NO. A12-2117

State of Minnesota
In Supreme Court

Medical Staff of Avera Marshall Regional Medical Center on Its Own Behalf and in Its Representative Capacity for Its Members; Chief of Staff Steven T. Meister, M.D.; Chief of Staff-Elect Jane Willett, D.O.; and John Does and Jane Does,

Appellants,

v.

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

Respondents.

BRIEF OF *AMICI CURIAE* MINNESOTA HOSPITAL ASSOCIATION AND AMERICAN HOSPITAL ASSOCIATION

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TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES

OTHER AUTHORITY

STATEMENT OF *AMICUS CURIAE*

The Minnesota Hospital Association ("MHA") is a Minnesota nonprofit corporation that represents hospitals in the State of Minnesota, including 145 community-based hospitals and health systems and the physicians employed at those hospitals and health systems.[1] MHA assists Minnesota hospitals in carrying out their responsibility to provide quality health care services to their communities, promote universal health care coverage, access, and value, and coordinate development of innovative health care delivery systems. MHA serves it members and the State of Minnesota as a trusted leader in health care policy and as a valued source for health care information and knowledge.

The American Hospital Association ("AHA") represents nearly 5,000 hospitals, health systems, and other health care organizations, as well as 43,000 individual members. AHA members include urban, rural, large, and small hospitals as well as health care systems. The members of the AHA are committed to finding innovative and effective ways of improving the health of the communities they serve. The AHA educates its members on health care issues and trends, and it also advocates on their behalf in legislative, regulatory, and judicial fora to ensure that their perspectives and needs are understood and addressed.

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[1] MHA and AHA certify that this brief was written by their counsel of record, and no party or counsel for a party authored any part of this brief. No person or entity other than the MHA, AHA, their members, or their counsel made any monetary contribution to the preparation or submission of this brief. *See* MINN. R. CIV. APP. P. 129.03.

MHA and AHA members have an interest in both maximizing the prospect that they and their medical staffs can work together productively to advance the quality of health services delivery and ensuring that, in the rare instance when dysfunction such as that apparently present at Avera Marshall does arise, the hospital's governing body is not powerless to effect needed improvements. To that end, MHA and AHA urge that the ruling by the court of appeals should be affirmed on the two holdings that were essential to it: under Minnesota law, (1) bylaws governing a hospital's medical staff may be amended by the hospital's governing body; and (2) a hospital's medical staff has no legal existence apart from the hospital such that it may bring suit against the hospital.[2]

[2] To the extent the district court opined on additional issues that were not necessary to resolution of the dispute before it, MHA and AHA respectfully submit that this Court need not, and should not, address such matters in the course of deciding this appeal.

ARGUMENT

This appeal presents challenging questions only because it arises from difficult facts. As a general rule, hospitals and their medical staffs work together toward the same goals of delivering quality health services to their communities. Those common goals are shared by hospitals, medical staffs, doctors, nurses, their respective trade associations, government regulators, and accreditation entities, such as The Joint Commission. In pursuit of those shared goals, hospitals and medical staffs throughout Minnesota (and elsewhere) aspire to function cooperatively. Nonetheless, when seemingly irreconcilable conflicts arise, it is the hospital's governing body, under which the medical staff operates, that is empowered to act with respect to the relationship between the hospital and the doctors who make up the medical staff. Minnesota law unequivocally supports that conclusion.

Policy considerations also dictate that the hospital have the authority to act even when it is unable to obtain the agreement of its medical staff. Although Appellants and their *Amici*[3] hark back to an era that may never have existed, in which hospitals were perceived by doctors as simply providing facilities in which the doctors could provide patient care, the reality of patient care within hospitals is quite different. As this Court has made clear, if the hospital's role ever was "limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices his

[3] *Amici* refers to the American Medical Association, Minnesota Medical Association, American Osteopathic Association, American Academy of Family Physicians, Minnesota Academy of Family Physicians, and the Minnesota Chapter of the American Academy of Pediatrics, whose brief will be cited as "*Amici* Br."

profession in his own individualized manner," that is no longer the case. *Larson v. Wasemiller*, 738 N.W.2d 300, 308 (Minn. 2007) (internal quotations omitted). In numerous ways and for numerous reasons, hospitals play a vital role in the provision of patient care and are not merely a landlord or property owner with whom a physician contracts.

The pressures brought to bear on hospitals in the past several decades – including changes in payment practices, increased competition, circumstances in which hospitals may be found liable to patients, and capital financing – have made it not only desirable, but necessary, for hospitals to be overseen by highly engaged and effective governing bodies. And the hospitals are not merely responsible for business operations; through the doctors, nurses, and other medical care professionals they employ, as well as the role they play with respect to doctors whom they do not employ, they are actively involved in the provision of patient care. Restricting the ability of governing bodies of hospitals to act, as Appellants and their *Amici* desire, would place boards in an untenable position – having the responsibility without the needed authority to perform their essential role of overseeing and facilitating the delivery of high quality medical services.

I. Public Policy Considerations Dictate That a Hospital's Governing Body Retain Ultimate Authority To Manage the Hospital as an Institution, Including Its Relationship with Its Medical Staff.

As is discussed in the opinion of the court of appeals, Respondent's Brief, the district court's careful opinions (and briefly herein), Minnesota law clearly supports the rulings made by the court of appeals and the district court. Public policy considerations further demonstrate that both courts reached the correct result.

A. A Hospital's Governing Body Must Have the Ultimate Authority and Responsibility To Make All Decisions Regarding Governance of the Hospital.

The overriding concern of MHA and AHA in this appeal is the effect that reversal would have on the authority of a hospital's governing body to make decisions that affect the continued viability of a hospital and the community's access to health care. Because hospital boards[4] – not medical staffs – bear ultimate responsibility for the hospital's accomplishment of its mission, hospital boards must be able to exercise their authority to meet that responsibility.

This is particularly true given changes in hospital-based healthcare over the last decade. *See generally* Brian M. Peters & Robin Locke Nagele, *Promoting Quality Care & Patient Safety: The Case for Abandoning the Joint Commission's "Self-Governing" Medical Staff Paradigm*, 14 MICH. ST. J. MED. & LAW 313, 316 (Spring 2010). Now more than ever, various members of medical staffs have become adverse to one another, and to the boards of directors at the hospitals at which they are credentialed. *Id.* This is due largely to the internal competition among and between physicians for identical hospital clinical privileges and differing payment incentives for hospitals and physicians. *See id.* A hospital's board of directors, and not its medical staff, must therefore retain ultimate authority to keep the hospital true to its mission.

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[4] Throughout this brief, "board" and "governing body" are used interchangeably. In this instance, the governing body is a board, but the important fact is not that the governing body is a board, but that the board or other type of governing body has ultimate responsibility for and authority over the hospital's operations.

Moreover, hospitals bear significant legal responsibility for the quality of patient care. Starting with *Darling v. Charleston Cmty. Mem'l Hosp.*, 211 N.E.2d 253, 255 (Ill. 1965), courts have recognized that hospitals are responsible and accountable for selecting the practitioners that care for their patients. A hospital not only provides care directly through its nursing staff and other medical care professionals, but it is responsible for monitoring the competence and conduct of the physicians to whom it grants privileges. If a hospital fails in that duty, this Court has held that it may be liable to a patient if harm results. *See Larson*, 738 N.W.2d at 313.

Apart from liability concerns, a hospital's governing body has myriad reasons to be concerned about the quality of care that is delivered in its facilities. The means by which hospital performance is measured, and corresponding decisions that are made with respect to how a hospital is paid for the services it delivers, look increasingly not only to the quantity of such service, but to its quality. Individual physicians may not have the same hospital-wide concern that the hospital's governing body has for such matters nor the authority to effect hospital-wide improvements, which is why the authority and responsibility for such concerns lies not with the hospital's medical staff, but with its governing body.

A decision in this case that diminished the authority of a hospital board to manage the affairs of the hospital – to place certain matters at the discretion of the medical staff to the point of being able to exercise veto power – would run contrary to public policy regarding hospital administration and accountability as it has developed over the last forty years. Minnesota law provides ample authority for the Court to avoid such a result.

B. The Positions Advanced by *Amici* Sound Not in Public Policy or in Law, but in Nothing More Than a Desire To Constrain the Authority of the Hospital Board over its Medical Staff.

Amici recognize the authority of the hospital board and profess not to want to interfere with the board's exercise of its role as the ultimate authority within a hospital. Beginning with their statement of the issue, they focus on whether the board can amend the bylaws unilaterally "without good cause[.]" *Amici* Br. 1. They explain that the bylaws "somewhat constrain a hospital's exercise of discretion, but not its ultimate authority" (*id.* at 8) and contend that a hospital board "can only overrule the medical staff for objectively valid reasons that do not involve patient care." *Id.*; *see also id.* at 9 ("the governing body should defer to the decisions of the medical staff itself, unless there is a valid reason why it should not"). With respect to bylaw amendments, *Amici* argue that the medical staff must have the right to "reject unreasonable amendments" (*id.* at 16) – but, notably, not all amendments.

The varying standards put forward by *Amici* beg the question: who decides whether the hospital governing body has good cause to act, whether it does so for an objectively valid reason, whether amendments it adopts are reasonable or unreasonable, or whether its actions are arbitrary?[5]

Respondent's actions in this case no doubt survive any of the various formulations put forward by *Amici*. Nonetheless, the court of appeals declined the invitation by *Amici*

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[5] In their brief filed in the court of appeals, *Amici* argued that the hospital governing body should be prohibited from amending the medical staff bylaws "arbitrarily." *Amici* Br. (Ct. App.) at 17. In their brief before this Court, they have amended their proffered standard from arbitrary to "unreasonable." Neither standard is grounded in applicable legal authority.

to create new law in Minnesota, and this Court should do the same. It may not be a good idea for a hospital governing body to amend such bylaws unilaterally, and a hospital would presumably only do so as a last resort (as was the case here), but the fundamental point is that the hospital governing body has power to do so because it must, consistent with its ultimate authority over the hospital.

II. A Hospital Board May Amend Medical Staff Bylaws Without Obtaining the Agreement of Its Medical Staff.

Appellants and their *Amici* argue that the medical staff bylaws are contractual in nature, meaning that the hospital's governing body either may not modify those bylaws without the medical staff's agreement or, at minimum, may do so only in certain ill-defined circumstances. In truth, the medical staff bylaws do not function as a contract either in theory (under contract law principles) or in practice (specifically with respect to peer review disputes). In addition, the statutory and regulatory law applicable to hospital's governing bodies precludes them from ceding control of the hospital's functions to the medical staff.

A. The Medical Staff Bylaws Do Not Function as a Contract.

If the medical staff has no legal existence apart from the hospital (*see infra* at 13), Appellants' contention that the medical staff bylaws constitute a contract raises the obvious question: with whom? Appellants contend that a contract is entered into each time a physician is granted privileges at a hospital. Must a physician actually use the hospital privileges that have been granted in order for a contract to have been formed? If not, why not? And what happens when the bylaws are amended in a process that

includes approval by the hospital's medical staff? Is such an amendment only effective if it also receives the approval of each physician? If so, what consideration is required as part of the amendment?

As these questions demonstrate, under standard contract law principles, medical staff bylaws do not function as a contract between the hospital and either the medical staff or individual physicians, they do not have the qualities required of contracts, and, for those reasons, they are not contracts.

B. Potential Individual Physician "Due Process" Concerns Do Not Make the Medical Staff Bylaws a Contract.

The district court expressed concern about disputes that may arise regarding the removal of a physician from a hospital's medical staff. As a threshold matter, it is undisputed that the hospital's governing body determines membership in the medical staff. *See, e.g.*, 42 C.F.R. § 482.12(a). No physician has a contractual right to be part of a hospital's medical staff. Even the strongest case cited by Appellants for that proposition refers only to "what may be termed" a physician's "contractual due process rights" and does not analyze whether medical staff "bylaws, rules, and regulations governing medical staff privileges" constitute a contract. *Campbell v. St. Mary's Hosp.*, 252 N.W.2d 581, 583 (Minn. 1977). This Court was not asked in that case (or in any other case) to consider whether medical staff bylaws constitute a contract or, if so, between which entities or persons. *See id.* at 586 (concluding physician had been afforded due process).

This case does not present any claim by an individual physician that he or she is entitled to membership in a hospital's medical staff, and the Court therefore need not address the issue. Nonetheless, it is important to note that disputes regarding the removal of a physician from a hospital's medical staff now frequently turn on statutory provisions, specifically the immunity provisions of the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 to 11152, and Section 145.63 of the Minnesota Statutes. Application of those two provisions renders a hospital's peer review process immune from suit so long as it satisfies certain standards and is not motivated by malice. As a practical matter, disputes with respect to the revocation or suspension of privileges are likely to be governed by federal and state law rather than by specific provisions in medical staff bylaws. A hospital's policies with respect to peer review may play a role in such disputes, but it does not follow that the policies or practices constitute a contract. *See, e.g.*, *In re Peer Review*, 749 N.W.2d 822, 828 (Minn. Ct. App. 2008) (treating violations of hospital procedure as evidence of malice under Section 145.63).

C. Chapter 317A of the Minnesota Statutes Requires that Nonprofit Corporations Be Managed by Their Boards.

Respondent, like virtually all hospitals in Minnesota, operates as a nonprofit corporation. Under Minnesota law, "the business and affairs of a corporation must be managed by or under the direction of a board of directors." MINN. STAT. § 317A.201; *see also id.* § 317A.241 (allowing for committees and subcommittees). The law governing nonprofit corporations in Minnesota does not permit a board to cede authority to a for-profit entity, as a majority of the members of the medical staff of Avera Marshall

would apparently have it. Because the board retains ultimate authority over the hospital's operations, consistent with the reservation of rights in the bylaws themselves, the medical staff cannot, in circumstances such as those present at Avera Marshall, exercise veto power over the operations of the hospital.

D. Minnesota's Hospital Licensing Standards Require that a Participating Hospital Have a Single Governing Body.

Under Minnesota law, the minimum standards for licensure of a hospital are found in the Conditions of Participation ("CoPs") that are promulgated by the Centers for Medicare & Medicaid Services ("CMS"). *See* MINN. STAT. § 144.55, subd. 3(a) & 8. The CoPs require, among other things, that a hospital have "an effective governing body that is legally responsible for the conduct of the hospital . . . ." 42 C.F.R. § 482.12. That governing body is not the medical staff. Rather, the governing body is charged, among other things, with holding the medical staff "accountable." *Id.* § 482.12(a)(5).

If a hospital were to cede veto power over its medical staff bylaws to its medical staff, it would do so in contravention of Minnesota's hospital licensing standards.

E. The Relevant Joint Commission Standards Support Avera Marshall's Actions.

Appellants and their *Amici* point to a standard promulgated by The Joint Commission, which prohibits unilateral amendment of medical staff bylaws. To put it simply, The Joint Commission standard cited by Appellants does not apply to this case.

(*See* Resp. Br. 47.[6]) Nonetheless, The Joint Commission does valuable work, and its positions as related to this appeal warrant further consideration.

It may be helpful to first explain the role that The Joint Commission plays with respect to certain hospitals. Hospitals licensed in Minnesota may either be inspected by the Commissioner of Health or may alternatively be accredited by "an approved accrediting organization." MINN. STAT. § 144.55, subd. 4; *see also* 42 U.S.C. § 1395bb(a)(1). CMS determines which entities qualify as approved accrediting organizations. *See* MINN. STAT. § 144.55, subd. 2(b). At present, three entities qualify as approved accreditation organizations for hospitals and critical access hospitals: American Osteopathic Association/Healthcare Facilities Accreditation Program, Det Norske Veritas Healthcare, and The Joint Commission. *See* CMS-Approved Accreditation Organization Contact Information (*available at* http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/AOContactInformation.pdf).

Under Minnesota's hospital licensing regime, a hospital may elect to be inspected by the Commissioner of Health or to be accredited by one of the three organizations approved by CMS. If a hospital elects not to be accredited by one of the organizations, then that organization's standards do not apply to that hospital. In no event do the standards of such an organization constitute Minnesota law.

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[6] Beyond the fact that Avera Marshall is not accredited by The Joint Commission, it also is a Critical Access Hospital, so The Joint Commission standard cited by Appellants and their *Amici* would not apply to Avera Marshall even if Avera Marshall were accredited by The Joint Commission. (*See* Resp. Br. 47-48.)

For these reasons, The Joint Commission's Standard MS.01.01.03 is not directly germane to this appeal. (*See* Resp. Br. 47-48.) The Standard sets forth a laudable goal – that hospital governing bodies and their medical staffs work together to achieve their common objectives with respect to delivery of quality patient care. All concerned agree that hospital governing bodies and medical staffs must work cooperatively to ensure delivery of quality patient care. When that goal proves unattainable, as appears to have been the case at Avera Marshall, then under Minnesota law the hospital governing body retains the authority to act. The applicable standards promulgated by The Joint Commission are consistent with that conclusion. (*See* Resp. Br. 48.) Indeed, The Joint Commission's Leadership Standards for Critical Access Hospitals expressly provide that "[t]he governing body is ultimately accountable for the safety and quality of care, treatment, and services." Standard LD.01.03.01.

III. A Hospital's Medical Staff Has No Legal Existence Apart from the Hospital.

A hospital's medical staff is part of the hospital. The medical staff has no existence independent of the hospital, and it exists only because of the individual physician member's connection to the hospital. If a physician obtains privileges at the hospital, she or he must become a member of the medical staff. In that sense – contrary to Appellants' arguments (*see* App. Br. 15) – membership in the medical staff is not "voluntary," as that adjective is ordinarily understood. A physician may certainly elect not to obtain privileges at a hospital, but once a physician makes the election to do so, she or he then becomes a member of the medical staff. In no sense is the medical staff

considered as separate from the hospital, and nothing in Minnesota law gives the medical staff any existence independent of the hospital.

A. Applicable Regulatory Law Makes Clear That a Medical Staff Is Part of a Hospital.

A hospital's medical staff plays an indispensable role in ensuring the delivery of high quality patient care. But the medical staff is a part of the hospital, as the relevant administrative rules make abundantly clear.

As is noted above, *supra* at 11, the CoPs set forth the minimum licensure standards applicable to a hospital in Minnesota. The hospital is required to have "an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital." *Id.* § 482.22. Similarly, under the heading "Basic Hospital Functions," the CoPs require a hospital to have medical record services, pharmaceutical services, radiologic services, laboratory services, and food and dietetic services. *See id.* §§ 482.24 to 482.28.

All parts of the hospital are accountable to the governing body. *See id.* § 482.12. Specifically with respect to the medical staff, the governing body (1) determines which practitioners are eligible to be members of the medical staff, (2) appoints the members of the medical staff, (3) assures that the medical staff has bylaws, (4) approves medical staff bylaws and other medical staff rules and regulations, and (5) ensures that the medical staff is accountable to the governing body for the quality of care provided to patients. *See id.* § 482.12(a).

Simply put, the medical staff of a hospital is one of its constituent parts – an extremely important part, but a part nonetheless. It makes no more sense for the medical staff to be considered a legal entity independent of the hospital (such that it may sue the hospital) than it does to treat the medical record services, pharmaceutical services, radiologic services, laboratory services, or food and dietetic services as "unincorporated associations" that have a legal existence independent of the hospital. *See generally George v. Univ. of Minn. Athletic Ass'n*, 120 N.W. 750, 751-52 (Minn. 1909) (association that is branch of University held "not proper party defendant").

B. MINN. STAT. § 540.151 Grants No Substantive Rights.

Appellants and their *Amici* claim to find authority for their position in Section 540.151 of the Minnesota Statutes, which no one contends was enacted with medical staffs in mind. Nonetheless, the language of the statute does allow individuals to associate and then to bring suit. In certain limited circumstances, the statute also addresses the enforcement of judgments when such suits are brought. The statute does not, however, confer any substantive rights. "[T]his statute is only procedural. Unincorporated associations derive their rights from the rights of their members." *Minn. Assoc. of Nurse Anesthetists v. Allina Health Sys. Corp.*, 276 F.3d 1032, 1049 (8th Cir. 2000). In that sense, the statute is similar to Federal Rule of Civil Procedure 17(b)(3)(A), which addresses the rights of "unincorporated associations" to bring suit. Under that Rule, however, "questions of legal or juridical existence and capacity to sue and be sued are distinct": "a group of persons working together for a common purpose must first be found to have legal existence before the question of capacity to sue or be sued can arise."

Brown v. Fifth Jud'l Dist. Drug Task Force, 255 F.3d 475, 477 (8th Cir. 2001). Similarly, here the initial question is whether a medical staff has a legal existence; because it does not, no rights arise under Section 540.151.

C. Minnesota Has Not Enacted the Uniform Unincorporated Nonprofit Association Act.

In their brief before the court of appeals, *Amici* relied upon a model act, the Uniform Unincorporated Nonprofit Association Act ("Uniform Act"), which was promulgated in 1996. (*See Amici* Br. (Ct. App.) 5, 8.) Although they have not advanced that argument before this Court, the fact of the uniform law's existence – and that it has not been adopted in Minnesota – further illustrates the current state of Minnesota law on this issue.

If the Uniform Act were the law in Minnesota, it would confer legal existence upon unincorporated nonprofit associations, but the Legislature has not adopted either that Act or the Revised Act promulgated in 2008. Thus, the common law governs. As the drafters of the 1996 Act explained, "[a]t common law an unincorporated association, whether nonprofit or for-profit, was not a separate legal entity. It was an aggregate of individuals. In many ways it had the characteristics of a business partnership." Uniform Unincorporated Nonprofit Association Act (1996), Prefatory Note at 1. Because neither the Act nor any analog thereto has been adopted in Minnesota, the drafters' description is accurate except for the verb tense: In Minnesota, an unincorporated association *is* not a separate legal entity.

Although there may be circumstances in which it would be advisable to allow unincorporated associations to bring suit, it is difficult to see how it would be beneficial to allow one part of an organization, which exists only by virtue of the larger organization's existence, to bring suit against another part of the organization. In this circumstance, the medical staff might well be subjecting itself to liability as an entity, in connection with its role in physician credentialing, for example. But even if one puts aside the potential consequences as they relate specifically to medical staff, more broadly, allowing such groups to sue and be sued would seem to encourage parties to seek judicial resolution of what are fundamentally internal disputes. If this Court were to both (a) grant a hospital's medical staff the power to sue and be sued, and (b) adopt the position that hospital governing bodies can only unilaterally amend medical staff bylaws when those amendments are "reasonable" or "objectively valid," then the Court would effectively invite all such intrahospital disputes to become matters for litigation. Minnesota law neither requires nor condones such a result.

CONCLUSION

For the reasons set forth in the rulings by the court of appeals and the district court, in Avera Marshall's brief, and herein, *amici curiae* Minnesota Hospital Association and American Hospital Association urge this Court to affirm the ruling by the court of appeals.

Dated: December 23, 2013

Respectfully submitted,

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