Creating Health Courts Through Consent:
Opportunities and Challenges for a Non-Legislative Approach to Administrative Injury Compensation
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Part of a National Initiative

This report is intended to promote discussion among health care providers and others about ways in which an alternative approach to medical injury litigation could be chartered outside the political process. We believe that voluntary reform efforts offer enormous promise for improving the liability system and enhancing patient safety. Fruitful discussions are currently under way at the state level about establishing pilot projects that can begin to test the feasibility of these ideas.

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For more information - or for more details about the health court proposal, model legislation, and exiting legislative proposals - please contact Common Good at 202-293-7450, extension 13.

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Medical liability remains a major public policy issue with substantial implications for the health care system. However, legislative alternatives to this issue seem unlikely in the current environment. In particular, the prospects for federal reform are remote in the 110th Congress; some states have enacted reforms, but in others, the chances are slim that any substantial reform proposal would receive anything other than a hostile response in the state legislature.

Today, health care providers and others seeking medical liability alternatives may do well to explore proposals that can be implemented without the need for substantial (or any) legislative action. Among the promising opportunities is the use of contractual arrangements to accomplish reforms through consent that would be difficult to achieve through legislation – such as the establishment of a private system for resolving medical injury disputes.

The Health Court Proposal

Over the past few years, the legal reform non-profit Common Good has expended substantial efforts in promoting the idea of developing specialized “health courts” to handle medical injury litigation. Working with a research team from the Harvard School of Public Health on several Robert Wood Johnson Foundation-supported initiatives, a conceptual proposal for establishing such a system has been developed and advanced.¹

Under the Common Good–Harvard proposal, a functioning health court would provide a specialized arena for resolving medical injury disputes, with specially trained adjudicators or judges, independent expert witnesses, and a predetermined schedule of damages, particularly for non-economic awards. There would be no juries. A primary goal of the proposal is to facilitate patient safety initiatives at the institutional level by promoting openness about the disclosure of errors. Consequently, health courts would have a range of linkages to patient safety initiatives and programs.

The health court proposal has generated substantial interest in the legislative arena. Bi-partisan bills have been introduced in the U.S. House and Senate that would facilitate experimentation with alternative approaches to resolving medical injury disputes, such as health courts. Bills have been introduced in a number of states as well.
Realistically, however, the political barriers to reform remain imposing. In particular, the trial bar is well-organized, politically influential and adamantly opposed to any change that would eliminate jury trials, and/or effectively limit non-economic damages (which many attorneys believe a schedule of damages would do).\(^2\) Proposals in the 1980s and 1990s to shift medical injury claims from the tort system to an administrative compensation system met with strong opposition from the trial bar, and the bar has vigorously opposed the various state and federal legislative efforts relating to health courts over the last several years.

**Alternatives to Litigation: Consent-Based Systems**

As opposed to creating a health court system through legislation (or judicial action, *sua sponte*), a similar system might be established on a contractual basis. In particular, patients might consent to the jurisdiction of an administrative injury compensation system through an agreement executed either at the initiation of a treatment episode or as part of the enrollment process with the patient’s health plan. Essentially, this would amount to an agreement on the part of the patient to submit any claims to binding arbitration should an injury occur. The system could be designed to incorporate a number of elements of the health court proposal.

Pursing an alternative to litigation grounded in patient consent is likely to be more fruitful in the long term than efforts pursued through the legislative arena. As a political matter, parties can waive rights by contract that the legislature would have a much harder time extinguishing on its own accord. Moreover, from a practical perspective, it is “easier to apologize than to ask permission.” In other words, establishing a program under existing legal authority and defending it against challenges is likely to be more feasible than waiting for legislative blessing before taking action.

This report sets forth a number of issues that would be implicated by creating a program like this, and also outlines one way in which such an initiative could be structured. Of course, the approach that will be feasible for particular stakeholders or in particular states may well differ from the specific approach contemplated in this report.
Key Elements of a Structured Arbitration Process

We believe that an administrative compensation system - or close iteration thereto - might well be established without legislation. Instead, health care providers could create a consent-based system with patients that worked in the following way:

- Patients could agree to participate in the program (or have the opportunity to opt out) at the initiation of a treatment relationship, or through a health plan subscriber agreement. Ideally, this agreement would be executed prior to the occurrence of an injury, although there may be options to gain parties’ agreement after injury.

- Participating health care institutions would have a process to inform patients when errors had occurred. As appropriate, these institutions would make early offers of compensation.

- Claims not resolved through early offers or mediation would go to arbitration, where arbitrators with some health care training would issue a decision, based on the testimony of one or more independent expert witnesses. The parties could each have attorneys.

- The patient agreement would include a provision specifying a consistent process for damage valuations, including some form of a schedule for any non-economic damages based on patient circumstances and severity of injury. In application, such guidelines or schedules should help to promote horizontal equity in determinations of non-economic damages.

- Compensation criteria would be “evidence-based,” in the sense that they would be derived from experts’ interpretations of the best available scientific literature. To the extent possible, compensation decisions would be based upon ex ante determinations about the compensability of particular injury scenarios. Such information would facilitate the development of decision support tools that could permit certain types of common injuries to be fast-tracked for compensation.

- The system would have strong and explicit linkages to patient safety initiatives, and would create feedback loops to increase the likelihood that health care providers could learn from their mistakes. Data from the claims process would be used by health care providers to conduct root cause analyses of errors. In de-identified form, such information could also be provided to the appropriate patient safety authorities.

- The administrative adjudicating body would need to function independently. Firewalls and safeguards would be put in place to ensure that the entity had independent authority in order to maintain public trust in the process. Also, the procedural rules governing the resolution of claims would be made highly public. These might be developed de novo, or could draw on existing arbitration rules.
Parameters of a Demonstration Project

Establishing an arbitration system on a demonstration basis could offer excellent opportunities to test the broader feasibility of the health court proposal, and to improve the liability and patient safety environments within participating health care facilities. One approach for establishing such a pilot would be through a group of hospitals and their captive insurer. Such insurers often cover at least some of the physicians practicing at a given hospital, and the hospitals not infrequently have some degree of control over the insurer’s overall strategy. Working together, such a hospital-insurer group could establish a new process – outside the court system – for resolving injury claims.

1. Opt-in

For purposes of this analysis, patients would opt into the system through agreements executed with the health care provider at the initiation of treatment episodes. The patient would need to have the choice of whether or not to sign the agreement to have any subsequent injury claims covered by the demonstration. However, once the patient agreed to be covered by the system, all subsequent claims for medical negligence would be pursued through the administrative system rather than in civil court.

2. Medical Injury & Disclosure

If a patient covered by the program was injured during treatment, the hospital or health care facility would make a determination as to whether the adverse event was among the types of events covered by the demonstration project. If so, the hospital would notify both the patient and the insurer. Generally the process for such disclosure and notification would be based on the kinds of early disclosure and offer programs which are already operating successfully around the country, most notably the “3-R” program initiated by the COPIC Insurance Company, which involves disclosure of adverse events, apologies where warranted, and relatively modest compensation for short-term losses.

3. Processing a Claim

If the early disclosure and offer process failed to satisfy an injured patient, he or she could file a claim by submitting a form to the insurer. The claims process would be patient-friendly and, for relatively simple cases, could be navigated without an attorney. Review of claims would begin at the provider level, where a group of experts convened by the facility would review the circumstances of the injury, and make a determination about the event’s compensability. Where the experts determined that the event ought to be compensable, the insurer would make an offer of compensation. Claimants would then be able to have this offer reviewed by an attorney, or to request review of the offer by the structured arbitration panel.
4. Review by an Arbitration Panel

If either the claimant or the health care provider was unsatisfied with the insurer’s offer, the structured arbitration panel would review the matter. Adjudicators would have expertise and training in health care issues. They would be drawn from a pre-constituted panel of neutral arbitrators who agreed to meet certifying requirements, including periodic training related to health care. The adjudicators in the health court would have authority and a budget to engage independent medical experts drawn from a pre-constituted panel of experts meeting pre-determined credentialing standards.

An expert testifying in a particular case would be qualified in the same area of practice as the defendant (for example, an obstetrician in a case involving obstetrics). The adjudicator would issue a written opinion explaining his or her decision; this opinion would be entered into a searchable electronic database that would be accessible in future cases involving similar injuries. With an explicit record of past decisions and independent medical experts, the process could be expected to enhance consistency in decision making from case to case.

Claim review by the panel would be on a de novo basis, and the panel would have access to materials used by the group of expert reviewers at the health care facility. Claims could be reviewed based on materials submitted by the parties in paper, but an in-person hearing would also be available should either party desire it. The parties could be represented by counsel, but as noted above the system would be designed to allow parties to proceed without counsel should they prefer.

To the extent that the arbitration panel determined that the injury was compensable, the insurer would pay the damages to the claimant. Economic damages would be paid in full; non-economic damages would be paid with reference to a sliding scale or schedule based on patient circumstances and severity of injury. Again, this schedule would be incorporated by reference into the patient-provider agreement. This scale or schedule would in turn be based on existing injury severity schedules such as the National Association of Insurance Commissioners (NAIC) disability scale and others. All damages could be paid on a periodic basis. Compensation would not cover amounts already paid by other sources (for example, medical bills paid by the patient’s employer).

Although the program could not be expected to eliminate all disincentives for reporting information about errors among physicians and other health care providers, it could help to foster a culture of safety, transparency, and disclosure by enhancing predictability and trust. The program could also be expected to provide a stronger and clear deterrent signal to health care providers by improving consistency of decision-making.
The program could also advance safety by providing more data for analysis by providers and patient safety authorities. For example, when a claim was filed, the provider and insurer would conduct a root cause analysis as part of the process of determining whether or not an offer of compensation ought to be made. Following resolution of the claim, significant cases could be referred back to risk management/quality assurance staff at the facility for enhanced discussion with clinicians.

Particularly to the extent that liability insurance premiums over time became experience-rated to a greater extent, the program could help to provide enhanced incentives to increase patient safety activities and to take the steps necessary to make improvements.

In addition, data generated in the adjudication process could be aggregated in a centralized database – for example, maintained by the captive insurer owned by the group of health care providers – that would be very useful to risk managers and others. Pooling and sharing of such data could help to promote greater awareness of problems and best practices across institutions participating in the program.
Legal Basis for Establishing a Structured Arbitration System

The foundation upon which the system discussed above ought to be established is the law of arbitration, particularly the Federal Arbitration Act (FAA), which – together with case law – provides procedural and substantive law for arbitration proceedings. The following analysis outlines the authority under which such an initiative could be established, as well as the kinds of legal issues this approach would likely implicate.

The Federal Arbitration Act (FAA)

The FAA was enacted in 1925 to ensure the validity and enforcement of arbitration agreements in any “maritime transaction or … contract evidencing a transaction involving commerce.” On its face, therefore, federal law is favorably disposed towards arbitration agreements. However, the application of the FAA to various types of arbitration agreements has been the subject of a substantial amount of litigation, including a number of cases taken before the U.S. Supreme Court.

As an initial matter, for any arbitration system to fit within the provisions of the Federal Arbitration Act, it would be vitally important that the dispute resolution process it provided conform to meaning of the term “arbitration.” As a statutory matter, the Federal Arbitration Act does not define the term “arbitration,” nor does the Uniform Arbitration Act, upon which most states’ arbitration laws are based. However, the term is generally held to include any kind of dispute resolution alternative which is consensual, conducted apart from judges and juries, and adjudicative in nature. At a minimum, the dispute resolution process ought to be clearly identified as an “arbitration” forum.

Purview of the Federal Arbitration Act

It is often said that the Federal Arbitration Act (FAA) creates a national policy in favor of arbitration. As a general statement, this may be true; however, it is also one that is subject to a number of constraints and limitations. To begin with, nineteen of fifty states have statutes prohibiting or limiting contracts to arbitrate personal injury claims; fourteen of them are specifically oriented towards the health care context. Of these states, the laws generally specify that pre-dispute arbitration agreements cannot be made subject to (or a condition of) the issuance of insurance or provision of a service, or that the agreements may be rescinded by the consumer within a certain number of days, or after injury. Some state laws have both limitations.

The FAA does not contain the restrictions on particular kinds of disputes that are found in state law, and arguably would pre-empt such laws. However, the issue has not been resolved, and there is conflicting law in state courts on this issue. Most notably, a Texas court has held that the FAA pre-empted requirements in the Texas
arbitration law for a consumer’s attorney to sign at the time of contracting. However, a Colorado court has held that the state’s health care arbitration act is exempt from federal pre-emption due to the McCarran-Ferguson Act.

State Law Challenges

State courts have traditionally not been eager to uphold contractual waivers of constitutional rights, such as the right to a jury trial, but generally pre-dispute waivers have been allowed – albeit with a higher level of scrutiny than might be applied to ordinary contracts. Of course, there is considerable state-to-state variability in this area. Among other issues, courts have looked at the degree to which mutual assent has been provided and the intentionality of the waiver, especially focusing on the clarity of the language. Factors considered by courts that have upheld waivers have included the relative sophistication and bargaining power of the parties, whether or not the parties were represented by counsel, and the obviousness of the waiver provision in the documents. Contracts of adhesion (“take-it-or-leave-it” contracts) where one party has substantially more bargaining power than the other may be particularly scrutinized, although they are not automatically unenforceable so long as procedural safeguards are met. Consents to waive the jury trial right that are deemed rather than explicitly granted may be especially likely to be challenged.

Even to the extent an arbitration agreement falls within the pre-emptive reach of the Federal Arbitration Act, it is still subject to state principles of contract law – particularly the law of unconscionability. Arbitration agreements are subject to challenge on the basis of “procedural unconscionability” and “substantive unconscionability.” Procedural unconscionability challenges address the extent to which the signer of an agreement had (or did not have) a meaningful choice about whether to sign the agreement. These typically consider lack of bargaining power, the use of fine print or convoluted language, and lack of understanding. Substantive unconscionability challenges address the quality of the arbitration process itself, and typically consider the reasonableness of the contract terms when the contract was made, the parties’ needs, and the setting in which the agreement was executed. To the extent that the terms are oppressive or extremely one-sided, they may be found substantively unconscionable.

Significantly, analyses tend to be heavily fact-specific, and individual agreements upheld as valid in one jurisdiction may be held as invalid in another. Still, one can identify certain scenarios which would be particularly problematic. For example an uninsured patient who was asked to sign an agreement to arbitrate at a treatment facility could not likely be refused care because of his or her refusal to sign the agreement. Certainly a patient who presented for care in an emergency situation could not be required to sign an arbitration clause before receiving care.

That said, physicians and health care providers do have the ability to set preconditions over the care they provide (e.g. patients have to pay for services, and
physicians can refuse to provide certain treatments for a variety of reasons). It is likely that patients could be asked to sign an agreement to arbitrate in non-emergent situations as long as they were given reasonable other options (e.g. other health care providers to render treatment). However, it would be vital for the participating patient to have been provided with clear notice of the waiver and a meaningful choice in the matter.\textsuperscript{17}

Again, state laws vary on these points. Those seeking to enforce arbitration agreements can always argue that the FAA should control; significantly, however, the first test – consistent with the FAA's provisions – is whether there is a valid contract under state law. In particular, Section 2 of the FAA provides that agreements to arbitrate shall be valid, except “upon such grounds as exist at law or in equity for the revocation of any contract.” To the extent that contract formation can be undermined, therefore, so too can the enforcement of arbitration. For example, the court in a recent Florida case invalidated a nursing home agreement made by a health care proxy on the basis of a state law prohibiting such proxies from waiving the jury trial right on behalf of a declarant.\textsuperscript{18} The key point is that contracts to arbitrate are placed on the same level as other kinds of contracts, rather than being either inferior or superior to other types of contracts.

Agreements to arbitrate have been challenged on other bases as well. For example, arbitration clauses have also been attacked as being contrary to public policy, although this argument has rarely prevailed. Other procedural challenges can include repeat user bias (arbitrators would favor health care providers who repeatedly appear before them), confusion as to whether non-signatories are bound, lack of fairness in the arbitration process, and prohibitive cost requirements to access arbitration. Again, these analyses tend to be highly fact-specific.\textsuperscript{19}
Constructing an Arbitration Program: Key Considerations

As described above, challenges to arbitration agreements can come in a variety of ways, depending upon the specific circumstances and state law. Of course, specific issues of state law would need to be addressed before an arbitration program could be initiated in any particular jurisdiction. As an initial matter, however, the following preliminary considerations ought to be kept firmly in mind:

A valid agreement would need to be created to secure patient participation. As a first step to securing binding arbitration, there must be a valid agreement to arbitrate. This means that there must be mutual assent by the parties. Moreover, the relinquishment of the right to a trial by jury ought to be made on a knowing, voluntary, and intelligent basis.

The patient ought to know what he or she is signing. An agreement to arbitrate that is buried in dense text will be more vulnerable to challenge. State law can play a major role in this respect, by specifying what exactly would constitute adequate notice in the context of arbitrating medical malpractice cases (i.e., essentially a safe harbor provision). In the absence of specifications, the notice that is provided should be conspicuous (e.g., as a stand-alone clause or in large bold type). Drafters are not unwise to invoke the FAA specifically. Providing some form of patient education (e.g., a consumer-oriented user’s guide) may also be a smart step.

Be careful in the context of unequal bargaining power. Disparate levels of bargaining power can create vulnerabilities for arbitration agreements. Take-it-or-leave-it agreements where the patient has no choice may be particularly problematic. On the other hand, providing an opt-out for patients can strengthen enforceability arguments.

Agreements should be mutual. An arbitration clause should bind both parties to the contract; it also ought to specify that all disputes (including enforcement and interpretation of the contract) will be decided by the arbitrator.

Be wary of undue burdens on patients. High filing fees or inconvenient, far-distant dispute resolution locations will likely not be looked on favorably by the courts.
Health Care Arbitration in Practice

The idea of employing arbitration in the context of medical malpractice litigation is not new, but a widespread shift to arbitration has not to date yet occurred. For example, a study several years ago by the RAND Institute for Civil Justice found that only 9 percent of physicians and hospitals ask patients to sign arbitration agreements. Factors inhibiting the use of arbitration include a reluctance on the part of health care providers to present an arbitration agreement to patients (which effectively brings up the potential for injury and a dispute even before treatment has occurred), and the perception that arbitrators tend simply to “split the baby” – that is, find a compromise position that may or may not be consistent with the provider’s own perception of not having been at fault. Given that health care providers – particularly physicians – tend to win most cases in today’s legal system, the prospect of shifting to traditional arbitration is not necessarily appealing. However, a structured arbitration approach – with educated adjudicators, independent experts, and linkages to patient safety programs – represents a new alternative which may be more appealing to health care providers and patients alike.

1. The Kaiser Permanente Example

Arbitration has been employed in some health care settings, and the proposed approach would be analogous to a number of proposals that have been successfully initiated around the country. The most well-known example of medical malpractice arbitration is the system employed by Kaiser Permanente, the California-based managed care plan. Kaiser first introduced its mandatory arbitration agreement in the early 1970s, and in the mid-1970s the California Code of Civil Procedure was amended to allow the use of binding arbitration to resolve medical malpractice disputes. Today, individuals who enroll in a Kaiser managed care plan consent to the use of binding arbitration for any injuries or disputes that may later occur.

Kaiser’s arbitration process has been extensively tested in the courts, and generally courts have ruled in Kaiser’s favor. Plaintiffs have argued that the program constitutes a contract of adhesion, but courts have rejected these arguments. Non-signatories to the arbitration agreement have been compelled to participate in arbitration. Employers are authorized to negotiate a health plan which imposes binding arbitration on any enrolling employee. In addition, a state appeals court has ruled that state health plan regulators do not violate state law or participants’ rights in approving managed care plans that include binding arbitration.

Kaiser did learn the limits of its arbitration program in the mid-late 1990s with the highly publicized Engalla case, in which the California Supreme Court ultimately held that arbitration could not be compelled if there were evidence of fraud that lessened the integrity of the arbitration process. In the case, the terminally ill plaintiff alleged that his lung cancer had been repeatedly misdiagnosed by Kaiser personnel and pressed a case through the Kaiser arbitration process. The arbitration agreement stipulated that a
neutral arbitrator must be appointed within 60 days of the initiation of the claim; it took Kaiser 144 days to do so, and the claimant died the following day. The court found evidence to suggest that Kaiser administered its arbitration program to its own benefit. The court declined, however, to find the arbitration agreement facially unconscionable. Following the decision, Kaiser fundamentally revamped its program by establishing an Office of Independent Administrator (OIA) to operate its arbitration system. In essence, the change removed Kaiser from the dual role of administrator and party. The OIA is completely separate from Kaiser; it is administered from the office of an attorney in Los Angeles, who maintains a lengthy list of neutrals for use in arbitration proceedings.

2. Other Examples

Arbitration has been employed by medical liability insurers as an option for resolving injury disputes. For example, CAP-MPT, the California physician-owned liability insurer, has offered binding arbitration to its members for several decades. Although there is no requirement that member physicians have their patients execute agreements to arbitrate, nearly half of the company’s physician members do. Moreover, nearly 90 percent of patients are willing to sign such agreements. Company representatives have estimated that defense costs are nearly a third lower in cases taken through arbitration rather than litigation. Similarly, The Doctors Company, a large physician-owned liability carrier that operates nationwide, makes arbitration materials available to member physicians, but does not require that they be used.

In addition, some health care providers employ arbitration for resolving disputes. For example, the Duke University Health System has a voluntary arbitration clause in its admission documents; patients have the option to sign the clause, but are not required to do so as a condition of receiving care. However, some do, and – to the extent they do – they are bound to participate in arbitration should a dispute arise. As with Kaiser, the Duke arbitration program has been challenged in the courts – and generally upheld. For example, a North Carolina court recently upheld Duke’s arbitration agreement in a case filed by a decedent’s estate for wrongful death, negligence, and failure to acquire informed consent. When the defendant moved to compel arbitration, the plaintiff argued that the agreement lacked mutual assent and consideration, did not encompass family claims, and violated public policy. The court rejected these arguments, and held instead that an arbitration agreement will be upheld when the patient is competent, agrees to be bound by the arbitration award, and assents to the agreement by signing it.

Legislative authorization of medical malpractice arbitration in Utah generated substantial interest and attention several years ago after the legislature passed a law in 2003 permitting arbitration of medical injury cases. The new law in turn generated substantial opposition after some health care providers began requiring that the arbitration agreement be signed as a condition for receiving care. In 2004, the law was amended to forbid denials of care to patients failing to sign the arbitration agreements,
to prohibit use of the agreements in the context of anesthesiology or emergency care, and to allow revocation by patients within 10 days of execution. The evolving Utah statute is not dissimilar to the kinds of legal frameworks that a number of states employ (as discussed earlier) to limit the kinds of disputes which may be arbitrated and the way in which arbitration must be conducted. Again, such laws would at least in theory be pre-empted by the Federal Arbitration Act to the extent that a valid contract was created under state law.

Some have observed greater interest in arbitration in recent years as a preferred dispute resolution alternative for health care providers. This is particularly the case in states where tort reform efforts have been stymied. For example, a group of New Jersey obstetricians insured by Montana-based Obstetricians & Gynecologists Risk Retention Group of American, Inc. (OGRGGA) has begun requiring an arbitration agreement as a condition of treatment. By signing the agreement, patients agree to forego their right to a jury trial and pursue any claim in arbitration, with non-economic damages limited to $250,000 and punitive damages limited as well. North Carolina Gov. Mike Easley (D) recently signed into law a bill establishing a process of voluntary arbitration for medical negligence claims. Under the new law, if the parties agree to arbitrate a claim for wrongful death or personal injury arising out of medical negligence, a $1 million cap on economic and non-economic damages applies (the state otherwise does not limit damages in personal injury cases).
A Word on Mediation

Arbitration is a process that leads to a final, binding decision. Opportunities for appeal of arbitration decisions may be limited or non-existent. By contrast, mediation is a process facilitated by a neutral third-party without any authority to make a decision. Mediators can cajole and persuade, but they cannot decide. Proponents of mediation argue that it is less expensive than litigation, takes less time, and – as a voluntary, non-binding process – does not invite the kinds of legal challenges that arbitration faces.

Among the most nationally prominent medical malpractice mediation programs is the one created in the mid-1990s by the Rush-Presbyterian-St. Luke’s Medical Center (Rush), a major teaching hospital in Chicago. Rush calls its mediation program “co-mediation,” since it involves the use of 2 co-mediators. In the Rush program, the hospital has a panel of lawyers composed of experienced and well-respected medical malpractice council from both the plaintiff and defense bars. To encourage plaintiffs and their attorneys to participate in the program, the plaintiff has the opportunity to choose both co-mediators: the plaintiff’s attorney co-mediator and the defense attorney co-mediator. Both co-mediators have specialized knowledge about medical issues, familiarity with evidentiary issues, and experience with medical malpractice litigation; all Rush co-mediators have also undergone mediation training.

According to Rush representatives, the program has led to the resolution of more than 90 cases, with a success rate greater than 80 percent. Cases taken through medication have included alleged medication, diagnosis, and treatment errors resulting in death or substantial injury. Most cases have been resolved within a matter of hours. Rush estimates that mediated cases have been resolved anywhere from two-thirds to one-half the time that non-mediated cases have taken to settle or try before a jury, with defense costs 50-70 percent less. Moreover, reports suggest that the number of lawsuits against Rush has not increased.

In certain contexts, mediation can clearly be very effective, and the Rush and similar programs have generated a great deal of favorable publicity. However, mediation also has limitations. For example, the principal investigators on a Robert Wood Johnson Foundation-supported initiative at Wake Forest University in the late 1990s found that the use of court-ordered mediation in several North Carolina counties did not have a significant impact on trial rates of medical malpractice cases. As reported by the principal investigators, the trial rate – the percentage of filed cases that reach the trial stage – was about 15 percent for all malpractice cases ordered to mediation and about 22 percent for cases actually mediated. More specifically, the investigators found that:

- Of 202 mediated cases, 25 percent were resolved at the mediation conference and in another 19 percent settlement was related to mediation. In the remaining 56 percent, mediation was unsuccessful.
In the two counties without court-ordered mediation, the average time from the filing of a case to its termination was 537 days — virtually identical to the 535 days in the pilot counties with court-ordered mediation. However, when controlled for severity of the alleged injury, disposition time in the pilot counties was significantly shorter for relatively minor injuries, suggesting that the availability of mediation may shorten disposition time for those claims.

Trial rates were slightly higher in the control counties than in the pilot counties, but the difference was not statistically significant. There was also no significant difference between the two groups in either trial outcomes or settlement rates.

**Conclusion**

State and federal legislators are not likely in the near term to take steps to address fundamental failings in the medical liability system. However, an arbitration-based private approach has substantial promise to improve patient safety and provide a more consistent process for resolving injury disputes. Given the framework of existing federal and state law, a group of health care providers have the power today — working with a captive insurer — to create such an initiative. With thorough research and careful planning, such an initiative could be operated well within the parameters of current law in many or most states — and provide a better dispute resolution alternative for patients and health care providers alike.
ENDNOTES

1 For more details about the health court proposal, visit www.commongood.org.

2 This is particularly the case in states such as Maryland and New York, where one or more of the key legislative positions with jurisdiction over any health court proposal is occupied by a legislator who is either engaged in suing health care providers for a living or a member of a firm which does so.

3 Again, as a conceptual matter, patient consent might also be gained through the subscriber agreement between the patient and his or her health plan.


7 Id.

8 Note that many courts have seemed willing to accept the premise that health care-related issues intrinsically involve interstate commerce, which in turn invokes the jurisdiction of the FAA.

9 In re Nexion Health at Humble, Inc., 173 S.W.3d 167 (Texas 2005).

10 Allen v. Pacheco, 71 P.3d 375 (Colo. 2003). Passed by Congress in 1945, the McCarran-Ferguson Act (MFA) [15 USC §§1011 et seq.] was designed to ensure that the states, rather than the federal government, controlled and regulated the insurance industry. Since the MFA authorizes states to regulate health insurance, it has been held to act as a reverse pre-emption to the FAA (as in Allen v. Pacheco). Again, state law varies.

11 Indeed, some states even require as a matter of statute that parties be represented by counsel.

12 For example, some states require that the pre-dispute arbitration clauses be identified in a particular type face.


14 Note that a state legislature might facilitate utilization of arbitration clauses by providing specifications for patient consent to coverage by the system. These “safe harbor” specifications would provide that any agreement satisfying the required specifications could not be found unconscionable or otherwise invalidated under state law. Such a safe harbor could be particularly helpful in the context of deemed consent arrangements.


17 Id.


19 See, e.g., Cannon v. Lane, 867 P.2d 1235, 1238 (Okla. 1993).

20 RAND Institute for Civil Justice, Binding Arbitration Is Not Frequently Used to Resolve Health Care Disputes, RB-9030 (1999), www.rand.org/pubs/research_briefs/RB9030/. Note that this study found that more than 70 percent of HMOs asked new enrollees to sign such agreements, although these mostly addressed coverage disputes rather than malpractice. The use of arbitration clauses by HMOs for coverage matters generated some concern and opposition in the late 1990s. For example, a Commission on Health Care Dispute Resolution – jointly created by the American Arbitration Association, the American Bar Association, and the American Medical Association – in 1998 issued a report encouraging the use of arbitration and mediation in health care disputes in the managed care environment, and setting guidelines to be followed in these disputes. This report, which specifically did not address malpractice, states that binding arbitration should only be used where the parties agree to do so after a dispute arises.
21 See Wilson v. Kaiser Found. Hosp., 141 Cal.App.3d. 891 (1983), relating to individuals unborn when the arbitration agreement was signed.
23 Viola v. California Department of Managed Care, Cal Ct. App., No. B174455 (October 11, 2005).
28 In fact, Duke personnel have suggested that line staff may tend to discourage patients from signing the arbitration clause.
30 Medical Dispute Resolution Amendments, 2004 Ut. SB 245, 2004 Ut. ALS 83.
34 Note that the Rush program has spawned imitators. For example, Drexel University College of Medicine in Philadelphia has a mediation program that is modeled on the Rush approach. Drexel’s program addresses those cases which are within 6 months of trial where the hospital acknowledges that a jury may find for the plaintiff. In this scenario, Drexel invites all parties to enter into mediation; if not all parties agree, the mediation may proceed with only those parties agreeing to participate. As in the Rush program, two co-mediators conduct the mediation; each is a well-respected and experienced medical malpractice attorney. The defendant can challenge the plaintiff’s selection for conflicts of interest, but mediators are counseled to decline appointments if they believe they may be subject to bias. Mediation costs are paid by the defendants. The parties are required to submit documents before the mediation to enable the co-mediators to understand the matter at issue. Of course, all settlements are purely voluntary. Significantly, settlements do not have to be reported to the National Practitioner Data Bank in the absence of a written demand for compensation.