

Operation Arbitration: Privatizing Medical Malpractice Claims

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Binding arbitration is generally less available in tort suits than in contract suits because most tort plaintiffs do not have a pre-dispute contract with the defendant, and are unlikely to consent to arbitration after the occurrence of an unforeseen injury. But the Federal Arbitration Act applies to all “contract[s] evincing a transaction involving commerce,” including contracts for healthcare and medical services. Given the broad trend towards arbitration in nearly every other business-to-consumer industry, coupled with some rollbacks in tort reform measures that have traditionally favored medical professionals in the judicial system, it is very possible that we may witness in the near future more medical contracts containing arbitration provisions. As a consequence, all manner of tort claims (including negligence, loss of chance, and other allegations of medical malpractice resulting in physical and psychological injury) might be hashed out in the sequestered universe of arbitration.

INTRODUCTION

In *Brown v. Genesis Healthcare Corp.*,¹ the West Virginia Supreme Court held that the Federal Arbitration Act (FAA) did not apply to agreements to arbitrate negligence claims in nursing home contracts: “[A]s a matter of public policy under West Virginia law, an arbitration clause in a nursing home admission agreement adopted prior to an occurrence of negligence that results

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1 *Brown v. Genesis Healthcare Corp.*, 228 W. Va. 646 (2011), *rev'd sub nom*, *Marmet Health Care Ctr. Inc. v. Brown*, 132 S. Ct. 1201 (2012).

in personal injury or death, shall not be enforced to compel arbitration of a dispute concerning the negligence.”²

In a striking passage, the state court lambasted the U.S. Supreme Court’s recent arbitration jurisprudence, deriding its “tendentious reasoning . . . stretch[ing] the application of the FAA,” and creating doctrines “from whole cloth.”³ The Supreme Court, in *Marmet Health Care Ctr. Inc. v. Brown*,⁴ took issue with this characterization, and in a terse, four-page per curiam opinion, overturned the West Virginia court’s “interpretation of the FAA [as] both incorrect and inconsistent with the clear instruction in the precedents of this Court.”⁵ Specifically, the state court’s “public policy” grounds for non-enforcement constituted “a categorical rule prohibiting arbitration of a particular type of claim,” which the Court held “contrary to the terms and coverage of the FAA” and, therefore, preempted by the federal statute.⁶

Nursing homes, assisted living facilities, and long-term-care providers have been pioneers of incorporating binding, pre-dispute arbitration clauses into their contracts with patients.⁷ These clauses require parties to refer their

2 228 W. Va. at 688; *see also* Federal Arbitration Act, Pub. L. No. 68-401, 43 Stat. 883 (1925) (codified as amended 9 U.S.C. §§ 1-16 (2012)).

3 228 W. Va. at 649. Specifically, the West Virginia court ruled that the FAA did not extend to “personal injury or wrongful death suits that only collaterally derive from a written agreement that evidences a transaction affecting interstate commerce.” *Id.*

4 132 S. Ct. 1201. The Court granted certiorari to consider three consolidated appeals regarding the application of the FAA to arbitration agreements in nursing home admissions contracts. In each case, a family member of the deceased patient sued the nursing home in state court alleging negligence resulting in death.

5 *Id.* at 1202. The scolding Justices reminded the West Virginia court that “[w]hen this Court has fulfilled its duty to interpret federal law, a state court may not contradict or fail to implement the rule so established.” *Id.*

6 On remand, the West Virginia Supreme Court again declared the nursing home’s arbitration agreement unenforceable — this time on common law unconscionability grounds. *Brown v. Genesis Health Care Corp.*, 229 W. Va. 382, 729 S.E.2d 217, 223 (2012) (“The doctrine of unconscionability . . . is a general, state, common-law, contract principle that is not specific to arbitration, and does not implicate the FAA.”). Surprisingly, the Justices did not grant a second review.

7 Nathan Koppel, *Nursing Homes, in Bid to Cut Costs, Prod Patients to Forgo Lawsuits*, WALL ST. J., Apr. 11, 2008 (“Nursing homes have been among the biggest converts to the practice since a wave of big jury awards in the late 1990s. Attorneys litigating nursing-home cases on both sides say arbitration has quickly become the rule rather than the exception.”); Lisa Tripp, *Arbitration Agreements Used by Nursing Homes: An Empirical Study and Critique of AT&T Mobility v. Conception*, 35 AM. J. TRIAL ADVOC. 87 (2011) (finding that forty-three percent

disputes to a third-party arbitrator, who can resolve claims on the merits and issue enforceable decisions with limited appeal to courts. Contemporary long-term-care arbitration clauses don't stop there: these clauses, drafted by astute lawyers, can also include significant procedural restrictions (e.g., limiting discovery, witnesses and evidence), as well as limitations on damages (e.g., prohibiting punitive damages).⁸ Some alter the burden of proof (e.g., clear and convincing instead of preponderance), shrink the relevant statutes of limitations (e.g. from five years after discovery to two years after procedure), and many require the losing party to pay all costs and fees of the process.⁹ And nearly all arbitration clauses in long-term-care contracts require the proceedings and outcome to remain strictly confidential.¹⁰

In states such as Alabama, Mississippi, Ohio and Texas — whose high courts have enforced arbitration clauses in medical malpractice claims brought against nursing homes¹¹ — these defendants have reaped significant benefits. One study, which examined nearly 1500 negligence-related claims against

of North Carolina nursing homes use arbitration clauses in their admissions contracts).

- 8 See Tripp, *supra* note 7, at 13-15 (finding in an empirical study of North Carolina nursing home arbitration clauses that 7.32% contained damage limitations and 13.41% explicitly limit discovery); Vesna Jaksic, *Patient Arbitration Pacts Are Alarming Attorneys*, LAW.COM (Mar. 28, 2008), www.law.com/jsp/article.jsp?id=1206614812624 (reporting on arbitration agreements in Florida which impose damage caps that are more restrictive than the state's statute).
- 9 See Tripp, *supra* note 7, at 14-16 (finding in an empirical study of North Carolina nursing home arbitration clauses that almost fifty percent require patients to pay arbitrators' fees).
- 10 See, e.g., Michelle Andrews, *Signing a Mandatory Arbitration Agreement with a Nursing Home Can Be Troublesome*, WASH. POST, Sept. 17, 2012, http://articles.washingtonpost.com/2012-09-17/national/35497405_1_arbitration-john-mitchell-vital-signs (reporting that arbitration hearings "are conducted in private and [these] proceedings and materials are often protected by confidentiality rules").
- 11 See, e.g., *McGuffey Health & Rehabilitation Ctr. v. Gibson ex rel. Jackson*, 864 So. 2d 1061 (Ala. 2003); *Vicksburg Partners, L.P. v. Stephens*, 911 So. 2d 507 (Miss. 2005); *In re Nexion Health at Humble, Inc.*, 173 S.W.3d 67 (Tex. 2005). Prior to *Marmet*, only seven states had declared arbitration agreements unenforceable in nursing home admissions contracts. See CAL. HEALTH & SAFETY CODE § 1430(b); GA. CODE ANN. § 9-9-62; ILL. COMP. STAT. ch. 210 § 45/3-606; N.J. STAT. ANN. § 30:13-8.1; N.Y. PUB. HEALTH LAW § 2801-d(7); OKLA. STAT. ANN. tit. 63, § 1-1939; W. VA. CODE ANN. § 16-5C-15. In three of those seven states — Georgia, Illinois, and New Jersey — the courts have recently declared the statutes preempted by the FAA. See *Triad Health Mgmt. of Georgia v. Johnson*, 679 S.E.2d 785, 789 (Ga. Ct. App. 2009); *Carter v. SSC Odin Operating Co.*, 927

such facilities brought between 2003 and 2011, found that “claims settled under valid [arbitration] agreements are 21% less costly than other claims.”¹² Further, while nearly twelve percent of litigated claims resulted in awards of \$250,000 or more, only 8.5% of claims brought in arbitration were as costly.¹³ Other risk analyses have similarly found that long-term-care facilities generally fare better in arbitration than in litigation.¹⁴ And many of these studies expressly factored in the costs and legal uncertainties of defending a challenge to the nursing home’s arbitration clause; once those challenges are no longer viable, which is quickly becoming the case, the benefits of arbitration will presumably be far greater.¹⁵

Despite the apparent success of arbitration in protecting the nursing home industry from the costs of liability, other healthcare providers have been slow to follow suit.¹⁶ Especially given the rising costs of medical malpractice litigation,

N.E.2d 1207, 1214 (Ill. 2010); *Estate of Ruzala ex rel. Mizerak v. Brookdale Living Communities, Inc.*, 1 A.3d 806, 817-18 (N.J. Super. App. Div. 2010).

12 AON RISK SOLUTIONS, 2012 LONG TERM CARE: GENERAL LIABILITY AND PROFESSIONAL LIABILITY ACTUARIAL ANALYSIS (2012), available at http://www.ahcancal.org/research_data/liability/Documents/2012_LongTermCare_Report_full.pdf. This study examined the cost of liability facing the long-term-care industry, and specifically, the “cost difference associated with the presence of valid arbitration agreements.” *Id.* at 3. According to its findings, the average total cost of arbitrating a claim is approximately \$140,000 (inclusive of the costs of defending the validity of the arbitration clause), while the cost of litigating a similar claim is about \$180,000.

13 *Id.* at 13.

14 Tripp, *supra* note 7; see also Koppel, *supra* note 7 (reporting on a Mississippi firm representing nursing homes which “defended 12 to 14 nursing home arbitrations . . . without seeing an award of more than \$100,000” and quoting a representative of Skilled HealthCare Group Inc., which operates seventy-five nursing homes in six states, that arbitration “significantly reduced our liability exposure”).

15 Presumably, the greatest benefit comes from claims that are simply never brought, either because lawyers are unfamiliar with arbitration or have calculated the financial risks to outweigh any potential rewards in this jury-free forum.

16 See Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 LAW & CONTEMP. PROBS. 153, 155 (1997) (a study of California healthcare providers in the mid-1990s found that nine percent of hospitals and ten percent of the physicians that were surveyed used binding arbitration agreements). Importantly, this Article will focus exclusively on medical malpractice claims, rather than claims involving payment (many of which are currently subject to arbitration pursuant to the AMERICAN ARBITRATION ASSOCIATION (AAA), HEALTHCARE PAYOR PROVIDER ARBITRATION RULES (2011), available at <https://www.adr.org/>

one might expect that all sorts of contemporary medical tort claims to end up in arbitration. Perhaps at first blush, this could appear counterintuitive, as arbitration is generally less available in tort suits than in contract suits because most tort plaintiffs do not have a pre-dispute contract with the defendant, and are unlikely to consent to arbitration after the occurrence of an unforeseen injury. But the FAA applies fully to “contract[s] evincing a transaction involving commerce,” including contracts for healthcare and medical services.¹⁷ Contracts governing the delivery of healthcare either by individual providers or through membership in health maintenance organizations (HMOs) therefore fall within the purview of the FAA.

Why, then, have other healthcare providers resisted the example of nursing homes, as well as most other business-to-consumer industries, in failing to include more and broader arbitration clauses in their agreements with patients? I am certainly not the first to ponder this question or to observe that malpractice claims seem ripe for arbitration. Indeed, a number of scholars and policymakers in the 1980s and 1990s argued strongly in favor of arbitration as a palliative to the medical malpractice litigation “crisis.”¹⁸ A notable example is the Medical Injury Compensation Fairness Act of 1991 — a bill introduced by then-Senator Pete Domenici (R-NM) proposing that all medical malpractice claims be brought in arbitration.¹⁹ Described by contemporaneous

aaa/ShowProperty?nodeId=/UCM/ADRSTG_004106&revision=latestreleased) or coverage determinations (which may also be subject to mediation and arbitration).

- 17 FAA § 1; *see also* *Perry v. Thomas*, 482 U.S. 483, 490 (1987) (stating that the FAA “embodies Congress’[s] intent to provide for the enforcement of arbitration agreements within the full reach of the Commerce Clause”); *Allied-Bruce Terminix Cos. v. Dobson*, 513 U.S. 265, 275 (1995) (asserting that a broad interpretation of interstate commerce “is consistent with the Act’s basic purpose,” to place arbitration clauses on equal footing with other contract provisions).
- 18 *See, e.g.*, Rolph et al., *supra* note 16; *see also* Ann H. Nevers, *Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?*, 1 PEPP. DISP. RESOL. L.J. 45, 89 (2000) (predicting that, given the “future direction for medical malpractice in the new millennium, arbitration may play a stronger role”). There were also a number of earlier calls for arbitration of med mal claims. *See, e.g.*, Stanley D. Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate*, 58 VA. L. REV. 947, 956 (1972); Martin Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 768 (1977) (asserting that arbitration could reduce medical malpractice litigation costs).
- 19 S. 1232, §§ 3(b)(1), (5), 102d CONG., 1ST SESS (June 6, 1991); *see also* Pete V. Domenici, *Health Care Reform*, 78 A.B.A. J., Aug. 1992, at 42; Pete V. Domenici & C. Everett Koop, *Sue the Doctor? There’s a Better Way*, N.Y. TIMES, June 6,

observers as “a bold attempt to impose mandatory and binding ADR for the great majority of medical malpractice claims,”²⁰ the Domenici bill ultimately failed to win broad support. Nonetheless, proposals such as this one and others like it²¹ are premised on the idea that mandatory arbitration holds the promise of ameliorating the costs and delays that characterize our “broken” medical malpractice litigation system. It is therefore worth exploring why, despite various efforts by federal, state and private actors, and some fairly clear cost-based incentives, the healthcare field has lagged conspicuously behind other business-to-consumer contracts in imposing binding arbitration.

In any event, I posit here that, in the near future, more medical contracts — hospital admissions forms, consent-to-treat agreements, etc. — might contain provisions that require disputes to be individually arbitrated, and that some will go further by seeking to limit both substantive and procedural rights in the arbitral fora.²² Ultimately, these ostensibly procedural changes could have serious substantive implications; in particular, arbitrating medical injury claims could undermine the regulatory effects of the malpractice regime by limiting the dissemination of information regarding medical errors, which aids in the creation and enhancement of standards of conduct, the reduction

1991, at A25. The Domenici bill was not the first time Congress had considered mandating arbitration of medical malpractice claims. *See, e.g.*, DEP’T OF HEALTH, EDUC. & WELFARE, THE REPORT OF THE SECRETARY’S COMMISSION ON MEDICAL MALPRACTICE (1973).

- 20 Clark Havighurst & Thomas Metzloff, Commentary, *S.1232: A Late Entry in the Race for Malpractice Reform*, 54 LAW & CONTEMP. PROBS. 179, 184 (1991).
- 21 For example, Michigan experimented with voluntary arbitration of med mal claims in the 1970s. MICH. COMP. LAWS ANN. § 500.3053(1) (1975). But, despite significant efforts, the Michigan program produced only 247 actual arbitrations out of approximately 20,000 malpractice claims. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: FEW CLAIMS RESOLVED THROUGH MICHIGAN’S VOLUNTARY ARBITRATION PROGRAM (1990), available at <http://www.gao.gov/assets/220/213545.pdf>; Rhoda M. Powsner & Frances Hamermesh, *Medical Malpractice Crisis the Second Time Around: Why Not Arbitrate?*, 8 J. LEGAL MED. 283, 291 (1987) (concluding that in the Michigan “program’s first 10 years of existence . . . arbitration has not been widely utilized for the resolution of medical malpractice disputes”).
- 22 Michael I. Krauss, *A Medical Liability Toolkit*, 2 J.L. PERIODICAL LABORATORY LEGAL SCHOLARSHIP 349, 387 (2012) (arguing that “[arbitration] agreements are on the increase, though until recently they were quite rare”); *see also* Havighurst & Metzloff, *supra* note 20, at 190 (noting that “private contracts have not heretofore been commonly thought of as legitimate vehicles for altering legal rights in this area,” yet indicating that may change).

of future medical accidents, the ability to hold wrongdoers accountable and the consequent instillation of public confidence in medical service providers.

Two recent trends point in this direction. First is the judicial embrace of arbitration. In recent years, piloted by the Supreme Court's radically pro-arbitration jurisprudence, courts have become utterly hostile to attacks on the enforceability of arbitration clauses. As a result, unconscionability and public policy challenges to arbitration are no longer available and state legislative schemes that put arbitration agreements on a different footing than other contracts cannot stand. A second and less certain trend that makes arbitration more desirable for hospitals, doctors and other healthcare providers is the rollback of some state tort reform measures. These legislative reforms, enacted in the midst of a "medical malpractice crisis" beginning in the 1970s, have included damage caps, periodic payment of damages, collateral-source offset rules, changes to joint and several liability, and the implementation of screening panels — all in an effort to render the judicial forum more favorable for medical malpractice defendants. But there are some glimmers of change afoot: for example, a number of state courts have ruled damage caps unconstitutional, and more challenges to these caps appear on the horizon. Further, the utility of caps and other tort reform measures have come under greater scrutiny. While one can never count tort reformers out completely, the tide has turned ever so slightly against these measures, which makes the traditional medical malpractice litigation regime less friendly for defendants and may therefore create some incentive to move towards arbitration as a means of resolving malpractice disputes.

As the use of arbitration clauses becomes ubiquitous in other consumer contexts, as courts are limited in their discretion to adjudicate arbitration clauses as unconscionable or otherwise unenforceable, and as public adjudication threatens to lose some of its protective features for doctor-defendants, it seems likely that more healthcare providers will include and enforce arbitration clauses in their contracts with patients. As a consequence, all manner of tort claims (including negligence, loss of chance, and other allegations of medical malpractice resulting in physical and psychological injury²³) could soon be hashed out in the sequestered universe of arbitration.

23 Wrongful death suits raise interesting questions of consent: a handful of states including Utah and Missouri have refused to compel arbitration of wrongful death suits, finding plaintiff-survivors were not parties to the underlying contract. *See, e.g.*, *Lawrence v. Manor*, 273 S.W.3d 525, 529 (Mo. 2009) (finding that an arbitration agreement entered into by the decedent was not binding on the wrongful death plaintiffs). But other states, such as Texas, Mississippi, Alabama and Michigan, have held that if the beneficiaries' right to sue is derivative of the

This Article will explore the possibility of a broad-scale shift of medical injury claims from the courts to the private arbitral bodies. In Part I, I begin by describing the recent and seemingly inexorable rise of arbitration, as aided by the Supreme Court's pro-arbitration jurisprudence over the past decade.²⁴ Part II asks why doctors and hospitals have traditionally been reluctant to impose binding arbitration on patients. This Part further considers the soft trends away from tort reform as shifting momentum in the healthcare field towards arbitrating claims.

I. ARBITRATION *ÜBER ALLES*

Arbitration clauses have become ubiquitous.²⁵ They can be found in all manner of standard-form contracts, including consumer agreements for the sale of goods or services, employment contracts, and even to the farther reaches of educational admissions forms, investment prospecti, and real estate agreements.²⁶ By signing, clicking, or simply activating and using products (such as credit cards or cell phones), millions of consumers "consent" to be bound by these dispute resolution provisions. A 2008 study found mandatory arbitration clauses in 92.9% of employment agreements and 76.9% of consumer agreements;²⁷ my strong sense is those numbers have only grown since that time.

decedent's interests, they are bound by the decedent's agreement to arbitrate. *See, e.g., In re Labatt Food Serv.*, 279 S.W.3d 640 (Tex. 2009).

- 24 Two provisos: first, this Article focuses exclusively on mandatory, binding, pre-dispute, contractual arbitration clauses — generally the most common form of business-to-consumer clause. Second, my discussion is limited to arbitration of medical malpractice claims based on a negligence theory, rather than on claims relating to failure of coverage, fraud, or other forms of alleged wrongdoing.
- 25 Myriam Gilles & Gary Friedman, *After Class: Aggregate Litigation in the Wake of AT&T Mobility v. Concepcion*, 79 U. CHI. L. REV. 623 (2012) (asserting that arbitration clauses are now used by most companies that "touch consumers' day-to-day lives," including "telephone companies, internet service providers, credit card issuers, payday lenders, health clubs, nursing homes, retail banks, investment banks, mutual funds, and the sellers of all manner of goods and services"); David Horton, *Arbitration as Delegation*, 86 N.Y.U. L. REV. 437, 439 (2011) ("Arbitration clauses appear in hundreds of millions of consumer and employment contracts.").
- 26 *See, e.g., Samuel Isaacharoff, Class Actions and State Authority*, 44 LOY. U. CHI. L.J. 369, 388 (2012).
- 27 Theodore Eisenberg et al., *Arbitration's Summer Soldiers: An Empirical Study of Arbitration Clauses in Consumer and Nonconsumer Contracts*, 41 U. MICH. J.L. REFORM 871, 886 (2008).

The Supreme Court has driven this development by its broad embrace of arbitration. Beginning in the late-1990s, the Court has decided a series of cases upholding arbitration in myriad contexts and propelling the FAA to a status that is increasingly impervious to legal challenge.²⁸ Of particular importance here are the Court's most recent arbitration rulings in *AT&T Mobility v. Concepcion* and *American Express v. Italian Colors*.²⁹ In *Concepcion*, the justices considered a California state law rule providing that arbitration clauses attended by class action waivers were unenforceable where contained in standard-form adhesion contracts.³⁰ In a five-to-four decision authored by Justice Scalia, the Court held the state law rule preempted, finding that "[s]tates cannot require a procedure that is inconsistent with the FAA."³¹ While *Concepcion* arguably leaves open the viability of a state law challenge to a bilateral arbitration clause based on a fact-intensive, case-specific finding of unconscionability — such as the analysis of the West Virginia court on remand in *Marmet*³² — the vast majority of post-*Concepcion* lower court opinions have held that the Court's ruling forecloses such challenges.³³ Further, certain enforceability provisions on arbitration agreements imposed by state legislation are also preempted by the FAA to the extent these single out arbitration for special or different consideration.³⁴ And, in June 2013, a five-to-three majority held in *Italian Colors*

28 See *CompuCredit Corp. v. Greenwood*, 132 S. Ct. 665, 671-73 (2012); *Stolt-Nielsen S.A. v. Animal Feeds Int'l Corp.*, 130 S. Ct. 1758 (2010) (holding that where an arbitration clause is silent on the availability of class arbitration, the agreement cannot be construed to provide for aggregate procedures); *Green Tree Fin. Corp. v. Randolph*, 531 U.S. 79, 89 (2000) ("[W]e have recognized that federal statutory claims can be appropriately resolved through arbitration"); *Allied-Bruce Terminix Cos., Inc. v. Dobson*, 513 U.S. 265, 280 (1995) ("The advantages of arbitration [over litigation] are many"); *Alexander v. Gardner-Denver*, 415 U.S. 36, 57-58 (1974) ("[I]t is the informality of arbitral procedure that enables it to function as an efficient, inexpensive, and expeditious means for dispute resolution.").

29 *Am. Express Co. v. Italian Colors Restaurant*, 133 S. Ct. 2304 (2013); *AT&T Mobility v. Concepcion*, 131 S. Ct. 1740 (2011), *abrogating* *Discover Bank v. Superior Court*, 113 P.3d 1100 (Cal. 2005).

30 131 S. Ct. 1740.

31 *Id.* at 1753.

32 *Marmet Health Care Ctr. Inc. v. Brown*, 132 S. Ct. 1201 (2012).

33 Myriam Gilles, *Killing Them with Kindness: Examining "Consumer-Friendly" Arbitration Clauses in the Wake of AT&T Mobility v. Concepcion*, 88 NOTRE DAME L. REV. 825, 843 (2013).

34 For example, state statutes which prohibit enforcement of pre-dispute arbitration clauses in medical contracts, provide for patient cancellation of the arbitration clause within a set period (generally seven to thirty days), or which require formal

that class action waivers embedded in arbitration clauses are enforceable even where proving the violation of a federal statute in an individual arbitration would prove too costly to pursue.³⁵ Together, these decisions evince the great solicitude of the majority of the court towards arbitration, as well as to the enforceability of contracts containing dispute resolution clauses.

Nor is the recent rise and expansion of arbitration likely to abate. Episodic legislative and regulatory measures have disallowed mandatory arbitration clauses in certain instances, or as against certain claimants,³⁶ but the chances of federal legislation overriding *Concepcion* or *Amex* “aren’t great in the current political environment.”³⁷ The unmistakable trend has been to funnel more and

typeset or visual warnings on the face of the agreement are likely preempted by the FAA. *See, e.g.*, N.C. GEN. STAT. § 90-21.60 (2009) (“[A]ny contract provision or other agreement entered into prior to the commencement of an action that purports to require a party to elect arbitration under this Article is void and unenforceable.”); VT. STAT. ANN. tit. 12, § 7002(a) (2002) (“A patient may not be requested to enter into such an agreement to arbitrate until after the patient is aware of the nature and the existence of the claim.”); *see also* ALASKA STAT. § 09.55.535(a) (2008); COLO. REV. STAT. ANN. § 13-64-403(7) (2005); OHIO REV. CODE ANN. § 2711.23(A); S.D. CODIFIED LAWS § 21-25B-3 (2004); UTAH CODE ANN. § 78B-3-421(3) (2008).

- 35 *American Express Co. v. Italian Colors Restaurant*, 133 S. Ct. 2302, 2311 (2013) (“[T]he fact that it is not worth the expense involved in *proving* a statutory remedy does not constitute the elimination of the *right to pursue* that remedy.”).
- 36 *See, e.g.*, The Franken Amendment, § 8116 of 2010 Defense Appropriations Act (prohibiting federal contractors who receive funds under the Act for contracts in excess of one million dollars from requiring their employees or independent contractors to arbitrate “claims involving Title VII of the civil rights act or any tort arising out of alleged sexual assault or harassment”); Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, § 748(n), 124 Stat. 1376 (2010) (providing that an employee cannot waive his right to a judicial forum regarding a dispute that arises under the whistleblower protection section of the act); Truth in Lending Act, 15 U.S.C.A. § 1639c (no mortgage lender may include a pre-dispute arbitration clause in its loan agreements).
- 37 In each of the past eight years, Congress has considered the Arbitration Fairness Act, which would amend the FAA to invalidate all arbitration clauses in consumer or employment contracts, but the bill has never made it through committee in either chamber. *See* Arbitration Fairness Act of 2009, H.R. 1020, 111th Cong., 1st Sess. § 4, 155 CONG. REC. H1517 (Feb. 12, 2009) (invalidating agreements requiring arbitration of employment, consumer and civil rights disputes). In the immediate wake of the Supreme Court’s decisions in both *Concepcion* and *Italian Colors*, Senators Al Franken and Richard Blumenthal reintroduced new versions of the bill, which would prohibit class waivers in all consumer,

more claims out of court into the arbitral fora. So long as there is a discernible contractual relationship between the plaintiff and defendant, an arbitration clause can be easily effectuated and, in the current legal environment, is likely to be enforced.

II. HESITANCY IN HEALTH CARE

Despite the greater ubiquity and more-assured enforceability of binding arbitration in nearly every other form of consumer contracting, these clauses have remained conspicuously absent from most healthcare contracts.³⁸ In the late 1990s, the RAND Corporation studied the incidence of arbitration clauses in healthcare contracts and found that, despite some popular misconceptions and myths circulating at the time,³⁹ only nine percent of doctors and hospitals incorporated arbitration into agreements with patients.⁴⁰ Another survey of hospital general counsels during the same period also “displayed scant use and lack of interest” in arbitration.⁴¹ A decade later, a study by the Harvard School of Public Health showed that there has been little progress in the acceptance of arbitration by the healthcare field.⁴² And more recent studies have similarly concluded that physicians and hospitals remain particularly

employment, and civil-rights-related contracts. These recent versions have also failed to garner much legislative support. *See, e.g.*, Editorial, *Gutting Class Actions*, N.Y. TIMES, May 12, 2011, at A26.

- 38 While a handful of HMOs have relied on arbitration to resolve disputes with medical plan subscribers since about the 1970s, these agreements raise different issues and challenges specific to insurance regulation. *See, e.g.*, Christine Stegehuis, *Mandatory Arbitration and the Medical Malpractice Plaintiff*, COLO. LAW., May 27, 1998, at 77 (discussing the interaction between the FAA and McCarran-Ferguson Act, which was enacted specifically to limit the applicability of federal statutes to the insurance industry).
- 39 Articles appearing in the popular press during this time period created a strong impression that arbitration was becoming the norm in medical contracts. *See, e.g.*, Barry Meier, *In Fine Print, Customers Lose Ability to Sue*, N.Y. TIMES, Mar. 10, 1997, at A1 (asserting that “Americans are giving up their right to . . . sue their doctors for malpractice or their health plans over coverage”).
- 40 Rolph et al., *supra* note 16, at 171.
- 41 EDWARD A. DAUER ET AL., HEALTH INDUSTRY DISPUTE RESOLUTION: STRATEGIES AND TOOLS FOR COST-EFFECTIVE DISPUTE MANAGEMENT 7-9 (1993).
- 42 EDWARD A. DAUER & LEONARD J. MARCUS, MEDICAL FAILURE AND LEGAL FAILURE: APPLYING ALTERNATIVE DISPUTE RESOLUTION METHODS TO ADDRESS HEALTH SYSTEM PROBLEMS AND IMPROVE HEALTH CARE OUTCOMES (2003).

slow in adopting arbitration as a means of resolving malpractice disputes.⁴³ As a result, it is estimated that only a tiny percentage of malpractice claims are determined in arbitration.⁴⁴

The healthcare industry's disinclination towards arbitration is worth examination, especially given that promoting arbitration as a means of resolving malpractice claims was an early tort reform agenda item going back to the 1970s, when nineteen states enacted specific legislation endorsing and creating incentives to arbitrate.⁴⁵ And while aspects of those early tort reform packages have proven ineffective in the intervening years,⁴⁶ the potential for arbitration to significantly reduce malpractice litigation costs remains viable — as long-term-care facilities have shown in their experiment in arbitrating claims of negligence.⁴⁷

There are a number of possible explanations for this early resistance, the most prominent of which I examine briefly here.

A. Traditional Explanations for Resistance to Arbitration in Med Mal

The traditional explanation for the paucity of arbitration in med mal is that doctors, when sued for malpractice, want very much to have their actions vindicated and their names cleared, and so are resistant to placing their

43 See, e.g., Tripp, *supra* note 7.

44 Thomas Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203 (1996).

45 See, e.g., U.S. GEN. ACCOUNTING OFFICE, *supra* note 21; Irving Ladimer & Joel Solomon, *Medical Malpractice Arbitration: Laws, Programs, Cases*, 653 INS. L.J. 335 (1977).

46 See *infra* Section II.C. Also, it is possible that the very reform statutes enacted to promote arbitration as a means of resolving medical malpractice claims have hampered its progress by “requiring extensive disclosure to patients,” “prohibiting physicians from conditioning the provision of medical services on the signing of an agreement,” and “mandating procedurally cumbersome arbitration rules.” Thomas B. Metzloff, *Alternative Dispute Resolution Strategies in Medical Malpractice*, 9 ALASKA L. REV. 429, 450 (1992).

47 Even if doctors themselves are reluctant to use arbitration, one might expect insurers or others to promote the practice. See Rolph et al., *supra* note 16, at 169 (“Medical malpractice insurers ultimately pay much of the cost of disputes and awards; thus they are likely to have strong preferences regarding arbitration agreements depending on whether they believe such agreements ultimately reduce their costs.”).

reputations in the hands of arbitrators who are too bent on compromise.⁴⁸ On this view, doctors worry that arbitrators may prefer to “split the baby” and send plaintiffs home with “a token award”⁴⁹ rather than declare them blameless.⁵⁰

But surely this perception is based on outdated views: contemporary arbitration is very focused on weeding out frivolous claims and limiting nuisance awards. Indeed, critical observers assert the mission of modern arbitration as the avoidance of liability.⁵¹ And, in any event, the traditional litigation system itself fails to provide opportunities for name-clearing in most cases, as the vast majority of medical malpractice claims currently settle prior to verdict, with no public vindication of the physician.⁵² Indeed, there is little reason to believe that the reputational consequences of arbitration and litigation differ much at all.⁵³

If neither arbitration nor litigation can guarantee name-clearing, then one might expect doctors to express a preference for private, confidential hearings over public adjudication.⁵⁴ For one, public allegations of malpractice can be easily transmitted via the internet. Indeed, a number of states have enacted

48 Metzloff, *supra* note 46, at 440 (“Particularly in the malpractice context, where physicians possess a strong interest in vindicating their conduct, this perception of arbitrators ‘splitting the baby’ represents a potentially significant problem.”) (citing PHYSICIAN INSURERS ASS’N OF AM., *A COMPREHENSIVE REVIEW OF ALTERNATIVES TO THE PRESENT SYSTEM OF RESOLVING MEDICAL LIABILITY CLAIMS* 49 (1989) (discussing possible disadvantages to arbitration, including the concern with compromise results)).

49 Rolph et al., *supra* note 16, at 156.

50 See, e.g., Metzloff, *supra* note 44, at 205.

51 See, e.g., Gilles & Friedman, *supra* note 25, at 645 (asserting that “the whole purpose of mandatory arbitration clauses in consumer and employment contracts” is liability-avoidance).

52 See, e.g., David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 N. ENG. J. MED. 2024, 2026 (2006), available at <http://www.hsph.harvard.edu/faculty/michelle-mello/files/litigation.pdf> (reporting that only fifteen percent of malpractice claims were decided by verdict, with the remainder settling or resolved by dismissal).

53 Currently, doctors and other healthcare providers must report to the National Practitioner Data Bank (NPDB) whenever a malpractice claim results in state disciplinary actions, adverse hospital privileging decisions, or payment of damages — whether the malpractice claim is adjudicated in arbitration or in litigation. The database was created as part of the Health Care Quality Improvement Act of 1986. Pub. L. No. 99-660, § 402, 100 Stat. 3784, 3784 (1986).

54 See, e.g., Patricia I. Carter, *Binding Arbitration in Malpractice Disputes: The Right Prescription for HMO Patients?*, 18 *HAMLIN J. PUB. L. & POL’Y* 423, 445-46 (1997):

reporting statutes that require state medical boards and hospitals to compile and publish physician malpractice information, with full online access to the public.⁵⁵ Beyond these state-run websites are websites that purport to “rate” doctors, featuring anonymous user reviews of individual doctors and listing “bad apple” doctors in various specialty areas.⁵⁶ This information revolution will “inevitably increase the transparency of medical successes and failures,” and not surprisingly, many doctors are “frightened by the expected transparency of the digital age.”⁵⁷ All this points towards broader adoption of arbitration and the complete confidentiality it provides.

Another rationale sometimes proffered for the failure to insist upon arbitration is the fear that if arbitration represented a truly expedited and easy-to-access process for asserting malpractice claims the number of malpractice claims would skyrocket.⁵⁸ If there are many more incidents of actionable malpractice

[P]hysicians facing allegations of medical malpractice may be primarily concerned with vindication, confidentiality and preserving their reputations. Physicians may regard allegations of malpractice almost as accusations of criminal misconduct. Arbitration hearings are private and the communication is privileged. This lack of publicity is an advantage to the physician and the HMO.

- 55 See, e.g., ARIZ. REV. STAT. ANN. § 32-1403.01 (2011); CAL. BUS. & PROF. CODE § 2027 (2000); FLA. STAT. § 456.041 (2005); GA. CODE ANN. § 43-34A-3 (2011); MASS. GEN. LAWS ANN. ch. 112, § 5 (2012); MD. CODE ANN., HEALTH OCC. § 14-411.1 (2000); N.Y. PUB. HEALTH LAW § 2995-a (2012); N.C. GEN. STAT. § 90-5.3 (2011); R.I. GEN. LAWS § 5-37-9.2 (2009); VT. STAT. ANN. tit. 26, § 1368 (2011); see also Carolyn Krupa, *States Eye Public Access to More Doctor Disciplinary Records*, AM. MED. NEWS, May 9, 2011, <http://www.ama-assn.org/amednews/2011/05/09/prl20509.htm> (reporting on recent state legislation and propositions aimed at creating more “transparency in the medical profession”).
- 56 See, e.g., HEALTHGRADES, www.healthgrades.com (last visited Dec. 18, 2013) (providing survey results of standard questions relating to how much time a patient had to wait before being seen and whether the doctor spent sufficient time with the patient); RATEMDS, www.ratemds.com (last visited Dec. 18, 2013) (providing anonymous patient reviews of doctors, including allegations bordering on negligence); www.vitals.com (last visited Dec. 18, 2013) (same); see also ADMINISTRATORS IN MEDICINE, www.docfinder.org (last visited Dec. 18, 2013) (this website is operated by the Association of State Medical Board Executive Directors and offers links to web pages for various state medical boards).
- 57 Thomas D. Lehrman, *Reconsidering Medical Malpractice Reform: The Case for Arbitration and Transparency in Non-Emergent Contexts*, 36 J. HEALTH L. 481 (2003).
- 58 See, e.g., Havighurst & Metzloff, *supra* note 20, at 184-85 (noting the possibility that “lower costs and quicker results associated with ADR would actually cause more cases to be litigated”).

than there are malpractice lawsuits, then a large, untapped pool of potential plaintiffs must exist who could theoretically pursue their claims in a less expensive forum.⁵⁹ Indeed, the high costs of pursuing a medical malpractice claim implies that only those cases in which the plaintiff's injury is relatively severe and the potential damages are large are likely to be heard.⁶⁰ But, if arbitration is indeed cheaper and faster — as its advocates often claim — many more cases of less serious malpractice could ostensibly be heard in the arbitral fora, to the detriment of defendant doctors and other healthcare providers.

This is a difficult argument to evaluate in the absence of reliable data on the relative costs of med mal claims in arbitration.⁶¹ We do not know, for example, whether malpractice arbitration will really be as cheap and efficient as its proponents contend.⁶² And, in any event, there are serious reasons to doubt that arbitration will increase the number of claims or the overall cost of claim resolution to defendants and their insurers. Claimants will hardly be attracted

59 Though, as Thomas Metzloff aptly points out, “it cannot be the case that an arbitration system, on the one hand, is inherently derogatory of patient’s rights, while, on the other hand, it is likely to result in an explosion of successful and lucrative awards to plaintiffs.” Metzloff, *supra* note 44, at 210; *see also* James A. Henderson, Jr., *Agreements Changing the Forum for Resolving Malpractice Claims*, 49 *LAW & CONTEMP. PROBS.* 243, 244 (1986) (“Recipients suffering relatively minor injuries that might not be worth a lawyer’s time to litigate on a contingent fee basis may find arbitration to be a more viable, and thus preferable, alternative.”).

60 Tom Baker & Timothy Lytton, *Allowing Patients to Waive the Right to Sue for Medical Malpractice*, 104 *NW. L. REV.* 233, 235 (2010).

61 Indeed, for purposes of comparison, we would first need “a rigorous cost-benefit analysis” of the existing med mal litigation regime, which itself would prove “an extraordinarily difficult task.” *Id.* at 234; *see also* Powsner & Hamermesh, *supra* note 21, at 287 (noting that authors of a report on Michigan’s proposed arbitration statute had concluded it was “virtually impossible to predict whether arbitration would reduce the number of large judgments”) (citations omitted).

62 *See, e.g.*, Utah State Bar, *Mandatory Binding Arbitration of Medical Malpractice Claims in Utah*, *UTAH BAR J.*, Oct. 2003, http://webster.utahbar.org/barjournal/2003/10/mandatory_binding_arbitration.html (“Arbitration of complex claims typically does not produce a faster decision, nor does the arbitration of complex claims generally save money.”). Note that the costs of arbitration would have to compare favorably to the costs of litigation, which is estimated at about two percent of total healthcare spending. *See* TOM BAKER, *THE MEDICAL MALPRACTICE MYTH* 22 (2005); CONG. BUDGET OFFICE, *CBO’S ANALYSIS OF THE EFFECTS OF PROPOSALS TO LIMIT COSTS RELATED TO MEDICAL MALPRACTICE* (2009), available at http://www.cbo.gov/ftpdocs/106xx/doc10641/10-09-Tort_Reform.pdf.

by the relative inability to obtain discovery, which is often critical in medical cases.⁶³ Likewise, contractual limitations on punitive and consequential damages are surefire claim repellants, and reduce the exposure of defendants and their insurers.⁶⁴ Of similar effect are provisions forcing claimants to advance a portion of the fees paid to neutrals or shifting the entire arbitrator fee onto a losing party.⁶⁵ Moreover, there is no telling the extent to which a physician-arbitrator may come to usurp the role traditionally played by the expert chosen by plaintiff's counsel.⁶⁶ While plaintiffs in the court system must pay their own experts, the prospect of shelling out real money for an arbitrator-cum-expert wholly outside the control of counsel is, presumably, a chilling prospect as well. So while it will take some time before empirical data is available on the narrow question of whether more med mal claims are brought in arbitration than in litigation, the procedures and practices of the arbitral fora may, in and of themselves, discourage significant numbers of claimants from choosing this regime.

Some observers have also posited that doctors may not want to sully their nascent relationships with new patients by foisting upon them arbitration provisions. After all, an arbitration clause may signal litigiousness by invoking the specter of medical injury. Others dismiss this concern, noting that the "private, arguably less adversarial arbitration proceeding enhances the possibility

63 For example, the AAA's Healthcare Payor-Provider Arbitration Rules, which govern billing-related disputes, limit discovery to one deposition per party unless ordered by the arbitrator. *See* 5 Commercial Arbitration Appendix A21, Healthcare Payor Provider Arbitration Rule 19 (Jan. 31, 2011). Similarly, the rules of the American Health Lawyers Association (AHLA) provide that the "arbitrator may allow the parties to conduct such reasonable discovery and exchange exhibits as the arbitrator believes necessary or proper." *See* AHLA ADR Rules of Procedure for Arbitration, Appendix II, Rule 4.02; *see also* *Foremost Yarn Mills v. Rose Mills*, 25 F.R.D 9 (E.D. Pa. 1960) (finding that the FAA does not make discovery procedures available to parties to an arbitration).

64 *See* David B. Simpson, *Compulsory Arbitration: An Instrument of Medical Malpractice Reform and a Step Towards Reduced Health Care Costs*, 17 SETON HALL LEGIS. J. 457, 466 (1993) (recommending arbitration clauses "incorporate specific limitations on the amounts or types of damages that may be awarded for a health provider's negligent or otherwise substandard performance of his duties").

65 *Id.* (discussing the payment of arbitral fees).

66 *See, e.g., id.* at 465 (voicing concern that arbitrators might be viewed as "creatures of, or to be co-opted by, any interested constituency, especially . . . health care providers or medical insurers").

of continuing positive relationships” between doctors and their patients.⁶⁷ At any rate, if we believe that consumers are not generally aware of the existence of arbitration clauses in the contracts they sign on a daily basis,⁶⁸ patients seeking medical attention are even less likely to read the fine print.⁶⁹ And even if they were, it is not at all clear that patients would attach a negative value to arbitration clauses at the time of contracting. Indeed, scholars such as Omri Ben-Shahar and Carl Schneider have shown that the vast majority of patients do not read medical disclosures, nor have the sophistication to understand or use the information contained within them.⁷⁰ In any event, I rather expect that, viewed *ex ante*, the prospect of medical malpractice litigation often appears very remote.⁷¹

67 Nevers, *supra* note 18, at 49-50; Rolph et al., *supra* note 16, at 155 (noting that “this attribute is a particularly important feature in the case of health care disputes where a claimant’s well-being may depend on continuity of care”); David Zukher, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will a Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 157-58 (1998).

68 See generally MARGARET JANE RADIN, *BOILERPLATE: THE FINE PRINT, VANISHING RIGHTS AND THE RULE OF LAW* 21 (2013) (describing the “sheer ignorance” of consumers in accepting contractual terms that limit or eliminate their legal rights); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173 (1983) (asserting that consumers rarely read contracts, or understand the various terms and conditions which they “agree” to when purchasing goods and services).

69 See Havighurst & Metzloff, *supra* note 20, at 191 (“[P]rivate contracts have generally not been viewed as useful instruments of consumer choice; instead, they have been seen primarily as vehicles by which powerful payers or providers can exploit consumer ignorance and deny desirable care.”).

70 Omri Ben Shahar & Carl Schneider, *The Failure of Mandated Disclosure*, 159 U. PA. L. REV. 647 (2011).

71 Note there is an important debate in the literature on replacing the state-run medical malpractice liability regime with contractual liability that this Article does not directly touch upon. Compare Jennifer Arlen, *Contracting Over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 959 (2010), with Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 505 (2005). While arbitration agreements raise facially similar questions about private ordering and informed decision-making, the debate on contracting over liability posits that “contracting is voluntary and patients know the expected benefits and costs of liability,” so these informed patients can bargain for optimal liability rules. My claim is that mandatory, pre-dispute arbitration agreements are not bargained-for provisions; they are imposed (possibly with notice) and

In the end, the traditional reasons for the medical industry to resist a broad-scale move of med mal claims to the arbitral arena seem fairly weak. For the same reasons that virtually all other business-to-consumer industries have ensured that consumer claiming proceed in arbitration (with liability avoidance surely near the top of that list of reasons), one might expect that the medical services industry would make broad use of standard-form arbitration provisions in all manner of patient agreements, both with insurers and healthcare providers.

B. Recent Trend #1: Judicial Embrace of Arbitration

To my mind, the most compelling rationale for the hesitancy in healthcare to date has been the uncertainty surrounding the judicial attitudes towards the enforceability of arbitration clauses in this context.⁷² Whether couched in terms of substantive unconscionability,⁷³ public policy,⁷⁴ lack of consent, or any number of doctrinal categories, judicial decisions on the enforceability of arbitration clauses have — until fairly recently — been quite solicitous of plaintiffs' rights. This judicial solicitude had a perfect partner in medical malpractice arbitration, where the adhesive nature of the medical agreement and the weaker party's inability to appreciate the consequences of "consent" provided abundant grounds for unenforceability.⁷⁵

enforced in the event of an injury. There is no quid pro quo, no negotiation, and no reduction in levels of care or cost; the only difference is the forum in which the injury claims are adjudicated. *See, e.g.,* RADIN, *supra* note 68, at 30 (arguing that the absence of informed consent to contractual terms undermines private ordering).

72 *See* Henderson, *supra* note 59, at 248 (describing in 1986, before the Supreme Court's string of pro-arbitration decisions, the judicial reactions to the enforceability of arbitration agreements as "present[ing] a somewhat troubling picture for reliance on arbitration by health care providers").

73 *See, e.g.,* Wheeler v. St. Joseph Hosp., 133 Cal. Rptr. 775, 782-91 (Ct. App. 1976) (holding an arbitration agreement in a hospital admission form unconscionable due to the patient's lack of knowledge as to the existence of the clause).

74 *See, e.g.,* Beynon v. Garden Grove Med. Grp., 161 Cal. Rptr. 146 (Ct. App. 1980) (finding an arbitration clause in a healthcare contract void as against public policy).

75 *See, e.g.,* Wheeler v. St. Joseph Hospital, 133 Cal. Rptr. 775 (Ct. App. 1976); Broemmer v. Abortion Serv. of Pheonix, Ltd., 840 P.2d 1014 (Ariz. 1992) (finding consent to arbitrate malpractice claims lacking); Sosa v. Paulos, 924 P.2d 357 (Utah 1996) (provision requiring patient to pay half of doctor's arbitration costs deemed unconscionable).

But, as discussed above, much of the uncertainty surrounding the general enforceability of arbitration clauses has surely abated in light of recent Supreme Court jurisprudence, which all but guarantees the availability of arbitration in the medical malpractice context. Most unconscionability and public policy-based challenges to arbitration clauses are unavailable after *Concepcion*.⁷⁶ This is not to say that courts are not still enraptured by unconscionability analyses, even in the wake of *Concepcion*, as the West Virginia court in *Marmet* and others reveal.⁷⁷ But at least some courts are beginning to absorb the reality that there is simply no basis under the FAA for treating healthcare contracts differently from other contractual agreements to arbitrate.⁷⁸ Further, to the limited extent that state statutes have restricted the availability of malpractice arbitration — like the Georgia statute providing that med mal arbitration is only available if the patient ratifies the arbitration agreement post-injury⁷⁹ — these laws are preempted by the FAA under any reading of *Concepcion*. Most importantly, the healthcare industry is waking up to the reality that these

76 *But see* Franks v. Bowers, 2013 WL 3064807 (Fla. 2013). In this recent decision, the Florida Supreme Court considered the enforceability of a voluntary arbitration clause which limited the plaintiff's damages in violation of state public policy as expressed in the legislative scheme to encourage arbitration of medical malpractice claims. Finding that the damages limitation "contravenes legislative intent in a way that is clearly injurious to the public good violates public policy," the court deemed the arbitration clause unenforceable. *Id.* at 7.

77 *See, e.g.*, Spring Lake NC, L.L.C. v. Beloff, 2013 WL 854586 (Fla. 2013) (reversing trial court's denial of motion to compel arbitration based on analysis of procedural unconscionability factors).

78 *See, e.g.*, Raymond v. Kram, 2012 WL 6063275 (Cal. Ct. App. 2012) (reversing trial court denial of motion to compel arbitration in med mal case, finding agreement was not substantively unconscionable because it required patient to pay neutrals' fees); SA-PG Sun City Ctr., LLC v. Kennedy, 79 So. 3d 916 (Fla. Dist. Ct. App. 2012) (reversing trial court denial of motion to compel arbitration, finding agreement not procedurally unconscionable); King v. Bryant, 737 S.E.2d 802 (N.C. 2013) (reversing trial court denial of motion to compel arbitration in a med mal case, finding arbitration agreement enforceable under Supreme Court precedents); *see also* Arlen, *supra* note 71, at 962 n.12 ("Courts also now enforce clauses requiring mandatory arbitration of medical claims; these clauses affect expected liability.").

79 *See, e.g.*, GA. CODE ANN. § 9-9-62 (Supp. 1992) (requiring physician to acquire the claimant's consent to arbitrate after the date of the physician's alleged negligence and only if the patient has consulted with an attorney).

legislative and judicial roadblocks to enforcement of arbitration clauses are no longer controlling.⁸⁰

C. Recent Trend #2: Rolling Back on Reforms?

Even as prior impediments to arbitration have fallen away, there might still be a strong sense in the medical community that the traditional litigation system — while far from perfect — is a known quantity, where the “repeat players” have gained “a certain comfort level with the protections afforded by the litigation process.”⁸¹ After all, litigation outcomes favor doctors by a wide margin: only about four to seven percent of injured patients file a lawsuit; very few (five to seven percent) of those suits get to a jury; and nearly seventy-eight percent of all malpractice suits are resolved in favor of defendants.⁸² Further, fewer med mal lawsuits are filed each year, with steady declines at all levels of injury.⁸³ We might therefore imagine that doctors and insurers would be unwilling to trade this success for the greater uncertainty and financial risk associated with experiments in new adjudicative regimes.

It is reasonable to believe that tort reform measures have played a key role in suppressing med mal claiming by providing defendant-friendly modifications of the ordinary rules governing litigation.⁸⁴ Forty states have enacted some

80 See, e.g., JULIE BARGNESI & JAMES MARRA, RECENT DEVELOPMENTS IN LONG TERM CARE LITIGATION: THE RISE OF CLASS ACTIONS AND THE EFFECT OF CONTRACTUAL ARBITRATION CLAUSES (2012).

81 Nevers, *supra* note 18, at 49; accord Michelle M. Mello et al., *Policy Experimentation with Administrative Compensation for Medical Injury: Issues Under State Constitutional Law*, 45 HARV. J. ON LEGIS. 59, 62 (2008) (“Despite widespread dissatisfaction with medical malpractice litigation, many stakeholder groups have vested interests in the status quo and could be expected to resist any [change].”).

82 See Anupam B. Jena, Seth Seabury, Darius Lakdawalla & Amitabh Chandra, *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629 (2011) (analyzing data from 1991-2005); see also BAKER, *supra* note 62, at 83-87 (reviewing empirical evidence on med mal litigation outcomes).

83 One study based on the NPDB data found that the number of malpractice awards had fallen 19.6% from 1991 to 2001. Katherine Baicker & Amitabh Chandra, *The Effect of Malpractice Liability on the Delivery of Health Care* 3 (Nat’l Bureau of Econ. Research, Working Paper No. 10709, 2004); see also PUB. CITIZEN, MEDICAL MALPRACTICE PAYMENTS DECLINED AGAIN IN 2010, at 2 (2011), available at <http://www.citizen.org/documents/NPDB-2010.pdf>.

84 CYNTHIA G. LEE & ROBERT C. LAFONTAINE, MEDICAL MALPRACTICE LITIGATION IN STATE COURTS (2011), available at <http://www.courtstatistics.org/flashmicrosites/csp/images/ch-18-1.pdf> (reporting on a 2011 study of court filings finding that

form of medical malpractice litigation reform over the past decades, affecting the ability of plaintiffs to (1) commence litigation (by, for example, shortening the relevant statute of limitations); (2) adjudicate claims (by raising standards for admissibility of expert testimony, requiring pretrial screening panels, or implementing heightened pleading or evidentiary standards); or (3) be compensated upon a verdict or settlement in their favor (by capping damages, limiting or eliminating joint and several liability, capping attorneys' fees, imposing collateral-source offsets, and requiring heightened burden of proof for punitive damages).⁸⁵ These reform measures were generally premised on the need to provide healthcare providers protection against the vagaries of frivolous claims and runaway jury verdicts.

But there are some signs that the traditional litigation system may become somewhat less friendly to med mal defendants, as courts and legislatures undertake to reconsider at least some of these reform measures.⁸⁶ For example, damage caps — the signature plank of most tort reform measures — have been challenged on due process and access to justice grounds in twenty-eight states,⁸⁷ and ruled unconstitutional in eleven.⁸⁸ In some jurisdictions, legislatures

medical malpractice litigation “represented well under 2% of all incoming civil cases, and less than 8% of incoming tort cases” and that med mal “filings from 1999 to 2008 fell somewhere between 22-45%,” depending on the practice area); NAT’L CTR. FOR STATE COURTS, TORT REFORMS CAN SHAPE MEDICAL MALPRACTICE CASELOAD TRENDS (2012), available at <http://www.courtstatistics.org/Civil/CivilMedicalMalpractice.aspx> (reporting that med mal filings had fallen by 18% in the seven states with reliable data).

85 Robert Winning, *Direct Regulation of Medical Malpractice Premiums: The Least Dangerous Reform*, 2010 COLUM. BUS. L. REV. 281, 282 (2010); see also David M. Studdert et al., *Medical Malpractice*, 350 NEW ENG. J. MED. 283, 287 (2004) (describing reform measures enacted during the three main medical malpractice “crises”); RONEN AVRAHAM, DATABASE OF STATE TORT LAW REFORMS (DSTLR 4TH 1980–2010), <http://www.utexas.edu/law/faculty/ravraham/dstlr.html> (last visited Mar. 18, 2014).

86 See, e.g., Ronen Avraham, *An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Payouts*, 36 J. LEGAL STUD. S183 (2007) (“Dozens of different reforms have been enacted, struck down, or reenacted in the recent decades.”).

87 See Carly N. Kelly & Michelle M. Mello, *Are Medical Malpractice Damages Caps Constitutional? An Overview of State Litigation*, 33 J.L. MED. & ETHICS 515 (2005).

88 Eleven state courts have overturned damages caps as unconstitutional, and some of these have been reinstated; currently, eight states have judicially overturned damages caps that have not been reinstated. See *Moore v. Mobile Infirmary Ass’n*, 592 So. 2d 156, 163 (Ala. 1992) (declaring \$400,000 economic damage

have responded by reenacting new caps;⁸⁹ but notably, some states have done so while restoring a degree of discretion to trial judges to determine whether to exceed the cap in especially egregious cases.⁹⁰

State courts have also invalidated other aspects of medical malpractice reform legislation.⁹¹ Ronen Avraham, in his empirical study of the impact of medical malpractice reforms, found that a significant number of statutory reform measures have been judicially nullified.⁹² According to this study, legislation abrogating joint and several liability and the collateral source rule, requiring periodic payment of large damage awards, and imposing pretrial screening panels have been amongst the many reformist measures struck down by courts.⁹³

cap unconstitutional); *Atlanta Oculoplastic Surgery, P.C. v. Nestlehutt*, 691 S.E.2d 218 (Ga. 2010) (declaring the state's \$350,000 damage cap in med mal cases unconstitutional); *Lebron v. Gottlieb Mem'l Hosp.*, 930 N.E.2d 895, 914 (Ill. 2010) (same); *Watts v. Lester E. Cox Med. Ctrs.*, 376 S.W.3d 633 (Mo. 2012) (\$350,000 cap on noneconomic damages unconstitutional); *Brannigan v. Usitalo*, 587 A.2d 1232 (N.H. 1991) (\$875,000 cap on noneconomic damages unconstitutional); *State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 715 N.E.2d 1062 (Ohio 1999) (same); *Lakin v. Senco Products, Inc.*, 987 P.2d 463 (Or. 1999) (\$500,000 cap on noneconomic damages unconstitutional); *Ferdon v. Wisconsin Patients Compensation Fund*, 701 N.W.2d 440 (Wis. 2005). Massachusetts, Mississippi, West Virginia and Nevada have also overturned or rolled back damages caps. See Kevin Sack, *Illinois Court Overturns Malpractice Statute*, N.Y. TIMES, Feb. 5, 2010, at A13 ("According to the American Medical Association, courts in 16 states have upheld the laws [imposing damage caps in med mal cases], while those in 11 states have overturned them.").

89 For example, courts in North Dakota, Ohio, Oklahoma, Texas and Wisconsin have struck down damage caps on various constitutional grounds, and their legislatures have responded by enacting new caps seeking to avoid the problems of due process identified by the judiciary.

90 See, e.g., FLA. STAT. ANN. § 766.118 (if the medical negligence resulted in a permanent vegetative state or death, noneconomic damages may exceed the state's one million dollars noneconomic damages cap if the trial court determines that "a manifest injustice would occur," based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe).

91 See, e.g., *Bernier v. Burris*, 497 N.E.2d 763 (Ill. 1986) (invalidating a pretrial screening panel on separation-of-powers grounds).

92 Avraham, *supra* note 86, at S211-12 (detailing judicial reversals of legislative med mal reforms).

93 *Id.* tbl. 6.

Furthermore, some new constitutional challenges to caps are on the horizon. For example, while the constitutionality of California's Medical Injury Compensation Reform Act (MICRA) was upheld in the 1980s,⁹⁴ its \$250,000 cap on damages was set in 1975 and has not been adjusted for cost of living or inflation in thirty-five years; the cap is valued at less than \$100,000 in 2014 dollars. Not surprisingly, a new generation of lawyers and activists are preparing to challenge MICRA on a series of constitutional and policy grounds.⁹⁵ The time is especially ripe given that various studies have reported on the inefficacy of damage caps at reducing malpractice premiums (which were the original basis for enacting the caps),⁹⁶ and that the actual incidence of medical malpractice has remained steady or even increased during this period of med mal reform.⁹⁷ Renewed challenges to other states'

94 *Fein v. Permanente Med. Grp.*, 695 P.2d 665 (Cal. 1985).

95 The Consumer Attorneys of California (CAOC) has implemented a project to identify med mal cases that might be appropriate to challenge MICRA. *See* CONSUMER ATTORNEYS OF CALIFORNIA, www.caoc.com/MICRAchallenge (last visited Apr. 21, 2013).

96 *See* U.S. GOV'T ACCOUNTABILITY OFFICE, *MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE* (2003); *see also* BAKER, *supra* note 62, at 51-58; *Weiss Ratings: Caps Fail to Contain Malpractice Cost Increases*, S. FLA. BUS. J., June 2, 2003, www.bizjournals.com/southflorida/stories/2003/06/02/daily3.html?page=all (reporting on studies finding that states with damages caps had higher medical malpractice insurance premium increases, while states without damages caps maintained stable rates; among states with damages caps, only 10.5% experienced flat or declining premiums, while 18.7% of states without damages caps experienced stable or declining premiums). *But see* CBO, *ECONOMIC AND BUDGET ISSUE BRIEF, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE* (2004), *available at* www.cbo.gov/sites/default/files/cbofiles/ftpdocs/49xx/doc4968/01-08-medicalmalpractice.pdf (concluding that caps are effective at reducing premiums, though have little effect on overall healthcare spending, given that "malpractice costs account for less than 2% of [healthcare] spending").

97 *See, e.g.*, David L. Classen et al., "Global Trigger Tool" Shows That Adverse Events in Hospitals May Be Ten Times Greater Than Previously Measured, 30 *HEALTH AFF.* 581, 581-82, 586 (2011) (implementing a new method for detecting adverse events in a hospital setting); David L. Hudson, Jr., *More States See Tort Limits Challenged as Unconstitutional*, *A.B.A. J.*, Apr. 2013, http://www.abajournal.com/magazine/article/more_states_see_tort_limits_challenged_as_unconstitutional/; Christopher P. Landrigan et al., *Temporal Trends in Rates of Patient Harm Resulting from Medical Care*, 363 *NEW ENG. J. MED.* 2124, 2130, 2133 (2010); Matt Dunning, *Industry Experts Predict a Sharp Rise in Medical Malpractice Claims*, *BUS. INS.*, Oct. 21, 2012, <http://www.businessinsurance.com/>

reform measures also appear likely.⁹⁸ In all, we can rationally assume that some aspects of med mal reform may be struck down in the coming years, and that even new reform legislation enacted in the wake of these upcoming decisions could take different, less industry-friendly forms.

Consequently, if medical malpractice reform measures face these uncertainties, there is good reason for providers and their insurers to expect an increase in med mal claims (especially at a time when a generation of aging baby boomers is just beginning to demand unprecedented levels of medical services⁹⁹). They may also foresee higher awards and overall increased costs. Taken together, this may suggest to doctors, hospitals and insurance companies that public adjudication of medical malpractice claims — without all the protections of reform statutes — may soon grow more hostile, expensive, and difficult.

Arbitration provides a ready option.¹⁰⁰ Protected by the FAA, in a post-*Concepcion* world, consensual arrangements providing for damage caps, heightened pleading, shortened statutes of limitation, the abolition of joint-and-several liability, collateral-source offsets, and other measures are virtually beyond challenge in state law cases. Whatever uncertainties attend constitutional or political challenges to tort reform legislation surely have little effect on private ordering that achieves the same result.¹⁰¹

article/20121021/NEWS06/310219983 (reporting that “[m]edical malpractice claim severity and frequency for hospitals and employed physicians nationwide are projected to have grown by 2.5% and 1% respectively”).

98 For example, in *Klotz v. St. Anthony's Med Ctr.*, 311 S.W.2d 752 (Mo. 2010), the Missouri Supreme Court issued a limited finding that the state's new damages cap could not constitutionally be applied to claims accruing before the effective date of the amendment. But, “in an encouraging sign for a future challenge,” two Justices dissented on the grounds that the caps themselves may be unconstitutional. See also AM. MED. ASS'N, CAPS UNDER FIRE (2011) (identifying “at least seven state court battles that could impact medical liability damages caps”).

99 See Matt Dunning, *Med Mal Claims Data Raises Fears*, BUS. INS., Oct. 2012, at 4 (predicting that “the sustained increase in the demand for medical care among aging baby boomers” will lead to even greater increases in medical malpractice claims in coming years).

100 One possibly illuminating study could chart increases in motions to compel arbitration by medical insurers or providers in jurisdictions that never enacted or that are currently rolling back on some of the more protective types of tort reform, such as damages caps, from *Concepcion* onward.

101 Compare Judith Resnik, *Procedure as Contract*, 80 NOTRE DAME L. REV. 593, 597 (2005) (describing arbitration agreements as “mini-codes of civil procedure” that are “created by . . . a multitude of private providers”), with Epstein, *supra* note 71, at 509 (“[I]t seems clear that the most forthright and sensible way to

CONCLUSION

The central issue addressed in this Article is whether it is reasonable to expect the medical field to follow the lead of other business-to-consumer industries in the headlong march into arbitration. The critical players here are the insurance companies. If malpractice insurers come to require that providers include arbitration clauses in their arrangements with patients (whether by direct contract or via health plans), then arbitration will take over. Courts' and state unconscionability law will not stand in the way — not in this era. Nor will patients. In industry after industry, experience teaches that consumers do not assign value, *ex ante*, to dispute resolution procedures, and there is no basis to believe that patients or the insured will or even could balk at standard-form arbitration clauses.

So the question really is whether insurance companies will conclude they are better served in the arbitral forum — whether arbitration will produce lower costs overall, taking into account claiming rates, settlement amounts, win-loss rates, transaction costs and other factors. One thing seems clear: if there is a substantial increase in med mal arbitrations, it will be because the insurers — like other consumer-facing industries everywhere — have come to value the ability to promulgate defendant-friendly provisions under the cover of FAA Section 2 and to place fact-finding in the hands of repeat-players dependent on the industry for their engagements.¹⁰² And while the medical services industry, substantially buffeted by tort reform, has seemingly fared very well in judicial fora — at least on the dimension of win-loss rates — I imagine that industry decision-makers are eyeing the even greener pastures of arbitration, lit as they are by the welcoming rays of the Supreme Court's recent jurisprudence.

deal with the liability crisis is to remove the minimum constraints on liability set by law and allow the parties to cut their own deals.”).

102 Simpson, *supra* note 64, at 465 (voicing concern that arbitrators might be viewed as “creatures of, or to be co-opted by, any interested constituency, especially . . . health care providers or of medical insurers”).

