

2013

Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties To Their Discharged Patients

Thomas L. Hafemeister
th4n@virginia.edu

Joshua Hinckley Porter

Follow this and additional works at: <http://digitalcommons.wcl.american.edu/aulr>



Part of the [Law Commons](#)

Recommended Citation

Hafemeister, Thomas L., and Joshua Hinckley Porter. "Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties To Their Discharged Patients." *American University Law Review* 62, no.3 (2013): 513-576.

This Article is brought to you for free and open access by the Washington College of Law Journals & Law Reviews at Digital Commons @ American University Washington College of Law. It has been accepted for inclusion in American University Law Review by an authorized administrator of Digital Commons @ American University Washington College of Law. For more information, please contact fbrown@wcl.american.edu.

Don't Let Go of the Rope: Reducing Readmissions by Recognizing Hospitals' Fiduciary Duties To Their Discharged Patients

Keywords

health care, hospitals, patient discharges/readmissions, PPACA of 2010, hospital liability/fiduciary duties, torts, HC policy, medical jurisprudence, law & society

DON'T LET GO OF THE ROPE: REDUCING READMISSIONS BY RECOGNIZING HOSPITALS' FIDUCIARY DUTIES TO THEIR DISCHARGED PATIENTS

THOMAS L. HAFEMEISTER* & JOSHUA HINCKLEY PORTER**

In the early years of the twenty-first century, it was widely speculated that massive, multi-purpose hospitals were becoming the “dinosaurs” of health care, to be largely replaced by community-based clinics providing specialty services on an outpatient basis. Hospitals, however, have roared back to life, in part by reworking their business model.

There has been a wave of consolidations and acquisitions (including acquisitions of community-based clinics), with deals valued at \$7.9 billion in 2011, the most in a decade, and the number of deals increasing another 18% in 2012. The costs of hospital care are enormous, with 31.5% (\$851 billion) of the total health expenditures in the United States in 2011 devoted to these services. Hospitals are (1) placing growing emphasis on increasing revenue and decreasing costs; (2) engaging in pervasive marketing campaigns encouraging patients to view hospitals as an all-purpose care provider; (3) geographically targeting the expansion of their services to “capture” well-insured patients, while placing greater pressure on patients to pay for the services delivered; (4) increasing their size, wealth, and clout, with two-thirds of hospitals undertaking renovations or additional construction and smaller hospitals being squeezed out, and (5) expanding their use of hospital-employed physicians, rather than relying on community-based physicians with hospital privileges, and exercising greater control over medical staff.

Hospitals have become so pivotal in the U.S. healthcare system that the Patient Protection and Affordable Care Act of 2010 (PPACA) frequently

* J.D., Ph.D., Associate Professor, *School of Law*; Associate Professor of Medical Education, *School of Medicine*; *University of Virginia*. The authors wish to thank Salima Ali for her invaluable assistance.

** J.D., *University of Virginia School of Law*.

targeted them as a vehicle to enhance patient safety and control escalating health care costs. One such provision—the Hospital Readmissions Reduction Program, which goes into effect in fiscal year 2013—will reduce payments ordinarily made to hospitals if they have an “excess readmission” rate.

It is estimated that adverse events following a hospital discharge impact as many as 19% of all discharged patients. When hospitals and similar health care facilities fail to adequately manage the discharge of their patients, devastating medical emergencies and sizeable healthcare costs can result. The urgency to better manage these discharges is compounded by the fact that the average length of hospital stays continues to shorten, potentially increasing the number of discharged patients who are at considerable risk of relapse. Also exacerbating the problem is a lack of clarity regarding who, if anyone, is responsible for these patients following discharge. Confusion over who bears responsibility for discharge-related preparation and community outreach, concerns about compensation, a lack of clear institutional policies, and the absence of legal mandates that patients be properly prepared for and monitored after discharge all contribute to the potential abandonment of patients at a crucial juncture.

Although the PPACA establishes financial incentives for hospitals and similar facilities to combat the long-standing problem of high readmission rates, it does not provide a remedy for patients who have suffered avoidable harm after being discharged without adequate preparation or post-discharge assistance. This omission is particularly problematic as existing legal remedies, including medical malpractice suits, have provided little recourse for patients who have suffered injury that could have been prevented through the implementation of reasonable discharge-related policies.

To protect the many patients who are highly vulnerable to complications following discharge and to provide them redress when needed services are not provided, hospitals’ obligations to these patients should be recognized for what they are: a fiduciary duty to provide adequate discharge preparation and post-discharge services. The recognition of this duty is driven by changes in the nature of hospital care that enhance the perception that hospitals have become a “big business” that should “carry their own freight.” Properly interpreted, this duty requires facilities to implement an appropriate discharge plan and provide post-discharge services for a period of time commensurate with a patient’s continuing health risks. Notably, this is not the same as a generalized duty to provide all patients with continuing post-discharge treatment. It is a more limited obligation to offer necessary clarification and direction to patients upon discharge, and to institute a reasonable post-discharge monitoring program for patients with continuing health risks.

This recognition of hospitals' responsibilities to discharged patients will have a number of beneficial effects. First, it will decrease healthcare costs by reducing the number of patients readmitted with post-discharge complications that could have been avoided through better communication and relatively simple, cost-effective follow-up services. Second, it will reduce confusion in the health care community regarding who is responsible for post-discharge services by affirmatively assigning responsibility to the entities best positioned to provide them, namely hospitals and similar discharging facilities. Third, specifically assigning these responsibilities to hospitals will establish them as a vital component of hospital care, which should help hospitals obtain reimbursement from third-party payors for providing them. Fourth, and most importantly, it will improve the well-being of discharged patients by better preparing them for discharge, increasing the availability of post-discharge services, and providing a means of recourse should they suffer readily preventable injury.

TABLE OF CONTENTS

Introduction.....	516
I. The Problem of Post-Discharge Injury: Causes and Consequences.....	525
II. Applicability of Current Legal Doctrines to Post-Discharge Injury.....	533
A. Lawsuits Targeting the Patient's Physician	534
B. Lawsuits Targeting the Discharging Hospital Seeking to Hold It Liable for the Negligence of Its Agents	538
C. Lawsuits Targeting the Discharging Hospital Seeking to Hold It Directly Liable for Failing to Take Adequate Steps to Protect Its Patients from Harm.....	540
III. Fiduciary Duties of Hospitals	544
A. Fiduciary Duties in General	544
B. The Fiduciary Duties of Physicians.....	547
C. The Evolving Nature and Role of Hospitals.....	548
D. The Fiduciary Nature of the Hospital-Patient Relationship.....	559
IV. The Nature of Hospitals' Discharge-Related Fiduciary Obligations	566
A. The Rationale for Imposing Discharge-Related Obligations.....	566
B. The Obligation to Prepare Patients for Discharge	570
C. The Obligation to Provide Reasonable Post-Discharge Assistance	571
D. Model Programs	571
E. Limits on Liability.....	575
Conclusion	575

“Although every handoff carries the potential for information loss, the most worrisome is at hospital discharge. Part of this is because patients are usually left ‘to their own recognizance,’ which means it’s up to them to obtain and take their meds, observe any physical precautions, and make follow-up appointments with their primary care physicians or recommended specialists. Many patients . . . are incapable of taking these important steps.”¹

INTRODUCTION

Health care in this country is rapidly and dramatically evolving.² The individualistic vision associated with portrayals such as “Dr. Kildare” and “Marcus Welby, MD” has faded into the mists of nostalgia, replaced by an industry both eager and expected to dominate and direct the delivery of health care. At the center of this maelstrom are the massive, multifaceted hospital complexes of today.³ Not surprisingly, just as their role, reach, and influence is expanding, so too is the law that governs them.⁴

This Article will focus on one set of hospital-related events that has received considerable attention in recent years: readmissions following a hospital discharge.⁵ Adverse events following a hospital

1. ROBERT M. WACHTER & KAVEH G. SHOJANIA, INTERNAL BLEEDING: THE TRUTH BEHIND AMERICA’S TERRIFYING EPIDEMIC OF MEDICAL MISTAKES 165 (2004).

2. See Robert Pear, *Gains in Health System Seen as Lasting by Some*, N.Y. TIMES, May 23, 2012, at A12 (reporting that health care delivery in this country has been and will continue to be transformed); see also *infra* notes 155–58 and accompanying text (noting the increased national attention to the high level of medical errors and the changes within the health care system).

3. See *infra* notes 155–81 and accompanying text (discussing the factors that make hospitals seem like “big business”).

4. See *infra* Parts III–IV (analyzing the legal duties placed on hospitals as courts increasingly recognize a relationship between hospitals and the well-being of their patients).

5. While this Article argues that hospitals are well-positioned to provide critically needed post-discharge monitoring to vulnerable patients, and thus should be held accountable for a failure to do so, it is recognized that a number of post-discharge models are being explored, including some that do not directly involve the discharging hospital. See, e.g., Mary Mosquera, *Hudson Valley Care Managers Reduce Readmissions*, GOV’T HEALTH IT (May 21, 2012), <http://www.govhealthit.com/news/hudson-valley-care-managers-reduce-readmissions> (describing a system where nurse care managers within primary care practices specifically attend to patients who require a lot of services and who tend to “fall off physicians’ radar,” and reporting that this system has shown “a pretty significant drop in readmissions”). This Article focuses on hospitals because (1) their discharge-related actions have an immediate impact on the well-being of the patient, (2) they have the most current information regarding the patient’s ongoing health risks, (3) patients naturally expect assistance to be forthcoming from hospitals, and (4) hospitals are the most logical and capable candidate for taking on responsibility for these patients. To the extent that another care provider has assumed responsibility for the patient, the responsibility of the discharging hospital should cease, although it will still be responsible for providing appropriate discharge planning and transitional services until responsibility for the patient has shifted. See

discharge impact approximately 20% of all discharged patients.⁶ According to data from the Agency for Healthcare Research and Quality, the lead federal agency charged with improving the quality, safety, efficiency, and effectiveness of healthcare, nearly 4.4 million hospital admissions per year, entailing costs of nearly \$30.8 billion, could be prevented with “timely and effective ambulatory care or adequate patient self-management.”⁷ It has also been calculated that “[a] typical hospital with 200 to 300 beds wastes up to \$3.8 million a year, or 9.6 percent of its total budget, on readmissions of patients who shouldn’t have had to come back.”⁸

Concern about these readmission rates is such that the Centers for Medicare and Medicaid Services (CMS) now publishes thirty-day readmission measures, updated quarterly, for patients originally admitted to hospitals across the country for heart failure, acute myocardial infarction (heart attack), and pneumonia, with hospitals classified as “better,” “no different from,” or “worse” than the national average.⁹ In addition, as part of its effort to control health

infra Part IV (analyzing the development of the hospital-patient fiduciary relationship and its applicability to hospital discharges).

6. See Alan J. Forster et al., *The Incidence and Severity of Adverse Events Affecting Patients After Discharge from the Hospital*, 138 ANNALS INTERNAL MED. 161, 164–65 (2003); see also Sunil Kripalani et al., *Promoting Effective Transitions of Care at Hospital Discharge: A Review of Key Issues for Hospitalists*, 2 J. HOSP. MED. 314, 314 (2007) (reporting that about half of adult hospital patients experience a medical error after discharge and between 19% and 23% suffer a post-discharge adverse event); *infra* notes 22–26 and accompanying text; *infra* Part II.

7. H. JOANNA JIANG ET AL., HEALTHCARE COST AND UTILIZATION PROJECT, NATIONWIDE FREQUENCY AND COSTS OF POTENTIALLY PREVENTABLE HOSPITALIZATIONS, 2006, STATISTICAL BRIEF #72, at 1–2 (2009), available at www.hcup-us.ahrq.gov/reports/statbriefs/sb72.jsp.

8. Jeffrey Young, *Typical Hospital Wastes Up to \$3.8 Million a Year on Readmissions: Study*, HUFFINGTON POST (Apr. 10, 2012, 11:46 PM), http://www.huffingtonpost.com/2012/04/09/hospital-cost-waste-premier_n_1413510.html.

9. Press Release, Centers for Medicare & Medicaid Services (CMS), CMS Fact Sheet: CMS Expands Information for Consumers About Outcomes of Care in America’s Hospitals (July 7, 2010), available at http://www.seniorhealthsciences.org/public/Weekly_Articles/073010/FactSheetHospitalCompare; see also *To Avoid a Return Trip to the Hospital, Take Action Before You Are Discharged*, WASH. POST (Mar. 12, 2012), http://www.washingtonpost.com/national/health-science/to-avoid-a-return-trip-to-the-hospital-take-action-before-you-are-discharged/2012/01/25/gIQAjqw7R_story.html (discussing Consumer Reports’ determination that 70% of hospitals earned the lowest or second-lowest rating for total readmissions). But see Arnold M. Epstein et al., *The Relationship Between Hospital Admission Rates and Rehospitalizations*, 365 NEW ENG. J. MED. 2287, 2288 (2011) (finding a “weak relationship between publicly reported measures of discharge planning and readmission rates”); Ashish K. Jha et al., *Public Reporting of Discharge Planning and Rates of Readmissions*, 361 NEW ENG. J. MED. 2637, 2642–43 (2009) (finding “large variations in readmission rates . . . underscoring the need for . . . a program [to reduce readmission rates in U.S. hospitals,] . . . [but also noting that t]he very modest association that we observed between readmission rates and discharge planning measures suggests that the use of public reporting as a strategy to improve performance on these measures is unlikely to yield large reductions in unnecessary readmissions.”); Andrew M. Ryan et al., *Medicare’s Public*

care costs, the Patient Protection and Affordable Care Act¹⁰ (PPACA), recently upheld by the Supreme Court,¹¹ seeks to reduce preventable readmissions by reducing Medicare payments to hospitals with “excess readmissions.”¹²

Yet in the ongoing, often political struggle over costs and readmissions, it is important to remember that saving trips to the hospital is about saving more than just money. Ray Freeland, a fifty-four year old man with a history of heart problems, may owe his life to a pilot program designed to monitor patients in their homes after

Reporting Initiative on Hospital Quality Had Modest or No Impact on Mortality from Three Key Conditions, 31 HEALTH AFF. 585, 585 (2012) (noting that it is unclear if improvements reduce mortality rates or sway patients when choosing a hospital).

10. Pub. L. No. 111-148, 124 Stat. 119 (2010), *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified in scattered sections of the U.S. Code).

11. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2608 (2012) (upholding key elements of the Patient Protection and Affordable Care Act as a constitutional exercise of Congress's power, although striking down a provision that required states to expand Medicaid coverage or lose existing federal payments).

12. Patient Protection and Affordable Care Act § 3025 (codified as amended at 42 U.S.C. § 1395ww(q) (Supp. V 2011)) (establishing that payments that would ordinarily be made to a hospital with “excess readmissions” are to be reduced by an amount equal to the product of the base operating diagnostic-related group (DRG) payment amount for the discharge and the adjustment factor for the hospital for the fiscal year). The calculation is based on a hospital's “excess readmission ratio,” which is defined in the Act as risk-adjusted actual readmissions divided by risk-adjusted expected readmissions, both of which are to be calculated by a method endorsed by the private nonprofit entity defined in § 1890(a) of the Social Security Act. *Id.*; *see also* Karen E. Joynt & Ashish K. Jha, *Characteristics of Hospitals Receiving Penalties Under the Hospital Readmissions Reduction Program*, 309 JAMA 342, 342 (2013) (describing the characteristics of the hospitals incurring penalties for high readmission rates); Cheryl Clark, *AHA Rejects Proposed Readmission Penalties*, HEALTHLEADERS MEDIA (June 25, 2012), <http://www.healthleadersmedia.com/print/FIN-281613/AHA-Rejects-Proposed-Readmission-Penalties> (projecting that 34.5% of the 3393 hospitals that could be subjected to a penalty will not receive a readmission penalty, but that the remainder will, with 14.2% (481 hospitals) receiving the maximum 1% penalty). In fiscal year 2013, the maximum penalty that can be imposed on hospitals if an excessive number of patients is readmitted is 1% of their total Medicare billings, which will rise to 2% in 2014 and 3% in 2015. DAVID C. GOODMAN ET AL., AFTER HOSPITALIZATION: A DARTMOUTH ATLAS REPORT ON POST-ACUTE CARE FOR MEDICARE BENEFICIARIES 2 (Kristen K. Bronner ed., 2011). *But see* Devan Kansagara et al., *Risk Prediction Models for Hospital Readmission: A Systematic Review*, 306 JAMA 1688, 1688 (2011) (suggesting that fairly defining a “normal” level of readmissions may be difficult); Douglas McCarthy et al., *Recasting Readmissions by Placing the Hospital Role in Community Context*, 309 JAMA 351, 351 (2013) (challenging policy-makers' narrow focus on readmission rates); Muthiah Vaduganathan et al., *Thirty-Day Readmissions: The Clock Is Ticking*, 309 JAMA 345, 345 (2013) (examining the use of a 30-day window for assessing hospital readmission rates); Clark, *supra* (reporting objections that the CMS is inappropriately counting planned and unrelated readmissions following discharges; that the proposed formula discriminates against hospitals with a higher percentage of non-white patients; and that the measure for gauging the rates of readmissions is unreliable for a majority of the hospitals subject to a possible penalty).

being discharged from a hospital.¹³ Rather than requiring frequent and oftentimes inconvenient visits to a doctor's office following heart surgery, the program places a wireless scale and blood pressure cuff in discharged patients' homes, which communicate data in real time to nurses monitoring them for signs of cardiac distress.¹⁴ When the monitoring of Freeland's pulse indicated an irregular heartbeat,¹⁵ he was immediately contacted and directed to see his doctor, who was able to "shock his heart back into a normal rhythm."¹⁶ The responsible medical center, Cedars-Sinai, a hospital and research facility in Los Angeles, concluded that a potentially serious health threat had been averted and that about \$30,000 in health care costs was saved as a result.¹⁷ Innovative programs such as this are designed to combat adverse events that follow a hospital discharge.¹⁸

13. Avery Johnson, *The Do-It-Yourself House Call: Insurer-Endorsed Remote-Monitoring Technology Leads Heart Patients to Take Their Readings at Home*, WALL ST. J. (July 27, 2010), <http://online.wsj.com/article/SB10001424052748704700404575391262635170370.html>.

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.*

18. See, e.g., Adam Darkins et al., *Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions*, 14 *TELEMEDICINE & E-HEALTH* 1118, 1118 (2008) (analyzing the success of a CareCoordination/Home Telehealth program implemented by the Veterans Health Administration); Mark V. Williams, *A Requirement to Reduce Readmissions: Take Care of the Patient, Not Just the Disease*, 309 *JAMA* 394, 394 (2012) (calling for a patient-centered approach to reduce readmissions); Press Release, AMC Health, Geisinger Health Plan and AMC Health Find Success with Remote Patient Monitoring: Improves Case Management Efficiency; Reduces All-Cause 30-Day Readmissions by 44% (Feb. 28, 2012), available at https://amchealth.com/uploads/PressRelease_GHP_and_AMC_Health_Find_Success_with_Remote_Patient_Monitoring_FINAL__v02282012.pdf (reporting the success of a post-hospital discharge telemonitoring program that uses an interactive voice response protocol); *Berg Insight Says 2.2 Million Patients Are Remotely Monitored Today*, BERG INSIGHT (Dec. 23, 2011), http://www.berginsight.com/News.aspx?m_m=6&s_m=1 (forecasting that the number of home monitoring systems with integrated cellular connectivity will reach 4.9 million connections globally by 2016); Dina Overland, *Readmissions Drop When Pharmacists Visit Patients' Homes*, FIERCEHEALTHPAYER (Apr. 16, 2012), <http://www.fiercehealthpayer.com/story/readmissions-drop-when-pharmacists-visit-patients-homes/2012-04-16> (describing a new post-discharge program where pharmacists make home visits to patients who are at an increased risk of readmission); *Pharmacists, Nurses Team Up in Pittsburgh Care Transition Project*, AM. PHARMACISTS ASS'N (May 21, 2012), <http://www.pharmacist.com/pharmacists-nurses-team-pittsburgh-care-transition-project> (describing the "Pittsburgh Project," a plan to offer more integrated care in Western Pennsylvania by creating support centers staffed by pharmacists and nurse care managers); Ken Terry, *Geisinger Plan Reduces Readmissions 44% with Telemonitoring*, FIERCEHEALTHIT (Mar. 2, 2012), <http://www.fiercehealthit.com/story/geisinger-plan-reduces-readmissions-44-telemonitoring/2012-03-02> (reporting on the success of the Geisinger Health Plan's telemonitoring of discharged patients). For a designed effort to facilitate patient participation in and improve the hospital discharge process, see *Discharge Planning*, CENTER FOR MEDICARE ADVOC., INC. (CMA), <http://www.medicareadvocacy.org/medicare-info/discharge-planning> (last visited Feb. 20, 2013).

Although the frequency of readmissions is alarming, the causes are hardly a mystery. Characterized as “a railroad whose tracks change gauge every few miles,”¹⁹ the Institute of Medicine has described America’s healthcare delivery system as

composed of a large set of interacting systems—paramedic, emergency, ambulatory, inpatient, and home health care; testing and imaging laboratories; pharmacies; and so forth—that are connected in loosely coupled but intricate networks of individuals, teams, procedures, regulations, communications, equipment and devices. These systems function within such diverse and diffuse management, accountability, and information structures that the overall term *health system* is today a misnomer.²⁰

Given the complexity of today’s healthcare system, it should come as no surprise that misunderstandings, fragmented lines of communication, and a bewildering diffusion of responsibility for patient care can lead to negative outcomes for vulnerable patients after their discharge from a hospital or similar care facility.²¹

Further exploration of the rates of adverse post-discharge incidents and hospital readmissions reveals the seriousness of the problem. One study found that 19% of 400 patients consecutively discharged from the general medical service of a hospital suffered an adverse health-related event within three weeks of discharge, with roughly 61% of these events being preventable or ameliorable.²² “System problems” were determined to have contributed to all preventable or ameliorable events, with poor communication between hospital caregivers and either the patient or the patient’s primary care physician in the community being the most common contributing cause.²³ Another study of over five million Medicare patients found that, depending on the initial reason for their hospitalization,

19. WACHTER & SHOJANIA, *supra* note 1, at 174.

20. COMM. ON QUALITY HEALTH CARE IN AM., INST. OF MED., CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 78 (2001); *see also* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS 1–3 (Einer Elhauge ed., 2010) (discussing the need for greater integration to produce more unified decision making within the healthcare system); François de Brantes et al., *Building a Bridge from Fragmentation to Accountability: The Prometheus Payment Model*, 361 NEW ENG. J. MED. 1033, 1033–34 (2009) (imparting the positive effects of a payment model that incentivizes provider collaboration and “efforts to reduce avoidable complications of care”); Randall D. Cebul et al., *Organizational Fragmentation and Care Quality in the U.S. Healthcare System*, 22 J. ECON. PERSPECTIVES 93, 93 (2008) (noting that a fragmented healthcare system “lead[s] to disrupted relationships, poor information flows, and misaligned incentives”).

21. *See infra* Part II (explaining the legal doctrines applicable to discharged patients who have been wrongfully injured).

22. Forster et al., *supra* note 6, at 164.

23. *Id.* at 165 (finding that 59% of the “preventable and ameliorable adverse events” were attributable to this deficit).

between about 13% and 21% of discharges were followed by a rehospitalization within thirty days.²⁴ A recent meta-analysis determined that nearly one in four discharged hospital patients were readmitted within thirty days under conditions described as urgent and *avoidable*.²⁵ Such studies have led commentators to assert:

The hospital discharge is poorly standardized and is characterized by discontinuity and fragmentation of care. Lack of coordination in the handoff from the hospital to community care, growth of the hospitalist movement that contributes to handoffs, gaps in social supports, high rates of low health literacy, and poor delineation of discharge responsibilities among hospital staff (often those early in training)—all place patients at high risk of post-discharge adverse events . . . and re-hospitalization. These problems are compounded by the length of the typical primary care visit in the United States, which is 18 minutes, and do not allow adequate time to become familiar with the details and issues of the recent hospitalization. These visits must be added to already overbooked schedules at the time of discharge and frequently occur without access to a discharge summary or to diagnostic and procedural reports.²⁶

24. GOODMAN ET AL., *supra* note 12, at 15.

25. Carl van Walraven et al., *A Meta-Analysis of Hospital 30-day Avoidable Readmission Rates*, 17 J. EVALUATION CLINICAL PRAC. 1211, 1213 (2011); *see also* JULIE STONE & GEOFFREY J. HOFFMAN, CONG. RESEARCH SERV., R40972, MEDICARE HOSPITAL READMISSIONS: ISSUES, POLICY OPTIONS AND PPACA 4 n.7 (2010) (noting that “in 2005 17.6% of hospital admissions resulted in readmissions within 30 days of discharge, 11.3% within 15 days, and 6.2% within 7 days”); Eric A. Coleman et al., *The Care Transitions Intervention: Results of a Randomized Controlled Trial*, 166 ARCHIVES INTERNAL MED. 1822, 1822 (2006) (“National 30-day readmission rates among older Medicare beneficiaries range from 15% to 25%.”); Kumar Dharmarajan et al., *Diagnoses and Timing of 30-Day Readmissions After Hospitalization for Heart Failure, Acute Myocardial Infarction, or Pneumonia*, 309 JAMA 355, 355 (2013) (reporting national readmission rates from 2007 through 2009); Stephen F. Jencks et al., *Rehospitalizations Among Patients in the Medicare Fee-for-Service Program*, 360 NEW ENG. J. MED. 1418, 1420–28 (2009) (recording that 19.6% of 11,855,702 hospitalized Medicare beneficiaries were rehospitalized within thirty days and 34% within ninety days at a cost of \$17.4 billion, with 90% of the readmissions potentially preventable); Sunil Kripalani et al., *Effect of a Pharmacist Intervention on Clinically Important Medication Errors After Hospital Discharge*, 157 ANNALS INTERNAL MED. 1, 1, 2, 5 (2012) (stating that 11% to 17% of patients discharged from hospitals suffer medication related injury during the first few weeks, with many of those injuries being preventable; and finding that 50.8% of 851 patients discharged following hospitalization for acute coronary syndromes or acute decompensated heart failure “had 1 or more clinically important medication errors during the 30 days after hospital discharge”); Overland, *supra* note 18 (reporting a 20% thirty-day readmission rate for Medicare Advantage patients); Pa. Patient Safety Auth., *Leveraging Healthcare Policy Changes to Decrease Hospital 30-Day Readmission Rates*, 7 PENN. PATIENT SAFETY ADVISORY 1, 2 (2010) (reporting 57,852 readmissions in Pennsylvania in 2008, resulting in \$2.5 billion in charges).

26. Jeffrey L. Greenwald et al., *The Hospital Discharge: A Review of a High Risk Care Transition with Highlights of a Reengineered Discharge Process*, 3 J. PATIENT SAFETY 97, 97

The “systems problems” associated with discharge may be compounded by pressures from third-party payors to discharge patients sooner to limit health care costs, even though this may make patients more vulnerable to relapse by encouraging hospitals to discharge them as quickly as possible.²⁷ In addition, patients are

(2007) (footnotes omitted); see also Eric A. Coleman & Robert A. Berenson, *Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care*, 140 ANNALS INTERNAL MED. 533, 533 (2004) (“Quantitative evidence increasingly indicates that patient safety is jeopardized during transitional care Qualitative studies have consistently shown that patients and their caregivers are unprepared for their role in the next care setting, do not understand essential steps in the management of their condition, and cannot contact appropriate health care practitioners for guidance.”); Epstein et al., *supra* note 9, at 2293 (explaining that the quality of transition care needs improvement, noting that elderly patients often do not receive ambulatory care prior to readmission and primary care physicians often do not receive important discharge information about their patients); Jencks et al., *supra* note 25, at 1426 (concluding that rehospitalization rates could be reduced based on five distinct lines of evidence); Jha et al., *supra* note 9, at 2638 (stating that failures in the communication of discharge instructions, the reconciliation of hospital and ambulatory records, and the arrangement of appropriate ambulatory care follow-up has led to high readmission rates).

The “hospitalist movement” refers to the increasing likelihood that patients will be treated by a hospital-based physician rather than by their community-based physician while hospitalized. Proponents assert this increases efficiency and safety. See Robert M. Wachter & Lee Goldman, *The Emerging Role of “Hospitalists” in the American Health Care System*, 335 NEW ENG. J. MED. 514, 514 (1996) (asserting that one of the reasons hospitalists are so efficient is because they can treat a large number of patients promptly within one location); Robert M. Wachter & Lee Goldman, *The Hospitalist Movement 5 Years Later*, 287 JAMA 487, 487–88, 493 (2002) (finding that the “hospitalist movement” has increased efficiency without lowering the quality of care). But see Shannon Pettypiece, *Doctors Heavy Caseloads Put Patients at Risk, Study Shows*, BLOOMBERG (Jan. 29, 2013, 12:00 AM), <http://www.bloomberg.com/news/2013-01-28/doctors-heavy-caseloads-put-patients-at-risk-study-shows.html> (“Almost half of hospital[-based] doctors said they routinely see more patients than they can safely manage, leading in some cases to unneeded tests, medication errors and deaths, according to a survey by researchers at Johns Hopkins University.”). Opponents cite the handoffs from community physician to hospitalist and back again as a source of discontinuity and potential medical error. See Thomas Bodenheimer, *Coordinating Care—A Perilous Journey Through the Health Care System*, 358 NEW ENG. J. MED. 1064, 1067 (2008) (recognizing the discontinuity that hospitalist care creates as the patient goes from outpatient to inpatient and vice versa).

27. See EUGENE A. KROCH ET AL., THE COMMONWEALTH FUND, HOSPITAL PERFORMANCE IMPROVEMENT: TRENDS IN QUALITY AND EFFICIENCY ix (2007) (stating that financial pressures on hospitals to reduce costs have caused a significant reduction in the risk-adjusted length of stay over time); WACHTER & SHOJANIA, *supra* note 1, at 165 (“This problem [of missed handoffs at hospital discharge] has been magnified in the last twenty years by the economic drive to discharge patients promptly—‘sicker and quicker.’”); Ann Marie Marciarille, *Healing Medicare Hospital Recidivism: Causes and Cures*, 37 AM. J.L. & MED. 41, 43 (2011) (“Contemporary Medicare hospital discharge planning’s dangerous, expensive and oddly truncated emphasis on acute care utilization review averts attention from promoting successful reentry into the pre-acute care environment for the patient.”); Therese A. Stukel et al., *Association of Hospital Spending Intensity with Mortality and Readmission Rates in Ontario Hospitals*, 307 JAMA 1037, 1042 (2012) (finding that hospitals that spend more on patient care had lower readmission rates and greater survival rates). But see Lena M. Chen et al., *Hospital Cost of Care, Quality of Care, and Readmission Rates: Penny Wise and Pound Foolish?*, 170 ARCHIVES INTERNAL MED. 340, 346 (2010) (“Most

increasingly checking themselves out of hospitals against their doctors' advice, perhaps because they are responsible for their health care costs and are concerned about paying for their hospital stay, or perhaps because they have personal obligations outside the hospital.²⁸

It is thus evident that the well-being of patients is jeopardized by the prevailing discharge process and subsequent post-discharge care,²⁹ a scenario that can be attributed at least in part to the inadequacy of existing legal doctrine regarding the division and assignment of related responsibilities among the various relevant health care providers.³⁰ In general, this void leaves discharged patients poorly protected from related harms, does nothing to

evidence did not support the penny-wise and pound-foolish hypothesis that low-cost hospitals discharge patients earlier, only to increase readmission rates and incur greater inpatient cost of care over time.”).

28. See William N. Southern et al., *Increased Risk of Mortality and Readmission Among Patients Discharged Against Medical Advice*, 125 AM. J. MED. 594, 594 (2012) (explaining that each year 500,000 patients are discharged from hospitals in the United States against medical advice); Tara Parker-Pope, *Leaving the Hospital Early*, WELL N.Y. TIMES BLOG (Mar. 10, 2011, 4:10 PM), <http://well.blogs.nytimes.com/2011/03/10/leaving-the-hospital-early/> (reporting a 40% increase in patients leaving a hospital against medical advice from 1997 to 2008); see also ROBIN A. COHEN ET AL., CENTERS FOR DISEASE CONTROL & PREVENTION, FINANCIAL BURDEN OF MEDICAL CARE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, JANUARY–JUNE 2011, at 1 (2012) (finding that one in three individuals was in a family experiencing a financial burden resulting from medical care, one in five was in a family having problems paying medical bills, one in four was in a family paying medical bills over time, and one in ten was in a family that had medical bills they were unable to pay at all). Indeed, patients discharging themselves against medical advice are at increased risk of both readmission and death. See Southern et al., *supra*, at 597 (reporting 24.7% of patients discharged against medical advice were readmitted within thirty days, and 1.3% died during this period, while the rates were 11.3% and 0.7%, respectively, for patients who went home pursuant to a planned discharge). It is believed that these patients often sign themselves out because they need to attend to personal obligations such as work or caring for a family member. See Amy Norton, *Patients Leaving Hospital Against Advice Fare Worse*, CHI. TRIB. (May 2, 2012), http://articles.chicagotribune.com/2012-05-02/lifestyle/sns-rt-us-patients-leavinghospital-bre8410qy-20120502_1_hospital-patients-medical-advice-shorter-hospital (weighing the risks of early discharge against the personal obligations to which patients must attend).

29. See Jencks et al., *supra* note 25, at 1427 (“Rehospitalization is a frequent, costly, and sometimes life-threatening event that is associated with gaps in follow-up care.”).

30. See GOODMAN ET AL., *supra* note 12, at 4–5 (stating that one of the most significant problems is the lack of clarity as to who is responsible for post discharge care, with accountability being scattered amongst hospital and rehabilitation facility staff, community physicians and nurses, and the patients' families). The lack of third-party reimbursement also significantly contributes to a paucity of related services. See Ann Wilde Mathews, *Why America's Doctors Are Struggling To Make Ends Meet: Some Upgrade Their Practices but Reimbursements Fall Short; Dr. Hammond Feels the Squeeze*, WALL ST. J. (Mar. 16, 2012, 1:06 PM), <http://online.wsj.com/article/SB10001424052970204603004577271340816194320.html> (reporting that traditional insurance contracts pay for face-to-face appointments with patients, so practices are not reimbursed for calling a patient's home and other forms of follow-up care).

address providers' confusion about their respective duties, and fails to give providers an incentive to supply needed information and services to their patients.³¹ For the well-being of these patients, as well as for the financial viability of the health care system as a whole,³² it is critical that this void be filled.

The party best positioned to ensure that patients receive the information and assistance they need both during and briefly following discharge is the discharging hospital.³³ Although courts

31. Traditionally in a fee-for-service payment system, a perverse incentive exists for hospitals to not assist recently discharged patients, as hospitals can receive greater overall compensation if discharged patients relapse and return requiring more services. Indeed, "health care professionals receive a premium for a defective product; physicians and hospitals can bill for the additional services that are needed when patients are injured by their mistakes." Lucian L. Leape & Donald M. Berwick, *Five Years After To Err Is Human: What Have We Learned?*, 293 J. AM. MED. ASS'N 2384, 2388 (2005); see also INST. OF MED., REWARDING PROVIDER PERFORMANCE: ALIGNING INCENTIVES IN MEDICARE (2006) (encouraging a pay for performance system to promote quality care). Provisions in the PPACA seek to counter this perverse incentive. See PATRICIA A. DAVIS ET AL., CONG. RESEARCH SERV., R41196, MEDICARE PROVISIONS IN THE PPACA: CONGRESSIONAL RESEARCH SERVICE REPORT FOR CONGRESS 23 (2010) (clarifying that under the PPACA, Medicare payments will be reduced based on the percentage of potentially preventable Medicare readmissions).

32. Increasing health care costs, which currently consume more than 17% of the Gross Domestic Product of the United States, have become a matter of growing concern. See *NHE Fact Sheet*, CMS.GOV (Jan. 9, 2013, 8:34 AM), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html> (reporting national health expenditures were \$2.7 trillion in 2011 or 17.9% of GDP); see also CONG. BUDGET OFFICE, THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING 1 (2007), available at <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/87xx/doc8758/11-13-lt-health.pdf> (reporting that the growth of spending on health care in the United States has outpaced economic growth for many years). As a result, patients and their family members are having an increasingly difficult time paying for their medical bills. See COHEN ET AL., *supra* note 28, at 1 (finding that more than one in five Americans in 2010 struggled to pay their medical bills). In 2007, 62.1% of all personal bankruptcies in the United States were related to illness and medical bills, an increase of 49.6% from 2001, while in 1981 these were the cause of only 8% of all bankruptcies. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 741, 744 (2009). At the same time, hospitals are facing increasing financial pressures of their own. See QUORUM HEALTH RES., HOSPITAL BANKRUPTCY: WHAT BOARD MEMBERS, EXECUTIVES, AND OTHER STAKEHOLDERS NEED TO KNOW 2 (2011) (stating that forty-two acute care hospitals filed for federal bankruptcy protection between 2000 and 2006, and industry analysts foresee hospitals' financial health continuing to decline).

33. See, e.g., GOODMAN ET AL., *supra* note 12, at 4 ("As the largest and most comprehensive providers of health care services, hospitals are increasingly seen as one of the most important potential foci of accountability for care of patient populations that should extend beyond the hospital walls to include community providers and caregivers."). Although this Article frequently uses the term "hospital" for grammatical efficiency, its arguments should not be read as applicable solely to traditional general hospitals. This Article's assertions are also germane to specialty hospitals, outpatient clinics, and other types of facilities that provide intensive health care services and often possess similar relevant characteristics. A full discussion of the applicability of these ideas to hospital-like facilities is beyond the scope of this Article.

applying a theory of corporate liability have widely established that hospitals have several enforceable duties to the patients cared for *in* their facilities, they have generally not addressed what duties may be owed *beyond the point of discharge*.³⁴ This Article asserts that the steady historical expansion of hospitals' services and their corresponding legal duties to patients has reached a point in today's medical environment where hospitals have assumed, and patients expect them to assume, a more central role in the delivery of health care than ever before—a role that increasingly can be seen as fiduciary in nature.³⁵ It further argues that formally recognizing this fiduciary relationship with respect to a hospital's recently discharged patients will not only enhance the well-being of these patients, but also improve the financial position of hospitals and the healthcare system as a whole.³⁶

I. THE PROBLEM OF POST-DISCHARGE INJURY: CAUSES AND CONSEQUENCES

A patient's discharge from the hospital is an especially critical transition point, one where the patient is particularly vulnerable to the problems that plague health care transitions in general.³⁷ Health care transitions of all kinds are notorious risk factors for patient injury and are responsible for an estimated 80% of all serious medical errors.³⁸ The Hand-off Communications Project of The Joint

34. For a discussion of various hospital duties required by law, see *infra* notes 111–15 and accompanying text.

35. See *infra* notes 108–10 and accompanying text; Part IV (describing the expansion of hospital corporate liability).

36. Undertaking this responsibility can benefit hospitals that might otherwise incur significant financial losses associated with readmissions of patients unable to pay for the care received, penalties under the PPACA and other mechanisms, diminished standing in the community, or jeopardized accreditation or certification. See *infra* Parts II–IV (detailing the potential financial losses associated with inadequate discharge and post-discharge procedures). With regard to the health care system as a whole, one of the primary reasons so much attention has been devoted to readmissions is their considerable cost, estimated at over thirty billion dollars a year, which could be avoided and is contributing to concerns about runaway health care costs in general. See *supra* notes 7–8, 17, 32 and accompanying text.

37. See Greenwald et al., *supra* note 26, at 97 (pointing to discontinuity and fragmentation of care as the primary causes of high readmission rates); see also *supra* notes 20–26 and accompanying text; *infra* Part II (describing the lack of legal tools available to patients injured by inadequate post-discharge care).

38. Press Release, Joint Comm'n Ctr. for Transforming Healthcare, Joint Comm'n Ctr. for Transforming Healthcare Tackles Miscommunication Among Caregivers (Oct. 21, 2010), available at http://www.pwrnewmedia.com/2010/joint-commission_01021_miscommunication/index.html; see also Mary Ann Friesen et al., *Handoffs: Implications for Nurses*, in PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES 1, 1 (Ronda G. Hughes ed., 2008) (reviewing reports of the risks associated with hospital handoffs); Bodenheimer, *supra* note 26, at 1064

Commission, a not-for-profit organization that examines, as part of its accreditation program, the quality of care provided by health care facilities across the country, found in a study of ten participating hospitals that “more than 37 percent of the time hand-offs were defective and didn’t allow the receiver to safely care for the patient.”³⁹ Because discharge removes the patient from a hospital’s internal monitoring systems, this can prove even more dangerous than intra-facility transitions and has been described as a “perfect storm” with risks of “loose ends,” communication problems, poor quality information and preparation, and fragmented care.⁴⁰

From the patients’ perspective, even when properly executed, discharge can be a difficult and stressful time.⁴¹ Patients may still be suffering lingering pain, discomfort, and vulnerability from their health problems and subsequent treatment,⁴² and they may be confused and distracted by the bustle of events surrounding the transition.⁴³ In addition, they may also be dreading what awaits them upon their return home, including unfulfilled work obligations, disrupted family relations, unpaid bills, and personal

(analyzing research that strongly suggests failures in coordination of care are both common and serious threats to the quality of patient care); Coleman et al., *supra* note 25, at 1822 (explaining that patient transitions between different settings are vulnerable periods when the quality of care and patient safety may be compromised).

39. Press Release, Joint Comm’n Ctr. for Transforming Healthcare, *supra* note 38; see also Barrett T. Kitch et al., *Handoffs Causing Patient Harm: A Survey of Medical and Surgical House Staff*, 34 JOINT COMM’N J. ON QUALITY & PATIENT SAFETY 563 (2008) (expounding that hospitals are failing to observe the best practices for patient handoffs).

40. *Re-engineered Discharge Project Dramatically Reduces Return Trips to the Hospital*, AGENCY FOR HEALTHCARE RES. & QUALITY (March 2011), <http://www.ahrq.gov/research/mar11/0311RA1.htm>.

41. The term “home” is used to indicate a placement somewhere in the community following a hospital discharge, including but not limited to rehabilitative centers, nursing homes, and the patient’s private residence. Each of these may pose unique hand-off challenges. See Friesen et al., *supra* note 38, at 1–2 (explaining that handoffs are largely dependent on the experience and skill of the caregivers, particularly their interpersonal communication skills, and noting factors that make these handoffs difficult).

42. See Preetha Basaviah & Mark V. Williams, *Hospital Discharge*, in HOSPITAL MEDICINE 31, 31 (Robert M. Wachter et al. eds., 2d ed. 2005) (describing the pain and confusion that discharged patients suffer shortly thereafter).

43. See Lara Alspaugh, *A Guide for Nurses: Teaching Healthcare Effectively to Patients*, HEALTH CAREERS J. (Feb. 29, 2008), <http://www.healthcareersjournal.com/a-guide-for-nurses-teaching-healthcare-effectively-to-patients> (suggesting effective communication strategies for the explanation of post-discharge care instructions to patients); Nicole Higgins DeSmet, *After Stints in Hospital, Facing a Fight with Bills*, N.Y. TIMES, Dec. 16, 2011, at A39 (recounting the financial struggles of an elderly man following a hospital stay). Indeed, the discharge process itself can be an unpleasant and disturbing experience. See Melanie Henwood, *Problems Leaving Hospital Will Be a Lasting Memory for Patients*, GUARDIAN: JOE PUBLIC BLOG (Sept. 13, 2011), <http://www.guardian.co.uk/society/joepublic/2011/sep/13/hospital-patients-discharge-problems> (recounting the stress that comes with leaving the hospital after treatment).

challenges such as adapting to reduced mobility, strength, endurance, and mental acuity.⁴⁴

It is during this challenging and sometimes chaotic transition period that patients are expected to assume greater responsibility for their own care, a task made even more difficult by one of the major causes of post-discharge injury: miscommunications between health care providers and their patients.⁴⁵ Even when a hospital provides complete and accurate instructions at discharge,⁴⁶ these instructions can be difficult for patients to understand, remember, and follow.⁴⁷ Many patients are given a host of complex and potentially confusing instructions regarding (a) signs that their condition is worsening, (b) obtaining and administering prescribed medications or other treatment and cautions about their side effects, (c) recommended changes in life style or behavior, (d) the value and use of various medical or monitoring devices, and (e) the need to return for periodic check-ups or additional care.⁴⁸ Though complex and often

44. See Basaviah & Williams, *supra* note 42, at 31 (noting that many patients continue to feel unwell after discharge but are expected to follow complex regimes of medication, as well as schedule and obtain needed follow-up visits and tests); Karen Grimmer et al., *Experiences of Elderly Patients Regarding Independent Community Living After Discharge from Hospital: A Longitudinal Study*, 16 INT'L J. FOR QUALITY HEALTH CARE 465, 467 (2004) (explaining that patients face many immediate problems upon discharge, including obtaining and preparing food, paying bills, transporting themselves, maintaining their household, and completing other basic daily tasks).

45. See Grimmer et al., *supra* note 44, at 467 (noting that “short hospital admissions, the general busyness of hospital staff, and patients’ ill health most likely constrained patient involvement in discharge planning”); Kripalani et al., *supra* note 6, at 314–15 (observing the challenges faced by patients and their families once responsibility for care is transferred from the inpatient provider or hospitalist to the patient or community care provider).

46. See *To Avoid a Return Trip to the Hospital, Take Action Before You Are Discharged*, WASH. POST (Mar. 12, 2012), http://www.washingtonpost.com/national/health-science/to-avoid-a-return-trip-to-the-hospital-take-action-before-you-are-discharged/2012/01/25/gIQAjqv7R_story.html (“[Although] Medicare regulations require hospitals to have a process for all patients to receive written discharge instructions, including lists of follow-up appointments, medication and dosage directions[,] . . . those plans are often incomplete.”).

47. See Sandra G. Boodman, *Many Americans Have Poor Health Literacy*, WASH. POST (Feb. 28, 2011, 8:37 PM), <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/28/AR2011022805957.html> (reporting that 36% of adults have only basic or below-basic skills for comprehending written health materials, meaning that ninety million Americans understand discharge instructions only when written at a fifth-grade level or lower); see also Overland, *supra* note 18 (explaining that discharge instructions are often hard to understand and thus difficult for patients to follow); Robert Preidt, *Poor Reading Skills Might Be Fatal for Older Folks: Inability To Understand Medical Instructions Associated with Higher Death Rates in 5-year Study*, HEALTHDAY NEWS (Mar. 16, 2012), <http://consumer.healthday.com/Article.asp?AID=662789> (noting that being unable to read medical instructions may actually cause death in elderly people).

48. Increasing numbers of patients are receiving “complete written discharge instructions,” which include information on “activity level, diet, discharge

voluminous, all of this information is critical; for example, many prescription medicines can do more harm than good if the patient is not given careful instructions and cautioned to watch for possible complications.⁴⁹

Perhaps unsurprisingly given the amount and detail of the information involved, miscommunication between health care providers and their patients at this stage is extremely common.⁵⁰ In one study, 95% of surveyed primary care nurses believed their patients understood the important side effects of their medications at the time of discharge, but the researchers discovered that only 57% of the patients actually did.⁵¹ Similarly, 99% of the nurses believed that their patients understood when it would be safe to resume normal activities, while only about 50% of the patients had an accurate understanding of this safety issue.⁵² Another study showed that physicians correctly assessed their patients' understanding of discharge information only 2% of the time.⁵³ Tellingly, there is even

medications, follow-up appointment, weight monitoring, and actions to take if symptoms worsen." AGENCY FOR HEALTHCARE RESEARCH & QUALITY, NATIONAL HEALTHCARE DISPARITIES REPORT, 2011, at 173–74 & fig.6.1 (2012), available at <http://www.ahrq.gov/qual/qdr11.htm>; see also Rebecca Hendren, *Prevent Readmissions with Nurse Intervention*, HEALTHLEADERS MEDIA (Sept. 27, 2011), <http://www.healthleadersmedia.com/page-2/NRS-271422/Prevent-Readmissions-With-Nurse-Intervention> ("Many patients with chronic illnesses face complicated medication regimens they may not understand . . . or wonder what to do about prescriptions they had been taking before hospitalization.").

49. See WACHTER & SHOJANIA, *supra* note 1, at 71–72 (explaining that 5% of hospital patients have experienced an adverse drug event partially due to the ubiquitous use of medications in modern medicine); Amy L. Friedman et al., *Medication Errors in the Outpatient Setting: Classification and Root Cause Analysis*, 142 ARCHIVES SURGERY 278 (2007) (finding that outpatient medication errors are frequent with significant adverse effects and are often linked to the health care system); Overland, *supra* note 18 (reporting that the most common cause of unnecessary readmissions is a medication management mistake, including "taking too many meds, taking meds that are contraindicated or not taking enough meds," with many patients left struggling to reconcile new and old prescriptions).

50. Coleman & Berenson, *supra* note 26, at 533 (describing the challenge of transitioning from the passive "patient" role to assuming a "self-management" role following discharge). The content and the language of discharge instructions need not even be complicated to result in misunderstanding. See Boodman, *supra* note 47, ("When we say 'diet,' we mean 'food,' but patients think we mean going on a diet. And when we say 'exercise,' we may mean 'walking,' but patients think we mean 'going to the gym.' At every step there's a potential for misunderstanding.").

51. Peggy Reiley et al., *Discharge Planning: Comparison of Patients' and Nurses' Perceptions of Patients Following Hospital Discharge*, 28 J. NURSING SCHOLARSHIP 143, 146 (1996).

52. *Id.*

53. See Basaviah & Williams, *supra* note 42, at 33; see also Kripalani et al., *supra* note 6, at 319–20 (observing that physicians often fail to adequately solicit questions from patients regarding their post-discharge care).

some evidence that patients themselves may not be any better at judging their own level of understanding.⁵⁴

Flawed communication between patients and health care providers is far from the only problem that can lead to post-discharge injury. A lack of communication between hospital physicians and the community physicians who assume responsibility for discharged patients is also the cause of many adverse events.⁵⁵ A study at the Mount Sinai School of Medicine in New York City found that 49% of discharged hospital patients who saw their primary care physician within two months of discharge experienced a medical error that could be attributed to a discontinuity of care in the transition from inpatient to outpatient care.⁵⁶ A “medication continuity error” was experienced by 42% of these patients, 8% experienced a “test follow-up error” (including 41% of the patients with tests pending at discharge), and 12% experienced a “work-up error” (including 22% of the patients with a planned outpatient work-up at discharge).⁵⁷ Patients with a work-up error were 6.2 times more likely to be re-hospitalized within three months after their first post-discharge visit with their primary care physician, 2.5 times more likely to be hospitalized if they experienced a medication continuity error, and 2.4 times more likely to be hospitalized if they experienced a test follow-up error.⁵⁸ Other studies have reported that less than half of all community-based primary care providers receive information about discharge medications and plans for their recently hospitalized patients.⁵⁹

54. See Kirsten G. Engel et al., *Patient Comprehension of Emergency Department Care and Instructions: Are Patients Aware of When They Do Not Understand?*, 53 ANNALS EMERGENCY MED. 454, 459 (2009) (finding that most patients demonstrated comprehension deficiencies that the patients themselves did not perceive).

55. See Alicia Gallegos, *Communication Key to Reducing Liability Claims in Patient Handoffs*, AM. MED. NEWS (June 20, 2011), <http://www.ama-assn.org/amednews/2011/06/20/prca0620.htm> (reporting that while almost 70% of physicians claim to regularly send patient history information to specialists, only about 35% of specialists report regularly receiving such information).

56. See Carlton Moore et al., *Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting*, 18 J. GEN. INTERNAL MED. 646, 647–48 (2003) (listing the categories of medical errors, including medication continuity, test follow-up, and work-up errors).

57. *Id.* at 648–49.

58. *Id.* at 649.

59. See R. J. Mageean, *Study of “Discharge Communications” from Hospital*, 293 BRIT. MED. J. 1283, 1283 (1986) (noting that 53% of the patients had contacted their general practitioner after discharge before the general practitioner received any information regarding the discharge); Stephen Wilson et al., *General Practitioner-Hospital Communications: A Review of Discharge Summaries*, 21 J. QUALITY CLINICAL PRAC. 104, 104 (2001) (finding that discharge summaries were received by only 27.1% of patient-nominated general practitioners, and that less than two-thirds of those actually received were rated as accurate).

The misuse of complex medical devices at home can be yet another source of post-discharge injury. As a result of hospitals discharging patients after increasingly shorter stays, more patients are recovering and continuing post-operative care at home with the assistance of sophisticated medical equipment.⁶⁰ It is estimated that 7.6 million individuals in the United States each year receive home health-care from one of 17,000 agencies and, in addition, an unpaid family caregiver is present in approximately thirty-six million American households.⁶¹ A medical device is used in a majority of these homes, but frequently only limited information or instruction is provided on the use of these devices, even when a home health-care agency is involved.⁶² These devices, the operation of which may be confusing for patients, can pose significant health risks: the Food and Drug Administration (FDA) alone received 19,000 reports of adverse events involving medical devices used in homes between 1997 and 2009.⁶³ When medical devices in the home fail or are used improperly, the results can be catastrophic.⁶⁴ One case reported to the FDA involved a patient who failed to remove a cap from the line on a drug infusion pump, resulting in a blockage of the flow of medication and the patient's subsequent hospitalization.⁶⁵ Another patient incorrectly connected the lines for overnight dialysis and died of blood loss.⁶⁶ It

60. See Jennifer Corbett Dooren, *FDA Pushes Oversight of Devices*, WALL ST. J. (Apr. 20, 2010), <http://online.wsj.com/article/SB10001424052748704671904575194310283186290.html> (stating that the FDA received more than 19,000 reports of adverse events involving home medical devices from 1997 to 2009); Molly Follette Story, *Medical Devices in Home Health Care*, in THE ROLE OF HUMAN FACTORS IN HOME HEALTH CARE: WORKSHOP SUMMARY 145, 147 (2010) (attributing the rise in outpatient care to the climbing cost of health care services and shortage of healthcare facilities and skilled personnel); Edward P. Richards & Charles Walter, *High Tech Devices in Low Tech Environments: The Lay Use of Medical Devices*, IEEE ENGINEERING MED. & BIOLOGY MAG. Dec. 1989, at 60, 60 (noting that efforts to further "cost containment" in healthcare created the "new phenomenon" of home medical devices).

61. CTR. FOR DEVICES & RADIOLOGICAL HEALTH, U.S. FOOD & DRUG ADMIN., MEDICAL DEVICE HOME USE INITIATIVE 2-3 (2010).

62. See Story, *supra* note 60, at 147-48 (outlining that some medical devices may not be the best fit for users because of the limited support, education, and training provided them); Dooren, *supra* note 60 (stating that complicated devices pose health risks to at-home patients).

63. CTR. FOR DEVICES & RADIOLOGICAL HEALTH, *supra* note 61, at 5; see also Jim Spencer & Janet Moore, *GAO Adds to Concerns About Medical Device Approval Process: Reviewers Criticize Process that Requires No Human Testing*, STAR TRIB. (Apr. 13, 2011), <http://www.startribune.com/business/119786949.html?refer=y> (noting that in April 2011 government reviewers stated that the "process for ensuring the safety and effectiveness of medical devices remains suspect").

64. See CTR. FOR DEVICES & RADIOLOGICAL HEALTH, *supra* note 61, at 5 (giving examples of catastrophic adverse events that occurred when at-home patients used medical devices).

65. *Id.*

66. *Id.* at 6.

has been noted that most of these devices were approved by the FDA for use by medical personnel in hospitals, not by the average person in his or her home.⁶⁷

While the potentially life-threatening health risks to patients who suffer post-discharge adverse events are perhaps self-evident, there are other troubling consequences. One such consequence is the potential need for hospital readmission, which the Medicare Payment Advisory Commission (MedPAC) of the CMS identified as the source of billions of dollars of unnecessary annual health care expenditures.⁶⁸ In today's cost-conscious debates over health care, the expensive nature of readmissions has led to their increased scrutiny by politicians and researchers alike.⁶⁹ For example, a recent MedPAC study determined that while the average duration of hospital stays by heart-failure patients has decreased, the likelihood of their returning to the hospital for additional care within a month of their initial treatment has increased.⁷⁰ Another report received considerable attention for its finding that readmission rates either held steady or increased in many places around the country from 2004 to 2009.⁷¹ Harlan Krumholz, a Yale University cardiologist and senior author of the MedPAC study, concluded that "hospitals need to invest more effort and resources to make sure 'the transition to

67. *Id.* at 4.

68. See MEDICARE PAYMENT ADVISORY COMM'N, REPORT TO THE CONGRESS: PROMOTING GREATER EFFICIENCY IN MEDICARE 103 (2007) (reporting that 17.6% of admissions result in \$15 billion in readmission spending). This report recommended that the Medicare payment system be revised to incentivize hospitals to reduce their readmission rates. See *id.* at 114–18 (comparing a penalty-only approach to a reward and penalty approach to incentivize hospitals). Ultimately, this and other studies formed the foundation for the PPACA's financial penalty on hospitals with "excess readmissions." See *supra* note 12 and accompanying text; see also Bernard Friedman & Jayasree Basu, *The Rate and Cost of Hospital Readmissions for Preventable Conditions*, 61 MED. CARE RES. & REV. 225, 233 (2004) (reporting that 19.4% of patients were readmitted during the six months following discharge, with more than two-thirds of readmissions occurring in the first three months and accounting for \$729 million in additional hospital costs or about \$7,400 per readmission); *supra* notes 7, 32 and accompanying text.

69. Nazima Allaudeen et al., *Inability of Providers To Predict Unplanned Readmissions*, 26 J. GEN. INTERNAL MED. 771, 771 (2011); Robert P. Kocher & Éli Y. Adashi, *Hospital Readmissions and the Affordable Care Act: Paying for Coordinated Quality Care*, 306 JAMA 1794, 1794 (2011).

70. See Héctor Bueno et al., *Trends in Length of Stay and Short-term Outcomes Among Medicare Patients Hospitalized for Heart Failure, 1993–2006*, 303 JAMA 2141, 2141, 2143–45 (2010) (noting that while the mean length of stay of 8.8 days in 1993 dropped to 6.3 days in 2006, the readmission rate increased from 17.2% to 20.1%).

71. See GOODMAN ET AL., *supra* note 12, at 15 (finding that "[t]here was little change in the U.S. 30-day readmission rates [for Medicare patients], regardless of the cause of the initial hospitalization").

outpatient status goes smoothly.”⁷² Dr. Krumholz adds that hospitals generally have not, until recently, tracked patients after discharge and that rather than reinstitute longer hospitalizations, the better remedy is to develop systems that make discharges safer.⁷³

As studies have highlighted the high rate, adverse impact, and significant costs of hospital readmissions, pilot programs have emerged to help prevent avoidable readmissions.⁷⁴ Furthermore, as previously noted, the PPACA seeks to reduce preventable readmissions as part of its effort to control health care costs and improve patient safety by reducing payments to hospitals with “excess readmissions.”⁷⁵ In addition, The Joint Commission, which accredits and certifies more than 18,000 health care organizations and programs in the United States and is widely recognized as a guardian of the quality of health care, has also recognized the importance of enhancing the quality of post-discharge care.⁷⁶ In its 2011 Annual Report on quality and safety standards governing hospitals, The Joint Commission noted the inclusion of the performance measure of “[p]ost discharge continuing care plan[s],”⁷⁷ which assesses whether the hospital has such a plan in place and, as a separate measure, examines whether that plan was subsequently transmitted to its patients or to their community-based health care providers.⁷⁸

72. Ron Winslow, *The Revolving Door at the Hospital: While Patient Stays Shorten, Readmission Rates Rise; Where's the Savings?*, WALL ST. J., June 2, 2010, at D3 (quoting Dr. Krumholz in an interview). Dr. Krumholz further asserts that while shorter hospital stays may reduce up-front costs, the resulting larger “downstream costs” have led to an overall increase in health care costs. *Id.*

73. *Id.*

74. See Johnson, *supra* note 13 (discussing pilot programs that will allow nurses to be alerted electronically when signs of heart failure arise); see also *supra* note 18. Of course, not all hospital readmissions are preventable. See Walraven et al., *supra* note 25, at 1211–13 (analyzing data and concluding that only a portion of readmissions are avoidable). A parallel approach to prevent readmissions involves the establishment of “medical homes” for patients, where community-based physicians provide direction, and their staff is expected to contact patients at home and coordinate care. See Mathews, *supra* note 30 (explaining the benefits of establishing “medical home[s]” for patients, and the role of medical staff). Such efforts are reportedly hindered by a lack of funding. See *id.* (explaining that one difficulty with the “medical home” approach is procuring insurance company reimbursements for related expenses). In addition, these physicians are often not well positioned to provide these services. See *infra* Part III (reviewing the history of the modern hospital business model and advancing the idea of a fiduciary hospital-patient relationship much like the fiduciary doctor-patient relationship).

75. See *supra* notes 11–12 and accompanying text.

76. See BARRY R. FURROW ET AL., HEALTH LAW 131 (2000) (explaining that The Joint Commission accredits hospitals and that quality assurance requirements and improvement programs are included in the accreditation standards).

77. JOINT COMM'N, IMPROVING AMERICA'S HOSPITALS: THE JOINT COMMISSION'S ANNUAL REPORT ON QUALITY AND SAFETY 35 (2011).

78. See *id.* at 35 (defining a post discharge continuing health plan as “[c]ommunication from the hospital to the next health provider after a patient is

Given all that is known about the frequency, severity, and costs of preventable post-discharge injuries, there can be little doubt that they pose a serious problem, both for individual patients and the health care system as a whole. Unfortunately, the predominant existing legal remedies offer little hope of providing a satisfactory remedy.⁷⁹

II. APPLICABILITY OF CURRENT LEGAL DOCTRINES TO POST-DISCHARGE INJURY

Several legal tools are currently available to discharged patients who believe they have been wrongfully injured by the acts or omissions of their health care provider, including lawsuits that target (1) the patient's physician, asserting the physician failed to meet the relevant standard of care; (2) the discharging hospital, seeking to impose vicarious liability for the negligence of health care providers acting as the hospital's actual or apparent agents; and (3) the discharging hospital, attempting to hold it directly liable for a failure to take adequate steps to protect patients from harm.⁸⁰ This section briefly examines the capacity of each of these mechanisms to incentivize conduct that will reduce the likelihood of post-discharge

discharged from the hospital. The plan must contain the reason for hospitalization, main diagnosis at discharge, a list of medications at discharge, and recommendations for the next level of care").

79. Compelled action does not provide the only means for addressing these problems. Indeed, considerable attention has been given to educating and persuading relevant parties to voluntarily undertake efforts to address them. *See supra* notes 18, 74–78 and accompanying text (describing programs aimed to prevent avoidable readmissions). However, the continuing high rates of readmissions suggest that voluntary efforts have not been sufficient. *See supra* notes 6, 22–26, 50–73 and accompanying text (presenting the volume at which excessive rehospitalizations occur).

Based on currently available data, there is little reason to conclude that any of these approaches have been widely successful or have had a significant impact on changing current practices. *See supra* notes 6–8, 22–26, 51–73 and accompanying text (presenting the continued rate of post-discharge preventable accidents, and the disconnect between patient and hospital staff of patient's condition upon discharge). It may be that these penalties and rewards do not outweigh existing incentives. *See infra* Part II (applying current law to post-discharge injuries). Furthermore, none of these approaches provide compensation to injured patients. *See infra* Part III (exploring the fiduciary duty of modern hospitals).

80. With regard to hospitals specifically, they also could be subjected to a loss of Joint Commission accreditation or CMS certification. *See supra* notes 76–78 and accompanying text (explaining The Joint Commission's requirements and analysis of post-discharge continuing care plans). However, there is little indication that accreditation will be withheld from a hospital for a failure to engage in post-discharge activities. Similarly, the federal government can withhold payments from hospitals with excess readmission rates, although there are few signs thus far that this has had a significant impact on readmission rates. *See supra* notes 11–12, 69 and accompanying text (discussing how programs have attempted to incentivize preventing readmissions by reducing funding to those entities with excessive readmission levels, but these efforts thus far have not proven successful).

injury and compensate patients who receive inadequate discharge and post-discharge assistance.

A. *Lawsuits Targeting the Patient's Physician*

Medical malpractice suits⁸¹ aimed at either the physician who treated the patient while hospitalized or the patient's community-based physician might seem, on their face, to provide a remedy that will compensate patients for post-discharge injury and encourage other physicians to better attend to the needs of their own discharged patients to avoid liability.⁸² Ostensibly, a physician who provided treatment to a patient while hospitalized and who was, or should have been, involved in the discharge process but failed to meet the requisite standard of care associated with hospital discharges could be found liable for resulting injuries incurred by the patient.⁸³ The

81. To establish a medical malpractice claim, traditionally the patient must first show that an express or implied patient-physician relationship existed at the time that the asserted malpractice occurred. *See* FURROW ET AL., *supra* note 76, at 260–61 (discussing the creation of an implied contract between patient and physician). Once the relationship is established, the physician must meet the applicable standard of care, typically defined as exercising the degree of skill, care, and diligence ordinarily provided by a physician with similar training under similar circumstances. *See id.* at 264–66 (explaining that liability relies on general negligence standards of care, which are in essence set by the medical profession itself). If a breach of the standard of care is the proximate cause of injuries to the patient, the patient is entitled to be compensated by the physician. *See id.* at 301 (presenting the elements of a malpractice tort claim).

82. *See* Hillary Rodham Clinton & Barack Obama, *Making Patient Safety the Centerpiece of Medical Liability Reform*, 354 NEW ENG. J. MED. 2205, 2205 (2006) (asserting that the tort system can improve patient safety by reducing injuries and increasing communication, while providing compensation for those injured).

83. *See, e.g.*, *Durflinger v. Artilles*, 727 F.2d 888, 890 (10th Cir. 1984) (affirming that physicians have a duty to exercise reasonable and ordinary care in making recommendations to discharge a patient); *Wickline v. State*, 239 Cal. Rptr. 810, 819 (Ct. App. 1986) (determining that when physicians discharge a patient they cannot avoid responsibility for the patient's care, even when the discharge reflects limitations imposed by a third party payer); *Hall v. Frankel*, 190 P.3d 852, 863–64 (Colo. App. 2008) (accepting a jury verdict finding physicians who controlled a patient's discharge to be negligent); *Durflinger v. Artilles*, 673 P.2d 86, 93 (Kan. 1983) (“Liability predicated upon negligent release of a patient . . . is a *medical malpractice* action.”); *Samuel v. Baton Rouge Gen. Med. Ctr.*, 757 So. 2d 43, 47–48 (La. Ct. App. 2000) (upholding a verdict that the discharge instructions given to a patient by the treating physician were inadequate and constituted a breach of care); *Bell v. N.Y.C. Health & Hosps. Corp.*, 456 N.Y.S.2d 787, 794 (App. Div. 1982) (“[It is a physician's] duty to rest his decision to release the patient upon a careful and competent examination”).

Alternatively, the failure to provide discharge and post-discharge assistance could be framed as a breach of a physician's duty not to abandon a patient, which in turn could serve as a basis for imposing license-related sanctions. *See* AMA CODE OF MED. ETHICS Opinion 10.01(5) (1993) (recognizing patients' right to continuity of health care “as long as further treatment is medically indicated”). However, hospitals are not subject to these ethical codes or their sanctions, and physicians are generally not the best-positioned parties to supply this assistance. *See infra* notes 87–95 and accompanying text (explaining the difficulties in holding hospitals to these ethical

fact that an injury to a patient does not manifest until sometime after the patient's discharge does not present an inherent obstacle to a traditional malpractice suit against the hospital-linked physician.⁸⁴ Alternatively, a community-based physician with whom the patient had established a continuing physician-patient relationship prior to hospitalization could be held liable for post-discharge injuries if that physician failed to meet the standard of care applicable under such circumstances, for example, by failing to schedule a needed appointment or otherwise adequately monitor the patient following discharge.⁸⁵ Thus, when the medical malpractice of these physicians is arguably the cause of a post-discharge injury, it would seem that a well-established mechanism is in place to provide a remedy.⁸⁶

codes, as well as the difficulties of identifying the treating doctor and requiring these doctors to implement post-discharge support on a wide-spread basis).

84. WILLIAM L. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 248 (4th ed. 1971) (explaining that proximate cause is not time-sensitive; liability can be incurred so long as the "'condition' remains static"). Additionally, the statute of limitations for filing medical malpractice suits typically does not begin to run until patients discover or should have discovered that they suffered harm. FURROW ET AL., *supra* note 76, at 300–01.

85. *See, e.g.,* Dunning v. Kerzner, 910 F.2d 1009, 1015 n.8 (1st Cir. 1990) (recognizing and citing other courts that have determined that a physician's duty of care encompasses follow-up care); *Lauderdale v. United States*, 666 F. Supp. 1511, 1515 (M.D. Ala. 1987) (determining that a physician has a responsibility to stress the importance of returning for a follow-up appointment to assess the effectiveness of a tentative treatment for a serious condition); *Cox v. Jones*, 470 N.W.2d 23, 26 (Iowa 1991) (stating that a physician who "leaves a patient in a critical stage of a disease without reason or sufficient notice to enable the patient to secure another physician" is liable).

86. An informed consent cause of action might also be pursued against a physician for failing to adequately disclose the risks associated with discharge and steps that should be taken to minimize them. *See, e.g.,* Bubb v. Brusky, 768 N.W.2d 903, 923–24 (Wis. 2009) (explaining that a physician failed to adequately inform the patient when he did not present alternate forms of treatment before discharging the patient). However, this cause of action is usually associated with the commencement of treatment rather than its conclusion. *See, e.g.,* *Hall*, 190 P.3d at 864–65 (stating that informed consent claims often arise out of a performed procedure, while those arising from a misdiagnosed condition are often negligence claims); *see also* Thomas L. Hafemeister & Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U. L. REV. 1167, 1205–06 (2009) (explaining that lawsuits focusing on the nondisclosure of an emergent medical risk should consider both the time during and after the period of treatment). Further, this cause of action can generally only be brought against the treating health care provider rather than the hospital where treatment was provided. *See* FURROW ET AL., *supra* note 76, at 338 (noting that hospitals have no duty to obtain informed consent); *see, e.g.,* *Sherwood v. Danbury Hosp.*, 896 A.2d 777, 791 (Conn. 2006) (finding that nearly every jurisdiction that has considered the issue has concluded that it is the nonemployee treating physician's duty and not the hospital's to obtain the patient's informed consent when necessary). *But see* *Sherwood*, 896 A.2s at 790–91 & n.19 (leaving open the possibility that the involvement of hospital-employed nurses or physicians may give rise to a hospital's vicarious duty to obtain informed consent).

Alternatively, a cause of action might allege the discharge effectively constituted patient abandonment. *See supra* note 83 (noting a physician's duty not to abandon a

Yet evidence suggests that post-discharge injury, despite being relatively easy to prevent in many cases, is often not readily attributable to the negligence of a particular physician. Patients can be injured as a result of forgetting or misunderstanding instructions about post-discharge activities, missing or never scheduling important follow-up appointments and procedures, or failing to recognize warning signs in time to avoid severe complications.⁸⁷ While

patient after forming a physician-patient relationship); *see also Ending the Patient-Physician Relationship*, AM. MED. ASS'N, <http://www.ama-assn.org/ama/pub/physician-resources/legal-topics/patient-physician-relationship-topics/ending-patient-physician-relationship.page> (last visited Feb. 20, 2013) (“Once a patient-physician relationship is begun, a physician generally is under both an ethical and legal obligation to provide services as long as the patient needs them.”). Here too, such a suit would generally only be able to reach a treating physician rather than the hospital. In addition, hospital-linked physicians will argue that their relationship was understood to terminate at discharge, and community-based physicians will argue their relationship was superseded when the patient was hospitalized and does not resume until they again provide medical services to the patient. *See, e.g., Ricks v. Budge*, 64 P.2d 208, 211–12 (Utah 1937) (recognizing that the law allows for a physician’s obligations to cease when, for example, the patient-doctor relationship ends); FURROW ET AL., *supra* note 76, at 260 (“[Physicians] have no obligation to offer . . . services outside the scope of the original physician-patient agreement . . .”).

A patient might also bring a cause of action pursuant to the Emergency Medical Treatment and Labor Act (EMTALA), which authorizes private rights of action if a patient who has come to a hospital’s emergency department (ED) is not appropriately screened and is discharged or transferred without an emergency medical condition being stabilized. *See* 42 U.S.C. § 1395dd(a), (b), (d)(2)(A), (d)(2)(B) (2006) (requiring hospitals to screen and stabilize emergency conditions, and allowing for civil actions to be brought against a hospital for injury stemming from a failure to do so). However, if the patient’s emergency medical condition has been stabilized, as is typically the case at discharge, EMTALA is not applicable. *See, e.g., Cleland v. Bronson Health Care Grp., Inc.*, 917 F.2d 266, 271 (6th Cir. 1990) (concluding that Congress did not require emergency rooms to continue treatment when a patient is believed to be stable); *Morgan v. N. Miss. Med. Ctr., Inc.*, 458 F. Supp. 2d 1341, 1357 (S.D. Ala. 2006) (“EMTALA does not require a hospital to diagnose a patient’s medical conditions properly or to treat them competently . . .”), *aff’d*, 225 F. App’x 828 (11th Cir. 2007). *But see* Special Responsibilities of Medicare Hospitals in Emergency Cases: Application to Inpatients—Admitted Emergency Patients, 67 Fed. Reg. 31,105, 31,496 (May 9, 2002) (stating that a hospital’s special responsibilities under EMTALA are satisfied after it documents the stabilization of a patient admitted as an inpatient with an unstable emergency medical condition). Furthermore, some courts have ruled that EMTALA only governs discharges or transfers from the ED, and thus is not applicable to discharges from elsewhere within the hospital. *See Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1135 (6th Cir. 1990) (ascertaining that Congress intended for the requirements of the Act to only pertain to the ED, and not to the other parts of the hospital).

87. *See, e.g.,* COMM. ON HEALTH LITERACY & BD. ON NEUROSCIENCE & BEHAV. HEALTH, HEALTH LITERACY: A PRESCRIPTION TO END CONFUSION 19 (Lynn Nielsen-Bohlman et al. eds., 2004) [hereinafter HEALTH LITERACY] (recounting an instance where a mother could not determine how her two-year-old daughter should take her prescribed medication for an ear infection and simply poured the antibiotic into her child’s ear); Amita Chugh et al., *Better Transitions: Improving Comprehension of Discharge Instructions*, 25 FRONTIERS HEALTH SERVS. MGMT. 11, 12 (2009) (telling the story of a distraught older man who admitted he had not been taking his pills to manage his heart condition because he had never learned how to read and thus could not understand

physicians may have a duty to adequately instruct patients about post-discharge care,⁸⁸ instructions alone are often not enough to avert avoidable patient injury.⁸⁹ In addition, the patient's hospital physician may not even be involved in the discharge process, with hospital staff generally responsible for discharge preparations.⁹⁰ Even when physicians are involved, it may be difficult to ascertain which of multiple physicians who provided treatment to a patient during a hospital stay failed to adequately prepare the patient for discharge.⁹¹

Further, it would be unreasonable to expect hospital-linked or community-based physicians to effectively monitor and provide post-discharge support to discharged patients on a wide-spread basis.⁹²

the accompanying instructions); Carol Einhorn, *Do Our Patients Hear What We Teach?*, ONCOLINK, <http://www.oncolink.org/coping/article.cfm?c=1&s=39&ss=85&id=456> (last modified June 24, 2005) (detailing a situation where a patient, despite being given repeated instructions on how to dress a wound and stating that he understood the instructions, was found applying the wrapper and throwing away the dressing itself).

88. See *supra* note 83 and accompanying text. But see *supra* note 86 (noting that hospital-linked physicians may assert that their duties are limited to the duration of the hospitalization).

89. See *supra* note 87. Moreover, action or inaction by a patient that could not reasonably have been foreseen will generally be viewed as an intervening cause that relieves the physician of liability. See *Bell v. N.Y.C. Health & Hosps. Corp.*, 456 N.Y.S.2d 787, 796–97 (App. Div. 1982) (reiterating that intervening acts can relieve a defendant from liability, but also noting that if the intervening act was “set in motion” by the defendant’s acts then the defendant will not be relieved of liability); *FURROW ET AL.*, *supra* note 76, at 296 (stating that the doctrine of contributory negligence may apply when a patient fails to follow a physician’s instructions, including failing to see the physician or another health care provider as instructed). However, “[c]ourts are reluctant to apply contributory negligence too liberally[,] . . . [thus foreseeable] [n]on-cooperation with the physician’s orders will mitigate damages, but not relieve the physician of responsibility.” *FURROW ET AL.*, *supra* note 76, at 296.

90. See, e.g., *Hall*, 190 P.3d at 863–64 (refusing to hold a physician’s assistant and pulmonologist liable because they were not involved in the patient’s final discharge).

91. See, e.g., *Germaine v. Yu*, 854 N.Y.S.2d 730, 732 (App. Div. 2008) (explaining that a physician was relieved of responsibility for discharge after transferring care of the patient to another physician). Although the joint tortfeasor doctrine is designed to prevent health care providers from avoiding liability when negligence has occurred and multiple health care providers were involved in the patient’s treatment, it can be difficult for a patient to prevail under this doctrine. See *FURROW ET AL.*, *supra* note 76, at 303 (defining joint tortfeasors as parties whose acts together cause an injury but remarking that “[a]llocating responsibility among several tortfeasors is complicated”); Martin B. Adams & Glenn W. Dopf, *Selected Topics in Damages in Personal Injury Actions*, 465 PRACTISING L. INST.: LITIG. & ADMIN. PRAC. COURSE HANDBOOK SERIES: LITIG. 55, 116–31 (1993) (discussing liability of initial and subsequent tortfeasors and the allocation of liability among tortfeasors); S. Y. Tan, Comment, *The Medical Malpractice Crisis: Will No-Fault Cure the Disease?*, 9 U. HAW. L. REV. 241, 259–60 (1987) (“Because of the inequities involved in the application of joint and several liability, a limitation on the common law doctrine is appropriate.”).

92. Community-based physicians may not have been in contact with their patient while the patient was hospitalized. Indeed, they may not even be aware of the hospitalization, particularly if it followed a medical emergency. Arguably, their responsibility to the patient will not resume until they receive notice that the patient has been discharged from the hospital and they are once again the patient’s treating physician. Failure to provide this notice contributes to the frequent absence of

This relatively complex and resource-dependent task is beyond what most physicians are equipped, situated, and able to administer.⁹³ Furthermore, even in institutions where such support is currently provided, physicians typically are not directly involved.⁹⁴ In addition, post-discharge assistance is not something physicians have customarily provided patients, the sine qua non for a successful medical malpractice suit.⁹⁵ Thus, patients will find it difficult to establish that a physician's failure to monitor constituted a breach of the standard of care, making a malpractice suit an unlikely vehicle to promote the delivery of such services or to compensate patients for associated injuries.

B. Lawsuits Targeting the Discharging Hospital Seeking to Hold It Liable for the Negligence of Its Agents

Similar problems arise in attempting to hold the treating hospital liable for post-discharge injury under the available doctrines of vicarious liability and apparent or ostensible agency.⁹⁶ The doctrine of respondeat superior holds a hospital vicariously liable for the acts or omissions of hospital-employed physicians, nurses, or other staff

continuing care being provided to discharged patients. *See supra* Parts I–II; *see also* Overland, *supra* note 18 (“Follow-up appointments with patients’ primary care providers are rarely scheduled, and primary care physicians often never know their patients were admitted to the hospital.”).

93. Coleman & Berenson, *supra* note 26, at 533 (noting that clinicians rarely have sufficient information to monitor or intervene); *see also* Bodenheimer, *supra* note 26, at 1068 (“Practice improvements often fail because they rely on the willingness of physicians, who are already too busy, to take on additional work.”); Mathews, *supra* note 30, at B.1 (asserting that placing the monitoring responsibility on community-based physicians has the potential to bankrupt many who are already struggling with their bottom lines).

94. *See, e.g.*, Darkins et al., *supra* note 18, at 1120 (explaining that the Veterans Health Administration’s Care Coordination/Home Telehealth model provides care that is actively coordinated by a cadre of nurses and social workers).

95. John W. Ely et al., *Determining the Standard of Care in Medical Malpractice: The Physician’s Perspective*, 37 WAKE FOREST L. REV. 861, 862 (2002) (ascertaining that physicians’ standard of care is based on what constitutes “customary” practice, which is “what physicians would customarily or typically do in similar circumstances”); *see, e.g.*, Gross v. Burt, 149 S.W.3d 213, 227 (Tex. App. 2004) (holding that a patient’s visit to the hospital does not necessarily impose a duty on treating physicians to continue care beyond that stay because “there would be no end to the physician-patient relationship”).

96. Courts tend to use the phrases “apparent agency” and “ostensible agency” interchangeably. *See, e.g.*, Sanchez v. Medicorp Health Sys., 618 S.E.2d 331, 333 (Va. 2005) (defining apparent or ostensible agency (agency by estoppel) as “[a]n agency created by operation of law and established by a principal’s actions that would reasonably lead a third person to conclude that an agency exists” (citation omitted)).

members if they negligently injure a patient while acting within the scope of their employment.⁹⁷ Nonetheless,

[t]raditionally, the respondeat superior theory does not hold the hospital liable for the tort, or professional negligence, of an independent contractor, based upon the reasoning that the contractor is not subject to the employer's right to control the details of the work. Hence, a staff doctor having no more relationship to the hospital than a staff appointment is solely responsible for his [or her] personal malpractice or negligence⁹⁸

Even when it can be established that it was an employee of the hospital who failed to take adequate steps in conjunction with the discharge decision, courts have generally not imposed a corresponding duty to provide post-discharge monitoring.⁹⁹

Alternatively, the apparent or ostensible agency doctrine holds that if a patient is led by a hospital's behavior to justifiably believe that a physician is acting pursuant to authority specifically delegated by the hospital, the hospital can be held liable for the actions of its apparent or ostensible agent, including those of a physician who is actually an independent contractor.¹⁰⁰ Although this doctrine

97. See, e.g., *Lewis v. State*, 983 So. 2d 231, 235–36 (La. Ct. App. 2008) (finding that a nurse breached the standard of care by failing to identify the patient's elevated blood pressure immediately prior to discharge, communicate this to the treating physicians, and retake vital signs prior to discharge, and that this breach contributed to the patient's death). Historically, hospitals were immune from liability for medical malpractice that occurred on site. See FURROW ET AL., *supra* note 76, at 374 (describing the traditional relationship of a physician to a hospital as that of an independent contractor rather than an employee, with the physician the subject of malpractice liability rather than the hospital). This immunity has eroded as hospitals have come to play a more active and integral role in the delivery of care. See Arthur F. Southwick, *The Hospital as an Institution: Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W. L. REV. 429, 440 n.23 (1973).

98. Southwick, *supra* note 97, at 440. This rule does not apply when the health care provider is an employee of the hospital, and hospitals have been held liable when their employees fail to take adequate steps to prevent the premature discharge of a patient. See, e.g., *Koeniguer v. Eckrich*, 422 N.W.2d 600, 602–03 (S.D. 1988) (ruling summary judgment was improperly granted to a hospital when it was claimed that the hospital's nursing staff failed to adequately question a physician's discharge of a patient with a high fever).

99. See, e.g., *Lewis*, 983 So. 2d at 236 (“[I]t is unnecessary to address if [the hospital-employed nurse] . . . had a continued duty to monitor [the patient's] blood pressure/vital signs post discharge.”).

100. RESTATEMENT (SECOND) OF AGENCY § 267 (1958) (“One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.”). In evaluating whether apparent agency exists, a court must determine whether the hospital's actions “would lead a reasonable person to conclude that the individual who was alleged to be negligent was an employee or agent of the hospital” *Pamperin v. Trinity Mem'l Hosp.*, 423 N.W.2d 848, 856 (Wis. 1988). These requirements are, at least in some

provides an avenue for holding a hospital liable for the negligent acts of health care providers providing services within the hospital¹⁰¹ (such as an independent contractor physician who prematurely discharges a patient or provides negligent discharge instruction), physician or staff negligence is often not the primary cause of post-discharge injury.¹⁰²

C. Lawsuits Targeting the Discharging Hospital Seeking to Hold It Directly Liable for Failing to Take Adequate Steps to Protect Its Patients from Harm

Hospital corporate liability, a doctrine that has been used somewhat interchangeably with the inherent function test, the non-delegable duty doctrine, and hospital enterprise liability,¹⁰³ is a potentially more comprehensive approach for assigning liability to a hospital, as it imposes direct duties on hospitals with respect to patient care that are independent of those that arise out of the hospital's relationship with its physicians or staff.¹⁰⁴ In the seminal

jurisdictions, becoming easier to satisfy, resulting in an overall expansion of hospital liability. *See, e.g.*, *Ermoian v. Desert Hosp.*, 61 Cal. Rptr. 3d 754, 780 (Ct. App. 2007) (requiring only that "(1) the service of the physician is performed on what appears to be the hospital's premises; (2) a reasonable person in [the] plaintiff's position would believe that the physician's services are part and parcel of [the] services provided by a hospital; and (3) the hospital does nothing to dispel this belief"); *Mejia v. Cmty. Hosp. of San Bernardino*, 122 Cal. Rptr. 2d 233, 237 (Ct. App. 2002) ("[O]stensible agency is readily inferred."); *Kashishian v. Port*, 481 N.W.2d 277, 282 (Wis. 1992) (concluding that hospitals can be held liable in malpractice suits under the doctrine of apparent authority beyond the emergency room context).

101. *See* Starlett M. Miller & Derek M. Daniels, *The Broad Extension of Hospital Liability*, 2 PROF. LIABILITY DEF. Q. 1, 6-7 (2010) (reviewing the application of vicarious liability under various state laws to a hospital's independent contractor physicians and determining that a hospital may be found vicariously liable when its independent contractors act as agents).

102. *See supra* notes 87-95 and accompanying text (reviewing the many causes of patient injury).

103. *See, e.g.*, *Jackson v. Power*, 743 P.2d 1376, 1385 (Alaska 1987) (recognizing that the hospital had a "non-delegable duty to provide non-negligent physician care in its emergency room"); *Beeck v. Tucson Gen. Hosp.*, 500 P.2d 1153, 1158 (Ariz. Ct. App. 1972) (finding that an employee-employer relationship was established when a radiologist performed a service that was an inherent function of the hospital); *Whittington v. Episcopal Hosp.*, 44 Pa. D. & C. 4th 449, 455 (Pa. Ct. Com. Pl. 2000) (explaining that the corporate negligence doctrine "creates a nondelegable duty which the hospital owes directly to the patient"), *aff'd*, 768 A.2d 1144 (Pa. Super. Ct. 2001); FURROW ET AL., *supra* note 76, at 386 (noting that the judicial expansion of the vicarious liability doctrine has made the medical professionals who use the hospital part of the "enterprise," even if they are independent contractors); Philip G. Peters, Jr., *Resuscitating Hospital Enterprise Liability*, 73 MO. L. REV. 369, 369 (2008) (asserting that hospital enterprise liability makes hospitals liable for all injuries occurring in the hospital regardless of the employment status of the health care provider involved, and such liability should uniquely improve the quality of hospital care).

104. *See* FURROW ET AL., *supra* note 76, at 393 (stating that hospitals have evolved into large institutions, which has expanded their tort liability exposure to vicarious liability and corporate negligence suits because their abilities to manage institutional behavior has increased significantly). Indeed, "[t]he non-delegable duty doctrine of

hospital corporate liability case, *Darling v. Charleston Community Memorial Hospital*,¹⁰⁵ the Illinois Supreme Court affirmed a jury's verdict awarding damages to a patient whose leg had to be amputated after a non-employee physician and hospital-employed nurses failed to note that a cast applied to the patient's leg impaired blood flow to his foot until the leg became gangrenous.¹⁰⁶ The court found the verdict supportable on the grounds that the hospital had negligently failed to review, supervise, and control the care provided, including the physician's work.¹⁰⁷ Criticizing the defendant's contention that the hospital's duty to the patient was limited to employing reasonable care in the selection of the physicians permitted to practice medicine within its facility and thus did not encompass a duty of continuing oversight of these physicians,¹⁰⁸ the court stated:

"The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility." The Standards for Hospital Accreditation, the state licensing regulations and the defendant's bylaws demonstrate that the medical profession and other responsible authorities regard it as both desirable and feasible that a hospital assume certain responsibilities for the care of the patient.¹⁰⁹

The court's reasoning in *Darling* has led a number of courts to adopt what is generally referred to as the hospital "corporate liability" doctrine and to recognize the existence of a number of duties that hospitals owe directly to patients.¹¹⁰ Over the past twenty-five years,

agency law, like the inherent function approach, is an exception to the independent contractor doctrine. It is typically allowed where the employer has a duty to protect others and delegates performance to an independent contractor." *Id.* at 380.

105. 211 N.E.2d 253 (Ill. 1965).

106. *Id.* at 255–56.

107. *Id.* at 258. The court also found the verdict supportable on grounds that the hospital negligently failed to employ an adequate number and quality of nurses to monitor and report the condition of the plaintiff's injured leg. *Id.*

108. *Id.* at 256.

109. *Id.* at 257 (citation omitted).

110. See, e.g., *Fridena v. Evans*, 622 P.2d 463, 466 (Ariz. 1980) (asserting that a hospital has a duty to oversee the competence of its staff, including doctors); *Elam v. Coll. Park Hosp.*, 183 Cal. Rptr. 156, 164 (Ct. App. 1982) (agreeing with decisions of courts in varying jurisdictions on the topic of corporate negligence for hospitals); *Candler Gen. Hosp., Inc. v. Purvis*, 181 S.E.2d 77, 79 (Ga. Ct. App. 1971) (explaining

these non-delegable duties of the hospital have tended to coalesce into the following:¹¹¹ “(1) a duty to use reasonable care in the maintenance of safe and adequate facilities and equipment”;¹¹² “(2) a duty to select and retain only competent physicians”;¹¹³ “(3) a duty to oversee all persons who practice medicine within its walls as to patient

that a commercial business transaction is not required for a visitor to a hospital to be an invitee and thus entitled to pursue a cause of action for negligence on the part of the hospital); *Felice v. St. Agnes Hosp.*, 411 N.Y.S.2d 901, 907 (App. Div. 1978) (ruling that even if doctors are not employees of the hospital, a hospital can be liable for the adverse effects of the doctors' treatment decisions); *Bost v. Riley*, 262 S.E.2d 391, 395–96 (N.C. Ct. App. 1980) (recognizing that a hospital may be liable to a patient under the doctrine of corporate negligence); *Thompson v. Nason Hosp.*, 591 A.2d 703, 707 (Pa. 1991) (defining corporate negligence as a “nondelegable duty which the hospital owes directly to [the] patient”); *Douglas v. Freeman*, 814 P.2d 1160, 1163–64 (Wash. 1991) (affirming that the duties owed by hospitals to patients include using reasonable care to maintain buildings and grounds, furnishing patient supplies and equipment without defects, selecting employees with reasonable care, and supervising all persons who practice medicine within the hospital); *Pedroza v. Bryant*, 677 P.2d 166, 170 (Wash. 1984) (upholding the adoption of the doctrine of corporate liability for hospitals). *But see* *Boyd v. Lynch*, 493 So. 2d 1315, 1318 (Miss. 1986) (concluding that “hospitals are not liable for medical malpractice liability since a hospital is not a person licensed as a physician”); *Strubhart v. Perry Mem'l Hosp. Trust Auth.*, 903 P.2d 263, 275–76 (Okla. 1995) (adopting a limited version of the doctrine of corporate liability for hospitals); *Barkes v. River Park Hosp., Inc.*, 328 S.W.3d 829, 832 (Tenn. 2010) (neither rejecting nor accepting the doctrine of corporate liability); David H. Rutchik, Note, *The Emerging Trend of Corporate Liability: Courts' Uneven Treatment of Hospital Standards Leaves Hospitals Uncertain and Exposed*, 47 VAND. L. REV. 535, 536–37 (1994) (advocating for a limited and clearly defined application of corporate liability to hospitals in malpractice suits).

111. *See* *Thompson*, 591 A.2d at 707 (setting out the four general areas of hospital duties); *see also* Barry R. Furrow, *Patient Safety and the Fiduciary Hospital: Sharpening Judicial Remedies*, 1 DREXEL L. REV. 439, 466 (2009) (stating the four general duties of hospitals as identified in *Thompson* (citing *Thompson*, 591 A.2d at 707)).

112. *Thompson*, 591 A.2d at 707; *see* *Candler Gen. Hosp., Inc.*, 181 S.E.2d at 79 (concluding that a worn metal strip on a step that caused a woman to fall constituted a breach of the hospital's duty); *Pullins v. Fentress Cnty. Gen. Hosp.*, 594 S.W.2d 663, 670 (Tenn. 1979) (determining that the hospital failed to protect its patients when a patient was bitten by a brown recluse spider while in her hospital bed).

113. *Thompson*, 591 A.2d at 707; *see also* *Horowitz v. Plantation Gen. Hosp. Ltd. P'ship*, 959 So. 2d 176, 180 (Fla. 2007) (reviewing other court rulings, concludes that a hospital has a duty to only hire and extend privileges to medically competent physicians); *Johnson v. Misericordia Cmty. Hosp.*, 301 N.W.2d 156, 163–64 (Wisc. 1981) (applying foreseeability rationale to impose a duty to exercise due care in the hiring of surgeons by a hospital). *But see* *Smith v. Pratt*, No. M2008-01540-COA-R9-CV, 2009 WL 1086953, at *4 (Tenn. Ct. App. Apr. 22, 2009) (reiterating that a hospital is not negligent simply because a negligent act was committed by a physician permitted to practice at that hospital (citing *Edmonds v. Chamberlain Mem'l Hosp.*, 629 S.W.2d 28, 30 (Tenn. Ct. App. 1981))).

care”;¹¹⁴ and “(4) a duty to formulate, adopt and enforce adequate rules and policies to ensure quality care for the patients.”¹¹⁵

These duties, at first glance, might appear broad enough to encompass a duty to exercise due care when discharging patients and to institute reasonable post-discharge monitoring of patients with continuing health risks. Certainly, a patient’s need for direction and assistance does not magically vanish once the patient has left the hospital’s grounds, particularly in this era of shortened hospital stays and early discharge.¹¹⁶ Thus, a component of a hospital’s duty to take steps to ensure the quality of the care provided patients should be to implement an appropriate discharge plan, provide information about subsequent risks and what to do if those risks arise, and avoid discharging patients prematurely.¹¹⁷ However, even here, courts have limited the application of this responsibility by requiring more than just proof that negligence occurred in a given case; instead, they have often mandated a showing of institutional negligence of a “systemic” nature.¹¹⁸ Moreover, courts appear reluctant to extend the corporate

114. *Thompson*, 591 A.2d at 707; *see Darling*, 211 N.E.2d at 261 (concluding that a hospital has a duty to instruct and supervise its staff members); *Barkes*, 328 S.W.3d at 834 (holding that the jury reasonably found that the hospital was negligent in failing to “implement a system of oversight and enforcement of its policies”).

115. *Thompson*, 591 A.2d at 707; *see Wood v. Samaritan Inst., Inc.*, 161 P.2d 556, 558 (Cal. 1945) (stating that the hospital’s duty to ensure patient care and safety is established as a matter of implied contract); *Barkes*, 328 S.W.3d at 835 (holding a hospital has a responsibility to oversee the activities of its emergency department through its policies and procedures); *O’Quin v. Baptist Mem’l Hosp.*, 201 S.W.2d 694, 697 (Tenn. 1947) (declaring that “a hospital is required to exercise such reasonable care toward a patient as his known condition may require”).

116. *See supra* note 27 and accompanying text (discussing “systems problems” associated with discharge).

117. *See, e.g., Whittington v. Episcopal Hosp.*, 44 Pa. D. & C. 4th 449, 455 (Pa. Ct. Com. Pl. 2000) (applying the corporate negligence doctrine, determined that a hospital could be held liable when, notwithstanding a diagnosis of preeclampsia, a pregnant patient was sent home with only a prescription for iron supplements and was not advised of the risks of preeclampsia despite her documented family history of preeclampsia), *aff’d*, 768 A.2d 1144 (Pa. Super. Ct. 2001); *see also Morrison v. Washington Cnty.*, 700 F.2d 678, 681, 683 (11th Cir. 1983) (noting that it was “the manner of discharge which is at issue in this case,” holding that a hospital can be held liable after transferring a patient who had initially sought treatment at the hospital for his diabetes but became agitated as a result of delirium tremens and at the direction of a physician was sent to a local jail without providing the jailer with any instructions, with the patient dying shortly thereafter, stating that “[w]e cannot agree that the hospital merely operates as a slavish handmaiden to the whims of physicians on its staff”); *Mason v. IHS Cedars Treatment Ctr.*, No. 05-98-00832-CV, 2001 WL 915215, at *8 (Tex. App. Aug. 15, 2001) (discussing duties hospitals owe to patients before discharge), *rev’d*, 143 S.W.3d 794 (Tex. 2004).

118. *See Edwards v. Brandywine Hosp.*, 652 A.2d 1382, 1387 (Pa. 1995) (stating that *Thompson* contemplates systemic negligence, where hospitals allow known incompetent physicians to practice (citing *Thompson*, 591 A.2d at 708)); *see also id.* at 1387–88 (requiring proof of the hospital’s knowledge of premature discharge, or

negligence doctrine beyond the physical grounds of a hospital,¹¹⁹ demonstrating little willingness to employ this doctrine to recognize a duty to supply reasonable post-discharge monitoring.¹²⁰ However, this leaves discharged patients essentially without a legal remedy for significant adverse events that could have been readily and reasonably prevented by an appropriately designed discharge process and post-discharge monitoring, and it provides hospitals with little legal incentive to supply such programs.

III. FIDUCIARY DUTIES OF HOSPITALS

A. *Fiduciary Duties in General*

Generally speaking, the object of fiduciary law is to protect and maintain important societal relationships that the “morals of the market place” would place in jeopardy.¹²¹ Although relatively

that its physicians were regularly making bad discharge decisions, for there to be liability); *Mazzarino v. Kushner*, 36 Pa. D. & C. 4th 517, 526 (Pa. Ct. Com. Pl. 1996) (“Even if the plaintiff had provided expert medical testimony sufficient to support her allegations of premature discharge and patient dumping, we would still grant summary judgment to the defendant . . . because her allegations do not involve institutional negligence of a systemic nature.”). *But see Whittington*, 44 Pa. D. & C. 4th at 459 (explaining that previous cases have rejected a requirement of “systemic” negligence to establish corporate liability by a hospital (citing *Welsh v. Bulger*, 698 A.2d 581, 586 (Pa. 1997))).

119. *See, e.g.*, *Jackson v. Power*, 743 P.2d 1376, 1385 (Alaska 1987) (limiting the court’s holding to instances when the patient actually comes to the hospital for treatment); *Insigna v. LaBella*, 543 So. 2d 209, 214 (Fla. 1989) (limiting a hospital’s liability to physician conduct that occurs during treatment in the hospital and refusing to extend that liability beyond the hospital premises); *Doe v. Garcia*, 961 P.2d 1181, 1193 (Idaho 1998) (concluding that any duty owed by a hospital extends only to activities by hospital employees on the hospital premises). *But see Riddle Mem’l Hosp. v. Dohan*, 475 A.2d 1314, 1318 (Pa. 1984) (maintaining that the hospital could be liable if the jury found it acted unreasonably in discharging the patient). Arguably, hospital “corporate liability” has been limited to the grounds of the hospital in part because initially this doctrine was focused on “slip-and-fall” cases where a patient sustained injury due to improperly maintained premises and in part because this provides a readily applied boundary on potential hospital liability. *See FURROW ET AL.*, *supra* note 76, at 382 (“The professional duty of a hospital is to provide a safe environment for patient diagnosis, treatment, and recovery. If an unsafe condition of the hospital’s premises causes injury to a patient, as a result of the hospital’s negligence, the hospital has breached its duty *qua* hospital.” (citations omitted)); *see also DiTeresi v. Stamford Health Sys., Inc.*, No. FSTCV065001340S, 2010 WL 5493514, *7–13 (Conn. Super. Ct. Dec. 14, 2010) (addressing a premises’ liability claim against a hospital for an unsafe condition following the sexual assault of a patient by a staff member).

120. *See, e.g.*, *Lewis v. State*, 983 So. 2d 231, 236 (La. Ct. App. 2008) (finding it unnecessary to address whether the hospital had a continuing duty to monitor the patient after discharge).

121. *Meinhard v. Salmon*, 164 N.E. 545, 546 (N.Y. 1928) (explaining that fiduciary obligations require individuals to remain loyal in a way that morals alone cannot); *see also Tamar Frankel, Fiduciary Law in the Twenty-First Century*, 91 B.U. L. REV. 1289,

unexplored,¹²² this doctrine imposes special obligations on those assuming specific roles in relationships deemed critical for an ordered and humane society, gives special rights to those to whom these obligations are owed, and establishes specific legal remedies when these obligations are not fulfilled.¹²³ In addition to its relatively lengthy history,¹²⁴ “[a] hallmark of fiduciary law is its flexibility to accommodate new situations as they arise,”¹²⁵ and to redress situations “where the ordinary laws of contract, tort and unjust enrichment are silent or insufficient.”¹²⁶

Relationships recognized as fiduciary in nature tend to be those in which one party, the beneficiary, is especially vulnerable and dependent upon another party, the fiduciary, who is expected to loyally employ specialized knowledge, skills, and power over some aspect of the beneficiary’s affairs to further the beneficiary’s

1291 (2011) (identifying the importance of trust and truthfulness as the basis for fiduciary duties).

122. See Tamar Frankel, *Fiduciary Law*, 71 CALIF. L. REV. 795, 796 (1983) (reporting that not much has been written on the origins and remedies of fiduciary duties); Leonard I. Rotman, *Fiduciary Law’s “Holy Grail”: Reconciling Theory and Practice in Fiduciary Jurisprudence*, 91 B.U. L. REV. 921, 923 (2011) (noting that fiduciary law is often “characterized as one of the least understood of all legal constructs”).

123. Furrow, *supra* note 111, at 440–41; see Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians to “Just Say No” if an “Informed” Patient Demands Services that Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 367–68 (2009) (listing the range of relationships encompassed by a fiduciary duty, including relationships of trust, such as agency relationships).

124. See Thomas L. Hafemeister & Sarah Payne Bryan, *Beware Those Bearing Gifts: Physicians’ Fiduciary Duty To Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491, 519, n.168 (2009) (noting that the fiduciary duty is rooted in the common law of trusts); Rotman, *supra* note 122, at 922 (citing the 1726 English decision of Keech v. Sandford, (1726) 25 Eng. Rep. 223, 223–24, as establishing fiduciary law as part of the common law).

125. Hafemeister & Bryan, *supra* note 124, at 519; see also Frankel, *supra* note 121, at 1290 (describing the accommodating and adjustable nature of fiduciary law in light of changes in social mores, while still maintaining its core values and norms).

126. Rotman, *supra* note 122, at 922. At the same time, courts have rejected fiduciary duty claims brought against health care providers when claimants fail to identify a duty beyond that already encompassed by a medical malpractice or informed consent claim. See, e.g., *Iacangelo v. Georgetown Univ.*, 760 F. Supp. 2d 63, 65–66 (D.D.C. 2011) (finding Plaintiff’s claim for breach of fiduciary duty to be encompassed by its other claims); *Neade v. Portes*, 739 N.E.2d 496, 500–01 (Ill. 2000) (citing examples of cases where courts determined breach of fiduciary duty claims were duplicative); *Hart v. Wright*, 16 S.W.3d 872, 877–78 (Tex. App. 2000) (determining breach of fiduciary duty claim was not factually independent from the plaintiff’s medical malpractice claim). *But see Birriel v. Odeh (In re Odeh)*, 431 B.R. 807, 813 (Bankr. N.D. Ill. 2010) (distinguishing the fiduciary claim at issue as qualitatively different from a medical malpractice claim and noting that the core of the fiduciary claim alleges that the physician “abused a position of power and confidence in a manner quite distinct from the quality of the medical services he rendered”).

interests.¹²⁷ Fiduciary law is routinely applied to relationships where one party is “charged with selflessly acting in the best interests of another,” including relationships between directors and corporations, parents and children, and lawyers and their clients.¹²⁸ Absent a fiduciary obligation, these relationships are ripe for exploitation by the fiduciary or others, potentially exposing the beneficiary to great harm and undercutting the purpose that the relationship was designed to serve.¹²⁹

As a result, a fiduciary duty is generally construed to be “[a] duty of utmost good faith, trust, confidence, and candor[,] . . . a duty to act with the highest degree of honesty and loyalty toward another person and in the best interests of the other person”¹³⁰ Because of the trust placed in the fiduciary, the fiduciary is expected to protect and promote the interests of the beneficiary even when this may require actions counter to the interests of the fiduciary.¹³¹ In addition, “fiduciaries [generally] have a duty to disclose to competent beneficiaries any information relevant to fulfilling their fiduciary obligations.”¹³²

127. See Furrow, *supra* note 111, at 441–42 (describing a fiduciary as a “super” agent); see, e.g., *Jarvis v. Lieder*, 978 A.2d 106, 115 (Conn. App. Ct. 2009) (pointing to the unique level of trust and confidence, along with a superior level of knowledge, skill, or expertise in one party, that characterizes the fiduciary relationship); see also Hafemeister & Gulbrandsen, *supra* note 123, at 368 (noting the recognition of fiduciary duties when one party is entrusted with the welfare of someone who is relatively vulnerable); Hafemeister & Spinos, *supra* note 86, at 1187 (finding that fiduciaries have specialized knowledge and the ability to deliver needed services not routinely available); Rotman, *supra* note 122, at 921 (“[Fiduciary law has been] applied solely in regard to socially or economically important or necessary interactions of high trust and confidence creating implicit dependency and peculiar vulnerability.”).

128. Leonard I. Rotman, *Is Fiduciary Law Efficient? A Preliminary Analysis* 7 (Oct. 8, 2009) (unpublished manuscript), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1485853; see also Frankel, *supra* note 122, at 795 (“Fiduciaries appear in a variety of forms, including agents, partners, directors and officers, trustees, executors and administrators, receivers, bailees, and guardians.”); Hafemeister & Gulbrandsen, *supra* note 123, at 367–68 (ascertaining fiduciary relationships cover a broad range of relationships).

129. See Frankel, *supra* note 121, at 1293–94 (cautioning that entrustment poses the serious and potentially harmful risks that fiduciaries will misuse entrusted property and power, not possess their claimed expertise, or not exercise their expertise well or at all).

130. BLACK’S LAW DICTIONARY 581 (9th ed. 2009).

131. Hafemeister & Gulbrandsen, *supra* note 123, at 368; Hafemeister & Spinos, *supra* note 86, at 1187; Sharona Hoffman & Jessica Wilen Berg, *The Suitability of IRB Liability*, 67 U. PITT. L. REV. 365, 393 (2005).

132. Hafemeister & Spinos, *supra* note 86, at 1188.

B. *The Fiduciary Duties of Physicians*

It is now widely asserted that fiduciary law also encompasses the relationships between physicians and their patients.¹³³ As early as 1956, a California Court of Appeals declared that “[t]he doctor-patient relationship is a fiduciary one,”¹³⁴ and many courts have recognized over the years that physicians owe a fiduciary duty to their patients because of the “intrinsic nature” of the physician-patient relationship.¹³⁵ This fiduciary obligation stems from patients’ dependency on their physicians for medical treatment, physicians’ superior medical expertise, and the trust society and patient impart to their physicians.¹³⁶ A related justification for imposing a fiduciary duty on physicians is that patients are not trained to diagnose their own medical conditions, so they must rely on their doctors for medical treatment.¹³⁷

A claim for a breach of a physician’s fiduciary duty to a patient will generally sound in tort,¹³⁸ with four required elements: “(1) the existence of a fiduciary duty, (2) a breach of that duty, (3) damages

133. See, e.g., Andrew Grubb, *The Doctor as Fiduciary*, 47 CURRENT LEGAL PROBS. 311, 311 (1994) (describing physicians’ fiduciary relationship with their patients); Hafemeister & Bryan, *supra* note 124, at 520 (noting that a fiduciary relationship exists between a physician and patient that places certain obligations on the physician); Hafemeister & Gulbrandsen, *supra* note 123, at 369–86 (explaining the history of the fiduciary relationship between doctors and patients and noting that many courts have recognized this relationship); Hafemeister & Spinos, *supra* note 86, at 1188–92 (discussing the legal precedent underlying the fiduciary relationship between a doctor and patient, including the duty of informed consent and duty to disclose emergent medical risks); Charity Scott, *Doctors as Advocates, Lawyers as Healers*, 29 HAMLIN J. PUB. L. & POL’Y 331, 337 (2008) (“This concept of the physician as fiduciary has become well accepted in both U.S. law and the ethical tenets of American professional medical associations.”).

134. *Wohlgemuth v. Meyer*, 293 P.2d 816, 820 (Cal. Ct. App. 1956); see also *Groendal v. Westrate*, 137 N.W. 87, 88 (Mich. 1912) (noting patients’ reliance on their physicians); *Schmucking v. Mayo*, 235 N.W. 633, 633 (Minn. 1931) (recognizing a fiduciary relationship between a physician and patient due to patients’ dependence on physicians); Hafemeister & Gulbrandsen, *supra* note 123, at 369 n.171 (citing precedents explicitly recognizing a fiduciary duty owed by a physician to a patient).

135. Hafemeister & Gulbrandsen, *supra* note 123, at 369; see, e.g., *Birriel v. Odeh (In re Odeh)*, 431 B.R. 807, 813 (Bankr. N.D. Ill. 2010) (finding a fiduciary relationship between a patient and his or her doctor); *Gonzales v. Palo Verde Mental Health Servs.*, 783 P.2d 833, 835 (Ariz. Ct. App. 1989) (same); *DiTeresi v. Stamford Health Sys., Inc.*, No. FSTCV065001340S, 2010 WL 5493514, at *31 (Conn. Super. Ct. Dec. 14, 2010) (same); *Hart v. Wright*, 16 S.W.3d 872, 877 (Tex. App. 2000) (acknowledging that “a fiduciary relationship might exist between a physician and patient in special circumstances”).

136. Hafemeister & Gulbrandsen, *supra* note 123, at 369–70.

137. See Hafemeister & Spinos, *supra* note 86, at 1186 (describing physicians as the “gatekeepers” to treatment because they possess critical information).

138. See Hafemeister & Gulbrandsen, *supra* note 123, at 375 (ascertaining that a breach of a fiduciary duty is usually viewed as a tort). *But see id.* at 375 n.197 (noting that a breach of fiduciary duty may constitute a contractual violation because a fiduciary breach violates the parties’ expectations).

(harm) incurred by the person to whom that duty was owed, and (4) a causal link between the breach and the resulting harm.”¹³⁹ Among the fiduciary duties physicians owe patients are obligations to keep medical information and records confidential and private, to not engage in a sexual relationship with a current patient, to exercise independent medical judgment during the course of the physician-patient relationship, to avoid conflicts of interests that may compromise medical judgment, and to disclose to a patient adverse medical conditions of which the patient is unaware.¹⁴⁰ Fiduciary duties benefit patients and society as a whole because they both induce better medical judgment and empower physicians “to fully exercise their training and skills and . . . minimize financial incentives that might otherwise lead them to diminish and perhaps even abdicate their role in medical decision making.”¹⁴¹

C. *The Evolving Nature and Role of Hospitals*

Although this Article takes the position that it is now appropriate to view the hospital-patient relationship as also possessing fiduciary characteristics, it should be noted that fiduciary obligations have not historically attached to this relationship.¹⁴² Indeed, hospitals were

139. Hafemeister & Gulbrandsen, *supra* note 123, at 375; *see Neade v. Portes*, 739 N.E.2d 496, 502 (Ill. 2000) (“[T]o state a claim for breach of fiduciary duty, it must be alleged that a fiduciary duty exists, that the fiduciary duty was breached, and that such breach proximately caused the injury of which the plaintiff complains”); Hafemeister & Bryan, *supra* note 124, at 521–25 (providing a detailed discussion of each element needed to prove a breach of fiduciary duty); *see also Birriel*, 431 B.R. at 812 (“[I]llinois law requires . . . existence of the duty, breach, and resulting damages [for a breach of fiduciary duty claim] . . .”).

140. *See Hafemeister & Bryan, supra* note 124, at 527 (listing obligations a physician owes to patients, including a duty of good faith); Hafemeister & Gulbrandsen, *supra* note 123, at 375–76 & n.200 (including obligations to abstain from engaging in sexual relations with patients and avoid conflicts of interests as part of a doctor’s fiduciary duty to her patients); Hafemeister & Spinos, *supra* note 86, at 1189–92 (discussing cases that held a doctor’s fiduciary duty included the obligation to inform a patient of adverse medical conditions, a duty that may extend beyond the termination of the doctor-patient relationship and may not require a patient to inquire about the condition to trigger the doctor’s duty).

141. Hafemeister & Gulbrandsen, *supra* note 123, at 381.

142. *See, e.g., Moore v. Regents of Univ. of Cal.*, 793 P.2d 479, 486 (Cal. 1990) (rejecting claim that medical center had a fiduciary relationship with a patient but recognizing the patient’s claim against his physician); *see also Harrison v. Christ St. Patrick Hosp.*, 430 F. Supp. 2d 591, 595 (W.D. La. 2006) (“No authority exists to support the plaintiff’s contention that the healthcare provider/patient contract creates a fiduciary duty.”); *Gonzales v. Palo Verde Mental Health Servs.*, 783 P.2d 833, 835 (Ariz. Ct. App. 1989) (“We find no logic in her contention that because a doctor owes a patient a fiduciary duty and because a hospital is subject to the same standard of care in a malpractice action as a doctor, the hospital, therefore, owes a patient a fiduciary duty.” (citation omitted)); *Cotton v. Fountain Valley Reg’l Hosp. & Med. Ctr.*, No. G044285, 2011 WL 332011, at *8–9 (Cal. Ct. App. Feb. 3, 2011) (holding that the hospital did not owe a fiduciary duty to the patient); *Sherwood v.*

traditionally thought to owe few, if any, duties to their patients because they were considered to be little more than a physical structure and a set of tools for physicians to employ when treating their patients.¹⁴³ Most early American hospitals arose from public almshouses in the 1800s and, as government institutions, sovereign immunity protected these early hospitals from being held legally accountable for the care provided to patients.¹⁴⁴ Similarly, the immunity doctrine protected the few privately funded and operated charitable, non-profit hospitals from liability.¹⁴⁵ Society was deemed to benefit from this charitable care, and courts generally viewed hospitals as immune from liability for any negligence occurring on their grounds, including negligent acts by physicians.¹⁴⁶ For many years, charity patients comprised the majority of the individuals

Danbury Hosp., 896 A.2d 777, 797 (Conn. 2006) (“The plaintiff has provided scant reason to conclude that a hospital owes a patient the duty of a fiduciary.”); DiTeresi v. Stamford Health Sys., Inc., No. FSTCV065001340S, 2010 WL 5493514, at *31 (Conn. Super. Ct. Dec. 14, 2010) (noting that Connecticut trial courts have found no fiduciary relationship between a hospital and its patient). *But see DiTeresi*, 2010 WL 5493514, at *31 (refusing to recognize a bright line rule as to what constitutes a fiduciary relationship and emphasizing that the existence of a fiduciary duty requires a case-by-case inquiry). However, until relatively recently physicians were also not considered to owe fiduciary duties to their patients, a position that has largely been reversed. *See supra* notes 133–38 and accompanying text.

143. *See, e.g.,* Bost v. Riley, 262 S.E.2d 391, 395 (N.C. App. 1980) (“Prior to modern times, a hospital undertook only to furnish room, food, facilities for operation, and attendants . . .” (internal quotation marks omitted)); Thompson v. Nason Hosp., 591 A.2d 703, 706 (Pa. 1991) (recognizing that hospitals used to serve as “charitable organizations,” but have evolved to play a more comprehensive role); *see also* JAMES WALKER SMITH, HOSPITAL LIABILITY § 3.02[1], at 3-7 (2005) (“[H]ospitals merely provided the facilities for the physicians to use.”); I. Trotter Hardy, Jr., *When Doctrines Collide: Corporate Negligence and Respondeat Superior When Hospital Employees Fail To Speak Up*, 61 TUL. L. REV. 85, 87 (1986) (noting the previously prevailing judicial attitude that hospitals did not owe a duty to patients because hospitals did not themselves treat patients but instead only provided a convenient facility for physicians and patients); Southwick, *supra* note 97, at 434 (explaining that the hospital’s role was traditionally nothing more than supplying a building with space to support physicians conducting their work).

144. LEIYU SHI & DOUGLAS A. SINGH, DELIVERING HEALTH CARE IN AMERICA: A SYSTEMS APPROACH 291 (2008).

145. *See* John D. Blum, *Feng Shui and the Restructuring of the Hospital Corporation: A Call for Change in the Face of the Medical Error Epidemic*, 14 HEALTH MATRIX 5, 7–8 (2004) (discussing the origin of hospitals’ immunities as related to governmental and charitable immunity, which sought to protect the assets of hospitals as governmental entities and non-profits, respectively).

146. *See Thompson*, 591 A.2d at 706 (recognizing that the doctrine of charitable immunity previously shielded hospitals from tort liability (citing McDonald v. Mass. Gen. Hosp., 120 Mass. 432, 432 (1876), *overruled by* Colby v. Carney Hosp., 254 N.E. 407, 408 (1969))); CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY 622 (1998) (discussing different cases that reasoned charitable immunity was based on the premise that a hospital should be protected from liability so that it can continue its charitable work); Note, *Theories for Imposing Liability Upon Hospitals for Medical Malpractice: Ostensible Agency and Corporate Liability*, 11 WM. MITCHELL L. REV. 561, 563–64 (1985).

receiving care in hospitals, as more affluent individuals received their medical care in their own homes.¹⁴⁷

In the latter half of the nineteenth century, scientific and technological advances, such as the germ theory of disease, anesthesia, and diagnostic imaging, altered the practice of medicine significantly. This attracted wealthy patients to hospitals for treatments and procedures that physicians could not readily perform in the patients' homes.¹⁴⁸ With this influx of patients who could pay for their own medical treatment, hospitals were no longer limited to a charitable model and became capable of generating profit.¹⁴⁹ By the 1940s, it was clear that hospitals were shifting from a charitable model to a business-like model, serving and billing virtually all segments of society and offering an increasingly wide range of medical services to patients.¹⁵⁰ Based on this emerging view that hospitals are comprehensive health care providers, courts in the mid-twentieth century began to withdraw the immunity previously afforded to hospitals¹⁵¹ and hold them liable for employee negligence under the doctrine of vicarious liability or respondeat superior.¹⁵²

As discussed, hospitals' liability expanded and now encompasses the doctrines of apparent or ostensible agency¹⁵³ and hospital corporate liability.¹⁵⁴ This expansion has continued with a pair of more recent events: the Institute of Medicine's issuing *To Err Is*

147. SHI & SINGH, *supra* note 144, at 291.

148. *Id.* at 292–93.

149. *Id.* at 293.

150. *Id.*

151. The charitable immunity doctrine was in decline by the 1940s, and today it no longer protects hospitals from suit. See Bradley C. Cannon & Dean Jaros, *The Impact of Changes in Judicial Doctrine: The Abrogation of Charitable Immunity*, 13 LAW & SOC'Y REV. 969, 972–73 (1979) (pinpointing 1942 as the year marking the charitable immunity doctrine's decline); Jerold Oshinsky & Gheiza M. Diaz, *Liability of Not-for-Profit Organizations and Insurance Coverage for Related Liability*, INT'L J. NOT-FOR-PROFIT L., Mar. 2002, at 1, 1–2, available at www.icnl.org/research/journal/vol4iss2_3/art_3.htm (noting that in the 1940s both state courts and state legislatures began to allow patients to recover damages from hospitals); see, e.g., Univ. of Va. Health Servs. Found. v. Morris, 657 S.E.2d 512, 522 (Va. 2008) (holding hospital was not entitled to charitable immunity because it operated like a commercial entity); Pierce v. Yakima Valley Mem'l Hosp., 260 P.2d 765, 765 (Wash. 1953) (abrogating the charitable immunity doctrine).

152. See RESTATEMENT (THIRD) OF AGENCY § 219 (2012) (“An employer is subject to vicarious liability for a tort committed by its employee acting within the scope of employment.”). Prior to 1957, hospitals were excepted from the application of this doctrine because they were not considered capable of controlling the medical decisions of their staff. The New York State Court of Appeals' rejection of this exception in *Bing v. Thunig* in 1957 was ultimately accepted around the country. See *Bing v. Thunig*, 2 N.Y.S.2d 3, 12 (1957) (abandoning the doctrine of hospital immunity for the negligence of a hospital-employed nurse); see also SMITH, *supra* note 143, § 3.02[1], at 3-6 to 3-8; see also *supra* notes 97–98 and accompanying text.

153. See *supra* notes 100–01 and accompanying text.

154. See *supra* notes 103–15 and accompanying text.

Human in 2000,¹⁵⁵ a report which focused national attention on the high level of medical errors occurring within the healthcare system and the need to systematically improve the quality and delivery of this care,¹⁵⁶ and Congress's enacting the Patient Protection and Affordable Care Act in 2010,¹⁵⁷ which introduced significant structural changes to the delivery of health care in this country.¹⁵⁸ This evolution will likely continue, driven by additional changes that will enhance the perception that hospitals have become a big business that should carry its own freight.¹⁵⁹ These changes include:

(1) the massive amount spent on hospital care, \$851 billion in 2011,¹⁶⁰

155. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn et al. eds., 2000). Although this report, with its emphasis on dysfunctional health care delivery "systems," has tended to be the central focus of efforts to improve health care quality, the issuance of the report was preceded and followed by a number of influential accounts. See generally HUMAN ERROR IN MEDICINE (Marilyn Sue Bogner, ed., 1994); ATUL GAWANDE, COMPLICATIONS: A SURGEON'S NOTES ON AN IMPERFECT SCIENCE (2002); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT (1984); WACHTER & SHOJANIA, *supra* note 1; Lucian L. Leape, *Error in Medicine*, 272 JAMA 1851 (1994).

156. See Thomas L. Hafemeister & Joshua Hinckley Porter, *The Health Care Reform Act of 2010 and Medical Malpractice Liability: Worlds in Collision or Ships Passing in the Night?*, 64 SMU L. REV. 735, 739 (2011) (discussing the impact the report had on efforts to improve the care patients receive). See generally INST. OF MED., *supra* note 155.

157. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3025, 124 Stat. 119, 408 (2010) (codified as amended at 42 U.S.C. § 1395ww(q) (Supp. V 2011)).

158. See David W. Hilgers & Sidney S. Welch, *Physicians Post-PPACA: Not Going Bust at the Healthcare Buffet*, 24 HEALTH LAW. 1, 1, 4 (2012) (discussing the structural impact of the Patient Protection and Affordable Care Act, including driving the healthcare industry in general and physicians in particular to a more integrated model for the delivery of medical services); Julie E. Kass & John S. Linehan, *Fostering Healthcare Reform Through a Bifurcated Model of Fraud and Abuse Regulation*, 5 J. HEALTH & LIFE SCI. L. 75, 101-08, 119-22 (2012) (arguing that the Patient Protection and Affordable Care Act enhances the success and sustainability of integrated delivery models); Pear, *supra* note 2, at A12 (reporting that these structural changes include coordinating care and fixed-fee pricing for bundled services). See generally Patient Protection and Affordable Care Act § 3025 (promoting a reformation of the existing healthcare model).

159. See Interview by Kai Ryssdal with Dr. Ezekiel Emanuel, Bioethicist, Univ. of Penn. (June 28, 2012), available at <http://www.marketplace.org/topics/economy/health-care/health-care-constant-work-progress> (interviewing the former White House health policy adviser, who stated that health care "is a \$2.8 trillion part of the American economy").

160. *National Health Expenditures 2011 Highlights*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf> (last visited Feb. 20, 2013) ("U.S. health care spending reached \$2.7 trillion in 2011, or \$8,680 per person."); see also Young, *supra* note 8 (noting that hospital costs increased to \$814 billion in 2010). Compare David Meltzer & Chad Whelan, *The Economics of Hospital Medicine*, in HOSPITAL MEDICINE, *supra* note 42, at 11, 11 (reporting that hospital care is expensive, with the U.S. spending \$512 billion on hospital care in 2003), with Harold Brubaker, *Hospitals Embrace Proton-Beam Therapy: The High-tech*

(2) pervasive hospital marketing campaigns encouraging patients to view hospitals as their all-purpose care provider,¹⁶¹

(3) the high levels of adverse events attributable to hospitalization,¹⁶²

Cancer Treatment Has Not Been Proven Superior to Cheaper Alternatives, PHILA. INQUIRER, Apr. 29, 2012, at C1 (discussing the fact that nonprofit hospitals and private investors have spent large sums of money on high-tech cancer treatments before it has been established that they work better than cheaper methods).

161. See Furrow, *supra* note 111, at 459–60 (arguing that hospitals have become big businesses that spend millions on marketing campaigns resulting in the public expecting a wide range of health services from them); *infra* note 225 (discussing direct mailings by hospitals as part of their advertising efforts).

162. See DANIEL R. LEVINSON, U.S. DEP'T OF HEALTH & HUMAN SERVS., ADVERSE EVENTS IN HOSPITALS: NATIONAL INCIDENCE AMONG MEDICARE BENEFICIARIES, at i-iii (2010) (estimating that one in seven Medicare beneficiaries experience an adverse event while hospitalized and an additional 13.5% experience an event that causes temporary harm, with 44% of these events considered preventable, resulting in costs of \$4.4 billion per year); DANIEL R. LEVINSON, U.S. DEP'T OF HEALTH & HUMAN SERVS., HOSPITAL INCIDENT REPORTING SYSTEMS DO NOT CAPTURE MOST PATIENT HARM, at ii (Jan. 2012) (“Hospital staff did not report 86 percent of events to incident reporting systems”); NPR, ROBERT WOOD JOHNSON FOUND., & HARVARD SCH. OF PUB. HEALTH, POLL: SICK IN AMERICA 4 (2012), available at http://www.rwjf.org/content/dam/farm/reports/surveys_and_polls/2012/rwjf72962 (“About one in ten hospitalized Americans report getting the wrong diagnosis, treatment or test (11%), and one in twelve hospitalized Americans report getting an infection in the hospital (8%).”); David C. Classen et al., *‘Global Trigger Tool’ Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured*, 30 HEALTH AFFAIRS 581, 584, 586 (2011) (finding adverse events occurred in 33.2% of hospital admissions and concluding the true rates are likely higher still because the methods commonly used to measure safety fail to detect more than 90% of the adverse events); Stephanie Rennke & Margaret C. Fang, *Hazards of Hospitalization: More Than Just “Never Events”*, 171 ARCHIVES INTERNAL MED. 1653, 1653 (2011) (listing specific adverse events, including medication errors and hospital acquired anemia); Richard P. Wenzel & Michael B. Edmond, *The Impact of Hospital-Acquired Bloodstream Infections*, 7 EMERGING INFECTIOUS DISEASES 174, 174 (2001) (reporting healthcare-associated infections are estimated to occur in 5% of all U.S. hospitalizations, approaching 10% in larger institutions, representing 1.75–3.5 million infections per year, with a “crude” mortality rate of 27% for hospital-acquired bloodstream infections); see also Janet Lavelle, *UCSD, Kaiser Hospitals Fined for Errors*, U-T SAN DIEGO NEWS (June 1, 2012), <http://www.utsandiego.com/news/2012/jun/01/ucsd-kaiser-hospitals-fined-errors/?print&page=all> (“Since 2007, state law has required hospitals to report any errors from a list of potentially deadly ‘adverse events’ Since the law went into effect, the state has issued 224 administrative penalties against 129 California hospitals”).

A number of entities have begun to issue “report cards” assessing hospitals’ performance, with many hospitals receiving “poor” grades. See *How Safe Is Your Hospital?*, LEAPFROG GRP. (June 6, 2012), http://www.leapfroggroup.org/policy_leadership/leapfrog_news/4894464 (“The Hospital Safety Score is calculated using publicly available data on patient injuries, medical and medication errors, and infections. . . . Of the 2,652 general hospitals issued a Hospital Safety Score, 729 earned an ‘A,’ 679 earned a ‘B,’ and 1243 earned a ‘C’ or below.”); see also *Best Hospitals*, U.S. NEWS & WORLD REP., <http://health.usnews.com/best-hospitals> (last visited Feb. 20, 2013) (ranking hospitals, categorized by specialty, thereby comparing 5000 hospitals); *Hospital Compare*, MEDICARE.GOV, <http://www.hospitalcompare.hhs.gov/> (last visited Feb. 20, 2013) (providing users the ability to perform a geographic search and compare hospitals). Hospital organizations, however, have criticized these rankings for employing flawed measures that “do not accurately portray a picture of the safety efforts made by hospitals.” Cheryl Clark, *Leapfrog Issues Hospital Safety Report Cards*, HEALTHLEADERS MEDIA (June 6,

(4) hospitals' growing emphasis on increasing revenue and decreasing costs,¹⁶³ an emphasis predominant within nonprofit hospitals as well,¹⁶⁴

(5) a surge in mergers and acquisitions,¹⁶⁵ with hospitals announcing eighty-six merger and acquisition deals valued at \$7.9 billion in 2011, the most in a decade,¹⁶⁶ which triggered government actions challenging them as prohibited monopolies and illegal restraints on competition in local markets,¹⁶⁷ as well as raising

2012), <http://www.healthleadersmedia.com/page-1/TEC-280925/Leapfrog-Issues-Hospital-Safety-Report-Cards>; see also Ashwini R. Sehgal, *The Role of Reputation in U.S. News & World Report's Rankings of the Top 50 American Hospitals*, 152 ANNALS INTERNAL MED. 521, 523–24 (2010) (researching the effect of a hospital's reputation on its *U.S. News & World Report's* ranking and concluding that hospitals' standings largely reflect their subjective reputations).

163. See Meltzer & Whelan, *supra* note 42, at 13 (calling the pressure to increase profits "ubiquitous").

164. See *id.* (explaining that all hospitals need to increase revenue because profits are used to attain various institutional goals); Lisa Goldstein & John C. Nelson, *Hospital Revenues in Critical Condition; Downgrades May Follow: Not-for-Profit Hospital Revenue Growth Lowest in Two Decades*, MOODY'S INVESTORS SERV.: U.S. PUB. FIN., Aug. 10, 2011, at 1, available at www.hhnmag.com/hhnmag/PDFs/2011PDFs/moodys.pdf.

165. See Robert A. Berenson et al., *The Growing Power of Some Providers to Win Steep Payment Increases from Insurers Suggests Policy Remedies May Be Needed*, 31 HEALTH AFF. 973, 975–76 (2012) (noting the growing number of mergers and acquisitions to form large multihospital health care systems and decrease competition); Steve Adams, *Empire Builder; Newcomer Steward Health Care Is the Driving Force Behind a Surge in Local Hospital Merger Talks*, PATRIOT LEDGER, Apr. 28, 2012, at B19 ("A wave of acquisitions is reshaping ownership of Massachusetts hospitals . . ."); Julie Appleby, *As They Consolidate, Hospitals Get Pricier*, KAISER HEALTH NEWS (Sept. 26, 2010), <http://www.kaiserhealthnews.org/stories/2010/september/26/hospital-mergers-costs.aspx> (finding that increasing health care prices are due, in part, to many hospitals' mergers); Sarah Kliff, *What Happens When Hospitals Consolidate*, WONKBLOG (Mar. 8, 2012, 11:47 AM), http://www.washingtonpost.com/blogs/ezra-klein/post/what-happens-when-hospitals-consolidate/2012/03/08/gIQAnE dFzR_blog.html (concluding that some hospitals consolidated to weather the economic downturn); Julian Pecquet, *Hospital Consolidation Hearing Sparks Debate on Healthcare Law's Merits*, HEALTHWATCH (Sept. 9, 2011, 02:41 PM), <http://thehill.com/blogs/healthwatch/health-reform-implementation/180663-consolidation-hearing-sparks-debate-on-whether-health-law-hurts-or-helps> (reporting on a congressional hearing to address the rising cost of health care resulting from an increasing trend of hospital mergers); Avik Roy, *Hospital Monopolies: The Biggest Driver of Health Costs That Nobody Talks About*, FORBES (Aug. 22, 2011, 7:00 PM), <http://www.forbes.com/sites/aroy/2011/08/22/hospital-monopolies-the-biggest-driver-of-health-costs-that-nobody-talks-about> (calling hospital monopolies the most "predatory force" in the healthcare system).

166. Brent Kendall, *Regulators Seek to Cool Hospital-Deal Fever: Washington Steps Up Merger Challenges, but Firms Say Campaign Ignores Economic Reality of Health-Care Overhaul*, WALL ST. J., Mar. 18, 2012, at B10; Dave Michaels, *Ruling on Health Care Law Won't Slow Down Growing Consolidations of Texas Hospitals*, DALL. MORNING NEWS (June 27, 2012, 09:39 PM), <http://www.dallasnews.com/business/health-care/20120627-ruling-on-health-care-law-won-t-slow-down-growing-consolidations-of-texas-hospitals.ece>.

167. See *FTC v. Phoebe Putney Health Sys., Inc.*, 663 F.3d 1369 (11th Cir. 2011) (agreeing to address a challenge by the Federal Trade Commission (FTC) to a hospital acquisition in Georgia that the FTC contended would have created a monopoly), *rev'd*, 2013 WL 598434 (Feb. 19, 2013); *Colon Health Ctrs. v. Hazel*, No. 1:12cv615, 2012 WL 4105063, at *1 (E.D. Va. Sept. 14, 2012) (addressing a filing by two medical groups from Delaware and Maryland alleging that Virginia law, which requires out-of-state

concerns about lost tax revenue because of the tax exemptions hospitals may enjoy¹⁶⁸ and increased healthcare costs in general;¹⁶⁹

(6) hospitals' geographically targeted expansion of services to "capture" well-insured patients, which encompasses building freestanding outpatient medical centers and hospitals close to their competitors;¹⁷⁰

(7) hospitals' increasing size, wealth, and clout,¹⁷¹ with nearly 67% undertaking renovations or additional construction¹⁷² and smaller hospitals being squeezed out;¹⁷³

providers to obtain a certificate demonstrating a need for their services within the state, violates the Commerce Clause and the Fourteenth Amendment of the U.S. Constitution); Karen Cheung-Larivee, *Public Hospital Sales to Face More Scrutiny*, FIERCEHEALTHCARE (Apr. 10, 2012), <http://www.fiercehealthcare.com/story/public-hospital-sales-face-more-scrutiny/2012-04-10> (discussing a Florida law that requires the state's healthcare oversight agency to review hospital sales); *see also* Eric Morath, *Corporate News: Hospitals Drop Plan for Merger*, WALL ST. J., Apr. 12, 2012, at B5 (reporting that two Illinois hospitals abandoned plans to merge because of pressure from federal regulators who claimed the merger would create a local monopoly—a decision that marks a new push by the FTC to block health-care consolidation). *But see* Berenson et al., *supra* note 165, at 978 ("Our findings did not suggest that more aggressive antitrust enforcement . . . would successfully restrain provider pricing power more generally.").

168. *See* Don Lee, *Healthcare Jobs Drive a Revival in Pittsburgh*, L.A. TIMES, May 13, 2012, at A1 (discussing official reports that exemptions for nonprofit hospitals cost Allegheny County, which includes Pittsburgh, tens of millions of dollars in tax revenues and reporting that several states are considering changing tax exemptions for non-profits in light of lost revenue).

169. *See* Alicia Caramenico, *Healthcare Consolidation to Cause Massive Inflation*, FIERCEHEALTHCARE (Jan. 16, 2013), <http://www.fiercehealthcare.com/story/healthcare-consolidation-cause-massive-inflation/2013-01-16> ("Adding to healthcare consolidation worries, mergers and acquisitions among hospitals, health systems and physician practices are producing a spike in inflation. . . . That's because with healthcare consolidation comes strong pricing power. . . . [H]ospitals are increasingly acquiring practices and converting them to outpatient entities or outpatient hospital departments to reap bigger payments from both Medicare and private insurers.").

170. *See* Emily R. Carrier et al., *Hospitals' Geographic Expansion in Quest of Well-Insured Patients: Will the Outcome Be Better Care, More Cost, or Both?*, 31 HEALTH AFF. 827, 827 (2012) (noting a shift to expanding into different geographical locations that have a dense population of well-insured clients); Jordan Rau, *Recession Boosted Hospital Expansions Into Affluent Areas, Study Finds*, CAPSULES: THE KHN BLOG (Apr. 9, 2012, 4:01 PM), <http://capsules.kaiserhealthnews.org/index.php/2012/04/hospitals-invading-affluent-neighborhoods-in-search-of-patients-study-says/> (discussing studies that show hospitals are more aggressively seeking clients by moving facilities into areas with dense populations of well-insured patients, although some areas are already well-served by competitors).

171. *See* Berenson et al., *supra* note 165, at 973 (concluding that hospitals' increased negotiating power is a result of the leverage provided by mergers); Lee, *supra* note 168, at A1 (noting growth in healthcare jobs across the country as "[h]ealthcare firms now dominate the rankings of major employers in large cities as well as rural communities" and "[h]ealthcare has fueled job growth for a generation"); Margot Sanger-Katz, *Hospitals Using New Strategies to Lock in High Prices*, NAT'L J., May 7, 2012, *available at* <http://www.nationaljournal.com/healthcare/hospitals-using-new-strategies-to-lock-in-high-prices-20120507> (stating hospitals are focusing on mergers as a means of growth); Paul Barr, *Taking a Different Path: Annual M&A Report Shows Year of Strong Growth, Rise of Nontraditional Deals*, MODERNHEALTHCARE.COM (Jan. 26, 2012, 12:01 AM),

(8) the high compensation levels received by hospital administrators and executives,¹⁷⁴ with special attention given to this

<http://www.modernhealthcare.com/article/20130126/MAGAZINE/301269951> (stating that the number of hospital deals climbed “more than 18% to 109 in 2012, up from 92 deals recorded for 2011”); Matt Dobias, *Study: Bigger Hospitals Drive Cost Increases*, POLITICO (May 7, 2012, 10:36 PM), <http://www.politico.com/news/stories/0512/76016.html> (discussing the increasing size of hospitals and its impact on health care payments); Gilbert M. Gaul, *Growing Size and Wealth of Children’s Hospitals Fueling Questions About Spending*, KAISER HEALTH NEWS (Sept. 25, 2011), <http://www.kaiserhealthnews.org/stories/2011/September/26/childrens-hospitals-part-one.aspx> (identifying a new \$400 million children’s hospital as exemplifying a national trend of increasing the size of hospitals); Michaels, *supra* note 166 (reporting the increase in hospital mergers both nationally and in Texas, with 86 hospital mergers nationwide in 2011, which is the most in a decade); Ken Terry, *The Hospital Construction Boom: Brought to You by Healthcare Reform*, CBS MONEYWATCH (Jan. 25, 2011, 5:36 PM), http://www.cbsnews.com/8301-505123_162-43842393/the-hospital-construction-boom-brought-to-you-by-healthcare-reform/ (addressing a survey finding 67% of hospitals involved in some type of construction).

172. See Terry, *supra* note 171 (reporting that a large number of hospitals are expanding); see also Gaul, *supra* note 171 (“[T]he surge in spending is also helping to fuel a multibillion-dollar building boom as hospitals add towers and beds.”).

173. See Lisa Chedekel, *Smaller Connecticut Hospitals Struggle with Deficits*, HARTFORD COURANT (Apr. 17, 2012), http://articles.courant.com/2012-04-17/health/hc-hospital-finances-20120417_1_smaller-hospitals-connecticut-hospitals-hospital-tax (concluding that smaller hospitals’ limited resources make them less flexible and more susceptible to financial challenges); see also Lee, *supra* note 168, at A1 (explaining that health firms across the country are merging with and buying smaller health enterprises to grow); Rich Lord, *West Penn Allegheny Files Amended Lawsuit Against UPMC*, PITTSBURGH POST-GAZETTE (Apr. 25, 2012, 12:42 AM), <http://www.post-gazette.com/stories/business/news/west-penn-allegheny-files-amended-lawsuit-against-upmc-632911/?print=1> (describing a hospital’s alleged use of “predatory tactics” against competitors).

174. See INTERNAL REVENUE SERV., IRS EXEMPT ORGANIZATIONS HOSPITAL STUDY: EXECUTIVE SUMMARY OF FINAL REPORT 3–4 (2009), available at http://www.irs.gov/pub/irs-tege/execsum_hosprojrept.pdf (reporting that an IRS study of nonprofit hospitals found: “[t]he average and median total compensation amounts reported as paid to the top management official by respondents to the questionnaire were \$490,000 and \$377,000, respectively”); Scott Thurm, *CEO Pay Moves with Corporate Results*, WALL ST. J., May 23, 2012, at A1 (finding executive pay in healthcare industry increased more than any other sector in 2011); Isabel Vincent & Melissa Klein, *Rich CEOs Performing Cashectomy on Hosps*, N.Y. POST, Nov. 27, 2011, at 8 (noting that the compensation of some CEOs of nonprofit medical centers included bonuses of over a million dollars, huge retirement payments, upgraded flights, housing stipends, and chauffeurs) David Brooks & Kevin Landrigan, *Report: Hospitals’ CEO Pay Rose Sharply in Recent Years*, NASHUA TELE. (July 3, 2012), <http://www.nashuatelegraph.com/news/966499-196/report-hospitals-ceo-pay-rose-sharply-in.html> (juxtaposing rising hospital CEO pay with a diminishing economy); Gaul, *supra* note 171 (“In 2009, most CEOs at the nation’s largest children’s hospitals were paid \$1 million or more. . . . Many of the executives [also] received hefty bonuses, country club memberships, cars or other perks.”); Cathey O’Donnell & Jane Lerner, *Business of Medicine, Part 2: Eight Local Hospital Officials Got \$1M in 2010*, J. NEWS (Feb. 12, 2012, 12:54 AM), <http://www.lohud.com/article/20120212/NEWS02/302120060/Business-Medicine-Part-2-Eight-local-hospital-officials-got-1M-2010> (focusing on healthcare CEOs earning over a million dollars a year in compensation); Ben Sutherly & Chelsey Levingston, *Some Health CEOs Earned Millions*, MIDDLETOWN J. (Dec. 12, 2011, 2:27 AM), <http://www.middletownjournal.com/news/news/local/some-health-ceos-earned-millions-1/nNK4W/> (“Seven executives at local nonprofit hospitals and their parent networks each collected \$1 million or more in 2009.”).

compensation when their relatively small community hospitals enter into bankruptcy,¹⁷⁵

(9) concerns over whether hospitals are providing appropriate levels of charity care, including failing to extend debt forgiveness to patients unable to pay their medical bills and applying undue or inappropriate pressure to collect these bills;¹⁷⁶

175. See Erin L. Nissley, *Marian Leaving \$19M hole*, TIMES-TRIBUNE, Dec. 5, 2011, at A7 (questioning the high salaries paid to hospital administrators and trustees at a bankrupt community hospital). An Executive Order was recently issued in New York that caps the amount of “State financial assistance or State-authorized payments” that may be used to pay executive officers of “for-profit entities that provide critical services to New Yorkers in need.” See GOV. ANDREW M. CUOMO, EXEC. ORDER NO. 38, LIMITS ON STATE-FUNDED ADMINISTRATIVE COSTS & EXECUTIVE COMPENSATION (Jan. 18, 2012), available at <http://www.governor.ny.gov/executiveorder/38>; see also SUSAN F. ZINDER, AM. HEALTH LAW. ASSOC., EXECUTIVE SUMMARY: NEW LIMITS ON COMPENSATION PAID TO EXECUTIVES OF STATE SERVICE PROVIDERS 1–2 (2012) (summarizing Cuomo’s executive order and examining its impact).

176. See, e.g., *New Colorado Law Sets Limits on Hospital Charges for Patients Eligible for Financial Aid*, 21 HEALTH L. RPT. 685 (2012) (reporting on a Colorado bill that requires hospitals to charge people who are eligible for financial aid the hospital’s lowest negotiated rate); Amanda W. Thai, Note, *Is Senator Grassley Our Savior?: The Crusade Against “Charitable” Hospitals Attacking Patients for Unpaid Bills*, 96 IOWA L. REV. 761, 764, 770–72 (2011) (discussing the debt-collection and bad-debt problem, and analyzing Senator Grassley’s additions to the Patient Protection and Affordable Care Act, which requires non-profits to meet stricter standards to earn tax exempt status); Ames Alexander & David Raynor, *Hospital Suits Force New Pain on Patients*, CHARLOTTE OBSERVER (Apr. 23, 2012), <http://www.charlotteobserver.com/2012/04/23/3193509/hospital-suits-force-new-pain.html> (investigating non-profit hospitals use of law suits to collect unpaid accounts from patients); Gaul, *supra* note 171 (finding one large hospital provided little free care despite having an investment portfolio valued at \$21 billion); Jenny Gold, *Sued Over an \$1,800 Hospital Bill*, KAISER HEALTH NEWS (Apr. 27, 2012), <http://www.kaiserhealthnews.org/stories/2012/april/27/charity-care-nonprofit-hospitals-patient-debt.aspx> (recounting the story of a local Catholic hospital’s use of a collection agency to coerce payment from a low-income patient); Bertrand M. Gutierrez, *Nonprofit Exemptions for Hospitals Worry Local Leaders Facing Tax Increases*, WINSTON-SALEM J. (May 27, 2012, 12:20 AM), http://www.journalnow.com/news/local/article_fd2f7a77-81ad-5a55-ab16-730e2e431c6e.html (“[L]ocal and state government leaders are questioning the tax-exempt status of nonprofit hospitals and calling on them to contribute more toward the cost of government services.”); Carla K. Johnson, *Illinois Bill Would Require Free Care for Poor*, BLOOMBERG BUSINESSWEEK (May 29, 2012), <http://www.businessweek.com/ap/2012-05-29/illinois-bill-would-require-free-care-for-poor> (discussing an Illinois bill that would require hospitals to see patients that are 125% or more below the federal poverty line free of charge); M.B. Pell, *Charity-care Hospital Regulations Scrutinized: State’s Tax-exemption Rules Aren’t Well Defined*, ATLANTA J.-CONST. (Aug. 7, 2011, 8:21 AM), <http://www.ajc.com/news/news/local/charity-care-hospital-regulations-scrutinized/nQKQd/> (“[W]ith tax revenues shrinking and the cost of public health care rising, policy makers across the country are starting to require not-for-profit hospitals to provide more evidence of tangible community benefits.”); James Ritchie, *For Cincinnati Hospitals, Charity Care Levels Come Under Scrutiny*, BUSINESS COURIER (Jan. 20, 2012, 6:00 AM), <http://www.bizjournals.com/cincinnati/print-edition/2012/01/20/for-cincinnati-hospitals-charity-care.html> (questioning whether hospitals provided enough charity care to warrant their tax exempt status); Ron Shinkman, *Hospitals Spend Little on Charitable Care, Yet Evade Taxes*, FIERCEHEALTHFINANCE (Oct. 18, 2011), <http://www.fiercehealthfinance.com/story/hospitals-spend-little-charitable-care-yet-evade-taxes/2011-10-18> (“Many Iowa [non-for-profit] hospitals spend far less than 1 percent

(10) concerns over whether hospitals engage in improper billing, referral, and compensation practices,¹⁷⁷ as well as admission practices designed to evade new Medicare rules that penalize hospitals for

of their revenues on care for poor patients while reaping tax exemptions [of \$58 million a year] on nearly \$2 billion worth of property.”); Ron Shinkman, *IRS Proposes New Rules to Govern Charity Care*, FIERCEHEALTHFINANCE (June 26, 2012), <http://www.fiercehealthfinance.com/story/irs-proposes-new-rules-govern-charity-care/2012-06-26> (issuing proposed regulations regarding what constitutes requisite charity care at not-for-profit hospitals, the IRS “would specifically rule out gross charges for uninsured patients and would require hospitals to charge no more than they would an insured patient”); Jessica Silver-Greenberg, *Debt Collector Is Faulted for Tough Tactics in Hospitals*, N.Y. TIMES (Apr. 24, 2012), http://www.nytimes.com/2012/04/25/business/debt-collector-is-faulted-for-tough-tactics-in-hospitals.html?pagewanted=all&_r=0 (listing types of aggressive collection tactics hospitals utilize, including demanding payment before providing treatment and employing debt collectors to sit in hospital lobbies); Elizabeth Stawicki, *Debt Collectors in the ER*, KAISER HEALTH NEWS (June 1, 2012), <http://www.kaiserhealthnews.org/Stories/2012/June/01/minnesota-ER-al-franken.aspx> (describing testimony at a U.S. Senate hearing from patients who were pressured to pay for their care up front while awaiting emergency room treatment); Karen Garloch, *Perdue Wants Hospitals To Publicize Charity Care Policies, Make Bills Understandable*, CHARLOTTE OBSERVER (May 14, 2012), <http://www.charlotteobserver.com/2012/05/14/3238250/perdue-wants-hospitals-to-publicize.html> (discussing North Carolina Governor Bev Perdue’s efforts to require hospitals to be more transparent about financial assistance programs).

177. See Hilgers & Welch, *supra* note 158, at 10 (pointing out that the hospital-physician employment model does not eliminate the potential for fraud and abuse); Press Release, U.S. Dep’t of Justice, Dallas-Based Tenet Healthcare Pays More Than \$42 Million to Settle Allegations of Improperly Billing Medicare: Settlement Related to Company’s Inpatient Rehabilitation Facilities (Apr. 10, 2012), *available at* <http://www.justice.gov/opa/pr/2012/April/12-civ-446.html> (reporting that the Justice Department has recovered more than \$6.6 billion in False Claims Act cases involving fraud against federal health care programs since January 2009); *Hospital Charges Show Huge Variance in Study*, U.S. NEWS & WORLD REP. (Apr. 24, 2012), <http://health.usnews.com/health-news/news/articles/2012/04/24/hospital-charges-show-huge-variance-in-study> (noting a \$178,500 discrepancy in hospitals’ billings for a common medical treatment); Cathy O’Donnell, *2 Westchester Hospitals Overbilled Medicaid; South Shore Agrees to Pay \$2.2 Million*, LOHUD.COM (Apr. 19, 2012, 12:40 AM), <http://www.lohud.com/article/20120419/NEWS02/304190062/2-Westchester-hospitals-overbilled-Medicaid-South-Shore-agrees-pay-2-2M> (discovering one hospital defrauded Medicaid out of over a million dollars); Jordan Rau, *Which Hospitals’ Patients Cost Medicare the Most? A Top 10 List*, CAPSULES: THE KHN BLOG (May 11, 2012, 6:00 AM), <http://capsules.kaiserhealthnews.org/index.php/2012/05/which-hospitals-patients-cost-medicare-the-most-a-top-10-list> (looking at government research that ranks which hospitals’ Medicare patients cost the most); *State’s High Court to Weigh in on Lawsuit over IU Health Billing*, INDIANAPOLIS BUS. J. (Apr. 29, 2012), <http://www.ijb.com/article/print?articleId=34123> (tracking a case alleging a hospital discriminated against its uninsured patients by charging them more than insured patients); Greta Weiderman, *Thomas Files Class Action Suit Against Tenet Health System*, ST. LOUIS BUS. J. (May 22, 2012, 7:49 AM CDT), <http://www.bizjournals.com/stlouis/news/2012/05/21/thomas-files-class-action-suit-against.html> (reporting the filing of a class action lawsuit that “seeks to recover the amounts that [two hospitals]... have charged for what the suit alleges are misleading and undisclosed ‘hospital’ facility fees for non-hospital services at doctors’ offices and outpatient clinics”); Sam Wood, *Temple University Settles with Feds in Multi-Million Dollar Hospital Fraud Schemes*, PHILA. INQUIRER, May 16, 2012, at A19 (reporting on a department chair at a medical school being charged with seventy-three counts of fraud).

patients who are readmitted within thirty days but which significantly increase out-of-pocket costs for patients or otherwise deny them access to needed follow-up care;¹⁷⁸

(11) the increased use of dedicated hospital physicians (hospitalists) directly employed by the hospital, rather than relying on relatively independent community-based physicians granted hospital privileges;¹⁷⁹ and

178. The growing use of observation stays, whereby patients are placed “under observation” rather than “admitted,” has gained particular attention of late. See Zhanlian Feng et al., *Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns About Causes and Consequences*, 31 HEALTH AFF. 1251, 1251–52, 1257 (2012) (speculating that the enactment of the Patient Protection and Affordable Care Act of 2010 may have exacerbated this trend because it imposes penalties on hospitals with higher-than-expected readmission rates; and noting that concerns about this practice recently led to a congressional briefing and class action lawsuits); J. Lester Feder, *Hospital Billing Shifting Costs*, POLITICO (June 4, 2012, 10:36 PM), <http://dyn.politico.com/printstory.cfm?uuid=5F26A362-8DFD-4A74-9E25-A7E7366C5A7E> (examining research that suggests placing Medicare patients on “observation status” can cause them significant financial harm); Susan Jaffe, *Study: Hospital Observation Stays Increase 25 Percent in 3 Years*, CAPSULES: THE KHN BLOG (June 4, 2012, 4:00 PM), <http://capsules.kaiserhealthnews.org/index.php/2012/06/study-hospital-observation-stays-increase-25-percent-in-3-years> (noting the “troubling” trend of an increasing number of Medicare patients entering hospitals being placed on observation status during their stay while the level of admissions declined, and expressing concern that hospitals may be using this practice to avoid having these patients counted as readmissions should they later return to the hospital after being discharged); David Morgan, *Medicare Beneficiaries Sue US Over Hospital Stays*, REUTERS (Nov. 3, 2011, 5:03 PM), <http://www.reuters.com/article/2011/11/03/usa-medicare-lawsuit-idUSN1E7A21ST20111103> (describing the filing of a lawsuit in which the sharp increase in the practice of placing Medicare patients on observation status and thereby denying them Medicare Part A coverage, which only covers admitted patients, was challenged); Bernice Yeung, *‘Observation Stays’ for Medicare Patients Create Coverage Problems*, CAL. WATCH (June 4, 2012), <http://californiawatch.org/dailyreport/observation-stays-medicare-patients-create-coverage-problems-16444> (relaying the account of a Medicare patient who unexpectedly incurred significant post-hospitalization expenses because when she previously entered a hospital she was placed on “observation” rather than admitted, with the latter necessary for Medicare to cover these expenses).

179. See Robert M. Wachter, *Models of Hospital Care*, in HOSPITAL MEDICINE, *supra* note 42, at 3, 3 (noting that the majority of hospital care in the U.S. is now provided by hospital-based physicians). This trend is fueled by more doctors, particularly younger doctors, wanting the job security and set hours of hospital employment. See Hilgers & Welch, *supra* note 158, at 3 (recognizing that younger physicians seek a different career and lifestyle track, inducing new doctors to become “physician-employees” rather than owners of their own practice); Harris Gardiner, *More Doctors Giving Up Private Clinics*, N.Y. TIMES, Mar. 26, 2010, at B1 (linking a decline in the number of privately owned clinics to young physicians needing to repay large medical debts and seeking a work-life balance); Appleby, *supra* note 165 (discussing the trend of an increasing number of doctors seeking employment with hospitals instead of running their own private practices); Bob Mook, *Docs Flock to Hospitals, Larger Group Practices*, DENV. BUS. J. (Jan. 17, 2010, 10:00 PM), <http://www.bizjournals.com/denver/stories/2010/01/18/story6.html> (blaming “bureaucratic red tape” for the increasing trend of doctors leaving private practice to seek employment with hospitals or large practice groups).

(12) the exercise of greater control over medical staff by hospital administrators,¹⁸⁰ including the purported widespread use of a physician “code of conduct.”¹⁸¹

D. The Fiduciary Nature of the Hospital-Patient Relationship

Concurrent with the emergence of these factors, a hospital’s legal responsibility for its patients’ well-being and associated liability for failing to provide adequate services has greatly expanded over the past century.¹⁸² Overall, the trajectory of this intertwined evolution of law and health care delivery predicts the same conclusion as present-day observational evidence; namely, that hospitals and their patients have developed a relationship that looks remarkably fiduciary in nature.¹⁸³

When viewed through a fiduciary lens, the hospital-patient relationship clearly reflects a striking superiority in expertise, knowledge, capability, power, and access to critical information and technology on one side, and a pronounced dependence and vulnerability on the other.¹⁸⁴ Hospitals have become a concentrated locus of complex health care delivery, through which multiple care providers treat a patient¹⁸⁵ using ever-more expensive and

180. See Richard L. Reece, *Hospitals Gaining Leverage Over Physicians*, MEDINNOVATION (Jan. 9, 2012), <http://medinnovationblog.blogspot.com/2012/01/hospitals-gaining-leverage-over.html> (explaining how over the last 24 years hospitals have steadily gained leverage over practicing physicians); see also Hilgers & Welch, *supra* note 158, at 10 (arguing that hospital employment will cause a transformation in the practices of physicians, resulting in their having less control over their clinical methods).

181. See Lawrence R. Huntoon, *Editorial: The Insulting Physician “Code of Conduct”*, 13 J. AMER. PHYSICIANS & SURGEONS 2, 2–3 (2008) (describing the physician “code of conduct” as a list of prohibited behaviors that physicians must sign to have hospital privileges, and arguing that the hospital’s purpose in imposing this code is to exert “authority and control over physicians”); see also Roger Collier, *Physician Codes of Conduct Becoming a Norm*, 183 CMAJ 892, 892 (2011) (explaining that supporters argue that such codes improve professionalism and decrease disruptive behavior, while critics argue they insult doctors and “reek[] of authoritarianism”).

182. See *supra* Part III (discussing hospitals’ legal duties to their patients); see, e.g., *Gillum v. Republic Health Corp.*, 778 S.W.2d 558, 565 (Tex. App. 1989) (“In Texas, . . . a duty exists between a hospital and its patients to provide them with a certain level of medical care, the breach of which duty results in liability on the hospital.”); see also Rutchik, *supra* note 110, at 551 & nn.129–31 (providing an overview of the evolution of hospital liability stemming from its physicians’ acts).

183. See Furrow, *supra* note 111, at 456–84 (identifying the existence of a fiduciary relationship between a hospital and its patients).

184. See *infra* notes 191–203 and accompanying text.

185. See Nicole Blay et al., *Patient Transfers in Australia: Implications for Nursing Workload and Patient Outcomes*, J. NURSING MGMT. 1, 4 (2011) (“During an average length of stay of 5 days, patient and health professional interactions can involve between 17 and 26 individuals.”); Naomi Whitt et al., *How Many Health Professionals Does a Patient See During an Average Hospital Stay?*, 120 N.Z. MED. J. 1253, 1253 (2007) (reporting that surgery patients saw an average of 26.6 health care professionals (including ten doctors) during their hospitalization, while all other patients saw an average of 17.8 health care professionals

sophisticated technology¹⁸⁶ in ways that increasingly usurp the role traditionally played by a designated treating physician.¹⁸⁷

Hospitals typically care for the sickest and most severely injured patients, with these patients tending to be the most vulnerable and dependent in the healthcare system, an increasingly pronounced trend.¹⁸⁸ Patients admitted through the emergency room, for example, are likely to be experiencing impaired decision-making capacity during a time of medical crisis.¹⁸⁹ Even patients fortunate enough to choose the time and place of their admission arrive under a cloud of serious illness or injury; one they must rely on their care providers to dispel.¹⁹⁰ When in such dire straits, patients tend to

(including six doctors)); *see also* NAT'L TRANSITIONS OF CARE COAL., IMPROVING TRANSITIONS OF CARE I (2010), available at <http://www.ntocc.org/Portals/0/PDF/Resources/NTOCCIssueBriefs.pdf> ("Between 41.9 and 70 percent of Medicare patients admitted to the hospital . . . received services from an average of 10 or more physicians during their stay.").

186. *See, e.g.*, Robert Langreth, *Prostate Cancer Therapy Too Good To Be True Explodes Health Care Cost*, BLOOMBERG (Mar. 26, 2012, 12 AM), <http://www.bloomberg.com/news/2012-03-26/prostate-cancer-therapy-too-good-to-be-true-explodes-health-cost.html> (describing proton beam technology used to treat prostate cancer as delivered by 500-ton machines in facilities costing \$100 million to \$200 million and requiring a football-field sized building to house it).

187. This trend has been observed for some time. *See, e.g.*, Philip G. Peters, Jr., *Making Hospitals Accountable*, 32 REGULATION 30, 30 (2009) (depicting today's healthcare delivery system as a "complex web of interactions" among diverse health care providers, which necessitates increased coordination and accountability); Southwick, *supra* note 97, at 429, 435 (explaining that modern hospitals play an active role in patient care as their "range of services continues to develop and expand").

188. *See* Classen et al., *supra* note 162, at 586 (suggesting that the increasing severity of hospital patients' illnesses may partially explain the increase in adverse events occurring in hospitals); Mark A. Hall, *The Legal and Historical Foundations of Patients as Medical Consumers*, 96 GEO. L.J. 583, 584–86 (2008) (noting that the law historically views the physician-patient relationship as one characterized by dependency and vulnerability).

189. *See* Cheryl Clark, *Sicker Patients Seeking Emergency Care*, HEALTHLEADERS MEDIA (July 29, 2009), <http://www.healthleadersmedia.com/page-2/PHY-236638/Sicker-Patients-Seeking-Emergency-Care> (discussing research results that suggest patients using emergency room care are significantly sicker than patients accessing emergency services in previous years); *Hope and Optimism May Cloud Judgment in ICUs*, HEALTHDAY NEWS (Mar. 7, 2012), <http://consumer.healthday.com/Article.asp?AID=662433> (finding that family members typically make medical decisions for family members who are seriously ill); *see also* INST. OF MED., THE FUTURE OF EMERGENCY CARE IN THE UNITED STATES HEALTH SYSTEM—REPORT BRIEF 6 (2006) (recommending improvements to the delivery of emergency care); John C. Moskop et al., *Emergency Department Crowding, Part I—Concept, Causes, and Moral Consequences*, 53 ANNALS EMERGENCY MED. 605, 606–08 (2009) (citing overcrowding as another reason for diminished emergency room care).

190. *See* Paul S. Appelbaum, *Assessment of Patients' Competence To Consent to Treatment*, 357 NEW ENG. J. MED. 1834, 1834 (2007) (asserting that ordinarily a critical first step in healthcare is "determin[ing] patients' capacity and decid[ing] when to seek substituted consent"); Vanessa Raymont et al., *Prevalence of Mental Incapacity in Medical Inpatients and Associated Risk Factors: Cross-sectional Study*, 364 LANCET 1421, 1421 (2004) (estimating that at least 40% of medical inpatients lacked the mental capacity to consent to treatment).

accept their health care providers' advice without question, rendering them dependent upon their providers and especially vulnerable to catastrophic results if these providers fail to devote themselves to addressing their needs.¹⁹¹ Traditionally, patients' treating physicians provided this expertise.¹⁹² Today, however, a range of specialists are likely to treat a hospital patient over short intervals of time, with hospital staff and hospitalists playing a more direct role in the care the patient receives.¹⁹³

Widespread levels of poor health literacy, compounded by the increasingly complex and technological nature of health care interventions, exacerbates the dependence and vulnerability of hospital patients.¹⁹⁴ Courts require physicians to obtain informed consent from their patients before performing any procedure,¹⁹⁵ yet almost half (47%) of adults "will find the process of informed consent arduous" and most will not be capable of providing true informed consent to the proposed procedure.¹⁹⁶ Studies have shown that "most [consumer] health materials fall into reading level ranges requiring high school, college, or graduate degrees . . . [which exceed] the reading abilities of the average American adult."¹⁹⁷ This pervasive healthcare illiteracy leaves hospitalized patients highly

191. See Coleman & Berenson, *supra* note 26, at 533 (noting the dependency and passivity of patients while hospitalized and how poorly they may do upon discharge when they are abruptly expected to assume responsibility for their recovery, often with little support or preparation); Moe Litman, *Fiduciary Law in the Hospital Context: The Prescriptive Duty of Protective Intervention*, 15 HEALTH L.J. 295, 307 (2007) (reiterating that hospitalized patients rely on their health care providers for care and expertise to the point of dependence "on the hospitals in whose care they are in").

192. See *supra* notes 26, 187 and accompanying text; see also Clark C. Havighurst, *Doctors and Hospitals: An Antitrust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1074-75 (noting that the physician used to be the "final arbitrator" of treatment).

193. See *supra* notes 26, 179, 185 and accompanying text; see also FURROW ET AL., *supra* note 76, at 373 ("The modern hospital—with . . . its complex diagnostic equipment and laboratories, its large staffs of nurses, doctors, and support personnel—has come to symbolize the delivery of medical care.").

194. See *supra* notes 185-86 and accompanying text.

195. See Robert Gatter, *The Mysterious Survival of the Policy Against Informed Consent Liability for Hospitals*, 81 NOTRE DAME L. REV. 1203, 1207 (2006) (listing the duties of hospitals as including: obtaining informed consent, disseminating information to patients, and assisting patients with the decision making process).

196. See HEALTH LITERACY, *supra* note 87, at 1, 62 (finding that illiteracy inhibits many patients from receiving proper treatment post-discharge and frustrates the purpose of informed consent). It has been noted that "informed consent law falls short of realizing shared decisionmaking because it does not require physicians to assure that patients understand the information that is provided to them or to help patients identify and apply their own values to the treatment information provided. . . . [I]t is possible for a physician to merely warn patients about treatment risks in order to comply with the law and yet fall far short of the shared decisionmaking ideal." Gatter, *supra* note 195, at 1213.

197. HEALTH LITERACY, *supra* note 87, at 22-23.

dependent on hospital staff for guidance. Notwithstanding that hospitals increasingly control the consent process by dictating how informed consent is obtained,¹⁹⁸ courts have consistently held that hospitals have no duty to ensure that patients receive relevant treatment information from their treating physician, nor are hospitals required to independently obtain informed consent.¹⁹⁹

The vulnerability of hospital patients is particularly acute because they may feel their condition and lack of understanding leave them little choice but to give their “consent” and hope that the hospital truly has their best interests at heart.²⁰⁰ While there are often steps that vulnerable parties in contractual relationships can take to protect themselves,²⁰¹ such tools tend to be unavailable to or ineffective for hospital patients.²⁰² In some cases, hospital patients are essentially a captive audience with no means to personally gauge the validity of the advice they are given, minimal opportunity to seek input from other experts due to time or financial limitations, and

198. See Gatter, *supra* note 195, at 1234, 1240 (noting that hospitals often develop their own consent forms that physicians use to record consent and explaining that hospitals may control the process of obtaining consent through electronic informed consent applications).

199. See *id.* at 1207–08, 1216–17 (noting that since 1967 courts have consistently found that hospitals do not have a duty to obtain informed consent as that duty continues to fall on physicians).

200. See Leslie F. Degner et al., *Information Needs and Decisional Preferences in Women with Breast Cancer*, 277 JAMA 1485, 1485, 1489 (1997) (noting that 34% of patients wanted to delegate responsibility for selecting their treatment).

201. Patients, for example, may have access to illness-specific support groups or seek treatment-related information via the Internet. See Jan Hoffman, *Getting Help: Patients Turn to Advocates, Support Groups and E-Mail, Too*, N.Y. TIMES, Aug. 14, 2005, at 19 (discussing groups that provide both support and education regarding treatment programs). Yet, while medical information may be increasingly available, patients’ ability to make use of that information remains suspect. See Hafemeister & Gulbrandsen, *supra* note 123, at 335 (illustrating a patient’s disregarding medical information through an example where a patient is warned about the dangers of a drug but demands it anyway). Alternatively, patients concerned about their future ability to make a medical decision may execute an advance directive in an attempt to guide the course of treatment when the occasion arises, but few individuals prepare such documents or accurately anticipate the decisions to be made. See Thomas L. Hafemeister, *End-of-Life Decision Making, Therapeutic Jurisprudence, and Preventive Law: Hierarchical v. Consensus-Based Decision-Making Model*, 41 ARIZ. L. REV. 329, 338–40, 345, 347 (1999) (discussing advance directive statutes and the general right of patients to execute advance directives, but describing the problems that frequently preclude their use); Sarah Barr, *Despite Best Intentions, Californian’s Don’t Talk About End-of-Life Wishes*, CAPSULES: THE KHN BLOG (Feb. 14, 2012, 4:19 PM), <http://capsules.kaiserhealthnews.org/index.php/2012/02/despite-best-intentions-californians-dont-talk-about-end-of-life-wishes> (reporting that although 82% of Californians believe it is important to put their end-of-life plans in writing, only 23% have done so).

202. See Litman, *supra* note 191, at 334 (recognizing that there is little that patients can do to protect themselves from suffering harm while visiting a hospital, for they are often “personally and situationally vulnerable”).

insufficient physical or mental capacity to simply walk away and seek care elsewhere.²⁰³

With their health and potentially their lives at risk, patients should be able to rely on their institutional care providers without fear that their interests will be sidelined for the sake of expediency or profit.²⁰⁴ However, evidence suggests that hospitals are susceptible to the same temptations to engage in self-interested behavior as more traditional fiduciaries when their financial interests conflict with those of the people it is their *raison d'être* to serve.²⁰⁵ And, unlike in an earlier era,²⁰⁶ hospitals' expanded operations and authority have a far greater ability to direct patient care,²⁰⁷ which means self-interested behavior poses a greater risk to their patients.

Some of the clearest indicators that hospitals are not always guided by their patients' best interests are metrics comparing the experiences of insured and uninsured patients. Despite federal legislation²⁰⁸ and institutional pronouncements²⁰⁹ championing equal

203. See *id.* (finding patients reliant on hospitals to treat serious illnesses and injuries, and provide them with quality care).

204. See Gatter, *supra* note 195, at 1268–69 (asserting that hospitals owe a fiduciary duty to patients because hospitals have an “obligation to protect the well-being of patients under their care”).

205. See *id.* at 1271–72 (enumerating the various interests a hospital may attempt to serve during the informed consent process, including: “its own interests to increase the likelihood that physicians will refer patients to the hospital, to free-up clinical time for physicians to provide additional fee-generating procedures, to improve the public image of the hospital, or to increase its patient satisfaction scores”).

206. See *supra* notes 143–47 and accompanying text (discussing how early hospital facilities were intended to only provide a physical structure and the tools and staff physicians needed to provide care for their patients).

207. See *supra* notes 179–81, 193 and accompanying text.

208. See, e.g., Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(a) (1982 & Supp. IV 1987) (mandating hospitals provide an appropriate medical screening examination to individuals who come to the hospital's emergency room requesting a medical examination or treatment, and if it is determined that they have an emergency medical condition, the hospital must provide such treatment as is needed to stabilize the medical condition, regardless of whether these individuals can pay for these services or are eligible for medical benefits). Congress passed EMTALA amid growing concerns of inadequate emergency room care for poor and uninsured patients. H.R. Rep. No. 99-241, at 5 (1985).

209. See, e.g., *Credit, Billing, and Collection Policy for Patients in Need of Financial Aid*, VIRGINIAHOSPITALCENTER.COM, http://www.virginiahospitalcenter.com/patients/financial_need.aspx (last visited Feb. 20, 2013) (“It is the policy of [the] Virginia Hospital Center to provide caring healthcare services to patients 24 hours a day 7 days a week regardless of the ability to pay . . .”); *Mission Statement and Vision*, GREENWICH HOSP., <http://www.greenhosp.org/about-greenwich-hospital/mission-statement-and-vision> (last visited Feb. 20, 2013) (“Individuals within the communities we serve are assured access to quality health care regardless of ability to pay.”); *Our Mission, Strategic Vision, and History*, ALAMEDA CNTY. MED. CTR., <http://www.acmedctr.org/> (last visited Feb. 20, 2013) (“It is our mission to maintain and improve the health of all residents of Alameda County, California, regardless of ability to pay.”).

quality of care for patients regardless of their insurance status or ability to pay, the data suggest that hospitals treat uninsured patients differently.²¹⁰ Though the precise mechanics underlying the discrepancies in hospital stay length, resource and procedure utilization, and treatment outcomes between insured and uninsured patients are debatable, these differences are precisely what one would expect to observe if a hospital were motivated by financial incentives rather than patient wellbeing: unprofitable patients receive fewer hospital resources.

Finally, imposing a fiduciary duty on hospitals is appropriate given that they are often the least cost avoider of problems that may otherwise be extraordinarily difficult and expensive to prevent.²¹¹ When the utility of a critically important and socially beneficial relationship would be lost due to the excessive costs of monitoring the quality and loyalty of one party's performance, fiduciary law imposes obligations on that party to remain loyal and forgo self-serving behavior that might otherwise be tolerable in ordinary contractual relationships.²¹² As described, the typical patient is not capable of personally evaluating whether a hospital's actions are motivated by loyalty or self-interest, or whether to retain an independent expert to monitor the hospital's actions.²¹³ Just as it is

210. See MIKA NAGAMINE ET AL., AGENCY FOR HEALTHCARE RESEARCH & QUALITY, STATISTICAL BRIEF NO. 88, HEALTHCARE COST AND UTILIZATION PROJECT TRENDS IN UNINSURED HOSPITAL STAYS, 1998–2007, at 2 (Mar. 2010), available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb88.pdf> (finding that the average amount spent by a hospital on a patient per stay, as well as the length of those stays, are less for uninsured patients); Wendy R. Greene et al., *Insurance Status Is a Potent Predictor of Outcomes in Both Blunt and Penetrating Trauma*, 199 AM. J. SURGERY 554, 556 (2010) (finding uninsured trauma patients were more likely to die than insured patients); Omar Hasan et al., *Insurance Status and Hospital Care for Myocardial Infarction, Stroke, and Pneumonia*, 5 J. HOSP. MED. 452, 456 (2010) (finding hospital resource utilization rates lower and mortality rates higher for uninsured patients); Arch G. Mainous III et al., *Impact of Insurance and Hospital Ownership on Hospital Length of Stay Among Patients with Ambulatory Care-Sensitive Conditions*, 9 ANNALS FAM. MED. 489, 493 (2011) (finding the average length of hospital stays are shorter for uninsured patients).

211. See Furrow, *supra* note 111, at 456–59 (noting that provider-caused injury is predictable and preventable yet continues to be ranked as one of the leading causes of death in the United States); Rotman, *supra* note 122, at 932–33 (explaining that due to the dependent and vulnerable nature of a beneficiary, fiduciary relationships benefit society “by enhancing productivity and knowledge, facilitating specialization, and creating fiscal and informational wealth.”).

212. Rotman, *supra* note 122, at 932–34, 951 (explaining that beneficiaries do not need to monitor the actions of a fiduciary because the fiduciary assumes the burden of compliance).

213. See *supra* notes 184–203 and accompanying text. See generally Furrow, *supra* note 111, at 456–84 (noting that patients rely on hospitals to provide them with adequate healthcare and highlighting that hospitals are in the best position to address a patient's medical needs).

unreasonable to expect litigants to hire a second attorney to monitor the work of one currently employed, or an investor to retain a second broker to oversee the one trading stocks, it is unreasonable to expect patients to monitor their hospital for self-serving behavior. In this context, fiduciary law provides a tool to promote loyalty and protect the integrity of the hospital-patient relationship.²¹⁴

In light of this, courts have grown more sympathetic to the predicament of patients and more willing to use available legal doctrine to hold hospitals accountable for their patients' wellbeing,²¹⁵ with "the language of fiduciary duty" entering the legal discourse about the provision of care and the occurrence of errors in the hospital setting.²¹⁶ With post-discharge injuries and avoidable rehospitalizations in the spotlight, the time has come to formally recognize the fiduciary relationship between hospitals and their patients, and to employ associated obligations to address these and other issues that currently lack a needed remedy.

214. See Rotman, *supra* note 122, at 932–34 (asserting that fiduciary law prevents those who hold power in the fiduciary relationship from abusing a beneficiary's trust and reliance); see also Furrow, *supra* note 111, at 440–45 (stating that fiduciary law obligates a fiduciary to be loyal to the beneficiary due to the beneficiary's dependence and reliance on the fiduciary's services, knowledge, and power).

215. See *supra* notes 100–01, 153–82 and accompanying text; see also Furrow, *supra* note 111, at 459 (noting that courts have been more willing to stretch agency exceptions to allow patients to recover against hospitals).

216. Furrow, *supra* note 111, at 460; see, e.g., DiCarlo v. St. Mary's Hosp., No. 05-1665 (DRD-SDW), 2006 WL 2038498, at *9 (D.N.J. July 19, 2006) (recognizing that a hospital owes a fiduciary duty to patients with regard to their capacity to provide medical services), *aff'd*, 530 F.3d 255 (3d Cir. 2008); Ballard v. Advocate Health & Hosp. Corps., No. 97 C 6104, 1999 WL 498702, at *3–4 (N.D. Ill. July 7, 1999) (denying defendant hospital's motion for summary judgment in a medical malpractice suit where the court found the patient justifiably relied on the hospital and not a specific physician); Gragg v. Calandra, 696 N.E.2d 1282, 1287–88 (Ill. App. Ct. 1998) (stating that under the doctrine of apparent authority, a hospital can be vicariously liable for a doctor's negligence unless the patient knew or should have known that the doctor was an independent contractor); Doe v. Bridgeton Hosp. Ass'n, 366 A.2d 641, 645 (N.J. 1976) (emphasizing that hospitals have a fiduciary duty to exercise their managerial powers reasonably and "for the public good" as they are a quasi-public trust); Grodjesk v. Jersey City Med. Ctr., 343 A.2d 489, 500 (N.J. Super. Ct. Ch. Div. 1975) (ascertaining that a hospital has a fiduciary duty to provide adequate facilities for its patients); Clark v. Southview Hosp. & Family Health Ctr., 628 N.E.2d 46, 52–53 (Ohio 1994) (ruling that a hospital that holds itself out to the public to be a medical provider is liable for a physician's negligent acts if a patient looks to the hospital, as opposed to a specific physician, to provide medical care); White v. Methodist Hosp. S., 844 S.W.2d 642, 647 (Tenn. Ct. App. 1992) (reasoning that hospitals can be held vicariously liable for doctors in emergency room or operating room settings because people often seek treatment from a particular hospital rather than a particular doctor).

IV. THE NATURE OF HOSPITALS' DISCHARGE-RELATED FIDUCIARY OBLIGATIONS

A. *The Rationale for Imposing Discharge-Related Obligations*

With respect to discharges, hospitals, as fiduciaries, should be obligated to take reasonable steps commensurate with their patients' continuing health risks to promote these patients' health until they have had a reasonable opportunity to establish or resume a relationship with a community-based physician. This duty, to assist patients during the transition to the care of another provider, is an integral part of the hospital-patient fiduciary relationship for several reasons. First, it recognizes the highly vulnerable and dependent state of many hospital patients following discharge and the unique ability of hospitals to provide this service. Second, it represents a logical extension of the services already provided by hospitals and reinforces the trust and loyalty that should permeate the hospital-patient relationship. Third, it requires a service that is critically needed by discharged patients (and society) that hospitals can readily, efficiently, and effectively supply, and it acts as a safeguard against the very type of injurious, self-interested behavior that fiduciary doctrine is designed to deter.

Unlike some fiduciary relationships, where the relationship revolves around a specific transaction that has a clearly defined end,²¹⁷ the needs of hospital patients often lack a similar level of demarcation. While one's reliance on legal representation may end with the closure of a case, or the value of financial management may end with the exhaustion of a trust, a patient's need for medical assistance frequently does not vanish after exiting the hospital. A discharge from the hospital rarely, if ever, means that a patient has fully recovered or attained perfect health.²¹⁸ On the contrary, a discharge is most often a transition from one stage of care and one care provider to another, not an indication that the need for care has passed. Knowing this, and recognizing patients' limited medical

217. See, e.g., *SEC v. Chenery Corp.*, 318 U.S. 80, 85–86 (1943) (assessing a set of stock transactions, finding a clear fiduciary relationship between the respondents and their company because they were to serve the company's best interests).

218. See, e.g., Liang-Kung Chen et al., *Effectiveness of Community Hospital-Based Post-Acute Care on Functional Recovery and 12-month Mortality in Older Patients: A Prospective Cohort Study*, 42 *ANNALS MED.* 630, 630 (2010) (noting that older patients are often discharged before they are fully recovered); *Patient Care Coordination*, ANTELOPE VALLEY HOSP., <http://www.avhospital.org/Services/PatientCareCoordination/Pages/default.aspx> (last visited Feb. 20, 2013) (warning that discharge does not signal that the patient is fully recovered, but rather that the patient's "condition is stable and no longer requires acute hospital care").

knowledge, general health illiteracy, vulnerability, and dependence,²¹⁹ an expectation that discharged patients can safely and effectively manage their own care is at best overly optimistic, and at worst dangerously irresponsible. As a fiduciary armed with this knowledge, a hospital cannot simply look the other way and hope for the best as its patients are waved out the door. Fiduciary law demands more.

Another aspect of the hospital-patient relationship that supports the recognition of post-discharge duties is that hospitals are the source of many patients' post-discharge risks. These risks typically arise out of the very circumstances that the patient's relationship with the hospital was intended to address, as a period of recovery and compromised bodily function typically follows most hospital treatments.²²⁰ But the hospital itself may have also inadvertently created risks, as is the case with a health care-acquired infection or some other care-related adverse event.²²¹ Once a hospital undertakes to treat a patient, so long as risks attendant to the hospitalization remain, it is patently unacceptable for it to withdraw all assistance before another care provider can reasonably assume responsibility for the patient. Just as there are restrictions on other fiduciaries walking away from their duties before a substitute is in place,²²² a hospital

219. See *supra* notes 188–98 and accompanying text.

220. See, e.g., Christopher P. Silveri & Mary Claire Walsh, *Surgery Recovery: From Hospital to Home*, SPINEUNIVERSE (Oct. 13, 2011), <http://www.spineuniverse.com/treatments/surgery/surgery-recovery-hospital-home> (explaining that all surgical procedures require a recovery period, both in the hospital and at home).

221. See R. DOUGLAS SCOTT, CTRES. FOR DISEASE CONTROL & PREVENTION, THE DIRECT MEDICAL COSTS OF HEALTHCARE-ASSOCIATED INFECTIONS IN U.S. HOSPITALS AND THE BENEFITS OF PREVENTION I (Mar. 2009) (stating that 4.5 healthcare-associated infections occur for every 100 hospital admissions); Bernard Friedman et al., *Do Patient Safety Events Increase Readmissions?*, 47 MED. CARE 583, 585 (2009) (reporting that approximately 2.6% of 1.5 million adult surgery patients experienced a patient safety event during hospitalization); Jeneen Interlandi, *Beating Back the Bugs: Some Hospitals Have Turned a Corner in Fighting Deadly Infections*, SCIENTIFIC AM., May 2011, at 24 (noting that “nearly two million hospital-acquired infections claim roughly 100,000 lives and add \$45 billion in costs” per year); Rebecca R. Roberts et al., *Costs Attributable to Healthcare-Acquired Infection in Hospitalized Adults and a Comparison of Economic Methods*, 48 MED. CARE 1026, 1028–29 (2010) (finding that 12.7% of hospitalized high-risk adult patients developed a healthcare-acquired infection, with an attributable mortality of 6.1%); see also *supra* note 162 and accompanying text (discussing the adverse effects of hospitalization and related costs). Hospital readmissions are often directly attributable to these events. See Friedman et al., *supra* note 221, at 583 (determining that the three-month readmission rate was 17% for patients with no hospital-related safety event, but 25% when such an event was recorded).

222. See, e.g., N.C. GEN. STAT. § 36C-7-707(a) (2011) (stating that a trustee retains duties and powers until property is delivered to successor); VA. CODE ANN. § 64.2-758(A) (West 2012) (requiring notice period or court order before trustee can resign).

should also be prohibited from abandoning responsibilities that flow from the services it provides and from which it profits.²²³

The expectations of patients further justify post-discharge duties. Patients expect hospitals, as institutions, to care for them,²²⁴ an expectation that hospitals do little to dispel.²²⁵ If anything, hospitals reinforce that expectation by employing ever greater numbers of their own physicians,²²⁶ by holding themselves out as full-service providers through extensive marketing campaigns,²²⁷ and by participating more directly than ever in the provision of care.²²⁸ Given that hospitals now interact more directly with patients in ways that were once exclusively within the realm of physicians, patients have the right to expect the same degree of loyalty and responsibility from a hospital as they expect from a physician.²²⁹ The long-standing legal and ethical prohibition on patient abandonment by physicians²³⁰ should be recognized to have an analog that prohibits hospitals, as part of their fiduciary duty, from abandoning at-risk patients when they are discharged from the hospital.

In addition, permitting hospitals to choose whether to provide reasonable oversight of recently discharged patients creates an unacceptable conflict of interest in light of hospitals' fiduciary obligations.²³¹ Under the current payment model, hospitals receive

223. See *supra* notes 163–78 and accompanying text.

224. See Litman, *supra* note 191, at 334 (“[I]t can hardly be doubted that there is a widespread and deeply held conviction that patients can expect loyal and dedicated commitment from hospitals and hospital staff.”).

225. Direct advertising by hospitals to prospective patients emphasizing that they are a comprehensive service provider has increased in recent years. See David Oxman, *Hospital Advertising: Is It Time for a Closer Look?*, HOSPITALIST (Jan. 2007), http://www.the-hospitalist.org/details/article/241425/Hospital_Advertising.html (explaining that advertising by health care providers, including hospitals, was taboo until increasing economic pressures and changing cultural norms led to the demise of these proscriptions, with such advertisements now common). Such advertisements frequently use language implying that the hospital is the treatment provider. See, e.g., Print Advertisement, Beaufort Memorial Hospital Orthopedics Program (on file with law review) (“Beaufort Memorial’s Total Joint Program assures personalized, individualized care, from diagnosis through recovery.”); Print Advertisement, Children’s Memorial Hospital (on file with Law Review) (“[W]e lead one of the largest pediatric stem cell transplant programs in the nation.”); Print Advertisement, Seattle Children’s, available at www.seattlechildrens.org/pdf/urgent-care-minus-the-traffic.pdf (last visited Feb. 20, 2013) (“Whether it’s a sports injury, the flu, or ongoing treatment of a chronic illness, you can count on the expertise and compassion of Seattle Children’s.”).

226. See *supra* note 179 and accompanying text.

227. See *supra* notes 161, 225 and accompanying text.

228. See *supra* notes 180–81, 185–87 and accompanying text.

229. See *supra* Part IV.

230. See *supra* note 86.

231. See Rotman, *supra* note 122, at 941–42, 959–60 (explaining that fiduciary law requires the fiduciary to avoid conflicts of interest and imposes “strict duties on fiduciaries, including . . . requiring fiduciaries to act selflessly and in the best

compensation for medical services supplied, not for minimizing service utilization.²³² This means that by failing to provide relatively inexpensive interventions that reduce the likelihood of post-discharge complications, hospitals can profit when they readmit and treat former patients.²³³ Consequently, despite the fact that it is the avowed purpose of hospitals to heal their patients, under the predominant legal doctrine hospitals can allow preventable harm to occur and then profit from their inactivity—conduct which should be impermissible when a fiduciary's beneficiary is involved.²³⁴ Though such behavior is perhaps within the “morals of the market place,”²³⁵ it is not tolerable from institutions charged with the delivery of health care.²³⁶

interests of their beneficiaries”); *see also supra* notes 79, 140, 205 and accompanying text.

232. *See* Abdulrahman El-Sayed, *Prevention vs. Treatment and the Perverse Incentives Inflating the Costs of Healthcare*, HUFFINGTON POST (Oct. 18, 2011 3:17 PM), http://www.huffingtonpost.com/abdulrahman-m-elsayed/health-care-prevention_b_1015734.html (noting that the current payment system pays health care providers for each action they provide to a patient). *But see Improving Care Coordination and Lowering Costs by Bundling Payments*, HEALTHCARE.GOV (Aug. 23, 2011), <http://www.healthcare.gov/news/factsheets/2011/08/bundling08232011a.html> (noting that rather than make separate payments for the various services provided, efforts are being made under the PPACA to reduce healthcare fragmentation and costs by bundling the payments for services across a given episode of care (e.g., a hip replacement) “to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients both when they are in the hospital and after they are discharged”); Michael L. Millenson, *Analysis: ACOs Could Have the Medicare Muscle To Transform Health System*, KAISER HEALTH NEWS (May 2, 2012), <http://www.kaiserhealthnews.org/stories/2012/may/02/millenson-acos-muscle-to-transform-system.aspx> (explaining that the “accountable care organization” introduced in conjunction with the 2010 passage of the PPACA replaces the idea of reimbursing individual doctors and hospitals for each procedure they perform with instead a lump-sum payment to a group of health care providers working as a team, with reimbursements based on a patient’s health outcome, satisfaction, and costs).

233. *See, e.g.,* Young, *supra* note 8 (analyzing records of 5.8 million incidents in which a patient went back to a hospital to be re-treated, and finding that readmissions added \$8.7 billion a year or 15.7% of the cost of caring for these patients). *But see supra* notes 10–12 and accompanying text (discussing PPACA provisions pursuant to which hospitals have begun to incur reductions in their Medicare reimbursement levels for unduly high readmission rates for Medicare patients).

234. *See* Furrow, *supra* note 111, at 446 (noting a hospital’s duty to protect patients from “unnecessarily risky operations”); Paul B. Miller & Charles Weijer, *Fiduciary Obligation in Clinical Research*, 34 J.L. MED. & ETHICS 424, 432 (2006) (stating that a fiduciary has a duty to act to protect, promote, preserve, or secure the interests of a beneficiary).

235. *See* Meinhard v. Salmon, 164 N.E. 545, 546 (N.Y. 1928) (explaining that conduct typical of an ordinary contractual relationship is impermissible in a fiduciary relationship where a fiduciary owes the beneficiary undivided loyalty).

236. *See infra* Part IV.B–C.

B. *The Obligation to Prepare Patients for Discharge*

Two primary obligations comprise a hospital's fiduciary duty to discharged patients. The first involves preparing a patient for discharge. For example, a congressional research report noted that:

Medicare regulations . . . require[] participating hospitals . . . to have a discharge planning process that applies to all patients. [They] must identify patients expected to experience adverse health consequences upon discharge and provide them with a discharge planning evaluation. . . . If the discharge planning evaluation indicates a need for a discharge plan, the hospital must develop one. . . . The hospital must arrange for initial implementation of the patient's discharge plan and must update the discharge plan, when necessary, and counsel the patient and family members (or interested parties) to prepare them for post-hospital care.²³⁷

This report also noted, in what may reflect some of the specific steps that a hospital may need to execute to meet a related fiduciary duty, that "[the discharge planning] evaluation must be made on a timely basis and must include an evaluation of the patient's likely need for post-acute services and the availability of those services," the results of this evaluation must be discussed with the patient or the patient's representative, and "[b]oth the discharge plan evaluation and a discharge plan must be developed by, or under the supervision of, a registered professional nurse, social worker, or other appropriately qualified personnel."²³⁸ The report further stated that, notwithstanding these requirements, studies have identified instances when the required discharge planning was incomplete and hospitals did not timely provide necessary information to involved post-discharge health care providers.²³⁹ Nevertheless, there is little controversy that adequate discharge planning is a hospital's responsibility.²⁴⁰

237. STONE & HOFFMAN, *supra* note 25, at 12 (noting that these Medicare regulations will cover more than 90% of all acute-care hospitals in the United States).

238. *Id.*

239. *See id.* (establishing that although Medicare requirements mandate such discharge planning, hospitals do not necessarily comply); *see also supra* Parts I–II.

240. *See* Amy J.H. Kind & Maureen A. Smith, *Documentation of Mandated Discharge Summary Components in Transitions from Acute to Subacute Care*, in *ADVANCES IN PATIENT SAFETY: NEW DIRECTIONS AND ALTERNATIVE APPROACHES* 1, 1 (Kirm Henriksen et al. eds., 2005) (noting the importance that hospital discharge summaries play in communicating a patient's care plan to the post-hospital care team, and discussing The Joint Commission's established standards (Standard IM.6.10, EP 7), which set forth the requisite components of hospital discharge summaries); *see also* JOINT COMM'N, *ADVANCING EFFECTIVE COMMUNICATION, CULTURAL COMPETENCE, AND PATIENT- AND FAMILY-CENTERED CARE: A ROADMAP FOR HOSPITALS* 29–31 (2010) (explaining that hospitals should take responsibility for discharge planning and work

C. *The Obligation to Provide Reasonable Post-Discharge Assistance*

The second obligation, which hospitals even more often fail to fulfill, is to provide reasonable post-discharge assistance for a period of time commensurate with their patients' continuing health care risks or until another health care provider has assumed responsibility for the patient.²⁴¹ However, a number of hospitals, no doubt recognizing the mutually beneficial nature of this service,²⁴² are now beginning to provide it voluntarily.²⁴³ Though the level of post-discharge contact and assistance that a hospital owes a patient will necessarily vary with the circumstances, some degree of medical monitoring is a critical component because it can detect dangerous situations and avert related crises.²⁴⁴ If monitoring detects a post-discharge problem arising, this information should be promptly communicated to the patient or the patient's surrogate, and the patient should be directed to seek medical assistance.²⁴⁵

D. *Model Programs*

This Article does not purport to fully outline what a hospital must reasonably do to meet its fiduciary obligations to discharged patients.

with patients on an individual basis to effectively satisfy each patient's unique post-discharge needs).

241. See *supra* notes 5–12, 22–29, 33 and accompanying text; *supra* Part II.

242. Based on their increased use, see *infra* note 243 and accompanying text, hospitals appear to be discovering that these services can be delivered efficiently, effectively, and without undue burden, and that they may also be financially beneficial. See Anna Sommers & Peter J. Cunningham, *Physician Visits After Hospital Discharge: Implications for Reducing Readmissions*, NAT'L INST. HEALTH CARE REFORM, RES. BRIEF NO. 6, Dec. 2011, at 1 (documenting the increased recognition, including by public and private payers, of the value of preventing readmissions to improve health care quality and reduce unnecessary costs); Karen M. Cheung-Larivee, *NQF Endorses Readmission Measures*, FIERCEHEALTHCARE (Apr. 27, 2012), <http://www.fiercehealthcare.com/story/nqf-endorses-readmissions-measures/2012-04-27> (discussing federal efforts to encourage increased communication and collaboration among all the stakeholders, including hospitals, needed to reduce avoidable re-hospitalizations).

243. See *supra* notes 13–18 and accompanying text; *infra* notes 248–60 and accompanying text (providing examples of the various methods that hospitals have voluntarily undertaken to prevent patient readmissions after discharge).

244. Ray Freeland's case, introduced at the beginning of this Article, provides an example of how monitoring can protect patients and reduce costs. See *supra* notes 13–17 and accompanying text.

245. This communication could be an automated electronic message triggered when a certain parameter is met, it could be a hospital nurse on the phone, or it could be an employee of a third party contracted to oversee monitoring, to name just a few possibilities. However, if a competent patient refuses post-discharge assistance, this should generally constitute an intervening event that relieves the hospital of post-discharge liability. See *supra* note 89. On the other hand, if the hospital is or should be aware that the patient is incapable of understanding the nature and value of this assistance or accepting it, the hospital should take reasonable steps to enhance its availability.

Nevertheless, what many hospitals are already doing, as described at the outset of this Article²⁴⁶ and as follows,²⁴⁷ provides guidance as to what the medical community considers both reasonable and necessary during and following a patient's discharge.

The Care Transitions Intervention study²⁴⁸ and Project Re-Engineered Discharge ("Project RED")²⁴⁹ are just two initiatives that demonstrate reasonable means by which hospitals can reduce post-discharge complications and re-hospitalizations.²⁵⁰ For the former, patients are provided with "a personal health record and [...] a series of visits and telephone calls with a transition coach."²⁵¹ This coach meets with the patient in the hospital before discharge to answer questions and to arrange for a home visit, typically within forty-eight to seventy-two hours after discharge.²⁵² During the home visit, the coach reconciles all of the patient's medication regimens and reviews each medication with the patient to ensure that he or she understands its purpose, when and how to take it, and potential

246. See *supra* notes 13–18 and accompanying text (discussing a wireless heart monitoring system to track the condition of discharged patients).

247. See *infra* notes 248–60 and accompanying text (discussing the ways hospitals can reduce hospital readmission after a patient is discharged, such as by offering home visits, coaches, and other forms of monitoring).

248. See Coleman et al., *supra* note 25, at 1822 (describing the Care Transitions Intervention study and the results following the implementation of this model, where patients and caregivers took on "more active role[s] during care transitions" to determine if this reduced rehospitalization rates).

249. See *Project Red (Re-Engineered Discharge)*, B.U. MED. CTR., <http://www.bu.edu/fammed/projectred> (last visited Feb. 20, 2013) (explaining that the project "develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates").

250. See *supra* notes 247–48; see also Bodenheimer, *supra* note 26, at 1067–68 (describing other model programs); Coleman & Berenson, *supra* note 26, at 533 (discussing controlled studies showing that management of transitional care by advance practice nurses can reduce rehospitalization rates); Mosquera, *supra* note 5 (noting that hospitals that use nurse care managers to coordinate care plans and help steer patients toward health goals have been successful in preventing hospital readmission). Research efforts continue to seek the optimal means for reducing hospital readmissions, with initial findings suggesting that there will be some between-site variation in what works best in a given setting. See Jha et al., *supra* note 9, at 2643–44 ("Some previous studies suggest that comprehensive discharge planning, effective case management, remote monitoring of the patient's condition from his or her home, and meticulous follow-up can reduce the frequency with which patients with congestive heart failure return to the emergency room or are rehospitalized. However, other studies have not shown, for example, that the use of nurse case managers or remote monitoring is helpful" (footnotes omitted)).

251. Coleman et al., *supra* note 25, at 1823. A personal health record is a document maintained by the patient that includes "an active problem list, medications and allergies, whether advance care directives had been completed, and a list of red flags, or warning symptoms or signs, that corresponded to the patient's chronic illnesses." *Id.* Transition coaches are advanced practice nurses whose purpose is to "provide continuity across settings, and to ensure that the patient's needs [are] being met irrespective of the care setting." *Id.*

252. *Id.*

adverse effects.²⁵³ The coach also instructs the patient on how to effectively communicate medical needs to health care providers, reviews warning signs pertaining to the patient's medical condition, and advises the patient on the best responses if warning signs emerge.²⁵⁴ The coach subsequently stays in touch with the patient by telephoning three times during a twenty-eight day post-hospitalization period to monitor progress.²⁵⁵ The re-hospitalization rates for patients receiving these services were significantly reduced when compared to a control group.²⁵⁶ In addition, even taking into account the added cost of these services, annual health care savings of \$295,594, or roughly \$780 per patient, were achieved because of the significantly reduced rate of re-hospitalization.²⁵⁷

Project RED uses a somewhat similar model to assist discharged patients, utilizing a personal discharge advocate but also a virtual discharge advocate named Louise to coordinate a patient's discharge from the moment of admission.²⁵⁸ The primary goal of the program is not to provide care, but to help the patient and the caregiver communicate more effectively and to supply needed information during and following discharge.²⁵⁹ The program educates the patient throughout the hospital stay, reconciles medications prescribed by the treatment team, and coordinates follow-up care with community-based providers, which includes ensuring that the patient's primary

253. *Id.* at 1823–24.

254. *See id.* at 1824 (discussing the ways coaches teach patients how to better communicate their needs, including role playing).

255. *Id.*

256. *See id.* at 1825–26 (stating that readmission rates were measured at thirty, ninety, and 180-day post-discharge intervals, and finding that participants in the intervention study had lower readmission rates at each interval).

257. *Id.* at 1827. Note that the calculated savings was probably conservative because the health delivery system participating in the study had already made “great progress” in reducing readmissions, indicating a greater potential for reduction and savings in systems that had not made similar progress. *See id.* (projecting that greater reductions in readmissions would probably be seen in other health delivery systems that had not previously attempted and achieved progress in reducing readmissions).

258. *See* AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, U.S. DEP'T OF HEALTH & HUMAN SERVS., RESEARCH ACTIVITIES NO. 367, RE-ENGINEERED DISCHARGE PROJECT DRAMATICALLY REDUCES RETURN TRIPS TO THE HOSPITAL 5 (2011), *available at* <http://www.ahrq.gov/research/mar11/0311RA.pdf> (explaining in detail the computer system, Louise, that tracks and guides patients). With a paper copy of an After Hospital Care Plan in hand, patients spend about forty minute walking through the plan with the aid of prompts from a touch screen computer and where they can also ask “Louise” questions. The computer program also checks the patient's comprehension of key information, such as when and how to take medications. If the patient does not understand something, the program will present the information again and ultimately alert a human discharge assistant if this second attempt at relaying the information is unsuccessful. *Id.*

259. *See id.* at 3–4 (emphasizing the plan's use of plain language).

care physician receives the discharge summary.²⁶⁰ Project RED achieved a 30% decrease in readmissions thirty days post-discharge.²⁶¹ This model has now been adopted by the National Quality Forum as one of the national “Safe Practices for Better Healthcare.”²⁶²

These programs are not anomalous; as noted, other hospitals around the country are experimenting with various ways of providing discharge and post-discharge assistance that are generating positive results.²⁶³ These programs have demonstrated that this type of assistance is increasingly viewed as something that hospitals can implement in a relatively cost-effective fashion while providing discharged patients with an enormously valuable service.

260. *See id.* at 3 (presenting a Project RED checklist, which includes communicating with primary care doctors).

261. *See id.* (discussing the results of a Project RED test conducted at Boston University Medical Center).

262. *Id.*

263. *See supra* notes 13–18 and accompanying text (noting the use of a wireless heart monitoring system); *see, e.g.*, Engel et al., *supra* note 56, at 459 (finding that the highest frequency of patient comprehension deficiencies occurs in conjunction with discharge instructions and suggesting remedies for this problem); Karen Minich-Pourshadi, *Predictive Modeling Options To Cut Preventable Admissions*, HEALTHLEADERS MEDIA, Apr. 2012, at 48–52 (reporting that several hospitals have successfully decreased patient readmissions after discharge by using a form of predictive modeling based on hospital records); Sommers & Cunningham, *supra* note 244, at 1 (noting that efforts to improve post-discharge plans alone have not led to fewer readmissions and lower costs, but discussing two new hospital payment plans that incentivize broader efforts to reduce hospital readmissions); Christina Hernandez Sherwood, *Hospitals Reach Out To Keep Patients from Returning*, PHILA. INQUIRER, Dec. 28, 2011, at A3 (describing a hospital’s success in preventing patient readmissions by using community health workers who work with patients on a continuing basis to ensure they receive proper treatment for their healthcare needs); Mary Bondmass et al., *The Effect of Physiologic Home Monitoring and Telemanagement on Chronic Heart Failure Outcomes*, 3 INTERNET J. ADVANCED NURSING PRAC. (1999), available at <http://www.ispub.com/journal/the-internet-journal-of-advanced-nursing-practice/volume-3-number-2/the-effect-of-physiologic-home-monitoring-and-telemanagement-on-chronic-heart-failure-outcomes-1.html#sthash.I5OR129r.dpbs> (describing a new strategy to reduce hospital readmissions involving telemonitoring where medical management and intervention is provided by telephone based on data from a transtelephonic monitoring system); Dina Overland, *BCBS Saves \$232M, Cuts Readmissions with Patient Registries*, FIERCEHEALTHPAYER (Apr. 21, 2012), <http://www.fiercehealthpayer.com/story/bcbs-saves-232m-lowers-readmissions-patient-registries/2012-04-21> (discussing the success of a collaborative program where hospitals share patient data to improve care, reduce costly complications, and identify best practices); *Studies Evaluate Programs to Transition Care of Patients After Hospital Discharge*, SCI. DAILY (July 25, 2011), <http://www.sciencedaily.com/releases/2011/07/110725190035.htm> (noting that hospital readmissions decreased when patients participated in a care transition intervention program where they received a home visit and two follow-up telephone calls, or in a transitional care program led by advance practice nurses who provided eight post-discharge house visits).

E. Limits on Liability

Naturally, there must be a limit to the extent of a hospital's duty both during and after a patient's discharge. The practice of medicine remains as much an art as a science,²⁶⁴ and tragic events can occur even when every feasible precaution has been taken.²⁶⁵ Lest a hospital be subjected to unrealistic expectations, second-guessing, and liability for events that could not have been reasonably anticipated nor prevented, some check on the extent of these duties must be in place. The widely accepted and employed legal element of foreseeability provides an important limit on hospitals' discharge-related duties by ensuring that they are not held liable for adverse events not reasonably foreseeable at the time of discharge or during post-discharge monitoring.²⁶⁶ Fortunately, there are now multiple approaches hospitals can adopt that adequately meet this responsibility without imposing an onerous burden.²⁶⁷

CONCLUSION

Formally recognizing the fiduciary duty of hospitals with regard to patient discharges and post-discharge monitoring will ensure that patients receive vital preparation for their discharge and are provided

264. See ALAIN C. ENTHOVEN, HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE 4 (1980) (acknowledging that applying the scientific knowledge associated with the practice of medicine remains an art form).

265. See *Jones v. Porretta*, 405 N.W.2d 863, 869 (Mich. 1987) (recognizing that physicians are at fault only when their conduct violates the standard of care, not simply when a patient experiences bad results); *Ehlinger v. Sipes*, 454 N.W.2d 754, 761 (Wis. 1990) ("The medical profession is not an exact science and its members are not subject to liability for mere unfavorable results. Physicians are not insurers or guarantors of their work." (citation omitted)).

266. See *supra* note 89 (noting that action or inaction by a discharged patient that could not reasonably have been foreseen will generally be viewed as an intervening cause that relieves the health care provider of liability); *supra* note 245 (commenting that if a competent patient refuses post-discharge assistance, this should generally constitute an intervening event that relieves the hospital of post-discharge liability); see, e.g., *Bornmann v. Great Sw. Gen. Hosp., Inc.*, 453 F.2d 616, 619 (5th Cir. 1971) (finding a hospital not liable for the death of a patient from a self-administered overdose of barbiturate drugs where no one, including the husband of the deceased, had observed any indications of potential suicide); *Gracey v. Eaker*, 837 So. 2d 348, 353 (Fla. 2002) (stating that the elements for breach of fiduciary duty require "the existence of a fiduciary duty, and the breach of that duty such that it is the proximate cause of the plaintiff's damages"). But see *supra* notes 89 and 245 (stating that foreseeable non-cooperation or a recognized lack of patient capacity to understand the nature and value of this assistance or capacity to accept it, may result in an imposition of hospital liability); see, e.g., *Riddle Mem'l Hosp. v. Dohan*, 475 A.2d 1314, 1317 (Pa. 1984) (reasoning that if the hospital acted unreasonably in discharging a patient, and it was "foreseeable that such removal would aggravate or increase the danger of the existing physical condition [of the patient], the hospital would be liable").

267. See *supra* notes 13–18, 248–60 and accompanying text.

needed follow-up assistance for a period of time commensurate with their continuing health risks or until another health care provider has assumed responsibility for the patient. Current applications of legal doctrines associated with traditional medical malpractice and hospital liability claims do not adequately redress or deter the preventable adverse events that can occur after a patient leaves a hospital or a similar health care facility, but recognition and enforcement of the hospital-patient fiduciary duty can mitigate this problem by ensuring that hospitals take reasonable steps to aid patients both during and after discharge. Patients who are injured as a result of inadequate discharge and follow-up services should be compensated for harm that is a foreseeable consequence of a failure to provide these services.

As physicians recognized long ago, proper health care cannot exist without mutual trust and respect between the parties. If hospitals are to effectively fill their modern role as the nexus of health care delivery, patients must be able to safely trust hospitals to guard their interests in the same manner they trust their doctor.