

# Denial of Continued Clinical Privileges of Excluded Physicians Following Hospital's New Exclusive Services Contract

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Practice Area: Health Law

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A May, 1999, decision of a California Court of Appeals case addresses the complex and sensitive issues in the aftermath of exclusive contract decisions regarding specialty medical services in hospitals. The case of *Major et al. vs. Memorial Hospitals Association et al.*, arose when the two hospitals owned by the defendant corporation implemented a closed department of anesthesiology and contracted for the exclusive provision of anesthesia services with a Clinic. In the process of implementing the exclusive relationship, several physicians previously providing services for the hospitals were denied the ability to continue to practice at the hospitals.

While the *Major* case addresses the circumstances arising when a hospital determines on a prospective basis to "close" a department and cover the need for services by means of an exclusive contract, similar issues can arise when a hospital concludes to discontinue an existing contract for a closed department or service and replace the current group with another. Related conflicts exist when members of a group with an exclusive contract separate from the contracted group and thereafter challenge the hospital's legal ability to foreclose the physician(s) from exercising staff privileges at the hospital. In that California law is often looked to by courts in others states, the principles and reasoning of the court in *Major* should have application to such situations.

Challenges to a hospital's ability to implement a clinical service by an exclusive contract with a physician or group of physicians have occurred often throughout the country, most involving radiology, pathology or anesthesiology. As the provision of services has changed in recent years, however, the exclusive contracting for specialty services has broadened to include more areas of medical practice. The direct contracting for employment of physicians by hospitals has also now heightened concerns by some nonemployed physicians that a next step might be to exclusively restrict entire areas of some services, e.g., surgery, to those employed physicians of hospitals. At the same time, all hospitals are under major pressure to control if not decrease costs of services. In some instances exclusive contracts with a group of physicians can provide opportunities for hospitals to have some control over the cost of medical services when dealing directly with payment programs.

## Summary of Facts

The facts in the *Major* case replicate many of those of hospitals and physicians in these disputes. In summary, the facts showed:

- An “open” anesthesia staffing of the two hospitals through the late 1980’s, with a major clinic providing about one-half of the coverage by its physicians and the balance provided by “independent” anesthesiologists, including the plaintiffs.
- Documented, ongoing department management problems involving coverage, scheduling, allegations of financial manipulation, intense disputes in front of patients and personnel, failure to implement narcotics control programs, and related disputes and non-accountability.
- Medical Executive Committee and Quality Assessment Committee involvement in the discussions and decision to “close” the department as well as the issuance of a Request For Proposal for exclusive contractual coverage of the department.
- Establishing of a special medical and management committee to review RFP’s replies and report its recommendation to the Board of Directors of the Hospitals.
- Awarding of a contract with the Clinic calling for anesthesia coverage by Clinic physicians and independent physicians under sub-contracts with the Clinic.
- Failure of the Clinic to offer sub-contracts to the three physician plaintiffs in the litigation.
- Denial of the excluded physicians their clinical privileges after the exclusive contract was implemented by the hospitals.

The plaintiff physicians’ lawsuit challenged the decision of the hospitals on a wide variety of grounds. These claims included a violation of a California Civil Rights Act, restraint of trade, tortious interference with professional business relationships, breach of contract, defamation and civil conspiracy. The lawsuit was commenced on July 31, 1992. A trial court issued a judgment in favor of all the defendants and the Court of Appeals affirmed the decision in a thorough decision.

### **Court’s Analysis**

In that the litigation commenced on the date the physicians’ membership and privileges were terminated concurrent with the contract with the Clinic, no hearings under the review procedures of the hospitals took place. One of the essential components of the physicians’ litigation, however, was their claim that the closing of the department by the hospitals was an “adjudicative” decision of the hospital entitling them to the medical staff hearing process. The hospitals maintained that the decision was a “legislative,” or “quasi-legislative” decision which would not create a right to any hearing for the physicians. Under long-standing California law, there is no right to individual minimal due process if a decision of this nature is as a result of quasi-legislative actions of the hospital.

The difference between an adjudicative action and a quasi-legislative action is, in essence, its impact. The court stated that 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. “Generally speaking, a legislative action is the formulation of a rule to be applied to all future cases, while an adjudicatory act involves the actual application of such a rule to a specific set of existing facts.” If the decision resulting in the deprivation of a physician’s staff privileges is adjudicative, the court reviews whether the physician was afforded the due process to which he or she is entitled under the by-laws or other governing law. If such action is quasi-legislative, judicial review is limited to determining whether the action is arbitrary, capricious or entirely lacking in evidentiary support or whether any required procedures or notices have not been provided.

In *Major*, the plaintiffs argued that the decision to close the department was aimed specifically at them, and thus adjudicative. Further, they claimed that even if quasi-legislative, the action was arbitrary, capricious and did not comply with the procedures called for in the medical staff bylaws.

In concluding that the action of closing the department was quasi-legislative, the court affirmed the finding of the trial court that the action was taken to rid the hospitals of the undesirable effects of an open department and not directed specifically at excluding the plaintiffs from practicing. The court found the decision was justified due to the hospital's over-riding concern for the quality of patient care. Evidence in the trial showing the shortage of anesthesiology coverage, the absence of appropriate professional relations between the anesthesiologists themselves and others, the absence of authority and leadership within the department and related matters requiring departmental accountability all enhanced the court's conclusion that such action supported concerns for patient care.

In a rather strong commentary, the court observed that "(C)onsidering the evidence, the question that comes to mind is not whether there were systemic problems in the anesthesia department which would justify closure of the department, but why it took Memorial Hospitals as long as it did to make this decision."

The court further found no basis for the physicians' contention that their exclusion as a result of closing the department is a de facto adverse reflection on their character, competency or qualifications, which might convert the decision to an adjudicative nature. Important to the court's conclusion was the fact that hospital was not involved in the Clinic's decision under the exclusive contract which resulted in the plaintiffs not being offered a sub-contract. Additionally, citing another California case, the court noted that "Where a doctor loses or does not attain staff privileges because of professional inadequacy or misconduct, the professional reputation of that doctor is at stake. In that circumstance, his or her ability to become a member of the staff at other hospitals is severely impaired. On the other hand, a doctor's elimination by reason of a departmental reorganization and his failure to sign a contract does not reflect upon the doctor's professional qualifications and should not affect his opportunities to obtain other employment."

The court stated that the plaintiffs want the court to give them insurance not available to the vast majority of the working public: absolute job security. "This," the court stated, "we decline to do."

Analyzing the process followed by the hospitals in closing the department, the court concluded that there were more than sufficient indications rationalizing the decision by the hospitals to overcome any challenges that the action was arbitrary, capricious or lacking any basis. Further, the hospitals' internal process comported to that referenced in the medical staff bylaws which directed in such decisions that there be involvement by the Medical Executive Committee as to matters of quality. In addition, in that the contract with the Clinic set forth only the requirement of adequacy of coverage and that the physicians with which the Clinic would sub-contract would be licensed and board certified in anesthesiology, the process of both closing the department and implementing an exclusive contract met acceptable standards. While noting that the selection process was "not a model of consistency and could have been done better or differently," the court stated that it is not the role of a reviewing court to question the wisdom of an employment decision.

### **Lessons of the Case**

This case was seven years in process, and may not be done yet. It is much more common in 1999 to have exclusive contracts covering some specialty services in hospitals than it was in 1992. Such contracts today often seek to address the issues presented in the *Major* case. Also, medical staff bylaws now often anticipate and acknowledge such contracts and attempt to define fair hearing procedures, if any, to which practitioners who lose contractual exclusivity may have.

Anticipating such possibilities by means of clear contract language, and having current medical staff bylaw provisions that are consistent with contract provisions in existing exclusive contracts, is the best approach to preventing long and costly litigation. Hospitals should also consider having exclusivity policies approved by the Governing Board setting forth the rationale supporting exclusive contracts, or updating existing policies if they are not current.

The policies should assure that the Board authorizes decisions in regard to such contracts. Advice and consultation from medical staff leadership related to assurances of quality care is appropriate in such arrangements. However, final decisions regarding such contracts need to rest with a Governing Board or pursuant to explicit Board delegated authorization.

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