

Investor-Owned Hospital Management Corporations: Will Quality Medical Care Survive?

I. INTRODUCTION

Since the mid-sixties radical changes have occurred in the ownership and management of a significant and rapidly growing number of hospitals in the United States. These changes promise to alter our traditional conceptions of the role hospitals play in society. They also promise to generate challenges to the legal setting in which these hospitals now find themselves.

In the last decade a relatively small number of corporations have been buying up generally older, failing hospitals and transforming them into chains of modern, highly efficient profit-producing medical facilities. That these hospitals are operated for profit is not an innovation. Proprietary hospitals date back to the nineteenth century.¹ The critical differences between this new generation of hospitals and the older proprietary hospitals are differences in style and scale. Proprietary hospitals are usually small and have generally been owned by a few physicians possessing a direct professional interest in the hospital.² In contrast, the new hospital chains are owned by a large number of private investors who have little or no interest in the hospital aside from their ability to produce a profit. Furthermore, the efficiencies introduced by sophisticated, business management techniques distinguish these new investor-owned hospitals from their older, proprietary cousins.

The rapid growth of these hospital chains has caused considerable controversy. The issues most commonly raised are whether the profit incentive has a place in the ideology and high standard of ethics of the medical profession, whether these hospitals will "skim the cream" of the paying patients from nonprofit hospitals and jeopardize a critical source of revenue of those hospitals, whether profit hospitals will fail to contribute to non-profitable ventures such as

¹HAMILTON, PATTERNS OF HOSPITAL OWNERSHIP AND CONTROL 93 (1961) [hereinafter cited as HAMILTON].

²*Id.* at 92.

professional training, medical research and development, and the treatment of low-income patients, and finally, whether the cost-consciousness of profit hospitals will cause a deterioration in the quality of care in the medical services which are provided. This article will concentrate only on the latter issue. It will be contended in this article that the cost-consciousness engendered by the profit motive in these hospitals does pose a danger to quality medical care. This danger requires that our legal theories of hospital liability be modernized to take cognizance of the spreading profit motive in hospital ownership and management. Likewise, regulatory laws must be updated to deal with the new hospital phenomenon. While the burgeoning investor-owned hospital is a national concern, emphasis will be placed primarily on California case law and regulations.

II. A BRIEF HISTORY OF THE HOSPITAL

The investor-owned hospital is a novel departure from the historical development of hospital ownership and management in the United States. This departure carries with it different notions of the role of hospitals in society. Today's hospitals can trace their origins back to the early middle ages in Western Europe. The precursors of modern hospitals were essentially nothing more than almshouses, maintained chiefly for the purpose of offering the infirm and indigent a relatively secure retreat. The first one of record in Western Europe was the Hotel Dieu of Lyons, France, which dates back to 542 A.D.³ America's first hospital, Philadelphia General Hospital, was founded in 1713 to oversee the welfare of the poor, and could boast of conditions no better than the earliest hospitals of Western Europe.⁴ However secure the retreat offered the poor and handicapped might have been, these early hospitals were neither safe nor sanitary. In fact, until the nineteenth century these voluntary, charitable institutions were best known for their uncleanliness, mismanagement and slovenly, incompetent care.⁵

The end of the nineteenth century, however, witnessed the evolution of hospitals from institutions caring for beggars, criminals, foundlings, the sick and insane, to institutions exclusively serving the community as health care centers. This shift from poorhouse to community health care center was brought about as the result of two late nineteenth century developments. The first was the growth of technology in combating illness.⁶ Second, a change took place in the financing of hospital care.⁷ The introduction of expensive new medi-

³Bromberg, *Charitable Hospitals*, 20 CATHOLIC U. L. REV. 237 (1970).

⁴*Id.* at 239.

⁵*Id.*

⁶*Id.*

⁷*Id.*

cal technology played a substantial role here. While pre-nineteenth century hospitals provided meager services whose costs could be underwritten by charity, the late nineteenth century hospitals had substantially increased costs due to the expense of new technology and were thereby forced to seek sources of financing in addition to charity. The most likely sources, of course, were the patients who began to pay for their medical care. The sophisticated new medical technology began to attract more and more of these paying patients to the hospitals, and as the patients' prosperity and ability to pay grew, hospitals came to resemble the large, modern hospitals of today.

Originally, almost all hospitals were owned and controlled as charities.⁸ With the dramatic rise in the costs of hospital services caused by the new medical technology, however, many hospitals formerly financed solely by charity reorganized as nonprofit corporations in order to attract much-needed investment from a broader field.⁹ As nonprofit corporations these hospitals have continued to be considered charitable institutions under California law.¹⁰ Not only are the vast majority of hospitals in the United States of this type, but substantially all the law dealing with hospital liability has derived from cases in which the hospital-defendant was a nonprofit, charitable institution. Additionally, increased costs and a spreading welfare ethic have encouraged federal, state and local governments to erect and maintain hospitals at public expense.

While most early hospitals were charitable or government institutions, a few of the earlier hospitals were operated for a profit. At the turn of the century it is estimated there were less than one-hundred proprietary hospitals in existence in the United States.¹¹ By mid-century that number had grown to 1208.¹² These proprietary hospitals are operated for a profit and are typically very small; averaging forty-two beds per hospital.¹³ They are organized either as sole proprietorships, partnerships, or corporations but are commonly financed and managed by a small group of physicians who have a direct professional interest in the hospital.¹⁴

Until recently, the types of hospitals mentioned above comprised the universe for hospitals. The new investor-owned hospital chains have constituted a novel introduction into this universe, however. These new hospitals are neither nonprofit nor charitable; nor are they

⁸*Id.*

⁹*Id.* at 250.

¹⁰*Scripps Memorial Hospital v. California Employment Comm'n.*, 24 Cal. 2d 669, 151 P.2d 109 (1944).

¹¹HAMILTON, *supra* note 1.

¹²*Id.* at 94.

¹³*Id.*

¹⁴*Id.* at 92.

small or closely-held like the older proprietary hospitals. Investor-owned hospital chains are a unique and peculiar breed. Before, however, examining their nature in closer detail, the current state of the law regarding hospital liability must be investigated.

III. DEVELOPMENT OF HOSPITAL LIABILITY FOR INJURY TO PATIENTS

Over the years there has been a steady breakdown of the obstacles posed to an injured patient trying to seek recovery against a hospital. Until the second half of this century, the injured patient's action could be blocked either by the hospital's charitable immunity or governmental immunity from tort defense.

A. CHARITABLE AND GOVERNMENTAL IMMUNITY

The doctrine of charitable immunity developed in an atmosphere of solicitude to charities. The first case in the United States to establish the doctrine of charitable immunity for hospitals was *McDonald v. Massachusetts General Hospital*.¹⁵ The case rested on the theory that it was better for the patient to shoulder the burden of injury rather than burden the charitable hospital with the costs of tort liability which it was not financially able to absorb. This antiquated theory has fallen into disfavor as a justification for charitable immunity due to the general recognition that charitable hospitals are typically financially secure and insurance is readily available and fairly inexpensive.¹⁶

Other courts have asserted different theories to justify charitable immunity. One of these theories held that *respondeat superior* should apply only when the negligent act of the servant is done to aid the master in reaping a profit.¹⁷ Another theory popular earlier in this century was the trust fund theory. According to that theory the funds of a charity constituted a "trust" and payment of tort claims out of the "trust" would unfairly divert the funds from the hospital's legitimate charitable purposes to specific individuals.¹⁸ A final theory and the theory which seems to have been adopted by California courts held that a patient, as a recipient of benefits from the charity, assumed the risk of negligence of the charity and im-

¹⁵*McDonald v. Massachusetts General Hospital*, 120 Mass. 432, 21 A. 529 (1876).

¹⁶Cases following this theory are cited in W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* § 127, at 1021 n. 43 (1969).

¹⁷*Evans v. Lawrence Hospital*, 133 Conn. 311, 50 A.2d 443 (1946). *Bochman v. Young Women's Christian Ass'n.*, 179 Wis. 178, 191 N.W. 751 (1922). *Emery v. Jewish Hospital Ass'n.*, 193 Ky. 400, 236 S.W. 577 (1921). *Thornton v. Franklin Square House*, 200 Mass. 465, 86 N.E. 909 (1909). *Fire Insurance Patrol v. Boyd*, 120 Pa. 624, 15 A. 553 (1888).

¹⁸W. PROSSER, *LAW OF TORTS* 993 (1971) [hereinafter cited as W. PROSSER].

pliedly waived his rights to recover for any injury incurred.¹⁹

Recognizing the spuriousness of the theories employed to justify the doctrine of charitable immunity, most jurisdictions have abrogated the immunity entirely and the strong current of judicial authority augurs that other jurisdictions will follow suit.²⁰ In 1951, California abolished the doctrine of charitable immunity altogether in *Malloy v. Fong* after several timid attempts to limit the applicability of the doctrine to non-paying patients.²¹ The Supreme Court based its holding on the policy that charitable hospitals should be just before they are generous.

While charitable hospitals found refuge from liability in the doctrine of charitable immunity, hospitals owned and managed by the government avoided liability by the doctrine of governmental immunity. The doctrine of governmental immunity had its origin in the ancient maxim that "the King can do no wrong". In its more modern formulation the doctrine shields the government from suit for the negligent acts of its agents or employees unless the government consents to such suit.²² Today a majority of hospitals owned and operated by the government still enjoy governmental immunity.²³

In 1961 California swept aside state governmental immunity for hospitals in the landmark case, *Muskopf v. Corning Hospital District*.²⁴ The California legislature reacted immediately to this dramatic and unexpected incursion into the doctrine of governmental immunity with a two year moratorium on suit, during which time the legislature was to study the problem and come to some conclusion. The result of the legislative study was the passage in 1963 of a governmental tort liability statute which restored, with some significant exceptions, the rule of governmental immunity.²⁵

B. *RESPONDEAT SUPERIOR*

In the absence of charitable or governmental immunity, hospital

¹⁹*Thomas v. German General Benevolent Soc'y.*, 168 Cal. 183, 141 P. 1186 (1914). *Powers v. Massachusetts Homeopathic Hospital*, 109 F. 294 (1st Cir. 1901). *Wilcox v. Idaho Falls Latter Day Saints Hospitals*, 59 Idaho 350, 82 P.2d 849 (1938). *Forrest v. Red Cross Hospital*, 265 S.W.2d 80 (Ky. App. 1954). *Duncan v. Nebraska Sanitarium Benevolent Ass'n.*, 92 Neb. 162, 137 N.W. 1120 (1912). *St. Vincent's Hospital v. Stine*, 195 Ind. 350, 144 N.E. 537 (1924).

²⁰W. PROSSER, *supra* note 18, at 985.

²¹37 Cal. 2d 356, 232 P.2d 241 (1951). For cases limiting the doctrine of charitable immunity to non-paying beneficiaries, see *Silva v. Providence Hospital*, 14 Cal. 2d 762, 97 P.2d 798 (1939). *England v. Hospital of the Good Samaritan*, 14 Cal. 2d 791, 97 P.2d 813 (1939).

²²*Lewis v. State*, 96 N.Y. 71 (1884). *Faber v. State*, 143 Colo. 240, 353 P.2d 609 (1960).

²³W. PROSSER, *supra* note 18, at 985.

²⁴55 Cal. 2d 211, 11 Cal. Rptr. 89, 359 P.2d 457 (1961).

²⁵CAL. GOV'T. CODE §§ 815, 815.2 (West 1966).

liability based on fault will follow either by *respondeat superior* or corporate negligence. In California the emphasis on liability has been via *respondeat superior*.²⁶ In order to recover from a hospital under *respondeat superior*, the injured patient must allege and prove either negligence or assault and battery, and that the person at fault was at the time an employee of the hospital acting within the scope of his employment. The crucial question becomes who is a hospital employee? Where it is alleged that a physician caused the injury, the traditional defense of the hospital has been that the physician was an independent contractor. Where the hospital has no right of control over the physician's conduct while he administers to the patient, as where the physician has mere staff privileges, it has been held in California that the hospital will not be found liable on the basis of *respondeat superior*.²⁷ However, judicial antipathy to the independent contractor doctrine has surfaced in California cases holding a hospital liable on the basis of a physician being an "ostensible agent" of the hospital.²⁸ Here liability would follow if a hospital led a patient to believe that the professional person attending him was an employee of the hospital.

It is well settled that nurses, interns, and residents are hospital employees for the purpose of the applicability of *respondeat superior*.²⁹ Complications arise, however, where the "borrowed servant" doctrine is applicable. This doctrine would relieve a hospital from liability where it is shown that a person, ordinarily a hospital employee, has temporarily become a servant under the exclusive and complete control and supervision of an attending physician who is himself an independent contractor.³⁰ In California a caveat has been made to the borrowed servant doctrine which lessens its value to hospitals. In *Rice v. California Lutheran Hospital*, the Supreme Court held in a case involving a nurse's negligence for an improper sponge count, that the hospital, not the attending physician, was liable.³¹ Only where the nurse's acts involve professional decisions on the part of the doctor and where the hospital surrenders control over the nurse to the doctor can the hospital escape liability as the nurse's employer. For all routine acts performed by nurses, interns, residents and other hospital employees, the hospital is held liable notwithstanding the borrowed servant doctrine.³²

²⁶Coyne, *Hospital Liability: Implications of Recent Physician's Assistant Statutes*, 21 CLEV. ST. L. REV. 106 (May 1972).

²⁷*Mayers v. Litow*, 154 Cal. App. 2d 413, 316 P.2d 351 (1957).

²⁸*Seneris v. Haas*, 45 Cal. 2d 811, 291 P.2d 915 (1955).

²⁹IIA HOSPITAL LAW MANUAL 8-11 (1962).

³⁰IIA HOSPITAL LAW MANUAL 14b-16 (1967).

³¹27 Cal. 2d 296, 163 P.2d 860 (1945).

³²27 Cal. 2d at 301, 163 P.2d at 865 (1945).

C. CORPORATE NEGLIGENCE

No California cases have been found which extend the doctrine of corporate negligence for hospitals beyond its traditional bounds. Nevertheless, a discussion of this doctrine is appropriate to show how other jurisdictions have made the hospital more vulnerable to liability by expanding the basis of corporate negligence. Under the traditional doctrine, there are four basic duties the corporate hospital owes its patients. First, the hospital owes a duty to maintain safe buildings and grounds; the extent of the duty changing depending upon whether the person injured is a trespasser, licensee, or visitor.³³ Second, the hospital has a duty to furnish standard equipment, not defective or inadequate, to make reasonable inspections of the equipment, and to remedy the defects discoverable by such inspections.³⁴ The hospital also has a duty to maintain adequate facilities to treat the patient, and to transfer the patient to another hospital if it lacks the necessary facilities.³⁵ Finally, hospitals are held to a duty of exercising reasonable care in the selection and retention of personnel. The references and training of professional personnel must be checked and in-service training programs must be operated in an up-to-date fashion.³⁶

The 1965 landmark decision by the Illinois Supreme Court in *Darling v. Charleston Community Memorial Hospital* significantly expanded the doctrine of corporate negligence of hospitals by imposing a fifth duty on hospitals in Illinois.³⁷ The Illinois court rejected summarily the antiquated notion that a corporation cannot practice medicine and went on to recognize that the institutionalization of medicine should carry with it an institutionalization of responsibilities. The plaintiff in the case suffered a broken leg and sought medical treatment in the hospital's emergency ward. An unqualified doctor applied a cast improperly to the plaintiff's leg, the plaintiff complained bitterly of the sharp pain in his leg for several days thereafter, and competent attention was delayed to the point where amputation of the leg was eventually necessitated. The doctor settled with the plaintiff out of court, but the hospital elected to contest, arguing that it had properly fulfilled its duty of care to the patient. The trial court allowed into evidence over defendant-hospital's objection the hospital's by-laws, state statutes, and accreditation rules

³³ IIA HOSPITAL LAW MANUAL 22-23 (1961).

³⁴ *Payne v. Garvey*, 264 N.C. 593, 142 S.E.2d 159 (1965). *Cf. also* *South Highlands Infirmary v. Camp*, 279 Ala. 1, 180 S.2d 904 (1965). *Emory University v. Porter*, 103 Ga. App. 752, 120 S.E.2d 668 (1961).

³⁵ For dicta supporting such a duty, see *Carrasco v. Bankoff*, 220 Cal. App. 2d 230, 33 Cal. Rptr. 673 (1963).

³⁶ *Hipp v. Hospital Authority*, 104 Ga. 174, 121 S.E.2d 273 (1961).

³⁷ 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

promulgated by the Joint Commission on Accreditation of Hospitals, each referring to the hospital's responsibility to see that patients receive competent medical care. With this evidence before it the jury awarded recovery to the plaintiff. In upholding the trial court, the Illinois Supreme Court ruled that a hospital has a duty to be aware of the care being given a patient by its physician, and to act when it becomes apparent that this care is below the standard warranted by the patient's condition. No longer can a hospital afford to ignore the standard of care being furnished a patient by his doctor in Illinois and the other jurisdictions which have followed the *Darling* lead.³⁸ Those jurisdictions now hold that the hospital shares a joint responsibility with the patient's physician for the standard of medical care received in the hospital.

D. TOWARDS STRICT LIABILITY?

Liability in the absence of fault might be suggested as a third basis of hospital liability. It appears that in California, a crossroads of sorts has been reached but not passed. While no state, including California, has found strict liability in tort in express terms in this area, the California Supreme Court has distinguished itself as having expanded the doctrine of *res ipsa loquitur* to such an extent in medical malpractice cases as to be tantamount to applying strict liability.³⁹ Traditionally the doctrine of strict liability has been reserved to keepers of animals and abnormally dangerous things and activities, and more recently has been applied to defective products.⁴⁰

In *Clark v. Gibbons*, *res ipsa loquitur* was applied to an unexplainable, rare accident. During the course of an operation on the plaintiff-patient the anesthesia wore off too soon and the operation was forced to terminate prematurely. The condition of the patient prevented a second operation in time to achieve success. The component elements of *res ipsa loquitur* have been threefold.⁴¹ First, the event must be of a kind which ordinarily does not occur in the absence of someone's negligence. Second, the event must be caused by an agency or instrumentality within the exclusive control of the defendant. Third, the injury complained of must not be due to any voluntary action or contribution on the part of the plaintiff. In *Clark* the majority upheld the *res ipsa loquitur* charge where there was, however, no basis at all for inferring the first and most important element of *res ipsa loquitur*: that the accident be of a kind which does not

³⁸For other jurisdictions following *Darling*, see *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967). For dicta supportive of *Darling*, see *Gridley v. Johnson*, 476 S.W.2d 475 (Mo. 1972). See also MICH. COMP. LAWS ANN. § 331.422 (1968).

³⁹*Clark v. Gibbons*, 66 Cal. 2d 399, 426 P.2d 525, 58 Cal. Rptr. 125 (1967).

⁴⁰W. PROSSER, *supra* note 18, at 494-496.

⁴¹*Id.* at 214.

ordinarily occur in the absence of negligence. At the trial court there was no showing that when in rare cases the anesthesia does terminate prematurely, the premature termination is more probably than not the result of negligence. There were showings of specific acts of negligence which could have caused the injury, however. The court held that where there is an unexplained, rare accident in addition to proof of specific acts of negligence which could have caused the injury, then the "likelihood of a negligent cause may be sufficiently great that the jury may properly conclude that the accident was more probably than not the result of someone's negligence."⁴²

In a separate concurring opinion in which he supported the result but disagreed with the majority opinion concerning the propriety of the *res ipsa loquitur* charge, Justice Tobriner asserted that the net effect of such a loose application of *res ipsa loquitur* was to "shift from plaintiffs to defendants the cost of a certain number of unexplainable accidents in which no meaningful basis exists for finding the defendants at fault." He went on to add, "If public policy demands that defendants be held responsible for unexplained accidents without a reasoned finding of fault, such responsibility should be fixed openly and uniformly, not under the guise of negligence and at the discretion of the jury."⁴³ While the doctrine of strict liability was not expressly invoked in *Clark v. Gibbons*, the holding of the case and concurring remarks of Justice Tobriner indicate that something more nearly akin to strict liability than any theory of negligence may serve as the basis for finding liability.⁴⁴

With this overview of the state of the law as it affects hospital liability for injuries sustained by their patients, the central subject of this article can now be brought into sharper focus.

IV. CHARACTERISTICS OF INVESTOR-OWNED HOSPITALS

At present there are more than 1008 investor-owned hospitals in the United States with 215 of these located in California.⁴⁵ Of the total number of investor-owned hospitals, 331 are owned and managed by hospital management corporations.⁴⁶ The hospital management corporations account for 102 hospitals in California.⁴⁷ The three largest corporations in this field account for one-hundred

⁴²Clark v. Gibbons, 66 Cal. 2d at 413, 426 P.2d at 534, 58 Cal. Rptr. at 134 (1967).

⁴³66 Cal. 2d at 416, 426 P.2d at 537, 58 Cal. Rptr. at 137 (1967).

⁴⁴Of course, the third element of *res ipsa loquitur*, lack of contributory negligence on the part of the injured party, distinguishes even an expanded view of *res ipsa* from strict liability. However, in most malpractice cases the element of contributory negligence is never litigated so that in practical terms an expanded form of *res ipsa* does resemble strict liability.

⁴⁵FEDERATION OF AMERICAN HOSPITALS, 1973 DIRECTORY (1973).

⁴⁶*Id.*

⁴⁷*Id.*

and forty-four hospitals, representing total assets of over \$680 million.⁴⁸ Investor-owned hospitals are clearly big business.

They are also profitable. The three largest corporations in the field in their latest annual reports reported net income of \$5½ million, \$7½ million, and more than \$10 million respectively.⁴⁹ The profitability of the hospital management corporations has been on a steady increase. For example, total revenues of the second largest of these corporations increased by over 700% since 1968, while net income for the same period increased by more than 750%, even in the face of a massive construction program.⁵⁰ With this kind of carrot held out to enterprising businessmen, it is not surprising that since 1968 the number of general community hospitals owned and operated by the hospital management corporations has increased from five to well over two-hundred.⁵¹ And the number of these hospitals is still rapidly increasing. Within the next few years, fifty-nine new hospitals will be built or acquired by the three largest hospital management corporations, representing a net addition of over 5800 hospital beds.⁵²

These hospital management corporations are organized according to the corporate laws of the states in which they are chartered. In California several such corporations are chartered, and still other corporations own and operate hospitals in this state.⁵³ The corporations are public issue and, as in other corporations, are managed by their respective boards of directors through appointed officers. As in any corporation, the primary objectives of management are to stimulate growth and increase profits. Hospital management corporations have consistently accomplished these objectives since their arrival on the health care scene. An inquiry must be made, however, to determine whether or not these objectives of striving for growth and profit have come into conflict with another objective which must supersede all others: namely, quality medical care.

A. THE PROFIT-MOTIVE AND COST-CONSCIOUSNESS IN INVESTOR-OWNED HOSPITALS

Hospital management corporations, like their proprietary hospital predecessors, seek to reap a profit for their efforts in the market-

⁴⁸EXTENDICARE, INC., ANNUAL REPORT 10 (1973) [hereinafter cited as EXTENDICARE]; AMERICAN MEDICAL INTERNATIONAL, INC., ANNUAL REPORT 35 (1973) [hereinafter cited as AMERICAN MEDICAL]; HOSPITAL CORPORATION OF AMERICA, INC., PROSPECTUS 12, 13 (1972) [hereinafter cited as HOSPITAL CORPORATION].

⁴⁹EXTENDICARE, *supra* note 48, at 1; AMERICAN MEDICAL, *supra* note 48, at 21; HOSPITAL CORPORATION, *supra* note 48, at 42.

⁵⁰AMERICAN MEDICAL, *supra* note 48, at 32, 33.

⁵¹EXTENDICARE, RESPONDING TO HUMAN HEALTH NEEDS 2 (July 1973). Available upon request from Extendicare, Inc.

⁵²EXTENDICARE, *supra* note 48, at 11; AMERICAN MEDICAL, *supra* note 48, at 5; HOSPITAL CORPORATION, *supra* note 48, at 16, 17.

⁵³FEDERATION OF AMERICAN HOSPITALS, 1973 DIRECTORY (1973).

place. In the case of the old proprietary hospitals, the profit-motive was present albeit in a less detached and business-oriented mode than is the case in the new hospital management corporations. Even so, one commentator remarked in the days when proprietary hospitals were more numerous:

Where proprietary hospitals exist, they are tolerated, either on the ground of the public's current need for the facilities or for lack of a legal basis for eliminating them.⁵⁴

This statement reflects the antipathy that many persons have had towards the idea of operating a hospital for a profit. More recently, economist Kenneth Arrow, in attempting to explain the preference against the profit-motive in the supply of hospital services, posited that "the association of profit-making with the supply of medical services arouses suspicion and antagonism on the part of patients and referring physicians, so they do prefer nonprofit institutions."⁵⁵ While concern has been expressed from many quarters about the propriety of the profit-motive in the health care field, the important inquiry to be made is whether or not this concern is justified. Does profit-making have a deleterious effect on the quality of health care? While all the empirical data necessary for a more conclusive answer to this inquiry has not been forthcoming,⁵⁶ the information that has been made available coupled with general economic theory indicates that the profit-motive does have a detrimental effect on health care.

Where prices are fixed as in a perfect competition market, in order to maximize profits, a firm must strive to reduce costs.⁵⁷ In the service industry this will mean that for any given service rendered, only those methods, personnel and equipment will be employed which minimize costs. Investor-owned hospitals find themselves in a market situation in which price rates are predetermined by their nonprofit competitors. Therefore, in order to increase profits, investor-owned hospitals are compelled to reduce costs.

Even if it is allowed that investor-owned hospitals only seek to achieve a steady rate of profit over the years and not to increase it, still the investor-owned hospital will be striving to minimize costs

⁵⁴KLASMAN, *THE ECONOMICS OF HEALTH* 113 (1965).

⁵⁵Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *AM. ECON. REV.* 941 (1963).

⁵⁶In researching this article, questionnaires were sent to several of the largest hospital management corporations, seeking data which could reveal how their hospitals compared to nonprofit hospitals with regard to malpractice litigation, post-operative infection rates, ratio of non-diseased tissue removed to diseased tissue, post-operative death rate, and other indices of medical care. The questionnaires were not answered. Since no other sources of this type of information exist, the discussion of investor-owned hospitals and the quality of medical care must of necessity be tentative, based as it is on less enlightening data.

⁵⁷SAMUELSON, *ECONOMICS* 518-520 (1967).

more than its nonprofit counterpart. The nonprofit hospital must keep costs down in order to stay in business and expand and enhance its medical services. The investor-owned hospital must do these things, and, in addition, show a profit at the end of the year. It is also important to note that investor-owned hospitals have the burden of federal and state corporate taxes with which to contend. For these reasons, at equivalent price rates for medical services, investor-owned hospitals must keep costs substantially lower than nonprofit hospitals in order to compete successfully with them.

In the large hospital management corporations costs can be minimized by large scale purchasing of equipment, food, drugs and laundry services. The economies gained by large scale purchasing is, however, available to any large institution. Since the overwhelming majority of hospitals of a size of two-hundred beds or more are nonprofit hospitals,⁵⁸ these large scale purchasing economies are also most certainly utilized by them and cannot fully account for investor-owned hospitals' relative success in the hospital services market.

Other avenues are available, however, for reducing costs to hospitals. Examples are the reduction of the hospital labor force, cutting down the number of high-cost, low-profit days a patient spends in bed to a minimum, and actively encouraging the use of services such as laboratory and X-ray which yield high profit margins. The statistics bear out the existence of some of these cost-minimizing methods. In the latest publication of Hospital Statistics compiled and published by the American Hospital Association, the figures indicate that patients have a shorter period of stay in acute care short-term general "for-profit" (the term assigned to all profit-making hospitals) hospitals than in the counterpart nonprofit hospitals. In for-profit hospitals the average stay per patient is 6.6 days as opposed to 8.0 days for nonprofit hospitals.⁵⁹

As for personnel, the AHA statistics indicate that not only do more full-time employees serve the nonprofit hospital patient than the for-profit hospital patient, but the payroll expenditures per patient day are greater for the nonprofit hospitals. In nonprofit hospitals 281 full-time-equivalent employees (adjusted for part-time employees) are on the job per 100 daily patient census, as compared with 250 full-time-equivalent employees in for-profit hospitals.⁶⁰ Similarly, there are 53 registered nurses per 100 average daily patient

⁵⁸AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 22 (1972). The figures are: nonprofit — 1169 hospitals; for-profit — 45 hospitals; government — 372 hospitals. The count for investor-owned hospitals for 200+ bed size is actually 76 according to the latest figures of the FEDERATION OF AMERICAN HOSPITALS, 1973 DIRECTORY.

⁵⁹AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 22 (1972).

⁶⁰*Id.* at 198.

census in the nonprofit hospitals as compared with 46 registered nurses for for-profit hospitals.⁶¹ It is noteworthy that while nonprofit hospitals have more registered nurses per patient than for-profit hospitals, for-profit hospitals employ 26 practical nurses per 100 average daily patient census compared to nonprofit hospitals' respective figure of 24.⁶² Since practical nurses are less highly qualified than registered nurses and can be used in certain instances as less expensive substitutes, the higher figure for practical nurses among for-profit hospitals is consistent with the cost-minimization efforts posited for the for-profit hospitals. A final and very significant figure on the subject of personnel regards the respective payroll expenses per adjusted (adjusting for out-patient services) patient day. Nonprofit hospitals expend \$54.99 per adjusted patient day on payroll expenses as opposed to \$47.62 per adjusted patient day for the for-profit hospitals.⁶³

In nonprofit hospitals, then, patients on the average are treated longer and are attended by more personnel who are paid higher for the relative time spent per patient than in for-profit hospitals. Various inferences can be drawn from these facts. One inference is that patients in nonprofit hospitals are getting better medical attention than those in for-profit hospitals. It may be mere coincidence that these statistics seem to bear out the theory that for-profit hospitals will endeavor to reduce costs substantially below those of their nonprofit competitors. Doubtless more comparative cost-expenditure data are required on the full spectrum of hospital services before it can be said definitely one way or another that investor-owned hospitals contribute to the deterioration of quality medical care by their cost minimizing efforts. Nevertheless, the inference can be drawn from the figures which are available that investor-owned hospitals provide inferior hospital services.

B. THE PROFIT-MOTIVE AND MALPRACTICE

It is difficult to draw the line where inferior medical care becomes malpractice. But it is one thing for a hospital to cut back its costs to the point where the patient is marginally less well-off than he otherwise would have been, and quite another thing for the hospital to engage in questionable profit-generating or cost-minimizing practices which constitute negligence. Whether or not an investor-owned hospital would engage in such practices involves many factors. The purpose of this section will be to discuss some of the more important ones.

⁶¹*Id.*

⁶²*Id.*

⁶³*Id.*

There are potentially many ways in which a hospital can unethically increase its profit margin. Simple surgery could be performed where it was not required. Tests could be conducted where there was no indication of their need. Ill-trained and unqualified professionals could be employed. Inferior equipment could be used. Repair and maintenance could be neglected. Any of these means will promote a greater profit margin. Would a hospital oriented towards making a profit see fit to employ any of these means?

Aside from the general humanitarian values that most persons in business as in other fields no doubt possess, there is a sound business reason why some of these profit-generating practices would not be engaged in. The reason, of course, is the cost of malpractice. Malpractice is expensive in two ways. First, litigation expenses and the recoveries awarded to successful plaintiffs can be exorbitant.⁶⁴ While these expenses are absorbed by insurance, the premiums paid for malpractice insurance rise as the insured's record for negligence increases.⁶⁵ Second, the publicity which attends malpractice cases can seriously damage a hospital's reputation and frighten away doctors and patients alike.

There is serious controversy in the legal community regarding the economic burden that negligence liability imposes on various enterprises. In the products liability and medical malpractice area the evidence indicates that the overwhelming majority of injuries go uncompensated.⁶⁶ Thus, it is by no means clear that the threat of malpractice litigation will motivate hospitals seeking a profit to turn their backs on some of the questionable practices alluded to above. In fact it is evident given the present state of malpractice law that many hospitals can "get away" with a certain level of malpractice at practically no expense. It has been established that many patients who suffer a medical injury are turned away from a lawyer, even though the injury was negligently caused, because the cost to the plaintiff's attorney in trying the case exceeds the likelihood of a recovery sufficient to enable the attorney to recoup his costs and pay his legal fees.⁶⁷ This being the case, the cost of malpractice to hospitals may not be sufficiently great to preclude some of the more questionable profit-generating practices.

In any event, the interplay between profit-making on the one hand and the cost of malpractice on the other hand in investor-owned

⁶⁴For a discussion of the trends towards substantially increasing costs in the malpractice area, see Brant, *Medical Malpractice Insurance: The Disease and How to Cure It*, 6 VAL. U. L. REV. 152 (1972) [hereinafter cited as Brant].

⁶⁵Due to delay caused by litigation it has been actuarially difficult to set rates strictly according to risk. See Brant, *supra* note 64, at 160-161.

⁶⁶O'Connell, *Elective No-Fault Liability Insurance for all Kinds of Accidents: A Proposal*, 608 INS. L. J. 495 (1973) [hereinafter cited as O'Connell].

⁶⁷*Id.* at 499.

hospitals calls for more thorough investigation. It is enough for the purposes of this article to raise the issue. The high stakes involved in the question — the direction and mode of future hospital services, and the critical “life and death” nature of the health care field — suggest the importance of an in-depth future empirical study on the issue.

V. SAFEGUARDING AGAINST POSSIBLE DETERIORATION IN THE STANDARD OF HEALTH CARE BY INVESTOR-OWNED HOSPITALS

A. JUDICIAL EXTENSION OF THEORIES OF LIABILITY

It has been shown above that cost-consciousness of investor-owned hospitals may cause a deterioration in the standard of health care, and that profit-making and cost-cutting might lead to hospital negligence. Does this conclusion require that our theories of hospital liability be modified?

1. CORPORATE NEGLIGENCE

It has been pointed out above that no California court has held a hospital liable for injury to a patient caused by a physician on the basis of the *Darling* theory of corporate negligence.⁶⁸ In *Darling* the court took judicial notice of the degree to which hospitals had become directly involved in the furnishing of medical care to patients, and meted out liability accordingly. *Darling* involved a nonprofit hospital, but the reasoning applies well to investor-owned hospitals. The *Darling* type of hospital duty should be applied to investor-owned hospitals. Modern investor-owned hospitals are generally more involved than their nonprofit counterparts in controlling, supervising, and monitoring medical care.⁶⁹ In order to streamline operations and acquire adequate feedback information to reduce waste and make planning decisions, the management of investor-owned hospitals takes an active and intrusive role in the precision control of medical care. Such a role is critical to maintain economic viability and increase rate of growth. Along with such increased control, management inevitably comes in closer contact with the day-to-day routine provision of medical care. Management thus comes to share the responsibility for the standard of health care. This shared responsibility does not mean that the management of investor-owned hospitals needs to impinge directly upon the purely medical decisions of their professional personnel. Rather, this shared responsibility would

⁶⁸*Darling v. Charleston Community Memorial Hospital*, 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

⁶⁹EXTENDICARE, INC., RESPONDING TO HUMAN HEALTH NEEDS 14 (July 1973).

require the hospital administration to organize its medical staff to review the work of professional personnel, to provide for consultation among physicians in certain types of cases, and to take appropriate action where it appears a patient is receiving inadequate medical attention.

The increased exposure of investor-owned hospitals to liability via a *Darling* approach to corporate negligence, imposing on these hospitals a direct duty to provide adequate medical care to patients, would serve two purposes. First, it would stand as a recognition of the degree to which the management of investor-owned hospitals collaborates with its medical staff to furnish medical care. Second, it would encourage investor-owned hospitals to organize their professional staff in a manner that would insure a higher standard of medical care. While the *Darling* type of duty would impose only a nominal additional burden on investor-owned hospitals, it would go far in allaying any threat to the standard of medical care.

2. STRICT LIABILITY

It has been proposed that no-fault liability be extended on an elective basis to the hospital industry as a whole.⁷⁰ While that subject goes somewhat beyond the scope of this article, something should be said about the advisability of imposing strict liability on investor-owned hospitals. As has been suggested above, one theory of the *Clark v. Gibbons* case is that it held the defendant liable on something that comes perilously close to strict liability. That case has generated much discussion about imposing strict liability in the health care field, although its precise holding has not been followed by later cases. Strict liability would certainly provide an incentive to improve safety standards, especially where the increased costs could not be passed along to the patients.⁷¹ Where prices cannot be increased the most efficient means of reducing liability costs is to reduce liability by improving quality. This reasoning would apply if strict liability were to be selectively imposed on investor-owned hospitals, due to the fact that investor-owned hospital rates are relatively fixed by their nonprofit competitors. At first blush, therefore, it would appear that strict liability might be appropriately imposed upon investor-owned hospitals.

Two factors militate against such an imposition at this time, however. First, no in-depth empirical study has been made indicating a degree of negligence on the part of investor-owned hospitals which would warrant the imposition of strict liability. Second, in an age of

⁷⁰O'Connell, *supra* note 66.

⁷¹Franklin, *Tort Liability for Hepatitis: An Analysis and a Proposal*, 24 STAN. L.R. 439 (1972).

generally inadequate and fragmented health care delivery systems,⁷² any proposal which might force health care facilities to close their doors should be looked upon with great skepticism. The cost of strict liability, where no correlative adjustment of prices can be made to pass costs on to patients, would most certainly force many investor-owned hospitals out of business. Unless the findings of a future empirical study demonstrate the existence of the abuses which this article has hypothesized, the imposition of a scheme that could have such dire consequences to a substantial number of hospitals as strict liability would be premature at this time.

B. STATUTORY SAFEGUARDS

It has been shown, albeit somewhat tentatively, that the standard of medical care is lower in investor-owned hospitals. It has not been shown that the standard of medical care in investor-owned hospitals has declined to the point of negligence. Only the potentiality for such a deterioration exists. In light of these conclusions, it is contended that regulatory legislation is appropriate. It is the purpose of this section to set out certain proposals which would have the effect of inhibiting a further decline in the standard of medical care, deterring any abusive practices, and providing a source for comparing the health care performance of hospitals.

In California the State Department of Public Health and the Board of Medical Examiners have the preponderant role in the regulation of medical care. Only under narrow circumstances, however, are any of these agencies permitted to prescribe minimum standards of health care.⁷³ In general, the State Department of Public Health under its hospital licensing provisions can prescribe minimum standards of safety and sanitation for a hospital's physical plant, equipment and facilities,⁷⁴ but it has no authority to prescribe the minimum standards of medical care to be furnished within those facilities. Likewise, the Board of Medical Examiners is authorized to promulgate rules and regulations concerning the medical profession, but none of the rules and regulations authorized by the statutes extend to the prescription of minimum standards of health care.⁷⁵ The Board of Medical Examiners is also authorized to make inspections of hospitals to investigate their practices,⁷⁶ but this is done on an irregular, piecemeal basis and only following reports of egregious misconduct. Finally, all hospitals are required by statute to pro-

⁷²COMMITTEE FOR ECONOMIC DEVELOPMENT, BUILDING A NATIONAL HEALTH CARE SYSTEM 12 (1973).

⁷³HEALTH & SAFETY CODE § 432.4 (West 1970).

⁷⁴HEALTH & SAFETY CODE § 1270 (West Supp. 1973).

⁷⁵BUS. & PROF. CODE §§ 2500-2508 (West Supp. 1973).

⁷⁶BUS. & PROF. CODE § 2122.5 (West Supp. 1973).

vide rules governing the operation of the hospital.⁷⁷ Such rules must include: 1) provisions for the organization of the hospital medical staff; 2) provisions for the selection of qualified physicians, as members of the hospital staff; 3) provisions for the self-government of medical staff and provisions for periodic review and analysis of medical work; and, 4) provisions for keeping adequate medical records.

The thrust of such legislation is laudatory, but it is not enough. Conspicuously lacking from the California statutes is legislation authorizing the promulgation of minimum standards of health care and the enforcement of those standards. Minimum standards could be formulated by the State Department of Public Health on the basis of performance records currently kept by California hospitals. These standards should include prescribed levels in the following areas: 1) Education and training of professional staff; 2) Ratio of staff doctors to average daily patient census; 3) Ratio of nurses and other professionals to average daily patient census; 4) Post-operative infection rate; 5) Ratio of malignant to non-malignant tissue removed; 6) Post-operative death rate; 7) Infant death rate; 8) Maternal death rate; 9) The amount and type of malpractice litigation.⁷⁸ Annual or semi-annual reports should be required of investor-owned hospitals indicating their levels in the above areas. These reports should be made available to the public. Finally, the State Department of Public Health should be authorized to take appropriate disciplinary action where investor-owned hospitals have consistently or flagrantly departed from the prescribed standards. The determination of departure from the standards should be made on the basis of the filed reports. Moreover, occasional "medical audits" by state officers should be made of hospitals to insure their good faith adherence to the reporting requirements. Currently, one state (New York) performs medical audits of its hospitals pursuant to its hospital licensing laws.⁷⁹

VI. CONCLUSION

This article has endeavored to place the growing phenomenon of hospitals owned and managed by large hospital management corporations in the context of California's current laws governing hospital liability and regulation. The central inquiry has been whether or not current laws are adequate to deal with the problems posed by investor-owned hospitals. No definite conclusions have been reached concerning the nature or scope of problems that investor-owned hos-

⁷⁷BUS. & PROF. CODE § 2392.5 (West Supp. 1973).

⁷⁸HEALTH & SAFETY CODE § 1430 (West 1970) now requires insurers to report to the State Department of Public Health final judgments and settlements exceeding \$3000 in malpractice actions brought against hospitals.

⁷⁹N. Y. PUB. HEALTH LAW § 2803 (McKinney Supp. 1970).

pitals might be expected to generate. However, on the basis of theoretical arguments regarding the profit-motive and cost-consciousness of investor-owned hospitals, and empirical data which inferentially support these arguments, the somewhat tentative conclusion has been reached that investor-owned hospitals may tend to contribute to a lower standard of medical care. Although the conclusion reached by this limited study does not at this time warrant stringent remedial measures such as strict liability, less costly and burdensome devices do seem justified. Thus, it has been proposed that a direct duty of care for medical treatment *à la Darling* be imposed upon investor-owned hospitals, and that a statewide regulatory scheme be devised to watchdog the quality of medical care being furnished by investor-owned hospitals. Above all else, more investigation is needed in this area. This requires at the minimum that data sources now inaccessible become open to examination. It behooves all concerned with the quality of medical care in the United States to thoroughly appreciate the changes that investor-owned hospital management corporations might be expected to produce in the hospital services field. Without such an appreciation no reliable assessment of the quality and direction of medical care in the United States can be made.

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