Wielding the Charitable Shield: Rethinking the Nonprofit Liability Cap for Medical Malpractice Claims Against Large Nonprofit Hospitals in Massachusetts

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“When people avail themselves to the services of a hospital, they are often at their most vulnerable. By allowing a hospital to shield itself from liability for its negligent practices, the charitable immunity cap is doing a disservice to the public by allowing substandard treatment practices to be rewarded by virtue of a corporate status.”

I. INTRODUCTION

Under Massachusetts law, a plaintiff seeking to recover damages for medical malpractice has the burden to prove that: a duty existed between the medical professional and the plaintiff; the patient suffered an injury due to the medical treatment; the medical treatment provided by the medical professional was the but-for cause of the plaintiff’s injury; and the treatment provided by the medical professional was the proximate cause of the plaintiff’s injury. A medical professional has a duty to each of their patients to exercise the care and skill of the average qualified practitioner, taking into account advances in the profession. This duty can even be imposed on a medical professional who did not meet with their patient. Additionally, hospitals and medical associations can be held liable for claims against their employees under the doctrine of respondeat superior.

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3. See Brune v. Belinkoff, 235 N.E.2d 793, 798 (Mass. 1968) (holding what duty of care physicians owe to patients). While the Brune court rejected the “locality” rule, which provides that the duty of care a physician owes to their patient is dependent on where the doctor was located, the court made clear that the resources available to the physician should be considered when determining the appropriate duty of care. See id. at 798.


When filing a medical malpractice suit, a plaintiff can seek damages for medical expenses, lost wages, lost earning potential, and pain and suffering, in addition to other damages the plaintiff may have suffered.6

Before a Massachusetts plaintiff can go to trial and argue the merits of their malpractice claim, they must appear before a tribunal composed of a judge, lawyer, and medical professional who practices “in the field of medicine in which the alleged injury occurred.”7 The medical malpractice tribunal separates medical malpractice cases into two groups: those appropriate for judicial review and those involving an unfortunate medical result.8 If the tribunal determines the medical malpractice claim is appropriate for judicial review, it will proceed to trial.9

Even after jumping over all these legislative and judicial hurdles, a plaintiff who succeeds in their medical malpractice claim still faces legislatively imposed recovery caps on their final judgment.10 One of the most controversial caps on judgments is the nonprofit liability cap, which limits a plaintiff’s recovery

liable for the negligence of its employee, the employee must be employed by the hospital and must have been working in the scope of their employment for the hospital at the time of the negligent act. See id. at 449-51. While the Supreme Judicial Court has not directly addressed the issue of whether a hospital can be liable for the acts of its independent-contractor physicians, at least one Superior Court has ruled that a hospital can be liable for the negligence of its independent-contractor physician if the plaintiff can prove that: the hospital indicated, by words or conduct, that the treating physician was a hospital employee or agent; the plaintiff relied on the representation when they allowed the physician to treat them; and the physician was working as the hospital’s apparent agent at the time of the negligent conduct. See Beauregard v. Peebles, No. MICV201200570, 2015 WL 506985, at *5 (Mass. Super. Ct. Feb. 3, 2015).

6. See MASS. GEN. LAWS ch. 231, § 60F (2022) (listing damages plaintiff can recover for medical malpractice). A plaintiff can also collect interest on their recovered medical-malpractice judgments, starting from the date their medical malpractice lawsuit commenced. See id. § 60K (noting interest equal to weekly average of one-year constant maturity Treasury yield plus 2%).

7. See id. § 60B (stating medical tribunal hearing required before every medical malpractice judicial inquiry); Andrea L. Davulis, Note, Tired of Tribunals: A Proposal to Combine Section 60L’s “Notice of Claim” Requirement with Certificates of Merit in Massachusetts Medical Malpractice Litigation, 48 SUFFOLK U. L. REV. 867, 877-78 (2015) (noting composition of medical tribunal).

8. See Davulis, supra note 7, at 879-80 (noting questions tribunal will answer). The tribunal will determine whether: the defendant health care provider had a duty to the plaintiff; the plaintiff’s evidence raises a legitimate question of liability appropriate for judicial inquiry; and the plaintiff suffered damages because of the medical treatment. See id. at 879; see also Champagne v. Mass. Nurses Ass’n, 532 N.E.2d 56, 57 (Mass. 1989) (stating purpose of tribunal requirement).

9. See Davulis, supra note 7, at 881 (explaining tribunal determines whether plaintiff’s case proceeds to trial). The determination that a medical malpractice claim is judiciable is not admissible at trial. See id.; see also ch. 231, § 60B (noting claim not found judicial can proceed to trial, but plaintiff must post $6,000 bond).

10. See ch. 231, § 60G (noting collateral-source statute bars plaintiff from double recovery). The collateral-source applies to a variety of different types of aid a plaintiff may receive prior to the judgment of the court, including payments from a state or federal income-disability act; any health sickness or income-disability program; or any contract or agreement of any group, organization, partnership, or corporation to provide, pay for or reimburse the cost of medical expenses. See id. Gratuitous payments or gifts made by third-parties will not be subtracted from a plaintiff’s ultimate monetary judgment. See id. Additionally, a plaintiff’s damages for pain and suffering are normally capped at $500,000. See ch. 231, § 60H. The only exceptions to this rule are if; “the jury determines that there is a substantial or permanent loss or impairment of a bodily function or substantial disfigurement, or other special circumstances in the case which warrant a finding that imposition of such limitation would deprive the plaintiff or just compensation for the injuries sustained.” See id.
against a nonprofit hospital to $100,000.\textsuperscript{11} Almost all hospitals in Massachusetts are considered nonprofit or charitable enterprises, which means some of the Commonwealth’s largest and wealthiest hospitals benefit from the nonprofit liability cap.\textsuperscript{12} As a result, several large judgments against nonprofit hospitals have been reduced.\textsuperscript{13} Massachusetts is one of only a handful of states that still retain a nonprofit liability cap, as most other states—either judicially or legislatively—have rebuked the charitable immunity doctrine.\textsuperscript{14}

This Note examines the history of the charitable immunity doctrine and the policy reasons behind why most states formerly embraced the doctrine.\textsuperscript{15} This Note then discusses the history of charitable hospitals and how they have changed over time.\textsuperscript{16} Next, this Note discusses the laws of states, other than Massachusetts, that still retain a version of charitable immunity.\textsuperscript{17} After

\textsuperscript{11} See ch. 231, § 85K (noting nonprofit organization providing health care subject to $100,000 liability cap); Gabriel H. Teninbaum & Benjamin R. Zimmerman, \textit{A Tale of Two Lawsuits}, 8 J. Health & Biomedical L. 443, 454-58 (2013) (explaining difference between ordinary negligence lawsuit and medical malpractice lawsuit against nonprofits). Even if a jury were to return a verdict of $10 million against a nonprofit hospital defendant, the plaintiff would only be entitled to recover $100,000 in damages under chapter 231, section 85K of the Massachusetts General Laws. See Teninbaum & Zimmerman, supra, at 456; see also Conners v. Ne. Hosp. Corp., 789 N.E.2d 129, 131 (Mass. 2003) (affirming decision to reduce plaintiff’s judgment against nonprofit hospital to statutory maximum); Liz Kowalczyk, \textit{A Challenge to Nonprofits: Suit by Family of Patient Who Died Seeks Exception to Law Shielding Charities}, BOS. GLOBE (May 25, 2005), http://archive.boston.com/business/articles/2005/05/25/a_challenge_to_nonprofits/ [https://perma.cc/GD9U-SPLN] (noting $4.1 million dollar judgment against hospital reduced to statutory maximum).

\textsuperscript{12} See Teninbaum & Zimmerman, supra note 11, at 454 (recognizing most hospitals in Massachusetts considered nonprofit entities); MASS. GEN. LAWS ch. 180, § 4(b) (2022) (stating charitable corporation can be created for medical purposes); Ass’n of Health Care Journalists, \textit{Facilities in Massachusetts, HOSPITALINSPECTIONS.ORG}, http://www.hospitalinspections.org/state/ma/ [https://perma.cc/JRL9-EUML] (noting ownership type of hospitals in Massachusetts). Massachusetts General Hospital, Brigham and Women’s Hospital, and Beth Israel Deaconess Medical Center are only some of the large hospitals that receive the benefit of nonprofit hospital medical malpractice immunity. See Ass’n of Health Care Journalists, supra; see also Alia Paavola, \textit{Mass General Brigham Records $1.1B Net Income in Q1}, BECKER’S HOSP. CFO REP. (Feb. 5, 2021), https://www.beckershospitalreview.com/finance/mass-general-brigham-records-1-1b-net-income-in-q1.html [https://perma.cc/4XYY-BH52] (reporting Massachusetts General Brigham recorded $1.1 billion in revenue in first financial quarter of 2021).

\textsuperscript{13} See, e.g., English v. New England Med. Ctr., Inc., 541 N.E.2d 329, 330-31 (Mass. 1989) (affirming lower court’s ruling reducing medical malpractice judgment to statutorily imposed liability cap); Keene v. Brigham & Women’s Hosp., Inc., 786 N.E.2d 824, 838 (Mass. 2003) (reversing lower court’s ruling and limiting plaintiff’s recovery for medical malpractice to $20,000); Conners, 789 N.E.2d at 131 (affirming lower court’s decision to reduce plaintiff’s judgment to statutorily imposed maximum).


\textsuperscript{15} See infra Sections II.A-B (discussing origins of charitable immunity doctrine and rationales for its implementation).

\textsuperscript{16} See infra Section II.C (discussing history of traditional and modern charitable hospitals).

\textsuperscript{17} See infra Section II.D (discussing other state’s use of charitable immunity doctrine and limited liability for charitable organizations).
reviewing the laws of other states, this Note examines the history of the charitable immunity doctrine in Massachusetts.18 This Note then analyzes the potential benefits and consequences if Massachusetts were to repeal the liability cap for nonprofit hospitals.19 Finally, this Note concludes by proposing that Massachusetts repeal the nonprofit liability cap for large corporate hospitals but leave in place some protection for small nonprofit charitable organizations.20

II. HISTORY

A. Origin of the Charitable Immunity Doctrine

1. England

The first known implementation of the charitable immunity doctrine was in the 1846 House of Lord’s case: Heriot’s Hospital v. Ross.21 Noting the dicta of Lord Cottenham, the court held that it would be inappropriate to force charities to use donated funds, held in trust, to settle lawsuits.22 The House of Lords, in the earlier case of Duncan v. Findlater,23 espoused similar dicta.24 Following the Heriot’s and Duncan decisions, the House of Lords ruled in Holliday v. Parish of St. Leonard25 that persons entrusted with carrying out a gratuitous public duty who are not personally responsible for the infliction of a tort are exempted from liability for the tortious conduct of the people employed by them.26 Neither the

18. See infra Section II.E (discussing history and implications of charitable immunity doctrine in Massachusetts).
19. See infra Sections III.A-B (analyzing inefficiency of traditional rationales for modern justification of charitable immunity doctrine in Massachusetts).
20. See infra Section III.C (advocating appealing charitable immunity for large hospitals while still protecting small charities).
22. See Heriot’s, 8 Eng. Rep. at 1511 (identifying proper purposes to divert trust funds). But see Paul T. O’Neil, Charitable Immunity: The Time to End Laissez-Faire Health Care in Massachusetts, 82 MASS. L. REV. 223, 226 (1997) (noting tort victims may recover money from trustees). Following Heriot’s, if injury occurred as a result of the tortious conduct of one the trustees, the victim could recover personally from the trustee who committed the tort, who would then be indemnified by the trust if their tortious conduct was committed during their administration of the trust. See id. at 226.
23. (1839) 7 Eng. Rep. 934 (HL) (appeal taken from Scot.).
24. See id. at 937-38 (holding funds raised to complete road cannot satisfy judgments); see also Georgetown Coll. v. Hughes, 130 F.2d 810, 815-16 (D.C. Cir. 1942) (noting dicta of Duncan and Heriot’s similar). Duncan rests on the proposition that: a plaintiff cannot sue a defendant at law if equity will not permit them to attach the defendant’s property to satisfy the judgment; and equity will not permit a plaintiff to attach trust funds to pay legal damages unless the trustee was personally at fault for the administration of the property held in trust. See Horwitz, supra note 21, at 8 n.26.
25. (1861) 7 Eng. Rep. 769 (HL) (appeal taken from Eng.).
26. See id. at 774 (relying on holding in Duncan to justify decision); see also O’Neil, supra note 22, at 226 (noting Holliday decision based on dicta of Heriot’s and Duncan).
dicta of Heriot’s, Duncan, not Holliday created a blanket protection of liability for charitable entities.27

Subsequently, in 1866, Mersey Docks Trustees v. Gibbs overruled Duncan and Heriot’s.28 In Gibbs, the owners of a cargo ship and the owners of the cargo on board—both damaged when entering the Liverpool Docks—brought suit against the Mersey Docks and Harbour Board, a body that operated for the public benefit without collecting a profit for running or maintaining the harbor.29 In Lord Cranworth’s opinion holding the harbor board responsible for the damages to the ship and cargo, he explained that it would be a strange distinction to not hold a nonprofit entity responsible for its negligence due to its nonprofit status, yet hold a for-profit entity responsible for the same negligent acts.30 The Holliday decision was also subsequently overruled in 1871.31 Subsequent to the overturning of Duncan, Heriot’s, and Holliday, English charities could be held liable for their torts.32

2. The United States

In the United States, Massachusetts was the first state to embrace the charitable immunity doctrine.33 In McDonald, the plaintiff sued Massachusetts General Hospital after its employees negligently treated his broken leg, leading to permanent injury.34 Relying on the decision in Holliday, the Supreme Judicial Court held that charitable organizations could not be held liable for the negligent acts

27. See Note, The Quality of Mercy: “Charitable Torts” and Their Continuing Immunity, 100 HARV. L. REV. 1382, 1383 n.9 (1987) [hereinafter Quality of Mercy] (providing reasons why dicta in three cases did not create blanket rule of charitable immunity). While Duncan held that trustees could not be held liable for the negligence of persons not shown to be their servants, Lord Cottenham’s dictum stated that trustees of a public body could be held personally liable for negligent acts committed in the course of their work as a trustee. See Duncan, 7 E.R. 934 at 939 (noting trustee still potentially personally liable for tortious conduct); Quality of Mercy, supra, at 1383 n.9 (explaining effect Duncan holding had on trustee liability); O’Neil, supra note 22, at 226 (recognizing trustees still sometimes personally liable following Heriot’s ruling).


30. See id. at 1516 (recognizing absurdity of basing liability on profit status). Lord Cranworth also admitted that the decision reached in Gibbs was inconsistent with prior decisions and agreed with Justice Blackburn’s concurring opinion that Duncan was overruled. See id. (noting past decisions cannot be reconciled with opinion reached in Gibbs); id. at 1513-14 (citing Justice Blackburn’s rationale for overruling Duncan).


34. See McDonald, 120 Mass. at 434 (stating facts of case).
of their employees if the trustees of the charitable organization were not negligent
in hiring their employees.35

Some commentators and courts criticized McDonald on the grounds that the
court relied on overturned dicta in making its decision, incorrectly applied the
overturned dicta it relied on, and created a virtual barrier that prevented litigants
from suing charitable institutions for negligence.36 Despite these criticisms, most
states across the county initially embraced the charitable immunity doctrine.37

B. Rationales for Implementing the Charitable Immunity Doctrine

1. Trust Fund Theory

The trust fund theory was one of the earliest and most frequently cited reasons
why courts embraced the charitable immunity doctrine.38 The trust fund theory’s
basic rationale is that because funds are donated with a specific intent, these
funds cannot be for any other purpose but the donative intent, including satisfy-
ing tort judgments.39 While courts found different public policy rationales for
supporting the trust fund theory, all courts embracing it held that charitable funds
held in trust cannot be used to pay out plaintiffs in tort liability judgments.40

35. See id. at 436 (announcing holding).
36. See O’Neil, supra note 22, at 226-27 (highlighting issues with McDonald). Unlike the trustees in the
Heriot’s decision—who could be sued for their individual liability—a nonprofit corporate director’s position by
definition makes his own personal assets inaccessible for tortious acts. See id. at 226; Glavin v. R.I. Hosp., 12
R.I. 411, 423 (1879) (noting authority of McDonald undermined by overturning of Holliday); Georgetown Coll.,
130 F.2d at 816 (emphasizing Supreme Judicial Court acted ignorantly by relying on Holliday). The Court of
Appeals for the District of Columbia also explained that when the charitable immunity doctrine is applied to a
corporation, a trustee’s liability disappears, and a tort sufferer will only be able to collect from the actual person
who inflicted the tort. See Georgetown Coll., 130 F.2d at 816.
37. See Bradley C. Canon & Dean Jaros, The Impact of Changes in Judicial Doctrine: The Abrogation
of Charitable Immunity, 13 L. & Soc’y Rev. 969, 971 (1979) (noting trend of state high courts embracing charitable
immunity doctrine). By 1938, forty state high courts had embraced some form of charitable immunity. See id.
at 971; Perry v. House of Refuge, 63 Md. 20, 26-28 (1885) (citing Heriot’s and McDonald in embracing chari-
table immunity doctrine); Andrews v. Young Men’s Christian Ass’n of Des Moines, 284 N.W. 186, 205 (Iowa
1939) (reasoning individual may suffer to protect charitable institutions); Taylor v. Flower Deaconess Home &
Hosp., 135 N.E. 287, 291 (Ohio 1922) (holding charitable hospital not responsible for torts committed by servants
selected with due care). But see Glavin, 12 R.I. at 428-29 (rejecting charitable immunity doctrine).
38. See O’Neil, supra note 22, at 227 (noting trust fund theory first rationale courts used to justify charitable
immunity doctrine); Courtney Jane Baltz, Comment, When Justice Should Precede Generosity: The Case Against
Charitable Immunity in Arkansas, 2021 Ark. L. Notes 1, 4 (2021) (highlighting trust fund theory most promi-
nent theory used by courts for implementing charitable immunity doctrine).
39. See Baltz, supra note 38, at 2 (explaining trust fund theory rationale to protect donative intent).
40. See Samantha Klauser LaBarbera, Secrecy and Settlements: Is the New Jersey Charitable Immunity Act
of trust fund theory); James W. Zirkle, Charitable Immunity—A Reappraisal, 39 Tenn. L. Rev. 289, 291 (1972)
(expressing reasons why courts use trust fund theory to uphold charitable immunity doctrine). Courts embracing
the trust fund theory have reasoned that allowing a trust fund to be used to satisfy tort judgments might: impair
or destroy the purposes of the charitable institution; defeat the settlor’s intent when they set up the charity; give
the trustee the power to do indirectly that which they cannot do directly—namely, divert funds held in trust for a
purpose they were not originally set up to achieve; or that such trust funds, having been set aside for charitable
enterprises, cannot be taken upon execution. See Zirkle, supra, at 291.
Despite its popularity, commentators have questioned the soundness of utilizing the trust fund theory to justify implementing the charitable immunity doctrine.\(^{41}\)

2. **Inapplicability of Respondent Superior**

Courts have also justified implementing the charitable immunity doctrine by deciding that the doctrine of respondent superior does not apply to cases against charitable organizations.\(^{42}\) Several courts rationalized that respondent superior was not appropriate in lawsuits against charitable organizations for the torts of their agents because nonprofit organizations do not receive a monetary benefit from the work of their employees.\(^{43}\) In presiding over medical malpractice claims, other courts have reasoned that that physicians employed by hospitals were more akin to “independent contractors,” and as such, the traditional master-servant relationship was not present.\(^{44}\) Commentators and other courts have criticized this rationale on the grounds that granting immunity to charitable organizations for the torts of their employees runs counter to the law of vicarious liability.\(^{45}\)

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42. See O’Neil, supra note 22, at 227-28 (noting courts used inapplicability of respondent superior to justify implementation of charitable immunity doctrine). The legal doctrine of respondent superior holds an employer or principal liable for their employee’s or agent’s wrongful acts committed within the scope of their employment or agency. See *Respondent Superior*, BLACK’S LAW DICTIONARY (11th ed. 2019) (defining respondent superior).

43. See North, supra note 32, at 1994 (noting reasons courts have in immunizing nonprofits from respondent superior); Morrison v. Henke, 160 N.W. 173, 174 (Wis. 1916) (holding respondent superior does not apply in suits against charities). The court in *Morrison* held that the fundamental reason why a charitable organization should not be held liable under the doctrine of respondent superior is because charities do not operate to make a profit and therefore should not be held liable for the negligence of their employees. See *Morrison*, 160 N.W. at 175; see also Hearns v. Waterbury Hosp., 33 A. 595, 604 (Conn. 1895) (explaining nonprofits do not profit from work of employees).

44. See O’Neil, supra note 22, at 227-28 (recognizing courts immunized hospitals from respondent superior because they do not exercise control over staff); Schloendorff v. Soc’y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (stating master-servant relationship not present between hospitals and physicians). The court in *Schloendorff* also noted that if a hospital exercised due care in the selection of its physicians, the hospital would not be responsible for the wrongs committed by the physicians the hospital employed. See *Schloendorff*, 105 N.E. at 93.

45. See RESTATEMENT (SECOND) OF TORTS § 895E cmt. c (2) (AM. L. INST. 2021) (explaining theory treated charities and corporations run for-profit differently); Baltz, supra note 38, at 6 (noting because employee under control of charitable institution, charitable organizations liable); Georgetown Coll. v. Hughes, 130 F.2d 810, 827 (D.C. Cir. 1942) (stating charitable status generally not applicable defense against respondent superior); Glavin v. R.I. Hosp. 12 R.I. 411, 424 (1879) (concluding hospital assumes responsibility when patient injured by employee of hospital). The court in *Glavin* stated that while the relationship between a charitable hospital and a
3. **Implied Waiver Theory**

Several courts have also embraced the so-called “implied waiver” theory when implementing the charitable immunity doctrine. The implied waiver theory rests on the premise that the beneficiary of a charitable organization impliedly waives liability by accepting the benefits of the charity. For a waiver to be effective under traditional tort principles, there must be a knowing, voluntary, and informed decision by the person waiving their rights. Some courts and commentators note that this theory goes against traditional tort principles and raises the issue that it is sometimes impossible to gain someone’s consent before receiving charitable care, especially where a person receives life-sustaining treatment at a hospital.

4. **Public Policy**

The final widely used rationale courts have used to justify implementing the charitable immunity doctrine is the belief that it would be against public policy to hold charitable organizations responsible for tort damage. Courts embracing this rationale theorized that if charitable funds were allowed to be used to settle tort judgments, benefactors would be less likely to donate funds. Some commentators argue that the public policy theory is not its own separate theory, but rather a “catchall” term that courts use to implement the charitable immunity

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doctor working for them may not be a master-servant relationship, the hospital will still be liable for the torts of its physicians because patients have the right to rely on the expertise of the hospital in hiring skillful and trustworthy employees. See Glavin, 12 R.I. at 424.

46. See O’Neill, supra note 22, at 228 (discussing implied waiver theory); Schloendorff, 105 N.E. at 93 (explaining one who accepts charity waives negligence of its servants).


48. See O’Neill, supra note 22, at 228 (stating principles of tort law regarding waiver of rights).

49. See id. (highlighting obtaining waiver for charitable services often impossible). In a situation where a patient is brought to a nonprofit hospital in an unconscious state, the patient will not be able to waive. See id.; Georgetown Coll., 130 F.2d at 826 (claiming implied waiver theory fictional justification for implementation of charitable immunity doctrine). The court in Georgetown College further noted that it would be impossible for certain patients to waive their rights when receiving treatment, including unconscious patients; infants and children, who are under the care of their parents or guardians; or the “insane,” who have no legal capacity to waive their rights. See Georgetown Coll., 130 F.2d at 826; see also O’Neil, supra note 22, at 228 (noting sick, conscious adults also lack requisite act of volition in choosing hospital); Restatement (Second) of Torts, supra note 45, § 895E cmt. c (3) (criticizing implied waiver theory).

50. See Restatement (Second) of Torts, supra note 45, § 895E cmt. c (3) (noting courts have relied on public policy theory to implement charitable immunity doctrine); see also Andrews v. Young Men’s Christian Ass’n of Des Moines, 284 N.W. 186, 204-05 (Iowa 1939) (defining public policy theory).

51. See O’Neil, supra note 22, at 228 (explaining courts’ use of public policy to implement charitable immunity doctrine). Without the support of benefactors donating to charitable organizations, the charitable organizations would go bankrupt, leading to the public being deprived of the benefits of the charitable organization. See id.; see also Vermillion v. Woman’s Coll. of Due W., 88 S.E. 649, 650 (S.C. 1916) (highlighting in civilized society, individual must subordinate rights for public good).
doctrine. Other commentators believe the public policy theory applied to rationalize implementing the charitable immunity doctrine in the late 19th and early 20th century, but has no place in modern times.

C. History of Charitable Hospitals

1. Origin of Charitable Hospitals in the United States

Early charitable hospitals were actually not hospitals at all; rather, people who could not afford to have private doctors come to their residences to treat them often went to almshouses to receive treatment. Almshouses’ responsibilities not only included taking care of the ill, but also providing custodial care for the poor and destitute. Until the late nineteenth century, the wealthy would usually pay for a doctor to treat them in their homes, rather than seek treatment at a hospital.

Voluntary hospitals, which were nonprofit hospitals that took care of both the rich and poor, began to appear in the early part of the nineteenth century. It would not be until the latter part of the nineteenth century or the beginning of the twentieth century that voluntary hospitals would grow in popularity.

52. See Charles Glidden Johnson, Charitable Immunity: A Diminishing Doctrine, 23 WASH. & LEE L. REV. 109, 114 (1966) (explaining courts use catchall phrase “public policy” to justify granting immunity to charities). The public policy theory actually incorporates the three previously mentioned theories—trust fund theory, inapplicability of respondent superior theory, and waiver theory—to justify the implementation of the charitable immunity doctrine. See id. at 114.

53. See O’Neil, supra note 22, at 228-29 (noting public policy theory had merit in late 19th and early 20th century). Most hospitals in the late 19th and early 20th century operated strictly for charitable purposes and almost exclusively treated the poor. See id.; see also Johnson, supra note 52, at 114 (preferring charities in states without charitable immunity do not appear harmed by lack of immunity). On the other hand, when a person is injured by a charitable organization, arguably “public policy” should support the plaintiff’s ability to seek compensation for their injury from the offending party. See Johnson, supra note 52, at 114; see also Baltz, supra note 38, at 6 (noting in modern times, most charitable hospitals have insurance, which eliminates need for charitable immunity).


56. See Daniel A. Barnfield, Better to Give than to Receive: Should Nonprofit Corporations and Charities Pay Punitive Damages?, 29 VAL. U. L. REV. 1193, 1203 n.51 (1995) (emphasizing rich people received medical treatment in their own homes); Kane, supra note 54 (noting in 1900, most rich people expected home medical treatment); Wall, supra note 55 (explaining surgeries performed in patients houses).

57. See Bromberg, supra note 54, at 239 (describing beginnings of voluntary hospitals). Voluntary hospitals grew out of a community need to have a place to house the sick. See id.

growth in voluntary hospitals in the latter part of the nineteenth century is attributable to multiple factors, including the development of new diagnostic procedures, which had made hospital care more attractive to more affluent patients.  

Voluntary hospitals were managed by trustees and funded by public subscriptions, bequests, and philanthropic donations. Free care provided to the indigent was subsidized by patients who could afford to pay for their treatment. State and local governments also subsidized voluntary hospitals by giving them tax-exempt status, thereby granting them immunity from lawsuits and directly paying them government funds to subsidize the cost of taking care of the poor. 

Beginning in the 1920s, voluntary hospitals started to behave more like for-profit businesses than nonprofit charities. Voluntary hospitals reduced the amount of care provided to indigent patients because government subsidies and private donations could no longer cover indigent patients’ medical costs. By 1923, 49.7% of the total patient days reported for general hospitals in the United States were attributable to paying patients.

59. See Bromberg, supra note 54, at 239 (noting factors contributing to popularity of receiving care at voluntary hospitals). Besides the development of diagnostic procedures, the specialization of the medical field, creation of expert nursing services, introduction of asepsis and anesthesia, development of clinical laboratory services, use of x-ray, and introduction of antibiotics led to the voluntary hospital being described as “the community’s centralized facility for medical care.” See id.; see also Wall, supra note 55 (explaining professionalizing of nursing played significant role in move from home care to hospital care).

60. See Wall, supra note 55 (stating who ran voluntary hospitals). Religiously run hospitals, or ecclesiastical hospitals, played a major role in treating patients in the eighteenth and nineteenth centuries. See Stevens, supra note 58, at 558 (articulating 30.2% of patients treated in hospitals in 1904 received care at ecclesiastical hospitals).

61. See Bromberg, supra note 54, at 239 (noting cost of free care to indigent underwritten by costs charged to paying patients).

62. See Stevens, supra note 58, at 557 (highlighting nonprofit hospitals in Massachusetts given protection from negligent suits). In several states, including South Carolina and Minnesota, personal property of public hospitals was exempt from taxation. See id. By 1910, Pennsylvania subsidized voluntary hospitals by allocating between $2 to $3 million per year in block grants programs. See id. at 562 (discussing Pennsylvania’s block grant program for voluntary hospitals). New York City created a per diem payment reimbursement system, which paid voluntary hospitals a certain amount each day an indigent patient received care at their hospital. See id. at 562-64 (describing New York City’s per diem reimbursement system).

63. See id. at 568 (highlighting shift in nature of voluntary hospitals). Poor patients who could not afford medical care stopped being seen as the primary drivers of establishing a charitable hospital, but rather started to be seen as “nuisances” by hospital staff. See id. at 569 (noting employees’ view of poor nonpaying patients).

64. See id. at 568-69 (explaining private hospitals reduced number of free days to indigent patients). While Baltimore’s private hospitals received increased amounts of city and state subsidies to treat indigent patients, the subsidies were still not enough to cover the increased cost of treating indigent patients. See id. at 569.

65. See id. at 569-70 (noting nearly one-half of total patient days reported in 1923 attributable to paying patients); see also PWC, MASS GENERAL BRIGHAM INCORPORATED AND AFFILIATES CONSOLIDATED FINANCIAL STATEMENTS (WITH CONSOLIDATED FINANCIAL INFORMATION) SEPTEMBER 30, 2020 AND 2019 4 (2020), https://www.mghhp.edu/sites/default/files/atoms/files/fy20-mgb-audit-report.pdf [https://perma.cc/W3C3-Y3F9] (noting Massachusetts Brigham received most of their revenue in 2019 and 2020 from patient services).
2. Modern Charitable Hospitals

Nonprofit hospitals receive their federal tax-exempt status from § 501(c)(3) of the Internal Revenue Code. This provision exempts nonprofit hospitals from paying federal income taxes if: the hospital is organized and operated exclusively for charitable purposes; no part of the net earnings of the hospital is used to benefit private shareholders or individuals of the hospital; and no substantial part of the hospital’s activities can be used to carry on propaganda. While § 501(3)(c) only grants federal tax-exempt status to nonprofits, state income tax laws typically “key off” the federal income tax exemption. Nonprofits in Massachusetts and other states also receive other important tax breaks—most importantly, property tax exemptions. Massachusetts nonprofit hospitals received the most significant tax exemption compared to every other state in 2011, with each hospital, on average, receiving more than $20 million in tax benefits.

In 1956, the Internal Revenue Service (IRS) released Revenue Ruling 56-185, which announced a substantive rule of charitable purpose. The ruling stated that nonprofit hospitals could charge patients for the services provided to them, but also stated that the nonprofit hospitals must be operated, to the extent of the hospital’s financial ability, for those unable to pay for the services rendered. Importantly, Revenue Ruling 56-185 made clear that a hospital could not turn


68. See Colombo, supra note 67, at 436 (noting “key off” refers to basing state statutes on federal statutes). For example, in Massachusetts, a charitable corporation that is exempt from federal income tax under § 501 of the Internal Revenue Code is also exempt from the state corporate excise tax. See Mass. Dept. of Revenue, Corporate Excise Tax Exemptions, MASS.GOV, https://www.mass.gov/service-details/corporate-excise-tax-exemptions [https://perma.cc/RRM3-GX2E] (explaining corporations filed under § 501 of Internal Revenue Code exempt from Massachusetts corporate tax).

69. See Mass. Gen. Laws ch. 59, § 5 (2022) (exempting property owned by nonprofit corporations from Massachusetts property tax); Colombo, supra note 67, at 436 (noting some states provide property and sales tax exemptions to nonprofit corporations). Property tax exemptions are especially important for nonprofit hospitals because hospitals often own significant amounts of property. See Colombo, supra note 67, at 436 (noting hospitals often highly capital-intensive businesses with significant property holdings).

70. See Sara Rosenbaum et al., The Value of the Nonprofit Hospital Tax Exemption Was $24.6 Billion in 2011, 34 Health Affairs 1225, 1229 (2015) (noting Massachusetts nonprofit hospitals, on average, received largest tax benefit in United States).

71. See Rev. Rul. 56-185, 1956-1 C.B. 202 (citing IRS Revenue Ruling); Courtney, supra note 66, at 368 (noting substantive rule change announced by IRS).

72. See Rev. Rul. 56-185, 1956-1 C.B. 202 (articulating nonprofit hospitals must operate to extent of their ability provide services to poor); Courtney, supra note 66, at 368 (stating nonprofit hospitals permitted to charge patients for services). The Revenue Ruling also clarified that if a nonprofit hospital provides care at a discounted rate to those who could not afford the full rate of the services provided, the hospital would be providing a form of charitable care to the patient receiving the rate decrease. See Rev. Rul. 56-185, 1956-1 C.B. 202 (noting discounted care qualifies equals charitable care).
away a patient in need of hospital care because they could not afford the care and remain eligible for the federal income tax exemption for charitable organizations.73

With the creation of the Medicare and Medicaid programs in 1965, which created government-run health insurance programs for the elderly and the poor, the hospital industry pushed for changes to the IRS’s tax-exemption standards for nonprofit hospitals.74 In response to the creation of the Medicare and Medicaid programs, as well as the issues raised by the hospital industry, the IRS issued Revenue Ruling 69-545 in 1969.75 The new standard instituted in Revenue Ruling 69-545, which became known as the “community benefit standard,” listed several factors the IRS would consider when determining whether a nonprofit hospital would be eligible for a federal income tax exemption.76 With Revenue Ruling 69-545, the IRS eliminated the requirement for nonprofit hospitals without an emergency room to offer free or below-cost care to those who could not afford the services provided by the hospital.77

In 2014, § 501(r) was added to the Internal Revenue Code after the passage of the Affordable Care Act.78 Section 501(r) adds four additional requirements that nonprofits must meet to remain exempt from federal income taxes under § 501(c)(3), namely that nonprofit hospitals: (1) must establish written policies regarding patient eligibility for financial assistance; (2) can only charge patients eligible for financial assistance a limited amount for emergency or medically necessary care; (3) must refrain from “extraordinary collection actions” without

73. See Rev. Rul. 56-185, 1956-1 C.B. 202 (stating nonprofit hospitals not allowed to turn away patients who could not afford care).
74. See Lynmore Seaton & Beth C. Koob, Tax-Exempt Hospitals and Community Benefit, 21 HEALTH LAW. REPORT 37, 38 (2009) (noting Medicare and Medicaid prompted push by hospital industry to change tax-exemption standards). The hospital industry claimed that because most people would be covered either by private insurance or the newly created government insurance programs, it would be difficult for nonprofit hospitals to satisfy the then-current requirements to maintain their tax-exempt status. See id. at 38.
75. See id. at 38 (noting IRS revised “charitable services” definition after hospital industry’s pressure); Courtney, supra note 66, at 369 (highlighting impetus for IRS to announce Revenue Ruling 69-545 in 1969); Rev. Rul. 69-545, 1969-2 C.B. 117 (creating factor’s IRS would consider when determining hospital’s charitable status).
76. See Rev. Rul. 69-545, 1969-2 C.B. 117 (listing factors). Revenue Ruling 69-545 listed five factors the IRS would consider in determining whether a nonprofit hospital would qualify for the federal income tax exemption under § 501(c)(3) of the Internal Revenue Code, namely whether: (1) the hospital operates an emergency room open to all persons regardless of their ability to pay care; (2) the hospital provides care to all persons able to pay for services either directly or through insurance; (3) the hospital serves a public interest; (4) whether the hospital maintains an open medical staff; and (5) revenues generated by the hospital are used to improve the quality of care, facilities, medical training, education, and research. See id.; see also Courtney, supra note 66, at 369 (noting new standard issued called “community benefit standard”).
77. See Rev. Rul. 69-545, 1969-2 C.B. 117 (modifying requirement relating to caring for patients without charge or at low costs); Seaton & Koob, supra note 74, at 38 (noting IRS eliminated clause requiring free or below-cost care except for hospitals with emergency rooms).
first determining whether a patient is eligible for financial assistance; and (4) must create a Community Health Needs Assessment (CHNA) and an implementation strategy to carry out the needs identified in their CHNA.\(^79\) One of the primary goals of the Affordable Care Act is to hold nonprofit hospitals accountable for addressing disparities in healthcare that exist among communities.\(^80\)

D. The Charitable Immunity Doctrine in States Other than Massachusetts

1. The Doctrine of Charitable Immunity Diminishes

By 1938, forty states embraced the charitable immunity doctrine.\(^81\) Only the Supreme Court of Minnesota expressly rejected the charitable immunity doctrine between the years 1900 and 1938.\(^82\) Beginning in 1942, however, a counter trend emerged against the charitable immunity doctrine after the United States Court of Appeals for the District of Columbia Circuit rejected the doctrine in Georgetown College v. Hughes.\(^83\)

Following the Georgetown College decision, many state high courts totally abrogated or rejected the charitable immunity doctrine.\(^84\) In reaching their decisions, many high courts noted that while the charitable immunity doctrine was

\(^79\) See Terry L. Corbett, Healthcare Corporate Structure and the ACA: A Need for Mission Primacy Through a New Organizational Paradigm?, 12 IND. HEALTH L. REV. 103, 156 (2015) (noting requirements hospitals must meet to remain § 501(c)(3) eligible). The written financial assistance policies must include which services will be eligible for free or discounted care, as well as the methodology for determining who is eligible for free or discounted care. See Rosenbaum, supra note 78 (stating requirements of financial assistance policy). In determining what to charge a patient without insurance for services rendered, the hospital can either charge the patient the amount the hospital would be paid by Medicare, or the amount it would be paid under a combination of Medicare and private insurance payments. See id. (providing calculations hospitals can use to charge patients without insurance). While nonprofit hospitals may still use “extraordinary collection tactics” when attempting to collect payment from patients who have not paid, they are now required to give the patient a thirty-day written notice of the actions it plans to take to collect payment, which must also include a copy of its financial assistance policy, and the hospital must make reasonable efforts to orally inform the patient about the availability of financial assistance. See id. (listing requirements nonprofit hospital must meet before conducting “extraordinary collection tactics”). The CHNA can assess not only unmet needs for healthcare in a community, but also significant health needs arising from social conditions, including inadequate access to proper nutrition and housing. See id. (recognizing social conditions potentially taken into account when creating CHNAs).


\(^81\) See Canon & Jaros, supra note 37, at 971 (noting irony of English courts rejecting doctrine, while forty states embraced it by 1938); see also 7 R.I. GEN. LAWS § 7-1-22 (repealed 1968) (creating charitable immunity doctrine by statute).

\(^82\) See Canon & Jaros, supra note 37, at 971 (noting Supreme Court of Minnesota only high court to reject doctrine between 1900 and 1938); McInerny v. St. Luke’s Hosp. Ass’n, 141 N.W. 837, 839 (Minn. 1913) (rejecting implementation of charitable immunity doctrine). The Supreme Court of Minnesota stated that if charitable organizations were to be given immunity in tort suits, the legislature should be the government body responsible for giving such immunity. See McInerny, 141 N.W. at 839 (holding duty for protection of servants absolute and no employer exempt absent action of legislature).

\(^83\) See Canon & Jaros, supra note 37, at 972 (stating counter trend against charitable immunity began after Georgetown College decision).

\(^84\) See id. at 972-73 (stating thirty-five state high courts rejected charitable immunity doctrine).
justifiable under public policy considerations in the 19th century, these considerations were no longer operable in the mid-20th century. Several courts also reasoned that charities were no longer low-budget operations, but rather large organizations with thousands of employees operating on modern business principles. Other courts noted that charitable hospitals could protect their assets from tort suits by purchasing liability insurance, which had been uncommon for organizations to purchase in the 19th century.

2. The Laws of States Who Limit Tort Recovery Other than Massachusetts

While most states have abolished the charitable immunity doctrine, four states have laws limiting nonprofit organizations’ liability by placing caps on damages awarded to plaintiffs. In Colorado, judgments against nonprofits are limited to the extent of existing insurance coverage maintained by the nonprofit. In Texas, claims against charitable hospitals are capped at $500,000. Regardless of the number of agencies, political subdivisions, or claims involved, South Carolina caps tort suits against charitable organizations not committed by physicians at $300,000 per person and $600,000 per occurrence. On the other hand, tort

85. See id. at 972 (describing state high courts conceded public policy considerations no longer justify charitable immunity doctrine); Haynes v. Presbyterian Hosp. Ass’n, 45 N.W.2d 151, 154 (Iowa 1950) (articulating public policy reasons for doctrine have changed, including charitable hospitals now operate like businesses); Pierce v. Yakima Valley Mem’l Hosp. Ass’n, 260 P.2d 765, 774 (Wash. 1953) (holding court-declared public policy reasons for supporting charitable immunity doctrine no longer valid); Parker v. Port Huron Hosp., 105 N.W.2d 1, 25 (Mich. 1960) (explaining changed conditions rendered charitable immunity doctrine no longer necessary).

86. See Canon & Jaros, supra note 37, at 972 (highlighting courts often noted charities no longer low-budget organizations); Foster v. Roman Cath. Diocese of Vt., 70 A.2d 230, 236 (Vt. 1950) (noting private charities now similar to big businesses); Adkins v. St. Francis Hosp., 143 S.E.2d 154, 159 (W. Va. 1965) (holding modern hospitals operate on businesslike basis and must take responsibility for its obligations).

87. See Canon & Jaros, supra note 37, at 974 (recognizing some courts acknowledged availability of liability insurance when overturning charitable immunity doctrine); Miss. Baptist Hosp. v. Holmes, 55 So. 2d 142, 156 (Miss. 1951) (discussing availability of liability insurance to protect funds held for charitable purpose).


89. See COLO. REV. STAT. § 7-123-105 (2023) (declaring judgments against nonprofits limited to extent of existing liability insurance coverage owned by nonprofit). But see Hemenway v. Presbyterian Hosp. Ass’n, 419 P.2d 312, 313 (Colo. 1966) (en banc) (holding plaintiff cannot maintain action against charitable trust if judgment will deplete trust fund).

90. See TEX. CIV. PRAC. & REMEDIES CODE ANN. § 84.006 (West 2023) (stating liability cap against charitable hospital of $500,000 for each person). In the case of bodily injury or death, the charitable cap is raised to $1,000,000. See id. (limiting recovery to $1,000,000 per occurrence of death or bodily injury).

91. See S.C. CODE ANN. § 33-56-180 (2021) (noting judgments against charitable organizations cannot exceed limits imposed by South Carolina Tort Claims Act); South Carolina Torts Claim Act, S.C. CODE ANN. § 15-78-120 (stating damages capped at $300,000 per person and $600,000 per occurrence).
claims against charitable organizations that are committed by physicians are capped at $1,200,000.\textsuperscript{92}

Several states retain a version of the common law doctrine of charitable immunity, either through judicial decisions or a state legislature’s codification of the doctrine.\textsuperscript{93} For example, Arkansas courts embrace an eight-factor test to determine whether a charitable organization is entitled to raise the charitable immunity doctrine.\textsuperscript{94} Georgia retains the “paying-patient” exception, which means a person who pays for their medical services at a charitable hospital will be entitled to sue a charitable hospital for its torts.\textsuperscript{95} Additionally, Georgia allows charitable hospitals to be sued when the hospital fails to exercise ordinary care in selecting competent employees or fails to exercise ordinary care in retaining such employees.\textsuperscript{96} New Jersey codified its version of the charitable immunity doctrine, which forbids lawsuits against nonhospital charities by beneficiaries of the charity.\textsuperscript{97} Additionally, New Jersey codified a separate statute stating that charitable organizations, organized exclusively for hospital purposes, can be liable up to $250,000 for a beneficiary’s injuries.\textsuperscript{98}

\textsuperscript{92} See South Carolina Torts Claim Act, § 15-78-120 (limiting tort damages against charitable organizations committed by physicians to $1,200,000).

\textsuperscript{93} See, e.g., Downing v. Lawrence Hall Nursing Ctr., 369 S.W.3d 8, 9-10 (Ark. 2010) (entitling charitable organization to immunity under certain circumstances); Thompson v. Mercy Hosp., 483 A.2d 706, 707 (Me. 1984) (holding nonprofits in Maine may raise charitable immunity where funds derived mainly from charity); N.J. STAT. ANN. § 2A: 53A-8 (West 2022) (allowing charitable organization organized exclusively for hospital purposes liable to beneficiary for $250,000); see Bogert et al., supra note 14, § 402 (acknowledging difficulty in categorizing approaches taken by states regarding charitable immunity doctrine).

\textsuperscript{94} See Downing, 369 S.W. at 9-10 (listing eight factors courts consider when determining whether charitable organization entitled to immunity). These eight factors consider whether: (1) the organization’s charter limits its scope to charitable or eleemosynary purposes; (2) the organization’s charter contains a “not-for-profit” limitation; (3) the charitable organization’s goal is to break even; (4) the organization earns a profit; (5) any profit or surplus of the charitable organization must be used for charitable purposes; (6) the organization depends on contributions or donations for its continued existence; (7) the organization provides its services for free to those who are unable to pay; and (8) the directors or officers of the charitable organization receive compensation. See id.; see also Ark. CODE ANN. § 23-79-210 (2023) (noting charitable organizations potentially liable for its torts). While a charitable organization’s liability insurance may be used for damages sustained because of the actions of the charitable organization, Arkansas law does not require charitable organizations to carry liability insurance. See § 23-79-210 (stressing nothing in statute construed requiring charitable organizations to carry liability insurance).


\textsuperscript{96} See Ponder v. Fulton-Dekalb Hosp. Auth., 355 S.E.2d 515, 516 (Ga. 1987) (discussing long-held rule allowing patients to sue charitable hospitals for negligent selection of employees).

\textsuperscript{97} See N.J. STAT. ANN. § 2A: 53A-7 (providing beneficiaries of charitable organizations not entitled to bring lawsuits against organization). Courts in New Jersey also embrace a two-prong test to determine whether a plaintiff was a beneficiary of the charity at the time of the injury: whether the charity, at the time of the injury, was engaged in the performance of the objectives it was organized to advance; and whether the injured party was a direct recipient of those good works. See Green v. Monmouth Univ., 206 A.3d 394, 403 (N.J. 2019) (elucidating two-prong test used to determine if plaintiff beneficiary of charity).

\textsuperscript{98} See N.J. STAT. ANN. § 2A: 53A-8 (West 2021) (stating charitable hospital liable up to $250,000, with interest and costs, for plaintiff’s injury).
Maine’s version of the charitable immunity doctrine was created and is enforced by the courts. Under the common law of Maine, for a nonprofit to qualify for charitable immunity, a charitable organization must obtain its funds “mainly from public and private charity.” The Maine Legislature, however, enacted a statute that prohibits charitable organizations from raising the doctrine if the organization carries liability insurance. Similarly, Maryland courts will apply the charitable immunity doctrine if a charity’s funds are held in trust, but if the charitable organization carries liability insurance, the charity’s insurance company can be held liable for the plaintiff’s damages.

E. The Charitable Immunity Doctrine in Massachusetts

1. Development of the Charitable Immunity Doctrine in Massachusetts

Massachusetts was the first state in the country to embrace the charitable immunity doctrine. The Supreme Judicial Court relied on the previously overruled English decision Holliday v. Parish of St. Leonard to support the implementation of the charitable immunity doctrine. Besides the fact that the case had already been overruled by the time of the Supreme Judicial Court decision, Holliday actually stood for the creation of a public duty rule to protect public employees and servants from liability—not for the creation of a liability shield for charitable trust funds. The Supreme Judicial Court never overturned the common law doctrine of charitable immunity, and it remained the law in Massachusetts until 1971.

In 1969, the Supreme Judicial Court announced in Colby v. Carney Hospital that it would abolish the charitable immunity doctrine the next time a legal

100. See id. (requiring majority charity funding to exercise charitable immunity defense); Child v. Cent. Maine Med. Ctr., 575 A.2d. 318, 320 (Me. 1990) (holding nonprofit hospital with only 1% of its funds from charity not entitled to immunity); see also Thompson, 483 A.2d at 708 (referring to “much criticized” doctrine of charitable immunity).
101. See Me. STAT. tit. 14, § 158 (2023) (providing nonprofits with liability insurance waive use of charitable immunity doctrine).
102. See Montrose Christian Sch. Corp. v. Walsh, 770 A.2d 111, 121 (Md. 2001) (holding charitable funds held in trust cannot satisfy tort judgments); MD. CODE ANN., INS. § 19-103 (LexisNexis 2021) (stating charitable organization’s liability insurance provider liable for claims).
103. See supra notes 33-35 (noting Massachusetts first state espousing charitable immunity doctrine).
105. See O’Neil, supra note 22, at 226 (describing Holliday created public duty rule protecting public employees, not charitable trust funds).
question regarding the doctrine confronted it. The Massachusetts legislature removed the common law doctrine of charitable immunity by statute two years later. With the enactment of Massachusetts General Laws, chapter 231, section 85K, charitable organizations could be held liable in lawsuits, but judgments against charities would be statutorily reduced to $20,000. The legislature amended the statute in 2012 to increase the liability cap for nonprofit hospitals in medical malpractice cases to $100,000.

In 2021, Massachusetts State Representative Carmine Gentile proposed removing the charitable immunity cap altogether. State Senator Mark Montigny introduced identical legislation in the Senate. Both Representative Gentile’s and Senator Montigny’s bills lack co-sponsors, and both are unlikely to pass in their respective legislative houses. Representative Gentile and Senator Montigny have introduced several bills since 2011 to either revise the charitable immunity cap to make it only applicable to small- or medium-sized charities or eliminate it altogether, to no avail.

2. Implications of Charitable Immunity Doctrine in Massachusetts

The statutorily imposed liability cap has reduced several significant judgments against nonprofit hospitals. Instead of a hospital’s liability insurance company being responsible for paying for all the damages of a medical malpractice lawsuit, which could include monetary damages to pay future medical bills associated with the malpractice, the burden of paying these expenses often falls

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108. See id. at 408 (warning court will overturn charitable immunity doctrine next time question regarding doctrine arises).
109. See ch. 231, § 85K.
110. See id. (providing lawsuits against nonprofits limited to $20,000).
111. See id. (increasing liability cap against nonprofit hospitals to $100,000).
114. See H.B. 1599 (noting only Representative Gentile listed petitioner, without any co-sponsors, for proposed legislation); S.B. 1101 (listing only Senator Montigny, without any co-sponsors, for proposed legislation); see also Opinion, Legislature Must Answer for Inaction on Charitable Immunity, MASS. LAW. WKLY. (Oct. 28, 2021) https://masslawyersweekly.com/2021/10/28/legislature-must-answer-for-inaction-on-charitable-immunity/ [hereinafter Inaction on Charitable Immunity] (recognizing no reason to believe Representative Gentile’s bill will make it out of committee).
on the taxpayer.\footnote{See Inaction on Charitable Immunity, supra note 114 (noting taxpayers of Massachusetts often subsidize care of medical malpractice victims).} Justice Ireland noted in his dissent in \textit{Keene} that the charitable immunity cap “fails to properly balance the interest of the innocent victim and that of the negligent charitable organization.”\footnote{See Keene, 786 N.E. at 838 (Ireland, J., dissenting) (contending charitable immunity cap improperly rewards negligent defendant in medical malpractice case).}

The existence of the charitable immunity cap may also dissuade a plaintiff from naming a charitable hospital as a defendant.\footnote{See O’Neil, supra note 22, at 232 (describing how lawsuit against hospital and staff can backfire if jury finds only hospital liable). While naming a hospital as a defendant early in a lawsuit for discovery purposes is a common litigation tactic, a plaintiff runs the risk of not being able to withdraw a hospital defendant in the later stages of litigation, which could result in the plaintiff only collecting against the hospital and its damages being reduced to the statutory cap. See id. at 232-33 (recognizing defendants other than charitable hospital may resist withdrawal of complaint against charitable hospital).} To avoid the liability cap, a lawyer could choose not to name a nonprofit hospital as a defendant, but this would allow the other defendants to cast blame on the “empty chair.”\footnote{See Teninbaum & Zimmermann, supra note 11, at 457 (explaining not naming nonprofit hospital defendant creates “empty chair” to blame). By not having any explanation as to why the hospital is not a defendant at trial, the jury could potentially reach a verdict in favor of the nonhospital defendants. See id. (emphasizing jury may find for nonhospital defendants because hospital not named defendant).} Naming a hospital as a co-defendant could also cause problems because the other defendants will make every effort to get the jury to find against the hospital instead of themselves.\footnote{See id. (contending defendants will make every effort to blame hospital for malpractice).} Additionally, jurors are not instructed about the charitable immunity cap before begging deliberations, which means they could potentially award a large judgment against a nonprofit hospital instead of the individual tortfeasors, believing the victim of the medical malpractice will receive the entire judgment when in fact they will receive a fraction of the judgment.\footnote{See Massachusetts Guide to Evidence § 411 (Supreme Jud. Ct. Advisory Comm. 2021) (stating inadmissibility of evidence of insurance on issues of negligence); see also David L. Yas, Change Sought in SJC Rule Prohibiting Juror Contact, Mass. Law. Wkly. (Mar. 25, 1996), https://masslawyersweekly-com.exproxsys.uf.io/1996/03/25/change-sought-in-sjc-rule-prohibiting-juror-contact/ (highlighting how juror upset not told of charitable immunity doctrine before holding only hospital liable).}

Some commentators and judges also note that by not holding charitable hospitals liable for their torts, charitable hospitals will be less incentivized to take adequate steps to protect against mistakes that lead to medical malpractice claims.\footnote{See O’Neil, supra note 22, at 234 (proffering without adverse monetary consequences for mistakes, less incentives present to protect against mistakes); Keene v. Brigham & Women’s Hosp., Inc., 786 N.E.2d 824, 842 (Mass. 2003) (Ireland, J., dissenting) (arguing by limiting liability, legislature allows hospital to hide negligent practices).} The Second Restatement of Torts states that organizations should not be immune from tort liability because of their charitable status.\footnote{See Restatement (Second) of Torts supra note 45, § 895E (noting charitable status no reason for organizations’ immunity from tort liability).}
III. ANALYSIS

A. The Original English Cases Espousing the Charitable Immunity Doctrine Never Provided Strong Support for the Implementation of the Doctrine by Courts in the United States

The first two states to embrace the charitable immunity doctrine, Massachusetts and Maryland, relied on the already overruled and factually inconsistent holdings of two mid-19th century House of Lords decisions to support the implementation of the charitable immunity doctrine.\textsuperscript{125} The \textit{Holliday} decision, which was the sole authority used by the Massachusetts Supreme Judicial Court to support the implementation of the charitable immunity doctrine, did not involve the creation of a total charitable liability rule, but rather created a public duty rule to protect public employees and servants from liability.\textsuperscript{126} Additionally, the \textit{Holliday} decision misinterpreted the dicta of two other English cases—\textit{Heriot’s} and \textit{Duncan}.\textsuperscript{127} The high courts of both Massachusetts and Maryland acted in ignorance to the fact that all the cases supposedly creating the charitable immunity doctrine had been overturned by the time the state courts had implemented the charitable immunity doctrine.\textsuperscript{128}

Additionally, the Supreme Judicial Court effectively eliminated all recovery avenues except from the actual tortfeasor by incorrectly applying English trust principles to American corporate law.\textsuperscript{129} A nonprofit trustee, who is acting in good faith and within the scope of their duties, cannot be held personally liable.

\textsuperscript{125} See McDonald v. Mass. Gen. Hosp., 120 Mass. 432, 436 (1876) (citing dicta of \textit{Holliday v. Parish of St. Leonard} to support charitable immunity doctrine); Perry v. House of Refuge, 63 Md. 20, 26-27 (1885) (citing dicta of \textit{Heriot’s} to support charitable immunity doctrine). The Court of Appeals of Maryland also cited McDonald when it decided to implement the charitable immunity doctrine. See Perry, 63 Md. at 26 (relaying on Massachusetts’ case law); see also Holliday v. Par. of St. Leonard [1861] 7 E.R. 769 (HL) 773 (appeal taken from Eng.) (concluding trustees not liable for negligent acts of persons employed by them); Heriot’s Hosp. v. Ross [1846] 8 Eng. Rep. 1508 (HL) 1510 (appeal taken from Scot.) (holding charity cannot use funds held in trust to settle judgments).

\textsuperscript{126} See O’Neil, supra note 22, at 226 (noting Holliday distinguishable from McDonald because Holliday created public duty rule, not charitable immunity rule); see also Holliday, 7 E.R. at 769 (noting issue of case).

\textsuperscript{127} See O’Neil, supra note 22, at 226 (stating House of Lords misinterpreted dicta of \textit{Heriot’s} and \textit{Duncan} when ruling on Holliday). While \textit{Heriot’s} stood for the proposition that funds held in trust by a charity could not be used to settle judgments, the House of Lords stated that a trustee could be held individually liable for their tortious conduct, who would then be indemnified by the trust if their tortious conduct occurred during their administration of the charitable trust. See \textit{Heriot’s}, 8 Eng. Rep. at 1510 (holding trust may still pay cost of trial); see also Georgetown Coll. v. Hughes, 130 F.2d 810, 815-16 (D.C. Cir. 1942) (recognizing similarity of dicta in Duncan and Heriot’s).

\textsuperscript{128} See supra notes 28, 31 and accompanying text (noting Duncan, Heriot’s Hospital, and Holliday overruled by time of decisions); see also Georgetown Coll., 130 F.2d at 816 (contending high courts of Massachusetts and Maryland “acted in ignorance” of English reversal).

\textsuperscript{129} See \textit{Quality of Mercy}, supra note 27 at 1383 n.9 (acknowledging dicta of English cases did not create blanket charitable immunity); O’Neil, supra note 22, at 226 (noting Supreme Judicial Court incorrectly applied trust principles to corporate law); Georgetown Coll., 130 F.2d. at 816-17 (stating charitable director’s position shuts off recourse to their assets).
for the tortious conduct of the organization they represent. By misconstruing already overruled English cases and applying trust principles to corporate law, the Supreme Judicial Court created a complete form of immunity for charitable organizations, which left the victim unable to collect a judgment against the entity with the greatest ability to pay.

B. The Traditional Rationales for Supporting the Charitable Immunity Doctrine No Longer Have a Place in Modern Society

Various rationales and theories have been used to justify implementing the charitable immunity doctrine. As previously noted, the trust fund theory was one of the earliest theories utilized by courts to justify implementing the charitable immunity doctrine. While the trust fund theory may have been a proper justification for implementing the doctrine in the late nineteenth century, the early twentieth century changes in the medical industry make this theory obsolete to justify the continued application of the charitable immunity doctrine. Additionally, courts created many exceptions to the rule, including when the tort victim is an employee of a charitable organization.

130. See O’Neil, supra note 22, at 226 (explaining corporate director’s position, by definition, makes their own personal assets inaccessible in lawsuits); see also MASS. GEN. LAWS ch. 231, § 85K (2022) (noting plaintiff cannot hold nonprofit director liable if they acted in good faith).

131. See Georgetown Coll., 130 F.2d at 816 (proffering rule embraced by Massachusetts strips victim of all claims except against negligent actor); O’Neil, supra note 22, at 226-27 (recognizing Supreme Judicial Court misconstrued English cases to create complete charitable immunity).

132. See supra notes 38-40 and accompanying text (stating courts embraced trust fund theory to justify charitable immunity doctrine); supra notes 42-44 and accompanying text (noting courts embraced view of respondent superior’s inapplicability to claims against charitable organizations); supra notes 46-48 and accompanying text (discussing how courts embraced implied waiver theory to support charitable immunity doctrine); supra notes 50-51 and accompanying text (describing how courts embraced public policy theory to support implementation of charitable immunity doctrine).

133. See supra note 38 (noting early court decisions embracing trust fund theory); LaBarbera, supra note 40, at 280-81 (explaining reasons why courts embraced trust fund theory to implement charitable immunity doctrine); see also O’Neil, supra note 22, at 227 (stating trust fund theory first rationale used to justify implementation of charitable immunity doctrine).

134. See O’Neil, supra note 22, at 227 (contending trust fund theory may have justified implementation of charitable immunity doctrine in nineteenth century); Kane, supra note 54 (noting most early charitable hospitals essentially almshouses). Early charitable hospitals not only provided medical care for the indigent, but also were tasked with providing custodial care to the poor and destitute. See Wall, supra note 55 (stating types of care and who benefited from almshouses). People who could afford to have medical treatment in their homes did so, and it was not until the advancement of technological equipment and sanitary improvements that rich people received care at hospitals. See Bromberg, supra note 54, at 239 (articulating factors leading to rich people receiving healthcare at hospitals); see also Kane, supra note 54 (recognizing in late 1900s, most rich people expected home medical treatment); Wall, supra note 55 (explaining surgeries performed in rich patients’ houses).

135. See Fairchild, supra note 47, § 2 (emphasizing trust fund theory became riddled with exceptions to rule of complete tort immunity); see also Georgetown Coll. v. Hughes, 130 F.2d 810, 825 (D.C. Cir. 1942) (contending trust fund theory no longer justifies charitable immunity doctrine). Modern charities also resemble big businesses and no longer require special treatment under the law because of the availability of inexpensive liability insurance. See Fairchild, supra note 47, § 2 (stating courts rejecting trust fund theory recognize modern charities operate like big businesses); see also Canon & Jaros, supra note 37, at 974 (acknowledging availability of liability
 Courts also utilized the theory that the doctrine of respondeat superior is inapplicable to charitable organizations to justify implementing the charitable immunity doctrine.136 Yet not holding a charity liable for the torts of its employees runs counter to the doctrine of vicarious liability.137 While some courts believed hospitals did not exercise the requisite control to hold hospitals vicariously liable for the negligence of their medical staff, Glavin v. Rhode Island Hospital held that a hospital will still be liable for the torts of their staff because patients have the right to rely on the hospital’s expertise in hiring skilled and trustworthy employees.138 Most states overruled this theory for supporting the charitable immunity doctrine in the early 1970s.139

Courts also utilized the implied waiver theory to support the implementation of the charitable immunity doctrine.140 When receiving hospital care, it is sometimes impossible for a patient to make a knowing, voluntary, and informed decision about care, which is required for a valid waiver.141 The Georgetown College court noted that when people present themselves to the hospital, they are often in desperate need of treatment and will not haggle about the terms of their insurance persuaded some courts to remove charitable immunity doctrine; O’Neil, supra note 22, at 227 (highlighting in 1940s, courts began to recognize damage claims “routine cost” of operating charity).  

136. See supra notes 42-44 and accompanying text (defining respondeat superior and noting courts often stated doctrine did not apply to charitable organizations); see also Morrison v. Henke, 160 N.W. 173, 175 (Wis. 1916) (holding respondeat superior does not apply in suits against charities); Schloendorff v. Soc’y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914) (stating independent contractor physicians do not create liability for hospital due to own negligence).  

137. See Restatement (Second) of Torts, supra note 45, § 895E cmt. c (2) (proffering granting charitable organizations tort immunity because of status counter to doctrine of vicarious liability); Fairchild, supra note 47, § 2 (explaining inapplicability of respondeat superior theory to grant charities immunity).  

138. See Schloendorff, 105 N.E. at 93 (noting master-servant relationship not present between hospitals and physicians). Other courts reasoned that because a charitable institution does not seek to make a profit off the work of their employees, the doctrine of respondeat superior would be inappropriately applied to charitable organizations. See supra note 43 and accompanying text (explaining some courts’ rationale for not applying respondeat superior to charitable organizations); see also Glavin v. R.I. Hosp., 12 R.I. 411, 424 (1879) (stating hospital does assume responsibility when patient injured by employee of hospital). While the Glavin court admitted that the traditional master-servant relationship is not present between a hospital and physician working at a hospital, the court found that hospitals are still responsible for the conduct of their physicians because the hospital uses its own judgment when selecting who works at their hospitals. See Glavin, 12 R.I. at 424 (concluding even absent master-servant relationship, hospital still liable for torts of employees); see also Georgetown Coll., 130 F.2d at 827 (noting charitable status generally not real defense against respondeat superior).  

139. See O’Neil, supra note 22, at 228 (explaining most states rejected inapplicability of respondeat superior theory in early 1970s).  

140. See supra note 46 and accompanying text (discussing how courts have utilized implied waiver theory to justify charitable immunity doctrine); supra note 47 and accompanying text (defining implied waiver theory); see also supra note 48 and accompanying text (providing traditional requirements for effective tort waivers).  

141. See O’Neil, supra note 22, at 228 (noting impossibility of obtaining consent when patient unconscious, immature, or incapacitated); Georgetown Coll. v. Hughes, 130 F.2d 810, 824-25 (D.C. Cir. 1942) (arguing implied waiver theory unjustifiably departs from general principles of liability). The Georgetown College court expressly lambasted the implied waiver theory on the grounds that certain patients being entirely unable to make a proper waiver. See Georgetown Coll., 130 F.2d at 826 (explaining fiction of adolescent, mentally ill, and sick patients possessing capacity to waive rights).
admission. The implied waiver theory contains riddles of exceptions, including the paying patient exception, which held that if a patient paid for their medical expenses, the hospital could not raise an implied waiver defense.

The last major theory used by courts to justify implementing the charitable immunity doctrine was the public policy theory. Like the trust fund theory, the public policy theory may have supported the implementation of the charitable immunity doctrine in the late nineteenth and early twentieth century when charitable hospitals provided care almost exclusively to destitute patients. The public policy theory should actually be used to support holding charitable organizations liable for their torts because charitable organizations are supposed to promote the public good, not harm those who are the intended beneficiaries of the charity. Additionally, charitable immunity infringes on an individual’s right to obtain a public good. If society believes charitable organizations should exist without the fear of going bankrupt because of tort lawsuits, society has many alternatives to both support charitable enterprises and protect the rights of tort sufferers.

142. See Georgetown Coll., 130 F.2d at 826 (articulating ordinary conscious adult will not haggle about terms of treatment). Additionally, the court explained that few hospitals would ever publish a policy requiring patients to explicitly release the hospital from liability for injuries and that only patients in poverty or desperate need of immediate treatment would ever agree to such a policy. See id. (acknowledging most hospitals would not implement policy requiring patients to waive rights for admittance).


144. See supra note 50 and accompanying text (explaining courts have justified charitable doctrine using public policy theory); supra note 52 and accompanying text (acknowledging public policy theory incorporates all three other major justifications for charitable immunity doctrine); supra note 51 and accompanying text (discussing courts’ rationale for embracing public policy theory to implement charitable immunity doctrine).

145. See O’Neil, supra note 22, at 228-29 (describing merits of public policy theory in late nineteenth and early twentieth century). At the turn of the twentieth century, medicine was a more inexact science, and a high percentage of patients died during treatment, which could have led to lawsuits that would bankrupt the institution. See id. at 229 (recognizing different state of medicine during last century); see also Quality of Mercy, supra note 27, at 1388 (contending without immunity, financial liability would destroy charities, and public benefits charities provide would cease); Vermillion v. Woman’s Coll. of D.C., 88 S.E. 649, 650 (S.C. 1916) (stating in organized society, individual must subordinate rights for public good).

146. See Quality of Mercy, supra note 27, at 1388 (recognizing public policy theory may actually justify holding charitable organizations accountable for their torts). It is also possible that a charitable organization can do more harm than good, which would justify courts to hold negligent charitable organizations liable for their negligence. See id. at 1388 n.51.

147. See id. at 1388-89 (noting charitable immunity analogous to arbitrary seizure of life, health, or property). The author of Quality of Mercy uses a compelling analogy to criticize the public policy theory supporting charitable immunity: “If a nonprofit blood bank is permitted without consequence to cause a wrongful death in order that it may go on to save other lives, why may it not also drain all five quarts of one person’s blood in order to save the lives of five others.” Id. at 1390; see also O’Neil, supra note 22, at 229 (arguing charitable immunity’s deprivation of life, health, or property contrary to Fifth Amendment).

148. See Quality of Mercy, supra note 27, at 1390 (explaining society may assist charitable organizations obtain liability insurance). In addition to helping charitable organizations obtain liability insurance, society may also give charitable organizations a direct subsidy to help pay for liability insurance or tort lawsuits, or society may choose to take responsibility and pay the tort sufferer directly for their damages sustained because of the
Providing subsidies to small, nonhospital charitable organizations protects needy nonprofits from catastrophic tort suits, however, this remedy should not be available to charitable hospitals because these organizations already receive large tax subsidies through the state and federal government. In fact, Massachusetts nonprofit hospitals receive some of the largest tax breaks in the country. It would be inherently unfair to burden the taxpayer to cover the cost of a nonprofit hospital’s liability insurance when nonprofit hospitals are operated as big businesses and receive tremendous amounts of revenue from paying patients.

C. Massachusetts Should Remove the Charitable Immunity Cap for Large Corporate Charitable Organizations but Retain a Smaller, Niche Form of Charitable Immunity for Small Charitable Organizations

The vast majority of states have completely abolished the charitable immunity doctrine. The current law does not distinguish small charitable organizations, which receive most of their funding through private donations, and large corporate charitable organizations like hospitals, which receive most of their funding from paying beneficiaries. There is a legitimate fear, however, that removing the charitable immunity cap could harm small nonprofit organizations that receive most of their funding from private donations. To protect small charitable institutions, the Massachusetts Legislature should enact a law that will help conduct of the nonprofit. See id. (recognizing additional alternatives society may take protect charitable organizations). Alternatively, a legislature could adopt a statute limiting tort judgments for charitable organizations that receive most of their funding from private or public donations, which is similar to the common law of Maine. See Thompson v. Mercy Hosp., 483 A.2d 706, 707 (Me. 1984) (holding charitable immunity defense unavailable to charities who do not receive majority funding from charity). Based on Mass General Brigham Incorporated and Affiliates 2020’s financial statement, they would not be eligible for charitable immunity under this alternative rule since more than 50% of their revenue came from providing services to patients. See PWC, supra note 65, at 4 (stating more than 50% of revenue obtained by providing services to patients).

149. See, e.g., I.R.C. § 501(3)(c) (exempting nonprofits from corporate income tax); MASS. GEN. LAWS ch. 59, § 5 (2022) (exempting nonprofits from property taxes); see also Mass. Dept. of Rev., supra note 68 (recognizing corporations filed under § 501 of Internal Revenue Code except from corporate excise tax).

150. See Rosenbaum et al., supra note 70, at 1229 (highlighting Massachusetts nonprofit hospitals, on average, received largest tax benefit compared to every other state).

151. See Paavola, supra note 12 (noting Massachusetts General Brigham recorded $1.1 billion in revenue in first financial quarter of 2021).

152. See O’Neil, supra note 22, at 230 (pointing out Massachusetts “out of step” in retaining partial charitable immunity); see also BOGERT ET AL., supra note 14, § 402 (noting by end of 20th century, three-quarters of states either abolished or limited charitable immunity).

153. See MASS. GEN. LAWS ch. 231, § 85K (2022) (stating charitable immunity provided to institutions regardless of size or revenue). The only exception to this rule is that in the context of medical malpractice lawsuits, nonprofit healthcare providers may be liable for up to $100,000, while all other tort lawsuits against charitable institutions are limited to $20,000. See id. (providing $100,000 liability cap for medical malpractice claims and $20,000 for all other claims).

154. See O’Neil, supra note 22, at 231 (differentiating between local charities receiving donations from private donations and major hospitals).
small, self-supported charities purchase liability insurance. This subsidy should be conditioned on the charitable organization having a limited operating income and a requirement that the organization receive most of its funds through either private or public donations. This solution provides both protections for small charities and protections for people who may be injured because of a charitable organization’s negligence. Because large charitable hospitals receive most of their funding through paying beneficiaries and can generate revenues of billions of dollars, they would not qualify for this subsidy.

Proponents of maintaining the doctrine of charitable immunity also argue that removing the charitable immunity cap could lead to additional frivolous medical malpractice lawsuits and increase the cost of liability insurance. This argument, however, ignores the fact that to prevent frivolous medical malpractice lawsuits from being filed, Massachusetts created a tribunal system to review a case before it ever reaches trial. Additionally, some superfluous frivolous lawsuits are a necessary evil to ensure actual tort sufferers receive the justice they deserve.

Even if liability insurance premiums increase for charitable hospitals, it will not be because of frivolous lawsuits; rather, it will be because hospitals make mistakes. As the House of Lords noted in Mersey Docks Trustees v. Gibbs, it would be a strange distinction to hold a for-profit corporation liable for its workers’ conduct while not holding a nonprofit institution liable for the same

155. Quality of Mercy, supra note 27, at 1390 (explaining alternative solutions to remove charitable immunity doctrine). Furthermore, the Massachusetts Legislature should limit this subsidy to only those charities that receive most of their funding through private and public donations, and whose net operating income is below a certain threshold. See Thompson v. Mercy Hosp., 483 A.2d 706, 707 (Me. 1984) (limiting charitable immunity defense to charities which receive majority funding from private and public donations).

156. See generally Me. STAT. tit. 14, § 158 (2023) (stating nonprofits with liability insurance waive charitable immunity); MD. CODE ANN., Ins. § 19-103 (LexisNexis 2021) (identifying charitable organization’s liability insurance liable for claims).

157. See Quality of Mercy, supra note 27, at 1390 (noting solutions to both protect public and needy charities).

158. See Paavola, supra note 12 (stating Massachusetts General Brigham recorded $1.1 billion revenue in first financial quarter of 2021); PWC, supra note 65 (noting Massachusetts General Bingham received over 50% of revenue from patient services).

159. See O’Neil, supra note 22, at 235 (addressing proliferation of medical malpractice lawsuits and skyrocketing malpractice premiums).

160. See supra note 7 and accompanying text (discussing medical malpractice tribunal statute and composition of tribunal); supra note 8 and accompanying text (stating questions tribunal will answer during proceedings); supra note 9 and accompanying text (describing what occurs after tribunal’s decision on justiciability of case).


162. See O’Neil, supra note 22, at 235 (arguing hospitals responsible for increased insurance premiums, not tort sufferers).
conduct. By holding nonprofit hospitals accountable for their negligence, hospitals will be more likely to correct past mistakes so they will not happen in the future.

IV. CONCLUSION

The harm that a patient suffers in a medical malpractice event does not change based on the charitable status of the hospital that treats them. A patient who suffers a missed cancer diagnosis at a for-profit hospital will suffer the same harm as a patient who receives a missed cancer diagnosis at a nonprofit hospital. In Massachusetts, the only difference between the two patients is that the patient who received their missed cancer diagnosis at the for-profit hospital can collect more than $100,000 from the negligent hospital, while the latter cannot. While this money will not cure the patient of whatever ailment afflicts them, it will provide the patient with the resources to take care of themselves, their spouses, and children.

Holding negligent charitable hospitals liable for their misconduct will not only benefit tort victims and their families, but will also benefit society as a whole. Significant tort judgments will force charitable hospitals to fix behaviors that gave rise to the medical malpractice events in the first place. This behavior change will result in better care for all patients. Learning from mistakes is a part of life, and holding charitable hospitals fully liable for their mistakes will force them to learn from theirs.


164. See O’Neil, supra note 22, at 234 (noting immunity likely breeds irresponsibility); Quality of Mercy, supra note 27, at 1387 (highlighting argument from accountability rationale for abandoning charitable immunity).