

NOTES

MEDICAL MALPRACTICE ARBITRATION: A PATIENT'S PERSPECTIVE

The medical malpractice "crisis" of the mid-1970s produced significant changes in the health care system nationwide. Physicians and hospitals faced skyrocketing malpractice insurance rates.¹ Many experienced difficulty procuring coverage² because insurers could no longer bear the risks of carrying medical malpractice insurance.³ The dramatic increase in the number of malpractice claims⁴ filed and the

1. Between 1960 and 1970, premiums for dentists rose 115%, for hospitals 262.7%, for physicians 540.8%, and for surgeons 949.2%. A surgeon paying 1.2% of gross income in 1964 for professional liability insurance paid 4.2% in 1970. U.S. DEPT OF HEALTH, EDUCATION & WELFARE, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE 13 (1973) [hereinafter cited as HEW REPORT].

Premiums for physicians in California rose 500% from 1974 to 1976. CALIFORNIA OFFICE OF AUDITOR GENERAL: THE MEDICAL MALPRACTICE INSURANCE CRISIS IN CALIFORNIA (December 1975). See AMERICAN HOSPITAL ASSOCIATION, SURVEY OF MALPRACTICE INSURANCE CONDITIONS (July 11, 1975); Comment, *Michigan's Medical Malpractice Legislation—Prognosis: Curable Defects*, 55 U. DET. J. URB. L. 309 (1978).

2. Doctors in "high risk" specialties, such as surgeons and anesthesiologists, faced complete cancellation of their policies. Solimine, *Ohio's Rx for the Medical Malpractice Crisis: The Patient Pays*, 45 U. CIN. L. REV. 90, 90 (1976).

Reduced availability of malpractice insurance for physicians and hospitals "led to a general increase in the cost of medical care and a decrease in the availability of medical services in some areas." Note, *Medical Malpractice Arbitration: Time for a Model Act*, 33 RUTGERS L. REV. 454, 454-55 (1981). See also Heintz, *Arbitration of Medical Malpractice Claims: Is It Cost Effective?*, 36 MD. L. REV. 533 (1977).

3. In Michigan, only one carrier writing physician insurance continued doing so after June 1, 1975. Shelby Mutual, which insured 20% of the physician market, and Argonaut Insurance Co., which wrote 25% of the hospital liability policies, pulled out of the market completely after June 1, 1975. R. LERNER, AMERICAN ARBITRATION ASS'N, MEMORANDUM: THE MICHIGAN MALPRACTICE ARBITRATION PLAN (May 10, 1975) (unpublished memorandum) [hereinafter cited as LERNER MEMORANDUM]. See also Siedel, *Malpractice Reform in Michigan*, 1976 DET. C.L. REV. 235, 236.

For a comprehensive statistical analysis of the insurance crisis between 1960-1972, see U.S. DEPT OF HEALTH, EDUCATION & WELFARE, REPORT OF THE SECRETARY'S COMM'N ON MEDICAL MALPRACTICE: APPENDIX 494 (1973) [hereinafter cited as HEW APPENDIX].

4. See HEW REPORT, *supra* note 1, at 8. See generally Heintz, *Medical Malpractice Arbitration: A Successful Hospital-Based Application*, 680 INS. L.J. 515 (1979); Jones, *Medical Malpractice Litigation: Alternatives for Pennsylvania*, 19 DUQ. L. REV. 407 (1981); Nocas, *Arbitration of Medical Malpractice Claims*, 13 FORUM 254 (1977); Note, *The Impact of Arbitration on Medical Malpractice: Madden v. Kaiser Foundation Hospitals*, 10 LOY. L.A.L. REV. 613 (1977).

One student author deemed the increase in medical malpractice claims a "legal rights explo-

size of jury awards⁵ significantly contributed to these escalating insurance rates. To protect themselves from possible litigation, doctors practice "defensive medicine"⁶ by performing unnecessary or extra procedures, contributing to the cost and maldistribution of health care resources. Increasing dissatisfaction with the inefficiencies associated with the traditional litigation process, such as delays in getting to trial, inability of lay jurors to comprehend technical medical testimony, and excessive jury awards,⁷ caused several state legislatures to sanction an

sion." Comment, *Recent Medical Malpractice Legislation—A First Checkup*, 50 TUL. L. REV. 655, 658 (1976).

5. In April 1975, the White House Conference on malpractice found that the average jury verdict in 1974 rose to \$103,000, up 60% from 1973 and up 200% from 1969. LERNER MEMORANDUM, *supra* note 3, at 3.

6. HEW Secretary Caspar Weinberger estimated that "defensive medicine" cost the public up to \$8 billion in 1974. LERNER MEMORANDUM, *supra* note 3, at 1. As much as \$1.4 billion of this total was on unnecessary X-rays alone. INSURANCE COMM'N, MICH. DEP'T OF COMM, MEDICAL MALPRACTICE IN MICHIGAN: A REPORT TO GOVERNOR WILLIAM G. MILLIKEN 2 (1975) [hereinafter cited as MEDICAL MALPRACTICE IN MICHIGAN]. Examples of "defensive medicine" include:

1. excessive utilization of X-ray and routine diagnostic procedures;
2. excessive utilization of laboratory tests;
3. additional office visits to follow-up medical conditions which might give rise to complications;
4. excessive utilization of medical consultations;
5. more instances of hospitalization for borderline cases which might be treated as well at home;
6. extended hospitalization of patients following surgery to avoid the possibility of premature discharge and possible complications at home.

Bernzweig, *Defensive Medicine*, in HEW APPENDIX, *supra* note 3, at 39.

The threat of litigation may also make doctors more reluctant or unwilling "to treat patients suffering from afflictions which require treatments or risky procedures that carry a low rate of success." MICH. H.R. LEGIS. ANALYSIS SECTION, SPECIAL ANALYSIS 2 (April 1975).

A comprehensive study of the practice of defensive medicine revealed three kinds of defensive medicine:

1. Positive defensive medicine—"is the conducting of a test or performance of a diagnostic or therapeutic procedure which is not medically justified but is carried out primarily (if not solely) to prevent or defend against the threat of medical-legal liability."
2. Negative defensive medicine—"occurs when a physician does not perform a procedure or conduct a test because of the physician's fear of a later malpractice suit, even though the patient is likely to benefit from the test or procedure in question."
3. Reluctance to publish adverse consequences in journals—"describing in detail noted adverse effects of diagnostic and therapeutic procedures. The fear is that the material will be picked up and used as evidence in a lawsuit."

HEW REPORT, *supra* note 1, at 14. See also *Project: The Medical Malpractice Threat: Study of Defensive Medicine*, 1971 DUKE L.J. 939; Comment, *supra* note 1, at 309.

7. The jury system is often criticized for its inability to resolve medical malpractice disputes. Many claim that the jury is unable to deal with complex medical facts and experts and that juries are vulnerable to emotional appeals by the plaintiff and plaintiff's attorney. See, e.g., Cohn, *Medical Malpractice Litigation: A Plague on Both Houses*, 52 A.M.A.J. 32, 33 (1966). Others claim that

alternative dispute resolution forum for medical malpractice claims: Arbitration.⁸

Presently, twelve states⁹ and Puerto Rico¹⁰ have statutes specifically providing for binding arbitration of medical malpractice disputes. In arbitration, disputants agree¹¹ to submit their claim for settlement to an independent panel¹² in lieu of a full-scale trial. Because arbitration was historically faster and less costly than litigation,¹³ the state legislatures believed it would help hold down the cost of insurance and increase its availability to health care providers.¹⁴

In their haste to promote arbitration, these states may deprive the

a jury will overcompensate a plaintiff with visible injuries and undercompensate a plaintiff with little visible damage. LERNER MEMORANDUM, *supra* note 3, at 2. See also Lash, *Arbitration of Medical Malpractice Disputes as a Response to the Medical Malpractice Crisis: Panacea or Pandora's Box for Insurers?*, 46 INS. COUNS. J. 102, 102 (1979).

Moreover, the delays and expenses associated with litigation present special problems for the parties. Because it is so expensive to go to court, many insurance companies may feel the pressure to settle, thereby creating a "file and settle syndrome." Plaintiff's lawyers may be reluctant to take small claims which may not adequately provide compensation for time and effort spent. HEW REPORT, *supra* note 1, at 19.

8. Arbitration is defined as: "The reference of a dispute to an impartial (third) person chosen by the parties to the dispute who agree in advance to abide by the arbitrator's award issued after a hearing at which both parties have an opportunity to be heard." BLACK'S LAW DICTIONARY 96 (5th ed. 1979).

9. ALA. CODE § 6-5-485 (1977); ALASKA STAT. § 09.55.535 (Supp. 1981); CAL. CIV. PROC. CODE § 1295 (Deering 1981), GA. CODE ANN. § 7-402 (Supp. 1982); ILL. ANN. STAT. ch. 10, ¶ 201 (Smith-Hurd Supp. 1982); LA. REV. STAT. ANN. § 9:4230 (West Supp. 1982); ME. REV. STAT. ANN. tit. 24, § 2701 (Supp. 1982); OHIO REV. CODE ANN. § 2711.21 (Page 1981); S.D. CODIFIED LAWS ANN. § 21-25B-1 (1979); VT. STAT. ANN. tit. 12, § 7002 (Supp. 1982); VA. CODE § 8.01-581.1 (1977 & Supp. 1982). North Dakota recently repealed its arbitration statute, N.D. CENT. CODE § 32-29.1 repealed by 1981 N.D. Sess. Laws ch. 358 § 1.

10. P.R. LAWS ANN. tit. 26, § 4110 (Supp. 1980).

11. See *infra* notes 158-214 and accompanying text for a discussion on the validity of such agreements.

12. See *infra* notes 215-27 and accompanying text for a discussion of the constitutionality of these panels.

13. "[A]rbitration as an alternative procedure . . . would expedite the processing of meretorious claims and reduce the emotional and financial stresses on claimants, the courts, and the medical profession and its insurance carriers." Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947, 947 (1972). See generally Friedman, *Arbitration in Medical Malpractice*, 13 TRIAL 49 (August 1977); Nocas, *supra* note 4; Comment, *supra* note 4.

14. The delays associated with litigation may be partially responsible for extremely high and erratic malpractice insurance rates because insurers are less able to accurately project claims losses. See *infra* note 23-35 and accompanying text. For a statistical analysis of the ability of arbitration plans to expedite claim closures, see *infra* notes 228-51 and accompanying text.

Another commentator suggests the contrary: "[Arbitration] actually may cause an increase [in claim frequency], and a subsequent overall increase in the cost of handling claims since its rela-

patient of valuable rights, including the constitutional right to a jury trial¹⁵ and the ability to receive adequate compensation for injuries. The belief that the patient entered into the arbitration agreement voluntarily may only be illusory.¹⁶ Consequently, a patient may sign away valuable rights at a time, and in a setting, when least able to evaluate the wisdom of selecting arbitration for malpractice claims.

Part I of this Note will examine the cause and effects of the malpractice "crisis" which led these state legislatures to adopt arbitration as an alternative to litigation. Part II will analyze the present state statutes, and Part III will critique the deficiencies present in these statutes. Part IV will evaluate the efficacy of malpractice arbitration to determine whether it is achieving its goals, and will suggest the implementation of statutory safeguards. The author contends that in responding to the financial difficulties of the insurance companies, doctors, and hospitals, state legislatures have inadequately provided protection for the rights of patients.

I. INTRODUCTION: THE SCOPE OF THE "CRISIS"

Several factors have contributed to the rapid increase in malpractice claims in the last few decades. First, greater sophistication in medical technology engenders greater risks.¹⁷ The increased risks not only expose the patient to more danger and uncertainty of success, but also may raise the patient's expectations beyond the efficacy of the medical procedure.¹⁸ Heightened consumerism, moreover, has made patients

tively speedier process may encourage claims which the slowness of the litigation system may have discouraged otherwise." Lash, *supra* note 7, at 104.

Michigan's Malpractice Arbitration Act, which took effect Sept. 1, 1975, purports "to enable insurers to more accurately project losses, [and] it is the belief of its sponsors that this legislation will expedite the settlement and resolution of claims and reduce or stabilize malpractice insurance costs." Desenberg, *Medical Malpractice Arbitration: The New Michigan Statute*, 54 MICH. ST. B.J. 536, 536 (1975). See also Note, *Medical Malpractice—A Question of Insurability*, 80 DICK. L. REV. 594, 596 (1976) (regarding similar legislative goals in the Pennsylvania legislation).

15. See generally J. NOWAK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW 377 (1978); L. TRIBE, AMERICAN CONSTITUTIONAL LAW 568 (1978).

16. See *infra* notes 158-214 and accompanying text.

17. "[A]fter World War II . . . many more people were able to afford, and received [sic] medical care . . . [s]ome of the new diagnostic and therapeutic procedures brought with them new risks of injury; as the potency of drugs increased, so did the potential hazards of using them." HEW REPORT, *supra* note 1, at 3. See also Chapman, *A New Malpractice Crisis?*, 8 LEG. ASPECTS MED. PRAC. 24, 26 (1980); Comment, *supra* note 4, at 655.

18. "Lacking an appreciation of the complexities and hazards of modern medical practice, many patients undervalued the inherent risks and assumed negligent conduct when the final out-

more aware of their rights,¹⁹ thereby fostering additional malpractice claims.

Second, specialization and depersonalization of the medical field has eroded the doctor-patient relationship.²⁰ The development of the medical specialist and team care has created a less intimate physician-patient relationship. This may result in more distrust and misunderstandings between patients and their physicians.²¹ Unfamiliar surroundings and personnel may overwhelm, and place at a distinct disadvantage, the patient seeking medical services, whether from a private physician, clinic, or hospital emergency room. Patients in the medical care setting want to believe that the medical staff will competently relieve their distress. A patient's inability, however, to develop a

come was less than had been expected." HEW REPORT, *supra* note 1, at 3. Another author commented that "medical technology, though highly sophisticated, has yet to overcome all untoward effects of drugs and surgical procedures." Comment, *supra* note 4, at 655. See also 1 D. LOUISELL & H. WILLIAMS, *MEDICAL MALPRACTICE* ¶ 1.01 (1981).

19. The mass media has been criticized as creating "unrealistic expectations about medicine's abilities" through expanded coverage of the latest technological and medical "miracles." HEW REPORT, *supra* note 1, at 3.

One study of the impact of the mass media, particularly of newspaper coverage, on medical malpractice concluded, however, that "despite isolated instances of emotionalism, bias, and inaccuracy, press, radio, and television coverage of medical malpractice cases is, on the whole, straight-forward, factual, and balanced." HEW APPENDIX, *supra* note 3, at 653. See also Comment, *supra* note 1, at 310.

20. Comment, *supra* note 4, at 655. Dr. Ronald E. Gots, Director of the National Medical Advisory Service, argued that the poor relationship persists years after the malpractice crisis. "We still have the same social problems, an expanded medical technology, the dissociation between doctors and patient, and a sense of alienation on the part of the patients." Chapman, *supra* note 17, at 26.

21. HEW REPORT, *supra* note 1, at 3. One physician commentator blamed the medical field for this "patient alienation," which is caused by doctors growing less sensitive to the patients' needs and the increase in the number of foreign doctors. Bachman, *Doctors: Move Closer to Your Patient*, 11 TRIAL 25, 25 (May-June 1975).

The shortage of doctors in this country may also affect the quality of health care.

Most physicians are inundated with more patients than they can handle. As a result, medical practice has lost much of the leisurely grace and personal warmth that it once had; and, physicians out of necessity have had to develop their practices into more of a commercial enterprise than a humanitarian experience.

Wecht, *Medicine: A Commercial Enterprise*, 11 TRIAL 39, 39 (MAY-JUNE 1975). See also Chapman, *supra* note 17, at 26; Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW. & CONTEMP. PROBS. 267 (1970).

One commentator suggested that the breakdown in doctor-patient relations may only be a result, and not a cause, of the malpractice crisis. Instead, he proposed that "the root cause of the current malpractice problem is the substantial number of injuries and other adverse results sustained by patients during the course of hospital and medical treatment." Bernzweig, *Getting to the Root of the Problem*, 11 TRIAL 58, 59 (May-June 1975).

rapport with his physician, "coupled with the frustration of having no effective channel for complaint,"²² may lead to the filing of a claim in the event of disappointing results.

The increase in medical malpractice claims caused significant changes in malpractice insurance. Insurance premiums soared²³ and many health care providers became unable to procure any insurance.²⁴ Insurers faced high, largely unpredictable risks,²⁵ extensive administra-

22. Comment, *supra* note 4, at 655. Creation of a Patient Grievance Mechanism (PGM) to handle formal complaints of patients may ameliorate the unfamiliarity of the hospital setting. See Thompson, Lupton, Renck & Feldesman, *Patient Grievance Mechanisms in Health Care Institutions*, in HEW APPENDIX, *supra* note 3, at 758.

Moreover, a Patient Service Representative, as suggested by the American Hospital Association, may improve communication between the medical staff and patient:

As the liaison between patients and the institution, he provides a specific channel through which patients can seek solutions to problems, concerns, and unmet needs. As management's representative, he interprets the institution's philosophy, policies, procedures . . . [a]s the patients' advocate, he enables patients and families to obtain solutions to problems by acting in their behalf with administration. . . .

Id. at 760.

23. "The cost of a constant level of medical malpractice insurance coverage increased seven-fold for physicians, ten-fold for surgeons, and five-fold for hospitals between 1960-1972." MEDICAL MALPRACTICE IN MICHIGAN, *supra* note 6, at 1-3. These soaring premiums rates were mirrored in every state. See Kendall, *The Medical Malpractice Insurance Market*, in HEW APPENDIX, *supra* note 3, at 494.

Premiums rose more rapidly for physicians in "high-risk" specialties. In New York, neurosurgeons and orthopedic surgeons paid \$14,329 in premiums in 1975, compared to \$2225 in 1969. Note, *Rx for New York's Medical Malpractice Crisis*, 11 COLUM. J. L. & SOC. PROBS. 467, 468-69 (1975). Also in New York, hospital malpractice premium rates rose 316% in a two-year period, from \$348 per bed in 1974 to \$1,447 per bed in 1976. NATIONAL CONFERENCE OF STATE LEGISLATURES, STATE HEALTH NOTES: MEDICAL MALPRACTICE 2 (February 1981).

Between 1960 and 1972, the relative cost of constant level of medical malpractice coverage rose more rapidly in some areas than others; namely, Arizona, California, Colorado, Florida, Michigan, Nevada, New Jersey, and New York. For example, in California, the average premium for a surgeon rose in 1972 to 252.2% of the national average. Kendall, *supra* at 540.

In Michigan, as of 1968, doctors' premiums were 85% of the national average for premiums. In 1972, they rose to 133.8% of the average, and in 1975, the rates were 160% higher than the 1973 rates. Siedel, *supra* note 3, at 236.

24. A 1974 survey conducted by the Michigan State Medical Society revealed that 5.7% of the 40% of all Michigan physicians who responded to the survey were refused renewal on their insurance policies, "while 14.8% had been named as codefendants with a hospital in a law suit." Siedel, *supra* note 3, at 236. See also Anthony, *MSMS Survey Provides First Data on Medical Malpractice Situation*, 73 MICH. MED. 612 (1974).

25. MEDICAL MALPRACTICE IN MICHIGAN, *supra* note 6, at 4. Between 1968 and 1974, one insurer experienced an increase in claims of 139% and an increase in the amount paid to claimants in settlement or by judgment of 117%. Abraham, *Medical Malpractice Reform: A Preliminary Analysis*, 36 MD. L. REV. 489, 490 n.3 (1977).

More recent statistics indicate that this insurance crisis continues. The National Association of Insurance Commissioners reports that between 1976 and 1978, the average payout for malpractice

tive costs, and uncertain returns for their efforts. Consequently, many insurers refused to provide malpractice coverage,²⁶ leaving many health care providers uninsured. Some physicians sought insurance from nonlicensed surplus-time companies which accepted higher risks²⁷ but provided inadequate protection. Many legislatures²⁸ created insurance funds to uncertain availability of insurance for health care providers. Doctors threatened slowdowns and strikes²⁹ to "dramatize the crisis" because many physicians no longer could afford to practice medicine.³⁰

Insurance companies also reacted by shifting away from "occur-

claims rose 28%. As of April 1978, the average cost of a closed claim rose to \$34,081, up 38% from 1976. Chapman, *supra* note 17, at 25.

26. See *supra* note 3 and accompanying text. Many insurance companies left the malpractice liability market, and the arduous task of finding a replacement carrier often resulted in higher premiums. For example, in 1973 in New York, Employers Insurance of Wausau refused to provide such coverage after 24 years of service. Argonaut Insurance Company of California agreed to provide such coverage, but only after a 100% increase in premium rates. Note, *supra* note 23, at 468.

In Pennsylvania, Argonaut agreed to renew policies for the 25% of the physicians it insured in that state only upon the condition of a 207% premium increase. Note, *Medical Malpractice—A Question of Insurability*, 80 DICK. L. REV. 594, 594 (1976).

In *St. Paul Fire & Marine Ins. Co. v. Insurance Comm'r*, 275 Md. 130, 134, 339 A.2d 291, 293 (1975), the Maryland court of appeals reversed the trial court in holding that St. Paul Fire & Marine Insurance Co. could avoid renewing malpractice insurance in Maryland for 3600 physicians after incurring a deficit of \$10 million. See also Quinn, *The Health Care Malpractice Claims Statute: Maryland's Response to the Medical Malpractice Crisis*, 10 U. BALT. L. REV. 74, 77 (1980).

27. Between 1973 and 1974, Michigan experienced a 40% increase in doctors obtaining insurance in this manner. MEDICAL MALPRACTICE IN MICHIGAN, *supra* note 6, at 2.

28. The goal of these professional liability insurance funds is to enable health care providers who are ineligible or unable to procure insurance on their own to obtain insurance at a reasonable premium. See Siedel, *supra* note 3, at 240.

"Risk-pooling mechanisms, such as joint underwriting associations [JUAs]. . . operate as a safeguard against total cancellation of professional liability coverage by requiring that all liability insurance carriers in a state join together to supply such coverage at the behest of the insurance commissioner." Comment, *supra* note 4, at 661.

See, e.g., LA. REV. STAT. ANN. § 40:1299.46 (West 1977); MD. ANN. CODE art. 48A, § 548 (1979 & Supp. 1981); MICH. STAT. ANN. § 24.125000 (Supp. 1981); N.Y. INS. LAW § 681 (McKinney Supp. 1981); PA. STAT. ANN. tit. 40, § 1301.701 (Purdon Supp. 1982).

29. See Siedel, *supra* note 3, at 238; Solimine, *supra* note 2, at 90.

30. The alarming and sudden increases in these malpractice premiums made practicing medicine prohibitively expensive for some physicians. "Older and part-time physicians have already indicated that their limited practice does not generate sufficient income to warrant the expense of malpractice insurance. . . . physicians may leave the state. This migration, coupled with retirements, would aggravate the present shortage of well-trained physicians." Note, *supra* note 23, at 469.

rence" policies toward "claims-made" policies.³¹ Because an "occurrence" policy covers torts during the policy period³² regardless of when a plaintiff files suit, it provides broad coverage and creates a "long-tail" effect.³³ This delay between the actual tort and the filing of a claim, however, makes it difficult for the insurer to accurately predict losses, and thus, future rate schedules.³⁴ A "claims-made" policy, in contrast, may only cover malpractice claims filed during the policy year, thus providing narrower coverage³⁵ and a lower risk to the insurer.

State legislatures responded swiftly to the crisis, through tort law reform, by statutorily limiting the amount of damage awards,³⁶ and by

31. Note, *The "Claims Made" Dilemma in Professional Liability Insurance*, 22 U.C.L.A. L. REV. 925, 926 (1975). In *St. Paul Fire & Marine Ins. Co. v. Barcy*, 438 U.S. 531 (1978), Rhode Island physicians and their patients brought suit against four insurance companies writing malpractice in the state, alleging a conspiracy in violation of § 3(b) of the Sherman Act. The claimants alleged that three of the four companies refused to sell insurance to any policyholders as a means of compelling them to accept "claims-made" policies. The Supreme Court affirmed the court of appeals in holding that this activity by the insurers constituted a boycott within § 3(b) of the McCarran-Ferguson Act because it foreclosed all opportunity for coverage in the relevant market. *Id.* at 553.

32. *St. Paul Fire & Marine Ins. Co. v. Barcy*, 438 U.S. 531, 553 (1978). "For example, the physician maintaining occurrence coverage knows that once he retires or ceases to practice, the policies he purchased in the past will provide him with complete coverage against any future claims. In contrast, the retired physician who practiced with claims-made insurance must continue to purchase yearly policies after he ceases treating patients and earning money to pay for premiums." Abraham, *supra* note 25, at 493.

33. This "long-tail" may also increase the cost of a claim. For example, a case filed in January 1970 worth \$100,000 will cost \$156,000 to settle in June 1975. LERNER MEMORANDUM, *supra* note 3, at 2.

34. "An 'occurrence' insurer must compute premiums for a professional liability policy at current rates even though claims may become highly inflated long after the premiums cease to be paid. . . . premiums received by this insurer may well be inadequate against the inflated claims of the future." Note, *supra* note 31, at 928-29.

35. Premiums under "claims-made" policies may be lower as well because insurers do not have to predict the risk that a claim will be filed after the expiration of the policy. Note, *supra* note 31, at 929. A "claims-made" policy also shifts the responsibility of the health care provider to invest funds to provide for future claims. Abraham, *supra* note 25, at 493.

One commentator suggested that the skyrocketing premium rates may not have been necessary. "Insurers were accused of raising premiums to recoup losses on the stock market and of computing premium rates in unwarranted secrecy." Solimine, *supra* note 2, at 90.

36. Several states have placed limits on the amount of damages in malpractice actions. See e.g., CAL. CIV. CODE § 3333.2(b) (Deering Supp. 1981) (\$250,000 limit on recovery); IDAHO CODE § 39-4204 (1977) (\$150,000); IND. CODE ANN. § 16-9.5-2-2(b) (Burns Supp. 1982) (\$100,000); LA. REV. STAT. ANN. § 40:1299.42(b)(2) (West 1982) (\$500,000); OHIO REV. CODE ANN. § 2307.43 (Page 1981) (\$200,000); VA. CODE § 8.01-581.15 (1977& Supp. 1981) (\$750,000). But see ILL. ANN. STAT. ch. 70, § 101 (Smith-Hurd Supp. 1981) (repealed P.A. 81-288, § 1 eff. Aug. 28, 1979)

The Illinois Supreme Court in *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347

eliminating *res ipsa loquitur*,³⁷ the collateral source rule,³⁸ and *ad damnum*³⁹ clauses. Extra-litigation reforms included encouraging the use of screening panels⁴⁰ and arbitration⁴¹ to resolve disputes.

N.E.2d 736 (1976), held that the statutory limit of \$500,000 violated the equal protection clause of the Illinois Constitution. *Id.* at 330, 347 N.E.2d at 744.

37. The doctrine of *res ipsa loquitur* may prove "unfair to the physician as it puts him in the position of having to prove his freedom from negligence without the plaintiff having to prove that any negligence occurred." HEW REPORT, *supra* note 1, at 28.

The doctrine applies in cases where foreign objects are left in the body. Plaintiffs, traditionally, have the burden of proving that the injury: "1) must be of a kind which ordinarily does not occur in the absence of someone's negligence; 2) must be caused by an instrumentality or agency within the exclusive control of the defendant; 3) must not have been due to any voluntary action or contribution on the part of the plaintiff." D. LOUISELL & H. WILLIAMS, *supra* note 18, at ¶ 14.04. See Abraham, *supra* note 25, at 499. See also Comment, *The Application of Res Ipsa Loquitur in Medical Malpractice Cases*, 60 Nw. U.L. REV. 852 (1966).

A few jurisdictions have limited or prohibited the use of *res ipsa* in medical malpractice cases to help shift the burden of proof from the defendant-physician. See, e.g., NEV. REV. STAT. § 41A.100 (1979) (creates rebuttable presumption for foreign body cases, burns, or surgery performed on wrong part of body); N.H. REV. STAT. ANN. § 507-C:2 (Supp. 1979) (prohibited); TENN. CODE ANN. § 29-26-115(c) (1980) (limited application of instrumentality within physician's control); WASH. REV. CODE ANN. § 4.24.290 (Supp. 1981) (prohibited).

38. The collateral source rule precludes the jury from considering other sources of compensation in assessing damages, thereby allowing the possibility of double recovery. Redish, *Legislative Response to the Medical Malpractice Insurance Crisis: Constitutional Implications*, 55 TEX. L. REV. 759, 964 (1977). Although use of the rule prevents penalizing plaintiffs for purchasing their own protection, it allegedly "inflated awards by forcing a health-care provider to pay for damages for which an injured patient had already been compensated." Comment, *supra* note 4, at 669.

States abrogating the collateral source rule include: CAL. CIV. PROC. CODE § 3333.1 (Deering Supp. 1981); IOWA CODE ANN. § 147.136 (West Supp. 1981); KAN. STAT. ANN. § 60-471 (Supp. 1981); N.Y. CIV. PRAC. LAW § 4010 (McKinney 1981); OHIO REV. CODE ANN. § 2305.27 (Page 1981); PA. STAT. ANN. tit. 40 § 1301.602 (Purdon Supp. 1981); TENN. CODE ANN. § 29-26-119 (1980); WASH. REV. CODE ANN. § 7.70.080 (Supp. 1981).

39. "Ad damnum clauses have been abandoned because of the belief that statements of specific sums have had a prejudicial effect on the public, both as prospective plaintiffs and jurors, by implanting an inflated idea of what claims are worth." Comment, *supra* note 4, at 670. See, e.g., ALA. CODE § 6-5-483 (1977); FLA. STAT. ANN. § 768.042 (West Supp. 1982); IND. CODE ANN. § 16-9.5-1.6 (Burns Supp. 1981); LA. REV. STAT. ANN. § 40:1299.41E (West 1977); MASS. GEN. LAWS ANN. ch. 231, § 60C (West Supp. 1981); OHIO REV. CODE ANN. § 2307.42C (Page 1981); TENN. CODE ANN. § 29-26-117 (1980); WIS. STAT. ANN. § 655.009(1) (West Supp. 1980).

40. Submission of malpractice disputes to a review board or screening panel is designed to "weed out" nonmeritorious claims, decreasing the present cost of defending such claims. Comment, *supra* note 4, at 679.

A panel typically consists of three physicians and a nonvoting attorney who serves as chairman. IND. CODE ANN. § 16-9.5-9-1 (Burns Supp. 1981). The panel may make a determination of liability and appropriate damages. See, e.g., ARK. STAT. ANN. § 34-2602 (Supp. 1981); IND. CODE ANN. § 16-9.5-9-7(d) (Burns Supp. 1981); LA. REV. STAT. ANN. § 40:1299.47(G) (West 1977); PA. STAT. ANN. tit. 40, § 1301.308 (Purdon Supp. 1981).

The panel's finding may be admissible into evidence in a subsequent trial *de novo*. One student author, however, observed that "the informality and lack of procedural safeguard . . . may lead to

a panel conclusion that is unfair to the patient or the health-care provider. . . . [T]he prejudicial effect of an admissible, adverse panel report could be virtually impossible to overcome, thus carrying over an unjust panel determination into a judgment. Comment, *supra* note 4, at 681.

Screening panels have been challenged recently on several grounds: *Aldana v. Holub*, 381 So.2d 231 (Fla. 1980) (unconstitutional as application of rigid jurisdictions; period is arbitrary and capricious); *Wright v. Central Du Page Hosp. Ass'n*, 63 Ill. 2d 313, 347 N.E.2d 736 (1976) (impermissible delegation of judicial functions to nonjudicial personnel); *Simon v. St. Elizabeth Medical Center*, 3 Ohio Op. 3d 164, 355 N.E.2d 903 (C.P. 1976) (violates state constitutional right to jury trial).

For a more thorough analysis of the structure and efficacy of these screening panels, see Abraham, *supra* note 25, at 513; Baird, Munsterman & Stevens, *Alternatives to Litigation I: Technical Analysis*, in HEW APPENDIX, *supra* note 3, at 214; Redish, *supra* note 38, at 766; Siedel, *supra* note 3, at 250; Comment, *supra* note 4, at 679; Note, *Medical Malpractice Mediation Panels: A Constitutional Analysis*, 46 FORDHAM L. REV. 322 (1977).

For a comparison of various state provisions, see ARIZ. REV. STAT. ANN. § 12-567 (1982); ARK. STAT. ANN. § 34-2602 (Supp. 1981); FLA. STAT. ANN. § 768.44 (West Supp. 1981); IDAHO CODE § 6-1001 (1979); IND. CODE ANN. § 16-9.5-9-1 (Burns Supp. 1981); KAN. STAT. ANN. § 65-4901 (1980); LA. REV. STAT. ANN. § 40:1299.47 (West 1977); MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-01 (1980); MASS. GEN. LAWS ANN. ch. 231, § 60B (West 1980); NEV. REV. STAT. ANN. § 41A.010 (1980); N.Y. JUD. LAW § 148-a (McKinney Supp. 1981); PA. STAT. ANN. tit. 40, § 1301.308 (Purdon Supp. 1981); TENN. CODE ANN. § 29-26-104 (1980); VA. CODE § 8.01-581.1 (1977 & Supp. 1981); WIS. STAT. ANN. § 655.065 (West 1980 & Supp. 1981).

41. See *supra* note 11 and accompanying text. Many state legislators believed that arbitration "could expedite the resolution of medical malpractice claims; expedite the expenditure of time by physicians, lawyers, witnesses and patients; render more realistic and equitable awards than juries; reduce the costs associated with investigation and case preparation; and provide a relatively private forum in which to resolve complex cases." Heintz, *supra* note 2, at 534.

On the federal level, Senator Gaylord Nelson, a member of the Senate Health Subcommittee, proposed a bill in January 1974 which would provide reinsurance to states that established arbitration programs for medical malpractice claims. The arbitrator's determination would be non-binding and admissible in a subsequent trial *de novo*. Nelson, *Mushrooming Malpractice: A Federal Rx*, 11 TRIAL 10, 19 (May-June 1975).

The Secretary's Commission on Medical Malpractice recommended the establishment of state arbitration statutes so long as the following characteristics are present:

1. Arbitration statutes . . . should be designed to give jurisdiction over all parties . . . involved in a specific medical malpractice case.
2. State arbitration laws should set a maximum monetary limit for invoking the jurisdiction, with cases demanding higher amounts being handled through the present jury system.
3. Arbitration panels should include some persons who are neither attorneys nor persons involved in the delivery of health care services.
4. There should be the right of trial *de novo* subsequent to arbitration in the highest level jury court in the State.
5. The State should provide economic and legal sanctions, in order to discourage subsequent trials *de novo* of questionable merit.

HEW REPORT, *supra* note 1, at 93. See generally Gilmore, *Medical Malpractice Arbitration: Insurance Developments*, 653 INS. L.J. 366 (1977); Ladimer, *Medical Malpractice Arbitration: 1978 Roundup*, 1978 INS. L.J. 530; Note, *Medical Malpractice Arbitration: A Comparative Analysis*, 62 VA. L. REV. 1285 (1976).

II. CONTEMPORARY ARBITRATION STATUTES

A. Characteristics of Arbitration

Arbitration is an ancient forum⁴² for dispute resolution that provides an alternative to litigation.⁴³ Critics of the traditional legal system⁴⁴ believe that arbitration reduces the time and expense associated with litigation⁴⁵ by removing technical rules of procedure and evidence,⁴⁶ by providing a more informal atmosphere, and by limiting judicial review.⁴⁷ The use of arbitration is also highly favored in commercial

42. "Some legal scholars have traced arbitration back to 700 B.C. in the Athenian culture. Indeed, historians who have studied the civilization and culture of the ancient Near East have found evidence that the Middle Bronze Age society of Babylonia and Sumeria (*circa* 18th century B.C.) had a detailed system of arbitration, as set out in the Code of Hammurabi." Ducastel, *Medical Malpractice Arbitration: Fact or Fiction?*, 60 MICH. ST. B.J. 940, 940 (1981). See also Lippman, *Arbitration as an Alternative to Judicial Settlement: Some Selected Perspectives*, 24 ME. L. REV. 215 (1972).

43. A few early cases recognized the use of arbitration upon the consent of both parties. See, e.g., *Snyder v. Superior Court*, 24 Cal. App. 2d 263, 74 P.2d 782 (1937); *Berkovitz v. Arbib & Houlberg*, 230 N.Y. 261, 130 N.E. 288 (1921); *Cutler v. Richley*, 151 Pa. 195, 25 A. 96 (1892). For a historical development and analysis of arbitration law in the United States, see F. KELLOR, *AMERICAN ARBITRATION: ITS HISTORY, FUNCTIONS AND ACHIEVEMENTS* (1948).

44. See *supra* notes 5-7 and accompanying text. The medical community blames the legal profession and the contingency fee system for the increase in malpractice suits. Cohn, *supra* note 7, at 33. Critics argue that the contingent fee arrangement, whereby an attorney recovers a proportion of the client's award in lieu of an hourly fee, "prompt[s] overzealous attorneys to accept non-meritorious cases and to win high awards from sympathetic juries." Quinn, *supra* note 26, at 98. See generally Jacobson, *Quicksilver—Emotion and Fear*, 11 TRIAL 15, 15 (May-June 1975); Solimine, *supra* note 2, at 90.

One study reveals that although the contingent fee system may discourage attorney's from accepting cases of minor damage, the differential between the effective hourly rate of plaintiff attorneys (\$63) and defense attorneys (\$50) does not warrant the concern of excessive fees. HEW REPORT, *supra* note 1, at 33. In accordance with the Commission's suggestions, *id.* at 34, some states have established a maximum contingent fee schedule. The Michigan Supreme Court adopted the following schedule: "not to exceed 40% of the first \$5,000 recovered, not to exceed 35% on the next \$20,000 recovered, not to exceed 25% on the next \$225,000 recovered, not to exceed 20% on the next \$250,000 recovered and not to exceed 10% on any amount recovered over \$500,000." MICH. GEN. CT. R. 928.2(1) (1973).

45. There is strong public policy favoring arbitration because it is "expeditious, inexpensive, and relieves overburdened courts." *Benyon v. Garden Grove Medical Group*, 100 Cal. App. 3d 698, 704, 161 Cal. Rptr. 146, 149 (1980). See generally Nocas, *supra* note 4, at 258; Note, *supra* note 26, at 610; Comment, *supra* note 4, at 682.

46. Some states are reluctant to abrogate formal rules of evidence in arbitration proceedings. Compare GA. CODE ANN. § 7-417 (Supp. 1982) (maintains formal evidence rules) with VT. STAT. ANN. tit. 12, § 7003 (Supp. 1982) (abrogates technical rules of procedure).

47. See *infra* note 273 and accompanying text. For example, the Georgia statute provides that the findings of the panel are conclusive unless: "(1) the findings were procured by fraud;

law⁴⁸ and in labor disputes.⁴⁹

Parties may either voluntarily elect medical malpractice arbitration⁵⁰ or have it statutorily imposed.⁵¹ To date, only Puerto Rico has mandatory, binding arbitration requiring the submission of every alleged malpractice claim to an arbitration panel⁵² with limited judicial review.⁵³ In contrast, voluntary binding arbitration arises from an agreement voluntarily and knowingly⁵⁴ entered into between the patient and the physician or health care provider.⁵⁵ Binding arbitration

(2) there is no evidence to support the findings of fact by the arbitrators; (3) the findings are contrary to law." GA. CODE ANN. § 7-421 (Supp. 1982).

48. See generally M. DOMKE, *THE LAW AND PRACTICE OF COMMERCIAL ARBITRATION* (1968). Many states have adopted commercial arbitration statutes modeled after the Uniform Arbitration Act, 7 UNIFORM LAWS ANN. 4 (1978). See, e.g., COLO. REV. STAT. § 13-22-202 (Supp. 1981), in which the purpose of Colorado's Uniform Arbitration Act is to "validate voluntary written arbitration agreements, make the arbitration process effective, provide necessary safeguards, and provide an efficient procedure when judicial assistance is necessary."

For a complete listing of states with modern arbitration acts, see Note, *supra* note 2, at 459 n.34 (1981).

49. See generally F. ELKOURI & E. ELKOURI, *HOW ARBITRATION WORKS* 44-67 (2d ed. 1973).

Federal policy also supports arbitration in labor disputes. Labor Management Relations (Taft-Hartley) Act § 203(d), 29 U.S.C. § 173(d) (1976 & Supp. IV 1980).

50. See *infra* notes 59-72 and accompanying text.

51. See *infra* notes 52-53 and accompanying text.

52. P.R. LAWS ANN. tit. 26, § 4110 (Supp. 1980).

53. The arbitration decision in Puerto Rico is final and binding on the parties, unless the court finds that: "(a) the findings of facts included in the decision are clearly erroneous; or (b) the decision was not rendered in keeping with the law; or (c) the proceedings necessary for rendering the decision were not carried out." P.R. LAWS ANN. tit. 26, § 4113(6) (Supp. 1980). Puerto Rico's requirement of mandatory and binding arbitration may be subject to equal protection challenge for "singling out a special class of injured persons, those who claim malpractice injuries, for different treatment under the law in violation of the 14th amendment equal protection standards." Comment, *supra* note 4, at 684.

54. The essence of the "knowing" requirement must be considered in light of the context in which the signature takes place. The medical surroundings may be unfamiliar to the patient, see *infra* notes 161-63 and accompanying text, and may be a coercive atmosphere in which to execute a legal document, see *infra* notes 164-205 and accompanying text.

55. This Note will not examine states such as Maryland and Pennsylvania, whose arbitration statutes, although voluntary, are nonbinding. In Maryland, "[a] party may reject an award for any reason," MD. CTS. & JUD. PROC. CODE ANN. § 3-2A-06 (1980 & Supp. 1982), and seek a trial *de novo* of the claim. Similarly, in Pennsylvania, "[a]ppeals from determinations made by the arbitration panel shall be a trial *de novo* in the court," PA. STAT. ANN. tit. 40, § 1301.509 (Purdon Supp. 1981).

For an excellent discussion of the Pennsylvania and Maryland arbitration statutes, see Jones, *Medical Malpractice Litigation: Alternatives for Pennsylvania*, 19 DUQ. L. REV. 407 (1981); Quinn, *supra* note 26.

precludes a subsequent trial de novo,⁵⁶ and thus, any opportunity for a trial by jury.⁵⁷ A party may enforce an arbitration award as a court judgment.⁵⁸

Under voluntary arbitration statutes, execution of an arbitration agreement may occur before or after discovery of the claim. These agreements are labeled preclaim⁵⁹ and postclaim,⁶⁰ respectively. Health care providers offer a preclaim arbitration agreement prior to treatment,⁶¹ although the consent to arbitration may not constitute a condition to receiving treatment.⁶² Consistent with any contract, a party may invoke against the agreement normal contractual defenses, such as lack of mutual assent and adhesiveness.⁶³ To ensure voluntary acceptance, the statutes typically establish a period of revocation⁶⁴ after

56. Ladimer, *Statutory Provisions for Binding Arbitration of Medical Malpractice Claims*, 1976 INS. L.J. 405, 406.

57. Comment, *supra* note 4, at 684. Because binding arbitration precludes the right to a jury trial, it is essential that the waiver is done knowingly and the patient is fully informed of the consequences of waiving the right when signing the arbitration agreement in the medical setting. See *infra* notes 198-216 and accompanying text.

58. Ladimer & Solomon, *Medical Malpractice Arbitration: Laws, Programs, Cases*, 1977 INS. L.J. 335, 336.

59. See ALASKA STAT. § 09.55.535(a) (Supp. 1982); CAL. CIV. PROC. CODE § 1295(a) (Deering 1981); ILL. STAT. ANN. ch. 10, § 203 (Smith-Hurd Supp. 1981); LA. REV. STAT. ANN. § 9:4231 (West Supp. 1982); ME. STAT. ANN. tit. 24, § 2702 (Supp. 1982); MICH. COMP. LAWS ANN. § 600.5041 (Supp. 1982); OHIO REV. CODE ANN. § 2711.22 (Page 1981); S.D. CODIFIED LAWS ANN. § 21-25B-1 (1979); VA. CODE § 8.01-581.12(A) (1977 & Supp. 1982).

Recently, some commentators have criticized the inequities associated with a preclaim agreement. The patient, signing prior to the medical treatment, may not fully appreciate the consequences of the election until after the tortious conduct. See *e.g.*, HEW REPORT, *supra* note 1, at 94.

Consumers Union, authors of the publication *Consumers Reports*, warned patients against signing preclaim agreements: "[N]o consumer should waive the right to a jury in advance of potential injury. But after a mishap has occurred, arbitration may offer a faster route to financial compensation than a lawsuit does." *Medical Malpractice: Is the Crisis Over?* CONSUMERS REPS., 598, 601 (Oct. 1977).

60. Only three states mandate postclaim agreements. See ALA. CODE § 6-5-485(a) (1975); GA. CODE ANN. § 7-403 (Supp. 1982); VT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1982).

ARBITRATION: COMMERCIAL DISPUTES, INSURANCE, AND TORT CLAIMS 305 (A. Widiss ed. 1979); Note, *supra* note 2, at 464 (1981).

61. In Michigan, "a person who receives health care" is offered the agreement, MICH. COMP. LAWS ANN. § 600.5041(1) (Supp. 1982), while in Maine, "a person admitted to a health care provider" is so offered. ME. REV. STAT. ANN. tit. 24, § 2702(1) (Supp. 1982).

62. See, *e.g.*, OHIO REV. CODE ANN. § 2711.23(A) (Page 1981) ("The Agreement shall provide that medical or hospital care, diagnosis, or treatment will be provided whether or not the patient signs the agreement to arbitrate.")

63. See *infra* notes 158-204 and accompanying text.

64. See *infra* notes 112-35 and accompanying text.

execution. Many states provide that some of the agreement's provisions be printed in boldface type.⁶⁵ The information printed in larger type may notify the patient that acceptance is not a prerequisite for treatment,⁶⁶ or alert him to the jury trial waiver,⁶⁷ or the revocation option.⁶⁸ Only Illinois alerts the patient to all three alternatives.

Three states provide for voluntary, postclaim arbitration.⁶⁹ After the alleged claim has arisen, both parties must agree in writing to arbitrate.⁷⁰ A party may enforce the panel's decision as a court judgment,⁷¹ and, in two of the three states, the panel's decision is subject to limited judicial review.⁷²

B. Persons Bound by Agreement

Many persons other than the patient and treating physician may enter into an arbitration agreement. Ten state statutes specifically enumerate the kinds of health care providers who may enter into such an agreement. The statute may include hospitals as well as medical doctors, and commonly covers osteopaths,⁷³ podiatrists,⁷⁴ and dentists.⁷⁵ Under more sweeping provisions, Alaska prescribes arbitration between patient and "health care provider,"⁷⁶ and Vermont provides for

65. *See infra* Appendix A.

66. *See* ALASKA STAT. § 09.55.535 (Supp. 1981); ILL. ANN. STAT. ch. 10, § 210 (Smith-Hurd Supp. 1982); ME. REV. STAT. ANN. tit. 24, § 2702(1)(C) (Supp. 1982); MICH. COMP. LAWS ANN. § 600.5042 (Supp. 1982); S.D. CODIFIED LAWS ANN. § 21-25B-1 (1979).

67. *See* CALIF. CIV. PROC. CODE § 1295(b) (Deering 1981); ILL. ANN. STAT. ch. 10, § 210 (Smith-Hurd Supp. 1982); OHIO REV. CODE ANN. § 2711.24 (Page 1981).

68. *See* ILL. ANN. STAT. ch. 10, § 210 (Smith-Hurd Supp. 1982); ME. REV. STAT. ANN. tit. 24, § 2702(1)(C) (Supp. 1982); MICH. COMP. LAWS ANN. § 600.5042 (Supp. 1982).

69. ALA. CODE §§ 6-5-484 to -488 (1977); GA. CODE ANN. §§ 7-401 to -424 (Supp. 1982); VT. STAT. ANN. tit. 12 §§ 7001 to 7008 (Supp. 1982).

70. ALA. CODE § 6-5-485(a) (1977); GA. CODE ANN. § 7-403 (Supp. 1982); VT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1982).

71. ALA. CODE § 6-5-485(b) (1977); GA. CODE ANN. § 7-420 (Supp. 1982); VT. STAT. ANN. tit. 12, § 7005 (Supp. 1982).

72. ALA. CODE § 6-6-14 (1977) (award final unless arbitrators guilty of fraud, partiality, or corruption); GA. CODE ANN. § 7-421 (Supp. 1982) (award set aside if fraud present, no evidence to support findings, or contrary to law); VT. STAT. ANN. tit. 12, § 7005 (Supp. 1982) (award subject to same appellate review as any civil action).

73. *See infra* Appendix B for a full illustration of health care providers covered under the various state statutes.

74. *Id.*

75. *Id.*

76. ALASKA STAT. § 09.55.535 (Supp. 1981).

arbitration for "claims based on medical malpractice."⁷⁷ Similarly, four of these states⁷⁸ allow for joinder of unnamed parties-in-interest.⁷⁹ Joinder may facilitate the resolution of the claim by bringing all the involved parties into one single proceeding and by preventing the plaintiff from bringing two actions, one in court and the other in arbitration, against two sets of defendants.⁸⁰

Presently, in six states,⁸¹ a parent or legal guardian can execute an agreement binding a minor child to arbitration. This removes, contrary to common law, infancy and lack of capacity as defenses to enforcement of the arbitration agreement.⁸²

In *Doyle v. Giuliucci*,⁸³ the California Supreme Court held that a father may bind a minor by a contract with a medical group. The court reasoned that the duty to contract for medical care of one's children, "is implicit in a parent's right and duty to provide for the care of his child."⁸⁴ The court feared that medical facilities would only reluctantly enter into contracts with minors if minors could disaffirm at majority.⁸⁵ Thus, the parents' ability to enter into medical contracts assures that their minor children receive the benefits of medical care.⁸⁶

Similarly, courts have allowed parents to bind unborn children. In *Lovell v. Sisters of Mercy Health Corp.*,⁸⁷ a Michigan trial court held that a pregnant woman who signed two arbitration agreements, one for herself, and one for her infant *en ventre sa mere*, could not contest the infant's agreement by asserting that the infant was not a minor within the statute.⁸⁸ The court reasoned that the legislature did not intend to

77. VT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1981).

78. See ILL. ANN. STAT. ch. 10, § 204 (Smith-Hurd Supp. 1981); ME. REV. STAT. ANN. tit. 24, § 2703(3) (Supp. 1982); MICH. COMP. LAWS ANN. § 600.5046(4) (Supp. 1982); S.D. CODIFIED LAWS ANN. § 21-25B-7 (1979).

79. Ladimer, *supra* note 57, at 408.

80. Nocas, *supra* note 4, at 255.

81. See ALASKA STAT. § 09.55.535(d) (Supp. 1981); CAL. CIV. PROC. CODE § 1295(d) (Deering 1981); ILL. ANN. STAT. ch. 10, § 207 (Smith-Hurd 1982); ME. REV. STAT. ANN. tit. 24, § 2703(4) (Supp. 1982); MICH. COMP. LAWS ANN. § 600.5046(2) (Supp. 1982); S.D. CODIFIED LAWS § 21-25B-2 (1979).

82. Henderson, *supra* note 13, at 960. See also 1 A. CORBIN, CORBIN ON CONTRACTS § 6 (1963 & Supp. 1980).

83. 62 Cal. 2d 606, 401 P.2d 1, 43 Cal. Rptr. 697 (1965).

84. *Id.* at 610, 401 P.2d at 3, 43 Cal. Rptr. at 699.

85. *Id.*

86. *Id.*

87. No. 78-823-624 NM (Mich. Cir. Ct. Aug. 9, 1979).

88. *Id.* at 15. The statute provides: "A minor child shall be bound by a written agreement to

distinguish between "post and *ante partum* infants."⁸⁹ In *Troy v. Leep*,⁹⁰ however, a Michigan court of appeals held that the same statute did not compel a woman to arbitrate her claim for the death of her premature infant.⁹¹ The mother had signed the agreement a day after the premature birth. The cases are distinguishable, however, because in *Troy* the mother never signed an agreement for her unborn infant. Further, the acts of prenatal care giving rise to the malpractice claim in *Troy* did not stem from the health care rendered during the mother's hospital stay, as required under the statute.⁹²

Currently, seven states⁹³ provide for arbitration of the patient's wrongful death. Courts only reluctantly enforce arbitration of a wrongful death claim because such a claim actually constitutes a separate cause of action vesting in the heirs. Unless the heirs have contracted separately to forego their rights, a court enforcing arbitration for wrongful death must uphold the questionable proposition that a decedent has the authority to bind his heirs to arbitration.⁹⁴ In *Rhodes v. California Hospital Medical Center*,⁹⁵ however, a California court of appeals refused to enforce an agreement to arbitrate against a husband and son's wrongful death claim.⁹⁶ Although the admissions form signed by the decedent wife and mother specifically required arbitra-

arbitrate disputes, controversies, or issues upon the execution of an agreement on his behalf by a parent or legal guardian. The minor child may not subsequently disaffirm the agreement." MICH. COMP. LAWS ANN. § 600.5046(2) (Supp. 1982).

89. No. 78-823-624 NM, slip op. at 15 (Mich. Cir. Ct. Aug. 9, 1979). In response to plaintiff's argument that the ability of the parent to bind the child violated the minor's due process rights, the court in *Lovell* added: "The law allows a parent, acting in good faith, to compel a child to have a medical examination, medical treatment, mental hospital confinement, and even surgery, without the child's consent." *Id.* at 17-18.

90. 101 Mich. App. 425, 300 N.W.2d 598 (1980).

91. *Id.* at 427, 300 N.W.2d at 599.

92. *Id.*

93. See CAL. CIV. PROC. CODE § 1295(g)(2) (Deering 1981); GA. CODE ANN. § 7-401 (Supp. 1982); ILL. ANN. STAT. ch. 10, § 202(d) (Smith-Hurd 1982); LA. REV. STAT. ANN. § 9:4231 (West Supp. 1982); ME. REV. STAT. ANN. tit. 24, § 2701(1) (Supp. 1982); MICH. COMP. LAWS ANN. § 600.5040(1) (Supp. 1982); OHIO REV. CODE ANN. § 2711.23(B) (Page 1981).

Presumably, Puerto Rico would arbitrate a wrongful death claim because arbitration is mandatory for "[e]very civil action arising from a malpractice claim." P.R. LAWS ANN. tit. 26, § 4110 (Supp. 1981).

94. Note, *supra* note 48, at 477.

95. 76 Cal. App. 2d 606, 143 Cal. Rptr. 59 (1978).

96. While a patient in defendant-hospital, the decedent leaped to her death from a hospital window. See Note, *California Medical Malpractice Arbitration and Wrongful Death Actions*, 51 S. CAL. L. REV. 401, 426-27 (1978) (suggests amendment to California statute to specifically allow arbitration of such claims).

tion of any wrongful death claim,⁹⁷ the court held that because the husband and son were not parties to the agreement, it was not binding upon them. The court reasoned that although public policy favored arbitration, that policy did not warrant extension of the agreement to those not directly party to it.⁹⁸ In contrast, the same court upheld arbitration of a wife's claim for her husband's wrongful death in *Hawkins v. Superior Court*.⁹⁹ The court stated that the wife was bound by the arbitration provisions of the health plan in which she and her husband were enrolled because spouses have an obligation to provide each other with care and support, including medical care.¹⁰⁰

C. *Special Considerations in the Emergency Room*

The urgencies of a patient's medical needs in the emergency room setting may substantially diminish the patient's ability to comprehend the consequences of an arbitration option.¹⁰¹ In *Ramirez v. Superior Court*,¹⁰² a Spanish-speaking woman brought her daughter into an emergency room. A nurse who spoke little Spanish offered her a Spanish version of the arbitration agreement, and the mother signed the agreement, purportedly without reading it. The mother later brought suit against the physician, alleging negligence in his failure to diagnose the daughter's meningitis, from which the daughter suffered severe injuries.¹⁰³ The appeals court remanded the case for a determination of whether the mother knowingly and voluntarily signed the agreement, emphasizing that "the Legislature may not establish a conclusive presumption that one signing an agreement . . . has in fact consented to arbitration."¹⁰⁴

97. 76 Cal. App. 3d 606, 608; 143 Cal. Rptr. 59, 60 (1978).

98. *Id.* at 609, 143 Cal. Rptr. at 61.

99. 89 Cal. App. 3d 413, 152 Cal. Rptr. 491 (1979).

100. *Id.* at 415, 152 Cal. Rptr. at 492. The plan specifically provided for binding arbitration on account of death.

101. One commentator warns that the medical malpractice arbitration agreement is subject to more inquiries into contractual mental capacity because the principal contract is for medical attention. See Henderson, *supra* note 13, at 963.

102. 103 Cal. App. 3d 746, 163 Cal. Rptr. 223 (1980).

103. *Id.* at 750, 163 Cal. Rptr. at 225.

104. *Id.* at 756, 163 Cal. Rptr. at 229. The court criticized § 1295(e) of the statute, which provides that "[s]uch a contract is not a contract of adhesion, nor unconscionable nor otherwise improper. . . . *Id.* See CAL. CIV. PROC. CODE § 1295(e) (Deering 1982). The court interpreted the provision, "[to permit] a party to seek to show that he or she was coerced into signing or did not read the many waiver notices provided and did not realize that the agreement was an agreement to arbitrate." 103 Cal. App. 3d at 756; 163 Cal. Rptr. at 229.

Both Maine and Michigan have specifically addressed the special problems of the emergency room setting in their statutes. Maine's statute requires the health care provider to give complete emergency treatment before offering the patient the option of signing an arbitration agreement.¹⁰⁵ Michigan similarly restricts the offer of arbitration.¹⁰⁶ The Michigan arbitration agreement states clearly that the health care provider may not present the agreement to the patient until after emergency care has been completed.

The severity of the injury may determine whether a patient is receiving emergency care. In *Pipper v. DiMusto*,¹⁰⁷ the plaintiff signed the agreement upon admission to the hospital during which she complained of uterine bleeding and abdominal pain.¹⁰⁸ The court held that whether she was a person receiving emergency health care under the Michigan statute¹⁰⁹ was a question of fact which would invalidate the agreement if substantiated.¹¹⁰

D. Statutory Voidability and Revocation

In an attempt to promote strict compliance with statutory provisions, two states specify limited conditions which void an otherwise valid arbitration agreement. Both the Alaska¹¹¹ and Illinois¹¹² statutes void an agreement that does not provide clearly and in bold print that the patient's election is not a prerequisite to receiving care or treatment. The Illinois statute also grants an opportunity for the patient to void an agreement.¹¹³ Upon discharge, a health care facility must give the patient or family a copy of the previously executed agreement. The patient at this time must either affirm or void the arbitration agreement.

105. Maine's statute reads: "No person receiving emergency treatment or care shall be offered the option of an arbitration agreement until such emergency treatment or care is completed." ME. REV. STAT. ANN. tit. 24, § 2702(1)(A) (Supp. 1982).

106. Michigan's statute provides: "A person receiving emergency health care or treatment may be offered the option to arbitrate but shall be offered the option after the emergency care or treatment is completed." MICH. COMP. LAWS ANN. § 600.5042(1) (Supp. 1982). For a copy of Michigan's Arbitration Agreement, see *infra* Appendix C.

107. 88 Mich. App. 743, 279 N.W.2d 542 (1979).

108. *Id.* at 744, 279 N.W.2d at 543.

109. *See supra* note 106.

110. 88 Mich. App. 743, 745-46, 279 N.W.2d 542, 544 (1979).

111. ALASKA STAT. § 09.55.535(b) (Supp. 1982).

112. ILL. ANN. STAT. ch. 10, § 209 (Smith-Hurd Supp. 1982).

113. *Id.* at § 208(e).

As in the bold print requirement, failure to offer the patient this opportunity voids the agreement *ab initio*.

After the parties have signed the arbitration agreement, many states sanction reevaluation of the arbitration election through subsequent revocation periods. The various state statutes offer differing requirements on who may revoke, and what time restrictions exist. In California,¹¹⁴ Illinois,¹¹⁵ and South Dakota,¹¹⁶ either the patient or health care provider may revoke, while in five other states—Alaska,¹¹⁷ Louisiana,¹¹⁸ Maine,¹¹⁹ Ohio,¹²⁰ and Virginia¹²¹—only the patient may revoke once signed. Time constraints are also crucial in revocability. In Alaska,¹²² California,¹²³ and Louisiana,¹²⁴ one may revoke within thirty days after execution; in Michigan,¹²⁵ sixty days after either execution or discharge from a hospital.¹²⁶ South Dakota¹²⁷ has no time constraints within which a patient must revoke, and in Ohio¹²⁸ one may revoke at the termination of the doctor-patient relationship. Illinois provides that either party may revoke, within sixty days of execution, discharge from a hospital, or after the last treatment for nonhospitalization care.¹²⁹ Illinois also allows the representative of a decedent who signed an agreement to revoke it within sixty days of appointment as estate representative.¹³⁰

Alaska¹³¹ and Virginia¹³² have contingency clauses which provide extra flexibility in the event that death, insanity, or age prevents a party from revoking the agreement. Under the Virginia statute, a legal repre-

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114. CAL. CIV. PROC. CODE § 1295(c) (Deering 1981).
 115. ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1982).
 116. S.D. CODIFIED LAWS ANN. § 21-25B-1 (1979).
 117. ALASKA STAT. § 09.55.535(c) (Supp. 1982).
 118. LA. REV. STAT. ANN. § 9:4235 (West Supp. 1982).
 119. ME. REV. STAT. ANN. tit. 24, § 2702(1)(C) (Supp. 1982).
 120. OHIO REV. CODE ANN. § 2711.23(B) (Page 1981).
 121. VA. CODE § 8.01-581.12(A) (1977 & Supp. 1982).
 122. ALASKA STAT. § 09.55.535(c) (Supp. 1982).
 123. CAL. CIV. PROC. CODE § 1295(c) (Deering 1981).
 124. LA. REV. STAT. ANN. § 9:4235 (West Supp. 1982).
 125. MICH. COMP. LAWS ANN. § 600.5041(3) (Supp. 1982).
 126. *Id.* at § 600.5042(3).
 127. S.D. CODIFIED LAWS ANN. § 21-25B-1 (1979).
 128. OHIO REV. CODE ANN. § 2711.23(B) (Page 1981).
 129. ILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1982).
 130. *Id.*
 131. ALASKA STAT. § 09.55.535(c) (Supp. 1981).
 132. VA. CODE § 8.01-581.12(A) (1977 & Supp. 1982).

sentative of a deceased or incapacitated person may revoke within sixty days after appointment. The Alaska statute similarly tolls the revocation period for physical incapacities. Michigan has no such incapacity provision. In *Capman v. Harper-Grace Hospital*,¹³³ the court refused to allow plaintiff to revoke the agreement within sixty days of discovering the alleged malpractice but more than sixty days after her discharge from the hospital. The court reasoned that the statute does not preclude her claim, as does a time-barred statute of limitation period.¹³⁴

E. Arbitration Panels

The selection, composition, and size of arbitration panels varies widely among the states. Alabama,¹³⁵ Georgia,¹³⁶ Illinois,¹³⁷ Louisiana,¹³⁸ and Maine¹³⁹ utilize the most common method, in which claimant and respondent each select one arbitrator, and these two arbitrators then select a third. The Alaska procedure differs in that the parties select the third arbitrator.¹⁴⁰ In most of these states, the statutes do not specify the professional status of the arbitrators. Only Louisiana specifies that the third arbitrator must be an attorney.¹⁴¹ To facilitate the process, in four of these states¹⁴² the parties may petition the court to assist them in their selection if unable to agree upon the third arbitrator. Similarly, in Ohio¹⁴³ each party selects an arbitrator and the court selects the third as chairman.

In contrast, Michigan,¹⁴⁴ Puerto Rico,¹⁴⁵ Virginia,¹⁴⁶ Vermont,¹⁴⁷

133. 96 Mich. App. 510, 294 N.W.2d 205 (1980).

134. *Id.* at 516, 294 N.W.2d at 208. The court distinguished *Amwake v. Mercy-Memorial Hosp.*, 92 Mich. App. 546, 285 N.W.2d 369 (1979), in which the court held that a transfer of a comatose patient to another hospital did not constitute a discharge within the statute to begin the running of the 60-day period and that the timely filing of a complaint in court impliedly revoked the arbitration agreement on the sixtieth day. 96 Mich. App. at 517, 294 N.W.2d at 208.

135. ALA. CODE § 6-5-485(b) (1975).

136. GA. CODE ANN. § 7-408(a) (Supp. 1982).

137. ILL. ANN. STAT. ch. 10, § 213(d) (Smith-Hurd Supp. 1982).

138. LA. REV. STAT. ANN. § 9:4231 (West Supp. 1982).

139. ME. REV. STAT. ANN. tit. 24, § 2705(1) (Supp. 1982).

140. ALASKA STAT. § 09.55.535(f) (Supp. 1982).

141. LA. REV. STAT. ANN. § 9:4233 (West Supp. 1982).

142. ALA. CODE § 6-5-485(b) (1975); ALASKA STAT. § 09.55.535(f) (Supp. 1982); GA. CODE ANN. § 7-408(b) (Supp. 1982); ILL. ANN. STAT. ch. 10, § 213(c) (Smith-Hurd Supp. 1982).

143. OHIO REV. CODE ANN. § 2711.21(A) (Page 1981).

144. MICH. COMP. LAWS ANN. § 600.5044(2) (Supp. 1982).

145. P.R. LAWS ANN. tit. 26, § 4111(2) (Supp. 1980).

146. VA. CODE § 8.01-581.3 (1977 & Supp. 1982).

and South Dakota¹⁴⁸ specify the professional status of each arbitrator. Michigan allows each party to select one arbitrator and mutually agree upon a third. The panel must consist of an attorney, a physician, and a layperson. The statute states a preference for a physician in the party-physician's specialty, and also precludes the layperson from being a physician in the disputed specialty, a lawyer, a hospital employee, or an insurance company employee.¹⁴⁹ Puerto Rico provides for similar panel composition, except that under mandatory arbitration, the Secretary of Health appoints the panel.¹⁵⁰

In Virginia, the chief justice of the state supreme court selects the panel. Three physicians, three attorneys, and one judge of the circuit court, to act as chairman, constitute the Virginia panel.¹⁵¹ In Vermont, the court selects a judicial referee and the parties select the professional and lay members by lot, subject to challenges for cause and three preemptory challenges.¹⁵²

In South Dakota, the amount of damages requested determines the size of the panel. For a requested award of less than \$10,000, each party selects a panel member from lists of approved medical, legal, and hospital professionals created by the state medical association, bar association, and hospital association, respectively.¹⁵³ If the requested damages exceed \$10,000, each party selects two panelists in a similar manner.¹⁵⁴ In Maine¹⁵⁵ and Michigan,¹⁵⁶ the American Arbitration Association provides a list of potential arbitrators from which the parties select the three panel members. Only California does not regulate panel composition or selection.

147. VT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1982).

148. S.D. CODIFIED LAWS ANN. § 21-25B-4 (1979).

149. MICH. COMP. LAWS ANN. § 600.5044(2) (Supp. 1982).

150. P.R. LAWS ANN. tit. 26, § 4111(3) (Supp. 1980).

151. VA. CODE § 8.01-581.3 (1977 & Supp. 1982).

152. VT. STAT. ANN. tit. 12, § 7002(c) (Supp. 1982).

153. S.D. CODIFIED LAWS ANN. § 21-25B-13 (1979).

154. *Id.* at § 21-25B-14.

155. ME. REV. STAT. ANN. tit. 24, § 2705(2) (Supp. 1982).

156. MICH. COMP. LAWS ANN. § 600.5044(3) (Supp. 1982).

III. THE ARBITRATION ALTERNATIVE: THE PATIENT'S PERSPECTIVE

A. *Contractual Defects*

Prior to ordering arbitration, a court must determine the validity¹⁵⁷ and enforceability of the arbitration agreement using traditional contract law standards. In the malpractice arbitration context, the courts primarily focus on the voluntariness of the patient's election to arbitrate, the unconscionability of the contract, and whether the patient made an informed and knowledgeable waiver. The courts also consider the arbitrable nature of the patient's claim.¹⁵⁸

An arbitration agreement may lack the mutual assent necessary for a valid and enforceable contract.¹⁵⁹ The special relationship between a patient and the health care provider, especially a physician,¹⁶⁰ may vitiate the element of free choice essential to the patient's election. The layperson's ignorance of medical terminology, diagnoses, and treatment forces the patient seeking medical services to depend on the doctor's judgment.¹⁶¹ Wishing to have faith in the ability of the physician to relieve an ailment, a patient only reluctantly refuses the options proffered by the health care professional. Because of the patient's possible inability to properly assess these options, mutual assent may not exist.

The patient's relatively weak bargaining position may make an arbitration agreement a contract of adhesion.¹⁶² Generally, the hospital¹⁶³

157. Maine's statute presumes that an agreement to arbitrate is valid, but a court may stay arbitration as provided by law or court rule. ME. REV. STAT. ANN. tit. 24, § 2701(2) (Supp. 1982).

158. *Miller v. Swanson*, 95 Mich. App. 36, 289 N.W.2d 875 (1980), adopted a three-part test to determine whether a dispute is arbitrable: "(1) Is there an arbitration agreement in a contract between the parties? (2) Is the insured's claim 'on its face' or 'arguably' related to the contract? and (3) Is the dispute 'expressly exempt' by the terms of the contract?" *Id.* at 39, 289 N.W.2d at 877 (citing *American Fidelity Fire Ins. Co. v. Barry*, 80 Mich. App. 670, 264 N.W.2d 92 (1978)).

159. The Restatement emphasizes the importance of knowledge of the terms of the bargain to manifest mutual assent: "(1) There is no manifestation of mutual assent to an exchange if the parties attach materially different meanings to their manifestations and (a) neither party knows or has reason to know the meaning attached by the other. . . ." RESTATEMENT (SECOND) CONTRACTS § 20 (1981). See also 1 A. CORBIN, *supra* note 82, at § 107.

160. As one court noted: "Doctors are held in high esteem and admiration by the public. The average person is not disposed to question or doubt a doctor's treatment." *Miner v. Walden*, 101 Misc. 2d 814, 818, 422 N.Y.S. 335, 338 (1979).

161. See Comment, *supra* note 1, at 325. One commentator criticized offering the agreement in advance of the claim as unfair because of the patient's dependence on the doctor and inability to appreciate the significance of his actions at a time of medical need. ARBITRATION: COMMERCIAL DISPUTES, INSURANCE, AND TORT CLAIMS, *supra* note 60, at 334.

162. "In dealing with standardized contracts courts have to determine what the weaker con-

or medical provider offers the patient a standardized, preprinted agreement. Because the patient frequently is not in a position to shop around for another health care provider,¹⁶⁴ the terms of the standardized form agreement become adhesive. This disparity of bargaining power combined with the patient's possibly deficient understanding of the contract terms may vitiate the voluntariness of the contract.¹⁶⁵

The exigencies of a patient's physical or mental distress may likewise interfere with a voluntary and rational election of arbitration. In *Wheeler v. St. Joseph Hospital*,¹⁶⁶ the court held that a hospital's "Conditions of Admission" form constituted a contract of adhesion because the patient had no realistic opportunity to elect arbitration.¹⁶⁷ To reject the arbitration election, the admissions form required the patient to initial a paragraph entitled "Arbitration Option." Thus, the admissions form imposed arbitration unless the patient repudiated the option upon admission. Plaintiff alleged that the hospital personnel neither called attention to this clause, nor provided the patient with a copy of the form to peruse at a later time.¹⁶⁸ The court held that the hospital's failure to give a reasonable explanation of the option rendered the

tracting party could legitimately expect by way of services according to the enterpriser's 'calling,' and to what extent the stronger party disappointed reasonable expectations based on the typical life situation." Kessler, *Contracts of Adhesion—Some Thoughts About Freedom of Contract*, 43 COLUM. L. REV. 629, 637 (1943). See also *Hellenic Lines, Ltd. v. Louis Dreyfus Corp.*, 372 F.2d 753 (2d Cir. 1967) (no contract of adhesion because parties of equal bargaining strength). Compare *Gray v. Zurich Ins. Co.*, 65 Cal. 2d 263, 419 P.2d 168, 54 Cal. Rptr. 104 (1966) (doubts regarding insurance coverage resolved against insurer, who is stronger bargainer) with *Kukowski v. Piskin*, 99 Mich. App. 1, 297 N.W.2d 612 (1980) (doubts about arbitrability resolved in favor of physician due to strong public policy favoring arbitration).

163. Michigan requires hospitals to offer the arbitration option in order to receive insurance. MICH. COMP. LAWS ANN., § 500.3053 (Supp. 1982).

164. See Kessler, *supra* note 162, at 632. See also *Miner v. Walden*, 101 Misc. 2d 814, 818, 422 N.Y.S. 335, 338 (1979). If the patient is not made aware of the consequences of choosing arbitration, such that his assent is manifested by a reflexive signature while he signs other consent and insurance forms, then the voluntariness of this election is rendered nugatory. See *supra* note 161 and accompanying text.

165. See Henderson, *supra* note 13, at 969; Kessler, *supra* note 162, at 632.

166. 63 Cal. App. 3d 345, 133 Cal. Rptr. 775 (1976).

167. The court reasoned that:

[t]o the ordinary person, admission to a hospital is an anxious, stressful, and frequently a traumatic experience. . . . the hospital can hardly expect the patient to read the printed conditions on an admission form, much less understand the meaning of a broad arbitration clause. . . . the patient normally feels he has no choice but to seek admission . . . and to accede to all of the terms. . . .

Id. at 360, 133 Cal. Rptr. at 786.

168. *Id.* at 351, 133 Cal. Rptr. at 780.

agreement void as a contract of adhesion because an arbitration clause is not within the reasonable expectations of a person seeking admission to a hospital.¹⁶⁹

Given this potentially superior bargaining position, courts closely scrutinize agreements presented by medical facilities. In *Tunkl v. Regents of University of California*,¹⁷⁰ the hospital's admission form exculpated the hospital from liability for negligent or wrongful acts.¹⁷¹ The court held that the agreement constituted a contract of adhesion¹⁷² and was contrary to public policy.¹⁷³ The court reasoned that "the patient, as the price of admission and as a result of his inferior bargaining position . . . subjected himself to control of the hospital and the possible infliction of negligence which he had thus been compelled to waive."¹⁷⁴ Similarly, in *Miner v. Walden*,¹⁷⁵ a New York court held that an arbitration agreement signed in a doctor's office as a condition to treatment¹⁷⁶ constituted an unconscionable adhesion contract.¹⁷⁷ In

169. The court reasoned that the patient may expect that the admissions form will obligate him to abide by hospital rules and regulations, but "would hardly expect his signature to . . . give the hospital as well as 'any doctor' the option to compel arbitration of a malpractice claim." *Id.* at 360-61, 133 Cal. Rptr. at 786.

170. 60 Cal. 2d 92, 383 P.2d 441, 32 Cal. Rptr. 33 (1963).

171. *Id.* at 94, 383 P.2d at 442, 32 Cal. Rptr. at 34.

172. The court reasoned that "[t]he would-be patient is in no position to reject the proffered agreement, to bargain with the hospital, or in lieu of agreement to find another hospital. The admission room of a hospital contains no bargaining table. . . ." *Id.* at 102, 383 P.2d at 447, 32 Cal. Rptr. at 39.

173. The court held that the hospital, as a business affected with a public interest and whose services are of great importance to the public, may not exculpate itself from liability and shift the entire risk to the patient who demands its services. *Id.* at 98-101, 383 P.2d at 445-46, 32 Cal. Rptr. at 37-38.

174. *Id.* at 102, 383 P.2d at 447, 32 Cal. Rptr. at 39.

175. 101 Misc. 2d 814, 422 N.Y.S.2d 335 (1979).

176. The court reasoned that the patient, in an inferior bargaining position, could not receive services unless he signed the required agreement. *Id.* at 816, 422 N.Y.S.2d at 337. *See also* Henderson, *supra* note 13, at 993-97.

177. 101 Misc.2d at 818, 422 N.Y.S.2d at 338. *See also* *Williams v. Walker-Thomas Furniture Co.*, 350 F.2d 445, 449 (D.C. Cir. 1965). Judge Wright's classic explication of unconscionability takes the following factors into consideration: 1) absence of meaningful choice on the part of one of the parties, 2) terms which unreasonably favor one party, 3) no opportunity to understand terms due to lack of education, and 4) party in weaker bargaining position has limited understanding of terms. *Id.*

In addition to the potential disparity in bargaining power, an agreement may be deficient for lack of consideration. The court in *Miner* held that an arbitration clause was unenforceable because the agreement was not mutually binding. In return for the patient's consent to arbitrate possible claims, the doctor agreed to arbitrate all claims except for disputes over fees, the only possible claim a doctor could have. 101 Misc.2d 814, 819-20, 422 N.Y.S.2d 335, 339 (1979).

deciding the unconscionability question, the court specifically noted the gross inequality of bargaining power between the parties.¹⁷⁸

In *Madden v. Kaiser Foundation Hospitals*,¹⁷⁹ the disparity of bargaining power did not exist when the State Employees Retirement System contracted for a group health plan which provided for arbitration. Plaintiff, a state employee, challenged the authority of the System's Board to bind her claim to arbitration,¹⁸⁰ and further asserted that the plan constituted an adhesion contract. Plaintiff based her latter claim on the grounds that the inconspicuous and unexpected clause disrupted the employee's reasonable expectation that a jury would adjudicate a malpractice claim.¹⁸¹ The court rejected plaintiff's claims, following *Doyle v. Giulucci*,¹⁸² and analogized the authority of an agent to that of a parent, who may enter into such a contract on behalf of a child.¹⁸³ Similarly, the court rejected the adhesion argument, reasoning that Kaiser and the Board possessed "parity of bargaining strength"¹⁸⁴ and that plaintiff had the opportunity to select from among several medical plans that did not include arbitration.¹⁸⁵

Courts, however, continue to scrutinize group health care policies. In *Benyon v. Garden Grove Medical Group*,¹⁸⁶ plaintiff obtained medical coverage as part of a group health care plan through her employer. Provisions within the master policy gave the medical provider the right to reject an arbitration decision without cause and to resubmit the dispute before an arbitration panel composed solely of physicians.¹⁸⁷ Relying on *Madden*¹⁸⁸ and *Wheeler*,¹⁸⁹ the *Benyon* court held that the master policy constituted a contract of adhesion because no agency in parity with the medical group bargained on behalf of the employee

178. 101 Misc. 2d at 818, 422 N.Y.S.2d at 338.

179. 17 Cal. 3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976).

180. *Id.* at 702, 552 P.2d at 1180, 131 Cal. Rptr. at 884.

181. *Id.* at 710, 552 P.2d at 1185, 131 Cal. Rptr. at 889.

182. 62 Cal. 2d 606, 401 P.2d 1, 43 Cal. Rptr. 697 (1965). *See also supra* notes 83-86 and accompanying text.

183. 17 Cal. 3d 699, 709, 552 P.2d 1778, 1184, 131 Cal. Rptr. 882, 888.

184. *Id.* at 711, 552 P.2d at 1185, 131 Cal. Rptr. at 889.

185. *Id.* at 711, 552 P.2d at 1186, 131 Cal. Rptr. at 890.

186. 100 Cal. App. 3d 698, 161 Cal. Rptr. 146 (1980).

187. *Id.* at 702, 161 Cal. Rptr. at 147.

188. 17 Cal. 3d 699, 552 P.2d 1178, 131 Cal. Rptr. 882 (1976). *See supra* notes 179-85 and accompanying text.

189. 63 Cal. App. 3d 345, 133 Cal. Rptr. 775 (1976). *See supra* notes 166-69 and accompanying text.

group.¹⁹⁰ The court emphasized the employee's lack of awareness of the arbitration terms, because the provisions were "especially disadvantageous" to the beneficiary-employee.¹⁹¹

Provisions for voluntary election and revocation of arbitration under state statutes affect judicial scrutiny of these agreements as contracts of adhesion. In *Brown v. Siang*,¹⁹² a Michigan court rejected the argument that the standardized form of the agreement always constitutes an adhesion contract because of the health care provider's bargaining advantage.¹⁹³ In upholding the agreement, the *Brown* court considered three factors: the health care provider may not require the agreement as a prerequisite to health care;¹⁹⁴ the patient may revoke at any time within the statutorily required sixty-day revocation period;¹⁹⁵ and the patient may make a realistic choice based on the information booklet which accompanies the form.¹⁹⁶

The validity of the *Brown* court's considerations depends on the patient's ability to understand the terms contained in an arbitration agreement, and the consequences of electing arbitration. Explanations by hospital personnel,¹⁹⁷ boldface provisions,¹⁹⁸ and information brochures¹⁹⁹ are meaningless unless the patient understands the terms "arbitration" and "revocation." Courts may attribute too much legal acumen²⁰⁰ to the average patient. The possible unfamiliarity of the

190. 100 Cal. App. 3d 698, 705-06, 161 Cal. Rptr. 146, 150-51 (1980).

191. The court relied on *Madden* in requiring actual knowledge on the part of the beneficiary if arbitration were an "extraordinary procedure" and one "especially disadvantageous" for the beneficiary. *Id.* at 708, 161 Cal. Rptr. at 151. See also *Madden v. Kaiser Found. Hosps.*, 17 Cal. 3d 699, 709 n.11; 552 P.2d 1178, 1184, n.11, 131 Cal. Rptr. 882, 888 n.11 (1976).

192. 107 Mich. App. 91, 309 N.W.2d 575 (1981).

193. *Id.* at 108, 309 N.W.2d at 582.

194. *Id.*

195. *Id.*

196. *Id.* The Michigan statute requires that the proffering of the agreement "shall be accompanied by an information brochure which clearly details the agreement and revocation provision." MICH. COMP. LAWS ANN. § 600.5041(6) (Supp. 1982). Maine has a similar provision. See ME. REV. STAT. ANN. tit. 24, § 2702(D) (Supp. 1982).

197. The court in *Wheeler* imposed procedural requirements on the hospital to better inform the patient: "The hospital's admission clerk need only direct the patient's attention to the arbitration provision, request him to read it, and give him a simple explanation of its purpose and effect, including available options." 63 Cal. App. 3d 345, 361, 133 Cal. Rptr. 775, 786 (1976).

198. To the extent that one does not understand the terms of the agreement, requiring the same to be printed in bold letters is like yelling at a deaf man. The patient has no greater comprehension of the significance of the terms because they are printed larger.

199. See *supra* note 196 and accompanying text.

200. The *Madden* court argued that persons selecting arbitration understood what they surren-

health care setting and the anxiety of seeking medical care creates an inappropriate atmosphere for explaining the legal consequences of electing arbitration.²⁰¹ A patient may not reasonably contemplate malpractice at such a time, let alone arbitrating such a claim.²⁰²

Disclosure of the legal consequences of the arbitration option also plays a part in determining whether the patient knowledgeably entered into the agreement. The health care provider should reveal all factors that might influence the patient's decision.²⁰³ It is not enough to inform a patient that due to the recent medical malpractice crisis²⁰⁴ legislatures²⁰⁵ have created an alternative forum for settling malpractice claims. The patient should know prior to election that arbitration may be as inefficient as litigation,²⁰⁶ and has resulted in fewer and lower awards for plaintiffs.²⁰⁷

dered. "When parties agree to submit their disputes to arbitration they select a forum . . . in which, as they well know, disputes are not resolved by juries." 17 Cal. 3d at 714, 552 P.2d at 1187, 131 Cal. Rptr. at 891.

The Patient Information Booklet supplied to the patient when offering arbitration under Michigan's statute defines "Arbitration" as "a substitute for going to court to settle disputes. It is a procedure by which disputing parties have a three-person panel of arbitrators, rather than a judge or jury, hear and make a final decision about the disagreement." PATIENT INFORMATION BOOKLET 1 (1976). This booklet is prepared by the Michigan Arbitration Advisory Committee, an 18-member group composed of health leaders, lawyers, insurance representatives and nine lay members, and is approved by the Michigan Commissioner of Insurance. See also Comment, *supra* note 1, at 325-26.

Printed at the top of the agreement, see *infra* Appendix C, is the message "This form is approved by the Michigan Commissioner of Insurance," set off in a box to attract the reader's attention. It is conceivable that a patient viewing this at the time of the offering will either infer that this is another insurance form which requires signature or that the agreement should be signed because it is approved by an authoritative government official.

201. One commentator suggested that inequality of bargaining power can result from incomplete knowledge: "[A]n extreme disproportion in values in a bargain transaction requires explanation, and the explanation can usually be found in some misplaced reliance on the opposite party's good faith, some misleading partial disclosure, or some extreme inequality of the parties in knowledge, experience, or economic resources." Dawson, *Economic Duress—An Essay in Perspective*, 45 MICH. L. REV. 253, 281 (1947).

202. See *Wheeler v. St. Joseph Hosp.*, 63 Cal. App. 3d 345, 360, 133 Cal. Rptr. 775, 786 (1976). See *supra* notes 166-69 and accompanying text.

203. As one commentator noted: "It is clear from the overwhelming 'acceptance' of the arbitral provisions embodied in the current treatment agreements that the public has not yet discovered what the fine print means." HEW APPENDIX, *supra* note 3, at 298.

204. See *supra* notes 1-5 & 23-35 and accompanying text.

205. See *supra* notes 36-41 and accompanying text. For a complete list of states that have created arbitration statutes, see *supra* notes 11 & 14 and accompanying text.

206. See *supra* note 7 and accompanying text.

207. See *infra* notes 252-67 and accompanying text.

Informed consent in the medical setting provides a comparable standard. Informed consent is crucial to the practice of medicine because it prevents an unlawful touching or battery action against a physician.²⁰⁸ In *Canterbury v. Spence*,²⁰⁹ the court held that a physician has a duty to disclose to the patient not only the proposed therapy but the potential and inherent dangers involved in the treatment.²¹⁰ Disclosure must encompass all material risks that may affect the patient's decision.²¹¹ True consent, the court reasoned, involves making a choice, which demands the "opportunity to evaluate knowledgeably the options available and the risks attendant upon each."²¹²

In applying the doctrine of informed consent to arbitration, the patient should know the risks, alternatives, and disadvantages of choosing arbitration. Any lower standard renders the assent involuntary, or at best, ill informed. The similarity between selecting the arbitration option and a medical procedure makes the *Canterbury* test of consent particularly applicable. Both depend upon the availability and communication of risk information essential to an informed decision, thereby respecting the patient's right to self determination.²¹³

208. See D. LOUISELL & H. WILLIAMS, *supra* note 18, at ¶ 22.08. For excellent reviews of cases applying informed consent in the medical field, see generally Hagman, *The Medical Patient's Right to Know: Report on a Medical-Legal-Ethical Empirical Study*, 17 U.C.L.A. L. REV. 758 (1970); Karchmer, *Informed Consent: A Plaintiff's Medical Malpractice "Wonder Drug"*, 31 MO. L. REV. 29 (1966); Oppenheim, *Informed Consent to Medical Treatment*, 11 CLEV.-MAR. L. REV. 249 (1962); Plante, *An Analysis of Informed Consent*, 36 FORDHAM L. REV. 639 (1968).

The Secretary's (HEW) Commission on Medical Malpractice criticized informed consent as placing an unfair burden on the doctor. Even if a patient consents, the physician may be liable if the patient can prove that the physician inadequately informed him of the risks associated with the procedure. HEW REPORT, *supra* note 1, at 29.

209. 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

210. *Id.* at 782.

211. "A risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to undergo the proposed therapy." Waltz & Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 640 (1970).

Courts apply an objective test in establishing consent: "whether a reasonable man would conclude from the patient's behavior that he was aware of the risk and that he manifested a willingness to encounter it." *Id.* at 645.

212. 464 F.2d at 790. The patient's consent must be informed because "uninformed consent is really no consent at all." Note, *supra* note 2, at 94.

213. 464 F.2d at 784. The court based its reasoning of the informed consent doctrine on the "root premise" that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Id.* at 780 (citing *Schloendorff v. Society of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914)).

B. Constitutional Considerations: Due Process and Panel Bias

The composition of an arbitration panel may violate the patient's due process right to a fair and impartial tribunal.²¹⁴ Although panel composition varies widely among the states, the arbitration statutes commonly provide for a three-member panel composed of a physician or hospital administrator, an attorney, and a layperson.²¹⁵ The physician's presence on the panel raises potential due process considerations.

An impartial decisionmaker can have neither a pecuniary²¹⁶ nor a financially related professional interest²¹⁷ in the outcome. A physician may have a significant pecuniary interest in an arbitration proceeding. A large award may affect the availability of insurance and increase the panelist's own malpractice rates. In an effort to reduce competition, or out of a feeling of professional responsibility, a physician may be tempted to punish his fellow medical practitioners. It is more likely, however, that a physician will empathize with a fellow doctor. This empathy, combined with the physician-panelist's own pecuniary interest in keeping insurance rates low, creates a tremendous disincentive to find fault or to make a large damage award, even if justified. Thus, the presence of the physician may violate the patient's due process rights.

In Michigan, lower appellate court panels have split on this question. In *Jackson v. Detroit Memorial Hospital*,²¹⁸ one panel held the state's malpractice arbitration statute unconstitutional because it included a physician on the panel. Although Michigan's statute contained a provision requiring that the American Arbitration Association screen all potential panel members,²¹⁹ the court found that the likelihood of phy-

214. *Arnett v. Kennedy*, 416 U.S. 134, 197 (1974) (White, J., concurring in part and dissenting in part); *In re Murchinson*, 349 U.S. 133, 136 (1965). See also *infra* Appendix E.

215. See *supra* notes 135-56 and accompanying text for a discussion of states that follow this pattern.

216. See *Ward v. Village of Monroe*, 409 U.S. 57 (1972) (mayor may not sit as judge in traffic court where large part of village income derived from fees and fines); *Tumey v. Ohio*, 273 U.S. 510 (1927) (mayor may not receive costs assessed against convicted defendants as compensation for acting as judge).

217. See *Gibson v. Berryhill*, 411 U.S. 564 (1973) (Optometric Board composed of optometrists in private practice may not revoke licenses of optometrists in business practice due to potential pecuniary gain); *Commonwealth Coatings Corp. v. Continental Casualty Co.*, 393 U.S. 145 (1969) (neutral third arbitrator's services utilized by one party prior to arbitration proceedings).

218. 110 Mich. App. 202, 312 N.W.2d 212 (1981).

219. In both Michigan and Maine, the American Arbitration Association actively aids the parties in selecting a panel. In those two states the panel consists of an attorney, a physician, preferably but not necessarily from the defendant's specialty, and a layman who is not a representative of the medical, hospital, or insurance fields. MICH. COMP. LAWS ANN. § 600.5044(2) (Supp.

sician bias was too high to be constitutionally permissible.²²⁰ The court based its findings on the pecuniary relationship between the size of malpractice awards and insurance premiums.²²¹ In *Brown v. Siang*,²²² however, another panel held that a nexus between damage awards and insurance premiums was too remote²²³ reasoning that the safeguards within the statute ensured the impartiality of the physician panel-member.²²⁴

1982); ME. REV. STAT. ANN. tit. 24, § 2705(1) (Supp. 1982). In contrast to the common method of selection, whereby each party selects an arbitrator, and the two arbitrators pick a third, the parties in Maine and Michigan combine their ranked preferences in each of the three categories to create the panel. MICH. COMP. LAWS ANN. § 600.5044(3) (Supp. 1982); ME. REV. STAT. ANN. tit. 24, § 2705(1) (Supp. 1982).

220. 110 Mich. App. at 204, 312 N.W.2d at 213.

221. *Murray v. Wilner*, No. 50386 (Mich. Ct. App. July 21, 1982). In *Murray*, the court held that the potential pecuniary bias threatened a physician's impartiality.

The threat from the interrelations between awards and the cost of insurance is that it may contribute to a subtle systematic bias in arbitrators chosen from the medical profession. It is a relationship that offers a possible temptation to the average man as a decisionmaker to forget the requisite burden of proof, and which might lead to a decisionmaker to fail to hold the balance between the parties nice, clear, and true.

Id. at 8-9. See also *supra* notes 23-35 and accompanying text.

222. 107 Mich. App. 91, 309 N.W.2d 575 (1981).

223. *Id.* at 104, 309 N.W.2d at 580.

224. *Id.* The appeals court panel in *Cushman v. Frankel*, 111 Mich. App. 604, 314 N.W.2d 705 (1981), cited several statutory procedures to reduce the possibility of bias among panel members:

- (1) arbitration association conducts an initial screening of potential candidates for potential bias;
- (2) each panel candidate must complete a personal disclosure statement under oath;
- (3) the parties will receive any information as to partiality;
- (4) the parties may also submit voir dire questions to a candidate within 10 days after receiving a candidate's name;
- (5) the parties may strike an unacceptable candidate from the suggested list;
- (6) panel members appointed by the association are subject to challenge for cause.

Id. at 610, 314 N.W.2d at 708.

In a vehement response to the majority's opinion in *Williams v. O'Connor*, 108 Mich. App. 613, 310 N.W.2d 825 (1981), the dissent argued that the failure of the arbitration agreement to indicate the composition of the panel vitiates any attempt to secure a patient's voluntary, knowing, and intelligent election of the arbitration option. *Id.* at 623, 310 N.W.2d at 829 (Burns, J., dissenting). Moreover, the dissent noted that a physician's bias may reach beyond pecuniary concerns: "members of the medical profession are not likely to have neutral feelings on the topic of medical malpractice claims as is evident by the reluctance of physicians to testify in medical malpractice actions." *Id.*

For other decisions among the Michigan court of appeals which have upheld the constitutionality of a physician on the arbitration panel, see *Gale v. Providence Hosp.*, No. 53097 (Mich. Ct. App. July 21, 1982); *Rome v. Sinai Hosp.*, 112 Mich. App. 387, 316 N.W.2d 428 (1982); *Cushman v. Frankel*, 111 Mich. App. 604, 314 N.W.2d 705 (1981); *Morris v. Metriyakool*, 107 Mich. App. 110, 309 N.W.2d 910 (1981). *But see* *Strong v. Oakwood Hosp. Corp.*, No. 52690 (Mich. Ct. App. July 21, 1982); *Malek v. Jayakar*, No. 44356, 45563 (Mich. Ct. App. May 5, 1982).

A previous employment relationship with one of the parties may also demonstrate bias. In *Wheeler v. St. Joseph Hospital*,²²⁵ a California court overturned an arbitration award because the physician-panelist failed to disclose that he had rendered services on behalf of the defendant's law firm after his appointment to the panel.²²⁶

IV. THE PATIENT'S BEST INTERESTS: EVALUATION AND REFORM

A. *The Effectiveness of Arbitration: Case Studies*

Through arbitration, legislatures hoped to reduce the delays and costs associated with litigation.²²⁷ They also believed that a panel composed of professionals would have a greater understanding of medical terminology and procedures, would be less subject to emotional appeals than juries,²²⁸ and would render more rational awards. The goals of arbitration, although laudatory from the viewpoint of the medical and insurance professions, may harm the interests of health care recipients.

One of the most comprehensive studies of arbitration programs developed from the Southern California Arbitration Project, designed in cooperation with the California Hospital Association and the California Medical Association.²²⁹ Between 1966 and 1975, eight hospitals in the Los Angeles area agreed to offer patients voluntary, binding arbitration agreements that allowed for a thirty day revocation period.²³⁰ The study targeted an additional group of hospitals as a control group which resolved disputes through litigation.

The data revealed that between 1966 and 1975 the arbitration and control groups closed approximately the same percentage of claims.²³¹ The data showed that arbitration resolved the average claim in approx-

225. 63 Cal. App. 3d 345, 133 Cal. Rptr. 775 (1976).

226. *Id.* at 370, 133 Cal. Rptr. at 792.

227. *See supra* notes 7 & 13 and accompanying text.

228. *See supra* note 7 and accompanying text.

229. *See Heintz, Medical Malpractice Arbitration: A Viable Alternative*, 34 ARB. J. 12 (Dec. 1979) [hereinafter cited as *Arbitration Study*]. For an evaluation of this study through 1975, see Heintz, *Arbitration of Medical Malpractice Claims: Is it Cost Effective?*, 36 MD. L. REV. 533 (1977).

230. *Arbitration Study, supra* note 229, at 13.

231. *Id.* at 15. Of the claims filed from 1966 to 1969, as of June 30, 1978, 98.14% and 97.58% were closed for arbitration and control groups, respectively. Of the claims filed between 1970 and 1975, the arbitration group closed 78.92%, the control group closed 78.05%. *Id.*

imately three months shorter time than litigation.²³² Arbitration settled the greatest percentage of claims in twelve to twenty-four months,²³³ compared to twenty-four to thirty-six months for litigation.²³⁴

Both forms of dispute resolution gave a virtually identical percentage of awards under \$15,000.²³⁵ Both groups closed 50% of the claims without any payment,²³⁶ although the arbitration group experienced nearly a 60% savings in defense costs.²³⁷ The largest percentage of awards for both groups was between \$1000 and \$5000.²³⁸ The greatest differential in awards arose in claims for over \$40,000. Under arbitration, 1.5% of all claims received over \$40,000; under litigation, 3.7%.²³⁹ In addition, only 1% of the 500,000 patients opted to revoke the contract for arbitration within the thirty-day revocation period.²⁴⁰ Thus, the data from this study reveal that arbitration may slightly decrease the time in the resolution of disputes, lower defense costs, and produce damage awards nearly equal to jury awards, except for claims worth more than \$40,000.

Michigan was the first state to adopt a medical malpractice arbitration statutory program statewide.²⁴¹ Since the start of the program in January 1976, 323 patients have filed claims for arbitration.²⁴² As of December 1981, 50%, or 173 claims, remain pending.²⁴³ Of the 150 closed claims, patients withdrew 24.7% prior to submission and settled 53.3%.²⁴⁴ Twenty-two percent resulted in an award to the claimant. Settlements ranged from \$300 to \$220,000, with a mean of \$20,000.²⁴⁵

232. Between 1970 and 1975, the arbitration group resolved the average claim in 31.22 months; the control group in 33.5 months. *Id.* at 16.

233. The arbitration group, between 1970 and 1975, closed 26.79% of all claims within 12 to 23 months. *Id.*

234. The control group, between 1970 and 1975, closed only 17.9% of claims within 12 to 23 months, but closed 23.36% of all claims within 24 to 35 months. *Id.*

235. *Id.* at 17.

236. *Id.*

237. *Id.* at 18. Defense costs were 58.93% less in arbitration than in litigation.

238. *See id.* at 17 table 2.

239. *Id.*

240. *Id.* at 13. The author noted that some of these agreements proved unenforceable because of inappropriate execution. *Id.*

241. *See* Schoonmaker, *The Medical Malpractice Arbitration Program in Michigan*, 642 INS. L.J. 370, 370 (June 1977).

242. MICHIGAN DEP'T OF LICENSING AND REGULATION, MICHIGAN ARBITRATION PROGRAM: SUMMARY CASE STATISTICS 1 (Dec. 31, 1981).

243. *Id.* Seventy-four of the 76 claims filed in 1981 were still pending as of December 31, 1981.

244. *Id.*

245. *Id.* at 2.

Of the thirty-three claims resolved through arbitration, the patient prevailed in only eight cases.²⁴⁶ The awards ranged from \$250 to \$20,100, with a mean of about \$9200, a figure substantially below the average settlement.²⁴⁷

From this limited data, arbitration apparently resolves malpractice claims more expeditiously and less expensively than litigation. Arbitration hearings averaged two days in length, with administrative costs²⁴⁸ and expenses averaging about \$1470. This figure does not include the cost of the six-month discovery period or attorney case preparation.²⁴⁹ On the average, 340 days elapsed from the filing of the claim to the award, excluding the discovery and thirty day award periods.²⁵⁰ Thus, under the Michigan plan, it takes nearly a year to receive an average award of about \$9000, a figure that resembles the average award under the California project.²⁵¹

B. Suggested Reforms

It is difficult to accurately predict from this preliminary data whether arbitration results in more expeditious and equitable awards for patients. Data suggest that arbitration provides a shorter time from the filing of a claim to the eventual award, although the savings is not substantial.²⁵² Congested court dockets demand that patients be encouraged to follow an alternative to litigation. By following the alternative, patients should not, however, forfeit their rights. Patients should decide whether arbitration is more advantageous for their situation. Because the decision is binding and subject to limited judicial review, the health care provider should fully inform patients of the consequences of their actions.

To ensure that the patient's consent is truly informed and voluntary, the health care provider should not offer the arbitration option prior to the claim.²⁵³ The anxieties present in unfamiliar surroundings, and the potential inability of the medical personnel to adequately explain the

246. *Id.* at 1.

247. *Id.* at 2.

248. *Id.*

249. *Id.* at 1.

250. *Id.*

251. *See supra* note 235 and accompanying text. The average claim under the California plan ranged between \$1000 and \$5000.

252. *See supra* notes 232-35 and accompanying text.

253. *See supra* notes 115-35 and accompanying text.

arbitration option, may nullify or interfere with the voluntariness of the election. The patient's physical or mental condition may inappropriately affect the decision to agree to arbitrate, although the patient's election appears voluntary.

Similarly, a patient may regret selecting the option prior to the manifestation of subsequent injuries. The statutory period for revocation²⁵⁴ becomes virtually meaningless if the patient lacked information and believed that his signature was required on the form. Upon completion of treatment, the average patient is not likely to spend the next thirty or sixty days deliberating whether or not to revoke.

Requiring that the agreement be presented after the claim has arisen, with an attorney present, is one solution to help ensure that the patient intentionally, knowingly, and voluntarily agreed to arbitration.²⁵⁵ Although this suggestion may seem burdensome, an attorney is more likely to be informed of the legal consequences of the election than medical personnel. The attorney could discuss with the patient the advantages and disadvantages of arbitration, perhaps by utilizing available data collected for this purpose. The health care provider should fully inform the patient about the risks and benefits associated with choosing arbitration. Anything less constitutes an inequitable deprivation of valuable patient rights.

V. CONCLUSION

In an attempt to combat the medical malpractice crisis and pacify the discontent in the health care profession, many states adopted arbitration statutes to provide an alternative forum for malpractice disputes. These statutes, however, deprive patients of valuable rights by prescribing inequitable procedures associated with the election of arbitration and resolution of their claims. Whether arbitration is ultimately in the patient's best interests is still unclear, and perhaps more data will provide the answer. Nevertheless, legislatures must ensure that arbitration is in the best interests not only of the medical profession, but of society as a whole.

Jacqueline R. Baum

254. *See supra* notes 114-34 and accompanying text.

255. *See supra* notes 157-213 and accompanying text.

APPENDIX A
ARBITRATION AGREEMENT: BOLDFACE
WARNINGS

ALASKA ^a	X			
CALIFORNIA ^b		X	X	
ILLINOIS ^c	X	X	X	X
MAINE ^d	X			X
MICHIGAN ^e	X			X
OHIO ^f		X		
S.DAKOTA ^g	X	X		
	Not prerequisite to treatment	Arbitration election	waive jury trial	Revocation

^aALASKA STAT. § 09.55.535(b) (Supp. 1982).

^bCALIF. CIV. PROC. CODE § 1295(b) (Deering 1982).

^cILL. ANN. STAT. ch. 10, § 209(d) (Smith-Hurd Supp. 1982).

^dME. REV. STAT. ANN. tit. 24, § 2702(1)(B) (Supp. 1982).

^eMICH. COMP. LAWS ANN. § 600.5041(5) (Supp. 1982).

^fOHIO REV. CODE ANN. § 2711.24 (Page 1981).

^gS.D. CODIFIED LAWS ANN. § 21-25B-3 (1979).

APPENDIX B^a
HEALTH CARE PROVIDERS COVERED BY
ARBITRATION

	ALABAMA ^a	ALASKA ^b	CALIFORNIA ^c	GEORGIA ^d	ILLINOIS ^e	LOUISIANA ^f	MAINE ^g	MICHIGAN ^h	OHIO ⁱ	S.DAKOTA ^j	VERMONT ^k	VIRGINIA ^l
Chiropractor			X		X	X		X				X
Clinic	X		X	X	X	X		X	X			X
Dentist	X		X	X	X	X		X				X
Doctor	X		X	X	X	X	X	X	X	X		X
Health Dispensary			X									
Health Facility			X									
HMO			X	X	X			X		X		
Hospital			X	X	X			X	X	X		X
Legal Rep.			X	X			X					
Nurse					X			X				X
Nursing Home				X	X							X
Optometrist					X	X		X				X
Osteopath	X		X									X
Pharmacist						X		X				X
Phys. Therapist					X	X		X				X
Podiatrist					X	X		X	X			X
Psychologist						X						X
Sanitarium					X			X				
Unspecified— "Health Care Prov"		X					X				X	

^aThis chart based on an earlier survey by Ladimer, *Statutory Provisions for Binding Arbitration of Medical Malpractice Claims*, 1976 INS. L.J. 405,409.

^bALA. CODE § 6-5-481 (1977).

^cALASKA STAT. § 09.55.535 (Supp. 1981).

^dCALIF. CIV. PROC. CODE § 1295(g)(1) (Deering 1981).

^eGA. CODE ANN. § 7-401 (Supp. 1982).

^fILL. ANN. STAT. ch. 10, § 202(a) (Smith-Hurd Supp. 1982).

^gLA. REV. STAT. ANN. § 9:4230(1) (West Supp. 1982).

^hME. REV. STAT. ANN. tit. 24, § 2701(1) (Supp. 1982).

ⁱMICH. COMP. LAWS ANN. § 600.5040(2)(b) (Supp. 1982).

^jOHIO REV. CODE ANN. § 2711.22 (Page 1981).

^kS.D. CODIFIED LAWS ANN. § 21-25B-1 (1979).

^lVT. STAT. ANN. tit. 12, § 7002 (Supp. 1982).

^mVA. CODE § 8.01-581.1 (1977 & Supp. 1982).

APPENDIX C

This form is approved by the Michigan Commissioner of Insurance

ARBITRATION AGREEMENT

HOSPITAL IN-PATIENT, OUT-PATIENT SURGERY AND EMERGENCY ROOM FORM

I understand that this hospital and I by signing this document agree to arbitrate any claims or disputes (except for disputes over charges for services rendered) which may arise in the future out of or in connection with the health care rendered to me during this hospital stay and/or emergency room visit by this hospital, its employees and those of its independent staff doctors and consultants who have agreed to arbitrate.

I understand that Michigan Law gives me the choice of trial by judge or jury or of arbitration. I understand that arbitration is a procedure by which a panel that is either mutually agreed upon or appointed decides the dispute rather than a judge or jury. I freely choose arbitration, and I agree that a judgment of any circuit court may be rendered upon any award or determination made pursuant to this agreement. I also understand that any arbitration will be conducted in accordance with Michigan Law and the Michigan Medical Arbitration Rules, as approved by the Commissioner of Insurance.

I understand that this agreement to arbitrate is binding on me and all my agents, representatives and heirs and assigns, as well as on this hospital, its employees and those of its independent staff doctors, and consultants who have agreed to arbitrate.

I certify that I have read this agreement or have had it read to me and that I fully understand its content and execute this agreement of my own free will. I have received a complete copy of the booklet which explains this agreement.

THIS AGREEMENT TO ARBITRATE IS NOT A PREREQUISITE TO HEALTH CARE OR TREATMENT AND MAY BE REVOKED WITHIN 60 DAYS AFTER DISCHARGE BY NOTIFICATION IN WRITING TO: _____

Signature of Hospital Representative

Patient Name (Type or Print)

Address

Patient Signature

Date

Patient Address

(I certify that I am the parent of the minor child, the guardian, or other legal representative of the patient involved.)

INSTRUCTIONS FOR USE

Give Booklet with proposed agreement to patient; if agreement is signed, place duplicate original in patient's file

Name of parent, legal guardian or other legal representative (type or print)

Emergency Room: Do not present for patient signature until after emergency care has been completed.

Signature of parent, legal guardian or other legal representative

FOR FURTHER INFORMATION CONTACT: AMERICAN ARBITRATION ASSOCIATION City National Bank Building - No. 1035 - Detroit, Michigan 48226 - Phone: (800) 486-0660

APPENDIX D

AGREEMENT REVOCATION SPECIFICATIONS

	By		Time Limitations				
	Whom						
	Either Party	Patient Only	Days after Execution	Days after Discharge	Termination of Medical Relationship	Termination of health care	No limit
ALASKA ^a		X	30				
CALIFORNIA ^b	X		30				
ILLINOIS ^c	X		60	60		60	
LOUISIANA ^d		X	30				
MAINE ^e		X	60	30			
MICHIGAN ^f		X	60	60			
OHIO ^g		X		60	X		
S.DAKOTA ^h	X						X
VIRGINIA ⁱ		X				60	

^aALASKA STAT. § 09.55.535(c) (Supp. 1981).

^bCALIF. CIV. PROC. CODE § 1295(c) (Deering 1981).

^cILL. ANN. STAT. ch. 10, § 209(c) (Smith-Hurd Supp. 1982).

^dLA. REV. STAT. ANN. § 9:4233 (West Supp. 1982).

^eME. REV. STAT. ANN. tit. 24, § 2702(c) (Supp. 1982).

^fMICH. COMP. LAWS ANN. §§ 600.5041(3), 600.5042(3) (Supp. 1982).

^gOHIO REV. CODE ANN. § 2711.23(B) (Page 1981).

^hS.D. CODIFIED LAWS ANN. § 21-25B-1 (1979).

ⁱVA. CODE § 8.01-581.12(A) (1977 & Supp. 1982).

**APPENDIX E
ARBITRATION PANEL SELECTION**

	SELECTION					COMPOSITION				
	By claimant	By Opponent	Parties select third	Arbitrators select third	Govt assisted to select third	Amer. Arbit Assn. aid	Doctor	Attorney	Layman	Not Specified
ALABAMA ^a	X	X		X	X					X
ALASKA ^b	X	X	X		X					X
CALIF. ^c			unspecified							
GEORGIA ^d	X	X		X	X					X
ILLINOIS ^e	X	X		X	X					X
LOUISIANA ^f	X	X		X						X
MAINE ^g	X	X		X		X				X
MICHIGAN ^h	X	X				X				X
OHIO ⁱ	X	X								X
P.RICO ^j		Secretary of Health					X	X	X	
S.DAKOTA ^k	X(1)	X(1)					X	X	hosp. admin.	
\$10,000 ^{k2}	X(2)	X(2)					X	X	hosp. admin.	
VERMONT ^l	X	X			X		X	X	X	
VIRGINIA ^m		Chief Justice of Va. Sup. Ct.					X(3)	X(3)	X(1)	

^aALA. CODE § 6-5485(b) (1977).

^bALASKA STAT. § 09.55.535(f) (Supp. 1981).

^cNot Applicable

^dGA. CODE ANN. § 7-408(a) (Supp. 1982).

^eILL. ANN. STAT. ch. 10, § 213 (Smith-Hurd Supp. 1982).

^fLA. REV. STAT. ANN. § 9:4231 (West. Supp. 1982).

^gME. REV. STAT. ANN. tit. 24, § 2705 (Supp. 1982).

^hMICH. COMP. LAWS ANN. § 600.5044(2) (Supp. 1982).

ⁱOHIO REV. CODE ANN. § 2711.23(F) (Page 1981).

^jP.R. LAWS ANN. tit. 26, § 4111 (Supp. 1980).

^kS.D. CODIFIED LAWS ANN. § 21-25B-4 (1979).

^{k2}S.D. CODIFIED LAWS ANN. § 21-25B-13 (1979).

^lVT. STAT. ANN. tit. 12, § 7002(a) (Supp. 1982).

^mVA. CODE § 8.01-581.3 (1977 & Supp. 1982).

