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Marc D. Ginsberg

THE EXECUTION OF AN ARBITRATION PROVISION AS A CONDITION PRECEDENT TO MEDICAL TREATMENT: LEGALLY ENFORCEABLE? MEDICALLY ETHICAL?

Marc D. Ginsberg†

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† Associate Professor of Law, The John Marshall Law School (Chicago). B.A., M.A., J.D., LL.M., (Health Law). The author thanks Professors Karen Halverson Cross and Gerald Berendt for their excellent counsel on the topic of arbitration. The author thanks his wife, Janice, for her inspiration and support. The author also thanks his research assistant, Ms. Tyler Duff, for her assistance in research, proofreading, and citation checking.

I. INTRODUCTION

> "[T]he practice of medicine is not a business and can never be one . . . . Our fellow creatures cannot be dealt with as a man deals in corn and coal . . . ."[1]

> "The virtue-based physician could never see his patient as a 'customer,' consumer, insured life or any other commercialized, industrialized transformations of the ancient and respectable word 'patient.'"[2]

> "Patients have always been consumers. Before health insurance was common, they shopped in a market for medical services just as they shopped in a market for toasters and tailors."[3]

In January 2011, a patient, a not yet pregnant mother (and her husband), went to a medical office in Florida seeking obstetrical care.[4] Upon becoming a patient of the office, she executed an arbitration agreement covering medical liability claims. Florida has a statute providing for voluntary arbitration of medical negligence claims but she never requested arbitration pursuant to this statute.[5] Although she "willingly signed the arbitration agreement,"[6] which stated, "the parties waive the right to a jury trial and consent to arbitrate all claims arising out of or related to medical care and

1. THE QUOTABLE OSLER 53 (Mark E. Silverman et al. eds., 2008).

2. Edmund D. Pellegrino, *Professionalism, Profession and the Virtues of the Good Physician*, 69 MT. SINAI J. MED. 382, 382 (2002).

3. Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 644 (2008).

4. Santiago v. Baker, 135 So. 3d 569, 570 (Fla. Dist. Ct. App. 2014).

5. FLA. STAT. ANN. § 766.207 (West 2011).

6. *Santiago,* 135 So. 3d at 571. The opinion states that "[the] record reflects no coercion or duress." *Id.*

treatment,"[7] one wonders if the execution of the arbitration agreement was a condition of treatment;[8] an assumption to which I will adhere for the purposes of this paper.

The patient had been taking a medication "to treat a chronic disease."[9] She took an at-home pregnancy test, which returned a positive result.[10] The clinic, however, advised the patient "that the pregnancy was nonviable,"[11] and recommended a D & C procedure,[12] which the patient refused. The patient "resumed taking the drug, allegedly believing that spontaneous passage of the fetus would occur."[13] The patient "also alleged that she was unaware of the possible adverse effects the drug might have on a fetus."[14] In fact, the patient remained pregnant and gave birth to a child with severe birth defects.[15]

Thereafter, the patient and her husband sued the clinic and her attending physician for medical negligence. The clinic "successfully moved to compel arbitration."[16] The order compelling arbitration was appealed and the trial court's order was affirmed on appeal.[17]

Is it reasonable for a physician to condition treatment upon the patient's execution of an arbitration agreement? Is such an agreement enforceable? Is such an agreement medically ethical? This paper will address these topics (and others) in an effort to determine whether a treatment conditioned upon the execution of an arbitration agreement covering medical liability claims is consistent with, and should be a defensible component of the physician-patient relationship.

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7. *Id.*

8. The *Santiago* occurrence at least suggested so. There, the Court stated: "this agreement may reflect Dr. Baker's 'intention' to require her patients to forego their constitutional rights in order to receive medical service." *Id.* at 572.

9. *Id.* at 570.

10. *Id.*

11. *Santiago,* 135 So. 3d at 570.

12. *Id.* "D&C is a surgical procedure in which the *cervix* is opened (dilated) and a thin instrument is inserted into the *uterus*. This instrument is used to remove tissue from the inside of the uterus (curettage)." The American College of Obstetricians & Gynecologists, FREQUENTLY ASKED QUESTIONS: SPECIAL PROCEDURES (May, 2012), http://www.acog.org/Patients/FAQs/Dilation-and-Curettage-DandC.

13. *Santiago,* 135 So. 3d at 570.

14. *Id.*

15. *Id.*

16. *Id.*

17. *Id.*

II. REFLECTIONS ON THE PHYSICIAN-PATIENT RELATIONSHIP

Before examining the arbitration process and the practice of conditioning medical treatment on the execution of an arbitration agreement, it is useful to examine the physician-patient relationship, at least in part from the patient's perspective. The patient arrives at a physician's office and is required to provide medical information to the office by completing forms. This process may be challenging due to well-described general-literacy and health-literacy issues.[18] Nevertheless, the patient will complete a medical history and provide medical insurance information. These forms are significant as they relate to treatment and billing. It is hoped, and, perhaps, it is reasonable to expect that patients are able to comprehend the forms and complete them, or ask for assistance in order to do so. Historically, patients have provided this information to physicians' offices. Despite literacy issues, it is the custom and practice involving the creation of the physician-patient relationship. Frankly, I do not believe that the formation of the physician-patient relationship contemplates the execution of a legal document—an arbitration agreement—which will so affect the legal rights of the patient, should a claim for medical liability arise.

It has been keenly observed that, "[t]he patient is not just a group of symptoms, damaged organs and altered emotions. The patient is a human being, at the same time worried and hopeful, who is searching for relief, help and trust."[19] As will be discussed later in this paper, various codes and principles of medical ethics, which will neither bind physicians nor courts,[20] implore, or at least encourage, physicians to act as patient advocates and assist with patient access to health care. It is fair to question whether conditioning treatment on the execution of an arbitration provision is consistent with the patient advocacy role of the physician.

Some years ago, Ezekiel and Linda Emanuel outlined "four models of the patient-physician interaction,"[21] the paternalistic

18. Ruth Parker, *Health literacy: A Challenge for American Patients and Their Health Care Providers*, 15 HEALTH PROMOTION INT'L. 277, 277 (2000).

19. R. Kaba & P. Sooriakumaran, *The Evolution of the Doctor-Patient Relationship*, 5 INT'L J. SURGERY 57, 57 (2007).

20. *See* Smith v. Radecki, 238 P.3d 111, 115–16 (Ala. 2010) (noting that the AMA's ethics guidelines are "a non-binding code for ethical behavior by member physicians."); Bryson v. Tinninghast, 749 P.2d 110, 114 (Okla. 1988) (noting that medical "ethical standards are aspirational in nature and not enforceable by law).

21. Ezekiel J. Emanuel & Linda L., *Four Models of the Physician-Patient Relation-*

model, the informative model, the interpretive model, and the deliberative model.[22] The paternalistic model envisions the physician as guardian.[23]The informative model contemplates the physician as a fact provider, allowing the patient to utilize his or her values in opting for treatment.[24] The interpretive model contemplates that the physician will assist the patient "in elucidating and articulating his or her values and in determining what medical interventions best realize the specified values, thus helping to interpret the patient's values for the patient."[25] The deliberative model contemplates "the physician . . . as a teacher or friend, engaging the patient in dialogue on what course of action would be best."[26]

These models represent reasonable approaches to the physician-patient relationship. These models largely involve the physician assisting the patient with health care decision-making. They do not involve the physician attempting to alter the legal relationship with the patient by compelling the execution of an arbitration agreement.

Having reflected on the physician-patient relationship, it is time to leave this topic and commence the examination of arbitration. The physician-patient relationship will be re-examined later in this paper.

III. ARBITRATION DEFINED

Prior to a discussion of arbitration in the context of medical liability claims, there is value in defining the concept. Quite fundamentally, arbitration, along with negotiation and mediation, is a form or model of alternative dispute resolution.[27] More specifically, it has been defined "as a process for hearing and deciding controversies of economic consequence arising between parties"[28] which "begins with and depends upon an agreement of the parties to submit their claims to one or more persons chosen by them to

ship, 267 JAMA 2221 (1992).

22. *Id.*

23. *Id.*

24. *Id.* at 2222.

25. *Id.*

26. *Id.*

27. Kathleen A. Devine, *Alternative Dispute Resolution: Policies, Participation, and Proposals*, 11 REV. LITIG. 83, 93 (1991).

28. Wesley A. Sturges, *Arbitration—What Is It?*, 35 N.Y.U. L. REV. 1031, 1031 (1960).

serve as their arbitrator."[29] Arbitration, as a form of alternative dispute resolution, is intended as a substitute for trial.[30] The arbitration process, consisting "of six stages; initiation, preparation, prehearing conferences, hearing, [decision-making] and award"[31] has been described in the literature.[32]

It has been urged that "arbitration is an expression of party autonomy."[33] The idea here is that arbitration is "a contractual and consensual mechanism that grants very broad freedom to the parties to define the manner of dispute resolution . . . ."[34] This paper will explore whether this arbitration characteristic realistically applies to medical negligence claims and concludes with the suggestion that arbitration of medical liability claims is likely unconscionable and medically unethical.

IV. ARBITRATION, HISTORICALLY

A confession, of sorts, is appropriate here. Until I happened upon *Santiago v. Baker*,[35] despite many years of representing physicians in professional negligence litigation, I was unaware that physicians around the county had sought, and were seeking, from patients the execution of arbitration agreements, which would apply to professional negligence claims.[36] This topic has received atten-

29. *Id.*; *see also* Edward C. King & Don W. Sears, *The Ethical Aspects of Compromise, Settlement And Arbitration*, 25 ROCKY MTN. L. REV. 454, 458 (1953).

30. Sturges, *supra* note 28 at 1032.

31. John W. Cooley, *Arbitration vs. Mediation—Explaining The Differences*, 69 JUDICATURE 263, 264 (1986).

32. *Id.* at 264–66

33. Gary B. Born, *Keynote Address: Arbitration and the Freedom to Associate*, 38 GA. J. INT'L & COMP. L. 7, 15 (2009).

34. *Id.*

35. 135 So. 3d 569 (Fla. Dist. Ct. App. 2014).

36. The author's prior professional life focused on representing physicians in Chicago, Illinois, a non-tort reform state. *See* Lebron v. Gottlieb Mem'l. Hosp., 930 N.E.2d 895 (Ill. 2010) (finding Illinois statutes instituting caps on non-economic damages unconstitutional); Best v. Taylor Mach. Works, 689 N.E.2d 1057 (Ill. 1997) (invalidating reform measures on medical review panels, medical insurance and damage caps); Wright v. Cent. DuPage Hosp., 347 N.E.2d 736 (Ill. 1976) (invalidating newly enacted statutory provisions for medical review panels and procedures); *see also* David M. Goldhaber & David Grycz, *Three Strikes and You're Out: Illinois Supreme Court Invalidates Damage Cap*, 24 CHI. B. ASS'N REC. 30 (2010); Marc D. Ginsberg, *The Locality Rule Lives! Why? Using Modern Medicine to Eradicate an Unhealthy Law*, 61 DRAKE L. REV. 321 (2013) (referring to the above cited case and literature regarding tort reform efforts in Illinois). Medical (including hospital) neg-

tion in the literature,[37] certainly from the 1970s,[38] although, in my estimation, it requires more attention with a focus on the patient and an assessment of whether compulsory arbitration ought to be embraced by the physician-patient relationship.

My point is simply that the classic use of arbitration did not arise in a physician-patient context. Scholarship suggests that arbitration has its origins (perhaps ancient) in commercial disputes.[39] This is more than reasonable as commercial disputes are contract based. The physician-patient relationship has been governed by tort law.[40]

That said, the majority of physicians are aware of the possibility of facing at least one medical negligence lawsuit in their respective careers.[41] Medical negligence litigation tends to be protracted, expensive and uncomfortable.[42] Compulsory arbitration of medical liability claims provides an alternate forum within which to resolve these disputes, if it is legally enforceable and medically ethical.

V. THE FEDERAL ARBITRATION ACT (FAA)

Although the notion of medical treatment conditioned upon the patient's execution of an arbitration agreement covering potential medical liability claims is troublesome, it would be misleading to suggest that state law could simply outlaw this practice. The FAA,[43] section 2, provides:

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ligence litigation remains quite active in Illinois.

37. *See* Irving Ladimer & Joel Solomon, *Medical Malpractice Arbitration: Laws, Programs, Cases*, 653 INS. L.J. 335 (1977); Thomas B. Metzloff, *The Unrealized Potential of Malpractice Arbitration*, 31 WAKE FOREST L. REV. 203 (1996).

38. *See* Ladimer & Solomon, *supra* note 37.

39. *See* Earl S. Wolaver, *The Historical Background of Commercial Arbitration*, 83 U. PA. L. REV. 132 (1934); Sabra A. Jones, *Historical Development of Commercial Arbitration in the United States*, 12 MINN. L. REV. 240 (1927).

40. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA A. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, HEALTH LAW § 6-2 (2000); David A. Hyman & Charles Silver, *Medical Malpractice and Compensation in Global Perspective: How Does the U.S. Do It?*, 87 CHI.-KENT L. REV. 163 (2012).

41. Anupam Jena et al., *Malpractice Risk According to Physician Specialty*, 365 N. ENG. J. MED. 630 (2011).

42. David A. Hyman & Charles Silver, *Five Myths of Medical Malpractice*, 143 CHEST J. 222, 226 (2013).

43. 9 U.S.C.A. §§ 1–16 (West 2015). It has been noted that "[t]hese sections comprise Chapter 1 of the FAA, which deals primarily with domestic arbitration." Christopher R. Drahozal, *Federal Arbitration Act Preemption*, 79 IND. L. J. 393, 393 n.1 (2004).

> A written provision in any maritime transaction or a contract evidencing a transaction involving commerce to settle by arbitration a controversy thereafter arising out of such contract or transaction, or the refusal to perform the whole or any part thereof, or an agreement in writing to submit to arbitration an existing controversy arising out of such a contract, transaction, or refusal, shall be valid, irrevocable, and enforceable, save upon such grounds as exist at law or in equity for the revocation of any contract.[44]

Section 2 of the FAA operates to preempt "state laws that invalidate parties' agreements to arbitrate"[45] thus reflecting a "national policy favoring arbitration."[46] Federal preemption of state law in this arena is "required by a line of Supreme Court cases dating from *Southland Corp. v. Keating*."[47] In its recent decisions, "*Am. Express Co. v. Italian Colors Rest.*[48] and *AT&T v. Concepcion*,[49] the Supreme Court has repeatedly decided that arbitration is an adequate forum for litigants . . . ."[50] Essentially, preemption by the FAA will prohibit a state from refusing to enforce specific types of arbitration agreements deemed unconscionable by the state, as that approach would violate the policy of the FAA.[51] Therefore, a state law (or state court) that targets an arbitration agreement that was executed by a patient as a condition of medical treatment as unconscionable would likely not withstand FAA scrutiny.[52] There is a po-

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44. 9 U.S.C.A. § 2 (West 1947).

45. Drahozal, *supra* note 43 at 393.

46. Southland Corp. v. Keating, 465 U.S. 1, 10 (1983) (O'Connor, J. & Rehnquist, C.J., dissenting). The dissent was cited in Susan Randall, *Judicial Attitudes Toward Arbitration and the Resurgence of Unconscionability*, 52 BUFF. L. REV. 185, 188 (2004).

47. *See* Drahozal, *supra* note 43 at 394 n.3 (citing *Southland*, 465 U.S. 1; Doctor's Assocs., Inc. v. Casarotto, 517 U.S. 681 (1996); Allied-Bruce Terminix Cos. V. Dobson, 513 U.S. 265 (1995); Mastrobuono v. Shearson Lehman Hutton, Inc., 514 U.S. 52 (1995*);* Volt Info. Scis., Inc. v. Bd. of Tr.'s. of Leland Stanford Jr. Univ., 489 U.S. 486 (1989); Perry v. Thomas, 482 U.S. 483 (1987)).

48. Am. Express Co. v. Italian Colors Rest.,133 S. Ct. 2304 (2013).

49. AT&T Mobility LLC v. Concepcion, 131 S. Ct. 1740 (2011).

50. Ramona Lampley, "*Underdog" Arbitration: A Plan for Transparency*, 90 WASH. L. REV., *2–3 (forthcoming, Dec. 2015).

51. *See* Drahozal, *supra* note 43 at 402.

52. *See* Fosler v. Midwest Care Ctr. II, Inc., 928 N.E.2d 1, 11–12 (Ill. App. Ct. 2009) (stating, "What States may not do is decide that a contract is fair enough to enforce all of its basic terms (price, service, credit), but not fair enough to enforce its arbitration clause. The [FAA] makes any such state policy unlawful, for that kind of policy would place arbitration clauses on an unequal 'footing,' directly

tential stumbling block to FAA application. The FAA only applies to transactions "involving commerce."[53] "Commerce" is supposedly defined in Section 1 of the FAA as[54]:

> [C]ommerce among the several States or with foreign nations, or in any Territory of the United States or in the District of Columbia, or between any such Territory and another, or between any such Territory and any State or foreign nation, or between the District of Columbia and any State or Territory or foreign nation . . . .[55]

This definition is not particularly helpful in determining if the practice of medicine involves commerce. Arguably, a physician-patient interaction is "local," not involving interstate commerce. As one court noted regarding a physician employment contract dispute and the medical clinic's effort to compel arbitration: "Instead, the evidence [the clinic] did present failed to demonstrate anything other than that it was a local clinic, with local physicians who had privileges at local hospitals, and treated local patients."[56] This approach, in the physician contract context, was followed by an appellate court in affirming the denial of a motion to compel arbitration.[57]

The modern practice of medicine is not that simplistic—it is not a stranger to commerce. Patients are mobile and seek treatment from physicians outside of their home states. Physicians utilize medical instruments, supplies and pharmaceutical products, which move through commerce. Payers may include insurance companies, which operate across the country, and Medicare, "the federal health insurance program."[58] Since these factors have led to the application of the FAA to a nursing home admission contract that includes a clause requiring arbitration of nursing home negligence claims,[59] arguably "the FAA would apply to nearly all medical transactions."[60]

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contrary to the [FAA's] language and Congress's intent." (citation omitted)).

53. 9 U.S.C.A. § 2 (West 1947).

54. *Id.*

55. *Id.* at § 1.

56. Ark. Diagnostic Ctr. v. Tahiri, 257 S.W.3d 884, 891–92 (Ark. 2007).

57. Flexon v. PHC-Jasper, Inc., 731 S.E.2d 1, 4 (S.C. Ct. App. 2012).

58. *What's Medicare?*, MEDICARE.GOV, http://www.medicare.gov/sign-up-change-plans/decide-how-to-get-medicare/whats-medicare/what-is-medicare.html (last visited Jan. 30, 2016).

59. Triad Health Mgmt. of Ga., III, LLC v. Johnson, 679 S.E.2d 785, 787 (Ga. Ct. App. 2009). *See also*, James C. Dunkelberger, *Between a Rock and a Hard Place:*

There is merit to this suggestion. Courts have held, without in-depth explanation, that medical care provided by physicians and clinics involves interstate commerce.[61] The theory is that medical treatment is a component part of economic activity that involves interstate commerce.[62] Of course, the difficulty with this "analysis" is that it is non-analytical.

On the other hand, in finding that Title III of the Americans with Disabilities Act[63] regulates the practice of dentistry, one court held that various "commercial activities" of dentists, including the "purchase of supplies and equipment from out of state, receipt of payments from out of state insurers and credit card companies, and attendance of classes and conferences out of state . . . taken together with the activities of other dentists similarly situated, have an effect on interstate commerce substantial enough to fall within the reach of congressional authority under the Commerce Clause."[64] The FAA has been applied to an arbitration provision contained in a physician's employment contract based on a clinic's treatment of Medicare patients and receipt of Medicare payments.[65] Although the court found other evidence lacking regarding FAA implication, it referred to other cases involving: (1) "acceptance of out-of-state and multi-state insurer reimbursements," (2) "purchase and receipt of goods, equipment, medication, and services from out-of-state vendors," (3) "out-of-state corporate offices," (4) "recruitment of physicians from out-of-state," (5) "service to out-of-state patients," and (6) "receipt of federal funds."[66]

The Plight of Health Care Arbitration Agreements Under Federal Law, 2010 BYU L. REV. 1869, 1887 (2010).

60. Dunkelberger, *supra* note 59 at 1887.

61. *See* Cleveland v. Mann, 942 So. 2d 108, 113 (Miss. 2006); Wilkerson v. Nelson, 395 F. Supp. 2d 281, 285 n.3 (M.D.N.C. 2005).

62. *Id.*

63. 42 U.S.C. § 12182(a) (West 1990).

64. Abbott v. Bragdon, 912 F. Supp. 580, 593 (D. Me. 1995). There, the United States District Court for the District of Maine analyzed a claim against a dentist for violations of the Americans with Disabilities Act and the Maine Human Rights Act. *Id.*

65. Sutcliffe v. Mercy Clinics, Inc., No. 13-1974, 2014 WL 4631406, at *4 (Iowa Ct. App. Sept. 17, 2014).

66. *Id.* at *3 (citing Briarcliff Nursing Home, Inc. v. Turcotte, 894 So. 2d 661, 668 (Ala. 2004); Triad Health Mgmt. of Ga., III, LLC v. Johnson, 679 S.E.2d 785, 787–88 (Ga. Ct. App. 2009); Fosler v. Midwest Care Ctr. II, Inc., 928 N.E.2d 1, 14–15 (Ill. App. Ct. 2009); In re Tenet Healthcare, Ltd., 84 S.W.3d 760, 765 (Tex. App. 2002)).

Therefore, it is fair to suggest that the practice of medicine "involves commerce." However, if a state court were to decide that the practice of medicine is a local activity, not involving commerce, then the court would apply state law to determine the enforceability of an arbitration provision covering medical negligence claims. That analysis will be explored when this paper surveys the development of the law in the states.

VI. FUNDAMENTAL CONTRACT PRINCIPLES

The potential enforcement of an arbitration provision in a contract for medical treatment, the execution of which is a condition precedent of medical treatment, requires a review of basic contract principles, specifically contracts of adhesion and unconscionability. These topics have been well discussed in legal scholarship.[67]

A. Contracts of Adhesion

Unquestionably, the arbitration provision upon which medical treatment is conditioned constitutes a component part of a contract of adhesion. The arbitration provision is a "standard form document[]," which is given to the patient on a "take-it-or-leave-it basis."[68] Professor Rakoff has identified the following characteristics that "define a model 'contract of adhesion'":[69]

> (1) The document whose legal validity is at issue is a printed form that contains many terms and clearly purports to be a contract.
> (2) The form has been drafted by, or on behalf of, one party to the transaction.
> (3) The drafting party participates in numerous transactions of the type represented by the form and enters into these transactions as a matter of routine.
> (4) The form is presented to the adhering party with the representation that, except perhaps for a few identified items

67. *See, e.g.*, Todd D. Rakoff, *Contracts Of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1174 (1983); Mark R. Patterson, *Standardization of Standard-Form Contracts: Competition and Contract Implications*, 52 WM. & MARY L. REV. 327 (2010); Melissa T. Lonegrass, *Finding Room for Fairness in Formalism—The Sliding Scale Approach to Unconscionability*, 44 LOY. U. CHI. L.J. 1 (2012); Jeffrey C. Fort, *Understanding Unconscionability: Defining the Principle*, 9 LOY. U. CHI. L.J. 765 (1978); JOSEPH M. PERILLO, CALAMARI AND PERILLO ON CONTRACTS (6th ed. 2009).

68. *See* Rakoff, *supra* note 67 at 1177; *see also* PERILLO, *supra* note 67 at 348.

69. Rakoff, *supra* note 67 at 1177.

> (such as the price term), the drafting party will enter into the transaction only on the terms contained in the document. This representation may be explicit or may be implicit in the situation, but it is understood by the adherent.
> (5) After the parties have dickered over whatever terms are open to bargaining, the document is signed by the adherent.
> (6) The adhering party enters into few transactions of the type represented by the form—few, at least, in comparison with the drafting party.
> (7) The principal obligation of the adhering party in the transaction considered as a whole is the payment of money.[70]

Although these characteristics apply more specifically to commercial agreements, they also apply "in the consumer context, where they . . . are contracts of adhesion that consumers neither read nor have the power to negotiate."[71] Required arbitration of medical liability claims is a derivative of the consumer contract of adhesion.

Contracts of adhesion are not necessarily unenforceable.[72] Unenforceability is typically a function of unconscionability, the basics of which will be addressed now.

B. Unconscionability

Unconscionability, as a contract defense, seems to require extreme unfairness. Unconscionability has been well described as follows:

> Typically the cases in which courts have found unconscionability involve gross overall one-sidedness or gross one-sidedness of a term . . . . In these cases, one-sidedness is often coupled with the fact that the imbalance is buried in small print and often couched in language unintelligible to even a person of moderate education.[73]

There are two categories of unconscionability: procedural and substantive. "[P]rocedural unconscionability targets the quality of . . . assent to the contract,"[74] proof of which is "evidence of 'oppression' and 'unfair surprise' indicating that the transaction lacked

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70. *See Id.*
71. Patterson, *supra* note 67 at 332.
72. *See* Obstetrics & Gynecologists Ltd. v. Pepper, 693 P.2d 1259, 1261 (Nev. 1985).
73. Perillo, *supra* note 67, at 339.
74. Lonegrass, *supra* note 67, at 10.

meaningful choice on the part of the complaining party."[75] "[S]ubstantive unconscionability targets the content of the terms themselves by looking for unfairness in the contract's substantive provisions."[76] Here, the focus is "on whether the allocation of risks in the contract or one of its terms is commercially unreasonable or unexpectedly one-sided."[77] The classic application of the unconscionability analysis requires a finding of both procedural and substantive unconscionability,[78] but "[t]he most troubling cases are those in which there is overwhelming evidence of one form of unconscionability and little evidence of the other form."[79]

With this basic review of fundamental contract principles, this paper now surveys states in which compulsory arbitration of medical liability claims has been sought, accepted, and rejected.

VII. SURVEYING THE STATES

A. Tennessee

In *Buraczynski v. Eyring*, the Tennessee Supreme Court considered, as a case of first impression, the enforceability of an arbitration provision foisted upon a patient by a physician.[80] *Buraczynski* is an appropriate case with which to begin the survey of states, as it involves all of the legal and policy issues implicated by the topic.[81] Procedurally, it involves the consolidation of two appeals concerning identical legal issues.

Two patients of Dr. Eyring, an orthopedic surgeon, engaged him to perform total knee replacement surgery.[82] They suffered complications, resulting in medical negligence claims against him.[83]

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75. *Id.* at 9 (citing U.C.C. § 2-302 (AM. LAW INST. & UNIF. LAW COMM'N 2015)).

76. *Id.* at 10.

77. *Id.* at 10–11 (citation omitted).

78. *See, e.g.*, Larry A. DiMatteo & Bruce Louis Rich, *A Consent Theory of Unconscionability: An Empirical Study of Law in Action*, 33 FLA. ST. L. REV. 1067, 1073 (Summer, 2006).

79. *Id.*

80. Buraczynski v. Evring, 919 S.W.2d 314, 317 (Tenn. 1996).

81. *See id.* at 314–22.

82. *Id.* at 316. One of the patients, Helen Parker, was the subject of another case involving Dr. Eyring's challenge to "the revocation of his staff appointment and clinical privileges." Eyring v. Fort Sanders Parkwest Med. Ctr., 991 S.W.2d 230, 232 (Tenn. 1999).

83. *See generally* Robert B. Bourne et al., *Patient Satisfaction after Total Knee Ar-*

Dr. Eyring required each patient to execute a "Physician-Patient Arbitration Agreement."[84] Medical treatment was conditioned upon the execution of the agreements, although, one of the patients executed her agreement post-surgery.[85] The agreement, by its terms, was retroactive to previous treatment provided to her by Dr. Eyring, including the knee replacement procedure.[86] The Court highlighted the details of the agreements as follows:

> The agreements are identical in all respects and require arbitration of any and all medical malpractice claims by the patient against the doctor. The provisions bind all potential parties, including the patient's spouse and heirs, on all claims for medical negligence. In return, the physician is bound by the arbitrators' malpractice decision, including any fee claims involved in the disputed treatment. Finally, the patient has an unconditional right to revoke the agreement by providing written notice to the physician within thirty (30) days of signing.[87]

The court's opinion related other details of the compulsory arbitration agreements. Each patient executed a single-page arbitration agreement.[88] "A short explanation was attached to each document which encouraged the patient to discuss questions about the agreement with [Dr.] Eyring."[89] The arbitration provision contemplated three arbitrators and required the patient and Dr. Eyring to each choose an arbitrator. Those arbitrators would select a third arbitrator.[90] The arbitrators' decision bound Dr. Eyring and the patients were advised that they are waiving their rights "'to a jury or court trial' on any medical malpractice claim."[91] The Court emphasized that "[f]inally, and perhaps most importantly, the agreements did not change the doctor's duty to use reasonable

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throplasty: Who is Satisfied and Who is Not?, 468 CLINICAL ORTHOPAEDICS & RELATED RES. 57 (Jan. 2010); Paul F. Fortin et al., *Outcomes of Total Hip and Knee Replacement: Preoperative Functional Status Predicts Outcomes at Six Months After Surgery*, 42 ARTHRITIS & RHEUMATISM 1722 (Aug. 1999); James E. Lovelock et al., *Complications of Total Knee Replacement*, 142 AM. J. ROENTGENOLOGY 985 (May 1984).

84. *Buraczynski*, 919 S.W.2d at 317 (noting that "the agreements signed by [the patients] were presented to them on a 'take it or leave it basis'").

85. *Id.* at 316–17.

86. *Id.*

87. *Id* at 317.

88. *Id.* at 321.

89. *Id.*

90. *Id.*

91. *Id.*

care in treating patients, nor limit liability for breach of that duty, but merely shifted the disputes to a different forum."[92]

Following the filing of the medical negligence actions, the defendants moved to compel arbitration. The trial court denied the motions, basing that decision on the incompatibility of the arbitration agreement with the Tennessee arbitration statute[93] and insufficient contract consideration.[94] The cases were consolidated on appeal and the trial court's judgment was reversed.[95] The Court of Appeals held "that the nature of the physician-patient relationship is unique and not a typical contractual relationship,"[96] that the Tennessee arbitration statute was applicable[97] and "found sufficient consideration[98] to support the agreements in question."[99] The Supreme Court of Tennessee "granted this appeal to consider an important question of first impression—the enforceability of arbitration agreements between physicians and patients."[100] In its opinion, the court addressed the related issues of public policy,[101] breadth of the application of the arbitration agreements,[102] and contracts of adhesion.[103]

As to public policy, the Supreme Court stated "that no court has ever reached the broad conclusion that public policy precludes the use of private arbitration agreements in the area of medical services."[104] This statement suggests the lack of an overarching principle that would require a finding that the arbitration provisions were unenforceable. Although recognizing the "unique nature of the physician-patient relationship,"[105] without explaining it, the court held that arbitration is "advantageous,"[106] not limiting po-

92. *Id.*
93. TENN. CODE ANN. § 29-5-302(a) (West 2015).
94. *Buraczynski,* 919 S.W.2d at 317.
95. *Id.*
96. *Id.*
97. *Id.*
98. *See* ALLAN E. FARNSWORTH, CONTRACTS § 2.3 (2d ed. 1998).
99. *Buraczynski,* 919 S.W.2d at 317.
100. *Id.*
101. *Id.* at 318.
102. *Id.* at 319.
103. *Id.* at 320.
104. *Id.* at 318 (citing Stanley D. Henderson, *Contractual Problems in the Enforcement of Agreements to Arbitrate Medical Malpractice*, 58 VA. L. REV. 947, 949 (1972)).
105. *Id.* at 319.
106. *Id.*

tential liability,[107] and designating a forum for dispute resolution.[108] As such, the court pronounced "that arbitration agreements between physicians and patients are not *per se* void as against public policy."[109]

As to the breadth of the arbitration provisions, the court simply dismissed the argument that the provision must be treatment or procedure specific, citing California precedent.[110] Rather curiously, this precedent suggests that requiring a treatment or procedure-specific arbitration provision would burden the physician and emasculate the arbitration process[111] by forcing the physician to seek the execution of a new arbitration provision with each change of the treatment regimen. Does that reasoning suggest that compulsory arbitration places no burden on the patient?

Begging the question of "patient understanding," the court had no difficulty with the retroactive effect of the arbitration provision which was executed after the patient received the medical treatment which was the subject of the claim. Here, the court simply concluded that because the patient "initialed the clause which applied to the previously rendered treatment," she "was therefore obviously aware of it."[112] It is necessary to remember that *Buraczynski* concerns "take it or leave it" arbitration.[113] The patient has no choice but to execute the agreement or find other treatment. Under these circumstances, whether the patient is "obviously aware" of the arbitration provision, its meaning, or arbitration process is questionable, and will be the subject of discussion in this article.

Turning to its discussion and analysis of adhesion contracts, the court emphasized the "take it or leave it"[114] character, i.e., required acquiescence,[115] and that the patient "has no realistic choice"[116] of contract terms. The court concluded that the subject arbitration agreements were adhesion contracts because: "the agreements are standardized form contracts prepared by the con-

107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.* (citing Hilleary v. Garvin, 238 Cal. Rptr. 247 (Cal. Ct. App. 1987)).
111. *Id.* at 319.
112. *Id.*
113. *See id.* at 317 (stating "had the patients refused to sign, [the doctor] would not have continued to treat them").
114. *Id.* at 320.
115. *Id.*
116. *Id.*

tracting party" the contracting physician has "superior knowledge of the subject matter—the rendition of medical services," and the physician conceded the take it or leave it basis of the agreement (a patient refusing to sign would no longer receive medical care).[117] Of course, the court noted that it's finding that the arbitration provisions were contracts of adhesion did not require a finding of unenforceability.[118]

Moving to the question of enforceability, the court emphasized that its characterization of the arbitration agreements as contracts of adhesion did not make the agreements unenforceable.[119] Here, the court stated that "[e]nforceability generally depends upon whether the terms of the contract are beyond the reasonable expectations of an ordinary person, or oppressive or unconscionable."[120] Unfortunately, the court did not state that patient literacy or medical ethics were factors to consider. These factors will be addressed later in some detail.

Instead, the court focused on whether the arbitration provisions were hidden, "not afford[ing] the patients an opportunity to question the terms or purpose of the agreement."[121] Remarkably, the court concluded that the provisions were quite fair, for the following reasons: the arbitration agreements were separate, entitled documents; attached explanations suggested that the patients discuss their questions about the agreements with the physician; the specified arbitration procedure was fair; the language of the agreement informed the patient of the waiver of a court or jury trial; there were no hidden terms; the "retroactivity" provision was separate and required the patient to initial it; the patients could revoke the agreements within 30 days of execution; and the agreements did not alter Dr. Eyring's duty to exercise reasonable care.[122]

Finally, the court proclaimed that "[n]one of the above described provisions can be construed as unconscionable, oppressive, or outside the reasonable expectations of the parties. As such, the agreements, though contracts of adhesion, are enforceable."[123] Of

117. *Id.*
118. *Id.*
119. *Id.*
120. *Id.* (citing Broemmer v. Abortion Serv.'s of Phoenix, Ltd., 840 P.2d 1013, 1016 (Ariz. 1992)).
121. *Id.* at 321.
122. *Id.*
123. *Id.* at 320

course this proclamation was not based upon any analysis of the reasonable expectation of a patient—a layperson. Should a patient expect an arbitration agreement as a condition of treatment? What is the likelihood that a patient could understand a legal document that profoundly affects the patient's legal rights?[124] This issue in "legal literacy"[125] compounds well-known and reported problems in general and health literacy—problems that make physician-patient communication a challenge.[126] Furthermore, the court did not consider the medical ethics of the compulsory arbitration agreement. Instead, the *Buraczynski* court equates the physician-patient encounters with arms-length business transactions—a misguided notion.[127]

B. Mississippi

In *Cleveland v. Mann*, the Supreme Court of Mississippi placed its stamp of approval on an arbitration agreement, the execution of which may have been compelled.[128] Here, the defendant-physician, a surgeon, treated the patient for stomach cancer. The treatment provided was a total gastrectomy.[129] Following that procedure, at a subsequent appointment for follow-up treatment for an apparent surgical complication, an arbitration agreement was presented to the patient.[130] The patient executed the agreement and follow-up surgery was performed nineteen days later.[131] The patient required

124. *See generally* James Boyd White, *The Invisible Discourse of the Law: Reflections on Legal Literacy and General Education*, 54 U. COLO. L. REV. 143 (1983) (discussing the "degree of competence in legal discourse required for meaningful and active life in our increasingly legalistic and litigious culture").

125. *Id.*

126. *See* Mark V. Williams et al., *The Role of Health Literacy in Patient-Physician Communication*, 34 FAM. MED. 383 (May 2002).

127. *Buraczynski*, 919 S.W.2d at 320.

128. Cleveland v. Mann, 942 So. 2d 108, 116 (Miss. 2006). "However, the parties dispute whether the agreement was presented on a 'take it or leave it' basis." *Id.* The dissent referred to the arbitration agreement as "offered to the patient as a prerequisite to necessary medical treatment." *Id.* at 121.

129. *Id.* at 110. There is considerable medical literature discussing grastectomy. *See, e.g.*, Scott A. Hundahl et al., *The National Cancer Data Base Report on Poor Survival of U.S. Gastric Carcinoma Patients Treated with Gastrectomy*, 88 CANCER 921 (2000); John R. T. Monson et al., *Total Gastrectomy for Advanced Cancer*, 68 CANCER 1863 (1991); Asgaut Viste et al., *Postoperative Complications and Mortality After Surgery for Gastric Cancer*, 207 ANNALS SURGERY 7 (1988).

130. *Cleveland*, 942 So. 2d at 111.

131. *Id.*

additional surgery and continued to deteriorate until his death.[132] A medical negligence action was commenced, triggering a motion to compel arbitration.[133] The response to this motion urged that the patient "did not enter into the agreement knowingly, voluntarily, and intelligently, and the agreement violated the Mississippi Arbitration Act."[134] The trial court denied the motion to compel arbitration, based upon an unconscionable contract of adhesion,[135] having stated that this was an issue of first impression.[136]

Following its discussion of the FAA and arbitrability,[137] the court undertook an analysis of procedural and substantive unconscionability. Evidence of procedural unconscionability would include "a lack of knowledge, lack of voluntariness, inconspicuous print, the use of complex legalistic language, disparity in sophistication or bargaining power of the parties and/or a lack of opportunity to study the contract and inquire about the contract terms."[138] Evidence of substantive unconscionability focuses on oppressive terms in the arbitration provision.[139]

Applying these concepts, the court held that the arbitration agreement was neither procedurally nor substantively unconscionable. Without citing any authority regarding "literacy" the court disposed of the argument that the patient's "lack of education and inability to read or understand the agreement"[140] created "a disparity in the sophistication of the parties"[141] and procedural unconscionability. The court referred only to its prior holding that "the inability to read does not render a person incapable of possessing adequate knowledge of the arbitration agreement he or she signed."[142] It seems unimaginable that the court would so readily

132. *Id.*

133. *Id.*

134. *Id.* It should be noted that the response also raised the issue of whether beneficiaries of the wrongful death claim could be bound by the provision, a topic not addressed by this paper. For a very recent opinion on whether a non-signatory to an arbitration agreement may be bound by the agreement. *See* Fiala v. Bickford Senior Living Grp., 32 N.E.3d 80 (Ill. App. Ct. 2015).

135. *Cleveland,* 942 So. 2d at 111–12.

136. *Id.* at 113.

137. *Id.* at 112–13.

138. East Ford, Inc. v. Taylor, 826 So. 2d 709, 714 (Miss. 2002).

139. *Cleveland,* 942 So. 2d at 111–12.

140. *Id.*at 114.

141. *Id.*

142. *Id.* (citing EquiFirst Corp. v. Jackson, 2005-CA-00621-SCT (¶ 19) (Miss. 2006)).

dismiss or discount the relationship between reading ability and likelihood of understanding a legal document.[143]

The court next considered the claim that the arbitration agreement was not explained to the patient, first by referring to the patient's signature on the first page of the agreement, providing as follows: "NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL."[144]Additionally, the patient initialed each term, presumably after a medical staff member explained each term.[145]

The court also referred to affidavits provided by the patient's sister-in-law and the defendant-physician. The sister-in-law had accompanied the patient to the appointment at which the arbitration agreement was executed. Her testimony revealed that the patient asked the defendant-physician about the meaning of the arbitration agreement, to which he replied, "It's so you won't sue me."[146]

The physician-defendant's affidavit indicated that the patient "signed the agreement and initialed his understanding on the second page of the agreement before meeting with him."[147] The physician then met with the patient and confirmed that the patient had read the arbitration agreement, "had its terms explained to him, fully understood its terms, and consented to the surgery."[148] This confirmation was based on his recollection of his conversation with the patient and the patient's signature and initials appearing on the agreement.[149]

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143. *See* Barry D. Weiss, Gregory Hart, Daniel L. McGee & Sandra D'Estelle, *Health Status of Illiterate Adults: Relation Between Literacy and Health Status Among Persons with Low Literacy Skills*, 5 J. AM. BOARD FAM. PRAC. 257, 257 (1992) (noting that millions of persons in the U.S. "lack basic reading skills" or have only "rudimentary reading skills that are not sufficient to permit full participation in society's economic and social activities.").

144. *Cleveland*, 942 So. 2d at 114.

145. *See id.* at 114–15 (explaining that the second page of the agreement contains a statement, acknowledged by the defendant-physician's medical staff member, that the arbitration agreement was explained to the patient).

146. *Id.* at 115.

147. *Id.*

148. *Id.*

149. *See id.*

The court next held that "[t]he language in this agreement is neither complex nor convoluted."[150] Here, the court relied on the boldness of the print, a statement in the agreement explaining its terms, a signature of the patient on a page of the agreement, the patient having initialed each term, "denoting his understanding of the terms"[151] and the patient having initialed the agreement to indicate "he was provided an opportunity to inquire about the agreement's terms."[152] Then, curiously, the court stated that "[plaintiffs] may not escape the agreement by simply stating [the patient] did not read the agreement or have it read to him or understand its terms."[153] The court did not address whether this patient had the wherewithal to understand the arbitration provision, and simply signed a document given to him in order to receive the medical treatment he desired.

The court next addressed contracts of adhesion and voluntariness relating to the claim that the patient had no choice but to execute the agreement. The court dispatched this argument, noting that the agreement, prepared by defense counsel, provided that the "[p]atient is not in need of emergency care or under immediate stress,"[154] the patient had the right to "make written changes in the Arbitration Agreement if they so desire and present these to the Clinic for approval,"[155] the patient could rescind the agreement within fifteen days, and that the patient's "surgery was not scheduled until nineteen days after he executed the agreement . . . ,"[156] presumably to suggest that the patient had the time and resources to seek legal counsel to consult about arbitration. In my estimation, this position defies logic and, again, suggests that the patient was fully involved in a business transaction. Of course, the court's position assumes that the patient knew that he executed an arbitration agreement, fully understood what it meant, including the concept of rescission and the waiver of basic legal rights, and would have had the presence of mind and capability of consulting with legal counsel. Undoubtedly, the patient simply desired medical treatment. In any event, for the aforementioned reasons, the court con-

150. *Id.* at115.
151. *Id.*
152. *Id.*
153. *Id.* at 115–16.
154. *Id.* at 116.
155. *Id.*
156. *Id.*

cluded that the arbitration agreement did not suffer from procedural unconscionability.[157]

Finally, the court held the arbitration provision was not substantively unconscionable. The court believed that the arbitration forum was fair and that the agreement neither limited the patient's legal rights or damages nor the defendant-physician's liability.[158] Therefore, the court held that the trial court incorrectly denied the motion to compel arbitration, reversed the judgment, and remanded the case "with instructions . . . compelling the parties to submit their dispute to arbitration."[159]

A vigorous dissent recognized the patient's "lack of bargaining power"[160] and the one-sidedness of the arbitration provision,[161] and apparently agreed with the trial court that the arbitration provision was a take it or leave it proposition. The dissent focused on the state constitutional provision of a right to trial by jury.[162] It noted that any interference with that right, including arbitration, must be reviewed with strict scrutiny.[163]

C. Utah

Truth is stranger than fiction. The facts of *Sosa v. Paulos*,[164] an opinion of the Supreme Court of Utah, certainly satisfy this maxim. Here, the patient was to undergo a posterior cruciate ligament reconstruction.[165] "[L]ess than one hour prior to surgery, after Ms. Sosa was undressed and in her surgical clothing, 'someone from Dr. Paulos' office' gave her three documents and asked her to sign them," including an arbitration agreement.[166] No one from the defendant-physician's office ever discussed the arbitration agreement with her and Ms. Sosa executed the agreement without reading it.[167]

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157. *See id.*
158. *See id.* at 117.
159. *Id.* at 119.
160. *Id.* at 121.
161. *See id.*
162. *See* MISS. CONST. art. III, § 31.
163. *Cleveland*, 942 So. 2d at 122.
164. Sosa v. Paulos, 924 P.2d 357 (Utah 1996).
165. *Sosa*, 924 P.2d at 359. *See, e.g.*, Edward L. Trickey, *Rupture of the Posterior Cruciate Ligament of the Knee*, 50 J. BONE & JOINT SURGERY 334 (1968) (discussing the mechanism of injury, physical signs of injury, treatment, surgical approach and repair, and results of treatment).
166. *Sosa*, 924 P.2d at 359.
167. *Id.*

At that time, the Utah Arbitration Act contemplated compulsory arbitration.[168] The patient believed that she was required to sign the agreement as a condition of the treatment.[169] Utah public policy favored arbitration agreements, including those between physicians and patients.[170]

Post-operatively, the patient suffered a complication and later commenced a medical negligence action.[171] The trial court denied the defendant-physician's motion to stay and compel arbitration, finding the arbitration agreement "procedurally and substantively unconscionable."[172]

The arbitration agreement executed by the patient was quite detailed, covering "all conceivable claims,"[173] providing an arduous cost-shifting process,[174] a fourteen day revocation provision in favor of the patient,[175] a declaration of patient understanding,[176] severability in the event of an unenforceable provision[177] and the patient's waiver of the right to a jury or court trial.[178] It should be emphasized that the patient was confronted with this arbitration agreement less than one hour before surgery.[179]

The court undertook a discussion of substantive and procedural unconscionability. As to substantive unconscionability—focusing on the terms of the arbitration agreement—the court focused on the requirement that the arbitrators would be orthopedic surgeons and the circumstance in which the patient would be required to absorb the arbitration fees.[180] In, regrettably, analogizing the physician-patient relationship to a business transaction, the court noted that "[t]he terms of the contract should be considered

168. UTAH CODE ANN. § 78-31a-3 (1992), *repealed by* UTAH CODE ANN. § 78-14-17 (West 2007) (current version at UTAH CODE ANN. § 78B-3-421 (West 2014)); Soriano v. Graul, 186 P.3d 960 (Utah Ct. App. 2008). The statute was subsequently amended to allow patients to decline arbitration and continue to receive treatment. UTAH CODE ANN. § 78B-3-421 (West 2014).

169. *Sosa*, 924 P.2d at 362.

170. *Id.* at 359.

171. *Id.*

172. *Id.*

173. *Id.*

174. *Id.* at 360.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.*

179. *Id.*

180. *Id.* at 361.

'according to the mores and business practices of the time and place.'"[181] The court held that the arbitrator selection process (neutrally selected orthopedic surgeons) was not biased in favor of the defendant-physician and was not substantively unconscionable.[182] The court, however, did hold the payment of costs provision substantively unconscionable due to cost shifting—"the award of attorney fees to the loser in malpractice arbitration"[183] and the embedding of the provision "in a non-negotiated agreement."[184] This latter factor also violated Utah public policy.[185]

As to procedural unconscionability, the court noted its agreement "with the trial court's conclusion that elements of procedural unconscionability surrounded the negotiation of this agreement."[186] Actually, there was no negotiation. The court recognized that the patient was given the agreement on the precipice of surgery, when the patient "was already in her surgical clothing and in a state of fear and anxiety."[187] She did not read the arbitration agreement and it was not explained to her. She did not have "a meaningful choice with respect to signing the agreement."[188] It is laudable that the court recognized the patient's pre-surgical vulnerability, anxiety and apprehension.[189]

The court then addressed the issue of whether the patient could have invoked the revocation clause of the arbitration agreement, giving the patient "fourteen days to unilaterally review and revoke the agreement."[190] Apparently, the record on appeal did not clearly address "whether Ms. Sosa actually received a signed copy of the arbitration agreement following her surgery."[191] If she had, a majority of the court would order the trial court to sever the unconscionable cost-shifting provision and enforce the remainder of the arbitration agreement if the patient was not "precluded from

181. *Id.* (citing Res. Mgmt. Co. v. Weston Ranch, 706 P.2d 1028, 1042 (Utah 1985) (quoting ARTHUR L. CORBIN, CORBIN ON CONTRACTS § 128 (1963))).
182. *Id.* at 361.
183. *Id.* at 362.
184. *Id.*
185. *Id.*
186. *Id.* at 362–63 (emphasis added).
187. *Id.* at 363.
188. *Id.*
189. *Id.*
190. *Id.* at 364.
191. *Id.*

exercising her right to revoke."[192] Why a majority of the court would think that a post-operative patient would be inclined to revisit an arbitration agreement, which the patient was likely unaware of in the first instance, is unexplained. Ultimately, the majority held that the defendant-physician's "behavior in negotiating the agreement was procedurally unconscionable" and that the arbitration cost-shifting provision was substantively unconscionable. [193] The issue on remand was the potential enforceability of the remainder of the arbitration agreement.

D. Florida

The opinion of the District Court of Appeal of Florida in *Santiago v. Baker*[194] is the opinion first referred to in this paper and is the opinion which piqued my interest in the compulsory arbitration of medical liability claims. *Santiago* involves a compulsory arbitration agreement executed by an obstetrical-gynecological patient on her initial visit to a women's medical practice.[195] Florida had a statute providing for voluntary, binding arbitration of medical negligence claims[196] but the patient never invoked the statute. Instead, upon the patient's filing of a medical negligence claim, the defendant successfully moved to compel arbitration pursuant to the private arbitration agreement.[197]

Without detailed analysis or discussion, the court stated, "Ms. Santiago willingly signed the arbitration agreement. Our record reflects no coercion or duress."[198] In conclusory fashion, the court held that the arbitration agreement was neither procedurally nor substantively unconscionable.[199] *Santiago* simply stands for the proposition that compulsory, private arbitration agreements between physicians and patients do not violate Florida public policy.[200]

The concurring opinion focused on the waiver of the right of trial by jury by non-signatories to the arbitration agreement—the

192. *Id.*
193. *Id.*
194. 135 So. 3d 569, 569 (Fla. Dist. Ct. App. 2014).
195. *Id.*
196. Medical Malpractice and Related Matters, 45 FLA. STAT. ANN. § 766 (West 2014).
197. Santiago, 135 So. 3d at 570.
198. *Id.* at 571.
199. *Id.*
200. *Id.*

patient's husband and child—but also referred to literacy and health literacy by stating:

> But somehow in deference to the supposed economic efficiency of arbitration, our society seems to be more and more willing to allow the use of form contracts, not subject to negotiation, that force patients, the elderly, the marginally literate, and ordinary consumers of everyday products to waive their constitutional right to trial by jury in common law cases—before the common law cause of action even exists—in order to receive basic goods and services.[201]

Nevertheless, of course, the concurrence supported the notion of the binding, private, compulsory arbitration agreement between a physician and a patient.

Not long after *Santiago*, a different appellate district issued an unpublished opinion[202] and disagreed with *Santiago*'s recognition of non-statutory medical arbitration agreements that do not adopt all of the statutory provisions. Presumably then, this opinion in *Crespo v. Hernandez*[203] would not endorse a take-it-or-leave-it arbitration provision but only an agreement which provided for voluntary arbitration, which could be invoked by physician or patient.

E. Nevada

In 1985, the Supreme Court of Nevada, in *Obstetrics & Gynecologists v. Pepper*, held unenforceable an arbitration agreement that a patient was required to execute as a condition of treatment.[204] Here, a patient appeared at a clinic seeking oral contraceptives.[205] Pursuant to the custom and practice of the clinic, the following would have occurred: the receptionist handed "the patient the arbitration agreement along with two information sheets;"[206] the receptionist informed the patient that any of the patient's questions about the arbitration agreement would be answered;[207] the patient executed the agreement as a condition of treatment;[208] a physician

201. *Id.* at 572.
202. Crespo v. Hernandez, 151 So.3d 495 (Fla. Dist. Ct. App. 2014).
203. *Id.*
204. Obstetrics & Gynecologists v. Pepper, 693 P.2d 1259 (Nev. 1985).
205. *Id.*
206. *Id.* at 1260.
207. *Id.*
208. *Id.*

executed the arbitration agreement;[209] and the arbitration agreement did not provide the patient a right to revoke it.[210] The arbitration agreement covered all disputes, provided for binding arbitration and waived the right to a trial.[211] The patient signed the agreement although she had no recollection of doing so and no recollection that it was explained to her.[212]

Presumably after taking the oral contraceptive, the patient "suffered a cerebral incident which left her partially paralyzed."[213] She filed suit for medical negligence, urging that the oral contraceptive "was contraindicated by her medical history."[214] The defendant moved the court to stay the litigation and compel arbitration.[215] The motions were denied and the appeal followed.[216]

First, the Nevada Supreme Court embarked on a discussion of adhesion contracts. It focused on the "take it or leave it"[217] feature of the agreement—an agreement "prepared by [the] . . . medical clinic and presented to [the patient] as a condition of treatment."[218] It did note that an adhesion contract which met "the reasonable expectations of the weaker . . . party and is not unduly oppressive"[219] will be enforceable. Next, the Nevada Supreme Court concluded that the patient did not consent to the provisions of the arbitration agreement, finding no "meeting of the minds"[220] and a lack of "informed consent."[221] This finding was based on the pa-

209. *Id.*

210. *Id.*

211. *Id.* at 1259.

212. *Id.* at 1260.

213. *Id.*

214. *Id. See* Alan B. Grindal et al., *Cerebral Infarction in Young Adults*, 9 STROKE 39, 39–40 (1978) (concluding that oral contraceptive use "may" be an explanation for increased incidences of cerebral infarction in women of childbearing age); William D. Odell, *An Analysis of the Reported Association of Oral Contraceptives to Thromboembolic Disease*, 122 W. J. MED. 26, 26–32 (1975) (discussing the relationship between oral contraceptives and cerebral infarction).

215. *Pepper*, 693 P.2d at 1260.

216. *Id.*

217. *Id.*

218. *Id.*

219. *Id.* at 1261.

220. *Id.* "Meeting of the minds" refers to a classic theory of contract law. *See* Joseph M. Perillo, *The Origins of the Objective Theory of Contract Formation and Interpretation*, 69 FORDHAM L. REV. 427 (2000); E. Allan Farnsworth, *"Meaning" in the Law of Contracts*, 76 YALE L.J. 939 (1967).

221. "Informed consent" is typically considered the physician's obligation to disclose the risks, benefits, complications of and alternatives to a recommended

tient's inability to recall "receiving any information regarding the terms of the arbitration agreement."[222]

The Nevada Supreme Court affirmed the trial court's denial of the motions to stay the action and to order arbitration. Essentially, the Supreme Court treated this dispute as a contract matter, without a mention of general literacy, health literacy or the medical ethics of proposing such an agreement.

F. Arizona

In *Broemmer v. Abortion Servs. of Phoenix,*[223] the Supreme Court of Arizona considered the enforceability of an arbitration agreement a patient was required to execute "prior to undergoing a clinical abortion."[224] The facts reveal that the patient was young, unmarried, of modest means, and the father-to-be insisted on the abortion—her parents wished otherwise.[225] By affidavit, the patient "describes the time as one of considerable confusion and emotion and physical turmoil for her."[226]

The relevant facts of the patient's encounter with the medical clinic are these: the patient "was escorted into an adjoining room and asked to complete three forms, one of which [was] the agreement to arbitrate."[227] The arbitration agreement applied to all disputes with the clinic, provided for binding arbitration and further provided that the arbitrators would be licensed OB-GYNs.[228] The patient completed the forms, was not given copies of them and re-

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treatment or procedure for a patient. *See* Marc. D. Ginsberg, *Informed Consent and the Differential Diagnosis: How the Law Can Overestimate Patient Autonomy and Compromise Health Care*, 60 WAYNE L. REV. 349, 352 (2014) (citing Canterbury v. Spence, 464 F.2d 772, 783 (D.C. Cir. 1972)).

222. *Pepper*, 693 P.2d at 1261.

223. Broemmer v. Abortion Serv. Phoenix, Ltd., 840 P.2d 1013, 1013 (Ariz. 1992).

224. *Id.* A clinical abortion has been defined as "[a]n abortion of a clinical pregnancy which takes place between the diagnosis of pregnancy and 20 completed weeks' gestational age." Fernando Zegers-Hochschild et al, *The ICMART Glossary on ART Terminology,* 21 HUMAN REPRODUCTION 1968, 1969 (2006).

225. *Broemmer,* 840 P.2d at 1014.

226. *Id.* See Catherine T. Coyle, Priscilla K. Coleman & Vincent M. Rue, *Inadequate Preabortion Counseling and Decision Conflict as Predictors of Subsequent Relationship Difficulties and Psychological Stress in Men and Women*, 16 TRAUMATOLOGY 16 (2010) (providing a discussion of unplanned pregnancy as a "crisis situation").

227. *Broemmer,* 840 P.2d at 1014.

228. *Id.*

ceived no explanation of the arbitration agreement.[229] The patient was told to return the next morning for the abortion procedure, which she did, and the abortion was performed. A complication occurred—a punctured uterus—requiring further treatment.[230] It prompted the filing of a medical negligence complaint.

The complaint was met by a motion to dismiss. Plaintiff submitted "uncontroverted" affidavits in response, apparently indicating that she "could recall completing and signing the medical history and consent-to-operate forms, but could not recall signing the agreement to arbitrate."[231] Treating the motion as one for summary judgment, due to the trial court's consideration of the affidavits, the trial court granted summary judgment for the clinic and denied the patient's motion for further relief. The court of appeals affirmed, holding that the arbitration agreement, despite its adhesive character, was "enforceable because it did not fall outside plaintiff's reasonable expectations and was not unconscionable."[232]

The Arizona Supreme Court refused to broadly address the enforceability of the arbitration agreement, declining to establish a "'bright-line rule' of broad applicability."[233] Based on the specific, "undisputed facts," the court held the arbitration agreement unenforceable.[234]

The court had no difficulty in identifying the arbitration agreement as a contract of adhesion. The patient's execution of the agreement was a condition of treatment, the agreement was not negotiated, it required the arbitrators to be OB-GYNs and its terms were not explained to the patient.[235] The arbitration agreement, therefore, had all of the characteristics of a contract of adhesion.[236]

Next, the court considered the reasonable expectations of the patient and enforceability of an adhesion contract. Here, the patient did not recall signing the agreement or having the clinic explain it to her.[237] The clinic "did not show whether [the patient] was required to sign the form or forfeit treatment."[238] Furthermore, the

229. *Id.* at 1015.
230. *Id.*
231. *Id.*
232. *Id.*
233. *Id.*
234. *Id.*
235. *Id.* at 1016.
236. *Id.* at 1015.
237. *Id.* at 1017.
238. *Id.* The arbitration agreement is appended to the opinion as Appendix A.

court emphasized that the provision requiring waiver of the right to a jury trial was inconspicuous, and "that waiver of such fundamental rights was beyond the reasonable expectations of [the patient]."[239]

Referring again to the patient's vulnerability, the court noted that she "was under a great deal of emotional stress, had only a high school education, was not experienced in commercial matters, and is still not sure 'what arbitration is.'"[240] The arbitration agreement was not encompassed by the patient's reasonable expectations and was unenforceable.[241]

A rather vigorous dissent suggests that the patient, "an adult, signed the document" and should be bound by the agreement.[242] Strangely, the dissent believes that the patient may have desired arbitration and that there is no harm in the arbitration process.[243] It noted the patient's opportunity to read the arbitration agreement, which "was legible and was hardly hidden from [the patient's] view."[244]

The difficulty with the dissent in *Broemmer*[245] is that it treats the arbitration agreement as the result of a business-like negotiation between the patient and clinic. The majority recognized that the patient was vulnerable for many reasons, as are many patients. Patient vulnerability is a characteristic of the physician-patient relationship and poses a significant roadblock to compulsory arbitration as a condition of treatment.

G. Hawaii

In *Siopen v. Kaiser Found. Health Plan*, the Supreme Court of Hawaii considered the enforceability of an arbitration provision contained in an agreement between a health care provider and a

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Id. at 1023. It states: "it is understood by the Patient that he or she is not required to use the aforesaid Doctor and that there are numerous other physicians in Phoenix, Arizona who are qualified to provide the same services as aforesaid Doctor." *Id.* This statement more than suggests that treatment was conditioned on patient's execution of the arbitration agreement. *Id.*

239. *Id.* at 1017.
240. *Id.*
241. *Id.*
242. *Id.* at 1018.
243. *Id.* at 1019.
244. *Id.* at 1020.
245. *Id.* at 1018.

patient's employer.[246] The patient was a public school teacher and his health insurance was provided through a union health benefits trust fund.[247] The trust fund contracted with Kaiser for health services.[248] The group agreement between Kaiser and the union contained an arbitration provision, which applied to all potential claims against Kaiser.[249] The arbitration provision contained limitations on discovery,[250] noted that arbitration decisions were "final and binding"[251] and noted a waiver of the right to trial before a jury or court.[252] Kaiser claimed that it was the employer's responsibility to make the group agreement available to the employees to review.[253]

The pertinent medical facts involve the patient's "persistent upper abdominal pain"[254] and his diagnosis with "a very rare, aggressive and fatal form of cancer"[255] that would be treated through Kaiser with "a complete surgical resection of [the patient's] stomach and esophagus."[256] The patient sought a second opinion at a university medical center, which concluded Kaiser's diagnosis was incorrect and different treatment was required.[257] The patient remained there for treatment, and Kaiser refused to cover the costs.[258]

The patient filed suit against Kaiser based on multiple theories of liability, including medical negligence, and "sought a declaration that the mandatory arbitration requirement" was void and unenforceable claiming it "provides an adjudicatory process that is unconscionable and heavily biased in Kaiser's favor."[259] The patient also alleged "that the arbitration provision is a provision of adhesion for which [the patient] had neither choice nor bargaining

246. Siopes v. Kaiser Found. Health Plan, Inc., 312 P.3d 869 (Haw. 2013).
247. *Id.*at 871–72.
248. *Id.* at 872.
249. *Id.* at 872–73.
250. *Id.* at 873.
251. *Id.* at 874.
252. *Id.*
253. *Id.*
254. *Id.* at 875.
255. *Id. See generally* Hannah H. Wong & Peiguo Chu, *Immunohistochemical Features of the Gastrointestinal Tract Tumors,* 3 J. GASTROINTESTINAL ONCOLOGY 262 (Sept. 2012), http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3418530/.
256. *Siopes,* 312 P.3d at 875.
257. *Id.* at 876.
258. *Id.*
259. *Id.*

power to challenge."[260] Kaiser responded by filing a "Motion to Compel Arbitration and Motion to Stay Discovery pending the ruling on the motion to compel."[261] Essentially, the patient's position was that he was completely unaware of the arbitration provision.[262] The trial court disagreed with the patient and compelled arbitration.[263]

The Hawaii Supreme Court focused on contract formation, stating that "the issue is whether [the patient] assented to the arbitration provision in the first instance, when he enrolled in the Kaiser plan by signing the Enrollment Form."[264] The court found an absence of mutual assent, reasoning the patient was uninformed of the arbitration provision or that it would be binding upon him, ruling he could not be compelled to participate in arbitration.[265]

Finally, the court noted that the trial court erred by not considering the unconscionability issue. The court vacated the trial court's orders with respect to arbitration and sent the case back to the trial court for further proceedings.[266]

H. What Have We Learned So Far?

Having surveyed the judicial opinions of various states on the issue of the compulsory arbitration of medical negligence claims, a rather simple, unhelpful fact is apparent. Courts, primarily using a basic contract law analysis, may find compulsory arbitration agreements covering medical negligence claims enforceable or unenforceable. If forming the physician-patient relationship is seen as a business transaction, a court will be more likely to enforce an arbitration agreement on the theory that the agreement is legible, not hidden, and furthers the policy of the state in preferring arbitration as an efficient and cost-conscious method of alternative dispute resolution. The physician-patient relationship, however, does not derive from an arm's-length business negotiation. Some courts have recognized the vulnerability of patients, including potential literacy issues. Patients are likely to execute whatever documents are necessary in order to receive treatment. Courts may understand

260. *Id.* at 876–77.
261. *Id.* at 877.
262. *Id.*
263. *Id.*
264. *Id.* at 880.
265. *Id.* at 885.
266. *Id.*

basic principles of contract law but, in my estimation, they typically neither understand medicine nor seek to learn about it when this knowledge can usefully inform judicial decision making.[267]

Medicine should provide some helpful information about compulsory arbitration. The remainder of this paper will search medicine in an effort to discover why medicine encourages patients to execute arbitration agreements as a condition of treatment and whether this practice is medically ethical.

VIII. THE MEDICAL PROFESSION HAS SUPPORTED BINDING ARBITRATION OF MEDICAL LIABILITY CLAIMS

I do not profess to know when a patient was first asked to execute an arbitration agreement as a condition of treatment or when a physician first thought to engage in this practice. It is, however, possible to trace physician support for binding arbitration of medical liability claims to 1975. In April of 1975, the president of the American Society of Internal Medicine (ASIM), Glenn Molyneaux, M.D., provided "Testimony on Medical Liability" to the Senate Subcommittee on Health.[268] This testimony, undoubtedly related to tort reform, emphasized that some "undesirable [medical] outcomes follow appropriate medical care" and that the legal system fails to distinguish these events from medical negligence.[269] The ASIM proposed legislative "reform of the entire legal process as it relates to medical liability," and suggested "that some form of arbitration would be the most equitable for all parties concerned."[270] In fact, in this testimony, the ASIM suggested binding arbitration as a substitute for the jury trial.[271] The testimony did not address medi-

267. This is a problem to which I have previously alluded. *See supra* notes 204–11 and accompanying text; *see also* Jackson v. Pollion, 733 F.3d 786, 790 (7th Cir. 2013) (providing Judge Posner's commentary on a court's understanding of medicine).

268. *See* AM. SOC'Y INTERNAL MED., TESTIMONY ON MED. LIAB., 94th Cong., at 1 (1975), https://www.acponline.org/acp_policy/testimony/medical_liability_testimony_before_subcommitte_health_us_senate_1975.pdf ("[The] ASIM is a federation of 51 component societies of internal medicine. It has more than 13,500 members who, by training and practice standards, are recognized as specialists in internal medicine. Most are private practice internists delivering primary care, subspecialty care or both.") (statement of Glenn Molyneaux, President, Amer. Soc. Internal Med.).

269. *Id.*

270. *Id.*

271. *Id.* at 3.

cal treatment conditioned on the patient's execution of an arbitration agreement.

The American College of Physicians (ACP)[272] has rather vigorously supported voluntary arbitration for medical liability claims. Its informational paper from March 1989, on "Medical Professional Liability" supported "voluntary binding arbitration" as a component of tort reform.[273] This informational paper was followed by the ACP's position paper, "Restructuring The Medical Professional Liability System," which similarly supported arbitration as a tort reform measure.[274] The ACP's 2003 position paper, "Reforming The Medical Professional Liability Insurance System" endorsed federal tort reform legislation, which included authorizing the Secretary of Health and Human Services "to make grants to states for the development and implementation of ADR programs."[275] The ACP reiterated this recommendation in 2006[276] and 2014.[277] In 2014, the American College of Surgeons (ACS)[278] commented on arbitration of medical liability claims. It published Surgeons and Medical Liability: A Guide to Understanding Medical Liability Reform, a "primer to inform ACS fellows about the history of medical liability as well as alternative, innovative reform approaches to the status quo of tort law in the U.S."[279] In this publication, the ACS referred to,

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272. *See* AM. COLL. PHYSICIANS, http://www.acponline.org/about_acp/who_we_are (last visited Jan 30, 2016) ("[The ACP] is a national organization of internists" and "is the largest medical-specialty organization and second largest physician group in the United States.").

273. AM. COLL. PHYSICIANS, MEDICAL PROFESSIONAL LIABILITY at 4 (1986), http://www.acponline.org/acp_policy/policies/medical_professional_liability_1984.pdf (last visited Oct.18, 2015).

274. AMERICAN COLLEGE OF PHYSICIANS, RESTRUCTURING THE MEDICAL PROFESSIONAL LIABILITY SYSTEM at 3, 4, 5, 16, 17 (1986).

275. AMERICAN COLLEGE OF PHYSICIANS, REFORMING THE MEDICAL PROFESSIONAL LIABILITY INSURANCE SYSTEM at 11 (2003).

276. AMERICAN COLLEGE OF PHYSICIANS, EXPLORING THE USE OF HEALTH COURTS—ADDENDUM TO "REFORMING THE MEDICAL PROFESSIONAL LIABILITY SYSTEM" at 4 (2006).

277. AMERICAN COLLEGE OF PHYSICIANS, MEDICAL LIABILITY REFORM: INNOVATIVE SOLUTIONS FOR A NEW HEALTH CARE SYSTEM at 5, 15 (2014).

278. AMERICAN COLLEGE OF SURGEONS, http://www.facs.org/about-acs (last visited October 2, 2015) ("The American College of Surgeons (ACS) is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice").

279. KATHLEEN M. O'NEILL ET AL., THE AMERICAN COLLEGE OF SURGEONS, SURGEONS AND MEDICAL LIABILITY: A GUIDE TO UNDERSTANDING MEDICAL LIABILITY

but did not recommend, mandatory pre-dispute binding arbitration, stating that "the American Arbitration Association . . . does not endorse mandatory [pre-dispute] binding arbitration for medical liability cases. They [sic] do not believe a sick patient has a fair amount of bargaining power when deciding whether or not to accept the arbitration contract."[280] Indeed, it seems that the ACS desires that physicians and patients understand that alternative dispute resolution is an option.[281]

The American Congress of Obstetricians and Gynecologists (ACOG),[282] through its Committee on Professional Liability, issued a Committee opinion entitled "Predispute, Voluntary, Binding Arbitration" in 2014.[283] ACOG's opinion appears supportive of arbitration of medical liability claims, but steadfastly emphasizes the need for "voluntariness"[284] and that the physician cannot refuse treatment to a patient who refuses to execute the arbitration agreement.[285] This is a laudable position, as it respects the vulnerability of patients and the environment surrounding the physician-patient relationship, including the initial patient visit.[286]

At this juncture, it is fair to state that some courts have enforced arbitration agreements executed by patients as a condition of treatment. Furthermore, influential professional medical associations have advocated the use of arbitration agreements covering potential medical liability claims. In my estimation, this is regretta-

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REFORM 4 (2014).

280. *Id.* at 17 (citing Erik Moller, Elizabeth Rolph & John Rolph, *Arbitration Agreements in Health Care: Myths and Reality*, 60 L. & CONTEMP. PROBS. at 153 (1997).

281. O'NEILL ET AL., *supra* note 279, at 41.

282. The American Congress of Obstetricians and Gynecologists' objectives are "to foster and stimulate improvements in all aspects of the health care of women; to establish and maintain the highest standards of practice; to promote high ethical standards; to establish and promote policy positions on issues affecting the specialty of obstetrics and gynecology; and to promote, represent, and advance the professional and socioeconomic interests of its members." AM. CONG. OF OBSTETRICIANS AND GYNECOLOGISTS, BYLAWS 1 (2015).

283. THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS COMMITTEE ON PROFESSIONAL LIABILITY, *Predispute, Voluntary, Binding Arbitration,* 583 COMMITTEE OPINION 1 (Jan. 2014).

284. *Id.* at 2.

285. *Id.*

286. *See* David H. Sohn, *Negligence, Genuine Error, and Litigation*, 6 INT'L J. GEN. MED. 49, 53 (2013) (noting that the practice of requiring the execution of an arbitration agreement as a condition of treatment may lead to an awkward discussion of "adversarial postures during the initial physician-patient visit").

ble but should not end the inquiry. Recognizing that the patients who are asked to execute arbitration agreements may be ill, in pain, medicated, fearful, unwilling to confront a physician, and simply incapable of understanding the gravity of the arbitration agreement, another inquiry remains: is the practice of requiring patients to execute arbitration agreements as a condition of treatment medically ethical?

IX. IS THE PRACTICE OF REQUIRING PATIENTS TO EXECUTE ARBITRATION AGREEMENTS AS A CONDITION OF TREATMENT MEDICALLY ETHICAL?

A. The Hippocratic Oath

I swear by Apollo Physician and Asclepius and Hygieia and Panaceia and all the gods and goddesses, making them my witness, that I will fulfill according to my ability and judgment this oath and this covenant:

> To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but to no one else.
>
> I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.
>
> I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. In purity and holiness I will guard my life and my art.
>
> I will not use the knife, nor even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.
>
> Whatever house I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular sexual relations with both female and male persons, be they free or slaves.

> Whatever I may see or hear in the course of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about.
>
> If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.[287]

It has been well noted that "[t]he Hippocratic Oath has stood as a major document of medical ethics from antiquity to the current day."[288] The Oath is routinely administered to medical students.[289] Abundant scholarship makes clear that "there is no such thing as a single, fixed Hippocratic Oath"[290] and the original author of the Oath is unknown.[291] If the Oath has continued traction for medical ethics, does it at all assist in determining if the practice of requiring a patient to execute an arbitration agreement as a condition of treatment is medically ethical?

An examination of the Oath immediately reveals a problem with its ethical depth. It focuses on the physician and only minimally speaks to the rights of patients, by nominal references to "injustice."[292] The historically recent value attached to patient autonomy and informed consent is not expressed in classical versions of the Oath.[293] Also absent are "commitments to patient rights."[294]

Insofar as the Oath compels physicians to "keep [patients] from harm and injustice,"[295] it seems to me that the Oath speaks to a broad ethical principle—that a physician should avoid using his or her position of power to take advantage of a vulnerable patient.

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287. Lisa R. Hasday, *The Hippocratic Oath as Literary Text: A Dialogue Between Law and Medicine*, 2 YALE J. HEALTH POL'Y L. & ETHICS 299, 299 (2002) (citing Ludwig Edelstein, THE HIPPOCRATIC OATH 3 (1943)).

288. Hasday, *supra* note 287 at 301.

289. *Id.* at 302. *See also* Lisa Keränen, *The Hippocratic Oath as Epideictic Rhetoric: Reanimating Medicine's Past for Its Future*, 22 J. MED. HUMANITIES 55, 57 (2001); Emily Woodbury, *The Fall of the Hippocratic Oath: Why the Hippocratic Oath Should Be Discarded in Favor of a Modified Version of Pellegrino's Precepts*, 6 GEO. U. J. HEALTH SCIS. 9 (2012); Samuel J. Huber, *The White Coat Ceremony: A Contemporary Medical Ritual*, 29 J. MED. ETHICS 364, 364 (2003).

290. Keränen, *supra* note 289, at 56.

291. *Id.* at 57.

292. Hasday, *supra* note 287, at 302–03.

293. Keränen,.*supra* note 289, at 60.

294. *Id.*

295. Hasday, *supra* note 287, at 299.

Vulnerable patients include those who are ill, medicated, scared, intimidated by their circumstances—including those who are literally on the precipice of treatment—and those challenged by issues of literacy to understand what they are told and what they are asked to read and sign. "Injustice" is an ominous and broad concept. Requiring a patient to execute an arbitration agreement as a condition of treatment may very well constitute an "injustice."

More modern versions of the Oath are the subject of comment in medical literature. It is significant that a more modern version of the Oath may "include assurances of . . . protection of patients' autonomy, and informed consent or assistance with decision making."[296] This ethical commitment may very well be at odds with requiring a patient to execute an arbitration agreement as a condition of treatment.

If the Oath, at least implicitly, is inconsistent with the practice of requiring the execution of the arbitration agreement as a condition of treatment, could it have legal significance? In other words, does the Oath have the force of law?

Unquestionably, courts recognize the existence of the Oath in various contexts.[297] However, courts also recognize that ethical standards and codes "are aspirational in nature and not enforceable by law"[298] and "that ethical standards levied within the medical community are not binding on courts."[299] If a court is not bound by a statement of medical ethics, then might a court take such an ethical standard into account as an unconscionability factor or as evidence of the medical professional's standard of care? If so, that a medical ethical principle or standard is not "the law" would not prohibit its consideration in determining the enforceability of the

296. Howard Markel, *"I Swear by Apollo"—On Taking the Hippocratic Oath*, 350 N. ENG. J. MED. 2026, 2028 (2004); Robert D. Orr et al., *Use of the Hippocratic Oath: A Review of Twentieth Century Practice and a Content Analysis of Oaths Administered in Medical School in the U.S. and Canada in 1993*, 8 J. CLINICAL ETHICS 377, 382 (1997).

297. *See, e.g.*, Wollschlaeger v. Governor of Fla., 760 F.3d 1195 (11th Cir. 2014) (Physician inquiry into patient private matters); O'Rear v. R.H., 69 So. 3d 106 (Ala. 2011) (Sexual contact with patient); Acosta v. Richter, 671 So. 2d 149 (Fla. 1996); Morrison v. Malmquist, 62 So. 2d 415 (Fla. 1953) (Disclosure of privileged information); Finucan v. Md. Bd. Physician Quality Servs., 846 A.2d 377 (Md. 2004) (Physician not to engage in sexual relationship with patient); Bryson v. Tillinghast, 749 P.2d 110 (Okla. 1988) (Disclosure of confidences); Steinberg v. Jensen, 534 N.W.2d 361 (Wis. 1995) (Confidentiality).

298. *Bryson*, 749 P.2d at 114.

299. Caldwell v. Chauvin, 464 S.W.3d 139, 156 (Ky. 2015).

arbitration agreement executed by the patient as a condition of treatment. Therefore, an examination of various codes of medical ethics is warranted.

B. American Medical Association (AMA) Code of Medical Ethics

The AMA[300] has published a Code of Medical Ethics,[301] which contains principles of medical ethics and opinions of the Council on Ethical and Judicial Affairs.[302] The following principles and opinions may have relevance to the practice of requiring patients to execute arbitration agreements as a condition of treatment:

> *Preamble*
> The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility to patients first and foremost, as well as to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct that define the essentials of honorable behavior for the physician. . . .
> VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical care. . . .
> IX. A physician shall support access to medical care for all people.[303]

> *Opinion 8.0501—Professionalism and Contractual Relations*

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300. The AMA, established in 1847, is a voluntary medical association that "has promoted scientific advancement, improved public health, and invested in the doctor and patient relationship." *See Our History*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/about-ama/our-history.page (last visited Jan 30, 2016). In 2012, the AMA had 224,503 members. AM. MED. ASS'N, REPORT ON PERFORMANCE, ACTIVITIES, AND STATUS IN 2012, 9 (2013).

301. AM. MED. ASS'N, CODE OF MEDICAL ETHICS (2014).

302. "The Council on Ethical and Judicial Affairs (CEJA) is one of three components of the Ethics Group of the American Medical Association," which "has two key responsibilities: To maintain and update the . . . Code of Medical Ethics," and "[t]o promote adherence to the professional ethical standards set out in the Code though its judicial function." *Council on Ethical and Judicial Affairs*, AM. MED. ASS'N, http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs.page (last visited Oct. 2, 2015).

303. CODE OF MEDICAL ETHICS, *supra* note 301 at xv.

> Physicians are free to enter into a wide range of contractual arrangements. However, physicians should not sign contracts containing provisions that may undermine their ethical obligation to advocate for patient welfare. Therefore, before entering into contractual agreements to provide services that directly or indirectly impact patient care, physicians should negotiate the removal of any terms, such as financial incentives or administrative conditions, that are known to compromise professional judgment or integrity. Particularly, when contractual compensation varies according to performance (see Opinion 8.054, "Financial Incentives and the Practice of Medicine"), physicians should beware of incentives that may adversely impact patient care. (VI, VIII)[304]

Opinion 9.06—Free Choice

> Free choice of physicians is the right of every individual. One may select and change at will one's physicians, or one may choose a medical care plan such as that provided by a closed panel or group practice or health maintenance or service organization. The individual's freedom to select a preferred system of health care and free competition among physicians and alternative systems of care are prerequisites of ethical practice and optimal patient care.
>
> In choosing to subscribe to a health maintenance or service organization or in choosing or accepting treatment in a particular hospital, the patient is thereby accepting limitations upon free choice of medical services.
>
> The need of an individual for emergency treatment in cases of accident or sudden illness may, as a practical matter, preclude free choice of a physician, particularly where there is loss of consciousness.
>
> Although the concept of free choice ensures that an individual can generally choose a physician, likewise a physician may decline to accept that individual as a patient. In selecting the physician of choice, the patient may sometimes be obliged to pay for medical services that might otherwise be paid by a third party. (VI)[305]

Opinion 9.0651—Financial Barriers to Health Care Access

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304. *Id.* at 246.
305. *Id.* at 355.

> Health care is a fundamental human good because it affects our opportunity to pursue life goals, reduces our pain and suffering, helps prevent premature loss of life, and provides information needed to plan for our lives. As professionals, physicians individually and collectively have an ethical responsibility to ensure that all persons have access to needed care regardless of their economic means. In view of this obligation:
> (1) Individual physicians should take steps to promote access to care for individual patients.
> (2) Individual physicians should help patients obtain needed care through public or charitable programs when patients cannot do so themselves.
> (3) Physicians, individually and collectively through their professional organizations and institutions, should participate in the political process as advocates for patients (or support those who do) so as to diminish financial obstacles to access health care.
> (4) The medical profession must work to ensure that societal decisions about the distribution of health resources safeguard the interests of all patients and promote access to health services.[306]

> *Opinion 9.12—Patient-Physician Relationship: Respect for Law and Human Rights*
> The creation of the patient-physician relationship is contractual in nature. Generally, both the physician and the patient are free to enter into or decline the relationship. A physician may decline to undertake the care of a patient whose medical condition is not within the physician's current competence. However, physicians who offer their services to the public may not decline to accept patients because of race, color, religion, national origin, sexual orientation, gender identity, or any other basis that would constitute invidious discrimination. Furthermore, physicians who are obligated under pre-existing contractual arrangements may not decline to accept patients as provided by those arrangements. (I, III, V, VI)[307]

> *Opinion 10.05—Potential Patients*
> (1) Physicians must keep their professional obligations to

306. *Id.* at 361.
307. *Id.* at 379.

> provide care to patients in accord with their prerogative to choose whether to enter into a patient-physician relationship. . . .
> (4) Physicians, as professionals and members of society, should work to ensure access to adequate health care (Opinion 10.01, "Fundamental Elements of the Patient-Physician Relationship"). Accordingly, physicians have an obligation to share in providing charity care (Opinion 9.065, "Caring for the Poor") but not to the degree that would seriously compromise the care provided to existing patients. When deciding whether to take on a new patient, physicians should consider the individual's need for medical service along with the needs of their current patients. Greater medical necessity of a service engenders a stronger obligation to treat. (I, VI, VIII, IX)[308]

Distilled from the aforementioned principles and opinions are a few common threads, sometimes laudable, sometimes conflicting. The AMA clearly promotes patient access to healthcare and freedom of contract. Patients should be able to choose their physicians but physicians are not obligated to accept all patients. Contracts entered into by physician should not contain "provisions that may undermine their ethical obligation to advocate for patient welfare."[309] Here, the AMA may not have contemplated the ethical ramifications of arbitration provisions but the required execution of these provisions is arguably not in the best interests of patients.

C. American College of Physicians (ACP) Ethics Manual

The ACP "is a national organization of internists,"[310] "the largest medical-specialty organization and second-largest physician group in the United States."[311] The ACP's Ethical Manual, Sixth Edition, was published in 2012.

The introductory portion of the ethics manual provides that "[c]urrent understanding of medical ethics is based on the principles from which positive duties emerge."[312] Included in these ethi-

308. *Id.* at 422.

309. *Id.* at 246.

310. AM. COLLEGE OF PHYSICIANS, http://www.acponline.org/about_acp/who_we_are (last visited Oct. 15, 2015).

311. *Id*; *see also* Charles S. Bryan, *The Art of Medicine—Osler Redux: the American College of Physicians* at 100, 385 LANCET 1720 (2015).

312. Lois Snyder, *American College of Physicians Ethics Manual*, 156 ANNALS INTERNAL MED. 73, 74 (2012).

cal principles "is respect for patient autonomy—the duty to protect and foster a patient's free, uncoerced choices."[313] The practice of requiring the execution of an arbitration agreement as a condition of treatment appears coercive and inconsistent with this principle.

The section of the manual entitled "The Physician and the Patient" recognizes "the imbalance of power between patient and physician."[314] The imbalance of power relates to patient vulnerability, a topic previously discussed in this article, which should be considered by courts in determining the unconscionability of an arbitration agreement.

The section of the manual entitled "Initiating and Discontinuing the Patient-Physician Relationship" requires the physician to "work toward an understanding of the patient's health problems, concerns, goals and expectations. . . . The physician has a duty to promote patient understanding and should be aware of barriers, including health literacy issues for the patient."[315] Should a patient expect to execute an arbitration agreement that the patient does not understand? I believe the answer is a resounding, "No."

Finally, in the section of the manual entitled "The Changing Practice Environment," the physician is admonished that the physician is the patient's health care agent and must advocate "through the necessary avenues to obtain treatment that is essential to the individual patient's care regardless of the barriers that may discourage the physician from doing so."[316] The practice of requiring the execution of an arbitration agreement as a condition of treatment appears inconsistent with the duty of patient advocacy and with an agent's classic duty of loyalty.[317]

D. American Academy of Orthopedic Surgeons (AAOS) Code of Ethics and Professionalism for Orthopedic Surgeons

The AAOS "is the preeminent provider of musculosketal education to orthopaedic surgeons and others in the world."[318] It has published a "Code of Ethics and Professionalism for Orthopedic

313. *Id.*
314. *Id.* at 75.
315. *Id.*
316. *Id.* at 87.
317. *See* WILLIAM A. GREGORY, THE LAW OF AGENCY AND PARTNERSHIP, § 68 (3d ed. 2001).
318. AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS, *About the AAOS,* http://www.aaos.org/about/about.asp (last visited Oct. 15, 2015).

Surgeons," "primarily for the benefit of . . . patients"[319] and orthopedic surgeons, and to "serve as guides for conduct of the physician in the physician-patient relationship."[320] The following are excerpts of the AAOS Code:

> *The Physician-Patient Relationship*
>
> A. The orthopaedic profession exists for the primary purpose of caring for the patient. The physician-patient relationship is the central focus of all ethical concerns.
>
> B. The physician-patient relationship has a contractual basis and is based on confidentiality, trust, and honesty. Both the patient and the orthopaedic surgeon are free to enter or discontinue the relationship within any existing constraints of a contract with a third party. . . .
>
> C. The orthopaedic surgeon may choose whom he or she will serve. . . .
>
> *Relationship to the Public*
>
> . . . .
>
> D. The orthopaedic surgeon may enter into a contractual relationship with a group, a prepaid practice plan, or a hospital. The physician has an obligation to serve as the patient's advocate and to ensure that the patient's welfare remains the paramount concern.[321]

These principles are quite similar to those previously discussed. They reveal the inherent conflict between the autonomy of the physician and the physician's duty to serve and advocate for the patient. Again, the practice of requiring patients to execute arbitration agreements as a condition of treatment seems at odds with the duty to advocate on behalf of vulnerable patients.

X. PATIENT LITERACY

A brief mention of literacy is appropriate here. Much has been written about health literacy and general literacy in the population. It is not an understatement to suggest that it is a challenge for patients to communicate with their physicians and to understand health related information they are given.[322] Laypersons with limited literacy are unlikely to understand medicine. This problem is

319. AMERICAN ACADEMY OF ORTHOPEDIC SURGEONS, *Code of Ethics and Professionalism for Orthopedic Surgeons,* http://www.aaos.org/about/papers/ethics/code.asp (last visited Oct. 15, 2015).

320. *Id.*

321. *Id.*

322. Williams, *supra* note 126.

exacerbated when a patient is given an arbitration agreement to execute. What is the likelihood that a patient will understand a legal document of such significance?[323] Here, neither the physician nor the physician's office can meaningfully advocate for the patient. As non-lawyers, they cannot advise the patient of the legal impact of executing the agreement. Patient literacy should constitute a component of the unconscionability discussion. I suggest that challenges to patient literacy support a presumption that arbitration agreements covering medical liability claims, executed as a condition of treatment, are unconscionable.

XI. CONCLUSION

Physicians Should Abandon the Practice of Requiring Patients to Execute Arbitration Agreements as a Condition of Treatment: Courts Should Hold These Agreements Unconscionable

Forcing a patient to execute an arbitration agreement as a condition of treatment is simply an unfortunate, and possibly unethical, aspect of medical practice. Physicians must recognize that patients are not consumers involved in commercial transactions. I am not advocating consumer arbitration of disputes in other contexts. My point is that the patient is different than the classic consumer in significant respects, well described recently by Goldstein and Bowers as follows:

> [A]n individual's use of the health care system is likely to be involuntary and, in this sense, necessary. . . . As compared to other marketplace transactions, this results in an almost powerless buyer. . . . Envisioning the individual as a consumer might result in a more business-like attitude towards the interaction on the part of the physician. . . . Instead of a collaborative decision-making process, the interactions could become adversarial.[324]

As mentioned earlier in this paper, patients are ill, anxious, frightened, dependent, in need of treatment, often medicated, and often challenged with literacy issues. Patients, in general, are unlikely to understand arbitration agreements, will not likely have the wherewithal, resources or time necessary to seek an attorney's opinion on the agreement, and will likely sign whatever documents are

323. Boyd, *supra* note 124.

324. Melissa M. Goldstein & Daniel G. Bowers, *The Patient as Consumer: Empowerment or Commodification?*,43 J. L., MED. & ETHICS 162, 163 (2015).

given to them in order to begin medical treatment. These problems are even more extreme when the arbitration agreement is given to the patient who is about to undergo a procedure that will not be performed if the patient "elects" not to execute the agreement.

Physicians should be patient advocates. Various principles of medical ethics, previously discussed, typically evidence a collision course of physician and patient interests. Physicians should enjoy the freedom of contract and the right to choose their patients, within reason. But patients need access to health care, and physicians should advocate for patients in this regard. Physicians should not force arbitration agreements upon patients. Doing so simply sets an adversarial tone to the physician-patient relationship.[325]

Courts considering the enforceability of adhesive arbitration provisions covering medical liability claims should refer to medical ethical principles as well as patient characteristics and conclude that these provisions are unconscionable. It is not reasonable to require patients to waive fundamental legal rights when they are most vulnerable and in need of healthcare.

325. *See* Sohn, *supra* note 286 at 53; Moller, Rolph, & Rolph, *supra* note 280 at 181.