WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Task Force on Medical Malpractice (ATF-MM)

Sample:

Record of Comm. Proceedings ... RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Appointments* ... *Appt*
- **

- *Clearinghouse Rules* ... *CRule*
- **

- *Committee Hearings* ... *CH*
- **

- *Committee Reports* ... *CR*
- **

- *Executive Sessions* ... *ES*
- **

- *Hearing Records* ... *HR*
- **

- *Miscellaneous* ... *Misc*
- **05hr_ATF-MM_Misc_pt23**

- *Record of Comm. Proceedings* ... *RCP*
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Perspective

*457 COMPULSORY ARBITRATION: AN INSTRUMENT OF MEDICAL MALPRACTICE REFORM AND A STEP TOWARDS REDUCED HEALTH CARE COSTS?

David B. Simpson [FNa]

The sharply escalating cost of health care in the United States, and particularly the disproportionate share of gross national product that it consumes in comparison with the experience of other advanced industrialized societies, is the subject of increasing attention, and justified concern. Health care costs in the United States will rise from $839 billion in 1992 to a projected $940 billion in 1993, and now consume 14 percent of gross national product (GNP). [FN1] In 1965, the nation spent only 6 percent of the GNP on health care. [FN2] The figure had risen to 9.3 percent by 1980, and observers believe we are headed towards spending 20 percent or more of the GNP on health care if present trends continue. [FN3] Annual spending per capita rose, in constant dollars, from $950 in 1970 to $2350 in 1989. [FN4] In comparison, other major industrialized countries spend between 6 percent and 10 percent of their GNP on health care. [FN5]

Obviously, this has created a search for the sources of the problem. Some of that search may have taken on aspects of a witch-hunt, inordinately focusing on "medical malpractice" or, more precisely, the process for resolving claims of medical malpractice and compensating persons injured thereby. This is not *458 to say, as some interest groups, such as trial lawyers, seem almost reflexively inclined to do, that the existing system does not warrant examination, and may not bear improvement.

To the contrary, as part of any endeavor to rationalize the delivery of health care and reduce overall costs, attention should be directed to existing methods for responding to claims for medical malpractice. Malpractice claims obviously affect the cost of health care services, at several levels and both directly and indirectly, by increasing the costs directly attendant to the existing claims disposition process and through increased professional liability insurance premiums resulting from such recoveries. This eventually translates into increased charges to consumers through additional fees for added testing, diagnostic services and other procedures employed defensively, without medical necessity, to protect against prospective malpractice claims.

The present system for addressing medical malpractice claims subscribes to a traditional litigation mode involving extensive and expensive pre-trial discovery, protracted delays until trial or settlement, and the use of lay jurors inexperienced in the practice of medicine. These jurors are charged with the task of determining actionable "fault" under applicable negligence standards. The nature of the litigation process, and the composition of the typical lay jury, operate to produce damage awards in an economic vacuum, without reference to, or appreciation of, the effects of excessive recoveries upon the economics of the health care system. [FN6] And there is the potential for excessive and irrational awards for non-objective injuries such as pain and suffering, or for punitive damages.

At the outset, however, it must be emphasized that it would be both irresponsible and counter-productive to approach the critical issue of medical malpractice reform from factually inaccurate preconceptions, or from the perspective of a partisan or ideological

*459 agenda which has objectives other than improved health care and cost control. [FN7] Much of the public discussion, and some of the more extravagant proposed correctives, may suffer in this respect. Unsupportable claims have been made that proliferating malpractice litigation and increasing recoveries are entirely, or substantially, the product of a legal system that allows contingency fees. In this vision, but for greedy and irresponsible plaintiffs' attorneys who constantly foment meritless litigation, the problem would largely dissipate.

When the Bush Administration finally produced its first health-care initiative, in May 1991, the emphasis was upon controlling what it called "the fastest-rising part of medical costs--malpractice litigation and the insurance to cover it." [FN8] The proposal involved encouraging states to adopt limits on the amount that malpractice victims could recover for pain and suffering, and setting up mediation systems for resolving disputes. [FN9] States failing to comply would lose some of the federal funding currently available to them under the Medicare and Medicaid system. [FN10]

While medical malpractice insurance premiums have risen *460 faster than other components of the health care system, [FN11] the overall impact of insurance premiums on the nation's almost one trillion dollar health care budget must be placed in perspective. Although total expenditures on malpractice insurance by doctors and hospitals rose a hundred-fold from $60 million in 1960 [FN12] to $5.6 billion in 1991, [FN13] total malpractice premiums have not risen appreciably faster than have expenditures on the health care system as a whole. Additionally, the premiums for 1991 did not equal even one percent of total health care expenditures for that year, although representing a substantially higher percentage of the total amount expended directly on physicians' services. [FN14]

This is not to suggest that the amounts paid for liability insurance are not, in absolute terms, meaningful, nor that premiums have not escalated dramatically for certain high-risk categories of medical practice to amounts which, in absolute terms, are very material. However, the average doctor's malpractice insurance premium in 1985 was only $15,000, [FN15] not the $200,000 paid by neurosurgeons and obstetricians practising in Miami, Florida, in that year, [FN16] nor the $150,000 annual premium paid in 1991 by neurosurgeons practicing in Chicago. [FN17]

Usually lost in the discussion about the amounts paid for liability insurance premiums, because far more difficult to quantify, but clearly more important as a component of total health care expense, is the cost of "defensive medicine." Defensive medicine is made up of the redundant or superfluous diagnostic tests and and treatment procedures employed to ward off charges of medical *461 malpractice. In assessing the relationship between rising health care costs and the medical malpractice claims disposition process, the influence of "defensive medicine" may be of greatest significance. There is, however, considerable dispute as to the amount actually at issue. The American Medical Association has put the cost of defensive tactics at $15 billion, [FN18] an insignificant amount in an almost one trillion dollar total health care budget. [FN19] Another source has estimated the cost at between 15 percent of the cost of physician services and 30 percent of the total cost of health care. [FN20]

The litigiousness of patients, allegedly inflamed by contingency-fee lawyers, is also far less clear than would be supposed from some of the discussion, as is any assumption that malpractice suits filed are, disproportionately in relation to other types of claims, without merit. A recent study by observers at Harvard Medical School commented that "the frequency of malpractice claims among patients injured by medical malpractice has been the subject of much speculation and little empirical investigation." [FN21] That study went on to conclude that far more people are injured than ever bring suit. [FN22] The study found that only a small fraction of patients who suffered disabling injuries from the negligence of doctors or other health care providers ever filed a tort claim, and noted that less than half of these claims produced a settlement or award. [FN23] Specifically, less than 2 percent of patients injured by medical negligence in a large number of cases studied in New York ever filed malpractice suits. This would suggest that, contrary to popular assumption, the recent growth in medical malpractice litigation has served only

to narrow the truly wide gap between actual negligently-caused injuries and successful suits for compensation, and not to overshoot that gap. [FN24]

***462** The assumption that juries are automatically more generous towards plaintiffs than are other fact-finders is also open to question. According to a study of a random group of federal court cases over a five-year period, plaintiffs litigating medical malpractice claims before juries won their cases in only 29 percent of the cases studied, compared to a 50 percent success rate for those whose cases were heard by a judge. [FN25] In addition, the average dollar amount of recovery was reported to be slightly higher in non-jury trials. [FN26]

Another study of malpractice cases in New Jersey indicated that juries found for medical defendants about two-thirds of the time. [FN27] Of equal interest, doctors won verdicts in about half of the cases which a physician-run insurance company's peer review found nondefensible. [FN28]

Such challenges to much of the popular wisdom about the infirmities of the dispute resolution process, particularly as it is employed to deal with claims of medical malpractice, do not obviate the need for a reexamination of the process with a view to possible reform. Given the astronomical cost of health care in absolute terms, and the fact that it is increasing faster than either the inflation rate or population growth, no aspect of it may responsibly be treated as "off limits." [FN29] Paradoxically, the "revisionist" studies may serve to reinforce, rather than detract from, the cause of reform. [FN30] For if the costs (direct and indirect) of the present system are considered too burdensome, consider the implications. The burden would be crushing, in terms both of health care costs and strain on a judicial system already ***463** overburdened, if injured parties were to come forward in vastly increased numbers to pursue, through the existing litigation process, legitimate, but heretofore neglected, claims. And, since trials before judges, as before lay jurors, are conducted subject to the same existing definitions of fault and legal principles and standards governing the award and calculation of damages, question concerning the continuing utility of these rules, would not be resolved merely by avoiding jury trials. The point is that the need for reform is far too important to for the case to be made through the falsification or manipulation of data, rhetorical extravagances, or by defining the issues to serve predetermined and discrete ideological or political objectives. A legitimate solution which commands the necessary degree of broad-based public support will only come through an honest and candid confrontation of the realities, including an honest acknowledgment of what interests will be affected by any changes. [FN31]

The interests of employers, insurers, welfare plans, physicians and other health-care providers are all caught up in the problem of escalating health care costs. So, too, are the federal, state, and local governments which collectively pay a substantial portion of the nation's health care bill. There should be sufficient community of interest among these groups to implement, if empirically shown to be useful, legal reforms concerning medical malpractice claims, even if the creation of a consensus for other types of health-care reform proves more elusive. What is missing for the moment is a sustained effort on the part of public officials, business executives and labor leaders to transform this community of interest into responsible and tangible reform initiatives.

The replacement of the existing litigation process with a suitable alternative dispute resolution methodology may contribute significantly to an amelioration of rising health care costs, even absent the implementation of the many other types of reforms ***464** in the health delivery system which are presently being discussed. Moreover, an arbitration system designed to provide for the fair, expeditious and efficient handling of medical malpractice claims may represent a significant improvement in the dispute resolution methodology applicable to malpractice claims, apart from its potential for reducing overall health care costs. Many states have strong judicial and legislative policies favoring arbitration over litigation as a means of settling disputes, including disputes arising out of medical malpractice claims. [FN32] Arbitration is generally seen as not only less expensive, but also more expeditious than litigation, and as contributing to relieving the serious congestion that most court systems are experiencing.

An alternative dispute resolution methodology could allow doctors and hospitals treating patients to require, as a condition to treatment, that patients enter into written agreements to submit malpractice claims to binding arbitration. [FN33] This procedure would obviously be inapplicable to patients seeking treatment under circumstances where they would not be deemed competent to give their informed consent, such as those being treated on an emergency basis. Health insurance programs could impose a similar requirement as a condition of enrollment. The procedure would also be applicable to minors receiving treatment, whose parents or other legal guardians could grant the necessary consent.

Most states today have enacted statutes which generally allow parties to agree to arbitrate disputes, and make such agreements, and any resulting arbitral awards, judicially enforceable. The Federal Arbitration Act [FN34] also enforces agreements to arbitrate. ***465** This Act, however, is limited in its application to arbitration provisions incorporated into contracts involving interstate commerce. [FN35] Contracts governing the delivery of health care either by individual providers or through membership in health maintenance organizations (HMOs) could be deemed to fall within the purview of the federal statute. Whether this circumstance would suffice to override existing state law impediments to arbitration of malpractice claims is a question yet to be definitively resolved. A physician's claim of wrongful exclusion from local hospital privileges has recently been held by the United States Supreme Court to involve a transaction affecting interstate commerce sufficient to fall under the jurisdiction of the federal anti-trust laws; [FN36] and the Federal Trade Commissions is examining the anti-competitive aspects of self-regulation by medical groups including health-care regulatory boards. [FN37] Such intrusion into an area traditionally perceived as intra-state in nature could portend similar determinations as to at least some provider contracts or relationships.

Any proposal entailing the extensive use of arbitration should contemplate that arbitrations would be conducted by arbitrators drawn from panels of persons who have both expertise and independence. It is essential to public acceptance of this procedure that the arbitrators not be perceived to be creatures of, or to be coopted by, any interested constituency, especially not that of health care providers or of medical insurers. One of the challenging aspects of any reform proposal is to identify appropriate sources from which arbitrators of sufficient independence can be selected.

As a general proposition, the ability to make a legally enforceable agreement to arbitrate generally depends on the capacity of the parties to enter into a legal agreement and to sue and be sued. So long as a party has a general legal capacity to contract with respect to the matter in dispute, either in his own right or in a legally recognized representative capacity, he can bind himself or the party he represents to arbitrate all disputes arising ***466** therefrom. [FN38]

A related issue involves the possible elimination or modification of certain types of damage awards in respect to medical malpractice claims. The existing system has been extensively criticized because, in many jurisdictions, there are no limitations on the amounts that may be awarded for pain and suffering or punitive damages. Critics of the present system contend that jurors are thus given carte blanche to indulge their sympathies for injured individuals entirely divorced from objective standards for the measurement of the injuries or for appropriate financial redress. Also, jurors are claimed to be essentially unconcerned with the larger effect of individually over-generous awards on the overall costs and economics of the health care system, and are not even permitted to be informed about such matters. There is also question as to whether punitive damages, which are designed to penalize the culpable wrongdoer, are properly awarded in many cases, especially where society as a whole, through elevated health care costs, ultimately bears the economic burden.

Although less clear than is the right to incorporate a mandatory arbitration provision into contracts for the provision of medical services, it may be possible to incorporate specific limitations on the amounts or types of damages that may be awarded for a health provider's negligent or otherwise substandard performance of his duties. It would clearly be inappropriate and against public policy to allow health providers to disclaim their

liability for negligence and any contract purporting to do so would surely be unenforceable (at least as to such a clause). It is far less certain, however, that agreements placing limitations on the dollar amounts of damages recoverable, such as for economically ***467** non-quantifiable claims for pain and suffering, would, or should, be deemed equally offensive to public policy. They should not be, so long as any such restrictions do not constitute an unconscionable curtailment of an injured patient's right to be made whole for measurable economic loss. In many types of commercial agreements parties are permitted to agree to significant limitations on the kinds and amounts of damages recoverable for breaches of contractual obligations. It is, for example, very common to exclude consequential damages such as lost profits, even though doing so necessarily limits the defaulting party's financial liability and, conversely, the claimant's right to be compensated for his losses and damages.

The use of the arbitration process should provide a means for curtailing the award of punitive damages in connection with arbitrated malpractice claims. In many, although not all, American jurisdictions, arbitrators are without power to grant punitive damages, even when the parties agree. [FN39] Punitive damages have been called a "sanction reserved to the State," and "this is a public policy of such magnitude as to call for judicial intrusion to prevent its contravention;" thus, "since enforcement of an award of punitive damages as a purely private remedy would violate strong public policy, an arbitrator's award which imposes punitive damages should be vacated." [FN40] If arbitrators were allowed to award punitive damages, courts would find it necessary to review arbitrators' decisions for abuse of discretion, since, "under common-law principles there is eventual supervision of jury awards of punitive damages, in the singularly rare cases where it is permitted, by the trial court's power to change awards and the appellate court's power to modify such awards." [FN41] Such required supervision of arbitrator's awards would run afoul of a basic purpose of arbitration--the avoidance of judicial review. If, notwithstanding, it were considered important in a malpractice scheme dealing with medical claims, to retain the availability of punitive damages to redress particularly acute cases of wrongdoing, the precise circumstances in which such damages would be recoverable could be defined with far greater precision, and specific ***468** monetary limitations could be placed on such awards. [FN42]

Proposing to address deficiencies in the medical malpractice system through a private, i.e., contractual, solution is prompted by a recognition that authorization through governmental action, whether in the form of legislation or regulation, will meet substantial resistance from entrenched interest groups. A legislative or regulatory resolution would, of course, be preferable. It would improve the prospect for avoiding issues as to enforceability, and even constitutionality, of contractual limitations on the right to litigate. It is, however, a reality that must be recognized that any attempt to deviate from the existing adversarial method for resolving medical malpractice claims will face intense and well-financed opposition from many attorneys. Not only the plaintiffs' negligence bar, but also the many attorneys representing insurance company defendants have a vested personal financial interest in the continuance of the existing process; and together they possess a disproportionately large influence over the political process, particularly at the state legislative level. Indeed, the state legislatures are filled with attorneys actively practicing negligence law.

Legislative or regulatory endorsement of the private arbitral approach would, of course, be desirable. Such action would serve to emphasize the consistency with overall public policy of compulsory arbitration provisions in contracts with physicians, health maintenance organizations or health insurers. Legislative (or administrative) endorsement could be as simple as a confirmation that medical malpractice claims fall within the purview of general arbitration statutes, or could be more detailed and particular and extend to such matters as the type and composition of the arbitral panel, right of appeal, and limitations on the permissible scope of damages.

The attitude of individual states to the compulsory arbitration of medical malpractice claims varies greatly. California, a leader in the development of the health maintenance organization, has for many years provided legislative and judicial support ***469** for

conditioning membership in such groups upon the participant's agreement to arbitrate. [FN43] New York, where this form of medical provider is far less common, has adopted a posture towards arbitration best described as grudging: a statute was enacted only in 1986. [FN44] This statute permitted health maintenance organizations during a limited five-year experimental period only, to allow, but not require, enrollees to elect to arbitrate malpractice claims. [FN45] Absent such enabling legislation, it would appear that arbitration could not be offered, even as a voluntary option. The New York statutory scheme [FN46] also makes clear that such arbitration may not deviate from the standards of care applicable to actions at law for medical malpractice, that damages are to be determined as in actions at law, [FN47] and that contingency fee arrangements with lawyers are permitted to the same extent as in actions at law. One useful study to be undertaken might be to compare medical malpractice "costs" in New York and California in light of the rather similar demographic characteristics of the two states and the radically differing approaches towards the malpractice claims disposition process which each has encouraged.

Governmental endorsement of the arbitral approach could also come at the federal level, either in the form of an act of Congress or through regulations of the Department of Health and Human Services. In light of the extensive federal involvement in the financing and other aspects of the provision of medical services, such as through the Medicare program, other federally-funded health insurance benefits or the financing of hospitals and clinics, the potential exists for "federalizing" the whole subject. [FN48] This could be effected through congressional action, or the issuance of regulations, mandating or endorsing the implementation ***470** through private contract of compulsory arbitration. Such action could also implement other related reforms described above, such as limitations on type or amount of allowable damages, in respect of those health care relationships in which there is sufficient degree of federal interest to confer upon Congress or the executive branch the power to make rules.

Such an approach has been proposed by the distinguished former Surgeon General, C. Everett Koop, and Senator Pete V. Domenici (R-NM), a highly respected member of the United States Senate. Contending that the Bush Administration proposals discussed above, although "sound," were insufficient, Koop and Domenici have jointly proposed "more fundamental change," calling for the removal of virtually all malpractice claims from courts and resolving them by binding arbitration. [FN49] They would require that participants in all federal health programs be required to resolve medical injury claims through binding arbitration. [FN50] The categories of persons who would be covered by this requirement would include: beneficiaries of Medicare, Medicaid and participants in Federal employees' health plans and public health and veterans programs, as well as employees of companies that obtain tax deductions for contributions to health plans. [FN51] The proponents suggest that that this would remove approximately 80 percent of all medical claims from the litigation process. [FN52]

"Federalization" would provide a means for avoiding state law disparities and for ensuring the availability of arbitration on a uniform basis throughout the nation. Moving towards such a national solution could also prove advantageous by reducing the ability of interest groups to thwart reform. "Federalization" could be implemented either through legislation or possibly, at least as to certain categories of claimants, through regulation. Congress might enact, or the Secretary of Health and Human Services might promulgate, regulations either endorsing the implementation, through private contract, of compulsory arbitration in respect of health care relationships in which there is a sufficient federal interest, or even mandating the arbitration of ***471** private claims arising out of such health care relationships. Federal intervention establishing arbitration as either a permissible or mandatory dispute-resolution procedure could, under principles of preemption, override conflicting state dispute-resolution policies permitting litigation or prohibiting or disfavoring arbitration.

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[FN1]. Robert Pear, Health-Care Costs Up Sharply Again, Posing New Threat, N.Y. TIMES, Jan. 5, 1993, at A1 [hereinafter Pear].

[FN2]. Senator Pete V. Domenici, Health Care Reform: Should curbing medical malpractice litigation be part of the solution?, 78 A.B.A.J. 42 (Aug. 1992).

[FN3]. Id.

[FN4]. Worrying About Health, ECONOMIST, June 15, 1991, at 27.

[FN5]. Id.

[FN6]. The present litigation process for handling personal injury claims generally has, of course, been subject to much criticism entirely apart from the particular problems which it may present when employed in disputes arising out of patient treatment. The characteristics of the personal injury litigation process may, however, be particularly inappropriate when the dispute involves a claim of medical malpractice on the part of a health care professional or institution. To the extent that such is the case, we may be paying a price in the dramatic overall escalation of health care costs.

[FN7]. The field of medical malpractice has been called "the forum for initial experimentation with a program pressed by the Reagan administration and others in the 1980s: reinstatement in the tort system of the true integrity of the fault principle in order to protect defendants from the unwarranted imposition of liability, along with a substantial cutback on the potential size of damages payable even by actors whose personal and legal culpability is clearly established." See AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 283 (1991). See also Less Litigation, More Justice, WALL ST. J., Aug. 14, 1991, at A8, summarizing the recommendations of the Final Report of the President's Council on Competitiveness, entitled "Agenda for Civil Justice Reform in America." The premise that rampant medial malpractice suits are significantly contributing to problems in the operation of the civil justice system has been seriously challenged by a recent study completed by the National Center for State Courts. See Study Challenges Some Public Perceptions About Wrongful-Act Suits WALL ST. J., Oct. 8, 1992, at B10.

[FN8]. Philip J. Hilts, Bush Enters Malpractice Debate With Plan to Limit Court Awards, N.Y. TIMES, May 13, 1991, at A1 [hereinafter Hilts]. The presumed relationship between malpractice and escalating health care costs is widely assumed; a fifth grader, writing in a student publication of this author's son's elementary school, lamented the plight of those unable to afford health care, concluding that "if doctors didn't have to pay all the malpractice bills they do, they wouldn't have to charge so much." To this writer's surprise, the student's parents were not even physicians!

[FN9]. Id.

[FN10]. Id.

[FN11]. Pete V. Domenici and C. Everett Koop, Sue the Doctors? There's A Better Way, N.Y. TIMES, June 6, 1991, at A25 [hereinafter Domenici and Koop]. This article cites an 18% annual increase in medical liability premiums from 1982 through 1988. There is, however, evidence that this trend has levelled off. See AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 3 (1991), noting that in the three-year period ending 1986, medical malpractice premiums rose from $2 billion to more than $5 billion. By comparison, in 1991 the total was only $5.6 billion.

[FN12]. AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 285 (1991).

[FN13]. Hilts, supra note 8, at A1.

[FN14]. AMERICAN LAW INSTITUTE REPORTER'S STUDY, ENTERPRISE RESPONSIBILITY FOR PERSONAL INJURY, at 287 (1991) (noting that such premiums represented almost 5% of amounts paid for physician services in 1988).

[FN15]. Id.

[FN16]. Id. at 288.

[FN17]. Domenici and Koop, supra note 11.

[FN18]. Hilts, supra note 8, at A1.

[FN19]. See Pear, supra note 1; see also James B. Couch, Employers' Role in Improving Medical Care Value, 14 SETON HALL LEGIS. J. 65 (1990).

[FN20]. Barry Manuel, M.D., Alternative Forms of Dispute Resolution, 75 AM. COLL. OF SURGEONS BULL. 9 (Dec. 1990)[hereinafter Manuel].

[FN21]. A. Russell Localio, et al., Relation Between Malpractice Claims and Adverse Events Due to Negligence, 325 NEW ENG. J. MED. 245 (July 25, 1991) (emphasis added).

[FN22]. Id.

[FN23]. Id.

[FN24]. In responding to the Bush Administration proposals, Paul C. Weiler, of Harvard Law School, contended, "[T]here is a problem, but it is a somewhat different problem than the administration thinks it is. There are many doctors who are sued when they should not be. The awards from juries can be far too high and are always unpredictable. But there is another side of the problem: There are far more people being hurt by doctors, and even hurt by negligence, than the number who actually file suit. We need to compensate them, too." Hilts, supra note 8, at A1.

[FN25]. Theodore Eisenberg and Kevin Clermont, Trial by Jury or Judge: Transcending Empiricism, 77 CORNELL L.REV. 1124 (July 1992).

[FN26]. Id. at 1137.

[FN27]. Randall R. Bovbjerg, Medical Malpractice: Folklore, Facts and the Future, 117 ANNALS OF INTERNAL MEDICINE 788 (Nov. 1, 1992).

[FN28]. Id. (emphasis added).

[FN29]. Michael J. Saks, Do We Really Know Anything About the Behavior of the Tort Litigation System--And Why Not?, 140 U.PA.L.REV. 1147 (1992). The author notes that "[h]ealth care costs have risen at a faster rate and to greater heights than the overall cost of living." Id.

[FN30]. This expresses the author's own opinion.

[FN31]. This discussion does not attempt to take into account other considerations which might militate in favor of reform. It has been argued that fear of medical malpractice claims has resulted in significant physician dissatisfaction and has contributed to a decrease in the number of persons entering the field of medicine. See Taragin, et al., The Influence of Standard of Care on the Resolution of Medical Malpractice Claims, 117 ANNALS OF INTERNAL MEDICINE 780 (Nov. 1, 1992); see also Manuel, supra note 20. It does not, of course, follow from this that merely changing the modality of dispute resolution--from litigation to arbitration--would necessarily, or in and of itself, correct physician dissatisfaction.

[FN32]. See, e.g., CAL.CIV.PROC.CODE § 1295 (West 1992); ARIZ.REV.STATE ANN. § 12-1501 (1993); MD.CTS. & JUD.PROC.CODE ANN. § 3-2A-01 (1992)

[FN33]. Bank of America, the nation's largest banking institution, has recently undertaken a program requiring its credit card customers and depositors to submit all disputes to binding arbitration. Ralph T. King, Jr., Banks Force Griping Customers to Forego Courts For Arbitration, WALL ST. J., Jan. 20, 1993, at B1. Notably, Consumer Action, a nonprofit organization, and the California Trial Lawyers Association immediately brought suit to cancel the policy change. The bank's approach represents an extension of the bank's previous policy of requiring arbitration in its commercial lending relationships. Employers are also now regularly utilizing agreements obligating their employees to arbitrate disputes, including claims relating to sexual harrassment and racial discrimination. Wade Lambert, Employee Pacts to Arbitrate Sought by Firms, WALL ST. J., Oct. 22, 1992, at B1.

[FN34]. 9 U.S.C. § 1 (1988).

[FN35]. Id.

[FN36]. Summit Health, Ltd. v. Pinhas, 111 S.Ct. 1842 (1991).

[FN37]. See Edward Felsenthal, Antitrust Suits Are on the Rise in Health Field, WALL ST. J., Oct. 26, 1992, at B1.

[FN38]. Disputes arising in tort, such as claims for personal injury, are arbitrable and there is case law in some states specifically sanctioning the enforcement of agreements to arbitrate medical malpractice claims, including agreements entered into as a condition to participation in health insurance plans. Such contracts have been upheld on the grounds that they do not take away rights but merely prescribe a particular remedial forum, and in the face of the contention that they are contracts of adhesion entered into between parties of vastly unequal bargaining power, and thus should not be enforced. There is also case law which indicates that such agreements may be made binding upon a patient's heirs, successors and assigns, so that a malpractice action involving a claim for wrongful death would also be subject to compulsory arbitration.

[FN39]. Garrity v. Lyle Stuart, Inc., 353 N.E.2d 793 (N.Y.1976).

[FN40]. Id. at 794.

[FN41]. Id. at 797.

[FN42]. Punitive damages have also been seen as sometimes necessary to encourage legitimate claimants to come forward where their identifiable economic losses are slight in relationship to the costs of prosecuting their claims; by employing an arbitration process which should be much less expensive, this concern will be alleviated and the rationale for allowing such damages substantially eroded.

[FN43]. See supra note 32.

[FN44]. N.Y. PUB. HEALTH LAW § 4406-a (McKinney 1993).

[FN45]. Id.

[FN46]. See N.Y. CIV. PRAC. L. & R. § 7552 (McKinney 1993); N.Y. INS. LAW § 5605 (McKinney 1993); N.Y. PUB. HEALTH LAW § 4406-a (McKinney 1993).

[FN47]. Query whether this means that, contrary to New York's general policy on punitive damages, arbitrators in such actions may award punitive damages?

[FN48]. Governments, federal and state, presently pay 42% of health care costs and lavishly subsidize private insurance using tax credits. See Robert J. Samuelson, Nationalize Health Care, NEWSWEEK, Oct. 26, 1992, at 20. The federal share of Medicaid in 1992 was $67.8 billion and federal spending for Medicare was $129.4 billion. See CONGRESSIONAL BUDGET OFFICE REPORT, THE ECONOMIC AND BUDGET OUTLOOK: FISCAL YEARS 1994-1998, at 132 (Jan. 26, 1993).

[FN49]. Domenici and Koop, supra, note 11.

[FN50]. Id.

[FN51]. Id.

[FN52]. Id.
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