

2016

Contracts: A Question of Consideration: Medical Staff Bylaws as an Enforceable Contract—Medical Staff of Avera Marshall Regional Medical Center v. Avera Marshall

Alexander Hsu

Follow this and additional works at: <http://open.mitchellhamline.edu/mhlr>



Part of the [Contracts Commons](#), and the [Health Law and Policy Commons](#)

Recommended Citation

Hsu, Alexander (2016) "Contracts: A Question of Consideration: Medical Staff Bylaws as an Enforceable Contract—Medical Staff of Avera Marshall Regional Medical Center v. Avera Marshall," *Mitchell Hamline Law Review*: Vol. 42: Iss. 1, Article 17.
Available at: <http://open.mitchellhamline.edu/mhlr/vol42/iss1/17>

This Note is brought to you for free and open access by the Law Reviews and Journals at Mitchell Hamline Open Access. It has been accepted for inclusion in Mitchell Hamline Law Review by an authorized administrator of Mitchell Hamline Open Access.

**CONTRACTS: A QUESTION OF CONSIDERATION:
MEDICAL STAFF BYLAWS AS AN ENFORCEABLE
CONTRACT—MEDICAL STAFF OF AVERA MARSHALL
REGIONAL MEDICAL CENTER V. AVERA MARSHALL**

Alexander Hsu[†]

I. INTRODUCTION..... 387

II. HISTORY OF THE RELEVANT LAW..... 388

 A. *Contract Formation in General* 388

 B. *Medical Staff Bylaws in General*..... 389

 C. *Medical Staff Bylaws as Enforceable Contracts*..... 390

 D. *Medical Staff Bylaws and Contractual Rights in
 Minnesota* 394

III. THE AVERA MARSHALL DECISION 396

 A. *Facts and Procedure* 396

 B. *Rationale of the Minnesota Supreme Court Decision*..... 399

 C. *Rationale of the Dissent* 401

IV. ANALYSIS 404

 A. *Lack of Consideration* 404

 B. *Lack of Mutual Assent* 406

 C. *Public Policy Considerations* 409

 D. *Noncontractual Judicial Enforceability* 413

V. CONCLUSION 416

I. INTRODUCTION

The Minnesota Supreme Court recently held in *Medical Staff of Avera Marshall Regional Medical Center v. Avera Marshall* that medical staff bylaws constitute an enforceable contract between a hospital and its medical staff.¹ Finding no preexisting duties, the majority

[†] JD Candidate, Mitchell Hamline School of Law, 2017; BA English, Saint Olaf College, 2014. I would like to extend special thanks to Debra Hsu, for the countless hours she spent listening to my ideas and supporting me through this process.

1. *Med. Staff of Avera Marshall Reg'l Med. Ctr. v. Avera Marshall (Avera*

determined that medical staff bylaws hold sufficient consideration to create an enforceable contract.²

This case note begins by exploring contract formation in general and the history of construing medical staff bylaws as contractual obligations.³ Then, it discusses the facts of *Avera Marshall*, the rationale of the majority, and the rationale of the dissent.⁴ Next, it argues that the Minnesota Supreme Court failed to accurately discern both a lack of consideration, as well as mutual assent that should have precluded the formation of a contract.⁵ Finally, this note raises several public policy concerns that the majority opinion overlooked and concludes that *Avera Marshall* may stifle hospital boards' future attempts to resolve staffing conflicts.⁶

II. HISTORY OF THE RELEVANT LAW

A. *Contract Formation in General*

The formation of a contract requires three elements: (1) a manifestation of mutual assent, (2) an exchange of bargained-for promises, and (3) consideration.⁷ Mutual assent is a “meeting of the minds concerning [a contract’s] essential elements.”⁸ Expressions of mutual assent are assessed under an objective standard.⁹ It is well settled that mutual assent is lacking where one party expresses a clear intent to not be bound by the agreement.¹⁰

Marshall IV), 857 N.W.2d 695, 703–04 (Minn. 2014).

2. *Id.*

3. *See infra* Part II.

4. *See infra* Part III.

5. *See infra* Part IV.A–B.

6. *See infra* Parts IV.C–D, V.

7. RESTATEMENT (SECOND) OF CONTRACTS § 17 (AM. LAW INST. 1981).

8. *SCI Minn. Funeral Servs., Inc. v. Washburn-McReavy Funeral Corp.*, 795 N.W.2d 855, 864 (Minn. 2011) (alteration in original) (quoting *Minneapolis Cablesystems v. City of Minneapolis*, 299 N.W.2d 121, 122 (Minn. 1980)).

9. *Cederstrand v. Lutheran Bhd.*, 263 Minn. 520, 532, 117 N.W.2d 213, 221 (1962) (“Expressions of mutual assent, by words or conduct, must be judged objectively, not subjectively.”).

10. *See Hamilton v. Boyce*, 234 Minn. 290, 292, 48 N.W.2d 172, 174 (1951) (“No contract is formed by the signing of an instrument when the offeree is aware that the offerer does not intend to be bound by the wording in the instrument.” (citing *Tyra v. Cheney*, 129 Minn. 428, 152 N.W. 835 (1915)); *Wells Constr. Co. v. Goder Incinerator Co.*, 173 Minn. 200, 205, 217 N.W. 112, 114 (1927) (holding that no contract was created when one party did not intend to be bound)).

“Consideration requires that one party to a transaction voluntarily assumes an obligation on the condition of an act or forbearance by the other party.”¹¹ However, it is plainly established that a promise to do something that one is already legally obligated to do does not constitute consideration.¹²

B. Medical Staff Bylaws in General

Under Minnesota Administrative Rule 4640.0800, any hospital used by two or more health practitioners is required to organize its practitioners into a medical staff.¹³ The medical staff oversees the clinical and scientific work of the hospital.¹⁴ Minnesota law also requires the medical staff to “adopt bylaws, rules, regulations, and policies for the proper conduct of its work.”¹⁵ From this statutory obligation springs a set of rules and regulations commonly referred to as medical staff bylaws.¹⁶ In their most basic form, medical staff bylaws outline the organizational and governing structure of the medical staff within the hospital’s broader institutional framework.¹⁷ Generally, the bylaws determine the procedural relationship between physicians and the hospital regarding

11. U.S. Sprint Commc’ns Co. v. Comm’r of Revenue, 578 N.W.2d 752, 754 (Minn. 1998); *see also* Baehr v. Penn-O-Tex Oil Corp., 258 Minn. 533, 539, 104 N.W.2d 661, 665 (1960) (“Consideration . . . insures that the promise enforced as a contract is not accidental, casual, or gratuitous, but has been uttered intentionally as the result of some deliberation, manifested by reciprocal bargaining or negotiation.”).

12. *See* Tonka Tours, Inc. v. Chadima, 372 N.W.2d 723, 728 (Minn. 1985) (stating the common law rule that a promise to do what one is already legally obligated to do is insufficient consideration); Hilde v. Int’l Harvester Co., 166 Minn. 259, 260, 207 N.W. 617, 618 (1926) (recognizing that a promise to perform a prior legal obligation was “a mere naked promise” and did not constitute consideration).

13. MINN. R. 4640.0800, subpart 2 (2013). Generally, a hospital’s medical staff consists of “fully licensed physicians and may include other licensed individuals permitted by law and by the hospital to provide patient care services independently in the hospitals.” Craig W. Dallon, *Understanding Judicial Review of Hospitals’ Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 604 (2000) (footnote omitted).

14. MINN. R. 4640.0800, subpart 1.

15. *Id.* R. 4640.0800, subpart 2.

16. *See id.*

17. *See* JAMES T. O’REILLY, JOLENE SOBOTKA & PHILIP HAGAN, *A PRACTITIONER’S GUIDE TO HOSPITAL LIABILITY* 18 (2011).

physician credentialing and the granting or revoking of clinical privileges.¹⁸

In this context, clinical “privileges” are the right of individual physicians to admit their patients to specific hospitals and administer care within that hospital.¹⁹ The most common relationship between hospitals and physicians involves the physicians as independent contractors who are granted privileges to admit and care for patients at a specific hospital.²⁰ In Minnesota, all patients admitted to a hospital must be placed under the care of a member of the hospital’s medical staff.²¹ Thus, any physician granted privileges at a Minnesota hospital is, by definition, a member of the medical staff and subject to all of the rights and obligations that status entails.²²

C. *Medical Staff Bylaws as Enforceable Contracts*

A majority of courts have determined “that a hospital’s medical staff bylaws . . . [constitute] a binding contract between the hospital and its medical staff”²³ These courts have generally been influenced by a concern that such bylaws would be meaningless if hospitals were not legally bound by them.²⁴ Countering this concern is an equally significant public interest in allowing hospitals free discretion to address medical staff issues that may affect the standard of patient care.²⁵ Thus, a number of courts have

18. *Id.* (“Bylaws include, e.g., what doctors can be credentialed, and what qualifications for requisite licensure, training, skill, and experience will have to be met and documented. Through medical staff policies, the medical staff sets criteria for conducting personnel evaluation, which is also known as the credentialing process.”).

19. *See id.*

20. *Id.* at 18–19.

21. MINN. R. 4640.0800, subpart 3.

22. O’REILLY, SOBOTKA & HAGAN, *supra* note 17, at 18–19.

23. Dallon, *supra* note 13, at 640 n.288 (listing cases that held medical staff bylaws were enforceable contracts).

24. *See, e.g.,* Bouquett v. St. Elizabeth Corp., 538 N.E.2d 113, 115 (Ohio 1989) (“The cases holding that a hospital is bound by its staff bylaws base their decisions on the reasoning that if the hospital is not bound by the bylaws, then essentially the bylaws would be meaningless.”).

25. *See* Zipper v. Health Midwest, 978 S.W.2d 398, 417 (Mo. Ct. App. 1998) (expressing concern that enforcing medical bylaws as a contract could cause a hospital’s concern of potential liability to “unduly impugn a hospital’s actions in terminating the privileges of a physician providing substandard patient care”).

also held that medical staff bylaws do not constitute an enforceable contract.²⁶

The most common ground for rejecting medical staff bylaws is a lack of consideration.²⁷ Often this perceived lack of consideration results from a preexisting duty under state law to adopt medical staff bylaws.²⁸ However, some courts consider all of the circumstances surrounding the hospital-physician relationship when determining the existence of a contract.²⁹ Such courts acknowledge a hospital's preexisting legal obligation to establish medical staff bylaws but consider the question of consideration under the hospital's discretionary decision to grant privileges to individual physicians.³⁰ Essentially, the consideration in question is not the bylaws themselves, but rather the individualized granting of privileges to a specified physician.³¹ While the hospital does have a statutory obligation to create and maintain medical staff bylaws, it does not have an obligation to grant clinical privileges to any

26. See Dallon, *supra* note 13, at 641 n.290 (listing cases that have declared that medical staff bylaws are not an enforceable contract).

27. See, e.g., *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1001–02 (N.D. Ga. 1992) (concluding that bylaws could not constitute a contract due to a lack of consideration); *Zipper*, 978 S.W.2d at 416 (holding that bylaws lacked the consideration required to form a contract).

28. See, e.g., *Kessel v. Monongalia Cty. Gen. Hosp. Co.*, 600 S.E.2d 321, 326 (W. Va. 2004) (finding consideration lacking where a hospital had a preexisting duty under state law to adopt medical staff bylaws); see also *O'Byrne v. Santa Monica-UCLA Med. Ctr.*, 114 Cal. Rptr. 2d 575, 583 (Cal. Ct. App. 2001) (“[State regulations] required the Medical Center to appoint a medical staff, they required the medical staff to adopt bylaws, and they required the medical staff to abide by those bylaws. Clearly . . . neither the Medical Center nor plaintiff conferred on the other any more than what was required by law.”).

29. See *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1254 (Conn. 1989) (holding that extending privileges to a physician was something beyond what a hospital was already bound to do and that the physician's return promise to abide by medical staff bylaws constituted adequate consideration); *Virmani v. Presbyterian Health Servs. Corp.*, 488 S.E.2d 284, 288 (N.C. Ct. App. 1997) (finding a contract by comparing a doctor's relationship with a hospital before and after joining its staff).

30. See, e.g., *Virmani*, 488 S.E.2d at 288 (acknowledging statutory requirements for staff bylaws as a preexisting duty but holding that when “a hospital offers to extend a particular physician the privilege to practice medicine in that hospital it goes beyond its statutory obligation”).

31. *Id.*

individual physician.³² Thus, it follows that there is no preexisting duty that would otherwise preclude the element of consideration.³³

Some jurisdictions that reject such arguments, finding no contractual consideration in medical staff bylaws, concede that the bylaws may yet form contractual rights where the bylaws contain language expressing the rights of medical staff under the bylaws.³⁴ Other jurisdictions reject medical staff bylaws as enforceable contracts but acknowledge that those same bylaws may be judicially enforceable despite their lack of contractual status.³⁵ Indeed, in *Robles v. Humana Hospital Cartersville*, the Northern District of Georgia expressly denied that medical staff bylaws create contractual rights but subsequently concluded that the bylaws at issue were nonetheless judicially enforceable.³⁶ The court reasoned that the “legislature would not have mandated that the hospital create these procedures, if the legislature had not intended that

32. See, e.g., *Gianetti*, 557 A.2d at 1254 (“It can hardly be said that the hospital must extend privileges to every physician who seeks them.”); *Virmani*, 488 S.E.2d at 288 (“When, however, a hospital offers to extend a particular physician the privilege to practice medicine in that hospital it goes beyond its statutory obligation.”).

33. *Gianetti*, 557 A.2d at 1255 (finding valid consideration where “[t]he hospital changed its position by granting medical staff privileges and the plaintiff physician [had] likewise changed his position in doing something he was not previously bound to do, i.e., to ‘abide’ by the hospital medical staff bylaws”); *Virmani*, 488 S.E.2d at 288 (“If the offer is accepted by the physician, the physician receives the benefit of being able to treat his patients in the hospital and the hospital receives the benefit of providing care to the physician’s patients. . . . [T]hese benefits constitute sufficient and legal consideration . . .”).

34. See *Mason v. Cent. Suffolk Hosp.*, 819 N.E.2d 1029, 1032 (N.Y. 2004) (stating that the court would enforce medical staff bylaws as a contract if clearly written, but concluding that the bylaws in the case before it formed no such contract); *Holt v. Good Samaritan Hosp. & Health Ctr.*, 590 N.E.2d 1318, 1322 (Ohio Ct. App. 1990) (“[Medical] staff bylaws constitute a binding contract ‘only where there can be found in the bylaws an intent by both parties to be bound.’” (quoting *Munoz v. Flower Hosp.*, 507 N.E.2d 360, 365 (Ohio Ct. App. 1985))).

35. See *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1002 (N.D. Ga. 1992) (“[T]his Court concludes that . . . the hospital bylaws, by themselves, do not constitute a contract *per se* between the hospital and the doctors. . . . [H]owever, . . . the hospital is bound by the bylaws it does create and . . . the Court can enjoin the hospital to follow those procedures.”); *Egan v. St. Anthony’s Med. Ctr.*, 244 S.W.3d 169, 174 (Mo. 2008) (holding that no contractual obligation arises from medical staff bylaws but a hospital is nevertheless bound to act in accordance with its bylaws insofar as the bylaws are required under a regulatory scheme).

36. 785 F. Supp. at 1002.

the hospital follow the procedures once they were implemented.”³⁷ According to the court, although a preexisting statutory duty precluded contract formation, that same statutory duty obligated the hospital to abide by its own bylaws and thereby empowered the court to enjoin the hospital to act on its obligation.³⁸ Importantly, this limited judicial review only pertained to a reinstatement of privileges or an injunction.³⁹ Therefore, a plaintiff could not recover damages under the medical staff bylaws.⁴⁰

In *Egan v. St. Anthony’s Medical Center*, the Supreme Court of Missouri followed a similar reasoning to *Robles*, holding that the public policy behind the governing regulation empowered the court to provide injunctive relief to a plaintiff-physician seeking enforcement of a hospital’s medical staff bylaws.⁴¹ The court specifically noted that “[a] hospital’s obligation to act in accordance with its bylaws . . . is independent of any contractual obligation the hospital may have to the doctor.”⁴² Additionally, the court emphasized that “the purpose of the regulation is to implement a system of medical staff peer review, rather than judicial oversight”⁴³ Despite the court’s limited judicial review of the hospital’s actions, the final authority regarding medical staffing decisions remains indisputably in the hands of the hospital’s governing body.⁴⁴ According to the court, this distinction arises from the underlying notion behind the regulatory scheme, which assumes that medical professionals are best qualified to police themselves.⁴⁵ Thus, any judicial oversight exercised under the court’s ruling may seek only to ensure substantial compliance with the hospital’s bylaws rather than questioning the merits of a hospital’s staffing decisions.⁴⁶

37. *Id.*

38. *Id.*

39. *Id.*

40. *Id.* (denying the plaintiff’s claim because he only sought damages rather than reinstatement or injunction).

41. *Egan*, 244 S.W.3d at 173–74 (stating that the public policy behind the regulation protects both patients and “physicians improperly subjected to disciplinary action” (citation omitted)).

42. *Id.* at 174.

43. *Id.*

44. *Id.*

45. *Id.* (citing the language of the governing state statute in support of its conclusion).

46. *Id.*

D. Medical Staff Bylaws and Contractual Rights in Minnesota

Although Minnesota law has never explicitly recognized medical staff bylaws as an enforceable contract, in 1977 the Minnesota Supreme Court in *Campbell v. St. Mary's Hospital* implied that an enforceable contract may arise from medical staff bylaws.⁴⁷ In *Campbell*, the court considered the narrow question of whether a surgeon had been afforded proper due process in the revocation of his medical privileges at St. Mary's Hospital.⁴⁸ Engaging in a twofold analysis, the court first assessed possible due process claims under the Fourteenth Amendment of the U.S. Constitution and, in dismissing the constitutional questions, subsequently examined the plaintiff's due process rights as established under the medical staff bylaws of St. Mary's Hospital.⁴⁹

First, the court questioned the applicability of constitutional due process to the plaintiff's claims.⁵⁰ Due to St. Mary's Hospital's status as a private hospital, rather than a public one, the potential application of constitutional protections was not readily apparent.⁵¹ The court briefly discussed an "entanglement" theory implemented by some jurisdictions wherein private hospitals receiving sufficient federal funds may be subject to Fourteenth Amendment requirements.⁵² However, due to the lack of meaningful facts in the record for determining the degree of entanglement, the court refused to consider the constitutional question and did not directly adopt or reject the entanglement theory.⁵³

47. 312 Minn. 379, 388, 252 N.W.2d 581, 587 (1977) (affirming summary judgment against a doctor's breach of contract claim because "under the bylaws plaintiff was afforded a full measure of his contractual due process rights at every stage of the proceedings to revoke his surgical privileges . . .").

48. *Id.* at 384, 252 N.W.2d at 584–85.

49. *Id.* at 386–87, 252 N.W.2d at 586.

50. *Id.* at 384, 252 N.W.2d at 585 (stating that constitutional due process would only apply "if the actions to terminate plaintiff's surgical privileges were done under color of state law").

51. *Id.* at 385, 252 N.W.2d at 585 ("While there is no doubt that the operation of a public hospital would constitute state action, the issue becomes considerably more complex when considering the activities of hospitals which, like St. Mary's, are wholly private.").

52. *Id.* (citing *Simkins v. Moses H. Cone Mem'l Hosp.*, 323 F.2d 959 (4th Cir. 1963)).

53. *Id.* at 386, 252 N.W.2d at 586 ("Since it would be mere conjecture for us to presuppose that such an entanglement existed, we review the revocation of plaintiff's privileges apart from any constitutional considerations.").

Following the court's refusal to apply Fourteenth Amendment considerations to the plaintiff's claim, the court examined the plaintiff's due process rights under St. Mary's Hospital medical staff bylaws.⁵⁴ Viewed in the light most favorable to the plaintiff, the facts of the case demonstrated that the plaintiff had received the full scope of his due process rights as outlined within the medical staff bylaws.⁵⁵ Therefore, the court concluded that there was no violation of the plaintiff's due process rights when St. Mary's Hospital revoked his surgical privileges.⁵⁶

While the court in *Campbell* did not explicitly address the contractual enforceability of medical staff bylaws, the specific language of the opinion appears to imply the contractual nature of such bylaws.⁵⁷ The court's specific recognition of the plaintiff's "contractual due process rights" under the medical staff bylaws suggests that such bylaws may forge certain contractual obligations.⁵⁸ In the context of the plaintiff's breach of contract claim,⁵⁹ however, such language may simply indicate the particular legal contours of an isolated case. Indeed, although the court did not challenge the plaintiff's claim that his due process rights were contractual in nature, there was no need to make such a challenge as the facts of the case indicate that, regardless of the specific nature of the plaintiff's rights, all due process procedures established by the medical staff bylaws were properly followed.⁶⁰ Thus, the court needed not, and did not, directly address the question of whether the bylaws constitute an enforceable contract. In fact, a careful reading of the court's opinion reveals a narrow resolution of the dispute predicated on the hospital's proper adherence to the due process procedure as required by the medical staff bylaws.⁶¹

Given the court's narrow resolution in *Campbell*, the jurisprudential value of its ruling as applied to contractual

54. *Id.* at 387, 252 N.W.2d at 586.

55. *Id.* at 388, 252 N.W.2d at 587.

56. *Id.*

57. *Id.*

58. *Id.* (emphasis added).

59. *Id.* at 380, 252 N.W.2d at 583.

60. *Id.* at 387, 252 N.W.2d at 586 ("We therefore hold that under the bylaws plaintiff was afforded a full measure of his contractual due process rights at every stage of the proceedings to revoke his surgical privileges . . .").

61. *Id.*

enforceability of medical staff bylaws is arguably minimal. Although the language of the opinion hints at an implied contractual status, the contextual background of the decision limits the scope of such an implication. Despite its narrow applicability, *Campbell* was the last major Minnesota case regarding medical staff bylaws and contractual rights prior to *Avera Marshall*.

III. THE AVERA MARSHALL DECISION

A. *Facts and Procedure*

Avera Marshall Regional Medical Center is a non-profit hospital located in Marshall, Minnesota.⁶² In accordance with Avera Marshall's corporate bylaws, Avera Marshall's board of directors is required to organize "a medical-dental staff under medical-dental staff bylaws approved by the [board]."⁶³ Under the bylaws, the medical staff is primarily "physicians with admitting and clinical privileges to care for patients at the hospital."⁶⁴ The medical staff is internally represented by the Medical Executive Committee (MEC), which acts on its behalf.⁶⁵

Prior to May 1, 2012, the medical staff bylaws stated that any practitioner wishing to admit patients to the hospital first needed to be a member of the medical staff.⁶⁶ To become a member of the medical staff, "a physician was required to agree to be bound by the medical staff bylaws."⁶⁷ Under the bylaws, the medical staff was granted authority, "[s]ubject to the authority and approval of [the board]," to "exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and under the corporate bylaws of the Medical Center."⁶⁸

Importantly, the medical staff bylaws also established the amendment and repeal process for the bylaws.⁶⁹ Under the medical staff bylaws, amendments to or repeal of the bylaws could be proposed by "the Chief of Staff, the MEC, the [executive] board, or

62. *Med. Staff of Avera Marshall Reg'l Med. Ctr. v. Avera Marshall*, 857 N.W.2d 695, 696 (Minn. 2014).

63. *Id.* (alteration in original).

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.* at 696–97.

68. *Id.* at 697 (alteration in original) (emphasis added).

69. *Id.*

one-third of active medical staff members.”⁷⁰ Specifically, section 17.2 of the former bylaws required that any proposed amendment or repeal had to receive an affirmative vote by two-thirds of the eligible medical staff members.⁷¹ Even with the approval of the medical staff, any change recommended by the medical staff required the executive board’s approval to become effective.⁷² However, the bylaws remained silent with regard to whether changes proposed by the board required the approval of the medical staff.⁷³ That being said, the bylaws plainly stated that the amendment and repeal process remained “‘subject to approval by a majority vote of [the board]’ and could not ‘supersede the general authority of [the board] as set forth in its corporate bylaws or applicable common law or statutes.’”⁷⁴

In 2012, Avera Marshall’s governing board announced its intent to repeal the current medical staff bylaws and proposed a revised set of bylaws.⁷⁵ Although the board solicited input from the medical staff, it refused to submit the proposed changes to the medical staff for a vote in accordance with section 17.2 of the bylaws.⁷⁶ Disregarding the board’s refusal to submit the proposed changes to a vote, the medical staff held a vote anyway, rejecting both the repeal of the former bylaws and the implementation of the revised bylaws.⁷⁷

Ultimately, the board’s unilateral revisions took effect on May 1, 2012.⁷⁸ As a result, two individual physicians and the medical staff as a whole filed a nine-count action against Avera Marshall seeking, among other things, a declaration that the former medical staff bylaws constituted an enforceable contract between Avera Marshall and the medical staff.⁷⁹ The medical staff “sought to enjoin Avera

70. *Id.*

71. *Id.* (“Section 17.2 of the bylaws specifically provided that, for the purposes of enacting a bylaws change, the change shall require an affirmative vote of . . . two-thirds of the Members eligible to vote.”) (internal quotation marks omitted).

72. *Id.*

73. *Id.*

74. *Id.* (alteration in original).

75. *Id.*

76. *Id.*

77. *Id.* (noting the medical staff’s invocation of section 17.2 of the former bylaws as the basis for justifying a medical staff vote in spite of the board’s actions).

78. *Id.*

79. Recognizing the medical staff bylaws as an enforceable contract would

Marshall from repealing the former bylaws and enforcing the revised bylaws.”⁸⁰

The district court granted Avera Marshall’s motion for summary judgment, holding that the medical staff bylaws did not constitute an enforceable contract.⁸¹ Additionally, the district court granted a second summary judgment motion, denying the medical staff’s standing to sue as a group.⁸² Furthermore, the district court concluded that Avera Marshall had the authority to unilaterally modify the bylaws without the medical staff’s approval so long as “[Avera Marshall] substantially complie[d] with the procedural prerequisites contained in the Medical Staff Bylaws.”⁸³

Affirming the district court, the Minnesota Court of Appeals concluded that the medical staff bylaws did not constitute an enforceable contract and that the medical staff lacked standing to sue.⁸⁴ Because the medical staff bylaws were not contractual, the court of appeals also concluded that Avera Marshall had the authority to unilaterally amend the laws.⁸⁵ On appeal to the Minnesota Supreme Court, the two primary issues argued were whether the medical staff had standing to sue and whether the medical staff bylaws constituted an enforceable contract.⁸⁶

mean that Avera Marshall’s unilateral amendment, in violation of the terms of the medical staff bylaws, was a breach of the contract between the medical staff and Avera Marshall and therefore judicially redressable by the court. *See id.* at 700 (“Appellants further argue that Avera Marshall was obligated to comply with the terms of the bylaws and that Avera Marshall breached the former bylaws’ amendment and repeal provision by unilaterally modifying the bylaws.”). In addition to a declaration of an enforceable contract, the medical staff also sought to establish that the medical staff, as a body, had standing and the capacity to sue Avera Marshall. *Id.* at 698.

80. *Id.*

81. *Med. Staff of Avera Marshall Reg’l Med. Ctr. v. Marshall (Avera Marshall I)*, No. 42-CV-12-69, 2012 WL 5962355 (Minn. Dist. Ct. Sept. 24, 2012).

82. *Med. Staff of Avera Marshall Reg’l Med. Ctr. v. Marshall (Avera Marshall II)*, No. 42-CV-12-69, 2012 WL 6755586 (Minn. Dist. Ct. July 6, 2012).

83. *Avera Marshall I*, 2012 WL 5962355, at *2.

84. *Med. Staff of Avera Marshall Reg’l Med. Ctr. v. Avera Marshall (Avera Marshall III)*, 836 N.W.2d 549, 562 (Minn. Ct. App. 2013).

85. *Id.* at 560.

86. *Avera Marshall IV*, 857 N.W.2d 695, 698–99 (Minn. 2014). This case note will focus on the issue of contract enforceability. The majority held that the medical staff had standing to sue because they satisfied the statutory criteria of section 540.151 of Minnesota Statutes. *See id.* at 699.

Regarding the enforceability issue, the primary question revolved around whether the medical staff bylaws constituted adequate consideration for the purposes of creating an enforceable contract.⁸⁷ The physicians and medical staff argued that the requisite consideration was each physician's agreement to be bound by the bylaws in return for appointment to Avera Marshall's medical staff.⁸⁸ Avera Marshall countered that adopting the bylaws did not constitute adequate consideration because the hospital had a preexisting legal duty to adopt such bylaws in accordance with Minnesota Administrative Rules.⁸⁹ Ultimately, the supreme court reversed the court of appeals' decision, holding that the former medical staff bylaws constituted an enforceable contract and, therefore, that Avera Marshall could not unilaterally amend the bylaws.⁹⁰

B. Rationale of the Minnesota Supreme Court Decision

The majority grounded its decision on two points of reasoning. First, the majority reasoned that although Minnesota Administrative Rules required the creation of medical staff bylaws, they did not require the bylaws to contain any specific provisions.⁹¹ Thus, the rules set only the minimum requirements for adopting bylaws.⁹² Following this conclusion, the court stated that “[b]ylaws which *exceed* the minimum standards required under state law satisfy the consideration requirement.”⁹³ Therefore, the court concluded that although the hospital had a preexisting obligation to adopt medical staff bylaws, that obligation was not dispositive with regard to whether the adopted bylaws provided the basis for an enforceable contract.⁹⁴

Second, because the hospital's obligation to adopt medical staff bylaws was not dispositive, the court then considered whether

87. *Id.* at 700.

88. *Id.*

89. *Id.*; see also MINN. R. 4640.0800, subpart 2 (2013) (requiring that a hospital's medical staff shall “formulate and, with the approval of the governing body, adopt bylaws, rules, regulations, and policies for the proper conduct of its work”).

90. *Avera Marshall IV*, 857 N.W.2d at 704.

91. *Id.* at 702.

92. *Id.*

93. *Id.* (citing Dallon, *supra* note 13, at 647).

94. *Id.*

the specific facts of the case demonstrated suitable consideration regarding the bylaws.⁹⁵ The central point of the court's rationale was the hospital's requirement that each physician agree to be bound by the medical staff bylaws in return for clinical privileges at the hospital.⁹⁶ Importantly, the majority made the clear distinction that the medical staff bylaws did not, in and of themselves, generate adequate consideration.⁹⁷ Rather, consideration arose because "with the appointment of each member to the Medical Staff . . . each member of the Medical Staff agreed to be bound by the medical staff bylaws and Avera Marshall agreed to let each member of the Medical Staff practice at its hospital."⁹⁸ The consideration provided by each member of the medical staff was his or her agreement to be bound by the medical staff bylaws.⁹⁹ Avera Marshall provided practicing privileges to each member in return for his or her agreement to be bound by the bylaws.¹⁰⁰ Since Avera Marshall and the members of its medical staff both "voluntarily assumed obligations on the condition of an act or forbearance on the part of the other," the requisite element of consideration was satisfied.¹⁰¹

Responding to the dissent's claim that a preexisting legal duty requires hospitals to impose and abide by medical staff bylaws,¹⁰² the majority stated that, while Avera Marshall may have had a preexisting duty to formulate medical staff bylaws, such a duty did not translate to a preexisting legal duty to grant a particular physician practicing privileges at its hospital.¹⁰³ Thus, the court

95. *Id.*

96. *Id.* at 703.

97. *Id.* at 703 n.6 ("[C]onsideration does not exist simply because the medical staff bylaws exist.").

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.* at 703.

102. *Id.* at 706 (Anderson, J., dissenting) ("[T]he Medical Staff was bound by law to formulate bylaws and Avera Marshall had a legal obligation to . . . also adopt bylaws Consequently, the Medical Staff's and Avera Marshall's fulfillment of their legal obligations . . . was simply the fulfillment of a preexisting legal duty" (citation omitted)).

103. *Id.* at 703 n.6 (majority opinion) ("The dissent, however, fails to explain how, before the appointment of each member to its medical staff, Avera Marshall was under a preexisting legal duty to allow that particular physician to practice at its hospital . . .").

ruled that adequate consideration existed.¹⁰⁴ In addition, the court determined that the transaction involved a bargained-for exchange of promises and mutual consent to the exchange because Avera Marshall offered clinical privileges to each member of the medical staff on the condition that they be bound by the medical staff bylaws, and each member of the medical staff accepted the offer of privileges and agreed to be bound by the bylaws.¹⁰⁵ Therefore, finding all of the requisite elements of a contract,¹⁰⁶ the court concluded that the medical staff bylaws constituted an enforceable contract.¹⁰⁷

C. *Rationale of the Dissent*

The dissent rejected the reasoning of the majority, maintaining that the medical staff bylaws lacked consideration because adoption of the bylaws was simply the “fulfillment of a preexisting legal duty, and thus neither party conferred on the other any more than what the law already required.”¹⁰⁸ Although the bylaws may exceed the minimum requirements of state law, the dissent concluded that the bylaws lacked consideration because the relevant Minnesota rule provides broad discretion for the medical staff and hospital to formulate and approve the bylaws.¹⁰⁹ The logic follows that, given the broad discretion granted by the governing state law, it is not clear how the medical staff bylaws exceed the minimum requirements.¹¹⁰

In addition, the dissent challenged the majority’s framing of the argument in terms of consideration given to each individual physician granted privileges by the hospital.¹¹¹ Despite the

104. *Id.* at 703.

105. *Id.*

106. Those elements are: (1) a manifestation of mutual assent, (2) a bargained-for exchange of promises, and (3) consideration. RESTATEMENT (SECOND) OF CONTRACTS § 17 (AM. LAW INST. 1981).

107. *Avera Marshall IV*, 857 N.W.2d at 704.

108. *Id.* at 706 (Anderson, J., dissenting). The dissent also extended its analysis by assessing that Avera Marshall had authority to unilaterally amend the bylaws despite the lack of an enforceable contract. *See id.* at 709–11 (holding that the broad discretion and final authority granted to the board of directors permitted the unilateral amendment of the medical staff bylaws).

109. *Id.* at 706 n.7; MINN. R. 4640.0800 (2013).

110. *Avera Marshall IV*, 857 N.W.2d at 706.

111. *Id.* (pressing the acknowledgment by the majority that “members of the Medical Staff had no ability to change or otherwise alter the bylaws” and stating

majority's insistence that consideration existed because "each member of the Medical Staff agreed to be bound . . . and Avera Marshall agreed to let each member of the Medical Staff practice at its hospital,"¹¹² the dissent contended that both parties were already under "a preexisting legal duty to perform these functions, and thus, there was no consideration."¹¹³

Furthermore, the dissent found that, even if consideration existed, the contract was invalid because it lacked mutual assent.¹¹⁴ There can be no mutual assent where one party clearly manifests intent to not be bound by the present agreement.¹¹⁵ Thus, where the language of the bylaws expressed a clear intent by Avera Marshall to retain final authority over the hospital and medical staff, it is plain that the board did not intend to be bound by the terms of those bylaws.¹¹⁶

Additionally, the dissent argued that the medical staff bylaws failed to clearly identify the parties subject to the alleged contract.¹¹⁷ The issue of party identification arises from the ambiguity of the medical staff's arguments, namely, *who* is the party allegedly contracting with Avera Marshall?¹¹⁸ Is it the medical staff as a whole, or is it each individual medical staff member and Avera Marshall?¹¹⁹ As the dissent stated, "The problem with the absence of clearly identified parties is that we simply do not know, and cannot know, whether an additional necessary component of contract formation is present here: an objective manifestation of mutual assent."¹²⁰ Given this ambiguity, the dissent contended that there could not have been objective assent to the contract's essential terms.¹²¹ Even if the contracting parties were not ambiguous, the

that "[t]here is no evidence to support the conclusion that the medical staff bylaws are supported by consideration regarding each individual medical staff member").

112. *Id.* at 703 n.6 (majority opinion).

113. *Id.* at 706 n.7 (Anderson, J., dissenting).

114. *Id.* at 707.

115. *Id.* (citing *Hamilton v. Boyce*, 234 Minn. 290, 292, 48 N.W.2d 172, 174 (1951); *Wells Constr. Co. v. Goder Incinerator Co.*, 173 Minn. 200, 205, 217 N.W. 112, 114 (1927)).

116. *Id.*

117. *Id.* at 708.

118. *Id.*

119. *Id.*

120. *Id.* (citing 1 RICHARD A. LORD, *WILLISTON ON CONTRACTS* § 3:2 (4th ed. 2008)).

121. *Id.*

dissent argued that the bylaws could not constitute an enforceable contract absent express language “stating that the provisions of the bylaws are enforceable against the hospital.”¹²²

Following this conclusion that the medical staff bylaws do not constitute a contract, the dissent addressed the final issue on appeal of whether Avera Marshall’s governing board had the authority to unilaterally amend the medical staff bylaws.¹²³ Dismissing the appellants’ arguments, the dissent concluded that Avera Marshall had the authority to unilaterally amend the medical staff bylaws.¹²⁴ The dissent’s conclusion included two primary arguments: (1) the corporate structure of Avera Marshall implied that any authority granted to the medical staff was necessarily derived from the ultimate authority of the governing board and the corporate bylaws,¹²⁵ and (2) Avera Marshall’s authority to unilaterally amend the medical staff bylaws was expressly reserved in the medical staff bylaws themselves.¹²⁶ Thus, Avera Marshall’s unilateral amendment of the medical staff bylaws violated neither a contractual obligation nor the designated bounds of its authority under its internal procedures.

Finally, the dissent appealed to public interest in allowing a hospital’s board of directors to address problems within its medical staff “by amending the medical staff bylaws, without fear of prolonged litigation.”¹²⁷ Although a hospital board may not necessarily make the correct decision, it must still be able to act within its authority “when it has expressly reserved ultimate

122. *Id.* at 709.

123. *Id.* (“The appellants, representing the interests of the medical staff, argue that Avera Marshall breached the medical staff bylaws by unilaterally changing the bylaws over the objection of the majority of medical staff members.”).

124. *Id.* (“[U]nder the terms of Avera Marshall’s corporate bylaws and the medical staff bylaws, the board of directors was authorized to unilaterally amend the medical staff bylaws.”).

125. *Id.* (“Any powers supposedly granted to the medical staff under the medical staff bylaws ‘must originate from, and be authorized by, the Board pursuant to the Corporate Bylaws.’” (quoting *Mahan v. Avera St. Luke’s*, 621 N.W.2d 150, 155 (S.D. 2001))).

126. *Id.* at 711 (“[T]he authority to unilaterally amend the medical staff bylaws, as stated in the corporate bylaws, was also expressly retained by Avera Marshall in the medical staff bylaws.”).

127. *Id.* at 713.

authority over the medical staff and determines that doing so is in the best interest of the hospital and patient care.”¹²⁸

IV. ANALYSIS

A. *Lack of Consideration*

Generally, consideration requires one party to voluntarily assume an obligation in return for an act or forbearance by the other party.¹²⁹ It is well settled that a promise to do something that one is already legally obligated to do does not constitute consideration.¹³⁰ Accordingly, the majority erred when it determined that there was sufficient consideration to create an enforceable contract between Avera Marshall and its medical staff.¹³¹

Under Minnesota law, a hospital is obligated to appoint a medical staff.¹³² Furthermore, the medical staff is required by state law to, “with the approval of the governing body, adopt bylaws, rules, regulations, and policies for the proper conduct of its work.”¹³³ Justice Anderson, dissenting in *Avera Marshall*, correctly stated that the rules impose an obligation on a hospital’s governing body to not only appoint a medical staff but also adopt bylaws regulating the conduct of that staff.¹³⁴ Additionally, state law requires that “all persons admitted to the hospital shall be under the professional care of a member of the medical staff.”¹³⁵ Hence, physicians administering care to patients at Avera Marshall are required by law to be members of the medical staff and thereby subject to the legally required medical staff bylaws.

The majority erroneously contended that the bylaws exceed the minimum standards required by state law and therefore satisfy

128. *Id.*

129. *See, e.g.*, U.S. Sprint Commc’ns Co. v. Comm’r of Revenue, 578 N.W.2d 752, 754 (Minn. 1998).

130. *See, e.g.*, Tonka Tours, Inc. v. Chadima, 372 N.W.2d 723, 728 (Minn. 1985) (“[I]f a party did or promised to do what he was already legally obligated to do, there existed no sufficient consideration to support this new promise.”).

131. *See Avera Marshall IV*, 857 N.W.2d at 703 (majority opinion).

132. MINN. R. 4640.0700, subpart 2 (2013).

133. *Id.* R. 4640.0800, subpart 2 (emphasis added).

134. *Avera Marshall IV*, 857 N.W.2d at 706 (Anderson, J., dissenting).

135. MINN. R. 4640.0800, subpart 3.

the consideration requirement.¹³⁶ However, the broad discretion granted to the medical staff in adopting appropriate bylaws obscures how exactly the bylaws could exceed the minimum requirements. Likewise, the inability of the majority to indicate any specific means of exceeding the minimum requirements supports the conclusion that its holding was erroneous.¹³⁷

Another argument is that consideration arises from the hospital's granting of clinical privileges in return for a physician's promise to be bound by the medical staff bylaws.¹³⁸ However, this argument overlooks the fact that Avera Marshall is obligated to appoint a medical staff¹³⁹ and legally required to place all admitted patients "under the professional care of . . . the medical staff."¹⁴⁰ These requirements, paired with the legal obligation to adopt bylaws governing the designated medical staff,¹⁴¹ demonstrate a plain preexisting duty negating any claim of consideration.¹⁴² State law already requires physicians to abide by the medical staff bylaws.¹⁴³ Furthermore, despite its discretion in granting privileges, Avera Marshall has no discretion in applying the medical staff bylaws to individual physicians.¹⁴⁴ All physicians treating patients in the hospital must be members of the medical staff, and all

136. *Avera Marshall IV*, 857 N.W.2d at 702 (majority opinion) ("[B]ylaws which exceed the minimum standards required under state law satisfy the consideration requirement." (alteration in original) (quoting Dallon, *supra* note 13, at 647)).

137. *Cf. O'Byrne v. Santa Monica-UCLA Med. Ctr.*, 114 Cal. Rptr. 2d 575, 584 (Ct. App. 2001) ("Plaintiff does not explain precisely how the Bylaws are more expansive and comprehensive than those provided for by law, in light of the broad discretion given the medical staff to adopt appropriate bylaws.").

138. *Avera Marshall IV*, 857 N.W.2d at 703 ("[F]ocusing solely on Avera Marshall's preexisting duty to adopt medical staff bylaws completely ignores the fact that, before a doctor can be granted privileges at the hospital, the doctor must agree to abide by the medical staff bylaws.").

139. *See* MINN. R. 4640.0700, subpart 2.

140. *Id.* R. 4640.0800, subpart 3.

141. *Id.* R. 4640.0800, subpart 2.

142. *O'Byrne*, 114 Cal. Rptr. 2d at 583 (finding no consideration where state law required a medical center to appoint medical staff, required medical staff to adopt bylaws, and required medical staff to abide by those bylaws).

143. *See* MINN. R. 4640.0800, subparts 1–2. By requiring medical staff to adopt bylaws governing the "proper conduct of its work," the statute implicitly requires them to abide by said bylaws. *Id.*

144. *See id.*; *see also Avera Marshall IV*, 857 N.W.2d 695, 700 (Minn. 2014) ("Avera Marshall maintains that it adopted the medical staff bylaws because it had a preexisting legal duty to do so under Minnesota administrative rules and Avera Marshall's own bylaws.").

members of the medical staff must abide by the medical staff bylaws.¹⁴⁵ Thus, physicians joining the medical staff have a preexisting legal duty to abide by medical staff bylaws, regardless of any specific request by Avera Marshall. In the face of a clear preexisting legal duty, it is evident that the medical staff bylaws lack the requisite consideration necessary to forge an enforceable contract.

B. Lack of Mutual Assent

Contract formation requires mutual assent among the parties to the contract's essential terms.¹⁴⁶ Thus, where a party expresses clear intent not to be bound by the terms of a contract, there is no mutual assent.¹⁴⁷ Specifically, where an element of mutual assent, such as an offer, provides express language reserving an unrestrained discretion to one party, a binding contract cannot arise from it.¹⁴⁸ Mutual assent and a party's intent are assessed under an objective standard.¹⁴⁹

One of the express purposes of Avera Marshall's medical staff bylaws is "[t]o provide a means whereby issues concerning the Medical Staff and Medical Center [could] be directly discussed . . . with the understanding that the Medical Staff [was] *subject to the ultimate authority of the Board of Directors.*"¹⁵⁰ Indeed, the explicit language of the medical staff bylaws as they apply to the disputed amendment and repeal process states that the entire process is "'subject to approval by a majority vote of [the board]' and could not 'supersede the general authority of [the board] as set forth in

145. See MINN. R. 4640.0800, subpart 2.

146. *SCI Minn. Funeral Servs., Inc. v. Washburn-McReavy Funeral Corp.*, 795 N.W.2d 855, 864 (Minn. 2011) (citing *Hy-Vee Food Stores, Inc. v. Minn. Dep't of Health*, 705 N.W.2d 181, 185 (Minn. 2005)).

147. See *Hamilton v. Boyce*, 234 Minn. 290, 292, 48 N.W.2d 172, 174 (1951) (citing *Tyra v. Cheney*, 129 Minn. 428, 152 N.W. 835 (1915)) (holding that no contract is formed where one party is aware that the other party does not intend to be bound by the written instrument).

148. *Grenier v. Air Express Int'l Corp.*, 132 F. Supp. 2d 1198, 1201 (D. Minn. 2001) (finding no contract where an offer contained an express reservation of discretion regarding the definition of a contractual term).

149. *Anderson Mktg., Inc. v. Maple Chase Co.*, 241 F.3d 1063, 1063 (8th Cir. 2001) (applying Minnesota law); *Cederstrand v. Lutheran Bhd.*, 263 Minn. 520, 532, 117 N.W.2d 213, 221 (1962).

150. *Avera Marshall IV*, 857 N.W.2d 695, 697 (Minn. 2014) (alteration in original) (emphasis added).

its corporate bylaws or applicable common law or statutes.”¹⁵¹ This plain language indicates an objective intent that Avera Marshall did not intend to be bound by the bylaws.¹⁵² Furthermore, where the medical staff bylaws, an alleged contract, unambiguously reserve final authority in one party, it stretches the bounds of logic to claim that such a party intended to be contractually bound by those bylaws.¹⁵³

Considered in tandem with the general public policy considerations present in this case,¹⁵⁴ the express reservation of discretionary authority by the hospital’s governing board supports an unambiguous interpretation that no contract arises from the medical staff bylaws. In fact, the governing board’s legal and ethical responsibility to ensure high standards of patient care establishes a clear contextual backdrop from which one may objectively ascertain intent to retain discretionary control over the administrative procedures of its medical staff.¹⁵⁵ Sound case law, express language, and contextual background all support the conclusion that Avera Marshall manifested an objective intent not to be bound by the medical staff bylaws.

Furthering such an interpretation is the fact that some courts have distinguished between medical staff bylaws and hospital bylaws created by the hospital’s governing board, noting that staff bylaws may be less likely to create contractual rights.¹⁵⁶ In this case, a level of bifurcated authority is evident in the specific language of the

151. *Id.* (alteration in original).

152. *Cf.* *Munoz v. Flower Hosp.*, 507 N.E.2d 360, 365 (Ohio Ct. App. 1985) (concluding that a hospital did not intend to be bound by staff bylaws where the preamble of staff bylaws stated that the bylaws were “subject to the ultimate authority of the applicable governing bodies”).

153. *See id.*; *see also* *Talwar v. Catholic Healthcare Partners*, 258 F. App’x 800, 805 (6th Cir. 2007) (“The self-declared purpose of the Bylaws and Credentials Manual is to protect the best interests of patients, regulate activities of the medical staff, and insure the provision of quality medical care for the hospital’s patients, not to declare or create contractual rights of individual members of the medical staff.”).

154. *See infra* Part IV.C.

155. *See infra* Part IV.C (exploring the law governing the liability of hospitals for substandard patient care).

156. *See* *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438–40 (Tex. App. 1994) (holding that plaintiff-physician could not have vested rights arising from medical staff bylaws); *see also* *Tredrea v. Anesthesia & Analgesia, P.C.*, 584 N.W.2d 276, 284–87 (Iowa 1998) (distinguishing hospital bylaws from medical staff bylaws).

bylaws, stating that the amendment and repeal process laid out in the medical staff bylaws cannot “supersede the general authority of [the board]’”¹⁵⁷ The language of the bylaws themselves directly implies a two-tiered structure wherein the governing board maintains control over and above the bylaws. Therefore, given the express language of Avera Marshall’s medical staff bylaws and the apparent intent not to be bound to the bylaws, the better holding appears to be that there can be no mutual assent and thus no contractual rights arising from the bylaws.¹⁵⁸

While the dissent did present a secondary argument contesting the element of mutual assent based on the difficulty of identifying the parties in the contract,¹⁵⁹ that argument ultimately fell flat. The dissent’s position hinged on the question of whether Avera Marshall’s opposite party in the purported contract is the medical staff as a whole or each individual medical staff member.¹⁶⁰ Setting aside the issue of whether the medical staff as a body has standing to sue,¹⁶¹ the facts of the present case do not support the dissent’s claim of party ambiguity. The facts evidence that, regardless of the capacity or status of the medical staff as a whole, the purported contract under dispute arose between Avera Marshall and each individual member of the medical staff with privileges at the hospital.¹⁶² Avera Marshall offered the individual members privileges as part of their agreement to be bound by the medical staff bylaws.¹⁶³ In general, most jurisdictions acknowledge the individual physician as an identifiable party when considering

157. *Avera Marshall IV*, 857 N.W.2d 695, 697 (Minn. 2014) (alteration in original).

158. *See* *Munoz v. Flower Hosp.*, 507 N.E.2d 360, 365 (Ohio Ct. App. 1985) (asserting that a trial court could reasonably conclude that staff bylaws did not constitute a contract where the hospital expressed clear intent not to be bound by the bylaws).

159. *Avera Marshall IV*, 857 N.W.2d at 708 (Anderson, J., dissenting) (“There is another problem with the appellants’ argument that the medical staff bylaws constitute a contract—namely, *who* are the parties to the contract?”).

160. *See id.*

161. *See id.* at 700 (majority opinion) (recognizing the medical staff’s “capacity to sue and be sued under Minnesota law”).

162. *See id.* at 702–03 (“The record in this case indicates that Avera Marshall formed a contractual relationship with each member of the Medical Staff upon appointment. Avera Marshall offered privileges to each member of the Medical Staff, so long as the Medical Staff member agreed to be bound by the medical staff bylaws . . .”).

163. *See id.*

medical staff bylaws as an enforceable contract.¹⁶⁴ However, this plain recognition of the individual physicians as parties to the alleged contract does not preclude the ultimate conclusion that consideration is lacking.¹⁶⁵ As previously stated, the formation of a contract requires both mutual assent *and* consideration.¹⁶⁶ Thus, although the parties may be readily identifiable, and assuming arguendo the bylaws satisfy the element of mutual assent,¹⁶⁷ a clear lack of consideration may still preclude contract formation.¹⁶⁸

C. *Public Policy Considerations*

Another pressing concern overlooked by the majority is the potentially chilling effect that this ruling may have on the ability of a hospital's governing body to effectively manage its medical staff and ensure optimal patient care.¹⁶⁹ Bearing the ultimate

164. See, e.g., *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1184 (E.D. Cal. 1998) (compiling cases from across the nation and concluding that “the majority of jurisdictions have held that hospital bylaws, when approved and adopted by the governing board, are a binding and enforceable contract between the hospital and physicians”); see also *Williams v. Univ. Med. Ctr. of S. Nev.*, 688 F. Supp. 2d 1134, 1142 (D. Nev. 2010) (“The physician makes an offer to become a member of the hospital staff by applying for privileges at the hospital. The hospital and staff accept that offer by granting the physician privileges.”).

165. See *O’Byrne v. Santa Monica-UCLA Med. Ctr.*, 114 Cal. Rptr. 2d 575, 584 (Ct. App. 2001) (acknowledging implicitly the status of an individual physician as a party in an alleged contract formed by medical staff bylaws but finding no enforceable contract for want of consideration); *Egan v. St. Anthony’s Med. Ctr.*, 244 S.W.3d 169, 174 (Mo. 2008) (finding no contract between individual physician and hospital under medical staff bylaws due to lack of consideration from the hospital, which had a preexisting duty under state regulation to conform to the bylaws).

166. See *supra* note 7 and accompanying text.

167. However, as addressed earlier, mutual assent is absent in this case due to the express intent of Avera Marshall not to be bound by the medical staff bylaws. See *supra* Part IV.B.

168. See *supra* Part IV.A; see also *Avera Marshall IV*, 857 N.W.2d at 701 (citing RESTATEMENT (SECOND) OF CONTRACTS § 17 (AM. LAW INST. 1981)) (“A contract is formed when two or more parties exchange bargained-for promises, manifest mutual assent to the exchange, and support their promises with consideration.”).

169. See *Avera Marshall IV*, 857 N.W.2d at 712–13 (Anderson, J., dissenting) (“[A] hospital’s board of directors must be allowed to amend medical staff bylaws when it has expressly reserved ultimate authority over the medical staff and determines that doing so is in the best interest of the hospital and patient care.”); see also Brief of Amici Curiae Minnesota Hospital Ass’n & American Hospital Ass’n at 5, *Avera Marshall III*, 836 N.W.2d 549 (Minn. Ct. App. 2013) (No. A12-2117),

responsibility for the quality of patient care,¹⁷⁰ the governing authority of a hospital must be able to aggressively respond to potential lapses in the quality of care provided by its medical staff.¹⁷¹ Contrary to this necessity, the majority opinion generated a potentially harmful expansion of a medical staff's autonomy from a hospital's governing body.¹⁷²

Under Minnesota law, the hospital bears significant responsibility for the safety and well-being of its patients.¹⁷³ Although individual physicians are certainly held liable for their own negligent actions, hospitals may also carry independent liability for their part in granting privileges to an allegedly incompetent physician.¹⁷⁴ In light of the hospital's substantial liability in the event of substandard patient care, a reasonable interpretation of the law concerning hospital administration and accountability as applied in recent decades manifests public policy

2013 WL 10123966, at *5 (“Because hospital boards—not medical staffs—bear ultimate responsibility for the hospital’s accomplishment of its mission, hospital boards must be able to exercise their authority to meet that responsibility.” (footnote omitted)).

170. See *Larson v. Wasemiller*, 738 N.W.2d 300, 313 (Minn. 2007) (recognizing the tort of negligent credentialing and thereby holding that a hospital can be held liable for substandard care arising from negligent monitoring of the competence and conduct of physicians granted privileges by the hospital).

171. See DEAN M. HARRIS, CONTEMPORARY ISSUES IN HEALTHCARE AND ETHICS 133–34 (2d ed. 2003) (“Human lives are at stake, and the governing board must be given discretion in its selection so it can be confident in the competence and moral commitment of its staff.” (quoting *Sosa v. Val Verde Mem’l Hosp.*, 437 F.2d 173, 177 (5th Cir. 1971))).

172. See Brian M. Peters & Robin Locke Nagele, *Promoting Quality Care & Patient Safety: The Case for Abandoning the Joint Commission’s “Self-Governing” Medical Staff Paradigm*, 14 MICH. ST. U. J. MED. & L. 313, 317–18 (2010) (“[T]he notional concept of medical staff ‘self-governance,’ or autonomy from the governing body, too often results in a paralytic environment characterized by the governing body either avoiding or inadequately pursuing aggressive compliance with Quality/Safety standards.”).

173. See *Larson*, 738 N.W.2d at 313 (adopting common law claim of negligent credentialing); see also *Sylvester v. Nw. Hosp. of Minneapolis*, 236 Minn. 384, 387–90, 53 N.W.2d 17, 19–21 (1952) (holding that a hospital owes a direct duty of care to patients to protect them from harm by third persons); *Mulliner v. Evangelischer Diakonniessenverein of Minn. Dist. of German Evangelical Synod of N. Am.*, 144 Minn. 392, 394, 175 N.W. 699, 699–700 (1920) (recognizing the duty of a hospital to provide its patients with as sufficient a number of attendants as the safety of the patients may require).

174. See *Larson*, 738 N.W.2d at 313.

considerations that strongly counter the conclusions of the majority opinion.¹⁷⁵ In so many words, the prevailing trend of hospital liability demonstrates a purpose and intent to identify hospitals and their administrative bodies as primary actors in credentialing physicians and ensuring safe, quality patient care.¹⁷⁶ Yet, the majority's decision in the present case undermines this purpose by potentially exposing hospitals to costly and disruptive litigation, placing governing boards in a catch-22: either aggressively respond to a physician's ineffective care and face litigation from medical staff members or handle ineffective physicians cautiously and risk patients suing for negligent credentialing.¹⁷⁷ By ruling as it did, the majority put forth a body of law that, when viewed in its broader context, simultaneously reproaches hospitals for failing to act against incompetent physicians while restricting the means by which hospitals may uphold their legal duty to act.

In ruling that the medical staff bylaws were an enforceable contract,¹⁷⁸ the majority decision effectively quashed the hospital governing board's ability to unilaterally amend the medical staff bylaws and thereby reinforced an outdated model of medical staff

175. Brief of Amici Curiae Minnesota Hospital Ass'n & American Hospital Ass'n, *supra* note 169, at 6 ("A decision in this case that diminished the authority of a hospital board to manage the affairs of the hospital . . . would run contrary to public policy regarding hospital administration and accountability as it has developed over the last forty years.").

176. The trend pervades not only Minnesota, but also the nation as a whole. *See, e.g.*, *Fridena v. Evans*, 622 P.2d 463, 466–67 (Ariz. 1980) (upholding the liability of a hospital for negligent supervision of the competence of its medical staff); *Larson*, 738 N.W.2d at 313; *Bost v. Riley*, 262 S.E.2d 391, 395–96 (N.C. Ct. App. 1980) (recognizing the duty of a hospital to "make a reasonable effort to monitor and oversee the treatment which is prescribed and administered by physicians practicing at the facility"); *Thompson v. Nason Hosp.*, 591 A.2d 703, 708 (Pa. 1991) (adopting a doctrine of corporate negligence under which "the hospital is liable if it fails to uphold the proper standard of care owed the patient, which is to ensure the patient's safety and well-being while at the hospital"); *Pedroza v. Bryant*, 677 P.2d 166, 168–70 (Wash. 1984) (holding that a hospital owes an independent duty to patients to supervise the medical treatment provided by members of its medical staff).

177. *See* Elisabeth Belmont et al., *Quality in Action: Paradigm for a Hospital Board-Driven Quality Program*, 4 J. HEALTH & LIFE SCI. L. 95, 128–29 (2011) ("Concern over the cost and disruption of such [physician] litigation can deter hospitals that otherwise would be more proactive in taking action against individual physicians based on quality concerns.").

178. *Avera Marshall IV*, 857 N.W.2d 695, 704 (Minn. 2014).

autonomy,¹⁷⁹ a model which has been described as “a prohibitive barrier to real progress in achieving a ‘zero-defect’ ‘safety culture.’”¹⁸⁰ Recognizing that one of the predominant goals of hospitals is safeguarding a high standard of medical care within their walls, multiple reformers have criticized the persistent model of bifurcated hospital leadership for diminishing the capacity of hospitals to effectively meet one of their driving objectives.¹⁸¹ In its reasoning in the present case, the court revealed a distressing blind spot to the broader implications of its ruling,¹⁸² particularly its effect of stifling systemic innovations that could markedly improve patient safety and quality of care.¹⁸³

Enforcing medical staff bylaws as a legal contract creates another obstacle on the path towards an administrative model of integrated executive authority that better ensures a high quality of care.¹⁸⁴ Threatened by possible litigation, hospitals may be hard-pressed to take the necessary steps towards substantive change in executive structures.¹⁸⁵ The unfortunate byproduct of such hesitancy is that it may hinder hospitals’ adoption of integrated governance models that can provide both higher quality and higher efficiency in health care delivery.¹⁸⁶

179. Where the medical staff bylaws constitute an enforceable contract, the hospital governing board is obligated to comply with the terms of the bylaws and therefore cannot unilaterally amend the bylaws without breaching the contract.

180. Peters & Nagele, *supra* note 172, at 371.

181. *See generally* Belmont et al., *supra* note 177, at 108 (explaining that “[the bifurcated] model can foster a diffusion of responsibility and accountability for the quality of professional services”); Peters & Nagele, *supra* note 172, at 371–72 (outlining “viable alternatives” that are “free from the deep-seated conflicts and performance barriers inherent in [the] bifurcated governance structure”).

182. *See supra* Part III.B (discussing the majority’s reasoning).

183. *See* Peters & Nagele, *supra* note 172, at 371 (“[E]mphasis on physician autonomy and ‘self-governance’ seriously detracts from, and operates as a barrier to, the industry’s overall move towards coordination and integration of care as a way of producing both higher quality and greater efficiency in the health care delivery system.”).

184. *See id.*

185. *Id.* at 367 (“[T]he threat of costly and contentious medical staff litigation . . . frequently deters a fragmented hospital leadership from taking needed disciplinary or corrective action.”).

186. *See id.* at 371 (crediting the international acclaim of high-achieving healthcare systems to their successful integration of the physician, governing body, and executive leadership into a unified, system-wide approach to quality and safety).

Thus, in addition to the issues of consideration and mutual assent that already plague the majority opinion,¹⁸⁷ the public policy considerations underlying the case reveal a backdrop of law and policy concerns directly countering the court's decision. Bearing such considerations in mind, the court's ruling and the resulting effect on the stated policy concerns are plainly erroneous and contrary to sound judicial policy.

D. Noncontractual Judicial Enforceability

Finally, although the medical staff bylaws may not be an enforceable contract, whether the court may still have a limited scope of judicial review independent of any contractual obligation merits consideration. Some jurisdictions have determined that medical staff bylaws, though not contractual, may still be subject to judicial review.¹⁸⁸ Such review is generally predicated on two public policy arguments: (1) the legislature would not mandate that hospitals create medical staff bylaws unless it intended for hospitals to be bound by them; and (2) there is an implicit statutory purpose not only to protect the well-being of patients, but also to protect doctors from arbitrary disciplinary processes.¹⁸⁹ In those cases where courts have granted judicial oversight, such review has been notably limited, providing only sufficient injunctive relief to compel hospitals to adhere to the procedures detailed in their medical staff bylaws.¹⁹⁰ The courts still recognize that the hospital's governing board, rather than the courts, retains ultimate authority over medical staffing decisions.¹⁹¹ Thus, even those jurisdictions that call for judicial review of medical staff bylaws explicitly

187. See *supra* Part IV.A–B.

188. See *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1002 (N.D. Ga. 1992) (ruling that medical staff bylaws do not constitute a contract per se, but hospitals may nonetheless be enjoined to adhere to their own procedures as established in the bylaws); *Egan v. St. Anthony's Med. Ctr.*, 244 S.W.3d 169, 174 (Mo. 2008) (“A hospital's obligation to act in accordance with its bylaws . . . is independent of any contractual obligation the hospital may have to the doctor.”); see *supra* notes 35–36 and accompanying text.

189. See *supra* notes 37–40 and accompanying text.

190. See *Egan*, 244 S.W.3d at 174 (“This Court, then, will not impose judicial review on the merits of a hospital's staffing decisions, but will act only to ensure substantial compliance with the hospital's bylaws.”).

191. See *id.* (“[I]t is clear that final authority to make staffing decisions is securely vested in the hospital's governing body with advice from the medical staff.”).

recognize the hospital's authority and notably restrict the scope of the court's decision.¹⁹²

In the present case, Minnesota law appears to strongly support the position that the legislature would not mandate bylaws unless it intended for the hospital to adhere to those bylaws.¹⁹³ To rule that statutorily mandated medical staff bylaws do not bind a hospital to some degree would render the governing statute ineffective.¹⁹⁴ Thus, one may reasonably conclude that medical staff bylaws, by virtue of their statutory requirement, may be judicially enforceable where a hospital refuses to adhere to the procedures laid out in its own governing bylaws.

Having affirmed that hospitals may be bound by the procedures of their bylaws, the next question to ask is whether Avera Marshall failed to abide by its own medical staff bylaws. Tracking similar points as its argument against mutual assent,¹⁹⁵ the dissent correctly deduced that Avera Marshall did not breach the medical staff bylaws by unilaterally changing the bylaws.¹⁹⁶ In *Mahan v. Avera Saint Luke's*, the court emphasized that staff bylaws are generally derived from corporate bylaws.¹⁹⁷ Although not binding in the present case, *Mahan* effectively illustrates the particular legal relationship between corporate bylaws and staff bylaws:

Their legal relationship is similar to that between statutes and a constitution. They are not separate and equal sovereigns. The former derives its power and authority from the latter. Hence, to determine whether the staff was granted the power that it now claims to possess, any

192. *See id.*

193. *See* MINN. STAT. § 645.17(2) (2014) (“[T]he legislature intends the entire statute to be effective and certain.”); *see also* *Country Joe, Inc. v. City of Eagan*, 548 N.W.2d 281, 284 (Minn. Ct. App. 1996) (“We must also assume that the legislature intended statutes to be effective and certain.” (citing MINN. STAT. § 645.17(2) (1994))), *aff'd*, 560 N.W.2d 681 (Minn. 1997).

194. *See* *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1002 (N.D. Ga. 1992) (“The Georgia legislature would not have mandated that the hospital create these procedures, if the legislature had not intended that the hospital follow the procedures once they were implemented.”).

195. Specifically, the express reservation of ultimate authority is in the hands of the governing board. *See supra* Part IV.B.

196. *Avera Marshall IV*, 857 N.W.2d 695, 711 (Minn. 2014) (Anderson, J., dissenting).

197. 621 N.W.2d 150, 155 (S.D. 2001) (“[A]ny powers supposedly granted under the Staff Bylaws must originate from, and be authorized by, the Board pursuant to the Corporate Bylaws.”).

judicial analysis must begin with an examination of the Corporate Bylaws.¹⁹⁸

As applied to *Avera Marshall*, this understanding of corporate bylaws as the origin of powers granted under medical staff bylaws supports the conclusion that the express language of the corporate bylaws supersedes any implied authority generated in the medical staff bylaws.¹⁹⁹

Therefore, where the corporate bylaws expressly reserve ultimate authority in Avera Marshall's governing board,²⁰⁰ it may reasonably be concluded that medical staff bylaws lack the authority to supersede the decisions of the governing board. Additionally, the language of the corporate bylaws did not specifically require approval from the medical staff for the governing board to unilaterally amend the medical staff bylaws.²⁰¹ This limitation on the medical staff's power to oppose the governing board, coupled with the broad power vested in the board, further supports the conclusion that the governing board acted within its authority under the corporate bylaws, and by extension under the medical staff bylaws, when it unilaterally changed the medical staff bylaws without a two-thirds vote from voting members of the medical staff.²⁰²

In conclusion, although Minnesota courts may indeed have the power to enjoin hospitals to adhere to the procedures established in their bylaws, the specific language of the bylaws in the present case precludes the court's judicial review. Avera Marshall's corporate bylaws expressly reserve ultimate authority to the hospital's governing board with regard to amending or

198. *Id.*

199. The explicit language of the medical staff bylaws themselves also supports this interpretation. *See Avera Marshall IV*, 857 N.W.2d at 697 (majority opinion) (noting that the amendment and repeal process "could not 'supersede the general authority of [the board] as set forth in its corporate bylaws or applicable common law or statutes'" (alteration in original)).

200. *See id.* at 710 (Anderson, J., dissenting) ("The Board of Directors shall exercise oversight of the business affairs of [Avera Marshall] and shall have and exercise all of the powers which may be exercised or performed by [Avera Marshall] under the laws of the State of Minnesota, the Corporation's Articles of Incorporation, and these Bylaws . . ." (alteration in original) (citation omitted)).

201. *Id.* ("Proposed bylaws, rules and regulations, or amendments thereto, may be recommended by the medical-dental staff or the Board of Directors." (quoting Avera Marshall Corporate Bylaws § 15.3)).

202. *Id.* at 704.

repealing the medical staff bylaws.²⁰³ Given this clear reservation of authority, Avera Marshall reasonably adhered to the procedures of its own bylaws when it unilaterally amended the medical staff bylaws. Thus, where the governing board does not exceed its authority, the court has no grounds for granting injunctive relief.

V. CONCLUSION

Avera Marshall presented the Minnesota Supreme Court with the novel question of determining whether medical staff bylaws could constitute an enforceable contract between a hospital and its medical staff.²⁰⁴ The court incorrectly held that there was suitable consideration in the bylaws to form a contract.²⁰⁵ The majority failed to closely analyze the governing state law and accurately identify the preexisting legal duties that precluded consideration. Furthermore, the majority's misinterpretation of the express language of the bylaws led it to incorrectly conclude that the defendant intended to be bound by the bylaws.²⁰⁶ This ruling may pose trouble in the future by limiting hospitals' abilities to resolve staffing concerns by amending medical staff bylaws.²⁰⁷

Minnesota contract law and sound public policy both support a finding contrary to the unfortunate ruling of the majority opinion.²⁰⁸ A better conclusion would be that the medical staff bylaws do not constitute an enforceable contract under Minnesota law and the hospital's governing body is within its rightful authority to unilaterally amend the medical staff bylaws where such authority has been expressly reserved.

203. *Id.* at 697 (majority opinion) (“[T]he amendment and repeal process was ‘subject to approval by a majority vote of [the board]’ and could not ‘supersede the general authority of [the board] as set forth in its corporate bylaws or applicable common law or statutes.’” (alteration in original)).

204. *Id.* at 698–99.

205. *Id.* at 703.

206. *See id.* at 702 n.4.

207. *See id.* at 712 (Anderson, J., dissenting) (“I am concerned that today’s majority opinion will encourage conflict between medical staffs and a hospital’s board of directors.”); *supra* Part IV.C.

208. *See supra* Part IV.