Medical Malpractice Arbitration Agreements: Is Uniformity the Solution?

By Alba Reyes Santos, LL. M. Candidate

Arbitration agreements in medical malpractice cases have been generally recognized as having advantages over traditional litigation, but there is a lack of evidence to prove these advantages, as well as lack of actual knowledge regarding how much these agreements are actually used. This limits the ability to determine the effects this practice has or could have on the current crisis on health care costs.\(^1\) Arbitration agreements for medical malpractice are written contracts between health care providers and patients in which both agree to arbitrate any dispute or claim arising from the medical care provided to the patient by the health care provider. Usually these agreements are presented to the patient while being admitted to a health care institution or before receiving treatment by a physician. The main problem that arbitration agreements face is that courts for many years have been unwilling to enforce them. Recently, there has been a change in the way courts interpret arbitration agreements, largely as a response to Congressional and state statutes that provide parties interested in arbitration with the tools to make such contracts enforceable.

During the last two decades, and as a response to the so called “medical malpractice crisis” of the 70's and the subsequent crises in the 80's and 2000's,\(^2\) much has been written about the cost of medical liability and its effects on health care costs. However, studies that show an exact figure are difficult to find, and the ones that do


provide specific numbers have limitations. For example, a study conducted in 2005 estimated the American tort system to have a cost of $260.8 billion, of which $29.4 billion were due to medical malpractice claims.\(^3\) In a more recent study that looked at the cost of medical liability for 2008, the estimated number was $55.64 billion.\(^4\) Even though this figure accounts for only 2.4% of health care costs, the amounts are significant. There is controversy about whether this percentage of health care costs related to medical liability is significant enough to be responsible for the increase cost of health care services and insurance premiums. Although there is debate about whether tort reform has helped to lower the cost of insurance premiums, a study of the U.S. Department of Health and Human Services found that states that have adopted some form of tort reform have experienced an increase of insurance premiums that is at least 50% lower than that found in states that have not.\(^5\)

It is possible that the same effect could be achieved through the use of arbitration agreements. The effects on insurance companies would be the same: they would pay less.

“This benefit to the insurance companies could potentially result in lowering the cost of medical-malpractice insurance for health-care practitioners required to carry it, and in theory would translate to lower overall health-care costs as insurance companies paying less in damages would charge less for consumers to buy health insurance. In a domino effect, if health-care practitioners paid less in medical-malpractice premiums, they may choose to charge less for their services.”\(^6\)

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\(^3\) *Id.* at 514.


\(^6\) *Id.* at 140.
The same author suggests that there are contradictory studies about the real impact of these reforms on the health care crisis and that there is no conclusive evidence that such reforms are responsible for the slower growth in the cost of premiums in states that have adopted the damages caps; however, he fails to discuss if there is any evidence that can relate and explain this impact in regards to other aspects of the insurance and health care industry.

The other area of the health care crisis that can benefit from the use of uniform arbitration statutes is physician migration and the lack of physicians in high-risk specialties that have created underserved areas of specialties and underserved communities. As happens with state tort reforms, there is a real possibility that health care providers will be more attracted to states in which arbitration and other methods are used widely for the resolution of medical malpractice claims. This is why it is important to analyze the need and possibility of adopting a uniform statute that will not create an incentive for health care providers to migrate to more favorable markets.

The first part of this Article presents some of the reasons why arbitration should be an alternative for the resolution of medical malpractice claims and the benefits associated with arbitration in comparison to litigation. The next section is an overview of the federal statutes that have been enacted to recognize and promote arbitration as well as a brief discussion of some of the problem that state statutes currently present and of some of the most common elements and requirements in state statutes regarding medical malpractice arbitration agreements. Third, a brief discussion follows of some of the problems arbitration agreements between doctors and patients may encounter in state and
federal courts to underscore why a uniform statute should be adopted. Finally, there will be a compilation of key points that an arbitration statute regarding doctors/patients arbitration agreements should contain in order to provide protection to patients, without creating an obstacle to the use of these agreements on a regular basis.

I. Arbitration versus litigation

There is at present a general recognition that arbitration has many benefits and advantages over traditional litigation in medical malpractice claims. It is recognized that arbitration provides the health care provider the advantages of privacy, lower defense costs, and objective damage awards. On the other hand, arbitration can provide patients the same benefits it offers to health care providers plus the benefits of a quick and fair decision much sooner than a trial, which also benefits those patients who may be forced to settle if they run out of financial resources while pursuing a claim in court. The patient not only receives compensation more quickly but, in the end, she is also subject to lower legal fees. It is important that patients understand that, while they waive the right to trial by jury, by using arbitration they can still fully recover. It is also true for both parties that arbitration is less adversarial and complex and ultimately may create less damage to the healthcare provider-patient relationship.  

Regardless of these advantages there has not been a great increase in the number of healthcare providers and patients who agree to arbitrate claims. A 1997 survey of doctors and hospitals demonstrated that only nine percent of those surveyed used arbitration agreements. Although the use of these agreements as part of the admission

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7 Kenneth A. DeVille. The Jury is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims; 28 J. Legal Med. 333, 340.(2007).
process to hospitals is at least twice that of doctors’ offices, it still only accounts for twenty percent of patients admitted to hospitals.⁸

Even though many seem to think that arbitration agreements between physicians and patients are always more favorable to doctors, the latter seem to think otherwise. This is probably the main obstacle that arbitration has found in the medical arena. Many doctors believe that trying the case and winning is better than reaching a settlement outside the courtroom. This feeling has only been reinforced by the adoption of “The Health Care Quality Improvement Act (HCQIA)”.⁹ The Act was sponsored by the American Medical Association (AMA) and was approved in Congress in 1986. Originally, the main purpose of the Act was to control the incidence of medical malpractice around the nation. Unfortunately, one negative side effect of the Act is that by requiring “any entity or individual that makes a payment on behalf of any licensed health care practitioner, resulting from a claim or judgment for medical malpractice, to report it to both the National Practitioner Data Bank and the appropriate state licensing board”¹⁰ it has reduced doctors’ willingness and motivation to arbitrate. Doctors feel that if they do not go to court and try to reach an agreement it will be used against them and will come to haunt them sooner or later. Doctors who have multiple listings of medical malpractices payments find it difficult to obtain hospital privileges, membership in

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⁸ Rolph, Moller & Rolph, supra note 1 at 171.
⁹ 42 USC §§ 11101 - 11152.
managed care organizations and face an increase in their liability insurance.\textsuperscript{11} Insurance companies are usually the ones that pay litigation costs and final awards, if any, towards patients. Since the money does not come directly from the doctor's pocket and the policy payments are pretty much standard today and a requirement for doing business, it may seem to some doctors that they do not have a real need to arbitrate in order to reduce the litigation expenses and the possible higher awards from a jury trial. However, as mentioned before, taken as a whole, the number and cost of successful claims has an effect on healthcare costs and on insurance premiums. Another thing to consider is that insurance companies will drop doctors who have several claims and awards under the insurance coverage.

On the flip side are the patients. Most of the cases addressing arbitration that are presented to the courts deal with patients trying to annul a medical arbitration agreement. Patients usually argue that they did not knowingly waive their right to trial by jury and that they did not understand or know what they were signing. It seems that many patients prefer litigation to arbitration. One reason could be that many relate jury trials to larger awards. Also there are many emotional aspects regarding medical malpractice claims that may compel patients to litigate their claims: "the emotionally charged issues of illness, death, and dying may create compelling reasons for the plaintiff to litigate to the full extent possible."\textsuperscript{12}

However, there is no doubt that there are serious disadvantages to litigation, especially its critical, if not irreversible, damage to the doctor-patient relationship, as well

\textsuperscript{11} Id. at 309.
as the “… high emotional and financial costs to the litigants, … and the inability of tort litigation to deter physician negligence.”\(^{13}\) This is where federal and state legislation have come into play trying to make both parties more comfortable when entering an arbitration agreement, by making a public policy that favors the resolution of medical malpractice and providing courts with the tools to enforce this kind of agreement.

II. Federal and State attempts to promote and regulate arbitration and arbitration agreements

The first attempt to promote arbitration was the Federal Arbitration Act (FAA) in 1925. The FAA has two main purposes: first, to end the feeling of animosity towards arbitration, and second to make courts enforce arbitration agreements involving interstate commerce and maritime transactions. The FAA declares such agreements "valid, irrevocable and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract."\(^{14}\) However, the FAA has found its way into the medical malpractice arena due to the generous interpretation of "interstate commerce". The courts, in order to determine if there is an interstate commerce matter, have taken into consideration: "…the receipt of Medicare funds, the receipt of materials from other states, treatment of out-of-state patients, and out-of-state offices…”\(^{15}\) Once a court determines

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\(^{13}\) Id.
that the agreement is one involving interstate commerce, the FAA applies, which in many cases results in the preemption of state laws affecting arbitration agreements.

The FAA provides only four circumstances in which a court may vacate an arbitration award: (1) "the award was procured by corruption, fraud, or undue means;" (2) "evident partiality or corruption" on the part of the arbitrators; (3) misconduct on the part of the arbitrators by improperly "refusing to postpone the hearing," refusing to hear material evidence, or prejudicing the rights of a party; or (4) the "arbitrators exceeded their powers, or ... imperfectly executed them."16

Thirty years after Congress passed the FAA, the National Conference of Commissioners on Uniform State Laws published the Uniform Arbitration Act (UAA). The UAA was created with the states in mind. It offers the states arbitration mechanisms that are more versatile than the FAA. At least 48 states have adopted the UAA.17

However, in an attempt to control their court dockets, several states have adopted tort reforms. With the states having different standards and requirements for medical malpractice claims, one can argue that this presents disadvantages to providers in states in which the system is still "plaintiff friendly". The same applies to differences regarding arbitration of medical malpractice claims between the different states. While some states mandate arbitration of medical malpractice claims, in others it is voluntary. Even in those states that have enacted specific statutes regarding arbitration of medical malpractice claims there are differences in the content and requirements making the use of arbitration agreement in some states something fairly simple and very burdensome in others. This

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creates a difference in the treatment physicians get when trying to enforce an arbitration agreement.

In 2011 the American Medical Association Advocacy Resource Center prepared a table that describes the different liability reforms adopted by each state, if any, including the possibility or requirement of arbitration as those reforms relate to medical malpractice arbitration agreements. There are several common principles shared by the different states that have adopted statutes that regulate arbitration agreements between patients and physicians. McCurdy summarizes them in his article. They include signature of the agreement as a condition to receive treatment, right to revoke agreement after treatment, notice provision of the agreement, and simplicity of language.18

The current options include different types of arbitration. Some states have voluntary binding and non-binding arbitration; others have mandatory arbitration for all medical malpractice claims, while in others it is mandatory if the damage claims are under a specific amount. There are differences even among the states that have mandatory arbitration. In some it is required but can be waived by one of the parties; in others the parties can reject the arbitration decision and proceed to trial. Other states do not have any provisions on arbitration and some provide the parties with the option of consenting to a rule of court referring all matters in controversy to arbitration. Even in those states that have statutes that specifically address arbitration agreements there is no consensus of when the agreement should be presented. There is also no consensus on caps on damages.

18 McCurdy, supra note 15, at 237.
III. The need for a uniform accepted statute

The past and present enforcement of medical malpractice arbitration agreements has not been easy. In the past, arbitration agreements between doctors and patients have been assailed based on the constitutional protection of the patient's right of trial by jury. Much of the courts' intervention regarding doctor/patient arbitration agreements has been about the enforceability of the agreements in terms of contracts of adhesion and the protections that are needed to make sure that the weaker party (the patient) enters into the agreement knowingly. McCurdy argues that the statutes concerning medical arbitration agreements adopted by states have two main purposes: first, to ensure that the patient "knowingly enters into the arbitration agreement" and second, to create a framework to "ensure the enforceability of the arbitration agreements." In an effort to comply with these requirements many state statutes provide procedural safeguards and requirements that sometimes are minimal while others go as far as providing the specific language and style of the waiver clause.

The main challenge posed is FAA pre-emption. In recent cases, courts have found that state laws that add requirements to enforce arbitration agreements are pre-empted by the FAA if certain factors are present: (1) the agreement is in writing, (2) it involves interstate commerce, (3) it can withstand scrutiny under traditional contract defenses, and (4) state law affects the enforceability of the agreement. In In re Nexion Health at Humble, the Texas Supreme Court determined that Medicare funds crossing state lines were interstate commerce and, therefore, brought the arbitration contract within the FAA.

19 Id. at 233.
In this case the Texas Arbitration Act (TAA) required the signature of a party’s counsel on arbitration agreements in personal injury cases, and the Court found that the federal law pre-empted this provision since it interfered with the enforceability of the arbitration contract. Some may think that this is a limited scenario, since it dealt with Medicare funds, but the problem is that different courts have interpreted interstate commerce to include a wide range of things. For example, in *Kroupa v. Casey*\(^{21}\) the Court found that the FAA applied to an arbitration agreement between a health care provider and a patient because the health care provider proved that he “used equipment, materials, and services acquired from out of state in his delivery of health care services, made out-of-state transactions through interstate forms of communication, and received most of his insurance payments from out of state”.\(^{22}\)

Another difficulty with state statutes is that such statutes cannot distinguish arbitration contracts from other types of contracts. In *Doctor’s Associates, Inc v. Casarotto*\(^{23}\) the Supreme Court of the United States held that state courts couldn’t invalidate arbitration agreements based on state laws applicable only to arbitration agreements. The state law required that the arbitration clause be printed on the first page in underlined capital letters, but this requirement was only applicable to arbitration agreements and not to contracts in general. The Court found this requirement to be pre-empted by the FAA. This ruling ignores the unique policy challenges in doctor/patient


\(^{22}\)DeVille, supra note 7, at 345.

arbitration agreements and thereby reduces the likelihood of their use.

IV. The solution: Uniform legislation

A federal or state uniform legislation regarding medical malpractice arbitration agreements should be enacted to avoid judicial inconsistencies and promote such agreements. Clauses based on the following suggestions should be included in any uniform statute in order to safeguard both patients and physicians.

(a) Arbitration agreements between health care providers and patients should be deemed valid, enforceable, and irrevocable, except on grounds that exist at law or in equity for the revocation of any contract.

(b) Arbitration should be permitted if the parties agree to binding arbitration by written agreement in advance of treatment.

(c) The arbitration agreement should contain a specific clause in which it is clear that the patient is knowingly entering into an arbitration contract and knowingly waiving his/her right to trial by jury. For example:

(1) "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state or federal law, and not by a lawsuit or resort to court process except as the law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

(2) Immediately before the signature line provided for the individual contracting for the medical services should appear the following in at least 10-point bold red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

(d) The agreement should describe the process by which the arbitration will take
place. The manner of the selection of arbitrators should be clear (i.e., either to be agreed by the parties, or provided by a private organization like National Arbitration Forum (NAF), American Health Lawyers Association (AHLA), American Arbitration Association (AAA), or Judicial Arbitration and Mediation Services (JAMS). The rules and procedures to follow, flow of information, hearing, and record keeping should be spelled out.

(e) The Arbitration Panel should be composed of three arbitrators, one picked by each party, and the third by the two selected arbitrators. There should also be a government appointed panel composed of a lay person, an attorney and a third member of the same profession as the defendant health care provider.24

(f) Arbitrators should be required to follow the procedural rules stipulated by the AAA, NAF, JAMS, or AHLA if one of those organizations is designated by the agreement.

(g) The arbitration agreement cannot be presented as a condition for treatment in an emergency situation or in any other situation where the patient is unable to select the service provider.

(h) The patient must have the ability to opt out of the proceeding within 60 days after termination of treatment.

(i) Damages:

(1) The arbitration panel should determine the existence of liability and provides the parties 30 days to agree on damages. If the parties fail to agree, the panel should make a determination.

(2) Caps on damages: the Arbitration awards should comply with the cap on non-economic damages applicable in any particular state.

(j) Appeal: A party may appeal an arbitration ruling, but the court will consider the ruling to be conclusive as to the facts of the case, unless the conclusion is not clearly supported by the evidence, is fraudulent, or the findings are contrary to law.

This list is not exhaustive but represents some of the common requirements used in state statutes. There is a fine line between protecting the patient's rights by means of requiring some specific language and procedures to enforce this type of arbitration

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24Some states statutes require the panel to be composed like this. I think this is a good idea in order to have different perspectives for the award of damages, since this type of arbitration is so different from other types. However, I don't want the parties to pay extra for this, so my suggestion is to have a government appointed panel.
agreements and establishing requirements that are so burdensome for the doctors that they limit or render almost impossible the use of the agreements.

**Conclusion**

Medical malpractice arbitration agreements could be of great use in any plan to deal with the health care cost crisis. To take advantage of and promote the use of arbitration, measures need to be taken in order for healthcare providers and patients to feel comfortable entering into enforceable medical malpractice arbitration agreements. The main difficulty at this point is that there is no federal legislation regarding specifically this type of arbitration agreement. There is also no uniformity in either state statutes or court decisions regarding what is required to make a medical malpractice arbitration agreement enforceable. Doctors need to know that if they use arbitration it will be enforced by the courts; patients need to have safeguards to protect their basic rights; and courts need sufficient guidance to promote more uniformity in interpretation of medical malpractice arbitration agreements. The lack of uniformity in existing law may be why the courts seem to be very cautious when dealing with arbitration disputes in medical malpractice cases. There has been debate about whether there is a need for a federal legislation that deals only with medical malpractice arbitration agreements since the current federal legislation was created before the current health care crisis and before anyone could imagine the use of this type of contracts in this scenario. On the other side, historically the regulation of the practice of medicine has been generally delegated to the states and some see federal legislation as an interference with states’ powers. One thing is clear: there is a need for uniform legislation in order to promote the use of medical malpractice arbitration agreements.