ARBITRATION: AN ANTIDOTE TO NEW YORK'S MEDICAL MALPRACTICE CRISIS

INTRODUCTION

In virtually every state, health care providers are besieged by medical malpractice claims.[1] According to a report by the United States General Accounting Office, both the frequency and severity of claims against physicians and hospitals have been rapidly increasing during the 1980-85 period.[2] Correspondingly, medical malpractice insurance premiums have skyrocketed[3] resulting in a potential breakdown of the health care system.[4] The increasing number of malpractice suits accompanied by rising premium rates and increased damage awards have brought about a crisis. Various parties have been blamed for causing this crisis. Commentators specifically place blame on greedy lawyers, insurance companies fixated on excessive profits, and litigious litigants.[5]

This note identifies two distinct causes of the medical malpractice crisis. The first cause stems from the tension between the medical profession and insurance companies. As a ramification of exorbitant premium rates, many physicians are refusing to take high-risk patients or to practice in certain specialty areas such as obstetrics because of the threat of being sued.[6] Some physicians are changing their specialties to less risky medical fields.[7] Other

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1. For a review of the medical malpractice situation in the United States, see U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: INSURANCE COSTS INCREASED BUT VARIED AMONG PHYSICIANS AND HOSPITALS (1986) [hereinafter MEDICAL MALPRACTICE REPORT].

2. *Id.* at 16. According to the St. Paul Fire and Marine Insurance Company (which in 1985 insured more than 55,000 physicians in 44 states and approximately 1,555 hospitals in 47 states), "both the frequency and severity of claims reported per 100 physicians increased from 10.5 in 1980 to 15.1 in 1983 to 17.8 in 1985—an overall increase of about 70% since 1980. The number of claims filed per 100 occupied hospital beds increased from 2.1 in 1980 to 3.0 in 1983 to 4.3 in 1985—an overall increase of about 104%." *Id.*

3. The American Medical Association (AMA) estimates that from 1983 to 1985, total premiums paid by the over 400,000 private patient care physicians increased by 100 percent. Furthermore, the AMA predicts that physician-owned companies (which insure more than half of practicing physicians) will increase their 1986 malpractice insurance rates substantially. *Id.* at 25.

4. *See* U.S. DEP'T OF HEALTH, EDUC. & WELFARE, MEDICAL MALPRACTICE: REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 5-12 (1973).

5. *Id.* at 27-49.

6. *See* U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: NO AGREEMENT ON THE PROBLEMS OR SOLUTIONS 10 (1986).

7. *Id.*

physicians are leaving the medical field by retiring early.[8] These responses to the crisis are causing a depletion of physicians that threatens to worsen the quality of health care available to citizens of the United States. Many other physicians have resorted to practicing defensive medicine, thereby driving up the cost of health care.[9] Ultimately, the cost of increased insurance premiums is passed on to the consumer of health care resulting in potential hardships to persons in need of medical attention.

The second cause of this crisis derives from the escalating number of malpractice suits which results in an increasing demand on the court system. The American Medical Association reported that Americans are filing more than three times as many medical malpractice claims as they did ten years ago.[10] This rise in medical malpractice litigation strains the effective operation of the court system.

In response to the first cause of the crisis, state legislatures have enacted remedial statutes. For instance, the Maryland Legislature enacted legislation which places a $350,000 cap on all noneconomic damages.[11] The Iowa Legislature placed limitations on punitive damages awards.[12] The Iowa bill states that seventy-five percent or more of a punitive award must be paid to a state civil reparations trust fund.[13] The Connecticut Legislature passed a bill which regulates attorneys' fees on a contingent fee scale basis.[14] Connecticut also passed a measure expanding the application of the collateral source rule.[15]

In addition to the focus on tort reform and attorneys' contingent fees, other noted resolutions to the crisis include the implementation of periodic payment of judgments, payment of prejudgment interest, and payment of post-judgment interest.[16] Some states, however, have chosen the more innovative technique of alternative dispute resolution. For example, Michigan instituted an arbitration system for medical malpractice disputes.[17] Arbitration

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8. *Id.*
9. *Id.*
10. *See* Blodgett, *Malpractice Crisis? Doctors' Premiums Jump*, 71 A.B.A. J. 18 (1986).
11. M.D. Cts. & Jud. Proc. Code Ann. § 11-108 (1986).
12. S. 2265, 71st Gen. Assembly, 2d Sess., 1986 Iowa Acts ___.
13. *Id.*
14. H.R. 6134, ___th Gen. Assembly, 2d Sess., 1986 Conn. Acts ___.
15. *Id.*
16. *See* Alliance of American Insurers, Civil Justice Enactments 1986 Session.
17. Mich. Stat. Ann. §§ 27A.5040-.5065 (Callaghan 1975).

is not only as effective as proposed tort reform measures regarding the medical aspect of the crisis, but will also reduce the strain on the court system resulting from the increased number of malpractice suits. The note will address New York's recently enacted remedial arbitration provision which was designed to curtail the medical malpractice crisis in the state.

Although the medical malpractice crisis is a present concern in New York, it certainly is not a new problem. In 1975, New York faced a critical threat to the health and welfare of the state due to the lack of adequate medical malpractice insurance at reasonable rates.[18] One way in which the New York Legislature dealt with this crisis was by establishing a medical malpractice panel.[19] This panel functions to provide juries in malpractice actions with an expert opinion of liability.[20]

Under this system, the members of the panel sign and forward to all parties in the dispute a formal recommendation of liability or non-liability.[21] The recommendation is dependent upon whether the members concur.[22] Moreover, the panel's recommendation is not binding on the jury and is only accorded such weight as the jury desires.[23] Consequently, under this system, the jury remains the final arbiter of factual questions and it determines the amount of damages, if any, to be awarded.[24]

Despite the legislature's good intentions, New York's malpractice panel has not been very successful in facilitating the disposition of medical malpractice disputes. The inadequacy is underscored by evidence within the state indicating an increasing number of malpractice suits[25] and escalating malpractice insurance

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18. Comiskey v. Arlen, 55 A.D.2d 304, ___, ___, 390 N.Y.S.2d 122, 129, 130 (1976).

19. N.Y. JUD. LAW § 148-a (McKinney 1983 & Supp. 1986). Section 148-a of the Judiciary Law created the medical malpractice panel. The New York Legislature stated that the purpose of its bill was "to deal comprehensively with the critical threat to the health and welfare of the state as a result of the lack of adequate malpractice coverage at reasonable rates." *Comiskey*, 55 A.D.2d at ___, 390 N.Y.S.2d at 130 (citing Memorandum of State Executive Dept., N.Y. Legis. Ann., 1975, p. 419).

20. *Comiskey*, 55 A.D.2d at ___, 390 N.Y.S.2d at 126.

21. *Id.* at ___, 390 N.Y.S.2d at 124.

22. *Id.*

23. *Id.*

24. *Id.* at ___, 390 N.Y.S.2d at 126.

25. According to a survey of 1,400 OB/GYNS by the American College of Obstetricians and Gynecologists, 12% of the OB/GYNS dropped obstetrics in 1984 because of the threat of suits. This is a three percent increase from 1983 figures. Almost 75% of the survey participants have been sued by patients, compared with 66% in 1983. USA Today, Nov. 15-17,

premium rates.[26]

Recognizing the need for alteration, the New York Legislature recently passed a tort reform bill which includes a provision for the *arbitration* of medical malpractice claims.[27] This arbitration provision establishes a temporary program which expires on December 1, 1991 or when 500,000 enrollees agree to arbitrate.[28] Thereafter, the Superintendent of Insurance is required to report to the Governor and Legislature on the implementation of this program.[29]

New York's arbitration provision is based largely upon the Michigan Arbitration Statute.[30] However, the New York legislation is more limited in its reach than the Michigan Arbitration Statute. Specifically, the New York legislation is only applicable to enrollees of health maintenance organization (HMO) plans.[31] Additionally, the arbitration panel does not include a representative of the medical profession.[32] These deviations from the Michigan statute sought to avoid two perceived challenges regarding the violation of due process rights[33] and unconscionable adhesion agreements.[34] As this note will conclude, however, the Michigan courts have persuasively negated these challenges.[35]

Section I of this note examines some of the proposed measures to deal with the medical malpractice crisis. This note specifically focuses on why arbitration is a viable response to the medical malpractice crisis. Section II sets forth the Michigan Arbitration Stat-

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1985, at A1, col. 1.

26. Total medical malpractice premiums paid by private patient care physicians increased from $1.7 billion in 1983 to $3.4 billion in 1985. According to the Medical Malpractice Report, the rates and increases varied considerably by specialty and geographic location. Generally, physicians practicing orthopedic surgery, neurosurgery, and obstetrics/gynecology paid the highest premiums. The report stated that the rate variance from state to state showed that in 1985, a Long Island, New York obstetrician/gynecologist purchasing coverage limits of $1,000,000/$3,000,000 would have paid $68,116 for medical malpractice premiums. In contrast, an obstetrician/gynecologist in Utah would have paid $13,376 for the same limits. MEDICAL MALPRACTICE REPORT, *supra* note 1, at 24.

27. 1986 N.Y. Laws ___ (to be codified at N.Y. JUD. LAW, Art. 75-a, §§ 7550-7566 (McKinney 1986)) [hereinafter N.Y. JUD. LAW].

28. Senator T. Lombardi, Medical Malpractice Update (August 1986).

29. *Id.*

30. *See* MICH. STAT. ANN. §§ 27A.5040-.5065 (Callaghan 1975); *compare* N.Y. JUD. LAW, Art. 75-a, §§ 7550-66 (McKinney 1986).

31. N.Y. JUD. LAW, Art. 75-a, § 7551.

32. *Id.* § 7554.

33. *See infra* note 104 and accompanying text.

34. *See infra* note 130 and accompanying text.

35. *See infra* text accompanying notes 102-43.

ute and analyzes the pertinent case law interpreting the statute. Section III reviews New York's malpractice panel and the new arbitration provision. Section IV addresses the shortcomings resulting from New York's deviations from the Michigan statute. Ultimately, this note suggests that the New York Legislature amend the arbitration provision to expand the coverage of the new legislation to include any patient who signs an arbitration agreement prior to receiving health care. In addition, the legislature should provide that the arbitration panel include a member of the medical profession. These amendments are necessary to secure more effective arbitration and to alleviate the medical malpractice crisis in New York State.

I. State Reform Proposals

Nationwide, state legislatures are proposing various measures in an effort to curb the increasing number of malpractice suits[36] and escalating malpractice insurance premium rates.[37] Each of these proposed reforms should not be considered as an exclusive remedy because there are numerous factors which have induced the medical malpractice crisis. Instead, each of these reforms should be viewed as one attempt to partially resolve the multifaceted medical malpractice crisis.

A. Contingent Fee Scales

Attacks on the medical malpractice system are widespread. One area under particularly heavy scrutiny is the contingent fee system. A contingent fee is a contractual arrangement between a lawyer and a client for legal services.[38] Under this system, a lawyer is compensated only if some recovery is awarded.[39] Consequently, if the plaintiff loses, the lawyer does not get paid. The amount of the attorney's fee under the contingent fee system is based on a percentage of the award.[40] The contingent fee system developed on the theory that "with contingent fees anyone could afford and choose even the best lawyer."[41]

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36. *See supra* note 2.

37. *See supra* note 3.

38. 7 Am. Jur. 2d *Attorneys at Law* § 254 (1980).

39. *Id. See, e.g.*, Pocious v. Halvorsen, 30 Ill.2d 73, ___, 195 N.E.2d 137, 139 (1963).

40. F. Mackinnon, Contingent Fees for Legal Services 17-29 (1964).

41. Alliance of American Insurers, Current Issues: Civil Justice 22 (2d ed. 1986) [hereinafter Alliance, Current Issues].

The contingent fee system has been attacked on a number of grounds. Some commentators assert that receiving a percentage of the recovery as a legal fee leads to exorbitant profits for the lawyer.[42] For example, in cases where the defendant's liability is clear, the lawyer may obtain a large settlement for a client after working only a few hours.[43] This leads to excessive profits for the lawyer.[44]

Another ground for discontent with the contingent fee system is that contingent fees create a potential conflict of interest between the lawyer and the client.[45] For example, a client may be faced with enormous medical bills and a loss of income and, therefore, may want to settle the case. The lawyer, on the other hand, who has other sources of income, may be more willing to wait for a higher settlement or judgment at trial.[46]

One attempted remedy to the perceived problem has been to determine lawyer's fees on a *sliding scale* of percentages based on the amount of the recovery.[47] Under this method, a lawyer might be allowed to receive thirty-three percent of the first $50,000, twenty-five percent for the next $100,000, fifteen percent for the next $350,000, and five percent of any portion over $500,000.[48] Allegedly, the contingency fee sliding scale would act as a disincentive to sue while ensuring that more of the money would go toward compensating the injured party and less to the lawyers.[49]

A study by the Rand Corporation on the resolution of medical malpractice claims reported, however, that "fee ceilings [i.e. contingency fee sliding scales] do more than cut down on 'windfall' returns—that they also *reduce* the attorney's efforts and hence the probability of victory for the plaintiff and the likely gross recovery and the net amount realized by the plaintiff."[50] Furthermore, a contingency fee system already adequately weeds out frivolous suits which is the primary reason for utilizing a contingency fee sliding scale system. A lawyer who is paid on a contingency fee sliding scale system is compensated only if he or she is successful

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42. *Id.* at 22-23.

43. *Id.*

44. *Id.* at 23.

45. *Id.; see also* Slovenko, *Medical Malpractice and the Lawyer's Contingent Fee*, 12 J. PSYCHIATRY & LAW 587, 588 (1984).

46. ALLIANCE, CURRENT ISSUES, *supra* note 41, at 23.

47. *Id.* at 24.

48. *Id.*

49. Slovenko, *supra* note 45, at 587.

50. *Id.* at 608 n.27 (emphasis added).

in obtaining either a settlement out of court or an award from a jury.[51] Thus, a lawyer is not likely to "invest time and several thousand dollars in out-of-pocket expenses on a case with little prospect of success."[52]

From a narrow perspective, it is true that a contingency fee sliding scale system acts as a disincentive to sue, thereby reducing the *frequency* of medical malpractice lawsuits. What advocates of the sliding scale system have perhaps overlooked, however, is that this system also serves as a disincentive for lawyers to take the more risky cases, which often involve plaintiffs with the greatest injuries. The contingency fee sliding scale system encourages lawyers to take the smaller and surer cases where there is a high probability of recovering a high percentage of the award. The lawyer is discouraged from taking a risky case because both the probability of recovery and the percentage of award is lower. Thus, the sliding scale system renders difficult cases economically undesirable for lawyers. Furthermore, the sliding scale system has no mitigating effect on the amount of damages awarded. Thus, even if a contingency fee sliding scale system were implemented, juries could nevertheless award exorbitant damage awards in malpractice actions. Therefore, the contingency fee sliding scale system should not be implemented to help remedy the medical malpractice crisis.

B. Cap on Pain and Suffering Awards

Another projected cause of the medical malpractice crisis has been the large awards given for pain and suffering. A number of state legislatures have attempted to regulate these awards.[53] Pain and suffering pertains not only to physical discomfort and distress but also to mental and emotional trauma.[54] Traditionally, juries, in their discretion, assess the extent of pain and suffering and the amount of damages awarded.[55]

When juries are charged with ascertaining the amout of the

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51. W. Schwartz & N. Komesar, *Doctors, Damages and Deterrence: An Economic View of Medical Malpractice*, 298 NEW ENG. J. OF MED. 1282, 1288 (1978).

52. *Id.*

53. *See, e.g.*, M.D. CTS. & JUD. PROC. CODE ANN. § 11-108 (1986). Notably, California, Indiana, Texas, New Hampshire, North Dakota, Ohio, and Illinois have placed legislative limits ranging from $50,000 to $250,000 on the amount of damages payable for "noneconomic" losses. Browning, *Doctors and Lawyers Face Off*, 72 A.B.A. J. 38, 39 (1986).

54. 22 AM. JUR. 2d *Damages* § 105 (1965).

55. *Id.* at § 86.

awards, they are often instructed to award damages based on past, present, and so much of future suffering as is "reasonably probable."[56] In addition, the juries are directed to take into account the plaintiff's life expectancy and the intensity and duration of the pain.[57]

Some commentators argue that allowing juries unlimited discretion in awarding damages for pain and suffering results in uneven and unpredictable recoveries.[58] As a result, insurers counter this uncertainty of awards by charging higher premiums, thereby fueling the medical malpractice crisis.[59]

Although capping pain and suffering would most definitely reduce exorbitant awards, such a method is unfair. A major criticism of a limitation on damages is that it tends to treat different cases alike, thereby imposing an "arbitrary cap on the total amount recovered."[60] For instance, given a cap of $250,000, a jury confronted with a situation in which the plaintiff has relatively little pain and suffering might view the $250,000 as a target rather than a limit.[61] This situation will result in the jury awarding a higher recovery than necessary.[62] On the other hand, in an egregious case, the jury is still limited to $250,000 for pain and suffering even though the situation warrants a much higher award.[63]

In the abstract, capping pain and suffering would result in lower damage awards for plaintiffs. Correspondingly, the lower awards would bring down the cost of premium rates, which are, it is often asserted, borne by health care consumers. Yet, there is a downside cost borne *directly* by health care consumers—the inability to obtain full compensation for injuries. This downside cost, when balanced with the foregone cost of increased medical care, is probably more detrimental to injured parties. These parties should not have to sustain a possible reduction in a "just" recovery simply to bring down premium rates. Additionally, a cap on pain and suffering does nothing to reduce the burden on the court system from

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56. *Id.*
57. *Id.*
58. ALLIANCE, CURRENT ISSUES, *supra* note 41, at 41.
59. *Id.*
60. R. Ackerman, *Medical Malpractice: A Time for More Talk and Less Rhetoric*, 37 MERCER L. REV. 725, 745-46 (1986).
61. *Id.* at 746.
62. *Id.*
63. *Id.*

the increasing number of malpractice suits. Thus, a cap on pain and suffering awards is not a recommended measure to be implemented by state legislatures to curtail the malpractice crisis.

C. Arbitration

Unlike the proposed remedies discussed above, arbitration is a viable alternative to the jury system and can significantly contribute to the reform of the malpractice crisis. Arbitration can accomplish the objective of curtailing the crisis without hurting the health care consumer in the process. It is also superior to the other tort reform proposals because it both lessens the load of malpractice cases on the court system and brings down runaway damage awards. As Chief Justice Warren Burger stated to the American Bar Association: "The notion that most people want black-robed judges, well dressed lawyers and fine paneled courtrooms as a setting to resolve their dispute is not correct. People with problems, like people with pains, want relief, and they want it as quickly and inexpensively as possible."[64]

Arbitration is a procedure by which parties submit their conflict to an impartial third party for resolution.[65] The determination made by the arbiter(s) is generally final and binding.[66] Some commentators argue that an arbitral forum is "less likely to produce excessive awards which are frequently less related to the merits of a claim than to the inflammatory factual situation from which the claim arose."[67]

An arbitration system has a number of advantages over the jury system. First, arbitration often results in a more rapid resolution of malpractice claims.[68] Second, the costs associated with arbitration are generally lower than the costs of a jury trial.[69] Finally,

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64. ALLIANCE, CURRENT ISSUES, *supra* note 41, at 3.

65. F. ELKOURI & A. ELKOURI, HOW ARBITRATION WORKS 2 (1973).

66. *Id.*

67. Letter from Judith M. Mears to James Clyne (Sept. 23, 1985) (discussing the Kaiser Permanente Medical Care Program) 4.

68. *Id.* at 3. Under the Kaiser Permanente Medical Care Program (California's Arbitration Program), the experience has been that the average arbitration proceeding in California takes 3 to 4 days as opposed to approximately 2 ½ weeks for a trial of comparable complexity. In addition, the average arbitration hearing takes place generally within 2 to 2 ½ years (and sometimes within one year) after the claim is made, whereas, a court trial usually begins closer to 4 years after suit is filed. *Id.*

69. *See, e.g.*, APPLIED SOCIAL RESEARCH, INC., EVALUATION OF MICHIGAN MEDICAL MALPRACTICE ARBITRATION PROGRAM: SUMMARY REPORT 28 (1983) [hereinafter SUMMARY REPORT].

the payment of compensation for comparable damages is more consistent under arbitration than under the jury system.[70]

A study by the Institute for Civil Justice showed that the costs of a jury trial are significantly higher than for a non-jury trial.[71] The Institute noted that a civil case that required one hearing, two conferences and a jury trial cost $3,000 in Florida, $2,800 in Washington, and almost $11,000 in Los Angeles.[72] Whereas, the Institute reported that state courts expended an average of $2,000 to $3,000 for non-jury trials and about $50 for a post-filing case settled without a trial.[73] It was also found that cases resolved via the court system were much slower than non-jury trials.[74]

State initiatives toward arbitration have been growing in an effort to contain rampant litigation. Many states already have some kind of court mandated arbitration system where court rules require pending cases to be arbitrated prior to holding a trial or trial de novo.[75] Michigan has implemented a full scale arbitration scheme to specifically deal with the medical malpractice crisis.

II. Michigan's Answer to the Medical Malpractice Crisis

A. Michigan's Arbitration Statute

1. Background

As important as the right to a jury trial may be, the Michigan Legislature realized that some other means for settling medical malpractice claims had to be encouraged to alleviate the health care crisis in Michigan.[76] Like New York's present situation, the Michigan crisis included the decreasing availability as well as the rising costs of medical malpractice insurance, an increase in the

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According to this report on the Michigan Arbitration Statute, arbitration is a less expensive method for resolving medical malpractice disputes. The report stated that the costs to the parties for settling a dispute was $240 less than the court system. It is also believed that if arbitration agreements were not challenged on constitutional grounds, the costs savings might be even greater (estimated additional savings of at least $500 per claim). The savings generated by lower defense costs and diminished legal expenses amount to $700 to $800 per claim. *Id.*

70. *Id.* at 7-14.

71. Alliance, Current Issues, *supra* note 41, at 2.

72. *Id.*

73. *Id.*

74. *Id.*

75. *See, e.g.*, Pa. Stat. Ann. tit. 5, § 21 (Purdon 1963).

76. Morris v. Metriyakool, 107 Mich. App. 110, 111, 309 N.W.2d 910, 911 (1981).

cost of health care, and the lengthy delay in the disposition of medical malpractice claims.[77] The Michigan Legislature adopted the Michigan Arbitration Statute on September 1, 1975,[78] which provides for arbitration as an alternative to litigation of medical malpractice claims.

2. *Methodology*

The Michigan statute is voluntary in that neither the patient nor the health care provider[79] is required to enter into an agreement to arbitrate malpractice disputes.[80] When arbitration is agreed to, the arbitration agreement form[81] must state that arbitration is not a prerequisite to health care or treatment and that the agreement may be revoked within sixty days after execution by

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77. *Id.*

78. MICH. STAT. ANN. §§ 27A.5040-.5065 (Callaghan 1975).

79. "Health Care Provider" means a person, partnership, or corporation lawfully engaged in the practice of medicine, surgery, dentistry, podiatry, optometry, chiropractic, nursing, or a person dispensing drugs or medicines. *Id.* § 27A.5040(2)(b).

80. MICH. STAT. ANN. § 27A.5041(1) (Callaghan 1975).

81. The standard arbitration form which the patient signs prior to receiving health care is as follows:

> I understand that this hospital and I by signing this document agree to arbitrate any claims or disputes (except for disputes over charges for services rendered) which may arise in the future out of or in connection with the health care rendered to me during this hospital stay and/or emergency room visit by this hospital, its employees and those of its independent staff doctors and consultants who have agreed to arbitrate.
>
> I understand that Michigan Law gives me the choice of trial by judge or jury or of arbitration. I understand that arbitration is a procedure by which a panel that is either mutually agreed upon or appointed decides the dispute rather than a judge or a jury. I freely choose arbitration and I agree that a judgment of any circuit court may be rendered upon any award or determination made pursuant to this agreement. I also understand that any arbitration will be conducted in accordance with Michigan Law and the Michigan Medical Arbitration Rules, as approved by the Commissioner of Insurance.
>
> I understand that this agreement to arbitrate is binding on me and all my agents, representatives and heirs and assigns, as well as on this hospital, its employees and those of its independent staff doctors, and consultants who have agreed to arbitrate.
>
> I certify that I have read this agreement or have had it read to me and that I fully understand its content and execute this agreement of my own free will. I have received a complete copy of the booklet which explains this agreement.
>
> THIS AGREEMENT TO ARBITRATE IS NOT A PREREQUISITE TO HEALTH CARE OR TREATMENT, AND MAY BE REVOKED WITHIN 60 DAYS AFTER DISCHARGE BY NOTIFICATION IN WRITING TO:_____ /s/_____. /s/_____

Brown v. Siang, 107 Mich. App. 91, ___, 309 N.W.2d 575, 577 n.3 (1981).

notification in writing.[82] This provision must be conspicuously written.[83] The agreement form must be accompanied by an information brochure which clearly details the agreement and revocation provision.[84] If the agreement is properly executed and is not revoked within sixty days, binding arbitration becomes the means by which malpractice claims are adjudicated.[85]

The Michigan statute provides for a three-member panel which is composed of a lawyer, a lay person, and a health care provider.[86] The panel is selected by the parties pursuant to the rules and procedures of the American Arbitration Association.[87] Each party in the dispute must receive an identical list of five arbiter candidates in each of the three categories together with a brief biography of the candidates.[88] Each party may strike from the list any name which is unacceptable, and shall number the remaining names in order of preference.[89] The first mutually agreeable candidate in each category shall be invited to serve on the panel.[90] If the members cannot be selected by mutual agreement, the association makes the selection, subject to challenge for cause by either party.[91]

After the appointment of the panel of arbiters, the parties to the arbitration may take depositions and obtain discovery regarding the subject matter of the dispute.[92] The parties may use and exercise the same rights, remedies, and procedures, and are subject to the same duties, liabilities, and obligations in the arbitration proceeding as in any civil action.[93] The hearing must also be informal.[94] The rules of evidence used are those provided under the rules of the association.[95] However, the panel must adhere to the

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82. MICH. STAT. ANN. § 27A.5041(2), (3) (Callaghan 1975).

83. *Id.* § 27A.5041(5). This provision must be printed in twelve-point boldface type immediately above the space for the signature of the parties. *Id.*

84. *Id.* § 27A.5041(6).

85. *Brown*, 107 Mich. App. at ___, 309 N.W.2d at 578.

86. MICH. STAT. ANN. § 27A.5044(2) (Callaghan 1975).

87. *Id.* § 27A.5044(3).

88. *Id.*

89. *Id.*

90. *Id.*

91. *Id.* § 27A.5044(5).

92. *Id.* § 27A.5048(1). Discovery must begin no later than twenty days after all the parties have received a copy of the demand for arbitration and conclude within six months. *Id.*

93. *Id.* § 27A.5048(1).

94. *Id.* § 27A.5050(1).

95. *Id.*

Michigan Rules of Evidence when substantial prejudice to the rights of a party would occur from the failure to follow the civil rules.[96]

The panel must render its award and opinion within thirty days after the close of the hearing or receipt of briefs.[97] The award must be in writing and signed by the chairperson or by a majority of the panel.[98] A majority of the panel may grant any relief deemed equitable and just.[99] For example, the panel can award money damages, provision for hospitalization, medical or rehabilitative procedures, support, or any combination thereof.[100] In addition to the award, the panel must render a written opinion which states its reasoning for the amount and kind of award given, if any.[101] A panel member may write a dissenting opinion if he or she disagrees with the majority.[102]

B. Challenges to the Michigan Statute

1. Due Process Right to a Fair and Impartial Tribunal

While the Michigan statute is administratively efficient, several important challenges have been made.[103] Several appellate courts in Michigan have considered whether the provision requiring that one of the three panel members be a physician or hospital administrator violates a claimant's right to a hearing before a fair and impartial tribunal.[104] The majority of the courts have concluded that no due process violation exists absent clear proof of bias on behalf of the particular physician or hospital administrator involved.[105]

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96. *Id.*

97. *Id.* § 27A.5054(3).

98. *Id.* § 27A.5054(4).

99. *Id.* § 27A.5054(1).

100. *Id.*

101. *Id.* § 27A.5055(1).

102. *Id.*

103. The most prominent challenges raised involve due process rights and adhesion contracts. *See infra* notes 104 and 127 and accompanying texts.

104. *See* Brown v. Siang, 107 Mich. App. 91, 309 N.W.2d 575 (1981); Gale v. Providence Hosp., 118 Mich. App. 405, 325 N.W.2d 439 (1982); Strong v. Oakwood Hospital Corp., 118 Mich. App. 395, 325 N.W.2d 535 (1982); Morris v. Metriyakool, 107 Mich. App. 110, 309 N.W.2d 910 (1981).

105. *See, e.g.*, Morris v. Metriyakool, 107 Mich. App. 110, 309 N.W.2d 910 (1981); Brown v. Siang, 107 Mich. App. 91, 309 N.W.2d 575 (1981).

In *Brown v. Siang*,[106] the plaintiff filed a suit against a doctor and a hospital alleging medical malpractice.[107] The defendants filed a motion for an accelerated judgment.[108] That motion alleged that the plaintiff's deceased, upon entering the hospital, signed an agreement to arbitrate all claims arising from the health care received during that admission.[109] Because the plaintiff's deceased had agreed to arbitration, the trial court granted the accelerated judgment to the defendant hospital and ordered the plaintiff to submit the dispute to arbitration.[110]

On appeal, the plaintiff alleged that the inclusion of a health care provider on the panel violated her due process right to an impartial tribunal.[111] The plaintiff asserted that a physician or hospital administrator who sits on the arbitration panel is "necessarily biased due to the direct pecuniary interest he possesses in purchasing malpractice insurance."[112] However, the court summarized and followed a Wisconsin Supreme Court case which held that any financial interest to be gained by a physician or hospital administrator was "too remote and speculative" to require disqualification.[113]

Moreover, the *Brown* court found that the "safeguards within the statute to insure impartiality cure any possibility that an irate health care provider will serve on the panel."[114] According to the court, the Michigan statute provides that the parties are permitted to select the panel members, the panel members are required to be screened for bias, and courts are allowed to vacate an arbitration award if there is evidence of partiality by the arbiter.[115] In addition, the court noted that the panels are required to consider highly technical medical issues. Thus, "[e]limination of the health care expert from the panel would 'emasculate' the review process."[116]

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106. Brown v. Siang, 107 Mich. App. 91, 309 N.W.2d 575 (1981).

107. *Id.* at ___, 309 N.W.2d at 576.

108. *Id.*

109. *Id.*

110. *Id.*

111. *Id.* at ___, 309 N.W.2d at 578.

112. *Id.*

113. *Id.* at ___, 309 N.W.2d at 580 (quoting State *ex rel.* Strykowski v. Wilkie, 81 Wis.2d 491, ___, 261 N.W.2d 434, 446 (1978)).

114. *Id.*

115. *Id.*

116. *Id.* (quoting Strykowski, 81 Wis.2d at ___, 261 N.W.2d at 446).

Strong v. Oakwood Hospital Corp.[117] represents the contrary but minority view in Michigan that appointment of a health care provider to the panel violates a plaintiff's right to a fair and impartial tribunal. In *Strong*, the court held that permitting a health care provider to be a member of the panel, along with the failure to advise the patient of the panel's composition, was unconstitutional.[118] The *Strong* court feared that the composition of the arbitration panel created a situation where the probability of bias was too high to be constitutionally tolerated.[119] Nevertheless, in *Morris v. Metriyakool*,[120] the court mirrored the *Brown* court's opinion in stating that this fear is unfounded due to the safeguards within the statute.[121]

In *Morris*, the plaintiff contended that the inclusion of a physician on the panel was a denial of due process because a physician does not sit as a neutral party.[122] The plaintiff further alleged that "physicians invariably unite as a clan against malpractice claimants and that such unity is motivated, not by professional ethic, but by pecuniary considerations."[123]

Similar to the reasoning of the *Brown* court, the *Morris* court stated that an allegation of bias must be supported by "demonstrable reality," not mere speculation.[124] The court also relied heavily on the safeguards within the arbitration statute to hold that there was no due process violation.[125] The court stated that the provisions within the statute which set forth the voluntariness of the arbitration statute, the panel selection process, and the opportunity to challenge the appointment of any panel member assure a claimant that his or her due process rights will not be violated.[126]

2. *Adhesion Contracts*

A second common challenge to the Michigan statute has been that the relative bargaining power of the parties to the arbitration

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117. 118 Mich. App. 395, 325 N.W.2d 435 (1982).
118. *Id.* at ___, 325 N.W.2d at 437.
119. *Id.*
120. 107 Mich. App. 110, 309 N.W.2d 910 (1981).
121. *Id.* at ___, 309 N.W.2d at 913.
122. *Id.* at ___, 309 N.W.2d at 911.
123. *Id.*
124. *Id.*
125. *Id.*
126. *Id.*

agreement is so disparate that the agreement constitutes an adhesion contract. As with the due process challenge, a majority of Michigan courts have held that the arbitration agreement does not constitute an adhesion contract.[127] For example, in *Brown v. Siang* the plaintiff alleged that the standardized arbitration form is always an adhesion contract because of the superior bargaining power that the hospital or doctor necessarily has over the patient.[128] The court rejected the plaintiff's contention.[129]

In *Brown*, the plaintiff relied upon *Wheeler v. St. Joseph Hospital*,[130] a California case that involved a medical malpractice arbitration agreement. The *Brown* court adopted the *Wheeler* definition of adhesion contracts:

> The term 'adhesion contract' refers to standardized contract forms offered to consumers of goods and services on essentially a 'take it or leave it' basis without affording the consumer a realistic opportunity to bargain and under such conditions that the consumer cannot obtain the desired product or services except by acquiescing in the form contract: . . . The distinctive feature of a contract of adhesion is that the weaker party has no realistic choice as to its terms.[131]

The *Brown* court stated that the determination that a contract is one of adhesion is only the first step.[132] It must also be established that "the terms of which the adherent was unaware are beyond the reasonable expectations of an ordinary person or are oppressive or unconscionable."[133] Thus, the Michigan court recognizes a two-tier test regarding the enforceability of contracts. First, the court must assess the relative bargaining power of the parties,[134] examining, for instance, the parties' options.[135] Second, the court must determine whether the challenged term is substan-

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127. *See* Morris v. Metriyakool, 107 Mich. App. 110, 309 N.W.2d 910 (1981); Brown v. Siang, 107 Mich. App. 91, 309 N.W.2d 575 (1981). *But see* Strong v. Oakwood Hospital Corp., 118 Mich. App. 395, 325 N.W.2d 435 (1982).

128. *Brown*, 107 Mich. App. at ___, 309 N.W.2d at 582.

129. *Id.*

130. 63 Cal. App. 3d 345, 133 Cal. Rptr. 775 (1976).

131. *Brown*, 107 Mich. App. ___, ___, 309 N.W.2d at 581, 582 (quoting *Wheeler*, 63 Cal. App. 3d at 356, 133 Cal. Rptr. at 783).

132. *Brown*, 107 Mich. App. at ___, 309 N.W.2d at 582.

133. *Id.* (quoting *Wheeler*, 63 Cal. App. 3d at 357, 133 Cal. Rptr. at 783).

134. *Brown*, 107 Mich. App. at ___, 309 N.W.2d at 582 (quoting Allen v. Michigan Bell Telephone Co., 18 Mich. App. 632, ___, 171 N.W.2d 689 (1969)).

135. *Id.*

tially reasonable.[136]

The *Brown* court distinguished *Wheeler* by noting that the parties in *Wheeler* entered into a private contract to arbitrate malpractice disputes.[137] No medical malpractice arbitration statute was involved in the *Wheeler* case.[138] Furthermore, the court stated that the parties' agreement to arbitrate in *Wheeler* was "unobtrusively inserted" in the middle of the document.[139] Whereas in *Brown*, the court noted that the agreement clearly stated that it was not a prerequisite to receiving health care.[140] Additionally, under the Michigan statute, the patient is given sixty days after execution in which to revoke the agreement.[141] The court held that these protective clauses in the agreement alleviated the possibility of coercion.[142] The court added that even if the patient felt obligated to sign the agreement to receive the best possible health care, the terms of the agreement were within the reasonable expectations of the patient.[143] Therefore, the court concluded that Michigan's arbitration statute did not provide for the creation of unconscionable adhesion contracts.[144]

III. New York's Attempt to Resolve its Medical Malpractice Crisis

A. New York's Medical Malpractice Panel

Faced with essentially the same predicament as Michigan,[145] in 1975 New York enacted legislation establishing its medical malpractice panel.[146] The purpose of this panel is to facilitate the disposition of medical malpractice actions by furnishing a jury with an expert opinion as to liability or non-liability.[147] Unlike the 1986 arbitration provisions which remove a dispute from the court system, the 1975 legislation simply established a panel to supplement a jury trial. In addition, the 1975 panel system is still significant

136. *Id.*
137. *Brown*, 107 Mich. App. at ___, 309 N.W.2d at 582.
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.*
142. *Id.*
143. *Id.*
144. *Id.*
145. *See supra* text accompanying notes 76-77.
146. N.Y. Jud. Law § 148-a (McKinney 1983 & Supp. 1986).
147. *Id.* § 148-a(1).

because the new 1986 legislation does not encompass all plaintiffs.[148]

The New York malpractice panel consists of a supreme court justice, a physician, and an attorney.[149] The presiding justice of the appellate division, with the assistance of the Medical Society of the State of New York, a county medical society, and/or the New York Academy of Medicine, prepares a list of doctors who are regularly admitted to practice medicine in New York State.[150] The list is then divided into categories of doctors by specialty.[151] The presiding justice also prepares a list of experienced trial lawyers.[152] These lawyers are not required to have experience in medical malpractice litigation.[153] The presiding justice can, in his or her discretion, add to or delete from the list the names of any doctor or attorney.[154] The presiding justice then selects the panel members from the lists.[155] Prior to the date set for the hearing, any party can file a written objection to the designation of a doctor or attorney.[156] The presiding justice rules on the objection.[157]

After the panel is established and prior to the date set for the hearing, the parties to the dispute must submit to the court all written materials, including pleadings, bills of particulars, and medical hospital reports.[158] These materials are available for any member of the panel to review.[159]

The hearing before the panel is informal.[160] Generally, no statement or expression of opinion made at the hearing is admissible in evidence at trial, either as an admission or otherwise.[161] The justice presiding at the hearing cannot preside at the trial, nor can the panel members participate in the trial as counsel or witness.[162] An exception to this rule is that if the panel's recommendation is

148. *See infra* text accompanying note 181.
149. *Id.* § 148-a(2).
150. *Id.* § 148-a(2)(a).
151. *Id.*
152. *Id.* § 148-a(2)(b).
153. *Id.*
154. *Id.* § 148-a(2)(c).
155. *Id.* § 148-a(2)(a).
156. *Id.* § 148-a(2)(d).
157. *Id.*
158. *Id.* § 148-a(3)(a).
159. *Id.*
160. *Id.* § 148-a(4).
161. *Id.*
162. *Id.*

read to the jury, the doctor and/or attorney can be called as a witness by any party with reference to the recommendation of the panel only.[163] The member can only be called as a witness to assist the jury in weighing the significance and probative worth to be accorded the panel's recommendation.[164] The examination of the panel member can only extend to such areas as the procedures followed by the panel, the materials considered, the extent of deliberation, and the education, training, and experience of the panel members.[165] The foregoing provisions demonstrate that panel members are insulated from substantive examination. This restricted scope of inquiry effectively deprives the jury of the benefit of the panel's expertise.

Following the panel's hearing, if there is a unanimous agreement, an order is entered with respect to either part or all of the case.[166] If there is no disposition, then the case proceeds to its regular place on the trial calendar as if the panel had never met.[167] A formal recommendation is forwarded to all the parties if all three members of the panel concur as to the issue of liability and becomes admissible evidence at any subsequent trial.[168] However, the recommendation is not binding upon the fact finder, but rather only accorded such weight as the jury or trial court chooses to ascribe to it.[169] Thus, the jury is preserved as "the ultimate arbiter of the factual questions raised."[170]

It was anticipated that many non-meritorious malpractice disputes would be eliminated by unanimous findings of no liability by the panel which would result in similar jury verdicts.[171] It was also hoped that trial calendars would be reduced by pre-trial settlements subsequent to the panel's recommendation.[172] However, the medical malpractice panel "not only failed to solve the malpractice problem, but exacerbated it."[173] In *Rosa v. Mohan Kulkarni*

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163. *Id.* § 148-a(8).

164. Felner v. Shapiro, 94 A.D.2d 317, 318, 464 N.Y.S.2d 150, 151 (1983).

165. *Id.*

166. N.Y. JUD. LAW § 148-a(7) (McKinney 1983 & Supp. 1986).

167. *Id.*

168. *Id.* § 148-a(8).

169. *Id.*

170. *Comiskey*, 55 A.D.2d at ___, 390 N.Y.S.2d at 126.

171. King v. Retz, 115 Misc.2d 836, 838, 454 N.Y.S.2d 594, 596 (1982).

172. *Id.*

173. Rosa v. Mohan Kulkarni Unibell Anesthesia, 113 Misc.2d 39, 40, 448 N.Y.S.2d 400, 402 (1982); *see also* Connors & Bull, *New York's Controversial Medical Malpractice Bill*, 58 N.Y.S. B.J. 14 n.5 (1986) (citing *Report of the Ad Hoc Committee on Medical Malpractice*

Unibell Anestesia,[174] the trial court stated that a unanimous finding of liability only serves to inflate the plaintiff's demand, a no-liability determination solidifies the defendant's resolve to proceed to trial, and the parties to a dispute are left in the same position as before the panel met in those cases where the panel is unable to reach a unanimous conclusion.[175]

Because the panel's determination must be unanimous to be admissible in court and cannot be the sole basis for the entry of judgment,[176] the benefit of having an expert panel to assist in expediently resolving medical malpractice disputes is vastly undermined. Thus, the New York medical malpractice panel often serves as merely another bureaucratic hurdle to the ultimate resolution of a malpractice claim.

B. New York's New Medical Malpractice Legislation

The continuing saga of escalating malpractice insurance premium rates[177] and the increased number of malpractice suits[178] forced the New York Legislature to enact new malpractice legislation in 1986.[179] New York's new malpractice legislation contains a provision for the resolution of malpractice disputes by arbitration.[180] However, New York's new legislation is more limited in its reach than the Michigan Arbitration Statute. The New York legislation only applies to claims for damages because of injury or death resulting from health care or treatment rendered or failed to be rendered to enrollees and other covered family members of HMO plans.[181]

Under the legislation, a malpractice dispute submitted to arbitration will be heard by a panel of three arbiters.[182] The composition of the panel is somewhat different than under the Michigan

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Panels of the Chief Administrative Judge of the State of New York on the Operation of Medical Malpractice Panels, p. 163). Conners and Bull noted that the Ad Hoc Committee suggested the abolition of panels as provided in the Judiciary Law and proposed the setting up of rules for alternative dispute resolution in medical malpractice actions. *Id.*

174. 113 Misc.2d 39, 448 N.Y.S.2d 400 (1982).

175. *Id.* at ___, 448 N.Y.S.2d at 402.

176. *Comiskey*, 55 A.D.2d at ___, 390 N.Y.S.2d at 127.

177. *See supra* note 26.

178. *See supra* note 25.

179. S. 9470, 209 Leg., 2d Sess., 1986 N.Y. Laws ___.

180. N.Y. JUD. LAW, Art. 75-a, §§ 7550-7566 (McKinney 1986).

181. *Id.* § 7551.

182. *Id.* § 7554(a).

statute. In New York, an attorney is appointed to serve as chairperson of the panel on a full-time basis for a fixed term.[183] The two remaining arbiters are selected from a pool of candidates established pursuant to the rules and procedures promulgated by the arbitration administrator and approved by the Superintendent of Insurance.[184] Attorneys whose practices substantially involve representation in personal injury matters, physicians, dentists, hospital and HMO personnel, and other health care providers are not eligible to serve on the panel.[185]

Like the Michigan statute, the parties to the arbitration may take depositions and obtain discovery regarding the subject matter of the arbitration.[186] The parties may use and exercise the same rights, remedies, and obligations in the arbitration as if the subject matter of the arbitration were pending in a civil action.[187] The arbitration hearing must also be informal.[188] The panel renders its decision by a majority vote within thirty days after the close of the hearing or receipt of the briefs.[189] Unlike the Michigan statute, if the panel finds that the action, claim, counterclaim, defense, or cross-claim of an unsuccessful party is frivolous, then the panel is empowered to award costs and reasonable attorney's fees to a successful party to the dispute.[190]

IV. The Shortcomings Resulting from New York's Deviations from the Michigan Statute

A. Due Process Right to a Fair and Impartial Tribunal

Although the New York Legislature based its new arbitration provision largely upon the Michigan statute, New York was more conservative in designing its legislation than Michigan had been. As previously stated, the New York legislation is only applicable to enrollees of HMO plans.[191] Additionally, the arbitration panel does not include a representative of the medical profession.[192] By incor-

183. *Id.*
184. *Id.* § 7554(b).
185. *Id.*
186. *Id.* § 7558(a).
187. *Id.*
188. *Id.* § 7559(a).
189. *Id.* § 7563(b).
190. *Id.* § 7564(b).
191. N.Y. Jud. Law, Art. 75-a, § 7551 (McKinney 1986).
192. *Id.* § 7554(b).

porating these restrictions into the statute, the New York Legislature ostensibly avoided the challenges regarding adhesion contracts and due process rights. These deviations from the Michigan statute are unnecessary and may ultimately have a negative impact on the success of the legislation.

As the Michigan court of appeals stated in *Morris v. Metriyakool*, the apprehension of bias by placing a health care provider on the panel is wholly unfounded.[193] According to the *Evaluation Report on the Michigan Arbitration Statute*, there is no basis for a presumption of bias on the part of the health care provider or any other member.[194] The study also concluded that the diversification of having one attorney, one health care provider, and one lay person "provides the panel with a combination of breadth of experience and expertise which is helpful to deliberations and should be retained."[195]

The safeguards within New York's arbitration provision will ensure that the panel is comprised of impartial members. New York's legislation included a provision for screening potential panel members for bias.[196] Under section 7555, the arbitration administrator must make an initial screening for bias and also require the candidates to complete a current disclosure statement under oath.[197] The statement should disclose any personal acquaintance with any of the parties or their counsel, the nature of such acquaintance, and any other relevant information.[198] The arbitration administrator must communicate any facts which suggest the possibility of partiality to the parties of the dispute.[199] At any time after the filing of the demand for arbitration, no party may communicate with a candidate, directly or indirectly, except through the arbitration administrator.[200] With this provision already intact, the New York Legislature should not be reluctant to amend the legislation to include a health care provider on the panel.

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193. *Morris*, 107 Mich. App. at ___, 309 N.W.2d at 913.
194. SUMMARY REPORT, *supra* note 69, at 40.
195. *Id.*
196. N.Y. JUD. LAW, Art. 75-a, § 7555 (1986).
197. *Id.* at § 7555(a).
198. *Id.*
199. *Id.*
200. *Id.* § 7555(b).

B. Adhesion Contracts

The second area in which the New York Legislature unnecessarily restricted the effectiveness of the legislation is in limiting the opportunity to arbitrate to only members of HMO plans. Essentially, an HMO plan is a plan by which members of an enrolled population[201] are entitled to receive comprehensive health services for an advanced or periodic charge.[202] Although limiting arbitral malpractice claims to members enrolled in HMO plans avoids the possible claim that the arbitration agreement is a contract of adhesion,[203] it also significantly reduces the number of claimants who can take advantage of arbitration to resolve a malpractice dispute.

There are many reasons why an individual might not participate in an HMO plan. A primary reason is attributable to a fear that HMOs are "too impersonal and bureaucratic"[204] and thereby lack the necessary tender loving care element. Furthermore, although HMOs are on the rise, there is much discord as to the quality of HMO care from doctors.[205] This discord may significantly diminish the growth of HMO plans.

Consequently, any individual who chooses not to enroll in an HMO plan is automatically precluded from New York's arbitration provision. Furthermore, those persons who are precluded from the arbitration provision are subjected to the medical malpractice panel. Because a substantial number of people are not enrolled in HMO plans and accordingly not within the reach of the arbitration provision, the medical malpractice panel continues to be the route that most plaintiffs follow when bringing a malpractice suit. Thus, the benefits of this arbitration legislation will be lost.

New York's arbitration provision should, therefore, be amended to cover any patient who signs an arbitration agreement prior to receiving health care rather than to only those persons enrolled in HMO plans. Prior to receiving health care treatment, the

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201. "Enrolled population" means a group of persons, defined as to probable age, sex, and family composition, which receives comprehensive health services from an HMO in consideration for a basic advanced or periodic charge, PUB. HEALTH LAW, Art. 44 § 4401(4) (1985).

202. F. Entin, *DRGs, HMOs, and PPOs: Introducing Economic Issues in the Medical Malpractice Case*, 20 FORUM 675, 681 (1985).

203. *See supra* text accompanying note 131.

204. *See Medical Discord: Some Doctors Assail Quality of Treatment Provided by HMOs*, Wall St. J., Sept. 16, 1986, at 1, col. 1.

205. *Id.*

patient should be given an arbitration form. The arbitration form should be similar to the form used in Michigan.[206] Thus, the form should state that an agreement to submit to arbitration is not a prerequisite to health care treatment and that the agreement may be revoked within sixty days after execution by notification in writing. The patient should also be given a brochure explaining the arbitration provision. Additionally, a representative from the medical staff should complete a verbal presentation to the patient explaining the arbitration agreement. To guarantee that the patient fully understands the provision, the patient should initial each pertinent clause of the agreement.[207]

To heighten patient understanding of the arbitration provision, the New York Legislature should disseminate information detailing the arbitration clause to state residents.[208] The objective of this measure is to ensure that people are familiar with arbitration before a health problem arises.

CONCLUSION

Although the right to a jury trial is paramount to our system of justice, an alternative method for settling medical malpractice claims must be encouraged to alleviate the medical malpractice crisis in New York State. Arbitration is an effective alternative system for facilitating the disposition of medical malpractice disputes. Arbitration has the advantage of providing claimants with a speedy, less costly, and less traumatic forum in which to resolve

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206. *See supra* note 81.

207. SUMMARY REPORT, *supra* note 69, at 33, 34. The report recommends that the following clauses be initialed by the patient:

> Patient understands that signing the Arbitration Agreement is not a prerequisite to the receipt of care or treatment.
>
> Patient understands the panel is composed of an attorney, a health care provider, and a lay citizen.
>
> Patient understands in signing an Arbitration Agreement patient is choosing to resolve any medical malpractice dispute by arbitration rather than in the courts.
>
> Patient understands that if he/she decides to revoke the Arbitration Agreement, patient must do so within 60 days of discharge (or from date of signing for emergency/outpatient admissions).
>
> Patient understands that the decision of the arbitration panel is final and binding on all parties except in rare circumstances.

208. SUMMARY REPORT, *supra* note 69, at 32, 33, revealed that people do not yet fully understand the arbitration system. Consequently, it is essential for the legislature to inform the state residents about arbitration so that people will feel comfortable with the concept when they are confronted with an arbitration form prior to receiving health care treatment.

malpractice disputes.[209] It also is more effective than caps and sliding fee scales, and will lessen the burden on the court system.

The arbitration provision in New York's new legislation is a step in the right direction in resolving their medical malpractice crisis. However, to maximize the effectiveness of the legislation, the arbitration provision should be expanded to cover any patient who signs an arbitration agreement prior to receiving health care. In addition, a member of the health care profession should be included on the panel. Although these amendments to the new legislation may invite constitutional and other challenges, these adjustments are necessary for an effective arbitration system. Moreover, the Michigan courts have successfully dealt with such challenges and will, therefore, provide the New York courts with persuasive authority as to the validity of the proposed amendments. These recommendations will assist in establishing a more effective arbitration statute to alleviate the medical malpractice crisis in New York State.

Karen R. O'Brien

209. *See supra* text accompanying notes 68-70.