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COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

No. 318583

Appeal from Benton County Cause No. 08-2-01534-1

**COURT OF APPEALS, DIVISION III OF THE STATE OF
WASHINGTON**

VENKATARAMAN SAMBASIVAN, an individual,

Appellant,

v.

KADLEC MEDICAL CENTER, a corporation,

Respondent.

BRIEF OF RESPONDENT

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I. INTRODUCTION

This appeal concerns the sole remaining claim in a lawsuit filed by a cardiologist, Plaintiff Venkataraman Sambasivan (“Sambasivan”) against Kadlec Regional Medical Center (“Kadlec”) in June 2008. Through his remaining claim, Sambasivan alleges that Kadlec’s Board of Directors (“Board”) retaliated against him for having filed a lawsuit that included a claim for discrimination when it adopted a minimum proficiency requirement for all physicians seeking clinical privileges in interventional cardiology. Because the Board adopted the requirement with immediate effect and Sambasivan had not performed a sufficient number of procedures during the previous two years to qualify, his interventional cardiology privileges were not renewed. (CP 318-19).

Although the trial court initially dismissed the retaliation claim on summary judgment, the court of appeals reversed and remanded the case for trial. (CP 177). Because the court of appeals did not consider or rule on a dispositive issue that Kadlec had briefed to the trial court (but was not decided by the trial court), Kadlec moved for summary judgment on that issue. The dispositive issue is whether Sambasivan produced evidence of a contractual relationship with Kadlec that can form the basis of a federal or state retaliation claim. The trial court ultimately agreed that Sambasivan did not meet this burden and the court of appeals should

affirm.

II. COUNTER-STATEMENT OF THE CASE

A. Background

Kadlec is a nonprofit health system in Richland, Washington. Sambasivan is an independent cardiologist with a medical practice in Pasco, Washington. (CP 1). He became a member of the Kadlec medical staff on November 17, 1993 and remained on the medical staff with clinical privileges in general cardiology until March 1, 2012 after he voluntarily resigned his staff membership and privileges. (CP 204). From September 7, 2001 until August 14, 2008, Sambasivan held privileges in interventional cardiology in addition to general cardiology, although at times he voluntarily relinquished those privileges to obtain remedial training in interventional cardiology. (*Id.*). On August 14, 2008, Sambasivan was no longer eligible to hold interventional cardiology privileges after the Kadlec Board voted to implement a heightened procedure volume requirement for all interventional cardiologists. Because Sambasivan had not performed at least 75 interventional procedures per year over the previous two years, he was no longer eligible to hold interventional cardiology privileges.

Physicians who wish to see patients at a hospital must be members of the hospital's medical staff and obtain privileges to provide delineated

categories of medical services. (CP 247) (Kadlec Medical Staff Bylaws (“Bylaws”) at iv (defining clinical privileges as “the permission granted by the Governing Body to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to the practitioner”)). As required by Washington law, all medical staff appointments and privilege delineations are “subject to final review and decision by the Governing Body [i.e., the Board of Directors of the Medical Center].” (CP 250). Physicians may only exercise those privileges that are “specifically granted to the physician by the Governing Body.” (CP 265). The Bylaws further provide that “[c]linical practice privileges may be granted based on prior and continuing education and training, prior and current experience, . . . and demonstrated current competence and judgment to provide quality and appropriate patient care in an efficient manner, as documented and verified in each physician’s credentials file.” (*Id.*).

B. Medical Staff Privileges and Medical Staff Bylaws

Kadlec medical staff appointments and conferrals of clinical privileges are for a period of two years. (CP 255). Physicians on active medical staff whose privileges are to expire must submit a reappointment application that is reviewed by the Kadlec Credentials Committee. (CP 273). The Credentials Committee then prepares a written report with

recommendations to the Medical Executive Committee (“MEC”), which is the committee of the medical staff responsible for making recommendations to the Board on requested clinical privileges for all medical staff members. (CP 273, 283). After reviewing the Credentials Committee report and recommendation, the MEC makes a recommendation to the Board. (CP 261). As noted above, all medical staff appointments and privilege delineations are subject to final review and decision by the Board. (CP 250, 261). *See also* WAC 246-320-161(2) (a hospital’s medical staff must “[f]orward medical staff recommendations for membership and clinical privileges to the governing authority for action”).

Kadlec’s medical staff, like all medical staffs in Washington, is required by law to “[a]dopt bylaws, rules, regulations, and [an] organizational structure” that address, among other things, membership qualification, the appointment and reappointment process, the granting of delineated clinical privileges, and due process. WAC 246-320-161(1). The hospital’s governing authority is responsible for actual appointment and approval of medical staff members, however, and is also required to approve the medical staff bylaws. WAC 246-320-131. Under the Bylaws, no physician is entitled to medical staff appointment or to the exercise of

any particular clinical privileges, even if the physician is an active medical staff member and currently holds those privileges. (CP 254).

C. Events Leading Up to the Board's August 14, 2008 Decision

In the summer of 2008, Sambasivan's clinical privileges were up for renewal. His two-year appointment had expired on April 1, 2008 and he was granted temporary privileges until a recommendation and final decision could be made about his reappointment request. (CP 204). In April 2008, due to renewed concerns about Sambasivan's clinical care in interventional cardiology, the Credentials Committee requested that the Medical Staff Quality Committee ("MSQ") obtain an external review of Sambasivan's interventional cardiology cases. (CP 226). On July 2, 2008, medical staff leadership met to discuss the outcome of a department-wide external review of interventional cardiology cases that was completed in May 2008 and review the department's mortality data. In this meeting, medical staff leadership decided to (i) invite Sambasivan to review the results of the May 2008 external review, (ii) set up an appointment for a collegial intervention, (iii) ask the MSQ to review and make recommendations concerning Sambasivan's interventional cardiology privileges, and (iv) ask that "MSQ consider recommending to the MEC increasing interventional cardiology volume requirements for credentialing to 75/year beginning January 2009." (CP 234). That

meeting and decision occurred before the service of Sambasivan's initial complaint on Kadlec in this litigation and no evidence exists that Kadlec was otherwise aware of the complaint.

On July 21, 2008, the MSQ decided to recommend to the MEC that beginning January 2009, interventional cardiology volume requirements for credentialing and reappointment be increased to an average of 75 procedures per year over a two-year credentialing period. (CP 237-39). The MSQ also decided to recommend that Sambasivan's interventional privileges reappointment be limited to elective, nonacute (i.e., nonemergent) interventional cardiology. (*Id.*).

The MEC considered the MSQ's proposal at August 7, 2008 meeting and adopted the MSQ's recommendation, with one modification: any cardiologist on active medical staff who did not meet the volume requirement at reappointment in 2009 would have until 2010 to get up to that number of cases. (CP 313-16).

While the Credentials Committee and the MSQ were considering Sambasivan's request for reappointment and obtaining an external review of cases, Sambasivan filed a lawsuit against Kadlec to complain about what he believed was unjustified scrutiny of his care. Sambasivan's initial complaint included many claims, including breach of express and implied contract, unfair competition, tortious interference a claim for

discrimination, which vaguely stated, seems to have been based on Sambasivan's race or national origin. (CP 6). He filed his initial complaint on June 23, 2008 and mailed it to Kadlec by letter dated July 3, 2008 and Kadlec's CEO Rand Wortman accepted service on July 7, 2008.

D. Board's Decision on August 14, 2008

As noted above, by the time that Kadlec was informed of Sambasivan's lawsuit, medical staff leadership had already met (on July 2) and decided that it would recommend limiting Sambasivan's acute interventional cardiology privileges and enhancing the interventional cardiology volume requirement. When the Board met on August 14, 2008 to consider, among other agenda items, Sambasivan's request for reappointment, it was the first Board meeting since Sambasivan's suit had been served. Thus, Kadlec's CEO Rand Wortman informed the Board that Sambasivan had "filed a lawsuit against the hospital making various allegations including discrimination, breach of implied contract and conspiracy." (CP 317). At the same meeting, Dr. Erick Isaacson, a member of the MSQ, presented the MEC's recommendations concerning the interventional cardiology volume requirement, which he noted mirrored competency criteria established by the Washington State Department of Health and the American College of Cardiology. (CP 317-18; 320-38). MEC and Board member Fred Foss, M.D., also presented the

MEC's recommendation regarding Sambasivan's interventional cardiology privileges (i.e., that his reappointment be restricted to elective cases). (CP 318).

Following a discussion about "the best way to ensure patient safety," the Board voted to adopt the MEC's recommendation concerning the procedure volume standard, but without a two-year phase-in period as there was no aspect of the phase-in proposal that promoted patient safety. (*Id.*). Because Sambasivan's recent procedure volumes did not meet this standard, he was no longer eligible for renewal of interventional cardiology privileges. As a result, the MEC's recommendation to limit Sambasivan's interventional cardiology privileges upon reappointment became moot. (*Id.*). The Board reappointed Sambasivan for two years with those privileges for which he was eligible (i.e., general cardiology). (*Id.*).

E. Proceedings Below

1. Trial Court

Sambasivan filed his case in June 2008 and twice amended his complaint. As noted, his Second Amended Complaint abandoned a discrimination claim in favor of a retaliation claim. (CP 6). In March 2010, Kadlec moved for summary judgment on all claims. In its retaliation summary judgment brief, Kadlec argued that "as a threshold

matter” the Kadlec Bylaws “do not constitute a contract or an agreement that gives rise to a claim under § 1981” and cited numerous federal court opinions supporting its argument.¹ (See appendix). In his response to Kadlec’s motion, Sambasivan denied that he was seeking “damages for interference with his contract with the defendant,” and argued instead that “he seeks damages for retaliation arising from the defendant’s interference with his right to form contracts with patients.” (CP 28). Kadlec’s reply emphasized that Kadlec’s alleged retaliation concerned the conferral of medical staff privileges, which is governed by the Bylaws, and because the Bylaws are not contractual, Kadlec argued that “[f]or that reason alone, Dr. Sambasivan’s retaliation claims must be dismissed.” (See appendix).²

After a hearing, the trial court summarily dismissed Sambasivan’s claims for breach of express contract, tortious interference, and retaliation. The trial court’s order dismissing the retaliation claim specified that “[f]or purposes of its analysis, the Court assumes, but does not decide, that a

¹ Defendant’s Motion for Partial Summary Judgment and Memorandum in Support (Retaliation) (CP 5xx-xx) (CP pages to be supplied following receipt; Kadlec submitted supplemental designation of Clerk’s Papers on November 22, 2013) (excerpts attached in appendix hereto).

² Reply in Support of Defendant’s Motion for Partial Summary Judgment (Retaliation) (CP 5xx-xx) (CP pages to be supplied following receipt; Kadlec submitted supplemental designation of Clerk’s Papers on November 22, 2013) (excerpts attached in appendix hereto).

contractual relationship exists between Dr. Sambasivan and Kadlec that gives rise to a retaliation claim under federal and state law.” (CP 121).

A bench trial was held on Sambasivan’s remaining breach of implied contract claim (relating to his providing uncompensated call coverage services in the emergency department), and Sambasivan prevailed. On May 26, 2011, the trial court entered final judgment, which included an award of attorney fees to Kadlec under the then-existing mandatory fee-shifting requirements of Washington’s peer review statute, RCW 7.71.030(3) for prevailing on the breach of express contract, tortious interference and retaliation claims, to the extent those claims involved allegations that Kadlec acted against Sambasivan’s privileges in peer review proceedings. The court also awarded Sambasivan attorney fees for prevailing on his unjust enrichment claim for call coverage based upon an employment wage statute. (CP 133-43).

2. Prior Appeal to Division III

On June 22, 2011, Sambasivan filed his first appeal in this case, requesting review of “all components of the [May 26, 2011] judgment,” except for the awards for damages for unjust enrichment and associated prejudgment interest and attorney fees and costs. (CP 895-900). Kadlec cross-appealed. Following oral argument, Division III issued its ruling upholding the trial court’s judgment with the exception of its summary

judgment dismissal of Sambasivan's retaliation claim. This Court disagreed with the trial court's conclusion that Sambasivan "failed to establish a causal connection between his filing of a lawsuit on June 23, 2008 that included a discrimination claim and the decision of the Kadlec board of directors on August 14, 2008, to adopt a proficient requirement for interventional cardiology privileges." (CP 162). Instead, in viewing certain facts in the light most favorable to Sambasivan, this Court found that a genuine issue of material fact existed as to whether Sambasivan established a prima facie case of retaliation and whether Kadlec's rationale for its actions was pretextual.³ The court of appeals remanded the retaliation claim for trial. (CP 178)

In reaching its decision, the court of appeal's analysis focused solely on the causal nexus element of a retaliation claim, presumably because that was the basis on which the trial court had granted summary judgment and because the court disagreed with the trial court's holding. The court of appeals did not decide the threshold issue of whether Sambasivan had identified a contractual nexus for a state or federal

³ As to the first element for a retaliation claim, this Court cited the temporal proximity of the Board's decision to adopt the proficiency requirement with immediate effect and its learning, at the same meeting, of Sambasivan's lawsuit. As to the pretext element, this court cited testimony of Dr. Chris Ravage that the Board's adoption of the proficiency standard with immediate effect was "unprecedented, unfair to the doctor, and not medically necessary." (CP 162).

retaliation claim, despite the fact that Kadlec had briefed the issue extensively for the trial court and had raised the issue for the court of appeals' consideration in its brief. *See* Brief of Respondent/Cross-Appellant Kadlec Medical Center at 17 (Nov. 17, 2011) (*See* appendix).

Because the existence of a contractual nexus is dispositive of Sambasivan's retaliation claim, and the issue had not been decided by the trial court or the court of appeals, Kadlec moved again for summary judgment on June 13, 2013 after the claim was remanded to the trial court.

In its opening brief, Kadlec argued that the Kadlec Bylaws—the only potential “contract” that Sambasivan has previously identified in support of his retaliation claim—are not contractual and therefore cannot provide the contractual nexus for a federal or state retaliation claim. (CP 186-202). In support of its argument, Kadlec cited numerous medical staff credentialing cases throughout the country deciding the issue of whether medical staff bylaws are contractual. Although some state courts have found bylaws to be contractual in certain contexts, Kadlec argued that the better-reasoned cases have concluded that medical staff bylaws are not contractual. Although the issue had not yet been decided by a Washington court, Kadlec cited to precedent in Division III and the Washington Supreme Court upholding the statutory autonomy of hospital governing bodies to set conditions for membership. (CP 188-89) (discussing *Perry v.*

Rado, 155 Wn. App. 626, 642, 230 P.3d 203 (2010) and *Ritter v. Board of Commissioners of Adams County Public Hospital District No. 1*, 96 Wn.2d 503, 637 P.2d 940 (1981)). These cases, Kadlec argued, affirm a public policy that would be vitiated if medical staff applicants could sue hospitals for breach of contract every time the hospital denied or limited the applicant's requested medical staff membership and clinical privileges.

In his response, Sambasivan argued that the issue should not be decided by the trial court based upon the "law of the case doctrine." See Section III.B *infra*. Without addressing Kadlec's argument that medical staff bylaws are not contractual, Sambasivan argued for the first time that his retaliation claim was actually based on (i) the Board's alleged interference with certain unidentified "patient contracts" when it adopted the credentialing requirement that made him ineligible for interventional cardiology privileges, and (ii) the Board's interference with his previous agreement with Kadlec to be compensated to taking emergency department call for interventional cardiology, which he could no longer take after August 14, 2008.

Following oral argument, the trial court issued its ruling granting summary judgment for Kadlec. (CP 490-95).

III. ARGUMENT

A. Standard of Review

The trial court's summary judgment dismissal is reviewed de novo. *Folsom v. Burger King*, 135 Wn.2d 658, 663, 958 P.2d 301 (1998). In reviewing a summary judgment order, an appellate court engages in the same inquiry as the trial court—whether the pleadings, affidavits, depositions, and admissions on file demonstrate “that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.” CR 56(c). A material fact “is a fact upon which the outcome of the litigation depends, in whole or in part.” *Lamon v. McDonnell Douglas Corp.*, 91 Wn.2d 345, 349, 588 P.2d 1346 (1979). All evidence must be considered in the light most favorable to the nonmoving party, and summary judgment may be granted only where there is but one conclusion that could be reached by a reasonable person. *Id.* at 349-50.

B. The Law of the Case Doctrine Does Not Preclude Granting Summary Judgment on a Dispositive Issue that Was Previously Raised but Never Decided

Sambasivan argues that the “law of the case” doctrine precluded the trial court from granting summary judgment on his remanded retaliation claim. That doctrine is inapposite here, where no court has previously decided the issue. Sambasivan's cited authorities (all decided

over 40 years ago) involve situations in which the appellant raised issues on appeal that were directly raised and expressly decided during a prior appeal. For example, in *Baxter v. Ford Motor Co.*, 179 Wash. 123, 125, 35 P.2d 1090 (1934), the Washington Supreme Court refused to reinterpret the underlying contracts on appeal when “[t]he legal effect of those two contracts was extensively argued on . . . appeal” and the appellate court made a decision regarding interpretation. Similarly, in *Columbia Steel Co. v. State*, 34 Wn.2d 700, 706, 209 P.2d 482 (1949), the Washington Supreme Court applied the law of the case doctrine because the appellant “present[ed] no question which was not determined on the previous appeal in this action, and no new question was raised by the pleadings or the evidence.”

Here, by contrast, the trial court expressly assumed but did not decide that medical staff bylaws create a contract that gives rise to a federal or state retaliation claim. (CP 121). Instead, it granted summary judgment based on a finding that Sambasivan did not identify facts to support the elements of a prima facie case of retaliation. The court of appeal’s analysis in the prior appeal followed the trial court’s lead, focusing solely on the elements of a retaliation claim and reversing the trial court’s determination. This Court did not decide the dispositive issue of whether Sambasivan had identified a contractual nexus for a state or

federal retaliation claim (which, as discussed below, was raised by Kadlec in its appeals brief).

Miller v. Sisters of St. Francis is also inapplicable. See App. Br. at 28 (citing *Miller*, 5 Wn.2d 204, 207, 105 P.2d 32 (1940)). Sambasivan cites *Miller* for the proposition that the law of the case doctrine “precludes questions that ‘might have been determined,’” App. Br. at 28, but omits language from *Miller* clarifying that the doctrine applies to issues ““which might have been determined had they been presented.”” *Miller*, 5 Wn.2d at 207 (emphasis added) (quoting *Perrault v. Emporium Dep’t Store Co.*, 83 Wash. 578, 582, 145 P. 438 (1915)). In *Miller*, after the close of the plaintiff’s case, defendant moved to strike certain testimony and to dismiss the case, which the court granted. *Id.* at 205. The plaintiff appealed, but did not raise the issue of “the admissibility of the testimony which the superior court on the last trial struck” even though this issue “could have been raised.” *Id.* at 209. Nevertheless, the appellate court held that, even without the stricken testimony, “the evidence . . . was sufficient to take the case to the jury, and that became the law of the case.” *Id.* Thus, on the second appeal, the evidentiary ruling from the first appeal was the law of the case. *Id.* at 210. The *Miller* court emphasized that the purpose of the law of the case is to prevent ““piecemeal”” litigation, and therefore a party that failed to present an issue on appeal, where that issue could have been

presented, cannot later appeal based on that issue. *See id.* at 207.

Here, by contrast, there is no threat of piecemeal litigation resulting from a party's failure to raise an issue. Here, as noted above, Kadlec extensively briefed the "contractual nexus" issue for the trial court, but the trial court declined to decide it because it dismissed the claim on other grounds; i.e., that Sambasivan did not provide evidence of "a causal connection between" his lawsuit that included a claim for discrimination and the Board's decision to adopt the proficiency requirement with immediate effect. (CP 122). In his appeal of this summary dismissal, Sambasivan did not raise the issue of whether he had a contractual nexus to support of retaliation claim. Instead, his argument mirrored the trial court's order and solely addressed the causation element of a prima facie case of retaliation:

Where, as here, Dr. Sambasivan has shown, at least inferentially, that the Kadlec Board's action against him was caused by his suit for unlawful discrimination, his retaliation claim should not be summarily dismissed.⁴

Kadlec's response, in turn, focused primarily on the trial court's order and the argument Sambasivan advanced. Kadlec also, however, raised the issue of whether the medical staff bylaws create a contract.

⁴ Brief of Appellant (Sept. 2, 2011) at ii, 43-50. (*See* appendix.)

Omitting the relevant excerpts from Kadlec's brief in the prior appeal, Sambasivan inaccurately maintains that "[t]he issues involving Dr. Sambasivan's contractual relationship could have been litigated in the prior appeal, but they were not." App. Br. at 28. The omitted excerpts demonstrate that Kadlec indeed raised the bylaws-as-a-contract issue in the appeal:⁵

As an initial matter, Sambasivan inexplicably devotes considerable attention to his argument that hospital bylaws create a binding contract between the hospital and a physician medical staff member. This Court need not reach that novel issue,¹³ however, because even if the contractual nature of the Bylaws is assumed for purposes of analyzing his breach of contract claim, the claim still fails as Sambasivan presented no evidence that Kadlec breached any Bylaw provision when it adopted the proficiency standard.¹⁴

¹³ Should this Court decide to reach the issue of whether hospital medical staff bylaws create an enforceable contract, Kadlec maintains they do not. See Kadlec's trial court briefing at CP 109-111 and CP 688.

¹⁴ The trial court assumed, but did not decide, that the Bylaws create a contract between Kadlec and Sambasivan, and concluded that Sambasivan failed to raise a material fact issue that any breach occurred. (CP 871)

Brief of Respondent/Cross-Appellant Kadlec Medical Center at 16-17 & nn.13-14 (Nov. 17, 2011) (emphasis added). (See appendix). Because the

⁵ Kadlec also briefed the issue of whether the Bylaws granted Sambasivan due process rights, but the court of appeals similarly declined to consider that issue. (CP 156) ("We decline to address the question [of whether hospital bylaws or employment contracts give rise to due process protections] in light of the facts that the doctor would obtain no relief even if we agreed with his theory.").

trial court did not reach that issue when it dismissed the retaliation claim (and because Kadlec believed Division III need not reach the issue in order to affirm the trial court's ruling), Kadlec did not devote substantial space to the argument and instead invited this court to review the trial court briefing if it chose to decide the issue. The trial court briefs, which were part of the Clerk's Papers available to the Court of Appeals, contained an extensive discussion of the issue. (*See* appendix).

Accordingly, through its June 2013 summary judgment motion, Kadlec reasserted a dispositive issue that it had raised below in both the trial court and in the court of appeals, but which had not been decided by either court.⁶ That is ordinary advocacy, not "piecemeal" litigation. *Miller*, 5 Wn.2d at 207.

Finally, even if the case law cited by Sambasivan applied, more modern cases caution against "[r]igid adherence" to the law of the case doctrine where the issue involves a "threshold determination of whether plaintiff possesses a cause of action." *Roberson v. Perez*, 156 Wn.2d 33, 44, 123 P.3d 844 (2005). Refusing to decide on summary judgment the fundamental legal basis for Sambasivan's claim would, as *Roberson*

⁶ *Greene v. Rothschild* is also not on point because the court decided the matter notwithstanding the applicability of the law of the case doctrine, explaining: "it is clear that this court does have the power to review and overrule its prior decisions." 68 Wn.2d 1, 8, 414 P.2d 1013 (1966), *cited in* App. Br. at 28. No law of the case was established in this case, and therefore *Greene* does not apply.

counsels, “actually violate the very purpose for which the law of the case doctrine exists—promoting finality and efficiency in the judicial process. The determination that a plaintiff cannot maintain a cause of action conserves judicial resources for those whose grievances are properly before the courts.” *Id.* Here, it was appropriate and prudent for the trial court to consider an alternative basis for summary dismissal of Sambasivan’s remaining claim where that issue has yet to be decided by any court—trial or appellate.

C. Sambasivan Has No Contractual Predicate for a Federal Retaliation Claim.

Section 1981 of the Civil Rights Act of 1866 provides that “[a]ll persons . . . shall have the same right . . . to make and enforce contracts . . . as is enjoyed by white citizens.” 42 U.S.C. § 1981. The statute defines “make and enforce contracts” to include “the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.” 42 U.S.C. § 1981(b) (emphasis added). “Any claim brought under § 1981, therefore, must initially identify an impaired ‘contractual relationship’ under which the plaintiff has rights.” *Domino’s Pizza, Inc. v. McDonald*, 546 U.S. 470, 476 (2006) (citation omitted).

Thus, as a threshold matter, Sambasivan’s retaliation claim must

concern the “making and enforcing” of a contract. *Walker v. Abbott Labs.*, 340 F.3d 471, 475 (7th Cir. 2003) (“There is no dispute . . . that even as amended § 1981’s protections still center on contractual rights and that proof of a contractual relationship is necessary to establish a § 1981 claim.”). The trial court correctly concluded that the action about which Sambasivan complains—his inability to qualify for interventional cardiology privileges following the Kadlec Board’s adoption of a heightened interventional cardiology procedure volume requirement on August 14, 2008—does not concern any contract identified by Sambasivan.

1. Sambasivan Does Not Challenge the Trial Court's Ruling that Medical Staff Bylaws Are Not Contractual and Therefore Do Not Provide a Contractual Predicate for His Claim

First, as Kadlec argued to the trial court, Sambasivan cannot base his retaliation claim on the Bylaws because medical staff bylaws are not contractual. In this appeal, Sambasivan does not challenge the trial court’s holding that medical staff and hospital bylaws are not contractual and therefore cannot provide the contractual predicate to a retaliation claim. His response to Kadlec’s summary judgment motion also did not address whether medical staff bylaws are contractual or present facts or evidence related thereto. (CP 373-79) Thus, Sambasivan legally concedes the

medical staff bylaws issue by solely citing and arguing alternative contractual bases—his prospective patient relationships and his emergency department call agreement with Kadlec—for his retaliation claim. *See Allard v. Bd. of Regents of Univ. of Wash.*, 25 Wn. App. 243, 247, 606 P.2d 280 (1980) (“To preclude summary judgment . . . the nonmoving party must set forth specific facts to rebut the moving party’s contentions and show that a genuine issue as to a material fact exists.”).

Although the court of appeals need look no further for a grounds to affirm than Sambasivan’s failure to answer, Kadlec’s argument that medical staff bylaws are not contractual is persuasive. As this Court has recognized, a hospital’s medical staff is not a separate legal entity capable of being sued because it is entirely subordinate to the hospital’s governing body. *Perry v. Rado*, 155 Wn. App. 626, 642, 230 P.2d 203, 211 (2010) (Division III). The court reasoned that a hospital’s medical staff is by state regulation subordinate to the hospital’s governing body. *Perry*, 155 Wn. App. at 642 (the role of the hospital’s governing body is to “[a]ppoint and approve a medical staff”) (quoting WAC 246-320-131(3)). The court also noted that the Kadlec medical staff is merely a “product of [hospital] bylaws,” which provide that the hospital’s Board “shall cause to be organized and maintained a medical staff for the hospital.” *Id.*

In addition, the Washington Supreme Court has held that the conferral of medical staff privileges does not create a property interest that would support a due process claim against a public hospital. *Ritter v. Bd. of Comm'rs of Adams Cnty. Pub. Hosp. Dist. No. 1*, 96 Wn.2d 503, 637 P.2d 940 (1981). Further, Washington law requires that “the governing body of every hospital . . . set standards and procedures to be applied by the hospital and its medical staff in considering and acting upon applications for staff membership or professional privileges.” RCW 70.43.010. Washington regulations further require the hospital’s governing authority to “[a]pprove and periodically review bylaws, rules, and regulations adopted by the medical staff before they become effective.” WAC 246-320-131(5).

In view of this legislative mandate, the Washington Supreme Court has held that hospitals in Washington have broad discretion to set criteria and make determinations concerning medical staff membership. *Grp. Health Coop. of Puget Sound v. King Cnty. Med. Soc’y*, 39 Wn.2d 586, 237 P.2d 737 (1951); *Rao v. Bd. of Cnty. Comm’rs*, 80 Wn.2d 695, 497 P.2d 591 (1972); *Rao v. Auburn Gen. Hosp.*, 10 Wn. App. 361, 367-68, 517 P.2d 240 (1973). These principles were affirmed by this Court in the prior appeal. (CP 157-59).

Given this precedent, the trial court correctly concluded that the more persuasive cases are those that have held that medical staff bylaws do not create a contract between a hospital and members of the medical staff, such as *Sambasivan*. (CP 503) (citing *Jimenez v. Wellstar Health Sys.*, 596 F.3d 1304 (11th Cir. 2010), *Johnson v. Spohn*, 334 F. App'x 673, 685 (5th Cir. 2009), *Adem v. Jefferson Mem'l Hosp. Ass'n*, No. 411-CV-2102-JAR, 2012 WL 5493856, at *4 (E.D. Mo. Nov. 13, 2012), and *Vesom v. Atchison Hosp. Ass'n*, No. 04-2218-JAR, 2006 WL 2714265, at *16-17 (D. Kan. Sept. 22, 2006), *aff'd*, 279 F. App'x 624 (10th Cir. 2008)).

Concluding that medical staff bylaws are contractual would frustrate public policy by exposing hospitals to an omnipresent threat of litigation for routine hospital management decisions. As the Minnesota Court of Appeals recently summarized, the issue of whether medical staff bylaws create an enforceable contract “presents two compelling and . . . competing policy interests”:

On one side is the interest of hospital management in controlling hospital operations and providing a safe environment for patients through bylaws governing the medical staff. On the other side is the interest of a medical staff in carrying out its obligations to patients by controlling how it organizes itself and how it influences the formation of and compliance with its bylaws.

Med. Staff of Avera Marshall Reg. Med. Ctr. v. Avera Marshall, 836 N.W.2d 549, 551 (Minn. Ct. App. 2013). Cases that have concluded that medical staff bylaws are contractual are placing “the remedy . . . before the theory.” *Med. Staff of Avera Marshall Reg. Med. Ctr. v. Avera Marshall*, No. 42-CV-12-69 at 28 (Minn. Dist. Ct., 5th Dist.) (Order on Motions for Summary Judgment). (CP 5xx).⁷ That is:

[T]he Courts in these cases appear to have a legitimate concern about providing an individual member of the medical staff with an avenue in which to obtain judicial relief of action taken by a hospital which is allegedly in contravention of its or the medical staff bylaws. This “ends justifies the means” approach is problematic not only for the reasons described, but for public policy reasons as well.

Id. See also *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1002 (N.D. Ga. 1992) (“Creating a breach of contract in this situation would run counter to this state’s policy of allowing the hospital to grant or withhold staff privileges from doctors it believes are unqualified to serve on its staff.”); *Tredea v. Anesthesia & Analgesia, P.C.*, 584 N.W.2d 276, 287 (Iowa 1998) (same).

Similarly here, the public policies expressed in Washington regulations governing hospital governing bodies and upheld in the case

⁷ The opinion is attached as Exhibit B to Kadlec’s 2013 Motion for Summary Judgment, but was not included with the copy of Kadlec’s brief in the clerk’s papers designated by Sambasivan; Kadlec’s supplemental designation of clerk’s papers was filed November 22, 2013 and the CP pages will be supplied when provided. (See appendix for excerpt.)

law would be frustrated were a court to determine that medical staff bylaws create contractual rights. Accordingly, the trial court's holding should be affirmed.⁸

2. Sambasivan's Emergency Call Coverage Contract Is Not a Contractual Predicate Because His Inability To Take Emergency Call Was a Collateral Consequence of Losing His Interventional Privileges and Was Not a "Right" with Which Kadlec Interfered.

Throughout this litigation Sambasivan argued that the Kadlec Bylaws provided that contractual nexus for his retaliation claim, and he has continued to defend that theory in earlier summary judgment briefings. (CP 17-20) (arguing that retaliation claim was based on alleged denial of due process under bylaws).

In his response to Kadlec's 2013 summary judgment motion, Sambasivan cited for the first time an entirely new contractual basis for his

⁸ Even if this Court were to determine (or assume without deciding) that the Bylaws are contractual, Kadlec took no action that interfered with the "making or enforcing" of that "contract." This Court has already affirmed that Sambasivan did not establish a genuine issue of material fact that the Board's action resulted in a breach of contract. For example, because the Board rejected the MEC's recommendation that interventional cardiologists currently on staff get a two-year grace period to achieve the recommended procedure volume, its recommendation to restrict Sambasivan's interventional cardiology privileges became moot, and therefore, Sambasivan was not entitled to a hearing to protest the recommended reduction of his clinical privileges. (*See* CP 156) ("the absence of a hearing did not harm Dr. Sambasivan and he would not benefit from a favorable ruling by this court"). Moreover, Sambasivan cannot show that the Board's action impaired any alleged rights or protections generally available to him under the Bylaws when it adopted the procedure volume requirement with immediate effect. Sambasivan continued to be a member of the Kadlec medical staff with privileges in general cardiology following the Board's action and thus remained subject to the very same Bylaws.

retaliation claim—his emergency department (“ED”) call coverage contract (“ED Contract”), which allowed him to be compensated for taking emergency department call for interventional cardiology when he held privileges to provide those services. (CP 378). While Sambasivan did indeed have such a contract with Kadlec, the ED Contract did not give Sambasivan any independent “right” to provide ED call services in the absence of possessing the requisite privileges. The agreement ended as a natural and direct consequence of Sambasivan no longer having interventional cardiology privileges. The alleged “rights” with which Sambasivan maintains the Board interfered were his “rights” to continue holding those interventional cardiology privileges, not to take ED call.

Courts have rejected similar attempts by physicians to cite to collateral consequences of losing medical staff privileges as a contractual basis for a civil rights claim. For example, in *Adem*, 2012 WL 5493856 at *5, the plaintiff physician argued that, by terminating his privileges, the defendant hospital precluded him from “consummating . . . contractual relationships with . . . patients . . . treated or hospitalized” at the defendant hospital. The court found that a ““doctor’s relationship with the patients he treated at the hospital was a benefit of the medical staff privileges to which he was no longer entitled.”” *Id.* (citing *Jimenez*, 596 F.3d at 1310). The court further noted that “the effect of having . . . privileges terminated

cannot be contractual and cannot form the basis of a § 1981 claim. The same conclusion precludes [the physician's] claim regarding potential 'business opportunities'" at the hospital. *Id.* at *6.

Similarly, in *Williams v. Columbus Regional Healthcare Systems, Inc.*, 499 F. App'x. 928, 930 (11th Cir. 2012), *cert. denied*, 133 S. Ct. 2340 (2013), the Eleventh Circuit noted that "[b]ecause [plaintiff] has no protected contractual interest in the continuation of his hospital staff privileges, . . . he cannot raise a claim that the Appellees interfered with his patient contracts because the Appellees' only action affecting those contracts was the limitation of his medical staff privileges." Similarly here, Sambasivan's inability to perform interventional cardiology procedures under the ED Contract is a collateral effect of his loss of those privileges, not an independent contractual basis that might support a § 1981 claim. His contractual right to be paid for taking ED call was contingent on having the appropriate clinical privileges (CP 438) (ED Contract, § 6.4(c)).

3. Sambasivan's Prospective Patient Relationships Do Not Provide a Contractual Predicate to a Retaliation Claim

Sambasivan also maintains that the Board's action "interfered with . . . [his] ability to serve prospective patients" and that "the economic aspect of the physician-patient relationship is contractual." App. Br. at 21

(citing *In re Shoptaw's Estate*, 54 Wn.2d 602, 605, 343 P.2d 740 (1959)).⁹ First, no summary judgment evidence exists to establish the existence of any supposed "patient contracts." In response to discovery requests that asked Sambasivan to identify these patient relationships and produce contracts and related writings, Sambasivan produced no agreements and claimed that such relationships and writings were "not relevant to the subject matter" of the litigation. (CP 463-65) Further, Sambasivan does not explain how the Board's action to adopt a credentialing requirement with immediate effect interfered with the supposed "patient contracts." Sambasivan remained on the medical staff of Kadlec following the Board's decision with privileges in general cardiology, and he could perform interventional procedures at any hospital where he held interventional privileges, such as Deaconess Medical Center in Spokane, Washington. (CP 470). No evidence exists that any "patient contracts" required him to treat patients requiring interventional cardiology services at Kadlec or precluded him from performing such procedures elsewhere.

Finally, even if such contracts existed, their legal effect is analogous to that of the ED Contract discussed above. As the Eleventh

⁹ *Shoptaw's Estate* is a probate case that cites to a state law prioritizing the debts of an estate, RCW 11.76.110. That statute makes "[e]xpenses of the last sickness" a second-priority debt, inferior to funeral expenses. *Id.* The case does not address the legal status of a relationship between a physician and a prospective patient.

Circuit observed in a similar case involving a § 1981 retaliation claim, a “[doctor’s] relationship with [the patients he treated at the hospital] was a benefit of the medical staff privileges to which he was no longer entitled.” *Jimenez*, 596 F.3d at 1310 (emphasis added). Thus, “[b]ecause [plaintiff] has no protected contractual interest in the continuation of his hospital staff privileges, . . . he cannot raise a claim that the Appellees interfered with his patient contracts because the Appellees’ only action affecting those contracts was the limitation of his medical staff privileges.” *Williams*, 499 F. App’x. at 930 (dismissing § 1981 retaliation claim). Similarly, Sambasivan’s inability to perform interventional cardiology call services under the ED Contract was a collateral effect of his loss of his interventional privileges, not an independent contractual basis that might support a § 1981 claim. Sambasivan identified no evidence that Kadlec’s action on August 14, 2008 was directed at his future patient relationships. As noted, Sambasivan remained on the Kadlec medical staff and could continue to perform interventional procedures in other facilities.

D. The Trial Court Correctly Determined That No Contractual Relationship Between Sambasivan and Kadlec Supports Sambasivan’s State Law Retaliation Claim.

The Washington Law Against Discrimination, Ch. 49.60 RCW (“WLAD”), provides that “It is an unfair practice for any employer, employment agency, labor union, or other person to discharge, expel, or

otherwise discriminate against any person because he or she has opposed any practices forbidden by this chapter, or because he or she has filed a charge, testified, or assisted in any proceeding under this chapter.” RCW 49.60.210(1). To maintain a retaliation claim under the WLAD, Sambasivan must establish that (i) he participated in a statutorily protected activity; (ii) an adverse employment action was taken against him; and (iii) his activity and the employer's adverse action were causally connected. *Hollenback v. Shriners Hosps. for Children*, 149 Wn. App. 810, 821, 206 P.3d 337, 343 (2009).

Thus, to defeat summary judgment, Sambasivan must demonstrate a genuine fact issue that the alleged retaliatory action took place in the context of an employment or independent contractor relationship through which the plaintiff performed professional services for the defendant. *See Hollenback*, 149 Wn. App. at 812; *Marquis v. City of Spokane*, 130 Wn.2d 97, 112-13, 922 P.2d 43 (1996). As discussed, neither the medical staff Bylaws nor the corporate bylaws create an employment relationship or independent contractor relationship between Kadlec and Sambasivan.¹⁰

¹⁰ Even if they did, the Board did not prevent him from continuing to be a member of the medical staff. Sambasivan remained on the Kadlec medical staff until he voluntarily resigned his membership and clinical privileges effective March 1, 2012. (CP 204, 217). The Bylaws do not guarantee that any physicians be awarded or continue to hold any specific category of clinical privileges, even if the physician previously held those privileges. (CP 254) (Bylaws § 1.3).

Further, the ED Contract cannot be the basis for Sambasivan's WLAD claim because the action at issue here (Sambasivan's loss of interventional cardiology privileges) did not take place relative to the ED Contract.

Sambasivan's assertion that Kadlec acted in a manner functionally similar to an employer when Sambasivan became ineligible for interventional cardiology is not supported by the law or facts. *See* App. Br. at 24. Kadlec's relationship with its medical staff is decidedly not a functional employment relationship given that Sambasivan put forth no evidence that the hospital purports to exercise control over or dictate Dr. Sambasivan's medical decision-making. *See Malo v. Alaska Trawl Fisheries, Inc.*, 92 Wn. App. 927, 930, 965 P.2d 1124 (1998) (defendant was not an "employer" under WLAD because he did not "employ, manage, or supervise" the plaintiff). The unusual circumstances of *Galbraith v. TAPCO Credit Union*, 88 Wn. App. 939, 946 P.2d 1242 (1997), are also not analogous to this situation. There, the court of appeals held that the plaintiff could maintain a WLAD claim against the defendant because the plaintiff was assisting the defendant's employees in a discrimination lawsuit, which "was directly related to their employment relationship with [the defendant]." *Galbraith*, 88 Wn. App. at 950. Here, by contrast, the action underlying Sambasivan's discrimination claim (his

loss of interventional cardiology privileges) does not implicate an employment relationships.

Even if a legally cognizable claim could exist under WLAD, Sambasivan did not provide evidence that Kadlec took any action that interfered with such a "contractual" relationship with him. Significantly, Sambasivan remained a member of the Kadlec medical staff with privileges in general cardiology well after he was no longer eligible to hold interventional cardiology privileges. He continued to hold those general cardiology privileges until he voluntarily relinquished his medical staff membership at Kadlec in March 2012, years after he lost his interventional cardiology privileges. (CP 204). The fact that he could no longer be called upon to take interventional cardiology call in the emergency department (and receive payment for it) was a collateral effect of his inability to qualify for interventional cardiology privileges after August 14, 2008. Sambasivan presented no evidence that the Board's action on August 14 was in any way directed at his ED Contract, or any other contract.

E. Sambasivan's Request for Attorney Fees Should be Denied

While difficult to discern what Sambasivan is requesting in his brief, *see* App. Br. at 29-30, to the extent he requests fees in connection with this appeal, any such request should be denied, as Sambasivan has

not yet prevailed on his claim. *See, e.g., Ino Ino, Inc. v. Bellevue*, 132 Wn.2d 103, 145-46, 937 P.2d 154 (1997) (recognizing that an award of attorney fees under 42 U.S.C. § 1988 is proper if the plaintiff prevails in an appellate court, but only “if a party’s rights under the federal constitution or federal law are violated.”); *Hinman v. Yakima Sch. Dist. No. 7*, 69 Wn. App. 445, 453, 850 P. 2d 536 (1993) (Div. III) (denying attorney fees on appeal from summary judgment because “[e]ntitlement to attorney fees cannot be determined until after trial on the merits”).

IV. CONCLUSION

For the foregoing reasons, the trial court’s summary judgment dismissal of Sambasivan’s retaliation claims should be affirmed.

DATED this 25th day of November, 2013.



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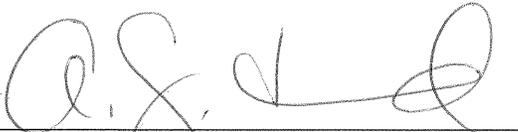
DECLARATION OF SERVICE

I declare under penalty of perjury under the laws of the State of Washington that on the 25th day of November, 2013, I caused a true and correct copy of the foregoing BRIEF OF RESPONDENT to be delivered via U.S. Mail to the following counsel of record at his last-known address:

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DATED this 25th day of November, 2013, at Seattle, Washington.



Andrea Lockwood, Legal Assistant

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United States District Court,
E.D. Missouri,
Eastern Division.

Antoine ADEM, M.D., Plaintiff,

v.

JEFFERSON MEMORIAL HOSPITAL
ASSOCIATION, d/b/a/ Jefferson Regional
Medical Center, et al., Defendants.

No. 4:11-CV-2102-JAR. | Nov. 13, 2012.

Attorneys and Law Firms

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Opinion

MEMORANDUM AND ORDER

JOHN A. ROSS, District Judge.

*1 This matter is before the Court on Defendants Jefferson Memorial Hospital Association d/b/a Jefferson Regional Medical Center and Warren Mark Breite, M.D.'s Motion to Dismiss Plaintiff's Amended Complaint for Failure to State a Claim Upon Which Relief can be Granted and for Lack of Subject Matter Jurisdiction [ECF No. 17] and Plaintiff Antoine Adem M.D.'s Motion for Partial Summary Judgment [ECF No. 33]. The motions are fully briefed and ready for disposition. The Court will first address Defendants' motion to dismiss, as the granting of that motion would render Plaintiff's motion for summary judgment moot.

Background ¹

This action arises out of the termination of Plaintiff Antoine Adem, M.D. ("Dr. Adem")'s medical staff privileges at Defendant Jefferson Memorial Hospital Association, d/b/a Jefferson Regional Medical Center ("JRMC"). Defendant Warren Mark Breite, M.D. ("Dr. Breite") is JRMC's Vice President of Medical Affairs and a member of the JRMC Medical Executive Committee ("MEC").

Dr. Adem, an invasive/interventional cardiologist, was granted staff membership and privileges by JRMC in 2002. In 2008, an investigation pursuant to Article 6 of JRMC's Medical Staff Bylaws ("the Bylaws") was opened in response to a complaint made about Dr. Adem. The Medical Care Appraisal Committee ("MCAC") recommended Dr. Adem's privileges be terminated as a result of unethical conduct and upon a finding that he had performed unnecessary medical procedures. On February 9, 2010, Dr. Adem was notified by JRMC of its summary suspension of his invasive/interventional cardiology privileges. On April 26, 2012, the MEC notified Dr. Adem that it was recommending to the JRMC Board of Directors ("the Board") that his privileges and medical staff membership be terminated. Dr. Adem then requested a hearing before a Hearing Review Committee ("HRC"). Under the Bylaws, the HRC acts as a fact-finding tribunal. On June 7, 2011, following six evidentiary hearings comprising over forty hours of testimony from fact and expert witnesses, the HRC concluded that JRMC did not provide conclusive evidence that Dr. Adem's medical procedures were unnecessary or harmful. However, the HRC agreed with the previous findings of both the MCAC and MEC that Dr. Adem had engaged in unethical conduct by submitting a false letter in an attempt to influence decisions regarding his privileges. The HRC recommended, by a vote of 2 to 1, that Dr. Adem's privileges be reinstated.

On June 23, 2011, the MEC met to review the HRC's decision and issued its final recommendation to the Board that Dr. Adem's privileges be suspended for fourteen days, a suspension he had already served, and that his medical staff membership and privileges be terminated as discipline for the ethical issue. As a result of its decision on the ethical issue, its recommendation on the medical issues was rendered moot.

Dr. Adem appealed under Section 7.5-2(b) of the Bylaws. An Appeal Board comprised of eight Board members heard arguments and reviewed written briefs. On September 1, 2011, the Appeal Board issued its decision and findings of fact and conclusions of law affirming the MEC's final recommendation, and terminating Dr. Adem's privileges.

*2 Dr. Adem alleges that prior to the Board's decision, he had a thriving cardiology practice at JRMC predicated on his ability to admit patients to JRMC, utilize JRMC facilities and staff to test, diagnose and treat his patients, and accept referrals of prospective patients from other members of the JRMC medical staff, all of which has been substantially impaired by the termination of his privileges.

In this action, Dr. Adem seeks a declaratory judgment that JRMC's Bylaws are invalid because they failed to afford him a fair hearing procedure and that Defendants violated his legal rights by conducting a hearing that was unfair, unlawful and racially motivated. Dr. Adem also seeks injunctive relief and damages for alleged tortious interference with business expectancy and breach of contract as well as for violations of 42 U.S.C. § 1981, all based on the revocation of his medical staff privileges at JRMC. Jurisdiction in this Court relies on the claim raised in Count III for violations of 42 U.S.C. § 1981.

Legal Standard

Motion to Dismiss

In ruling on a motion to dismiss, the Court must view the allegations in the complaint liberally in the light most favorable to the plaintiff. *Eckert v. Titan Tire Corp.*, 514 F.3d 801, 806 (8th Cir.2008) (citing *Luney v. SGS Auto Servs.*, 432 F.3d 866, 867 (8th Cir.2005)). Additionally, the Court “must accept the allegations contained in the complaint as true and draw all reasonable inferences in favor of the nonmoving party.” *Coons v. Mineta*, 410 F.3d 1036, 1039 (8th Cir.2005) (citation omitted). To survive a motion to dismiss, a complaint must contain “enough facts to state a claim to relief that is plausible on its face.” *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007) (abrogating the “no set of facts” standard for Fed.R.Civ.P. 12(b)(6) found in *Conley v. Gibson*, 355 U.S. 41, 45–46 (1957)). Thus, as a practical matter, a dismissal under Rule 12(b)(6) should be granted “only in the unusual case in which a plaintiff includes allegations that show, on the face of the complaint, that there is some insuperable bar to relief.” *Strand v. Diversified Collection Serv., Inc.*, 380 F.3d 316, 317 (8th Cir.2004). The issue on a motion to dismiss is not whether the plaintiff will ultimately prevail, but whether the plaintiff is entitled to present evidence in support of his or her claim. *Rosenberg v. Crandell*, 56 F.3d 35, 37 (8th Cir.1995).

Count III—42 U.S.C. § 1981

Because Count III is the basis for Dr. Adem's assertion that jurisdiction is proper in this Court, the Court will address Defendants' motion to dismiss with respect to this claim first. Dr. Adem alleges a claim of racial discrimination under 42 U.S.C. § 1981, specifically, that Defendants were motivated by racial animus towards him, a person of Arabic race and Lebanese national origin, in pursuing the charges against

him, and that the Board's decision to revoke his medical staff privileges “was precipitated, in substantial part, by racial animus” towards him. (First Amended Complaint (“FAC”), ¶ 33)

*3 To establish a prima facie case of discrimination, a § 1981 plaintiff must show (1) membership in a protected class, (2) discriminatory intent on the part of the defendant, (3) engagement in a protected activity; and (4) interference with that activity by the defendant. *Gregory v. Dillard's, Inc.*, 565 F.3d 464, 469 (8th Cir.2009) (citing *Green v. Dillard's, Inc.*, 483 F.3d 533, 538 (8th Cir.2007); *Bediako v. Stein Mart, Inc.*, 354 F.3d 835, 839 (8th Cir.2004)). Section 1981 prohibits racial discrimination in “all phases and incidents” of a contractual relationship, but “does not provide a general cause of action for race discrimination.” *Gregory*, 565 F.3d at 468 (citing *Youngblood v. Hy-Vee Food Stores, Inc.*, 266 F.3d 851, 855 (8th Cir.2001)). Therefore, a claim brought under § 1981 must initially identify a protected contractual relationship or interest under which the plaintiff has rights. *Id.* (citing *Domino's Pizza, Inc. v. McDonald*, 546 U.S. 470, 477 (2006)). Defendants urge dismissal of Dr. Adem's claim because he has not identified a contractual relationship that could form the basis of a § 1981 claim.

Arguments of the Parties

In support of their motion, Defendants state that under Missouri law, medical staff bylaws do not create contracts between physicians and hospitals because there is no consideration. *See Egan v. St. Anthony's Medical Center*, 244 S.W.3d 169 (Mo.banc 2008) and *Zipper, D.O. v. Health Midwest*, 978 S.W.2d 398 (Mo.Ct.App.1998). (Memorandum in Support of Motion to Dismiss, Doc. No. 18, pp. 4–5) With respect to Dr. Adem's allegations that contractual relationships with patients and business opportunities with colleagues form the basis of his claim, Defendants argue the termination of Dr. Adem's staff privileges does not interfere with his ability to contract; rather, it is his ability to treat patients at JRMC, a benefit of his privileges, that has been affected. (*Id.*, pp. 6–7) Moreover, Dr. Adem has failed to identify any contract he attempted to enter or maintain that has been interfered with by the Board's decision. (*Id.*, p. 7) Finally, Defendants argue that even if Dr. Adem could demonstrate a contractual relationship in which he has rights, he has not pled facts sufficient to demonstrate discriminatory intent. (*Id.*, pp. 9–10)

In response, Dr. Adem argues that JRMC made the Bylaws a binding contract through its acceptance of his application

for membership on the medical staff. (Memorandum in Opposition, Doc. No. 24, p. 6) By virtue of paying annual dues pursuant to section 2.6 of the Bylaws, Dr. Adem contends he entered into a bargained for exchange of consideration with JRMC, whereby JRMC obligated itself to act in accordance with the Bylaws. He cites *Ennix v. Stanten*, 556 F.Supp.2d 1073 (N.D.Cal.2008), in support of his claim. In *Ennix*, an African-American cardiac surgeon sued a hospital and physicians under § 1981, claiming racial discrimination in connection with a medical peer review that resulted in a temporary loss of hospital privileges. The Northern District of California, at summary judgment, held there was a genuine issue of material fact as to whether or not a contractual relationship existed between the surgeon and the hospital. Dr. Adem also alleges Defendants' discrimination has impaired his "quasi-contractual" obligation to care for his existing patients by virtue of his inability to treat them at JRMC, and precluded him from consummating such contractual relationships with potential patients who want to or must be treated at JRMC. (*Id.*, p. 5)

*4 In reply, Defendants reiterate their position that under Missouri law, medical staff bylaws cannot be considered a contract, and that if a hospital wants to impose duties and incur obligations with its employees, it must do so in a separate document that is not the bylaws. See *Zipper*, 978 S.W.2d at 417. (Defendants' Reply to Plaintiff's Memorandum in Opposition, Doc. No. 27, p. 6) Dr. Adem has not pled the existence of such a document. Furthermore, the Bylaws themselves specifically state in section 7.6-5 that "nothing set forth in these Bylaws shall be deemed to establish any contractual rights ..." (*Id.*, p. 5)

Discussion

Dr. Adem advances two theories as to why the termination of his medical staff privileges violated rights protected under § 1981. First, he contends the termination of his privileges violated his contractual relationship with JRMC. Second, Dr. Adem contends the termination of his privileges impaired his contractual relationships with patients and business opportunities with colleagues.

With respect to Dr. Adem's alleged contractual relationship with JRMC, the Bylaws provide that "nothing set forth in these Bylaws shall be deemed to establish any contractual rights ..." Section 7.6-5. Where medical staff bylaws specifically state that they do not constitute a contract, courts have held they confer no contractual rights. See *Grain v. Trinity Health*, 431 Fed.Appx. 434 (6th Cir.2011), holding

that medical staff bylaws did not constitute a contract given unambiguous language stating they "shall not constitute a contract between the medical staff and the hospital." *Id.* at 450. See also, *Jimenez v. Wellstar Health System*, 596 F.3d 1304, 1309 (11th Cir.2010), holding that, for purposes of a § 1981 claim, medical staff bylaws created no contract between a hospital and a doctor where the bylaws stated, "[m]embership on the Medical Staff does not create a contractual relationship between WellStar or any Medical Staff and the Medical Staff Member."

In addition to the plain language of the Bylaws, the law in Missouri is clear that medical staff bylaws do not constitute a contract between doctors and hospitals. For this reason, Dr. Adem's reliance on *Ennix* is misplaced. In Missouri, the essential elements of a contract are: (1) competency of the parties to contract; (2) subject matter; (3) legal consideration; (4) mutuality of agreement; and (5) mutuality of obligation. *Zipper*, 978 S.W.2d at 416 (citations omitted). A valid contract must include an offer, an acceptance and consideration. *Id.* (citing *Johnson v. McDonnell Douglas Corp.*, 745 S.W.2d 661, 662 (Mo. banc 1988)). Hospital bylaws cannot be considered a contract under Missouri law because there is no consideration. By state board of health regulation, Missouri hospitals are required to adopt bylaws governing their professional activities. *Zipper*, 978 S.W.2d at 416 (internal quotation omitted). "[A] promise to do that which one is already legally obligated to do cannot serve as consideration for a contract." *Id.* "Additionally, there is no bargained for exchange as to the procedures adopted in hospital bylaws as required to have an enforceable contract." *Id.* This is because the hospital has the right to change the bylaws unilaterally and impose those bylaws on its medical staff. *Id.* See also *Egan*, 244 S.W.3d at 174 ("A hospital's duty to adopt and conform its actions to medical staff bylaws as required by the regulation is a preexisting duty, and a preexisting duty cannot furnish consideration for a contract. A hospital's obligation to act in accordance with its bylaws, in other words, is independent of any contractual obligation the hospital may have to the doctor.")

*5 In further support of his alleged contractual relationship with JRMC, Dr. Adem contends that by accepting his application for staff membership "on terms and conditions that JRMC set forth in its application form," JRMC has made the Bylaws a binding contract. (Plaintiff's Memorandum in Opposition, Doc. No. 24, p. 6 (citing FAC, ¶¶ 4, 7)) He also asserts that his payment of annual dues to JRMC is "consideration" for JRMC's continuing extension

of privileges and staff membership to him. The Eighth Circuit recognizes that under Missouri law, a hospital can be subjected to contractual enforcement of its medical staff bylaws if a contractual relationship is established in a separate document. *See Madsen v. Audrain Health Care, Inc.*, 297 F.3d 694, 699 (8th Cir.2002) (citing *Zipper*, 978 S.W.2d at 417). Dr. Adem has not, however, identified any document in which JRMC separately sets forth its obligations under the Bylaws. He has not alleged that the Bylaws were incorporated into his membership application, and he has not attached a copy of the application to his complaint. Again, if a hospital wants to impose duties and incur obligations with its employees, it must do so in a separate document that is not the bylaws. *See Zipper*, 978 S.W.2d at 417. Because the Bylaws are not considered a contract under Missouri law, and because Dr. Adem does not allege that JRMC separately obligated itself to comply with any other set of standards, his allegations regarding his payment of dues or the acceptance of his membership application are insufficient to form the basis of a separate contractual relationship.

Thus, in light of the well established law in Missouri, and the Bylaws' unambiguous language repudiating the existence of a contract, the Court finds JRMC's medical staff bylaws do not constitute a contract between Dr. Adem and JRMC.

In addition to claiming a contractual relationship with JRMC as a basis for his § 1981 claim, Dr. Adem alleges Defendants' conduct has impaired his contractual opportunities with patients and colleagues. Specifically, he contends that Defendants have interfered with his "quasi-contractual" obligation to care for his existing patients by virtue of his inability to treat them at JRMC, and precluded him from consummating such contractual relationships with potential patients who want to, or must be, treated or hospitalized at JRMC. (Plaintiff's Memorandum in Opposition, Doc. No. 24, p. 5) The Eleventh Circuit rejected a similar argument in *Jimenez*, 596 F.3d 1304.

In *Jimenez*, the plaintiff doctor filed an EEOC charge claiming his medical privileges were suspended because of his race. The court found the suspension of these privileges did not implicate any right protected by § 1981 because the doctor did not have any contractual or property interest in maintaining his medical staff privileges at the hospital. *Id.* at 1310–11. The doctor also argued the suspension interfered with his right to contract with patients and third-party payors. *Id.* at 1310. The court ruled that the doctor's relationship with the patients he treated at the hospital was

a benefit of the medical staff privileges to which he was no longer entitled. Moreover, future contracts he might have formed with patients admitted after his suspension were too speculative to form the basis of a § 1981 claim. *Id.*

*6 As in *Jimenez*, Dr. Adem's relationships with patients and colleagues at JRMC was a benefit of having privileges there. As discussed above, his privileges were not contractual. Therefore, the effect of having those privileges terminated cannot be contractual and cannot form the basis of a § 1981 claim. The same conclusion precludes Dr. Adem's claim regarding potential "business opportunities" with colleagues at JRMC. *Jimenez*, 596 F.3d at 1310. Accordingly, Defendants' motion to dismiss Count III will be granted.

Defendants have asked the Court not to exercise supplemental jurisdiction over Dr. Adem's remaining claims, and Dr. Adem has not objected or otherwise responded to their request. (Memorandum in Support, Doc. No. 18, p. 15) District courts "may decline to exercise supplemental jurisdiction over" a state law claim if "the district court has dismissed all claims over which it has original jurisdiction." 28 U.S.C. § 1367(c)(3). Count III is the only count over which this Court has original jurisdiction. Because Defendants' motion to dismiss is granted as to Dr. Adem's federal law claim, there are no claims remaining over which the Court has original jurisdiction. Thus, the Court may decline to exercise supplemental jurisdiction to hear the remaining claims. Because the Court sees no reason why the parties should not adjudicate this dispute in state court, the Court declines to exercise supplemental jurisdiction over the remaining claims and will dismiss those claims without prejudice.

Accordingly,

IT IS HEREBY ORDERED that Defendants. Jefferson Memorial Hospital Association d/b/a Jefferson Regional Medical Center and Warren Mark Breite, M.D.'s Motion to Dismiss Plaintiff's Amended Complaint for Failure to State a Claim Upon Which Relief can be Granted and for Lack of Subject Matter Jurisdiction [17] is **GRANTED**. Count III of the First Amended Complaint is dismissed, with prejudice, for failure to state a claim. Because this Court declines to exercise supplemental jurisdiction over Plaintiff's remaining state law claims, Counts I, II, IV and V are dismissed without prejudice to be refiled in state court.

IT IS FURTHER ORDERED that Plaintiff Antoine Adem M.D.'s Motion for Partial Summary Judgment [33] is **DENIED** as moot.

A separate order of dismissal will accompany this Memorandum and Order.

Footnotes

- 1 The factual background is taken from Dr. Adem's First Amended Complaint, as well as from JRMC's recitation of the chronology of events in the peer review process taken from its Memorandum in Support of Motion to Dismiss (Doc. No. 18). Dr. Adem adopts JRMC's recitation in his Motion for Partial Summary Judgment. (Doc. No. 33, ¶ 3)

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334 Fed.Appx. 673

This case was not selected for publication in the Federal Reporter. Not for Publication in West's Federal Reporter See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Fifth Circuit Rules 28.7, 47.5.3, 47.5.4. (Find CTA5 Rule 28 and Find CTA5 Rule 47) United States Court of Appeals, Fifth Circuit.

Dr. Tone JOHNSON and Complete Medical Care, PC, Plaintiffs-Appellants v. Christus SPOHN, et al., Defendants-Appellees.

No. 08-40262. | June 23, 2009.

Synopsis

Background: Physician, along with his solely owned general family practice, brought action against hospital alleging his medical staff membership and clinical privileges were unlawfully revoked. The United States District Court for the Southern District of Texas, John D. Rainey, J., 2008 WL 375417, granted summary judgment in favor of hospital. Physician appealed.

Holdings: The Court of Appeals held that:

- [1] district court did not abuse its discretion by admitting hospital's summary judgment evidence of a timeline purporting to show the sequence of events leading up to a patient's death;
[2] district court did not commit error when it admitted into evidence 20 summary judgment affidavits;
[3] district court did not abuse its discretion by refusing to exclude summary judgment evidence of documents created during peer review proceedings;
[4] hospital and peer-review committee were immune under the Health Care Quality Improvement Act (HCQIA);
[5] hospital's medical staff bylaws did not create a contractual relationship between hospital and physician; and

[6] physician's provision of substandard medical care was legitimate, non-discriminatory reason for hospital's revocation of privileges.

Affirmed.

West Headnotes (6)

[1] Federal Civil Procedure

Admissibility

In physician's action against hospital challenging the revocation of his membership and clinical privileges at hospital, district court did not abuse its discretion by admitting hospital's summary judgment evidence of a timeline purporting to show the sequence of events leading up to a patient's death, even if timeline was not relied upon by hospital's review committees which ultimately made decision to revoke privileges, since timeline assisted district court in understanding the other evidence considered by those committees and timeline was accompanied by affidavits attesting to the accuracy of the information. Fed.Rules Civ.Proc.Rule 56(c), 28 U.S.C.A.

1 Cases that cite this headnote

[2] Federal Civil Procedure

Affidavits

In physician's action against hospital challenging the revocation of his membership and clinical privileges at hospital, district court did not commit error when it admitted into evidence 20 summary judgment affidavits submitted by persons either involved in patient's treatment or in peer review process stating, among other things, that physician's treatment of patient was below the required standard of care and that review process was fair, where district court stated it did not take the statements into consideration and there was ample additional evidence to support district court's conclusions. Fed.Rules Civ.Proc.Rule 56(c), 28 U.S.C.A.

[3] **Evidence**

↳ Unofficial or business records in general

Evidence

↳ Form and Sufficiency in General

Federal Civil Procedure

↳ Admissibility

In physician's action against hospital challenging the revocation of his membership and clinical privileges at hospital, district court did not abuse its discretion by refusing to exclude summary judgment evidence of documents created during peer review proceedings, since documents were properly authenticated business records; vice president of medical affairs at hospital submitted affidavit attesting that documents were business records compiled at time of peer review hearings during regular course of business, and documents showed what evidence the peer review committee considered. Fed.Rules Evid.Rule 803(6), 28 U.S.C.A.

[4] **Health**

↳ Liability or immunity

Hospital and peer-review committee were immune from money damages under the Health Care Quality Improvement Act (HCQIA) in claim brought by physician following revocation of his medical staff membership and clinical privileges at hospital following peer review committee investigation of death of patient under physician's care; evidence showed that revocation was in furtherance of quality health care, committee conducted reasonable investigation, physician was afforded right to counsel and right to present evidence at hearing, and committee found that physician failed to attend to patient promptly or to provide urgently needed medical care. Health Care Quality Improvement Act of 1986, § 402, 42 U.S.C.A. § 11101.

3 Cases that cite this headnote

[5] **Civil Rights**

↳ Contracts, trade, and commercial activity

Hospital's medical staff bylaws, which limited the authority of the medical staff, did not create a contractual relationship between hospital and physician, under Texas law, for purposes of physician's § 1981 claim against hospital challenging the revocation of his membership and clinical privileges at hospital; hospital's board of directors retained ultimate authority over physician's fate. 42 U.S.C.A. § 1981.

[6] **Civil Rights**

↳ Contracts, trade, and commercial activity

Physician's provision of substandard medical care which posed danger to patient safety was legitimate, non-discriminatory reason for hospital's revocation of physician's medical staff membership and clinical privileges at hospital. 42 U.S.C.A. § 1981.

Attorneys and Law Firms

*674 Joe A. Flores, Robert J. Heil, Juan P. Reyna, Corpus Christi, TX, for Plaintiffs-Appellants.

Ben Addison Donnell, Donnell Abernethy & Kieschnick, Corpus Christi, TX, Daniel McClure, Robert J. Swift, Hannah DeMarco Sibiski, Peter Stokes, Fulbright & Jaworski, LLP, Dallas, TX, for Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Texas, 2:06-CV-138.

Before GARWOOD, DENNIS, and PRADO, Circuit Judges.

Opinion

*675 PER CURIAM: *

Plaintiffs-appellants Tone Johnson, M.D. (Johnson) and Complete Medical Care, P.C. (Complete Medical Care) appeal the district court's summary judgment dismissal of their claims alleging that Dr. Johnson's medical staff membership and clinical privileges at defendant-appellee Christus Spohn Hospital (the Hospital) were unlawfully revoked. For the following reasons, we AFFIRM.

I. FACTS AND PROCEEDINGS BELOW

Dr. Johnson is an African-American physician and the sole owner of Complete Medical Care, a general family practice in Corpus Christi, Texas. Although not a Hospital employee, Dr. Johnson was a member of the medical staff and enjoyed clinical privileges there, meaning that he could admit and treat patients at the Hospital, for over twenty years at the time of the events underlying this suit. Dr. Johnson's medical staff membership and clinical privileges at the Hospital were suspended and eventually revoked following the death of a patient under his care. The legal issues in this case involve the peer review process that followed and whether Dr. Johnson's medical staff membership and clinical privileges were lawfully revoked.

On the morning of March 16, 2004, Dr. Reveron, an employee of Complete Medical Care, admitted patient RM to the Hospital for treatment through Dr. Johnson. Dr. Reveron suspected that RM was suffering from varicella (commonly known as chicken pox) and ordered lab tests to be performed, which indicated that RM had a low white blood cell count. Although Dr. Reveron ordered a hematology consult upon admitting RM, either through the fault of Dr. Johnson or the nursing staff, this initial request was never carried out. Dr. Johnson claims that he visited RM on March 16, whereas appellees assert that Dr. Johnson did not examine RM personally until the following evening.

Regardless, shortly after midnight on March 17, RM suffered a grand mal seizure. No action was taken until approximately 9:00 a.m., when Dr. Johnson requested that nurses contact several hematologists and neurologists, none of whom arrived until that evening. Concerned over her husband's treatment, RM's wife submitted a request that Dr. Johnson be removed from RM's care, which the charge nurse passed on to Dr. McCullough (Executive Vice President of the Medical Staff) and Dr. Cleaves (Chairman of the Department of Family Practice). When informed of this complaint, Dr. Johnson responded that RM was "2x stupid" and that he was being singled out because of his race. Following an examination by a hematologist and Dr. Johnson at around 7 p.m. that evening, RM was immediately transferred to the intensive care unit, where he was intubated and placed on a ventilator. Soon thereafter, RM's wife requested that Dr. Johnson be removed as treating physician and Dr. Johnson either removed himself or was involuntarily removed. Despite the efforts of several specialists, RM died on the morning of March 19, 2004.

At a regularly-scheduled meeting held on March 25, 2004, the Hospital's Medical Executive Committee (MEC), which was comprised of approximately thirty physicians responsible for overseeing the quality of medical care at the Hospital and recommending disciplinary action to the *676 Christus Spohn Board of Directors (Board of Directors), heard reports from Dr. McCullough, who also served on the MEC, and another family practitioner about the events leading up to RM's death. Although Dr. Cleaves was unable to attend the meeting, he was a member of the MEC and recommended that Dr. Johnson's privileges be suspended. The MEC voted to suspend Dr. Johnson's privileges and to appoint a Departmental Action Committee (DAC) composed of five physicians from the Department of Family Practice, including Dr. Cleaves, to investigate further. Dr. Johnson was promptly informed that his privileges were summarily suspended and that he would be granted an "interview" to present his side of the story to the DAC. Pursuant to Dr. Johnson's request, the MEC met again on April 1, 2004 to hear personally from Dr. Johnson and unanimously voted to continue his suspension pending the DAC's investigation.

At a meeting of the DAC held on April 7, 2004, Dr. Johnson, without the aid of counsel, was permitted to explain his treatment of RM and to refute the allegations of substandard care. The DAC also heard from several other doctors and Hospital staff who were on duty at the time that RM was being treated. With Dr. Cleaves abstaining, the DAC unanimously voted to continue the suspension and recommended revocation of Dr. Johnson's medical staff membership and clinical privileges. On April 22, 2004, the MEC adopted the DAC's findings and made the same recommendation to the Board of Directors.

Thereafter, in accordance with the Medical Staff Bylaws,¹ Dr. Johnson requested review by a Fair Hearing Committee. At several hearings held between April and July of 2005, Dr. Johnson was represented by counsel, presented evidence, and called and cross-examined witnesses. On July 14, 2005, the Fair Hearing Committee, which was comprised of five of Dr. Johnson's fellow physicians, unanimously concluded that Dr. Johnson had failed to meet the burden imposed by the Medical Staff Bylaws of showing by clear and convincing evidence that the MEC's decision lacked "substantial factual basis or that such basis and the conclusions drawn therefrom [were] arbitrary, unreasonable, and capricious." The MEC voted to affirm its recommendation on July 28, 2005, and Dr. Johnson appealed to the Appellate Review Body. After hearing oral

argument from the Hospital and Dr. Johnson's counsel, the six person Appellate Review Body unanimously concluded that "(a) this matter has been handled in substantial compliance with the Hospital Bylaws, (b) the decision of the hearing committee was based upon the evidence presented to it, and (c) the hearing committee decision was reasonable in light of the hospital's duty to its patients." Further, the Appellate Review Body specifically found that the revocation was not based upon race and that Dr. Johnson was afforded a fair hearing and a full opportunity to present his case. Finally, on November 18, 2005, the Board of Directors reviewed the Appellate Review Body's decision and voted to adopt the MEC's recommendation to revoke Dr. Johnson's medical staff membership and clinical privileges.²

*677 On March 24, 2006, Dr. Johnson and Complete Medical Care filed this suit in the Southern District of Texas against the Hospital and the various individual administrators and several physician members of the MEC and DAC, asserting the following claims: violations of federal and Texas antitrust laws; violations of the Texas Deceptive Trade Practices Act; breach of contract; various state torts, including business disparagement, defamation, slander, libel, tortious interference with contract, intentional infliction of emotional distress, fraud, and misrepresentation; violations of the constitutional rights to free speech, due process, and equal protection; and race discrimination in violation of 42 U.S.C. § 1981. The district court concluded that, as to all but the section 1981 claim, appellees were immune from civil liability under the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 *et seq.*, and its Texas counterpart, the Texas Health Care Quality Improvement Act, TEX. OCC.CODE ANN. §§ 160.001 *et seq.* In regard to the section 1981 claim, the district court determined that appellants had failed to create a genuine issue of material fact as to whether the Hospital's proffered reason for the revocation of Dr. Johnson's privileges was a pretext for an underlying discriminatory motive or that race was a motivating factor in the decision. Therefore, the district court granted summary judgment for appellees as to all claims. Dr. Johnson and Complete Medical Care timely appealed.

II. DISCUSSION

A. Standard of Review

We review a grant of summary judgment *de novo*, applying the same standards as the district court. *Jenkins v. Methodist Hosps. of Dallas, Inc.*, 478 F.3d 255, 260 (5th Cir.2007). In

doing so, we view the evidence in the light most favorable to the non-movant. *Patel v. Midland Mem'l Hosp. & Med. Ctr.*, 298 F.3d 333, 339 (5th Cir.2002). Summary judgment is proper "if the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." FED.R.CIV.P. 56(c).

B. Summary Judgment Evidence

Appellants claim that the district court erred in overruling their evidentiary objections and therefore improperly relied on three categories of allegedly inadmissible evidence: a timeline of the events leading up to RM's death created by Hospital personnel for trial; affidavits from numerous individuals involved in RM's treatment and the peer review process stating that Dr. Johnson's care for RM was substandard and that the revocation proceedings were fair; and various notes, letters, and committee minutes created during the peer review process. Evidence that is inadmissible at trial may not be relied upon at the summary judgment stage. *Duplantis v. Shell Offshore, Inc.*, 948 F.2d 187, 192 (5th Cir.1991). Unauthenticated documents may not be used, but "discovery and disclosure materials on file, and any affidavits" may be relied upon. *Id.*; FED.R.CIV.P. 56(c). We review a district court's evidentiary rulings for abuse of discretion. *McConathy v. Dr. Pepper/Seven Up Corp.*, 131 F.3d 558, 562 (5th Cir.1998).

[1] As part of their summary judgment evidence, appellees introduced a timeline purporting to show the sequence of events leading up to RM's death. Appellants argue that, because the timeline was created after-the-fact and never relied upon by any of the review committees, it *678 was irrelevant for the purposes of evaluating what evidence those committees considered. Although the timeline itself was not considered by the review committees, it nevertheless assisted the district court in understanding the other evidence considered by those committees. Moreover, the timeline was accompanied by the affidavits of seven physicians and hospital staff members who had personal knowledge of the events described therein and attested to the accuracy of that information. The district court did not abuse its discretion in admitting the timeline for summary judgment purposes.

[2] The second category of challenged evidence includes twenty affidavits submitted by persons either involved in RM's treatment or in the peer review process stating, among other things, that Dr. Johnson's treatment of RM was below the required standard of care and that the review process

was fair. Appellants claim that the statements contained in those affidavits were conclusory and their objections should have been sustained. Affidavits setting forth "ultimate or conclusory facts and conclusions of law" are insufficient of themselves to support a grant of summary judgment. *Galindo v. Precision Am. Corp.*, 754 F.2d 1212, 1216 (5th Cir.1985). The district court overruled these objections as moot because the court did not rely on those statements in granting summary judgment for appellees. Because the district court did not take those statements into consideration and there is ample additional evidence to support the district court's conclusions, we find no error.

[3] Finally, appellants argue that the various notes, letters, and committee minutes created during the peer review process contained hearsay and should not have been admitted. To authenticate those documents, appellees submitted the affidavit of Dr. Davis, who was Vice President of Medical Affairs at the Hospital and served as the Hospital's representative throughout the entire peer review process. Dr. Davis attested that the documents were business records compiled at the time of the hearings during the regular course of business by individuals with personal knowledge of the information contained therein. *See* FED.R.EVID. 803(6). Given Dr. Davis's position at the Hospital and his attendance at most, if not all, of the hearings, we conclude that the district court did not err in admitting those documents as properly authenticated business records. Moreover, as the district court correctly observed, those documents were also admissible for the non-hearsay purposes of "showing what evidence the Medical Executive Committee considered, what actions were taken by Defendants, whether the procedures taken were fair and whether the committee members reasonably believed they were acting to further quality healthcare." Therefore, we find that the district court did not abuse its discretion in refusing to exclude the various documents created during the peer review proceedings.

Ultimately, district courts are afforded broad discretion on evidentiary matters. *Gomez v. St. Jude Med. Daig Div. Inc.*, 442 F.3d 919, 927 (5th Cir.2006). The district court did not abuse its discretion here.

C. Immunity under the Health Care Quality Improvement Act

[4] With the exception of appellants' section 1981 claim, the district court dismissed all other claims against appellees pursuant to the Health Care Quality Improvement

Act (HCQIA), 42 U.S.C. §§ 11101 *et seq.* Congress enacted the HCQIA to prevent malpractice, to improve the quality of healthcare, and to ensure that incompetent physicians would be prevented from "mov[ing] from State to State *679 without disclosure or discovery of the physician's previous damaging or incompetent performance." 42 U.S.C. § 11101(1)-(2). The HCQIA seeks to promote these goals through professional peer review, which it accomplishes in part by limiting the civil liability of the physicians, administrators, and health care entities involved in professional review actions. *Id.* § 11101(3)-(5).

To that end, the HCQIA provides that, if certain standards are met, participants in a peer review process that results in a "professional review action"³ "shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action." *Id.* § 11111(a) (1). In order for immunity to attach under the HCQIA, the professional review action must be taken

"(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)."

Id. § 11112(a). Further, the statute expressly provides that it "shall be presumed" that these standards have been met, unless the presumption is rebutted by a preponderance of the evidence. *Id.* (emphasis added).⁴ Thus, we apply an "unusual" standard of review to a grant of summary judgment under the HCQIA's immunity provision, which the Eleventh Circuit has articulated as follows: "'whether [the plaintiff] provided sufficient evidence to permit a jury to find that he ha[d] overcome, by a preponderance of the evidence, the presumption that [the Hospital] would reasonably have believed' that it had met the standards of section 11112(a)." *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1333-34 (11th Cir.1994) (quoting

Austin v. McNamara, 979 F.2d 728, 734 (9th Cir.1992)); see also *Van v. Anderson*, 199 F.Supp.2d 550, 571 (N.D.Tex.2002), *aff'd*, 66 Fed.Appx. 524 (5th Cir.2003) (per curiam).

The district court held that appellees had met the requirements of section 11112(a) and therefore they were entitled to immunity as to all claims except the section 1981 claim, which is specifically exempted from immunity under the statute. See *id.* § 11111(a)(1). Appellants assert that appellees failed to satisfy any of the standards laid out in section 11112(a). In doing so, appellants spend much of their briefs arguing contested factual matters and challenging the merits of the MEC's decision. However, we remind appellants that the "[t]he intent of [the HCQIA] was not to disturb, but to reinforce, *680 the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise." *Bryan*, 33 F.3d at 1337 (internal citation and quotations omitted). Therefore, our role is not to second-guess the merits of the MEC's decision, but rather to consider whether the procedures afforded were fair and whether the members of the MEC made a reasonable investigation and a reasonable decision based on the facts before them. See 42 U.S.C. § 11112(a).

i. Furtherance of Quality Health Care

In determining whether members of the MEC acted "in the reasonable belief that the action was in the furtherance of quality health care," we apply an objective "totality of the circumstances" test. See *Poliner v. Tex. Health Sys.*, 537 F.3d 368, 378 (5th Cir.2008). In doing so, we consider whether " 'the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.' " *Id.* (quoting *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 468 (6th Cir.2003)).

Appellees clearly met this standard. The peer review action was prompted by the death of a patient under Dr. Johnson's care. The MEC members were presented with evidence suggesting that Dr. Johnson had failed to examine the patient in a timely manner, that he had failed to order a necessary hematology consult, that he had been inaccessible to nursing staff attempting to confirm orders, and that his interactions with RM and his wife had grown so acrimonious that she requested that he be removed as treating physician. Given this evidence, the MEC clearly acted in the reasonable belief that suspension and revocation of Dr. Johnson's privileges "would

restrict incompetent behavior or would protect patients." See *id.* Appellants have failed to overcome the presumption that the MEC members reasonably believed that revocation of Dr. Johnson's privileges would further quality health care at the Hospital.

ii. Reasonable Effort to Obtain the Facts

The HCQIA also requires that peer reviewers make "a reasonable effort to obtain the facts of the matter." 42 U.S.C. § 11112(a)(2). Appellants contend that appellees suspended and revoked Dr. Johnson's privileges and medical staff membership without conducting a reasonable investigation. We disagree.

The record reveals that the MEC conducted a reasonable investigation prior to making its final decision. At the initial meeting held on March 25, 2004, the MEC heard the testimony of two of Dr. Johnson's fellow physicians with first-hand knowledge regarding Dr. Johnson's care for RM. Further, the committee members considered the recommendation of Dr. Cleaves, who, as head of the Department of Family Care, was familiar with the events leading up to RM's death. This information was sufficient to warrant a temporary suspension and the appointment of a DAC to investigate further. Dr. Johnson was also granted the requested interview to present his own side of the facts to the MEC in a meeting held on April 1, 2004.

At the DAC hearing held on April 7, 2004, in addition to considering RM's medical records, committee members heard from Dr. McCullough, Dr. Cleaves, and the shift supervisor and charge nurse on duty at the time of RM's treatment. Dr. Johnson was again allowed to give his version of events. The DAC's factual findings were eventually adopted by the MEC when it recommended revocation of Dr. *681 Johnson's privileges on April 22, 2004. The Fair Hearing Committee, which heard further testimony and reviewed the evidence relied upon by the MEC, eventually concluded that the MEC's decision was supported by the facts. Finally, the Appellate Review Body determined that the Fair Hearing Committee's decision was reasonably based on the facts presented to it. Thus, the Hospital's internal appellate process further confirmed that the MEC's efforts to investigate were reasonable. Therefore, we conclude that appellants have not presented sufficient evidence to overcome the presumption that the MEC made a reasonable effort to obtain the facts.

iii. Adequate Notice and Hearing Procedures

For immunity to attach under the HCQIA, the professional review action must be taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." *Id.* § 11112(a)(3). Section 11112(b) lists a number of procedures that, if followed, constitute a "safe harbor" under which the requirements of section 11112(a)(3) are deemed to be met. *Poliner*, 537 F.3d at 381-82. Appellants do not claim that Dr. Johnson received insufficient notice, but rather that the procedures provided by the Hospital were inadequate and unfair. Thus, the safe harbor provisions relevant to this case are as follows:

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)-

(C) in the hearing the physician involved has the right-

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing....

A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.

42 U.S.C. § 11112(b). Thus, observing the procedures listed in section 11112(b)(3) ensures that section 11112(a)(3) is satisfied. However, the statute makes clear that the safe harbor examples are not mandatory, and any procedures that are "fair to the physician under the circumstances" will suffice. *See id.* § 11112(a)(3).

Additionally, section 11112(c) provides two exceptions where adequate notice and hearing procedures are not required: (1) "in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action"; and (2) in the case of "an immediate suspension or restriction of clinical *682 privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." *Id.* §§ 11112(c)(1)(B), (c)(2).

Appellants first argue that Dr. Johnson was not provided with adequate notice and hearing procedures prior to his initial suspension and that appellees' actions do not fall within the exceptions in section 11112(c). We disagree. Section 11112(c)(1)(B) authorized the suspension of Dr. Johnson's privileges for the thirteen days that the investigation was being conducted between his initial suspension on March 25, 2004 and the DAC hearing on April 7, 2004. Nevertheless, appellants maintain that the investigation continued past the fourteen-day limit in section 11112(c)(1)(B), because the MEC did not make its final recommendation to revoke Dr. Johnson's privileges until April 22, 2004.

Even assuming this is true and that the DAC hearing did not represent the end of the MEC's investigation, Dr. Johnson's continued suspension was justified under the "imminent danger" exception in section 11112(c)(2). While discussing this provision in *Poliner*, we cited with approval to the district court's decision in the instant case, which held that "[b]ased on the purportedly negligent treatment of RM, the Court has little trouble finding Dr. Johnson's summary suspension was appropriately based on the reasonable belief he failed to care for a patient and thus may have represented an imminent danger to the health of an individual." 537 F.3d at 383 n. 47 (quoting *Johnson v. Christus Spohn*, No. C-06-138, 2008 WL

375417, at *12 (S.D.Tex. Feb. 8, 2008)) (alteration omitted). We agree with the district court's assessment. As we noted in *Poliner*, "the process provisions of the HCQIA work in tandem: legitimate concerns lead to temporary restrictions and an investigation; an investigation reveals that a doctor may in fact be a danger; and in response, the hospital continues to limit the physician's privileges." *Id.* at 384. This is precisely what happened here; therefore, whatever procedural failings may have accompanied Dr. Johnson's initial suspension were authorized under section 11112(c).

Even under the imminent danger exception, however, appellees were required to grant Dr. Johnson due process protections *at some point* prior to the final revocation of his medical staff membership and clinical privileges. At the meetings held by the MEC and the DAC between March 25, 2004 and April 22, 2004, the Hospital essentially formulated an advisory recommendation to the Board of Directors. Although Dr. Johnson was permitted to speak before the committees, he was not afforded the right to counsel or any other procedural protections. Later, however, when Dr. Johnson appeared before the Fair Hearing Committee, the Medical Staff Bylaws granted, and Dr. Johnson was afforded, the right to representation by counsel, to examine and cross-examine witnesses, to present and rebut evidence, to request a record of the hearing, and to submit a written statement at the close of the hearing.⁵

Appellants complain that, at that point in the proceedings, Dr. Johnson's burden of proof was so high as to deny him an adequate hearing under section 11112(a)(3). Before the Fair Hearing Committee, Dr. Johnson had the "burden of proving, by clear and convincing evidence, that the adverse recommendation or action lack[ed] any substantial factual basis or that such basis and the conclusions *683 drawn therefrom [we]re arbitrary, unreasonable, and capricious." Similarly, the Medical Staff Bylaws limited the Appellate Review Body's review of the Fair Hearing Committee's decision to considering only: "(a) Whether there has been substantial compliance with the Bylaws; (b) Whether the decision of the hearing committee was based upon the evidence presented to the hearing committee; [and] (c) Whether the hearing committee decision was reasonable in light of the hospital's duty to patients."

Thus, appellants contend that Dr. Johnson was denied procedural protections at the most critical stage of the proceedings, when the merits were decided, and that the due process afforded later could not remove the "taint" of the

earlier proceedings. We reject this argument. The HCQIA requires that procedural protections be afforded at some point in the proceedings, but it does not specify *when*. Moreover, neither section 11112(a)(3) nor the safe harbor provisions in section 11112(b)(3) speak to the burden of proof that should be applied in peer review actions. Finally, these procedures were those specified in the Medical Staff Bylaws, and they were only required to be "fair ... under the circumstances." *See* 42 U.S.C. § 11112(a)(3).

We note that other courts have found the adequate notice and hearing requirement in section 11112(a)(3) to be satisfied in cases involving nearly identical peer review procedures and similar burdens of proof. *E.g.*, *Bryan*, 33 F.3d at 1336; *Bhatt v. Brownsville Gen. Hosp.*, No. 2:03-CV-1578, 2006 WL 167955, at *25-26 (W.D.Pa. Jan. 20, 2006) (unpublished), *aff'd*, 236 Fed.Appx. 764 (3d Cir.2007) (per curiam). For instance, in *Bryan* the executive committee was charged with making a recommendation to the board of directors regarding whether sanctions should be imposed against the physician. 33 F.3d at 1324. The physician then had the right to request a hearing, at which point he was "entitled to representation, and ha[d] full rights of cross-examination and confrontation of witnesses." *Id.* at 1325. Significantly, at that hearing the physician had the burden of proving "that the recommendation which prompted the hearing was unreasonable, not sustained by the evidence, or otherwise unfounded." *Id.* The Eleventh Circuit held that these procedures were adequate and met the safe harbor provisions under section 11112(b). *Id.* at 1336.

Similarly, in *Bhatt*, the physician was afforded counsel and other procedural protections when he appeared before the Fair Hearing Committee, which was charged with reviewing the MEC's decision to revoke his privileges. 2006 WL 167955, at *2-3. At that hearing, the physician had the burden "to prove, by a preponderance of the evidence, that the grounds for the [MEC's] recommendation lacked any substantial factual basis or that the basis or conclusions drawn therefrom were arbitrary, unreasonable, or capricious." *Id.* at *3. The district court, whose decision was affirmed by the Third Circuit, concluded that the hearing was adequate under the safe harbor provisions in section 11112(b)(3)(C). *Id.* at *26.

Likewise, we conclude that the procedures provided by the Hospital satisfied the safe harbor requirements in section 11112(b)(3)(C). Dr. Johnson was afforded the right to counsel, the right to have a record made of the proceedings, the right to call and cross-examine witnesses, the right to

present evidence, and the right to submit a written statement at the end of the hearing. Indeed, it appears that the Medical Staff Bylaws were intentionally drafted to mirror the safer harbor provisions in section 11112(b)(3)(C). The fact that these procedural protections were not *684 provided until Dr. Johnson appeared before the Fair Hearing Committee does not render them inadequate. And although Dr. Johnson's burden of proof was "clear and convincing evidence" and therefore slightly more onerous than those faced by the physicians in *Bryan* and *Bhatt*, we do not believe that imposing such a burden violated the strictures of section 11112(a)(3). Ultimately, Dr. Johnson's case was considered by five separate peer review bodies—the MEC, the DAC, the Fair Hearing Committee, the Appellate Review Body, and the Board of Directors—in a peer review process that lasted over one and a half years. We find that the procedures provided by the Hospital were adequate, and that therefore appellants have failed to overcome the presumption that the Hospital satisfied the requirements of 11112(a)(3).

iv. Reasonable Belief that the Action Was Warranted by the Facts

Finally, section 11112(a)(4) requires that, after a reasonable investigation and adequate hearings, a professional review action be taken in the "reasonable belief that the action was warranted by the facts." Essentially, appellants contest the factual findings of the MEC and assert that it was unreasonable for the MEC not to accept Dr. Johnson's version of events. Further, appellants claim that revocation of Dr. Johnson's medical staff membership and clinical privileges was too harsh under the circumstances and thus unwarranted by the facts. As stated above, we will not substitute our own judgment for that of Dr. Johnson's colleagues, who are much more qualified to make decisions regarding the adequacy of medical treatment and professional competency. See *Bryan*, 33 F.3d at 1337. The MEC found that Dr. Johnson had failed to attend to RM promptly, failed to provide urgently needed medical care, was unavailable to Hospital staff, and was unresponsive to the needs of RM and his family, all of which ultimately may have contributed in some fashion to RM's death. Certainly, under these facts the MEC members could have reasonably believed that revocation of Dr. Johnson's privileges was warranted, and appellants have failed to overcome the presumption that they acted in that belief.

v. Appellees Are Immune under the HCQIA

We conclude that appellants have failed to meet their burden of demonstrating that a reasonable jury could find, by a preponderance of the evidence, that appellees did not satisfy the requirements of section 11112(a) of the HCQIA. Because we find that appellees are immune from liability pursuant to the HCQIA, we need not consider whether they are also immune under the Texas Health Care Quality Improvement Act, TEX. OCC.CODE ANN. 160.001 *et seq.*

D. Race Discrimination under Section 1981

The HCQIA specifically excludes civil rights claims from immunity, including those brought under 42 U.S.C. § 1981 *et seq.* 42 U.S.C. § 11111(a)(1). Therefore, we consider separately appellants' assertion that appellees violated Dr. Johnson's contractual rights under 42 U.S.C. § 1981.

Section 1981 provides that "[a]ll persons within the jurisdiction of the United States shall have the same right in every State and Territory to make and enforce contracts ... as is enjoyed by white citizens." 42 U.S.C. § 1981(a). The statute defines the phrase to "make and enforce contracts" as including "the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship." 42 U.S.C. § 1981(b).

*685 In analyzing appellants' section 1981 claim, the district court correctly employed the modified *McDonnell Douglas* burden-shifting framework.⁶ See *Jenkins*, 478 F.3d at 260-61; see also *Rachid v. Jack In The Box, Inc.*, 376 F.3d 305, 312 (5th Cir.2004). First, appellants were required to establish a *prima facie* case of intentional discrimination. See *Jenkins*, 478 F.3d at 260. To do so, appellants had to demonstrate that (1) Dr. Johnson was a member of a racial minority; (2) appellees intended to discriminate on the basis of race; and (3) the discrimination concerned the making and enforcing of a contract. See *id.* at 260-61 (citing *Bellows v. Amoco Oil Co.*, 118 F.3d 268, 274 (5th Cir.1997)). Next, appellees were required to present a legitimate, non-discriminatory reason for revoking Dr. Johnson's privileges. See *id.* at 261. Finally, appellants had to show either that the proffered reason was merely a pretext for discrimination or that Dr. Johnson's race was a motivating factor in the decision, meaning that "his race 'actually played a role in [the Hospital's decision-making] process and had a determinative influence on the outcome.'" See *id.* at 261 (quoting *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 120 S.Ct. 2097, 2105, 147 L.Ed.2d 105 (2000)) (alteration in

original). At all times, the ultimate burden of proof remained on appellants to create a genuine issue of material fact as to whether Dr. Johnson's privileges were revoked due to intentional race discrimination. *See id.* at 261.

We first consider whether appellants met their burden of establishing a *prima facie* case. Although Dr. Johnson was not a Hospital employee, appellants claim that Dr. Johnson's clinical privileges, bestowed on him by virtue of the Medical Staff Bylaws,⁷ constituted a contractual right of which he was unlawfully deprived. To determine whether a contract existed between Dr. Johnson and the Hospital, we look to Texas law. In Texas, *hospital* bylaws can create contractual rights in favor of doctors, whereas *medical staff* bylaws generally do not. *Stephan v. Baylor Med. Ctr. at Garland*, 20 S.W.3d 880, 887-88 (Tex.App.-Dallas 2000, no pet.). In *Stephan*, the court found that the medical staff bylaws at issue did not grant the doctor the contractual right to receive an application to reapply for hospital privileges. *Id.* at 888. After observing that the medical staff and the hospital were distinct entities, the court considered the nature of the hospital board's authority in relation to the medical staff bylaws:

“[T]he preamble to [the hospital's] medical staff bylaws recognizes that the staff ‘is subject to the ultimate authority of the board.’ The medical staff bylaws do not attempt to define or limit [the hospital's] power to act through its board of trustees. Bylaws that do not define or limit the power of a hospital as it acts through its governing board do not create contractual obligations for the hospital. This is true despite the fact that the board may have approved and adopted the staff bylaws.”

Id. (internal citation omitted). Therefore, the court concluded that the medical staff bylaws created no contractual rights on behalf of the doctor, because the staff bylaws were not binding on the hospital itself. *Id.*

Federal courts applying Texas law have also found that medical staff bylaws do not generally create contractual rights in favor of doctors. *E.g., Van*, 199 F.Supp.2d at 562-63; *Monroe v. AMI Hosps. of Tex.*, 877 F.Supp. 1022, 1029 n. 5 (S.D.Tex.1994). In *Van*, which was affirmed by this court, the district court relied on the preamble to the medical staff bylaws in determining that those bylaws did not create contractual rights on the part of the plaintiff physician. *See* 199 F.Supp.2d at 563. The district court observed that:

“[T]he Medical Staff Bylaws in place at the Hospital provided in their preamble that the medical staff was ‘responsible for the quality of medical care in the hospital

and for the ethical conduct and professional practices of its members and must accept and discharge this responsibility, *subject to the ultimate authority of the hospital Governing Body ...*”

Id. (emphasis in original). The court also noted that “although the various hospital committees, including the Executive Committee, were charged with making *recommendations* on a member's reappointment application under the medical staff's bylaws, ... the final authority on this decision rested solely with the Hospital's Governing Body.” *Id.* at 563-64 (emphasis added). Therefore, the district court found that “no contract was created between Plaintiff and the Defendant Hospital simply by virtue of the fact that Dr. Van had been granted staff privileges at the hospital,” and thus Dr. Van could not recover under section 1981. *Id.* at 564-65.

[5] Similarly, in this case the preamble to the Medical Staff Bylaws limits the authority of the medical staff, and therefore the Medical Staff Bylaws themselves, to bind the Board of Directors:

“There shall be an organized and self governing Medical Staff to which is delegated by the Governing Board the overall responsibility for the quality of professional services and the ethical and professional practice provided by members of the Medical Staff and other individuals with clinical privileges. The activities of the Medical Staff in fulfilling these responsibilities are *subject to final review and approval of the Governing Board.*”

(emphasis added). Additionally, as was the case in *Van*, none of the peer review committees in this case had the power to make a final decision in Dr. Johnson's case that would bind the Board of Directors. Rather, the MEC, the Fair Hearing Committee, and the Appellate Review Body could only make recommendations to the Board of Directors, which retained the ultimate authority over Dr. Johnson's fate. Therefore, because we find that the clinical privileges bestowed upon Dr. Johnson under the Medical Staff Bylaws did not give him any contractual rights, we hold that appellants have failed to establish a *prima facie* case under section 1981. *See Jenkins*, 478 F.3d at 260.⁸

[6] Moreover, even if we were to assume, as the district court did, that appellants established a *prima facie* case, we conclude that appellants' section 1981 claim would still fail as a matter of law. Appellees have presented a legitimate, non-discriminatory reason for the revocation of Dr. Johnson's privileges: namely, that Dr. Johnson's provision of substandard medical care posed a danger to patient safety. We find that appellants have not satisfied their ultimate burden of presenting sufficient evidence such that a reasonable jury could find that appellee's justification for revoking Dr. Johnson's privileges was a pretext for discrimination *687 or that race was a motivating factor in the decision.

Appellants' strongest evidence consists of statements made by the Chairman of the MEC, Dr. Acebo, who allegedly told Dr. Johnson during the peer review process: "I guess you are being made an example of. Man, I thought they were going to drop this for sure. It looks like it's because you're black. They wouldn't be doing this to someone white or Hispanic, you know." Later, when appearing as a witness before the Fair Hearing Committee, Dr. Acebo admitted to previously stating under oath that "if Dr. Johnson was not black, things may have been a little different." In a subsequent deposition, Dr. Acebo attempted to clarify his previous statements, observing that Dr. Johnson was "probably" treated more severely because of his personality, which, in his mind, was affected by Dr. Johnson's race, *i.e.*, "black man with an attitude." As Chairman of the MEC, Dr. Acebo did have some authority over that particular committee's decision, but he was only one of the dozens of doctors that reviewed Dr. Johnson's case. *See id.* at 262. Moreover, Dr. Acebo testified that he was one of only two or three committee members who actually advocated *lesser* sanctions, and he was not even present at the July 28, 2005 meeting at which the MEC accepted the Fair Hearing Committee's report and made its final recommendation to the Board of Directors to revoke Dr. Johnson's privileges. Thus any discriminatory animus that he himself may have harbored did not contribute to the revocation of Dr. Johnson's privileges. In the end, Dr. Acebo's remarks amount to nothing more than mere speculation as to the motives of the other committee members, which Dr. Acebo admitted was founded solely on his own personal opinion. Dr. Acebo testified that his suspicions were based on his knowledge of two other unspecified peer review proceeding in which unnamed white doctors were not punished as severely as Dr. Johnson. Other than the very briefest generic descriptions, there is no evidence regarding the circumstances of those wholly unidentified peer review actions (or the conduct charged

against the doctor or doctors or the severity of any results thereof). As we observed in *Jenkins*, mere "opinions, with no supporting evidence," that a suspension or revocation of privileges was based on race are insufficient to support a claim of discrimination. *See id.* at 262 (emphasis in original).

Appellants also allege that Dr. McCullough complained a few months before the peer review that Dr. Johnson "took his place in medical school," thus allegedly demonstrating his resentment toward African-American doctors. Further, appellants claim that when Dr. Johnson arrived at the Hospital over twenty years ago, Dr. Cleaves indicated that he did not wish to practice in the same building as Dr. Johnson because of his race. As these alleged statements are removed in time and substance from the peer review process, we find them to be mere "stray remarks," which are insufficient to support a section 1981 claim. *See id.* at 261-62. Appellants' assertion that the MEC was "all-white" is not correct, as the record reflects that the committee included several Hispanic and Indian doctors. Finally, other than Dr. Acebo's unsubstantiated suspicions, appellants provide no proof for their assertion that Dr. Johnson was treated more severely than a white doctor would have been under similar circumstances.

Therefore, we hold that appellants have failed to present sufficient evidence for a reasonable jury to conclude that appellees violated section 1981 when they revoked Dr. Johnson's clinical privileges. Appellants have not established a contractual relationship that would support a claim under section 1981, nor have they created a fact issue as to whether appellees' proffered *688 reason for revoking Dr. Johnson's privileges was pretextual or that race was a motivating factor in the decision.

III. CONCLUSION

We find that the district court did not abuse its discretion in overruling appellants' evidentiary objections. We also conclude that the district court did not err in granting appellees immunity under the HCQIA. Finally, we hold that the district court correctly dismissed appellants' section 1981 claim because: (1) appellants failed to establish that the Hospital breached his contractual rights; and in any event (2) appellants failed to demonstrate that the proffered reason for the revocation of Dr. Johnson's privileges was pretextual or that race was a motivating factor in the decision. Therefore, the district court's judgment is

AFFIRMED.

Parallel Citations

2009 WL 1766557 (C.A.5 (Tex.))

Footnotes

- * Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.
- 1 The procedures for conducting a peer review were contained within the Hospital's "Credentials Policy and Procedure Manual," which was incorporated by reference into the Medical Staff Bylaws.
- 2 We also note that, well after the revocation of Dr. Johnson's privileges at the Hospital, he was also disciplined by the Texas State Board of Medical Examiners for his role in treating RM. The Board of Medical Examiners determined that Dr. Johnson had failed to observe the required standard of care under Texas law, therefore it imposed a one-year probated suspension of Dr. Johnson's license. Dr. Johnson has apparently appealed those sanctions in state court proceedings that are still pending.
- 3 The HCQIA defines a "professional review action" in part as "an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician." 42 U.S.C. § 11151(9). In this case, it is undisputed that the Medical Executive Committee's recommendation to revoke Dr. Johnson's medical staff membership and clinical privileges met this definition.
- 4 Section 11112(a) concludes by stating:

"A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence."
- 5 Dr. Johnson also exercised all these rights, with the possible exception that he may have failed to submit a written statement at the close of the hearing.
- 6 *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 93 S.Ct. 1817, 36 L.Ed.2d 668 (1973).
- 7 As with the procedures observed during the revocation process, Dr. Johnson's privileges were granted pursuant to the Hospital's "Credentials Policy and Procedure Manual," which, as noted above, was incorporated by reference into the Medical Staff Bylaws.
- 8 The case relied on by appellants, *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438 (Tex.App.-Texarkana 1994, writ denied), involved the bylaws of the Hospital itself, not Medical Staff bylaws (and in any event no actionable violation was found).

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Pitt VESOM, M.D., Plaintiff,

v.

ATCHISON HOSPITAL
ASSOCIATION, et al., Defendants.

No. 04-2218-JAR. | Sept. 22, 2006.

Attorneys and Law Firms

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Opinion

MEMORANDUM AND ORDER

JULIE A. ROBINSON, District Judge.

*1 Plaintiff Pitt Vesom, M.D. filed this action against Atchison Hospital Association (“AHA”) and three physicians, Ryan Thomas, M.D., Douglas Goracke, M.D., and Donald Swayze, D.O., who were members of the AHA Medical Executive Committee (“MEC”), and who voted to deny plaintiff's application for reappointment of medical and staff privileges at AHA. Plaintiff contends that the denial of his staff privileges at AHA resulted from an agreement and conspiracy to fabricate reasons for refusing to continue his staff privileges because he is Asian, he had reported incidents of professional incompetence at AHA, and because defendants prevented or restrained him from practicing medicine in the Atchison community.

The Court now considers the following motions: (1) plaintiff's Motion for Leave to file Declaration and Exhibits under Seal (Doc. 183); (2) defendants' Motion for Summary Judgment (Doc. 161); (3) defendants' Motion to Exclude Declaration and Expert Testimony of John-Henry Pfifferling, Ph.D. (Doc. 142); and (4) defendants' Motion to Exclude Affidavits and Expert Testimony of Kurt V. Krueger, Ph.D. (Doc. 145).

As described more fully below, the Court grants plaintiff's Motion for Leave to File Declaration and Exhibits under Seal, grants defendants' Motion for Summary Judgment, and denies as moot both of defendants' motions to exclude expert testimony.

I. Summary Judgment Standard

Summary judgment is appropriate “if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law.”¹ A fact is only material under this standard if a dispute over it would affect the outcome of the suit.² An issue is only genuine if it “is such that a reasonable jury could return a verdict for the nonmoving party.”³ The inquiry essentially determines if there is a need for trial, or whether the evidence “is so one-sided that one party must prevail as a matter of law.”⁴

The moving party bears the initial burden of providing the court with the basis for the motion and identifying those portions of the record that show the absence of a genuine issue of material fact.⁵ “A movant that will not bear the burden of persuasion at trial need not negate the nonmovant's claim.”⁶ The burden may be met by showing that there is no evidence to support the nonmoving party's case.⁷ If this initial burden is met, the nonmovant must then “go beyond the pleadings and ‘set forth specific facts’ that would be admissible in evidence in the event of trial from which a rational trier of fact could find for the nonmovant.”⁸ When examining the underlying facts of the case, the Court is cognizant that all inferences must be viewed in the light most favorable to the nonmoving party and that it may not make credibility determinations or weigh the evidence.⁹

*2 When deciding a summary judgment motion, the Court may consider evidence submitted, if admissible in substance, even if it would not be admissible, in form, at the trial.¹⁰ The Tenth Circuit recently explained,

Parties may, for example, submit affidavits in support of summary judgment, despite the fact that affidavits are often inadmissible at trial as hearsay, on the theory that the evidence may ultimately be presented at trial in an admissible form. Nonetheless, “the content or

substance of the evidence must be admissible." Thus, for example, at summary judgment courts should disregard inadmissible hearsay statements contained in affidavits, as those statements could not be presented at trial in any form. The requirement that the substance of the evidence must be admissible is not only explicit in Rule 56, which provides that "[s]upporting and opposing affidavits shall ... set forth such facts as would be admissible in evidence," Fed.R.Civ.P. 56(e), but also implicit in the court's role at the summary judgment stage. To determine whether genuine issues of material fact make a jury trial necessary, a court necessarily may consider only the evidence that would be available to the jury.¹¹

II. Factual Background

A. Evidentiary Objections

At the outset, the Court notes that significant portions of the voluminous recitation of facts by both parties are immaterial to the resolution of the summary judgment motion. Although they aid in the Court's understanding of the context of the claims made in this case, they do not impact the resolution of claims and affirmative defenses under the applicable summary judgment standard.

There are a number of evidentiary issues the Court must resolve before determining the material uncontroverted facts in this matter. In their reply memorandum, defendants move to strike numerous declarations submitted by plaintiff with his response, including plaintiff's own declarations made subsequent to his deposition. Specifically, defendants seek to strike the declarations of Dr. James Rider, Kathy Jackson, Rosetta Birch, Dr. David Ware, and Dr. James Asher on various grounds. Plaintiff filed a separate motion for leave to file his third declaration with exhibits under seal (Doc. 194). In response, defendants argue that the third declaration is irrelevant and a "sham affidavit," and should not be filed for the same reasons that they oppose consideration of plaintiff's second declaration. The Court ordered plaintiff to submit this third declaration for *in camera* review so that it may decide those issues. The Court has now reviewed the declarations in question, as well as reviewed *in camera* plaintiff's third declaration and supporting exhibits by plaintiff.

1. Plaintiff's Declarations

Plaintiff submitted two declarations with his response to the summary judgment motion, titled Vesom Declaration I ("Vesom I") and Vesom Declaration II ("Vesom II"). Plaintiff relies on these declarations to support various

factual statements in his response brief. At the time he filed his response, plaintiff also filed a motion to file a third declaration, along with attached exhibits, under seal ("Vesom III"). To be clear, there is no citation in the fact section of plaintiff's response memorandum to Vesom III, although plaintiff does discuss the declaration in the argument section. Defendants ask the Court in their reply to disregard all portions of plaintiff's "affidavit"¹² that are either not based on personal knowledge, or create "sham" fact issues. Defendants also filed a separate response to the motion to file a third declaration under seal on the same grounds.

Sham Affidavit

*3 Defendants argue that Vesom II and III should be stricken because they constitute "sham affidavits," since they were composed long after plaintiff's deposition and attempt to change the answers he gave during that deposition. The Court may not disregard Vesom II and III simply because they conflict with plaintiff's prior sworn statements.¹³ But "such evidence may be disregarded when a court concludes that the evidence is merely an attempt to create a sham fact issue."¹⁴ "[T]he utility of summary judgment as a procedure for screening out sham fact issues would be greatly undermined if a party could create an issue of fact merely by submitting [evidence] contradicting his own prior testimony."¹⁵ The Court looks at the following factors to determine if Vesom II or III present a sham fact issue: "whether the [party] was cross-examined during his earlier testimony, whether the [party] had access to pertinent evidence at the time of his earlier testimony, or whether the [contested evidence] was based on newly discovered evidence, and whether the earlier testimony reflects confusion which the [contested evidence] attempts to explain."¹⁶

Vesom was deposed on March 28 and June 18, 2005. It appears from the transcripts that plaintiff was not cross-examined by his own counsel during the deposition. Discovery was due to be complete in this case on July 15, 2005.¹⁷ Plaintiff argues that the documents attached to Vesom II and Vesom III were not produced to him until May 25, 2005, and that KDHE documents were not made available to him until June 16, 2005, two days before the second day of his deposition. Plaintiff maintains that he "did not know of the content of these records and could not have testified from his personal knowledge of these examples of disparate treatment." The Court agrees that plaintiff could not

have answered questions about these documents during his deposition.

Defendants point the Court to one example of plaintiff's attempt to create a sham issue of fact. Defendants argue that during plaintiff's deposition, he itemized instances of alleged discrimination that formed the basis of his Complaint. At the conclusion of the March 28 deposition, counsel for defendants remarked: "Also marked as Vesom Deposition Exhibit No. 114 a one page handwritten notes [sic] that was on the inside cover of Dr. Vesom's version of Vesom Deposition Exhibit No. 101 that he has referred to as an itemized list of the specific instances, I believe of racial discrimination."¹⁸ Plaintiff's counsel responded, "We agree that is Exhibit 114, notes of some of his complaints about discrimination."¹⁹ At the June 18 deposition, plaintiff answered defendants' questions about Exhibit 114. At one point, defendants' counsel asked if the exhibit constituted a "full compilation of all the incidents that you believe support the fact that you were racially discriminated against."²⁰ Plaintiff replied, "That is correct."²¹ Defendants argue that Vesom II and III are subsequent attempts to change this answer and create sham fact issues.

*4 The Court declines to find that these affidavits are "sham affidavits" as defendants urge. Defendants seem particularly concerned that plaintiff repeatedly refers to actions that constitute "disparate treatment" of Asian physicians compared to other similarly situated physicians at Atchison Hospital Association. Defendants maintain that "[n]owhere was disparate treatment, or the specific 'examples' and arguments contained in the Declaration, mentioned." The Court is not persuaded by this argument. Plaintiff alleges a number of counts in his Complaint that are based on race discrimination. " 'Disparate treatment ... is the most easily understood type of discrimination. The employer simply treats some people less favorably than others because of their race. Proof of discriminatory motive is critical.'²² Disparate treatment is simply a way of referring to intentional discrimination, as compared to disparate impact claims which "involve employment practices that are facially neutral in their treatment of different groups but that in fact fall more harshly on one group than another and cannot be justified by business necessity. Proof of discriminatory motive ... is not required."²³ Although the Court sincerely doubts the term "disparate treatment" was originally coined by plaintiff without the guidance of his attorney, the Court finds no impropriety or unfair surprise in its inclusion in

the declarations. The question of its materiality will be addressed under the Court's discussion of the substantive discrimination counts, as this evidence primarily points to plaintiff's perceived differences in treatment between himself and other physicians at AHA.

Further, the Court finds that the differences in plaintiff's deposition and his declarations do not amount to the creation of a sham issue of fact. The deposition transcript reveals that plaintiff's counsel clarified at the end of the first day of testimony, that Deposition Exhibit 114 alleged *some* of the instances of discriminatory conduct. Further, unlike most cases that strike an affidavit as improper on these grounds, plaintiff added to an answer given in his deposition, rather than changing his answers entirely. Given that plaintiff was not cross-examined, and that he did not have an opportunity to review many of the documents discussed in his declaration prior to the deposition, the Court declines to strike them on the grounds that they constitute sham affidavits.

Personal Knowledge Requirement

Fed.R.Evid. 602 requires that a testifying witness "ha[ve] personal knowledge of the matter" testified to.²⁴ Also, Fed.R.Civ.P. 56(e) requires that affidavits be made on personal knowledge and "set forth such facts as would be admissible in evidence.... The court may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, or further affidavits." "Under the personal knowledge standard, an affidavit is inadmissible if 'the witness could not have actually perceived or observed that which he testifies to.' "²⁵ Statements of "mere belief in an affidavit must be disregarded."²⁶

*5 The Court finds that Vesom II and III contain plaintiff's statements based on personal knowledge; recitations of his attorney's correspondence with defendants; and reaction, beliefs, and opinions concerning certain documents provided to him through discovery in this case. The majority of Vesom II contains plaintiff's arguments about why each document in his credentials file is "manufactured to make it appear that my behavior was inappropriate." In the course of making this point, plaintiff construes the hospital bylaws, recites exhibits, and makes legal and factual arguments. Often, plaintiff's contentions make reference to "manufactured" or "doctored" documents created by defendants. Vesom III similarly construes documents produced through discovery, but covered by protective order.

The Court disregards the statements in plaintiff's declarations to the extent he attempts to construe and interpret other summary judgment evidence. Such construction and interpretation is not an appropriate task for a witness's affidavit, which is a tool used to present *facts* and not *beliefs* and argument.²⁷ While the Court will duly consider plaintiff's arguments made in his summary judgment brief—the appropriate forum for argumentation—it will not consider such arguments couched in a party's own affidavit, which should represent pure statements of fact. Instead, the Court construes the summary judgment record under the applicable guidelines and determines if the uncontroverted evidence sufficiently demonstrates a genuine issue of material fact.

There are many statements in Vesom II and III that are not based on personal knowledge, but are conclusory opinions. Examples of such statements in Vesom II include: “[T]he aforementioned medical staff at AHA ... conspired to prevent me from practicing at AHA;” and “When I reapplied for privileges at AHA in 1998 ... my application was treated differently from any other application received prior to or since that date.” The Court declines to itemize each and every incidence of such statements, as Vesom II spans fourteen pages and contains sixty-one paragraphs of statements and Vesom III spans three pages with eleven paragraphs of information. The Court will disregard all statements in Vesom II and III that are not supported by other portions of the record, or that do not represent statements based on plaintiff's personal knowledge. The Court will only consider, for purposes of determining the uncontroverted evidence, those statements that plaintiff could have perceived or observed, and will construe the evidence in the light most favorable to plaintiff as the non-moving party. As such, the Court **grants plaintiff's motion to file the declaration and exhibits under seal (Doc. 183) and orders the Clerk's Office to file under seal the declaration and exhibits delivered to the Court for *in camera* review.**

2. Birch and Jackson Declarations

Defendants urge the Court to strike the declarations of Rosetta Birch and Kathy Jackson because they were not properly disclosed under Fed.R.Civ.P. 26. Rule 26(a)(1) requires the parties to provide, without waiting for a discovery request, the name of each person “likely to have discoverable information that the disclosing party may use to support its claims or defenses, unless solely for impeachment.” Under Rule 26(e), the parties are under a duty to supplement these initial

disclosures. Sanctions for violating the disclosure rules in Rule 26 are provided for in Rule 37:

*6 A party that without substantial justification fails to disclose information required by Rule 26(a) or 26(e)(1), or to amend a prior response to discovery as required by Rule 26(a)(2), is not, unless such failure is harmless, permitted to use as evidence at a trial, at a hearing, or on a motion any witness or information not so disclosed.²⁸

Plaintiff filed an amended witness and exhibit list on February 1, 2005, which did not list either Birch or Jackson as witnesses. Supplemental disclosures under Fed.R.Civ.P. 26(e) were ordered to be served by June 6, 2005. The record does not reveal that an amended witness list or a Notice of Service for supplemental disclosures under Rule 26(e) was filed after the February 1, 2005 disclosures. Birch and Jackson both dated their declarations in January 2006, soon before the response to the summary judgment motion was filed. Plaintiff uses these declarations to support additional material facts in his response to summary judgment. Specifically, plaintiff uses the Birch Declaration to support his contention that certain documents relied upon by defendants in their decision not to renew plaintiff's privileges, contain false information. Both declarations are used to support plaintiff's contention that any legitimate reason for the denial of his privileges is a pretext for discrimination. Because these declarations are being used by plaintiff to support elements of his discrimination claims, the Court finds that the failure to disclose Birch and Jackson as potential witnesses, who could then be deposed by defendants, is not harmless.

Under these circumstances, the Court is unable to find that plaintiff was substantially justified in failing to disclose this information. Both witnesses attest that they were employed by AHA for years, during the same period of time that plaintiff was affiliated with the hospital. These are not instances of witnesses who were unknown to the plaintiff. Neither declaration relies upon documents that were not produced prior to the deadline to file supplemental disclosures. Even if these witnesses were discovered after that deadline, Rule 26 imposes a continuing duty upon parties to supplement their disclosures. Certainly, it was feasible for plaintiff to disclose these two witnesses some time prior to when he responded to the summary judgment motion.

Because the Court finds that plaintiff was not substantially justified in withholding this information, and that the failure to disclose was not harmless, the Court grants defendants' motion to strike the Birch and Jackson declarations.

3. Dr. Rider's Declaration

Defendants move to strike Dr. James Rider's first declaration ("Rider I"), because it contains hearsay statements and is not based on personal knowledge. Much like plaintiff's declarations, Dr. Rider's declaration contains both facts based on personal knowledge, as well as conclusory opinions or beliefs. The Court finds that Dr. Rider's account of the committee meetings he attended are based on personal knowledge. However, his conclusions about how the other members felt toward plaintiff could not be based on personal knowledge.

*7 Alternatively, Dr. Rider's belief that the other committee members were "angry" at plaintiff, as stated in paragraph 2, must be based on things those members told him, which is inadmissible hearsay evidence. Inadmissible hearsay evidence in an affidavit is not to be considered on a motion for summary judgment.²⁹ However, the Court finds that as a member of the MEC at the time the decision about plaintiff's privileges was made, Dr. Rider does have firsthand, personal knowledge of events that transpired in the meetings that he attended and during the collective decision-making process. Therefore, the Court will only disregard the declaration to the extent it states Dr. Rider's conclusory beliefs about the feelings or intent of others.

4. Dr. Ware's Declaration

Defendants move to strike Dr. David Ware's Declaration because it contains inadmissible hearsay and is not entirely based on personal knowledge. The Court agrees. Paragraphs 2, 3, 4, 5, 7, and 8 all amount to inadmissible hearsay—the witness is recounting statements he heard that were made by other declarants. The Court does not anticipate any exclusion or exception to the hearsay rule that would apply to these statements. Further, Dr. Ware states his opinions about the feelings and attitudes of certain physicians toward plaintiff. The Court will only consider the small amount of Dr. Ware's declaration that is based on admissible evidence and will not consider hearsay statements or statements about Dr. Ware's conclusory opinions.

5. Dr. Asher's Declaration

Defendants move to strike Dr. James Asher's declaration because it is not based on personal knowledge. Dr. Asher was the chief executive officer of AHA for a number of years until his retirement in 1990. He was responsible for recruiting plaintiff to establish a practice in Atchison in 1983. Much of Dr. Asher's declaration is based on information that "he has learned" or that is his "belief."³⁰ As defendants point out, much of Dr. Asher's statements concern events that occurred after he retired in 1990. There is no basis provided in the declaration for his personal knowledge of these later events. Therefore, because Dr. Asher's declaration relies almost entirely on hearsay and information that Dr. Asher has not acquired through personal knowledge, the Court disregards the majority of the declaration.

6. Authentication of Documents

Defendants argue that many documents filed in support of plaintiff's summary judgment response are not properly authenticated and are therefore inadmissible. Specifically, defendants object to a number of handwritten notes filed as attachments to Vesom II.

Unauthenticated documents, once challenged, cannot be considered by a court in determining a summary judgment motion. In order for documents not yet part of the court record to be considered by a court in support of or in opposition to a summary judgment motion they must meet a two-prong test: (1) the document must be attached to and authenticated by an affidavit which conforms to rule 56(e); and (2) the affiant must be a competent witness through whom the document can be received into evidence.... Documentary evidence for which a proper foundation has not been laid cannot support a summary judgment motion, even if the documents in question are highly probative of a central and essential issue in the case.³¹

*8 The Court agrees with defendants that the handwritten notes attached to Vesom II do not appear to be authenticated under this standard. It appears to the Court that, at the very least, these notes were written by more than one person. These documents could only be authenticated in Vesom II if Vesom himself composed all of these handwritten notes, or if he was familiar with the handwriting.³² Because Vesom II does not set forth either method of authentication, the Court may not consider these documents.

B. Uncontroverted Facts³³

The following facts are either uncontroverted, stipulated to, or viewed in the light most favorable to plaintiff. Plaintiff is a medical doctor licensed to practice medicine by the Kansas Board of Healing Arts, certified in the specialties of cardiology and internal medicine. Plaintiff is a citizen of the United States and of Kansas, but was born in Thailand and has Thai ancestry. Defendant AHA is a not-for-profit corporation organized and existing under the laws of the State of Kansas and has its principal place of business in Atchison, Kansas.³⁴ In 2003, defendants Ryan Thomas, M.D., Douglas Goracke, M.D., and Donald Swayze, D.O., were members of the Hospital's MEC. Dr. Thomas is a board certified family practitioner with obstetrical privileges and was the past Chief of Medical Staff. Dr. Goracke is a board certified anesthesiologist and was Chief of Staff at the time. Dr. Swayze is a board certified surgeon and was Vice Chief of Staff at the time.

The Bylaws

The Atchison Hospital Medical Staff Bylaws ("Bylaws") are organized by the medical staff at AHA.³⁵ They "establish the mechanisms to carry out the direct and delegated responsibilities of the Medical Staff in cooperation with the Hospital Administration and the Governing Board." The Governing Board ("Board") is a group of individuals who constitute the Board of Directors at AHA, "having the ultimate responsibility for the operation of the Hospital and for providing patient care."

The medical staff are practicing and licensed physicians and dentists who have been formally appointed and enjoy the privilege of attending patients at AHA. The Bylaws state that the medical staff agrees to accept and abide by the Bylaws. Under the Bylaws, membership to the medical staff is a privilege and no physician is "entitled to membership to the Medical Staff or to the exercise of particular clinical

privileges at the Hospital merely by virtue of the fact that he/she ... has previously had Medical staff membership or privileges in this Hospital." Physicians are appointed medical staff privileges at AHA for a two-year period. After such period is over, physicians must file an application for reappointment if they wish to maintain their privileges.

Disruptive Behavior Provisions

Among other things, the Bylaws dictate that, as a condition to accepting medical staff membership, the member must agree to "conduct him/herself in a professional, cooperative manner with colleagues and members of the Hospital Staff." Also, Article X of the Bylaws dictates AHA's policies concerning medical staff conduct and the impaired provider. This article provides guidelines for medical staff concerning unacceptable disruptive behavior. This list includes, but is not limited to: impertinent and inappropriate comments (or illustrations) made in patient medical records and physicians' orders or other official documents including the impugning of the quality of care in the Hospital or attacking particular individuals, nurses, or Hospital policies; non-constructive criticism addressed to the recipient in such a way that intimidates, undermines confidence, belittles, or implies stupidity or incompetence; refusal to accept medical staff assignments or participate in committee or departmental affairs on anything but his or her own terms or to do so in a disruptive manner; and verbal or physical threats of retribution, litigation or violence directed at individuals, Hospital personnel or patients.

*9 Under Article X, any reports of violations of disruptive conduct or the impaired provider provision must be in writing and submitted and investigated in accordance with Article XII, which governs "Corrective Action." Corrective action requires any report regarding a medical staff member to be made to the Chief of Staff. The procedures set forth for implementation of corrective action in Appendix B provide that upon receiving notice of a reportable incident, including for disruptive behavior, "any officer of the Medical Staff, the chairperson of a Service or Committee, the Chief Executive Officer of the Hospital or any member of the Governing Board of the Hospital may request corrective action against such practitioner." If corrective action is requested, then the MEC investigates the report and submits a written report of the investigation to the Board. Before the report is made, however, the practitioner has the opportunity to interview with the MEC so that he or she may discuss, explain, or refute the nature of the charge. The summary is then submitted with

the report to the Board. Ultimately, the Board either approves or modifies the MEC recommendation.

The MEC

The medical staff elects three officers for the purpose of carrying out certain functions on behalf of the staff. These officers are the Chief of Medical Staff, Vice Chief of Staff, and Secretary/Treasurer and they are nominated and elected by the medical staff to serve one-year terms. The Medical Executive Committee ("MEC") consists of these three officers, as well as the immediate past Chief of Staff and a "member at large" elected from the active medical staff annually. In general, the MEC is charged with overseeing the functions of the medical staff. "Its authority is limited, however, to making recommendations to the Governing Board."³⁶ The Credentials Committee consists of the members of the MEC and evaluates new applicants to the medical staff, as well as those members applying for reappointment.

In 2003, defendants Dr. Thomas, Dr. Goracke, and Dr. Swayze were members of the MEC. At that time, Dr. Thomas was the past Chief of Medical Staff, Dr. Goracke was Chief of Staff, and Dr. Swayze was Vice Chief of Staff. In addition to the defendant, the MEC included Dr. James Rider, who was a member-at-large, and Dr. Michael Jones, who was the Secretary/Treasurer. Neither of these members of the Executive Committee are parties to this dispute.

Application Process and Fair Hearing Procedures

Physicians seeking medical staff membership must apply in writing after a preapplication screening process. The Credentials Committee then collects all of the documentation (licenses, references, etc.) and prepares a report to submit along with the application and supporting material to the Chief of Staff for review by the MEC. The MEC then investigates and makes a recommendation to the Board whether the application should be granted, and if so, if any restrictions should apply. The MEC is to evaluate evidence of character, professional and personal competence, and qualifications and ethical standing of the practitioner before making its recommendation. Finally, the Board reviews the application material and is the ultimate authority in granting a practitioner privileges and decides whether to accept or reject the MEC's recommendation.

*10 Once the period of appointment ends, which is usually after two years, the medical staff member must be reappointed

to continue their privileges. The same procedures apply to the reappointment process as the initial appointment process, in addition to the procedures set forth in Appendix A. Section 5(f) of Appendix A provides a list of fourteen criteria upon which the MEC bases its recommendation for reappointment. This criteria includes attendance at medical staff meetings and participation in staff duties; compliance with the Bylaws; and behavior in the Hospital, including cooperation with medical and Hospital personnel. The MEC recommends to the Board whether a staff member's privileges should be increased, reduced, terminated, or remain the same. Finally, the Board reviews the MEC's recommendation and the application materials, and makes the final reappointment decision.

The denial of reappointment by the Board, and/or a recommendation by the MEC to deny reappointment are adverse recommendations that trigger the Fair Hearing Procedure set forth in the Bylaws. Under the Fair Hearing Procedures, the practitioner against whom the decision has been made is given special notice in writing of the recommendation or decision, which must contain a statement of and reasons for the recommendation or decision and inform the practitioner of his or her right to request a hearing. Appendix A of the Bylaws sets forth the procedures specific to the Fair Hearing. If a hearing is requested, the Chief Executive Officer and/or the Chief of Staff appoints a Hearing Committee, which must be composed of at least five members composed of medical staff or outside physicians who have not been actively involved in the consideration of the matter at previous levels of investigation or consideration.

At the hearing, the practitioner, the MEC and Board may each have counsel present. Each party is entitled to call and examine witnesses, to introduce written evidence, to cross-examine any witnesses, to challenge any witness and to rebut any evidence. The Hearing Committee may consider any pertinent material on file with AHA and any evidence produced at the hearing, including "any information regarding the practitioner who requested the hearing, including, but not limited to, any material contained in the records of the Hospital regarding the practitioner who requested the hearing, so long as such material has been admitted into evidence at the hearing and the affected practitioner had the opportunity to comment thereon, or, by other evidence, to refute it." Appendix A requires the CEO to promptly send a copy of the Hearing Committee's written report of its recommendation to the practitioner and Chief of Staff by certified mail.

Appendix A also allows for a practitioner to appeal an adverse recommendation from the Hearing Committee within ten days. The appeal must be held only on the record upon which the Hearing Committee recommendation was made based on the grounds of: (1) substantial and prejudicial failure on the part of the Hearing Committee to comply with the Bylaws or requirements of law; (2) an arbitrary or capricious decision, or decision made with bias; or (3) the action of the Hearing Committee is not supported by evidence in the record. Appellate review is conducted by the Board. The Board then must render a final decision in writing within ten days after the appellate review hearing.

1998 Application

*11 Plaintiff was first granted medical staff privileges at AHA in 1983. He was born in Thailand, came to the United States in 1977, and became a United States citizen in 1996. During his time at AHA, plaintiff and his wife felt socially ostracized by other physicians at AHA. Plaintiff applied for and was granted reappointment every two years after his initial appointment until 1996. On July 22, 1996, plaintiff voluntarily resigned his staff privileges and left the Atchison community and spent a period of time in Thailand. In March 1998, plaintiff returned and applied for appointment at AHA. On October 9, 1998, the MEC recommended that plaintiff not be granted staff membership privileges. Plaintiff requested a fair hearing, but the Board did not follow the MEC recommendation. Instead, the Board offered plaintiff a conditional reappointment, which granted him staff membership on a provisional one-year basis pursuant to a Settlement Agreement.³⁷ The Settlement Agreement provided for an independent proctor to review plaintiff's medical records for three months, and to review the manner of practice used by plaintiff, including critiquing care decisions and monitoring the results of care rendered. For nine months, 30% of plaintiff's medical records would be reviewed randomly. The proctor would report his reviews to the CEO, the MEC, and to plaintiff. The Settlement Agreement also required certain departments to submit written reports for the purpose of identifying any problems or concerns that arose regarding plaintiff's interaction with medical and hospital staff. Also part of this agreement is a condition that during plaintiff's provisional period, he is not to be alone with any female employee or patient within the Hospital, except in emergency situations. Finally, the Settlement Agreement releases the parties from any liability or claims that arose before the agreement. The Settlement Agreement provides

for AHA's response to inquiries about whether plaintiff's privileges had ever been suspended, revoked, or disciplined:

On December 19, 1995, Dr. Vesom's clinical privileges were summarily suspended by decision of the Hospital's Chief of Staff and CEO for non-compliance with recommendations of the Kansas Medical Society–Medical Advocacy Program (“KMS–MAP”). Thereafter, the Hospital was informed that Dr. Vesom was in compliance with the recommendations of KMS–MAP. Accordingly, on December 22, 1995 the summary suspension was withdrawn prior to any hearing.³⁸

The Settlement Agreement is signed by plaintiff and by Dr. W. David Drew, President and CEO of AHA at the time.

On February, 27, 2001, plaintiff was notified that his next application for reappointment was approved by the Board. Plaintiff was never an employee of AHA or of the individual defendants.

Plaintiff's Complaints

The Peer Review Committee at AHA performs peer review for the Medical Staff, utilizing criteria and indicators established by the Medical Staff. Under the Bylaws, the Chief of Staff reviews cases and the MEC then performs a screening. The committee meets ten times per year.

*12 On January 3, 2003, plaintiff and Dr. David Ware met with the CEO of the Hospital, Virgil Bourne, and Chief of Staff, Dr. Goracke, about concerns and recommendations they had about certain hospital policies. According to a letter signed by plaintiff, Dr. Ware, and Dr. A.K. Tayiem documenting these concerns, AHA “employees” had been systematically violating the federal and state health rights of its patients for years through its over-reliance on generalist care and sham peer reviews, and blatantly discriminating against the federal rights of independent specialists by sanctioning them “at the behest” of its own generalists. The physicians asked for such changes as, among other things, peer review of major cases by outside reviewers and less political credentialing of physicians. This letter was sent to William R. Thornton, the Chairperson of the Board of Directors, on January 22, 2003. Thornton responded on January 29, 2003 that he had forwarded the letter on to the Risk Manager for investigation.

On January 23, 2003, the Board of Directors held a meeting where they discussed Dr. Ware's contract. A motion passed

unanimously to implement a clause in Dr. Ware's contract that terminates the contract with or without cause upon ninety days written notice. The Board agreed to immediately serve notice of this decision to Dr. Ware by letter.

On March 4, 2003, Mary Kabriel, a risk management specialist with the Kansas Department of Health and the Environment ("KDHE"), Bureau of Health Facilities, arrived at AHA for an unannounced survey due to a report that had been filed against AHA. Later, it became known that Dr. Ware and plaintiff had complained about the handling of a particular case where a mother suffered an amniotic fluid embolism during birth. Dr. Ware and plaintiff were critical of the peer review process in that case and argued for outside peer review. In *Vesom I*, plaintiff concedes that he filed this report with the KDHE, and that it was not investigated until after he was notified of the denial of his application for reappointment. Kabriel conducted a total of six on-site visits to AHA in March 2003.

2003 Reappointment

When plaintiff applied for reappointment on December 15, 2002, he signed an "Authority and Liability Waiver." The waiver states:

I further waive any rights under Educational Rights and Privacy Act or any statute granting immunity to such Boards or Committees and further agree to hold harmless such President, Board or Committees evaluating my application from any claim or action by or on my behalf in the event such application for reappointment is denied for any reason.

The waiver is on a preprinted form and further states that the applicant, "agree[s] to abide by the Bylaws, Rules and Regulations of the Medical/Dental Staff."³⁹

In February 2003, the MEC reviewed plaintiff's application and the records from his "credentials file" at AHA. On February 18, 2003, plaintiff was provided a three-page letter signed by CEO Bourne, titled Notice of Adverse Recommendation and Fair Hearing Rights that fully advised plaintiff of his rights under the Fair Hearing provisions of the Bylaws. The reasons for the denial of plaintiff's reappointment stated in the letter are: (1) "failure to comply with Medical Staff Bylaws and Rules and Regulations"; (2)

"[his] behavior in the hospital, which showed a lack of cooperation with medical and hospital personnel as it relates to patient care, and the orderly operation of AHA, and [his] general attitude toward AHA and its personnel"; (3) "fail[ure] to discharge [his] responsibilities for Staff, Committee and Hospital functions for which [he] was responsible by staff category assignment, appointment, and election or otherwise"; (4) "[he] engaged in verbal attacks on individuals and AHA personnel that were personal, irrelevant, and went beyond the bounds of fair professional conduct"; (5) "[he] made impertinent and inappropriate comments in official documents, including the impugning of the quality of care in AHA and attacked particular individuals and AHA policies"; (6) "[he] engaged in non-constructive criticism addressed to recipients in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence"; (7) "[he] refused to accept Medical Staff assignments or participate in committee or departmental affairs on anything but [his] own terms, and did so in a disruptive manner"; (8) "[he] made verbal threats of retribution and litigation towards individuals and AHA personnel including members of the Medical Staff"; and (9) "[he] used abusive language."

*13 On February 24, 2003, the Board of Directors met and the MEC/Credentials Committee informed the Board of their recommendation to give Dr. Ware notice of Termination of his provisional privileges effective March 18, 2003. The MEC/Credential Committee further informed the Board of their recommendation to notify plaintiff of termination of his medical staff membership effective March 18, 2003.

On March 6, 2003, plaintiff delivered a written request for a hearing to the Chief Executive Officer of AHA.⁴⁰ The March 6, 2003 letter advised AHA that plaintiff had retained counsel to represent his interests in the matter, and that any questions regarding scheduling of the hearing should be directed to the attention of his attorney, Charles Kugler.

By letter dated March 18, 2003, AHA sent plaintiff a Notice of Hearing stating the place, time, and date of the Fair Hearing. The letter identified five proposed members of the Fair Hearing Panel. Pursuant to the letter, plaintiff was expressly given the right to object to any of the individuals identified to serve on the Fair Hearing Panel with whom plaintiff believed he was in direct economic competition. The letter identified the specific charges made against plaintiff, and included an itemized listing of the specific information upon which the MEC relied in making its recommendation. The letter also

identified the witnesses that would be requested to testify at the Fair Hearing in support of the charges against plaintiff.

By letter dated March 21, 2003, plaintiff's legal counsel acknowledged receipt of the March 18, 2003 letter and made written objections to the composition of two of the proposed members of the Fair Hearing Panel.

On June 5, 2003, AHA provided plaintiff's counsel with all of the written exhibits that would be (and were) used at the Fair Hearing in support of the charges against him.⁴¹ Subsequent amended notices of hearing were sent to plaintiff and ultimately the Fair Hearing was scheduled for January 22, 2004. Plaintiff was given a new opportunity to object to the composition of the Fair Hearing Panel in each amended notice. Plaintiff was also provided with another copy of all expected exhibits on January 9, 2004, just prior to the hearing.

The Hearing Panel was composed of five physicians, only one of whom was from Atchison. At the Hearing, plaintiff was represented by Charles Kugler, plaintiff's attorney in this action. The MEC was represented by Andrew Ramirez. Each party had the opportunity to present witnesses and offered testimony to support their case. The witnesses were cross-examined by the other party. The attorneys provided statements of their position at the Hearing. The members of the Fair Hearing Panel were permitted to ask questions of the parties, the witnesses, and the attorneys during the Hearing. Plaintiff presented evidence, including exhibits and documents to the Fair Hearing Panel.

The Fair Hearing Panel voted to uphold the MEC's recommendation to not reappoint plaintiff to the medical staff. Dr. Mark Lierz, an adult and pediatric urologist from St. Joseph, Missouri, wrote the report of the Panel's findings as Chair of the Panel. Dr. Lierz noted that plaintiff had "an established pattern of disruptive behavior that created a poor environment for hospital personnel, medical staff, patients and his physician colleagues as he was warned on multiple occasions that this was in direct violation of the Medical Staff Bylaws."

*14 An Appeal Hearing was conducted before the Board on March 25, 2004. Plaintiff was allowed legal counsel and to make oral argument at the hearing. On April 2, 2004, the Board issued its written decision and decided to not reappoint plaintiff to the medical staff, effective April 2, 2004. The Board's decision was based on the recommendation of the MEC and the Hearing Panel.

Between February 18, 2003, when plaintiff received notice of the MEC's adverse recommendation, and April 2, 2004, when the Board issued its decision on appeal, plaintiff had maintained active medical staff privileges at AHA. After his appeal was denied, plaintiff resigned his other medical staff privileges with Cushing Memorial and with Horton County Hospital and decided to relocate to Poplar Bluffs, Missouri.

III. Discussion

Plaintiff asserts in his Complaint the following claims: (1) race discrimination under 42 U.S.C. § 1981; (2) race discrimination under Title VI of the Civil Rights Act of 1964; (3) conspiracy to discriminate under 42 U.S.C. § 1985(3); (4) an antitrust violation under Section 1 of the Sherman Act;⁴² (5) retaliatory discharge in violation of Kansas public policy; and (6) intentional interference with business relations under Kansas law. Defendants assert there is no evidence creating a genuine issue of material fact on any of plaintiff's claims and assert various defenses to suit, including waiver. The Court first addresses the substantive claims alleged by plaintiff. Then, the Court will turn to the affirmative defense of waiver.

A. Race Discrimination under Sections 1981 and Title VI
Section 1981, as amended by the Civil Rights Act of 1981, states:

All persons within the jurisdiction of the United States shall have the same right in every State and Territory to make and enforce contracts, to sue, be parties, give evidence, and to the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens, and shall be subject to like punishment, pains, penalties, taxes, licenses, and exactions of every kind, and to no other.⁴³

In a similar vein, Title VI of the Civil Rights Act of 1964 provides that no person shall, "on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity" covered by Title VI.⁴⁴ "[P]rivate individuals may sue to enforce § 601 of Title VI

and obtain both injunctive relief and damages.”⁴⁵ Title VI only prohibits intentional discrimination.⁴⁶

It is undisputed that plaintiff was not an employee of AHA, nor of the individual defendants. Plaintiff's legal status in relation to defendants is that of an independent contractor.⁴⁷ Yet, plaintiff formulates the elements of his Section 1981 claim under the *McDonnell–Douglas Corp. v. Green*⁴⁸ burden-shifting framework, normally applicable in employment discrimination cases that involve termination. Defendants object that *McDonnell–Douglas* is inapplicable because plaintiff is not an employee. Defendants also maintain that plaintiff did not have a contractual relationship with AHA, such that would allow for a claim under Section 1981.

*15 In the employment discrimination context, claims brought pursuant to Section 1981 and Title VI are governed by the same evidentiary framework as claims brought under Title VII; that is, in the absence of direct evidence of discrimination,⁴⁹ the court applies the burden-shifting scheme of *McDonnell–Douglas* and *Texas Department of Community Affairs v. Burdine*.⁵⁰ Under this framework, plaintiff must first prove a prima facie case of race discrimination.⁵¹ If plaintiff is able to sustain this burden, the burden of production shifts to defendants to “articulate a legitimate, nondiscriminatory reason for rejection.”⁵² If defendants sustain that burden, the burden of production shifts back to plaintiff to show that defendants' proffered reason for rejection is false, or merely a pretext, and the presumption of discrimination created by establishing a prima facie case “drops out of the picture.”⁵³ Although the burden of production shifts back and forth between the parties, the ultimate burden of persuasion remains at all times with the plaintiff.⁵⁴

Despite the fact that these claims do not arise in the employment context, the Court may still apply the *McDonnell–Douglas* test for indirect evidence of intentional discrimination.⁵⁵ Also, multiple courts have utilized the *McDonnell–Douglas* test for intentional discrimination claims when a physician makes such a claim against hospital entities for suspension or termination of staff privileges.⁵⁶

The Court rejects the formulation of the prima facie case that plaintiff advocates in the Pretrial Order and, instead, would

apply the elements of a claim under Section 1981 in the non-employment context, as articulated by the Tenth Circuit in *Hampton v. Dillard Department Stores, Inc.*⁵⁷ Plaintiff must show, (1) he is a member of a protected class; (2) that defendants had an intent to discriminate on the basis of race; and (3) the discrimination interfered with a protected activity as defined in section 1981.⁵⁸ Plaintiff claims that defendants interfered with the protected activity of making and enforcing a contract. It is undisputed that plaintiff is a member of a protected class. Defendants seek summary judgment because they argue plaintiff is unable to prove that he had a contract interest that defendants interfered with, and further, that there is no evidence of intentional discrimination.

1. Interference with the Making and Enforcement of a Contract

Under Section 1981(b), to “make and enforce contracts” includes: “the making, performance, modification, and termination of contracts, and the enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.” To state a claim under Section 1981 for interference with a contract, it must involve, “the actual loss of a contract interest, not merely the possible loss of future contract opportunities.”⁵⁹ Although most litigation under Section 1981 arises from employment discrimination claims, it has also been applied to claims regarding the retail sector and the restaurant industry if a contract is established.⁶⁰

*16 The parties dispute whether the Bylaws created a contract interest upon which plaintiff may base his Section 1981 claim.⁶¹ Plaintiff points the Court to cases that he believes show that other courts have allowed claims under Section 1981 by physicians who are denied medical staff benefits without proving the existence of a contract. First, plaintiff points the Court to *Jatoi v. Hurst–Eules–Bedford Hospital Authority*,⁶² where the Fifth Circuit remanded back to the district court to make specific findings on the elements of the prima facie case and did not speak to the contract issue.⁶³ Next, plaintiff cites *Islami v. Covenant Medical Center*,⁶⁴ which did not consider a claim under Section 1981, but did find that, under Iowa law, the hospital bylaws created a contract between the defendants and the physician plaintiff in the context of a breach of contract action.⁶⁵ The Supreme Court of Iowa later disagreed with that holding.⁶⁶ Finally, plaintiffs cite *Janda v. Madera Community Hospital*,⁶⁷ which also found that hospital bylaws created a contract

between the hospital and the physician plaintiff under California law.⁶⁸

Neither party identifies, nor is the Court able to locate, Kansas law on the issue of whether hospital bylaws create an enforceable contract between the hospital and its medical staff. The closest the Kansas Supreme Court has come to answering this question was in the context of a breach of contract action by a radiologist who sued a hospital for breach of contract based on due process provisions in the hospital bylaws.⁶⁹ The Kansas Supreme Court declined to address the issue before this Court, stating: "The threshold issue in *Lewisburg* was whether the bylaws formed a contract with the plaintiff radiologist as a member of the medical staff. St. Francis, in this case at bar, has admitted to the contractual relationship."⁷⁰ Therefore, the Court must predict how Kansas courts would resolve the issue.

As discussed in the cases cited by plaintiff, there is a split of authority outside of the jurisdiction.⁷¹ It is also difficult to discern a general rule from these cases. Plaintiff quotes *Corpus Juris Secundum* for the proposition that "a hospital's medical staff bylaws constitute a contract between the hospital and its medical staff, particularly where the hospital and its staff indicate an intent to be bound by their terms, but not otherwise."⁷² But the revised version of this section states that there is also authority that "absent express language to the contrary, a hospital's medical staff bylaws do not constitute a contract between the hospital and its staff physicians, since the essential element of valuable consideration is absent."⁷³

The Court concludes that the better-reasoned line of cases hold that hospital bylaws do not create a contract. Like the bylaws discussed in *Tredrea*, the Bylaws here do not imply an agreement for continued staff privileges. In fact, the Bylaws explicitly provide that medical staff privileges are *not* a right and that staff members have *no* entitlement to continued staff privileges.

*17 The preamble to the Bylaws state:

the physicians and dentists practicing
at Atchison Hospital Association, ...
hereby organize themselves in
conformity with these Bylaws,
which establish the mechanisms to
carry out the direct and delegated

responsibilities of the Medical Staff
in cooperation with the Hospital
Administration and the Governing
Board of the Hospital, and do hereby
agree to accept and abide by the
following Bylaws and such Rules
and Regulations which are adopted in
accord with these Bylaws.

The Court finds that these Bylaws do not create a contract between physicians and the hospital. AHA gave no consideration for any agreement created by the Bylaws, despite the fact that plaintiff was required to abide by them as a consequence of medical staff privileges. Further, the Bylaws are required to be passed by state regulation,⁷⁴ so AHA is merely complying with the law in promulgating Bylaws.⁷⁵ The Court finds, like the Supreme Court of Iowa, that construing medical staff bylaws as a contract could actually be contrary to public policy:

[W]e believe it would improperly impinge on the statutory mandate to the board of directors to establish criteria for staff privileges, perpetuate the problems that had led to the establishment of the independent contractor system, and ultimately affect the successful operation of the hospital. Such a contract, impacting as it would on the statutory responsibilities of the hospital on matters affecting staff qualifications, might well be argued to be against public policy. In any event, we conclude that continued staff privileges are not implied by the bylaws, and we will not give the bylaws the effect of a contract.⁷⁶

The Court agrees with the reasoning of the Supreme Court of Iowa. This Court predicts that under Kansas law, the bylaws do not constitute a contract between medical staff and the hospital. There is a lack of consideration, lack of intent to be bound, and it is contrary to public policy to take away the authority of the Governing Board as "the ultimate authority in the hospital."⁷⁷ Accordingly, the Court finds that plaintiff is unable to establish a genuine issue of material fact over the third element of a *prima facie* case, which requires him to show that defendants interfered with the making or enforcement of a contract.

2. Pretext

Assuming *arguendo* plaintiff is able to satisfy the *prima facie* elements of a Section 1981 and Title VI claim, defendant must offer a legitimate, nondiscriminatory reason for the

discrimination. Defendants argue that they abided by the peer review process according to the Bylaws in denying plaintiff's application for reappointment in 2003 because he was a disruptive physician. Plaintiff, in turn, argues that this reason is simply a pretext for discrimination.

The Court finds that defendants offer legitimate, non-discriminatory reasons for denying plaintiff's application for reappointment, and proceeds to determine if this act was a pretext for discrimination. "A plaintiff can show pretext by revealing such weaknesses, implausibilities, inconsistencies, incoherencies, or contradictions in the employer's proffered legitimate reasons for its action that a reasonable factfinder could rationally find them unworthy of credence."⁷⁸ Plaintiffs typically show pretext in one of these three ways: (1) evidence that defendant's stated reasons for the adverse employment action was false; (2) evidence that defendant acted contrary to a written company policy prescribing the action to be taken by defendant under the circumstances, and (3) evidence that the defendant acted contrary to an unwritten policy or practice when making the decision.⁷⁹ Plaintiff also may show pretext through evidence that the "employer's proffered non-discriminatory reasons [were] either a *post hoc* fabrication or otherwise did not actually motivate the employment action (that is, the proffered reason is a pretext)."⁸⁰ Defendants argue that plaintiff's only evidence of pretext is in the form of his own conclusory opinions, found in his deposition testimony and various declarations. The Court will now turn to each of plaintiff's arguments that the denial of his reappointment based on disruptive behavior was pretextual.

Comments and Conduct

*18 First, plaintiff argues that many physicians, including the individual defendants, made discriminatory comments to him or about him during his tenure at AHA. Yet, he specifically references only two comments in his argument. First, he references a loud comment made by Dr. Harry Franz, now deceased, at a barbeque for the hospital employees and physicians, that they should give plaintiff chopsticks to eat with.⁸¹ Second, in his deposition, he talks about how Dr. Eplee "years ago" laughed at his accent while dictating a medical chart, and implied that he spoke slowly. The Court finds that these comments do not amount to either direct evidence of discrimination or of pretext. The comment plaintiff attributes to Dr. Franz, now deceased former member of the Executive Committee, was admittedly

made "years ago" and at least some time before 1998.⁸² Similarly, the incident with Dr. Eplee occurred many years prior to the decision not to renew plaintiff's privileges. At best, these are discriminatory comments made by nondecision-makers, which carry little evidentiary weight. "Discriminatory incidents which occurred either several years before the contested action or anytime after are 'not sufficiently connected to the employment action in question to demonstrate pretext.'"⁸³ The contested action here took place in 2003, years after these comments were made sometime prior to 1998. These stray remarks should not even be admitted on summary judgment, "unless plaintiff can link them to personnel decisions or the individuals making those decisions."⁸⁴ Plaintiff makes no attempt to do.

Next, plaintiff argues that he and his wife were socially ostracized by his fellow physicians at AHA and that they refused to refer patients to him for care unless it was an emergency that came up at night or on the weekend. Again, plaintiff does not explain who specifically engaged in this conduct, nor how it related to the ultimate decision to not reappoint him. Plaintiff's deposition testimony indicates that he and his wife were socially excluded by other physicians for a long period of time, beginning years before. Plaintiff enjoyed staff privileges during the majority of this time, and was reappointed after initially being turned down for privileges in 1999 and reappointed in again 2001.

Proffered Reason was Post Hoc Fabrication

Plaintiff argues that Dr. Rider's testimony provides evidence of pretext because he presents an alternate interpretation of the basis for the MEC's decision not to recommend that he be reappointed. According to Dr. Rider, members of the MEC had decided not to recommend reappointment before actually discussing the grounds for doing so. The Court finds that Dr. Rider's declaration supports the allegation that members of the MEC made the decision not to renew plaintiff's staff privileges before determining a basis upon which to do so. However, Dr. Rider's declaration does not support the allegation that the true reason behind the decision was racial animus.

*19 As previously discussed, the Court disregards this declaration to the extent it provides conclusory opinions about the feelings and intent of others. At best, Dr. Rider's declaration supports the argument that the decision to not reappoint plaintiff to the medical staff was the result of plaintiff's and Dr. Ware's active disagreement with members

of the MEC regarding the handling of certain peer review cases. In fact, the only statement made by Dr. Rider that even intimates there was a race-based motivation in deciding not to renew plaintiff's privileges is the following paragraph from his second declaration:

The animus directed at Dr. Vesom by members of the MEC was not the result of disruptive behavior on his part. Rather, it was the result of professional jealousy of a better qualified foreign doctor whose competition and demanding standards of care were resented by the hospital employed medical staff doctors.⁸⁵

As described in the Court's evidentiary ruling, this statement amounts to a conclusory opinion to which Dr. Rider cites no supporting facts and for which he has no personal knowledge. Further, both declarations more clearly support his view that the decision not to renew plaintiff's staff privileges was the result of hostility due to plaintiff's and Dr. Ware's complaints about the peer review process at AHA. To be sure, Dr. Rider discusses the letter Dr. Vesom and Dr. Ware wrote on January 22, 2003, criticizing peer review at AHA: "This letter further served to anger my fellow committee members who then decided to not renew the hospital privileges of Dr. Vesom and Dr. Ware."⁸⁶ Even though plaintiff provides evidence of an ad hoc fabrication of the reasons behind the denial of his reappointment, the Court finds that he has failed "to create a question of fact for the jury that *race* motivated [the decision]."⁸⁷

Stated Reason for Decision is Contrary to the Bylaws

Although not explicitly referenced in his argument, plaintiff contends in his declarations and factual recitations, that AHA and the MEC did not comply with the Bylaws in denying him reappointment. Specifically, plaintiff maintains that if he was a "disruptive physician" under the Bylaws, he was entitled to "corrective action" under Appendix B when the complaints were made. Instead, plaintiff contends that the MEC reviewed his credentials file that included a number of complaints made during his tenure that he never had a chance to explain or refute. Defendants argue that plaintiff was never entitled to corrective action under Appendix B, and that they complied with the Fair Hearing procedures set forth in Appendix A, as the recommendation and ultimate decision not to reappoint plaintiff constituted a triggering action for a Fair Hearing and

not for corrective action. Plaintiff's argument appears to be that if the complaints referenced in his credentials file were valid, he would have been accorded corrective action each time a complaint was made. Instead, he claims that the Fair Hearing process was the first opportunity he had to review many of these documents and complaints, and is therefore circumstantial evidence of pretext.

*20 The Court finds that this disagreement is based on a patent misreading of the Bylaws by plaintiff. The Bylaws require allegations of disruption, under the criteria set forth in Article X, to be reported. If a report is made, Appendix B procedures apply for corrective action. However, Appendix B explicitly provides that, "any officer of the Medical Staff, the chairperson of a Service or Committee, the Chief Executive Officer of the Hospital or any member of the Governing Board of the Hospital may request corrective action against such practitioner." If corrective action is requested, then the MEC investigates the report and submits a written report of the investigation to the Board. Before the report is made, however, the practitioner has the opportunity to interview with the MEC so that he or she may discuss, explain, or refute the nature of the charge. The summary is then submitted with the report to the Board. Ultimately, the Board either approves or modifies the MEC recommendation. Contrary to plaintiff's contentions, this procedure never gets underway unless an officer, Chair of a committee, or the CEO of AHA requests corrective action.

Appendix B does not, by its plain terms, require corrective action be taken every time a report is filed. Therefore, even if plaintiff is correct that the MEC and Board evaluated his credentials file containing allegations that he was never able to explain, this does not contravene the Bylaws. It is clear from the undisputed facts in this matter that defendants complied with the Fair Hearing procedures set forth in Appendix A of the Bylaws, which apply when a member is denied reappointment to the medical staff.

Similarly Situated Individuals

Plaintiff points to his third declaration as proof that similarly-situated Caucasian medical staff members were treated more favorably than he was. A plaintiff may show pretext by proving that similarly situated nonprotected individuals were treated more favorably for committing comparable conduct.⁸⁸ "Similarly situated employees are those who deal with the same supervisor and are subject to the same standards governing performance evaluation and discipline."⁸⁹ As

previously discussed, Vesom III consists of plaintiff's opinions and explanations of certain confidential documents located in other physicians' credentials files. According to plaintiff, these documents reveal inconsistencies in the treatment of nonprotected physicians compared to him.

Plaintiff attaches "Topic Incident Reports" with regard to two of the physicians, which briefly summarize incidences of problems reported, the physicians' response, and the committee findings, comments, and recommendations. But these reports do not indicate who the "Committee" is, or what procedure the committee went through in order to reach the conclusion it did. There is no evidence presented by plaintiff's third declaration that leads the Court to believe that these reports were reviewed in the context of applications for renewal of medical staff privileges. Nor do all of these reports deal with the same time period, and therefore the same MEC, as the period during which plaintiff applied for and was denied renewal of staff privileges.

*21 Of these two physicians, one was also investigated by the KDHE after it received a complaint from plaintiff in January 2003.⁹⁰ The allegation regarded the peer review of a particular medical decision by this physician and the KDHE found the complaint substantiated. The hospital records show that the committee reviewing this allegation reviewed the case as a follow-up to the KDHE survey twice in 2003, and ultimately found the case to be within the standard of care and determined that no further action should be taken. Again, this is not a similarly situated individual to plaintiff. The stated reason for the decision to not reappoint plaintiff was based on a pattern of disruptive behavior, not a complaint over peer review in a particular case.

The third physician plaintiff references in his declaration was up for reappointment in the Fall of 2001. This physician had a documented mental illness and problems with alcohol dependency. Documents attached to plaintiff's declaration show that this information was disclosed to the MEC upon the physician's reapplication and that at least one physician intervened on the physician's behalf and was personally monitoring this physician's performance. The documentation further shows that the MEC addressed these issues with that physician and assured itself that the physician had sought help through an impaired physicians group and was being treated with a number of medications. The Court fails to see how this physician is at all similarly situated to the plaintiff. First, the application was filed in 2001, the same year that plaintiff was reappointed for the last time, without incident.

In 2003, a different MEC was in place when plaintiff was not reappointed. Plaintiff has not admitted, nor contended that medical impairments were involved in the decision not to renew his privileges. Further, the issue was not ignored by the MEC, but was discussed with this other applicant and other individuals on the medical staff were monitoring the physician and would report to Dr. Thomas, Chief of Medical Staff at the time, about this physician's progress. In fact, this appears to be more similar to the circumstances of the MEC's first recommendation in 1998 to deny plaintiff privileges, which was later rejected by the Board, under the conditions set forth in the Settlement Agreement.

Further, defendants have come forward with evidence that Dr. Tayiem, who is Palestinian, also had objections to the peer review process but that his medical staff privileges were unaffected. Dr. Tayiem also signed the letter that plaintiff and Dr. Ware sent to the Board in January 2003. Dr. Tayiem is a much more similarly situated individual to plaintiff, in that he made the same types of complaints and was of a foreign nationality. The fact that Dr. Tayiem did not suffer from a denial of medical staff privilege reappointment belies plaintiff's conclusory allegations that the MEC declined to renew his privileges based on race.

*22 This is a case where summary judgment is appropriate because, "the record conclusively revealed some other, nondiscriminatory reason for the employer's decision, or ... the plaintiff created only a weak issue of fact as to whether the employer's reason was untrue and there was abundant and uncontroverted independent evidence that no discrimination occurred."⁹¹ Defendants' motion for summary judgment is granted on plaintiff's Section 1981 and Title VI claims.

B. Conspiracy under Section 1985(3)

The essential elements of a claim under Section 1985(3) are: (1) a conspiracy; (2) to deprive plaintiff of equal privileges and immunities; (3) an act in furtherance of the conspiracy; and (4) an injury resulting therefrom.⁹² Section 1985(3),

does not 'apply to all tortious, conspiratorial interferences with the rights of others,' but rather, only to conspiracies motivated by 'some racial, or perhaps otherwise class-based, invidiously discriminatory animus. The other 'class-based animus' language of this requirement has been narrowly construed and does not, for example, reach

conspiracies motivated by an economic or commercial bias.⁹³

As the Court has already explained, there is no genuine issue of material fact concerning the second element of this claim—an intent to deprive plaintiff of equal privileges or immunities. Plaintiff has failed to present a genuine issue of material fact that would allow a reasonable factfinder to conclude that the decision to not reappoint him to the medical staff was due to an invidiously discriminatory animus. Therefore, summary judgment is granted on this claim.

C. Sherman Act

Plaintiff's fourth claim asserts a violation of Section 1 of the Sherman Act. He maintains that defendants conspired to deny him staff privileges at AHA for the purpose of unreasonably restraining trade, causing him to suffer economic losses. Section 1 of the Sherman Act states that:

Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal. Every person who shall make any contract or engage in any combination or conspiracy hereby declared to be illegal shall be deemed guilty of a felony.⁹⁴

Generally, the Sherman Act only prohibits restraints on trade that are unreasonable.⁹⁵ The plaintiff must establish: (1) concerted action in the form of a contract, combination, or conspiracy, and (2) an unreasonable restraint of trade.⁹⁶

“A doctor's unreasonable exclusion from the relevant market via adverse and unfair peer review proceedings obviously affects patient choice and concomitantly, interferes with competition in the marketplace.”⁹⁷ Normally, courts apply a “rule of reason” analysis to Section 1 cases, which requires “the fact finder [to] weigh[] all of the circumstances of a case in deciding whether a restrictive practice should be prohibited as imposing an unreasonable restraint on competition.”⁹⁸ Under such review, the misuse of the peer review process is unjustified.⁹⁹

*23 Defendants argue that there was no concerted action or conspiracy and that denying staff benefits is not a plainly

anti-competitive activity. Plaintiff argues that Dr. Rider's declaration supports the allegation that “concerted actions of defendants” drove plaintiff from the Atchison community, which produced an anti-competitive effect on interstate commerce. Plaintiff argues that he was injured because he was driven from a practice he had developed over a period of more than twenty years.

Dr. Rider's declarations attest to what occurred at certain MEC meetings at which he was present. Taking his declarations as true, plaintiff has established concerted activity among some members of the MEC.¹⁰⁰ However, as defendants stress, the Board was the ultimate authority who denied plaintiff's reappointment application and plaintiff has come forward with no evidence of concerted action by members of the Board. “Where a hospital Board has ultimate decision making authority, [s]imply making a peer review recommendation does not prove the existence of a conspiracy [among the hospital and its staff]; there must be something more such as a conscious commitment by the medical staff to coerce the hospital into accepting its recommendation.”¹⁰¹ Plaintiff has not come forward with any evidence suggesting that the Board did not act independently in following the MEC's recommendation, after the Fair Hearing process was invoked and utilized by plaintiff.¹⁰² The evidence is consistent with AHA's lawful motive of following its Bylaws in denying plaintiff's reappointment. Therefore, plaintiff is unable to present a genuine issue of material fact over whether there was concerted action by defendants and defendants' motion for summary judgment on this claim is granted.

Also, plaintiff fails to come forward with evidence tending to show an injury to consumers due to the Board's decision. Plaintiff argues that “the evidence” in this case shows anti-competitive activity, without any specific reference to the record. As already discussed, there is no evidence that plaintiff had exclusive contracts with any of his patients, or that the Board's decision drove up prices of cardiology service to patient consumers. To show an antitrust injury, plaintiff would need to show that defendants' conduct “‘affected the prices, quantity or quality of goods or services,’ not just his own welfare.”¹⁰³ “A claim that a practice reduces (particular) producers' incomes has nothing to do with the antitrust laws, which are designed to drive producers' prices down rather than up.”¹⁰⁴ Plaintiff has not come forward with any evidence, beyond conclusory opinions that certain general physicians refused to refer patients to him, that the decision not to reappoint him affected prices or the quality of

goods or services. Even assuming plaintiff's belief about the non-referrals is true, this was happening well before the 2003 decision not to reappoint him. The Court finds no genuine issue of material fact over the existence of an antitrust injury and grants defendant's motion on this claim.

D. State Law Claims

*24 Defendants further argue that they are entitled to summary judgment on the state law claims on the merits. Because the Court grants summary judgment to defendants on the federal claims, the Court is authorized to decline supplemental jurisdiction over the remaining state law claims.¹⁰⁵ Whether to exercise supplemental jurisdiction is committed to the court's sound discretion.¹⁰⁶ 28 U.S.C. § 1367 "reflects the understanding that, when deciding whether to exercise supplemental jurisdiction, 'a federal court should consider and weigh in each case, and at every stage of the litigation, the values of judicial economy, convenience, fairness and comity.'" ¹⁰⁷

Upon a pretrial disposition of the federal claims, district courts will generally dismiss the state law claims without prejudice.¹⁰⁸ This general practice is in keeping with the holdings of the Supreme Court and the Tenth Circuit.¹⁰⁹ "Notions of comity and federalism demand that a state court try its own lawsuits, absent compelling reasons to the contrary."¹¹⁰ Nevertheless, in this case, the Court concludes that judicial economy and convenience weigh heavily in favor of exercising supplemental jurisdiction and deciding the state law claims on summary judgment. This case is now two years old and the events forming the basis of plaintiff's state law claims are identical to those already considered by the Court in deciding the federal claims. Therefore, the Court exercises supplemental jurisdiction and proceeds to decide the remaining state law claims.

1. Whistleblower Retaliation

Plaintiff argues that his medical staff privileges were terminated because he reported complaints about peer review and the standard of care at AHA to the KDHE, and was therefore retaliated against for his "whistleblowing" activity. Under Kansas law,¹¹¹ there is a so-called whistleblower's exception to the employment-at-will doctrine.¹¹² The at-will employment doctrine normally allows for the employer or employee to terminate the employment relationship at any time, for any reason.¹¹³ The Kansas Supreme Court has

recognized that "termination of an employee in retaliation for the good faith reporting of a serious infraction of such rules, regulations, or the law by a co-worker or an employer to either company management or law enforcement officials (whistle-blowing) is an actionable tort."¹¹⁴

To establish a prima facie case of retaliation for whistleblowing, the plaintiff has the burden to show, (1) a reasonably prudent person would have concluded that the employee's coworker or employer was engaged in activities in violation of rules, regulations, or the law pertaining to public health, safety, and the general welfare, (2) that the employer had knowledge of the employee's reporting of such violation prior to discharge of the employee, and (3) that the employee was discharged in retaliation for making the report.¹¹⁵ Additionally, the "whistle blowing must have been done out of a good faith concern over the wrongful activity reported rather than from a corrupt motive such as malice, spite, jealousy or personal gain."¹¹⁶ Plaintiff must prove this claim by a preponderance of the evidence that is clear and convincing in nature.¹¹⁷

*25 Defendants argue that plaintiff fails to establish a genuine issue of material fact on this claim because (1) he was not an employee of the hospital, (2) the tort does not extend to independent contractors, (3) the claim is preempted by other causes of action in the Complaint, and (4) there is no causation between plaintiff's report to the KDHE and the decision to not reappoint him to the medical staff. Because the Court agrees that plaintiff has failed to come forward with evidence that he was an employee of defendants, his claim fails as a matter of law.

As the Court has already stated, it is undisputed that plaintiff was not an employee of AHA or any of the individual defendants.¹¹⁸ The Court concluded in its discussion of the discrimination claims that he is properly classified as an independent contractor. In *Parsells v. Manhattan Radiology Group*,¹¹⁹ Judge Lungstrum recognized that a "clear majority" of cases have held that a claim for retaliation for whistleblowing does not extend to independent contractors.¹²⁰ Because the plaintiffs in that case had not addressed the issue in their brief, the court ordered them to show cause why the claim should not be dismissed on those grounds, as it had already found that the plaintiffs were independent contractors and not employees under Title VII. No further order was issued by the court after the parties

briefed the issue, however, as a stipulation of dismissal was filed soon after.

Plaintiff argues that *Parsells* should not control here because Judge Lungstrum did not rule on the summary judgment motion as to this tort. While the Court acknowledges that *Parsells* did not grant summary judgment to the defendant on this ground, the court did point to the overwhelming majority position of the courts not to extend whistleblower protection to independent contractors or non-employees. This tort is only an exception to the employment-atwill doctrine and is based on "the wrongful conduct of an entity with the power to terminate the employee."¹²¹ Plaintiff has come forward with no law to the contrary and no evidence that he should be considered an employee,¹²² nor does he even contest this point.

Plaintiff's only argument is that medical staff physicians at AHA and employees of the hospital "performed the same services ... under the same regulatory scheme." The only evidence plaintiff brings forward to support this statement is his own declaration.¹²³ He argues in his declaration that "the only difference is the independent physicians bill for the services directly to the patient or third-party payer, while the Hospital compensates its employed physicians with a salary." But, he argues they are subject to the same rules and regulations. The Court is not persuaded by this evidence. Plaintiff makes no attempt to argue how these facts defeat his independent contractor status, or under what legal theory this cause of action would be applicable to him. They are simply conclusory opinions or beliefs made by him about purely legal arguments.

*26 Defendants met their burden of pointing to the absence of evidence on the point of plaintiff's employment status, yet plaintiff was unable to come forward with evidence that would present a genuine issue of material fact. Because the Court finds that there is no genuine issue of material fact about whether plaintiff was an employee of AHA, it grants defendants summary judgment and declines to address their remaining arguments.¹²⁴

2. Intentional Interference with Business Relations

To establish a claim for tortious interference with business relations under Kansas law, plaintiff must show, (1) the existence of a business relationship or expectancy with the probability of future economic benefit to the plaintiff; (2) knowledge of the relationship or expectancy

by the defendants; (3) that, except for the conduct of the defendants, plaintiff was reasonably certain to have continued the relationship or realized the expectancy; (4) intentional misconduct by defendant; and (5) damages suffered by plaintiff as a direct or proximate cause of defendant's misconduct.¹²⁵ Malice is a predicate for tortious interference.¹²⁶

Under the first element of this tort, plaintiff alleges in the Complaint that he maintained relationships and expectancies with a large number of patients in the Atchison market with the probability of future economic benefit to him from those relationships. Defendants argue that plaintiff has failed to come forward with evidence to support that fact. Plaintiff's response to the summary judgment motion is the conclusory statement, "[p]lainly, plaintiff had a thriving medical practice which was destroyed by defendants' intentional and unlawful misconduct. This point is wholly unsupported by defendants' moving papers."

The only evidence the Court is able to locate on this point is plaintiff's own declaration where he states that he had a thriving medical practice in Atchison that was destroyed when he no longer had a local hospital to which he could refer patients. He states that this "forced" him to move to Poplar Bluffs, Missouri. But plaintiff stated in his deposition that he was allowed to maintain active medical staff privileges during the fourteen month period between receiving notice of the MEC's recommendation and the decision on appeal, until April 2, 2004. Further, it is undisputed that plaintiff still had privileges at two other hospitals, Horton Community Hospital and Cushing Memorial Hospital. Until plaintiff voluntarily moved to Poplar Bluff, Missouri, he continued to treat patients at these hospitals. Nor is there any evidence that plaintiff had an exclusive arrangement with any of his patients.¹²⁷

Plaintiff misapprehends the summary judgment burden. Defendants need only point to the absence of evidence on an essential element of this claim before the burden shifts back to plaintiff to come forward with facts to show a genuine issue of material fact. A one paragraph response to this showing is insufficient. The Court finds plaintiff has failed to produce evidence upon which a reasonable factfinder could conclude that plaintiff enjoyed a business relationship or expectancy with his patients.

F. Waiver

*27 Defendants raise a number of defenses to plaintiff's claims in their summary judgment motion. Having granted summary judgment to defendants on all of plaintiff's claims on the merits, the Court need not address each and every defense raised. Out of an abundance of caution, however, the Court proceeds to discuss the affirmative defense of waiver. Defendants argue that all of plaintiff's claims are barred by the Authority and Liability Waiver ("the Waiver") that plaintiff signed on December 15, 2002 when he applied for reappointment to the AHA staff. Plaintiff contends that the cases cited by defendants are inapplicable to an application for medical staff privileges, that waivers of prospective claims for intentional torts or statutory violations are void as against public policy, and that waivers for civil rights violations are "absolutely void." "The existence of a release is an affirmative defense; the defendant bears the burden of establishing it."¹²⁸

Plaintiff relies on a number of cases that stand for the proposition that an employee's rights under Title VII may not be prospectively waived, as it would defeat the "paramount congressional purpose behind Title VII."¹²⁹ Defendants make the overarching argument that because plaintiff was not an employee of AHA or of any of the individually named defendants, he may not now rely upon employment discrimination theories of recovery, such as analogies to Title VII. Although plaintiff does not assert a claim here under Title VII, he does assert race discrimination under Title VI and Sections 1981 and 1985(3).

The issue of the effect of a release or covenant not to sue is a legal question.¹³⁰ In Kansas, a release is treated as a contract and a party who signs a written contract "is bound by its provisions regardless of failure to read or understand the terms, unless the contract was entered into through fraud, undue influence, or mutual mistake."¹³¹ As a general rule in Kansas, the court must ascertain the intent of the parties and "if the language of the written instrument is clear, there is no room for rules of construction."¹³² The waiver provides that plaintiff agrees to "hold harmless such President, Board or Committees evaluating my application from *any claim or action* by or on my behalf in the event such application for reappointment is denied for any reason."¹³³ Here, the release language specifically states that it includes any claim that could arise from the denial of plaintiff's reappointment for any reason.¹³⁴ The Court finds that the language is clear and unambiguous that the release proscribes all claims concerning

the denial of reappointment.¹³⁵ All of plaintiff's claims are based on the decision not to reappoint him in 2003, and are thus covered by the language in the waiver.

Plaintiff is incorrect that waivers of federal civil rights and intentional tort claims are void as against public policy. An employee may waive potential claims under the civil rights statutes, so long as the waiver is made knowingly and voluntarily.¹³⁶ However, "[w]aivers of federal remedial rights [], are not lightly to be inferred."¹³⁷ To determine if a waiver is knowing and voluntary, courts look beyond the contract language to the totality of the circumstances under which the waiver is signed, considering the following factors:

- *28 (1) the clarity and specificity of the release language; (2) the plaintiff's education and business experience; (3) the amount of time plaintiff had for deliberation about the release before signing it; (4) whether [p]laintiff knew or should have known his rights upon execution of the release; (5) whether plaintiff was encouraged to seek, or in fact received benefit of counsel; (6) whether there was an opportunity for negotiation of the terms of the Agreement; and (7) whether the consideration given in exchange for the waiver and accepted by the employee exceeds the benefits to which the employee was already entitled by contract or law.¹³⁸

The Court finds, under the totality of the circumstances, that defendants meet their burden of showing no genuine issue of material fact regarding whether the waiver was knowing and voluntary. In addition to the clear language of the release, there is no issue about whether plaintiff knew the implications of the document he signed. He had applied for reappointment multiple times since he began his appointment at AHA in 1983. In 1999, he executed a Settlement Agreement that also contained release language after he was initially denied reappointment by the MEC. There is no evidence that plaintiff did not have adequate time to review the application materials before turning them in. The Court finds under the language of the waiver, as well as the totality of the circumstances, plaintiff waived all claims stemming from the decision in 2003 not to reappoint him to the medical staff. Therefore, even if the Court were to find that any of plaintiff's claims survived summary judgment on the merits, they would be waived.

IV. Motions to Exclude Expert Testimony

The Court declines to address defendants' Motion to Exclude Declaration and Expert Testimony of John-Henry Pfifferling, Ph.D. (Doc. 142); and Motion to Exclude Affidavits and Expert Testimony of Kurt V. Krueger, Ph.D. (Doc. 145). The experts defendants seek to exclude from the Court's consideration were not relied upon by plaintiff at this stage of the proceedings on the issues that were dispositive on summary judgment. Because the Court grants defendants' motion without considering these declarations, the motions to exclude should be denied as moot.

IT IS THEREFORE ORDERED BY THE COURT that:

1. Plaintiff's Motion for Leave to file Declaration and Exhibits under Seal (Doc. 183) is **granted**. The Clerk's Office is

directed to file plaintiff's third Declaration and exhibits submitted to the Court in camera on August 31, 2006;

2. defendants' Motion for Summary Judgment (Doc. 161) is **granted**; and

3. defendants' Motion to Exclude Declaration and Expert Testimony of John-Henry Pfifferling, Ph.D. (Doc. 142); and Motion to Exclude Affidavits and Expert Testimony of Kurt V. Krueger, Ph.D. (Doc. 145) are **denied as moot**.

IT IS SO ORDERED.

Footnotes

- 1 Fed.R.Civ.P. 56(e).
- 2 *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).
- 3 *Id.*
- 4 *Id.* at 251-52.
- 5 *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986).
- 6 *Thom v. Bristol-Myers Squibb Co.*, 353 F.3d 848, 851 (10th Cir.2003) (citing *Celotex Corp.*, 477 U.S. at 325).
- 7 *Id.*
- 8 *Id.*
- 9 *Matsushita Elec. Indus. Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986).
- 10 *Argo v. Blue Cross Blue Shield*, 452 F.3d 1193, 1199 (10th Cir.2006).
- 11 *Id.* (quoting *Thomas v. Int'l Bus. Machs.*, 48 F.3d 478, 485 (10th Cir.1995); Fed.R.Civ.P. 56(e)) (citations omitted).
- 12 The Court will discuss defendants' objections as applied to both Vesom II and III.
- 13 *Martinez v. Barnhart*, 177 Fed. App'x 796, 800 (10th Cir.2006).
- 14 *Id.* (citing *Franks v. Nimmo*, 796 F.2d 1230, 1237 (10th Cir.1986)).
- 15 *Franks*, 796 F.2d at 1237.
- 16 *Id.*
- 17 See Doc. 95 at 2.
- 18 (Doc. 164, Ex. 35, Vesom Depo. at 306.) The Court is unable to locate this deposition exhibit in the record.
- 19 *Id.* at 307.
- 20 (Doc. 164, Ex. 36, Vesom Depo. at 357-58.)
- 21 *Id.* at 358.
- 22 *Carpenter v. Boeing Co.*, 456 F.3d 1183, 1187 (10th Cir.2006) (quoting *Int'l Bd. of Teamsters v. United States*, 431 U.S. 324, 335 n. 15 (1977)).
- 23 *Id.* The Court accepts that plaintiff's claims encompass claims of intentional discrimination. Nothing in the briefs or the pretrial order suggest that plaintiff advances a cause of action encompassing "harassment," as defendants suggest in their Reply. (Doc. 193 at 28.)
- 24 Fed.R.Evid. 602.
- 25 *Argo v. Blue Cross Blue Shield*, 452 F.3d 1193, 1200 (10th Cir.2006).
- 26 *Id.* (quoting *Tavery v. United States*, 32 F.3d 1423, 1427 n. 4 (10th Cir.1994)).
- 27 For example, plaintiff's statement that "[t]he failure to give notice also contravened the hospital bylaws and their requirements for dealing with disruptive behavior..." (Doc. 182 ¶ 13), is clearly a conclusory interpretation of other evidence in the record—the Hospital Bylaws. Although this type of legal argument is appropriate for the Court's consideration on the summary judgment motion,

it is inappropriate as a submission of fact. Indeed, it appears that much of plaintiff's statement of additional material facts is cut and pasted directly from the witnesses' declarations.

28 Fed.R.Civ.P. 37(c)(1).

29 *Treff v. Galetka*, 74 F.3d 191, 195 (10th Cir.1996); *Ryan v. Shawnee Mission Unif. Sch. Dist. No. 512*, 438 F.Supp.2d 1233, 1236 (D.Kan.2006).

30 For example, in paragraph 4: "I have learned from staff at AHA" and "I believe the reduction in the size and function of the ICU is directly related to the termination of [his] staff privileges." In paragraph 5: "It is my belief ... that the decision to get rid of [plaintiff] was and continues to be economically destructive to the hospital" and "I have learned that ... the hospital census has been drastically reduced."

31 *In re Harris*, 209 B.R. 990, 996 (B.A.P. 10th Cir.1997) (quoting 11 James Wm. Moore, et al., *Moore's Federal Practice* §§ 56.10[4][c] [i], 56.14[2][c] (3d ed.1997)); *see also Toney v. Cuomo*, 92 F.Supp.2d 1186, 1196 (D.Kan.2000), *aff'd*, 221 F.3d 1353 (10th Cir.2000).

32 *See Fed.R.Evid.* 901(b).

33 In the future, the parties are encouraged to follow the local rules in this district on page limitations, as well as content of briefs, which encourages a *concise* statement of facts. D. Kan. R. 7.1, 7.6 (limiting the argument section of briefs and memoranda to thirty (30) pages if no prior leave of court requested and providing for content of briefs). Moreover, plaintiff's practice of controverting facts with general citations to exhibits, or a general reference to his statement of additional material facts, presents a cumbersome task for the Court in determining the truly uncontroverted material facts in this matter. Given that plaintiff submitted 116 paragraphs of additional facts (many of which are repetitive of facts already narrated by defendants), the Court should not be presumed to glean which statements or general references plaintiff contends specifically controvert the statements made by defendants. Plaintiff's counsel is strongly discouraged from this method of controverting factual statements and the Court declines to conduct a fishing expedition to uncover evidentiary support for plaintiff's contention that certain facts are controverted when not provided with a specific citation to the record. *See D. Kan. R.* 56.1(b).

34 42 U.S.C. § 2000d.

35 The parties agree that the December 19, 2002 Bylaws, attached to defendants' motion for summary judgment, govern this dispute.

36 (Doc. 164, Ex. 4A, Bylaws at 11 ¶ 2.)

37 Plaintiff was due for reappointment, however, in two years pursuant to the Bylaws.

38 (Doc. 163, Ex. 38 ¶ 16.)

39 (Def.Ex.7.)

40 Plaintiff requested a hearing in writing within thirty days of receipt of the February 18, 2003 letter, as provided by the Bylaws.

41 This particular fact was stipulated to in the Pretrial Order and will be deemed uncontroverted.

42 15 U.S.C. § 1.

43 42 U.S.C. § 1981(a).

44 Pub.L. 88-352, Title VI, § 601, 78 Stat. 252 (codified at 42 U.S.C. § 2000d). The parties have stipulated that AHA is the recipient of federal financial assistance within the meaning of Title VI.

45 *Alexander v. Sandoval*, 532 U.S. 275, 280 (2001).

46 *Id.*

47 *See, e.g., Shah v. Deaconess Hospital*, 355 F.3d 496 (6th Cir.2004) (applying the common law agency test to determine that plaintiff surgeon was an independent contractor of the hospital, in accord with the Fourth, Seventh, and Fifth Circuits); *McPherson v. HCA-HealthOne, LLC.*, 202 F.Supp.2d 1156, 1164-68 (D.Colo.2002) (collecting cases). *See generally Lambertsen v. Utah Dept. of Corr.*, 79 F.3d 1024, 1028-29 (10th Cir.1996) (discussing how to determine employer-employee relationship for purposes of anti-discrimination statutes).

48 411 U.S. 792 (1973).

49 Here plaintiff does not appear to argue that direct evidence of race discrimination is present, as he advocates the *McDonnell-Douglas* burden-shifting framework in the Pretrial Order. Yet, in his response, he maintains that certain comments made by "individuals associated with the Hospital," constitute direct evidence of discrimination. As the Court will discuss in more detail when it evaluates pretext, these stray comments are insufficient to support a claim of intentional discrimination.

50 450 U.S. 248 (1981); *see Antonio v. Sygma Network, Inc.*, — F.3d —, No. 05-1374, 2006 WL 2361633, at *2 (10th Cir. Aug. 16, 2006); *Maldonado v. City of Altus*, 433 F.3d 1294, 1307 (10th Cir.2006); *Black Educ. Network, Inc. v. AT & T Broadband, LLC*, 154 Fed. App'x 33, 44 (10th Cir.2005).

51 *See Burdine*, 450 U.S. at 252-53; *McDonnell Douglas Corp.*, 411 U.S. at 802.

52 *See McDonnell Douglas Corp.*, 411 U.S. at 802.

- 53 *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 143 (2000) (quoting *St. Mary's Honor Ctr. v. Hicks*, 509 U.S. 502, 511 (1993)).
- 54 *Burdine*, 450 U.S. at 253.
- 55 *PAS Commc'ns, Inc. v. Sprint Corp.*, 139 F.Supp.2d 1149, 1167 (D.Kan.2001) (collecting cases supporting use of *McDonnell Douglas* in a variety of Section 1981 cases).
- 56 *See, e.g., Patel v. Midland Memorial Hosp. & Med. Ctr.*, 298 F.3d 333, 341–344 (5th Cir.2002), *cert. denied*, 537 U.S. 1108 (2003); *Jeung v. McKrow*, 264 F.Supp.2d 557, 566–67 (E.D.Mich.2003); *Van v. Anderson*, 199 F.Supp.2d 550, 562–70 (N.D.Tex.2002), *aff'd*, 66 Fed. App'x 524 (5th Cir.2003).
- 57 247 F.3d 1091 (10th Cir.2001), *cert. denied*, 534 U.S. 1131 (2002). As the Court has already stated, it is uncontested that plaintiff is not an employee of AHA, nor any of the individual defendants. *See Bhatt v. Brownsville Gen. Hosp.*, No. 03–1578, 2006 WL 167955, at *17 n. 2 (W.D.Pa. Jan. 20, 2006) (explaining that the prima facie case for wrongful termination is inapplicable in a case where the physician is not an employee of the hospital).
- 58 *Hampton*, 247 F.3d at 1101; *see also Patel*, 298 F.3d at 341–44; *Pamintuan v. Nanticoke Memorial Hosp., Inc.*, No. 96–233–SLR, 1998 WL 743680 (D.Del.1998), *aff'd*, 192 F.3d 378 (3d Cir.1999). *But see Jeung*, 264 F.Supp.2d at 568 (applying a modified prima facie case).
- 59 *Hampton*, 247 F.3d. at 1104.
- 60 *Id.* at 1102.
- 61 The Court is unclear about why plaintiff insists that he need not prove he had “vested contract rights.” The Court evaluates this prong of the prima facie case as whether he had an enforceable contract interest, as the statute explicitly requires.
- 62 807 F.2d 1214 (5th Cir.1987).
- 63 *Id.* at 1219.
- 64 822 F.Supp. 1361 (N.D.Iowa 1992).
- 65 *Id.* at 1370–71.
- 66 *Tredrea v. Anesthesia & Analgesia, P. C.*, 584 N.W.2d 276, 285–87 (Iowa 1998).
- 67 16 F.Supp.2d 1181, 1186 (E.D.Cal.1998).
- 68 *Id.* at 1188.
- 69 *Dutta v. St. Francis Reg. Med. Ctr., Inc.*, 867 P.2d 1057, 1062 (Kan.1994).
- 70 *Id.* (discussing *Lewisburg Comm 'y Hosp. v. Alfredson*, 805 S.W.2d 756 (Tenn.1991)).
- 71 *See Janda*, 16 F.Supp.2d at 1184–85 (collecting cases); *Islami*, 822 F.Supp. at 1370 (same); *Rahimi v. St. Elizabeth Med. Ctr., Inc.*, No. C3–96–126, 1997 WL 33426269, at *5–7 (S.D.Ohio July 16, 1997); *Kessel v. Monongalia County Gen. Hosp.*, 600 S.E.2d 321, 326 (W.Va.2004); *Tredrea*, 584 N.W.2d at 285–87.
- 72 41 C.J.S. Hospitals § 16 (1991).
- 73 41 C.J.S. Hospitals § 27 (2006).
- 74 *See K.A.R.* 28–34–5a(b).
- 75 *See Kessel v. Monongalia County Gen. Hosp. Co.*, 600 S.E.2d 32, 326 (W.Va.2004); *Tredrea*, 584 N.W.2d at 285.
- 76 *Tredrea*, 584 N.W.2d at 287.
- 77 *K.A.R.* 28–34–5(a); *see Doc. 163, Ex. 4a at 29* (“The Governing Board of the Hospital shall have the ultimate authority in granting a practitioner clinical privileges and in all actions concerned with the exercise or limitation of the same.”).
- 78 *Mickelson v. New York Life Ins. Co.*, 460 F.3d 1304, 2006 WL 2468302, at *9 (10th Cir. Aug. 28, 2006) (quoting *Green v. New Mexico*, 420 F.3d 1189, 1192–93 (10th Cir.2005) (internal quotations omitted)).
- 79 *Plotke v. White*, 405 F.3d 1092, 1102 (10th Cir.2005) (quoting *Kendrick v. Penske Transp. Servs., Inc.*, 220 F.3d 1220, 1230 (10th Cir.2000)).
- 80 *Id.* (quoting *Fuentes v. Perskie*, 32 F.3d 759 764 (3d Cir.1994)).
- 81 He also references a statement by “a member of Hospital Management” who said that “Dr. Vesom should just go back where he came from.” Plaintiff makes no reference to who made this comment, when it was made, or which paragraph of factual assertions or declaration it comes from. The Court has searched the record as is unable to locate the source of this comment.
- 82 (Doc. 182, Vesom Depo. at 169, 174.)
- 83 *Heno v. Sprint/United Mgmt. Co.*, 208 F.3d 847, 856 (10th Cir.2000) (quoting *Simms v. Oklahoma*, 165 F.3d 1321, 1330 (10th Cir.1999)).
- 84 *Id.*; *see also Van v. Anderson*, 199 F.Supp.2d 550, 567 (N.D.Tex.2002), *aff'd*, 66 Fed. App'x 524 (5th Cir.2003) (explaining that stray remarks and threats were insufficient to establish direct evidence of discrimination); *Patel v. Midland Memorial Hosp. & Med. Ctr.*, 298 F.3d 333, 341–344 (5th Cir.2002), *cert. denied*, 537 U.S. 1108 (2003).

- 85 (Doc. 182, Rider Declaration II ¶ 4.)
- 86 (Doc. 182, Rider Declaration I at 2.)
- 87 *Patel*, 298 F.3d at 342 (emphasis in original).
- 88 *Kendrick v. Penske Transp. Servs., Inc.*, 220 F.3d 1220, 1232 (10th Cir.2000).
- 89 *Rivera v. City & County of Denver*, 365 F.3d 912, 922–23 (10th Cir.2004) (quoting *Aramburu v. Boeing Co.*, 112 F.3d 1398, 1404 (10th Cir.1997) (internal quotation marks omitted)).
- 90 Although not discussed in detail by the parties, this appears to be a separate complaint from the complaint regarding peer review of the maternal mortality after birth, which caused the KDHE to investigate in March 2003.
- 91 *Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 148, 120 S.Ct. 2097, 2109, 147 L.Ed.2d 105 (2000).
- 92 *Tilton v. Richardson*, 6 F.3d 683, 686 (10th Cir.1993).
- 93 *Id.* (quoting *Griffin v. Breckenridge*, 403 U.S. 88, 102–03 (1971)) (citations omitted).
- 94 15 U.S.C. § 1.
- 95 *Diaz v. Parley*, 215 F.3d 1175, 1182 (10th Cir.2000) (citing *N.J. Wholesale Stationers, Inc. v. Pac. Stationary & Printing Co.*, 472 U.S. 284, 289 (1985)).
- 96 *Systemcare, Inc. v. Wang Labs. Corp.*, 117 F.3d 1137, 1139 (10th Cir.1997) (overruling *McKenzie v. Mercy Hospital*, 854 F.2d 365 (10th Cir.1988)).
- 97 *Columbia v. Arden Health Servs., L.L.C.*, 448 F.Supp.2d 1253, 2006 WL 2441942, at *6 (N.D.Okla. Aug. 9, 2006) (collecting cases).
- 98 *Diaz*, 215 F.3d at 1182.
- 99 *Columbia*, 2006 WL 2441942, at *6.
- 100 Based on Dr. Rider's declaration, he did not join in this activity.
- 101 *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 639–40 (3d Cir.1996) (quoting *Okamen v. Page Memorial Hosp.*, 945 F.2d 696, 706 (4th Cir.1991)); see *Todorov v. DCH Healthcare Authority*, 921 F.2d 1438, 1459 (11th Cir.1991).
- 102 *Mathews*, 87 F.3d at 640 (explaining that there must be evidence that excludes the possibility of independent action by the Board).
- 103 *Id.* at 641 (quoting *Tunis Bros. Co. v. Ford Motor Co.*, 952 F.2d 715, 728 (3d Cir.1991)).
- 104 *Sanjuan v. Am. Bd. of Psychiatry & Neurology, Inc.*, 40 F.3d 247, 251 (7th Cir.1994), cert. denied, 516 U.S. 1159 (1996).
- 105 28 U.S.C. § 1367(c)(3).
- 106 *City of Chicago v. Int'l Coll. of Surgeons*, 522 U.S. 156, 172–73 (1997); see *Anglemeyer v. Hamilton County Hosp.*, 58 F.3d 533, 541 (10th Cir.1995).
- 107 *City of Chicago*, 522 U.S. at 173 (quoting *Carnegie–Mellon University v. Cohill*, 484 U.S. 343, 350 (1988)); see also *Gold v. Local 7 United Food & Commercial Workers Union*, 159 F.3d 1307, 1310 (10th Cir.1998), overruled on other grounds by *Spyskal v. Weld County Commr's*, 365 F.3d 855 (10th Cir.2004).
- 108 *Ball v. Renner*, 54 F.3d 664, 669 (10th Cir.1995) (collecting cases); see also *Roe v. Cheyenne Mountain Conference Resort, Inc.*, 124 F.3d 1221, 1237 (10th Cir.1997).
- 109 *Ball*, 54 F.3d at 669.
- 110 *Thatcher Enters. v. Cache County Corp.*, 902 F.2d 1472, 1478 (10th Cir.1990).
- 111 The parties do not contest that Kansas law controls the State law claims in this matter.
- 112 *Zinn v. McKinn*, 949 F.Supp. 1530, 1536–37 (D.Kan.1996), *aff'd*, 143 F.3d 1353 (10th Cir.1998).
- 113 *Id.* at 1536 (citing *Moyer v. Allen Freight Lines, Inc.*, 885 P.2d 391 (Kan.Ct.App.1995)).
- 114 *Palmer v. Brown*, 752 P.2d 685, 690 (Kan.1988).
- 115 *Zinn*, 949 F.Supp. at 1537.
- 116 *Id.*
- 117 *Id.* (citing *Oregon v. BP, Inc.*, 874 P.2d 1188 (1994)).
- 118 See also *supra* note 44.
- 119 255 F.Supp.2d 1217, 1236–37 (D.Kan.2003).
- 120 *Id.* (collecting cases).
- 121 *Zinn*, 949 F.Supp. at 1538.
- 122 See, e.g., *McPherson v. HCA–HealthOne, LLC*, 202 F.Supp.2d 1156, 1164–68 (D.Colo.2002) (considering but rejecting the medical staff physician plaintiffs' arguments about why he should be considered an employee of the hospital).
- 123 (Doc. 181 at 22 ¶ 24, citing *Vesom II* ¶ 2.)

- 124 The Court notes, however, that plaintiff's reliance on *Wabaunsee County v. Umbehr* is misplaced. 518 U.S. 668 (1996). That case dealt with distinguishing between employees and independent contractors with regard to First Amendment free speech rights. Certainly, plaintiff must concede that he is advancing a state law claim here that is not constitutional in nature.
- 125 *E.g., Turner v. Halliburton Co.*, 722 P.2d 1106, 1115 (Kan.1986).
- 126 *L & M Enters., Inc. v. BEI Sensors & Sys. Co.*, 231 F.3d 1284, 1288 (10th Cir.2000).
- 127 *See Van v. Anderson*, 199 F.Supp.2d 550, 565 (N.D.Tex.2002) (finding no tortious interference with patient contracts where plaintiff admitted in deposition that he continued to admit patients to the hospital after receipt of notice of committee recommendation and that plaintiff did not have exclusive arrangements with patients), *aff'd*, 66 Fed. App'x 524 (5th Cir.2003).
- 128 *White v. Gen. Motors Corp.*, 908 F.2d 669, 672 (10th Cir.1990), *cert. denied*, 498 U.S. 1069 (1991).
- 129 *See, e.g., Alexander v. Gardner-Denver Co.*, 415 U.S. 36, 51-52 (1974). However, the Court made clear in *Alexander*, that an employee may waive a cause of action under Title VII as part of a voluntary settlement agreement, so long as the employee's consent to the agreement was knowing and voluntary. *Id.* at 52 n. 15.
- 130 *See, e.g., Cobb v. Corbett*, 95 P.3d 1028, 1030 (Kan.Ct.App.2004).
- 131 *Dorner v. Polsinelli, White, Vardeman, & Shalton, P.C.*, 856 F.Supp. 1483, 1487 (D.Kan.1994).
- 132 *Marquis v. State Farm Fire & Cas. Co.*, 961 P.2d 1213, 1219 (Kan.1998) (citing *Simon v. Nat'l Farmers Org., Inc.*, 829 P.2d 884 (1992)).
- 133 (Doc. 164, Ex. 7 (emphasis added)).
- 134 *Am. Registry of Radiologic Technologists v. McClellan*, No. 300CV2577K, 2003 WL 22171702, at *2 (N.D.Tex. Mar. 5, 2003) (approving language in a certification application that releases all claims arising out of the application); *see Wright v. Southwestern Bell Tele. Co.*, 925 F.2d 1288, 1292-93 (10th Cir.1991); *Bohne v. Closings of Tulsa, L.L.C.*, No. 05-0197-TCK-SAJ, 2006 WL 966517, at *4 n. 2 (N.D.Okla. Apr. 12, 2006).
- 135 *See Bohne*, 2006 WL 966517, at *4-5 (waiving "any known or unknown claim"); *Rodriguez v. Wackenhut Corp.*, No. 00-0264, 2000 WL 825677, at *2 (E.D. La. June 23, 2000) (waiving claims plaintiff "now has or may have in the future"). In this case, "current claims" is somewhat of a misnomer, as the release only applies to future conduct, i.e., in the event reappointment is denied.
- 136 *Torrez v. Pub. Serv. Co. of N.M., Inc.*, 908 F.2d 687, 689 (10th Cir.1990); *see also Stafford v. Crane*, 382 F.3d 1175, 1180 (10th Cir.2004); *Reed v. Nellcor Puritan Bennett*, 244 F.Supp.2d 1205, 1210-12 (D.Kan.2003); *Mazzoni Farms, Inc. v. E.I. DuPont De Nemours & Co.*, 761 So.2d 306, 313 (Fla.2000) (applying Kansas law). Likewise, there is no prohibition under Kansas law or in the Tenth Circuit of waivers of intentional torts. *See, e.g., Bennett v. Coors Brewing Co.*, 189 F.3d 1221, 1232-33 (10th Cir.1999) (concluding scope of release included ADEA and intentional tort claims).
- 137 *Torrez*, 908 F.2d at 689.
- 138 *Id.* at 689-90 (quoting *Cirillo v. Arco Chem. Co.*, 862 F.2d 448, 451 (3d Cir.1988)).

499 Fed.Appx. 928

This case was not selected for publication in the Federal Reporter. Not for Publication in West's Federal Reporter.

See Fed. Rule of Appellate Procedure 32.1 generally governing citation of judicial decisions issued on or after Jan. 1, 2007. See also Eleventh Circuit Rules 36-2, 36-3. (Find CTA11 Rule 36-2 and Find CTA11 Rule 36-3) United States Court of Appeals, Eleventh Circuit.

Reginald WILLIAMS, M.D., Nicole Williams, Plaintiffs–Appellants,

v.

COLUMBUS REGIONAL HEALTHCARE SYSTEMS, INC., Doctors Hospital, Medical Center, et al., Defendants–Appellees.

No. 12–11122 | Non–Argument
Calendar. | Dec. 3, 2012.

Synopsis

Background: African–American physician, whose medical staff privileges at hospital were suspended, brought § 1981 action against healthcare corporation and various individuals alleging that they intentionally interfered with his right to the full and equal benefit of the laws and his right to contract with third parties on the basis of his race. The United States District Court for the Middle District of Georgia, 2012 WL 315482, dismissed the complaint for failure to state a claim. Physician appealed.

Holdings: The Court of Appeals held that:

[1] physician did not have a protected property interest in continuing to practice medicine, as required to state § 1981 claim based on suspension of medical staff privileges, and

[2] suspension of medical staff privileges did not implicate any contractual relationship, so as to create a cognizable claim under § 1981.

Affirmed.

West Headnotes (2)

[1] **Civil Rights**

↔ Contracts, trade, and commercial activity

African-American physician did not have a protected property interest in continuing to practice medicine, as required to state § 1981 claim based on suspension of medical staff privileges. 42 U.S.C.A. § 1981.

[2] **Civil Rights**

↔ Contracts, trade, and commercial activity

Suspension of African-American physician's medical staff privileges at hospital did not implicate any contractual relationship, so as to create cognizable claim under § 1981. 42 U.S.C.A. § 1981.

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Appeal from the United States District Court for the Middle District of Georgia. D.C. Docket No. 4:11–cv–00028–CDL.

Before CARNES, WILSON and BLACK, Circuit Judges.

Opinion

PER CURIAM:

Reginald Williams, an African–American male, appeals the district court's dismissal of his 42 U.S.C. § 1981 complaint

for failure to state a claim. In his complaint, Williams alleged that Columbus Regional Healthcare Systems, Inc., Howard Weldon, Andrew Morley, Scott Hannay, and John Does A–J (collectively, Appellees) intentionally interfered with his right to the full and equal benefit of the laws and his right to contract with third parties on the basis of his race. After review,¹ we affirm the district court.

“To state a claim for non-employment discrimination under § 1981, a plaintiff must allege (1) he is a member of a racial minority, (2) the defendant intended to racially discriminate against him, and (3) the discrimination concerned one or more of the activities enumerated in the statute.” *Jimenez v. WellStar Health System*, 596 F.3d 1304, 1308 (11th Cir.2010). The rights enumerated in the statute include the right to the full and equal benefit of all laws and proceedings for the security of persons and property as is enjoyed by white citizens, and the right to make and enforce contracts. 42 U.S.C. § 1981(a).

[1] Williams contends the Appellees interfered with his equal enjoyment of the laws and proceedings afforded by the hospitals' *930 bylaws in depriving him of his medical staff privileges. However, we have previously held the suspension of medical staff privileges cannot be challenged in a § 1981 claim because under Georgia law, medical staff bylaws do not create a contractual right to the continuation of those privileges, and physicians do not have a broad property

interest in continuing to practice medicine. *Jimenez*, 596 F.3d at 1309–11. Thus, Williams' argument is foreclosed by our holding in *Jimenez*, and he cannot allege a § 1981 violation because he has not identified a protected liberty or property interest with which the Appellees interfered.

[2] Additionally, we have previously held that alleging suspension of medical staff privileges does not implicate any contractual relationship, and cannot be the basis of a § 1981 discrimination claim. *Id.* at 1310. Thus, Williams' claims of interference with his right to contract all fail because they are predicated on the suspension or revocation of his medical staff privileges. Because he has no protected contractual interest in the continuation of his hospital staff privileges, he has no cognizable claim that Weldon interfered with his contract with the hospitals at which he worked. Similarly, he cannot raise a claim that the Appellees interfered with his patient contracts because the Appellees' only action affecting those contracts was the limitation of his medical staff privileges. Finally, he cannot raise a claim of interference with future employment contracts because such contracts are too speculative. *See id.*

AFFIRMED.

Parallel Citations

2012 WL 6013196 (C.A.11 (Ga.))

Footnotes

¹ We review *de novo* a district court's grant of a motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) for failure to state a claim. *Hill v. White*, 321 F.3d 1334, 1335 (11th Cir.2003). We accept the allegations in the complaint as true, and construe them in the light most favorable to the plaintiff. *Id.*

No. 86177-3

Appeal from Benton County Cause No. 08-2-01534-1

SUPREME COURT OF THE STATE OF WASHINGTON

VENKATARAMAN SAMBASIVAN, an individual,

Appellant/Cross-Respondent,

v.

KADLEC MEDICAL CENTER, a corporation,

Respondent/Cross-Appellant.

BRIEF OF RESPONDENT/CROSS-APPELLANT
KADLEC MEDICAL CENTER

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issue,¹³ however, because even if the contractual nature of the Bylaws is assumed for purposes of analyzing his breach of contract claim, the claim still fails as Sambasivan presented no evidence that Kadlec breached any Bylaw provision when it adopted the proficiency standard.¹⁴

Sambasivan argues he was not afforded a hearing following the MEC's vote to recommend restricting his privileges on August 7, 2008 (CP 383, 434), a recommendation that was not ultimately adopted by the Board when it decided, seven days later, to adopt the proficiency threshold with immediate effect, rendering moot any restriction on interventional cardiology privileges for which Sambasivan was no longer eligible. As the trial court observed: "it is uncontested that the [MEC] recommendation was not acted upon by the board, and Plaintiff's privileges were not lost, reduced or restricted due to the [MEC's] recommendation."¹⁵ (CP 871) Rather, he became ineligible for the privileges because he had not performed the requisite number of procedures in the previous two years. "Therefore," the court concluded, "Plaintiff could show no causal relationship between any damage suffered and the [MEC's]

¹³ Should this Court decide to reach the issue of whether hospital medical staff bylaws create an enforceable contract, Kadlec maintains they do not. *See* Kadlec's trial court briefing at CP 109-111 and CP 688.

¹⁴ The trial court assumed, but did not decide, that the Bylaws create a contract between Kadlec and Sambasivan, and concluded that Sambasivan failed to raise a material fact issue that any breach occurred. (CP 871)

¹⁵ *Id.*

v. McDonnell Douglas Corp., 91 Wn.2d 345, 349, 588 P.2d 1346 (1979).

All evidence must be considered in the light most favorable to the nonmoving party, and summary judgment may be granted only where there is but one conclusion that could be reached by a reasonable person.

Id. at 349–50.

B. The Trial Court Appropriately Dismissed Sambasivan's Breach of Express Contract Claim for Failure To Establish a Breach.

Although Sambasivan's breach of express contract claim initially concerned three events—two “collegial interventions” where he voluntarily relinquished his privileges in 2005 and 2006–2007, and the August 14, 2008 decision of the Board to adopt an interventional cardiology proficiency threshold—his appeal concerns solely the third event, *i.e.*, the Board's adoption of the proficiency standard.¹² As an initial matter, Sambasivan inexplicably devotes considerable attention to his argument that hospital bylaws create a binding contract between the hospital and a physician medical staff member. This Court need not reach that novel

¹² The trial court dismissed his breach of contract and tortious interference claims relative to the two earlier collegial interventions as being time-barred under the one-year statute of limitations in Washington's peer review law, RCW 7.71.030(4). (CP 870) Sambasivan's assignments of error do not include the statute of limitations dismissal of these claims.

No. 86177-3

SUPREME COURT OF THE STATE OF WASHINGTON

VENKATARAMAN SAMBASIVAN,
an individual,

Appellant,

vs.

KADLEC MEDICAL CENTER, a
corporation,

Respondent.

BRIEF OF APPELLANT

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the medical staff bylaws purport to protect staff physicians against. The trial court should be reversed.

VI. WHERE, AS HERE, DR. SAMBASIVAN HAS SHOWN THAT KADLEC'S INTENTIONAL CONDUCT INTERFERED WITH HIS ABILITY TO RETAIN AND ATTRACT PATIENTS WHO WOULD CONTRACT WITH HIM FOR MEDICAL SERVICES, HIS TORT CLAIM FOR INTERFERENCE WITH BUSINESS EXPECTANCIES SHOULD NOT BE SUMMARILY DISMISSED.

As shown by the plaintiff's declaration, all elements of the intentional tort of interference with business expectancies have been met. (CP 556) The seminal case of Cherberg v. Peoples Nat'l Bank, 88 Wn. 2d 595,602, 564 P. 2d 1137 (1977) sets forth the elements of this tort: (1) a valid business expectancy; (2) knowledge of the expectancy on the part of the defendant; (3) intentional interference causing a breach or termination of that expectancy; (4) resulting damage. By its groundless and intentional action stripping Dr. Sambasivan of his privileges to practice interventional cardiology, Kadlec, with full knowledge, interfered with Dr. Sambasivan's ability to provide services of interventional

cardiology to future patients. (CP 556) Dr. Sambasivan was damaged. (CP 558-559)

The economic loss rule has no place in this case. The economic loss rule marks a boundary between the law of contracts and the law of negligence. The economic loss rule does not apply where, as here, Dr. Sambasivan's tort claim involves breach of a duty owed by Kadlec that is independent of Dr. Sambasivan's contract claim. Eastwood v. Horse Harbor Foundation, Inc., 170 Wn. 2d 380, 387-388, 241 P. 3d 1256 (2010). The trial court should be reversed.

VII. WHERE, AS HERE, DR. SAMBASIVAN HAS SHOWN, AT LEAST INFERENTIALLY, THAT THE KADLEC BOARD'S ACTION AGAINST HIM WAS CAUSED BY HIS SUIT FOR UNLAWFUL DISCRIMINATION, HIS RETALIATION CLAIM SHOULD NOT BE SUMMARILY DISMISSED.

Dr. Sambasivan, as a person of color and of Indian origin, is protected against retaliation arising from his June, 2008, unlawful discrimination claim. The sources of this protection are found in federal and state statutes. Retaliation claims are cognizable under the federal civil rights act codified as 42 USC 1981. CBOCS West, Inc. v.

Humphries, 553 U.S. 442, 170 L. Ed 2d 864, 128 S. Ct. 1951 (2008). Claims of retaliation are cognizable under Washington State Law, RCW 49.60.210. All these sources of protection apply to Dr. Sambasivan because he is a "person." That Dr. Sambasivan is not a statutory employee of Kadlec matters not. The Washington Law Against Discrimination is not limited to discrimination in the employment setting. Its purpose is to make persons free of improper discrimination in a broad way. Marquis v. Spokane, 130 Wn. 2d 97, 112, 922 P. 2d 43

(1996) Finally, the Kadlec medical staff bylaws Section 1.4 expressly prohibit discrimination of the type alleged by Dr. Sambasivan. (CP 388)

To prove his retaliation claim, Dr. Sambasivan must show that: (1) he engaged in protected activity; (2) Kadlec acted adversely against him; and (3) his protected activity was a substantial factor behind Kadlec's adverse action. Employment discharge cases are analogous to Dr. Sambasivan's case. Stripping clinical privileges from a staff physician is like firing an employee. "Retaliatory motive need not be the principal reason for the discharge." Vasquez v. State, 94 Wn. App. 976, 984-85, 974 P.

2d 348 (1999). The principle recognized in Vasquez concerning causation should be applied here.

That the first and second elements of Dr. Sambasivan's retaliation claim have been established is beyond dispute. As stated in Dr. Sambasivan's declaration (CP 553-554), and as confirmed by findings at trial (CP 881), Dr. Sambasivan had good grounds for the unlawful discrimination suit that he filed in June, 2008. (CP 3,8) By filing suit against Kadlec for unlawful discrimination, Dr. Sambasivan engaged in protected activity. Thus, the first element of his retaliation claim is proved.

Proof of the second element of Dr. Sambasivan's retaliation claim is uncomplicated. On the agenda of the Kadlec board meeting of August 14, 2008, were two recommendations of the Medical Executive Committee. The first recommendation, with respect to which Dr. Sambasivan had a right to a hearing which was never allowed, was to take away Dr. Sambasivan's privileges to perform acute and emergent interventions. (CP 449) The second recommendation was to phase in a credentialing requirement that increased the number of

procedures that must be performed annually to maintain privileges as an interventional cardiologist. (CP 449) The Kadlec board did not accept these recommendations. The Kadlec board did not return these recommendations to the Medical Executive Committee with questions or for further study. Instead, the Kadlec board revised these recommendations on its own, without further medical advice, and without foundation in practice, national standards or medical science. (CP 449-450, 550-551, 591-592) The recrafted recommendations constituted a direct attack on Dr. Sambasivan, and caused a total loss of all his privileges to practice interventional cardiology. (CP 550) Adverse action equivalent to discharge in an employment setting has been shown.

The adverse action by the Kadlec board against Dr. Sambasivan was caused by his unlawful discrimination suit. At a minimum, it must be inferred that "retaliation was a substantial factor behind" the adverse action. Vasquez, 94 Wn. App. at 984. The Kadlec board radically revised recommendations by the Medical Executive Committee after it was advised of Dr. Sambasivan's

unlawful discrimination suit. In fact, the Kadlec board was told of Dr. Sambasivan's unlawful discrimination suit in the same meeting in which it stripped Dr. Sambasivan of his privileges to practice interventional cardiology. (CP 448,344)

Retaliatory intent should be inferred where, as here, the adverse action closely followed the defendant's awareness of the protected activity.

Moreover, we have held that evidence based on timing can be sufficient to let the issue go to the jury, even in the face of alternative reasons proffered by the defendant. Miller v. Fairchild Industries, Inc., 885 F. 2d 498,505 (9th Cir. 1989)

In the analogous employment setting, a retaliation suit may not be dismissed if it is shown that an employee participated in protected activity, the employer knew of that activity and adverse action was taken against the employee. Kahn v. Salerno, 90 Wn. App. 110,131, 951 P. 2d 321 (1998).

Summary judgment is disfavored in cases involving inherently factual questions of intent and motivation. Lowe v. City of Monrovia, 775 F. 2d 998,1009 (9th Cir. 1985), amended, 784 F. 2d 1407 (9th Cir. 1986). This Court should follow the logic of disparate treatment cases,

and hold that the question of the true motivation behind an allegedly discriminatory act is a "pure question of fact." Pullman-Standard v. Swint, 456 U.S. 273,287-88, 72 L. Ed. 2d 66 102 S. Ct. 1781 (1982). More specifically, a plaintiff like Dr. Sambasivan in a retaliation case should be allowed to show pretext by relying on his initial evidence of a prima facie case, any other evidence, as well as effective cross-examination. Miller v. Fairchild Industries, Inc., 885 F. 2d 498,505, n. 8 (9th Cir. 1989), citing Texas Department of Community Affairs v. Burdine, 450 U.S. 248,255, n. 10, 67 L. Ed. 2d 207, 101 S. Ct. 1089 (1981).

Much of the evidence concerning Kadlec's defense of Dr. Sambasivan's retaliation claim depends on the intent and motivation of the members of the Kadlec board who attended the meeting of August 14, 2008, and there took action against Dr. Sambasivan. Knowledge of what occurred at that meeting is particularly within the minds of those witnesses. In this setting, the rule articulated by Judge Sweeney in Estate of Black, 116 Wn. App. 476,487, 66 P. 3d 670 (2003), affirmed on other grounds, 153

Wn. 2d 152 (2004) should apply:

And this was proper in light of the general rule that, where material facts averred in an affidavit are particularly within the knowledge of the moving party, summary judgment should be denied. The matter should proceed to trial so that the opponent may attempt to disprove the alleged facts by cross-examination and by the demeanor of the witnesses while testifying. Mich. Nat'l Bank v. Olson, 22 Wn. App. 898, 905 723 P.2d 438 (1986); Balise v. Underwood, 62 Wn. 2d 195, 199-200, 381 P. 2d 966 (1963). This exception to the summary judgment rules is not limited just to the moving party herself, but to her witnesses also.²

²This is the federal practice also. See, e.g., United States v. Logan Co., 147 F. Supp. 330, 333 (W.D. Pa. 1957); Frederick Hart & Co. v. Recordgraph Corp., 169 F.2d 580, 581 (3d Cir. 1948).

The manner in which Kadlec has attempted to explain its motives in stripping Dr. Sambasivan of clinical privileges depends on witnesses with particularized knowledge. That knowledge is little other than a state of mind. Knowledge of this sort is inherently not beyond dispute. Cross-examination should be allowed. A properly constituted trier of fact should evaluate the assertions made by these witnesses. Therefore, summary judgment should be denied. The trial court should be reversed.

BEFORE HON. ROBERT G. SWISHER

JOSIE DELVIN
BENTON COUNTY CLERK

MAR 04 2010

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SUPERIOR COURT OF WASHINGTON FOR BENTON COUNTY

VENKATARAMAN SAMBASIVAN,

Plaintiff,

vs.

KADLEC MEDICAL CENTER, a corporation,

Defendant.

NO. 08-2-01534-1

**DEFENDANT'S MOTION FOR
PARTIAL SUMMARY JUDG-
MENT AND MEMORANDUM IN
SUPPORT (RETALIATION)**

**(ARGUMENT WILL EXCEED 10
MINUTES)**

COMES NOW Defendant Kadlec Regional Medical Center (f/k/a Kadlec Medical Center) ("Defendant" or "Kadlec") and moves this Court to award partial summary judgment to it, dismissing Plaintiff's claim for retaliation under federal and state law. Plaintiff's retaliation claims are subject to dismissal because he cannot establish a prima facie case for retaliation under either federal or state law, and even if he could, he is unable to produce sufficient evidence to rebut the legitimate, non-retaliatory reasons for the action about which he complains. Kadlec submits the following memorandum in support of its motion.

INTRODUCTION

Plaintiff Venkataraman Sambasivan, M.D. is a cardiologist with a solo medical practice located in Kennewick, Washington. He has been a member of the medical staff of Kadlec since 1994 which permits him to see his patients when they are hospitalized at Kadlec

**DEFENDANT'S MOTION FOR PARTIAL
SUMMARY JUDGMENT AND MEMORANDUM IN
SUPPORT (RETALIATION) - Page 1**

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1 If a non-moving party lacks competent evidence to support an essential element of its
2 case, the moving party is entitled to summary judgment because a failure of proof concerning
3 an element necessarily renders all other facts immaterial. *Boyce v. West*, 71 Wn. App. 657,
4 665, 862 P.2d 592 (1993); *see also Aldi Tire, Inc. v. State Farm Mut. Fire & Auto Ins. Co.*, 78
5 Wn. App. 902, 906, 902 P.2d 166 (1995) (“A defendant may move for summary judgment by
6 either (1) pointing out the absence of competent evidence to support the plaintiff’s case or
7 (2) establishing through affidavits that no genuine issue of material fact exists.”). Dr.
8 Sambasivan has the burden to prove each of his allegations by a preponderance of the
9 evidence. He “may not rest upon the mere allegations or denials of [its] pleading,” but
10 instead, “by affidavits or as otherwise provided in [CR 56], must set forth specific facts
11 showing that there is a genuine issue for trial.” *Grimwood v. Univ. of Puget Sound*, 110
12 Wn.2d 355, 359, 753 P.2d 517 (1991).

13 **II. DR. SAMBASIVAN CANNOT ESTABLISH A PRIMA FACIE CASE OF § 1981**
14 **RETALIATION, NOR CAN HE REBUT THE BOARD’S LEGITIMATE**
15 **REASONS FOR ADOPTING THE PROFICIENCY THRESHOLD.**

16 Both Title VII and 42 U.S.C. § 1981 prohibit an employer from retaliating against an
17 employee because he has opposed perceived race discrimination.² Section 1981 provides that:
18 “[a]ll persons . . . shall have the same right . . . to make and enforce contracts . . . as enjoyed
19 by white citizens.” The statute defines the phrase “to make and enforce contracts” as
20 including “the making, performance, modification, and termination of contracts, and the
21 enjoyment of all benefits, privileges, terms, and conditions of the contractual relationship.”
22 42 U.S.C. § 1981(b). Thus, as a threshold matter, Dr. Sambasivan’s retaliation claim must
23 concern the “making and enforcing” of a contract. As discussed below (and in Kadlec’s
24 Motion for Partial Summary Judgment for its breach of contract claim), medical staff bylaws
25 do not constitute a contract or an agreement that gives rise to a claim under § 1981, and in any
26 event Dr. Sambasivan remains a member of the Kadlec Medical Staff.

² *See CROCS W., Inc. v. Humphries*, ___ U.S. ___, 128 S.Ct. 1951 (2008).

1 Assuming a contract existed, to establish a prima facie case of retaliation under
2 § 1981, Dr. Sambasivan must prove "(1) [he] was engaged in protected activity; (2) [he]
3 suffered an adverse employment action; and (3) there was a causal connection between the
4 two." *Surrell v. California Water Serv. Co.*, 518 F.3d 1097, 1108 (9th Cir. 2008). "Once
5 established, the burden shifts to the defendant to set forth a legitimate, non-retaliatory reason
6 for its actions; at that point, the plaintiff must produce evidence to show that the stated reasons
7 were a pretext for retaliation." *Id.*

8 At all times, the "burden of proof remain[s] on [the plaintiff] to create a genuine issue
9 of material fact as to whether" the action complained of was retaliatory. *See Johnson v.*
10 *Spohn*, 334 Fed. Appx. 673, 685 (5th Cir. 2009).

11 As discussed below, Dr. Sambasivan has no competent evidence to establish a prima
12 facie case of retaliation, much less any evidence to overcome the legitimate reasons for the
13 Board's action on August 14, 2008. He has no witnesses with personal knowledge of the
14 events nor can he put forth anything beyond rank speculation and inference, which is itself
15 unqualifiedly rejected by the sworn testimony of the participants in the action.

16 **A. Dr. Sambasivan Cannot Meet His Burden to Establish a Prima Facie Case of**
17 **Retaliation.**

18 Dr. Sambasivan's retaliation claim must first concern the "making and enforcing" of a
19 contract. Dr. Sambasivan's complaint does not, however, identify the contractual
20 underpinning for a § 1981 claim. As there can be no dispute that Dr. Sambasivan has not been
21 an employee of Kadlec,³ presumably he relies on the Kadlec medical staff bylaws to provide
22 the requisite "employment" nexus for a § 1981 claim (just as he presumes the bylaws
23 constitute a binding contract for purposes of his breach of contract claim). Courts that have
24 considered this issue, however, have refused to find that medical staff bylaws confer
25 contractual rights on a physician that give rise to a § 1981 claim. Most recently, the Eleventh

26 ³ See accompanying Declaration of Rand Wortman, Kadlec's Chief Executive Officer, at ¶ 8.

1 Circuit ruled in February that the suspension of a physician's medical staff privileges could
2 not provide a basis for his § 1981 claim, because "the medical staff bylaws, which govern
3 medical staff privileges, do not create a contractual right to the continuation of those
4 privileges." *Jimenez v. Wellstar Health Sys.*, 2010 WL 550827, 2, -- F.3d -- (11th Cir. Feb. 18,
5 2010) (copy attached as **Exhibit 1**).

6 Similarly, in *Johnson v. Spohn*, 334 Fed. Appx. 673, 685 (5th Cir. 2009) (copy attached
7 as **Exhibit 2**), the Fifth Circuit held that a non-employed physician did not establish a prima
8 facie case for discrimination under § 1981 by virtue of his membership on the hospital's
9 medical staff. The court affirmed the rulings of other courts that medical staff bylaws do not
10 constitute a binding contract between the hospital and members of the medical staff, because
11 the bylaws themselves are not binding on the hospital and its Board of Directors. *Id.* at 685.
12 The Court favorably cited *Van v. Anderson*, 199 F. Supp. 2d 550 (N.D. Tex. 2002), another
13 case involving a physician who asserted a § 1981 claim in connection with a peer review
14 action based solely on the physician's status as a member of the hospital's medical staff.
15 There, the court also found that the plaintiff's "Section 1981 claims . . . fail here since he has
16 not provided the court with any evidence to prove the existence of a contractual relationship . .
17 . based on being granted staff privileges or its adoption of the medical staff bylaws." *Id.* at
18 564.⁴

19 The same analysis applies here. Kadlec's medical staff bylaws are subject to the
20 ultimate authority of the Board, which must approve the bylaws. *See* Ex. 1 to Declaration of
21 Donna Zulauf, Amended and Restated Bylaws of Kadlec Medical Center at Art. XII.1 ("The
22 Bylaws of the Medical Staff shall at all times be subject to approval and/or change by the
23 Board of Directors."). The Board also has ultimately authority for decisions regarding
24 medical staff membership. *Id.* This issue is briefed in more detail in Kadlec's Memorandum
25

26 ⁴ *See also Madsen v. Audrain Health Care, Inc.*, 297 F.3d 694, 699 (8th Cir. 2002) ("hospital bylaws cannot be considered a contract under Missouri law because consideration is lacking").

1 in Support of Its Motion for Summary Judgment (Breach of Contract and Tortious
2 Interference), at pages 6-8.

3 To make a prima facie case for retaliation Dr. Sambasivan must also show that there is
4 a causal nexus between the allegedly retaliatory action (the Board's adoption of the
5 proficiency requirement) and his participation in the alleged protected activity. Here, there is
6 no dispute that the Board was aware of the existence of the lawsuit that he filed on June 23,
7 2008 that contained a discrimination claim. See Ex. 3 to Zulauf Decl. (Board Minutes of Aug.
8 14 meeting) at 1. The only evidence he identifies in support of a causal link between the
9 lawsuit and the Board's action, however, is the minutes of the August 14, 2008 meeting,
10 which state that Kadlec's CEO Rand Wortman reported that Dr. Sambasivan "has filed a
11 lawsuit against the hospital making various allegations including discrimination, breach of
12 implied contract and conspiracy." *Id.*

13 Dr. Sambasivan has and can provide no evidence, though, that the Board's decision
14 was motivated by the existence of his lawsuit or its specific allegations, rather than the many
15 other reasons articulated in the minutes for adopting the proficiency requirement. In his
16 deposition, Dr. Sambasivan admitted that he has no evidence of any retaliatory animus among
17 the Board members, other than the unadorned statement in the minutes regarding the existence
18 of his lawsuit, and the fact that the Board adopted the proficiency threshold effective
19 immediately, rather than phasing it in.⁵

20 Finally, Dr. Sambasivan cannot establish a prima facie case of retaliation because the
21 supposed "contract" he relies upon, the medical staff bylaws, remains in effect between
22 himself and Kadlec, and as such there was no action taken that interfered with the "making or
23 enforcing" of a contract. Dr. Sambasivan continued to be a member of the Kadlec Medical
24

25 ⁵ See Ex. 3 to Robbins Decl., Sambasivan Deposition trans. (Sept. 29, 2009) at 167:12-23 ("Q. Now, you
26 suggested that the hospital is somehow retaliating against you in its board of directors meeting of August 14,
2008; is that right? A. That's correct. Q. And what information do you have that would lead you to believe that
this was a retaliation against you? A. Well, it's clearly discussed in the lawsuit and they did not follow the
medical staff quality and Medical Executive Committee decision, and they made the decision on their own...").
LAW OFFICES

**DEFENDANT'S MOTION FOR PARTIAL
SUMMARY JUDGMENT AND MEMORANDUM IN
SUPPORT (RETALIATION) - Page 7**

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BEFORE HON. ROBERT G. SWISHER
JOSIE DELVIN
BENTON COUNTY CLERK

MAR 29 2010

FILED

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SUPERIOR COURT OF WASHINGTON FOR BENTON COUNTY

VENKATARAMAN SAMBASIVAN,

Plaintiff,

vs.

KADLEC MEDICAL CENTER, a corporation,

Defendant.

NO. 08-2-01534-1

**REPLY IN SUPPORT OF
DEFENDANT'S MOTION FOR
PARTIAL SUMMARY JUDG-
MENT (RETALIATION)**

INTRODUCTION

Dr. Sambasivan's opposition to Plaintiff's motion for summary judgment here is striking in that it fails to address or meet the legal standards for his state and federal retaliation claims, and fails to address most of the multiple bases upon which summary judgment should be granted. In fact, the only additional "evidence" identified in support of his claim is his own self-serving declaration, which itself consists almost entirely of inadmissible hearsay, legal conclusions, statements made without personal knowledge, and improper conclusions of ultimate fact. Ultimately, Dr. Sambasivan provides no basis to defeat Kadlec's motion, and summary judgment should be granted.

REPLY IN SUPPORT OF DEFENDANT'S MOTION
FOR PARTIAL SUMMARY JUDGMENT
(RETALIATION) - Page 1

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ARGUMENT

A. Dr. Sambasivan Has No Evidence To Establish the Requisite Contractual Relationship with Kadlec to Support a Federal and State Retaliation Claim.

Dr. Sambasivan offers no support for his apparent contention that his status as a Kadlec medical staff member somehow provides him with the requisite contractual relationship to assert a retaliation claim under federal law (42 U.S.C. § 1981) and Washington's Law Against Discrimination (RCW 49.60.210(1)). While he cites, with no analysis, *Marquis v. Spokane*, 130 Wn.2d 97, 922 P.2d 43 (1996), he does not state what "independent contractor" relationship for "personal services" Dr. Sambasivan has with Kadlec that would somehow make *Marquis* relevant to the analysis. Certainly, medical staff membership does not constitute such a relationship, as numerous courts have held. *See, e.g., Jimenez v. Wellstar Health Sys.*, -- F.3d --, 2010 WL 550827, *4 (Feb. 18, 2010) (dismissing physician's § 1981 retaliation claim because "the suspension of medical staff privileges does not implicate any rights protected by § 1981"). *See also* Kadlec's Motion for Partial Summary Judgment (Retaliation) at 5-7.

For that reason alone, Dr. Sambasivan's retaliation claims must be dismissed.

B. Dr. Sambasivan Has No Evidence of a Causal Link Between the Board's Action and His Filing of a Discrimination Claim.

Even if Dr. Sambasivan had a contractual basis to bring a federal or state retaliation claim, his claim fails because he has put forth no competent evidence of a causal link between the alleged retaliation (the board's August 14, 2008 action) and the protected activity (filing a lawsuit on June 23, 2008 that included a discrimination claim). The only evidence offered is the August 14, 2008 board minutes, which reflect that the board was informed that Dr. Sambasivan "has filed a lawsuit against the hospital making various allegations including discrimination, breach of implied contract and conspiracy." Plaintiff's Opp. at 18 (emphasis added)

**Case Law Summary: Do Medical Staff Bylaws Create a Binding Contract?
Compiled June 2013**

State	Key Case(s)
Medical Staff Bylaws Are Not Contractual (15 states)	
Georgia	<p>(1) <i>Williams v. Columbus Reg'l Healthcare Sys., Inc.</i>, 499 Fed. Appx. 928 (11th Cir. 2012), <i>cert. denied</i>, No. 12-1079, 2013 WL 799570 (U.S. May 13, 2013)</p> <p>(2) <i>Jimenez v. Wellstar Health System</i>, 596 F.3d 1304 (11th Cir. 2010)</p> <p>(3) <i>St. Mary's Hosp. of Athens, Inc. v. Radiology Prof'l Corp.</i>, 421 S.E. 2d 731, 736 (Ga. App. 1993)</p> <p>(4) <i>Robles v. Humana Hosp. Corp.</i>, 785 F. Supp. 989, 1001-02 & 1001 n.10 (N.D. Ga. 1992)</p> <p>(5) <i>Stein v. Tri-City Hospital Authority</i>, 384 S.E.2d 430, 432 (Ga. Ct. App. 1989)</p>
Iowa	<i>Tredrea v. Anesthesia & Analgesia, P.C.</i> , 584 N.W.2d 276, 284-87 (Iowa 1998)
Kansas (federal court deciding state law)	<p>(1) <i>Vesom v. Atchison Hosp. Assn.</i>, No. 04-2218-JAR, 2006 WL 2714265, at **16-17 (D. Kan. Sept. 22, 2006), <i>aff'd</i> 279 Fed. Appx. 624 (10th Cir. 2008)</p> <p>(2) <i>Hildyard v. Citizens Med. Ctr.</i>, 286 P.3d 239 (Kan. Ct. App. 2012) (unpublished decision)</p>
Kentucky	<i>Shure v. Ford</i> , No. 2011-CA-000144-MR, 2012 WL 1657133, at *8 (Ky. Ct. App. May 11, 2012)
Massachusetts (can sue to enforce procedural rights only)	<i>Birbiglia v. St. Vincent Hosp.</i> , 3 Mass. L. Rptr. 407, 1994 WL 878836, at *11 (Mass. Super. Ct. Dec. 29, 1994), <i>aff'd sub nom.</i> , 427 Mass. 80, 692 N.E.2d 9 (1998)
Michigan	<i>Brintley v. St. Mary Mercy Hosp.</i> , 904 F. Supp. 2d 699, No. 09-cv-14014, 2012 WL 5817237, at **15-16 (E.D. Mich. Nov. 16, 2012)
Minnesota	<i>Med. Staff of Avera Marshall Regional Med. Ctr. v. Avera Marshall</i> , No. 42-CV-12-69 (D. Minn. Sept. 25, 2012) (order on motions for summary judgment)

EXHIBIT A
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State	Key Case(s)
Mississippi	<i>Sullivan v. Baptist Mem'l Hosp. - Golden Triangle, Inc.</i> , 722 So. 2d 675, 680-81 (Miss. 1998)
Missouri	<p>(1) <i>Adem v. Jefferson Memorial Hospital Association</i>, No. 411-cv-2102-JAR, 2012 WL 5493856, at **4-5 (E.D. Mo. Nov. 13, 2012)</p> <p>(2) <i>Egan v. St. Anthony's Med. Ctr.</i>, 244 S.W. 3d 169, 174 (Mo. 2008)</p> <p>(3) <i>Madsen v. Audrain Health Care, Inc.</i>, 297 F.3d 694, 699 (8th Cir. 2002)</p> <p>(4) <i>Zipper v. Health Midwest</i>, 978 S.W. 2d 398, 417 (Mo. Ct. App. 1998)</p>
New York	<i>Mason v. Cent. Suffolk Hosp.</i> , 819 N.E.2d 2019 (NY 2004)
Ohio	<p>(1) <i>Wilkey v. McCullough-Hyde Mem'l Hosp.</i>, No. 1:04cv768, 2007 WL 3047234, at *10 (S.D. Ohio Oct. 18, 2007)</p> <p>(2) <i>Levy v. Clinton Mem'l Hosp.</i>, 2007 WL 4555196, at *8 (Ohio Ct. App. Dec. 28, 2007)</p> <p>(3) <i>Holt v. Good Samaritan Hosp. & Health Ctr.</i>, 590 N.E.2d 1318, 1321 (Ohio Ct. App. 1990)</p> <p>(4) <i>Munoz v. Flower Hosp.</i>, 507 N.E.2d 360, 365 (Ohio Ct. App. 1985)</p>
Oklahoma	<i>Thornton v. Holdenville Gen. Hosp.</i> , 2001 OK CIV APP 133, 36 P.3d 456, 462 (2001)
South Carolina	<i>Hein-Muniz v. Aiken Reg. Med. Ctrs.</i> , No. 1:10-cv-986-JFA, 2012 WL 5300691, at *10 (D.S.C. Oct. 25, 2012)
Texas	<p>(1) <i>Park v. Mem'l Hosp. Sys. of E. Texas</i>, 397 S.W.3d 283, No. 12-11-00257-CV, 2013 WL 811668, at *14 (Tex. Ct. App. Mar. 4, 2013)</p> <p>(2) <i>Marlin v. Robertson</i>, 307 S.W.3d 418, 434-35 (Tex. App. 2009)</p> <p>(3) <i>Johnson v. Spohn</i>, 334 Fed. Appx. 673, 685 (5th Cir. 2009)</p> <p>(4) <i>Van v. Anderson</i>, 199 F. Supp. 2d 550, 562-64 (N.D. Tex.</p>

State	Key Case(s)
	2002)
West Virginia	<p>(1) <i>Kessel v. Monongalia Cnty. Gen. Hosp. Co.</i>, 600 S.E.2d 321, 326 (W. Va. 2004)</p> <p>(2) <i>Mahmoodian v. United Hosp. Ctr., Inc.</i>, 404 S.E.2d 750, 755 (W. Va. 1991)</p> <p>(3) <i>Wahi v. Charleston Area Med. Ctr., Inc.</i>, 562 F.3d 599, 617 (4th Cir. 2009)</p>
Medical Staff Bylaws Are Contractual (expressly analyzing the issue) (15 states)	
Arizona	<i>Samaritan Health Sys. v. Superior Court</i> , 194 Ariz. 284, 288, 981 P.2d 584 (Ariz. Ct. App. 1998)
California (but only if the bylaws contain provisions that exceed the scope of state law requirements)	<p>(1) <i>Smith v. Adventist Health System/West</i>, 182 Cal. App. 4th 729, 753 (2010)</p> <p>(2) <i>O'Byrne v. Santa Monica-UCLA Med. Ctr.</i>, 94 Cal. App. 4th 797, 808 (2001)</p>
Connecticut	<p>(1) <i>Deutsch v. Backus Corp.</i>, No. CV 106004265, 2011 WL 522849, at *9 (Conn. Super. Ct. Jan. 14, 2011)</p> <p>(2) <i>Gianetti v. Norwalk Hosp.</i>, 557 A.2d 1249, 1252-55 (Conn. 1989)</p>
Florida	<i>Naples Cmty. Hosp., Inc. v. Hussey</i> , 918 So.2d 323 (Fla. D. Ct. App. 2005)
Illinois	<i>Lo v. Provena Covenant Med. Ctr.</i> , 256 Ill. App.3d 538, 543 (Ill. App. Ct. 2005)
Indiana	<p>(1) <i>W.S.K. v. M.H.S.B.</i>, 922 N.E.2d 671, 695 (Ind. Ct. App. 2010)</p> <p>(2) <i>Terre Haute Reg'l Hosp., Inc. v. El-Issa</i>, 470 N.E.2d 1371, 1377 (Ind. Ct. App. 1984)</p>
Louisiana	<i>Granger v. Christus Health Central Louisiana</i> , 97 So.3d 604, 638-39 (La. Ct. App. 2012)
Maryland	(1) <i>Strauss v. Peninsula Reg. Med. Ctr.</i> , 916 F. Supp. 528 (D. Md. 1996)

State	Key Case(s)
	(2) <i>Anne Arundel Gen. Hosp., Inc. v. O'Brien</i> , 432 A.2d 483, 488 (Md. Ct. Spec. App. 1981)
Nevada	<i>Williams v. Univ. Med. Ctr. of S. Nevada</i> , 688 F. Supp. 2d 1134, 1142 (D. Nev. 2010) (no state court decision)
New Mexico	<i>Osuagwu v. Gila Reg'l Med. Ctr.</i> , No. 11cv001 MV/SMV, 2013 WL 1491890, -- F.Supp.2d -- (D.N.M. Feb. 25, 2013)
North Carolina	<i>Virmani v. Presbyterian Health Servs. Corp.</i> , 488 S.E.2d 284, 287-88 (N.C. Ct. App. 1997)
Oregon	<i>Ford v. Cascade Health Services</i> , No. 03-6256-TC, 2006 WL 1805954 (D. Or. June 29, 2006) (no state court decision)
South Dakota	(1) <i>Schwaiger v. Avera Queen of Peace Health Servs.</i> , 714 N.W.2d 874, 882 (S.D. 2006) (2) <i>Mahan v. Avera St. Luke's</i> , 621 N.W.2d 150, 154 (S.D. 2001)
Tennessee	<i>Lewisburg Cmty. Hosp., Inc. v. Alfredson</i> , 805 S.W.2d 756, 759 (Tenn. 1991)
Wisconsin	<i>Bass v. Ambrosius</i> , 520 N.W.2d 625, 627-29 (Wis. Ct. App. 1994)
Medical Staff Bylaws Are Contractual (with little or no analysis of issue) (7 jurisdictions)	
Alabama	<i>Radiation Therapy Oncology, P.C. v. Providence Hosp.</i> , 906 So.2d 904 (Ala. 2005)
Alaska	(1) <i>Eidelson v. Archer</i> , 645 P.2d 171, 178-79 (Alaska 1982) (2) <i>McMillan v. Anchorage Community Hosp.</i> , 646 P.2d 857, 862 (Alaska 1982)
Arkansas	<i>Lubin v. Crittenden Hosp. Ass'n</i> , 748 S.W.2d 663, 665 (1988)
District of Columbia	<i>Balkissoon v. Capitol Hill Hosp.</i> , 558 A.2d 304, 307-08 (D.C. Cir. 1989)
Maine	<i>Bartley v. Eastern Maine Med. Ctr.</i> , 617 A.2d 1020, 1021 (Me. 1992)

State	Key Case(s)
Pennsylvania	(1) <i>Miller v. Indiana Hosp.</i> , 277 Pa. Super. 370, 375, 419 A.2d 1191, 1193 (1980) (2) <i>Lewis v. UPMC Bedford & UPMC</i> , 2009 WL 840385, at *11 (W.D. Pa. Mar. 30, 2009)
Utah	(1) <i>Brinton v. IHC Hosps., Inc.</i> , 973 P.2d 956, 966 (Utah 1998) (2) <i>Don Houston, M.D., Inc. v. Intermountain Health Care, Inc.</i> , 933 P.2d 403, 408 (Utah Ct. App. 1997) (3) <i>Rees v. Intermountain Health Care, Inc.</i> , 808 P.2d 1069, 1076-77 (Utah 1991)
Unclear or Undecided (14 states)	
Colorado	<i>Even v. Longmont United Hosp. Ass'n</i> , 629 P.2d 1100, 1103 (Colo. Ct. App. 1981)
Delaware	<i>Yatco, M.D. v. Nanticoke Mem'l Hosp., Inc.</i> , No. 08C-12-038 JRS, 2010 WL 2336866 (Del. Super. June 10, 2010)
Hawaii	Has not considered the issue
Idaho	<i>Miller v. St. Alphonsus Reg. Med. Ctr., Inc.</i> , 87 P.3d 934, 940 (Ida. 2004)
Montana	<i>Hughes v. Pullman</i> , 36 P.3d 339, 344-45 (Mont. 2001)
Nebraska	(1) <i>Kandel v. Nebraska Med. Ctr.</i> , No. A-09-1241, 2010 WL 4009049, at *3 (Neb. Ct. App. Oct. 12, 2010) (2) <i>Babcock v. St. Francis Med. Ctr.</i> , 543 N.W.2d 749, 760-61 (Neb. Ct. App. 1996)
New Hampshire	<i>Strang v. Frisbie Mem'l Hosp.</i> , No. 00-C-0021, 2002 WL 31059369, at **2-3 (N.H. Super. Ct. Jan. 30, 2002)
New Jersey	(1) <i>Petrocco v. Dover General Hospital and Medical Center</i> , 273 N.J. Super. 501, 642 A.2d 1016 (1994) (2) <i>Joseph v. Passaic Hosp. Ass'n</i> , 118 A.2d 696, 700 (N.J. Super. Ct. App. Div. 1955)
North Dakota	<i>Van Valkenburg v. Paracelsus Healthcare Corp.</i> , 606 N.W.2d

State	Key Case(s)
	908, 918 (2000)
Rhode Island	<i>Sterry Street Auto Sales v. Pare</i> , No. C.A. 04-5086, 2005 WL 524806, at *5 (R.I. Mar. 3, 2005)
Vermont	Has not considered the issue
Virginia	(1) <i>Atta v. Nelson</i> , No. 7:11-cv-00463, 2012 WL 178355, at *3 (W.D. Va. Jan. 23, 2012) (2) <i>Medical Ctr. Hosps. v. Terzis</i> , 367 S.E.2d 728, 729 (Va. 1988)
Washington	Has not considered the issue, but the Supreme Court has held that medical staff membership is not a property interest, <i>Ritter v. Bd. of Comm'rs of Adams County Public Hosp. Dist. No. 1</i> , 96 Wn.2d 503, 637 P.2d 940 (1981), and that a hospital's medical staff is not a separate legal entity capable of being sued, <i>Perry v. Rado</i> , 155 Wn. App. 626, 642, 230 P.3d 203, 211 (2010).
Wyoming	Has not considered the issue

EXHIBIT B

STATE OF MINNESOTA

IN DISTRICT COURT

COUNTY OF LYON

FIFTH JUDICIAL DISTRICT

Medical Staff of Avera Marshall
Regional Medical Center et.al.,

Plaintiffs,

**ORDER ON MOTIONS FOR
SUMMARY JUDGMENT**

vs.

Avera Marshall d/b/a Avera
Marshall Regional Medical
Center, and John Roes and
Jane Roes,

Court File: 42-CV-12-69

Defendants.

The above-captioned matter came before the Court on June 27, 2012, on Plaintiff's and Defendant's motion to dismiss. Kathy Kimmel and Margo Struthers, Attorneys at Law, appeared on behalf of the Plaintiffs. David Crosby and Bryant Tchida, Attorneys at Law, appeared on behalf of the Defendants.

The issues posed in the Plaintiffs' Amended Complaint are as follows:

- a. Count II: Are the Medical Staff Bylaws a contract between Avera and the Medical Staff (individually or otherwise)?
- b. Count III: Can Avera conduct the application process, consider physician applicant reports and information, and make determinations regarding physician appointments, reappointments, and clinical privileges in a manner that is in contravention of the medical staff bylaws?
- c. Count IV: Can Avera impinge upon the rights and duties of the Chief of Staff and the Medical Executive Committee and prohibit members of the Medical Staff from attending Medical Executive Committee meetings in contravention of the medical staff bylaws?
- d. Count V: Can Avera impinge on the rights and duties of the Chief of Staff and the Medical Executive Committee by making appointments to the Medical Staff Quality Improvement Committee and/or altering the duties and responsibilities of the Medical Staff Quality Improvement Committee in contravention of the medical staff bylaws?
- e. Count VI: Can Avera impinge upon the rights and duties of the Medical Staff, the Medical Executive Committee, and other committees to evaluate patient care, to conduct productive interaction and investigations, and peer review in contravention of the medical staff bylaws?
- f. Count VII: Can Avera modify the medical staff bylaws without the two-thirds approval of the Medical Staff?

FILED IN THIS OFFICE

92472
Karen J. Bierman
COURT ADMINISTRATOR
Marshall, Lyon County, Minnesota

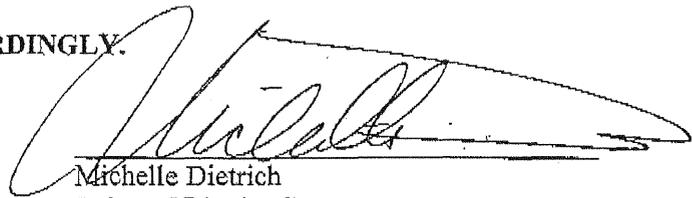
Based upon the files, records, and proceedings herein,

IT IS HEREBY ORDERED:

1. That the Defendant's motion for summary judgment as to Count II of the Complaint is GRANTED. The Medical Staff Bylaws are not a contract between Avera and the Medical Staff or with any individual member of the Medical Staff.
2. That the Plaintiffs' motion for summary judgment as to Counts III-VI of the Complaint is GRANTED. Avera is required to follow the provisions of existing and duly adopted Medical Staff Bylaws and policies and procedures that are enacted under the Medical Staff Bylaws and that have been duly adopted by the Board of Directors.
3. That the Defendant's motion for summary judgment as to Count VII of the Complaint is GRANTED. Avera can modify the Medical Staff Bylaws without Medical Staff approval if it substantially complies with the procedural prerequisites contained in the Medical Staff Bylaws.
4. That the Plaintiffs' request for an injunction as stated in Count VIII of the Complaint is DENIED.
5. That the attached Memorandum is incorporated herein by reference.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated this 24th day of September, 2012


Michelle Dietrich
Judge of District Court

MEMORANDUM***I. Facts***

Avera Marshall (hereinafter, "Avera") is a nonprofit corporation organized pursuant to Minn.Stat.Ch. 317A. Avera owns and operates the Avera Marshall Regional Medical Center (hereinafter, the "Medical Center"). Avera operates under the Bylaws of Avera Marshall (hereinafter, "Hospital Bylaws"). Affiliated Community Medical Center ("ACMC") is a health care organization which operates facilities in Marshall, Minnesota, as well as in other surrounding communities. Avera and Avera operate in and compete within the same market. The relationship between Avera and Avera became strained at some point¹.

Avera adopted medical staff bylaws governing its relationship with its medical-dental staff (hereinafter, the "Medical Staff"). The Medical Staff is comprised of physicians who have been granted privileges at the Medical Center pursuant to the medical staff bylaws. The Medical Staff is comprised of physicians who are employed by Avera and those who are not, including physicians employed by Avera. The majority of the Medical Staff is comprised of non-Avera physicians. All applicants for privileges at the Medical Center must agree to follow the medical staff bylaws.

Medical staff bylaws were enacted by Avera's Board of Directors (hereinafter, the "Board") in 1995. The medical staff bylaws have been amended from time to time since their enactment. Prior to the present action, the medical staff bylaws were last amended in May 2010. On or about January 17, 2012, Avera notified the Medical Staff, including the Chief of Staff, in writing that it intended to revise the then-existing medical staff bylaws (hereinafter, the "Original Medical Staff Bylaws") and provided a copy of the intended revisions. The revisions were, at

¹ See, Order on Plaintiff's Motion for a Temporary Restraining Order, page 5, ¶¶32-33.

least in part, proposed to address the deteriorating relationship between the Board and the Medical Staff.² Avera sought comment from the Medical Staff stating that any comments should be provided on or before March 1, 2012. The revisions were provided by one or more members of the Medical Staff to the Medical Executive Committee ("MEC") who, under the Original Medical Staff Bylaws, was required to review proposed revisions and make comments regarding said revisions. The MEC conducted such a review and sent its findings to all members of the Medical Staff as required by the Original Medical Staff Bylaws via a report dated February 15, 2012.³ Pursuant to the Original Medical Staff Bylaws, a Medical Staff meeting was held to discuss and vote on Avera's revisions on March 20, 2012. A quorum was present at the meeting. The ballot questions presented to the Medical Staff at the meeting were (a) "Vote on Avera Marshall Board of Directors' stated repeal of the current Medical Staff Bylaws, Rules, Regulations, and Policies and Procedures"; and (b) "Vote on Avera Marshall Board of Directors' stated adoption of amended Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures". Of the 29 Medical Staff voting at the meeting, 18 voted in opposition to the Board's repeal of the documents and 10 voted in favor of the repeal and 17 voted in opposition to "stated adoption" of the documents and 11 voted in favor of the "stated adoption".⁴ The revisions submitted by the Board were not approved by two-thirds of the Medical Staff. After receiving input from various members of the Medical Staff, Avera made additional changes to

² See, Order on Plaintiffs' Motion for a Temporary Restraining Order, page 10, ¶¶69-71.

³ It is unclear when and if the MEC's report was provided to the Board. It is also unclear if the Medical Staff or any of its members asked the Board to extend the March 1, 2012, deadline for receipt of comments.

⁴ One ballot was apparently left blank on both questions. In addition, it is unclear based upon the phraseology of the ballot questions whether votes were cast because the members disagreed with the process the Board followed in revising the documents, because they disagreed with the revisions, or some combination thereof. Indeed, in Plaintiffs' Memorandum of Law in Support of Their Motion for Summary Judgment, Plaintiffs refer to the ballot questions as asking the members to vote on the Board's "unilateral" repeal and "unilateral" approval of the documents. Plaintiff's Memorandum, page 12.

the medical staff bylaws. Avera subsequently approved new medical staff bylaws (hereinafter, "New Medical Staff Bylaws") that took effect on May 1, 2012.

Plaintiffs commenced this action on or about January 18, 2012 (the day after Avera provided the Medical Staff with the proposed revisions to the medical staff bylaws) seeking declaratory relief. The Court previously denied Plaintiffs' request for a temporary restraining order in an Order on Plaintiffs' Motion for a Temporary Restraining Order dated April 30, 2012. The Court previously granted summary judgment in favor of Defendant on Count I of the Complaint in its Order on Motion to Dismiss dated July 6, 2012. Both parties now seek summary judgment on the remaining counts.

II. *Summary Judgment Standard*

Summary judgment is appropriate if no genuine issue of material fact exists and either party is entitled to judgment as a matter of law. Minn. R. Civ. P. 56.03; *Liebenstein v. Allstate Ins. Co.*, 517 N.W.2d 73, 75 (Minn. Ct. App. 1994). A fact is material only if its resolution will affect the outcome of the case; and a dispute is genuine if the evidence is such that a reasonable jury could return a verdict for the non-moving party. *See Valtakis v. Putnam*, 504 N.W.2d 264, 266 (Minn. Ct. App. 1993). "Summary judgment is appropriate when the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party." *DLH, Inc v. Russ*, 566 N.W.2d 60, 69 (Minn. 1997).

In considering a summary judgment motion, the Court must determine whether there are genuine issues of fact. *Pine Island Farmers Co-op v. Erstad & Reimer*, 649 N.W.2d 444, 447 (Minn. 2002). In analyzing the motion, the Court reviews the evidence in the light most favorable to the party opposing the motion. *Fabio v. Bellomo*, 504 N.W.2d 758, 761 (Minn. 1993). The burden is on the moving party to show the absence of any genuine issue of material

fact. Minn. R. Civ. P. 56.03; *Bixler v. J.C. Penney Co.*, 376 N.W.2d 209, 215 (Minn. 1985). However, Rule 56.05 provides: "An adverse party may not rest upon the mere averments or denials of the adverse party's pleading, but must present specific facts showing that there is a genuine issue for trial." Minn. R. Civ. P. 56.05; *see also Gorath v. Rockwell International, Inc.*, 441 N.W.2d 128 (Minn. Ct. App. 1989).

In this case, the parties have agreed that the relevant facts are not in dispute and that the issues raised in the Complaint are, therefore, legal issues to be determined following the application of the undisputed facts.

III. Are the Medical Staff Bylaws a Contract (Count II)?

In Minnesota, the formation of a contract requires an offer, acceptance, and consideration. *Murray v. MINNCOR*, 596 N.W.2d 702, 704 (Minn.Ct.App. 1999). Whether or not a contract exists is generally an issue for the fact-finder. *Morrisette v. Harrison Int'l Corp.*, 486 N.W.2d 424, 427 (Minn. 1992). "But where the relevant facts are undisputed, the existence of a contract is a question of law." *TNT Props. Ltd. V. Tri-Star Developers LLC*, 677 N.W.2d 94, 101 (Minn.Ct.App. 2004). Whether a contract has been formed is dependent upon an objective evaluation of the parties' actions and words, not on the parties' subjective intent. *Thomas B. Olson & Assoc., P.A. v. Leffert, Jay & Polglaze P.A.*, 756 N.W.2d 907, 918 (Minn.Ct.App. 2008). In addition to the parties' words and actions, the Court may also consider "the surrounding facts and circumstances in the context of the entire transaction, including the purpose, subject matter, and the nature of it" in determining whether a contract has been formed. *Morrisette*, 486 N.W.2d at 427. "An intent to be ... bound is determined by the objective manifestations of the parties' words, conduct, and documents, and not by their subjective intent." *Norwest Bank Minn. N., N.A. v. Beckler*, 663 N.W.2d 571, 578 (Minn.Ct.App. 2003). "No

contract is formed by the signing of an instrument when one party knows the other does not intend to be bound by the document.” *Hansen v. Phillips Beverage Co.*, 487 N.W.2d 925, 927 (Minn.Ct.App. 1992).

A. Consideration

Whether or not consideration exists is a question of law. *Brooksbank v. Anderson*, 586 N.W.2d 789, 794 (Minn.Ct.App. 1998). Consideration is the bargain which is at the core of a contract and represents the reciprocal exchange of value given and value received. *Powell v. MVE Holdings, Inc.*, 626 N.W.2d 451, 463 (Minn.Ct.App. 2001). Consideration must be the result of a bargain. *Baehi v. Penn-O-Tex Oil Corp.*, 258 Minn. 533, 538-39, 104 N.W.2d 661, 665 (1960).

“Bargain” does not mean an exchange of things equivalent, or any, value. It means a negotiation resulting in the voluntary assumption of an obligation by one party upon condition of an act or forbearance by the other. Consideration thus 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 ... Consideration, as essential evidence of the parties’ intent to create a legal obligation, must be something adopted and regarded by the parties as such. Thus, the same thing may be consideration or not, as it is dealt with by the parties.

Id.

“Consideration requires the voluntary assumption of an obligation by one party on the condition of an act or forbearance by the other.” *Cady v. Coleman*, 315 N.W.2d 593, 596 (Minn. 1982).

“Consideration may consist of either a benefit accruing to a party or a detriment suffered by another party.” *C&D Invs. V. Beaudoin*, 364 N.W.2d 850, 853 (Minn.Ct.App. 1985). The value or amount of consideration is not relevant so long as some benefit or detriment has been established. *Estrada v. Hanson*, 215 Minn. 353, 356, 10 N.W.2d 223, 225-26 (1943). “It is, however, necessary to distinguish the adequacy of consideration from the existence of

consideration. The issue of whether consideration truly exists is not one of mere formalism.” *Brooksbank*, 586 N.W.2d at 794. “A promise is a sufficient consideration for a return promise.” *BOB Acres, LLC v. Schumacher Farms, LLC*, 797 N.W.2d 723, 726 (Minn.Ct.App. 2011).

1. Preexisting Condition and Consideration

Parties are presumed not to contract to obtain what they already have. *See, Gransbury v. Saterbak*, 116 Minn. 339, 341, 133 N.W.2d 851, 852 (1911). “A promise to do something that one is already legally obligated to do does not constitute consideration. Instead, it is a ‘mere naked promise.’” *Deli v. Hasselmo*, 542 N.W.2d 649, 656 (Minn.Ct.App. 1996)

If a promisee is already bound by official duty to render a service, it undergoes no detriment and confers no benefit on the promisor beyond what the law requires it to suffer or to give, for it to perform or agree to perform the service on request ... As such, the promisor has a right, although it may be not one enforceable at law, to the performance in question, and therefore, no contract can be based upon such consideration ... However, if the official upon request does or agrees to do more than its legal duty requires, it gives sufficient consideration by doing so to support a promise, though the promise might still violate public policy or otherwise be subject to illegality, and hence remain unenforceable.

3 *Williston on Contracts*, §7:42 (4th ed.).

B. Medical Staff Bylaws as a Contract

1. Minnesota Case Law

The issue of whether or not medical staff bylaws are a contract is one of first impression in Minnesota. While Minnesota appellate courts have discussed medical staff bylaws in conjunction with an individual physician’s due process rights, the courts have not addressed, nor does it appear that they have been presented with, the issue of whether or not medical staff bylaws are contracts.

In *Campbell v. St. Mary’s Hospital*, 252 N.W.2d 581 (Minn. 1977), the plaintiff physician brought action against the hospital following the termination of his staff privileges. As

a condition of plaintiff's receipt of staff privileges at the hospital, he agreed to abide by the bylaws, rules and regulations governing the medical staff and the hospital. Prior to the termination of the plaintiff's privileges, the Duluth Surgical Board of Recommendations recommended that the plaintiff should be allowed to perform surgery only under the observation of another surgeon as sponsor. The hospital adopted this recommendation and plaintiff did not seek review of the recommendation. At some point thereafter, the plaintiff lost his sponsor and the hospital then initiated an investigation into plaintiff's performance under the medical staff bylaws. Pursuant to the procedures outlined in the medical staff bylaws, plaintiff's privileges were terminated. The Court in *Campbell* did not analyze the issue of whether or not the medical staff bylaws were a contract and, indeed, it does not appear that this was an issue raised in the case. The Court appeared to analyze the issue in terms of whether or not the plaintiff was afforded due process in conjunction with the revocation of his surgical privileges. *Id.* at 584-85. Therefore, while the Court referred to the procedural provisions of the medical staff bylaws as "contractual due process", this Court cannot find that *Campbell* stands for the proposition that medical staff bylaws are contracts. Again, the specific issue of whether medical staff bylaws are a contract was not presented to the *Campbell* Court nor does *Campbell* itself include such a holding.

In *In re Peer Review Action*, 749 N.W.2d 822 (Minn.Ct.App. 2008), a physician brought an action to enjoin a hospital from disciplining him. The Court found that the hospital did not follow its peer review process. As in *Campbell*, there was no discussion regarding whether or not the medical staff bylaws was a contract and, indeed, this question did not appear to be at issue in that case. Therefore, *Peer Review* is not instructive on the issue presently before the Court.

Other jurisdictions have addressed the issue of whether or not medical staff bylaws are a contract⁵. There is no consensus of authority from these other jurisdictions.

2. Non-Minnesota Case Law – Medical Staff Bylaws are a Contract

In *Gianetti v. Norwalk Hospital*, 557 A.2d 1249 (Conn. 1989), plaintiff physician brought an action against the hospital for breach of contract arising out of the hospital's refusal to reappoint the plaintiff to the medical staff. The Court in *Gianetti* held that the medical staff bylaws were not a *per se* contract between the hospital and the plaintiff because state regulations required that the hospital adopt bylaws and such adoption was a preexisting duty that could not constitute consideration for a contract. *Id.* at 1252-53. However, the Court held that an aggrieved physician could obtain judicial review of action taken or not taken under the bylaws.

Id. at 1254. The Court stated:

In granting privileges, this hospital extended to the plaintiff those benefits to his medical practice that are to be gained by the use of the hospital, including its facilities and admissions to the hospital. "Whatever else the granting of staff privileges may connote, it is clear ... that it [at least] involves a delegation by the hospital [to the physician] of authority to make decisions on utilizations of its facilities." In return for that, the plaintiff agreed to abide by its medical staff bylaws. Therefore, the requisite contractual mutuality was then present. This agreement was supported by valid consideration ... Therefore, there is a contractual relationship between the hospital and the plaintiff. Therefore, the plaintiff has a right to judicial review.

Id. at 1254-55 (citations omitted).

In *Janda v. Madera Community Hospital*, 16 F.Supp.2d 1181 (E.D.Cal. 1998), plaintiff orthopedic surgeon brought an action against the hospital claiming, among other things, breach

⁵ Those cases not discussed specifically herein that were cited by the parties in their respective briefs did not describe the legal analysis (i.e., how the medical staff bylaws did or did not meet the applicable jurisdiction's requirements for formation of a contract) that the Court engaged in in reaching such a conclusion. Those decisions either stated, in conclusory fashion, that the medical staff bylaws were or were not a contract and/or simply cited to other caselaw that reached the same conclusion without any further analysis. Other cases were cited by the parties that did not reach the issue of whether or not medical staff bylaws were a contract. Finally, both parties cited unpublished cases from other jurisdictions to support their arguments. Those cases have no precedential value. For the sake of brevity, the cases discussed herein are limited to those published cases in which the courts described the legal/contract analysis used in reaching their conclusions.

of contract, following the hospital's decision to limit its orthopedic department to an exclusive group of physicians. The *Janda* Court found that the bylaws⁶ constituted "an express employment contract" between the plaintiff and the hospital. *Id.* at 1186. The *Janda* Court found that the consideration for the contract⁷ was that the hospital granted the plaintiff medical staff privileges and the plaintiff agreed to perform medical services at the hospital and abide by the hospital's bylaws. *Id.* The Court rejected the hospital's argument that there was no consideration because the hospital had a preexisting duty to adopt medical staff bylaws. The Court stated that the California regulation at issue "requires physicians to comply with the rules adopted by the *medical staff*, *i.e.*, his medical peers and colleagues and did not impose a requirement on physicians to comply with the bylaws adopted by the *governing body* of the hospital." *Id.* at 1187 (emphasis in original). The *Janda* Court also found that the hospital's bylaws were more expansive than California's regulations required. *Id.* This also differs from the regulatory framework in Minnesota which does not contain any minimum or mandatory requirements; only that medical staff bylaws be adopted. Minn.R. §4640.0800, subp. 2. Because the regulatory scheme in Minnesota materially differs from that in California⁸ and for the reasons discussed below, the Court does not find that *Janda's* analysis is particularly persuasive.

In *Lo v. Provena Covenant Medical Center*, 826 N.E.2d 592 (Ill.App.Ct. 2005), plaintiff physician brought action against the hospital alleging that the hospital had violated the medical staff bylaws by restricting his clinical privileges without a hearing. The *Lo* Court expressed a concern that, if the procedures in the bylaws were not enforceable under a theory of contract, that

⁶ It is unclear if the bylaws at issue were the hospital's bylaws, medical staff bylaws, or both. *But see, O'Byrne v. Santa Monica-UCLA Medical Center*, 94 Cal.App.4th 797, 808 (Cal.Dist.Ct.App. 2001), discussed below, wherein the Court stated the result in *Janda* may have been different if the bylaws at issue were medical staff bylaws, rather than hospital bylaws. Indeed, in many of the cases cited by the parties, it was unclear if the bylaws at issue were medical staff bylaws or hospital bylaws.

⁷ It is unclear from the opinion whether the plaintiff had a separate employment contract or if the Court was relying solely on the medical staff bylaws.

⁸ *See, e.g.*, the Court's Order on Motion to Dismiss, page 8, note 11.

no other legal theory was available. *Id.* at 598. The Court based its decision, in part, on its conclusion that the medical staff was a voluntary association.⁹ The *Lo* Court assumed that the medical staff bylaws were a contract between the medical staff and its members. The Court reasoned that, when the hospital board adopted the bylaws, the hospital board became a party to the contract between the medical staff and its members. The Court recognized that if the hospital had promised procedures that the law had already required and nothing more, that the preexisting duty rule would have prevented the formation of a contract between the hospital and the medical staff. *Id.* However, the Court reasoned that the hospital exceeded any preexisting duty to grant the plaintiff privileges, that mutual benefits were exchanged, and that such exchange constituted consideration. *Id.* at 598-99.

In *Virmani v. Presbyterian Health Services Corp.*, 488 S.E.2d 284 (N.C.Ct.App. 1997), plaintiff physician brought an action against the hospital following the hospital's suspension of his staff privileges. The Court held that merely enacting medical staff bylaws cannot constitute consideration for the formation of a contract when such enactment is required by law. *Id.* at 287-88. The Court went on to state, however, that when

a hospital offers to extend a particular physician the privilege to practice medicine in that hospital it goes beyond its statutory obligation. 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. If the privilege is offered and accepted, each confers a benefit on the other and these benefits constitute sufficient and legal consideration ... If the offer includes a condition that the physician be bound by certain bylaws promulgated by the hospital and the physician accepts the offer, those bylaws become part of the contract, as there is mutual assent to be bound by the bylaws.

Id. at 288. *Virmani*, therefore, takes the position that once the physician's application is accepted, that this is action beyond the hospital's preexisting duty to adopt bylaws and, therefore,

⁹ This Court rejected that conclusion in this case in its July 6, 2012, Order on Motion to Dismiss.

consideration is present. *See also, Williams v. University Medical Center of Southern Nevada*, 688 F.Supp.2d 1134 (D.Nev. 2010).

3. Non-Minnesota Case Law – Medical Staff Bylaws are not a Contract

In *Egan v. St. Anthony's Medical Center*, 244 S.W.2d 169 (Mo. 2008), plaintiff surgeon brought action against the hospital seeking to compel the hospital to hold a new hearing regarding its decision to suspend the plaintiff's privileges at the hospital. The *Egan* Court recognized the plaintiff's right to bring an equitable action for injunctive relief to require the hospital to substantially comply with its bylaws. *Id.* at 174. The Court went on to note, however,

[t]hat is not to say, however, that the bylaws create, or are themselves, an enforceable contract between doctors and hospitals, the breach of which gives rise to an action for damages ... [A] hospital's duty to adopt and conform its actions to medical staff bylaws as required by the regulation is a preexisting duty, and a preexisting duty cannot furnish consideration for a contract. A hospital's obligation to act in accordance with its bylaws, in other words, is independent of any contractual obligation the hospital may have to the doctor ... [I]t must be recognized that the purpose of the regulation is to implement a system of medical staff peer review, rather than judicial oversight, and it is clear that final authority to make staffing decisions is securely vested in the hospital's governing body with advice from the medical staff. This is so because the notion underlying the internal governance structure required by the regulatory scheme is that medical professionals are best qualified to police themselves. The 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. In this case, an action at equity will lie for that purpose.

Id.

In *Kessel v. Monongalia County General Hospital Co.*, 600 S.E.2d 321 (W.Va. 2004), anesthesiologists who had staff privileges at the hospital brought action against the hospital when the hospital entered into an exclusive contract with other anesthesia providers for, among other things, breach of contract, relying on the medical staff bylaws. The *Kessel* Court held that the medical staff bylaws were not a contract because there was no consideration.

“The doing by one of that which he is already legally bound to do is not a valuable consideration for a promise made to him, since it gives the promisor nothing more than that to which the latter is already entitled” ... Because the hospital was already bound by law to approve the bylaws of the medical staff, and the medical staff was bound to initiate and adopt bylaws, neither party conferred on the other any more than what the law already required. Thus, we conclude that the medical staff bylaws do not constitute a contract ... [M]edical staff bylaws generally are intended to require fair proceedings when an individual practitioner is alleged to be substandard in skill and are not intended to apply to hospital board management decisions ... [A]bsent express language to the contrary, a hospital’s medical staff bylaws do not constitute a contract between the hospital and its staff physicians. However, where it is alleged that a physician is guilty of professional incompetencè or misconduct, the hospital is bound by the fair hearing procedural provisions contained in the medical staff bylaws.

Id. at 326, 327 (citations omitted).

In *Munoz v. Flower Hospital*, 507 N.E.2d 360 (Ohio Ct.App. 1985), plaintiff anesthesiologist brought action against the hospital when the hospital refused to reappoint the plaintiff to its medical staff. The *Munoz* Court found that, because the preamble to the bylaws stated that the bylaws were subject to the ultimate authority of the hospital board, “[t]he obvious interpretation of the bylaws’ preamble is that the trustees are, and therefore the hospital is, not to be bound by the staff bylaws and that there is no contractual relationship arising from these staff bylaws because there is no mutuality of obligation between the parties.” *Id.* at 365.

In *O’Byrne*, plaintiff physician brought action against the hospital claiming, among other things, breach of contract under the medical staff bylaws following the denial of his application for privileges and the threatened termination of privileges. The Court found that California’s regulations required that the hospital appoint a medical staff, adopt bylaws, and require staff to follow those bylaws. “Clearly, there was no consideration given for the Bylaws—neither the Medical Center nor plaintiff conferred on the other more than what was required by law.” *O’Byrne*, 94 Cal.App.4th at 808. The Court noted that the decision in *Janda* may have been different if the bylaws at issue in that case had been medical staff bylaws rather than hospital

bylaws. *Id.* The Court noted that holding that medical staff bylaws are not a contract did not deprive a member of the medical staff from seeking equitable relief to enjoin a hospital from acting in contravention of its bylaws. *Id.* at 810.

In *Robles v. Humana Hospital Cartersville*, 785 F.Supp. 989 (N.D.Ga. 1992), plaintiff physician brought action against the hospital following termination of his privileges claiming, among other things, breach of contract arising out of the medical staff bylaws. The Court held that medical staff bylaws are not an enforceable contract *per se*, but they may be judicially enforced, presumably through an equitable action for injunctive relief. *Id.* at 1001. The Court, in finding that the bylaws were not a contract, engaged in the following analysis:

[C]onsideration must be stated in the contract or at least be ascertainable from the contract. However, that consideration cannot be a promise to do something which the promisor is already obligated to do. The bylaws cannot be considered a contract *per se* because there is no mutual exchange of consideration which brought them into existence. The Hospital had the previous obligation to create those bylaws and to develop a procedure for reviewing a doctor's competency ... [B]ecause the hospital had the legal duty to develop the bylaws and the procedures therein independently of its association with [plaintiff], no consideration could have been given for their creation, and, as stated above, without consideration, there cannot be a contract. Furthermore, there was no bargained for exchange as to the procedures utilized in the bylaws. Plaintiff had no input into the bylaws, nor did he have the power to change them. Only the Hospital had the power to change the bylaws.

Id. at 1001, 1002.

In *Zipper v. Health Midwest*, 978 S.W.2d 398 (W.D.Mo. 1998), plaintiff surgeon brought action against the hospital following termination of plaintiff's staff privileges. Plaintiff argued that a valid contract existed between plaintiff and the hospital because he applied for and was granted staff privileges subject to the medical staff bylaws. The Court noted that the majority of jurisdictions addressing the issue have held that medical staff bylaws are contracts, but that there

was a "substantial minority" of jurisdictions holding the opposite. *Id.* at 415-16. The Court stated:

The hospital bylaws cannot be considered a contract under Missouri law because consideration is lacking. By state regulation, Missouri hospitals are required to "adopt bylaws, rules and policies governing their professional activities in the hospital." MCI, therefore, had a preexisting legal duty to adopt the bylaws independent of its relationship with [plaintiff] ... [A] promise to do that which a party is already legally obligated to do does not constitute valid consideration ... Additionally, there is no bargained for exchange as to the procedures adopted in hospital bylaws as required to have an enforceable contract. [Plaintiff] did not have input in the bylaws nor did he have the power to change the bylaws.

Id. at 416 (citations omitted).

C. Discussion

It is significant that all of the cases relied upon by the parties, with the exception of *St. John's Hospital Medical Staff v. St. John Regional Medical Center*, 245 N.W.2d 472 (S.D. 1976), discussed *infra*, that have found that medical staff bylaws are or can be contracts, have reached that conclusion in the context of an individual physician's due process rights. Furthermore, the majority of said cases have declined to extend or find that the medical staff bylaws are contractual as they may apply to a hospital board's administrative decisions and/or organizational structure. See, e.g., *Bartley v. Eastern Maine Medical Center*, 617 A.2d 1020, 1022 (Me. 1992) ("It is clear from these bylaw provisions that the board of trustees ... has the authority to manage all the affairs of the hospital. This would necessarily include decisions on who to operate individual departments in order to best serve the corporation's purposes of 'car[ing] for ill or disabled persons ... and ... promot[ing] community health'"); *Gonzalez v. San Jacinto Methodist Hospital*, 880 S.W.2d 436, 440 (Tex.Ct.App. 1994) (bylaws' procedural requirements do not involve matters of administrative decisions but are limited to issues of

professional competence and ethical conduct).¹⁰ These are interesting, but troubling, distinctions. If medical staff bylaws are a contract, aren't the medical staff bylaws, in their entirety, the contract? How can one say that some provisions are "contractual" and others are not? How can a Court sever the provisions of such a "contract"?¹¹

While, as noted, the majority of courts that concluded that medical staff bylaws are or can be a contract have not extended the medical staff bylaws' purview to administrative decisions, some courts, after finding that medical staff bylaws are contractual, *have* extended their application to limit administrative and organizational decisions made by a hospital board. *See, e.g., Janda*, 16 F.Supp.2d at 1189 (hospital's decision to close its orthopedic department subject to judicial review under breach of contract/medical staff bylaws theory); *Strauss v. Peninsula Regional Medical Center*, 916 F.Supp. 528 (D.Md. 1996)(hospital's decision to close the medical staff of the oncology division subject to judicial review under breach of contract/medical staff bylaws theory)¹². While Plaintiffs have stated, through counsel, that they have no intention to so impinge the decisions of the Board in this case, if the Original or New Medical Staff Bylaws are held to be a contract, it is possible that, at some point in the future, a member of the medical staff could seek to limit the hospital's action as part of a breach of contract action.

¹⁰ *See also, Seitzinger v. Community Health Network*, 676 N.W.2d 426, 433 (Wis. 2004) ("a hospital's interpretation of its bylaws should stand if reasonable"). If medical staff bylaws are truly a contract, how can one party's interpretation of the contract be controlling?

¹¹ A contract can only be severable when the parties intended to make the contract apportionable and it can be apportioned fairly. *See, Bentley v. Edwards*, 125 Minn. 179, 184, 146 N.W. 347, 349 (1914). Intent is likely always to be a question of fact and can be difficult to ascertain from documents in which at least one of the individual parties—the physician—had no involvement in negotiating and, in all likelihood, had limited if any contact with the hospital's governing board regarding the bylaws and their application.

¹² The *Strauss* Court indicated that "what decisional environments mandate [the due process protections of the medical staff bylaws] must be afforded to individual practitioners" is open to judicial review. *Id.* at 539. The *Strauss* Court specifically held that Maryland law would not support a "narrow" interpretation of the medical staff bylaws limiting their application to competence and ethical issues relating to members of the medical staff. *Id.* at 538.

1. The Original and New Medical Staff Bylaws are not a Contract Because There is no Consideration

Minn.R. §4640.0700, subp. 2 provides:

The governing body or the person or persons designated as the governing authority in each institution shall be responsible for its management, control, and operation. It shall appoint a hospital administrator and the medical staff. It shall formulate the administrative policies for the hospital.

Minn.R. §4640.0800 subp. 1 provides:

The medical staff shall be responsible to the governing body of the hospital for the clinical and scientific work of the hospital. It shall be called upon to advise regarding professional problems and policies.

Minn.R. §4640.0800, subp. 2 provides:

In any hospital used by two or more practitioners, the medical staff shall be an organized group which shall formulate and, with the approval of the governing body, adopt bylaws, rules, regulations, and policies for the proper conduct of its work.

Avera and the Medical Center operate under the Hospital Bylaws. The Hospital Bylaws govern Avera's relationship with its Medical Staff. Article XV, §15.1 of the Hospital Bylaws provides:

(a) The Board of Directors shall organize the physicians and appropriate other persons granted practice privileges in the hospital owned and operated by the Corporation into medical-dental staff under medical-dental staff bylaws approved by the Board of Directors. The Board of Directors shall consider recommendations of the medical-dental staff and appoint to the medical-dental staff, physicians and others who meet the qualifications for membership as set forth in the bylaws of the medical-dental staff ...

...

(c) ... When an appointment is not to be renewed, or when privileges have been or are proposed to be reduced, altered, suspended, or terminated, the staff member shall be afforded an opportunity of a hearing before a committee designated in the medical-dental staff bylaws, whose recommendations shall be considered by the Board of Directors prior to taking any final action. Such hearings shall be conducted under procedures adopted by the Board of

Directors so as to ensure due process and to afford full opportunity for the presentation of all information.

Article XV, § 15.3 of the Hospital Bylaws specifically addresses the Medical Staff

Bylaws:

There shall be bylaws, rules and regulations, or amendments thereto, for the medical-dental staff that set forth its organization and government. Proposed bylaws, rules and regulations, or amendments thereto, may be recommended by the medical-dental staff or the Board of Directors.

Minnesota regulations require that hospitals approve medical staff bylaws. Minn.R. §4640.0800, subp. 2. In addition, the Hospital Bylaws require that Avera adopt medical staff bylaws. Hospital Bylaws, Article XV, §§15.1(a) and 15.3. Bylaws are the laws adopted by a corporation for the regulation of its actions and the rights and duties of its members. *Brennan v. Minneapolis Soc. For Blind, Inc.*, 282 N.W.2d 515, 523 (Minn. 1979). “[B]y-laws must be obeyed by the corporation, its directors, officers, and stockholders.” *Little Canada Charity Bingo Hall Ass’n v. Movers Warehouse, Inc.*, 498 N.W.2d 22, 24 (Minn.Ct.App. 1993). Therefore, the adoption of medical staff bylaws is not, in and of itself, consideration because Avera had a preexisting duty under Minnesota regulations and its own Hospital Bylaws to adopt medical staff bylaws.

Furthermore, the appointment by the Board of a physician to Avera’s Medical Staff does not constitute separate consideration. While it is true that an individual physician is under no obligation to apply for privileges at the hospital, the Hospital Bylaws *require* that the Board appoint individuals who are qualified under the medical staff bylaws. Hospital Bylaws, Article XV, §15.1(a). Therefore, the appointment of persons so qualified cannot constitute

consideration, or an additional “promise”, on the part of Avera as required for the formation of a contract with an individual physician.¹³

Even if Avera’s decision to grant a physician applicant privileges were considered a “promise” for purposes of consideration, a promise is only an offer if the party intends to be bound by it. *See, Cedarstrand v. Lutheran Bhd.*, 263 Minn. 520, 533, 117 N.W.2d 213, 222 (1962). Some cases analyzing whether or not medical staff bylaws are contracts have done so based, in part, by drawing an analogy between medical staff bylaws and employee handbooks. *See, e.g., Bass v. Ambrosius*, 520 N.W.2d 625 (Wis.Ct.App. 1994); *Bender v. Suburban Hospital*, 758 A.2d 1090 (Md.Ct.Spec.App. 2000); *Sullivan v. Baptist Memorial Hospital*, 722 So.2d 675 (Miss. 1998); *Tredrea v. Anesthesia & Analgesia*, 584 N.W.2d 276 (Iowa 1998).

Insofar as the analogy involves a situation in which the parties are, clearly, in an employer/employee relationship, the analogy is of limited application in this case because Avera and the entirety of the Medical Staff are not in such a relationship. That being said, under Minnesota law addressing the contractual effect of employee handbooks, the disclaimer and reservation language contained in the Original and New Medical Staff Bylaws, in conjunction with the Hospital Bylaws, is such that the medical staff bylaws would not be given contractual effect. While an employee handbook may be a contract between an employer and employee, an employer can prevent its handbook from having contractual effect by expressly providing in the handbook that the employer reserves a right to modify or amend the handbook, exercises discretion in the enforcement of the handbook, and/or does not intend that the handbook should be part of an employment contract. *Feges v. Perkins Restaurant, Inc.*, 483 N.W.2d 701, 708 (Minn. 1992). “Even if the language in an employee handbook satisfies the four requirements of

¹³ For the same reasons, adoption of the medical staff bylaws is not consideration for formation of a contract between Avera and the Medical Staff, even if the Medical Staff were a voluntary association or other entity that could legitimately be a party to a contract.

Feges, other language in the handbook may preclude the formation of an enforceable contract. 'A disclaimer in an employment handbook that clearly expresses an employer's intent to retain the at-will nature of the employment relationship will prevent the formation of a contractual right to continued employment.'" *Coursolle v. EMC Ins. Group, Inc.*, 794 N.W.2d 652, 659 (Minn.Ct.App. 2011)(citation omitted). See also, *Alexandria Housing and Redevelopment Authority v. Rost*, 756 N.W.2d 896, 906 (Minn.Ct.App. 2008).

Here, the Original and New Medical Staff Bylaws, read in conjunction with the Hospital Bylaws, clearly state that the Medical Staff and the Medical Staff's activities under both the Original and the New Medical Staff Bylaws are subject to the authority of the board and that the medical staff only has such authority that is delegated to it by the board.¹⁴ Furthermore, Article 17 of the Original and New Medical Staff Bylaws contains a provision specifically stating that nothing in the medical staff bylaws shall supersede the authority of the Board as set forth in the Hospital Bylaws or applicable law. Article XV of the Hospital Bylaws specifically describes the Board's continuing authority over the Medical Staff and provide that medical staff bylaws must be approved by the Board. The intent of the Hospital Bylaws could not have been that the Medical Staff be given authority to hinder the Board or that the medical staff bylaws take precedence over the Hospital Bylaws. Just as "[n]o reasonable person would have relied on representations found in a handbook that were disclaimed in the very same handbook", *Barker v. County of Lyon*, 813 N.W.2d 424, 427 (Minn.Ct.App. 2012)(citation omitted), no reasonable person would have relied on the medical staff bylaws as a contract when nearly all rights "granted" under said bylaws were subject to the ultimate authority and discretion of the Hospital Board.

¹⁴ See, e.g., Original Medical Staff Bylaws §§2.2, 4.2.1(c), 4.3.1, 4.6, 4.7, 5.1, ; New Medical Staff Bylaws §§2.2, 3.2.1(a)(i)(d), 4.2.1(c), 4.2.3, 4.3.1, 4.4.3, 4.6, 4.7, 5.1, 5.2, 5.5, 5.5.7, 5.5.10, 7.1.7, 8.1, 9.1, 16.1(d).

In sum, consideration is lacking in this case not only because Avera's adoption of the medical staff bylaws was a preexisting condition, but the medical staff bylaws, by its clear terms, indicated an intent by the Board not to be bound by them.¹⁵

2. Giving the Medical Staff Bylaws Contractual Effect Improperly Impinges on Avera's Authority

The medical staff bylaws cannot be considered in isolation. Rather, the Original and New Medical Staff Bylaws must be examined in conjunction with other sources that describe and circumscribe the relationship between a hospital and its medical staff. Those sources include Minnesota's statutes governing nonprofit corporations, Minnesota regulations, and the Hospital Bylaws.

Avera is incorporated as a Minnesota nonprofit corporation pursuant to Minn.Stat.Ch. §317A. The business and affairs of a corporation must be managed by or under the direction of a board of directors. Minn.Stat. §317A.201. Any agreement by which the board abdicates or bargains away in advance the judgment which the law contemplates they shall exercise over the affairs of the corporation is contrary to public policy and void. *Ray v. Homewood Hosp.*, 223 Minn. 440, 444, 27 N.W.2d 409, 411 (1947). "They may not agree to abstain from discharging their fiduciary duty to participate actively and fully in the management of corporate affairs." *Id.*

A nonprofit corporation may adopt bylaws that contain provisions relating to the management or regulation of the affairs of the corporation consistent with law or the articles of incorporation. Minn.Stat. §317A.181. Once a nonprofit corporation adopts bylaws, the board is bound to abide by them. Bylaws are the laws adopted by the corporation for the regulation of its

¹⁵ Except with respect to the procedural due process protections afforded to physicians who are faced with discipline or restriction of privileges. However, this is a protection that the Board is obligated to extend not simply under the medical staff bylaws, but by the Hospital Bylaws. Hospital Bylaws, Article XV, §15.1(c).

actions and the rights and duties of its members. *See, Diedrick v. Helm*, 217 Minn. 483, 14 N.W.2d 913 (1949).

Pursuant to Minn.Stat.Ch. §317A, Avera has established bylaws. These bylaws make it clear that, as required by Minnesota law, the Board has the ultimate authority and oversight for the affairs and business of the Medical Center.

POWER OF THE BOARD OF DIRECTORS. The Board of Directors shall exercise oversight of the business affairs of the Corporation and shall have an exercise all of the powers which may be exercised or performed by the Corporation under the laws of the State of Minnesota, the Corporation's Articles of Incorporation and these Bylaws, subject to the powers reserved to the Member of the Corporation as stated in the Articles of Incorporation and these bylaws.

Hospital Bylaws, Article IV, §4.1. Article XV of the Hospital Bylaws describes the role of the Medical Staff. The role of the Medical Staff is advisory in nature¹⁶.

The Hospital Bylaws grant members of the Medical Staff "appropriate authority and responsibility" for patient care "subject to such limitations as are contained in these Bylaws" and the Medical Staff Bylaws. Hospital Bylaws, Article XV, §15.1(a). The Hospital Bylaws provide that the Board shall assign to the Medical Staff "reasonable authority" for ensuring appropriate patient care, subject to the Board's "exercise of its overall authority and responsibility." Hospital Bylaws, Article XV, §15.2(a). The Hospital Bylaws also afford members of the Medical Staff due process when their privileges are altered, suspended, or terminated. Hospital Bylaws, Article XV, §15.1(c) and (d).

Minnesota regulations promulgated by the Minnesota Commissioner of Health, as discussed above, require that medical staff bylaws be formulated and adopted. Minn.R. §4640.0800, subp. 2. The ultimate authority of hospital administration recognized in Minn.R.

¹⁶ See, e.g., Hospital Bylaws, Article XV, §15.2(c)(Medical Staff makes "recommendations" to the Board concerning appointments, clinical privileges, disciplinary actions, matters relating to professional competency, and specific matters referred to the Medical Staff by the Board); Hospital Bylaws, Article XV, §15.3 (amendments to the Medical Staff Bylaws may be "recommended" by the Medical Staff).

§4640.0700 is analogous to Minn.Stat.Ch. 317A and the Hospital Bylaws discussed above, insofar as the regulation states that the governing body of the hospital is responsible for the hospital's management, control and operation.

Plaintiffs' position that the Original and New Medical Staff Bylaws are contractual is in contravention of the Hospital Bylaws and Minn.Stat.Ch. 317A. Both the Hospital Bylaws and the statute require that the Board retain ultimate authority for the oversight of the hospital. The vast majority of cases that have found that medical staff bylaws are or can be a contract have stated that the "contract" cannot be extended to a hospital's administrative and organizational decisions. *See, e.g., Weary v. Baylor University Hospital*, 360 S.W.2d 895, 897 (Tex.Civ.App. 1962)("internal procedures set forth in the Medical Staff By-Laws, even though such By-Laws be approved and adopted by the Board, cannot limit the power of the Governing Board of the Hospital"); *Bartley*, 617 A.2d at 1022 (board has the authority to manage all the affairs of the hospital); *Gonzalez*, 880 S.W.2d at 349-40; *Marlin v. Robertson*, 307 S.W.2d 418, 433-34 (Tex.Ct.App. 2009).

The South Dakota Supreme Court's analysis in *Mahan v. Avera St. Luke*, 621 N.W.2d 150 (S.D. 2001), is instructive in this regard. In *Mahan*, the hospital closed its medical staff to any additional orthopedic surgeons and a group of orthopedic surgeons seeking privileges sued the hospital as a result. The lower court found in favor of the applicant-surgeons, finding that the closure of the staff violated the hospital's medical staff bylaws. The lower court reasoned that the hospital had delegated a significant degree of power to the medical staff regarding staff privileges and, as a result of this delegation, the board could no longer take action that affected the privileges of the medical staff.

The South Dakota Supreme Court reversed. While holding that a hospital's bylaws are a binding contract between the hospital and the hospital staff members, the Court also held that the hospital had authority to make business decisions pursuant to its corporate bylaws. The *Mahan* Court emphasized that the medical staff bylaws were derived from the corporate bylaws and, therefore, any power granted under the medical staff bylaws must first be authorized by the board pursuant to the hospital bylaws. In other words, the hospital's delegation of certain authority to the medical staff did not trump or override the decision-making power of the board. The *Mahan* Court compared the legal relationship between the medical staff bylaws and the hospital bylaws with that of statutes and the Constitution.

Their legal relationship is similar to that between statutes and 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, a judicial analysis must begin with an examination of the Corporate Bylaws. Article V, section 11 states that "[t]he business and the property of the Corporation shall be managed and controlled, ... by a Board of Trustees ..." In addition, the Corporate Bylaws provide that: "[a]ll the corporate powers, except such as reserved to the Member of the Corporation, and except such as are otherwise provided in these Bylaws and in the laws of the State of South Dakota, shall be vested in and shall be exercised by the Members of the Board of Trustees." Therefore, the medical staff has no authority over any corporate decisions unless specifically granted that power in the Corporate Bylaws or under the laws of the State of South Dakota.

Id. at 155.

In holding that the board had the sole authority to make business decisions without consulting the medical staff, the *Mahan* Court rejected the notion that the "spirit" of the bylaws should be considered.

[R]eliance on the "spirit of the [Staff] bylaws" turns the corporate structure of ASL upside down, granting control over day to day hospital administration to a medical staff that is not legally accountable for the hospital's decisions, has no obligation to further the mission of the Presentation Sisters, and has unknown experience in running a hospital or meeting the medical needs of the community. Such a result is contrary to South Dakota corporate law and thus cannot be

allowed to stand ... When the Board delegated power to the medical staff through the Staff Bylaws, it had the authority under the corporate bylaws to delegate *only* the "authority to evaluate the professional competence of staff Members and applicants for staff privileges..." The purpose of this limited delegation of authority was to obtain input from the staff on areas of its expertise. Decisions relating to the competence, training, qualifications and ethics of a particular physician are matters for which the medical staff is uniquely qualified, while the Board admittedly has limited expertise in those areas. Under the Corporate Bylaws, it is *only* in those confined areas of expertise that the staff has any authority at all ... Within its broad powers of management, some of the business decisions made by the Board will undoubtedly impinge upon matters that relate to or affect the medical staff of the hospital. This fact is unavoidable. However, merely because a decision by the Board affects the staff does not give the staff authority to overrule a valid business decision made by the Board. Allowing the staff this amount of administrative authority would cripple the governing Board of ASL. ASL would cease to function in its current corporate form if its staff were given such power ... Imagine the confusion and lack of clear lines of management authority that would ensue at the hospital if the Board had only the minimal amount of control over its medical staff that the circuit court would give it.

Id. at 156, 157, 158, 159.

Of concern in the context of the procedural due process versus the administrative/organizational components of medical staff bylaws, is the very real danger that, even when this distinction has been recognized by the courts, there has been a willingness to, at least, open the door to judicial review of management decisions in the context of an alleged breach of contract of medical staff bylaws. In *Anne Arundel General Hospital v. O'Brien*, 432 A.2d 483 (Md.Ct.Spec.App. 1981) the Court, while holding that a hearing on a hospital's management decision was not contemplated by the charter and bylaws of the hospital, went on to state (quoting other authority) that

"A managerial decision concerning operation of the hospital made *rationaly* and *in good faith* by the board to which operation of the hospital is committed by law should not be countermanded by the courts *unless* it clearly appears it is unlawful or *will seriously injure a significant public interest.*"

Id. at 490 (emphasis added). Does this mean that, in recognizing a contractual relationship between a hospital and its medical staff, courts may then have the authority, or otherwise be

asked, to review managerial decisions (not associated with an individual physician's due process rights) of a hospital board on a breach of contract claim to determine if those managerial decisions are "rational", "made in good faith", or will "seriously injure a significant public interest"? To recognize medical staff bylaws as a contract would seem to, effectively, open the floodgates to judicial review of a hospital's management decisions. What is rational or in good faith are generally questions of fact. Various "public interests" could be identified (e.g., a public interest in the hospital providing a particular clinical service, the public interest in additional hospital services such as telemedicine, etc.) that, under *O'Brien*, could be used as a basis for initiating a breach of contract action (regardless of the ultimate success on the merits)¹⁷.

Plaintiffs state that they are not, as part of this action, seeking to interfere with managerial decisions of the Board. Therefore, the Plaintiffs seem to indicate, and most of the extra-jurisdictional case law addressing this issue directly or otherwise seems to hold, that those portions of medical staff bylaws that would affect managerial (i.e., administrative/organizational) issues are not enforceable under a breach of contract theory. However, the issue posed by Plaintiffs in their declaratory judgment action in Count II is whether or not the Original or New Medical Staff Bylaws are a contract between Avera and the Medical Staff.¹⁸ If the Original or New Medical Staff Bylaws are a contract, then the Original or New Medical Staff Bylaws in their entirety are a contract unless certain provisions are deemed severable. In other words, if the Court found that the Original or New Medical Staff Bylaws were a contract, then all of the provisions thereof would be, necessarily, given contractual effect. For the reasons described above, the Court finds that, even if the Original or New Medical Staff Bylaws were a contract,

¹⁷ The public policy concerns associated with such claims is discussed *infra*.

¹⁸ In other words, the question posed is not whether certain portions of the medical staff bylaws are contractual, but whether the bylaws as a whole are a contract.

the provisions of the Original or New Medical Staff Bylaws that pertain to administrative/organizational issues are unenforceable.

The mere fact that a contract is organized by numbered provisions and may be divided does not make a contract severable. *See, e.g., Bentley*, 125 Minn. at 183, 146 N.W. at 349. Rather, a contract is severable only when the parties intend to make the contract apportionable and it can be apportioned fairly. *See, id.* at 184, 146 N.W.2d at 349. So, which portions of the Original or New Medical Staff Bylaws are unenforceable because they are administrative/organizational rather than affecting the individual "rights" of members of the medical staff? In reviewing the medical staff bylaws in detail, there are few, if any, provisions that can be so delineated.

Under Article 2 (Purpose and Authority of the Medical Staff¹⁹), the medical staff bylaws address the authority of the medical staff to "initiate and maintain rules, regulations, and policies for the internal governance of the medical staff". This provision may be construed as providing a member of the medical staff individual rights and the provision also contains managerial and aspirational statements. Article 3 addresses membership in and responsibilities of the medical staff; Article 4 addresses categories of membership in the medical staff; Article 5 addresses medical staff appointment, including appointment and reappointment, modification of privileges, and leave status; Article 6 addresses clinical privileges, monitoring, proctoring, and various types of privileges and how and when they are granted; Article 7 addresses officers of the medical staff, how they are nominated and elected, their terms of office, and how they are removed; Article 8 addresses committees of the medical staff (including the MEC), what their duties are, and how members are appointed and removed; Article 9 addresses clinical departments and services, how clinical services are organized, what the current clinical services are, what the

¹⁹ For purposes of this discussion, the Court is referencing the Original Medical Staff Bylaws.

functions of the services will be, how service chairs are selected and what their duties are; Article 10 addresses meetings of the medical staff and its committees, including attendance requirements; Article 11 describes a problem solving mechanism; Article 12 addresses corrective and disciplinary action against a staff member, how actions are initiated and investigated, and how disciplinary or corrective action is imposed; Article 13 sets forth the hospital's fair hearing plan; Article 14 addresses the medical staff files, how such files are accessed, and what information can be accessed; Article 15 addresses confidentiality, immunity and releases, the confidentiality of individual member and applicant data, consequences for breaches, and who is immune and when; Article 16 sets forth the general rules for governance²⁰, including the medical staff's role in exclusive contracting; and Article 17 addresses how the Medical Staff Bylaws are adopted and amended. Taking these articles separately, do they define individual rights or are they related to Avera's administrative/organizational rights and duties? Both individual rights/interests and administrative/organizational rights and duties appear to be implicated to such a degree that it would be difficult, if not impossible, to determine which articles should be severed and/or which subsections of articles should be severed.

Because provisions of the Original and New Medical Staff Bylaws that impinge on the authority of the Board are unenforceable as in violation of Minn.Stat.Ch. 317A and the Hospital Bylaws and because there is no reasonable way to sever the provisions of the Original and New Medical Staff Bylaws to address this concern, neither the Original or the New Medical Staff Bylaws are an enforceable contract.

²⁰ This provision is significant insofar as it describes the MEC as formulating rules, regulations, and policies. If these rules, regulations and policies are, consequently, part of an enforceable "contract" between medical staff members and the hospital, it impinges even more significantly on hospital administration. Such rules, regulations and policies include creation of other committees, sexual harassment, unacceptable behavior/disruption, documentation and medical records (including how the records are accessed, which implicates possible liability or the hospital if a person accesses a record contrary to law, regardless of a policy provision), and mandatory reporting protocols.

3. Recognizing a Breach of Contract Action for Noncompliance with Medical Staff Bylaws Would be Contrary to Public Policy

In many of the extra-jurisdictional cases in which medical staff bylaws have been found to be contracts, particularly those which did not describe any contract analysis, it appears to the Court that the remedy has been placed before the theory. That is, that the Courts in those cases appear to have a legitimate concern about providing an individual member of the medical staff with an avenue in which to obtain judicial review of action taken by a hospital which is allegedly in contravention of its or the medical staff's bylaws. This "ends justifies the means" approach is problematic not only for the reasons described above, but for public policy reasons as well.

Some Courts, in holding that medical staff bylaws are not contract, have accurately described these public policy concerns. In *Zipper*, the Court found that recognizing medical staff bylaws as contracts would be contrary to public policy. *Zipper*, 978 S.W.2d at 417. In so finding, the Court stated:

Allowing a physician to seek damages for an alleged failure of a hospital to follow the procedures established by its bylaws is counter to [public policy]. A hospital's consideration, when terminating the privileges of a physician, of its potential liability for monetary damages could unduly impugn a hospital's actions in terminating the privileges of a physician providing substandard patient care. Because creating a breach of contract action would run counter to Missouri's expressed policy of assuring quality health care, public policy principles support the finding that the bylaws did not constitute a contract between [the hospital and the plaintiff].

Id.

Likewise, in *Robles*, the Court, in describing the public policy concerns associated with construing medical staff bylaws as contracts, stated:

The bylaws are a method by which a hospital can control the quality of care it offers to the public ... If this Court were to declare that HHC's bylaws are a contract, it would be tantamount to creating an additional damages action against a hospital for failure to follow its statutory mandate of having a peer review system. Creating a breach of contract action in this situation would run counter to

this state's policy of allowing the hospital to grant or withhold staff privileges from doctors it believes are unqualified to serve on its staff.

Robles, 785 F.Supp. at 1002.

In *Tredrea*, the Court described the public policy concern as follows:

Under our statutory scheme, the board simply must be allowed to make key decisions on the method of delivery of anesthesiology services that best suit the needs of its patients and most completely satisfies the requirements of the law. If the view of these plaintiffs prevailed, the hospital could not scale down or close a department, regardless of the advisability of doing so, without incurring liability to doctors who are incidentally affected ...[Construing medical staff bylaws as a contract] would improperly impinge on the statutory mandate to the board of directors to establish criteria for staff privileges, perpetuate the problems that led to the establishment of the independent contractor system, and ultimately affect the successful operation of the hospital.

Tredrea, 584 N.W.2d at 287.

In this case, the Court is being asked to determine whether the Original and/or New Medical Staff Bylaws, as a whole, are a contract.²¹ In a breach of contract action, a party may seek monetary damages as relief. Therefore, in addition to the costs of litigation, a hospital would be likely be compelled to consider the possibility that it would be required to pay monetary damages for administrative or organizational decisions it may make that may, in some way, negatively impact an individual physician. In light of the nature of the work performed by the medical staff (i.e., a medical staff, in all likelihood, is comprised entirely of physicians), the potential damage amount at issue (leaving the merits of the claim aside) would be substantial. This would not only affect a hospital's decision to terminate, suspend or restrict a physician's privileges at the hospital, but could also affect a hospital's administrative decisions that had some actual or perceived effect on a physician or group of physicians.

²¹ Again, Plaintiffs are not, for example, as and for Count II of the Complaint, asking the Court to construe only certain portions of the Original and/or New Medical Staff Bylaws.

For example, the hospital could decide to close a service area because it was not financially feasible to continue to offer that service in the community. Physician members practicing in that service area could, potentially, bring a breach of contract action seeking monetary damages against the hospital, arguing that the decision was not rational, was not made in good faith, and/or would seriously injure some public interest. *See, e.g., O'Brien*, 432 A.2d at 490. The hospital would then be in a position, in the course of making legitimate business decisions, to factor in the possible civil liability for those decisions as a "cost of doing business." Similarly, the hospital may wish to institute or discontinue a telemedicine policy.²² Instituting or discontinuing this policy could negatively impact an individual physician (e.g., could reduce his or her patient pool). Again, the hospital would be in a position of evaluating the possible litigation costs associated with this this managerial decision because it has some impact on one or more members of the medical staff.

In short, recognizing a breach of contract action for an alleged violation of medical staff bylaws, under the circumstances of this case, would be contrary to public policy. Such a recognition would improperly restrict the ability of the Board to make legitimate decisions not only about the business operations of the hospital but also about policy decisions surrounding the provision of patient care in the community.

4. Enforceability of Medical Staff Bylaws

The foregoing does not, however, mean that the Original and New Medical Staff Bylaws are meaningless. Such cannot have been the intention of the Board in approving medical staff bylaws and such a unilateral interpretation would be unreasonable and unfair. "[T]o suggest [that the hospital has no legal duty to follow its own bylaws] would be to reduce the bylaws to meaningless mouthing of words." *Lewisburg Community Hospital v. Alfredson*, 805 S.W.2d

²² Currently, this policy was instituted as part of the New Medical Staff Bylaws §6.10.

756, 759 (Tenn. 1991)(citation omitted). "If a hospital's bylaws were not binding upon a board of directors, the bylaws 'would, of course, [be] rendered ... essentially meaningless. They would then be a catalogue of rules, which, although binding on the medical staff, were merely horatory as to [the hospital]—much 'sound and fury, signifying nothing'." *Austin v. Mercy Health System Corp.*, 197 Wis.2d 117, 541 N.W.2d 838, *2 (1995)(citation omitted).

The Court concludes, in reviewing the applicable Minnesota regulations and the Hospital Bylaws, that the requirement of implementing medical staff bylaws would not have been imposed if there were no intention to follow the procedures once they were implemented. Avera is bound to abide by the Hospital Bylaws. *Little Canada*, 498 N.W.2d at 24. The Board adopted medical staff bylaws in conjunction with the duties and responsibilities conferred upon it under the Hospital Bylaws. The Board and Avera are bound to abide by the medical staff bylaws once they have been duly adopted by the Board. Therefore, if Avera does not follow the procedures contained in duly adopted medical staff bylaws, an aggrieved or affected member of the medical staff can bring an action in equity (i.e., an injunctive action) to enjoin Avera from acting or to require Avera to act in accordance with the Medical Staff Bylaws. *See, e.g., Robles*, 785 F.Supp. at 1002 (cases cited therein).

D. Conclusion

The Original and New Medical Staff Bylaws are not a contract because there is a lack of consideration. Avera had a preexisting duty under Minnesota regulations and the Hospital Bylaws to adopt medical staff bylaws and to appoint qualified applicants to its medical staff. Likewise, based upon the express language in the Original and New Medical Staff Bylaws and the Hospital Bylaws reserving all authority to the Board, there is no enforceable contract because there was no intent to be so bound. Furthermore, granting contractual effect to the Original or

New Medical Staff Bylaws would improperly infringe on the authority and responsibilities of the Board under Minn.Stat.Ch. §317A, the Hospital Bylaws, and applicable case law. Finally, construing the Original or New Medical Staff Bylaws as a contract would be contrary to public policy in Minnesota because such a construction would improperly restrict Avera's ability to make necessary business and policy decisions regarding the provision of patient care in the community.

However, Avera is required to abide by the provisions in the medical staff bylaws once they have been adopted by the Board. Adoption of medical staff bylaws is required by the Hospital Bylaws and the Board is required to follow its own bylaws. Therefore, if Avera fails to follow the medical staff bylaws, a court may enjoin Avera to follow those procedures.

IV. Can Avera Take Action in Contravention of the Medical Staff Bylaws (Counts III-VI)?

As discussed above, Avera is required to abide by duly adopted medical staff bylaws. The Plaintiffs allege that Avera acted in contravention of the Original Medical Staff Bylaws as follows:

1. By "unilaterally conducting the application process, considering physician applicant reports and information, and making determinations regarding physician appointments, reappointments, and clinical privileges" without the input from the MEC and/or the Medical Staff. Amended Complaint, ¶203.
2. By impinging on the rights and duties of the Chief of Staff and the MEC and by prohibiting members of the Medical Staff from attending MEC meetings. Amended Complaint, ¶¶208-11.
3. By impinging on the rights and duties of the Chief of Staff and MEC by making unilateral appointments to the MSQIC and restricting and/or altering the duties and responsibilities of MSQIC. Amended Complaint, ¶¶216-19.
4. By impinging on the rights and duties of the Medical Staff, the MEC, and other committees to evaluate patient care, to conduct productive interaction and investigations, and peer review by attempting to unilaterally control such proceedings. Amended Complaint, ¶¶222-25.

Without ruling on the underlying validity of the claims²³, for the reasons stated above, Avera is required to follow the provisions of existing and duly adopted medical staff bylaws and policies and procedures that are enacted under the medical staff bylaws and which are duly adopted by the Board. For the reasons discussed in the next section, however, injunctive relief is moot at this time.

V. Can Avera Modify or Amend the Medical Staff Bylaws and Related Policies Without Medical Staff Approval (Count VII)?

The Court is unaware of any Minnesota case law addressing this particular issue. Few cases have addressed the issue of whether or not a hospital can amend its medical staff bylaws without the approval of its medical staff.²⁴

In *St. John's*, the medical staff brought a declaratory judgment action against the hospital when the hospital amended its bylaws without the approval of the medical staff. The *St. John's* Court found that the bylaws of a corporation are binding between the corporation and its shareholders²⁵ and then cited case law from other jurisdictions holding that medical staff bylaws are a contract.²⁶ *St. John's*, 245 N.W.2d at 474. The Court held that the medical staff and the hospital are bound by the medical staff bylaws until the medical staff bylaws are amended in accordance with the medical staff bylaw procedures. *Id.* at 475. "The medical center by ignoring the procedures set forth [in the medical staff bylaws] and by not including the medical

²³ Indeed, the Court is unable to do so at this procedural posture. Avera disputes the validity of these claims and there is, therefore, a factual dispute regarding what did or did not occur. However, resolution of any factual dispute is not necessary. Plaintiffs are not asking that the Court enjoin any *particular* action or inaction or invalidate any *particular* action. Rather, Plaintiffs are merely requesting a ruling on the issue of whether or not the Board is required act in accordance with duly adopted medical staff bylaws and policies and procedures created thereunder.

²⁴ In *Todd v. Physicians & Surgeons Community Hospital, Inc.*, 302 So.2d 378 (Ga.Ct.App. 1983), plaintiff podiatrists brought an action against the hospital for breach of contract when their staff privileges were terminated. The Court found that there was no contractual relationship between the parties and that the hospital, therefore, had an absolute right to change the bylaws. The case did not contain an analysis of how the Court reached this conclusion and this case is, therefore, of little assistance to the Court on this issue.

²⁵ There is a fundamental distinction between a corporation's shareholders and the medical staff of a hospital.

²⁶ The Court did not describe the analysis it engaged in in reaching the conclusion that medical staff bylaws are a contract.

staff in the attempted bylaws amendment has breached this contractual relationship with the medical staff.” *Id.*

St. John's is distinguishable from the present case. First, the Original and New Medical Staff Bylaws are not a contract. However, as discussed above, Avera is required to follow existing and duly adopted medical staff bylaws.

Secondly, however, the *St. John's* Court based its ruling, in part, on its finding that the hospital ignored the procedures in the medical staff bylaws and excluded the medical staff from the amendment. That is not the case here. In this case, under the Original Medical Staff Bylaws, the following procedures applied to amendments or modifications of the medical staff bylaws: (a) a request is made to amend the medical staff bylaws; (b) proposed amendments are reviewed by the MEC; (c) the MEC, or its designated subcommittee, would provide the exact wording of the changes and its findings, to the members of the Medical Staff at least 30 days before the medical staff's regular or special meeting; and (d) the Medical Staff votes on the proposed change. Original Medical Staff Bylaws, §17.1.3.

In this case, a request was made by the Board to amend the Original Medical Staff Bylaws. On or about January 17, 2012, Avera provided a copy of revised medical staff bylaws, rules and regulations, and policies to the Medical Staff, including the Chief of Staff. Affidavit of Steven T. Meister in Support of Plaintiff's Motion for a Temporary Restraining Order (hereinafter “Meister Affidavit”), Exhibit C. The Court considers this to be the functional equivalent of a request to modify the Original Medical Staff Bylaws. The purpose of the request requirement in the Original and New Medical Staff Bylaws is, necessarily, to give the Medical Staff and the Board notice of a proposed change. Providing the Medical Staff with the revised

bylaws satisfied this requirement. The revisions were to be effective April 1, 2012.²⁷ The letter accompanying the revisions stated that the Board was seeking the input of the Medical Staff and provided that any comments should be submitted on or before March 1, 2012—more than 30 days after the revisions had been provided. The revisions were discussed at the Medical Staff's Annual Meeting on January 24, 2012. The MEC conducted a review of the revisions and issued a report dated February 25, 2012, directed to the Medical Staff. Meister Affidavit, Exhibit G. On March 20, 2012 a special meeting of the Medical Staff was held. Of the 29 Medical Staff noting at the special meeting, 17 voted in opposition to the revisions and 11 voted in favor of the revisions.²⁸

Here, a request/notice was made to amend the Original Medical Staff Bylaws by the Board. The revisions were provided to the MEC, who provided the Medical Staff with its report. The Medical Staff voted on the changes. The Board solicited input from the Medical Staff on the revisions²⁹. Unlike *St. John's*, the Court cannot conclude that the Board "ignored" the amendment provisions of the Original Medical Staff Bylaws or that it failed to include the Medical Staff in its decision. It is immaterial whether or not the Medical Staff chose to provide input to the Board, so long as they were given an opportunity to do so and the Board considered such input.

Finally, in *St. John's*, the hospital argued that the power to amend the medical staff bylaws should not be curtailed by the medical staff as a matter of public policy because allowing the medical staff to do so may impact the hospital's independent civil liability. The *St. John's*

²⁷ The effective date was subsequently extended.

²⁸ One ballot was returned without a response.

²⁹ The record is unclear as to whether and when the Medical Staff provided the MEC report to the Board. Also, while it is clear that the Medical Staff special meeting when the vote occurred was after the March 1, 2012, deadline, there is nothing in the record that indicates that the Medical Staff asked that for an extension of the March 1, 2012, deadline or, if it did, that the request was denied. It is also unclear from the record when the Board voted on the revisions.

Court, in responding to that concern, stated that “the medical center’s assertions regarding independent liability are premature and not vital to this appeal.” *Id.* at 474. In the 36 years that have passed since *St. John’s* was decided, the legal landscape has changed in this regard. Courts have recognized an independent cause of action against a hospital for decisions made under, at least in part, the hospital’s medical staff bylaws.

In *Larson v. Wasemiller*, 738 N.W.2d 300 (Minn. 2007) the plaintiff sued physicians and the hospital for negligent credentialing. The Court held that the claim was not precluded by the peer review statute. In so holding the Court recognized a hospital’s duty of care to protect its patients from harm from third persons. *Id.* at 306. The Court noted that other jurisdictions have adopted a theory of corporate negligence in negligent credentialing cases.

“To implement this duty of providing competent medical care to the patients, it is the responsibility of the institution to create a workable system whereby the medical staff of the hospital continually reviews and evaluates the quality of care being rendered within the institution ... The hospital’s role is no longer limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices his profession in his own individualized manner.”

Id. at 308 (quoting, *Pedroza v. Bryant*, 677 P.2d 166, 169 (Wash. 1984)). The Court went on to note that other courts have considered the tort of negligent credentialing as an extension of (a) a hospital’s duty to exercise ordinary care and attention for their patient’s safety; (b) negligent hiring; and (c) negligent selection of independent contractors. *Id.* at 308-09. The Court did not reject any of these analyses. The Court did not reject the policy favoring hospital liability proffered by the plaintiff—“that if a hospital grants privileges to a problem physician, public policy goals are well served by holding the hospital liable for injuries not compensated for by the physician’s insurance.” *Id.* at 312. See also, *Johnson v. Misericordia Community Hospital*, 301 N.W.2d 156 (Wis. 1981)(plaintiff sued hospital for negligently appointing physician to medical staff and granting privileges); *Pedroza*, 677 P.2d 166 (plaintiff sued hospital alleging negligence

in violating a duty of care). The realities of a hospital's corporate liability for the acts of physicians granted privileges at the hospital have, therefore, changed since *St. John's* was decided.

While the issue of authority to amend medical staff bylaws was not specifically before the Court in *Mahan*, the Court accurately described the problem with limiting the board to so act.

[T]he negligent act of a doctor can impute liability to a hospital under a theory of *respondeat superior* unless it can be shown that the doctor was acting as an independent contractor ... [S]eparate liability for negligence attaches to a hospital when it has breached its own standards, or those available in the same or similar community or hospitals generally, such as allowing a known incompetent doctor to remain on staff. It would be completely illogical to first impose a duty of reasonable care upon a hospital, and then later strip the hospital of the ability and power to implement the policies and programs required to fulfill that duty.

Mahan, 621 N.W.2d at 160-61.

The Court finds that the facts in *St. John's* are distinguishable from those presently before the Court. Furthermore, because of the changes that have occurred in terms of a hospital's liability for actions of those on its medical staff, the rationale in *St. John's* is stale. The Court finds the rationale in *Mahan* in this regard far more compelling. If hospitals are being exposed to potential civil liability for the acts of its medical staff, it stretches credulity to impose such a liability on them and at the same time tie a hospital's hands to make changes in medical staff bylaws that would serve, in part, as a basis for the negligence action unless the medical staff allowed such a change.

As discussed above, however, Avera has an obligation to abide by the terms of medical staff bylaws that have been duly adopted by the Board. While few cases have specifically discussed a hospital board's ability to amend medical staff bylaws, many cases have discussed the degree to which a hospital must comply with the procedural due process rights granted to

individual physicians under its medical staff bylaws.³⁰ Seemingly universally, the standard applied is substantial compliance³¹. In *Owens v. New Britain General Hospital*, 643 N.W.2d 233 (Conn. 1994), the Court stated:

[A] substantial compliance test ... is the proper test by which to measure whether a hospital has sufficiently complied with its bylaws in terminating a physician's medical staff privileges ... We therefore recognize that the obligation to follow medical staff bylaws is paramount and that a hospital must afford its medical staff all the process and protections encompassed by its bylaws ... There must also be concern, however, for unnecessary judicial interference with those whose duty it is to make the decisions and who have the necessary expertise with which to act. Courts are generally unwilling "to substitute their judgment on the merits for the professional judgment of medical and hospital officials with superior qualifications to make such decisions." "In so specialized and sensitive an activity as governing a hospital, courts are well advised to defer to those with the duty to govern."

Id. at 240, 241 (citations omitted). Under the substantial compliance standard, mere technical violations of procedures or policies will not give rise to a cause of action. *Brinton*, 973 P.2d at 965.

As discussed above, the Original Medical Staff Bylaws included a series of procedural steps to be taken when a change in the medical staff bylaws was desired. These procedural requirements are clearly connected to the need for a review of changes to the medical staff bylaws by the Medical Staff to ensure that patient care would not be adversely affected by the proposed change(s) and to identify other consequences the changes would have on the Medical Staff. As discussed above, these procedural steps were substantially complied with by Avera.

A second issue, however, is the voting requirements in Section 17 of the Original Medical Staff Bylaws. Section 17.2 of the Original Medical Staff Bylaws provided that, "If a

³⁰ The Court is unaware of any Minnesota caselaw addressing this issue.

³¹ See, *Gianetti*, 43 A.3d 567, 606; *Egan*, 291 S.W.3d at 759-60; *Pierson v. Orlando Regional Healthcare Systems, Inc.*, 619 F.Supp.2d 1260, 1283 (M.D.Fla. 2009); *Mahmoodian v. United Hospital Ctr., Inc.*, 404 S.E.2d 750, 755 (W.Va. 1991); *Brinton v. IHC Hospitals*, 973 P.2d 956, 964-65 (Utah 1999); *Ray v. St. John's Health Care Corp.*, 582 N.E.2d 464, 469 (Ind.App. 1991).

quorum is present for the purposes of enacting a bylaws change, the change shall require an affirmative vote of a two-thirds of the Members eligible to vote.” Plaintiffs contend that the Board was precluded from amending the Original Medical Staff Bylaws unless the Medical Staff approves the change as described in §17.2. For the reasons stated above, the Court rejects this contention. Furthermore, immediately preceding §17.2--the section describing amendment or repeal of the Medical Staff Bylaws--it states that, “Nothing contained herein shall supersede the authority of the Medical Center Board of Directors as set forth in its corporate bylaws or applicable common law or statutes.” Original Medical Center Bylaws, §17.1.3. The Hospital Bylaws provide as follows:

The Board of Directors shall organize the physicians and other appropriate persons granted practice privileges in the hospital owned and operated by the Corporation into a medical-dental staff under medical-staff bylaw approved by the Board of Directors.

Hospital Bylaws, Article XV, §15.1(a)(emphasis added). Therefore, the Hospital Bylaws vest with the Board the authority to organize physicians and others under medical staff bylaws that are approved by the Board. For reasons discussed above, Board cannot permanently divest itself of its authority and responsibility to operate the hospital. To do so would not only violate the Hospital Bylaws and Minn.Stat.Ch. 317A (as discussed in more detail in the preceding sections of this Memorandum), but would also prevent Avera from taking necessary and appropriate steps to protect itself and its member physicians from liability—concerns that the Medical Staff may or may not share or recognize.³²

³² There are claims that members of the medical staff have improperly accessed records and interfered with a treating physician's relationship with his/her patient, among other things. The Court makes no comment on the validity of these claims, but the general concerns expressed as part of the claims are legitimate and Avera cannot be precluded from initiating procedures to address these concerns, which could expose it to liability. Furthermore, a concern was expressed regarding a treating physician not being available for post-operative consultation or issues. Again, leaving aside the accuracy of the individual report, Avera may have a legitimate business concern to initiate a policy regarding post-operative responsibilities. If more than one-third of the medical staff are not willing to take on

The Court concludes that Avera may amend the medical staff bylaws and the related policies, procedures and regulations without the two-thirds approval of the Medical Staff provided that it has substantially complied with the procedures described in the medical staff bylaws in effect at the time the amendment is proposed. The Court concludes that Avera substantially complied with the procedural requirements when it amended the Original Medical Staff Bylaws.

M.A.D.

that responsibility, under Plaintiffs' theory, Avera would be precluded from amending the medical staff bylaws (which include the policies and procedures) to address this issue. Allowing this outcome is illogical.