USE OF ARBITRATION FOR RESOLUTION OF HEALTH CARE DISPUTES: A CRITICAL APPRAISAL

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The paradigm shift towards non-judicial avenues for dispute resolution, such as arbitration, has gained traction in the healthcare sector over the past few decades. This paper critically evaluates the prevalence and effectiveness of arbitration in healthcare disputes, especially focusing on the use of arbitration clauses in contracts and consent forms within the industry. By conducting a comparative analysis on a global scale, the study aims to shed light on whether arbitration serves as a fair and efficient means of resolving disputes or merely functions as a tool for healthcare entities to circumvent public scrutiny and legal processes. Methodologically, this research employs a doctrinal approach, analysing primary and secondary data sources to gauge the prevalence and success rates of arbitration in healthcare across different jurisdictions. The research scrutinises the lack of procedural guidelines, undefined evidentiary standards, and questions of arbitrator impartiality in healthcare arbitrations. One of the main contentions surrounding healthcare arbitration is the perceived imbalance of power between corporate hospitals and patients, as well as the additional financial burden placed on parties due to the costs associated with arbitral proceedings. The paper also delves into how confidentiality clauses in arbitration agreements can shield healthcare providers from negative publicity, potentially hindering transparency in holding wrongdoers accountable. The analysis reveals concerns related to mandatory arbitration clauses in healthcare contracts, including issues of patient awareness, mental capacity, and vulnerability during stressful situations. The paper also examines the enforcement of arbitration agreements in court and the implications of recent legal precedents in upholding such clauses.

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I. INTRODUCTION

In the course of the last two decades there has been a paradigm shift in the role of judiciary in settlement and adjudication of legal disputes, where several parallel institutions emerged to share this burden. Courts have always been the primary means of justice delivery system wherein judges were the sole flag bearers of dispensing justice to respective parties. However, this ever-increasing burden reached its pinnacle and cases kept piling for years at end, without seeing the light of day which led to serious denial of justice to the concerned parties. In this scenario, the aggrieved turned their attention to non-judicial avenues of alternative dispute resolution like arbitration and mediation, in pursuit of their quest for justice. Arbitration emerged as one of the most effective and efficient forums for redressal of countless issues, which is used across a variety of sectors with much ease.

With the emergence of arbitration as an effective means of dispute resolution it was witnessed that a lot of business organisations began to include arbitration clauses in their transactional contracts as a matter of policy. For most of its existence, matters subject to arbitration were largely confined to labour disputes, certain consumer issues and business disputes where particular businesses included in their transactional documents an arbitration provision. The practice is found to be more prevalent in

sectors where consumer interaction is extensive, as this gives an organisation an alternative to the contemporary judicial approach which is more public in nature and hence more damaging to the reputation of companies involved in legal trials and class actions. The most fitting example of this situation is the healthcare sector where most of the business and market value is reputation driven. In the United States of America, this practice is widespread and recently, *The New York Times* also brought to light the extent of use of arbitration in medical cases.[1]

II. METHODOLOGY

The present research will focus on the extent to which arbitration in the healthcare sector is prevalent in India by giving a comparative analysis of its use across the world. An attempt shall be made to critically evaluate the extent of prevalence of the practice of arbitration in the healthcare sector in India. Also, an analysis shall be made to understand whether arbitration is a fair and effective way of resolution of disputes or, whether it is merely a route taken by big players in the industry to bypass the judicial process in order to avoid bad press. Furthermore, an investigative endeavour shall be made to discover whether arbitration clauses form a part of standard form of contracts. If yes, then does it cast any shadow of doubt in the context of informed consent of the patient.

The hypothetical establishment is that use of arbitration clauses is not widespread in the healthcare sector, and, where they are utilised, it is essentially owing to an organisation's policy requirements. The author will make an effort to identify the prospective effects of arbitration in the healthcare sector by critically evaluating the existing literature on the issue. The research methodology adopted for the same shall be doctrinal research, where both primary and secondary sources of data shall be evaluated from both jurisdictions which give indication towards the prevalence and success of its use.

The main point of contention in healthcare arbitration is the same as arbitration in any other sector. There is a suspected absence of procedural guidelines in arbitration and the evidentiary standards are not well defined. There is always a question of

[1] J Silver-Greenberg and M Corkery, 'In Arbitration, a 'Privatization of the Justice System' *New York Times* (1 Nov. 2015) <https://www.nytimes.com/2015/11/02/business/dealbook/in-arbitration-a-privatization-of-the-justice-system.html>.

impartiality of the arbitrator as they are on the payroll of the parties involved. This predicament is more pronounced in health care related arbitrations as there is a huge economic gap between corporate hospitals and their patients. Also, bearing the expenses of the entire arbitral proceedings adds to the financial burden of the parties. Arbitral awards are not straightforwardly enforceable, and eventually the parties have to approach a court of law for enforcement of awards. Therefore, this adds another layer of institutional interference in seeking justice. Therefore, it is often said that the so-called benefits of arbitration are nothing but veiled drawbacks. Furthermore, there have been several studies which indicate that in the majority of cases, arbitration proceedings are often tilted in favour of big corporations.[2] The confidentiality clauses in arbitration agreements shield the healthcare providers from negative publicity about their wrongdoing and the general population is kept from getting answers concerning the litigant's wrongdoing, for example, negligence. The New York Times inferred that notwithstanding precluding legal claims, constrained intervention understandings drive people into a '*privatised adjudication system*' that works without the straightforwardness, or consistency of the judicial process.[3]

III. A HISTORY OF DISPUTE RESOLUTION IN HEALTH CARE

Law and medicine are reckoned to feature amongst some of the oldest professions practiced since the dawn of human civilisation. As societies progressed from their elemental state to more organised entities, there was a shift in approach towards treatment of disease and illness, as well as in crime and punishment. Since its inception, the field of medical science has proliferated itself from its rudimentary state which was limited to diagnoses of disease, prescription of medication or at the most surgical treatment. Contemporary healthcare has overstepped its original boundaries and extended to new subject matters and advancement in technology in healthcare has revolutionised the earlier organic forms of treatment to new, but sometimes, ambiguous issues. Medical profession has earned the reputation of being a noble cause because it deals with saving human life. History stands witness to the fact that in every civilisation, doctors and physicians were held in the highest social regard for

[2] J Silver-Greenberg and R Gebeloff, 'Arbitration Everywhere, Stacking the Deck of Justice', *New York Times* (31 October 2015) <https://www.nytimes.com/2015/11/01/business/dealbook/arbitration-everywhere-stacking-the-deck-of-justice.html>.
[3] J Silver-Greenberg and R Gebeloff (n 1).

they were considered to have the power of healing. Historical traditions like the swearing of the Hippocratic Oath reiterate the faith of humanity in the physician, and in turn, the physician takes upon himself the moral and ethical responsibility to work to the best of his knowledge, care and ability and lead a life devoted to this cause. In a country like India, where logic often makes way for sentiment, superstition prevails over science and emotions are hugely exaggerated, doctors are considered to be no less than gods. We heedlessly place ourselves in the vigilant care of doctors who are trusted to perform their duties in the patient's best interest. However, we fail to accommodate the thought that doctors too, like the patients they are responsible for treating, are human, and hence, fallible. One may be able to endure pecuniary loss caused by negligent act or behaviour of another even and the hardship may fade with time. However, the loss of a loved one or physical incapability caused due to the negligence of a medical practitioner bears scars that are incomparable and we often feel compelled to circumvent our anguish. Although making a generalisation for each medical negligence case might be unsympathetic, it is the opinion of the author that in cases of medical negligence the petitioner's anger or a feeling of fixing responsibility often stems from a feeling of grief. Having stated that, a lapse in duty to take reasonable care cannot be completely ruled out in the case of healthcare professionals, especially in an overpopulated and over-burdened medical system like India. However, this fact cannot be used as an excuse to deviate from standards; moral, ethical, professional or legal which are expected of a physician as the stakes are high.

The idea of holding a medical professional or a physician accountable for his/her actions can be traced way back to the Code of Hammurabi, an extensive legal document from Mesopotamia, wherein it is stated that, "*If the doctor has treated a gentleman with a lancet of bronze and has caused the gentleman to die, or has opened an abscess of the eye for a gentleman with a bronze lancet, and has caused the loss of the gentleman's eye, one shall cut off his hands*".[4] The punishment prescribed by the Code of Hammurabi may seem harsh, even barbaric for the present times, but the reader here has to bear in mind that punishment dates back to the times when retributive form of justice prevailed. However, human civilisation as well as the justice system has evolved into its compensatory and reformative alternatives.

[4] Kim Price, 'Towards the History of Medical Negligence', (2010) 375 The Lancet 192.

Medical malpractice law, as it is known today in much of the Western world, can be traced back to the Romans, who developed the legal foundation of medical malpractice. Roman law spread throughout continental Europe around 1200 AD, and many countries' current laws regarding personal injury and medical malpractice are derived them.[5] English common law was greatly influenced by the Romans, and in turn, 19th century English common law had a substantial influence on the Indian legal system.[6]

In the Indian context, several ancient literatures make mention of law relating to negligence. According to Kautilya's *Arthashastra*, any physician desirous of practicing medicine could only do so with the prior permission of the King and if during the course of his practice, he caused harm to a vital organ of the patient, it was considered equivalent to causing physical harm.[7] The *Brihaspati Smriti* also stated that, "*a physician who, though unacquainted with drugs and their effects or is ignorant of the nature of diseases, yet takes money from the sick (for giving treatment) shall be punished like a thief*".[8] Even during the Mughal regime, only those *hakims* could practice who had successfully qualified in the examination. Even a *Hadith* stipulates that "*he who does not know the science of medicine and treats the patient is too held liable to pay compensation*".

At the time when the British set foot in India, there were not many physicians who practiced modern medicine, and most physicians were brought to India by the British themselves to look after the officers of the East India Company. Even though it took several decades, the British eventually realised that the conduct of doctors who were practicing medicine in India had to be regulated in order to fix some accountability. During this period a number of events of indiscipline, insubordination, malpractice was recorded and penalised.[9] Finally, in 1857, with the enactment of the General Medical Council in Britain, British doctors serving in India were brought under a legal regulatory and disciplinary system. The newly established council also provided for compulsory registration of British doctors, irrespective of whether they served in

[5] 'Medical Malpractice Law: Ancient History to Recent Controversies, A Brief History of Medical Malpractice Law*'* (*American Baby and Child Law Centre*) <https://www.abclawcenters.com/resources/medical-malpractice-overview/>.
[6] ibid.
[7] Kautilya, *Arthashastra* (RP Kangle tr, 2nd edn, Motilal Banarsidass 1972).
[8] "Brihaspati Smriti" 8:360.
[9] D. G. Crawford, *A History of Indian Medical Service:1600-1913* 677 (W. Thacker, 1914).

Britain or in its colonies. However, as the system of imparting medical education evolved in India, the British Government took the inevitable step of establishing some form of regulatory mechanisms for them as well. This was realised with the establishment of Grant Medical College Society in 1880 and introduction of the Bombay Medical Act, 1912, which was closely followed by the Bengal Medical Act, 1914, the Madras Medical Act, 1914 and the Medical Council. The success of these legislations was followed by the enactment of Indian Medical Degree Act, 1916 by Legislative Council which was approved by the then Governor General in the year 1916.

Once India became independent and adopted its own Constitution, health, medical education, medicine and drug control and family planning were enumerated under the Concurrent List and hence are matters of concern for the Union Government as well as State Government.[10] Over the course of the last seven decades, several legislations were enacted in order to regulate the conduct of medical professionals. However, for the purpose of this paper it is pertinent to mention that in the context of medical negligence, regulatory bodies serve as a deterrent wherein medical professionals ensure that proper care is taken while performing their duties, failing which their registration may be cancelled. Additionally, the act of medical negligence was also kept in check through various consumer protection legislations. Even though patients are not customers in a strict sense of the word, nonetheless they could sue a medical practitioner under consumer protection law in case of any deficiency of service. Initially the issues of civil medical negligence were covered under the Consumer Protection Act, 1986 which was repealed keeping in view advancements in the field of information technology which widened the ambit of consumer access. Presently, the Consumer Protection Act, 2019 governs all matters related to consumer grievances. In addition to civil medical negligence, the law on criminal medical negligence is addressed in Section 106 of the Bharatiya Nyaya Sanhita, 2023 ('**BNS**') (previously the Indian Penal Code, 1860).

IV. ISSUES IN HEALTHCARE ARBITRATION

A. THE JOURNEY FROM LITIGATION TO ARBITRATION: A PARADIGM SHIFT

[10] M.P. Jain, *Indian Constitutional Law* (4th ed., LexisNexis, 1987).

Conventionally speaking, healthcare disputes typically were positioned on the medical negligence landscape where adjudication was limited to determining if a healthcare professional had failed to meet the legal standard of care. As stated above, with the passage of time, the patient became more aware and educated about his rights and healthcare professional's corresponding duties and hence a spurt in litigation was observed. This litigation, which was mostly limited to consumer disputes, fell in the domain of public information, nonetheless. Owing to the public nature of the proceedings which were sometimes aggressively reported in the media, there were grave concerns voiced by the medical fraternity expressing fears of damage to reputation which was seldom restored even if the case was decided in favour of the healthcare professional. Hence, there was a sharp increase in the shift towards including arbitration clauses in contracts and consent forms, at least in the case of corporate hospitals. Since arbitration proceedings are confidential in nature, the hospitals could guard their reputation from being unnecessarily smeared in public.

B. CONFIDENTIALITY: A DOUBLE-EDGED SWORD

Where on one hand, confidentiality can protect the reputation of the doctors (and sometimes even patients involved); on the other, it creates an unnecessary layer of opaqueness in matters which are of immense social importance. If this is allowed, it would amount to a cover-up, espacially in cases which ought to be brought out in the public domain so that the medical fraternity does not become complacent about the duty owed to its patients. Allowing arbitration in health care disputes could set a very dangerous precedent wherein doctors and healthcare professionals could begin to exploit this to their benefit given the reassurance that all proceedings against them shall be confidential. We cannot deny that moral and legal compliance is largely driven by fear of social or societal shaming; and if we remove the aspect of public accessibility to healthcare disputes, the motivation behind moral and legal compliance may be diminished to a certain extent. This goes to question the very root of validity of such contracts and enforceability of arbitration clauses.

C. ENFORCEABILITY OF ARBITRATION CLAUSES IN HEALTHCARE

At this juncture, a question of extreme importance needs to be asked. Whether health care facilities can enforce arbitration contacts in a court of law. In 2017, the United States' Supreme Court ('**SC**') answered this question in affirmative even though the

issue did not concern a doctor patient relationship, but a long-term care facility and its residents. Nonetheless, this species of geriatric care falls in the larger genus of health care. The Court, in *Kindred Nursing Centers v. Clark*,[11] while confirming (ruling in favour of nursing homes in ratio 7:1) the enforceability of binding arbitration agreements with its residents held that, "*mandatory arbitration agreements are enforceable even when an individual with a power of attorney binds someone else to mandatory arbitration agreements and that such agreements should not be disfavoured compared to other agreements*". It is interesting to note here that the lower courts in this case had decided against the enforceability of arbitration agreements and had allowed litigation to proceed. Even when the case reached the Kentucky SC, it was held that such arbitration agreements which were mandatory in nature were effectively non-binding if entered with people under a power of attorney as such people did not have specific permission to enter into binding arbitration agreements in the first place as it violated the "*clear statement rule*". The Kentucky SC stated that if a person wished to give up his rights in such a manner, then he/she can only do so by making an explicit statement of forfeiture to that end. However, when the matter reached the US SC, the decision of the lower courts was overturned. The Court observed that mandatory arbitration agreements should be kept on the same footing as any other ordinary arbitration agreement. It went one step ahead and expressed that even lower courts should exercise caution in disfavouring or undermining arbitration agreements as the Federal Arbitration Act ('**FAA**') states that an arbitration agreement must ordinarily be treated as "*valid, irrevocable, and enforceable*".[12]

D. MANDATORY ARBITRATION CLAUSES

Mandatory arbitration clauses have become ubiquitous in a broad range of industries, including the healthcare industry.[13] Unfortunately, most patients are unaware they are waiving their right to a jury trial or judicial oversight of their disputes when signing health providers' patient intake contracts.[14] A vast majority of patients do not read medical disclosures, or have the sophistication to understand the information

[11] *Kindred Nursing Centers v. Clark* [2017] 137 S. Ct. 1421.
[12] Federal Arbitration Act, 1947 s 2.
[13] Jean R. Sternlight, 'Creeping Mandatory Arbitration: Is It Just?' [2005] Stan. L. Rev. 1631.
[14] Sarah Sachs, 'The Jury is Out: Mandating Pre-Treatment Arbitration Clauses in Patient Intake Contracts' [2018] J. Disp. Resol. 54.

contained within them and even if patients were to read the fine print of health providers' contracts, patients are still likely to fail to recognise that the contract contained an arbitration clause.[15] Also, one has to be mindful of the situation and circumstances in which these mandatory arbitration agreements may be signed. Imagine someone whose child or parent has to undergo a life-saving surgery in urgent circumstances. Now this person, who is entirely physically and emotionally consumed with concern for their parents or child, would hardly be in the mental state to read or comprehend the implications of signing this piece of paper. The researcher draws attention to this point based on personal experience of signing a consent form before a surgery was due to be performed on her child. Even though upon affixing the signature, the consent form becomes a legally binding document, the researcher would argue that such form or contract would not have been signed while being in charge of full mental faculties. Also, one cannot deny that arbitration clauses are based on contract law. Therefore, courts must first determine whether a valid contract exists prior to assessing the validity of the arbitration clause.[16] Therefore, in the absence of a valid arbitration clause, the courts can not compel the parties to enforce it, as even the law of arbitration does not require parties to arbitrate when they have not agreed to do so.

E. LACK OF CAPACITY: MENTAL DISTRESS

Corporate hospitals may compel their patients into signing arbitration clauses, which they may have signed at a time when they were under tremendous mental or physical stress. This would again raise questions about the validity of arbitration clauses as one party can always argue that there was diminished legal capacity owing to mental distress experienced by them at the time of signing the agreement. However, it is pertinent to bring to the attention of the reader that arguing against validity of an arbitration agreement on the basis of diminished mental capacity may prove to be exceedingly difficult in a court of law. Usually, mental distress is not viewed on the same footing as incapacity of the mind, even though one's decision-making power/capacity may be compromised to some degree. Diminished mental capacity due to stress may not prove useful in arguing in favour of violability of contract but

[15] Myriam E. Gilles, 'Operation Arbitration: Privatizing Medical Malpractice Claims' [2014] TIL 671.
[16] *TranSouth Fin. Corp. v Rooks* [2004] 604 S.E.2d 562.

can play a key role in determining coercion or fraud. Irrespective of that, one cannot deny that there is a certain element of coercion at play here because patients are rarely in a position to negotiate the contract.[17] However, with the ongoing debate surrounding mental health it is difficult to predict if courts will begin to take a sympathetic view of the same in the times to come. At the end of the day, the acceptance or rejection of a defence boils down to the sensibility and perception of the judges as well (who are also human and may bring their own mindset in each case).

V. CONCLUSION

Originally, theology, medicine, and law were regarded as learned professions; special knowledge is a *sine qua non* for professional attainment.[18] Therefore, medicine is regarded as one of the noble professions and doctors are held in highest regards among their patients. One often comes across the signboard in hospitals and clinics, which says, "*We Serve, He Cures*", which points to the fact that the medical profession is a service to humanity and not a business. During their training and education, medical students are moulded in such a fashion that they treat their patient as the priority, with highest regard and this emotion is reciprocated by the patients who treat them equivalent to God. The medical profession has always been regarded as noble and has commanded respect in society. The recent outbreak of the Coronavirus has brought the entire world to a standstill. People from all walks of life and professions were forced to give up their normal way of life and be trapped within the four walls of their homes to ensure safety of their own and their loved ones. However, there were a select few who were not afforded the luxury of being within the warmth of their homes and those select few are fighting on behalf of the rest of us. The tireless work of healthcare professionals involved in the fight against this pandemic is commendable, and they deserve the much-needed credit that was due to them.

As much as the public may be sympathetic towards healthcare professionals, with the ongoing healthcare crisis continuing to develop, health providers will leave no stone unturned to cut costs to deal with the present situation. It is predicted that there will

[17] Lydia Nussbaum, 'Trial and Error: Legislating ADR for Medical Malpractice Reform' [2017] Md. L. Rev. 275.
[18] A. Prasad & C.P. Singh, *Legal Education and the Ethics of Legal profession in India* (University Law House, 2005).

be a spurt in litigation in the post-COVID world, and arbitration may be seen as a cost-effective way to settle any disputes that may arise. Numerous wellbeing suppliers view arbitration clauses as an expense-saver for clinical negligence claims. Doctors and medical clinics are discreetly including mandatory arbitration clauses in their pre-treatment forms. Arbitration clauses are getting more normal and could turn into an acknowledged practice in the clinical field, without patient mindfulness, until after a debate emerges. In the medical care setting, patients with an agreement with an arbitration ckause are the more vulnerable party, who have not yet imagined the chance of future clinical negligence debates emerging. Reforms should occur to secure patients. Sooner or later, all people depend on clinical consideration from a doctor or an emergency clinic framework. Reliance on doctors and medical clinic frameworks is crucial to people's prosperity. The present set of laws weakens patients, and unreasonable supports doctors when clinical negligence claims emerge.

Recently, the New York Times ran a report highlighting the impact of forced arbitration on consumers, citing a number of examples in the healthcare arena.[19] The problem has led a group of US senators to express deep concerns about a system that "*consumers are involuntarily forced into, that lacks transparency and is not subject to meaningful appeal*".[20] A gathering of Senators called constrained discretion in long haul care arrangements "*unreasonable to occupants and their families*" and encouraged the Centres for Medicare and Medicaid Services to deny senior-care offices it contracts with from utilising intervention arrangements. The counter contention is that mediation arrangements are a helpful device for saving patients and offices time and cash—assets that are better spent on persistent consideration, with reports that dispute resolutions reached outside of the court system cost, on average, sixteen percent less than claims not involving arbitration.[21]

[19] J Silver-Greenberg and R Gebeloff (n 2).
[20] Steven P. Blonder, 'Arbitration in Health Care: Have We Created a Private Court System?' [2015] Health Care L. Monthly 2.
[21] 'Long Term Care General Liability and Professional Liability Actuarial Analysis' (Aon Risk Solutions 2013) <http://www.aon.com/risk-services/thought-leadership/reports-pubs_2013-long-term-care-benchmarking-report.jsp>.