IN THE TENNESSEE SUPREME COURT AT NASHVILLE

CITY OF COOKEVILLE, TENNESSEE, by and through COOKEVILLE REGIONAL MEDICAL CENTER, and COOKEVILLE REGIONAL MEDICAL CENTER AUTHORITY Plaintiffs-Appellees	)	
v.	)	Case No.M2001-00695-SC-R11-CV On Appeal from the Chancery Court for Putnam County (No. 99-219)
WILLIAM H. HUMPHREY, M.D., JOHN P. LIMBACHER, M.D., DANIEL F. COONCE, M.D., GEORGE O. MEAD, M.D., and PUTNAM RADIOLOGY, P.C. Defendants-Appellants	)	

BRIEF OF *AMICI CURIAE* AMERICAN MEDICAL ASSOCIATION, AMERICAN COLLEGE OF RADIOLOGY, TENNESSEE MEDICAL ASSOCIATION, PUTNAM COUNTY MEDICAL SOCIETY, AND MEDICAL STAFF OF COOKEVILLE REGIONAL MEDICAL CENTER

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATE STATUTES

MISCELLANEOUS

ISSUES PRESENTED

I. Whether it is permissible for a hospital, particularly a public hospital such as CRMC, to use the power to grant and revoke physicians' medical staff privileges to eliminate perceived competition from the physicians without consideration of the effect upon the quality of care?

II. Whether The Medical Staff Bylaws contractually prohibit CRMC from denying medical staff privileges "on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality", and thereby preclude termination of Defendants' Medical Staff privileges for anti-competitive reasons?

III. Whether CRMC can avoid its due process and other obligations under the Medical Staff Bylaws by eliminating medical staff privileges under the guise of "exclusive contracting?

A. Whether CRMC's failure to provide the radiologists with a hearing before terminating Defendant's clinical privileges through an exclusive contract is a contractual breach of the Medical Staff Bylaws?

B. Whether *Alfredson v. Lewisburg Community Hospital*[1], which holds that the hospital is bound by the requirements of the Medical Staff Bylaws even in exclusive contracting transitions, requires a hearing in these circumstances?

[1] 805 S.W.2d 756 (Tenn. App. 1989).

C. Whether T.C.A. § 7-57-603 reflects a clear intent to overrule the *Alfredson* case and authorizes CRMC's actions to remove the radiologists from the hospital?

D. Whether T.C.A.§ 68-11-227(b) provides that hospitals cannot automatically terminate other physicians' staff privileges through the use of an exclusive contract in the absence of a separate written agreement to that effect?

E. Whether T.C.A.§ 68-11-227(b) confirms that the General Assembly did not intend to overrule *Alfredson* in 1996?

IV. Whether T.C.A. § 7-57-603 reflects a clear intent to overrule the right of physicians to practice at public hospital such as CRMC, which was recognized in *Henderson v. City of Knoxville*?

SUMMARY OF ARGUMENT

I. Introduction.

II. Hospitals, particularly public hospitals such as CRMC, should not be allowed to use "economic credentialing", the granting and revocation of medical staff privileges to accomplish a hospital's anticompetitive or other financial objectives, without considering their effect upon the quality of care.

III. The Medical Staff Bylaws prohibit the hospital from denying medical staff privileges "on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality", and thereby preclude termination of Defendants' Medical Staff privileges for anti-competitive purposes.

IV. Hospitals cannot avoid their due process and other obligations under the Medical Staff Bylaws by eliminating medical staff privileges under the guise of "exclusive contracting".

A. CRMC's failure to provide the radiologists with a hearing before closing the radiology department to them is a breach of the Bylaws contract.

B. *Alfredson v. Lewisburg Community Hospital* decision, which holds that the hospital is bound by the requirements of the Medical Staff Bylaws even in exclusive contracting transitions, requires a hearing in these circumstances.

C. T.C.A. § 7-57-603 did not indicate a clear intent to overrule the *Alfredson* case and does not authorize CRMC's actions.

INTEREST OF THE *AMICI*

The American Medical Association and the Tennessee Medical Association are voluntary membership organizations representing thousands of physicians throughout Tennessee. The rights and interests of all physicians who treat patients in Tennessee hospitals will be directly affected by the Court's decision in this case. As representatives of physicians who are members of hospital medical staffs throughout the state, the AMA and TMA have a substantial interest in the case. They can assist the Court in providing the perspective of the physicians who understand the workings of hospitals, the historical evolution of the language used in the medical staff bylaws, and the impact of this Court's decision on physicians and their ability to provide quality patient care free of undue influence from hospitals.[2]

The American College of Radiology also represents almost eight hundred radiologists in Tennessee. As physicians with the same specialty as the defendants in this case, these members will be directly affected by the Court's decisions in this case. They may face similar inappropriate hospital action.

The Putnam County Medical Association represents physicians who admit their patients to CRMC, Cookeville's only hospital. They will be affected by the impact that this decision has upon the quality and availability of medical services at CRMC.

The CRMC Medical Staff also has an interest in the outcome of this case. The CRMC Medical Staff Bylaws provide that the Medical Staff of CRMC must account for the quality and appropriateness of patient care rendered at CRMC.[3] This responsibility includes the duty "to

[2] AMA and TMA appear not only on their own behalves as corporate entities but as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition of the AMA and the state medical societies of every state, plus the Medical Society of the District of Columbia. It was established to concentrate the resources of its members and represent the views of organized medicine in the courts.
[3] J.S. 4, Section 2.2-1, p. 4.

recommend to the Board action with respect to appointments, reappointments, staff category, departmental assignments, *clinical privileges*, and corrective action".[4] (Emphasis added.) The Medical Staff therefore has a significant interest in the issues of this case as they relate to the effect that the Board's privileging actions will have upon the quality of care at CRMC. This perspective will be of assistance to the Court.

The individual members of the Medical Staff also have an interest in this matter. The quality of radiology services available at CRMC will directly impact staff physicians' ability to provide quality care to their patients, because they rely upon the skill of the radiologists in obtaining information upon which they base their diagnoses. Also, if CRMC is permitted to disregard the protections and procedures of the Medical Staff Bylaws in this instance, the hospital may also deny other physicians' privileges for inappropriate reasons and without complying with the Medical Staff Bylaws.

[4] J.S. 4, Section 2.2-2, pp. 4-5.

ARGUMENT

I. INTRODUCTION

The power to deprive physicians of the ability to practice at a hospital through the denial of medical staff privileges is extremely important, not only to the physicians whose professional livelihood may be destroyed, but also to the patients who need the care of their physicians in a hospital setting. The potential that this power will be misused for inappropriate purposes is very real, as demonstrated by this case. The opinions of the lower courts are based upon a misinterpretation of the law, and if not reversed, will open the door to further abuse of this power. For this reason, *amici curiae* urge the Court to reverse the decision of the Court of Appeals.

This case is of particular concern for several reasons. First, the hospital's efforts to eliminate the radiologists from the medical staff are based upon improper motives, are without good cause, and were taken without consideration of the effect upon the quality of care. Second, the hospital has run roughshod over contractual bylaws provisions designed to prevent just this type of abuse of the hospital's power to grant and deny medical staff privileges. Third, because the vehicle used to arbitrarily eliminate the radiologists' privileges was "exclusive contracting", this case will have implications for all physicians whose privileges may be terminated through the guise of exclusive contracting. Finally, this case is determinative of the rights of physicians to practice at public hospitals.

II. Hospitals, particularly public hospitals such as CRMC, should not be allowed to use "economic credentialing", the granting and revocation of medical staff privileges to accomplish a hospital's anticompetitive or other financial objectives, without considering their effect upon the quality of care.

For years, the American Medical Association and the American College of Radiology have opposed "economic credentialing" by hospitals, such as occurred in this case. The AMA defines "economic credentialing" as "the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges".[5]

The concern of the AMA and other *amici* is that credentialing decisions that are made to discourage competition or for other inappropriate reasons can have an adverse effect upon the ability of physicians to provide quality care in the hospital setting free of undue influences. The hospital's granting of the right to practice at a hospital is of extreme importance to the patients who need the care of their physician at the hospital, as well as to the physicians whose professional livelihood may depend upon the ability to practice in a hospital. This is particularly true at public hospitals, or when there is only one hospital in a community. The physicians who rely upon the medical services of the hospital based physicians in the treatment of their patients need to assure the quality of these services. Therefore, it is important that the power to grant or deny staff privileges should not be used capriciously or for improper purposes.

[5] AMA Policy H-230.975 "Economic Credentialing".

III. The Medical Staff Bylaws prohibit the hospital from denying medical staff privileges "on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality", and thereby preclude termination of Defendants' Medical Staff privileges for anti-competitive reasons.

The CRMC Medical Staff Bylaws substantively limit the hospital's right to unilaterally or arbitrarily deny medical staff privileges. They provide:

> Staff membership or particular clinical privileges ***shall not be denied on the basis of any criterion unrelated to the efficient delivery of patient care at the generally recognized professional level of quality in the hospital***, including, but not limited to, sex, race, creed, religious beliefs and national origin or to an otherwise qualified handicapped practitioner. (Emphasis added.) J.S. Exh. 4, § 3.2-3.

Here, CRMC is contractually limited in the reasons upon which privileges can be reduced. In *Amici's* experience, only in recent years have medical staff bylaws included such provisions, which are intended to preclude arbitrary action by the hospital based upon inappropriate criteria. Because the issue before the Court involves the interpretation of the Bylaws contract, the presence of this language is of critical importance to the determination of the case. Unless the hospital can demonstrate how the denial of clinical privileges to the Defendants is related to the "efficient delivery of patient care at the generally recognized professional level of quality in the hospital", the hospital is in breach of this contract term if those privileges are denied.

This Bylaws provision also avoids the conclusion that loss of clinical privileges does not invoke due process rights so long as Medical Staff membership is not affected. The Bylaws expressly prohibit denial of either Medical Staff privileges *or* clinical privileges on impermissible criteria.

It does not appear that this Bylaws provision quoted above has been interpreted in any of the cases cited by the Court of Appeals as failing to follow the *Alfredson*[6] view.[7] Clearly, had this key language been included in the Bylaws in those cases, the opinions would have included that fact. Many of the cases cited by the Court of Appeals as rejecting *Alfredson* in fact distinguished it based upon differences in Bylaws language. E.g., *Bryant v. Glen Oaks Medical Center*, 650 N.E.2d 622 (Ill.App. 1995) (Unlike *Alfredson*, the physician's right to use the hospital was not eliminated by the hospital's actions); *Dutta v. St. Francis Reg. Med. Ctr.*, 867 P.2d 1057 (Kan. 1994) (the Bylaws had a specific clause that the right to a hearing was limited to those matters bearing on professional competency and conduct).

The case of *Van Valkenburg v. Paracelsus Healthcare Corporation*[8], cited by the Court of Appeals, is factually distinguishable from the instant case. In *Van Valkenburg*, the Court concluded that the plaintiff emergency physicians were <u>not</u> precluded from using the hospital facilities. The Court noted that the plaintiff physicians were still able to see their patients in the emergency department, and that the only restriction on their exercise of privileges was that they were not assigned staff coverage shifts in the emergency department.[9] Unlike the *Van Valkenburg* situation, in which the physicians were able to continue using the emergency department, it is clear from the Request for Proposals that defendant radiologists would not be permitted to perform imaging services after the execution of the exclusive contract:

> Under the contractual arrangement we are seeking to establish, a single radiology group will operate and administer the entire imaging department, and the members of the that radiology group **will be the only physician members of the Imaging Department and will be the sole providers if physician staffing for the Imaging Department**. There may be other radiologists who are members of the CRMC Medical Staff and who will have privileges at CRMC, but who are not

[6] *Alfredson v. Lewisburg Community Hospital*, 805 S. W. 2d 756 (Tenn. 1991).
[7] See cases cited at page 9 in Court of Appeals opinion.
[8] 606 N.W.2d 908 (ND 2000).
[9] 606 N.W.2d 918.

> part of the contracting group and **who will not be part of the Imaging Department**.[10] (Emphasis added.)

The Bylaws were also different than the CRMC Bylaws, in that the "Hearing and Appellate Review" section of the Bylaws in *Van Valkenburg* were expressly limited to those corrective actions that had a bearing on professional conduct, competency, or character.[11] There is no such limitation in the CRMC Medical Staff Bylaws. Clearly, the outcome of these cases is very fact-specific.

Tennessee law mandates that privileging decisions can only be based on criteria related to patient care. The state regulations governing hospitals in Tennessee specify that privileging decisions *must be based upon "clearly defined", appropriate criteria*. Chapter 1200-8-1-.06(2)(c)[12] of the regulations provides that:

> Criteria for appointment and delineation of privileges shall be ***clearly defined*** and included in the Medical Staff Bylaws, and ***related to standards of patient care, patient welfare, the objectives of the institution, or the character or competency of the individual practitioner***. (Emphasis added.)

Even if one were to argue that "stifling perceived competition" could be an acceptable criterion for denying privileges, it would still be improper unless this criterion is clearly defined in the Medical Staff Bylaws.

If the hospital does reduce or deny the Defendants' medical staff privileges, the reduction is a breach of the Bylaws contract if the denial is based upon impermissible criteria as defined above. Trying to destroy the hospital's perceived competition is unrelated to the "efficient delivery of patient care", and certainly has nothing to do with its quality.

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[10] Exhibit 7, pages 1-2, ¶ I.
[11] 606 N.W.2d at 917.
[12] Comp. Rules and Regs. of the State of Tennessee.

The importance of assuring that medical staff privilege decisions are based upon quality of care is further demonstrated by the fact that the Hospital Accreditation Program Standards of the Joint Commission on Accreditation of Health Care Organizations (JCAHO) [13] mandate that decisions on clinical privileges must "consider criteria that are directly related to the quality of care", and that a hearing on these issues is *mandatory*:

> MS. 5.4.4 Decisions on reappointments or on revocation, revision, or renewal of clinical privileges ***must consider criteria that are directly related to the quality of care***.
>
> MS. 5.4.4.1 Such decisions are ***subject to a fair hearing*** and appeal process.
>
> MS. 5.4.5 Decisions on appointments or on granting of clinical privileges must consider criteria that are ***directly related to quality of care***.
>
> INTENT OF MS. 5.4.4-MS. 5.4.5.
>
> The determination of initial appointment or reappointment or of granting, revocation, revision or renewal of clinical privileges is based on a variety of criteria**.** ***If criteria are used that are unrelated to the quality of care or professional competency, evidence exists that the impact of resulting decisions on the quality of care is evaluated. For medical staff members and other individuals holding clinical privileges, the decisions about the impact on the quality of care is subject to a fair hearing and appeal process (as are credentialing decisions that are based on criteria directly related to the quality of care).*** (Emphasis added.)[14]

Thus, basing credentialing decisions on economic factors, without consideration of the effect on quality of care, and without a hearing, would violate industry standards could adversely affect

[13]JCAHO is a national organization that inspects approximately 80% of the hospitals in the United States to determine whether they meets accreditation standards. Failure to comply with these standards can affect the hospital's ability to receive federal Medicare payments. 42 U.S.C. 1395bb(a)(1). The Tennessee Court of Appeals, Middle Section, has noted that the JCAHO Standards "are the most comprehensive guidelines available to hospitals regarding the delineation of clinical privileges" and are "recognized as an expression of the hospital industry's desire to maintain the quality of professional practice in its institutions". *Alfredson v. Lewisburg Community Hospital*, M.S. Tenn. App. No. 88331-II (November 8, 1989).

[14] Joint Commission Hospital Accreditation Standards, copy attached.

the hospital's accreditation status. These accreditation standards contain no exception for anticompetitive actions cloaked as "business decisions" or "exclusive contracting"; they are not limited to privilege decisions based upon a practitioner's competency.

CRMC seems to argue that it has the absolute, unfettered ability to revoke medical staff privileges if it does so for what it determines are "administrative reasons" *or any reasons that do not relate to the competency of the physician*. Should the Court adopt such reasoning, every physician's staff privileges are at risk of revocation for any reason *or without reason*.

In this case, the hospital does not even pretend that its use of hospital staff privileging power to retaliate against the radiologists for their involvement in another imaging facility was motivated by concerns relating to quality of care. Although CRMC's brief suggests that there were "efficiency" reasons for closing the radiology department, in fact the only support for this assertion is boilerplate recitals in a Request for Proposal (J.S. Exh. 7), and in a draft contract (J.S. Exh. 10). A review of the Hospital Board minutes leaves no doubt that the hospital's actions were purely for economic, anticompetitive purposes:

> **Based upon the intention of Putnam Radiology to establish Premier Diagnostic Imaging Center, LLC**, Mr. Gaw moved that the Board direct the Administrator to issue a request for proposals for an exclusive imaging department services contract, and upon evaluation of the proposals to present to the Board the best proposal. (Emphasis added.)

The hospital's brief characterized its hardball tactic as "a business decision" that it justified as removing a "Trojan Horse" "to meet the competitive challenge created by the Defendants".[15]

Also problematic is that the hospital made no effort to assure that the quality of care would not <u>decline</u> at the hospital as a result of its actions. Contrary to the requirements of the Medical Staff Bylaws, Tennessee Regulations, and the JCAHO standards, CRMC's actions were

[15] CRMC Brief, p. 18.

taken to quash potential competition, without regard to whether the quality of imaging services would be adversely affected.

It is bad enough that the hospital is making medical staff decisions based upon such economic criteria to the exclusion of quality of care concerns. Equally troubling is that the hospital contends that it can ignore the due process procedures of the Medical Staff Bylaws if it denies staff privileges without allegations of incompetence or other quality issues: *i.e.*, for purely economic reasons, or, extending the logic further, *for no reason at all*. Under the hospital's reasoning, so long as the hospital does not attribute the privilege revocation to incompetence, it need not provide a hearing to explore whether there are valid reasons for the loss of privileges *or even give an explanation for the action.* In other words, the hospital suggests that the less the decision is related to the quality of care, *the less right the physician has to challenge the action*. Surely this cannot be the law of Tennessee.

If hospitals are allowed to utilize medical staff privileges to capriciously discourage competition in this instance, they may use such tactics to punish other physician conduct. The hospital may decide that it will unilaterally revoke the privileges of a physician who declines to participate in managed care plans in which the hospital participates. The hospital may decide it no longer wants competition from physicians who provide physical therapy services in their office. The potential ways in which the hospital could utilize this power to exercise undue influence is limitless.

It is common for physicians to have privileges at more than one hospital that may compete with one another. Will hospitals decide, as a "business decision", to "close the surgery department" to any surgeon who obtains staff privileges at another hospital because the surgeon might admit patients to the other hospital? Will CRMC have the right to "close" the hospital to

physicians who have laboratory equipment or x-ray machines in their offices, because this would compete with services provided by CRMC? Under the CRMC reasoning, it could do so, without even giving notice of the reasons or giving the affected physician a hearing, so long as it did not contend the physician was incompetent.

Might the hospital make the "administrative decision" to close a department to exclude those who express disagreement with the administration of the hospital? To a physician who suggests that the hospital has an inadequate number of nurses and that patient safety is in jeopardy? To those who speak up when the hospital fails to comply with the Bylaws? Without the protection of due process and the right to explore the true reasons for terminating staff privileges, possible misuse of the power wielded by those who grant staff privileges is unchecked.

In the case of *Garibaldi v. Applebaum*[16], the concurring opinion of Justice Rathje foresaw the situation that has occurred in this case:

> My concern is that this analysis, as written, might be read to give *carte blanche* authority to a hospital to avoid obligations assumed under its Bylaws to provide notice and hearing before revoking a physician's privileges, simply by entering into exclusive contracts. It is conceivable that, under a different set of facts, a plaintiff doctor might show that an exclusive contract was entered into by a hospital simply to revoke a physician's privileges as an end run around notice and hearing obligations of its Bylaws in order to get rid of him. 742 N.E.2d at 287.

It is apparent that CRMC's decisions in this matter were unrelated to the quality of care in the hospital. If decisions are not guided by the compass of quality care, there is no limit to the actions that might next be taken by CRMC for improper reasons. The opinion of the Court of Appeals is an extremely dangerous precedent. At a minimum, the Court should find as a matter of policy that when privileging decisions are based upon matters unrelated to the quality of care,

[16] 742 N.E.2d 279 (Ill. App. 2000).

particularly when based upon anticompetitive motives, the actions of the hospital should be scrutinized closely and should not be entitled to any deference.

IV. Hospitals cannot avoid their due process and other obligations under the Medical Staff Bylaws by eliminating medical staff privileges under the guise of "exclusive contracting".

Because exclusive contracts restrict the ability of physicians to practice at a given hospital and limit patients' choice of physicians who are available to provide their treatment, issues relating to exclusive contracting are of extreme interest to Tennessee's citizens, physicians and patients alike. The AMA, recognizing the potential for hospitals to misuse exclusive contracting for improper purposes, has adopted policies that emphasize the importance of full due process in any attempt to abridge medical staff privileges by the granting of exclusive contracts by the hospital governing body. The American Medical Association House of Delegates has adopted the following policy:

> The American Medical Association supports the concept that **individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting exclusive contracts** by the hospital governing body. (Emphasis added.) [1] AMA Policy H-230.987

The AMA position should not be viewed as a "physician-protection" issue. As many physicians will be unfavorably affected by the requirement of due process as will be favorably affected; in other words, for each physician whose medical staff privileges are terminated, another physician would theoretically step in to perform the same services. This policy arises out of concerns about the quality of care that may be affected by arbitrary, exclusive contracting

decisions. It arises from the concern that without the openness required by a hearing, hospitals will abuse the privileging power for improper purposes, as they seek to do in this case, without concern for the effect upon the quality of care.

Requiring the hospital to base its actions on proper purposes, to explain its reasons to those affected by the action, to obtain input from the Medical Staff leaders, and to defend its actions in a hearing can have a healthy effect upon the process by providing some disincentive for arbitrary or capricious actions. The saying "Absolute power corrupts absolutely" applies to those granting and denying staff privileges.

A. CRMC's failure to provide the radiologists with a hearing before closing the radiology department to them is a breach of the Bylaws contract.

Section 16.1-1 of the Medical Staff Bylaws states in pertinent part as follows:

> The following recommendations or actions shall, if deemed adverse pursuant to Section 16.1-2, entitle the practitioner affected thereby to a hearing: . . .
>
> B. Denial of reappointment, . . .
>
> J. Reduction in clinical privileges, . . .
>
> L. Revocation of clinical privileges, . . .

Section 16.1-2 of the Bylaws states:

> A recommendation or action listed in Section 16.1-1 shall be deemed adverse action only when it has been:
>
> (D) taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee,

The CRMC Medical Staff Bylaws Fair Hearing Plan ("FHP") thus clearly and expressly addresses the situation presented by this case, a reduction in privileges "taken by the Board on its own initiative without benefit of a prior recommendation by the Medical Executive Committee". J.S. Exh. No. 4, §16.1-1 and §16.1-2 (D), pp. 72-73. There is no stated or implied exception for privilege reductions that are "business decisions" or "unrelated to the physicians' competency".

Hospitals are required to provide the protections of the Medical Staff Bylaws by Tennessee state regulations. Comp. Rules and Regs. of the State of Tennessee, Chapter 1200-8-1-.06(2)(b), provides:

> The hospital and medical staff bylaws shall contain procedures, governing decisions or recommendations of appropriate authorities concerning the granting, revocation, suspension, and renewal of medical staff appointments, reappointments, and/or delineation of privileges. ***At a minimum, such procedures shall include the following elements: A procedure for appeals and hearing by the governing body or other designated committee if the applicant or medical staff feels the decision is unfair or wrong***. (Emphasis added.)

The above regulation expressly requires a "procedure for appeal and hearing" regarding "decisions or recommendations of appropriate authorities concerning the granting, revocation, suspension, and renewal of medical staff appointments, reappointments, and/or delineation of privileges." The regulation does not limit the hearing requirement to decisions based on allegations of incompetence or misconduct against a physician. The Bylaws in this case should be construed, according to their plain language, in harmony with the regulation. If the Medical Staff Bylaws could somehow be construed to limit the right to a hearing only to privileging decisions pertaining to competence or misconduct, they would violate this regulation.

There is good reason why the Medical Staff Bylaws require a hearing even without a claim of incompetence. A hearing prior to a reduction of privileges serves the purpose of developing a record upon which to judge the appropriateness and legality of the hospital's actions. Without a hearing, there is no way to determine or challenge the basis for the hospital's decision. CRMC's failure to conduct a hearing in this case deprived the Putnam radiologists of the right to develop a record to demonstrate that terminating their privileges was not necessary for efficiency or quality reasons, even if another group of radiologists had been contracted to "run the radiology department". A hearing would allow the radiologists to demonstrate that a completely "exclusive" contract was unnecessary. They could refute the allegations that they would "steer" insured patients to a competing facility.

The Medical Staff Bylaws contain no exception to the requirement of a hearing in circumstances when medical staff privileges are reduced by an exclusive contracting decision of the hospital. Such a hearing would be useful in this situation. The hearing would provide the radiologists an opportunity to demonstrate that the hospital's actions were not in fact based upon any "efficiencies" derived from removing them from the medical staff, but rather were based upon unfounded suspicions and accusations that the radiologists would "steer" profitable patients away from the hospital, and that they were a "Trojan Horse within the walls of the hospital".[17] The hospital's admission that its decision to utilize exclusive contracting in an effort to terminate the staff privileges of Putnam Radiology was based purely on economic considerations makes it all the more important that a hearing be conducted to assess the <u>effect</u> upon the quality of care provided in the institution.

[17] CRMC Brief, p. 18.

B. *Alfredson v. Lewisburg Community Hospital*[18] , which holds that the hospital is bound by the requirements of the Medical Staff Bylaws even in exclusive contracting transitions, requires a hearing in these circumstances.

The Tennessee Court of Appeals acknowledged, correctly, that unless *Alfredson* has been legislatively overruled, "…this case would have to be reversed and remanded as Appellees must grant a hearing to the Appellants pursuant to the Medical Staff Bylaws". [19] *Alfredson* leaves no doubt that a hospital's desire to enter into an exclusive contract does not discharge its contractual obligation to comply with the Medical Staff Bylaws before revocation or reduction of a physician's staff privileges. The *Alfredson* case stands for the proposition that the termination of an exclusive contract does not entitle the hospital to terminate medical staff privileges without following the Medical Staff Bylaws in the absence of the physician's prior explicit contractual waiver of his rights under the Bylaws. In the absence of such an agreement, the Medical Staff Bylaws, procedurally and substantively, limit the right to significantly reduce a physician's medical staff privileges.

CRMC's brief misinteprets the *Alfredson* ruling. CRMC's brief states as follows:

> The [*Alfredson*] Court found a breach of the "Fair Hearing" clause of the Medical Staff Bylaws because (a) Dr. Alfredson's second exclusive contract did not permit the hospital to reduce Dr. Alfredson's privileges without cause, and (b) reduction of privileges "with cause" triggered the right to a hearing under the bylaws.[20]

[18] 805 S.W.2d 756 (Tenn. App. 1989).
[19] P. 11, Opinion of the Court of Appeals, appended to Appellants' brief.
[20] CRMC Brief, p. 40, first full paragraph.

CRMC cites no authority for this conclusion. Nothing in the *Alfredson* opinion states that there was a "with cause/without cause" distinction involved in the Court's decision. In fact, the Tennessee Supreme Court summarized its holding as follows:

> We, therefore, hold that the Hospital's refusal to give Dr. Alfredson access to its radiological equipment and staff after January 2, 1986, significantly reduced his privileges. It follows that Dr. Alfredson **was entitled to a hearing under the Medical Staff Bylaws**, and that the Hospital breached its contract by failing to provide him a hearing.[21] (Emphasis added.)

CRMC unsuccessfully attempts to distinguish the *Alfredson* decision by incorrectly contending that the decision in that case was based upon the clause in Dr. Alfredson's exclusive contract stating that his staff appointment would remain intact if the exclusive contract were terminated[22]. In fact, however, the *Alfredson* decision was based upon the hospital's <u>obligation to follow its Medical Staff Bylaws</u> by virtue of Dr. Alfredson's membership on the medical staff:

> Dr. Alfredson, as a member of the Hospital's active medical staff, had a contractual right to insist that the Hospital follow its Bylaws.
>
> * * * * *
>
> We, therefore, hold that the Hospital's refusal to give Dr. Alfredson access to its radiological equipment and staff after January 2, 1986, significantly reduced his privileges. It follows that Dr. Alfredson was entitled to a hearing under the Medical Staff Bylaws, and that the Hospital breached its contract by failing to provide him a hearing.

Alfredson, 805 S.W.2d at 761. It is clear that the Medical Staff Bylaws were the source of the hospital's contractual obligation to provide Dr. Alfredson a hearing before his privileges were reduced, even when the reduction in privileges was occurring in the context of an exclusive contract transition. The *Alfredson* case is thus on "all fours" with this case.

[21] *Alfredson*, 805 S.W.2d at 761.

C. T.C.A. § 7-57-603 did not indicate a clear intent to overrule *Alfredson* and does not authorize CRMC's actions.

In order to repeal the common law, there must be a showing of a clear legislative intent to do so. As this Court has recently held:

> [W]hile the General Assembly unquestionably has the constitutional and legislative authority to change the common law of this state, ***it must make clear its intention to do so***. Without some clear indication to the contrary, we simply ***will not presume that the legislature intended to change the common law by implication.*** **(**Emphasis added.)

Heirs of Ellis v. Estate of Ellis, 71 S.W.3d 705, 712 (Tenn. 2002).

This Court held in *Alfredson* that Medical Staff Bylaws represent a contract between the hospital and members of the Medical Staff. Nowhere does the statutory language relied upon by CRMC reflect an intent to change that conclusion.

Reviewing the statutory provisions that the Court of Appeals held "legislatively overruled" *Alfredson* reveals that there is also no expressed intention (much less a *clearly* expressed intention) by the General Assembly to allow CRMC to *breach* its Medical Staff Bylaws contract with members of the Medical Staff, or any other contracts. T.C.A. § 7-57-502(c) authorizes public hospitals to *enter into* contracts or ventures with third parties, but does not relieve the hospitals of existing contractual obligations:

> In the exercise of its powers, including, without limitation, the powers in this section, any other provisions of this part and of any

[22] CRMC Brief, pp. 29-32.

> other law, a private act metropolitan hospital authority[23] may acquire, manage, lease, purchase, sell, contract for or otherwise participate solely or with others in the ownership or operation of hospital, medical or health program properties and facilities and properties, facilities, and programs supporting or relating thereto of any kind and nature whatsoever and in any form of ownership whenever the board of trustees in its discretion shall determine it is consistent with the purposes and policies of this part or any private act applicable to it, and may exercise such powers regardless of the competitive consequences thereof.

This statute simply does not clearly reflect any intent of the General Assembly to change the common law of *Alfredson* relating to a hospital's revocation of staff privileges under "exclusive contracting" pretenses. The Court's reasoning, borrowed from the Attorney General, did not provide a reasonable explanation as to how these statutes evince any intention by the General Assembly to overrule *Alfredson*, let alone reflect a *clear intention* to do so. The Court of Appeals emphasized the statutory language that the hospital "…may exercise such powers regardless of the competitive consequences thereof", and concluded that:

> Among the 'competitive consequences' necessarily envisioned by such enactment are the significant reductions in the clinical privileges of competing staff physicians displaced by an administrative business decision to 'close' a department of a hospital by means of an exclusive contract.[24]

The Court of Appeals acknowledged that unless *Alfredson* has been legislatively overruled, reversal is required "as Appellees must grant a hearing to the Appellants pursuant to the Medical Staff Bylaws", i.e. there was a contract that required a hearing.[25]

The Court of Appeals decision, in effect, reflects the assumption that the language "regardless of the competitive consequences" means "regardless of whether the hospital's action

[23] CRMC, which is a private act hospital authority, is granted the powers given private act metropolitan hospital authorities in §§ 7-57-501 to 504 through § 7-57-603.
[24] Opinion, Court of Appeals, p. 13, copy appended to Appellants' brief.
[25] *Id.*

breaches an existing contract, such as the Medical Staff Bylaws". It is not reasonable, however, to conclude that the General Assembly was so intent on making public hospitals competitive that they would free them from the contractual obligations with which every other entity and individual in the country must comply. As pointed out in the *Alfredson* case:

> Like any other legal entity, hospitals are capable of breaching contracts, committing torts, or violating others' constitutional or statutory rights. When they do, they are no less subject to the courts' jurisdiction than anyone else.

Alfredson, 805 S.W.2d at 759.

Businesses frequently contract with competitors in various respects. The fact that the businesses are competitors does not remove the enforceability of contracts. Here, CRMC had contracted with the radiologists, and CRMC breached that contract.

The ability to enter into exclusive contracts in appropriate circumstances does not necessarily require that the hospital have the right to immediately terminate the clinical privileges of other physicians with staff privileges. There is nothing in the record to suggest that the hospital could not have entered into a contract with another radiology group that would have allowed the defendants to continue practicing, but which would have given preferential treatment to the new group. In the event that there was a problem with the groups coexisting, the hospital would have the right to address those problems with appropriate action. The hospital had functioned for decades without a "closed" imaging department, and there was no suggestion that this had created any problem for the hospital.

The hospital retained every right to bring in additional radiologists to "run its Imaging Department". There was no contractual limitation on this action. If, however, the CRMC believed that continuing the clinical privileges of the Putnam radiologists would adversely affect the "efficient delivery of patient care at the generally recognized professional level of quality",

then the hospital would have the opportunity to terminate the Putnam radiologists' staff privileges on that basis in accordance with the Medical Staff Bylaws. The Putnam radiologists, however, would have the contractual right under the Bylaws to have a fair hearing to determine if this conclusion by the hospital was lacking in factual basis or arbitrary, unreasonable, or capricious.

In *Alfredson,* the Tennessee Supreme Court rejected the argument that the Medical Staff Bylaws could be ignored because allowing the continuation of Dr. Alfredson's privileges would mean that the hospital had "…effectively relinquished its ability to enter into an exclusive contract after termination of Dr. Alfredson's contract..". *Id. at 760*. There is nothing that places the desire of a hospital to enter into a totally exclusive contract above the contractual obligations of the hospital.

The record in this case contains no evidence that the present radiologists could not coexist with a new radiology group. If two radiology groups could not coexist, why had the hospital not entered into an exclusive arrangement during the years prior to 1999? Obviously, the possibility of more than one group of radiologists practicing at the hospital had not been deemed problematic until Putnam Radiology sought a certificate of need for an imaging center.

D. T.C.A.§ 68-11-227(b) confirms that exclusive contracts do not automatically remove other physicians' staff privileges, and that *Alfredson* has not been legislatively overruled.

It is clear from T.C.A. § 68-11-227(b) that "automatic" termination of staff privileges is prohibited by statute and contrary to the public policy of Tennessee:

68-11-227. **Prohibited hospital actions** –

(b) The **termination of an oral or written contract** between a hospital and a hospital-based physician **shall not result in loss of medical staff privileges**, through contractual provisions or hospital policy, **unless there is a written contract that contains a section separately executed by the parties that provides for the loss of medical staff privileges**:

(1) If such physician is provided with at least six (6) months' written notice of the termination of the contract; and

(2) If such physician either:

(A) Provides medical services under the contract to a department of the hospital that has a closed staff and will have a closed staff after termination of the contract; or

(B) **Provides medical services under the contract to a department of the hospital that has an open staff, but will have a closed staff after termination of the contract.** In the case of an emergency physician, the notice of termination described in the preceding sentence may be less than six (6) months in order to obtain emergency coverage to satisfy requirements of state licensing rules, accreditation or applicable managed care plans. (Emphasis added.)

The public policy against automatic loss of staff privileges is apparent from the protections incorporated into this statute. The General Assembly, in passing T.C.A. § 68-11-227, provided that automatic termination of staff privileges for hospital based physicians shall occur *only* if "there is a written contract that contains a *section separately executed* that provides for the loss of staff privileges". The statute goes further and requires at least six months' written notice of the termination. It expressly applies to physicians who "provide services to a department of the hospital that has an open staff, but will have a closed staff after termination of the contract".

Thus, even though a physician may have signed a contract that provides for the automatic termination of his staff privileges, the statute provides that his privileges cannot be automatically

revoked if the hospital terminates the contract and enters into another "exclusive contract". This is true whether the department was previously closed or previously open, and even when physicians were providing services with only an oral contract, as in this case. It expressly applies to radiologists.

What this statute also shows is that the strained interpretation given by the Court of Appeals to T.C.A. § 7-57-502(c) to authorize "automatic termination of staff privileges" is contrary to the clear intent of T.C.A. § 68-11-227(b) precluding such automatic termination. There is no need for conflict between the two statutes, because they can be read in harmony if the phrase "regardless of the competitive consequences" in T.C.A. § 7-57-504 is not misinterpreted to include "regardless of whether this breaches a contract", as discussed above.

CRMC's interpretation of T.C.A. § 68-11-227(b) as not applying to the CRMC situation is unsupportable. CRMC admits that a contract providing for "particular staffing arrangements, coverage, or management responsibilities" would suffice as a "contract" for purposes of the statute. That is precisely what was involved here: the defendant radiologists had an oral contract, within the framework of the Medical Staff Bylaws, under which they provided coverage for radiology services that were needed at the hospital in return for medical staff privileges. Without this oral contract, the hospital would not have had radiology coverage.

E. The right to a hearing serves a useful purpose in the setting of exclusive contracts.

There is also good reason for requiring a hearing even when there is no claim of incompetence. First, the requirement of a notice and hearing prior to the Board's reduction of privileges requires the hospital to actually articulate the reasons that the hospital is taking the

action. Using this case as an example, although the hospital tries to claim its actions were for "efficiency", the minutes of the Board make it clear that the true objective is to prevent the radiologists from starting another imaging center, and to get rid of them if they did. CRMC's brief makes it totally clear that "playing hardball with the potential competition" was the true objective. The record is devoid of any evidence that there was "inefficiency" in the way the imaging department had functioned for the two decades in which the radiologists had provided service to the hospital.

The hearing is also useful in developing a record upon which to judge the validity of the hospital's stated reasons for the reduction in privileges, as well as the appropriateness and legality of the hospital's actions. CRMC's failure to conduct a hearing deprived the Putnam radiologists of the right to develop a record to demonstrate that terminating their privileges was not necessary for efficiency or quality reasons even if another group of radiologists was contracted to "run the radiology department". A hearing would allow the radiologists to introduce evidence to demonstrate that a completely "exclusive" contract was not necessary. It would also allow them to refute the serious accusations that they would "steer" profitable patients to another facility, and to offer methods to assure that inappropriate conduct would not occur. This record would be helpful to the Medical (Staff) Executive Committee and the Medical Staff in providing their mandated input on the hospital's planned action. It would also be helpful to the Hospital Board, as it is possible that the hospital administration may not have presented the issue to the Board in a balanced way, and may have even misrepresented the situation to them. Here, for example, the suggestion that the radiologists would "cherry-pick" insured patients might have been dispelled by a hearing, had the radiologists been told of this accusation and been given an opportunity to address it.

The Medical Staff Bylaws contain no exception to the requirement of a hearing in circumstances when medical staff privileges are reduced in conjunction with an exclusive contracting decision of the hospital. Because the Bylaws specifically address a possible department closure, it is unreasonable to conclude that they intend an exception in this circumstance. Had such an exception been intended, it would have been stated.

F. The Medical Staff's comment pursuant to Medical Staff Bylaw § 14.1-D is not a substitute for a hearing to determine the effect of a reduction in the Putnam radiologists' staff privileges.

CRMC and THA contend that the fact that the Board belatedly obtained input from the Medical Staff regarding its plan to enter into an exclusive contract excuses the necessity for a hearing to determine the effect of the loss of the Putnam radiologists upon the provision of quality care at the hospital. This is incorrect for two reasons.

First, although Medical Staff input is clearly required in matters of exclusive contracting pursuant to § 14.1-D, nothing in the Bylaws obviates the need for notice to affected physicians and an opportunity for a hearing. If entering into the new exclusive contract does not require the reduction of the staff privileges of other physicians, this input is all that is required. Otherwise, the affected physicians also have a right to present evidence to the Medical Staff. § 14.1- D[26] does not include a procedure for obtaining input from those whose staff privileges will be affected.

Secondly, in this case, the input from the Medical Staff reflected concern about the loss of the Putnam radiologists in this situation. The Medical Staff, even without input from the

affected physicians, desired that Putnam Radiology continue to provide radiology services at the hospital as exclusive provider:

> The Medical Staff approved a motion to support Putnam Radiology for the exclusive radiological services contract with CRMC if an agreement can be reached concerning the contents of the contract. This recommendation will [be] forwarded to the Board of Trustees.
>
> * * *
>
> The Medical Staff approved a motion that the CRMC Medical Staff prefers the pursuit of a joint venture between CRMC and Putnam Radiology. The recommendation will be forwarded to the Board of Trustees.[27]

The Medical Staff did not make a recommendation regarding the course of action if Putnam Radiology was not given an exclusive contract. Clearly, there was concern about the effect of the loss of the Putnam radiologists upon the quality of radiology care at CRMC.

V. T.C.A. § 7-57-603 does not overrule the right, recognized in *Henderson v. City of Knoxville,* of the radiologists to practice at public hospitals such as CRMC.

Henderson [28] held that physicians have the right to practice at public hospitals so long as they comply with the rules of the hospital. T.C.A. § 7-57-603, by giving CRMC the powers granted private act metropolitan housing authorities in §§ 7-57-501 to 504, did not strip the radiologists of their right to practice at CRMC. These statutes can be read to exist in harmony with the common law right recognized in *Henderson*, and therefore such an interpretation should be adopted. There is no indication that the General Assembly, in enacting the Hospital Authority

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[26] J.S. Exhibit # 4, pp. 68-9.
[27] J.S. Exhibit # 8, pp. 3-4.
[28] *Henderson v. City of Knoxville*, 9 S.W. 2d 697 (Tenn. 1928).

Acts, intended to interfere with the long-recognized right of a licensed physician to practice in the public hospitals of this state.

In *Henderson*, this Court held the following in reference to the physician who was expelled by the hospital:

> [S]o long as he stays within the law ***he has a right*** to practice in the public hospitals of the state; provided, of course, that he conforms to all ***reasonable regulations*** of the institutions. (Emphasis added.)

See Henderson, 9 S.W.2d at 698. Thus, the Court of Appeals properly noted that *Henderson* stands for the proposition that "a licensed physician who complies with hospital rules and regulations has a right to practice medicine in the public hospitals of the State." (Ct. App. Opinion, p. 4.)

Can it be seriously contended that this ambiguous language in T.C.A § 7-57-603 makes it ***clear*** that it intended to eliminate the rights of physicians to practice at public hospitals? Can it be assumed, or even seriously contended, that eliminating these rights is necessary to public hospitals to "compete with private hospitals"?

The right of physicians to practice in public hospitals had endured for over seventy years before the Court of Appeals interpreted T.C.A. § 7-57-603 as destroying it. Yet the Court's reasoning, borrowed from the Attorney General, did not explain how the statutes evince any intention by the General Assembly to overrule *Henderson*, let alone a ***clear intention*** to do so. Lacking is any explanation of how excluding physicians from the staff would improve Cookeville Regional Medical Center's ability to compete with other hospitals. There are not even any competing hospitals in Cookeville.

The Court need not decide whether there should be an exception to *Henderson* in situations where there has been a strong showing that an exclusive contract is needed, because there has been no such showing here.

VI. CONCLUSION.

This Court should reverse the Court of Appeals, and remand to the Trial Court with instructions to declare that termination of the radiologists' staff privileges without a hearing violates the contractual procedural provisions of the Medical Staff Bylaws and T.C.A. § 68-11-227(b); and that to the extent that the termination is based upon grounds unrelated to the efficient delivery of patient care, such as anticompetitive purposes, the substantive provisions of the Bylaws are violated. If the Court finds it necessary to reach the issue, it should find that the rights of physicians to practice in public hospitals, established in the *Henderson*, case have not been legislatively overruled.

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CERTIFICATE OF SERVICE

I do hereby certify that a true and exact copy of the foregoing has been sent by U.S. Mail, postage prepaid, to **William H. West**, Baker, Donelson, Bearman & Caldwell, 2100 Commerce Street, Suite 1000, Nashville, Tennessee, 37201; **Andree S. Blumstein** and **John R. Voigt**, Sherrard & Roe, 424 Church Street, Suite 2000, Nashville, Tennessee 37219; and **William L. Hubbard**, Weed, Hubbard, Berry & Doughty, PLLC, SunTrust Bank Building, Suite 1420, 201 Fourth Avenue, North, Nashville, Tennessee 37219 on this _____ day of _____, 2003.

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David L. Steed

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