

Medical Malpractice Arbitration in the New Millennium: Much Ado About Nothing?

SUMMARY

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Arbitration of medical malpractice cases has been used as a method to control the risk and cost of litigation for a number of years. However, the number of medical malpractice claims has remained low even though legislatures and the courts have upheld arbitration. The question is whether we have made "much ado about nothing" by creating an environment conducive to medical malpractice arbitration even though it is so rarely used. This paper reviews the constitutional issues surrounding medical malpractice arbitration clauses and the implementation of arbitration contracts, and the existing medical malpractice process. Federal preemption issues under the Federal Arbitration Act, enterprise liability and ERISA preemption, and cybermalpractice will be discussed. Finally, dispute resolution industry standards implemented by the American Arbitration Association and American Health Lawyers Association will be reviewed as well as current medical malpractice mediation practices in industry. While the past has shown that arbitration has not been used a great deal future trends may increase use. Emerging medical malpractice arbitration issues arising in the new millennium include (1) the use of medical malpractice awards in credentialing and provider selection (2) the use of arbitration in collective bargaining agreements between physicians and hospitals or managed care organizations (3) the finding of enterprise liability for hospitals, health plans, and managed care organizations and the extent of ERISA preemption of such liability and (4) cybermalpractice issues that arise from negligent provision of health care through telemedicine or on the Internet.

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Medical malpractice litigation and arbitration have been part of the human experience for millennia. One of the earliest reported malpractice cases was in 1374 involving a surgeon who was sued for negligent treatment of a wound.¹

Historically, medical malpractice claims have been resolved through tort-based litigation.² Some of the problems associated with the tort system include “the high emotional and financial costs to the litigants, the detrimental effect on the doctor-patient relationship, and the inability of tort litigation to deter physician negligence.”³ There have also been concerns about the quality of medical expert witnesses, the high number of non-meritorious cases, and the high visibility of such litigation.⁴ Medical practitioners facing lawsuits strongly defend themselves from lawsuits because of concerns about the loss of reputation and future discipline or credentialing deparicipation,⁵ while the emotionally charged issues of illness, death, and dying may create compelling reasons for the plaintiff to litigate to the full extent possible.⁶

1. See Tom J. Manos, *Take Half an Aspirin and Call Your HMO in the Morning – Medical Malpractice in Managed Care: Are HMOs Practicing Medicine Without a License?*, 53 U. MIAMI L. REV. 195, 199 (1998).

2. See Scott Forehand, *Helping the Medicine Go Down: How a Spoonful of Mediation Can Alleviate the Problems of Medical Malpractice Litigation*, 17 OHIO ST. J. ON DISP. RESOL. 907 (1999).

3. *Id.*

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

5. See David Zukher, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will A Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 145 (1998).

6. See Bryan A. Liang, *Understanding and Applying Alternative Dispute Resolution Methods in Modern Medical Conflict*, 19 J. Legal Med. 397 (1998).

These concerns only arise after the patient has entered the system by filing a lawsuit. A Harvard study of the relationship between malpractice claims and adverse events from negligence found that only about one in eight patients who had experienced negligent care filed a lawsuit.⁷ Similarly a 1991 General Accounting Office (GAO) Study of the Michigan arbitration system found that between 1975 and 1991 (sixteen years) there were only 882 arbitration proceedings that emerged from an estimated 20,000 malpractice claims. The GAO study recommended mandatory arbitration or the creation of economic incentives such as the reduction of health care insurance premiums to encourage potential plaintiffs to arbitrate rather than litigate their claims.⁸ Because relatively few patients who have experienced negligent care file a malpractice lawsuit, few patients are properly compensated for the injuries sustained.⁹ Because of this lack of access to the judicial system for medical negligence claims, the ability of any system to provide redress for the patient and thus impact the future behavior of negligent practitioners is severely limited. A study of 1,000 anesthesiology claims found that 54% of the medical malpractice claims involved inappropriate care. Of these cases, 80% of the plaintiffs received a recovery. Most cases of inappropriate care did not receive compensation. In addition, there were a number of malpractice lawsuits filed where the care had been appropriate.¹⁰ Even though two-thirds of malpractice claims filed turn out to be without merit, malpractice claims are still twice as likely to go to trial as other types of personal injury lawsuits.¹¹

Other systems for recovery have been proposed including a no-fault liability system that would compensate injuries from a pool of money without determining negligence. Under this system, compensation would be more accessible to more people. On the other hand, the cost of compensating more people while providing no deterrence for negligence conduct is a significant disadvantage to this approach.¹² Furthermore, a total

7. The study also found that the risk of sustaining an adverse event increased with age. Those over sixty-five had more than twice the chance of an adverse event as those between sixteen and forty-four. See Russel A. Localio, *Relation Between Malpractice Claims and Adverse Events Due to Negligence: Results of the Harvard Medical Practice Study III*, 325 *NEW ENG. J. MED.* 245, 248 (1991).

8. See *Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program*, GAO/HRDD 91-38 (Dec. 1990) [hereinafter Michigan GAO Report].

9. See Forehand, *supra* note 2, at 907.

10. See Thomas B. Metzloff, *Book Review: Understanding the Malpractice Wars Medical Malpractice on Trial*, (Paul C. Weiler), 106 *HAR. L. REV.* 1157, 1162 (1993).

11. Paul C. Weiler, *Fixing the Tail: The Place of Malpractice in Health Care Reform*, 47 *RUTGERS L. REV.* 1157, 1162 (1995).

12. See *id.* at 915.

system transformation would make the impact and costs of a new system hard to predict. Arbitration is a solution based on contract law.¹³ In 1991, the Utah Medical Association conducted a study of 500 closed malpractice claims and 500 potential claims and concluded that a no-fault plan would reduce the severity of the claims, but the increased frequency of claims would increase the total costs by one-third. Insurance consumers would face premium increases of 50%.¹⁴

In the 1970's the focus turned to cost. Large jury awards led to higher malpractice insurance costs and created a malpractice crisis that legislatures responded to with a volley of tort reform legislation.¹⁵ Processes implemented to control the risk and costs of large verdicts included shortened statutes of limitations, limitation of non-economic damage awards through "damage caps", structuring of malpractice payments through periodic payments, implementation of "collateral source" rules requiring the courts to look at other sources through which compensation may be available to avoid "double compensation" for one event, development of state and medical association sponsored liability insurance, statutory immunity provisions for state entities including state hospitals and employees, and the advent of arbitration as the preferred means of resolving the dispute.¹⁶ Through the 1980's these systems were implemented through a variety of methods in many states and tested by the courts.

The reasons to resolve medical malpractice disputes through arbitration include the parties ability to control the procedure, the ability to select the arbitrator or expert, reduced cost, shortened time to resolve the dispute, finality of the decision, privacy, reduced emotional trauma of litigation, and self autonomy through the ability to contract and resolve disputes outside of the courts.¹⁷ Arbitration makes it easier for the parties in-

13. See *id.*

14. See Neville M. Bilimoria, *New Medicine for Medical Malpractice: The Empirical Truth About Legislative Initiatives for Medical Malpractice Reform – Part II*, 27 *HOSP. L.* 10, 306, 312 (1994).

15. Malpractice concerns also lead to increased practice of "defensive medicine" in which multiple tests and procedures were performed to satisfy patient expectations or to defend against malpractice. See Rebecca A. Cerny, *Arbitration or Litigation: Efficacy and Fairness in Resolving Medical Malpractice Disputes Through Arbitration Proceedings*, 27 *J. HEALTH L.* 7, 193, 194 (1994).

16. See Forehand, *supra* note 2, at 912. See also Zukher, *supra* note 5, at 148.

17. See Metzloff *supra* note 4, at 210. See also Zukher, *supra* note 5, at 152.

volved to maintain their relationships while increasing the opportunity for the claimant to be satisfied.¹⁸ A 1992 General Accounting Office (GAO) study of medical malpractice litigation found that arbitration took less time than litigation,¹⁹ was effective in compensating more plaintiff's for their injuries,²⁰ and yielded lower and more consistent awards.²¹ In arbitration, every dollar of the arbitration award goes to the plaintiff whereas in traditional litigation, a large amount of the award lands in the pockets of the plaintiff's attorney. Arbitration is also seen as a tool to limit the risk of conflict.²²

In spite of the reasons given for use of arbitration, arbitration has not been widely used. Reasons for this include judicial hostility that questions the use of arbitration in the malpractice context.²³ State statutes intended to facilitate arbitration created detailed requirements that may have become a barrier to arbitration,²⁴ and empirical research has shown that malpractice arbitration statutes have not increased the incidence of medical malpractice arbitration.²⁵ There is also a bias against arbitration among the parties. "Repeat Players" in the litigation context such as malpractice insurers and defense attorneys have a certain comfort level with the protections afforded by the litigation process including judicial encouragement of settlement, availability of summary judgment, and other motion activities while the plaintiffs' bar perceives arbitration as being biased towards the defendant.²⁶ Arbitration does not alleviate the concerns inherent in the litigation system, but simply replaces a judge with an arbitrator.²⁷ Even within the alternative dispute resolution arena, there is no consensus that arbitration is the best form of ADR for medical malpractice since there may be a predisposition toward making compromise decisions that may

18. See Elizabeth Rolph, Erik Moller and John E. Rolph, *Medical Malpractice: External Influences and Controls: Article: Arbitration Agreements in Health Care: Myths and Reality*, 60 L. & CONTEMP PROB. 155 (1997).

19. Medical malpractice litigation took thirty-three months to resolve the claim through the court, while arbitration took nineteen months. See *Medical Malpractice: Alternatives to Litigation*, United States General Accounting Office Report to Congress, 9 (January, 1992).

20. Plaintiffs in litigation won about one-third (33%) of their cases, while plaintiffs in arbitration won 52% of their cases. See *id.*

21. See *id.*

22. See Metzloff, *supra* note 4, at 211.

23. See *id.*

24. See *id.*

25. See *id.* at 213.

26. See *id.* at 212, 220.

27. See *id.* at 215.

not fully compensate harm.²⁸ Some also feel that the arbitrator as a “repeat player” in arbitration proceedings may have a bias towards the party that would be in a position to reselect the arbitrator. If a truly simple approach to administrating these cases were found, then there is a concern that the number of malpractice claims would increase.²⁹

A malpractice project at Duke Law School’s Private Adjudication Center used a case-by case-approach to inform parties of the opportunity to use binding arbitration. Nineteen cases went to arbitration with seven focusing on liability and twelve focusing on damages.³⁰ The arbitrations were shown to be efficient with the average proceeding lasting six hours.³¹ Other economic analysis have also indicated that ADR is more efficient than traditional approaches.³² However, in the Duke study, there were a number of times when the parties, attorneys, and malpractice insurer did not all agree to arbitration. This lack of agreement lessened the total number of lawsuits that used arbitration as a tool to resolve the dispute.³³

A Rand survey that asked California physicians, hospitals and HMOs about the prevalence of arbitration agreements found that “only nine percent of the hospitals and nine percent of the physicians” routinely used arbitration agreements.³⁴ However, “twenty percent of patients admitted to hospitals signed arbitration agreements.”³⁵ Even though the percentage of physicians using agreements was small, it was increasing. Of those physicians currently using arbitration agreements, over sixty percent had adopted them since 1990.³⁶ Two factors were found to relate to the incidence of arbitration agreements: insurer support for the agreements and physician practice within HMOs.³⁷ Fifty-seven percent of physicians who were members of CAP/MPT, a professional liability coverage provider that strongly encouraged arbitration agreements, used arbitration agree-

28. *See id.* at 217, 219.

29. *See id.* at 218.

30. *See id.* at 223.

31. *See id.* at 224.

32. *See* Liang, *supra* note 6, at 414-26.

33. *See* Metzloff, *supra* note 4, at 222.

34. *See* Rolph, *et al.*, *supra* note 18, at 171.

35. *Id.*

36. *See id.* at 178.

37. *See id.*

ments in their practice compared with six percent of physicians insured by other providers.³⁸ Thirty-one percent of the physicians use arbitration agreements because it is the policy of their practice group, while thirty-four percent use them because they believe arbitration is a more cost effective way to resolve disputes.³⁹ Of those with arbitration agreements in place, ninety-six percent of physicians were satisfied with them.⁴⁰

In contrast, the California Association of Health Maintenance Organizations (CAHMO) reported that while seventy-one percent of the HMOs used arbitration agreements with their members, none of the PPOs used arbitration agreements.⁴¹ While HMO arbitration clauses could be used for coverage disputes or medical malpractice issues, the survey found that the arbitration agreements were used in coverage disputes and the total number of arbitrations actually held were less than four per million.⁴² The study concluded that few disputes take place through private binding arbitration, yet arbitration agreements are becoming more common in the marketplace as a result of pro-arbitration organizational policies.⁴³

So what is the future of medical malpractice arbitration in the new millennium? Have we made "much ado about nothing" with statutes, research, and pilot programs demonstrating that extremely low numbers of cases actually use arbitration in medical malpractice? This article will examine the current status of medical malpractice arbitration, the constitutionality of arbitration clauses, use and enforceability of arbitration contracts, the arbitration process itself including prelitigation panels, arbitration statutes and practices, damage limits, and reportability of awards. Federal preemption under the Federal Arbitration Act (FAA), theories of enterprise liability, the Employee Retirement Income and Security Act (ERISA), and current telemedicine, cybermedicine, and cybermalpractice issues will be discussed. Finally, dispute resolution industry standards that apply in medical malpractice arbitration will be reviewed along with the use of mediation in medical malpractice.

38. *See id.* at 175.

39. *See id.* at 174.

40. *See* Elizabeth Rolph, Erik Moller, and John E. Rolph, *Medical Malpractice: External Influences and Controls: Article: Arbitration Agreements in Health Care: Myths and Reality*, 60 L. & CONTEMP PROB. 155 (1997).

41. *See id.* at 173.

42. *See id.*

43. *See id.* at 177.

I. CONSTITUTIONALITY OF MEDICAL MALPRACTICE ARBITRATION

The constitutionality of medical malpractice arbitration has been challenged on a number of grounds. Some have argued that arbitration violates due process either on grounds of substantive due process, when medical malpractice litigants are treated differently than other litigants because of the arbitration agreement, or on grounds of procedural due process when parties are required to proceed in the arbitration forum without the same procedural protections available through judicial proceedings.⁴⁴ The use of a medical review panel composed of practitioners has also been challenged as a violation of substantive due process because the panel assumes the role of the jury as the primary factfinder.⁴⁵ An early Alaska Supreme Court decision dismissed this argument holding that decision making regarding the complex medical issues involved in malpractice cases is facilitated by expert panel members and there is no inherent bias based on being a medical provider.⁴⁶ This is similar to the equal protection challenges that focus on different treatment of medical malpractice litigants from others litigants.

Others have argued that an agreement to arbitrate violates the constitutional right to trial by jury and is therefore unconstitutional. To address this issue, some arbitration statutes provide procedural protections that require that arbitration agreements "cannot be a condition for providing health care, must be in a separate instrument, may not limit substantive rights, and must be given to a patient for reaffirmation upon discharge from the hospital."⁴⁷

In 1980, the New Hampshire Supreme Court reviewed the constitutionality of the state medical malpractice statute and found the statute to be unconstitutional on a several grounds. The court found that the expert witness requirements were too burdensome for plaintiffs to prove their case.⁴⁸ The court further found that the restriction barring minors from bringing a cause of ac-

44. See *Keys v. Humana Hospital, Inc.*, 750 P.2d 343 (Alas. 1988) (holding that a statute mandating pretrial review of medical malpractice claims by expert advisory panel does not violate substantive due process).

45. See *id.* at 351.

46. In making the decision, the court distinguished an Illinois court decision to not uphold a prelitigation panel in that the Illinois panel was the sole basis for making a malpractice decision, while the Alaska panel merely served as an expert opinion at trial. See *id.* at 356.

47. Norman P. Jeddeloh, *Use of Arbitration in Health Care Industry: Non-Labor Matters*, 22 J. OF HEALTH L. 11, 354 (1989).

48. *Carson v. Maurer*, 424 A.2d 825, 833 (N.H. 1980).

tion was unreasonable in light of the small numbers of plaintiffs in this category.⁴⁹ Elimination of the collateral source rule in malpractice actions raised the cost on the general public.⁵⁰ Damage caps for pain and suffering prevented victims from receiving full compensation for their injuries and limiting attorney fees had a questionable relationship to containing jury awards.⁵¹ Finally, the two year statute of limitation based on occurrence precluded a lawsuit before the plaintiff had the opportunity to discover the cause of action.⁵²

The Ohio legislature and the Ohio Supreme Court have disagreed about malpractice legislative provisions. In August 1999, the court struck down the Ohio Comprehensive Tort Reform Act as unconstitutional for the following reasons.⁵³ The court held that the Act violated the state constitutional one-subject provision that requires legislation to focus on one subject. Further, it held that punitive damage caps of \$100,000 or three times compensatory damages for small corporations and \$250,000 for large corporations were an unconstitutional violation of the right to a jury trial. The jury should be allowed to decide the amount of damages. Non-economic damage caps in the Act had expanded the scope of a statute previously declared unconstitutional. The damage cap was held unconstitutional because there was no rational connection between non-economic damages and malpractice insurance.⁵⁴ The statute of limitations within the statute was six years. Another similar statute that deprived a claimant of the right to a remedy before he or she knows of the lawsuit had previously been declared unconstitutional, so when the Ohio legislature enacted the statute of limitations for the tort reform act it indicated that it "respectfully disagreed" with the Ohio Supreme Court.⁵⁵ The Ohio Supreme Court struck down the new provision as unconstitutional. The collateral benefit provision provided for the jury to be instructed about collateral benefits. The court held that it was unconstitutional to permit a setoff without showing what payments would be set off from.⁵⁶ Finally, the legislature set a standard of review for toxic tort cases. The court held that it was an unconstitutional separation of legal power for the legislature to establish the standard of review, the standard of review was something that the court should

49. *See id.* at 833-34.

50. *See id.* at 835-36.

51. *See id.* at 835-40.

52. *See id.*

53. *State Supreme Court Strikes Down Tort Reform Statute in Entirety*, 7 HEALTH CARE POL'Y REP. 35 (BNA) 1409 (August 30, 1999).

54. *See State ex rel. Ohio Academy of Trial Lawyers v. Sheward*, 715 N.E. 2d 1062 (1999).

55. *See supra* note 49.

56. *See Sheward, supra* note 50, at 1095.

decide.⁵⁷

II. MEDICAL MALPRACTICE ARBITRATION CONTRACTS

1. Adhesion Contracts

Medical malpractice arbitration contracts have been attacked on the grounds that they are unconscionable adhesion contracts.⁵⁸ An adhesion contract is defined as a standardized contract form offered to a consumer on a take it or leave it basis without affording the consumer a realistic opportunity to bargain so that the consumer does not have a choice to accept or refuse it.⁵⁹ For example, the Nevada Supreme Court held a medical malpractice arbitration agreement to be an unenforceable adhesion contract because the weaker party was not alerted to the agreement or its consequences.⁶⁰ In Arizona, the Broemmer case involved a 21-year-old who sought an abortion. Prior to the abortion, she was given three things to sign including the arbitration agreement. The caregivers did not discuss the arbitration agreement with her. During the abortion, her uterus ruptured.⁶¹ The court found that knowing consent and reasonable expectation are fundamental to valid contracts. The court found that the arbitration agreement went beyond plaintiff's reasonable expectation since there was no evidence that she knowingly waived her right to a jury trial.⁶² In looking at the facts that the party had no real choice of terms and could not obtain the desired services elsewhere, the court decided that the agreement to arbitrate was not enforceable.⁶³

On the other hand, in *Buraczynski v. Eyring*, the Tennessee Supreme Court reviewed two medical malpractice arbitration agreements.⁶⁴ The appellants argued that the agreements were too broad to be enforceable and that the statute did not apply to retroactive agreements. Respondents claimed that specificity was not required in arbitration agreements and that these agree-

57. *See id.*

58. *See* Zukher, *supra* note 5, at 142.

59. *See id.*

60. *See* *Obstetrics and Gynecologists William G. Wixted, M.D., Patrick M. Flanagan, M.D., William F. Robinson, M.D. Ltd. V. Pepper*, 693 P.2d 1259 (Nev. 1985).

61. *See* *Broemmer v. Abortion Services of Pheonix, Ltd.*, 840 P.2d 1014-15 (Ariz. 1992).

62. *See id.*

63. *See id.* at 1015.

64. *See* *Buraczynski v. Eyring*, 919 S.W.2d 314 (Tenn. 1996).

ments have been uniformly upheld. The Tennessee Supreme Court upheld the arbitration agreement and found that the agreements were enforceable because they were supported by consideration and not oppressive or unconscionable.⁶⁵ The Tennessee court reviewed the facts to find that there was no indication that the patient could not question the agreement, nor did the patient have to choose between a jury trial right and necessary medical treatment, nor that there was an unequal advantage in the arbitration process itself.⁶⁶ Because of procedural safeguards that make arbitration feasible, the Tennessee Uniform Arbitration Act was passed to establish the desirability of upholding arbitration agreements. Such procedural protections include having the agreement on a separate document that does not provide an unfair advantage to the doctor or limit his liability, contract provisions that draw attention to the fact that the right to a jury trial is being waived, and provision of a revocation period are all elements that allow the member to make an informed choice.⁶⁷

When state statutes create a framework for guidelines to regulate arbitration agreements with safeguards against overreaching by the health care provider, the courts will uphold the agreements in an attempt to maintain public policy that encourages arbitration.⁶⁸ Arbitration agreements that comply with statutory law and protect against overreaching are likely to survive judicial determination of unconscionability.⁶⁹ Unconscionability can be in the form of substantive unconscionability that “deals with contract terms that are unreasonably favorable to one side”⁷⁰ or procedural unconscionability that “deals with the process of contract formation, encompassing the employment of sharp practices, the use of fine print and convoluted language, lack of understanding, and inequality of bargaining power.”⁷¹ Questions of unconscionability often are decided based on the facts.

A well-drafted arbitration clause can be “self-executing.” This means that it will allow the party to go forward with the arbitration including the appointment of the arbitrator and the arbitration hearing whether the other party agrees to arbitrate or not.⁷² A self-executing clause “shifts the burden to the party resisting arbitration to obtain an order from the court staying the arbi-

65. *See id.* at 321.

66. *Id.*

67. Jennifer Gillespie, *Physician-Patient Arbitration Agreements: Procedural Safeguards May Not be Enough*, 1997 J. DISP. RESOL. 119, 130.

68. Zukher, *supra* note 5, at 143.

69. *Id.* at 144. *See also* *Flora v. Moses*, 727 A.2d 596 (PA. 1999) which upheld a state arbitration statute.

70. *See* Zukher, *supra* note 5, at 163.

71. *Id.*

72. *Id.* at 166.

tration by making a showing that the dispute is beyond the scope of the arbitration agreement, or contains an illegal aspect precluding the resolution of the dispute by arbitration.”⁷³ Anything that would require the party seeking to arbitrate to go to court to compel arbitration would not be considered when a “self-executing” arbitration clause is in place.⁷⁴ Therefore language that indicates that the party seeking arbitration has the right to proceed despite the refusal of the opposing party and that “arbitration may only be avoided by a valid court order” would create a self-executing arbitration agreement.⁷⁵

It has also been proposed that notice of the agreement to arbitrate be included in a document that should be provided so that the patient is aware that he or she waived the right to have a judge or jury decide the claim.⁷⁶ Some have proposed that a separate consent form and patient booklet describing arbitration be provided to the patient.⁷⁷ The arbitration clause provision itself should contain information regarding any standards that limit the arbitrator’s decision, designate how the parties will submit their dispute to arbitration, and indicate choice of law provisions.⁷⁸ The arbitration agreement can also require the arbitrator to prepare a written opinion explaining the basis and reasons for the arbitrator decision.⁷⁹

2. Timing of the Agreement

Some state statutes provide for a period of time to revoke an arbitration clause. For example, a California statute provides for a thirty day revocation.⁸⁰ This has been upheld by the California Court of Appeals and arbitration agreements have been applied to subsequent treatment when there was no written revocation within the thirty days.⁸¹ Colorado gives ninety days to revoke an agreement.⁸² Louisiana and New York limit revocation to a specific

73. *Id.*

74. *Id.*

75. *Id.*

76. See David Zukher, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will a Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 168 (1998).

77. See *id.* at 170.

78. See *id.* at 169-72.

79. See *id.* at 173.

80. See Cal. Civ. Proc. Code §1295 (West 1999).

81. See *Gross v. Recabaren*, 253 Cal. Rptr. 820 (Cal. Ct. App. 1988).

82. COLO. REV. STAT. ANN. § 13-64-403 (Supp. 1994).

period of time as long as treatment has not been rendered.⁸³

Medical malpractice arbitration agreements are typically signed when services are rendered. However, a case in Utah where the arbitration agreement was signed minutes or hours before surgery was held invalid.⁸⁴ The arbitration included a provision requiring the patient to pay the physician's arbitration fees if the arbitration award was less than half of the amount claimed. This was found to be substantially unconscionable and to violate public policy.⁸⁵ In Michigan, a 60-day period of revocation was tolled until the personal representative of the decedent had an opportunity to discover the arbitration provision.⁸⁶ In California, an arbitration clause signed after non-emergency treatment, where there were other available physicians, that included a 30-day revocation clause was upheld.⁸⁷ The Alabama Medical Liability Act requires that an agreement to arbitrate a medical liability dispute be agreed to after the medical services were rendered and the claim has arisen.⁸⁸

3. Collective Bargaining

Managed care has changed the practice of medicine for physicians as "the managed care model inserts insurers as an intermediary into medical decision making and the practice of medicine."⁸⁹ This has resulted in legal challenges to hospitals, managed care organizations, and other entities for medical malpractice under various theories of enterprise liability as discussed later.⁹⁰ It has also impacted the bargaining power of physicians leading to increased interest in physician unionization.⁹¹ It has been estimated that about 14,000 to 20,000 of the nation's 700,000 physicians belong to unions.⁹² Of these, about half are residents or interns.⁹³ The two largest unions are the Union of American Physicians and Dentists (UAPD) which has about 5,000 members most of whom reside in California, and the Federation of Physicians and Dentists

83. See LA. REV. STAT. ANN. § 9:4235 (West 1997); see also N.Y. Civ. Prac. L. & R. § 7550 (McKinney 1998).

84. See *Sosa v. Paulos*, 924 P.2d 357 (Utah 1996).

85. See *id.*

86. See *Appeals Court Overturns Arbitration Agreement Between Patient, Hospital*, 7 HEALTH L. REP. 20 (BNA), 776, May 14, 1998.

87. See CAL. CIV. PROC. CODE § 1295.

88. Alabama Medical Liability Act § 6-5-485 (1975).

89. Ellen L. Luepke, *White Collar, Blue Collar: Physician Unionization and Managed Care*, 8 ANN. HEALTH L. 275 (1999).

90. Zukher, *supra* note 5, at 161.

91. Luepke, *supra* note 88, at 275.

92. *Id.*

93. *Id.*

(FPD) which represents physicians and dentists in Florida and other states.⁹⁴ Further, the American Medical Association (AMA) has formally announced support for physician unionization and has formed an independent organization called Physicians for Responsible Negotiation (PRN).⁹⁵ PRN has since been asked to represent Detroit HMO doctors who have voted for union representation. The HMO had questioned the right of physicians to unionize claiming that they were supervisory employees and that other caregivers should be included in the union. However, the NLRB rejected the HMO claims clearing the way for the physicians to vote on unionization. PRN who represents the physicians has indicated that the physicians do not plan to strike or with hold essential services if a dispute arises.⁹⁶

The Clayton Act enables labor organizations to represent their members in collective bargaining.⁹⁷ The Clayton Act specifically exempts human labor from antitrust laws by indicating that human labor is not an item or commodity in commerce subject to antitrust regulation.⁹⁸ Thus, physicians who are employees can join unions that will collectively negotiate for them as long as they are true employees as defined under the National Labor Relations Act (NLRA).⁹⁹ However, independent contractors and supervisory employees are excluded from the definition of "employee" and many physicians have contractual relationships as staff members affiliated with a hospital or preferred providers in a managed care network.¹⁰⁰

In determining whether the physician is an employee qualified for collective bargaining, the courts will look at a number of factors to determine whether the physician still retains a large amount of autonomy and control or whether the employer directs the place, type and other activities of work.

94. Other physicians unions include the Doctors Council, a New York based union for physicians employed in New York, the Physicians Professional Networks Group based in Florida, and the Office of Professional Employer International Union. *See id.* at 281, 282.

95. *Press Release: AMA Announces Next Steps in Creating A National Negotiating Organization for Employed Physicians*, (visited Sept. 9, 1999), <<http://www.ama-assn.org/ad-com/release/1999/prnnextstep.htm>>.

96. *See Physicians at Detroit HMO vote for Union after NLRB rejects health plans appeal*, 8 HEALTH CARE POL'Y REP. (BNA) 12, 453 (March 20, 2000). *See also AMA-Created Unit Files NLRB petition seeking representation of HMO doctors*, 9 HEALTH LAW REP. (BNA) 5, 171 (Feb. 3, 2000)

97. Clayton Act, 15 U.S.C. § 17 (1914).

98. *See id.*

99. 29 U.S.C. § 152(3) (1947).

100. *See id.*

Specific factors that will be reviewed include the amount of control the individual has over the work, whether the occupation is separate and distinct, the type of occupation, whether the employer directs the work, whether the employer provides the workplace and equipment to complete the work, the degree of skill required to complete the task, the length of time the agreement between the parties is in place, the method of payment, and the parties belief concerning the work.¹⁰¹

Questions that remain unanswered in the malpractice context of physician collective bargaining are whether use of arbitration clauses will become a routine part of bargaining as they are in the labor setting and whether arbitration would be perceived as favoring one party over the other. Further, will such agreements include provisions determining who bears the responsibility for negligence? Will arbitration clauses formed in collective bargaining context with physicians be used to resolve negligence cases?

4. Contract Enforceability

Arbitration agreements are generally considered enforceable against the party who signed the valid arbitration agreement. However, a Court of Appeals in Washington D.C. found that the presumption of arbitrability attaches after the court has determined that a valid arbitration agreement does in fact exist. Because their were questions of fact about an insurance contract that included an agreement to arbitrate, the trial court denied summary judgment in order to determine the validity of the arbitration contract. The court then went on to find that the claims for health care coverage did not arise under the agreement with the arbitration clause, therefore the arbitration clause did not apply. The Court of Appeals affirmed this decision.¹⁰²

California arbitration cases have found that medical malpractice arbitration agreements can be enforced against a number of non-signatory parties. In California, a contract against a pregnant minor is enforceable as a matter of public policy. There was a concern that medical providers would refuse to treat minors if the provisions were not upheld.¹⁰³ Further a minor child can be bound by the mother in an agreement to arbitrate made during the prenatal period. The court has interpreted the arbitration clause to apply to any claim arising from the services under the agreement, even though the plaintiff had not been born at the time the arbitration agreement was signed.¹⁰⁴ A key to

101. Luepke, *supra* note 88, at 290.

102. *George Washington University v. Scott*, 711 A.2d 1257 (D.C. Ct. App. 1998).

103. *See Weeks v. Crow*, 169 Cal. Rptr 830, 832 (1980).

104. *See Wilson v. Kaiser Found Hosp.*, 190 Cal Rptr. 649, 651 (Cal. Ct. App. 1983).

enforceability of arbitration in the future is the general policy of upholding arbitration agreements.¹⁰⁵ In 1987, the California Court of Appeals established that an arbitration agreement between a physician and patient covered the continuing professional relationship, not just the initial treatment.¹⁰⁶ The court found that compliance with the arbitration act was sufficient to uphold the arbitration agreement.¹⁰⁷ In *Gross v. Recabaren*, a noncontractual spouse filed a lawsuit for loss of consortium because of the malpractice negligence in the doctor's failure to diagnose the patient. The court found that when a patient contracts to submit any dispute regarding medical malpractice to arbitration, that all claims arising from the alleged malpractice must be arbitrated.¹⁰⁸ In 1993, the California Court of Appeals also upheld an arbitration agreement that was made retroactively.¹⁰⁹ Similarly, heirs in a wrongful death action, were found to be bound by the decedent's agreement to arbitrate when the contract specifically required that claims by "a member's heir or personal representative" be arbitrated.¹¹⁰ On the other hand, where there is no privity of contract with the hospital, parties can still sue the hospital even if there is an arbitration clause with the provider.¹¹¹

III. MEDICAL MALPRACTICE ARBITRATION PROCESSES

1. Statutes of Limitation

Statutes of limitations were enacted in the 1970's as part of tort reform legislation. These statutes were enacted to fix the problem of the "long tail" in which claims for injuries are not immediately apparent and may not be apparent for a number of years. The slowness of the claims development process made it difficult to project claims experience, losses, and payouts.¹¹² Every state now has a statute of limitations that applies specifically to medi-

105. See *Pietrelli v. Peacock*, 16 Cal. Rptr. 2d 688, 691 (Cal. Ct. App. 1993).

106. See *Hilleary v. Garvin*, 238 Cal. Rptr. 247, 250 (Cal. Ct. App. 1987).

107. See *id.*

108. See *Gross v. Recabaren*, 253 Cal. Rptr. 820, 821 (Cal. Ct. App. 1988).

109. See *Coon v. Nicola*, 21 Cal. Rptr. 2d 846, 849 (Cal. Ct. App. 1993).

110. See *Herbert v. Superior Court*, 215 Cal. Rptr. 447, 478 (Cal. Court. App 1999).

111. See *Hollister v. Benzl*, 83 Cal. Rptr 2d 903, 905 (Cal. Court. App. 1999).

112. See Peter Zablotsky, *From a Whimper to a Bang: The Trend Toward Finding Occurrence Based Statutes of Limitation Governing Negligent Misdiagnosis of Diseases with Long Latency Periods Unconstitutional*, 103 DICK. L. REV. 455, 460 (1999).

cal malpractice claims.¹¹³ On the average, medical malpractice statutes of limitations are about two years. Typically, they run from the date of the occurrence of the negligence, date of discovery, or date of discovery with maximum time from occurrence.¹¹⁴

Provisions which have been found to be unconstitutional are those with a maximum time from occurrence because the right to sue could be precluded before the plaintiff has a chance to discover the wrong.¹¹⁵ States which have held occurrence based statutes of limitations unconstitutional are New Hampshire, New Mexico, Ohio, Oklahoma, and Oregon. Texas also indicated the possibility of doing so.¹¹⁶ These statutes have been held as unconstitutional violations of equal protection, due process, or access to court clauses of the United States or individual state constitutions.¹¹⁷ The equal protection challenges arise under the Fourteenth Amendment to the Constitution which states that no state can deny any person equal protection of the law.¹¹⁸ There are two primary challenges to the equal protection clause in regards to medical malpractice statutes of limitation. The first is that medical negligence plaintiffs are treated differently than plaintiffs for other negligence.¹¹⁹ The second is that different types of medical malpractice victims may be treated differently when discovery based statutes have exceptions for "foreign objects, continuous treatment, or fraudulent concealment."¹²⁰ Courts have found that when a statute treats medical malpractice plaintiffs differently because of these exceptions, then the statute is an unconstitutional violation of equal protection because the statutes are not rationally related to the legitimate state interest involved.¹²¹

The due process challenges arise under the Fifth Amendment to the Constitution which requires that no state may deprive a person of "life, liberty, or property without due process of law."¹²² In the context of the statutes of limitations, due process procedural protections requiring someone to be heard at a meaningful time and in a meaningful way can be balanced against other social interests to limit the time within which a claim can be asserted.¹²³ Courts

113. *See id.*

114. *See id.* at 461.

115. *See id.* at 456.

116. *See id.*

117. *See id.*

118. *See* U.S. CONST. amend. XIV.

119. *See* Zablotzky, *supra* note 109, at 468.

120. *Id.*

121. *See id.* at 474.

122. U.S. CONST. amend. V.

123. *See* Zablotzky, *supra* note 109, at 484.

have generally found that statutes of limitations that expire before the plaintiff has a chance to discover the injury are unconstitutional.¹²⁴ Other states have interpreted the statute of limitations in a way to avoid finding the statute unconstitutional by finding that injury occurred after the occurrence of the malpractice.¹²⁵ In California, the statute of limitation for arbitration is the same as that covering written contracts generally for a period of four years.¹²⁶ Therefore, a medical malpractice lawsuit would need to be filed within the time frame for tort litigation, but arbitration proceedings could wait for four years to be filed.¹²⁷

2. Prelitigation Panels

Twenty-five states have implemented a prelitigation process that includes a prelitigation panel. While the exact name and function of the panels vary from state to state, generally they have been established by statute to provide for early case screening through discovery and fact finding and early neutral evaluation analysis that can include standard of care, liability, and damage issues. The panels often include a physician who can serve as an expert in determining the standard of care as part of the panel process. Panels have been implemented in efforts to encourage early resolution of claims, reduction of litigation costs, and lower malpractice premiums.¹²⁸ Critics of the pre-trial screening panels contend that they are not effective, non-binding, and add another administrative layer to court proceedings resulting in increased costs.¹²⁹

Prelitigation panels function in different ways in different states.¹³⁰ The panels primarily either serve an expert function in reviewing the case and determining whether there is a negligent breach of the standard of care or in the role of non-binding early neutral evaluation to promote settlement. Upon agreement of the parties, the decision of the panel can become binding. Three states provide for panel mediation of claims. Washington provides for

124. *See id.*

125. *Id.* at 493.

126. *See Meyer v. Carnoue*, 229 Cal. Rptr. 617 (Cal. Ct. App. 1986). (Shepardize)

127. Cerny, *supra* note 15, at 204.

128. Zukher, *supra* note 5, at 150.

129. *Id.*

130. The states which have prelitigation panels are: Alaska, Connecticut, Delaware, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Montana, Nebraska, Nevada, New Mexico, Ohio, South Dakota, Utah, Vermont, and Virginia.

mandatory mediation of health care claims.¹³¹ The statute of limitations is tolled until the mediation is complete and the case can still go to trial.¹³² In Wisconsin, mediation panels are available for health care providers and families. The statute of limitations is again tolled until the mediation is complete or mediation may be requested within 154 days of filing the complaint.¹³³ In North Carolina, all civil cases are required to participate in a mediated settlement within 120-180 days of filing the law suit.¹³⁴ Wyoming has declared its panel to be unconstitutional. In 1988, the Wyoming Supreme Court declared the Medical Review Panels for medical malpractice to be an unconstitutional denial of equal protection.¹³⁵

Some prelitigation panels serve an expert role in determining liability with the determination resulting in admissibility in court. In Alaska, a three member expert panel prepares a written report to the court that is admissible as expert testimony at trial.¹³⁶ The Connecticut screening panel comprised of one attorney and two doctors is voluntary. If convened, the panel will review and determine liability which decision is admissible in court.¹³⁷ In Delaware, a mandatory malpractice review panel gives advice to the court on whether evidence supports a breach of the standard of care. A negative panel opinion is "prima facie" evidence of negligence, but is not conclusive. Panel members are protected from testifying in court and the court itself can strike down the panel opinion.¹³⁸ In Indiana, a medical review panel is convened for medical malpractice claims that exceed \$15,000. The panel consists of one attorney and three health care providers who serve as experts in reviewing the medical situation. The decision of the Indiana Medical Review Panel is admissible at trial, but is not conclusive of fault.¹³⁹ In Kansas, the Kansas Medical Screening Panel report is admissible at trial and panel members may serve as witnesses.¹⁴⁰ Maryland's Arbitration Panel in the Health Claims Arbitration Offices determines the liability of the parties and then apportions damages if needed. Parties can reject the panel decision, but panel recommendations are

131. Michigan also provides for a Mediation Panel. However, the Michigan Panel functions by holding a hearing and evaluating the merits of the lawsuit so that it acts more like an arbitration panel than a mediation panel. See MICH. COMP. LAWS ANN. § 27-6-105 & § 27-6-701.

132. WASH. REV. CODE ANN. § 7.70.100.

133. WISC. STAT. ANN. § 655.445.

134. N.C. GEN. STAT. § 7A-38.1.

135. See *Hoem v. State*, 756 P.2d 780, 783 (Wyo. 1988).

136. See ALAS. STAT. § 09.55.535.

137. See CONN. GEN. STAT. ANN. § 38A-36.

138. See DEL. CODE ANN. 18 §68003, 6811, 6812, 6853.

139. See IND. CODE ANN. § 34-18-8-4 TO 34-18-8-6.

140. See KAN. STAT. ANN. § 65-4904.

admissible in court.¹⁴¹ Massachusetts requires a Tribunal Review by a judge, physician and attorney with the panel findings admissible at trial.¹⁴² The Nebraska Medical Review Panel meets prior to filing a lawsuit and tolls the statute of limitations. The panel determines the standard of care, and decisions are non-binding, but are admissible in court. The Virginia Medical Malpractice Review Panel holds a hearing on the standard of care and issues a non-binding decision. The panel opinion is admissible as evidence and the panel members can serve as witnesses. Parties also have the option of binding arbitration.¹⁴³

Other prelitigation panels serve as non-binding early neutral evaluation to encourage early settlement of the case without the panel decision being admissible in court. Hawaii requires that a Conciliation Panel meet prior to the filing of a lawsuit to review the case and issue an advisory opinion on negligence liability and damages. Parties can reject the recommendations of the panel and sue in court.¹⁴⁴ Idaho requires that the Idaho Board of Medicine convene a hearing panel prior to filing a lawsuit. However, the proceeding is informal, nonbinding, and inadmissible in court.¹⁴⁵ Louisiana gives parties the choice of a review by a Medical Review Panel or an arbitration proceeding.¹⁴⁶ In Maine, the Prelitigation Screening panel meets prior to a lawsuit being filed. However, the panel can be waived or enforced by agreement of the parties.¹⁴⁷ Michigan convenes a Mediation Panel that holds a hearing and evaluates the situation including the standards of care.¹⁴⁸ In Montana, either a Medical Legal Panel convenes prior to filing a lawsuit or arbitration can be held to determine the evidence available, whether malpractice occurred, and the extent of the injury. The Montana Panel decision is not binding or admissible in court.¹⁴⁹ The Nevada screening panel determines injury or malpractice before the parties can file suit. If the panel determines that malpractice occurred, a mandatory settlement conference is held to determine the value of the claim. The decision of the settlement court is non-binding, but requires

141. See MD. CODE ANN. § 3-2A-02.

142. See MASS. ANN. LAWS 231 § 60B.

143. See VA. CODE ANN. § 8.01-581.2.

144. See HAW. REV. STAT. § 671-12.

145. See IDAHO CODE § 6-1001 to 1-11.

146. See LA. REV. STAT. ANN. § 40:1299.57.

147. See ME. REV. STAT. ANN. 24 § 2851 – 2857.

148. See MICH. COMP. LAWS ANN. § 600.4915.

149. See MONT. CODE ANN. § 27-6-105 to 27-6-701.

payment of costs to the other party if a smaller amount is awarded at trial.¹⁵⁰ New Mexico's Medical Review Commission decisions are not binding and not admissible in court.¹⁵¹ The Ohio voluntary arbitration board renders non-binding inadmissible opinions.¹⁵² The South Dakota Panel must determine liability, and if liability is found, the panel has thirty days to determine damages.¹⁵³ In Utah a Prelitigation Panel determines the merit of the case. The decision is non-binding and inadmissible in court. However, parties may waive the panel or convert to binding arbitration by agreement.¹⁵⁴ The Vermont arbitration panel convenes before trial and the decision of the panel can be binding by agreement of the parties.¹⁵⁵ Pre-trial screening panels have been criticized as another administrative hurdle that comes too early in the process to be effective.¹⁵⁶

3. Arbitration Statutes

All fifty states have general arbitration statutes based on the Uniform Arbitration Act.¹⁵⁷ The Uniform Arbitration Statutes are based upon the Uniform Arbitration Model Act which has been adopted with variations in each of the states. The Model Arbitration Act generally provides for the validity of written agreements to arbitrate. The court has jurisdiction to review proceed-

150. See NEV. REV. STAT. ANN. § 41A.059.

151. See N. M. STAT. ANN. § 41-5-15.

152. See OHIO REV. CODE ANN. § 2711.21.

153. See S. D. § 21-25B-1 TO 21-25B-26.

154. See UTAH CODE ANN. 78-14-8 TO 78-14-12.

155. See VT. STAT. ANN. 12 § 7002.

156. See Metzloff, *supra* note 4, at 217.

157. GENERAL ARBITRATION STATUTES FOR EACH STATE. ALA. CODE §§ 6-6-1 to -16 (1993); ALASKA STAT. §§ 09.43.010 to .180 (Michie 1998); ARIZ. REV. STAT. ANN. §§ 12-1501 to -1518 (West 1994); ARK. CODE ANN. § § 16-180-101 to —107 (Michie 1987); CAL. CIV. PROC. CODE; COLO. REV. STAT. §§ 13-22-201 to -223 (1987); CONN. GEN. STAT. ANN. §§ 52-408 to -424 (West 1991); DEL. CODE ANN. tit. 10 §§ 5701-5725 (Michie 1999); HAW. REV. STAT. §§ 658-1 to -15 (1993); IDAHO CODE §§ 7-901 to -922 (1998); 710 ILL. COMP. STAT. ANN. 5118 (West 1999); IND. CODE ANN. §§ 34-57-1-1 to -26 (Michie 1982); IOWA CODE ANN. §§ 679A.1 - .19 (West 1998); KAN. STAT. ANN. § 5-401 to -422 (1982); KY. REV. STAT. ANN. §§ 41.045 to .160 (Michie 1992); LA. REV. STAT. ANN. §§ 9:4201 to :4217 (West 1997); ME. REV. STAT. ANN. tit. 14 §§ 5927-5949 (West 1980); Mo. Code Ann., Arbitration § 3-201 to -234 (1998); MASS. GEN. LAWS ANN. ch. 251, §§ 1-12 (West 1981); MICH. COMP. LAWS ANN. §§ 600.5001-15035 (West 1994); MIN. STAT. ANN. §§ 572.08 to .30 (West 1998); MONT. CODE ANN. §§ 27-5-111 to -324 (1997); NEB. REV. STAT. ANN. §§ 25-7601 to -2622 (Michie 1998); N.C. GEN. STAT. §§ 1.567.188.20 (1996); N.D. CENT. CODE §§ 32-29.2-01 to -20 (1998); Okla. Stat. Ann. tit. 15 §§ 801-818 (1998); 42. PA. CONS. STAT. ANN. §§ 7301-7320 (West 1998); S.C. CODE ANN. § 215-48-10 to -240; TENN. CODE ANN. §§ 29-5-301 to -320 (1997); TEX. CIV. ST. CODE ANN. §§ 224 to 238-6 (West 1998); UTAH CODE ANN. §§ 78-31a-1 to -18 (1994); VT. STAT. ANN. tit. 12 §§ 5651-5681 (1997); VA. CODE ANN. §§ 8.01-581.016 (Michie 1998); WYO. STAT. ANN. §§ 1-36-101 to -119 (Michie 1998).

ings to compel or stay arbitration pursuant to an arbitration agreement. When an agreement goes to arbitration, there is a period of discovery, followed by an arbitration hearing. Parties may be represented by an attorney if they so desire. Parties, by application, can request that an arbitration award be modified. Arbitration awards are typically upheld unless there is demonstrated fraud, impartiality, the arbitrator exceeded his authority, or other limited grounds. A court entered award is given the same force as any other judgment.¹⁵⁸ The adoption of the Uniform Arbitration Act in a state provides statutory framework favoring arbitration. Any medical malpractice arbitration could take place under the Uniform Arbitration Act enacted in any of the states by complying with any specific provisions of the statute within that state. Some states have also enacted medical malpractice specific arbitration statutes. These statutes provide a more specific framework for arbitration in the medical malpractice context. These state statutes are discussed in more detail below.

Michigan was the first state to establish medical malpractice arbitration by statute.¹⁵⁹ The Michigan statutes provided for voluntary arbitration by a three person panel chosen from an advisory committee comprised of public member, health care professionals, and attorneys.¹⁶⁰ The process included notice to patients of their option to arbitrate medical malpractice claims. During a thirteen year period only 847 Malpractice disputes out of a pool of 20,000 claims were arbitrated.¹⁶¹ When statutory arbitration requirements were met, the court presumed the validity of the arbitration agreement unless the party challenging the agreement could show reasons not to enforce the agreement.¹⁶² The arbitration agreement was upheld because the form and content complied with the statute even though there was no indication that information about the arbitration agreement had been given the patient and he was

158. The Uniform Arbitration Act adopted by the National Conference of Commissioners on Uniform State Laws in 1995, amended in 1956, and approved by the House of Delegates of the American Bar Association on August 25, 1955 and August 30, 1956. <http://www.adr.org>.

159. In 1975, the Michigan Medical Malpractice Arbitration Act also included restrictions on expert witness qualification, damage caps, and use of a mediation panel in a role similar to other pre-litigation panels. These provisions were tightened in 1993 with revised limits and exceptions on damage caps and modified terms of voluntary agreements. See MICH. COMP. LAWS ANN. § § 600.5040-600.5065 (repealed 1993); See also MICH. COMP. LAWS ANN. § 600.2912g(1) (1993).

160. MICH. COMP. LAW ANN. § 600.5040 (West 1993) Now repealed.

161. Arbitration Potential, *supra* note 4, at 203.

162. *McKinstry v. Valley Obstetrics-Gynecology Clinic, et al.* 405 N.W.2d 88 (Mich 1987).

simply given the agreement to sign without explanation.¹⁶³ Generally, courts have favored arbitration and have enforced arbitration agreements which do not meet the statutory requirements.¹⁶⁴ *However, a recent Michigan court of appeals case found a medical malpractice arbitration agreement unenforceable for not complying with the statutory purpose of including provisions regarding how and who could revoke the arbitration clause.*¹⁶⁵

In 1993, the Michigan Medical Malpractice Arbitration Act was repealed¹⁶⁶ and more stringent damage caps and modified voluntary arbitration agreements were enacted.¹⁶⁷ Michigan later established a mediation award panel that functioned similar to an arbitration panel.¹⁶⁸ This panel determined the amount of the award which the parties could accept or reject. A study of the Michigan Mediation panel award process found that the mediation awards were generally higher than settlement payments and trial awards, the awards did not tend to be erratic, and actual negligence had an impact on accepting mediation awards.¹⁶⁹

The Alabama Medical Liability Act provides for settlement of medical liability disputes by arbitration. The act applies to physicians, dentists, medical institutions, and other health care providers and specifically indicates that American Arbitration Association rules will be followed.¹⁷⁰ Alaska specifically provides for the voluntary arbitration of malpractice actions if certain contract formalities are met. It also indicates that the arbitration agreement cannot be a prerequisite of treatment. While Alaska has a statute to promote private arbitration of medical malpractice claims, there is no indication that any malpractice cases have been arbitrated under it.¹⁷¹

California and Colorado have notice provisions. California requires the first article of the contract to state

163. *Id.* at 96.

164. *Haywood v. Fowler*, 475 N.W.2d 458 (Mich. Ct. App. 1991).

165. *Kosmyna v. Botsford Community Hospital*, 607 N.W.2d 134 (Mich. Ct. App. 2000). *In this case the arbitration agreement indicated that the person has 60 days after hospitalization to revoke the arbitration agreement in writing. However, the agreement did not indicate that a legal representative of the person can cancel, nor did it indicate that the hospital could cancel the agreement. Because the agreement did not meet the statutory purpose it was held to be unenforceable.*

166. Michigan Medical Malpractice Arbitration Act MICH. COMP. LAWS ANN § 600.5040.5065 (1993), now repealed, and Michigan Uniform Arbitration Act at MICH. COMP. LAWS ANN. § 600.5001 – 5035 .

167. MICH. COMP. LAWS ANN. § 600.2912g.

168. Walter Orlando Simmons, *An Economic Analysis of Mandatory Mediation and the Disposition of Medical Malpractice Claims*, 6 J. LEG. ECON. 41, 42 (1996).

169. *Id.* at 66-68.

170. Alabama Medical Liability Act, § 6-5-485 (1975).

171. Arbitration Potential, *supra* note 4, at 203, at 204.

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 California law, and not by a lawsuit or resort to court process except as California 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.¹⁷²

Before the signature line in 10-point bold red type the notice should say:

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING 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 2 OF THIS CONTRACT.¹⁷³

The California Medical Injury Compensation Reform Act (MICRA) also included a \$250,000 non-economic damage cap, collateral source reductions, short statute of limitations, and limits on attorneys fees.¹⁷⁴ The California statute gives parties thirty days to revoke the arbitration agreement.¹⁷⁵ The MICRA statute did reduce medical malpractice premiums between 1975 and 1991.¹⁷⁶

4. Arbitration Practices

In 1997, the California Supreme Court decided *Engalla v. Permanente*.¹⁷⁷ This involved a young man who came in during a several year period with respiratory and other lung problems. No diagnostic tests were performed. Eventually, an x-ray was performed and he was diagnosed with lung cancer. By then it was inoperable.¹⁷⁸ Pursuant to an arbitration agreement, petitioner gave notice of intent to arbitrate. They also gave notice that petitioner's condition was terminal and that this needed to be resolved expediently. This was

172. MICRA, Cal. Civil Proc. Code §1295 (1999).

173. Cal. Civ. Proc. Code § 1295(a) (1999).

174. MICRA contingency fee limitation Cal. Bus & Prof. Code s 6146 (West 1993), collateral source benefits Cal. Civ Code 3333.1 , \$250,000 noneconomic damage cap s 3333.2, statute of limitations 340.5, arbitration requirements s1295.

175. Cal. Civ. Proc. Code § 1295(c)(1999).

176. Cerny, *supra* note 15, at 194.

177. *Engalla v. The Permanente Medical Group Inc.*, 938 P.2d 903 (1997).

178. *Id.* at 909.

the end of May.¹⁷⁹ It took until October for the parties to agree on the panel of three arbitrators. Kaiser was involved in a variety of stalling and delay tactics that including picking an arbitrator they knew would not be available until November, not facilitating selection of the arbitrator, etc. The day after the arbitrator was selected, the petitioner died.¹⁸⁰ A lawsuit was filed in the court requesting that the arbitration agreement be unenforceable and claiming fraud, duress, and waiver of enforcement based on the actions of Kaiser in interfering with the arbitration process. The California Supreme Court reiterated the public policy encouraging arbitration, but indicated that there were times, such as the procedural abuses in the Kaiser case, when arbitration could not be enforceable.¹⁸¹

Following the case, Kaiser put together a panel to consider how to resolve the problem.¹⁸² They recommended an independent administrator to administer the program on behalf of Kaiser.¹⁸³ Kaiser contracted with a small 15 person law firm who administers the arbitration through AAA processes.¹⁸⁴ Following the Kaiser case, the American Arbitration Association, American Medical Association and American Bar Association formed a Committee which recommended Due Process Protocols to ensure fairness in alternative dispute resolution processes.¹⁸⁵ There has also been consumer protection legislation and discussion at both the state and national level.¹⁸⁶

Maine Medical Association began a five year medical malpractice experiment in 1992. The Maine statute required a State committee to establish practice guidelines for anesthesia, emergency medicine and obstetrics and gynecology. Physician can choose to participate in the program through use of the practice guidelines. If sued for malpractice, then the lawsuit will be dismissed if the physician can prove compliance with the practice guidelines. The proposal was to be effective only if a majority of the physicians in the three specialties choose to participate.¹⁸⁷

179. *Id.* at 910.

180. *Id.* at 914.

181. *Id.* at 927.

182. *Kaiser Appoints Panel to Oversee Arbitration Program in California*, 6 HEALTH CARE POL'Y REP. 18 (BNA), 763 (1998).

183. *Kaiser Should Create Independent Arbitration Administrator, Panel Says*, 7 HEALTH L. REP. 2 (BNA) 54 (1998).

184. *See id.*

185. *Consumer Due Process Protocol: Statement of Principles of the National Consumer Dispute Advisory Committee*, 10, April 1, 1998 <http://www.adr.org>.

186. *Consumer Bill of Rights and Responsibilities: Chapter 7: Complaints and Appeals*, Presidential Advisory Commission on Consumer Protection and Quality in the Health Care Industry, Report to the President of the United States (1997).

187. James Ludlam, *The Real World of Malpractice Tort Reform Part II*, 33 HOSP. L. 12,

5. Damage Limits

Limitations on non-economic damages have been established in some states as a way to maximize jury verdicts so that there is more consistency among awards.¹⁸⁸ The damage caps provide guidelines for the jury to prevent arbitrary awards with wide differences in verdicts for similarly situated plaintiffs.¹⁸⁹ Twenty-five states have damages caps in place for damages.¹⁹⁰ An early study found that by 1978 statutory damage caps had decreased the rise in claim severity.¹⁹¹ The Florida courts have specifically upheld the statutory non-economic damage caps in the arbitration setting. In *University v. Echarte*, the court found that the agreement to arbitrate with limitations on damages did not violate the plaintiff's constitutional right to access to the courts. The need to control medical malpractice insurance premiums was seen as a legitimate reason to cap damages.¹⁹² These damage caps were challenged as constitutional violations of the right to access to the courts, right to trial by jury, equal protection guarantees, and procedural and substantive due process. The court relied on public policy favoring damage caps and use of arbitration.¹⁹³ Sixteen states do not have any damage caps.¹⁹⁴ Critics of damage caps claim that they are unresponsive to individual cases and unjustly limit recovery in individual cases.¹⁹⁵

Nine states have declared damage caps as unconstitutional under differ-

353, 363.

188. Zukher, *supra* note 5, at 147.

189. *Id.*

190. The states which have damage caps include Alaska, California, Colorado, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Louisiana, Maine, Maryland, Massachusetts (there is an exception for showing of loss or impairment of body function which is relatively easy to prove), Michigan, Missouri, Montana, Nebraska, Nevada, New Jersey, Oklahoma, Pennsylvania, Utah, Virginia, West Virginia, Wisconsin.

191. Patricia J. Chupkovich, *Statutory Caps: An Involuntary Contribution to the Medical Malpractice Insurance Crisis or a Reasonable Mechanism for Obtaining Affordable Health Care?*, 9 J. CONTEMP. H. L. & POL'Y 337, 342 (1993).

192. *University of Miami v. Echarte*, 618 So. 2d 189 (Fla. 1993).

193. *See id.*

194. The states that have damage caps include Arizona, Arkansas, Connecticut, Delaware, Georgia, Iowa, Kentucky, Maine, Minnesota, Mississippi, Montana, Nevada, New York, South Carolina, Vermont, Wyoming. *See* Patricia Chupkovich, *Statutory Caps: An Involuntary Contribution to the Medical Malpractice Insurance Crisis or a Reasonable Mechanism for obtaining Affordable Health Care?*, 9 J. CONTEMP. H. L. & POL'Y 337 (1993).

195. Zukher, *supra* note 5, at 147.

ent theories.¹⁹⁶ Equal protection is the most common ground for challenge to the damage caps.¹⁹⁷ The argument is that statutes violate the equal protection clause because the damage limits discriminate between more severely injured persons and less severely injured person as well as discriminate between medical malpractice plaintiffs and other tort plaintiffs.¹⁹⁸ Others have challenged the constitutionality of damages as a violation of due process rights. "In reviewing statutory caps under substantive due process, courts consistently apply a reasonableness test: Whether the legislation is reasonably related to a proper legislative goal and is neither arbitrary nor discriminatory."¹⁹⁹ Other challenges have claimed that damage caps violate the Seventh Amendment right to a jury trial because the caps limit the ability of the jury to determine the outcome of the trial through determination of damages.²⁰⁰ Other challenges are based on "open courts" provisions that guarantee access to the court.²⁰¹

A recent study of the effects of damage caps on pretrial settlement rates gave paired negotiation subjects facts with which to negotiate a settlement. Some of the pairs were given damage caps and others were not. The study found that damages caps increase the settlement rate by reducing uncertainty about the predicted trial outcome.²⁰² Further, while both parties to the negotiation had self-serving beliefs about the trial outcome, the damage caps reduced the difference between the biases.²⁰³ Plaintiffs and defendants incorporated the cap into their decision-making in different ways. While defendants used caps to lower trial predictions, plaintiffs used caps to generate higher trial predictions. Finally, fairness considerations played an important role in pretrial bargaining.²⁰⁴

196. Nine states that have held damage caps to be unconstitutional include Alabama, Illinois, Kansas, New Hampshire, Oregon, Ohio, South Dakota, Texas, and Washington. See Chupkovich, *supra* note 190.

197. Chupkovich, *supra* note 190, at 351.

198. States which have held damage caps unconstitutional based on equal protection include New Hampshire, North Dakota, and Idaho. See Mary Ann Willis, *Limitation on Recovery of Damages Medical Malpractice Cases: A Violation of Equal Protection?* 54 U. CIN. L. REV. 1329, 1338 (1986).

199. Courts in Ohio and Kansas have found that statutory caps violate substantive due process. See Chupkovich, *supra* note 190, 337, 351.

200. *Id.*

201. *Id.* at 359-75.

202. Linda Babcock and Greg Pogarsky, *Damage Caps and Settlement: A Behavioral Approach*, 24 J. LEGAL STUD. 341, 363 (1999)

203. *Id.* at 364.

204. *Id.* at 367.

6. Award Reportability

The Health Care Quality Improvement Act (HCQIA) of 1986 requires reporting of medical malpractice awards to the National Practitioner Data Base (NPDB).²⁰⁵ Liability insurers are required to report all malpractice payments made on behalf of doctors whether through jury verdict, arbitration award, or settlement. The intent was to create a database that could be accessed by Medical Boards, hospital staff privileging entities, and managed care organizations and others seeking information about physician qualifications as part of quality of care monitoring and credentialing decision making.²⁰⁶

Hospitals, managed care organizations, and other interested parties can access the data base to find out about a physician's malpractice award history.²⁰⁷ These awards are then used for credentialing of physicians by hospitals and HMOs to decide if the doctor should be included in their network or have privileges at their hospital.²⁰⁸

Mandatory reporting can make physician hesitant to settle lawsuits and can encourage them to fight to protect their good name since even a settlement in which there is no liability will be reported.²⁰⁹ Some states specifically require reporting of malpractice verdicts and awards to the State Board of Medicine.²¹⁰ The states then prepare a physician profile that includes information about the physician that can be used to compare practitioners.²¹¹ In Arizona, the Board of Medical Examiners collects information including medical malpractice judgments and awards to prepare a profile that is publicly disseminated.²¹² The malpractice information must include the following statement:

The Settlement of a medical malpractice action may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor.

205. 42 U.S.C. § 11134 .

206. Weiler Malpractice Tail, *supra* note 11, at 1168.

207. Arbitration Potential, *supra* note 4, at 205.

208. *Id.*

209. *Id.*

210. States that require reporting include Arizona, at A.R.S. § 32-1403.01; Massachusetts, at M.G.L.A. 112 § 5; New Jersey, at N.J. Stat. § 17:30D-17 (1999); Tennessee, at T.C.A. § 63-51-105; and Rhode Island, at R.I. 5-37-9.2.

211. Massachusetts, at M.G.L.A. 112 § 5 (1999) and Tennessee, at T.C.A. § 63-51-105.

212. A.R.S. § 32-1403.01(A) (1999).

A payment in settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.²¹³

Rhode Island also requires similar language to be included with public dissemination or data.²¹⁴ Rhode Island also requires malpractice data to be accompanied by (1) an explanation of the fact that physicians treating certain types of patients and performing certain procedures are more likely to be the subject of litigation than others (2) a statement that ten years worth of information is included (3) an explanation that an incident can occur a long time before malpractice awards are actually decided (4) an explanation of the impact of treating high-risk patients on the medical malpractice history and (5) an explanation that claims may be settled for reasons other than liability and are sometimes made by the insurer without the physicians consent.²¹⁵

IV. FEDERAL PREEMPTION

1. Federal Arbitration Act (FAA)

The Federal Arbitration Act (FAA) was established to promote and encourage arbitration. This federal act is valid. The act states that

A written provision of any . . . contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or any agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and unenforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.²¹⁶

The Supreme Court in interpreting the FAA has established that the FAA is substantive rather than procedural law that was enacted pursuant to the power of congress to regulate interstate commerce.²¹⁷ FAA preempts state law when interstate commerce is effected to the extent that state law is inconsistent with the FAA or stands as an obstacle to the objectives of Congress.²¹⁸

In 1996 the U.S. Supreme Court decided the *Doctor's Associates v.*

213. A.R.S. § 32-1403.01(A)(4) (1999).

214. R.I. 5-37-9.2 (1998).

215. R.I. 5-37-9.2 (a)(1)(G), (1998).

216. 9 U.S.C. §2 (West 1999).

217. See *Bernhardt v. Polygraphic Co. of Am.*, 350 U.S. 198, 203 (1956). See also *Prima Paint Corp. v. Flood & Conklin Mfg. Co.*, 388 U.S. 395, 4003—05 (1967).

218. See *Southland Corp. v. Keating*, 465 U.S. 1 (1984); see also *Moses H. Cone Mem'l Hosp. V. Mercury Constr. Corp.*, 460 U.S. 1 (1983); see also *Volt Info Sciences, Inc. v. Board of Trustees*, 489 U.S. 468 (1989).

Casarotto case.²¹⁹ In this case, the Supreme Court reviewed a Montana statute which required that arbitration clauses be printed on the first page of a contract in underlined capital letters. The Court found that the statute placed specific requirements on arbitration clauses and conditioned enforcement of provisions on compliance with these requirements which were not applicable to contracts generally. This state statutory treatment of arbitration clauses differently than other standard contract language was inconsistent with the FAA.²²⁰ Although FAA preempts state law where the two conflict, state substantive law regarding the use of arbitration clauses can still be formed by the states.²²¹ For example, Doctor's Associates case indicates that the determination of whether a contract is unconscionable under state law is appropriate without contravening the FAA.²²² It leaves open the question of whether statutes such as the California code with specific arbitration contract drafting requirements similar to those in the Doctor's Association case would be preempted by FAA.²²³

Similarly, the Colorado Court found the Colorado Health Care Availability Act with provisions setting forth specific language for the medical arbitration clause was preempted by the FAA which requires that an arbitration clause in a contract involving commerce is revocable only on the grounds applicable to contracts generally.²²⁴

2. Enterprise Liability & ERISA

Enterprise liability refers broadly to the theories that courts have used to hold hospitals or health plans liable for medical malpractice.²²⁵ With managed care cost containment incentives, the financial incentives on physicians to control costs may also create incentives to limit quality of care. This can lead to health care with increased malpractice liability.²²⁶ There are also more people involved in health care decision-making including financial coverage deci-

219. Doctor's Associates v. Casarotto, 517 U.S. 681 (1996).

220. *Id.* at 1652, 1657.

221. Rolph, *supra* note 18, at 165.

222. Doctors Associates v. Casarotto, 517 U.S. 681, 686-88 (1996).

223. Rolph, *supra* note 18, at 166.

224. Morrison v. Colorado Permanente Medical Group P.C. 983 F. Supp. 937 (1997).

225. Zukher, *supra* note 5, at 151.

226. Gary T. Schwartz, *Symposium: Medical Malpractice, Tort, Contract, and Managed Care*, 1998 U. ILL. L. REV. 885 (1998).

sions.²²⁷ When a physician is employed by the hospital or health plan, the theory of respondeat superior is used to establish direct liability.²²⁸ Under this theory, the plaintiff must establish “(a) malpractice of the physician or other provider, (b) the existence of an employment relationship between the MCO (managed care organization) and the provider, and (c) that the provider was acting in the scope of his employment or agency in negligently administering medical services.”²²⁹ Respondeat Superior has also been extended to non-employed physicians under a theory of vicarious liability when the hospital or health plan exercises control over the affiliated physician.²³⁰

When the physician has independently contracted to provide services for the hospital or health plan, vicarious liability can also be established through the theory of actual or ostensible agency or agency by estoppel.²³¹ This theory was initially applied to hold hospitals liable for in-house physicians such as radiologists, pathologists, anesthesiologists, and emergency room physicians, but has since expanded to include other specialties as well.²³² In order to prove liability for an affiliated physician, the plaintiff must show “(1) an MCO [Managed Care Organization] holds out the affiliated physician as its employee, and (2) a patient looks to the MCO, rather than the individual physician, for medical care.”²³³ When the hospital or health plan “hold out” that the practitioner is affiliated with the organization and the consumer “relies on” this in receiving care, then the health care organization becomes liable for the actions of its ostensible agent.²³⁴

About one-half of the states use one of these theories to hold hospitals, health maintenance organization (HMO), managed care organization (MCO) liable for medical malpractice. About one-fourth of the states recognize the theory but haven’t applied it yet. Another one-fourth of the states have not addressed or deny the theory. Kansas has a statute that specifically denies enterprise liability.

If enterprise liability has been shown, then the medical malpractice claims could potentially be subject to arbitration if the hospital at the time of treatment had the patient sign an arbitration agreement or if the health plan

227. Rolph, *supra* note 18, at 153.

228. Zukher, *supra* note 5, at 151.

229. *Id.*

230. J. Bradley Buckhalter, *ERISA Preemption of Medical Malpractice Claims: Can Managed Care Organizations Avoid Vicarious Liability?* 22 SEATTLE UNIV. L. R. 1165, 1167 (1999).

231. Zukher, *supra* note 5, at 151.

232. Roger N. Braden and Jennifer L. Lawrence, *Medical Malpractice: Understanding the Evolution-Rebuking the Revolution*, 25 N. KY. L. REV. 675, 683 (1998).

233. Buckhalter, *supra* note 226, at 1165.

234. Zukher, *supra* note 5, at 151.

had an arbitration agreement in its contract. In Oklahoma, for example, the Supreme Court found that an HMO could not compel a plaintiff to arbitrate claims, even though the subscriber agreement had a mandatory arbitration clause. The court found the HMO's health services contract was excluded from coverage under Oklahoma's Uniform Arbitration Act which excluded arbitration for "insurance except those contracts between insurance companies". The court found that the HMO's functions were similar to health insurance and therefore covered by the statutory exclusion.²³⁵ A model arbitration clause that complied with the Michigan Uniform Arbitration Act was recently proposed for managed care organizations. It says:

Any controversy or claim arising out of or relating to this Managed Care Organization contract, or the breach thereof, shall be settled by binding arbitration. The arbitration process will be administered by the American Arbitration Association under its Health Care Claim Settlement Procedures, and judgment on the award rendered by the arbitrators may be entered in any court having jurisdiction thereof. The controversy or claim will be submitted to arbitration upon the written demand of one of the parties directed to the other party. The arbitration process shall commence within the following time frames: acute emergencies – 24 hours; general emergencies – 72 hours; non-emergencies – 45 days. Three (3) arbitrators will be selected, within ten (10) days of notice to the AAA of the existence of the dispute. If either of the parties fails to agree to any of the arbitrators named, the AAA shall advance on-half of the AAA fees that are operative at the time of filing; the opposing party will pay the remainder. By signing this agreement you are agreeing to have any dispute regarding health care coverage decided by the aforementioned arbitrators and you are giving up your right to a court or jury trial. This agreement to arbitrate is not a prerequisite to health care or treatment and it may be revoked by the member or his legal representative within sixty (60) days after execution by notifying the MCO in writing.²³⁵

The provisions are drafted with the intent to comply with FAA provisions as well as the more uniform arbitration act in Michigan.²³⁷

Different actions have been taken to reduce enterprise liability. A Harvard Medical School Anesthesia study was performed in the mid 1980's because Harvard anesthesia premiums were among the highest in the country for any specialty. The study found that the previous lawsuits were valid and a result of patient injuries that could have been avoided. The focus was on development of new procedures and technologies to avoid similar lawsuits in

235. Cannon v. Lane, 867 P.2d 1235, 1239 (1993).

236. Aimee E. Bierman, *A Modest Proposal: Model Arbitration Provisions in the Age of Managed Care*, 45 Wayne L. Rev. 173 (1999).

237. *Id.* at 181.

the future. These procedures and technologies to reduce medical negligence were implemented on a mandated basis. It was found that anesthesia-related mishaps had dropped and that malpractice premiums for the group had been cut in half.²³⁸ Enterprise liability may provide more of an opportunity to “improve the process” within the health care setting that led the adverse claim.²³⁹

Even if enterprise liability can be proven in the state where the malpractice arises, the Employee Retirement Income Security Act (ERISA) creates another hurdle to enforceability of liability in court. ERISA governs employee benefit plans (EBP) that are put in place pursuant to ERISA.²⁴⁰ These employee welfare plans include any plan put in place to provide medical or other health benefits for employees or their beneficiaries through the purchase of insurance or otherwise.²⁴¹ The purpose of ERISA was to allow multi-state employers the ability to provide uniform benefits to their employees without complying with specific and different state law provisions.²⁴² As part of this federal uniformity, ERISA pre-empts any claims made in state court and gives the federal district court exclusive jurisdiction over ERISA claims.²⁴³

Preemption can occur under two provisions of the act. The first provides for complete preemption. Complete preemption arises when a well-pleaded complaint raises issues of federal law. This federal law question creates federal question jurisdiction subject to removal by the defendant to federal court.²⁴⁴ The defendant cannot raise a federal defense to create federal jurisdiction, but must rely on the claims raised by plaintiff.²⁴⁵ The complete preemption doctrine is less an issue of preemption than of federal law jurisdiction over the claim. If federal legislation, such as ERISA, has characterized a claim as a federal law claim, then federal subject matter jurisdiction exists. Whether the plaintiff complies with the well-pleaded complaint rule or not, the defendant can remove the case to federal court and raise a federal law defense.²⁴⁶

238. Weiler Malpractice Tail, *supra* note 11, at 1186.

239. *Id.* at 1188.

240. Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et. seq. [Hereinafter ERISA]

241. ERISA, 29 U.S.C. §1002(1).

242. New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Insurance Company, 514 U.S. 645 (1995). [Hereinafter, Travelers].

243. 29 U.S.C. § 1144(a).

244. 28 U.S.C. § 1331.

245. Buckhalter, *supra* note 226, at 1169.

246. *Id.* at 1170.

With ERISA, the court looks at whether the plaintiff is attempting to “recover benefits” or “clarify rights to future benefits” under the plan. In *Dukes v. U.S. Healthcare*, the court held that the quality of benefit issues such as negligence are not preempted while quantity of benefit decisions such as denial of services were preempted by ERISA. This case involved a claim of enterprise liability under the theory of ostensible agency.²⁴⁷ When the court must interpret the employee benefit plan terms to determine the state law claim, then complete preemption applies and the case is removed to federal court. On the other hand, if the court can resolve the state law claim without look at the benefit plan contract, then there is no federal preemption and state court remedies apply.²⁴⁸ This becomes important because different remedies are available in different courts. ERISA specifically limits remedies to civil enforcement provisions to recover benefits due or enforce rights under the plan.²⁴⁹ Remedies such as punitive damages are not available under ERISA.²⁵⁰

Even if complete preemption does not apply in an ERISA case, conflict preemption under § 514 (a) may still apply.²⁵¹ Section 514 states that ERISA supercedes “state laws insofar as they may now or hereafter relate to any employee benefit plan”.²⁵² Numerous courts have reviewed whether a benefit plan “relates to” an employer benefit plan. In *Shaw v. Delta AirLines, Inc.*, the Supreme Court interpreted the “relates to” provision of the act to find that a law that has a “connection with or reference to” an employee benefit plan “relates to” the plan. The court then found that a New York law which forbade health plan discrimination because of pregnancy was preempted by ERISA.²⁵³ The Supreme Court decided *Blue Cross & Blue Shield Plans v. Travelers Insurance Company* by looking at the purpose of ERISA to determine whether the state statute impacted the uniform benefit plan administration.²⁵⁴ The court found that an indirect economic impact on choice of insurance did not trigger ERISA preemption because it did not preclude uniform

247. *Dukes v. U.S. Healthcare Inc.*, 88 F. 3d 1482 (7th Cir. 1996).

248. *Id.*

249. 29 U.S.C. § 1132(a) (1)(B).

250. The statute indicates the Congresses purpose was to avoid a multiplicity of regulation to permit national uniformity in administration of health plans. *See Travelers, supra* note 238, at 657.

251. ERISA § 514(a), 29 U.S.C. §1144(a).

252. *Id.*

253. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

254. *Travelers, supra* note 238, at 645.

administration of plan benefits.²⁵⁵ Two 1997 Supreme Court cases narrowed ERISA preemption by looking at (1) whether it was a traditional area of state regulation (2) whether the state law specifically “relates to” ERISA areas of concern and (3) reading preemption narrowly in traditional state substantive law areas even if there is an indirect economic effect on the EBP.²⁵⁶

While the ERISA preemption is broadly construed, the courts have begun to “pierce” ERISA to allow for lawsuits in state court for “quality” of care such as malpractice.²⁵⁷ Because the medical malpractice is a “quality” of care issue, there can be a lawsuit under ERISA to hold the health plan liable for medical malpractice if the enterprise liability is available in state court.²⁵⁸ For example, in *Dukes v. U.S. Healthcare*, the plaintiffs alleged negligence on behalf of the hospital and medical staff. The court found that complete preemption did not apply because the lawsuit did not fall within the scope of civil enforcement provisions for recovery of benefit or to enforce rights under the plan.²⁵⁹ In *Rice v. Panchal*, the plaintiff sued both his physician and health plan for medical malpractice under the theory of respondeat superior. The court found that ERISA did not completely preempt the plaintiff’s vicarious liability medical malpractice claim. The court based its decision on the fact that the civil enforcement provisions did not involve plan administration or quality of benefits under the plan. There was also no need to refer to the EBP to resolve the claim.²⁶⁰ These cases indicate that complete preemption will not apply when the claim can be resolved without looking at the terms of the plan or quality issues arise that do not impact civil enforcement proceedings.²⁶¹

Courts have been more varied in their interpretation of conflict preemption cases under 514(a). While some courts interpret the “relates to” provisions under 514(a) to find that indirect but substantial effect on employee benefit plan can be sufficient to trigger preemption of a vicarious liability claim to federal court. Thus, ERISA preempts the vicarious liability claim filed against a health plan.²⁶² On the other hand, some courts have interpreted

255. *Id.* at 659-660.

256. *California Division of Labor Standards Enforcement v. Dillingham*, 519 U.S. at 330 (1997); *DeBuono v. NYSA – ILA Medical Clinical Services Fund*, 520 U.S. 806 (1997).

257. *Dukes v. U.S. Healthcare Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996).

258. *Id.*

259. *Dukes v. U.S. Healthcare*, 88 F.3d at 1482.

260. *Rice v. Panchal*, 65 F.3d at 638-39 (7th Cir. 1995). *See also Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 153 (10th Cir. 1995).

261. Buckhalter, *supra* note 226, at 1179.

262. *Id.* at 1180; *See also, Altieri v. Cigna Dental Health*, 753 F. Supp. 61 (D. Conn. 1990).

the “relates to” provisions to find that the indirect effect on administrative procedures of a plan would not trigger ERISA preemption. Thus, the medical malpractice claim did not “relate to” the benefit plan and there was not ERISA preemption. The malpractice claim could be heard in state court.²⁶³ However, applying the three-prong analysis of the *Travelers*, *Dillingham*, and *DeBuono* cases, conflict preemption may not occur for medical malpractice. (1) Medical malpractice is a traditionally area of state law. (2) State vicarious liability medical malpractice claims do not implicate an express area of ERISA concern. (3) The indirect economic effect of vicarious liability medical malpractice claims would not trigger ERISA conflict preemption.²⁶⁴

3. TeleMedicine, CyberMedicine, and CyberMalpractice

Telemedicine is “the use of advanced telecommunications technologies to exchange health information and provide health care services across geographic, time, social and cultural barriers.”²⁵⁴ Telemedicine allow an interactive televideo to transfer information to physicians at both ends of the communication. The technology allows a physician to “see” the patient through video technology.²⁶⁶ Telemedicine is often used to provide expertise which may not be available in a more rural or other area where health care specialists are less available.²⁶⁷ Telemedicine is currently used with static imaging whereby information is digitized and compressed to be transferred through the telephone cables to produce images at the other end. Fiber-optic cables are used to produce these images.²⁶⁸ Since states regulate the practice of medicine, some states have amended their licensing statute to include the practice of telemedicine or permit out of state license exceptions to those from bordering states, those providing limited consultations, or emergency services.²⁶⁹ Three proposals to lessen the burden of state licensure include: (1) patients are considered to be “electronically transported” to the state of the

263. *Id.* at 1181; *See also, Haas v. Group Health Plan*, 875 F. Supp. at 548.

264. Buckhalter, J. Bradley at 1183 – 1185.

265. Christopher J. Caryl, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine*, 12 J.L. & HEALTH 173, 174 (1997/1998).

266. Nicolas P. Terry, *Cyber-Malpractice: Legal Exposure for Cybermedicine*, 25 AM. J. L. & MED. 327 (1999).

267. Caryl, *supra* note 261, at 173.

268. *Id.*

269. *Id.* at 176.

consulting telephysician so that there is no new licensure requirement, (2) create a national licensure system to regulate telemedicine or (3) adopt model acts that require all physicians practicing telemedicine across state lines to obtain a special purpose license for the specific purpose of practicing telemedicine.²⁷⁰ In terms of establishing the breach of the standard of care, the question is the proper standard of care for telemedicine. The modern trend towards a national standard of care would seem to fit the non-geographic nature of telemedicine, but that has yet to be determined. The broader issues are "choice of law" questions over which state law would decide when the doctor and patient reside in different states. By contracting prior to services, contracts could spell out these choice of law provisions and provide for private proceedings such as arbitration as well.

Malpractice issues that arise from telemedicine are the same as arise under standard malpractice cases. The plaintiff must prove that there is a duty, the duty was breached, the breach was the proximate cause of injury, and there was harm or damage.²⁷¹ Courts have not yet established when the patient-physician relationship is sufficiently established to create a duty. It has been suggested that if the following elements are shown, a telemedicine consult would have created a physician-patient relationship: (1) if the consultant has met the patient or knows his name and (2) the consultant has examined the patient's record and (3) the consultant examined the patient or (4) the consultant accepts a fee for his services.²⁷²

Cybermedicine is defined in a broader way to include telemedicine and all technology enabled interactions among health care providers and consumer-patients. Cybermedicine includes "marketing, relationship creation, advice, prescribing and selling drugs and devices," and . . . other future activities.²⁷³ This definition of cybermedicine overstates those activities involved in the usual practice of medicine to include any health related activity that may incur liability through the internet. For purposes of this discussion, cybermedicine will focus on those areas in which where the health care provider would be responsible for a negligent breach of a duty of care as opposed to strict liability issues from marketing, drug sales, or other health activities where there is no provider-patient relationship.

While the practice of medicine has traditionally been a state law function, the practice of cybermedicine can extend beyond state or national bounda-

270. *Id.* at 189-191.

271. *Id.* at 195.

272. *Id.* at 196.

273. Terry, *supra* note 262, at 327.

ries.²⁷⁴ This raises the question of the legitimacy and power of state governments to regulate such activities.²⁷⁵ Of the trends in cybermedicine, web based marketing of health care and health advice sites are primarily relevant to medical malpractice liability.²⁷⁶ Web based marketing has the potential to impact enterprise liability if marketing materials hold out that a provider is affiliated with the hospital or health plan and the patient relies on this in choosing health care.²⁷⁷ The issues of enterprise liability and ERISA preemption would then apply. The question that remains is the "choice of forum" to determine which law applies when the issues arises.²⁷⁸ This confusion of forum creates an ideal environment for the use of contract provision to specify in advance which state law would apply and whether arbitration can be used as a private means to resolve the dispute. By including contract language specifying state law and use of arbitration, the health care enterprise can control the forum and privatize the proceedings.

Advice and content web sites include a broad range of interactive models from the mere publishing of health care information on the internet to the visit to a CyberDoc. The publishing of information or giving of generic advice would be similar to the duty owed by a book publisher who has no general legal duty to investigate the accuracy and contents of the books it publishes.²⁷⁹ On the other hand a site like Cyberdoc that gives specific advice to a specific individual may have created a patient-doctor relationship sufficient to find a duty of care.²⁸⁰ These are the more difficult cases because no one knows whether a Cyberdoc will "replace" the local physician in providing health care or serve in the role of a "second opinion", triage center referring to local practitioners, or source of information. To date, these services would seem to serve the latter role and will probably stay that way unless health plans agree to reimburse cyberservices. This then raises questions of whether on-line agreements are enforceable and where. Some have tried to manage potential liability through internet disclaimers of liability or exculpatory statements encouraging the person to still consult with a health care provider.²⁸¹

274. *Id.* at 329.

275. *Id.* at 329.

276. *Id.* at 336.

277. *Id.* at 339.

278. *Id.* at 329.

279. Terry, *Supra* note 262, at 352.

280. *Id.* at 350.

281. *Id.* at 360.

V. DISPUTE RESOLUTION INDUSTRY STANDARDS

1. American Arbitration Association (AAA)

The American Arbitration Association is non-profit corporation founded in 1926. It specializes in business related arbitration. In 1992, the AAA established Health Care Claims Settlement Procedures which establishes procedures for health care settlement of disputes through mediation and arbitration. Participation in the program is voluntary. The parties have the right to be represented by an attorney or non-attorney at any time. In 1997, it was reported that there had been approximately 300 arbitration cases under the AAA Health Care rules.²⁸²

AAA arbitration rules for health care claims provide for a panel of professionals to serve as arbitrators. The party requesting the arbitration completes a request for arbitration form and filing fee. The opposing party has ten days from the notice by AAA to file an answering statement. Any new or different claim must be made in writing and filed with AAA with notice to the other party before the arbitrator is appointed or with the arbitrators consent. The opposing party has ten days to respond to a new claim. The parties will be provided with a list of names of arbitrators from which to choose. Parties have ten days to select an arbitrator and return the list to AAA. If parties fail to agree on an arbitrator, AAA will select one. The arbitrator is required to disclose any conflict of interest. At the request of any party of the AAA an administrative conference will be scheduled within ninety days of the filing of the claim. The parties will exchange information at this preliminary hearing and establish the breadth of discovery. Notice of hearing shall be sent ten days prior to the hearing and parties shall have the right to representation or the presence of an interpreter. The arbitrator has the discretion to allow or exclude the testimony of any witness at the hearing. At the hearing, both parties will have the opportunity to present testimony, present witnesses, and exhibits. There is no direct communication between the parties and arbitrator other than at the oral hearing. The arbitrator is the judge of the materiality of information presented. The hearing may later be reopened on the arbitrator's initiative or for good cause. The arbitrator may grant any remedy or relief deemed just and equitable within the scope of the agreement of the parties. This award is delivered in writing to the parties. The AAA will furnish written copies of the award to the party at his own expense as may be required in judicial proceedings relation to the arbitration. The AAA also pro-

282. Josef Rohlik, *Symposium: Arbitration as a Model for Resolution of Health Care Disputes*, 41 St. Louis L. J. 1005, 1013 (1997).

vide for certain filing and processing fees. The filing fee for one arbitrator is \$500.²⁸³

Mediation rules provide that the parties requesting the mediation to give a brief statement regarding the nature of the dispute and provide this to the other party and AAA. The parties will choose a mediator from the AAA panel unless the parties cannot agree in which case AAA will appoint a qualified mediator. A date time and place that is agreeable to the parties and the mediator will be set. Ten days before the mediation session, the parties will provide the mediator with a statement of their position. The mediator does not have authority to impose a settlement, but helps them try to reach a satisfactory resolution of the dispute. The mediation sessions are private and confidential. There is not stenographic record made of the mediation. Parties share the cost of compensating the mediator.²⁸⁴

2. American Health Lawyers Association

The American Health Lawyers Association (AHLA) provides dispute resolution services for health care industry disputes including disputes between providers and community members. It has established Rules of Procedure for Arbitration and Mediation. Parties may request mediation, arbitration, or med-arb in which the process begins as a mediation, then is completed as an arbitration if the parties do not resolve the dispute.²⁸⁵

The rules provide for the process of arbitration unless the parties have agreed otherwise by contract in which case the parties agreement will be followed. The AHLA rules provide for an arbitrator to be selected from an arbitration panel. One arbitrator decides the case unless the parties agree otherwise. When there is more than one arbitrator and they are not all in agreement, the majority decision will decide the case.²⁸⁶ Unless otherwise specified by contract, the parties will request and receive a list of seven arbitrators within ten days for a request. Each party may strike on name, then indicate the order of preference for the remaining arbitrators. The person with the lowest sum from the lists will be contacted to serve as arbitrator. If there

283. *Health Care Claims Settlement Procedures*, American Arbitration Association, Effective July 1, 1992, 5-13. <http://www.adr.org>.

284. *Id.* at 2-5.

285. *Rules of Procedure for Mediation and Rules of Procedure for Arbitration*, American Health Lawyers Association, (1991).

286. *Id.*

is a tie, the Service will select one of the arbitrators who has tied at random and notify the parties. The arbitrator who is chosen will receive a notice of appointment and will have ten days to respond. If the arbitrator fails to respond within the specified time, the next name on the list will be used.²⁸⁷ The arbitrator is required to disclose any conflicts of interest that would effect impartiality at the outset.²⁸⁸

Once the selection process is complete, the arbitrator or one of the parties by request may schedule a preliminary hearing or preliminary teleconference to consider any matters to expedite the process including schedule for the production of documents, the identity of witnesses to be called and the schedule for other discovery. Discovery can be allowed by the arbitrator as necessary to ensure a full and fair presentation of the issues. The parties can agree on a location for the arbitration hearing. If they cannot agree, it will be held at the location indicated on the request for ADR form, or be determined by the arbitrator.²⁸⁹ The arbitrator will provide notice of the set hearing time, date, and place. Parties may be represented by counsel or other authorized representative. If either party desires a stenographic record of the hearing, they shall make arrangements and bear the costs of the stenography and give notice to all other parties. The arbitrator can determine the propriety of any person in attendance at the hearing. The hearing will include oral or written statements of the parties to clarify information. Witness can be presented to support the claim. The arbitration can proceed even if a party who has received notice fails to appear. The arbitrator has discretion regarding evidence to be admitted during the proceeding. Once the hearing has completed, the arbitrator has thirty days to render an award.²⁹⁰

The AHLA Rules also provide for expedited procedures. The expedited procedures provide for telephone notice and communication. The arbitrator will give notice of the hearing seven days in advance by telephone and the hearing will be held within thirty days from the selection of the arbitrator. There is no provision for discovery under the expedited procedure. The hearing itself must be completed within one day or two consecutive days. The decision should be complete within twenty days of the hearing.²⁹¹

Arbitration awards should be in writing. The arbitrator may grant relief deemed equitable within the scope of the arbitration agreement. The parties

287. *Id.* at Rule 2.02 & Rule 2.03.

288. *Id.* at Rule 2.05.

289. *Id.* at Rule 4.01, 4.02, 4.03.

290. *Id.* at Rule 4.01 – 4.15, 6.04.

291. *Rules of Procedure for Mediation and Rules for Procedure for Arbitration*, American Health Lawyers Association, Rule 5.01–5.03, 6.04 (1991).

agree that the arbitrator may not award consequential, exemplary, incidental, punitive, or special damages arising from a tort unrelated to employment or the termination of employment unless the arbitrator determines that there is clear and convincing evidence that the party is guilty of intentional conduct, or acted with reckless disregard for the rights of the other party, or if there was fraud. The arbitrator may award any liquidated damages to which the parties have agreed. The decision of the arbitrator is binding upon the parties.²⁹²

3. Mediation in Medical Malpractice

Mediation is a process in which a neutral third party facilitates communication between two or more parties to encourage reconciliation and resolution of the dispute. Mediation is sometimes referred to as “facilitated negotiation” because the mediator facilitates negotiation between the parties to encourage the parties to come to a mutually acceptable agreement.²⁹³ Unlike arbitration, in which the arbitrator makes a decision for the parties, in mediation the parties decide how they will resolve the dispute.²⁹⁴ Generally, mediation has lower costs than litigation, can finalize the dispute much more quickly, and reduce the emotional toll of adversarial litigation.²⁹⁵ Further, parties are often more satisfied with the process because of their ability to control the outcome of the settlement.²⁹⁶

In medical malpractice cases, mediation can have advantages for both parties. Health care providers may prefer the cost and time efficiency, privacy of the forum that protects the reputation of the health care provider, and the ability to control the outcome of the case and preclude large jury awards. The patient may prefer mediation because of the ability to communicate dissatisfaction with the clinical care received and achieve redress through monetary and non-monetary compensation, the ability to structure an agreement that includes incentives to preclude further medical negligence, and the ability to re-

292. *Id.* at Rule 6.06

293. Forehand, *supra* note 2, 907, 919.

294. Amy Saravia, *Overview of Alternative Dispute Resolution in Healthcare Disputes*, 32 J. OF HEALTH LAW 1, 141, 142 (1999).

295. Forehand, *supra* note 1, at 919,920.

296. *Id.* at 919. Rita Lowery Gitchell, and Andres Plattner, *Mediation: A Viable Alternative to Litigation for Medical Malpractice Cases*, 2 DEPAUL J. HEALTH CARE L. 421, 422 (1999).

solve the dispute quickly and efficiently.²⁹⁷ For both parties, there is the advantage that the communication process of mediation will help maintain the doctor-patient relationship.²⁹⁸ The mediation process can also help the parties focus on the issues of concern to the parties in contrast to the legal theories of proof that are required in the courtroom.²⁹⁹ Mediation can also increase satisfaction with the outcome when the parties are empowered to come to their own decision in the dispute.³⁰⁰

Mediation raises potential concerns as well. Common concerns with mediation in the malpractice context include the concern that the patient will receive less compensation for injury than through litigation, concern that patients will be intimidated into a premature settlement, and concern that mediation merely delays the process of litigation.³⁰¹

In 1994 a study of several hundred medical malpractice cases arising in a hospital that provided a voluntary, informal complaint process for patients was conducted by Farber and White.³⁰² Some of the patients began the medical malpractice process by filing a complaint with the dispute resolution office and some filed a lawsuit. The complaint process was less formal than mediation and involved complainants and hospital staff discussing the dispute. The intent was to encourage early settlement of claims.³⁰³ The study found that about half of the complaint-based disputes were resolved without filing a lawsuit. Of the 465 cases that ended up in court, only 26 were tried to a verdict and plaintiffs won only four cases.³⁰⁴ The study found that the manner in which the case was resolved did not depend on whether there had been participation in the informal complaint process. However, those cases that did settle at the complaint stage settled for about one-third the amount of settlement at later stages of the lawsuit. The study concluded that the informal complaint process was an effective way to facilitate the flow of information between the hospital and patients.³⁰⁵

More recently a mediation process for resolving medical malpractice has been implemented at Rush-Presbyterian-St. Luke's Medical Center in Chi-

297. Gitchell, *supra* note 292, at 441.

298. Forehand, *supra* note 2, at 920.

299. *Id.*

300. *Id.* at 921.

301. *Id.*

302. Henry S. Farber and Michelle J. White, *A Comparison of Formal and Informal Dispute Resolution in Medical Malpractice*, 23 J. LEGAL STUD. 777 (1994).

303. *Id.* at 791.

304. *Id.* at 802.

305. Farber, *supra* note 258, at 777.

chicago.³⁰⁶ The program was established in 1995 by the hospital because of the “volatility and unpredictability” of jury awards.³⁰⁷ Prominent trial lawyers and judges were asked to participate in the program and attend a mediation training course at Loyola University’s Institute for Health Law.³⁰⁸ After the training, voluntary mediation was available to parties of medical malpractice cases. There have been forty-five mediations during the period of program operation.³⁰⁹ The parties select either a retired judge or two attorney mediators (one plaintiff and one defense attorney) to mediate. Prior to the mediation, parties submitted statements of the facts, description of the injury, special damages, and past and future expenses. The parties meet at a neutral location. The mediation process used is for each party to present an opening statement, then the mediators meet separately with the individual parties, then for the parties to reconvene to conclude negotiations.³¹⁰ In most cases, the negotiations have been successful. The program has found that mediation takes about four or five hours and costs less than \$5,000 per case as opposed to a jury trial that may take days or weeks and cost \$15,000 to \$25,000.³¹¹ Mediation may be another viable alternative to litigation in the malpractice setting, however, like arbitration, little use of the alternative is the reality of the current marketplace.

CONCLUSIONS

Medical malpractice arbitration has been encouraged through a variety of legislation and reform, yet the number of cases going to arbitration is limited. Have we created much ado about nothing by establishing the framework for a system that is so little used? Maybe, but in light of future direction for medical malpractice in the new millennium, arbitration may play a stronger role as more corporate entities become involved in the malpractice process. The ma-

306. *News Release: Alternative Dispute Resolution Using Mediation Proves Successful for Chicago Hospital*, July 27, 1999. <http://www.rush.edu/New/News/MediaRelations/99/072799mediation.html>.

307. *Id.*

308. *Id.*

309. *Id.*

310. *Id.* at 2.

311. *News Release: Alternative Dispute Resolution Using Mediation Proves Successful for Chicago Hospital*, June 27, 1999. <http://www.rush.edu/new/news/medicalrelations/99/072799mediation.html>

for medical malpractice arbitration trends in the year 2000 are (1) continued use of medical malpractice awards in the process of credentialing and privileging physicians, (2) use of arbitration clauses in collective bargaining agreements between physicians and hospitals or managed care organizations, (3) the finding of enterprise liability for hospitals, health plans, and managed care organizations for the actions of affiliated health care providers and the extent of the ERISA preemption of entity liability, and (4) Cybermalpractice issues that arise from negligent health care in cyberspace. Because these issues all relate to corporate involvement in the malpractice arena there may be an upsurge in use of arbitration agreements encouraged by corporate attempts to limit liability through arbitration. While arbitration is no panacea for the now chronic ills of the medical malpractice system, it has been shown to be effective and efficient tool when used to resolve medical malpractice claims.