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NOTE

PHYSICIAN PRIVILEGES: JUDICIAL TREATMENT OF THE DISCHARGED PHYSICIAN

*Brian Lester**

INTRODUCTION

Remedies for physicians whose privileges are reduced depend, in large part, on a court's determination of the character of the hospital's decision, rather than a court's ascertainment of the shared expectations between the physician and the hospital. Some courts, however, have applied contractual principals to medical staff bylaws to effect the expectations of the parties. Arthur Corbin characterized the primary purpose of contract law as "the realization of reasonable expectations that have been induced by the making of a promise."¹ As late as the 1970s, however, most courts refused to recognize the existence of reasonable expectations between physicians and hospitals that would allow physicians to recover under breach of contract for wrongful discharge.² A physician's remedy against the hospital was subject to minimal judicial review in order to avoid adversely interfering with arbitrary and discriminatory hospital decisions.³

* Candidate for Juris Doctor, Notre Dame Law School, 2002; B.A., University of Washington, 1998. This Note is dedicated to my parents for their love and generous support. I would like to thank Professors Jay Tidmarsh and Anthony Bellia of the Notre Dame Law School for providing me with invaluable suggestions throughout the process. I also wish to thank Ed Caspar, Lee DeJulius, Christina Rissler, and Christian Schultz for their helpful comments and encouragement from the beginning.

1 ARTHUR L. CORBIN, CORBIN ON CONTRACTS § 1 (1952).

2 See *infra* Part II.

3 See *Shulman v. Wash. Hosp. Ctr.*, 222 F. Supp. 59, 64-65 (D.D.C. 1963); see also *Sosa v. Bd. of Managers*, 437 F.2d 173, 176-77 (5th Cir. 1971); *Suess v. Pugh*, 245 F. Supp. 661, 667-68 (N.D. W. Va. 1965).

About the same time, state legislatures enacted legislation requiring hospitals to enact medical staff bylaws⁴ to govern the hospitals' relationships with all practicing physicians,⁵ partly in response to the malpractice "crisis."⁶ Eventually most courts recognized bylaws as a set of enforceable promises, establishing procedural protections for physicians who were not re-appointed or were discharged, even to those physicians who enjoy medical staff privileges as members of an open medical staff because they do not have an independent employment contract.⁷

4 Medical staff bylaws are a set of policies and procedures that govern physicians on the medical staff, which is comprised of member physicians at a particular hospital. See June D. Zellers & Michael R. Poulin, *Termination of Hospital Medical Staff Privileges for Economic Reasons: An Appeal for Consistency*, 46 ME. L. REV. 67, 69 (1994). Bylaws define the scope of the relationship between the physician and the hospital, including organizational principles within the medical staff, the standards of physician conduct, the requirements and procedures for obtaining and maintaining medical staff privileges, and amendment of the bylaws. See *id.* As the servicing of health care has grown in complexity to include insurance companies, hospitals, physicians, and government, bylaws "lay the foundation for those business relationships that will carry physicians, in conjunction with the rest of the hospital, to success in the fulfillment of quality and economic goals." DANIEL A. LANG ET AL., *MANAGING MEDICAL STAFF CHANGE THROUGH BYLAWS AND OTHER STRATEGIES*, at ix (1995).

5 See Craig W. Dallan, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 608 (2000) (citation omitted).

6 Through increased malpractice claims, the public and the courts exerted pressure on hospitals to change their organizational structure to improve quality of care. See Jennifer S. Anderson, Comment, *All True Histories Contain Instruction: Why HMOs Cannot Avoid Malpractice Liability Through Independent Contracting with Physicians*, 29 MC. GEORGE L. REV. 323, 324, 333-38 (1998); Dallan, *supra* note 5, at 603.

7 See Brad Dallet, Note, *Economic Credentialing: Your Money or Your Life!*, 4 HEALTH MATRIX 325, 331-37 (1994).

Although many state courts recognize that medical staff bylaws carry contractual obligations, approaches differ significantly in the extent to which a physician is protected under the bylaws. Several courts have rejected bylaws as contractually enforceable. See, e.g., *Ingraffia v. NME Hosps., Inc.*, 943 F.2d 561, 565-66 (5th Cir. 1991); *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1000-02 (N.D. Ga. 1992); *Balkissoon v. Capitol Hill Hosp.*, 558 A.2d 304, 308 (D.C. Cir. 1989); *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1255 (Conn. 1989); *St. Mary's Hosp., Inc. v. Radiology Prof'l Corp.*, 421 S.E.2d 731, 736 (Ga. Ct. App. 1992); *Long v. Chelsea Cmty. Hosp.*, 557 N.W.2d 157, 161-62 (Mich. Ct. App. 1996); *Zipper v. Health Midwest*, 978 S.W.2d 398, 417 (Mo. Ct. App. 1998); *Manczur v. Southside Hosp.*, 183 N.Y.S.2d 960, 962 (App. Div. 1959); *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750, 755-56 (W. Va. 1991).

Other courts construe bylaws as a contract on a case-by-case basis. See, e.g., *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1186-89 (E.D. Cal. 1998); *Steuer v. Nat'l Med. Enters., Inc.*, 672 F. Supp. 1489, 1527 (D.S.C. 1987); *Richter v. Danbury*, 759 A.2d 106, 110-11 (Conn. App. Ct. 2000); *Keskin v. Munster Med. Research Found.*, 580 N.E.2d 354, 359-62 (Ind. Ct. App. 1991); *Terre Haute Reg'l Hosp., Inc. v. El-Issa*,

In deciding these types of cases, courts would determine whether the hospital complied with the express bylaw reappointment and termination provisions.⁸ Hospitals continue to have the option of maintaining an open staff in which any individual physician may apply for membership to the medical staff, or alternatively, they, as a collective whole, can establish a closed staff by entering into an exclusive contract with a third party physician. With an exclusive contract, the staff is "closed" in the sense that the parties are bound "to buy or sell only from each other for their total requirements."⁹ When a hospital enters into an exclusive contract with a physician or group of physicians, those physicians who had enjoyed the privileges from open staff membership are estopped from further exercising those privileges contained in the exclusive contract. This phenomenon is referred to as "constructive revocation."¹⁰

Traditionally, courts have limited a physician's remedy under the bylaws to hospital decisions based upon judgment of the physician's competence. In the exclusive contract setting, courts have had difficulty justifying a remedy, since the expressed bylaw procedures usually do not account for these decisions.¹¹ Bylaws are typically silent as to hospital managerial decisions motivated for economic reasons having little, if any, relationship to the physician's competence, and courts

470 N.E.2d 1371, 1376-77 (Ind. Ct. App. 1984); *Tredrea v. Anesthesia & Analgesia, P.C.*, 584 N.W.2d 276, 284-87 (Iowa 1998); *Munoz v. Flower Hosp.*, 507 N.E.2d 360, 364-66 (Ohio Ct. App. 1985); *Weary v. Baylor Univ. Hosp.*, 360 S.W.2d 895, 897 (Tex. Civ. App. 1962); *Bass v. Ambrosius*, 520 N.W.2d 625, 628 (Wis. Ct. App. 1994); *cf. Bryant v. Glen Oaks Med. Ctr.*, 650 N.E.2d 622, 629 (Ill. App. Ct. 1995) (holding that the presence of an at-will arrangement barred relief).

Still other courts treat bylaws as a contract per se. *See, e.g., Pariser v. Christian Health Care Sys., Inc.*, 816 F.2d 1248, 1251 (8th Cir. 1987); *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102, 1106, 1111 (E.D. Pa. 1986); *Samaritan Health Sys. v. Superior Court*, 981 P.2d 584, 588 (Ariz. Ct. App. 1998); *Lawler v. Eugene Wuesthoff Mem'l Hosp. Ass'n*, 497 So. 2d 1261, 1264-66 (Fla. Dist. Ct. App. 1986); *Gashgai v. Me. Med. Ass'n*, 350 A.2d 571, 575 (Me. 1976); *Virmani v. Presbyterian Health Servs. Corp.*, 488 S.E.2d 284, 288-89 (N.C. Ct. App. 1997); *St. John's Hosp. Med. Staff v. St. John Reg'l Med. Ctr., Inc.*, 245 N.W.2d 472, 474-75 (S.D. 1976); *Lewisburg Cmty. Hosp., Inc. v. Alfredson*, 805 S.W.2d 756, 759 (Tenn. 1991).

8 *See infra* Part III.B.

9 Charles R. Galloway, Comment, *Observation: Exclusive Contracts and the Staff Physician*, 66 Miss. L.J. 479, 480 (1996).

10 *Bartley v. E. Me. Med. Ctr.*, 617 A.2d 1020, 1021, 1023 (Me. 1992).

11 *See* John D. Blum, *The Evolution of Physician Credentialing into Managed Care Selective Contracting*, 22 AM. J.L. & MED. 173, 182 (1996); Neil L. Chayet & Thomas M. Reardon, *Trouble in the Medical Staff: A Practical Guide to Hospital Initiated Quality Assurance*, 7 AM. J.L. & MED. 301, 309 (1981) (citations omitted).

have generally refused to "second guess" managerial decisions.¹² Thus, many courts that have held that medical staff bylaws may constitute a contract also hold that a hospital's decision to enter into an exclusive contract is outside the contemplation of the parties and, consequently, unenforceable.¹³

Unfortunately, courts' general refusal to provide a remedy to a hospital's decision to contract exclusively with another physician leaves the physician whose privileges become nonexercisable at the mercy of a hospital's managerial discretion and without adequate judicial review. While courts have made great strides in protecting physicians' interests in fair and informed decisions and the public's interest in quality care, the remedial protection does not go far enough. To more accurately effect the reasonable expectations of the physicians and hospitals, courts should extend protection under contract law to provide physicians whose privileges have been constructively revoked, due to an exclusive contract, a remedy for breach of the bylaw contract.

Part I provides background on the typical hospital organizational structure and the evolving relationship between the hospital and the physician. Part II explores past jurisprudential approaches to reviewing hospitals' decisions that fail to conform to the reappointment and disciplinary procedures outlined in the medical staff bylaws. Part III discusses the emerging judicial trend toward recognizing bylaws as

12 See *Richter v. Danbury Hosp.*, No. 307869, 1998 WL 321853, at *4 (Conn. Super. Ct. June 9, 1998), *rev'd in part*, 759 A.2d 106 (Conn. App. Ct. 2000); *Bloom v. Clara Maass Med. Ctr.*, 685 A.2d 966, 972 (N.J. Super. Ct. App. Div. 1996); *Read v. McKennan Hosp.*, 610 N.W.2d 782, 786 (S.D. 2000); *Tenet Health Ltd. v. Zamora*, 13 S.W.3d 464, 469 (Tex. App. 2000).

13 See *Blum*, *supra* note 11, at 181-82 (citations omitted); *see also, e.g.*, *Hager v. Venice Hosp.*, 944 F. Supp. 1530, 1534 (M.D. Fla. 1996); *Hutton v. Mem'l Hosp.*, 824 P.2d 61, 62-63 (Colo. Ct. App. 1991); *Richter*, 1998 WL 321853, at *4; *Garibaldi v. Applebaum*, 742 N.E.2d 279, 284-85 (Ill. 2000); *Janes v. Centegra Health Sys.*, 721 N.E.2d 702, 708-09 (Ill. App. Ct. 1999); *Keskin v. Munster Med. Research Found.*, 580 N.E.2d 354, 359-62 (Ind. Ct. App. 1991); *Dutta v. St. Francis Reg'l Med. Ctr., Inc.*, 867 P.2d 1057, 1062-63 (Kan. 1994); *St. Louis v. Baystate Med. Ctr.*, 568 N.E.2d 1181, 1187-88 (Mass. App. Ct. 1991); *Bloom*, 685 A.2d at 972; *Lyons v. St. Vincent Health Ctr.*, 731 A.2d 206, 212-13 (Pa. Commw. Ct. 1999) (in dicta); *Read*, 610 N.W.2d at 786-87; *Tenet Health Ltd.*, 13 S.W.3d at 469-70; *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 439-40 (Tex. App. 1994), *rev'd on other grounds sub nom. Calvillo v. Gonzalez*, 922 S.W.2d 928, 929 (Tex. 1996). *But see Vakharia v. Little Co. of Mary Hosp. & Health Care Ctrs.*, 917 F. Supp. 1282, 1292-93 (N.D. Ill. 1996); *Lobo v. Rock*, No. CV 920332930S, 1996 WL 564049, at *8-*9 (Conn. Super. Ct. Sept. 20, 1996); *Ray v. St. John's Health Care Corp.*, 582 N.E.2d 464, 470-71 (Ind. Ct. App. 1991); *Volcjak v. Wash. County Hosp. Ass'n*, 723 A.2d 463, 471-72 (Md. Ct. Spec. App. 1999).

contractually binding when a physician's privileges are revoked or restricted on grounds relating to the physician's competence. Part IV will suggest that the courts should extend to the physician procedural remedies when a physician's membership on the medical staff is adversely affected due to a hospital's decision to enter into an exclusive contract with a third party. This would provide an "at-will" physician who is a member of the medical staff and whose privileges are constructively revoked a remedy when the hospital breaches implied promises found in the bylaws and in the parties' conduct.

I. BACKGROUND

A. *Hospital Organization and Reorganization*

Hospitals, as recently as the early twentieth century, consisted of physicians independently providing community-based care, utilizing the hospital only when the patient's health required. The hospital simply acted as a forum for patient and physician interaction.¹⁴ By contrast, today's hospitals have been transformed into corporation-type entities with responsibilities for advancing quality health care and controlling escalating costs through managed care.¹⁵ Traditional hospitals maintained little physician oversight and were ill-prepared for malpractice claims; thus, a new system had to be structured around managed quality in the servicing of health care.¹⁶ Hospitals have realized that they can become profit-driven enterprises through applying the structural and operational principles of corporations.¹⁷

14 See John G. Day, *Managed Care and the Medical Profession: Old Issues and Old Tensions the Building Blocks of Tomorrow's Health Care Delivery and Financing System*, 3 CONN. INS. L.J. 1, 6-7 (1996); Paul L. Scibetta, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1025 (1990); Zellers & Poulin, *supra* note 4, at 67.

15 See Scibetta, *supra* note 14, at 1025. In fact, surveys indicate that nonprofit hospitals are converting to for-profit at a record rate, finding that between 1990 and 1996 approximately 200 of the remaining 5000 nonprofit hospitals converted. See Terri R. Reicher, *Assuring Competent Oversight to Hospital Conversion Transactions*, 52 BAYLOR L. REV. 83, 84 (2000) (citation omitted).

16 See Scibetta, *supra* note 14, at 1026-27. Courts began imposing vicarious tort liability on hospitals, replacing the charitable immunity doctrine that shielded hospitals from their physicians' negligence. See Barry R. Furrow, *Enterprise Liability and Health Care Reform: Managing Care and Managing Risk*, 39 ST. LOUIS U. L.J. 79, 83-84 (1994).

17 See David H. Rutchik, *The Emerging Trend of Corporate Liability: Courts' Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 538-39 (1994). Private hospitals are often owned by large corporations, and some hospitals are even traded on the New York Stock Exchange. *Id.*; see also Thomas

Modern hospitals are typically organized with a Board of Directors¹⁸ and a medical staff, both organized to ensure quality through oversight and enforcement of policies and procedures.¹⁹ The Board of Directors approves bylaws and, pursuant to the bylaws, makes final decisions relating to appointments and re-appointments to the staff, as well as the granting and revising of privileges.²⁰ Standards promulgated by the Joint Commission on Accreditation of Health Care Organizations (JCAHO)²¹ require that accredited hospitals establish and maintain medical staff bylaws.²² Membership on the medical staff provides physicians with access to the hospital's facilities and provides the hospital with quality control capability.²³ The medical staff, comprised of fully licensed practitioners permitted by law to provide unsupervised patient care,²⁴ performs two primary functions for physicians and hospitals: credentialing and peer review.²⁵ The former entails determining which physicians are granted staff membership and the types of privileges they will have as a member, while the latter involves monitoring the physicians' services.²⁶ In all but rare cases,²⁷ appointment to the medical staff is a prerequisite to enjoyment of privileges that permit physicians to admit patients to the hospital within a specified area of practice.²⁸

B. Medical Staff Privileges

Hospitals are increasingly cautious in granting and renewing staff privileges because of public pressure to maintain quality care and vica-

William Malone & Deborah Haas Thaler, *Managed Health Care: A Plaintiff's Perspective*, 32 TORT & INS. L.J. 123, 124-30 (1996) (citation omitted).

18 Also referred to as the Board of Trustees or the Governing Board.

19 See generally William M. Copeland & Phyllis E. Brown, *Hospital Medical Staff Privilege Issues: "Brother's Keeper" Revisited*, 17 N. KY. L. REV. 513 (1990) (describing the relationship between the Governing Board and the medical staff).

20 See Dallan, *supra* note 5, at 610.

21 JCAHO is a private accrediting institution that determines the acceptability of the services at a particular hospital through articulating standards. See Berry R. Furrow, *Regulating the Managed Care Revolution: Private Accreditation and a New System Ethos*, 43 VILL. L. REV. 361, 396 (1998) (citations omitted).

22 See Chayet & Reardon, *supra* note 11, at 304.

23 See Scibetta, *supra* note 14, at 1029-30.

24 See Dale H. Cowan, *Medical Staff Legal Issues*, 17 U. TOL. L. REV. 851, 857 (1986).

25 See Dallan, *supra* note 5, at 598; Mark A. Kadzielski et al., *The Hospital Medical Staff: What Is Its Future?*, 16 WHITTIER L. REV. 987, 999 (1995).

26 See Blum, *supra* note 11, at 176-79; Dallan, *supra* note 5, at 598.

27 See Cowan, *supra* note 24, at 857-58.

28 See Dallan, *supra* note 5, at 608-09.

rious malpractice liability for the negligence of their medical staff.²⁹ In order to practice at a particular hospital, physicians must obtain privileges.³⁰ Furthermore, competition among physicians has intensified as numbers in the profession have risen,³¹ while the number of hospitals has declined.³² While past physicians could maintain an independent practice, physicians today, who are almost all specialized, increasingly rely on hospitals for staff privileges for access to patients.³³ As the relationship between physicians and hospitals continues to evolve, denial or revocation of medical staff privileges may essentially prevent a physician from practicing in a community.³⁴ As exclusive contracts are increasingly used for physician staffing,³⁵ those physicians not privy to the exclusive contract and whose privileges are covered in the exclusive contract are prevented from practicing at that hospital.

29 The application of vicarious liability to hospitals was first adopted by the Illinois Supreme Court in *Darling v. Charleston Community Memorial Hospital*, 200 N.E.2d 149 (Ill. 1964) (holding that the hospital has a duty to provide sufficient medical care).

30 See *Hayman v. Galveston*, 273 U.S. 414, 417 (1927).

31 See Jerry Cromwell, *Barriers to Achieving a Cost-Effective Workforce Mix: Lessons from Anesthesiology*, 24 J. HEALTH POL., POL'Y & L. 1331, 1332-35 (1999).

32 See Thomas R. Prince, *The Healthcare Industry Bankruptcy Workouts*, 8 AM. BANKR. INST. L. REV. 5, 30 (2000).

33 See Dallet, *supra* note 7, at 326; Day, *supra* note 14, at 11-12; Furrow, *supra* note 21, at 377; Jesse A. Goldner, *Managed Care and Mental Health: Clinical Perspectives and Legal Realities*, 35 Hous. L. REV. 1437, 1439-40 (1999); Prince, *supra* note 32, at 55; Ann R. Gough, Note, *Quality of Care, Staff Privileges, and Antitrust Law*, 64 U. DET. L. REV. 505, 506 (1987).

34 See *Mallare v. St. Luke's Hosp.*, 699 F. Supp. 1127, 1130 (E.D. Pa. 1988); Dallon, *supra* note 5, at 613; Kathleen M. Dorr, Annotation, *Exclusion of, or Discrimination Against, Physician or Surgeon by Hospital*, 28 A.L.R.5TH 107 § 2(a) (1995).

35 See Bruce I. McDaniel, Annotation, *Validity and Construction of Contract Between Hospital and Physician Providing for Exclusive Medical Services*, 74 A.L.R.3D 1268, 1269 (1976). This phenomenon is otherwise known as a "closed staff." *Id.* Before the movement toward medical staffs and hospital standardization, some hospitals operated on an "open staff" basis and allowed most physicians to direct patients to the hospital. See Dallon, *supra* note 5, at 602. An era where the physician is periodically re-evaluated for reappointment has replaced an era where the community-based physician's privileges could only be lost upon a finding of incompetence. See Zellers & Poulin, *supra* note 4, at 67.

C. *The Legal Relationship Between the Hospital and the Physician*

Often arrangements between the hospital and the physician permit the physician to leave at will.³⁶ An at-will physician with staff membership remains bound by the bylaws and faces sanctions for violations.³⁷ Courts have generally held that a physician's membership status to the medical staff and enjoyment of privileges, absent a separate employee contract, does not independently constitute an employment relationship.³⁸ In most instances,³⁹ a physician is an independent contractor because the hospital lacks direct control over the physician's practice and the physician is paid directly by the patient or insurer.⁴⁰ Due to the independent contractor status, typical employment law remedies are unavailable.⁴¹ As discussed below, this makes the staff physician without a contract vulnerable should the hospital decide to contract exclusively with another physician or group of physicians.

II. COMMON-LAW APPROACHES TOWARD PHYSICIANS

A. *Private Hospitals*

The outcome of a controversy involving a physician who sought relief against the hospital originally depended on whether the hospital was private or public.⁴² Today, this distinction has eroded in many

36 See, e.g., *Abrams v. St. John's Hosp. & Health Ctr.*, 30 Cal. Rptr. 2d 603, 605 (Ct. App. 1994); *Hrehorovich v. Harbor Hosp. Ctr., Inc.*, 614 A.2d 1021, 1030 (Md. Ct. Spec. App. 1992); Galloway, *supra* note 9, at 488.

37 See *Terre Haute Reg'l Hosp., Inc. v. El-Issa*, 470 N.E.2d 1371, 1377 (Ind. Ct. App. 1984).

38 See, e.g., *Abrams*, 30 Cal. Rptr. 2d at 604-05; see also Dallon, *supra* note 5, at 605 n.45.

39 In the area of malpractice action against hospitals, courts are applying agency principles that hold hospitals vicariously liable for their physicians' negligence. See Furrow, *supra* note 16, at 86-87.

40 See William S. Brewbaker III, *Physician Unions and the Future of Competition in the Health Care Sector*, 33 U.C. DAVIS L. REV. 545, 553-55 (2000); Dallon, *supra* note 5, at 606.

41 See Dallon, *supra* note 5, at 606-07.

42 See, e.g., *Shulman v. Wash. Hosp. Ctr.*, 222 F. Supp. 59, 61 (D.D.C. 1963); *Kiracofe v. Reid Mem'l Hosp.*, 461 N.E.2d 1134, 1137-38 (Ind. Ct. App. 1984); *Gotsis v. Lorain Cmty. Hosp.*, 345 N.E.2d 641, 646 (Ohio Ct. App. 1974); Dorr, *supra* note 34, § 2(a). The *Shulman* court, in its discussion of determining the status of a hospital, cited the Supreme Court of Maryland which posited:

A public corporation is an instrumentality of the State, founded and owned by the State in the public interest, supported by public funds, and governed by managers deriving their authority from the State On the other hand, a corporation organized by permission of the Legislature, supported largely

jurisdictions.⁴³ Courts gave private hospitals near absolute discretion to exclude a physician from medical staffs,⁴⁴ unless acting under "color of law."⁴⁵ The court in *Shulman v. Washington Hospital Center* explained that "[j]udicial tribunals are not equipped to review the action of hospital authorities in selecting or refusing to appoint members of medical staffs, declining to review appointments previously made, or excluding physicians or surgeons from hospital facilities."⁴⁶ After state legislatures began requiring hospitals to promulgate medical staff bylaws, courts modified judicial review for private hospitals to ensure that the hospital's decision to discipline or deny reappointment substantially complied with the procedures in its bylaws.⁴⁷ In

by voluntary contributions, and managed by officers and directors who are not representatives of the State or any political subdivision, is a private corporation, although engaged in charitable work or performing duties similar to those of public corporations.

Shulman, 222 F. Supp. at 61-62 (quoting *Levin v. Sinai Hosp.*, 46 A.2d 298, 300 (Md. 1946)).

43 See, e.g., *Truly v. Madison Gen. Hosp.*, 673 F.2d 763, 765 (5th Cir. 1982) (recognizing that disciplinary actions subject to limited review of "any hospital licensed"); *Duffield v. Mem'l Hosp. Ass'n*, 361 F. Supp. 398, 401 n.2 (S.D. W. Va. 1973); *Cipriotti v. Bd. of Dirs. of Northridge Hosp. Found. Med. Ctr.*, 196 Cal. Rptr. 367, 372-74 (Ct. App. 1983); *Claycomb v. HCA-Raleigh Cmty. Hosp.*, 333 S.E.2d 333, 335-36 (N.C. Ct. App. 1985).

44 See *Yarnell v. Sisters of St. Francis Health Servs., Inc.*, 446 N.E.2d 359, 361 (Ind. Ct. App. 1983); see, e.g., *Brooks v. Arlington Hosp. Ass'n*, 850 F.2d 191, 198-99 (4th Cir. 1988); *Wong v. Garden Park Cmty. Hosp.*, 565 So. 2d 550, 553 (Miss. 1990) (noting that at common law, the hospital had a right to revoke privileges for good cause); cf. *Willis v. Santa Ana Cmty. Hosp. Ass'n*, 376 P.2d 568, 570 (Cal. 1962) (holding that the hospital's discretion acts "as fiduciary power[] to be exercised reasonably and for the public good"); *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 824 (N.J. 1963); *Woodard v. Porter Hosp., Inc.*, 217 A.2d 37, 40 (Vt. 1966) (limiting private hospital discretion to reasonable and sound decisions).

45 See *Gotsis*, 345 N.E.2d at 646 ("The test for determining 'state action' is whether or not there was significant state involvement in the private conduct warranting the application of constitutional due process; and that action must proximately result in the injury which is the subject of the complaint."); see also *Eaton v. Grubbs*, 329 F.2d 710, 712-15 (4th Cir. 1964); *Sokol v. Univ. Hosp., Inc.*, 402 F. Supp. 1029, 1030-32 (D. Mass. 1975); *Natale v. Sisters of Mercy*, 52 N.W.2d 701, 709 (Iowa 1952).

46 *Shulman*, 222 F. Supp. at 64.

47 See, e.g., *Samuel v. Herrick Mem'l Hosp.*, 201 F.3d 830, 835-36 (6th Cir. 2000); *Shulman*, 222 F. Supp. at 62-63; *Kiester v. Humana Hosp. Alaska, Inc.*, 843 P.2d 1219, 1223 n.2 (Alaska 1992); *Owens v. New Britain Gen. Hosp.*, 643 A.2d 233, 239-40 (Conn. 1994); *Jain v. N.W. Cmty. Hosp.*, 385 N.E.2d 108, 112-13 (Ill. App. Ct. 1978); *Nagib v. St. Therese Hosp., Inc.*, 355 N.E.2d 211, 213 (Ill. App. Ct. 1976) (citing *Virgin v. Am. Coll. of Surgeons*, 192 N.E.2d 414, 422 (Ill. App. Ct. 1963)); *Süller v. La Porte Hosp., Inc.*, 570 N.E.2d 99, 103 (Ind. Ct. App. 1991); *Yarnell*, 446 N.E.2d at 361; *Wong*, 565 So. 2d at 553; *Gotsis*, 345 N.E.2d at 647. Some courts add that the hospital's

doing so, courts began to recognize the emergence of reasonable expectations of the physician brought about through the hospital's promulgation of medical staff bylaws. Courts introduced limited judicial review of private hospitals to reflect the increasing importance of hospitals in determining the physician's livelihood, which courts began to recognize needed more judicial oversight.⁴⁸

B. Public Hospitals

Even prior to the introduction of bylaws, courts required public hospitals to give sufficient notice and provide a fair hearing, aimed at protecting physicians from arbitrary, capricious, and discriminatory decisions.⁴⁹ Courts applied greater scrutiny to public hospitals' decisions on due process and equal protection grounds.⁵⁰ Despite constitutional protection, however, judges gave public hospitals significant discretion, as exemplified by the Oregon State Supreme Court:

An additional reason for allowing hospitals, even though they are public hospitals, a wide range of discretion is the possibility of independent tort liability . . . including liability for the mere selection and admission of physicians In such circumstances a hospital must necessarily be vested with considerable discretion in staff matters.⁵¹

Public hospitals enjoyed judicial discretion based upon the belief that "courts should not substitute their judgment for hospital agency judgment."⁵² One court, in dicta, admitted to the inherent harshness of granting hospitals broad discretion, but held that not all wrongs are legally actionable.⁵³

Illustrative of an approach limited to arbitrary, capricious, and discriminatory decisions is *Balkissoon v. Capital Hill Hospital*.⁵⁴ There,

decision be rational and procedurally fair. See *Sywak v. O'Connor Hosp.*, 244 Cal. Rptr. 753, 758-59 (Ct. App. 1988); *Leider v. Beth Israel Hosp. Ass'n*, 229 N.Y.S.2d 134, 136-37 (Sup. Ct. 1960), *aff'd*, 182 N.E.2d 393, 394 (N.Y. 1962), *overruled by* *Gelbard v. Genesee Hosp.*, 664 N.E.2d 1240, 1241-42 (N.Y. 1996); *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750, 756-57 (W. Va. 1991).

48 See *Scibetta*, *supra* note 14, at 1036-37.

49 See *Leonard v. Prowers County Hosp. Dist.*, 673 P.2d 1019, 1022-26 (Colo. Ct. App. 1983); *Stiller*, 570 N.E.2d at 107; *Giles v. Breau*, 160 So. 2d 608, 613-15 (La. Ct. App. 1964); *Ritter v. Bd. of Comm'rs*, 637 P.2d 940, 945-47 (Wash. 1981) (en banc).

50 *Dallon*, *supra* note 5, at 626-27 & 626 n.172.

51 *Huffaker v. Bailey*, 540 P.2d 1398, 1402 (Or. 1975) (citations omitted).

52 *Shulman*, 222 F. Supp. at 64; see also *Sosa v. Bd. of Managers of the Val Verde Mem'l Hosp.*, 437 F.2d 173, 177 (5th Cir. 1971); *Suess v. Pugh*, 245 F. Supp. 661, 667-68 (N.D. W. Va. 1965).

53 See *Shulman*, 222 F. Supp. at 64.

54 558 A.2d 304 (D.C. Cir. 1989).

the District of Columbia Court of Appeals, rather than deciding the issue on breach of contract grounds, emphasized the public interest in protecting the physician from arbitrary hospital decisions.⁵⁵ The court recognized the importance of bylaws in that they affect public access to physicians and the quality of treatment.⁵⁶ According to the court, the hospital's obligation to adhere to its bylaws was independent of any finding that the hospital had a contractual duty to abide by its bylaws.⁵⁷ As a quasi-administrative review board,⁵⁸ courts can require that hospitals follow their bylaws to "reduce[] the risk of arbitrary decisions without unnecessary interference with those who have the duty and the expertise to make the decisions."⁵⁹ As hospitals became increasingly important to a physician's practice, courts began to realize that hospitals' decisions regarding physician appointment and retention required greater oversight than an arbitrary, capricious, and discriminatory standard, and this was accomplished through construing bylaws as enforceable contractually.

III. THE SHIFT TOWARDS APPLICATION OF CONTRACTUAL PRINCIPLES

The inherent limits of arbitrary, capricious, and discriminatory⁶⁰ as a standard for judicial review of a hospital's decision brought some courts to incorporate contract analysis into hospitals' decisions that adversely affect the physicians' privileges.⁶¹ Usually, a physician who is a member of the medical staff challenges a Board of Director's decision to revoke or refuse to grant privileges on the grounds that the hospital failed to follow promises contained in the bylaws. Judicial acceptance of medical staff bylaws as a contract differs by jurisdiction and usually limits relief to circumstances where the hospital does not abide by a particular reappointment and disciplinary provision in the bylaws.⁶² Many of those same courts, on the other hand, have struggled with applying a breach of the bylaws remedy when confronted with a hospital's decision to enter into an exclusive contract with a

55 See *id.* at 308.

56 See *id.*

57 See *id.*

58 In reviewing bylaws, courts try to mitigate against the risk of arbitrary decisions without unduly interfering with those with decision-making authority and expertise. See *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1254-55 (Conn. 1989); *Garrow v. Elizabeth Gen. Hosp. & Dispensary*, 401 A.2d 533, 538-39 (N.J. 1979).

59 *Balkissoon*, 558 A.2d at 308.

60 See *supra* notes 3, 47 and accompanying text.

61 See *supra* notes 6-7 and accompanying text.

62 See Peter E. Borkon, *Exclusive Contracts: Are Constructively Terminated Incumbent Physicians Entitled to a Fair Hearing?*, 17 J. LEGAL MED. 143, 152 (1996).

physician or group of physicians. Consequently, staff member physicians in these cases are protected only under an arbitrary, capricious, or discriminatory standard with no inquiry into the hospitals' conformance with the bylaws. Because the reasons for which courts either accept or reject bylaws as a contract⁶³ aids in the analysis of bylaws in an exclusive contract setting, an analysis of bylaws' applicability to contract law follows.

A. *Contract Analysis*

An enforceable contract requires (1) parties with capacity, (2) proper subject matter, (3) consideration, (4) a bargain, and (5) manifestation of mutual assent.⁶⁴ In the context of medical staff bylaws, courts' analysis has centered on the areas of proper subject matter,⁶⁵ consideration,⁶⁶ and mutual assent.⁶⁷ Medical staff bylaws, which typically define the relationship between the physician and hospital—covering departmental organization and quality control—create rights and corresponding duties.⁶⁸ Courts disagree, however, over the extent to which medical staff bylaws provide the physician with a breach of contract action against the hospital, finding that bylaws either do not constitute adequate consideration or fail because neither party assented. If medical staff bylaws are treated as a contract, hospitals must abide by the procedures in the bylaws before they can decide to revoke or restrict a physician's privileges, and failure to do so entitles the physician to contractual remedies.⁶⁹

1. Consideration

With respect to consideration, some courts have held that the consideration requirement is not met because of the presence of a pre-existing duty.⁷⁰ This issue arises because both the JCAHO and state

63 See *infra* Part III.B.

64 See 1 SAMUEL WILLISTON, WILLISTON ON CONTRACTS § 3, ch. 2 (4th ed. 1990).

65 See *infra* Part III.A.3.

66 See *infra* Part III.A.1.

67 See *infra* Part III.A.2.

68 See *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1001 (N.D. Ga. 1992); Galloway, *supra* note 9, at 489.

69 See *Rees v. Intermountain Health Care, Inc.*, 808 P.2d 1069, 1076 (Utah 1991); *cf. Smith v. Cleburne County Hosp.*, 870 F.2d 1375, 1381 (8th Cir. 1989) (holding a hospital entitled to relief when the physician fails to abide by the bylaws).

70 See *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1187 (E.D. Cal. 1998); *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1253-54 (Conn. 1989); *Tredrea v. Anesthesia & Analgesia, P.C.*, 584 N.W.2d 276, 285 (Iowa 1998); *Zipper v. Health Midwest*, 978 S.W.2d 398, 416 (Mo. Ct. App. 1998).

statutes require that hospitals promulgate bylaws.⁷¹ Thus, a hospital's pre-existing duty to enact bylaws arises independently of its relationship with the physician.⁷² Corbin acknowledged that consideration may still be present even when there appears to be a pre-existing duty:

[I]f the bargained-for performance rendered by the promisee includes something that is not within the requirements of the promisee's pre-existing duty, the law of consideration is satisfied. It makes no difference that the agreed consideration consists almost wholly of a performance that is already required and that the receipt of this performance is the principal goal of the promisor. It is enough that some small additional performance is bargained-for and given.⁷³

While a hospital's execution of its bylaws by itself, as the *Virmani* Court recognized, may not be sufficient consideration to form an enforceable contract, when "a hospital offers to extend a particular physician the privilege to practice medicine in that hospital it goes beyond its statutory obligation."⁷⁴ Similarly in *Janda v. Madera Community Hospital*, the California District Court held that consideration was met with "the [h]ospital's promise to employ Dr. Janda on stated terms and conditions and Dr. Janda's promise to work under these conditions."⁷⁵ Furthermore, statutes provide the hospital and medical staff with the discretion of determining the form and content of medical staff bylaws.⁷⁶ This discretion provides hospitals and the medical staff flexibility in creating corresponding rights and duties that exceed what hospitals are legally required to do.⁷⁷ Thus, courts require some finding of an additional duty not legally imposed on the hospital, as an Indiana Court of Appeals opined that an enforceable contract does not require that each duty have a corresponding right.⁷⁸

Other courts have found that bylaws fail to satisfy the consideration requirement for want of mutuality, because an at-will physician may leave without cause. But, an initial agreement wanting mutuality becomes an enforceable contract upon performance of the condition

71 See *Tredrea*, 584 N.W.2d at 285; Galloway, *supra* note 9, at 487.

72 See *Robles*, 785 F. Supp. at 1001-02; *Zipper*, 978 S.W.2d at 416.

73 2 ARTHUR L. CORBIN, CORBIN ON CONTRACTS § 7.20 (rev. ed. 1995).

74 *Virmani v. Presbyterian Health Servs. Corp.*, 488 S.E.2d 284, 288 (N.C. Ct. App. 1997); see also *Richter v. Danbury*, 759 A.2d 106, 110-11 (Conn. App. Ct. 2000).

75 *Janda*, 16 F. Supp. 2d at 1186.

76 See *Dallon*, *supra* note 5, at 647.

77 See *id.*

78 See *Terre Haute Reg'l Hosp., Inc. v. El-Issa*, 470 N.E.2d 1371, 1377 (Ind. Ct. App. 1984) and cases cited therein; *Kokomo Veterans, Inc. v. Schick*, 439 N.E.2d 639, 645 (Ind. Ct. App. 1982).

precedent, which occurs when the physician begins practicing at a hospital.⁷⁹ A physician's decision to practice at a hospital, therefore, binds that physician to abide with the bylaws. With physicians becoming increasingly dependent on a particular hospital, a physician's reliance on a continued relationship with a hospital, even where an at-will arrangement exists, emerges from necessity. Once a physician agrees to abide by rules and procedures outlined in the bylaws, the consideration requirement is satisfied to the extent that the physician creates and modifies his/her legal relationship with the hospital.⁸⁰ Many judges have held that as long as the physician practices at a hospital, that physician is bound by the bylaws, and thus the hospital is bound.

A third aspect of consideration some courts have found lacking is bargained-for exchange, because bylaws are self-imposed rules for the hospital and are not a result of negotiating with the physician(s).⁸¹ The *Second Restatement of Contracts* defines bargaining as occurring when "it is sought by the promisor in exchange for his promise and is given by the promisee in exchange for that promise."⁸² Upon acceptance of the privileges granted in the bylaws, the physician benefits from the facilities and services of the hospital, and correspondingly, the hospital benefits from the unique services provided by the physician and the assurances that the physician will abide by the bylaws.⁸³ In addition, should a physician during the application process refuse to abide by the bylaws, the hospital could then refuse to extend privileges.⁸⁴ Some courts construe bylaws as part of the contractual relationship between the physician and the hospital, and as such, the parties are not required to negotiate over every term to satisfy bargained-for consideration.⁸⁵

2. Manifestation of Mutual Assent

Some courts have had difficulty finding mutual assent to be bound by the bylaws, since the hospital often retains power to unilaterally amend the bylaws and/or reserves final authority with the Board

79 See *Schick*, 439 N.E.2d at 644-45 (citing *Obering v. Swain-Roach Lumber Co.*, 155 N.E. 712 (Ind. Ct. App. 1927)).

80 See *Lyons v. St. Vincent Health Ctr.*, 731 A.2d 206, 210 (Pa. Commw. Ct. 1999); RESTATEMENT (SECOND) OF CONTRACTS § 71(1), (3)(c) (1981).

81 See *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1252-53 (Conn. 1989).

82 RESTATEMENT (SECOND) OF CONTRACTS § 71(2) (1981).

83 See *Virmani v. Presbyterian Health Servs. Corp.*, 488 S.E.2d 284, 287-88 (N.C. Ct. App. 1997).

84 See *Dallon*, *supra* note 5, at 656.

85 See 1 E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS § 2.3 (1990).

of Directors.⁸⁶ This argument raises two separate issues. First, the hospital may not have assented to be bound when the Board's role is limited to approval of bylaws adopted by the medical staff for the purpose of self-regulation.⁸⁷ As indicated earlier, the very purpose of bylaws is to codify the procedural requirements for the hospital when the hospital seeks to revoke, restrict, or terminate a physician's privileges. Second, retention of the hospital's authority to unilaterally amend bylaws and/or a reservation of final authority with the Board may manifest an intention not to be bound.⁸⁸ In these situations, a hospital's intent to be bound may still manifest itself through the actions between the parties, language of the bylaws, or both.⁸⁹ Frequently, a physician's membership and privileges are conditioned upon agreement to follow the bylaws.⁹⁰ Furthermore, the JCAHO places responsibility on accredited hospitals to assure that physician-applicants understand the bylaw procedures for granting appointments and privileges,⁹¹ suggesting a common understanding through trade practice. It seems that, given the importance of medical staff bylaws in defining the hospital and physician relationship, a finding of mutual assent naturally follows in most circumstances.

3. Public Policy Grounds

A reason, falling under appropriateness of subject matter, some courts have found for not enforcing bylaws as a contract is that doing so would undermine the hospital's administration and unjustifiably impede on what should be a discretionary judgment.⁹² To construe

86 Cf. *Terre Haute Reg'l Hosp., Inc. v. El-Issa*, 470 N.E.2d 1371, 1377 (Ind. Ct. App. 1984) (holding that the Board manifested an intent to be bound despite it having final authority), with *Zipper v. Health Midwest*, 978 S.W.2d 398, 416-17 (Mo. Ct. App. 1998) (holding that one of the reasons bylaws do not constitute a contract is that the Board had ultimate authority with respect to bylaw procedure).

87 See *Berberian v. Lancaster Osteopathic Hosp. Ass'n*, 149 A.2d 456, 461 (Pa. 1959) (Bell, J., dissenting).

88 See *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1002 (N.D. Ga. 1992).

89 See *Terre Haute Reg'l Hosp., Inc.*, 470 N.E.2d at 1377.

90 See, e.g., *Wuchenich v. Shenandoah Mem'l Hosp.*, No. 99-1273, 2000 U.S. App. LEXIS 11557, at *23-*24 (4th Cir. May 22, 2000); *Robles*, 785 F. Supp. at 1001; *Richter v. Danbury*, 759 A.2d 106, 109 (Conn. App. Ct. 2000); *Rees v. Intermountain Health Care, Inc.*, 808 P.2d 1069, 1076 (Utah 1991); *Bass v. Ambrosius*, 520 N.W.2d 625, 628 (Wis. Ct. App. 1994).

91 See Cowan, *supra* note 24, at 859.

92 See *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249, 1253 (Conn. 1989); *Zipper v. Health Midwest*, 978 S.W.2d 398, 417 (Mo. Ct. App. 1998) (citing *Richardson v. St. John's Mercy Hosp.*, 674 S.W.2d 200, 201 (Mo. Ct. App. 1984)).

bylaws as a contract, under this view, would require the courts to substitute its judgment for the hospital's on internal matters that are best determined by those more informed.⁹³ According to this view, a hospital is most aware of its surrounding circumstances, and the threat of contractual liability may deter hospitals from terminating physicians when such decisions ultimately may be in the public's best interests.⁹⁴ Therefore, the more effective balance between the physicians' interest and the public's interest, the argument goes, is achieved by limiting judicial review to guard against the risk of arbitrary decisions.⁹⁵ Fear of judicial intervention on grounds of substituting its judgment amounts to unjustified refusal by the courts to provide physicians with a remedy against the hospital when it breaches implied promises.

B. *Judicial Treatment of Bylaws as Contracts*

Courts, on occasion, have drawn analogies between hospital bylaws and employee handbooks.⁹⁶ Some jurisdictions rule in favor of treating bylaws as an enforceable contract by viewing them as analogous to employee handbooks.⁹⁷ Other jurisdictions deny contractual relief for employee handbooks on the grounds that they are unilateral expressions of policy but uphold bylaws as enforceable promises by distinguishing them from employee handbooks.⁹⁸ Still, other jurisdictions reject both bylaws and employee handbooks as contractually enforceable on the same grounds as employee handbooks because in both cases they find that the language, under most circumstances, is nonspecific and goal oriented.⁹⁹

A court's ruling that bylaws are contractually enforceable is not determinative of the probability of relief granted to a physician. As discussed below, a court's finding that bylaws are generally contractually binding requires further determination of whether contractual

93 See *Robles*, 785 F. Supp. at 1002. Perhaps, as one court suggested, this would impute onto the physician an absolute right to work at a hospital. See *Zipper*, 978 S.W.2d at 417.

94 See *Zipper*, 978 S.W.2d at 417.

95 See *Owens v. New Britain Gen. Hosp.*, 643 A.2d 233, 240-41 (Conn. 1994); *Yeargin v. Hamilton Mem'l Hosp.*, 171 S.E.2d 136, 139 (Ga. 1969).

96 See, e.g., *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1188-89 (E.D. Cal. 1998); *Tredrea v. Anesthesia & Analgesia, P.C.*, 584 N.W.2d 276, 285-86 (Iowa 1998); *Virmani v. Presbyterian Health Servs. Corp.*, 488 S.E.2d 284, 288 n.5 (N.C. Ct. App. 1997).

97 See, e.g., *Bass v. Ambrosius*, 520 N.W.2d 625, 627-28 (Wis. Ct. App. 1994).

98 See, e.g., *Virmani*, 488 S.E.2d at 288 n.5.

99 See, e.g., *Tredrea*, 584 N.W.2d at 286; *Bender v. Suburban Hosp., Inc.*, No. 2000, 2000 Md. App. LEXIS 148, at *67-*68 (Ct. Spec. App. Sept. 7, 2000); *Hrehorovich v. Harbor Hosp. Ctr., Inc.*, 614 A.2d 1021, 1031-34 (Md. Ct. Spec. App. 1992).

remedies are available on a case-by-case basis or without regard to the factual circumstances.

1. Bylaws Not Enforceable as a Contract

The most judicially deferential approach rejects the notion that bylaws may be contractually enforceable. Instead, judicial review is limited to a hospital's substantial compliance with the reappointment or disciplinary procedures in the bylaws.¹⁰⁰ The idea here is that if the parties truly intended the "promises" contained in bylaws to be binding, then they could have arranged for this in a separate employment contract.¹⁰¹ Courts deny relief under contract law for failure of bylaws to satisfy contractual requirements of consideration or assent¹⁰² and on policy grounds that additional court involvement would unduly interfere with the hospital's ability to determine adequately their medical staff needs.¹⁰³ According to this view, a court's requirement that a hospital substantially comply with its bylaws advances fairness for both parties and best balances the physician's occupational interests with the hospital's interest in determining its own affairs.¹⁰⁴ By contrast, where bylaws are construed as a legally binding contract, the hospital may be held to a standard of "strict compliance,"¹⁰⁵ rather than "substantial compliance."¹⁰⁶

100 See *Robles v. Humana Hosp. Cartersville*, 785 F. Supp. 989, 1001-02 (N.D. Ga. 1992); *St. Mary's Hosp. v. Radiology Prof'l Corp.*, 421 S.E.2d 731, 736 (Ga. Ct. App. 1992); *Long v. Chelsea Cmty. Hosp.*, 557 N.W.2d 157, 162 (Mich. Ct. App. 1996); *Zipper v. Health Midwest*, 978 S.W.2d 398, 416 (Mo. Ct. App. 1998); *Manczur v. Southside Hosp.*, 183 N.Y.S.2d 960, 962 (App. Div. 1959); *Mahmoodian v. United Hosp. Ctr., Inc.*, 404 S.E.2d 750, 756 (W. Va. 1991).

101 See *Zipper*, 978 S.W.2d at 417; *Manczur*, 183 N.Y.S.2d at 962.

102 See *supra* Part III.A.1-2; see also, e.g., *Shulman v. Wash. Hosp. Ctr.*, 319 F. Supp. 252, 255 (D.D.C. 1970).

103 See *supra* Part III.A.3; see also, e.g., *Claycomb v. HCA-Raleigh Cmty. Hosp.*, 333 S.E.2d 333, 336 (N.C. Ct. App. 1985) (holding that decisions must be rationally "related to the operation of the hospital").

104 See *Mahmoodian*, 404 S.E.2d at 757.

105 See *Miller v. Ind. Hosp.*, 419 A.2d 1191, 1193 (Pa. Super. Ct. 1980).

106 See *Islami v. Covenant Med. Ctr., Inc.*, 822 F. Supp. 1361, 1372-73 (N.D. Iowa 1992); *Even v. Longmont United Hosp. Ass'n*, 629 P.2d 1100, 1102 (Colo. Ct. App. 1981); *Owens v. New Britain Gen. Hosp.*, 643 A.2d 233, 240-41 (Conn. 1994) (citing *Gianetti v. Norwalk Hosp.*, 557 A.2d 1249 (Conn. 1989)); *Keskin v. Munster Med. Research Found.*, 580 N.E.2d 354, 359 (Ind. Ct. App. 1991); *Friedman v. Mem'l Hosp.*, 523 N.E.2d 252, 523 (Ind. Ct. App. 1988); *Mahmoodian*, 404 S.E.2d at 755.

2. Bylaws Enforceable as a Contract on a Case-by-Case Basis

Another approach is to determine whether bylaws constitute a contract on a case-by-case basis; that is, bylaws may become contractually binding only upon a factual determination.¹⁰⁷ For example, an Indiana court held that medical staff bylaws constitute a contract when both parties had admitted an intention to be bound.¹⁰⁸ Courts using this approach usually analyze the language of the bylaws and the conduct of the parties to ascertain the existence of an intent to contract.¹⁰⁹ In so ruling, courts often limit a physician's breach of contract claim under the bylaws to those procedures provided for expressly in the bylaws.¹¹⁰ Typically, courts will incorporate the bylaws into any other existing contractual agreements between the physician and the hospital, viewing bylaws as part of the contractual relationship.¹¹¹

3. Bylaws Enforceable as a Contract Per Se

Another treatment of hospital bylaws is to view them as a contract per se upon approval by the Board of Directors, without inquiry into the language of the bylaws or conduct of the parties.¹¹² The idea here

107 See, e.g., *Ingraffia v. NME Hosps., Inc.*, 943 F.2d 561, 565-66 (5th Cir. 1991); *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1186-89 (E.D. Cal. 1998); *Steuer v. Nat'l Med. Enters., Inc.*, 672 F. Supp. 1489, 1527 (D.S.C. 1987); *Gianetti*, 557 A.2d at 1255; *Richter v. Danbury*, 759 A.2d 106, 110-11 (Conn. App. Ct. 2000); *Keshin*, 580 N.E.2d at 359-62; *Terre Haute Reg'l Hosp., Inc. v. El-Issa*, 470 N.E.2d 1371, 1377-79 (Ind. Ct. App. 1984); *Tredrea v. Anesthesia & Analgesia, P.C.*, 584 N.W.2d 276, 284-87 (Iowa 1998); *Munoz v. Flower Hosp.*, 507 N.E.2d 360, 365 (Ohio Ct. App. 1985); *Weary v. Baylor Univ. Hosp.*, 360 S.W.2d 895, 897 (Tex. Civ. App. 1962); *Bass v. Ambrosius*, 520 N.W.2d 625, 628 (Wis. Ct. App. 1994); cf. *Bryant v. Glen Oaks Med. Ctr.*, 650 N.E.2d 622, 629 (Ill. App. Ct. 1995) (holding that the presence of an at-will arrangement precludes granting relief).

108 See *Porter Mem'l Hosp. v. Malak*, 484 N.E.2d 54, 61 (Ind. Ct. App. 1985).

109 See *Islami*, 822 F. Supp. at 1371; *Tredrea*, 584 N.W.2d at 285.

110 See *Posner v. Lankenau Hosp.*, 645 F. Supp. 1102, 1107 (E.D. Pa. 1986) (citing *Adler v. Montefiore Hosp. Ass'n*, 311 A.2d 634 (Pa. 1973)); see also *Tredrea*, 584 N.W.2d at 285, 287.

111 See, e.g., *Pariser v. Christian Health Care Sys., Inc.*, 816 F.2d 1248, 1251 (8th Cir. 1987), *aff'd*, 859 F.2d 78 (8th Cir. 1988); *Eidelson v. Archer*, 645 P.2d 171, 178 (Alaska 1982); *Adler*, 311 A.2d at 645; *Berberian v. Lancaster Osteopathic Hosp. Ass'n*, 149 A.2d 456, 458-60 (Pa. 1959).

112 See *Posner*, 645 F. Supp. at 1106, 1111 (citing *Berberian*, 149 A.2d at 456); *Samaritan Health Sys. v. Superior Court*, 981 P.2d 584, 588 (Ariz. Ct. App. 1998); *Gashgari v. Me. Med. Ass'n*, 350 A.2d 571, 575 (Me. 1976) (citing *Libby v. Perry*, 311 A.2d 527, 532 (Me. 1973)); *Virmani v. Presbyterian Health Servs. Corp.*, 488 S.E.2d 284, 288 (N.C. Ct. App. 1997); *St. John's Hosp. Med. Staff v. St. John Reg'l Med. Ctr., Inc.*, 245 N.W.2d 472, 474-75 (S.D. 1976).

is that if hospitals are not required to abide strictly with its bylaws, the bylaws are void of any meaning.¹¹³ If a hospital fails to follow bylaw procedures, the physician is entitled to hospital compliance. For example, the Supreme Court of Pennsylvania granted a physician an injunction, requiring the hospital to strictly comply with its procedural provisions of notice of charges and a hearing.¹¹⁴

4. Remedy Under Breach of Bylaw Contract

The importance of recognizing bylaws as a contract not only lies in the greater judicial review, but also in the relief available to the physician. If a court holds that an enforceable contract exists, a physician may be entitled to damages.¹¹⁵ To recover damages, a physician must demonstrate that the hospital's decision would have been different had it followed its bylaw procedures.¹¹⁶ Without sufficient evidence, a physician is only entitled to nominal damages unless the physician can show reasonable reliance in foregoing other offered positions while awaiting a hospital's decision to follow its bylaws.¹¹⁷ The granting of an injunction, requiring the hospital to abide by its bylaw procedures, varies from state to state.¹¹⁸

113 See *Berberian*, 149 A.2d at 459; see also *Lewisburg Cmty. Hosp., Inc. v. Alfredson*, 805 S.W.2d 756, 759 (Tenn. 1991).

114 See *Berberian*, 149 A.2d at 459-60.

115 See *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1186 (E.D. Cal. 1998); see also *Brader v. Allegheny Gen. Hosp.*, 64 F.3d 869, 878-79 (3d Cir. 1995); *Rees v. Intermountain Health Care, Inc.*, 808 P.2d 1069, 1078-79 (Utah 1991).

116 See *Sibley v. Lutheran Hosp.*, 709 F. Supp. 657, 662 (D. Md. 1989).

117 See *id.*

118 See, e.g., *Lawler v. Eugene Wuesthoff Mem'l Hosp. Ass'n*, 497 So. 2d 1261, 1264-65 (Fla. Dist. Ct. App. 1986); *Porter Mem'l Hosp. v. Malak*, 484 N.E.2d 54, 61-62 (Ind. Ct. App. 1985) (holding that an injunction is available where plaintiff "will suffer great injury" and shows that the legal remedy is inadequate); *Missouri ex rel. Willman v. St. Joseph Hosp.*, 684 S.W. 2d 408, 411 (Mo. Ct. App. 1984) (holding that an injunction is not granted where deviation from bylaws was of "no consequence"); *Berberian*, 149 A.2d at 459 (finding that remedies provided by statute or found in a "voluntary association" require strict compliance as the exclusive remedy); *Das v. Greene County Mem'l Hosp.*, No. 8, 1987 Pa. D. & C. LEXIS 202, at *11 (Commw. Ct. June 12, 1987) (holding that no injunction is issued when damages adequately compensate).

IV. BREACH OF BYLAWS CAUSED BY CONSTRUCTIVE REVOCATION

A. *Enforcement of Bylaws as a Remedy for Constructive Revocation*

The court in *Strauss v. Peninsula Regional Medical Center*¹¹⁹ had the opportunity to recognize that a breach of the bylaw contract can occur where a physician's privileges are constructively revoked. The court, instead, held that Strauss,¹²⁰ the physician, was entitled to relief for breach of the bylaws once the hospital had independently decided to terminate his privileges,¹²¹ rather than choosing to base its holding on a hospital's decision to enter into an exclusive contract with a third party group of physicians.

Strauss brought a breach of contract action, among other claims, for the termination of his staff privileges upon the execution of an exclusive contract with a "new management group."¹²² Peninsula Regional Medical Center (Peninsula) and Strauss previously entered into an exclusive contract, which granted Strauss active medical staff privileges pursuant to Peninsula bylaws.¹²³ In 1992, after his exclusive contract had expired, Strauss remained as a member of the open medical staff.¹²⁴ During this time, Peninsula grew concerned after Strauss disclosed that he was in the process of building a nearby radiation therapy facility and as animosity intensified between the two radiation oncology groups.¹²⁵ In response, the Board of Directors at Peninsula granted an exclusive contract to the Drake/Blumberg group, over a unanimous objection from the medical staff and a proposal by Strauss for the two to work jointly.¹²⁶ Strauss's privileges would continue only after the hospital accepted him into the Drake/Blumberg group.¹²⁷ Soon after their agreement, the Board adopted a resolution to terminate his medical staff privileges.¹²⁸

Rather than deny that the bylaws ever created contractual obligations, Peninsula contended that the medical staff bylaws only applied where a physician's privileges are "restricted or revoked due to specific acts or omissions"¹²⁹ and did not apply to managerial decisions

119 916 F. Supp. 528 (D. Md. 1996).

120 Dr. DeMassi, by virtue of being hired by Dr. Strauss, joined in the litigation.

121 *Strauss*, 916 F. Supp. at 533-34.

122 *Id.* at 532.

123 *See id.* at 531.

124 *See id.* at 532.

125 *See id.*

126 *See id.* at 534.

127 *See id.* at 535.

128 *See id.* at 536.

129 *Id.* at 538 (citation omitted).

concerning operational and financial matters.¹³⁰ Peninsula also argued that their medical staff privileges terminated, in any event, upon the expiration of the exclusive contract.¹³¹ The court refused to apply *Anne Arundel General Hospital, Inc. v. O'Brien*,¹³² which held that the bylaws were not binding where the hospital's decision was managerial and not covered by the bylaws.¹³³ Unlike *O'Brien*, where an exclusive contract was awarded to another physician immediately following the expiration of the previous exclusive contract,¹³⁴ Strauss maintained and exercised his medical staff privileges as a member of the open medical staff.¹³⁵ Another notable difference was that the Peninsula board failed to completely close their staff since Peninsula extended opportunities, conditioned on acceptance of certain concessions, to members of the previous medical staff, excluding the plaintiffs.¹³⁶ A third difference was that, in *O'Brien*, the medical staff privileges expired at the same time as the exclusive contract, whereas in *Strauss*, Strauss's privileges continued for an additional two years until Peninsula formally revoked them.¹³⁷ Finally, Strauss submitted sufficient evidence in the trial court to suggest that the Peninsula's decision to terminate his privileges was motivated by disciplinary reasons.¹³⁸

The *Strauss* court held that Strauss had introduced sufficient evidence to permit the trial court to consider a breach of contract action for the hospital's failure to follow procedural bylaw protections before formally terminating his privileges.¹³⁹ In remanding the case to the trial court, the *Strauss* court should have instructed the trial court to consider Peninsula's decision to enter into an exclusive contract with the Drake/Blumberg group as a constructive revocation of Strauss's privileges. It is uncertain whether the outcome would have been the same had the hospital never officially terminated Strauss's privileges, although his privileges in either case would have become nonexercisable. In such cases, not only does a strong inference arise that the actions of the hospital might have been in bad faith, but the conduct of the parties may also give rise to a contract implied-in-fact.¹⁴⁰

130 See *id.* at 537-38.

131 See *id.* at 538.

132 432 A.2d 483 (Md. Ct. Spec. App. 1981).

133 See *Strauss*, 916 F. Supp. at 538-40.

134 See *O'Brien*, 432 A.2d at 486.

135 See *Strauss*, 916 F. Supp. at 539-40.

136 See *id.* at 540.

137 See *id.*

138 See *id.* at 540-43.

139 See *id.* at 543-44.

140 Examples may include situations where the physician and/or hospital follows policies that extend beyond the scope of the bylaws or where the hospital—in the

The *Strauss* court fell short of ensuring that hospital decisions, even those not expressly covered in the bylaws, must conform to the parties' reasonable expectations.

B. Bylaws Not Providing a Remedy for Constructive Revocation

A court refusing to recognize constructive revocation as a breach of the bylaws can be found in *Garibaldi v. Applebaum*.¹⁴¹ In *Garibaldi*, the plaintiff, Garibaldi, was a member of the medical staff who enjoyed clinical privileges.¹⁴² While he retained membership, Applebaum, who had previously not been a member of the physician medical staff, entered into an exclusive contract with St. Francis Hospital, which Garibaldi contended terminated his privileges without notice and a hearing pursuant to the bylaws.¹⁴³ The court rejected the plaintiff's argument that the exclusive contract agreement revoked his privileges, finding that the hospital's decision was not based upon judgment regarding the physician's ability to work at a hospital and not based on the physician's exercise of privileges, which must have been influenced by numerous reasons including disciplinary or economic.¹⁴⁴ The *O'Brien* court added,

A managerial decision concerning operation of the hospital made rationally 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.

Judges are untrained and courts ill-equipped for hospital administration, and it is neither possible nor desirable for the courts to act as supervening boards of directors for every nonprofit hospital corporation in the state.¹⁴⁵

process of deciding whether to execute an exclusive contract—abides by some of the bylaw procedures.

141 742 N.E.2d 279 (Ill. 2000).

142 *Id.* at 280.

143 *Id.* at 281. Incidentally, while the case was on appeal, the bylaws had been amended to provide for at least sixty days notice in order to conform to recently enacted statutory requirements for instances when the hospital entered into an exclusive contract with a third party. See *id.* at 282.

144 See *id.* at 284–85; see also *Bartley v. E. Me. Med. Ctr.*, 617 A.2d 1020, 1022–23 (Me. 1992); *Holt v. Good Samaritan Hosp. & Health Ctr.*, 590 N.E.2d 1318, 1323 (Ohio Ct. App. 1990); *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 440 (Tex. App. 1994), *rev'd on other grounds sub nom. Calvillo v. Gonzalez*, 922 S.W.2d 928, 929 (Tex. 1996).

145 *Anne Arundel Gen. Hosp., Inc. v. O'Brien*, 432 A.2d 483, 490 (Md. Ct. Spec. App. 1981) (quoting *Centero v. Roseville Cmty. Hosp.*, 107 Cal. Rptr. 183 (Ct. App. 1979)).

The bylaws, the court found, only apply to hospital decisions relating to the physician's competence, not administratively motivated decisions.¹⁴⁶ Because no revocation, suspension, or reduction of existing privileges occurred, the court declined to subject the hospital's decision to judicial review.¹⁴⁷

Many courts while recognizing that exclusive contract arrangements might have the incidental effect of terminating one's privileges hold that "it does not reduce or alter . . . staff privileges as such."¹⁴⁸ Indeed, a physician whose privileges remain intact despite an exclusive contract between the hospital and a third party may use such privileges to find other employment opportunities in the hospital.¹⁴⁹ Bylaw procedures only protect the physician from exclusion or expulsion arising from a hospital's determination that a physician is unfit to practice at that hospital.¹⁵⁰ Membership to the medical staff does not afford a physician with a vested right to practice absent an employment contract for a specified term.¹⁵¹ Counterbalanced against the physician's interest, hospitals must be provided with administrative discretion "to implement policies and programs that it deems reasonable."¹⁵² Despite policy considerations favoring greater hospital discretion in negotiating exclusive contracts, strong legal and policy reasons provide support for adoption of the doctrine of constructive revocation in the context of medical staff privileges.

C. *The Rationale for Bylaws Remediating Constructive Revocation*

Courts should not immediately assume that a hospital's decision to enter into an exclusive contract is outside the contemplation of the parties. Rather, they should consider the exchange of implied promises in determining whether the hospital followed bylaw proce-

146 See *Garibaldi*, 742 N.E.2d at 280.

147 See *id.* at 284-85.

148 *Tenet Health Ltd. v. Zamora*, 13 S.W.3d 464, 469 (Tex. App. 2000); see also *Hager v. Venice Hosp.*, 944 F. Supp. 1530, 1533-34 (M.D. Fla. 1996); *Garibaldi*, 742 N.E.2d at 284-85.

149 See *Hager*, 944 F. Supp. at 1534; *Gonzalez*, 880 S.W.2d at 440.

150 See *Richter v. Danbury Hosp.*, No. 307869, 1998 WL 321853, at *4 (Conn. Super. Ct. June 9, 1998), *rev'd in part*, 759 A.2d 106 (Conn. App. Ct. 2000); *Bloom v. Clara Maass Med. Ctr.*, 685 A.2d 966, 972 (N.J. Super. Ct. App. Div. 1996); *Read v. McKennan Hosp.*, 610 N.W.2d 782, 786-87 (S.D. 2000), *criticized in Richter v. Danbury Hosp.*, 759 A.2d 106, 112-13 (Conn. App. Ct. 2000); *Tenet Health Ltd.*, 13 S.W.3d at 469.

151 See *Leider v. Beth Israel Hosp. Ass'n*, 229 N.Y.S.2d 134, 137 (Sup. Ct. 1960), *aff'd*, 182 N.E.2d 393, 394 (N.Y. 1962), *overruled by Gelbard v. Genesee Hosp.*, 664 N.E.2d 1240, 1241-42 (N.Y. 1996); *Tenet Health Ltd.*, 13 S.W.3d at 471-72.

152 *Tenet Health Ltd.*, 13 S.W.3d at 471.

dures upon entering into a third party exclusive contract. The presence of mixed disciplinary and managerial motives, as described in *Strauss*, provides the most compelling example of where the physician's reasonable expectations are that a hospital's decision, stemming from evaluation or disciplinary action, must conform to the bylaws. Courts should not wait until a hospital has formally decided to reduce or terminate a physician's privileges, usually limited to disciplinary matters and judgments based on one's qualifications.¹⁵³ For one, a court's inquiry into a hospital's decision can prevent hospitals from circumventing bylaw procedural protections afforded to the physician.¹⁵⁴ Under some circumstances, reasonable expectations may extend to include hospital decisions that are not expressly mentioned in the bylaws.

Those courts that deny relief to a physician whose privileges are constructively revoked due to an exclusive contract fail to recognize the potential existence of an implied-in-fact contract or one made by "process of implication and inference."¹⁵⁵ Drawing from employee handbook cases, reasonable expectations may arise from a number of factors "including 'the personnel policies or practices of the [hospital], the [physician's] longevity of service, actions or communications by the [hospital] reflecting assurances of continued employment, and the practices in the industry . . .'"¹⁵⁶ Courts should revisit this issue in light of the fact that the relationship between the physician and the hospital is changing through greater specialization and increased competition among physicians for access to hospitals. Thus, the physician's ability to engage in self-help is becoming less practical as physicians are unable to exercise privileges outside their specialty and as the opportunity for referral to another hospital in the community is

153 See Chayet & Reardon, *supra* note 11, at 309.

154 See *Spunberg v. Columbia/JFK Med. Ctr.*, No. 97-8937 AH, 1997 WL 868607, at *2 (Fla. Cir. Ct. Dec. 23, 1997).

155 1 CORBIN, *supra* note 73, § 1.19.

156 *Janda v. Madera Cmty. Hosp.*, 16 F. Supp. 2d 1181, 1188 (E.D. Cal. 1998) (quoting *Foley v. Interactive Data Corp.*, 765 P.2d 373, 387 (Cal. 1988)). Invariably, this determination is a question of fact. *Id.*

[Other factors] include written or oral negotiations, the conduct of the parties from the commencement of the employment relationship, the usages of the business, the situation and objective of the parties giving rise to the relationship, the nature of the employment, and any other circumstances surrounding the employment relationship which would tend to explain or make clear the intention of the parties at the time said employment commenced.

Koehler v. Hunter Care Ctrs., Inc., 6 F. Supp. 2d 1237, 1242 (D. Kan. 1998) (quoting *Morris v. Coleman Co.*, 738 P.2d 841, 848-49 (Kan. 1987)).

dwindling. As the Florida Court of Appeals held, "the loss of staff privileges equates to loss of patients and ability to practice in this doctor's specialty" ¹⁵⁷ Courts should extend this line of reasoning to physicians whose privileges are adversely affected by the closing of a hospital's medical staff by an exclusive contract. This is merely recognizing that there are circumstances under which the fair notice and hearing provisions may be within the contemplation of the parties.

The current approach is inadequate insofar as instances arise in which a physician, seeking protection against an unfair and/or arbitrary hospital decision, is denied relief because the court limits its analysis to the express provisions in the bylaws. Instead, courts should inquire into the nature of the relationship shared between the particular physician and the hospital and the motivating factors underlying the hospital's decision. Without explicit reference in the bylaws to all types of hospital decisions, physicians are sometimes left without a remedy for what amounts to a loss of privileges, despite the fact that a physician may have reasonably expected the hospital to follow procedures, including instances where the introduction of a third party exclusive contract adversely affects the physician's ability to exercise privileges. Where the court determines that the hospital, through its conduct, provided assurances to staff member physicians of continued employment, relief should be provided when a hospital breaches those promises by entering into a third party exclusive contract without first following bylaw procedures. Even where no such reasonable expectations of continued employment exist, the physician, at the very least, should be entitled to a review of the hospital's motivations where evidence suggests mixed motives. In cases where the hospital's decision is based largely on a judgment of competence or is disciplinary, physicians should be entitled to relief where the hospital fails to abide by its bylaws, such as providing fair notice and a hearing.

The interactions between the physician and the hospital, notwithstanding the motives surrounding a hospital's decision, may give rise to reasonable expectations that any decision adversely affecting the physician's privileges will be subject to the bylaw's notice and fair hearing procedures. Indeed, providing a cause of action to a constructively terminated physician is not much different from many courts that provide relief for a hospital's decision based on grounds of a physician's competency. A hospital's decision to enter into an exclusive contract is as much a managerial decision as it is a judgment of the staff physicians' competency, as the former similarly involves eco-

¹⁵⁷ *Lawler v. Eugene Wuesthoff Mem'l Hosp. Ass'n*, 497 So. 2d 1261, 1264 (Fla. Dist. Ct. App. 1986).

nomic considerations, as well as the physicians' relative strengths and weaknesses. Hospital decisions to discipline or deny reappointment, by nature, entail managerial considerations, yet many courts have found little difficulty in applying contractual relief. Moreover, bylaws typically contain procedures for reappointment on a periodic basis, which requires the hospital to balance considerations ranging from the physician's qualifications to the hospital's needs.

Such an extension, given the peculiarity of the physician/hospital relationship, would be limited in application to physicians and would not place an undue burden on the hospital. The unique relationship between the physician and the hospital would limit application of this rule to specialized physicians. Physicians, unlike in other employment contexts, are granted privileges of the type found in the bylaws which govern the parties' duties and obligations (specifically hiring and reappointing). Organizationally, as members of the medical staff, and statutorily, physicians share a relationship with the hospital not found anywhere else and, as a result, enjoy additional protections such as a fair hearing and prior notice even though no employment contract so provides.

Also, the public's interest in ensuring the availability of quality physicians is unparalleled, suggesting that courts are justified in determining whether the expectations of the parties were realized beyond the express language of the bylaws. Requiring that hospitals use the notice and hearing provisions in the bylaws can also ensure that the hospital's decision is informed and fair.¹⁵⁸ Hospitals, through reasonable foresight, can guard against this risk through such measures as coordinating the commencement and termination of exclusive contracts and ensuring, through its policies, procedures, and careful record-keeping, its decision is not meant as disciplinary or as a judgment of the physician's competence, and no reasonable expectations of continued employment arose. Hospitals may also provide physicians opportunity to contribute to those hospital decisions in which the physician has a material interest.¹⁵⁹ Any fear, therefore, that litigation against the hospital will increase is unfounded since hospitals themselves can mitigate against the risk of litigation.

Those situations, similar to *O'Brien*, in which the terms of the exclusive contract and medical staff membership terminate at once or within a reasonable period of time ordinarily will not give rise to an

158 See *Volcjak v. Wash. County Hosp. Ass'n*, 723 A.2d 463, 471 (Md. Ct. Spec. App. 1999).

159 See, e.g., *Anne Arundel Gen. Hosp., Inc. v. O'Brien*, 432 A.2d 483, 491 (Md. Ct. Spec. App. 1981).

inference between the parties that an implied-in-fact contract exists. The scope of the physician's remedy would extend only to hospital decisions adversely affecting the physician's enjoyment of staff privileges and allow a hospital's managerial decision to be reviewable by the courts when factual circumstances give rise to the existence of continued employment or nonmanagerial motives. Courts ought to be cognizant of the fact that reasonable expectations of physicians and hospitals and strong public policy interests justify determination on a case-by-case basis of whether implied promises stemming from the bylaws and the relationship between the physician and the hospital were breached.

CONCLUSION

The evolving role of the hospital has challenged courts and academics to re-analyze the relationship between the hospital and the physician. With the emergence of medical staff bylaws, courts have been confronted with the issue of whether breach of contract remedies should be available. Judicial deference did not adequately realize the expectations of both parties, nor, as a collateral yet important matter, did they satisfy the concerns of the public. Courts through applying breach of contract remedies to bylaws have made progress in protecting the physician beyond those hospital decisions that are arbitrary or discriminatory. Where courts decide to limit bylaw contractual relief to formal revocation of membership privileges, they unfairly exclude those physicians whose privileges, by virtue of a hospital's decision, become nonexercisable. At a time where physicians increasingly rely on access to hospitals and the denial or revocation of privileges has devastating consequences to physicians, courts must also ensure that medical staff bylaws are adhered to where the physician's privileges have been constructively revoked. Instances will arise in which a hospital adequately follows bylaw procedure in terminating a physician's privileges or the factual circumstances will not give rise to an implied-in-fact contract. Nevertheless, courts, by recognizing that bylaws should be contractually enforceable when medical staff privileges are constructively revoked, provide physicians with protection from hospitals' decisions consistent with the parties' reasonable expectations and our notion of fairness.

