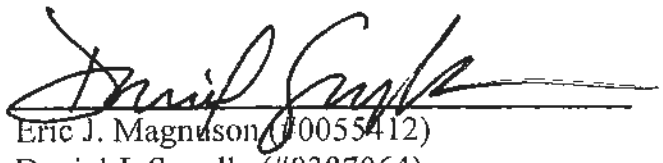
CONCLUSION

The trial court erred in not following the language and spirit of Section 540.151 and provisions of the DJA when it held that the Medical Staff lacked the legal capacity to bring suit on behalf of its members as an unincorporated association. Further, the trial court misinterpreted the language and purpose of the Medical Staff Bylaws when it ruled that the Medical Staff Bylaws were enforceable only to the extent the Hospital Board of Directors chose to honor them and that the Board of Directors could amend them without the consent of the Medical Staff.

For these reasons, and for the reasons so ably stated in the brief of Appellants, *Amici* urge this Court to reverse the summary judgments entered against Appellants and remand this case for further proceedings.

Date: February 6, 2013

Respectfully submitted,



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APPENDIX

APPENDIX

Applicable Joint Commission Hospital Accreditation Standards for the Medical Staff (2012)

Overview

The organized medical staff must create and maintain a set of bylaws that define its role within the context of a hospital setting and responsibilities in the oversight of care, treatment, and services. The medical staff bylaws, rules, and regulations create a framework within medical staff members can act with a reasonable degree of freedom and confidence.

Standard MS.01.01.01: Medical staff bylaws address self-governance and accountability to the governing body.

Elements of Performance for MS.01.01.01.

A2: The organized medical staff adopts and amends medical staff bylaws.

A7: The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

Standard MS.01.01.03: Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

Standard MS.02.01.01: There is a medical executive committee.

Elements of Performance for MS.02.01.01

A5. The medical executive committee acts on behalf of the organized medical staff between medical staff meetings.

Rationale for MS.02.01.01: The organized medical staff delegates authority in accordance with law and regulation to the medical executive committee to carry out medical staff responsibilities. … The medical staff executive committee has the primary authority for activities related to self governance of the medical staff.

Introduction to Standard MS.06.01.05: The organized medical staff is responsible for planning and implementing a privileging process.

Standard MS.06.01.05: The decision to grant or deny a privilege (s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

Standard MS.09.01.01: The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner's clinical practice and/or competence.