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BOOK REVIEWS

IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY. By Rosemary Stevens. New York: Basic Books. 1989. 432 Pp. \$25.95.

*Reviewed by Jeffrey O'Connell**

THE AMERICAN HOSPITAL: OH HOW THE MIGHTY HAVE FALLEN

In her well-crafted book, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY*,¹ Rosemary Stevens, Professor of History and Sociology of Science at the University of Pennsylvania, tells us that in the great depression almost no community hospital in the United States became insolvent.² This was at a time when other American institutions were going under at an appalling rate. Almost sixty years later, former Governor Richard Lamm of Colorado, an outspoken critic of the cost of American health care, urged at a meeting of community hospitals that—even at a time of relative prosperity—only if many U.S. hospitals went bankrupt could Americans begin to reign in health care costs.³

Quite a change.

Despite the bitter ring to her title, Rosemary Stevens is surprisingly without bitterness in her narrative. On the contrary, she comes across (as foreigners often do—she is of British origin) admiring the eleemosynary nature of American voluntary institutions, including its hospitals. She especially admires the generous nature of those who support such institutions, including donors of both money and services. But the facts that are the mortar of her tale vividly explain why the situation of America's not-for-profit hospitals has changed so radically in this century—from almost unalloyed confidence and success in the past to beleaguered fright and failure in the present.

In short, Professor Stevens is quite generous in her outlook toward hospi-

* John Allan Love Professor of Law, University of Virginia; A.B., 1951, Dartmouth College; J.D., 1954, Harvard University.

1. R. STEVENS, *IN SICKNESS AND IN WEALTH: AMERICAN HOSPITALS IN THE TWENTIETH CENTURY* (1989) [hereinafter *AMERICAN HOSPITALS*].

2. *Id.* at 142.

3. R. Lamm, Remarks at a Meeting of Estes Park Institute, Palm Beach, Fla. (Dec. 3, 1989).

tals while providing the reader with the basis for a devastating indictment framed as follows:

From the turn of the century until the 1970's, American not-for-profit community hospitals could not have had it better. They were viewed with awe as inherently "good"⁴ such that flowing to them were huge amounts of capital from philanthropists and high fees from patients—each without any strings attached.⁵ In this connection, turn-of-the-century philanthropists were in a measure laundering their often ill-gotten gains by supporting institutions above reproach.⁶ While the United States Constitution forbids the creation of nobility,⁷ we have managed to create an attractive substitute: becoming a hospital trustee. And without any religious barriers—not only Protestants but Catholics and Jews can find their counterpart hospitals. (Hospital volunteering also "defined the role of society women.")⁸

And such roles were largely honorific. As Professor Stevens points out, hard-headed, shrewd businessmen left their business judgment at the door when it came to second-guessing the administration of the institutions they "owned" as trustees. Raise the hospital's money they were most certainly expected to do; question the hospital's operations (either literally or figuratively) they were most certainly *not* expected to do.⁹ Even less questioning, of course, was expected from patients who paid (often lavish) fees for the hospital's services. Furthermore, even the Government, in the form of Hill-Burton grants, for example, could be expected to donate vast amounts of capital with relatively little control exacted in return.¹⁰

Although hospitals were often the biggest—or certainly one of the two or three biggest—enterprises (and employers) in many large and affluent geographical areas,¹¹ they faced neither tax¹² nor tort liability.¹³ Also, they were neither subject to laws requiring employers to bargain with their employees,¹⁴ nor to employee Social Security coverage.¹⁵

Although hospitals were charities and beneficiaries of others' vast beneficence, they provided precious little charity themselves in the form of care for

4. AMERICAN HOSPITALS, *supra* note 1, at 123.

5. *Id.* at 21.

6. *Id.* at 57, 354, 357-58.

7. U.S. CONST. art. I, § 9, cl. 8.

8. AMERICAN HOSPITALS, *supra* note 1, at 357.

9. *Id.* at 38-39.

10. *Id.* at 222.

11. *See, e.g., id.* at 358.

12. *Id.* at 41.

13. *Id.*

14. *Id.* at 237.

15. *Id.* at 166.

the poor.¹⁶ Indeed they successfully thrust the poor, whom, in their smug middle class way, they found distasteful in demeanor and other ways, out to city-run¹⁷ and Veterans Administration hospitals.¹⁸ Similarly, they arranged to shed another category they shunned into often wretched governmental institutions—the mentally ill.¹⁹

More broadly, hospitals undertook the relatively easy and dramatic tasks of acute, short-term care, largely ignoring the more intractable (and arguably more beneficial) tasks of not only preventive care, but even postoperative care and rehabilitation.²⁰

When the federal government finally recognized the need to care for those ignored by community hospitals—with the aged and the poor through Medicare and Medicaid joining Veterans as recipients of governmental largesse—hospitals successfully lobbied to arrange that the intermediate payor between themselves and the government be their own agent (Blue Cross), with manifest conflicts of interest.²¹ In addition, government payment—like those sweetheart deals with Blue Cross and private health insurers—was to be on a cost-plus basis, with generous inclusion for capital expenditures and, once again, almost no controls on costs or quality.²²

So here they were, charities which provided almost no charity, receiving extravagant charitable and commercial support from others, with no (or few) strings attached, earning huge sums with no liability for taxes, torts, labor laws, or social security, and ignoring the most important if less dramatic tasks of health care.

This was such an intolerable deal from society's point of view, it was bound to come to a halt—with a vengeance. A residue of deep public distrust (and even hostility) was felt toward hospitals by politicians, civil servants, consumer advocates, journalists, lawyers, and the general public.

The result? Now, far from being trusted as “good,” hospitals are often distrusted as “bad.”

Hospitals face the prejudice (validated in every Presidential election following Lyndon Johnson's victory in 1964) favoring “for profit” institutions, disciplined by market place pressures, and reflecting, in turn, deep distrust of government (even by government itself) and other nonprofit institutions that were seen as inefficient and self-serving while hiding behind the rhetoric of

16. *Id.* at 42, 354.

17. *Id.* at 310-13.

18. *Id.* at 126, 221.

19. *Id.* at 125-26.

20. *Id.* at 11-12, 88.

21. *Id.* at 281-82.

22. *Id.* at 275.

selflessness.²³ Witness the movement to "privatize" functions formerly conducted by "public" institutions.

Government (with other insurers and payors following suit) now not only limits payment to hospitals (even below cost), *but* seeks to control hospital functions (through diagnosis-related groups (DRG's) and other complex regulations),²⁴ while also calling for treatment of the uninsured.²⁵ Thus, hospitals are now required to behave like efficient corporations in the market place while being regulated more than public utilities.

Far from having immunity from tort liability, hospitals are prime targets as "deep pockets" not only for their own, but others', malpractice (e.g., physicians with staff privileges, through joint and several liability).²⁶

As old line blue collar industries fade, unions aggressively seek other industries to unionize, including hospitals,²⁷ which also lost their Social Security exemption in 1983.²⁸

From a broad social perspective, hospitals, as Professor Stevens points out, are seen as embodying some of the worst features of class, gender, and racial discrimination in the United States with arrogant, overpaid white males at the top; underpaid, overworked, demeaned females in the middle; and blacks, hispanics, and orientals paid almost poverty level wages for dirty, menial work at the bottom.²⁹

Voluntary not-for-profit hospitals are the core of our entire hospital system, and our hospitals, in turn, are the core of our whole health care system. As such, they will have to be part of the solution to our health care ills. They have also long been the core of that system's problems. Putting trust in them (which is necessary if they are to be part of the solution) will be very

23. Witness the recent emphasis on public choice theory: "Public choice can be defined as the economic study of nonmarket decisionmaking, or simply the application of economics to political science. . . . The basic behavioral postulate of public choice, as for economics, is that man is an egotistic, rational, utility maximizer." D. MUELLER, *PUBLIC CHOICE* 1 (1979) (footnotes omitted). As an example of the application of public choice theory, legislators are assumed to be motivated solely by the desire to be reelected. For an introductory discussion of public choice, as well as the pros and cons as to its validity, see W. ESKRIDGE & P. FRICKEY, *CASES AND MATERIALS ON LEGISLATION* 40-61 (1988).

24. *AMERICAN HOSPITALS*, *supra* note 1, at 323-27.

25. See, e.g., Pear, *Tax Exemptions of Nonprofit Hospitals Scrutinized*, *N.Y. Times*, Dec. 18, 1990, at A1, col. 2 ("Congressional investigators have found that many private nonprofit hospitals provide charity care worth less than the financial benefits they get from their tax-exempt status.").

26. *AMERICAN HOSPITALS*, *supra* note 1, at 249-50.

27. E.g., Freudenheim, *Labor's Hospital Drive Gets a Lift*, *N.Y. Times*, May 10, 1990, at D1, col. 3.

28. Social Security Amendments of 1983, Pub. L. No. 98-21, 97 Stat. 65, 70-71 (codified as amended at 42 U.S.C. § 410 (1991)).

29. *AMERICAN HOSPITALS*, *supra* note 1, at 357-58.

hard in that, as Professor Stevens's history tends to show, they were trusted too much too long.

One can only hope that health care providers reading Professor Stevens's book will begin to understand this distrust and deal with it, rather than react, as they too often do, with paranoia at the unhappy turn of events overtaking their (overly) happy past.³⁰

ABORTION AND PROTECTION OF THE HUMAN FETUS: LEGAL PROBLEMS IN A CROSS-CULTURAL PERSPECTIVE. Edited by S.J. Frankowski and G.F. Cole. Boston: Martinus Nijhoff. 1987. 334 Pp. \$86.00.

*Reviewed by Jude P. Dougherty, Ph.D. **

ABORTION AND PROTECTION OF THE HUMAN FETUS: LEGAL PROBLEMS IN A CROSS-CULTURAL PERSPECTIVE is at once a valuable and a depressing survey of abortion practice and law throughout most of the West and Japan. There are specific reports on Austria, England, France, Ireland, the Federal Republic of Germany, the Netherlands, Sweden, and the United States. There is a collective report on abortion policy in *European Socialist Countries*¹ and another on *International Law and the Protection of the Fetus*.² No attempt is made to address the practice of abortion in the Southern Hemisphere. I say "depressing," since anyone who, for biological or metaphysical reasons, is certain that the human being exists from conception is bound to

30. Of course there's more to it than I've stated. Consider the wildly fluctuating attitudes toward technical expertise in our hospitals. For example, during the first half of this century, women insisted on giving birth in a hospital under the care of M.D.'s (as opposed to midwives), who advocated maximum pain-relief. But once hospital delivery became the overwhelming norm, along with anesthesia and fetal monitoring, women began insisting on giving birth in their homes, along with minimal intervention in labor, through the care of sympathetic midwives (as opposed to obstetricians). How can you win? See Cullen, Book Review, *The Times Literary Supp.* (London), May 18-24, 1990, at 525, col. 1 (reviewing *THE POLITICS OF MATERNITY CARE: SERVICES FOR CHILDBEARING WOMEN IN TWENTIETH CENTURY BRITAIN* (J. Garcia, R. Kilpatrick & M. Richards eds. 1990)).

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1. Zielinska, *European Socialist Countries*, in **ABORTION AND PROTECTION OF THE HUMAN FETUS: LEGAL PROBLEMS IN A CROSS-CULTURAL PERSPECTIVE** 241 (1987) [hereinafter **ABORTION**].

2. Shelton, *International Law on Protection of the Fetus*, in **ABORTION**, *supra* note 1, at 1.