

UNINTENDED SIDE EFFECTS: ARBITRATION AND THE DETERRENCE OF MEDICAL ERROR

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As many as 98,000 people die each year as a result of medical error. According to law and economics scholars, the solution to this problem is straightforward: When calibrated correctly, medical malpractice liability will force healthcare providers to internalize the cost of their negligence, incentivizing improvements to patient safety that will reduce medical error. Debate has raged for decades over the coherence of deterrence theory, but little attention has been paid to the erosion of one of its bedrock assumptions: that the procedural mechanism through which claims are to be resolved is litigation. Arbitration has become pervasive in the healthcare context, but its effects on medical malpractice liability's ability to deter medical error have been largely overlooked by public health and legal scholars. This Note argues that the adoption of arbitration will not, as law and economics scholars assume, improve the medical malpractice regime's ability to deter error. In addition to drawing on existing law and economics and public health scholarship to advance this descriptive claim, this Note studies the experience of Kaiser Permanente, the nation's largest integrated healthcare consortium, in using arbitration to resolve medical malpractice disputes with its seven million members in California.

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INTRODUCTION

In recent years physicians have been encouraging—and sometimes forcing—patients to sign arbitration agreements before providing medical care.¹ These agreements, which often come buried in a stack of medical releases or embedded in complex health plan documents,² require patients to waive their right to jury trial and submit any medical malpractice claim to binding arbitration.³ Critics have

¹ See Kenneth A. DeVille, *The Jury Is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims: Law, Ethics, and Prudence*, 28 J. LEGAL MED. 333, 334, 336 (2007) (“Arbitration agreements ordinarily, but not always, state that completion of the form is not a precondition to treatment.”). Although most healthcare providers who use predispute agreements to arbitrate medical malpractice claims still render service if a patient refuses to sign the arbitration clause, there are exceptions. First Professionals Insurance Company, a professional liability insurer based in Florida, has required patients to sign an arbitration clause as a precondition to receiving medical care since 2004. See Adam S. Levine, *I Need a Lawyer to See My Doctor: Pre-Treatment Mandatory Arbitration Agreements as a Condition Precedent to Receiving Medical Care in Florida*, ABA HEALTH eSOURCE (ABA Health L. Sec., Chi., Ill.), Oct. 2010, available at http://www.americanbar.org/newsletter/publications/aba_health_esource_home/Volume7_02_levine.html. In 2003, the Utah legislature amended a state statute governing medical malpractice arbitration to allow healthcare providers to require patients to sign an arbitration agreement as a precondition to nonemergency care. James C. Dunkelberger, Comment, *Between a Rock and a Hard Place: The Plight of Health Care Arbitration Agreements Under Federal Law*, 2010 B.Y.U. L. REV. 1869, 1877. Following public outcry, the statute was amended in 2004 to remove that provision. *Id.*

² See DeVille, *supra* note 1, at 336 (noting that patients are often presented preprinted arbitration agreements that are attached or incorporated into other forms); see also Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 LAW & CONTEMP. PROBS. 153, 154 (1997) (“[Predispute arbitration agreements] take the form of language embedded in health plan contracts with purchasers and enrollees, and of specific contracts presented to patients by hospitals and physicians at the outset of the relationship.”).

³ Cf. CAL. CIV. PROC. CODE § 1295 (West 2007) (requiring that predispute agreements to arbitrate medical malpractice claims include notice in red, ten-point font that the patient relinquishes their right to jury trial and agrees to submit any medical malpractice claim to binding arbitration).

long contended that these so-called “pre-dispute arbitration agreements” force patients to contract away important rights in a moment of vulnerability and should not be enforced.⁴ But enthusiasm for medical malpractice arbitration has carried the day. Thirteen states have enacted statutes that recognize the validity of medical malpractice arbitration clauses,⁵ and state courts have shown an ever-increasing

⁴ As a baseline, critics of medical malpractice arbitration agreements object to the perennial problems of bargaining power differentials and mutual assent that plague most consumer contracts. *See, e.g.*, Engalla v. Permanente Med. Grp., Inc., 938 P.2d 903, 926–27 (Cal. 1997) (Kennard, J., concurring) (noting that for consumers, often the only choice is to either accept an arbitration agreement or foreclose the transaction entirely). Although courts may be willing to accept contractual terms that affect one party’s negligence liability in recreational activities, they are wary of doing so in an area considered to be a public service—and particularly, perhaps, in an area that implicates bodily integrity and other cases “affected with a public interest.” *See* Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 444–45 (Cal. 1963) (en banc) (noting courts’ reluctance to approve clauses exculpating parties from liability where those parties provide “a service of great importance to the public, which is often a matter of practical necessity for some members of the public”).

Evidencing the ambivalence surrounding the use of arbitration clauses in this context, the American Arbitration Association (AAA) announced in March 2002 that it would no longer allow its arbitrators to handle claims brought by patients against managed care providers if they originated from predispute arbitration clauses. Charles Ornstein, *Health Care Disputes at Issue*, L.A. TIMES (Mar. 11, 2002), <http://articles.latimes.com/2002/mar/11/local/me-hmo11>. The National Arbitration Forum followed suit in 2009, halting arbitration of all consumer cases—including medical disputes—after reaching a settlement with Minnesota’s attorney general over its arbitration practices in consumer credit card arbitrations. Paul Bland, *Representing the Elderly: Fighting Mandatory Arbitration Clauses*, 48 TRIAL 22, 24 (2012); *see also* Robin Sidel & Amol Sharma, *Credit Card Disputes Tossed Into Disarray*, WALL ST. J., July 22, 2009, at A1 (exploring the possible implications of the American Arbitration Association and National Arbitration Forum’s decisions to stop accepting new matters related to arbitration clauses between consumers and their credit card and cellphone companies). Explaining its policy shift in an interview with the Los Angeles Times, the AAA drew a distinction between healthcare claims and other types of legal disputes: “Nothing is more emotional or personal or devastating than a health care problem. . . . If you buy a lemon car, it’s not life or death. It’s not a medical problem. That’s what puts this on a higher playing field.” Ornstein, *supra* (quoting Robert E. Meade, Senior Vice President of the AAA). Some commentators have disputed whether the AAA has stuck to this decision. *See* Paul Bland, *American Arbitration Association Breaks Its Promise Not to Hear Pre-Dispute Arbitrations in Health Care Cases*, TORTDEFORM (Feb. 22, 2007, 12:35 PM), http://www.tortdeform.com/archives/2007/02/american_arbitration_as_sociati.html (arguing that the AAA had continued to resolve arbitration disputes in spite of its announcement that it would no longer handle such types of cases).

⁵ ALA. CODE § 6-5-485 (2005); ALASKA STAT. § 09.55.535 (2012); CAL. CIV. PROC. CODE § 1295 (West 2007); COLO. REV. STAT. § 13-64-403 (2013); 710 ILL. COMP. STAT. 15/1 to 15/14 (2013); LA. REV. STAT. ANN. §§ 9:4230–4236 (2009); MICH. COMP. LAWS § 600.2912g (2013); N.Y. PUB. HEALTH LAW § 4406-a (McKinney 2012); OHIO REV. CODE ANN. §§ 2711.21–23 (West 2006); S.D. CODIFIED LAWS § 21–25B (2004); UTAH CODE ANN. § 78B-3-421 (West 2009); VA. CODE ANN. § 8.01-581.12 (2004). In Vermont, patients may enter into arbitration agreements only once they are aware of their potential claims. VT. STAT. ANN. tit. 12, § 7002 (2009). New York and Florida allow for *postdispute* agreements to arbitrate damages where the defendant has admitted negligence. FLA. STAT. § 766.207 (2013); N.Y. C.P.L.R. 3045 (McKinney 2010). Florida’s *postdispute* arbitration statute is

willingness to enforce such clauses.⁶ This solicitude for medical malpractice arbitration has even reached the Supreme Court, which extended the ambit of its arbitration-friendly jurisprudence in *Marmet Health Care Center v. Brown* to protect arbitration clauses capturing medical malpractice claims.⁷

Given persistent angst over the cost of medical care in the United States,⁸ it is unsurprising that medical malpractice arbitration—assumed by many to provide a cheaper and more accurate alternative

notable in that it serves functionally as a noneconomic damages cap. If the defendant is willing to admit negligence after a “presuit investigation” and offers to arbitrate damages, then noneconomic damages recoverable by the plaintiff are capped at \$250,000. FLA. STAT. § 766.207. If the plaintiff declines the defendant’s offer to arbitrate, noneconomic damages recoverable at trial are capped at \$350,000. *Univ. of Miami v. Echarte*, 618 So. 2d 189, 193 (Fla. 1993). Where the defendant does not admit liability and the parties proceed to trial, recovery is only limited by a cap on punitive damages. See FLA. STAT. § 768.73 (2013) (presuming punitive damages in excess of either three times the plaintiff’s compensatory damages or \$500,000 to be unreasonable, with the presumption rebuttable by clear and convincing evidence that the amount is not excessive).

⁶ See, e.g., *Engalla*, 938 P.2d at 925 (reaffirming the enforceability of predispute agreements to arbitrate medical malpractice claims despite remanding to the trial court for a determination of whether the specific agreement in question could be voided based on a promissory fraud theory); *Buraczynski v. Eyring*, 919 S.W.2d 314, 316 (Tenn. 1996) (rejecting the argument that arbitration agreements between physicians and patients are categorically void on unconscionability grounds and finding the specific agreement in question not unconscionable even though it was a contract of adhesion); see also *Franks v. Bowers*, 116 So. 3d 1240, 1241–42, 1248 (Fla. 2013) (reaffirming the role of arbitration in “lower[ing] the costs of medical care” in Florida but voiding a clause limiting damages on the grounds that it contravened the public policy purposes animating Florida’s statutory scheme for medical malpractice arbitration).

⁷ 132 S. Ct. 1201 (2012) (per curiam) (reversing the West Virginia Supreme Court of Appeals’s decision that predispute agreements to arbitrate tort claims arising from nursing home contracts were per se unconscionable and holding that the decision’s rule was preempted by the Federal Arbitration Act). In *Marmet*, the Court made clear that its earlier decision in *AT&T Mobility LLC v. Concepcion*, 131 S. Ct. 1740 (2011), which rejected an unconscionability challenge to an arbitration clause that included a class action waiver, made no exception for claims sounding in tort, reaffirming the “emphatic federal policy in favor of arbitral dispute resolution.” *Marmet*, 131 S. Ct. at 1203 (quoting *KPMG LLP v. Cocchi*, 132 S. Ct. 23, 25 (2011)). Nevertheless, the *Marmet* Court acknowledged that the plaintiffs could argue that the particular clause at issue was unconscionable under state law as long as they did not rely on a “categorical” rule against predispute agreements capturing medical malpractice claims. *Id.* at 1204. The Court thus remanded to the West Virginia Supreme Court of Appeals for a determination of whether “the arbitration clauses in Brown’s case and Taylor’s case are unenforceable under state common law principles that are not specific to arbitration and pre-empted by the [Federal Arbitration Act].” *Id.* at 1204.

⁸ See, e.g., Atul Gawande, *The Cost Conundrum*, NEW YORKER, June 1, 2009, at 36, available at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all (documenting the high cost of healthcare in a small Texas town and explaining how for-profit hospitals can drastically drive up these costs); Elisabeth Rosenthal, *As Hospital Prices Soar, Single Stitch Tops \$500*, N.Y. TIMES, Dec. 3, 2013, at A1 (exploring the high cost of healthcare in the United States and some of the possible causes).

to litigation—has attracted such widespread legislative and judicial support. When California passed legislation expressly recognizing the enforceability of medical malpractice arbitration clauses,⁹ state legislators trumpeted the cost savings and increased decisionmaking accuracy that arbitration would bring the state's healthcare system.¹⁰ These dual rationales continue to drive adoption of medical malpractice arbitration, and professional liability insurers have renewed a push in the last decade to encourage doctors to employ arbitration clauses in their practices.¹¹

This Note does not address the normative question of whether medical malpractice arbitration clauses should be enforced, which has become all but moot in the wake of the Supreme Court's decision in *Marmet*.¹² Instead, it asks a question that has received scant attention in the academic literature—namely, what effect the increasing use of arbitration will have on medical malpractice liability's primary goal: the deterrence of medical error. Law and economics scholars have theorized that arbitration's oft-touted cost and accuracy gains generally improve a legal regime's ability to effectuate its deterrence goals, but this Note takes a more skeptical view, at least in the medical malpractice context. Drawing in part on an examination of the arbitration system used by Kaiser Permanente—a massive integrated healthcare

⁹ CAL. CIV. PROC. CODE § 1295 (West 2007).

¹⁰ In the words of California's governor at the time, arbitration's informal procedures and lack of appeals would "quickly and fairly resolve malpractice claims," reducing the time and cost incurred by litigants. Gross v. Recabaren, 253 Cal. Rptr. 820, 822 (Ct. App. 1988) (internal quotation marks omitted); see also Rosenfield v. Superior Court of L.A. Cnty., 191 Cal. Rptr. 611, 614 (Ct. App. 1983) (explaining that the elimination of juries would avoid "high jury awards" that were thought to inflate malpractice insurance premiums and limit health care availability); Duane H. Heintz, *Arbitration of Medical Malpractice Claims: Is It Cost Effective?*, 36 MD. L. REV. 533, 534–35 (1977) (listing rationales for the use of arbitration to resolve medical malpractice disputes).

¹¹ In 2008, First Professionals Insurance Company (FPIC), a professional liability insurer based in Florida, conveyed to its insureds that arbitration results in time savings as well as "lower indemnity payments" due to "an arbitration panel that, relative to a jury pool, will likely make a more well-reasoned and educated decision based upon the medical facts of the case." Levine, *supra* note 1 (quoting a newsletter sent by FPIC to its insureds explaining the benefits of arbitration). Similarly, The Doctors Company (Doctors), has begun encouraging its members to adopt the use of predispute arbitration agreements in their medical practices, trumpeting arbitration's ability to save time and money spent resolving legal claims and to reduce the risk of "runaway jury awards"; Doctors noted that "in some cases arbitration has proven to be faster, more flexible and efficient, and it can result in a more predictable outcome." Robin Diamond, *Tips for Implementing Contractual Arbitration in California Practices*, THE DOCTORS COMPANY, http://www.thedoctors.com/KnowledgeCenter/PatientSafety/CON_ID_006332 (last visited Oct. 24, 2014).

¹² See *supra* note 7 and accompanying text (noting the Court's rejection of state efforts to categorically cabin the use of arbitration clauses).

consortium¹³—to resolve medical malpractice disputes with its seven million members in California, this Note argues that medical malpractice arbitration’s theoretical benefits are accompanied in practice by a host of inefficiencies that threaten to undermine the regime’s ability to deter medical error.

In making the descriptive claim above, this Note seeks to fill a gap in the existing academic literature. Perhaps as many as 98,000 people die each year from medical error,¹⁴ and a heated debate has raged for decades amongst legal and public health scholars over whether medical malpractice liability is successful in keeping that number as low as possible.¹⁵ What has been overlooked in this debate, however, is the erosion of a basic assumption about our medical malpractice regime: that the procedural mechanism through which claims are to be resolved is litigation. Indeed, confronted with the increasingly prevalent use of arbitration to resolve medical malpractice disputes,¹⁶ most scholars have skirted the significance of this shift, dismissing the increasing use of arbitration as a purely procedural change with no effect on substantive outcomes¹⁷ or discussing poten-

¹³ See Reed Abelson, *The Face of Future Health Care*, N.Y. TIMES, Mar. 21, 2013, at B1 (“[Kaiser has] some \$50 billion in annual revenue, owns 37 hospitals and employs 17,000 doctors, all on salary.”).

¹⁴ COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn et al. eds., 1999), available at http://www.nap.edu/openbook.php?record_id=9728.

¹⁵ See, e.g., David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 896–900 (2005) (exploring whether an increased risk of medical malpractice claims causes the quality of healthcare to improve or decline); Michelle M. Mello & Troyen A. Brennan, *Deterrence of Medical Errors: Theory and Evidence for Malpractice Reform*, 80 TEX. L. REV. 1595, 1602–03 (2002) (evaluating the theory of tort deterrence and its impact on costs and savings for insurance providers); Gary T. Schwartz, *Reality in the Economic Analysis of Tort Law: Does Tort Law Really Deter?*, 42 UCLA L. REV. 377, 397–405 (1994) (considering whether tort rules can be used to deter medical malpractice).

¹⁶ A 1997 study found that 9% of California healthcare providers used arbitration clauses covering medical malpractice claims. Rolph et al., *supra* note 2, at 171. While no empirical studies have been conducted since, there are structural reasons to believe that this figure is now significantly higher. With the Supreme Court’s ruling in *Marmet*, ambiguity over judicial acceptance of arbitration clauses in the medical malpractice context has decreased significantly. See *supra* note 7 and accompanying text (explaining how the *Marmet* holding reemphasized the federal preference for arbitral dispute resolution). And institutional actors—namely, professional liability insurers and managed care organizations—have begun pushing their insureds to utilize such clauses. For media reports indicating an increase in the use of medical malpractice arbitration, see Michelle Andrews, *For Patients, Unpleasant Surprises in Arbitration*, N.Y. TIMES, Mar. 16, 2003, at BU8; Jane Musgrave, *More Doctors Avoid Jury Trials, Require Arbitration Agreement*, PALM BEACH POST, May 27, 2012, at A1, available at <http://www.palmbeachpost.com/news/business/more-doctors-avoid-jury-trials-require-arbitration/nPKgx/>.

¹⁷ See, e.g., Richard A. Epstein, *Medical Malpractice, Imperfect Information, and the Contractual Foundation for Medical Services*, 49 LAW & CONTEMP. PROBS. 201, 205, 209–10

tial effects in only a cursory manner.¹⁸ And while law and economics scholars have analyzed arbitration and its implications for deterrence at a high level, those scholars have not grappled with the issues particular to medical malpractice.¹⁹

Part I of this Note presents the argument advanced by law and economics scholars that a shift from litigation to arbitration generally will result in a stronger deterrence regime due to arbitration's lower cost and increased decisionmaking accuracy. Part I applies this theory to medical malpractice arbitration and demonstrates how certain inefficiencies that plague medical malpractice litigation could be alleviated—at least in theory—by a procedural mechanism that imposes liability at lower cost and with increased accuracy.

Starting from this theoretical baseline, Part II argues that deterrence is not in fact served by the introduction of arbitration in the medical malpractice context. The framework introduced in Part I cannot adequately capture behavior in the medical malpractice context because it relies on the assumption that information asymmetry and differentials in bargaining power do not distort the contracting process. This assumption does not hold true in the medical malpractice context, which is fatal to the theory's application. The cost savings and increased accuracy promised by medical malpractice arbitration are elusive. Theoretical cost benefits are lost to arbitration's unique cost structure and the reluctance of plaintiffs' attorneys to offer contingency fee arrangements in the arbitration context. Accuracy, in turn, is undermined by problems with repeat play; the susceptibility of

(1986) ("Here, one can think of three distinct subjects that such contracts might address. . . . [T]he third, the choice of a forum for resolving disputes, concerns procedure.").

¹⁸ See, e.g., Jennifer Arlen, *Contracting over Liability: Medical Malpractice and the Cost of Choice*, 158 U. PA. L. REV. 957, 962 n.12 (2010) ("Courts also now enforce clauses requiring mandatory arbitration of medical claims; these clauses affect expected liability."); Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, 49 LAW & CONTEMP. PROBS. 143, 167 (1986) ("[A]n arbitration clause can affect substantive outcomes and cannot be entirely differentiated from other contractual modifications of the parties' rights and duties."); see also Daniel P. Kessler, *Evaluating the Medical Malpractice System and Options for Reform*, 25 J. ECON. PERSP. 93, 103 (2011) ("There is a surprising lack of recent empirical evidence about the effects of binding alternative dispute resolution, especially in the realm of medical malpractice, although early work . . . offer[s] empirical examinations of arbitration and mediation more broadly.").

¹⁹ See Keith N. Hylton, *Agreements to Waive or to Arbitrate Legal Claims: An Economic Analysis*, 8 SUP. CT. ECON. REV. 209 (2000) (discussing issues particular to arbitration in the consumer and employment contracting contexts); Steven Shavell, *Alternative Dispute Resolution: An Economic Analysis*, 24 J. LEGAL STUD. 1 (1995) (analyzing arbitration's implications for deterrence using "stylized models of parties' behavior").

arbitration to manipulation in the managed care context; and the lack of meaningful judicial review, which would otherwise rein in inaccurate judgments. Further, these concerns are not merely theoretical; they have in fact arisen in Kaiser Permanente's use of binding arbitration to resolve medical malpractice disputes with its seven million members in California.

Finally, Part III, drawing on the Kaiser case study, suggests reforms to medical malpractice arbitration that would increase medical malpractice liability's ability to deter medical error.

I

THE LAW AND ECONOMICS ACCOUNT: ARBITRATION IMPROVES DETERRENCE

Although public health and legal scholars studying medical malpractice liability have largely ignored arbitration's implications for deterrence, existing law and economics scholarship provides a starting point. Conventional law and economics wisdom holds that a shift from litigation to arbitration generally will result in an improved deterrence regime due to efficiencies that flow from arbitration's decreased cost and increased accuracy. In the abstract, this theory seems to apply to the medical malpractice context. Part I.A details problems facing the current medical malpractice regime and focuses on litigation inefficiencies that frustrate the regime's ability to effectuate its primary goal: deterring medical error. Part I.B draws on existing law and economics scholarship and develops the theoretical argument that a shift to arbitration would have a salutary effect on the medical malpractice regime's ability to deter medical error.

A. *Medical Malpractice Liability's Imperfect Deterrent Signal*

Although the imposition of medical malpractice liability historically has been justified by theories of compensation and retribution, the dominant modern theory is deterrence based.²⁰ Whereas theories of compensation and retribution aim to redress the individual harms to a victim of medical malpractice, a deterrence-based view takes a more systemic approach and uses tort liability as a means to reach the optimal level of accidents across society.²¹ Under a deterrence theory of medical malpractice, liability forces healthcare providers to bear

²⁰ See, e.g., Mello & Brennan, *supra* note 15, at 1603 ("For law-and-economics scholars, deterrence is the primary rationale for torts, easily outstripping corrective justice and compensation. The costs of litigation create an incentive to take safety precautions.").

²¹ See JENNIFER ARLEN, *Economic Analysis of Medical Malpractice Liability and Its Reform*, in RESEARCH HANDBOOK ON THE ECONOMICS OF TORTS 33, 36–39 (2013) (providing an overview of the deterrence theory of medical malpractice liability).

the cost of their tortious conduct and incentivizes them to make cost-effective investments in patient safety, thereby reducing medical error system-wide.²²

Academics uniformly acknowledge, however, that medical malpractice liability is not as effective in deterring medical error as it could be, in large part due to problems with the litigation regime through which medical malpractice liability is funneled.²³ These litigation-related inefficiencies—in addition to other features of the medical malpractice regime beyond the scope of this Note²⁴—hamper medical malpractice liability’s ability to optimally deter medical error, and they allow healthcare providers to escape the full cost of their patients’ injuries, thus underincentivizing investments in patient safety.

In particular, scholars studying medical malpractice liability have identified three procedural inefficiencies that hamper optimal deterrence of medical error. First, medical malpractice litigation imposes significant costs on the litigants because it requires extensive discovery periods and reliance on expert witnesses. A 2006 study published in the *New England Journal of Medicine* found that an average of five

²² See Mello & Brennan, *supra* note 15, at 1602–03.

²³ See, e.g., Arlen, *supra* note 18, at 960 (stating that medical malpractice liability is “not as effective as it could be” and detailing the different approaches that have been suggested to improve the process); Mello & Brennan, *supra* note 15, at 1616–23 (exploring the different factors that might be clouding the deterrent signals that should otherwise result from malpractice claims).

²⁴ This Note does not discuss two commonly cited factors that dull medical malpractice liability’s efficacy as a deterrent—liability insurance and statutory damages caps—because they do not relate to the procedural mechanism through which liability is assessed and thus cannot be remedied by a shift from litigation to arbitration or vice versa. These are nonetheless crucial, nonprocedural factors affecting medical malpractice liability’s ability to deter medical error. Professional liability insurance, for example, generally does not inhibit deterrence in contexts outside medical malpractice, but scholars argue that medical malpractice insurance, unlike other common forms of professional liability insurance, is not “experience-rated” and thus thwarts deterrence objectives. Mello & Brennan, *supra* note 15, at 1616. Experience-rated insurance policies calculate their premiums partially on the basis of the policyholder’s past claims. KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION: CASES AND MATERIALS 7 (5th ed. 2010). But because it is widely believed to be impossible or highly difficult to experience-rate medical malpractice insurance policies, medical malpractice insurance is generally not experience-rated—meaning that doctors do not see their individual premiums fluctuate on the basis of their accident history, minimizing the direct financial repercussions of errors and thereby reducing the incentive to exercise care. See Mello & Brennan, *supra* note 15, at 1616–17 (explaining the difficulty of experience-rating medical malpractice insurance policies). Statutory caps, in turn, are considered by some scholars to artificially constrain the medical malpractice regime’s ability to set optimal liability levels where the appropriate level of damages would be barred under a damages cap. See, e.g., ARLEN, *supra* note 21, at 55 (arguing that traditional and politically popular reforms, including damage caps, don’t just fail to fix the problems associated with our current tort system but can actually harm patients with legitimate claims).

years elapsed between injury and final resolution of a medical malpractice claim and that one-third of cases took more than six years to resolve.²⁵ Further, the total costs of litigating claims—taking into account defense costs and the contingency fees charged by plaintiffs' attorneys—were equivalent to 54% of the compensation ultimately paid to plaintiffs.²⁶ Second, medical malpractice violations are under-enforced. Few people who are victims of medical malpractice actually bring suit, either because they choose not to assert their claim or because they do not realize that it is viable.²⁷ For example, an examination of 30,121 patient records in New York found that in 1984 only 1.53% of patients with a viable malpractice claim brought suit.²⁸ Finally, even when plaintiffs do come forward with claims, scholars argue that courts and juries cannot determine which claims are meritorious due to the complex, technical questions at issue in medical malpractice litigation.²⁹ This can lead to windfall awards for plaintiffs who have not been injured negligently and underpayment for those who have been.³⁰

Critics argue that these inefficiencies combine to weaken the medical malpractice regime and hamper its ability to deter medical error. Due to underenforcement, the regime does not force healthcare providers to internalize the full costs of their negligent acts, giving them a suboptimal incentive to invest in patient safety.³¹ The high cost

²⁵ David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024, 2031 (2006).

²⁶ *Id.*

²⁷ See Mello & Brennan, *supra* note 15, at 1618 (noting that research indicates that most instances of medical negligence never result in a malpractice claim by the patient); see also A. Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence—Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 248 (1991) (detailing efforts to quantify at what rate victims of medical malpractice bring claims).

²⁸ Localio et al., *supra* note 27, at 248.

²⁹ See Mello & Brennan, *supra* note 15, at 1619 (explaining that in one multivariate study, the presence of negligence was not a statistically significant predictor for the outcome of the trial).

³⁰ Cf. Studdert et al., *supra* note 25, at 2031 (concluding that underpayment for legitimate claims is more common than payment for meritless claims).

³¹ Law and economics scholars have provided a theoretical solution to this problem: Where underdetection of a certain category of claims is common, punitive damages can compensate. Under such a conception, punitive damages should be awarded not to punish particularly reprehensible behavior, but instead to achieve full deterrence. Specifically, they should be determined by multiplying the monetary harm by the rate of detection of the category of such claims. See A. Mitchell Polinsky & Steven Shavell, *Punitive Damages: An Economic Analysis*, 111 HARV. L. REV. 869, 889–90 (1998) (equating the rate of detection to the ratio between the defendant's chance of avoiding liability and chance of being held liable). In reality, however, punitive damages are rarely awarded in the medical malpractice context, and some states have specifically enacted limits on punitive damages

of litigation not only contributes to this underenforcement problem—at least to the extent that parties are deterred from pursuing meritorious claims due to litigation costs—but also raises the overall cost of obtaining deterrence.³² Like high litigation costs, defects in decisionmaking accuracy compound the problem by allowing health-care providers to avoid fully internalizing the cost of their errors, and by injecting a degree of uncertainty into the litigation process that may itself result in excessive care by risk-averse healthcare providers.³³

B. Arbitration's Potential Ameliorative Effects for Deterrence Regimes

Law and economics scholars—most prominently Steven Shavell and Keith Hylton—have theorized that a shift to arbitration generally will have a salutary effect on a legal regime's deterrent function.³⁴ Shavell and Hylton have not specifically addressed the medical malpractice context, but they each argue that when parties voluntarily enter into predispute arbitration agreements—assuming, importantly, that the parties do not suffer from information asymmetry, an issue that Part II.A, *infra*, will address—arbitration offers decreased cost and increased accuracy over a relatively inefficient litigation regime.³⁵ These cost and accuracy gains, in turn, generate a cluster of related

in medical malpractice cases. Catherine M. Sharkey, *Unintended Consequences of Medical Malpractice Damages Caps*, 80 N.Y.U. L. REV. 391, 415 & n.99, 417 n.110 (2005).

³² Cf. William M. Sage, *Medical Malpractice Insurance and the Emperor's Clothes*, 54 DEPAUL L. REV. 463, 480 (2005) (noting that the length of time it takes to resolve medical malpractice disputes contributes to the difficulty of properly pricing professional liability insurance).

³³ See, e.g., Ronen Avraham, *Putting a Price on Pain-and-Suffering Damages: A Critique of the Current Approaches and a Preliminary Proposal for Change*, 100 NW. U. L. REV. 87, 95–96 (2006) (detailing warranted and unwarranted variance in pain-and-suffering awards and how it affects choices of individuals); Mark Geistfeld, *Placing a Price on Pain and Suffering: A Method for Helping Juries Determine Tort Damages for Nonmonetary Injuries*, 83 CALIF. L. REV. 773, 786–87 (1995) (noting that uncertainty results in underdeterrence and overdeterrence, both of which have negative consequences on both sides of the medical malpractice issue). But see Tom Baker et al., *The Virtues of Uncertainty in Law: An Experimental Approach*, 89 IOWA L. REV. 443, 478–79 (2004) (arguing that unpredictability can be manipulated to amplify deterrence in areas where detection is difficult).

³⁴ See Hylton, *supra* note 19, at 229, 259 (discussing arbitration's positive effect on deterrence due to a variety of factors, including lower costs and increased decisionmaking accuracy); Shavell, *supra* note 19, at 19–20 (discussing the effects of arbitration on risk aversion).

³⁵ Hylton, *supra* note 19, at 229; Shavell, *supra* note 19, at 5–6.

efficiencies that increase a legal regime's ability to effectuate its deterrence goals.³⁶

How so? First, an increase in decisionmaking accuracy improves the incentives of the parties to the arbitration agreement to exercise the optimal standard of care. In situations where courts and juries have difficulty detecting departures from the relevant standard of care, parties to a contract may elect to resolve their disputes via an expert arbitrator who is more knowledgeable about the standard of care in a given industry.³⁷ Because departures from the standard of care are more likely to result in liability for the parties under an arbitration regime, the parties have greater incentive to exercise the proper standard of care than they would have under a litigation regime.³⁸

Second, where parties are risk-averse, increased decisionmaking accuracy sharpens deterrence by reducing uncertainty.³⁹ Under a litigation regime where decisionmaking error is common, risk-averse parties will pay a premium to avoid the risk of liability—say, by investing in excessive precautions based on the specter of a runaway jury award.⁴⁰ By reducing the uncertainty over whether decisionmaking error will result in excessive liability, an arbitration regime eliminates the excess cost that risk-averse parties otherwise would bear in a litigation regime.⁴¹

Third, reducing the transaction costs involved in resolving claims helps ameliorate the problem of underenforcement. In contexts such as medical malpractice, many parties are able to escape liability because not all parties who have been injured ultimately decide to bring suit.⁴² To the extent that this problem is caused by underenforcement rather than underdetection, reducing the costs of bringing suit may incentivize a larger number of potential plaintiffs to

³⁶ See Shavell, *supra* note 19, at 5–8 (discussing benefits of arbitration, including reductions in risk and disputes, improvements in incentives to perform, and increased social welfare).

³⁷ See *id.* at 6 (illustrating how arbitrators may be better at discerning substandard contractual performance).

³⁸ See *id.* (positing that increased decisionmaking accuracy would result in higher likelihood of liability).

³⁹ *Id.* at 5.

⁴⁰ See *id.* (arguing that rational parties want to avoid unreliable jury verdicts); see also *supra* note 33 and accompanying text (discussing negative effects, including overdeterrence, caused by uncertainty and decisionmaking error in litigation).

⁴¹ Shavell, *supra* note 19, at 4–5.

⁴² See *supra* notes 27–28 and accompanying text (discussing in what proportion and for what reason patients do not sue).

enforce their claims and in turn force tortfeasors to internalize a fuller proportion of the costs caused by their conduct.⁴³

Finally, the decrease in transaction costs resulting from arbitration's relatively informal, expedient procedures allows claims to be resolved with less time and expense and provides deterrence at a lower cost to the parties and the system.⁴⁴

Thus, in theory, a shift from litigation to arbitration could ameliorate the procedural inefficiencies identified in medical malpractice litigation: inaccurate decisionmaking, excess litigation costs, and underenforcement of claims. By increasing accuracy and decreasing cost, the shift to arbitration theoretically improves the incentives of the parties to abide by their end of the contract, reduces uncertainty created by litigation risk, and ensures fuller enforcement of potential claims—all at lower cost to parties. Whether these benefits are likely to materialize in practice is the focus of the next Part of this Note.

II

MEDICAL MALPRACTICE ARBITRATION IN PRACTICE: ELUSIVE DETERRENCE GAINS

As is evident from Part I, law and economics scholars have discussed arbitration and its effect on deterrence in highly stylized terms, taking almost for granted that a switch to arbitration leads to lower costs, increased accuracy, and, therefore, a more efficient deterrence regime. In practice, however, it is far from clear that these benefits will materialize in the medical malpractice context. To substantiate this claim, this Part makes two primary arguments—one theoretical and one empirical. First, Shavell's and Hylton's theoretical models are unable to fully explain behavior in the medical malpractice context because they both rely on the premise that the parties to the contracting process have equal access to information. Second, a close examination of how medical malpractice arbitration has actually been carried out in the United States suggests that its vaunted cost and accuracy benefits are elusive in reality. Existing public health and legal scholarship, as well as a case study of Kaiser Permanente's arbitration system, under which over seven million California residents are required to arbitrate medical malpractice claims,⁴⁵ support this argument. These data points illustrate problematic aspects of medical malpractice arbitration that are unanticipated in the theoretical

⁴³ See Shavell, *supra* note 19, at 7, 21 (discussing the beneficial effect of ex ante arbitration agreements on the frequency of disputes).

⁴⁴ See *id.* at 5, 21 (concluding that the lower cost of arbitration is a major reason, if not the main one, why arbitration is better than litigation).

⁴⁵ See *infra* notes 86–87 and accompanying text.

framework and potentially harmful to arbitration's ability to lower cost and increase accuracy.

Part II.A analyzes how the problem of information asymmetry in healthcare contracting affects the applicability of Shavell's and Hylton's theories to medical malpractice arbitration. Part II.B details factors endemic to medical malpractice arbitration that suggest that the cost and accuracy gains commonly attributed to arbitration may be difficult to obtain in the medical malpractice context. Part II.C grounds these claims in empiric reality and uses a case study of Kaiser Permanente to illustrate how these concerns have materialized in one particular context. Finally, Part II.D explores the efficacy of medical malpractice arbitration in deterring medical error when the lack of accuracy and cost gains are taken into account.

A. An Incomplete Theoretical Framework: The Problem of Information Asymmetry in Healthcare Contracting

At first blush, the proposition that arbitration would have a negative impact on the deterrent effect of medical malpractice liability seems to run contrary to the model introduced by Shavell and Hylton. Their model predicts that cost and accuracy benefits will surface whenever parties voluntarily enter into predispute arbitration agreements. According to them, such benefits will materialize because parties will only enter into predispute agreements to arbitrate claims (rather than litigate those claims) when each party stands to gain from the arrangement.⁴⁶ The prediction, however, assumes that information asymmetry and differentials in bargaining power do not affect what otherwise might be a voluntary contract between two rational, utility-maximizing parties. As Shavell notes, the prediction that arbitration leads to cost and accuracy benefits is subject to the "usual qualification[]" that "a party to an agreement [must be] properly informed about relevant information."⁴⁷ Similarly, Hylton includes the caveat that "[t]he basic theory may not hold when one of the parties is misinformed as to the relevant costs and benefits of a waiver or arbitration agreement."⁴⁸

⁴⁶ See Hylton, *supra* note 19, at 213 (noting that parties will prefer arbitration whenever litigation is "wealth-reducing"); Shavell, *supra* note 19, at 5, 8 (noting that parties will adopt arbitration when they expect it will lead to mutual benefits).

⁴⁷ Shavell, *supra* note 19, at 8 ("When parties elect to use ADR, they are both made better off . . . This statement is, of course, subject to the . . . usual qualifications about the desirability of enforcement of any agreements. First, it may be that a party to an agreement was not properly informed about relevant information . . .").

⁴⁸ Hylton, *supra* note 19, at 239.

As Jennifer Arlen has argued, patients often do not possess adequate information in the healthcare context to contract in their own best interests.⁴⁹ They often underestimate the risk of becoming ill and the risk of medical error.⁵⁰ Moreover, Arlen argues that healthcare providers can include liability waivers and, ostensibly, arbitration clauses—even if they know that most patients would not contract voluntarily for them—because patients cannot obtain adequate information or do not have a genuine choice in the matter, either because they seek emergency care or a health plan limits their options.⁵¹ Hylton posits that such problems in the consumer contracts context often can be alleviated when representatives of a group of consumers—such as an employer negotiating for a healthcare policy on behalf of a group of employees—engage in the negotiations.⁵² But, even then, information asymmetry and bargaining power differentials may affect contracting. As the California Supreme Court noted in *Engalla v. Permanente Medical Group*, the plaintiff Wilfredo Engalla's employer, “although . . . a corporation of considerable size . . . had only a small number of employees enrolled in Kaiser, and did not have the strength to bargain with Kaiser to alter the terms of the contract.”⁵³ And Engalla, for his part, only had “one other health plan from which to choose” when he was electing insurance plans.⁵⁴

B. *The Reality of Medical Malpractice Arbitration: Elusive Cost and Accuracy Gains*

The conceit that arbitration allows litigants to resolve disputes with less cost and increased accuracy is pervasive in the healthcare context and is one that largely has been taken at face value by healthcare professionals, politicians, and scholars.⁵⁵ But taking a closer look at the realities of medical malpractice arbitration suggests that its effects on cost and accuracy are not as straightforward as advertised.

1. *The Problem of Upfront Costs*

The conventional wisdom as to why arbitration is less costly than litigation is as follows: Whereas traditional litigation imposes high

⁴⁹ ARLEN, *supra* note 21, at 47.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² See Hylton, *supra* note 19, at 254–56 (concluding that agents, such as union representatives, are able to negotiate overall better deals, which may not necessarily benefit every single worker).

⁵³ *Engalla v. Permanente Med. Grp., Inc.*, 938 P.2d 903, 924–25 (Cal. 1997).

⁵⁴ *Id.* at 925.

⁵⁵ Cf. *supra* notes 5–11 and accompanying text (discussing support that arbitration has garnered among courts, legislatures, and liability insurers).

costs on parties seeking to resolve medical malpractice claims, arbitration significantly reduces these costs by abbreviating discovery, relaxing procedural safeguards, and virtually eliminating the possibility of appeal.⁵⁶ This streamlined mechanism for resolving legal claims is supposed to reduce attorney fees and opportunity cost for the parties, which make up a large part of the transaction costs associated with litigation.⁵⁷

Whether these purported benefits do in fact lower the overall cost of resolving medical malpractice claims has not been established with empirical precision.⁵⁸ But even assuming that arbitration has some beneficial effect on overall transaction costs in the medical malpractice context, arbitration nonetheless introduces a problematic set of upfront costs that compromise its ability to deliver its purported cost savings. Aside from the substantial filing fees required for initiating arbitrations, parties to arbitration must pay arbitrator fees, which can balloon quickly with the three-member arbitration panels that are common in medical malpractice arbitration.⁵⁹ Additionally, some arbitration providers require that parties pay a separate fee for every

⁵⁶ See DeVille, *supra* note 1, at 336–39 (comparing theoretical and practical effects of arbitration); see also *supra* note 10 and accompanying text (presenting arbitration’s cost reductions as discussed by legislators, courts, and commentators).

⁵⁷ See *supra* note 10 and accompanying text.

⁵⁸ Compare PUBLIC CITIZEN, THE COSTS OF ARBITRATION 1–3 (2002), available at <http://www.citizen.org/documents/ACF110A.pdf> (arguing that “in the vast majority of cases, arbitration will necessarily increase the transaction costs of litigation” based on lack of competition between arbitration providers, high upfront costs, and small sampling of case studies), with Christopher R. Drahoszal, *Arbitration Costs and Forum Accessibility: Empirical Evidence*, 41 U. MICH. J.L. REFORM 813, 815 (2008) (surveying “limited” empirical evidence available on total cost of arbitration and noting that “definitive conclusions on the comparative cost of arbitration and litigation . . . are difficult to reach”). The proliferation of trial-like procedures in the arbitration setting suggests that the cost of arbitration may be inching toward that of litigation. For example, materials that Kaiser Permanente distributes to pro se claimants in Kaiser medical malpractice arbitration note that proceedings include all of the standard components of traditional discovery—requests for admissions, interrogatories, document production requests, and depositions. OFFICE OF THE INDEP. ADM’R, IF YOU DO NOT HAVE AN ATTORNEY 1–2 (July 3, 2013), available at <http://www.eria-kaiserarb.com/pdfs/pro-per-handout-7-1-13.pdf>. The document also notes that claimants will need medical expert testimony, *id.* at 2 (“Under California law, a medical expert’s testimony is almost always needed to prove medical malpractice. This is true both in arbitration and in court. If you do not have a medical expert, you will probably lose the case.”), as well as other expert testimony to establish damages, *id.* (“[I]f you are asking for lost wages or future damages, you may need an economist or other financial expert to testify. Other experts may be needed depending on the nature of your claims.”).

⁵⁹ DeVille, *supra* note 1, at 370–71; PUBLIC CITIZEN, *supra* note 58, at 1–3. DeVille notes, for example, that “AAA’s initial filing fee schedule ranges from \$2250 for claims between \$75,000 and \$150,000 to \$4000 for claims between \$150,000 and \$300,000,” with arbitrator fees “generally in the range of \$200 to \$600 per hour or higher.” DeVille, *supra* note 1, at 370–71.

motion and request that they make during the proceedings.⁶⁰ These upfront costs vary among arbitration providers,⁶¹ but they do not exist in litigation, where such costs are subsidized by the government.⁶²

Arbitration's upfront costs are particularly problematic in the medical malpractice context because they reduce the benefit that the contingency fee model provides to medical malpractice plaintiffs.⁶³ Contingency fee arrangements, under which attorneys take a cut of the ultimate damage award rather than charge hourly fees, allow potential plaintiffs to pursue claims with few out-of-pocket expenses⁶⁴ and are prevalent in the medical malpractice context. However, the upfront fees required in arbitration reintroduce out-of-pocket costs to the equation and render it more difficult for plaintiffs to pursue claims. Some scholars have posited that clients will pursue arbitration despite these upfront costs because the overall cost of arbitration may still make it a more attractive option than litigation.⁶⁵ This line of argument fails to account for the liquidity concerns and risk aversion

⁶⁰ See DeVille, *supra* note 1, at 371 (noting that National Arbitration Forum charges \$500 for “expedited document hearing,” \$1000 for “expedited participatory hearing,” \$100 for “request for adjournment or time extension,” and \$50 for “objection to request for adjournment”).

⁶¹ See *id.* at 370 (contrasting rates charged by the American Arbitration Association and the National Arbitration Forum).

⁶² Some commentators go as far as to argue that the government subsidy of forum costs in litigation encourages inefficiency because the parties do not fully bear the cost of the litigation. See Shavell, *supra* note 19, at 8 (arguing that subsidizing litigation costs leads to overutilization of courts).

⁶³ See PUBLIC CITIZEN, *supra* note 58, at 65 (“The requirement of a large upfront filing fee and deposit toward arbitrator fees severely restricts, or eliminates, the advantage a consumer has under the contingency fee system.”). But see Christopher R. Drahoszal, *Arbitration Costs and Contingent Fee Contracts*, 59 VAND. L. REV. 729, 734–35 (2006) (arguing that the contingency fee model could in theory be adapted to arbitration, with attorneys advancing upfront costs on behalf of their clients and ultimately billing clients only if their claims are successful). One might also posit that attorneys are less likely to offer contingency fee arrangements in the arbitration context because of a perception—whether grounded in fact or not—that arbitration awards are likely to be lower than those in litigation and therefore a relatively poor investment. Cf. Samuel Estreicher, *Saturns for Rickshaws: The Stakes in the Debate over Predispute Employment Arbitration Agreements*, 16 OHIO ST. J. ON DISP. RESOL. 559, 563–64 (2001) (“The unspoken (yet undeniable) truth is that most claims filed by employees do not attract the attention of private lawyers because the stakes are too small and outcomes too uncertain to warrant the investment of lawyer time and resources.”).

⁶⁴ See PUBLIC CITIZEN, *supra* note 58, at 65 (noting that contingency fees have commonly been referred to as the “poor man’s key to the courthouse”).

⁶⁵ See, e.g., Drahoszal, *supra* note 63, at 734 (“[C]laimants consider the total cost of the dispute resolution process in evaluating whether to bring a claim As an economic matter, then, arbitration costs would preclude claimants from asserting their claims when the expected total costs (not just the upfront costs) of arbitration exceed the expected value of the claim.”).

common to potential plaintiffs,⁶⁶ particularly consumer plaintiffs who are the victims of medical malpractice.⁶⁷

2. *Arbitration's Susceptibility to Bias*

The argument that arbitration yields more accurate decisions than litigation originates from skepticism of generalist judges and juries. Specifically, the argument is that complex issues prevalent in medical malpractice disputes are too complicated for generalist judges to understand.⁶⁸ Juries, for their part, are particularly susceptible to making decisions based on an emotionally inflamed response, thus inflating damages far beyond what a more rational decisionmaker would award.⁶⁹ Under this line of reasoning, expert arbitrators provide what neither generalist judges nor juries can offer: They are less likely to be swayed by emotion and more likely to understand the complex issues at play in the dispute. This produces a “well-reasoned and educated decision based upon the medical facts of the case.”⁷⁰

Like the debate over whether arbitration lowers the overall cost of resolving a medical malpractice claim, whether arbitrators are better equipped than generalist judges and juries to accurately assess the merits of a medical malpractice dispute has not been resolved definitively.⁷¹ Whatever edge arbitrators may have over judges and juries in decisionmaking accuracy, certain features of the arbitration process make it particularly susceptible to bias in favor of defendant

⁶⁶ See *id.* (noting that the argument that arbitration’s upfront costs deter potential medical malpractice plaintiffs from bringing claims is based upon the view that risk aversion and liquidity concerns plague potential plaintiffs).

⁶⁷ See *supra* notes 50–54 and accompanying text (detailing information asymmetry and bargaining power problems that affect medical malpractice plaintiffs).

⁶⁸ Cf. *supra* note 10 and accompanying text (discussing arguments that arbitration improves decisionmaking accuracy).

⁶⁹ Cf. Diamond, *supra* note 11 (counseling doctors on how to transition to arbitration programs to avoid inflated jury awards and other litigation problems); see also *supra* note 10 (discussing the argument that arbitration prevents inflated jury awards, which are common in malpractice litigation).

⁷⁰ Levine, *supra* note 1 (quoting a newsletter sent by FPIC to its insureds explaining the benefits of arbitration); see also *supra* note 10 and accompanying text (discussing the positive effects of arbitration on decisionmaking accuracy).

⁷¹ Compare Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203, 208 (1996) (noting that the perceived benefit of arbitration has long been the use of more qualified decisionmakers), and David Zukher, Note, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will a Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 155–56 (1998) (arguing that arbitrators, due to their experience and subject-area expertise, are better able to deal with complex scientific and medical issues than juries), with Neil Vidmar, *Pap and Circumstance: What Jury Verdict Statistics Can Tell Us About Jury Behavior and the Tort System*, 28 SUFFOLK U. L. REV. 1205, 1205–06 (1994) (attempting to debunk the idea that juries award irrationally large damages to tort plaintiffs).

healthcare providers. These must be considered when assessing the decisionmaking accuracy of an arbitration regime.

Academics studying arbitration outside the medical malpractice context have theorized that arbitration favors parties who use arbitration for multiple cases, such as employers who resolve all disputes with employees via binding arbitration.⁷² These scholars suggest that such “repeat players” have two structural advantages in the arbitration process. First, repeat players are better able to navigate the arbitration process and select arbitrators who will be favorable to their position.⁷³ Second, arbitrators, whose livelihoods depend on being selected for future arbitrations, are more likely to craft decisions that please repeat players.⁷⁴ Although repeat play was discussed first in the context of employment arbitration,⁷⁵ it is equally applicable in the healthcare context. While healthcare providers have repeat experience with medical malpractice arbitration, the process is largely one-off for patients,⁷⁶ whose only experience with medical malpractice arbitration prior to filing a claim may be signing a predispute agreement while sitting in a hospital waiting room.⁷⁷

A second issue is the risk that a healthcare organization may opt to establish its own arbitration system (rather than contracting with an independent third party) and run that system in an “adversarial” manner.⁷⁸ This goes beyond the problem of repeat play. While the

⁷² For academic articles discussing the repeat-player effect, see generally Lisa B. Bingham, *Employment Arbitration: The Repeat Player Effect*, 1 EMP. RTS. & EMP. POL’Y J. 189 (1997), Julius G. Getman, *Labor Arbitration and Dispute Resolution*, 88 YALE L.J. 916, 928, 936 (1979), and Jean R. Sternlight, *Panacea or Corporate Tool?: Debunking the Supreme Court’s Preference for Binding Arbitration*, 74 WASH. U. L.Q. 637, 685 (1996). See also Green Tree Fin. Corp. v. Randolph, 531 U.S. 79, 96 (2000) (“As a repeat player in the arbitration required by its form contract, Green Tree has superior information about the cost to consumers of pursuing arbitration.”); Cole v. Burns Int’l Sec. Servs., 105 F.3d 1465, 1476 (D.C. Cir. 1997) (“Unlike the labor case, in which both union and employer are regular participants in the arbitration process, only the employer is a repeat player in cases involving individual statutory claims. As a result, the employer gains some advantage in having superior knowledge with respect to selection of an arbitrator.”).

⁷³ See Bingham, *supra* note 72, at 195 (enumerating advantages that repeat players have over “one-shotters” in navigating the arbitration process).

⁷⁴ See Getman, *supra* note 72, at 927–28 (summarizing arguments that arbitrators are compromised because of their “financial dependence on the parties”).

⁷⁵ See *supra* note 72 (introducing various articles that discuss repeat play in context of employment arbitration).

⁷⁶ DeVille, *supra* note 1, at 373–74.

⁷⁷ Cf. *id.* at 336 (noting that arbitration agreements are often attached to other healthcare admission documents, such as releases of medical information).

⁷⁸ See Engalla v. Permanente Med. Grp., Inc., 938 P.2d 903, 909 (Cal. 1997) (noting that Kaiser Permanente’s arbitration system was not designed, administered, or overseen by any independent third party, but was instead “designed and administer[ed] . . . from an adversarial perspective”).

concern in repeat play revolves around the influence that a repeat customer exerts on an arbitration system, a healthcare organization may operate its private dispute resolution system in a manner designed to frustrate the claims of medical malpractice victims or to place obstacles in their paths. For example, in a landmark decision discussed in more detail in Part II.C, the California Supreme Court found that Kaiser Permanente had run its arbitration system in an “adversarial” manner, engaging in a “course of nonresponse and delay and add[ing] extracontractual conditions to the arbitration selection process.”⁷⁹ The system thwarted the claims of the plaintiff, who was required under his healthcare contract to arbitrate all medical malpractice claims against Kaiser physicians.⁸⁰

Finally, judicial review of arbitration decisions is essentially unavailable. The Federal Arbitration Act⁸¹ (FAA) provides very limited grounds on which an arbitration award can be reviewed by federal courts,⁸² and the Supreme Court has interpreted the FAA’s statutory language strictly.⁸³ While lack of judicial review may not contribute to decisionmaking inaccuracy itself, it does remove an important check on bias and error.

⁷⁹ *Id.* at 909, 921.

⁸⁰ *Id.* at 909.

⁸¹ Pub. L. No. 68-401, 43 Stat. 883 (1925) (codified as amended at 9 U.S.C. §§ 1–14 (2006)).

⁸² See 9 U.S.C. § 10 (2012) (detailing grounds on which arbitration decisions may be vacated); § 11 (detailing grounds on which arbitration decisions may be modified or corrected).

⁸³ The Supreme Court recently noted in *Stolt-Nielsen S.A. v. AnimalFeeds Int’l Corp.* that in order for an arbitration award to be vacated, a party contesting the award “must clear a high hurdle.” 559 U.S. 662, 671 (2010). “It is not enough for petitioners to show that the panel committed an error—or even a serious error. . . . ‘It is only when [an] arbitrator strays from interpretation and application of the agreement and effectively “dispense[s] his own brand of industrial justice” that his decision may be unenforceable.’” *Id.* (alterations in original) (quoting Major League Baseball Players Ass’n v. Garvey, 532 U.S. 504, 509 (2001) (per curiam)). *Stolt-Nielsen* specifically declined to address whether the “manifest disregard” standard that the Court had previously articulated for the review of arbitration awards survived its decision, *id.* at 672 n.3, and some circuits have continued to apply the standard, *see, e.g.*, *Schafer v. Multiband Corp.*, 551 F. App’x 814, 819 & n.1 (6th Cir. 2014) (noting that the Sixth Circuit has continued to apply the “manifest disregard” standard, albeit only in unpublished opinions), which standard was characterized as “severely limited,” “highly deferential,” and confined to “those exceedingly rare instances where some egregious impropriety on the part of the arbitrators is apparent,” *Stolt-Nielsen S.A. v. AnimalFeeds Int’l Corp.*, 548 F.3d 85, 91–92 (2d Cir. 2008) (citations omitted), *rev’d*, 559 U.S. 662. Further, attacks to arbitration clauses themselves are unlikely to succeed in the wake of *Marmet*. *See supra* note 7 and accompanying text (discussing the Supreme Court’s protection of arbitration clauses under the FAA in *Marmet*).

C. Case Study: Kaiser Permanente's Arbitration System

Kaiser Permanente's use of arbitration to resolve medical malpractice disputes provides a particularly illuminating example of the potential issues with medical malpractice arbitration's touted accuracy and cost benefits. The discussion of Kaiser's arbitration system in this Subpart is not meant to provide a comprehensive description of how all medical malpractice arbitration systems function; that undertaking would pose significant challenges given that arbitration remains a creature of contract, customizable to the needs of the contracting parties. Kaiser's experience is nonetheless a crucial reference point for three reasons. First, the depth of information available about Kaiser's arbitration system is unmatched, in large part because Kaiser conducted a well-documented review of cost and accuracy shortcomings in its system⁸⁴ following the California Supreme Court ruling in 1997 that found "strong evidence" of fraud in the way that Kaiser had administered its arbitration system.⁸⁵ Second, Kaiser is one of the largest managed care organizations in the United States, providing healthcare services to more than 9.3 million health plan members in multiple states and the District of Columbia.⁸⁶ The vast majority of Kaiser's members—over seven million—are located in California and subject to its arbitration provisions.⁸⁷ Finally, Kaiser has long been recognized as an innovator within the healthcare arena, pioneering cost containment measures that other healthcare organizations have tried to emulate.⁸⁸

Under sample plan documents for Kaiser members in California kept by the California Department of Insurance, any dispute that "arises from or is related to an alleged violation of any duty" regarding the member's relationship to Kaiser or any Kaiser doctor, "including any claim for medical or hospital malpractice," must be submitted to binding arbitration.⁸⁹ California courts have consistently

⁸⁴ See generally EUGENE F. LYNCH ET AL., BLUE RIBBON ADVISORY PANEL ON KAISER PERMANENTE ARBITRATION, THE KAISER PERMANENTE ARBITRATION SYSTEM: A REVIEW AND RECOMMENDATIONS FOR IMPROVEMENT (1998) [hereinafter BLUE RIBBON REPORT], available at <http://www.oia-kaiserrarb.com/pdfs/BRP-Report.pdf> (recommending changes to improve speed and efficiency and reduce bias and costs).

⁸⁵ Engalla v. Permanente Med. Grp., Inc., 938 P.2d 903, 921 (Cal. 1997).

⁸⁶ *Fast Facts About Kaiser Permanente*, KAISER PERMANENTE, <http://share.kaiserpermanente.org/article/fast-facts-about-kaiser-permanente> (last visited Oct. 24, 2014).

⁸⁷ See *id.* (showing Kaiser has 7,246,467 members in Northern and Southern California as of March 31, 2014).

⁸⁸ See Abelson, *supra* note 13, at B1 (describing Kaiser as the kind of "holistic health system that President Obama's health care law encourages").

⁸⁹ KAISER PERMANENTE, EVIDENCE OF COVERAGE FOR SAMPLE GROUP AGREEMENT 49 (Aug. 15, 2011), available at https://www.statereform.org/sites/default/files/ca_kaiser_smallgroup.pdf.

enforced this provision.⁹⁰ Although arbitration is also used to resolve coverage disputes, the vast majority of Kaiser arbitrations (nearly ninety-five percent in 2012) involve medical malpractice claims.⁹¹

Kaiser first introduced binding arbitration to resolve medical malpractice disputes in 1971,⁹² citing the conventional reasons—arbitration would be “faster” and “less expensive” than litigation, “more fair and sound” in its ultimate result, and able to provide these benefits while “protecting the rights of individuals to adequate compensation in the event of medical malpractice.”⁹³ Under the pre-1997 procedures, a Kaiser member initiated arbitration by paying a \$150 fee and serving a written “Demand for Arbitration” upon Kaiser’s legal department.⁹⁴ For significant claims over \$200,000, within thirty days of service, the parties were each to select party arbitrators, who would then select a neutral third arbitrator by mutual agreement within sixty days of service.⁹⁵ However, if the claims were for less than \$200,000, only the neutral third arbitrator would preside.⁹⁶ The fees of the neutral arbitrator were split between the parties, and each party paid its own arbitrator’s fees.⁹⁷ Discovery was conducted pursuant to

⁹⁰ See, e.g., *Engalla*, 938 P.2d at 922 (reaffirming the enforceability of predispute agreements to arbitrate medical malpractice claims despite remanding to the trial court for a determination of whether the specific agreement in question could be voided based on a promissory fraud theory); *Madden v. Kaiser Found. Hosps.*, 552 P.2d 1178, 1188 (Cal. 1976) (holding that enforcement of a Kaiser arbitration agreement did not violate the right to jury trial or run afoul of the principles governing adhesive contracts).

⁹¹ OFFICE OF THE INDEP. ADM’R, ANNUAL REPORT, at ii (2012), available at <http://www.eria-kaiserrarb.com/pdfs/2012-Annual-Report.pdf>.

⁹² BLUE RIBBON REPORT, *supra* note 84, at 6.

⁹³ *Id.* at 8. Other justifications for the adoption of arbitration included the propositions that arbitration would be better able to protect the privacy of the parties involved in a medical malpractice dispute and more flexible and better able to accommodate the schedules of the parties. *Id.* That Kaiser was a pioneer in introducing arbitration into its dispute resolution processes is perhaps not surprising. Kaiser has been praised often by healthcare reformers for its “holistic,” integrated approach to lowering the cost of healthcare. Abelson, *supra* note 13; see also Letter from Eugene F. Lynch et al., Chairs of the Blue Ribbon Advisory Panel, to David M. Lawrence, Chairman and CEO, Kaiser Foundation Health Plan (Jan. 5, 1998), reprinted in BLUE RIBBON REPORT, *supra* note 84, at app. D (“In a competitive health care market the need to control costs and simultaneously guarantee the quality of medical care are vital goals of the system. Within this context lies the medical malpractice arbitration system developed by Kaiser Permanente.”).

⁹⁴ BLUE RIBBON REPORT, *supra* note 84, at 21–22. Prior to initiating arbitration, Kaiser members were permitted to attempt to address claims through an informal grievance procedure, *see id.* at 17–20 (setting out Kaiser’s informal grievance procedures), but claims processed through the grievance procedure more often concerned coverage disputes, parking fees, and other administrative matters, *id.* at 19.

⁹⁵ *Engalla*, 938 P.2d at 909 n.3.

⁹⁶ BLUE RIBBON REPORT, *supra* note 84, at 23.

⁹⁷ *Id.* at 42.

state civil procedure rules,⁹⁸ with the arbitration hearing to be held “within a reasonable time” after the selection of the neutral arbitrator.⁹⁹ As the California Supreme Court would later note, Kaiser’s arbitration system was not run by an independent third party—it was “designed, written, mandated and administered by Kaiser.”¹⁰⁰

In 1997, these arbitration procedures came under the scrutiny of the California Supreme Court. In *Engalla v. Permanente Medical Group*, the court found that Kaiser had violated its own internal deadlines for appointing neutral arbitrators in ninety-nine percent of all medical malpractice arbitrations.¹⁰¹ In only one percent of its arbitrations was a neutral arbitrator appointed within the prescribed sixty-day time limit.¹⁰² Indeed, it took an average of 674 days for a neutral arbitrator to be appointed, and an average of 863 days to reach a hearing.¹⁰³ The systemic delays brought to light in *Engalla* had particularly egregious consequences for individual claimants. Due to Kaiser’s “course of nonresponse and delay” and practice of “add[ing] extracontractual conditions to the arbitration selection process,”¹⁰⁴ a neutral arbitrator was not appointed until the day following Engalla’s death, effectively cutting by half his family’s potential recovery for noneconomic damages under California law.¹⁰⁵

While the *Engalla* court showed no appetite for dialing back the enforceability of medical malpractice arbitration clauses,¹⁰⁶ the majority and concurrence in *Engalla* strongly condemned Kaiser for its manipulation of the arbitration process and its failure to meet the deadlines that it had promised in its plan documents due to a lack of

⁹⁸ *Id.* at 25.

⁹⁹ *Engalla*, 938 P.2d at 909 n.3.

¹⁰⁰ *Id.* at 909.

¹⁰¹ *Id.* at 912.

¹⁰² *Id.* at 912–13.

¹⁰³ *Id.* at 913.

¹⁰⁴ *Id.* at 921.

¹⁰⁵ The California Supreme Court acknowledged the plaintiffs’ argument that, according to state appellate precedent, the relevant damages cap would be applied separately to the claims of a living patient and the simultaneous claims of his spouse for loss of consortium, which would have allowed for noneconomic damages of \$500,000. *Id.* at 914. The court did not directly make that ruling, however, because upon Engalla’s death precedent dictated that the claims would be merged into a single claim for wrongful death, thus limiting recovery to \$250,000 in noneconomic damages. *Id.* (citation omitted).

¹⁰⁶ *Id.* at 925 (holding that the features of Kaiser’s arbitration program did not “render[] the arbitration agreement per se unconscionable. . . . The alleged problem with Kaiser’s arbitration in this case was not any defect or one-sidedness in its contractual provisions, but rather in the gap between its contractual representations and the actual workings of its arbitration program”).

“either reasonable diligence, good faith, or both.”¹⁰⁷ It noted, in particular, that Kaiser’s arbitration system was not designed, administered, or overseen by any independent third party, but was instead “designed and administer[ed] . . . from an adversarial perspective.”¹⁰⁸ This detail was “not set forth in the arbitration provision itself, or in any of Kaiser’s publications or disclosures about the arbitration program.”¹⁰⁹ Instead, Kaiser represented that “its members would find the arbitration process to be a fair approach to protecting their rights.”¹¹⁰ Remanding the case for a determination of whether the “strong evidence”¹¹¹ of fraud or waiver shown in the proceedings could suffice to void the arbitration agreement,¹¹² the majority stopped just short of accusing Kaiser of deliberately waiting for Engalla to die before appointing a neutral arbitrator.¹¹³ The concurrence warned that the case was an example of how “[p]rocedural manipulations can be used by a party . . . to affect the possible outcome” of a proceeding.¹¹⁴

Following the California Supreme Court’s ruling, Kaiser assembled an independent advisory panel to “evaluate the arbitration process and to recommend improvements to that process” in a deliberate response to the *Engalla* court’s criticisms.¹¹⁵ The panel acknowledged that Kaiser’s arbitration system was perceived to be “weighted in favor of Kaiser Permanente” and generated costs “too high . . . for arbitration.”¹¹⁶ While remaining agnostic about whether these perceptions were borne out by evidence,¹¹⁷ the panel discussed in detail the

¹⁰⁷ *Id.* at 921; *accord id.* at 926 (Kennard, J., concurring) (“As the majority opinion makes clear, courts must be alert to procedural manipulations of arbitration proceedings and should grant appropriate relief when such manipulation occurs.”).

¹⁰⁸ *Id.* at 909 (majority opinion).

¹⁰⁹ *Id.*

¹¹⁰ *Id.* at 910.

¹¹¹ *Id.* at 921.

¹¹² *Id.* at 922, 924.

¹¹³ See *id.* at 921 (“Here, there is strong evidence that . . . Kaiser lacked either reasonable diligence, good faith, or both, in cooperating on these timely appointments. Instead, the evidence shows that it engaged in a course of nonresponse and delay and added extracontractual conditions to the arbitration selection process . . .”).

¹¹⁴ *Id.* at 926 (Kennard, J., concurring); see also *id.* (“By delaying arbitration in this case until after Wilfredo Engalla died, Kaiser also affected the potential outcome of his malpractice claims. Engalla’s death reduced Kaiser’s potential liability for noneconomic damages to \$250,000 from the \$500,000 potential liability it would have faced had the claims been arbitrated during Engalla’s life.”).

¹¹⁵ BLUE RIBBON REPORT, *supra* note 84, at 3.

¹¹⁶ *Id.* at 10.

¹¹⁷ See *id.* at 11 (noting that such perceptions had to be addressed, whether the issues were “real or perceived”).

problems thought to be preventing Kaiser's promised accuracy and cost gains from materializing.

First, the panel acknowledged suggestions that Kaiser, "as the repeat party, has greater knowledge of the past performance of potential neutral arbitrators," putting "less experienced counsel and unrepresented parties . . . at a disadvantage."¹¹⁸ In a discussion of whether to adopt a system in which Kaiser outsourced all dispute resolution to a single, independent arbitration provider, the panel noted that doing so would "create[] the appearance of a 'captive' provider, who is beholden to Kaiser Permanente for repeat business and therefore perceived to favor Kaiser Permanente."¹¹⁹

Second, the panel concluded that the arbitration system as it existed was "essentially unmanaged"¹²⁰ and intimated—echoing the California Supreme Court—that the system was susceptible to adversarial manipulation.¹²¹ Rather than having an independent administrator run the arbitration system, Kaiser had its own attorneys administer it.¹²² The panel continued: "Attorneys who represent clients are under a clear ethical and legal duty to represent their clients and to pursue their interests before any other. . . . We are concerned . . . that talented practitioners in the court system might unconsciously bring with them some of the less desirable features of litigation"¹²³

Finally, turning to the issue of costs, the panel addressed the problem of upfront costs, noting that "[t]he major costs of the Kaiser Permanente arbitration system are the fees of the arbitrators, substantial costs which do not exist in court cases."¹²⁴ The panel also noted skepticism as to whether the overall costs of arbitration were in fact lower than those of litigation, noting that Kaiser's arbitration process was "becoming more and more like the court process. . . . [I]t is as adversarial [as litigation] and does not necessarily process cases any

¹¹⁸ *Id.* at 39.

¹¹⁹ *Id.* at 32. An annual summary report prepared by Kaiser also notes the importance of the creation of a large pool of neutral arbitrators in combatting potential bias. See OFFICE OF THE INDEP. ADM'R, *supra* note 91, at iv ("A large and balanced pool of neutral arbitrators, among whom work is distributed, is a crucial ingredient to a fair system. It minimizes the likelihood of a captive pool of neutral arbitrators, beholden to Kaiser for their livelihood.").

¹²⁰ BLUE RIBBON REPORT, *supra* note 84, at 27.

¹²¹ See *id.* ("The Kaiser Permanente arbitration system is clearly run to meet the schedules and competing demands of the attorneys who are arbitrators and those attorneys who represent clients—as the court system is run by and for the procedural convenience of judges and attorneys.").

¹²² *Id.*

¹²³ *Id.* at 27–28.

¹²⁴ *Id.* at 42.

more rapidly. The evidence is unclear on the comparative costs of arbitration versus court, but many have suggested to us that the hard dollar costs may be roughly equal.”¹²⁵

D. Implications for Deterrence

The accuracy and cost problems discussed in the legal and public health literature and illustrated by Kaiser’s experience suggest that arbitration may not benefit medical malpractice liability’s ability to deter medical error. First, the upfront costs of arbitration pose an additional barrier to bringing a medical malpractice claim, thus exacerbating the underenforcement problem that already prevents healthcare providers from fully internalizing the costs of their medical errors.¹²⁶ Furthermore, it is unclear that these upfront costs are outweighed by an overall decrease in the cost of arbitration—and such a decrease in overall costs would be little solace to those who suffer from liquidity problems or are risk averse.¹²⁷ Second, the susceptibility of arbitration systems to adversarial manipulation by healthcare providers may lead to systematic bias in favor of healthcare providers.¹²⁸ Third, even where an arbitration system is not being run in an adversarial manner by a healthcare provider, the possibility of bias remains due to the repeat player effect.¹²⁹

Whether the combined effect of these potential inefficiencies outweighs the potential benefits of arbitration identified earlier is ultimately an empirical question that cannot be answered definitively in this Note.¹³⁰ However, these factors suggest that, at the very least, the

¹²⁵ *Id.* at 27; see also OFFICE OF THE INDEP. ADM’R, *supra* note 58, at 2 (describing the significant discovery and expert witness testimony necessary to bring a claim in the Kaiser arbitration system).

¹²⁶ See *supra* notes 27–28 and accompanying text (describing the issue of underenforcement of medical malpractice claims).

¹²⁷ See *supra* notes 58–67 and accompanying text (describing the need for greater empirical data to determine the costs of arbitrating medical malpractice claims relative to litigating them).

¹²⁸ See *supra* notes 78–79 and accompanying text (describing how private dispute resolution systems can systematically frustrate claims of medical malpractice victims).

¹²⁹ See *supra* notes 72–77 and accompanying text (setting out how arbitration favors repeat players).

¹³⁰ Those interested in empirical avenues of research may find useful the California Department of Managed Health Care’s online database of all arbitration decisions involving claims against California healthcare plans filed since 2000. *Complaint & Arbitration Decisions*, CAL. DEPT’ OF MANAGED HEALTH CARE, <http://www.dmhc.ca.gov/fileacomplaint/consumerindependentmedicalreviewcomplaint/complaintandarbitrationdecisions.aspx#.U7gvQhbCWYY> (last visited Oct. 24, 2014). While it is beyond the scope of this Note to opine on whether this dataset is sufficiently detailed to facilitate fruitful empirical analysis, it may provide a starting point for future studies on medical malpractice arbitration.

picture of cost and accuracy benefits arbitration proponents have painted is more complicated than is disclosed in the medical malpractice arena. If upfront costs, susceptibility to adversarial manipulation, and repeat play combine to exacerbate the underenforcement problem and systematically bias awards in favor of healthcare providers, then these providers will not fully internalize the cost of their medical errors. This in turn underincentivizes investment in patient safety and keeps the rate of medical error above optimal levels.

III

PROPOSED REFORMS TO THE ARBITRATION OF MEDICAL MALPRACTICE CLAIMS

Part III discusses potential reforms that can be employed by those looking to design medical malpractice arbitration regimes that optimize medical malpractice liability's deterrent effect. It concludes that private guideline setting by healthcare providers and arbitration providers would work best in the current legal climate. This solution draws on Kaiser Permanente's reforms to its arbitration system in the wake of *Engalla* to suggest a potential roadmap for reform that permits arbitration to better deliver on its promised accuracy and cost gains.

A. How Best to Effectuate Reform?

Given the limited judicial review afforded to arbitration awards¹³¹ and the difficulty that litigants face in challenging arbitration clauses on unconscionability grounds,¹³² the best solution for retooling medical malpractice arbitration is for healthcare providers and arbitration providers to set private guidelines. Although critics of so-called "private regulation" have suggested it is ineffective because it lacks an enforcement mechanism,¹³³ others have argued that private entities can enforce such regulations by simply refusing to arbitrate a case when the arbitration clause in question does not comply with private regulations.¹³⁴ Indeed, organizations like the American Arbitration Association and the National Arbitration Forum have

¹³¹ See *supra* notes 82–83 and accompanying text (setting out the standard of judicial review for arbitration claims).

¹³² See *supra* note 7 and accompanying text (describing Supreme Court precedent limiting unconscionability claims in the arbitration context).

¹³³ See, e.g., Margaret M. Harding, *The Limits of the Due Process Protocols*, 19 OHIO ST. J. ON DISP. RESOL. 369, 372 (2004); Jean R. Sternlight, *Consumer Arbitration, in Arbitration Law in America* 127, 174 (Edward Brunet et al. eds., 2006).

¹³⁴ Christopher R. Drahoszal & Samantha Zyontz, *Private Regulation of Consumer Arbitration*, 79 TENN. L. REV. 289, 292–93 (2012).

declined to arbitrate certain categories of noncompliant cases,¹³⁵ and recent empirical research suggests that refusal to arbitrate when arbitration clauses do not comply with private regulations and norms has been a successful enforcement mechanism.¹³⁶

B. Kaiser Permanente as a Model for Private Reform

Kaiser's experiences with its medical malpractice arbitration system suggest a way forward for those looking to design arbitration systems that maximize arbitration's promised cost and accuracy benefits and thereby sharpen the medical malpractice liability regime's deterrence of medical error. Without an empirical study it is difficult to determine whether such reforms will sufficiently combat medical malpractice arbitration's problematic cost structure and susceptibility to bias, but Kaiser's reforms begin to address these problems.

In promulgating its reforms, the Kaiser advisory panel focused on improving the arbitration system's ability to deliver on its promises of increased accuracy and decreased cost.¹³⁷ The first proposal was aimed at battling the repeat-player effect. The panel suggested that Kaiser "develop the largest possible list of qualified neutral arbitrators"¹³⁸ and provide "the history of the arbitrator's rulings in Kaiser arbitrations, written decisions (if any) in those cases, a biography and any additional information necessary to enable parties to screen for bias and possible conflicts of interest."¹³⁹ The panel also recommended instituting a strike system for panel selection such that both parties could easily eliminate arbitrators they perceived as unfavorable.¹⁴⁰

¹³⁵ See *supra* note 4 (describing AAA's and NAF's policies regarding arbitration arising from predispute arbitration clauses).

¹³⁶ Drahozal & Zyontz, *supra* note 134, at 294–95.

¹³⁷ BLUE RIBBON REPORT, *supra* note 84, at 10–11 ("[M]any of our recommendations are directed at the assertion that the system is too heavily weighted in favor of Kaiser Permanente."); *id.* at 32 ("The costs of the system should be sufficiently low as to enable members, regardless of income, to effectively assert valid claims"). Subsequent materials promulgated by the entity that administers Kaiser's arbitration system reflects these goals. See OFFICE OF THE INDEP. ADM'R, RULES FOR KAISER PERMANENTE MEMBER ARBITRATIONS 1 (July 1, 2014) [hereinafter OIA RULES], available at <http://www.oiakaisersarb.com/olia/Forms/system%20description.pdf> ("These Rules are intended to provide an arbitration process that is fair, timely, lower in cost than litigation, and that protects the privacy interests of all Parties."); OFFICE OF THE INDEP. ADM'R, SYSTEM DESCRIPTION 1 (Sept. 1, 2009), available at <http://www.oiakaisersarb.com/pdfs/system-description.pdf> ("The system is designed to provide Health Plan members with a fair, speedy, cost effective, and confidential means of resolving disputes.").

¹³⁸ BLUE RIBBON REPORT, *supra* note 84, at 35.

¹³⁹ *Id.* at 38.

¹⁴⁰ *Id.* at 36–38.

Another set of reforms designed to promote accuracy in Kaiser's arbitration system was aimed at preventing Kaiser from operating its system in an adversarial manner and running out the clock on potential plaintiffs. The panel called on Kaiser to create an "independent, accountable administrator" that was not itself "a provider of neutral arbitrators or mediators" to oversee the arbitration system.¹⁴¹ To ensure that delays similar to those in *Engalla* did not recur, this independent administrator would establish deadlines for arbitrator selection, arrange for scheduling conferences throughout the discovery process, and ensure timely resolution of arbitrations.¹⁴²

Finally, in order to lessen upfront costs for potential claimants, the panel recommended that Kaiser pay the full fee of a single, neutral arbitrator so long as the claimant was willing to have that arbitrator alone adjudicate the dispute.¹⁴³ If Kaiser or the claimant insisted on using a three-arbitrator panel to oversee the proceedings, the panel recommended that Kaiser pay for all fees for both the neutral arbitrator and its own party arbitrator.¹⁴⁴

These suggested reforms established the contours of Kaiser's current rules governing its medical malpractice arbitrations. Under the current rules promulgated by the newly-formed Office of the Independent Administrator (OIA), arbitration awards must be granted to the parties within eighteen months of Kaiser's receipt of a member's demand for arbitration.¹⁴⁵ The OIA rules also include deadlines with which Kaiser must comply during the arbitrator selection process,¹⁴⁶ a strike system for selecting arbitrators,¹⁴⁷ and expedited procedures for members who "suffer[] from an illness or condition raising substantial medical doubt of survival" or for "other good cause."¹⁴⁸ Parties are also provided with information regarding the past decisions of 272 neutral arbitrators that OIA utilizes.¹⁴⁹ Finally, under the present guidelines, Kaiser will pay neutral arbitrator fees if the claimant waives any objections relating to Kaiser's willingness to assume such payments, and the arbitration has only a single neutral

¹⁴¹ *Id.* at 31.

¹⁴² *Id.* at 33–35.

¹⁴³ *Id.* at 41–42.

¹⁴⁴ *Id.*

¹⁴⁵ OIA RULES, *supra* note 137, at 10.

¹⁴⁶ *Id.* at 9.

¹⁴⁷ *Id.* at 7–8.

¹⁴⁸ *Id.* at 14.

¹⁴⁹ OFFICE OF THE INDEP. ADM'R, *supra* note 91, at 12.

arbitrator or the parties have waived the use of additional party arbitrators.¹⁵⁰

Again, whether Kaiser's reforms have been successful in better providing the cost and accuracy benefits promised by arbitration cannot be determined without further empirical study, but its reforms suggest a way forward for those approaching the question of how to adjust arbitration systems to promote the deterrence of medical error.

CONCLUSION

This Note has sought to highlight the ways in which medical malpractice arbitration may not fulfill its theoretical promise of improving the deterrence of medical error. Although further empirical research is necessary to assess the effects of the inefficiencies identified here, legislators and healthcare providers should not continue to assume that arbitration is a net benefit for our medical malpractice regime. Instead, they should pay attention to the potential for upfront costs and susceptibility to bias to derail arbitration's touted accuracy and cost benefits, thereby weakening the regime's ability to deter medical error.

¹⁵⁰ OIA RULES, *supra* note 137, at 5. Nonetheless, the rules stipulate that “[t]he expenses of witnesses for any Party shall be paid by the Party producing them. The fees and expenses of the Party Arbitrator shall be paid by the Party who selected that Party Arbitrator.” *Id.* at 17.