



Is Binding Arbitration The Answer?

By Brian S. Kern, Esq. (6/2007)

An age-old concept has recently resurfaced, this time as *the* “solution” to the medical malpractice insurance problem in New Jersey. Though the concept of binding arbitration may indeed prove effective over time, physicians willing to bet their entire careers today on its success tomorrow should pay close attention.

Binding arbitration has been repeatedly hailed as an effective tool for both major corporations and the little guy, as corporations often escape heavy punitive damages (e.g. coffee that is too hot), and individuals without the resources to mount a large-scale trial can save enormous amounts of time and money (e.g. an employee fired without cause). Binding arbitration has also played a key role in lightening the load for the overcrowded U.S. court system, and has already established its rightful place in American jurisprudence.

Applied to medical malpractice insurance, the benefits to the physicians, at first blush, seem clear. Instead of rolling the dice with a jury that has little to no knowledge of medicine, potentially innate prejudices against the “rich” doctors and insurance companies, as well as wide discretion over awards, physicians can breathe easier with a perceived competent arbitrator residing over proceedings. Additionally, insurance companies could save measurable dollars by avoiding the high costs of full-blown litigation.

Unfortunately, the benefits to the patients may be much greater. Binding arbitration may encourage an influx of new patients seeking damages too low to justify filing a lawsuit with the courts. While jackpot jury awards may be contained, countless new plaintiff attorneys might suddenly have unprecedented access to the faster, less expensive means of recovery. This in turn could produce more litigation, more settlements, and more awards, seriously damaging a physician’s reputation, and eating away at funds assumed to be safe under this model.

According to Abbott Brown, prominent NJ plaintiff attorney, and author of the text on NJ Medical Malpractice law, “Since arbitrations are less expensive, there may well be a greater likelihood of getting sued if the patient has signed a binding arbitration agreement. The plaintiff’s attorney knows that he may be able to pursue the case at much less expense and with much less risk. In many situations, I would be more inclined to sue a doctor if I knew I could force the case to go to binding arbitration... This is the reason

most experienced medical malpractice insurance companies would never agree to binding arbitration...”

Moreover, the binding arbitration contract between a physician and patient will likely come under fire. Although the freedom to contract is well founded in law, upholding such an agreement would require a finding that the playing field was level for all involved parties. Language can certainly be created to help validate a binding arbitration agreement. Consider the following for a patient seeking a new physician for non-emergent care:

“I am fully aware that I am under no obligation to sign this agreement, and that several alternatives are available to me, including using another physician. I further understand that I am not entering into this agreement merely to receive treatment that I feel is imperative, and am under no duress at this time. I have no need for immediate care at this time, and can choose to refuse entering into this agreement.”

But also consider the uneducated pregnant woman that has used her obstetrician to deliver her first two children, and is now asked to sign another form prior to the delivery of her third. Despite the physician verbally detailing exactly what the document means before signing, the woman implicitly trusts her physician, and though she does not fully comprehend the explanation, feels compelled to go along with whatever the doctor prescribes. However, when the relationship turns sour over a complicated shoulder dystocia delivery, the patient reluctantly engages an attorney, who believes the agreement was signed without an understanding of the legal implications.

Grounds for attacking binding arbitration include the inherent disadvantage that a patient has when entering into an agreement with a physician, especially when a patient is seeking much needed treatment. Can the doctor-patient relationship ever be considered arms-length? What is more, theories such as duress, informed consent, or even fraud can and may all be used in an effort to reject arbitration.

Even if arbitration is ultimately permitted, fast forward to the arbitration proceeding itself. Nowhere in the rules of arbitration is there a guarantee that a patient will recover less money than at trial. Nowhere does it say The Rova Farms rule - which requires insurance companies to pay awards above policy limits if they did not make a good faith attempt to settle the case within policy limits – is off the table. And nowhere does it say that an arbitrator cannot be as sympathetic as a jury.

In fact, the arbitration process is not guaranteed to produce better outcomes than trials for physicians (physicians win the overwhelming percentage of cases that go to trial). Notably though, an arbitrator’s decision is far less likely to be reversed on appeal, as under arbitration rules, grounds for appeal are substantially circumscribed.

Only time will tell whether NJ will welcome binding arbitration in the physician-patient relationship. To date, the NJ Supreme Court has upheld the use of binding arbitration in other areas, and may also bless it in this context. That does not mean though, that the Court will uphold other provisions injected into a binding arbitration agreement, such as

one that prohibits the ability to sue for punitive damages or pain and suffering. Indeed, the more onerous the terms of the arbitration provision, the less likely it will be sustained.

Since binding arbitration in a medical malpractice context remains a relatively untested concept, experienced companies may want to solicit volunteers to study the short and long-term results of its impact under close supervision, and perhaps even increase its use if successful. However, beware of any company with no experience touting itself as the cure to medical malpractice insurance simply because it mandates using a concept with little statistical support, and one that ultimately may prove more troublesome than even the current system.

Perhaps one of the greatest risks to physicians is when the companies using these aggressive new ideas are actually Risk Retention Groups (“RRG’s.”) These carriers are formed under a federal charter, The Risk Retention Act of 1986, which allows carriers to evade stringent state filings, while simultaneously barring them from access to state guarantee funds. Prohibition from these funds means that physicians will bear the full risk in the event that an RRG cannot meet its financial obligations.

Still true to this day, the best way to judge whether to back a new venture may be by following an age old adage: If it seems too good to be true, it probably is.

Brian S. Kern, Esq. is a principal with McLachlan Kane Insurance Agency and of counsel with Kern Augustine Conroy & Schoppmann. He can be reached at bsk@insuranceagent.com