

An Ounce of Prevention

Contracts to Prevent Frivolous Suits

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Frivolous medical malpractice claims are expensive and time-consuming. However, there are a number of available mechanisms that may deter such suits. Countersuit for malicious prosecution is one such avenue. Seeking redress against expert witnesses who deliver false or exaggerated testimony is another. Options continue to emerge that are designed to decrease legal costs associated with using such deterrents.

Exposure to medical malpractice litigation is part and parcel of medical practice in the 21st century. Tort reform is often viewed as a useful tool that could provide relief to physicians burdened by rising professional liability premiums. Tort reform, however, might be nowhere near a silver bullet for addressing frivolous claims. In California, which enacted substantive tort reform in the 1970s through the Medical Injury Compensation Reform Act (MICRA), physicians are actually sued at a *higher* frequency than those in other parts of the country. Further, in some states such as Alabama and most recently Wisconsin, courts have found that tort reform efforts violated state constitutions. See *Moore v. Moore Infirmity Ass'n*, 592 So.2d 156 (Ala. 1991); *Smith v. Schulte & Pulmonary Assoc. of Mobile, P.A.*, 671 So.2d 1334 (Ala. 1995); and *Ferdon v. Wisconsin Patients Compensation Fund*, ___ N.W.2d ___, 2005 WL 1639450 (Wis. July 14, 2005). See also *The Crisis of 2002–2003*; Keynote Address, Richard Anderson, CEO, The Doctors Company, PLUS Medical Professional Liability Symposium, Chicago, March 12, 2003; <http://www.plusweb.org/Downloads/Events/RAnderson-Keynote.ppt>. Hence, this nagging problem might require a different solution.

Malicious Prosecution— A Remedy Rarely Used

What remedies are generally available to physicians if they are the victims of frivolous suits? Physicians can file a separate suit against plaintiff and his or her attorney using the tort of malicious prosecution.



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The elements of malicious prosecution are:

- that the defendant initiated a cause of action against plaintiff;
- that the defendant acted with malice—malice may be inferred by failure to make a reasonable inquiry—or action was brought without a credible basis to believe that malpractice occurred or could be proven;
- that the cause of action was terminated in plaintiff's favor (such as winning malpractice case in court);
- that the plaintiff was damaged by defendant's action.

There is case law to suggest that a plaintiff in an underlying medical malpractice suit might still be liable if he or she *initiated* the case in good faith but later learned that the case had no merit. In *Zamos v. Stroud*, the California Supreme Court ruled that “*continuing* an action one discovers to be baseless harms the defendant and burdens the court system just as much as initiating an action known to be baseless from the outset....As the court of appeal in this case observed, ‘It makes little sense to hold attorneys accountable for their knowledge when they file a lawsuit, but not for their knowledge the next day.’” *Zamos v. Stroud*, 32 Cal.4th 958, 969 (2004) (emphasis added).

That said, the bar to successful suit for malicious prosecution is quite high. Physicians have generally not prevailed in such cases. Courts seem only too willing to grant plaintiffs and their attorneys wide latitude in exploring and/or pursuing claims of medical malpractice. Further, one needs to demonstrate malice to prevail. That element, in particular, is difficult to prove. Finally, some states such as Florida and Pennsylvania require a medical expert's affidavit as pre-requisite to plaintiff initiating suit. Most agree that such an

affidavit serves as an impenetrable defense to claims for malicious prosecution.

Can Contract Law Protect Physicians from Frivolous Suits?

The short answer would seem to be possibly yes. Contract law is a separate body of law from tort law. Although contract law has not traditionally been used a prospective vehicle to deal with potential frivolous malpractice actions, it is now being used by physicians around the country.

What types of contracts with patients will not work? Asking a patient to forego *all* remedies is not a workable solution. For example, a contract demanding that a patient not sue for any reason will be unenforced. Public policy dictates that a patient needs to have some remedy for negligent action. Having a patient sign a “blanket release” would be considered an “abuse of power” and courts have routinely dismissed such agreements.

What Is Required to Make Contracts Enforceable?

If the demands of a contract are narrower, the contract will more easily withstand challenges to enforceability. Establishing contracts between physicians and patients requires significant forethought. Restriction or exclusion of legal rights may fatally flaw the contract, making it unenforceable. The system for resolution of differences should be the focus of the contractual terms, not a limitation of legal remedies. For example, a term that, in the event of a patient/physician dispute, requires both parties to exclusively use experts that are members of and follow the code of ethics adopted by a medical specialty society likely will be enforceable. Here are some points to keep in mind when drafting a patient/physician contract:

Content and Procedure for Patient-Physician Contract

1. The mutuality of the agreement is important.
2. The agreement should not make any attempt to limit the liability of the physician or to change the nature of the physician's duty to the patient, *i.e.*, the

physician still must exercise reasonable care under the circumstances.

3. Whether the agreement stands alone or is part of another agreement, there should be a definite method of calling attention to these provisions. If the agreement is part of a larger agreement, making the print somewhat larger and bolder would be helpful to make it stand out. If embedded within an existing form, take pains to make sure that a reasonable person would not perceive the text as being “buried” or “hidden.”
4. The contract should be presented to the patient, whenever possible, in sufficient time to give the patient ample opportunity to think about the contract and its consequences and to ask questions about it.
5. If the agreement is obtained when the medical care is needed on an urgent or emergent basis, a court may deem the contract to be unconscionable. A better approach would be to obtain an agreement after the fact (that is, after the emergent or urgent situation has abated; such as a post-hospitalization office visit) and make the agreement retroactive to include the urgent and emergent care—so long as there is the date of the agreement is clearly reflected.
6. It is probably not appropriate to condition treatment on the signing of the agreement even in non-urgent or non-emergent settings.
7. When a patient is given the opportunity to ask questions, the person being asked questions must be knowledgeable and respond in a meaningful way. The physician, of course, would be the ideal person. Alternatively, an office representative can substitute if he/she is reasonably trained and capable.

Enforceability

One test that will determine enforceability is whether the document is a contract of adhesion. An adhesion contract, generally speaking, is “a standardized contract, which, imposed and drafted by the party of superior bargaining strength, relegates to the subscribing party only the opportunity to adhere to the contract or reject it” *San-*

ford v. Castleton Health Care Center, LLC., 813 N.E.2d 411, 417 (Ind.App.2004). While “adhesion contract” is usually viewed as a pejorative label for an agreement, one court has recognized the basic truth that the vast majority of all contracts in the United States fit the description of adhesion contract. *Ingles v. State Farm Mutual Insurance*, 265 F.Supp.2d 655 (D.W.Va. 2003). As the *Ingles* court noted, however, *the important task is to distinguish which adhesion con-*

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tracts are appropriate and therefore enforceable, and which are not.

The usual term to describe the unenforceable adhesion contract is “unconscionable.” This concept is described in various ways. The court in *Sanford v. Castleton Medical Center*, had this to say about unconscionable contracts:

...a contract is unconscionable if a great disparity in bargaining power exists between the parties, such that the weaker party is made to sign a contract unwillingly or without being aware of its terms. To be unconscionable ‘the contract much be such as no sensible man not under delusion, duress, or in distress would make, and such as no honest and fair man would accept.’”

See *Sanford*, 813 N.E.2d at 417 (citations omitted).

Unconscionability is very much a fact sensitive and case-by-case issue. There are two aspects to unconscionability, procedural and substantive. *Sosa v. Paulos*, 924 P.2d 357 (Utah 1996). The procedural aspect refers to the way the contract is reached and the substantive aspect refers to the actual terms of the contract.

It seems likely that certain provisions of an agreement would pass judicial review for unconscionability. Such provisions would include: 1) the promise not to bring a frivolous lawsuit and; 2) the mutual promise to use as an expert at trial only a physician who practices the same spe-

cialty and who follows the code of ethics for his medical specialty society.

The first provision could be “unconscionable” only if the court concludes that it is intended to have a chilling effect on bringing lawsuits which, the argument would state, is against public policy. Such a promise, however, is nothing more than an obligation *already imposed* on litigants through statute or common law. This principle is reflected in various types of statutes. For example, an Indiana statute permits the winning party to recover an amount of attorney fees if the losing party’s suit was frivolous. I.C. 34-52-1-1.

The second provision focuses on how evidence may be brought forward. A well-reputed treatise on contract law has stated that “[t]here is a growing tendency for courts to uphold the right of parties to prescribe certain rules of evidence should a lawsuit arise out of the bargain between them, so long as it does not unduly interfere with the inherent power and right of the court to consider relevant evidence.” 7 Williston on Contracts, Section 15:13 (4th Edition).

It is well established that patients and physicians can contractually opt out of the legal system through the use of binding arbitration. Arbitration asks the plaintiffs to forego their right to trial by jury. Further, cases will not be tried by judges. Imposing reasonable conditions on expert witness behavior would seem less restrictive than arbitration by at least an order of magnitude. Agreements to arbitrate are a far greater intrusion into the traditional judicial system.

However, it should be noted that some contractual efforts by medical providers to prospectively address potential malpractice claims have failed. In *Sosa v. Paulos*, *supra*, the Supreme Court of Utah struck down an arbitration agreement between a patient and physician on grounds that the provision was unconscionable. In *Sosa*, a patient was asked to sign an arbitration agreement just prior to undergoing knee surgery. Because the patient did not have an opportunity to read the agreement or discuss it with the physician, the arbitration provision was deemed unconscionable.

Other jurisdictions have upheld the enforceability of arbitration provisions in patient/physician contracts. Two such cases were *Buraczynsky v. Eyring*, 919 S.W.2d 314 (1996 Tenn.) and *Sanford v. Castleton Health Care Center, LLC*, *supra*. In the *Buraczynsky* and *Sanford* cases, there were a number of factors the courts relied upon to find that the contracts were not unconscionable on either a substantive or procedural basis and therefore were enforceable. Among those factors were:

- The contractual provisions in question were not hidden but were highlighted in some manner so as to call attention to them;
- There was an opportunity for the patient signing the agreement to read the contract in an unhurried situation and to ask questions;
- The contractual language was easy to read and understand;
- The process of obtaining agreement was unhurried and the patient was not pressured;
- The contractual language did nothing to change the health care provider's duty to use reasonable care in providing services; and
- The contract did nothing to limit the liability of the provider to the patient.

Enforceability thus becomes a very fact sensitive determination. While few cases, if any, exist relating to the provisions suggested above, case law surrounding the use of arbitration provisions in patient/medical provider contracts does provide some guidance. Critics will argue that provisions such as those described above attempt to restrict evidence in an effort to unnecessarily increase expenses to plaintiffs. Proponents of those terms fall back on basic contract law and the narrow scope of the terms. Ultimately, whether the provisions discussed above are enforceable may come down to the exact language of the agreement, the manner in which the contract was executed, and the jurisdiction reviewing the terms.

Enforceability of Contract for Non-Signatory Parties

Even though it is the patient who signs

the contract, is it possible to have terms which mandate that any attorney he or she hires follows the same rules? Again, falling back on the analogy with arbitration, there are precedents for holding non-signatory parties to agreements.

In California, a contract against a pregnant minor was enforceable as a matter of public policy. There was a concern that medical providers would refuse to treat minors if the provisions were not upheld. See *Weeks v. Crow*, 113 Cal.App.3d 350 (1980). Further, a minor child can be bound by the mother in an agreement to arbitrate made during the prenatal period. The court has interpreted the arbitration clause to apply to any claim arising from the services under the agreement, even though the plaintiff had not been born at the time the arbitration agreement was signed. See *Wilson v. Kaiser Found Hosp.*, 141 Cal.App.3d 891 (1983).

In *Gross v. Recabaren*, a noncontractual spouse filed a lawsuit for loss of consortium because of the malpractice negligence in the doctor's failure to diagnose the patient. The court found that when a patient contracts to submit any dispute regarding medical malpractice to arbitration, that all claims arising from the alleged malpractice must be arbitrated. See *Gross v. Recabaren*, 206 Cal.App.3d 771 (1988). Similarly, heirs in a wrongful death action were found to be bound by the decedent's agreement to arbitrate when the contract specifically required that claims by "a member's heir or personal representative" be arbitrated. See *Herbert v. Superior Court*, 169 Cal.App.3d 718 (1985).

However, critics and consumer advocates have put forward arguments that call into question the use of contractual clauses aimed at restricting litigation options. "Accordingly, consumer notice, or lack thereof, should always be a decisive factor in deciding whether to enforce an arbitration clause. Without notice of the waiver of their rights, it is hard to reason that the consumer intended to waive them." See Shelly Smith, *Mandatory Arbitration Clauses in Consumer Contracts: Consumer Protection and the Circumvention of the Judicial System*, 50 DePaul Law

Review 1191 at 1250 (2001). A patient's substantive and procedural rights can be signed away in exchange for necessary medical care. "These procedural rights were created to place less powerful parties on a level playing field when resolving a dispute with a more powerful party." *Id.* at 1250. How much of a limitation upon a patient's procedural rights will be upheld by the courts remains an open question.

Retroactive Enforcement

Physicians often have ongoing, long-term relationships with many patients. Is it possible to script a new contract to address past actions? The answer is maybe. In California, there is precedent for retroactive activation of an arbitration agreement. In 1993, the California Court of Appeals upheld an arbitration agreement that was made retroactively. See *Coon v. Nicola*, 17 Cal.App.4th 1225 (1993). Clearly, retroactive use of contractual provisions generates additional defenses for a patient advocating unenforceability. Issues of lack of consideration and adhesion for patients in the midst of a treatment regimen will come front and center, causing many to speculate as to the unenforceability of retroactive execution of contractual provisions in a patient/physician agreement.

Definition of Frivolous

Because of the fact-sensitive nature of determining whether a claim is "frivolous," drafting a tight definition is problematic. What is frivolous to one person might be entirely legitimate to another. How can the definition be tightened so as to make a contract to avoid pursuing a frivolous case meaningful? The difficulty of formally defining a frivolous suit has analogy in other issues. Justice Potter Stewart remarked in a 1964 case that "I shall not today attempt further to define (obscenity)... and perhaps I never could succeed in intelligibly doing so. *But I know it when I see it.*" *Jacobellis v. Ohio*, 378 U.S. 184 (1964) (emphasis added). Care needs to be taken in drafting a clause dealing with "frivolous claim" so as to avoid arguments that the clause is void due to its ambiguity.

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One way to address this issue is to focus on frivolous *testimony* as a determinant of breach. For example, a conclusion by the Professional Conduct Committee of an organization such as the American Association of Neurological Surgeons might serve as the basis that the expert witness testimony was indeed frivolous. Many professional societies for specialties and subspecialties of medicine have developed codes of conduct and ethical rules for their members. These codes and rules often address issues of the

scope and nature of expert witness testimony. Hence, the definition of frivolous or the process for determining if testimony is frivolous could be incorporated from professional associates representing the medical specialty in question.

Conclusion

Contracts can be used with patients to decrease the likelihood that the physician will be sued for a frivolous reason. It should be noted that there is some case law that casts doubt upon the use of contractual

clauses to limit patient rights, and final judicial determination as to the enforceability of the provisions contemplated above remains open. However, there is ample precedent with arbitration contracts to believe that such contracts can be enforced. Proper attention needs to be paid to both the content of such contracts as well as the procedure used for obtaining agreement. Given that tort reform may not be the best tool to deal specifically with frivolous suits, contract law should be helpful to fill the gaps.

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