Medical Staff Bylaws and Hospital Contracts: Practical Considerations for Closed Departments

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Hospitals and their medical staffs share the common goal of working to provide consistently high-quality care for patients. In practice, however, hospitals and physicians often have different financial needs, pressures, and operational parameters that can result in split interests in achieving this common goal. Alignment between the entities is vital to success in meeting the needs of patients and the community.

An approach often used by hospitals is to utilize exclusive contracts with medical groups or individual practitioners to provide identified professional services.[1] The contract can allow the hospital to set requirements for the practitioner beyond what may be set forth in the medical staff bylaws. In return, the practitioner can negotiate for a more secure income and schedule, including the exclusive right to provide the identified services.

While the potential benefit can be great, the process of engaging in exclusive contracts and creating closed departments must be thoughtful and methodical.[2] Hospital administration and medical staff leadership should strive for consensus through a quasi-legislative process when contemplating closing a department through the use of exclusive contracts. There are also key considerations that need to be undertaken regarding the respective legal documents utilized by the entities: the medical staff bylaws and the contract between the hospital and the practitioner.

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Overview of Exclusive Contracts

An exclusive contract generally is a contract between the hospital and a group of practitioners, wherein the practitioners agree to perform certain services for the hospital, and the practitioners are then granted the exclusive right to perform those services.[3] The contracts can cover all aspects of running a department or they can cover certain services such as taking call or performing certain tests. Traditionally, the most common departments within hospitals to have exclusive contract relationships are radiology, anesthesiology, pathology, and emergency services.[4]

While the specific reasons that an exclusive contract may be of interest to a hospital can vary, the focus should always be on providing quality patient care.[5] From the hospital's perspective, exclusive contracts can provide uniformity or standardization of patient care, clinical administration, and be a useful tool to help ensure compliance with legal requirements and standards. Exclusive contracts also are a way for hospitals to guarantee that they have various specialists available to provide patient care.[6]

Medical staffs also may find the use of exclusive contracts appealing.[7] These arrangements are often used to provide adequate call coverage and may alleviate some administrative burdens that could otherwise fall to medical staff leadership. For some practice specialties, having a dedicated physician group providing certain services can be invaluable to improving scheduling of vital procedures at the hospital.

Quasi-Legislative Process for Closing Departments

While it is the hospital and physician groups that ultimately enter into the contracts, the medical staff is responsible for credentialing and is the authority on patient care. Issues regarding the quality of the proposed exclusive services should be discussed prior to any ultimate decision on exclusivity.

Accordingly, hospitals should undertake a "quasi-legislative" process when making these decisions, taking into account their history regarding exclusive contracts and the corresponding reception by the medical staff.[8] Each step also should be conducted in a manner that focuses on patient care and on creating a rule of general application (not focused on a specific practitioner or group).[9]

- *Identify the issues.* The first step is to articulate the concern and justifications for why a closed department or exclusive contract is being considered. There should be a rational relationship between the concern to be addressed, patient care, and the implementation of an exclusive contract. For example, inability to fill the emergency room call schedule with the existing members of the medical staff can negatively impact patient care and administrative efficiency. Engaging a hospitalist group to be contractually bound to provide coverage for unassigned patients would address the identified concern.
- *Encourage Collaboration.* While the hospital makes the ultimate determination, the decision to close a department should include opportunity for members of the medical staff to comment. In the example above, there may be a communication problem that could be resolved without engaging an outside hospitalist group. By employing a "notice-and-comment" approach, the hospital becomes aware of concerns prior to the execution of a contract, promotes acceptance by the medical staff, and works to insulate itself from potential challenges.[10]
- *RFP Process.* Once the decision is made to enter into an exclusive contract, the hospital should engage in a fair and open Request for Proposal (RFP) process. Hospitals should consider using independent consultants to assist with requesting and compiling proposals and provide an opportunity for various groups to submit proposals. An open

RFP allows for submissions from within the medical staff as well as from outside hospitalist groups. Again, input from the medical staff should be sought to assist in outlining the performance metrics, vendor-clinical requirements, and necessary clinical expertise.

- *Executing the Contract*. Where possible, the hospital should have some input from the medical staff (usually through the Medical Executive Committee or MEC) regarding the group or individual selected, in addition to the medical staff's comments on the quality issues related to exclusivity generally. This part of the process tends to become more political, as the conversation shifts from general considerations to specific decisions regarding the potential recipients of the contract. It behooves the hospital to be aware of possible opposition prior to executing any binding agreement. The MEC should not, however, be involved in, or knowledgeable of, the economic terms of the contract.
- *Implementation of a Closed Department.* All parties should be advised of structural changes before they are implemented, again with a period to voice concerns. The opportunity to be heard creates goodwill and allows the parties to ensure the primary focus is on patient well-being.

Once a department has been closed, hospitals should consider periodically reviewing the arrangement with the medical staff. While it is not necessary to do so each time the contract is renewed, the need to engage a new group or alter the structure of the closed department should, at the very least, trigger a discussion with medical staff leadership.

Considerations for Medical Staff Bylaws

While the medical staff is not a party to the contracts, the medical staff bylaws play an important role. A practitioner who has been engaged to practice at a hospital exclusively through a contract must still apply for and obtain privileges at that hospital.

Typically, practitioners are able to avail themselves to hearing rights should their privileges be curtailed because of concerns regarding quality of care or competence of the physician. Where hospital administration can terminate (or decline to renew) a contract for managerial reasons, it can be problematic if that decision requires the cost and expense of a fair hearing. Alternatively, in instances where quality of care is the real issue, action should be subject to the MEC's decisions with any needed hearing rights.

When drafting or revising bylaws, the following provisions should be considered:

- Include bylaw language that expressly defers to contract provisions except when medical disciplinary cause or reason is involved. This clarifies the role of the medical staff in addressing different types of issues. At the same time, it also avoids obligating the medical staff to respond to, investigate, and defend actions taken by the hospital for administrative purposes.[11]
- Include specific language requiring that practitioners be affiliated with a contracted group to exercise clinical privileges within a particular specialty.
- Include provisions that anticipate possible future closure of a department. For example, the bylaws should make clear that termination of medical staff membership/clinical privileges of incumbent physicians due to proper execution of an exclusive contract do not give rise to hearing rights.[12]
- Expressly state that medical staff membership and clinical privileges for providers in a closed department will automatically end upon termination of the agreement (or removal of the individual practitioner from the contracted group), without hearing rights where such membership was granted for the sole purpose of providing services pursuant to that agreement.[13] This provision also can be replicated in each contract.

Hospital Considerations

Generally speaking, hospitals have the right to enter into contracts, with the Board making decisions as to exclusivity. The hospital needs to ensure that the terms bear a relationship to the issues identified through the quasi-legislative process. The contract should allow the hospital to set forth performance requirements that go beyond membership to the medical staff. The terms of the contract should complement the medical staff bylaws in a manner that facilitates cooperation between the entities and the provision of quality patient care.[14]

Specifically, hospitals should consider the following:

- Including provisions that require group practitioners to obtain medical staff membership and the appropriate clinical privileges, through the regular medical staff process.[15]

Once a department has been closed, hospitals should consider periodically reviewing the arrangement with the medical staff.

- Also including no-cause termination provisions within the contract, creating the structural equivalent of an at-will professional relationship.
- The contract should exempt from its termination provisions actions taken for medical disciplinary cause or reason. The contract should separately confirm that hearing rights under the medical staff bylaws do not apply to exclusive contract terminations that do not trigger reporting obligations.[16]
- The termination provision should include a notice period, which should be decided based on the needs of replacing a physician or physician group post-termination, the average timeframe for privileging with the medical staff, state licensing times, as well as the credentialing process for insurance carriers that may be required for a contract with the hospital.
- To the extent possible, the medical staff bylaws and the hospital contracts should be cohesive documents. However, there should be language indicating that the contract language prevails in the event that the there is a conflict between the two documents. This will help to ensure that the parties bound by the contract—the hospital and the practitioner—are aware of their rights and obligations and reduce the possibility of confusion arising from the practitioner's separate membership on the medical staff. For clarity, this language also should appear in the medical staff bylaws, with the provision that no hearing rights required by law may be denied.

Conclusion

The decision whether to close a department should be made based on the specific needs and structure of the hospital and the medical staff. By engaging in a fair and open process that actively involves the medical staff in the decision, hospitals will promote cooperation and acceptance of the use of contracts as well as keeping the focus on patient care. By undertaking the necessary steps of structuring the medical staff bylaws and the exclusive contracts to complement each other, the parties will have taken steps to protect their respective rights before any conflict arises.

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Endnotes

1 This article is focused on best practices and practical considerations regarding procedural issues faced by hospitals and medical staffs when utilizing exclusive contracts. The authors are not taking a position as to threshold policy questions regarding the appropriateness of exclusive contracting in any given set of circumstances.

2 Determining whether exclusive contracts are a viable option for a hospital requires a case-by-case analysis. An initial review of existing legal documents (such as existing hospital or medical staff bylaws) and applicable law (which varies by jurisdiction) must be undertaken by each hospital prior to any efforts to close departments and/or engage in an professional services arrangement pursuant to an exclusive contract.

3 Depending on the jurisdiction, these contracts can form an employment or an independent contractor relationship. In a minority of states, including California and Texas, hospitals are prohibited from employing physicians. *See, e.g.*, Dep't of Health and Human Servs., Office of Inspector Gen., *Executive Summary, State Prohibitions on Hospital Employment of Physicians* (Nov. 1991).

4 *See, e.g., Know Your Facility's Exclusive Contracts*, 4 Credentialing & Peer Rev. Legal Insider, No. 7, at 1 (July 2007).

5 *See, e.g., Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984), *abrogated on other grounds by Ill. Works Inc. v. Indep. Ink, Inc.,* 547 U.S. 28, 43 (2006) (Brennan, W., concurring in judgment) (listing the ways the exclusive arrangement improved "patient care and permits more efficient hospital operation"); *Hutton v. Mem'l Hosp.,* 824 P.2d 61, 64 (Colo. App. 1991); *Redding v. St. Francis Med. Ctr.,* 255 Cal. Rptr. 806 (Ct. App. 1989) ("The trial court found the hospital's interest in improving patient care and, most significantly, reducing mortality rates outweighed the potential adverse economic impact on a group of doctors, including plaintiffs. The trial court was entitled to attach great importance to the public policy considerations involved, the societal, public interest in the best possible medical care."); *Belmar v. Cipolla,* 475 A.2d 533 (N.J. 1984) ("The evidence points to the conclusion that the decision to enter an exclusive contract for the provision of anesthesia services was motivated by the hospital's desire to insure a high standard of medical care."); *see also* Cal. Med. Ass'n, *California* Physician's Legal Handbook, Vol. 5, § 32.18, (2016).

6 Controlling costs is often a reason provided for exclusive contracts. However, depending on the geographical area or resources available, hospitals could need to pay a premium due to practitioner unavailability and necessity for a specific service. *See* Jeff Goldsmith, Nathan Kaufman & Lawton Burns, *The Tangled Hospital-Physician Relationship,* Health Affairs Blog, (May 9, 2016), *available at* http://healthaffairs.org/blog/2016/05/09/the-tangled-hospital-physician-relationship/.

7 There are also arguments against the use of exclusive contracts that should be considered. For example, an exclusive contract may disrupt existing patient care and working relationships or the group contracted to provide services may not have the same level or diversity of expertise available through an open staffing arrangement. *See, e.g.,* Cal. Med. Ass'n, *California Physician's Legal Handbook*, Volume 5, § 32.18, (2016). Implementing a formal process, as outlined in this article, will help to ensure that the hospital and the medical staff has ample opportunity to weigh the pros and cons of an exclusive contract for the specific circumstances faced by that hospital.

8 "A decision is considered quasi-legislative if it is one of general application intended to address an administrative problem as a whole and not directed at specific individuals." *Major v. Mem'l Hosp. Ass'n,* 84 Cal. Rptr. 2d 510 (Ct. App. 1999); *see also Anne Arundel Gen. Hosp., Inc. v. O'Brien,* 432 A.2d 483, 491 (Md. Ct. Spec. App. 1981) (explaining that due process rights are not violated "where the determinations to be made are quasi-legislative or administrative" and holding that the practitioners were "given due process during the administrative procedures in which the Hospital made its decision" to close the department); *Martin v. Mem'l Hosp. at Gulfport,* 130 F.3d 1143 (5th Cir. 1997) ("Generally applicable legislative and quasi-legislative decisions, wherein the competency or integrity of the individual appellants is not in question, are not subject to procedural due process constraints, even though they result in a deprivation of a recognized liberty interest. Rather, such decisions are subject only to substantive due process analysis.").

9 Documentation is very important as the hospital and the medical staff may need to be able to produce evidence demonstrating the process. Because confidentiality is always a concern when addressing issues of patient care, conscious consideration should be given to where these discussions take place and how this documentation is maintained. *See, e.g.,* Cal. Evid. Code § 1157 (West).

10 *See, e.g., Redding v. St. Francis Med. Ctr.,* 255 Cal. Rptr. 806 (Ct. App. 1989) (noting that "[t]he proposed change was openly discussed at St. Francis during early 1988.").

11 For example, a practitioner whose exclusive contract is terminated or not renewed may continue to have privileges but have no means to exercise those privileges due entirely to actions by the hospital. *See, e.g., Stears v. Sheridan County Mem'l Hosp. Bd. of Trs.,* 491 F.3d 1160 (10th Cir. 2007).

12 *See, e.g., Bartley v. E. Me. Med. Ctr.,* 617 A.2d 1020 (Me. 1992) (noting the distinction between a grant of privileges and the right to exercise privileges and that "[b]ecause their staff privileges have not been constructively revoked or significantly reduced, Plaintiffs are not entitled to invoke the notice and hearing provisions of the Medical Staff Bylaws."); *Dutta v. St. Francis Reg'l Med. Ctr., Inc.,* 867 P.2d 1057, 1060-63 (Kan. 1994) (holding that the hospital terminated an exclusive contract without triggering the hearing provisions in the bylaws because the reasons for doing so were solely economic and unrelated to the physician's professional competency); *see also Garibaldi v. Applebaum,* 742 N.E.2d 279 (2000); *Engelstad v. Va. Mun. Hosp.,* 718 F.2d 262 (8th Cir. 1983).

13 *See Anne Arundel Gen. Hosp., Inc. v. O'Brien, 432 A.2d 483, 492 (Md.* Ct. Spec. App. 1981) (holding that radiologists, who had been under exclusive contract, were not entitled to a due process hearing regarding their medical staff privileges where the contract and privileges expired by agreement on a date certain); *Nilavar v. Mercy Health System-Western Ohio,* 494 F. Supp. 2d 604, 625-26 (S.D. Ohio 2005) (holding that termination of privileges pursuant to contract and "not for any reason that relates to his professional duties or his medical competence" did not give rise to hearing rights); *see also Abrams v. St. John's Hosp. & Health Ctr.,* 30 Cal. Rptr. 2d 603 (Ct. App. 1994); *Kessel v. Monongalia Cnty. Gen. Hosp. Co.*, 600 S.E.2d 321 (W. Va. 2004); *Van Valkenburg v. Paracelsus Healthcare Corp.,* 606 N.W.2d 908 (N.D. 2000); *Hutton v. Mem'l Hosp.,* 824 P.2d 61, 64 (Colo. App. 1991).

14 This article sets forth a non-exhaustive list of potential contract provisions that is focused on the need for cohesion between the medical staff bylaws and the contract terms. Other important legal considerations also apply, including, but not limited to, fraud and abuse laws, antitrust laws, The Joint Commission requirements, Medicare regulations, etc.

15 The decision whether to grant membership must be reserved for the medical staffs. California law, for example, prohibits hospitals from controlling the medical practice of any physician, including by controlling the outcome of the appointment and reapplication process. *See* Cal. Bus. & Prof. Code §§ 2052, 2400 (West).

16 The contract should specifically identify the applicable jurisdiction's reporting requirements as well as reporting required to the National Practitioner Data Bank.