PATIENTS AS STAKEHOLDERS

ISAAC D. BUCK*

ABSTRACT

Once a provider of public support and charity, the American hospital is now a source of dividends for private actors. Profit interests have encroached on, and increasingly replaced, the publicly minded heroism of the American hospital, the central hub of a complex and disordered health care system. This new profit-first posture creates ill effects for the people who rely on health care delivery: those who work within it, those who are treated within it, and those who pay for it. When hospitals need to deliver for their corporate shareholders, legitimate questions arise about how much they are delivering for patients and physicians within their walls and citizens within their communities, and how much they are delivering for their stock price.

The tensions between profits and patients are on display especially during transformative transactions—specifically, when a hospital moves from a nonprofit charitable institution to one owned by, or part of, a corporate for-profit entity. The naturally adverse interests between a charitable hospital and a for-profit corporate entity are hard to miss. Much of health law is organized to navigate these challenges: Various governmental and nongovernmental actors orbit

* Associate Dean of Faculty Development and Professor of Law, University of Tennessee College of Law; *Juris Doctor*, University of Pennsylvania Law School; *Master of Bioethics*, University of Pennsylvania; *Bachelor of Arts*, Miami University (Ohio). As always, this is for Audrey and Lucy, and all those coffee shops. Any errors or omissions are my own.

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the institution, using a matrix of carrots and sticks to try to steer the corporate hospital away from the worst of its corporate impulses. These well-worn rules include preventing corporations from "practicing medicine," bundling government payments to disincentivize overbilling, and applying draconian fraud laws to hospitals that cut corners. But despite best efforts, hospital ownership in the United States continues to march toward corporatization and financialization, with impacts that should not surprise the American patients who lack real regulatory recourse.

This Article takes the first step toward addressing this regulatory hole by seeking to bring corporate law—and its new understanding related to stakeholderism—within the doors of the American hospital. Suggesting that the modern American corporation should owe duties beyond those owed to shareholders, stakeholderism can serve as an ameliorative patient-protective governance doctrine for for-profit hospitals. Implementation-related challenges exist to such a move, for sure, but the value of importing a doctrine that broadens the focal point for corporate hospitals—to fix a duty to patients within the decision-making process of the health care corporation—installs a patient-protective bulwark within a governance structure that currently lacks it. The growing number of American patients of for-profit corporate hospitals deserve such protection.

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INTRODUCTION

The money always wins.

—Charlie Warzel[1]

One year after the sale of Mission Hospital to the for-profit Hospital Corporation of America (HCA)[2] was finalized, the public officials of Asheville, North Carolina, could no longer stay silent about what they feared had become of their hometown's hospital.[3] In the city's largest newspaper, Asheville Mayor Esther Manheimer wrote an open letter to the independent monitor tasked with overseeing the hospital and its post-transaction management.[4] She expressed "deep concern" over the hospital's state, citing three main areas of focus: change, and constraint, of the hospital's charity care policy; worry about worsening patient safety; and alarm over a dramatic physician exodus from the hospital.[5]

Four years later, Mayor Manheimer's letter felt foreboding: Reports had emerged about patient deaths at Mission Hospital related to substantial delays and lapses in the provision of adequate care and tests.[6] These included reports of individuals waiting in the hallways for treatment, failures to provide oxygen to patients who needed it, and even delays in blood draws and critical infusions.[7]

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1. Charlie Warzel (@cwarzel), X (Nov. 21, 2023, at 16:20 ET), https://x.com/cwarzel/status/1727074602374037978?mx=2 [https://perma.cc/68VF-64KZ].

2. *See generally Fact Sheet*, HCA HEALTHCARE (June 30, 2022), https://web.archive.org/web/20221007123139/https://www.hcahealthcare.com/util/documents/2022/2022-HCA-Healthcare-Fact-Sheet- Digital-20220914-a.pdf [https://perma.cc/3YRW-SHL6] (describing the vast network of hospitals and health care centers amassed by HCA Healthcare, including North Carolina's Mission Hospital).

3. *See* Esther Manheimer, Opinion, *Patient Care to Staff Safety: Concerns over HCA's Management of Mission Run Deep*, ASHEVILLE CITIZEN TIMES (Feb. 12, 2020, at 22:35 ET), https://www.citizen-times.com/story/opinion/2020/02/11/hcas-management-mission-health-hospital-cause-deep-concern/4721205002/ [https://perma.cc/7ULV-LSNM].

4. *See id.*

5. *See id.*

6. *See* Andrew R. Jones, *'The Patient Was Subsequently Found Unresponsive in a Hallway Bed': CMS Report on Mission Hospital Details Deaths of Patients, Significant Delays in Care*, ASHEVILLE WATCHDOG (Feb. 15, 2024), https://avlwatchdog.org/cms-immediate-jeopardy-report-on-mission-details-deaths-of-patients-significant-delays-in-care/ [https://perma.cc/4RXU-HDE6].

7. *See id.*

According to these reports, between 2022 and 2023, eighteen of Mission's patients had been harmed, and four patients had died—all due to alleged violations of standards of care.[8] At the same time, hundreds of doctors had left Mission Hospital after allegedly being sidelined or silenced; the hospital had shrunk or closed vital services.[9] For sure, the story of Mission Hospital had been an ongoing pain point for the citizens of Asheville in a year that had been nothing short of hell on many other fronts.[10]

Few experiences feature greater vulnerability than that of a patient lying on a gurney being wheeled into a hospital emergency room. Wholly dependent on the expertise and training of the doctors, the coordination and compassion of the nurses, and the resources and standards of the facility, the patient's experience is dominated by crisis, uncertainty, and fear. Regarding the care hospital employees should provide the vulnerable patient, the legal standard is straightforward. The hospital is required to treat the patient no different than it would treat any other patient—it is required to treat and stabilize, and to do so without regard to the patient's ability to pay for the care they receive.[11] Patients expect and deserve nothing less.

But what about the hospital's adequacy of resources and scope of services it provides? What if the private monetary interests that now own or control that hospital are pressuring it to cut costs and

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8. *See* Andrew R. Jones, *The Year in Review: Mission Hospital's Immediate Jeopardy Sanction Highlighted a Crisis in Care*, ASHEVILLE WATCHDOG (Dec. 27, 2024), https://avlwatchdog.org/the-year-in-review-mission-hospitals-immediate-jeopardy-sanction-highlighted-a-crisis-in-care/ [https://perma.cc/48DU-REV6] (summarizing the results of a Department of Health and Human Services Report investigation into Mission Hospital). For the full report, see CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUM. SERVS., STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (2024), https://drive.google.com/file/d/1oz_V4371DkaqET7123157BOpjYCCWKtr/view [https://perma.cc/R7XP-KRP9].

9. *See* Susanna Vogel, *HCA Pushed Out Providers, Downgraded Care After Acquiring Mission Health: Report*, HEALTHCARE DIVE (Aug. 16, 2024), https://www.healthcaredive.com/news/hca-staffing-shortage-mission-health-research/724442/ [https://perma.cc/V6U8-Z6WG].

10. *See* Mike Belleme, *Capturing a Community in Ruin*, N.Y. TIMES (Oct. 4, 2024), https://www.nytimes.com/2024/10/04/us/politics/photojournalist-climate-change-asheville-helene.html [https://perma.cc/GN2Q-H5UL] (depicting the aftermath of catastrophic flooding brought by Hurricane Helene in Asheville).

11. The Emergency Medical Treatment and Labor Act is the federal law that requires Medicare-participating hospitals that operate emergency departments to provide timely medical screening and stabilizing care to every patient who enters their doors. *See* 42 U.S.C. § 1395dd.

drive up profits for its shareholders? How does that impact patient care—and, perhaps more importantly, what recourse does the patient on the gurney have in response? In short, the modern American hospital has become targeted as a source of capital for the modern American investor—with all sorts of impacts on patient care. Sadly, but unsurprisingly, patient care and profit motives often do not mix.[12]

Back in Asheville, while Mission Hospital became much more profitable, quality concerns began to mount.[13] And this presented a paradox: As a nonprofit hospital, the Attorney General of North Carolina had enjoyed regulatory oversight over it.[14] Under the North Carolina Nonprofit Corporation Act, then-Attorney General Josh Stein[15] was to be notified "before consummating any merger with any unincorporated entity or with any business or nonprofit corporation (other than another charitable or religious corporation), unless the charitable or religious corporation ha[d] already received

12. *See* Isaac D. Buck, *Patients Versus Profits*, 97 TEMP. L. REV. 321, 347-51 (2025).

13. *See* Andrew R. Jones, *Staff Reductions Contributed to Mission's Soaring Profits After HCA Sale, Draft Report Says*, ASHEVILLE WATCHDOG (Apr. 23, 2024), https://avlwatchdog.org/staff-reductions-contributed-to-missions-soaring-profits-after-hca-sale-draft-report-says/ [https://perma.cc/LS3N-QXPY].

14. *See* N.C. GEN. STAT. § 55A-12-02(a)-(c) (2025) (granting the attorney general authority to approve transactions involving the transfer of a charitable organization's assets and enforce the term of the approved agreement). State attorney general oversight is a common feature of nonprofit health care. *See, e.g.*, *Nonprofit Health Facility Transaction Notices*, CAL. DEP'T. OF JUST., https://oag.ca.gov/charities/nonprofithosp [https://perma.cc/846D-HAR7] ("California law requires the Attorney General's review and consent for any sale or transfer of a health care facility owned or operated by a nonprofit corporation.... The review process includes a public meeting and, when necessary, preparation of an independent health care impact statement to evaluate whether the transaction may create a significant effect on the availability or accessibility of health care services to the affected community."). Indeed, "[s]tate attorneys general are frequently the only government actors who interpret and apply restrictions on conversions and the proceeds they generate; consequently, the rigor with which statutes are applied, or whether they are applied at all, varies dramatically by state." David M. Cutler & Jill R. Horwitz, *Converting Hospitals from Not-for-Profit to For-Profit Status: Why and What Effects?*, *in* THE CHANGING HOSPITAL INDUSTRY: COMPARING NOT-FOR-PROFIT AND FOR-PROFIT INSTITUTIONS 45, 49 (David M. Cutler ed., 2000).

15. Josh Stein served as Attorney General of North Carolina from 2017 through 2024, and he began his term as the state's governor on January 1, 2025. *See* Gary D. Robertson, *North Carolina's Latest Democratic Governor Is Sworn In*, ASSOCIATED PRESS (Jan. 1, 2025, at 15:50 ET), https://apnews.com/article/north-carolina-new-governor-election-oath-8d2f4be11b5abaa025ba441305c50408 [https://perma.cc/84AQ-TVC6].

prior approval for the merger."[16] In short, his office exercised oversight over the public entities of the state.

But after Mission Hospital abandoned its nonprofit history and became part of the massive HCA network, Attorney General Stein had limited tools available to protect the quality of Mission's health care services. At the time of the transaction, he pushed for HCA to enter a contract to ensure that the corporate parent maintained the same types of care that Mission Hospital had provided to the citizens of Asheville before the sale.[17] As a result, Stein sued HCA in 2023, seeking contract law remedies for what happened at Mission postacquisition.[18]

The Mission story highlights a little-known regulatory truth: Once a hospital—at one time, *the quintessential public entity*—becomes a for-profit entity, many fewer tools exist to protect the public. Instead, under corporate law, the primary mandate driving the for-profit corporation is the obligation to create value for its shareholders.[19] Presumably, these shareholders serve as moderating influences to constrain the company; within the health care space, a for-profit hospital engaging in activity that may harm its "brand" would be theoretically limited by shareholders concerned about a loss of share price.[20]

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16. *Notice of Merger or Transfer of Assets*, N.C. DEP'T OF JUST., https://ncdoj.gov/notice-of-merger-or-transfer-of-assets/ [https://perma.cc/SUG4-CUNP]; *see also* § 55A-11-02.

17. *See* Rebecca Pifer, *HCA's $1.5B Buy of Mission Gets North Carolina AG Nod*, HEALTHCARE DIVE (Jan. 17, 2019), https://www.healthcaredive.com/news/hcas-15b-buy-of-mission-gets-north-carolina-ag-nod/546296/ [https://perma.cc/K427-6W98].

18. *See* Amended Complaint at 70-73, Stein *ex rel.* Dogwood Health Trust v. HCA Mgmt. Servs., LP, No. 23CVS5013 (N.C. Super. Ct. Apr. 26, 2024), 2024 WL 2319750; Richard Craver, *NC Attorney General Sues For-Profit HCA over Mission Contract*, WINSTON-SALEM J. (Dec. 14, 2023), https://journalnow.com/news/local/business/health-care/nc-attorney-general-sues-for-profit-hca-over-mission-contract/article_c739f12e-9a9f-11ee-8127-f79ea94b54b6.html [https://perma.cc/5EFF-WACL].

19. *See* ADOLPH A. BERLE & GARDINER C. MEANS, THE MODERN CORPORATION AND PRIVATE PROPERTY 310-13 (rev. ed. 1967); D. Gordon Smith, *The Shareholder Primacy Norm*, 23 J. CORP. L. 277, 278 (1998) ("Employees, creditors, suppliers, customers, and others may possess contractual claims against a corporation, but shareholders claim the corporation's heart.").

20. *See* William W. Bratton & Michael L. Wachter, *The Case Against Shareholder Empowerment*, 158 U. PA. L. REV. 653, 660 (2010) (presenting, and criticizing, the argument that "the efficiency of stock prices ameliorates the problem of information asymmetry and reliably communicates both the value implications of corporate policy to the shareholders and the business preferences of the shareholders to the managers").

But, for various reasons, some unique to health care,[21] these pressures infrequently work to constrain a for-profit hospital. Instead, various stakeholders interested in the quality of care provided by that hospital—from taxpayers to providers to patients—lack protection of their interests. A gap exists in the for-profit hospital—without American patients even knowing about it.[22]

Due to the lack of meaningful public oversight, this Article borrows from corporate law and recent scholarly work around the doctrine of stakeholderism to argue that for-profit hospitals, as unique corporate entities, should treat *patients* as an important stakeholder interest deserving of attention for hospital governance. Beyond paying heed only to their shareholders, hospitals should owe duties to patients, vital actors who serve as the raison d'être of the hospital. Indeed, there remain several implementation-related concerns with this proposal, but the thrust of this Article seeks to open the conversation to import doctrinal insights from corporate law to improve the care of the patient on the gurney.

This Article unfolds in four parts. Part I summarizes the stories of Mission Hospital in Asheville, North Carolina, and two hospitals in Providence, Rhode Island. Part II documents the public oversight of their transitions—different legal procedures and processes. Part III sketches the interests at stake—from the taxpayer to the shareholder to the patient and provider. Part IV presents the promise and perils of corporate law's new and newly reawakened, repackaged doctrine of stakeholderism, complete with an argument pushing for the doctrinal adoption and reconceptualization of patients as stakeholders.

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21. *See* discussion *infra* Part III (documenting various interests in the hospital).

22. Recent studies have shown that most American patients do not know the ownership status of their hospitals. *See* Lauren A. Taylor, Berkeley Franz, Amanda Zink, Andrew Fair & Cory E. Cronin, *Public Perceptions of US For-Profit, Nonprofit, and Public Hospitals*, HEALTH AFF. SCHOLAR, Oct. 2023, at 1, 6, https://academic.oup.com/healthaffairsscholar/article/1/4/qxad046/7273707 [https://perma.cc/4TXA-HCD8] ("[L]ess than half of respondents who were familiar with [the national hospital brands] were able to correctly identify the ownership status.... Among respondents who indicated that they were familiar with a local hospital, less than half [] were able to correctly identify the ownership status.").

I. PRIVATIZING PUBLIC HOSPITALS

The most dramatic illustrations of the difference between the inner workings and priorities of nonprofit hospitals and those overseen by for-profit parents feature entities that have recently transformed from charity-focused institutions to those organized to deliver profit for their shareholders. Two stories involving the conversion of nonprofit hospitals to for-profit-controlled entities involve one hospital in Asheville, North Carolina, and two hospitals in the Providence, Rhode Island, metro region. Sketches of both stories—which form the foundation of this Article—follow immediately below.

A. From Mission to Margin

Mission Hospital was founded in 1885 in a rented five-room Asheville home.[23] For the ensuing 130-plus years, it operated as a charitable nonprofit hospital in the foothills of the Blue Ridge Mountains in North Carolina.[24] During that impressive lifespan, it was a pillar with "deep roots in the community."[25]

On that front, Mission was known for offering food insecurity screening and "food prescriptions" at its clinics,[26] for providing "free dental care to children in rural areas via the 'ToothBus' mobile clinic,"[27] for fighting to end chronic homelessness in Asheville,[28] and

23. *Our History,* MISSION HEALTH, https://www.missionhealth.org/about-us/our-history [https://perma.cc/F8YB-VKX4].

24. *See* Steven Findlay, *Can a Community Hospital Stay True to Its Mission After Sale to Large Corporation?*, KFF HEALTH NEWS (July 23, 2018), https://kffhealthnews.org/news/can-a-community-hospital-stay-true-to-its-mission-after-sale-to-large-corporation/ [https://perma.cc/6LH8-LRN8].

25. *Id.*

26. *Partners in Nutrition: MANNA Foodbank, Mission Health, and YMCA*, MANNA FOODBANK (Oct. 12, 2016), https://mannafoodbank.org/partners-nutrition-manna-foodbank-mission-health-ymca/ [https://perma.cc/JE4T-FG9L] ("The $65,000 grant will support two initiatives at MANNA: nutrition and health education activities at pantry sites across our 16 counties, as well as a pilot project to test the use of food insecurity screening and 'food prescriptions' at Mission Health Partners clinics.").

27. Findlay, *supra* note 24.

28. *See* Angie Newsome, *City: Chronic Homelessness Down in Asheville, Buncombe*, CAROLINA PUB. PRESS (Mar. 19, 2013), https://carolinapublicpress.org/14381/city-chronic-

for encouraging its "12,000 employees to volunteer at schools, churches and nonprofit groups."[29] Over the decades, it became an "essential resource" and part of the backbone of western North Carolina.[30] It was also well-regarded: Mission developed a "reputation for quality that ... drew esteemed doctors from across the country."[31]

But following a surprise announcement in 2018,[32] Mission shed its nonprofit history and became part of America's largest for-profit hospital system, the Hospital Corporation of America (HCA).[33] The for-profit behemoth, which owns scores of hospitals across the United States,[34] had acquired the six-hospital nonprofit Mission Health—which included Mission Hospital in downtown Asheville—in February of 2019 for $1.5 billion,[35] extending HCA tentacles into the Blue Ridge. Essentially overnight, Asheville's Mission Hospital transformed from the engine of a relatively small nonprofit hospital system to one of scores of hospitals under the umbrella of for-profit (and handsomely profitable)[36] HCA.

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homelessness-down-in-asheville-buncombe/ [https://perma.cc/U2E6-8WVY] (noting that Mission Health was a partner to a local initiative which assisted in housing the local homeless population).

29. Findlay, *supra* note 24.

30. *Id.*

31. Tara Bannow, *HCA Doctors Say Its Cost-Cutting Is Endangering Appalachian Patients—A Warning for the Whole U.S. Health Care System*, STAT (Nov. 30, 2023), https://www.statnews.com/2023/11/30/hca-mission-hospital-cost-cutting-appalachia/ [https://perma.cc/H85J-JHLJ].

32. *See* Editorial, *Who Will Profit from Mission's Impending Merger?*, ASHEVILLE CITIZEN TIMES (Mar. 24, 2018, at 08:50 ET), https://www.citizen-times.com/story/opinion/2018/03/24/editorial-who-profit-missions-impending-merger/451201002/ [https://perma.cc/NJ9D-JWT5] ("To say that Wednesday's announcement that the two planned to get together was a surprise would be an understatement. There has not been the slightest hint anything was afoot until Mission announced that its board had approved the deal unanimously.").

33. *See* Ethan Popowitz, *Top 10 Largest Health Systems in the U.S.*, DEFINITIVE HEALTHCARE (Apr. 4, 2025), https://www.definitivehc.com/blog/top-10-largest-health-systems [https://perma.cc/54V8-YF46].

34. *See* HCA HEALTHCARE, *supra* note 2.

35. *See* Dillon Davis, *Today's the Day: Asheville's Mission Health, HCA Healthcare Finalize $1.5B Deal*, ASHEVILLE CITIZEN TIMES (Feb. 1, 2019, at 13:46 ET), https://www.citizen-times.com/story/news/local/2019/02/01/ashevilles-mission-health-hca-healthcare-finalize-1-5-billion-deal/2721743002/ [https://perma.cc/7SJM-W5JU].

36. *See* HCA Healthcare, Inc., Annual Report (Form 10-K) at 58 (Feb. 10, 2026).

Quickly, the Editorial Board of the local newspaper shared its concerns about the deal.[37] "We would feel better," the Board wrote, "were Western North Carolina's leading health-care provider to remain master of its own fate."[38] To be sure, this feeble request was outnumbered by the letters expressing support for the deal—as was surely trumpeted by HCA's website.[39] Once the transaction was finally consummated, all told, HCA acquired Mission Health; this included the 763-bed Mission Hospital in Asheville, an 80-bed rehabilitation hospital, and 5 smaller hospitals that totaled 148 beds.[40]

But following the acquisition, citizens of Asheville quickly noticed a change at Mission.[41] The public expressed "deep concern" over the state of the hospital, focused on changes around charity care, patient safety, and physician employment and contracting.[42] Reading these accounts makes one aware of the migration of Mission from the centerpiece of the "crown jewel" health system of this idyllic mountain town in western North Carolina.[43]

1. Supercharging Profits

Mark Hall, a health law professor and scholar, undertook a deep analysis of the result of Mission's migration to HCA, drafting a report detailing Mission Hospital's financial performance since its

37. *See Who Will Profit from Mission's Impending Merger?*, *supra* note 32.

38. *Id.*

39. *See* Dillon Davis, *Anger, Hope, Concern: 180 Letters Written to AG on Mission-HCA Deal. Here's What They Say.*, ASHEVILLE CITIZEN TIMES (Dec. 31, 2018, at 09:03 ET), https://www.citizen-times.com/story/news/local/2018/12/31/hca-healthcare-mission-sale-180-letters-written-nc-attorney-general-billion-dollar-deal/2147322002/[https://perma.cc/3YCK-3GLL].

40. *HCA Healthcare Announces Agreement to Acquire Mission Health*, HCA HEALTHCARE: NEWS DETAILS (Aug. 31, 2018), https://investor.hcahealthcare.com/news/news-details/2018/HCA-Healthcare-Announces-Agreement-to-Acquire-Mission-Health/[https://perma.cc/ZAX2-KTAB].

41. *See* Manheimer, *supra* note 3.

42. *Id.; see* Bannow, *supra* note 31 ("In total, more than 200 doctors have stopped practicing at Mission since HCA took over, according to a local media report.").

43. *See* Sara Murphy, *Lawsuit Targets HCA's Hospital Monopoly in Western North Carolina*, FACING S. (Sep. 1, 2021), https://www.facingsouth.org/2021/09/lawsuit-targets-hcas-hospital-monopoly-western-north-carolina [https://perma.cc/95AJ-Y5WG] (according to attorneys who represented plaintiffs in an antitrust suit against HCA after its acquisition, "Mission Health was once the crown jewel of North Carolina's health care system").

acquisition.[44] His report covers the dramatic changes that have transpired at Mission Hospital as it has moved from a highly awarded nonprofit hospital prior to acquisition, to a highly profitable for-profit hospital in the years since.[45] Hall's work provides important data documenting and elucidating a trend that Asheville's residents have noticed.[46]

The short story is that the hospital seems to be more profitable than it has ever been. To this point, Professor Hall found that Mission Hospital's patient care profits in 2023—years after the acquisition by HCA—totaled $167 million.[47] Remarkably, this was "six times its profits the year before HCA's purchase."[48]

To at least partially explain this increased profitability, Hall found that Mission Hospital's list price markup under HCA has sharply increased.[49] It has moved from the middle of its peers before acquisition to doubling after acquisition, landing it among the very top of its peers in list price markup.[50] This means that since acquisition, Mission has been able to charge higher prices for its services and capture more of the profit that spread generates.[51]

Even though the list price markup has been substantial, the main reason Mission Hospital has become so profitable is its ability to control costs.[52] "Prior to HCA, Mission Hospital on average lost 4

44. *See* MARK A. HALL, LESSONS LEARNED FROM HCA'S PURCHASE OF MISSION HOSPITAL IN ASHEVILLE, NORTH CAROLINA 35, 37 (2025), https://prod.wp.cdn.aws.wfu.edu/sites/499/2025/04/Lessons-Learned-from-HCAs-Purchase-of-Mission-Hospital_Final-Report.pdf [https://perma.cc/9EWN-7DWC].

45. *See id.*

46. *See, e.g.*, Comment, Remarkable-Owl20234, *on* Post by SpiritedSpecialist15, REDDIT (r/asheville), *WTF Is Wrong With Mission Hospital?* (2024), https://www.reddit.com/r/asheville/comments/1eosv7y/wtf_is_wrong_with_mission_hospital/ [https://perma.cc/AW47-FEF8] ("The hospital has gone downhill since it was acquired by HCA five years ago and we in the community are trying to turn it around although it will be a long slog—we hope we can convince them to sell eventually. It is a tragedy all the way around."); Manheimer, *supra* note 3 (detailing several concerns presented by patients, Asheville City Council, and others in North Carolina).

47. *See* HALL, *supra* note 44, at 37.

48. *Id.* (emphasis omitted).

49. *Id.* at 40.

50. *Id.*

51. *See* Bannow, *supra* note 31 (according to reporting, in 2022, HCA's "charges for services were nine times the cost of delivering them. The national average is closer to three times. Since buying Mission, HCA has spiked prices to be more in line with the rest of its hospitals").

52. *See* HALL, *supra* note 44, at 39, 41.

percent each year on Medicare patients. Within three years after HCA's acquisition ... it was making almost a 15 percent profit on Medicare patients."[53] At the same time, the average patient care cost "dropped sharply and abruptly—by almost 30 percent in 2020 and remaining 20 percent lower in 2023."[54]

In other words, Mission Hospital's profitability has been supercharged by the hospital's ability to cut how much it costs to treat each patient.[55] As Professor Hall notes, considering Mission's average case severity (relatively high), its average patient care cost per patient places it within the range of hospitals that treat much less severe cases.[56] It has become more financially stable by raising its prices but also by dramatically cutting costs—even for a patient population that arrives at the emergency room in need of serious interventions.

Finally, Professor Hall notes that the cost savings brought to Mission Hospital are directly related to staffing reductions.[57] Remarkably, right after the HCA acquisition, staffing levels "plummeted," "and staffing has remained at a level that is 30 percent below the peer group average."[58] According to his findings, staffing at Mission Hospital dropped "to a level that is roughly a third less than state and national levels."[59] This, according to Hall, "explains a large component of the hospital's markedly increased profitability under HCA."[60] Mission's profitability, therefore, is not exclusively a result of increased purchasing power and back-office efficiencies, as was perhaps believed by Mission Hospital's board members at the time of acquisition.[61] It is, instead, a result of less staffing in the hospital,[62] which tracks a recent study that places HCA's average

53. *Id.* at 41.

54. *Id.*

55. This has been demonstrated by earlier studies. *See* Cutler & Horwitz, *supra* note 14, at 47 (finding that for-profit hospitals' financial success can be owed to the fact that "for-profit hospitals cut costs where not-for-profit hospitals do not").

56. HALL, *supra* note 44, at 42.

57. *Id.* ("[S]taffing reductions have been a major source of cost savings—especially staffing for direct patient care (as opposed to general management/administration).").

58. *Id.* at 43.

59. *Id.*

60. *Id.* at 44.

61. *See id.*

62. *See* Cutler & Horwitz, *supra* note 14, at 68 (noting, in the context of a case study of a previous nonprofit hospital transition to a for-profit that "the reduction in nurses and nurses

hospital staffing ratios at about 30 percent below the national average.[63]

2. Quality of Care Concerns

While Mission Hospital has become much more profitable under the HCA umbrella, the quality of care it has delivered has been subject to extensive media coverage and critique.[64] Since the transaction, Mission Hospital's patient experience ratings have suffered dramatically.[65] This has been noticed by the local citizenry[66] and state officials, who have alleged that Mission is putting "profits over patients."[67]

According to Professor Hall, Mission Hospital went from being "regarded as one of the highest quality hospitals in the country" to a hospital with patient experience ratings outside the state's top twenty-five.[68] Its patient experience star ratings dropped from

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aids was described as a major source of tension between physicians and [the new corporate parent]").

63. *See* Gretchen Morgenson, Natalie Jimenez Peel & Cynthia McFadden, *Some Workers at U.S. Hospital Giant HCA Say It Puts Profits Above Patient Care*, NBC NEWS (Jan. 12, 2023, at 12:01 ET), https://www.nbcnews.com/health/health-news/workers-us-hospital-giant-hca-say-puts-profits-patient-care-rcna64122 [https://perma.cc/2YJA-6P5S] ("In 19 of the 20 states in which it operated hospitals, HCA staffing ratios were 8% to 41% lower than the average for all other hospitals, the report says.").

64. *See, e.g.*, Justin Berger, *Doctors, Patients Voice Outrage at HCA, Mission over Lack of Quality Health Care During Public Meeting*, WLOS ABC13 NEWS (Oct. 20, 2023, at 00:02 ET), https://wlos.com/news/local/doctors-patients-voice-concerns-outrage-public-meeting-quality-of-healthcare-since-hca-purchased-mission-health-hospital [https://perma.cc/D3HM-LVM6]; Andrew R. Jones, *Conditions at Asheville's Mission Hospital Pose 'Immediate Jeopardy to Patients' Health and Safety,' State Investigators Report*, ASHEVILLE WATCHDOG (Jan. 23, 2024), https://avlwatchdog.org/conditions-at-ashevilles-mission-hospital-pose-immediate-jeopardy-to-patients-health-and-safety-state-investigators-report/ [https://perma.cc/53N5-N3ZJ].

65. *See* HALL, *supra* note 44, at 94.

66. *See* Kimberly King, *Limited Power of Mission Hospital's Independent Monitor Has Doctors, Patients Seeking Accountability Elsewhere,* WLOS ABC13 NEWS (Oct. 20, 2023, at 21:19 ET), https://wlos.com/news/local/mission-hospital-hca-healthcare-limited-power-independent-monitor-to-effect-change-doctors-patients-seek-accountability-elsewhere-lack-of-quality-healthcare-decline-ron-winters [https://perma.cc/MQ5R-2F88] ("Mission Health-affiliated doctors and Asheville-area citizens vented concerns on Oct. 19 about alleged declining care at the hospital.").

67. *See* Morgenson et al., *supra* note 63 (noting that the North Carolina State Treasurer "since the HCA takeover ... has watched costs at Mission Health rise significantly while care has declined").

68. HALL, *supra* note 44, at 93-94.

averaging four out of five between 2014 and 2018 to just two stars in 2019 (the first year postacquisition) to just one star in 2022.[69] Understanding the quality-of-care story is vital to understanding the larger Mission Hospital story.

Within one year of the $1.5 billion deal's closing, concerns began to be aired in public.[70] By the spring of 2021, media reported several patient quality of care lapses due largely to Mission Hospital's understaffing.[71] The stories were horrifying: a patient soiling herself because no one came to help her to the bathroom,[72] and another waiting for six hours with a broken leg in the emergency room without water, ice, or pain medication.[73] Many quality failures were attributed to an alleged worsening of the nurse-to-patient ratio and alleged drop in the number of support staff, such as housekeepers and security personnel.[74]

Independent agencies downgraded the quality of care at Mission, finding the "hospital fell short in various measures, including blood and surgical site infections, high-risk baby deliveries, some cancer procedures, and the experience of patients for elective surgeries."[75] More basic patient safety concerns also arose.[76] "In one case, a patient fell off a table and was injured because the hospital 'failed to provide care in a safe setting.'"[77] In another case, "the hospital

69. *Id.* at 94-95.

70. *See, e.g.*, Manheimer, *supra* note 3.

71. *See* Barbara Durr, *Quality of Care Concerns Rise at Mission Hospital*, BPR NEWS (May 21, 2021, at 14:55 ET), https://www.bpr.org/news/2021-05-21/quality-of-care-concerns-rise-at-mission-hospital [https://perma.cc/GR5A-JVAS].

72. *Id.*

73. *Id.*

74. *Id.* ("Since investor-owned HCA Healthcare bought nonprofit Mission Health System in 2019, stories are increasingly common of long waits in the emergency room, unsanitary conditions, broken or missing equipment, patients having to lie in their own urine and feces, doctors leaving because of pay disputes, and nurses weeping in the hallways because of stress and chronic understaffing.").

75. *Id.*

76. *See* Bannow, *supra* note 31 ("One of the medical oncologists who quit explained that the conditions had become unsafe because of a lack of nurses and other support staff. 'I left because I couldn't in good faith take care of patients somewhere that I didn't think was safe. Giving chemo is a big deal. Safety is paramount, and it just wasn't a safe place to do it,' said the oncologist, who still works in health care and asked to remain anonymous because of concerns about retaliation.").

77. Durr, *supra* note 71.

'failed to monitor the condition of a patient' in restraints for violent behavior."[78]

The reports of the nursing care at Mission during this time were heartbreaking:

> On one unit at Mission Hospital, with several dozen beds, nurses are assigned six or seven patients each—double their normal workload—and provided a single [certified nursing assistant], where protocols call for four. "It's just not safe. It's led to an increase in falls, and I believe people are getting sicker," said a nurse in the unit.
>
> "Patients are lying in their own feces for up to an hour," she said, "and they are not getting their meds for hours."
>
> Patients can see how short-staffed the nurses are and "feel guilty calling for help," she said, while nurses are so frustrated that they are sometimes seen sobbing in the hallways. Yet, despite the strain, she said, "My team is amazing. They're all trying to make it work. They work so hard."[79]

By October 2023, more than 130 physicians had signed an open letter in which they criticized the postacquisition management of the hospital, lamenting the cuts to staff that took place.[80] Later that year, the North Carolina Department of Health and Human Services conducted an on-site inspection of Mission Hospital.[81] But, for its part, a Mission spokesperson called the inspection "routine."[82]

In early 2024, Mission Hospital was placed in "immediate jeopardy" by the Centers for Medicare and Medicaid Services (CMS) of losing federal funding due to "deficiencies in care."[83] This

78. *Id.* ("More recently, DHHS completed a complaint investigation of sexual misconduct in the behavioral health unit, again citing a failure to provide care in a safe setting.").

79. *Id.*

80. Andrew R. Jones, '*I Was Beginning to Feel Like I Was on a Sinking Ship,' Says Former Mission Hospitalist*, ASHEVILLE WATCHDOG (Jan. 2, 2024), https://avlwatchdog.org/i-was-beginning-to-feel-like-i-was-on-a-sinking-ship-says-former-mission-hospitalist/ [https://perma.cc/6FTG-SZ5W].

81. Andrew R. Jones, *State Inspectors Visit Mission Hospital Following Nurses' Complaints*, ASHEVILLE WATCHDOG (Nov. 14, 2023), https://avlwatchdog.org/state-inspectors-visit-mission-hospital-following-nurses-complaints/ [https://perma.cc/TR9F-WGU6].

82. *Id.*

83. *See* Andrew R. Jones, *Feds Cite Asheville's Mission Hospital for 'Immediate Jeopardy,'*

accompanied a damning report from CMS, which documented multiple failures at the hospital.[84] The report found failures in the emergency department and the oncology unit, citing a patient who received "expired" chemotherapy.[85] The report included details about the "deaths of at least three patients in the emergency department or intensive care unit" related to delays in care.[86] At the time, North Carolina Attorney General Josh Stein called the report "extremely alarming."[87] Around the same time, reports surfaced regarding HCA's dramatic cuts to charity care at Mission.[88]

In one of the examples reported by the media, "paramedics took a 66-year-old man to Mission Hospital ... with chest pains and shortness of breath," but he "did not receive an EKG until over an hour after arrival."[89] After experiencing a heart attack, he "died less than three hours after his arrival," apparently due to delayed care.[90] Specifically, he arrived at the hospital around 6:00 p.m., was transferred to hospital staff care at 7:07 p.m., and went into cardiac arrest just before 8:00 p.m.[91] Regulators found "there was a delay in triage, medical screening and interventions" for the man.[92] As a

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HCA Division President Tells Staff, ASHEVILLE WATCHDOG (Feb. 2, 2024), https://avlwatchdog.org/feds-cite-ashevilles-mission-hospital-for-immediate-jeopardy-hca-regional-president-tells-staff/ [https://perma.cc/7JM7-AQLZ].

84. *See* Jones, *supra* note 6. For the full report, see CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 8.

85. Jones, *supra* note 6.

86. *Id.*; CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 8, at 286-91.

87. Felicia Sonmez, *Attorney General Calls Report on Conditions at Mission Hospital 'Extremely Alarming,'* BPR NEWS (Jan. 12, 2024, at 15:37 ET), https://www.bpr.org/bpr-news/2024-01-12/attorney-general-calls-report-on-conditions-at-mission-hospital-extremely-alarming [https://perma.cc/H8VR-FM94].

88. *See* Andrew R. Jones, *Draft Report Says Charity Care Has Declined 'Extensively' at Mission After HCA Takeover*, ASHEVILLE WATCHDOG (Jan. 22, 2024), https://avlwatchdog.org/draft-report-says-charity-care-has-declined-extensively-at-mission-after-hca-takeover/ [https://perma.cc/8GZD-ARAX] ("Between 2018 and 2022, according to public reports authored by Mission, the hospital system reported a 72 percent drop in the proportion of its visits or days that were for charity care patients, the report shows.").

89. Grace Vitaglione, *How HCA Says It Will Fix Mission Hospital. Why Advocates Say It Will Fail.*, CAROLINA PUB. PRESS (Feb. 22, 2024), https://carolinapublicpress.org/63191/mission-hospital-hca-fix-plans-asheville-nc-advocates-skeptical/ [https://perma.cc/TJ76-28HT].

90. *Id.*

91. *See* Erica Cerutti, *Details Emerge on HCA Mission's EMTALA Violation*, BECKER'S CLINICAL LEADERSHIP (Apr. 1, 2024), https://www.beckershospitalreview.com/patient-safety-outcomes/details-emerge-on-hca-missions-emtala-violation.html [https://perma.cc/YHH5-CU4N].

92. *Id.* ("The patient's death is one of four mentioned in CMS' initial report detailing what

result of the death, CMS notified the hospital it was in violation of the Emergency Medical Treatment and Labor Act (EMTALA).[93] CMS required "substantial compliance" by June 2024.[94]

By the end of July 2024, Dogwood Health Trust, the entity created following the transaction between HCA and Mission Health, reported to the North Carolina Office of the Attorney General that it was going to warn HCA that it was potentially out of compliance following an independent monitor's report.[95] The issues cited by Dogwood were all related to CMS's previous reports.[96] Specifically, the deficiencies focused on three different areas: the "[p]rovision of emergency and trauma services and oncology services at Mission Health," the "[f]ailure to remain 'enrolled and in good standing' in Medicare and Medicaid," and "[i]ssues with uninsured and charity care policies."[97] HCA maintained that it followed the asset purchase agreement, which is what HCA executed upon acquiring Mission.[98] Attorney General Stein had thirty days to respond to Dogwood's letter.[99]

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led to an immediate jeopardy sanction at the hospital in December, which has since been lifted.").

93. *See* Andrew R. Jones, *In Second Blow, Feds Now Cite HCA's Mission Hospital for Violating Emergency Treatment Standards*, ASHEVILLE WATCHDOG (Mar. 15, 2024), https://avlwatchdog.org/feds-cite-hcas-mission-hospital-for-violating-emergency-treatment-standards/ [https://perma.cc/BR5S-R9KX]. EMTALA is the federal law that requires hospitals that operate emergency rooms to provide timely medical screening and stabilizing care to every patient who walks in their doors. *See* 42 U.S.C. § 1395dd.

94. Jones, *supra* note 93.

95. *See* Jane Winik Sartwell, *Dogwood Warns HCA of Potential Violations of Terms of Mission Health Deal*, CAROLINA PUB. PRESS (July 30, 2024), https://carolinapublicpress.org/64808/dogwood-accuses-hca-of-violating-terms-of-mission-health-deal/ [https://perma.cc/24NP-P8NC].

96. *See* Andrew R. Jones, *New Independent Monitor Finds HCA in Potential Non-Compliance with Mission Asset Purchase Agreement*, ASHEVILLE WATCHDOG (July 30, 2024), https://avlwatchdog.org/new-independent-monitor-finds-hca-in-potential-non-compliance-with-mission-asset-purchase-agreement/ [https://perma.cc/BPQ8-H6UY] ("The report also found that issues related to federal care standards dictated by participation with the U.S. Centers for Medicare & Medicaid Services caused probable non-compliance in 2023.").

97. Sartwell, *supra* note 95.

98. *See* Jennifer Emert, *Dogwood Health Trust Reports Possible Noncompliance with HCA, Mission Purchase Agreement*, ABC 13 NEWS (July 30, 2024, at 14:03 ET), https://wlos.com/news/local/dogwood-health-trust-reports-hca-healthcares-non-compliance-in-2023 [https://perma.cc/N6PS-BLGP].

99. Ray Gronberg, *Mission Hospital's Watchdog Pushes for System Improvements*, BUS. N.C. (July 30, 2024), https://businessnc.com/mission-hospitals-watchdog-pushes-for-system-improvements/ [https://perma.cc/CBN8-KKCX].

Other reported events from Mission Hospital have included episodes of medications that were not properly administered, care and treatment that were not provided in an appropriate and timely manner (provided upon arrival to the hospital), and medical errors that were not adequately documented.[100] According to advocates and medical professionals, the chronic quality failures at Mission Hospital have been related mostly to understaffing.[101]

B. The Privatization of Providence

The story of Mission is not unique. Nine hundred miles to the northeast, two hospitals in the Providence, Rhode Island, metropolitan area had made the transition from nonprofit to for-profit a few years before Mission embarked on a similar path.[102] And their story features striking similarities.

In 2014, Rhode Island Attorney General, at the time, Peter Kilmartin, approved the merger of the two nonprofit hospitals, Roger Williams Medical Center and Our Lady of Fatima Hospital, into a new ownership arrangement with a privately held for-profit company known as Prospect Medical Holdings ("Prospect").[103] Less than one week later, the Rhode Island Department of Health approved the change in ownership and control for the two nonprofit hospitals and other related facilities.[104]

Seen as a hero that was there to swoop in to prop up the financially struggling hospitals,[105] Prospect, along with CharterCare

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100. *See* Vitaglione, *supra* note 89.

101. *See id.*; *see also* Morgenson et al., *supra* note 63 ("All of the current and former HCA employees interviewed by NBC News—12 at Mission and five at other facilities—said they consider the company's staffing inadequate.").

102. *See* Barbara Polichetti, *R.I. Attorney General Approves New Partnership for Fatima Hospital and Roger Williams Medical Center,* PROVIDENCE J. (May 16, 2014, at 15:47 ET), https://www.providencejournal.com/story/lifestyle/healthfitness/2014/05/16/20140516-chartercare-affiliation-gets-riattorney-general-s-ok-ece/35352538007/ [https://perma.cc/23AY-WASN].

103. *Id.*

104. *See* Press Release, R.I. Dep't of Health, Rhode Island Department of Health Approves Prospect-CharterCARE Joint-Venture (May 20, 2014), https://www.ri.gov/ press/view/21985 [https://perma.cc/QD59-734G].

105. *See, e.g.*, Kelly L. Anderson, *For-Profits See Opportunity in Struggling Hospitals*, PROVIDENCE BUS. NEWS (May 17, 2014), https://pbn.com/for-profits-see-opportunity-in-struggling-hospitals97206/ [https://perma.cc/TT7X-EEN7] (explaining how Roger Williams Medical Center and Our Lady of Fatima Hospital "appeared to be heading down a ... dim

Health Partners (the corporate parent of the hospitals), announced the launch of "their 'innovative' partnership offering 'a new way forward for Rhode Island health care.'"[106] The President of Prospect East Holdings, Inc., was quoted as noting that the arrangement's "goal [was] to provide Rhode Islanders with the health care they need at the right time, in the right place, compassionately and efficiently."[107]

The hope was that the transaction would "strengthen the fiscal condition" of the two hospitals.[108] Attorney General Kilmartin called the transaction in "the best interest of Rhode Island's healthcare marketplace."[109] The CEO of the new owner of the two hospitals "predicted that patients would experience no noticeable changes due to the merger."[110]

The new arrangement—which, interestingly, had to be approved by the Rhode Island state government *and* the Vatican itself—left Prospect as a controlling owner in the new company that operated the two hospitals.[111] The arrangement allowed for much-needed debt relief for the hospitals and provided more funding for improvements, but ended a period of 100 years in which the Bishop and the Diocese of Providence controlled Fatima Hospital.[112] As part of the deal, the new oversight company "pledged its acceptance of the ethical and religious directives established by the U.S. Conference

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financial path" and needed Prospect's cash to "retire debt" and make "capital improvements" or otherwise face closure).

106. *CharterCARE Health and Prospect Medical Launch New Partnership*, VALLEY BREEZE: NEWS (July 1, 2014), https://www.valleybreeze.com/news/chartercare-health-and-prospect-medical-launch-partnership/article_c8a279d3-049a-549e-9f61-7b227fea686f.html [https://perma.cc/NG85-857G].

107. *Id.*; *see also Mission & Vision*, CHARTERCARE HEALTH PARTNERS: ABOUT US, https://www.chartercare.org/about-us/mission-and-vision/ [https://perma.cc/BG5G-5VTN] ("The mission of CharterCARE Health Partners is to ensure that residents of Rhode Island receive exceptional quality care at the right time, in the right setting, with the utmost compassion and efficiency.").

108. R.I. DEP'T OF HEALTH, *supra* note 104.

109. Polichetti, *supra* note 102.

110. *Id.*

111. *See* Rick Snizek, *A Historic Change in the Healthcare Landscape*, R.I. CATHOLIC (Aug. 21, 2014, at 00:00 ET), https://thericatholic.com/stories/a-historic-change-in-the-healthcare-landscape,6750 [https://perma.cc/946Z-WCHW].

112. *See id.*

of Catholic Bishops."[113] But it did not take long for the relationship between the owners and its employees to sour.[114]

By the end of 2022, "Prospect's unpaid bills to vendors began to pile up."[115] At the same time, the number of quality-of-care concerns at the hospitals mounted.[116] These included reports of unsafe, hazardous, and unclean conditions at both facilities—raising concerns from multiple government entities.

At Fatima, nineteen elective surgeries had been canceled due to "a lack of supplies caused by credit holds from vendors."[117] Further, the Occupational Safety and Health Administration (OSHA) issued a letter informing Fatima that it had "received notice of alleged hazards at [Fatima], including mold; bedbug infestations; cockroaches unaddressed by a pest control service; mice in various areas; a lack of functioning buttons to monitor radiation exposure; and leaking ceilings and pipes causing slip and fall hazards."[118]

The Joint Commission—a body that oversees hospital accreditation for the federal program of Medicare[119]—had also recorded several reported incidents at Roger Williams and Fatima.[120] At Fatima, the Joint Commission reported:

> employees failing to follow proper risk assessments before and during operations; a lack of documentation of devices and

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113. *Id.*

114. *See* Steve Ahlquist, *Healthcare Workers Picket Outside Fatima About Patient Safety Concerns*, UPRISE R.I. (Nov. 4, 2022, at 14:19 ET), https://upriseri.com/healthcare-workers-picket-outside-fatima-about-patient-safety-concerns/ [https://perma.cc/QM9D-NFJ3] (noting health care workers picketing at Fatima Hospital).

115. *See* Alexa Gagosz, *Owner of 2 Safety-Net Hospitals in R.I. Ordered to Pay $17M Within 10 Days*, BOS. GLOBE (June 13, 2024, at 11:48 ET), https://www.bostonglobe.com/2024/06/12/metro/prospect-medical-holdings-rhode-island-hospitals-court-order/ [https://perma.cc/5KGG-3FEH].

116. *See infra* notes 117-30 and accompanying text.

117. Neronha v. Prospect Med. Holdings, Inc., No. PC-2023-05832, at 9 (R.I. Super. Ct. June 12, 2024).

118. *Id.* at 11; *see also* Alexa Gagosz, *'Falling into Disrepair': Two R.I. Hospitals Riddled with Bedbugs, Dirty Water, and Serious Safety Hazards, Court Docs Say*, BOS. GLOBE (June 14, 2024), https://www.bostonglobe.com/2024/06/14/metro/patients-at-risk-lady-fatima-roger-williams-medical-center-prospect-medical/ [https://perma.cc/3WJS-ZPZ8].

119. Timothy Stoltzfus Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 839 (1983) (explaining that the Joint Commission is "the organization which has primary responsibility for regulating the quality of care provided in American hospitals").

120. *See* Gagosz, *supra* note 118.

> inventory; expired filters on osmosis devices; water damage on walls and ceilings; a lack of competency assessments for nurses administering sedation and performing blood-glucose testing; improper sterilization techniques; unsecured supplies and medications that could be taken by unauthorized individuals; expired medications; improper sedation of patients; failure to record vital signs during blood transfusions; and a lack of proper inspection for AED devices.[121]

Reported incidents at Roger Williams mirrored those at Fatima.[122] These included:

> brown water flowing from an eye wash device; empty oxygen cylinders mixed in with full oxygen cylinders; failure to inspect and evaluate devices; black substances observed on walls; improper sterilization; failure to wear personal protective equipment for hazardous medications like chemotherapy; lack of education or evaluation regarding procedures for anesthesia staff; failure to record vital signs following blood transfusions; discharge instructions issued to patients in the wrong language; a lack of process for ensuring suppliers of implantation tissues are registered with the FDA; and failure to create and implement infection prevention and control.[123]

Accordingly, upon the completion of an investigation survey, the Rhode Island Department of Health found that Roger Williams's condition "posed an 'Immediate Jeopardy' to the health and safety of patients based on the report."[124] This specific condition was "water leaking through the ceiling and into a light fixture with live electrical wires"—which was removed, but general noncompliance that threatened patient safety remained.[125] These included reports of a "failure to maintain emergency lighting systems; failure to maintain fire suppression systems in the hospital's kitchen; and extensive water leaks in multiple areas of the hospital."[126]

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121. *Neronha*, No. PC-2023-05832 at 12-13.
122. *Id.* at 13.
123. *Id.*
124. *Id.*
125. *Id.* at 13-14.
126. *Id.* at 14.

Finally, in March 2024, regulators found that Fatima failed to report the death of a patient that, according to the *Boston Globe*, "was associated with the use of restraints."[127] "The patient ... [had been] placed in four restraints after attempting to jump off the bed, spit, and scratch staff."[128] "Within an hour, the patient was found unresponsive and 'had a cardiac arrest while in restraints.'"[129] Notwithstanding the breadth and depth of the reports, a spokesman for the hospitals said the deficiencies "have been corrected promptly."[130]

II. PUBLIC OVERSIGHT AND RESPONSE

One may ask whether the public authorities should have approved these deals when they were proposed. After all, due to the hospitals' statuses as nonprofits, both North Carolina and Rhode Island empowered their top law enforcement officers, their attorneys general, to review the proposed transactions.[131] These laws allow the state to guard the public trust, prevent any violation of state law, and to protect the mission of the nonprofit.[132] Due to the governance structure of nonprofits, the states' top law enforcement officer has the power to oversee these transactions.[133]

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127. Gagosz, *supra* note 118.

128. *Id.*

129. *Id.*

130. *Id.*

131. *See* N.C. GEN. STAT. § 55A-12-02(g) (2025); 23 R.I. GEN. LAWS § 23-17.14-5 (2026); *cf.* David A. Fahrenthold, Cade Metz & Mike Isaac, *How OpenAI Hopes to Sever Its Nonprofit Roots*, N.Y. TIMES (Dec. 17, 2024), https://www.nytimes.com/2024/12/17/technology/openai-nonprofit-control.html [https://perma.cc/6HY3-VQSG] (noting that the attorneys general of Delaware and California have the job of overseeing nonprofits and have the possibility to block certain changes to the nonprofits).

132. *See* Mark A. Hall & John D. Colombo, *The Charitable Status of Nonprofit Hospitals: Toward a Donative Theory of Tax Exemption*, 66 WASH. L. REV. 307, 381 (1991) (noting nonprofit governance as part of the "public trust" theory, in which "managers of nonprofit corporations have a fiduciary responsibility to the public to exercise care in managing the corporation's assets, a public trust duty enforceable by state attorneys general").

133. *See id.*; *see* Johnny Rex Buckles, *The Federalization of the Duty of Loyalty Governing Charity Fiduciaries Under United States Tax Law*, 99 KY. L.J. 645, 645 (2011) ("Charitable trusts and nonprofit corporations have long been governed by state law and overseen by state officials, such as state attorneys general."); Melanie B. Leslie, *The Wisdom of Crowds? Groupthink and Nonprofit Governance*, 62 FLA. L. REV. 1179, 1222 (2010) ("A nonprofit's 'beneficiaries' are represented by the attorney general."); Jessica Owley, *Unforeseen Land Uses: The Effect of Marijuana Legalization on Land Conservation Programs*, 51 U.C. DAVIS

Concordantly, attorneys general in North Carolina and Rhode Island were involved in the review of the hospital transactions. While both offices granted their approval of the transactions, both attorneys general also sought conditions to protect the public interest.[134] This has laid a groundwork for current adversarial proceedings. Further, even after the transactions transformed these hospitals from nonprofits to for-profit control, the attorneys general in both these states became highly involved in their oversight, resorting to lawsuits and public relations campaigns.[135] Ultimately, these developments make one wonder about the wisdom of the approval of these types of transactions in the first place.

A. North Carolina: A Conditional Waiver

Notwithstanding the pleas of Asheville Citizen Times' Editorial Board,[136] HCA's deal brought Mission Health (the system that owned Mission Hospital) under the massive and powerful HCA umbrella.[137] Even though, reportedly, the Attorney General's office had, after completing an investigation, "great concerns about how HCA was selected" as a partner, and that "the deck had been stacked in its favor from the beginning,"[138] the transaction was ultimately not stopped.[139] Indeed, the office in charge was that of

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L. REV. 1673, 1710 (2018) ("[A] decision to allow marijuana cultivation could endanger tax-exempt nonprofit organization status or invoke scrutiny from the state attorneys general worried that a land trust is not complying with its charter.").

134. *See infra* notes 145-66, 183-200 and accompanying text.

135. *See infra* notes 145-66, 183-200 and accompanying text.

136. *See Who Will Profit from Mission's Impending Merger?*, *supra* note 32.

137. Mark Barrett, *Mission-HCA Deal Gets Key Regulatory OK from State Attorney General Stein*, ASHEVILLE CITIZEN TIMES (Jan. 17, 2019, at 10:05 ET), https://www.citizen-times.com/story/news/local/2019/01/16/mission-health-asheville-josh-stein-hca-deal-can-go-forward-changes/2591769002/ [https://perma.cc/ABE5-CH9Q].

138. *See* Peter H. Lewis, *Attorney General's Office Had 'Great Concerns' Mission-HCA Deal Was Rigged 'From the Beginning,'* ASHEVILLE WATCHDOG (Mar. 15, 2022), https://avlwatchdog.org/attorney-generals-office-had-great-concerns-mission-hca-deal-was-rigged-from-the-beginning/ [https://perma.cc/GN6J-D66V] ("The attorney general's office was so concerned about potential conflicts of interest by [then-Mission Health System CEO Ronald A.] Paulus and [his advisor Philip D.] Green that it requested the Mission board revote on the transaction, the attorney general's deputy chief of staff, Laura Brewer, wrote to the *Asheville Watchdog* this week. After considering the information, the Mission board voted again, unanimously, to approve it.").

139. Barrett, *supra* note 137.

North Carolina Attorney General Josh Stein, whose office was tasked under state law to review transactions involving nonprofit hospitals.[140]

Attorney General Stein's office is reported to have believed it had limited power under state law to challenge or block such a transaction.[141] According to Attorney General Stein, "state law limited his authority to halt the sale despite the information uncovered by his investigation."[142] Notwithstanding this, according to reporting at the time, state law gave his office the power to sue to block transactions, and his office had sixty days to decide to pursue that plan of action.[143] Indeed, under the relevant North Carolina statute, the attorney general is empowered to object to such proposed transactions in the state.[144] Specifically under the law, Stein was directed to review the transaction to "ensure that (1) the sale price [was] fair, and (2) any charitable assets remain[ed] dedicated to a charitable purpose."[145]

Regardless of the intricacies of North Carolina law in this regard, in exchange for Attorney General Stein's approval of the deal, his office required that HCA include certain terms in its asset purchase agreement (APA).[146] The APA contained additional promises made

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140. *Id.*

141. *See* Lewis, *supra* note 138 ("In a statement to *Asheville Watchdog* last week, Brewer, Stein's deputy chief of staff, wrote, 'Under North Carolina law (unlike in many other states), the Attorney General's authority in these kinds of deals is quite limited' to ensuring a fair purchase price and 'that the charitable mission of the nonprofit is being carried forward.' 'North Carolina law does not give our Office the general authority to police health care transactions based on how they would impact patients, quality of care, rural access, and other issues,' Brewer wrote. 'Even though the Attorney General's legal authority over this type of transaction is quite limited, we succeeded in negotiating a number of significant improvements to the agreement.'"). *But see* Barrett, *supra* note 137 ("Stein's department could have sued to block the deal."); N.C. GEN. STAT. § 55A-12-02(g) (2025) (requiring charitable or religious corporations in North Carolina to provide "written notice to the Attorney General 30 days before it sells, leases, exchanges, or otherwise disposes of all, or a majority of, its property if the transaction is not in the usual and regular course of its activities unless the Attorney General has given the corporation a written waiver of this subsection").

142. Lewis, *supra* note 138.

143. *See* Mark Barrett, *NC Attorney General Wants to See More Protections for Medical Services in Mission-HCA Deal*, ASHEVILLE CITIZEN TIMES (Dec. 4, 2018, at 17:29 ET), https://www.citizen-times.com/story/news/local/2018/12/04/nc-attorney-general-josh-stein-has-questions-mission-health-sale/2197447002/ [https://perma.cc/79PH-TGJV].

144. *See* § 55A-12-02(g).

145. Amended Complaint, *supra* note 18, at 2.

146. *See id.* at 2-3.

by HCA,[147] as the Attorney General confirmed that those two requirements—fair price and that the charitable purposes were protected—were met.[148]

At the time, Attorney General Stein noted that, "[a]fter extensive negotiations, I am satisfied that this new agreement protects healthcare in western North Carolina, ensures that the full value of Mission's assets will continue to be used for public purposes, and requires that the Dogwood Health Trust will be independent and representative."[149] Upon the consummation of the deal, Mission Health System and its related charitable corporations transferred all of their operating assets to an affiliate of HCA Healthcare, Inc.[150] The net assets were transferred to Dogwood Health Trust, "a new North Carolina charitable corporation."[151]

For the instant purposes, the conditional waiver required HCA (1) to maintain and provide certain services at Mission Health's hospitals and (2) to appoint an independent monitor to ensure compliance with the deal.[152] Specifically, the attorney general ensured that the agreement included language preventing HCA from discontinuing the provision of specific services such as multiple inpatient and outpatient services "including oncology services and emergency and trauma services."[153] This would become important years after the deal was consummated.

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147. *See* Pifer, *supra* note 17.

148. *Id.*

149. *Id. But see* Amended Complaint, *supra* note 18, at 1-2 ("Nevertheless, the Attorney General remained deeply concerned that HCA's profit-driven business model might lead them to slash essential medical services in western North Carolina. He therefore demanded that HCA commit to a range of additional protections and conditioned his nonobjection to the acquisition on those protections. Those protections were ultimately memorialized in the Asset Purchase Agreement ("APA") that the parties signed consummating the acquisition. Most critically, HCA promised in the APA not to discontinue providing certain critical services for a 10-year period from 2019 to 2029, barring certain contingencies or extenuating circumstances." (footnote omitted)).

150. *See* Letter from Jennifer T. Harrod, Special Deputy Att'y Gen., N.C. Dep't of Just., to Donald R. Esposito, Jr., Senior Vice President & Couns., Mission Health Sys. (Jan. 16, 2019), https://ncdoj.gov/wp-content/uploads/2023/10/Nonobjection-letter-final-executed.pdf [https://perma.cc/7DF6-YCHH].

151. *Id.*

152. *Id.*

153. Letter from Sarah G. Boyce, Deputy Att'y Gen. & Gen. Couns., N.C. Dep't of Just., to Rachel Ryan, Gen. Couns., Dogwood Health Tr. (Oct. 31, 2023), https://wlos.com/resources/pdf/25e357c1-ba53-4019-92b5-f73a6760b8d7-LetterreAPABreach10.31.23.pdf [https://perma.cc/738W-RB7Q].

By December of 2023, Attorney General Stein had filed suit against HCA, alleging a contract breach.[154] Arguing that "HCA apparently cares more about its profits than its patients," the suit asserted that HCA breached the APA that was excuted as part of the 2019 deal.[155] In the complaint, Stein asked the court to order an injunction and specific performance, and to command HCA to offer emergency, trauma, and oncology services at the level that existed prior to the transaction.[156] Specifically, Stein alleged that Section 7.13(a) of the APA was violated.[157] Under 7.13(a), the APA states:

> Unless otherwise consented to in writing by the Advisory Board for a period of ten (10) years immediately following the Closing Date, Buyer shall not discontinue the provision of the services set forth on Schedule 7.13(a) (the "Mission Hospital / CarePartners Services") at the Mission Hospital Campus Facility, the Community CarePartners Facilities or the Mission Children's Hospital Reuter Outpatient Center, as applicable, subject to Force Majeure making the provision of such services impossible or commercially unreasonable (but only for the period of Force Majeure and the applicable Remediation Period).[158]

In response, HCA noted that the contract it entered into did not include promises related to the quality of care provided.[159] Instead, according to HCA, under the APA, it "promised only to continue to make its facilities, staff, and equipment available to medical staff physicians who want to use those facilities to offer the same services that Mission offered before HCA acquired it."[160] HCA also said that the contract was "silent as to the quantity or quality of services

154. *See* Press Release, N.C. Dep't of Just., Attorney General Josh Stein Sues HCA Healthcare (Dec. 14, 2023), https://ncdoj.gov/attorney-general-josh-stein-sues-hca-healthcare/ [https://perma.cc/F2A9-CQK3].

155. *Id.*

156. *See* Amended Complaint, *supra* note 18, at 8-9.

157. *Id.* at 9.

158. Amended and Restated Asset Purchase Agreement by and among Mission Health System, Inc., et al., 110 (Jan. 2019), https://www.searchwnc.org/apa-main-text [https://perma.cc/24KL-57AD].

159. *See* Andrew R. Jones, *HCA, Responding to Stein Lawsuit, Says It Never Committed to Quality Care at Mission*, ASHEVILLE WATCHDOG (Feb. 14, 2024), https://avlwatchdog.org/hca-mission-respond-to-stein-lawsuit-denying-they-have-broken-commitments-made-at-time-of-sale/ [https://perma.cc/ZCS5-FX3D].

160. *Id.*

required at Mission Hospital,"[161] which highlights the challenge of the litigation.[162]

In its July 12, 2024 report, the independent monitor noted that the litigation between the attorney general and HCA demonstrated the "complexity of resolving this controversy."[163] Further, in analyzing whether the parties followed the all-important Section 7.13(a) of the APA, the independent monitor noted that

> we have heard a number of questions regarding the continuation of protected services at both the critical care hospitals as well as Mission Hospital. Although HCA has not petitioned to discontinue any protected services under the APA, concern has been raised that reductions in staffing have limited access to certain specific services so dramatically that those services should be considered constructively "discontinued." Because those reductions did not comply with the procedures outlined in the Asset Purchase Agreement, these actions, according to this argument, violate the APA.[164]

Further, the independent monitor highlighted the split between the Attorney General and HCA—citing HCA's response arguing that HCA, under the APA, was required "only to offer the facilities and equipment necessary to provide the services, rather than requiring HCA to actually *provide* the services."[165]

While litigation continued, by the summer of 2024, a coalition emerged to engage in a campaign to pressure HCA to relinquish control over Mission.[166] Reclaim Healthcare WNC, the new coalitional group, also sought to improve the quality of care in the

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161. *Id.*

162. *See* Bannow, *supra* note 31 ("[T]hat agreement doesn't hold HCA to any quality or staffing metrics for the hospital.").

163. *See* AFFILIATED MONITORS, INC., MONITORING REPORT FOR FIFTH ANNUAL COMPLIANCE REVIEW CYCLE: TO ASSESS COMPLIANCE ACTIVITIES OF HCA HEALTHCARE, INC. OPERATING UNDER THE ASSET PURCHASE AGREEMENT FOR MISSION HEALTH SYSTEM (JANUARY 19, 2019-JANUARY 19, 2029), at 19 (July 12, 2024), https://dogwoodhealthtrust.org/wp-content/uploads/2024/07/IM-Annual-Report-Compliance-Evaluation-2023_FINAL.pdf [https://perma.cc/W8L7-TQG4].

164. *Id.* at 16.

165. *Id.* at 19.

166. *See* Andrew R. Jones, *'They Must Leave': Coalition Begins Push for HCA to Relinquish Mission*, ASHEVILLE WATCHDOG (July 27, 2024), https://avlwatchdog.org/they-must-leave-coalition-launches-campaign-to-push-hca-to-relinquish-mission/ [https://perma.cc/4JY6-RHE4].

system.[167] Its leader, a State Senator, noted that the coalition was created to give "voice to the people of this region who are disappointed and angry at the degradation in the quality of care being provided in the Mission system, and particularly at Mission Hospital."[168]

B. Rhode Island: State Law and Conditional Approval

Back in Rhode Island, in December 2019, when the controlling shareholder wanted to sell its ownership interest in the parent company of Prospect, the change in ownership triggered the Rhode Island Hospital Conversions Act.[169] This was a law passed in 1997 that required "transfers of 20% or more of ownership ... authority or control of a hospital in Rhode Island" to receive approval by the Rhode Island Department of Health and the state's Attorney General.[170] This process included a review by the Rhode Island Attorney General—a process that quickly grew contentious, culminating in Prospect's threat to close the two hospitals.[171]

Following the review, the report generated by Attorney General Peter Neronha included several less-than-flattering details about both hospitals and their ownership.[172] These concerns centered on quality-of-care issues; both hospitals ranked near the bottom half of Rhode Island hospitals on several metrics, according to CMS.[173] It also highlighted the highly leveraged financial status of the hospitals.[174]

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167. *See* Dean Hensley & Kelly Doty, *New Coalition Aims to Compel HCA to Sell Mission Health*, WLOS ABC13 NEWS (July 25, 2024, at 20:21 ET), https://wlos.com/news/local/reclaim-healthcare-wnc-coalition-officially-forms-pushing-hca-sell-mission-health-state-senator-julie-mayfield-bruce-kelly-gofundme [https://perma.cc/YR5K-5CBU].

168. *Id.*

169. Neronha v. Prospect Medical Holdings, Inc., No. PC-2023-05832, at 4, 33-34 (R.I. Super. Ct. June 12, 2024).

170. *See Hospital Conversions/Mergers Program*, R.I. DEP'T OF HEALTH (2024), https://health.ri.gov/programs/hospitalconversionsmerger/ [https://perma.cc/C9SR-TM7A].

171. *See* Ted Nesi, *'A Focus on Wealth': AG Paints Owners of Roger Williams, Fatima Hospitals as Greedy and Irresponsible*, WPRI 12 NEWS (June 2, 2021, at 18:46 ET), https://www.wpri.com/target-12/a-focus-on-wealth-ag-paints-owners-of-roger-williams-fatima-hospitals-as-greedy-and-irresponsible/ [https://perma.cc/SXQ7-3GYN].

172. *Id.*

173. *See id.*

174. *See id.*

Specifically, the Attorney General's report highlighted the overwhelming amount of debt that was held by the entities, and squarely blamed Prospect for their undercapitalization.[175] The report stated, "[o]ur investigation revealed a company whose principals and investors have issued millions of dollars in dividends from a business responsible for the safety-net hospitals and services they own, which has translated into debt held by the entire system, such that liabilities now exceed assets by over $1 billion."[176] It also noted that this debt may become "unstable" and "threatening," "putting every hospital in its system including [the] Rhode Island Hospitals at risk of reduction in services, sale, or closure."[177]

Nor did the report hold back on the quality rankings of the hospitals.[178] Neronha referenced the "mediocre star ratings of these hospitals," noting that both "are in the bottom half of the state's hospitals overall based on CMS ratings."[179] Referencing penalties for infection rates, blood clots, and "other preventable complications" at the hospitals;[180] a COVID outbreak in the geriatric psychiatric unit at Fatima that infected nearly all of the twenty-one patients; the high turnover of, and assault of, employees (due to an alleged lack of security); "empty" shelves; and "substandard" equipment,[181] the report included a litany of negative details about the hospitals.[182] For their part, nurses and other allied professionals had previously contacted the Attorney General's office reporting that they lacked appropriate equipment, noting staffing shortages, and referencing a lack of morale.[183]

As a result of the challenges faced by the hospitals, Attorney General Neronha conditionally approved the proposed transaction,

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175. *See* STATE OF R.I. OFF. OF ATT'Y GEN., DECISION RE: INITIAL APPLICATION OF CHAMBER INC. 2, 4 (2021), https://riag.ri.gov/sites/g/files/xkgbur496/files/documents/Prospect_Chamber_Ivy_ AG_HCA_Decision.pdf [https://perma.cc/W7WZ-CC9H].

176. *Id.* at 2.

177. *Id.*

178. *Id.* at 64-65.

179. *Id.* at 64.

180. *Id.* at 64-65 ("The Attorney General received a 2017 consulting report that outlines findings of inspection of the equipment in operating rooms at [Fatima] and identifies priority items to address as well as an action plan.").

181. *Id.* at 65.

182. *Id.* at 64-67.

183. *Id.* at 66.

resulting in a change of ownership of the two hospitals.[184] Under this transaction, Leonard Green & Partners[185] and other shareholders sought to sell the 60 percent of shares they held in Ivy Holdings Inc. (the parent company of Prospect).[186] Further, the approval required that Prospect make "upfront financial commitments—not mere verbal promises" to ensure that the two hospitals functioned at a level that could deliver sufficient quality of care.[187]

These conditions, put in place in 2021, required a multiyear financial commitment, capital investments, creating a substantial escrow account, maintaining essential health services, paying debt, and committing to a monitoring program, among other requirements.[188] Similar to the conditions placed around HCA for Mission Hospital, Attorney General Neronha called the "strong" conditions necessary to "ensure the continuity of health care services and operations at the hospitals for the benefit of Rhode Islanders."[189] These conditions were imposed to require "full financial commitment to the Rhode Island hospitals to cover operational and capital expenses through 2026."[190]

Nonetheless, in 2023, Attorney General Neronha sued Prospect, alleging that it had violated multiple conditions of his 2021 Hospital Conversion Act decision.[191] The allegations included a "failure to

184. *See* Press Release, State of R.I. Off. of Att'y Gen., Attorney General Imposes Unprecedented Conditions on Hospital Ownership Change to Ensure Future Operations (June 1, 2021), https://riag.ri.gov/press-releases/attorney-general-imposes-unprecedented-conditions-hospital-ownership-change-ensure [https://perma.cc/5GQN-DJ36].

185. Leonard Green & Partners calls itself a "leading private equity investment firm based in Los Angeles." *About LGP*, LEONARD GREEN & PARTNERS, https://www.leonardgreen.com/about-lgp/ [https://perma.cc/R7JU-2XR9].

186. *See* Neronha v. Prospect Medical Holdings, No. PC-2023-05832, at 4 (R.I. Super. Ct. June 12, 2024).

187. Press Release, State of R.I. Off. of Att'y Gen., *supra* note 184 ("The current financial health of [Prospect] is thus of critical importance to the health of Roger Williams and Fatima Hospitals—and our review raised real concerns about that.").

188. *See id.*

189. Press Release, State of R.I. Off. of Att'y Gen., Attorney General Neronha Seeks to Hold Owners of Fatima and Roger Williams Hospitals in Contempt of Court Over Unpaid Bills (July 12, 2024), https://riag.ri.gov/press-releases/attorney-general-neronha-seeks-hold-owners-fatima-and-roger-williams-hospitals [https://perma.cc/ET9K-6REJ].

190. *Id.*

191. *See Court Unseals AG's Lawsuit Against Owners of Fatima and Roger Williams*, VALLEY BREEZE (Nov. 21, 2023), https://www.valleybreeze.com/news/court-unseals-ags-lawsuit-against-owners-of-fatima-and-roger-williams/article_2dd4e16e-86ff-11ee-9f44-cb7b473be6a1.html [https://perma.cc/2JLL-UUMX].

ensure that vendors serving the hospitals" were paid on time; the lawsuit alleged that the hospitals owed $24 million in debts to vendors that were ninety days past due.[192] Neronha noted concern over the deteriorating financial conditions and took note of Prospect's actions across the country, which included "closing and ... disinvesting in their hospitals."[193]

Neronha's suit led to a June 2024 state court decision ordering that Prospect pay $17 million in unpaid bills.[194] According to the Attorney General, Judge Stern's decision "unambiguously and correctly conclude[d] that Prospect repeatedly failed to comply with important conditions set in our 2021 decision."[195] Prospect paid the outstanding bills to vendors in July 2024.[196]

Nonetheless, following Judge Stern's order, state regulators conditionally approved the sale of the two hospitals to Centurion Foundation, a Georgia-based nonprofit.[197] By November of 2024, after a license application was approved, the hospitals' sales were set to be finalized by January 2025.[198] Referencing the conditions on Prospect, Attorney General Neronha noted that the new ownership gives "the hospitals a fighting chance while imposing a major penalty on the private equity backed owners who put the hospitals

192. *Id.*

193. *Id.*

194. *See* Neronha v. Prospect Medical Holdings, No. PC-2023-05832, at 45 (R.I. Super. Ct. June 12, 2024); Press Release, State of R.I. Off. of Att'y Gen., Attorney General Neronha Applauds RI Superior Court Justice Brian P. Stern's Decision Ordering Prospect Medical Holdings to Pay $17M in Unpaid Bills (June 12, 2024), https://riag.ri.gov/press-releases/attorney-general-neronha-applauds-ri-superior-court-justice-brian-p-sterns-decision [https://perma.cc/4KT9-ES4L]; *see also* Gagosz, *supra* note 115.

195. Press Release, State of R.I. Off. of Att'y Gen., *supra* note 194.

196. Nancy Lavin, *Roger Williams, Fatima Hospital Sale Set to Close in January After License Application Approved*, R.I. CURRENT (Nov. 26, 2024, at 10:23 ET), https://rhodeislandcurrent.com/2024/11/26/roger-williams-fatima-hospital-sale-set-to-close-in-january-after-license-application-approved/ [https://perma.cc/X3ER-SHF9].

197. Janine L. Weisman, *Sale of Roger Williams, Fatima Hospitals Can Proceed if Conditions Are Met*, R.I. CURRENT (June 20, 2024, at 17:08 ET), https://rhodeislandcurrent.com/2024/06/20/sale-of-roger-williams-fatima-hospitals-can-proceed-if-conditions-are-met/ [https://perma.cc/CE46-P59D].

198. *See* Lavin, *supra* note 196.

in distress in the first place."[199] Prospect Medical Holdings filed for bankruptcy in January 2025.[200]

III. WHO OWNS A HOSPITAL?

Aside from government-run facilities, the regulation of American hospitals dramatically diverges into two broad categories that are based upon the tax status of the hospital.[201] In moving from non-profit hospitals to for-profit ones, Mission, Fatima, and Roger Williams traversed an underappreciated but significant line: Most Americans do not know the ownership status of their own local hospitals, and few find it relevant in deciding where to seek care.[202]

According to the Department of Health and Human Services, 49 percent of all Medicare-enrolled hospitals nationwide are nonprofit, and 36 percent are for-profit.[203] A separate set of data shows that about 58 percent of community hospitals (which themselves are 85 percent of all hospitals) have nonprofit tax status.[204] The number of for-profit community hospitals has been steadily growing in the United States.[205] In 1999, only 15 percent of community hospitals

199. Press Release, State of R.I. Off. of Att'y Gen., Attorney General Neronha Announces Recovery of More Than $45 Million for Roger Williams and Fatima Hospitals Upon Sale from Prospect Medical Holdings (Nov. 19, 2024), https://riag.ri.gov/press-releases/attorney-general-neronha-announces-recovery-more-45-million-roger-williams-and [https://perma.cc/AAGC6-HGJ6].

200. *See* Michael Kaplan, *Prospect Medical Holdings Files for Bankruptcy After Owners Took Hundreds of Millions in Payouts*, CBS NEWS (Jan. 12, 2025, at 15:37 ET), https://www.cbsnews.com/news/prospect-medical-holdings-bankruptcy-private-equity/ [https://perma.cc/3UNF-VBLX].

201. *See, e.g.*, Cecilia M. Jardon McGregor, Comment, *The Community Benefit Standard for Non-Profit Hospitals: Which Community, and for Whose Benefit?*, 23 J. CONTEMP. HEALTH L. & POL'Y 302, 302 (2007) ("Non-profit hospitals ... that qualify as charities receive beneficial tax treatment from federal, state and local governments.").

202. *See* Taylor et al., *supra* note 22, at 4, 6.

203. *See* W. PETE WELCH, LANLAN XU, NANCY DE LEW & BENJAMIN D. SOMMERS, OFF. OF THE ASSISTANT SEC'Y FOR PLAN. & EVALUATION, OWNERSHIP OF HOSPITALS: AN ANALYSIS OF NEWLY-RELEASED FEDERAL DATA & A METHOD FOR ASSESSING COMMON OWNERS 1 (2023), https://aspe.hhs.gov/sites/default/files/documents/582de65f285646af741e14f82b6df1f6/hospital-ownership-data-brief.pdf [https://perma.cc/8E87-UK8A] ("The new CMS data show that nearly half of the 4,644 Medicare-enrolled hospitals are non-profit (49.2 percent), 36.1 percent are for-profit, and 14.7 percent are government-owned.").

204. *Hospitals by Ownership Type*, KAISER FAM. FOUND., https://www.kff.org/state-health-policy-data/state-indicator/hospitals-by-ownership/ [https://perma.cc/2MBB-DZJK] (refining results to for-profit hospitals in 2022).

205. *Id.*

had for-profit tax status, and by 2012, that number exceeded 21 percent.[206]

Given the complexity in the requirements to qualify for tax exempt status, a 2020 Government Accountability Office (GAO) report suggested that Congress clarify the nonprofit hospital requirements and that the IRS "should establish a well-documented process to identify hospitals at risk for noncompliance with the community benefit standard that would ensure hospitals' community benefit activities are being consistently reviewed."[207] Although other IRS recommendations were heeded, in a follow-up, the GAO noted that changes made by January of 2025 "[were] not sufficient to ensure that community benefit information is clear and can be easily identified by Congress and the public, as we recommended."[208] Prior to this report, the community benefit standard had been the target of critique.[209]

Notwithstanding appropriate regulatory oversight, providers and academics are embroiled in policy debates about the impact of profit interests on quality of care. At least as it relates to the most aggressive profit interests—the intervention of private equity in the hospital space—a 2023 study found an increase in adverse events at hospitals following private equity acquisition.[210] This and other studies suggest that as corporate interests increase, patient care suffers.[211] For their part, physicians' surveys echo these findings.[212]

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206. *Id.* (refining results for 1999 and 2012 in percentages).

207. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-679, TAX ADMINISTRATION: OPPORTUNITIES EXIST TO IMPROVE OVERSIGHT OF HOSPITALS' TAX-EXEMPT STATUS (2020), https://www.gao.gov/products/gao-20-679 [https://perma.cc/8SMK-UVER].

208. *Id.*

209. *See* Mark C. Westenberger, *Tax-Exempt Hospitals and the Community Benefit Standard: A Flawed Standard and Way Forward*, 17 FLA. TAX REV. 407, 410-11 (2015) (arguing that the community benefit standard is flawed in three ways).

210. *See* Sneha Kannan, Joseph Dov Bruch & Zirui Song, *Changes in Hospital Adverse Events and Patient Outcomes Associated with Private Equity Acquisition*, 330 JAMA 2365, 2366 (2023), https://jamanetwork.com/journals/jama/fullarticle/2813379 [https://perma.cc/KHN4-TRLK] ("[P]rivate equity acquisition was associated with a 25.4% increase in hospital-acquired conditions, which was driven by falls and central line-associated bloodstream infections.").

211. *See* Buck, *supra* note 12, at 336-37.

212. *See* Susanna Vogel, *Corporate Healthcare Ownership Reduces Care Quality, Physician Survey Finds*, HEALTHCARE DIVE (Dec. 6, 2023), https://www.healthcaredive.com/news/non-physician-ownership-reduces-care-quality-physician-advocacy-institute/701719/ [https://perma.cc/M6JK-XFKY] (noting that, after a survey of 1000 doctors employed by

A. An Insufficient Binary

Notwithstanding the more intricate differences, the chief distinction between for-profit and nonprofit hospitals for our instant purpose focuses on the role and structure of regulatory oversight—and particularly on the identity of the parties who are primarily responsible for supervising and steering the entity. For the nonprofit entity, the *state* is solely responsible for regulatory oversight, typically represented by the state's top law enforcement officer, the attorney general.[213] In the for-profit entity, it is the *shareholder* who is in the position of primacy, and at the heart of corporate governance.[214]

But a legal regime that recognizes only these two primary interests—the state's agent in the case of a nonprofit hospital, and the stockholders of the corporation that owns the for-profit hospital—may discount other important interests. Most importantly for the instant analysis, in the for-profit hospital, there is no party whose primary interest is to represent the public citizenry (from which patients emerge). Regardless, there are several stakeholders who could have legitimate interests in the future and functioning of the entity. In addition to the attorney general and corporate shareholders, taxpayers, current and future patients, and employees and independent contractors have legitimate interests in the functioning of the hospital. Current regulatory oversight fails to account for all these interests, a fact that is glaringly prevalent in the for-profit context.

1. Taxpayers

Taxpayers have a legitimate interest in both for-profit and nonprofit hospitals. Taxpayers occupy two somewhat opposing, but

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corporations and hospitals, nearly 60 percent said that nonphysician practice ownership harms patient care quality. The reason for the harm included decreased time with patients and management's focus on financial success, and 70 percent of the respondents hired by corporate employers "reported their employer used incentives or penalties to have them see more patients a day").

213. *See* Buckles, *supra* note 133, at 645; Leslie, *supra* note 133, at 1186-87; Owley, *supra* note 133, at 1710.

214. *See* Robert J. Rhee, *A Legal Theory of Shareholder Primacy*, 102 MINN. L. REV. 1951, 1951-52 (2018).

highly interrelated, roles. The first role focuses on providing unique benefits to the hospital (specifically in the case of nonprofit hospitals), and the second focuses on serving as payer of health care services (which benefits both types of hospitals). Both are detailed below.

a. Taxpayer as Funder of the Entity

The first taxpayer role manifests as an agent of the public corpus. Within this role, taxpayers serve as representatives of the whole polity—a polity that does not insist on collecting taxes from the nonprofit hospital due to the public mission of the institution.[215] In effect, the polity absolves the nonprofit of a typical tax burden due to its special status and role it occupies in society.[216] Instead of the state being responsible for the work of the entity, the nonprofit hospital steps up to take on the charitable undertaking.

In this way, nonprofit hospitals have struck a deal with the public. Theoretically, they agree to care for the entirety of the populace (including those who cannot afford to pay for the services the hospital renders), and society both rewards them with tax breaks and, to ensure it is protecting its investment, more actively supervises their activities.[217] To safeguard the publicness of the entity, states empower and deputize their attorneys general to consent to conversions,[218] or at least receive notice of proposed

215. *See* Barak D. Richman, *Antitrust and Nonprofit Hospital Mergers: A Return to Basics*, 156 U. PA. L. REV. 121, 127 (2007) (noting that nonprofits may need additional antitrust scrutiny due to their goal of minimizing cost to taxpayers).

216. *See* Danielle Ofri, Opinion, *Why Are Nonprofit Hospitals So Highly Profitable?*, N.Y. TIMES (Feb. 20, 2020), https://www.nytimes.com/2020/02/20/opinion/nonprofit-hospitals.html [https://perma.cc/YXN2-PNW7] ("[B]ecause nonprofit hospitals are defined as charitable institutions, they can benefit from tax-free contributions from donors and tax-free bonds for capital projects .... The real question surrounding nonprofit hospitals is whether the benefits to the community equal what taxpayers donate to these hospitals in the form of tax-exempt status.").

217. *See* R. Chad Nelson, *McCarran-Ferguson Is Protecting the Wrong Health Care Entities*, 31 HEALTH MATRIX: J.L.-MED. 133, 134 (2021) ("Currently, non-profit hospitals are subject to a substantial regulatory code that restricts its business practices in order to protect consumers, the government, and taxpayers.").

218. *See, e.g.*, CAL. CORP. CODE §§ 5914, 5917, 5920, 5923 (West 2023); Jaime S. King, Alexandra D. Montague, Daniel R. Arnold & Thomas L. Greaney, *Antitrust's Healthcare Conundrum: Cross-Market Mergers and the Rise of System Power*, 74 HASTINGS L.J. 1057, 1067 n.40 (2023) ("The Attorney General has broad discretion in reviewing these transactions

transactions involving nonprofit hospitals in an effort to protect competition.[219] State attorneys general may sue nonprofit hospitals that fail to serve charity care patients as expected or promised.[220]

For sure, this tax exemption amounts to more than just a symbolic representation of the state: It amounts to a real benefit to nonprofit hospitals. In 2020, the total tax exemption awarded to nonprofit hospitals in the United States was worth $28 billion.[221] That year, the total charity care provided by nonprofit hospitals amounted to $16 billion.[222]

Although the nonprofit hospital oversight structure is subject to criticism,[223] it is well-accepted that nonprofit hospitals benefit their communities.[224] According to the American Hospital Association, the

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and may consider whether the transaction is in the public interest, or any other factors the Attorney General deems relevant."); Marion R. Fremont-Smith, Mark Urban & Sandy Praeger, *The Challenge of For-Profit Health Care Conversions*, 31 J.L. MED. & ETHICS (SPECIAL SUPPLEMENT) 49, 49 (2003) ("California passed legislation setting up a system of mandatory Attorney General consent for sale of non-profit hospitals to for-profit and non-profit entities.").

219. Elizabeth Sepper & James D. Nelson, *Government's Religious Hospitals*, 109 VA. L. REV. 61, 111 (2023).

220. *See* Medha D. Makhlouf, *Charity Care for All: State Efforts to Ensure Equitable Access to Financial Assistance for Noncitizen Patients*, 23 HOU. J. HEALTH L. & POL'Y 55, 76, 78 (2024) (highlighting a Washington case in which the Attorney General sued a nonprofit that failed to "offer charity care applications to all low-income patients").

221. Jamie Godwin, Zachary Levinson & Scott Hulver, *The Estimated Value of Tax Exemption for Nonprofit Hospitals Was About $28 Billion in 2020*, KAISER FAM. FOUND. (Mar. 27, 2023), https://www.kff.org/health-costs/issue-brief/the-estimated-value-of-tax-exemption-for-nonprofit-hospitals-was-about-28-billion-in-2020/ [https://perma.cc/N3KN-JDEL] (this total consisted of $14.4 billion in federal exemptions and $13.7 billion in state and local tax exemptions).

222. *Id.*

223. *See, e.g.*, George A. Nation III, *Non-Profit Charitable Tax-Exempt Hospitals—Wolves in Sheep's Clothing: To Increase Fairness and Enhance Competition in Health Care All Hospitals Should Be For-Profit and Taxable*, 42 RUTGERS L.J. 141, 149, 150-51 (2010) ("Achieving healthcare access for the poor by hidden cost transfers structured by non-profit hospital administrators and/or required by the government through below-cost Medicare/Medicaid reimbursements, or requiring tax-exempt hospitals to provide a set level of free care to the poor, is an inefficient, deceitful, non-democratic approach that undermines the basic foundations of our democracy.").

224. *See* AM. HOSP. ASS'N, TAX-EXEMPT HOSPITALS PROVIDED NEARLY $130 BILLION IN TOTAL BENEFITS TO THEIR COMMUNITIES 1 (2023), https://www.aha.org/system/files/media/file/2023/10/Results-from-2020-Tax-Exempt-Hospitals-Schedule-H-Community-Benefit-Reports.pdf [https://perma.cc/HBY5-47DW] (according to the American Hospital Association, "[t]ax-exempt hospitals provided nearly $130 billion in total benefits to their communities in 2020 alone").

benefit that nonprofit hospitals provide (in a broad and holistic sense) amounted to nearly $130 billion in 2020.[225] This included financial assistance and services that furthered community wellbeing.[226]

The total amount of tax exemption has grown in recent years.[227] It rose from $19 billion in 2011 to $28 billion in 2020,[228] as governments have been "foregoing increasing amounts of revenue over time to provide tax benefits to nonprofit hospitals."[229] As mentioned above, this is a substantial amount; remarkably, this exemption amounted to 44 percent of net income at nonprofit hospitals in 2020.[230] While the amount of foregone tax revenue is increasing, the requirements that must be met to qualify as a nonprofit hospital remain murky.[231] This vagueness is nothing new to tax status in the health care space. Clarifying and codifying what entitles a hospital to nonprofit status is the topic of a long and winding endeavor.[232]

Notwithstanding confusion around the standards, the interests of the taxpayer—recognized in effect as a quasi owner of the nonprofit hospital—are purportedly protected by an agent of the state.[233] Once that status changes, the citizenry loses a considerable amount of structural leverage over the nonprofit hospital—the governance of the hospital, in effect, becomes privatized.[234] The regulation of the hospital's activities moves from public law oversight to private law

225. *Id.*

226. *Id.*

227. *See* Godwin et al., *supra* note 221.

228. *Id.*

229. *Id.* ("This has raised questions about whether nonprofit facilities provide sufficient benefit to their communities to justify this tax benefit.").

230. *Id.*

231. *See, e.g.*, BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JONHNSON, TIMOTHY STOLTZFUS JOST & ROBERT L. SCHWARTZ, HEALTH LAW 554-56 (3d ed. 2015) (noting the complexity of distinguishing between nonprofit and for-profit hospitals).

232. The most recent change to this space was brought about by the Patient Protection and Affordable Care Act (ACA) more than a decade ago. *See Requirements for 501(c)(3) Hospitals Under the Affordable Care Act—Section 501(r)*, IRS (July 1, 2025), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r [https://perma.cc/AH4T-GEUG]. Nonetheless, new confusion has arisen around the new requirements. The ACA imposes new requirements on nonprofit hospitals, such as the completion of a community health needs assessment and the creation of a financial assistance policy, under a new IRS Section known as 501(r). *See id.*

233. *See supra* notes 14-16 and accompanying text.

234. *See supra* notes 19-20 and accompanying text.

enforcement based solely on corporate law principles—notwithstanding state attempts to obtain new owners' compliance through contract law.[235]

b. Taxpayer as Payer for Care

As compared to the direct relationship of the taxpayer to the nonprofit entity, the second role of the taxpayer is more diffuse. This second role is that of a funder of publicly provided health care goods and services,[236] and, of course, public insurance.[237] American taxpayers foot the bill for a large percentage of health care costs.[238] Indeed, both nonprofit and for-profit hospitals take advantage of this funding, but to say that a for-profit entity is not in any way beholden to the public would be a misstatement. As payers for health care services (like any other consumers), taxpayers have a clear interest in the functioning and quality of the hospitals they pay to care for their fellow citizens covered by America's massive public insurance structure.[239] Taxpayers pay the bills for these programs, whose price tags, collectively, approach $2 trillion.[240]

Around 34.2 percent of patients who visit nonprofit hospitals for service are Medicare beneficiaries, slightly more than the 33.1 percent of patients who visit for-profit hospitals.[241] Further, 9.4

235. *See supra* notes 18-20 and accompanying text.

236. *See* Yaniv Heled, Liza Vertinsky & Cass Brewer, *Why Healthcare Companies Should Be(come) Benefit Corporations*, 60 B.C. L. REV. 73, 116 (2019) (noting that taxpayer funds cover a multitude of health care goods aside from public insurance financing).

237. *See id.* (noting the public support provided as payers for Medicare and Medicaid).

238. According to Centers for Medicare and Medicaid Services, 32 percent of health care expenditures were covered by the federal government, 27 percent by households, and 16 percent by state and local governments. *See NHE Fact Sheet*, CTRS. FOR MEDICARE & MEDICAID SERVS. (June 24, 2025, at 10:05 ET), https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet [https://perma.cc/F5DV-X5YY].

239. As of 2023, according to the Census Bureau, 18.9 percent of Americans were covered by Medicaid, and 18.9 percent were covered by Medicare. *See* KATHERINE KEISLER-STARKEY & LISA N. BUNCH 2, U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2023 (2024), https://www.census.gov/library/publications/2024/demo/p60-284.pdf [https://perma.cc/DB7F-TA9T]. More than 120 million Americans were covered by public health insurance. *Id.*

240. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 238.

241. *Payor Mix at Nonprofit vs. For-Profit Hospitals*, DEFINITIVE HEALTHCARE (Oct. 5, 2023), https://www.definitivehc.com/resources/healthcare-insights/payor-mix-nonprofit-vs-for-profit-hospitals [https://perma.cc/M2D5-2ET3].

percent of patients visiting a nonprofit are on Medicaid—nearly identical to the 9.1 percent visiting a for-profit hospital.[242] Nonetheless, with public insurance paying for 45 percent of national health care spending, taxpayers have a vested interest in both the quality of care the hospitals administer and in the cost of those services.[243]

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One can imagine subtle differences between the two interests presented by taxpayers here. *Taxpayers as funders* of a nonprofit may have a primary interest in ensuring the quality of their investment. Perhaps they would want to ensure the hospital delivered on its promised mission in an efficient and sustainable way.

Alternatively, *taxpayers as payers for care* may have similar interests but may be primarily concerned with the quality and cost of care that is provided to the beneficiaries of the public insurance programs. In other words, taxpayers as funders may worry about being *cheated* by the hospital in some way; taxpayers as payers may be worried about beneficiaries of the public programs being *cheated* by the health care system writ large. These differences are subtle, no doubt, but, in some scenarios one can easily imagine these interests becoming adverse to one another. At the very least, the interests—between taxpayers as funders and taxpayers as payers—do not always perfectly align. After all, they represent two opposing sides of the health care system.

Interestingly, a hypothetical taxpayer who has absolved the nonprofit hospital from having to pay taxes might be interested in their return on investment. Specifically, they may be interested in the quality of care that the hospital provides—indeed, wanting to ensure that their hard-earned funds support a hospital that delivers on quality metrics—but they also may be concerned about overall costs. The taxpayer may understand that the hospital has secured a deal with the public fisc—one that requires the hospital to deliver for the length of the tax-exempt status.

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242. *Id.*

243. *How Does Government Healthcare Spending Differ from Private Insurance?*, PETER G. PETERSON FOUND. (Apr. 11, 2025), https://www.pgpf.org/article/how-does-government-health care-spending-differ-from-private-insurance/ [https://perma.cc/QTD6-7K9U].

Similar to the interests of taxpayers above, here, the taxpayer may be concerned about the use of their taxpayer contribution to the public health insurance programs. As it relates to the taxpayer, they may rightfully be concerned about whether the public program is well run: Does it maintain solvency such that the program remains a worthwhile political endeavor and program? And, even more bluntly, does the Medicare program remain solvent such that today's taxpayer will be able to join the program when they reach retirement age? Regardless, taxpayers—both versions sketched here—have limited roles in the oversight of a for-profit hospital.

2. Current and Future Patients

In the unique industry of health care, a large interest group that cares extensively about the inner workings of a local hospital are those being wheeled through its byzantine hallways, sitting in its waiting rooms, and laying on its operating tables.[244] From the Latin "*patiens*," and "*patior*," meaning "to suffer or bear," they are the American patients.[245] In many ways, the patient lies at the root of America's misbegotten health care system: Legal rules seek to protect the patient—rules that regulate the patient-physician relationship,[246] or the licensure of hospitals,[247] for instance, seek to protect the patient from a system that can inflict major harm and exploit vulnerability.[248] Consequently, the primary interest—of both current and future patients—is whether the hospital is providing, and will continue to provide, high-quality care that can heal them.

244. *See* Deb Gordon, *60% of Americans Have Had a Recent Bad Healthcare Experience, New Survey Shows*, FORBES (Nov. 28, 2022, at 08:50 ET), https://www.forbes.com/sites/debgordon/2022/11/28/60-of-americans-have-had-a-recent-bad-healthcare-experience-new-survey-shows/ [https://perma.cc/J8GV-J3QD] (noting that 60 percent of Americans had a negative healthcare experience in a three month period).

245. *See* Julia Neuberger, *Let's Do Away with "Patients,"* 318 BMJ 1756, 1756 (1999).

246. *See* Barbara J. Evans, *The HIPAA Privacy Rule at Age 25: Privacy for Equitable AI*, 50 FLA. ST. U. L. REV. 741, 745 (2023) (noting, for instance, the regulation of privacy within the physician-patient relationship).

247. *See* Barry R. Furrow, *The Limits of Current A.I. in Health Care: Patient Safety Policing in Hospitals*, 12 NE. U. L. REV. 1, 42 (2020) (referencing hospital licensure laws).

248. *See, e.g.*, Elizabeth Kukura, *Obstetric Violence*, 106 GEO. L.J. 721, 724 (2018) (noting and exploring the vulnerability of women giving birth and suggesting legal and regulatory responses).

Relatedly, this system must deliver in a way that can earn and maintain the patient's trust.[249] This is a basic interest.

Imagine what defines a "good" health care experience, and it is easy to imagine what patients want. Generally, this includes open access to health care services, sufficient and competent staffing, and—perhaps above all—high-quality care. Nonetheless, mirroring the differences that exist between the two roles occupied by taxpayers, there are similarly divergent interests between current and future patients.

Where the future patient may slightly diverge from the current patient may relate to issues that touch on the future solvency of the hospital. In their most basic of interests, current patients want the hospital to offer services of sufficient current quality without limit. The current patient is seeking an end to current suffering—long-term efficiencies, or whether the taxpayer is getting a good return on investment are of lesser importance. One may easily imagine a family member of a suffering patient imploring the doctors and hospital to make their loved one better with no mind to the efficiency or the long-term sustainability of the hospital's bottom line. One may also think about care that is deemed "futile"—typically end-of-life interventions that do not benefit the patient—as where the interests of a current and future patient diverge.[250]

Somewhat conversely, future patients are interested in quality of care, for sure, but may be more circumspect about the no-holds-barred strategy for today's patients. Instead, there may be more of an interest in ensuring the hospital does not provide care that is wasteful and that the hospital makes decisions that are reflective of an interest in long-term sustainability.[251] Like the dual nature of the taxpayers' roles, it is not the case that these interests are always diametrically opposed, but they may differ in the prioritization of

249. Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463, 470-71 (2002).

250. *See* Kristen McConnell, *The Medical Care That Helps No One*, ATLANTIC (May 10, 2023), https://www.theatlantic.com/ideas/archive/2023/05/icu-nurse-palliative-care-ventilators-intubation/673984/ [https://perma.cc/UHC6-992Q] (noting that 11 percent of American patients receive futile care and that another 8.6 percent received treatment that "was probably futile").

251. *See The Role of Clinical Waste in Excess US Health Spending*, HEALTH AFFS. (June 9, 2022), https://www.healthaffairs.org/content/briefs/role-clinical-waste-excess-us-health-spending [https://perma.cc/2LC2-8HMC] (summarizing a study focused on the ways clinical waste contributes to the unsustainable increases in health expenditures).

various interests.[252] Recognizing the nuance, a future patient may be interested in the hospital's sustainability in the same way that a taxpayer as a funder also takes a longer-term view.[253] But like the taxpayer, the oversight of for-profit hospitals makes little room for patients, both current and future.[254]

3. Employees and Providers

The employees of the institution have a strong interest in *both* making sure the hospital is financially healthy *and* delivering high-quality care.[255] For example, the providers at Mission Hospital have led the charge in demanding quality improvements since the purchase by HCA.[256] But it goes without saying that the providers who remain[257] also have an interest in making sure that Mission Hospital remains a going concern.[258]

The primary legal obligation of providers practicing in Providence, Asheville, and elsewhere is the obligation to deliver high-quality, legally-compliant[259] care.[260] For providers who work at

252. *See supra* Part III.A.1.

253. *See supra* Part III.A.1.a.

254. *See supra* Part III.A.1.b.

255. *See* Lucian A. Bebchuk & Roberto Tallarita, *The Illusory Promise of Stakeholder Governance*, 106 CORN. L. REV. 91, 108-09, 116-17 (2020) (explaining that employees are a key stakeholder group who are dependent on the corporation for their jobs and salaries); Lisa Doggett, *Doctors Have Their Own Diagnosis: 'Moral Distress' from an Inhumane Health System*, NPR (Aug. 2, 2023, 11:48 ET), https://www.npr.org/sections/health-shots/2023/08/02/1191446579/doctors-have-their-own-diagnosis-moral-distress-from-an-inhumane-health-system [https://perma.cc/QG39-5MLB] (testifying to doctors' intrinsic motivation to offer the best care possible to patients).

256. *See* King, *supra* note 66.

257. *See* Dave Muoio, *Report: Over 220 Doctors Left Mission Health Since Its 2019 Acquisition by HCA Healthcare*, FIERCE HEALTHCARE (Mar. 29, 2022, at 07:20 ET), https://www.fiercehealthcare.com/providers/report-over-220-doctors-left-mission-health-its-2019-acquisition-hca-healthcare [https://perma.cc/Q3TY-PSLU] (noting that 223 doctors who were listed in August 2019 had been removed by February 2022 and that these "included 33 family medicine physicians, 25 surgeons and 15 pediatricians or pediatric specialists").

258. *See* Bebchuk & Tallarita, *supra* note 255, at 108-09, 116.

259. For sure, providers must deliver care that does not violate the fraud and abuse laws. *See, e.g.*, Chinelo Diké-Minor, *The Devil Made Me Do It: An Argument for Expanding the Anti-Kickback Statute to Cover Private Payers*, 56 CONN. L. REV. 87, 99-102 (2023).

260. *See* Philip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 913 (2002) ("Medical customs are not merely admissible, they define the physician's legal standard of care."); Khiara M. Bridges, *Race in the Machine: Racial Disparities in Health and Medical AI*, 110 VA. L. REV. 243, 274 n.144 (2024) (documenting sources discussing

a hospital that has undertaken dramatic cuts to the cost of the care it provides, these professionals must be cognizant of the impact of those cuts on their patients.[261] In this way, employees and providers facing cuts today may deprioritize their real interest in ensuring the hospital continues as a going concern because one challenge takes precedence over the other.[262]

And although one may hypothesize that physicians in a hospital enjoy more employment protection than other providers, stories featuring short staffing challenges impact physicians as well.[263] Relatedly, recent reporting has found that emergency rooms have been increasingly staffed by other professionals as opposed to physicians.[264] Nonetheless, regardless of the long-term financial health of the hospital, providers are often negatively impacted by the realities of the profit motive, resulting in moral distress and even moral injury.[265] Like the previous actors, providers have limited structural input over a for-profit hospital.[266]

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deviations from the standard of care).

261. *See* Bannow, *supra* note 31.

262. *See id.*

263. *See, e.g.*, Gretchen Morgenson, *Doctor Fired from ER Warns About Effect of For-Profit Firms on U.S. Health Care*, NBC NEWS (Mar. 28, 2022, 14:54 ET), https://www.nbcnews.com/health/health-care/doctor-fired-er-warns-effect-profit-firms-us-health-care-rcna19975 [https://perma.cc/NG5L-AUW5] (relaying stories of physicians being stretched thin).

264. *See* Brett Kelman & Blake Farmer, *ERs Staffed by Private Equity Firms Aim to Cut Costs by Hiring Fewer Doctors*, NPR (Feb. 11, 2023, 07:00 ET), https://www.wusf.org/2023-02-11/ers-staffed-by-private-equity-firms-aim-to-cut-costs-by-hiring-fewer-doctors [https://perma.cc/3HBJ-5FEU] (documenting stories of physician cuts and increased use of nurse practitioners for the delivery of care).

265. *See* Doggett, *supra* note 255 (noting physician frustration over their inability to "spend time with patients who need it" and how they "have little control over their schedules"); Eyal Press, *The Moral Crisis of America's Doctors*, N.Y. TIMES: MAG. (July 14, 2023), https://www.nytimes.com/2023/06/15/magazine/doctors-moral-crises.html [https://perma.cc/Z29U-X9HP] (documenting the pressure and frustrations felt by doctors working in an increasingly profit-driven health care system).

266. *See supra* Parts III.A.1, III.A.2.

4. Shareholders

The shareholders serve as owners of for-profit hospitals.[267] Shareholders are interested in maximizing the value of their investments; if Mission Hospital is highly profitable, for instance, HCA's shareholders may express satisfaction—full stop.[268] And shareholders have been expressing a lot of satisfaction with HCA lately.[269] HCA has outperformed the S&P 500 for years, and its primary goal has been to maximize the value of its shares for its stockholders—"making it the darling of health care investors and analysts."[270]

Because HCA's shareholders are often not located in the local community—nor likely to be potential future patients at Mission, for instance—there may not be the same incentive for these individuals to follow the local story and the impact of the hospital's increased profitability on the quality of care available at that facility.[271] For a company that owns 184 hospitals,[272] the shareholders likely do not even know of the bad press surrounding one. The typical tools available to signal to the market shareholder dissatisfaction—due to bad press, for example[273]—are unavailable.

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267. Barak D. Richman & Steven L. Schwarcz, *Macromedical Regulation*, 82 OHIO ST. L.J. 727, 770 (2021) ("For-profit corporate entities generally, including not only financial institutions but also for-profit hospitals and other healthcare providers, are managed for the primary benefit of their shareholders." (footnote omitted)).

268. *See, e.g.*, Simply Wall St, *Those Who Invested in HCA Healthcare (NYSE: HCA) Five Years Ago Are Up 138%*, YAHOO FIN. (Dec. 2, 2024), https://finance.yahoo.com/news/those-invested-hca-healthcare-nyse-120027306.html [https://perma.cc/D5B8-VCXM] ("But in stark contrast, the returns over the last half decade have impressed. It's fair to say most would be happy with [the] 129% ... gain in that time").

269. *See* Bannow, *supra* note 31.

270. *Id.*

271. Guifeng Shi, Jianfei Sun, Li Zhang & Yufang Jin, *Corporate Social Responsibility and Geographic Dispersion*, 36 J. ACCT. & PUB. POL'Y 417, 418-19, 427 (2017) (finding that businesses with geographically dispersed shareholders have lower corporate social responsibility scores because shareholders have less social interaction with stakeholders).

272. *See HCA Reports Fourth Quarter 2019 Results and Provides 2020 Guidance*, HCA HEALTHCARE 10 (Jan. 28, 2020), https://investor.hcahealthcare.com/news/news-details/2020/HCA-Reports-Fourth-Quarter-2019-Results-and-Provides-2020-Guidance/default.aspx [https://perma.cc/F46K-BRT8].

273. *See 12 PR Catastrophes That Crushed Company Shareholders*, BUS. INSIDER (Oct. 13, 2010, 15:03 ET), https://www.businessinsider.com/pr-train-wrecks-2010-10 [https://perma.cc/BUL3-8FPT]. *But see* Emmie Martin, *Here's How Warren Buffett Decides Whether or Not to Sell a Stock When He Gets Bad News*, CNBC: MAKE IT (Feb. 28, 2019, at 09:35 ET),

B. Indirect Influence of Patients and Physicians for Nonprofits

In the nonprofit context, it is the taxpayer, represented through the actions of the state attorney general, who exerts power over the hospital.[274] In the for-profit context, it is the corporate shareholder that can direct the actions of the entity.[275] In both models, two stakeholders intimately familiar with the condition of the hospital on the ground—both providers and patients—are conspicuously absent.[276] These actors, the two most closely connected to the day-to-day functioning of the hospital and those who are most likely to suffer following changing governing priorities, lack direct input over the entity's governance, whether organized as a for-profit or nonprofit.[277]

Nonetheless, there is an important difference between nonprofit and for-profit governance that can crystalize the distinction: Both providers and patients *are* taxpayers. In this way, physicians and patients have their interests at least indirectly represented.[278] Presumably, the taxpayer can exert public regulatory pressure over the hospital if patients are unhappy with how the hospital treats patients or if physicians are frustrated with how little autonomy they enjoy.[279]

In the for-profit context, however, the shareholders frequently have no local connection to the hospital whatsoever.[280] In addition to not sharing any indirect interest with the governance structure, patients in the for-profit context have nearly no connection to the

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https://www.cnbc.com/2019/02/28/how-warren-buffett-decides-whether-to-sell-stock-when-he-gets-bad-news.html [https://perma.cc/WAM7-CDNG] ("Even when press turns negative or the markets drop, Warren Buffett doesn't dump his holdings in a company.").

274. *See supra* note 213 and accompanying text.

275. *See supra* note 214 and accompanying text.

276. *See supra* Parts III.A.2, III.A.3.

277. *See supra* Parts III.A.2, III.A.3; *see also* WELCH ET AL., *supra* note 203, at 8 (finding that organizations own approximately 91 percent of the shares of all Medicare-enrolled hospitals, while individuals own 8 percent).

278. *See supra* Part III.A.1.

279. *See supra* Part III.A.1.a; *see also* Doggett, *supra* note 255.

280. *See* WELCH ET AL., *supra* note 203 (finding that organizations own almost all of the shares of Medicare-enrolled hospitals); Shi et al., *supra* note 271, at 418-19, 427 (concluding firms with geographically dispersed shareholders experience lower corporate social responsibility due to limited interaction with local stakeholders).

party in interest within the corporate structure: the shareholders.[281] And in the case of national systems, the shareholders may not even be aware of the extent to which the patients or providers in a region may be affected by new resource allocation and governance choices foisted upon one hospital.[282]

In this way, as compared to a nonprofit hospital, the governance structure of a for-profit hospital misses important feedback from the patients on the ground. This should seem unsurprising if you view the modern hospital as another manifestation of the same pressures that exist in any other private industry—for sure, corporate behaviors are not determined by their employees or customers.[283] But this challenge—that patients and physicians lack appropriate empowerment and agency such that their work and care are impacted—is a pervasive and apparent limitation on the appropriate functioning of a public-facing entity such as a hospital.[284] Due to these policy concerns, one wonders if an external governance structure can ever be effective in sufficiently elevating the concerns of patients and providers.

For that, one may examine ideas in corporate law and the theory of stakeholderism.[285] The advantage, of course, of such a doctrine is that it would empower a party not currently trusted with governance oversight with the ability to influence the modern hospital from the perspective of patient protection.[286] There are major challenges associated with implementing this kind of doctrine into the for-profit organization of a modern hospital, but its use may be particularly influential in an industry like health care.[287]

The following Part posits the argument that it is patients, and to a more limited extent, those providers who treat them, whose voices

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281. *See* Bebchuk & Tallarita, *supra* note 255, at 99-100, 146-47.

282. *See* Shi et al., *supra* note 271.

283. *But see* Ashley E. Jaramillo, Note, *Hippies in the Boardroom: A Historical Critique of Addressing Stakeholder Interests Through Private Ordering*, 96 N.Y.U. L. REV. 2213, 2225 (2021) (highlighting the growing influence of stakeholderism).

284. *See, e.g.*, Bannow, *supra* note 31.

285. Stakeholderism is an approach to corporate governance that embraces "the view that corporations should operate in a manner that benefits society and all of the corporations' stakeholders." Lisa M. Fairfax, *Stakeholderism, Corporate Purpose, and Credible Commitment*, 108 VA. L. REV. 1163, 1165 (2022); *see also* Bebchuk & Tallarita, *supra* note 255, at 94.

286. *See infra* Part IV.D.1.

287. *See infra* Part IV.D.2.

should be amplified to better protect their interests.[288] Due to the particular interests of patients, the remainder of this piece focuses on the interests of patients and the impact of this doctrine on their ability to influence the actions of the for-profit hospital.

IV. INTO THE THICKET OF STAKEHOLDERISM

Perhaps the modern corporation could be moved to internalize the plight of patients. After all, for-profit hospitals, beyond just maximizing shareholder value, surely have an interest in the interests of patients. Perhaps there is a way to reimagine corporate law to provide for a new such duty for the modern American hospital corporation.

On that front, corporate law has been involved in a scholarly debate about the benefits and downsides of a concept known as stakeholderism.[289] An idea that has surfaced at various points throughout the development of the modern corporation,[290] stakeholderism "has been on the rise, especially in terms of its acceptance by corporate executives, management advisors, and policy thought leaders."[291] And although it is a commonly referenced doctrine in literature, its implementation remains cloudy.[292] Still, iterations of a more stakeholderist posture have led to backlash in well-known examples across industries. These topics and examples are presented immediately below.

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288. *See* Hajin Kim, *Expecting Corporate Prosociality*, 53 J. LEGAL STUD. 267, 287 (2024) (noting that employees "may be slow to protest," given the power imbalances experienced by employees vis-à-vis employers).

289. *See* Dorothy S. Lund & Elizabeth Pollman, Essay, *The Corporate Governance Machine*, 121 COLUM. L. REV. 2563, 2629 (2021) (noting "the doctrinal debate over corporate purpose that has consumed much scholarly attention for the past few decades").

290. *See* Jeff Schwartz, *De Facto Shareholder Primacy*, 79 MD. L. REV. 652, 668 (2020) ("In the United States, waves of shareholder primacy thinking and stakeholderism rise and fall.").

291. Bebchuk & Tallarita, *supra* note 255, at 106; *see also* Michal Barzuza, Quinn Curtis & David H. Webber, *The Millennial Corporation: Strong Stakeholders, Weak Managers*, 28 STAN. J.L. BUS. & FIN. 255, 268 (2023) ("Corporate law scholars have tried to explain the recent rise of ESG and stakeholderism and to make predictions on where it will lead us.").

292. *See* Fairfax, *supra* note 285, at 1191-94.

A. Stakeholderism in Corporate Law

At base, stakeholderism stands for the proposition that, unlike traditional corporate law, the corporation must owe and discharge its governance duties to more parties than just its shareholders.[293] Stakeholderism, which turns shareholder primacy on its head, argues that the corporation must act for the benefit of actors beyond its shareholders.[294] This includes all individuals affected by corporate decisions, such as customers, citizens, regulators, and—in the health care context—patients.[295]

In this view, corporations must show they have concern for the greater social good.[296] It is here where the seemingly increasingly controversial ESG (environmental, social, governance) movement is located.[297] According to these voices, the corporation should care about environmental protection, good governance, and human rights, not because it is good for shareholder value, but because it is the right thing for the modern and ethical corporation to do.[298]

While stakeholderism might be viewed in stark contrast to shareholder primacy, there are examples of the doctrine that do not create conflict. Corporations, often to maximize shareholder profit, must consider the longevity of stakeholders to boost societal buy-in because stakeholders provide "financial and human capital, institutional infrastructure, and revenues."[299] Nonetheless, in typical corporate law, mutual benefit is simply a welcomed byproduct.[300] The real tension between stakeholderism and shareholder primacy

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293. *See* Barzuza et al., *supra* note 291, at 267-68.

294. *See id.* at 259, 267-68.

295. *See* Bebchuk & Tallarita, *supra* note 255, at 116, 118-19.

296. Gregory H. Shill & Matthew L. Strand, *Diversity, ESG, and Latent Board Power*, 46 DEL. J. CORP. L. 255, 309-10 (2022).

297. *See, e.g.*, Stefan J. Padfield, *Does Stakeholder Capitalism Have A (Viewpoint) Diversity Problem?*, 13 U. P.R. BUS. L.J. 1, 11-15 (2022) (discussing how some view the ESG movement as politically divisive); *The Criticism of ESG: Why Is It Becoming Controversial?*, UNIV. OF THE BUILT ENV'T (Oct. 16, 2024), https://www.ucem.ac.uk/whats-happening/articles/criticism-of-esg/ [https://perma.cc/S65K-DQNC]; Saijel Kishan & Tasneem Hanfi Brogger, *Why ESG Faces Backlash and Its Future Under Trump 2.0*, BLOOMBERG (Mar. 3, 2025, at 06:33 ET), https://www.bloomberg.com/news/articles/2025-03-03/why-esg-faces-backlash-under-trump-2-0 [https://perma.cc/RU7K-J75U].

298. Aneil Kovvali & Yair Listokin, *Valuing ESG*, 49 B.Y.U. L. REV. 705, 717-19 (2024).

299. Bebchuk & Tallarita, *supra* note 255, at 108-09.

300. *Id.* at 119-20.

arises when benefits to stakeholders are viewed not as a means to the end of delivering on shareholder value, but as an end in itself.[301]

The most potent conflicts arise when corporations must make decisions based on what is best for stakeholders, even if they come at a cost to shareholders.[302] Here, values of shareholders and stakeholders may misalign or corporate leaders may be forced to expend considerable resources to identify relevant stakeholders, discern their positions, and determine how to prioritize potentially competing interests among them.[303] Thus, without an affirmative commitment from corporate leaders to subscribe to these goals, especially in the face of detriment to shareholders, legal scholars hesitate to exude optimism toward stakeholderism.[304] Additionally, even if corporate leaders morally subscribe to an ends paradigm of stakeholderism, without accompanying policy changes, they may face legal restraints that ultimately confine their discretion to mutually beneficial outcomes.[305]

Outside of external regulation or legal reform of the modern corporation, shareholders can voluntarily cede their interests from within using the shareholder proposal rule.[306] This rule provides shareholders with the agency to invoke stakeholder-oriented

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301. *Id.* at 97; *see also* Jill E. Fisch, *Purpose Proposals*, 1 U. CHI. BUS. L. REV. 113, 120 (2022) (pointing out that "[a]lthough support for stakeholder governance is widespread, there is considerably less agreement on what stakeholder governance entails," and recounting the two dominant versions of stakeholderism: "instrumental stakeholderism," or a means paradigm, and "pluralistic stakeholderism," or an ends paradigm).

302. Bebchuk & Tallarita, *supra* note 255, at 119-20.

303. *Id.* at 116-19.

304. *See id.* at 100-01 (warning that acceptance of stakeholderism without clear boundaries will incur major costs, including "mak[ing] corporate leaders less accountable and more insulated from investor oversight" ultimately impeding or delaying reforms that could bring "real, meaningful protection to stakeholders"); *see also* Fairfax, *supra* note 285, at 1187-93 (arguing that without corporate leaders making a credible commitment—being held accountable for promises made in economic exchanges—stakeholderism is "empty rhetoric"). *See generally* Lucian A. Bebchuk & Roberto Tallarita, *Will Corporations Deliver Value to All Stakeholders?*, 75 VAND. L. REV. 1031, 1035 (2022) (proposing that the Business Round Table's 2019 Statement was "largely for show" and the companies that joined did not intend or expect it to bring about any material changes in how they treat stakeholders).

305. *See* Colin Mayer, Essay, *Shareholderism Versus Stakeholderism—A Misconceived Contradiction: A Comment on "The Illusory Promise of Stakeholder Governance," by Lucian Bebchuk and Roberto Tallarita*, 106 CORN. L. REV. 1859, 1868-69 (2021) (noting that, unless subject to a state that enacted constituency statutes, corporations are legally confined to considering stakeholders only to the extent it promotes shareholder interest).

306. *See* Fisch, *supra* note 301, at 116.

governance or even amend charters to alter the underlying corporate form to a public benefit corporation.[307] Whatever the potential, such proposals have historically failed to receive the requisite support from fellow shareholders.[308] Thus, stakeholderism will likely require both internal reform and external regulation to truly dominate the corporate form and achieve desired outcomes.[309]

While grounded in seemingly altruistic intentions, some legal scholars fear that stakeholderism equips corporate leaders with justification for "more expansive lobbying efforts," will likely fail to redistribute power and resources to weaker stakeholders, and can end up being "counter-productive."[310] One prevailing criticism is that by devaluing the shareholder, there will be less investment channeled into new businesses to the overall detriment of the economy.[311] Another is that stakeholderism lacks clear metrics and competing interests among stakeholders which will tax the corporate decision-making process, leading to "toothless enforcement," and ultimately provide corporate leaders with the freedom to "cherry pick" which interests align with their own personal agendas.[312]

Additionally, some posit that the business judgment rule renders stakeholderism irrelevant as corporate leaders currently possess the wherewithal to pursue prostakeholder agendas.[313] Further, even if corporate reform can infuse stakeholderism into the fold, the business judgment rule can paradoxically provide corporate leaders an escape route back to shareholder primacy.[314] This would ultimately require a more robust overhaul of corporate law to truly serve stakeholders.[315]

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307. *Id.* at 116-18.

308. *See id.* at 135-39.

309. *See* generally Matteo Gatti & Chrystin Ondersma, *The Perils of a Stakeholderist Corporate Law Reform: A Reply to Professor Kovvali*, 123 COLUM. L. REV. F. 229 (2023) (responding to a critique of earlier work and clarifying that internal and external regulation are not mutually exclusive, but compatible to effectuate stakeholderism).

310. Matteo Gatti & Chrystin Ondersma, *Can a Broader Corporate Purpose Redress Inequality? The Stakeholder Approach Chimera*, 46 J. CORP. L. 1, 9-10 (2020).

311. *Id.* at 18-19.

312. *Id.* at 19-20.

313. *See id.* at 21.

314. *Id.*

315. *See id.* ("Paradoxically, the presence of the business judgment rule would make an express stakeholder reform meaningless if directors intended to keep catering to the interests

This is because, at its core, stakeholderism is a challenge to the traditional and normative view of corporate duties. Shareholder primacy is a foundational and durable feature within modern corporate law.[316] And it is notoriously difficult to dislodge.[317]

As Professors Dorothy Lund and Elizabeth Pollman make clear, "stakeholderism is unlikely to dethrone shareholder primacy as the dominant decisionmaking framework" largely because the "shareholder primacy viewpoint has become enmeshed in our cultural and institutional understanding of good governance and as multiple powerful players operate as gatekeepers for the shareholder primacy norm, it becomes difficult to move to another paradigm."[318] Shareholder primacy is so foundational to and embedded in what it means to be a corporation as an organizing principle that uprooting it seems deeply unlikely.

However, other potential landing points exist short of wholesale replacement of shareholder primacy; perhaps stakeholderism could simply infuse some new form of shareholder dominance. In a world in which shareholder governance is immovable, it may instead simply incorporate some of stakeholderism's influences. But Professors Lund and Pollman observe substantial challenges to this as a landing point, including that "important issues may slip through the cracks."[319]

Contorting and limiting stakeholderism until it stands for an idea that simply requires the corporation to take a longer view, but still fit it within the shareholder primacy paradigm, may lead to even worse results. As Lund and Pollman note, "tying the consideration of stakeholder welfare to long-term shareholder value limits acceptable rationales and favors activity that can be reduced to measurable metrics tied to risk or financial value."[320] Further, it requires a merging of stakeholder interests with discernible and

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of shareholders only, as such a decision could be reconciled with the business judgment rule. Following this logic, the only way to make a stakeholder reform truly effective would be to abandon the business judgment rule.").

316. Rhee, *supra* note 214, at 1951.

317. Joe Nocera, Opinion, *Down With Shareholder Value*, N.Y. TIMES (Aug. 10, 2012), https://www.nytimes.com/2012/08/11/opinion/nocera-down-with-shareholder-value.html [https://perma.cc/P4EL-HZCF].

318. Lund & Pollman, *supra* note 289, at 2630-31.

319. *Id.* at 2632.

320. *Id.* at 2631.

concrete shareholder interests, and "renders the promotion of stakeholder welfare that cannot be justified as benefitting shareholders as outside the bounds of acceptable corporate activity, no matter the overall welfare benefits."[321]

Melding the goals of stakeholderism with a dominant shareholder paradigm may result in hollow achievements. Goals from stakeholders may run the risk of being resolved in a "check-the-box fashion," especially when translated into the goals of the corporate governance machine, as Lund and Pollman point out.[322] The whole point behind requiring the corporation to care about a wider swath of stakeholders gets reduced to an easily measurable standard without accounting for any of the larger public goals.

B. Stakeholderism in Other Industries

Notwithstanding its durability, stakeholderism has experienced renewed energy, and corporations have been pushed to be more aware of the public good. But the backlash has been powerful; particularly those on the political right assail "woke capital" as seeking to mandate a particular view or influence the virulent culture wars.[323] And this backlash is not just hypothetical; corporations have had their bottom line impacted by boycotts following a show of support for a public cause.[324] This has spooked shareholders and raised serious questions about the future of stakeholderism.

A discussion of boycotting in the context of stakeholderism would be incomplete without mentioning the recent boycott of Anheuser-Busch's Bud Light and the lasting financial, reputational, and political damage that ensued.[325] In a marketing campaign to

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321. *Id.*

322. *See id.* at 2633.

323. *See* James Surowiecki, *The War on 'Woke Capital' Is Backfiring*, ATLANTIC (Jan. 31, 2024), https://www.theatlantic.com/ideas/archive/2024/01/republicans-woke-capital-esg-investment/677294/ [https://perma.cc/2C9U-DDQJ].

324. *See* Susan A. Maslow, *The ESG Backlash: Politics and Shareholder Primacy*, A.B.A. BUS. L. TODAY (Apr. 21, 2023), https://www.americanbar.org/groups/business_law/resources/business-law-today/2023-april/politics-shareholder-primacy/ [https://perma.cc/34WA-ZU9H]. *But see* Carolyn Berkowitz, *Why the ESG Backlash Has Little Effect on Corporations*, INV. NEWS (May 3, 2023), https://www.investmentnews.com/esg/opinion/why-the-esg-backlash-has-little-effect-on-corporations-237034 [https://perma.cc/BPT9-8KHL].

325. *See* Hanna Ziady, *Bud Light Boycott Likely Cost Anheuser-Busch InBev Over $1 Billion in Lost Sales*, CNN BUS. (Feb. 29, 2024, at 12:05 ET), https://www.cnn.com/ 2024/02/29/

promote LGBTQ equality, Bud Light's partnership with transgender social media influencer Dylan Mulvaney received harsh and enduring backlash from consumers.[326] One social media post reportedly cost Bud Light over $1 billion in lost sales and over $25 billion in lost shareholder value.[327]

Bud Light, previously the number one selling beer in the United States, has since fallen to third in terms of beer sales.[328] While the loudest cries against Bud Light came from the political right, financial metrics showed that after boycotts began, Bud Light sales took steep declines even in politically left-leaning areas of the country.[329] While other companies promoting ESG, such as Nike and Pepsi, experienced minor, temporary backlash, Bud Light's attempts struck a political nerve that resulted in far more backlash than its peers faced.[330] In terms of gauging public support or contempt, Bud Light's campaign revealed how little guidance companies have on promoting ESG, particularly on how to navigate the risks.

While some companies, such as Bud Light, suffered financial backlash after promoting social values, companies in other industries have experienced financial success while promoting ESG. BlackRock, one of the world's largest asset management firms, has been an industry leader in promoting green energy investments, and its efforts have resulted in billions of dollars' worth of investments in clean energy.[331] BlackRock has taken the ESG approach of specifically promoting investment opportunities in renewable energy infrastructure, which has drawn investor support, while

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business/bud-light-boycott-ab-inbev-sales/index.html [https://perma.cc/V64H-UHA6]; J. Edward Moreno, *Bud Light Is No Longer America's Top-Selling Beer After Boycott*, N.Y. TIMES (June 14, 2023), https://www.nytimes.com/2023/06/14/business/bud-light-lgbtq-backlash.html [https://perma.cc/J4PV-U4DE].

326. *See* Alicia Park, *Bud Light Boycott Effects Endure—Brand Drops to Third*, FORBES (July 23, 2024, at 19:10 ET), https://www.forbes.com/sites/aliciapark/2024/07/18/bud-light-boycott-effects-endure-brand-drops-to-third/ [https://perma.cc/6BTY-2GPG].

327. *Id.*

328. *Id.*

329. *See* Jura Liaukonyte, Anna Tuchman & Xinrong Zhu, *Lessons from the Bud Light Boycott, One Year Later*, HARV. BUS. REV. (Mar. 20, 2024), https://hbr.org/2024/03/lessons-from-the-bud-light-boycott-one-year-later [https://perma.cc/S4LQ-2MUU].

330. *Id.*

331. Jack Pitcher & Amrith Ramkumar, *Step Aside, ESG. BlackRock Is Doing 'Transition Investing' Now.*, WALL ST. J. (Mar. 3, 2024, at 07:00 ET), https://www.wsj.com/finance/investing/step-aside-esg-blackrock-is-doing-transition-investing-now-59df3908 [https://perma.cc/PA84-WCSQ].

investors simultaneously pulled billions of dollars out of other publicly traded ESG funds.[332] BlackRock CEO Larry Fink has shown that stakeholderism, ESG, and investor support may be able to coexist, but even he has stopped using the term.[333]

While companies like BlackRock can draw investor support in some circumstances, ESG-conscious investment strategies have drawn sharp criticism. For example, before adopting the investment opportunity approach to promoting ESG, BlackRock's Fink originally advocated for broad ESG reform but abandoned the approach after receiving harsh criticism from prominent members of the investment community.[334] Beyond backlash from peers within the investment community, BlackRock's ESG efforts also spurred political backlash, exemplifying the conservative revolt against "woke capitalism."[335]

Since 2021, nearly four hundred "anti-ESG" bills have been introduced by state lawmakers, with twenty states having officially enacted some form of anti-ESG legislation.[336] These legislative actions attempt to force ESG concerns out of decision-making processes, particularly for organizations handling public funding.[337] Specifically, state laws have prevented pension fund managers from factoring ESG considerations into investment decisions.[338] Missouri, in response to BlackRock's environmental spending mentioned above, pulled $500 million in pension funds from BlackRock, claiming that BlackRock's environmental investing emphasis constituted a "massive fiduciary breach."[339]

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332. *Id.*

333. *See* Shannon Thaler, *BlackRock Admits CEO Larry Fink's 'Woke' ESG Activism Focus Could 'Materially Adversely' Hit Business*, N.Y. POST (Mar. 1, 2024, at 15:39 ET), https://nypost.com/2024/03/01/business/blackrock-admits-ceos-focus-on-esg-activism-could-hit-business/ [https://perma.cc/YM9U-T8KN].

334. Pitcher & Ramkumar, *supra* note 331.

335. *Id.*

336. Mark F. Walsh, *Backlash Benefits*, A.B.A. J., Aug.-Sep. 2024, at 9, 10.

337. *Id.* at 10.

338. Amanda Shanor & Sarah E. Light, *Anti-Woke Capitalism, the First Amendment, and the Decline of Libertarianism*, 118 NW. U. L. REV. 347, 383 (2023).

339. *Id.* at 384 (quoting Press Release, Scott Fitzpatrick, Mo. State Treasurer, Treasurer Fitzpatrick Announces MOSERS Has Pulled $500 Million in State Pension Funds from BlackRock (Oct. 18, 2022), https://treasurer.mo.gov/newsroom/news-and-events-item?pr=80669a5f-5c6b-491f-a0f0-6abe4c012604 [https://perma.cc/2YNG-CCSW]).

Additionally, private companies that boycott other companies involved in the fossil fuel industry, mining industry, or other industries deemed harmful to the environment are being legislatively barred from transacting with state entities and state-managed pension funds.[340] For example, in Texas, recent legislation requires the state comptroller to maintain a list of all financial companies that boycott energy companies.[341] Texas state entities are prohibited from investing in the listed companies, and state entities must divest any funds currently invested in companies on the list.[342]

CEOs from companies that support stakeholderism and ESG efforts like BlackRock have nonetheless banded together to show support for stakeholderism. One of the leading business policy organizations in the United States, the Business Roundtable, issued a "Statement on the Purpose of a Corporation" in 2019, which emphasized the importance of promoting stakeholderism.[343] The Business Roundtable's membership consists of prominent business executives like Fink who advocate for stakeholderism and other measures of delivering value to more than just internal shareholders.[344]

While business leaders can advocate for stakeholderism in press conferences and applaud ESG efforts in news articles, actual implementation of these policies still faces fierce opposition. In a response to the 2019 Business Roundtable's advocacy of stakeholderism, Harvard Law School Professor Jesse Fried described the legal and fiduciary requirements that effectively handcuff corporations to their shareholders' interests.[345] Companies are bound by a fiduciary duty to make decisions that benefit the investors who fund

340. Alexander L. Norman, Note, *The ESG War: Public Pension Fiduciaries and Anti-ESG Laws*, 74 WASH. U. J.L. & POL'Y 245, 259 (2024).

341. *Id.* at 260.

342. *Id.*

343. *Business Roundtable Redefines the Purpose of a Corporation to Promote 'An Economy That Serves All Americans*,*'* BUS. ROUNDTABLE (Aug. 19, 2019), https://www.businessroundtable.org/business-roundtable-redefines-the-purpose-of-a-corporation-to-promote-an-economy-that-serves-all-americans [https://perma.cc/ST5C-DN6V].

344. *See id.*

345. *See* Jesse Fried, *The Roundtable's Stakeholderism Rhetoric Is Empty, Thankfully*, HARV. L. SCH. F. ON CORP. GOVERNANCE (Nov. 22, 2019), https://corpgov.law.harvard.edu/2019/11/22/the-roundtables-stakeholderism-rhetoric-is-empty-thankfully/ [https://perma.cc/W9KG-EWB3].

those companies, despite what CEOs claim in public statements about serving other interests.[346]

Likewise, Professors Lucian A. Bebchuk and Roberto Tallarita note that 70 percent of the companies that signed the Business Roundtable Statement are incorporated in Delaware, a state with "strong shareholder-centric corporate law."[347] Quoting the former Chief Justice of the Delaware Supreme Court, Bebchuk and Tallarita point out that, under Delaware law, "directors must make stockholder welfare their sole end."[348] This raises questions about the enduring effect and power of stakeholderism.

Beyond the adverse commentary from critics, corporations can also face legal backlash for promoting stakeholderism and ESG. Because companies owe a fiduciary duty to investors, misguided attempts to promote stakeholderism that go awry could potentially constitute a breach of fiduciary duty. Courts have long recognized this duty to investors; in the early twentieth century, the Supreme Court of Michigan ruled against Henry Ford, holding that Ford Motor Company's duty to its shareholders prevented the company from cutting prices to make vehicles more affordable for consumers.[349] More recently, a Delaware court barred the directors of Craigslist from operating the business entirely to benefit local communities, citing the directors' fiduciary duty owed to Craiglist's investors, which mandated the corporation to pursue profit-based motives.[350] Considering that most large businesses in a position to promote stakeholderism are incorporated as for-profit business entities, those businesses are constrained to the extent that any benefits to stakeholders must still measurably benefit internal shareholders.

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346. *See id.*

347. Bebchuk & Tallarita, *supra* note 255, at 137.

348. *Id.* at 138 (quoting Leo E. Strine, Jr., *The Dangers of Denial: The Need for a Clear-Eyed Understanding of the Power and Accountability Structure Established by the Delaware General Corporation Law*, 50 WAKE FOREST L. REV. 761, 768 (2015)).

349. *See* Dodge v. Ford Motor Co., 170 N.W. 668, 684 (Mich. 1919) ("A business corporation is organized and carried on primarily for the profit of the stockholders. The powers of the directors are to be employed for that end.").

350. *See* Jaramillo, *supra* note 283, at 2251 (citing *eBay Domestic Holdings, Inc. v. Newmark*, 16 A.3d 1, 34 (Del. Ch. 2010)).

C. Public Benefit Corporations

An alternative option that avoids the constraints of maximizing shareholder value comes in the form of an entirely different business entity: the benefit corporation, or B-Corp. These business entities are specifically created with a "double bottom line" in mind and are designed to benefit both investors and outside stakeholders simultaneously.[351] Between 2010 and 2018, thirty-three states and the District of Columbia enacted benefit corporation statutes.[352] These statutes represent a backlash to the backlash that corporations received after attempting to implement stakeholderism, and they indicate a legislative support for stakeholderism.

Other scholars have also suggested relying on public benefit corporations in health care. In their prescient work in 2019, Professors Yaniv Heled, Liza Vertinsky, and Cass Brewer argued for the creation of public benefit companies—corporations with a different public form in which the institution has changed incentives from the inside of the institution itself.[353] Pushing for the creation of benefit corporations within the health care space, they observe that this would solve some of the worst conflicts between public need and profit.[354] Their proposal applies to all health care companies, seeking to neutralize some of the worst incentives of the corporate structure.[355] It also seeks to address some of the same issues this current work raises. Of course, the conceptual advantages of benefit corporations are limited by practical considerations—and particularly the concern that, just because a benefit corporation writes public purposes in its articles of incorporation does not guarantee adherence to those public purposes.[356]

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351. *See* Christopher Lacovara, Note, *Strange Creatures: A Hybrid Approach to Fiduciary Duty in Benefit Corporations*, 2011 COLUM. BUS. L. REV. 815, 818-20 (quoting Thomas Kelley, *Law and Choice of Entity on the Social Enterprise Frontier*, 84 TUL. L. REV. 337, 339 (2009)).

352. Ellen Berrey, *Social Enterprise Law in Action: Organizational Characteristics of U.S. Benefit Corporations*, 20 TRANSACTIONS: TENN. J. BUS. L. 21, 24 (2018).

353. *See* Heled et al. *supra* note 236, at 80-81.

354. *See id.*

355. *See id.*

356. *See* Heather Landi, *Aledade, Mark Cuban's Drug Company and a Handful of Others Are Public Benefit Corporations. Could It Be the Rx to Improve Healthcare?*, FIERCE HEALTHCARE (Feb. 3, 2023, at 13:00 ET), https://www.fiercehealthcare.com/providers/aledade-transitions-public-benefit-corporation-heres-why-handful-healthcare-companies [https://perma.cc/6DMQ-VLK4].

If hospitals like Mission transition from a for-profit model to a benefit corporation model, there is no guarantee that the hospitals will truly prioritize the public purpose instead of leaving profit motive as the driving compass, just as before. Instead, requiring for-profit hospitals to take account of the interests of parties outside of shareholders may go further in changing the internal governance of for-profit hospitals.

D. Patients as Stakeholders

Hospitals exist to treat patients, and the people in their regulatory structures need to think hard about what to do with hospitals that are making decisions antithetical to the interests of patient care. As such, this Article posits that for-profit hospitals should seek to adopt and implement some of the best reasons for considering stakeholderism—all to benefit patients. This proposal understands the potential backlash to such a rule, but argues that hospitals are sufficiently well-positioned, and patients are particularly sympathetic, that the stakeholderist impulse makes a lot of sense in the health care context.

This proposal has multiple benefits. The most important benefits include the elimination of a regulatory gulf between for-profit and nonprofit hospitals, and the empowerment of patients in the for-profit hospital. Further, this proposal can claim legitimacy due to the state's interests in protecting its funding—dollars that continue to flow to for-profit hospitals through major subsidies like grant projects, public insurance coverage, and even the subsidies that prop up the private insurance marketplace. Additionally, this proposal—applying stakeholderist principles to for-profit hospitals—is likely to avoid backlash due to the prioritization of the wellbeing of patients. Nonetheless, this thought experiment has downsides and may engender several concerns, and those are identified below as well.

First, this proposal—explicitly requiring hospitals to have a corporate law duty to the interests of patients—would make progress toward eliminating the regulatory gulf that currently exists between nonprofit and for-profit hospitals. For nonprofit hospitals, the state—commonly through its attorney general—is given the authority to oversee their activities or protect their

"missions."[357] Why not apply a similar duty of oversight to for-profit hospitals in much the same way by empowering patients?

As aforementioned, when a nonprofit hospital seeks to enter a new transaction or combination, the state has the authority to review or approve that request.[358] Nonprofit hospitals across the country are constrained by the actions of the state attorney general or secretary of state, and in some instances, they cannot close deals they otherwise would choose.[359] But, when a for-profit entity such as Mission Health has alleged quality of care challenges, it is not the state that gets involved; it is only patients who suffer and the public who complains—seemingly to no avail.

Eliminating this inconsistency makes sense in a marketplace in which the difference between nonprofit and for-profit hospitals is not discernable nor understood by the average patient.[360] Without a notable marker between for-profits and nonprofits for patients, patients cannot make knowledgeable decisions about where to seek care. Of course, patients who suffer an emergency or lack decision-making authority over which facility they visit are not making decisions about where to seek care in the first place. From the perspective of the public and the patient, why one type of hospital should be subject to publicly protective rules and the other should not lacks a rational defense.

It is patients who are on the front lines for the worst of the quality-of-care challenges, and it is patients who suffer the most when their local hospitals scale back services and otherwise cut expenditures on patient care. A policy that seeks to provide a pathway for patient interests to influence corporate decision-making would, above all, be patient protective. From a legal and structural perspective, patients do not fit neatly within the typical corporate

357. *See* Katharina Lewellen, Gordon M. Phillips & Giorgo Sertsios, *Control Without Ownership: Governance of Nonprofit Hospitals* 6 (Nat'l Bureau of Econ. Rsch., Working Paper No. 34132, 2025), https://www.nber.org/system/files/working_papers/w34132/w34132.pdf [https://perma.cc/KE7R-398E] ("The state AG is charged with protecting a nonprofit's charitable assets and ensuring that its activities are consistent with the stated mission.").

358. *See, e.g.*, N.Y. NOT-FOR-PROFIT CORP. LAW § 510(3) (McKinney 2025) (addressing the sale of nonprofits in New York); *see also supra* notes 14-15 and accompanying text.

359. *See* Press Release, Off. of Att'y Gen., Court Blocks Closure of Former Nonprofit Hospital at Request of Attorney General Lockyer, (Aug. 13, 2002), https://oag.ca.gov/news/press-releases/court-blocks-closure-former-nonprofit-hospital-request-attorney-general-lockyer [https://perma.cc/LDT6-CX89].

360. *See* Taylor et al., *supra* note 22, at 6.

law categories of actors, but this uncommon relationship that does not cleanly map on to other areas of law is nothing new to health law.

This thought experiment—to treat patients as stakeholders for purposes of corporate law oversight—bases its conclusions on the unique position that patients occupy. As mentioned above, patients are not typically shareholders—they have no ownership interest, besides perhaps an indirect taxpayer-related interest, in the hospital's bottom line. As a result, they are unable to influence the actions of the corporate hospital. And patients surely do not have an interest in that entity profiting to their detriment.[361]

Nor are patients typical consumers, in that they may not choose to visit the hospital or emergency room they are being driven to or wheeled into. In this way, they are left to occupy an exceptionally vulnerable position: They are at the mercy of a for-profit entity with limited ability to influence the governance of, or even leave, that institution. Unlike in other industries, patients do not have the power to walk away from a poorly performing or harm-causing hospital because they *need* the health care they are seeking. In this way, they are the opposite of rational actors.

On the other end of the relationship, this creates a situation in which the for-profit hospital can act with near impunity. Knowing that a local market is uncompetitive and that patients may have no choice in where they seek care, for-profit hospitals are unmoved to adopt policies that—in other industries—would be necessary to attract business. A hospital cutting resources that may impact care can effectively act without fear of an impact to its bottom line. After all, over the last few years, Mission has triggered questions surrounding its quality of care, but it has also been its most profitable era—and it's not even close.[362]

Finally, the "regulator paradigm" does not work, largely because of the so-called "remedy" problem. In other industries, if an entity is performing poorly, the regulator—perhaps the federal government—can threaten it with devastating sanction. It can withhold

361. Many for-profit hospitals have been in the news for suing patients for unpaid medical bills. *See* Isaac D. Buck, *When Hospitals Sue Patients*, 73 HASTINGS L.J. 191, 193 (2022). But, surprisingly, the practice is not limited to for-profit hospitals; several nonprofit hospitals frequently engage in the practice. *See id.* at 193 n.3.

362. *See supra* Part I.A.

funding or even threaten to exclude it from a federal program in which all federal dollars are at risk.[363] But this paradigm does not work in the scenario in which the for-profit hospital's quality of care has been negatively impacted. It stretches credulity to imagine that patients who experienced poor care at their local hospital would want the federal government to penalize or exclude it from Medicare, which often results in closure.[364] It is simply that they want a *better* hospital—one that concerns itself with patient care—it is not the case that they want it *closed*.

1. Specific Upsides

Other ESG and stakeholder proposals have generated political backlash. But the structure of the political backlash suggests that hospitals—in adopting a model in which patients are the stakeholders—may be able to escape the worst of the blowback. An important consideration when adopting stakeholderism is ensuring that any such proposal or undertaking has legitimacy in a way that will make its adoption sticky; this suggestion seems to have a more durable shot at success than some of the other highly publicized failures in this space.

When it comes to health care, hospitals are in a unique spot. First, so much of a hospital's revenue is directly supported by public funding. Some researchers have even found that public reimbursement plans and subsidies have led to the proliferation and growth of for-profit hospitals.[365] The American health care system features private delivery and public payment, which leads to a set of externalities that hamstring the health care system, but so much of health care's expenditures are publicly supported. Because of this, patients should be empowered with a role in ensuring that hospitals provide the type of care to them that is satisfactory. In this way, a move toward stakeholderism seems more legitimate.

Second, patients occupy a position of unique sympathy in society. Such a new corporate law duty, one that forces hospitals to undertake corporate activity with an eye on how those actions impact

363. *See, e.g.*, 42 U.S.C. § 1320a-7a.

364. *See, e.g.*, *Exclusions Program*, U.S. DEPT. OF HEALTH & HUMAN SERVS., https://oig.hhs.gov/exclusions/ [https://perma.cc/7YMA-ZMEL].

365. *See* Patrick P.T. Jeurissen, Florien M. Kruse, Reinhard Busse, David U. Himmelstein, Elias Mossialos & Steffie Woolhandler, *For-Profit Hospitals Have Thrived Because of Generous Public Reimbursement Schemes, Not Greater Efficiency: A Multi-Country Case Study*, 51 INT'L J. HEALTH SERVS. 67, 82 (2021) ("In the United States, the advent of Medicare and Medicaid, implemented by a Democratic president as part of a broad expansion of social programs, offered vast public subsidies to for-profit hospitals, accelerating their growth.").

patients, would seem to be relatively benign. This is also because patients are not typical consumers; in so many instances, patients cannot shop or choose whether to ultimately seek health care. Because patients are so vulnerable in these scenarios, such a proposal would be seen as primarily patient protective, and, more likely to be politically supported.

Finally, Americans are not particularly sympathetic to the corporatization of American medicine. For sure, many have soured on American health care—on its quality, cost, and even their own insurance coverage.[366] This kind of data all makes the same point: Americans are in support of any kind of change in health care that could improve their experience. If that means that hospitals have a new corporate duty to ensure that patients have their interests protected, all the better.

2. Challenges

A work that seeks to import corporate law doctrinal development into the governance of a for-profit hospital is undoubtedly set to run into limitations. The first, of course, is related to the doctrinal uptake and durability of stakeholderism writ large. This surely would demonstrate a sea change within the world of corporate law.[367]

The remaining concerns—which are beyond the scope of this work—focus on the implementation of such a doctrinal move. First, how, exactly, would the patients' interests be considered? One must be particularly cognizant of preventing hospitals from "checking the box" of this effort without making meaningful change to their governing decision-making. Questions for future inquiry would examine how the patient would be treated as a stakeholder—and how the clear adversity that their position is likely to create would be handled in the C-suite.

Beyond questions surrounding the *how*, the second implementation-related challenge would ask the *who*? Most basically, *which* patient's interest would be considered? Under such a patient-centered design, there would surely be scenarios in which patient interests are not monolithic. These pose problems of measurement and specificity.

366. *See* Lydia Saad, *Americans Sour on U.S. Healthcare Quality*, GALLUP (Jan. 19, 2023), https://news.gallup.com/poll/468176/americans-sour-healthcare-quality.aspx [https://perma.cc/JSE5-G3R9].

367. *See supra* notes 293-319 and accompanying text.

Further, might the patient's view diverge from the public interest? Would this pose problems to a governance regime that seeks to comparatively tip the power balance of the hospital away from the corporate shareholders? These are all questions that would need to be answered and addressed during the implementation of such a new regime, and could be centered in future work in this space.

CONCLUSION

Stakeholderism, in which the corporate entity is required to take account of the interests of American patients, is a doctrine that can be applied to improve the governance of for-profit hospitals. Stakeholderism could work in health care due to the public funding of so much of American health care, the unique vulnerability of patients, and the current dissatisfaction with American hospitals. In the end, a legal doctrine that protects American patients should be strongly considered to prevent the worst excesses of the corporate hospital.