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NOTES

IN SEARCH OF AN ENFORCEABLE MEDICAL MALPRACTICE EXCULPATORY AGREEMENT: INTRODUCING CONFIDENTIAL CONTRACTS AS A SOLUTION TO THE DOCTOR-PATIENT RELATIONSHIP PROBLEM

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Scholars have argued that the malpractice system would be better off if patients had the option of waiving the right to sue for malpractice in exchange for a lower fee. Some doctors have tried to follow this advice by having their patients sign medical malpractice exculpatory agreements, but courts usually have refused to enforce these agreements, invoking a void-for-public-policy rationale. This Note argues that a doctor could maximize the odds that a court would enforce her medical malpractice exculpatory agreement by somehow ensuring that she will never find out whether her patient decided to sign. A case study of the law in New York highlights the ambiguity in the void-for-public-policy rationale as to whether the simple fact that the doctor-patient relationship is implicated in a medical malpractice contract is fatal to enforcement, or whether such a contract could be enforced if it were nonadhesive and clearly worded. A behavioral-economic analysis of the patient's decision to sign a medical malpractice exculpatory agreement reveals a reason why the agreements may be categorically barred: Some patients might unwillingly agree to sign for fear of signaling distrust or litigiousness to their doctors. A confidential contract—in which the offeror never knew whether the offeree had accepted or not—would avoid this signaling effect. A provider using such a contract could distinguish those cases in which the doctor-patient relationship alone seemed to justify nonenforcement as not involving this prophylactic measure.

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INTRODUCTION

The rising cost of healthcare in the United States has prompted many reform proposals pertaining to malpractice.¹ One of the most promising is the reform of medical malpractice rules to allow patients to sacrifice their ability to bring malpractice suits against doctors in exchange for lower fees. If the cost of having the option to bring a malpractice suit truly outweighs the benefit, patients will choose to sign malpractice exculpatory agreements prior to treatment, contracting out of the malpractice system and paying less for healthcare.² Scholars of law and economics have long contemplated versions of this proposal,³ although currently there is no uniform endorsement of the idea.⁴

The actual enforceability of medical malpractice exculpatory agreements is an unsettled question, however. Courts treat general exculpatory agreements—like those signed at amusement parks—as they do any other contract, enforcing the contracts as long as they are entered into voluntarily.⁵ But medical malpractice exculpatory agree-

¹ Whether malpractice reform is actually needed is a subject of great debate. Some reports suggest that malpractice payouts are actually fairly small, and that high insurance premiums are the result not just of payouts but also of the difficulty in pooling and pricing malpractice risk. See SYLVIA LAW & STEVEN POLAN, *PAIN AND PROFIT: THE POLITICS OF MALPRACTICE* 170 (1978) (“[T]he timing and abruptness of the malpractice crisis were generated more out of the economic insecurity of the industry as a whole rather than by factors strictly related to malpractice.”); THOMAS H. COHEN & KRISTEN A. HUGHES, U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *MEDICAL MALPRACTICE INSURANCE CLAIMS IN SEVEN STATES, 2000-2004* at 1–2 (2007), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mmics04.pdf> (finding that most claims were closed without compensation and that fewer than ten percent of patient payouts were for \$1 million or more). But see Michelle M. Mello & David M. Studdert, *The Medical Malpractice System: Structure and Performance*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM* 11, 22 (William M. Sage & Rogan Kersh eds., 2006) (concluding that only forty cents of every dollar paid in malpractice insurance premiums goes to patients); David M. Studdert, Michelle M. Mello & Troyen A. Brennan, *Medical Malpractice*, 350 *NEW ENG. J. MED.* 283, 286 (2004) (arguing that threat of malpractice lawsuits leads to administration of unnecessary procedures and avoidance of high-risk patients).

² This argument has received a great deal of attention, especially among economists, over the past three decades. For an overview of the literature, provided in the context of arguments against the desirability of exculpatory agreements as a policy matter, see Jennifer Arlen, *Contracting Over Malpractice Liability* 2–3 nn.3–5 (N.Y. Univ. Ctr. for Law & Econ., Working Paper No. 08-12, 2008), available at <http://ssrn.com/abstract=1105368>, and Maxwell J. Mehlman, *Fiduciary Contracting: Limitations on Bargaining Between Patients and Health Care Providers*, 51 *U. PITT. L. REV.* 365, 365 n.4 (1990).

³ An early example is Richard A. Epstein’s influential article *Medical Malpractice: The Case for Contract*, 1976 *AM. B. FOUND. RES. J.* 87 (1976).

⁴ See, e.g., Jennifer Arlen, *Private Contractual Alternatives to Malpractice Liability*, in *MEDICAL MALPRACTICE AND THE U.S. HEALTH CARE SYSTEM*, *supra* note 1, at 245, 246, 266 (using economic analysis to argue against exculpatory agreements).

⁵ See, e.g., *Cefali v. Buffalo Brass Co.*, 748 F. Supp. 1011, 1026–28 (W.D.N.Y. 1990) (awarding attorney’s fees as result of breach of covenant not to sue).

ments have been repeatedly invalidated, often under the mysterious “void-for-public-policy” rationale.⁶ If private medical malpractice exculpatory agreements are not enforceable in court, this type of reform will not be possible absent legislative intervention.⁷

In one symposium, *Medical Malpractice: Can the Private Sector Find Relief?* (“Private Malpractice Symposium”), several participating scholars recommended ways to make medical malpractice exculpatory agreements enforceable.⁸ They argued that courts would enforce such agreements if they featured a few adjustments, noting that most agreements challenged in courts so far have featured certain objectionable traits,⁹ making it easy for courts to invalidate the contracts. The symposium authors argued that future agreements might be easier “for . . . courts to swallow”¹⁰ if three conditions were satisfied. First, the agreements would have to be nonadhesive: Patients would not be required to sign to obtain medical service. Second, they would have to be specific and clearly worded, so as to actually inform the consumer. Third, they would have to be relatively narrow and only waive either negligence (as opposed to gross negligence) or punitive damages.¹¹

⁶ Thomas A. Moore & Matthew Gaier, *Courts Disfavor Exculpatory Releases*, N.Y. L.J., Oct. 6, 1998, at 3, 7 (describing validity of waivers in New York); see also A.M. Swarthout, Annotation, *Validity and Construction of Contract Exempting Hospital or Doctor from Liability for Negligence to Patient*, 6 A.L.R.3d 704, § 2, at 705 (1966) (describing validity of waivers generally).

⁷ The need for legislative intervention would undercut much of these proposals’ appeal. See CLARK C. HAVIGHURST, *HEALTH CARE CHOICES: PRIVATE CONTRACTS AS INSTRUMENTS OF HEALTH REFORM* 303–10 (1995) (discussing need to persuade courts to accept medical malpractice contracts); Eleanor Kinney, *Health Care Choices: Private Contracts as Instruments of Health Reform*, 17 J. LEGAL MED. 331, 337–38 (1996) (book review) (exploring difficulty of enabling private reform through political process).

⁸ Symposium, *Medical Malpractice: Can the Private Sector Find Relief?*, LAW & CONTEMP. PROBS., Spring 1986, at 1, 143–320.

⁹ For example, some of the agreements have left patients without meaningful choices or have been too broad. See William H. Ginsburg et al., *Contractual Revisions to Medical Malpractice Liability*, LAW & CONTEMP. PROBS., Spring 1986, at 253, 254 (“[M]ost [exculpatory agreements] were one-sided efforts by the healthcare provider to completely exculpate itself from tort liability.”); Clark C. Havighurst, *Private Reform of Tort-Law Dogma: Market Opportunities and Legal Obstacles*, LAW & CONTEMP. PROBS., Spring 1986, at 143, 163–64 (noting that prior agreements reviewed by courts had made poor test cases).

¹⁰ Havighurst, *supra* note 9, at 165.

¹¹ Ginsburg et al., *supra* note 9, at 255–57, 262–63; Havighurst, *supra* note 9, at 165–66; see also HAVIGHURST, *supra* note 7, at 303–10 (outlining changes to contracts—notably, greater information and menus of options—necessary to facilitate contracting over healthcare, including malpractice, and cautioning courts to enforce agreements). The requirement that a patient have alternatives is not satisfied by a doctor’s claim that the patient simply could have sought out a different doctor—as observers have pointed out, such an arrangement still threatens choice when *no* local doctor will treat a patient who refuses to sign. See Randy Cohen, *Doctor, Bully*, N.Y. TIMES, Mar. 30, 2008, § 6 (Magazine), at 20 (“If a single physician were so skittish about malpractice suits . . . that she would see only

This Note argues that the recommendations of the Private Malpractice Symposium scholars are helpful but incomplete. While the odds that an agreement will be enforced are undoubtedly increased if it is nonadhesive, clearly worded, and narrow, I argue that a doctor or patient who wants to maximize the chances that an agreement will be enforced should find a way to make sure the patient's choice to sign or not sign remains confidential.

The legal analysis contained herein mainly focuses on New York case law,¹² which inconsistently applies the void-for-public-policy rationale to medical malpractice exculpatory agreements. In some cases, New York courts have investigated the clarity and adhesiveness of an agreement before invalidating it, a practice which bolsters the symposium scholars' argument that clear, nonadhesive agreements could be enforced. However, in other cases, the courts have categorically barred agreements from being enforced once they have ascertained that the exculpatory agreement restricts medical malpractice claims. It seems doubtful that the scholars' recommendations could save an agreement in these latter cases. But it is not clear what aspect of the doctor-patient relationship justifies nonenforcement in these cases. A behavioral law and economics-based analysis of a patient's decision as to whether to sign an exculpatory agreement highlights one reason why the doctor-patient relationship may serve as a categorical bar. A patient who refuses to sign an exculpatory agreement may signal to her doctor both that she is willing to litigate and that she believes there is a chance her doctor could perform negligently (or worse). Patients that are fairness-regarding—that is, those concerned with appearing to be fair—are afraid to send these signals. As I explain in this Note, these patients may sign exculpatory agreements due to the pressure resulting from this signaling effect.

The observation of this signaling-pressure barrier presents a possible new argument against the enforcement of these agreements. But the identification of signaling pressure surrounding the patient's decision to sign an agreement could provide not just a sword to plaintiffs, but also a shield to doctors arguing for the enforcement of these agreements. If the courts that apply the void-for-public-policy rationale to invalidate medical malpractice exculpatory agreements are doing so because of the signaling pressure between doctor and patient,

patients who would forgo access to the courts, no problem But if all, or nearly all, doctors make the same demand, there's nowhere else to go; a fundamental right is eradicated.”).

¹² While confining the discussion to only one state may seem limiting upon first glance, a fifty-state survey is unmanageable, and attempts to gloss over the majority rule across jurisdictions have failed to yield a clear picture. See *infra* note 20 and accompanying text.

then they may not be as concerned if the doctor is unaware of her patient's decision. A confidential exculpatory agreement would therefore be able to circumvent this barrier to enforcement.

Part I of this Note identifies the incongruous treatment of exculpatory agreements by New York courts. Part II performs a behavioral analysis of the decision to sign a medical malpractice exculpatory agreement and identifies a possible barrier to voluntary contracting over malpractice: Otherwise unwilling patients who are fairness-regarding may sign exculpatory agreements to avoid the signaling costs associated with saying "no." Part III argues that a confidential exculpatory agreement that avoids the signaling pressure identified in Part II would, at the very least, have a better chance of enforcement than a similar agreement that was not entered into confidentially. Part IV then explores the ways in which a medical malpractice exculpatory agreement might be designed to assure the patient that her decision to sign, or not, would remain confidential.

I

THE UNCERTAIN ENFORCEABILITY OF MEDICAL MALPRACTICE EXCULPATORY AGREEMENTS

Contracts are usually enforced if entered into voluntarily, but sometimes an "overriding interest of society" justifies invalidating a contract "on grounds of public policy."¹³ While exculpatory agreements in general are "disfavored," they are typically enforced if found to be voluntary.¹⁴ But *medical malpractice* exculpatory agreements have often been found void as against public policy.¹⁵ Cases using the

¹³ RESTATEMENT (SECOND) OF CONTRACTS ch. 8, introductory note (1981) ("In general, . . . courts will enforce . . . agreements without passing on their substance. Sometimes, however, a court will decide that the interest in freedom of contract is outweighed by some overriding interest of society and will refuse to enforce a promise or other term on grounds of public policy.").

¹⁴ *E.g.*, *Rosenthal v. Bologna*, 620 N.Y.S.2d 376, 378 (App. Div. 1995) ("Contractual clauses which purport to exculpate a party from liability for his own negligence are disfavored, and invite close judicial scrutiny." (citing *Gross v. Sweet*, 400 N.E.2d 306 (N.Y. 1979))); *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 310 (App. Div. 1990) ("Our analysis begins with the long-settled general proposition that the law frowns upon an agreement intended to exculpate a party from the consequences of its own negligence and requires that such contracts be subjected to close judicial scrutiny." (citing *Gross*, 400 N.E.2d 306)); *see also Gross*, 400 N.E.2d at 307–09 (holding that exculpatory agreement for parachute school did not specify, and therefore did not cover, negligence, and setting policy for exculpatory agreements generally); *supra* note 5 and accompanying text (explaining general enforceability of exculpatory agreements).

¹⁵ As an oft-cited article explains: "The application of [the void-for-public-policy test] to exculpatory contracts between hospitals or physicians, on the one hand, and patients, on the other, has been considered in relatively few instances. . . . [H]owever, . . . what rulings there are indicate generally, but not uniformly, that contracts of the kind mentioned are

void-for-public-policy rationale to invalidate medical malpractice exculpatory agreements abound,¹⁶ while cases upholding the agreements are difficult to find.¹⁷ However, it is unclear whether the resistance to these agreements is a result of something that renders them categorically void or, alternatively, of some quality of the subset of agreements that are actually brought to court. In the Private Malpractice Symposium, the scholars noted that the agreements that have been challenged in court have all been either vaguely worded or adhesive, which made it easy for courts to conclude that the contracts were, in fact, not entered into voluntarily.¹⁸ Thus, these agreements would have been held unenforceable regardless of their medical treatment issues; all things considered, they were simply poor test cases.¹⁹

There are no reported cases of a court confronting a medical malpractice exculpatory agreement of the sort suggested by the symposium scholars. Thus, it is unclear whether a patient and provider implementing solely the scholars' suggestions would see their agreement enforced. I argue that while their recommendations are necessary to having a medical malpractice exculpatory agreement enforced, they are by no means sufficient.

invalid." Swarthout, *supra* note 6, § 2, at 705, cited in, e.g., *Ash*, 564 N.Y.S.2d at 313; *Colton v. N.Y. Hosp.*, 414 N.Y.S.2d 866, 872 (Sup. Ct. 1979).

¹⁶ See, e.g., *Rosenthal*, 620 N.Y.S.2d at 378 (refusing to enforce agreement); *Creed v. United Hosp.*, 600 N.Y.S.2d 151, 153 (App. Div. 1993) (same); *Ash*, 564 N.Y.S.2d at 313 (same); *Poag v. Atkins*, 806 N.Y.S.2d 448, 2005 WL 2219689, at *3 (Sup. Ct. 2005) (unpublished table decision) (same).

¹⁷ While these cases are difficult to find, they do exist, as the *Ash* court noted in its opinion. 564 N.Y.S.2d at 309–10 (citing *Morabito v. N.Y. Univ. Dental Ctr.*, 481 N.Y.S.2d 936 (App. Div. 1984) (unpublished table decision); *Black v. N.Y. Univ.*, N.Y. L.J., Mar. 6, 1986, at 6 (Sup. Ct. 1986) (upholding exculpatory agreement since plaintiffs received reduced fee for services and "parties were not in an inequitable bargaining position"); *Fearn v. Columbia Univ. Sch. of Dental and Oral Hygiene*, N.Y. L.J., May 15, 1979, at 10 (App. Div. June 2, 1978) (same)).

¹⁸ Ginsburg et al., *supra* note 9, at 253, 254; Havighurst, *supra* note 9, at 165–68. "Adhesive" is not necessarily a synonym for "involuntary," especially when substitutes are readily available, but a contract's adhesiveness can be a basis for invalidation, traditionally under freedom-of-contract concerns. See generally Douglas A. Baird, *The Boilerplate Puzzle*, 104 MICH. L. REV. 933 (2006) (discussing court decisions striking down standardized contract terms and arguing that generic attacks on boilerplate contracts as contracts of adhesion ring hollow); Todd D. Rakoff, *Contracts of Adhesion: An Essay in Reconstruction*, 96 HARV. L. REV. 1173 (1983) (arguing that form terms present in contracts of adhesion should have rebuttable presumption of unenforceability). This Note does not take a position on this question.

¹⁹ See Mark A. Hall, *Paying for What You Get and Getting What You Pay for: Legal Responses to Consumer-Driven Health Care*, LAW & CONTEMP. PROBS., Autumn 2006, at 159, 176 (noting that relevant case law contained "a highly polarized framing of the issues, such as fully insured versus indigent patients or full liability versus complete waiver of liability").

A. *Medical Malpractice Exculpatory Agreements in New York*

A case study is a valuable way to approach the enforceability of voluntary medical malpractice exculpatory agreements. Since these agreements are governed by common law, each state jurisdiction applies its own rule. Attempts to sum up these cases across multiple states have glossed over the doctrine and have failed to provide substantial clarification.²⁰ As other scholars have recognized,²¹ New York provides an excellent body of law for such a study.²² This is especially true because, although there are no recently reported cases in which New York courts have upheld an exculpatory agreement in the healthcare context, some healthcare providers in New York continue to use these agreements.²³

²⁰ Scholars that have touched on the commensurability of suggestions for contracting around malpractice through a voluntary agreement with current doctrine have treated the case law in only a general manner, if at all, recognizing that courts typically disfavor exculpatory agreements in the healthcare context or discussing the majority rule in very general terms. See, e.g., Ginsburg et al., *supra* note 9, at 253–55 (speaking generally about disfavored status of contracts); Havighurst, *supra* note 9, at 144, 163–65 (stating that courts have resisted recognizing exculpatory agreements but should stop doing so); Mehlman, *supra* note 2, at 401–14 (broadly discussing confused state of law and arguing that it may be understood in fiduciary terms).

²¹ See James Brock, *Contractual Disclaimer and Limitation of Liability Under the Law of New York*, 49 BROOK. L. REV. 1, 1–2 (1982) (analyzing enforceability of exculpatory agreements generally through study of New York case law); A.M. Swarthout, Annotation, *Validity and Construction of Contract Exempting Hospital or Doctor From Liability for Negligence to Patient*, 6 A.L.R.3d § 2, at 72–73 (Supp. 2008) (discussing seven cases, three of which are from New York, in reviewing validity of exculpatory agreements under majority rule).

²² First, New York is a large state that has a rich case law on the topic of exculpatory agreements. See sources cited *supra* note 21. Second, New York is representative of the majority view found in *Tunkl v. Regents of the University of California*, 383 P.2d 441 (Cal. 1963). See *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 313 (App. Div. 1990) (viewing itself in “full agreement” with majority rule); see also Mehlman, *supra* note 2, at 401 (“The landmark decision is *Tunkl* . . .”). Although *Ash* did not specifically refer to *Tunkl* as the source of the majority rule, it relied on a lengthy quotation from the decision. 564 N.Y.S.2d at 312–13. Third, as in other jurisdictions, courts in New York have generally, but not uniformly, refused to enforce medical malpractice exculpatory agreements. Compare, e.g., *Rosenthal v. Bologna*, 620 N.Y.S.2d 376, 378 (App. Div. 1995) (invalidating exculpatory agreement) with *Morabito v. N.Y. Univ. Dental Ctr.*, 481 N.Y.S.2d 936 (App. Div. 1984) (unpublished table decision) (upholding agreement).

²³ For example, in *Glazer v. Lee*, 859 N.Y.S.2d 250, 252 (App. Div. 2008), the plaintiffs lost a summary judgment motion on a separate issue, and thus the court never ruled on the validity of the exculpatory agreement they had signed in their medical malpractice case. Brief of Plaintiffs-Appellants at 19–20, *Glazer*, 859 N.Y.S.2d 250 (No. 2006-07768), 2007 WL 5232175 (arguing exculpatory provisions in agreement should be unenforceable); see also *Dunham v. City of New York*, 766 N.Y.S.2d 854, 854 (App. Div. 2003) (declining to rule on whether waiver of liability should have been void as matter of public policy); *Poag v. Atkins*, 806 N.Y.S.2d 448, 2005 WL 2219689, at *3 (Sup. Ct. 2005) (unpublished table decision) (holding exculpatory agreement for unorthodox cancer treatment was invalid).

In New York, the void-for-public-policy rationale was first applied against medical malpractice exculpatory agreements in *Ash v. New York University Dental Center*.²⁴ An exculpatory agreement used by the New York University (NYU) Dental Center had been invalidated in an earlier case because it did not mention negligence specifically.²⁵ The NYU Dental Center simply added a negligence clause to its agreement,²⁶ and the court was forced to confront a question that prior courts had been able to avoid through strict interpretation:²⁷ Could this properly worded agreement be enforced? While a prior New York Supreme Court case had found a release valid (and was affirmed without opinion),²⁸ the *Ash* court expressly declined to follow that holding.²⁹ It read the issue as one of first impression and joined a growing majority of state courts in finding the exculpatory agreement void as a matter of public policy.³⁰ Specifically, the court employed a two-pronged test, finding that the “special relationship” between the doctor and the patient, along with the State’s interest in the level of care received by its citizens, meant that the agreement could not be upheld.³¹

The inclusion of these terms in contracts, even when such contracts are not enforceable, could have implications on the patient’s decision to sue.

²⁴ 564 N.Y.S.2d 308, 310 (App. Div. 1990).

²⁵ *Abramowitz v. N.Y. Univ. Dental Ctr., Coll. of Dentistry*, 494 N.Y.S.2d 721, 722, 724 (App. Div. 1985) (invalidating agreement because language was not specific).

²⁶ *Moore & Gaier, supra* note 6, at 7 (describing history of *Ash*).

²⁷ *See Abramowitz*, 494 N.Y.S.2d at 723 (“[P]arties will not be presumed to have intended to exempt themselves from the consequences of their own negligence in the absence of express and unmistakable language to that effect”); *see also* *Schneider v. Revici*, 817 F.2d 987, 993–94 (2d Cir. 1987) (holding that while New York allows exculpatory agreements, they are strictly construed and particular agreement before court did not clearly release defendants from future claims); *DeVito v. N.Y. Univ. Coll. of Dentistry*, 544 N.Y.S.2d 109, 109, 111 (Sup. Ct. 1989) (holding that language was not clear enough to exculpate negligence, as it did not say “negligence” or words of similar import, and noting that those cases that upheld agreements involved “considerably stronger” language).

²⁸ *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 309 (App. Div. 1990) (citing *Morabito v. N.Y. Univ. Dental Ctr.*, 481 N.Y.S.2d 936 (App. Div. 1984) (unpublished table decision)).

²⁹ *Id.* at 309–10.

³⁰ *Id.* at 313 (“We are in full agreement with the foregoing conclusions and analyses which are consistent with the majority view in this country that an exculpatory clause of the type here in issue must be held invalid as a matter of public policy.”) (citation omitted); *see also, e.g.*, *Tunkl v. Regents of the Univ. of Cal.*, 383 P.2d 441, 441–42 (Cal. 1963) (finding exculpatory agreement invalid because it “affects the public interest”); *Clark v. Brooks*, 377 A.2d 365, 374 (Del. Super. Ct. 1977) (finding that language of release did not bar plaintiff’s claim against defendant); *Olson v. Molzen*, 558 S.W.2d 429, 432 (Tenn. 1977) (holding that exculpatory contract between patient and doctor was void based on public policy grounds).

³¹ *Ash*, 564 N.Y.S.2d at 310.

B. *The Void-for-Public-Policy Test: Categorical Rule or Case-by-Case Analysis?*

New York courts now cite *Ash* as the controlling case on medical malpractice exculpatory agreements,³² but the courts applying the *Ash* court's void-for-public-policy holding have been unclear about whether the *Ash* court created a categorical rule against the enforcement of all such agreements or rather meant to limit its holding to a particular type of agreement.³³ Two post-*Ash* appellate cases in New York, *Rosenthal v. Bologna*³⁴ and *Creed v. United Hospital*,³⁵ interpret *Ash* as creating a categorical rule. In *Rosenthal*, the First Department,³⁶ without a great deal of discussion, cited *Ash* in holding an exculpatory agreement void because of "the State's interest in the health and welfare of its citizens, and also because of the highly dependent (and thus unequal) relationship between patient and health care provider."³⁷ In *Creed*, the Second Department did not discuss the waiver it held invalid at all, solely stating that it agreed "with our colleagues in the First Department [in *Ash*] that an agreement such as the one upon which these affirmative defenses are based[] violates public policy."³⁸ The *Creed* court's one-sentence dismissal by citation to *Ash* strongly supports reading *Ash* as establishing a categorical rule.

But there is also good reason to read *Ash* for the narrower finding that a *particular* medical malpractice exculpatory agreement—one that featured an absence of bargaining power, among other things—would be invalid as a matter of public policy. First, such a reading is supported by *Ash* itself. The court did not mention that it was departing from previous cases, which might have been expected if

³² See, e.g., *Rosenthal v. Bologna*, 620 N.Y.S.2d 376, 378 (App. Div. 1995) (citing *Ash* for rule); *Creed v. United Hosp.*, 600 N.Y.S.2d 151, 153 (App. Div. 1993) (same); *Poag v. Atkins*, 806 N.Y.S.2d 448, 2005 WL 2219689, at *3 (Sup. Ct. 2005) (unpublished table decision) (same).

³³ Cf. Mehlman, *supra* note 2, at 401 ("[T]here is no consistency in the rationales offered by the courts, little practical guidance for future cases, and no way to distinguish cases that have invalidated such agreements as a matter of law from those that have upheld them or permitted their validity to be decided by the jury.").

³⁴ 620 N.Y.S.2d 376, 378 (App. Div. 1995).

³⁵ 600 N.Y.S.2d 151, 153 (App. Div. 1993).

³⁶ Under the New York State court system, Appellate Division courts—those at the intermediate appellate level—are divided into four geographical "departments." The First Department, for example, deals with appeals from trial courts in Manhattan and the Bronx, whereas the Second Department covers the other New York City boroughs, much of Long Island, and several New York City suburbs. New York State Unified Court System, Appellate Divisions, <http://www.courts.state.ny.us/courts/appellatedivisions.shtml> (last visited Apr. 1, 2009).

³⁷ *Rosenthal*, 620 N.Y.S.2d at 378.

³⁸ *Creed*, 600 N.Y.S.2d at 153.

it were adopting a new rule that no longer followed a case-by-case analysis. More importantly, the court entered into an analysis of the particular bargaining dynamics and implications of the agreement, suggesting that the mere fact that the agreement dealt with malpractice and was between provider and patient was not enough to render it unenforceable.³⁹ Additionally, the *Ash* court limited its holding to “the instant case”⁴⁰ and to exculpatory clauses “of the type here in issue.”⁴¹

This interpretation is reflected in several post-*Ash* decisions. Cases subsequent to *Creed* applying *Ash* have required more than a simple finding that an agreement is between provider and patient and concerns medical treatment to find it invalid. For one, the court in *Rosenthal*, while citing *Ash*, considered evidence that the plaintiff had “entered the agreement . . . from a disadvantaged position” to be important.⁴² In the recent case of *Poag v. Atkins*, the court stated that these types of agreements are “typically”—but not always—invalid.⁴³ While the court invalidated the agreement in that case, it also considered the same interpretive issues raised in the line of cases discussed above.⁴⁴ Other post-*Ash* decisions have engaged in a similar case-by-case analysis.⁴⁵

C. Possible Sources of the Categorical Rule

Determining whether New York has a categorical or case-by-case rule is important because the former type of rule would presumably invalidate even agreements that patients enter into voluntarily and bargain for fairly. This would create tension in the doctrine because it would significantly depart from a separate line of cases that have suggested that voluntary medical malpractice exculpatory agreements are

³⁹ *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 309–13 (App. Div. 1990).

⁴⁰ *Id.* at 310.

⁴¹ *Id.* at 313. It is unclear what “type” the *Ash* court was referring to—read broadly, this line may appear to support a categorical rule against enforcement of medical malpractice exculpatory agreements. See Brief for Plaintiffs-Appellants at 13–14, *Dunham v. City of New York*, 766 N.Y.S.2d 854 (App. Div. 2003) (No. 2003-00146), 2003 WL 23321316 (arguing this exact point).

⁴² *Rosenthal v. Bologna*, 620 N.Y.S.2d 376, 378 (App. Div. 1995).

⁴³ *Poag v. Atkins*, 806 N.Y.S.2d 448, 2005 WL 2219689, at *3 (Sup. Ct. 2005) (unpublished table decision).

⁴⁴ See *id.* (“[T]he ‘agreement’ consists of several sentences in the middle of the informed consent form signed by the plaintiff’s decedent; no separate heading or caption was present to alert the decedent that she was foregoing the right to bring suit. Thus, the ‘agreement’ is unenforceable.”) (citation omitted).

⁴⁵ See, e.g., *Dedely v. Kings Highway Hosp. Ctr., Inc.*, 617 N.Y.S.2d 445, 447 (Sup. Ct. 1994) (citing *Ash* for “a higher standard of responsibility” and finding contract was invalid because it was signed by parent on behalf of minor).

theoretically enforceable,⁴⁶ and have engaged in an analysis of the language and circumstances of each contract.⁴⁷ Perhaps even more troubling, such a rule would leave little room for those hoping to craft an enforceable exculpatory agreement.

This Section explores possible explanations for why some courts might have interpreted *Ash* as creating a categorical rule. It argues, by process of elimination, that the most likely source of such an interpretation is the greater-responsibility justification of the void-for-public-policy rationale. The *Ash* court's two-prong void-for-public-policy rule focuses on: (1) the public interest in the quality of health-care being administered and (2) the "special relationship"⁴⁸ that exists between doctors and patients, which entails a "greater responsibility" owed by doctors.⁴⁹ This section discusses each prong in turn.

First, the public-interest-in-healthcare prong does not justify a categorical rule. This prong was the product of the court's concern that agreements allowing cheaper, reduced-quality care would lead to "a *de facto* system in which the medical services received by the less affluent are permitted to be governed by lesser minimal standards of care and skill than that received by other segments of society."⁵⁰ But exculpatory agreements need not affect quality to be value-adding in

⁴⁶ See *Colton v. N.Y. Hosp.*, 385 N.Y.S.2d 65, 67 (App. Div. 1976) ("This is not to say, however, that one may not, by agreement, relinquish a present right or claim or one which subsequently accrues."), *remanded to Colton v. N.Y. Hosp.*, 414 N.Y.S.2d 866 (Sup. Ct. 1979); *Colton*, 414 N.Y.S.2d at 874 ("Does it include negligence and medical malpractice as defendants claim? Is it void in its entirety on public policy grounds, as plaintiffs claim? These questions must both be answered in the negative.").

⁴⁷ See *supra* note 23 (providing several such decisions). A number of other cases have similarly refused to read a release as having exculpated negligence without very specific—and centrally placed—language. These courts require that agreements be not only "clear and unambiguous on [their] face but also . . . understandable to the particular patient." *DeVito v. N.Y. Univ. Coll. of Dentistry*, 544 N.Y.S.2d 109, 110 (Sup. Ct. 1989) (citing *Abramowitz v. N.Y. Univ. Dental Ctr., Coll. of Dentistry*, 494 N.Y.S.2d 721 (App. Div. 1985)).

⁴⁸ See *supra* text accompanying note 31.

⁴⁹ *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 311 (App. Div. 1990).

⁵⁰ *Id.* The dental clinic in *Ash* was no ordinary hospital or clinic, but rather a teaching clinic where the students were not "sufficiently prepared and supervised so that the treatment which is provided to human patients is at least at the minimally acceptable reasonable level of skill and care." *Id.* The court implied that the negligence waiver would result in reduced-quality care for the less affluent: "It is clear that the State's substantial interest in protecting the welfare of all of its citizens, irrespective of economic status, extends to ensuring that they be provided with health care in a safe and professional manner." *Id.* at 310; see also *id.* at 311 (noting patients may tolerate longer wait times, fewer amenities, or other inconveniences in exchange for reduced-cost care, but that "[t]here cannot . . . be any justification for a policy which sanctions an agreement which negates the minimal standards of professional care which have been carefully forged by State regulations and imposed by law").

healthcare, and they certainly need not affect the quality of care for the less affluent.⁵¹ Even assuming that the malpractice system plays the role it is traditionally thought to in ensuring quality, to the extent that “quality” is not a treatment-by-treatment decision and at least some patients choose to retain the possibility of suing for malpractice, an incentive for the doctor to meet the malpractice standard remains.⁵² Furthermore, informed patients might refuse to sign contracts that negatively affect quality.⁵³

The second prong of the *Ash* rule draws upon concerns that healthcare providers could abuse their “special relationship” with their patients.⁵⁴ The *Ash* court gave two different justifications for the special-relationship prong. At the time *Ash* was written, a prominent contracts treatise—speaking of the use of “special relationships” to invalidate exculpatory agreements generally—explained that there were multiple “bases for deciding that a bargain, otherwise valid, which exempts one from future liability to another that would arise except for the bargain is invalid because the parties are in a certain relationship to each other.”⁵⁵ One basis was that “a relation often represents a situation in which the parties have not equal bargaining

⁵¹ See PAUL C. WEILER, *MEDICAL MALPRACTICE ON TRIAL* 6 (1991) (arguing physicians view malpractice judgments as accidents—not as evidence of quality); Richard A. Epstein & Alan O. Sykes, *The Assault on Managed Care: Vicarious Liability, ERISA Preemption, and Class Actions*, 30 J. LEGAL STUD. 625, 642 (2001) (claiming malpractice liability is essentially random); Stephen D. Sugarman, *Doctor No*, 58 U. CHI. L. REV. 1499, 1500–02, 1504 (1991) (reviewing WEILER, *supra*) (noting that very small fraction of those harmed by malpractice actually bring suit); Lori L. Darling, Note, *The Applicability of Experience Rating to Medical Malpractice Insurance*, 38 CASE W. RES. L. REV. 255, 259–62 (1987) (arguing malpractice premiums are not connected to quality). *But see* Jennifer Arlen & W. Bentley MacLeod, *Malpractice Liability for Physicians and Managed Care Organizations*, 78 N.Y.U. L. REV. 1929, 1940 n.36 (2003) (arguing Weiler study’s sample size was too small to draw statistically significant conclusion that malpractice liability is random).

⁵² See, e.g., LAW & POLAN, *supra* note 1, at 18–19, 61–62, 251–52 nn.18–19 (claiming quality of healthcare outcomes is largely influenced by unnecessary treatment); Mark R. Chassin et al., *Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services?*, 258 J. AM. MED. ASS’N 2533, 2536 (1987) (arguing that seventeen to thirty-two percent of studied procedures were unnecessary).

⁵³ Indeed, it seems unlikely that patients would willingly sign contracts that give them reduced-quality care if they had the meaningful option of paying for the higher-quality care, since “[p]atients generally want high quality at reduced costs, not cut rates with fewer protections.” Sylvia A. Law, *A Consumer Perspective on Medical Malpractice*, LAW & CONTEMP. PROBS., Spring 1986, at 305, 317. Even if a voluntary exculpatory agreement did affect quality, the *Ash* court’s concern was with a departure from the minimal standard of care for less affluent patients who could not afford otherwise, *Ash*, 564 N.Y.S.2d at 311, and a doctor might provide evidence that the patient had the financial wherewithal to pay the higher fee and not sign.

⁵⁴ *Ash*, 564 N.Y.S.2d at 310–11.

⁵⁵ 15 SAMUEL WILLISTON & WALTER H. E. JAEGER, *A TREATISE ON THE LAW OF CONTRACTS* § 1751 (3d ed. 1972).

power; and one of them must either accept what is offered or be deprived of the advantages of the relation.”⁵⁶ But a second and independent basis was that “some relationships are such that once entered upon they involve a status requiring of one party greater responsibility than that required of the ordinary person, and, therefore, a provision avoiding liability is peculiarly obnoxious.”⁵⁷ The court in *Ash* did not commit to either of these justifications for the special-relationship prong it employed, though it did address both.⁵⁸

The “bargaining power” justification is relatively straightforward and does not suggest a categorical rule. Rather, the *Ash* court made clear that the contract involved was adhesive⁵⁹ (the patient either had to sign or seek treatment from a different provider), which is a traditional ground for invalidating contracts on a case-by-case basis.⁶⁰

The greater-responsibility justification, however, is the more likely source of a categorical rule against the enforcement of medical malpractice exculpatory agreements. Read literally, the justification applies if the parties to the exculpatory agreement consist of a provider and a patient to whom the provider owes a “greater responsibility” than that owed to a non-patient. Ostensibly, this greater

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ The court seemed to base its holding on both justifications. The court explicitly states that the “greater responsibility” of the doctor in the patient-provider relationship is a concern, citing WILLISTON & JAEGER, *supra* note 55, for this proposition. *Ash*, 564 N.Y.S.2d at 311. But the court turns to the “bargaining power” justification after providing the following inconclusive justifications: “In the context of that professional relationship ‘a provision avoiding liability is peculiarly obnoxious.’ Also significant in evaluating the provision’s validity are the unequal positions of the parties entering into this agreement, creating a substantial opportunity for abuse.” *Id.* (quoting WILLISTON & JAEGER, *supra* note 55, § 1751).

⁵⁹ The *Ash* court’s analysis of why the special relationship justified nonenforcement makes this clear: “[T]he individual responsibility bestowed upon defendants by the physician-patient relationship, *in the context of the disadvantageous position from which plaintiff necessarily entered into the agreement*, militates strongly against its propriety.” *Id.* at 312 (emphasis added). Furthermore, the court in *Ash* used the adhesive nature of the contract to distinguish the case law upholding voluntary exculpatory agreements, stating that: “[The clinic’s patients] must either accept what is offered or be deprived of the advantages of the relation’ . . . [They] cannot be considered to have freely bargained for a sub-standard level of care in exchange for a financial savings.” *Id.* at 311–12 (quoting WILLISTON & JAEGER, *supra* note 55, § 1751).

⁶⁰ Thus, courts have compared healthcare services to those of other services invalidated under this prong, such as common carriers or public utilities—industries in which the provider effectively has a monopoly and might impose the contract on the consumer even when it is not in the consumer’s best interest. See *DeVito v. N.Y. Univ. Coll. of Dentistry*, 544 N.Y.S.2d 109, 110 (Sup. Ct. 1989) (“In these relationships, the consumer’s need for the service creates an inequality in bargaining strength which enables the purveyor to insist upon a release, generally on its own prepared form, as a condition to providing the service.”).

responsibility is a necessary element of every patient-provider relationship. It is important to note that the *Ash* court does not explain why one party owing the other a greater responsibility might undermine a contract. Thus, there is no underlying purpose that could be used to guide application of the greater-responsibility justification on a case-by-case basis. Instead, it seems like a categorical rule.

If courts applying *Ash* as a categorical rule base this finding on the greater-responsibility justification, the next step for a doctor hoping to craft an enforceable medical malpractice exculpatory agreement is unclear. An agreement incorporating the suggestions of the Private Malpractice Symposium scholars could meet both the public-interest-in-healthcare prong and the bargaining-power justification for the special-relationship prong of the void-for-public-policy rationale because the contract need not affect quality and would not be adhesive. But courts have not articulated the reason why the “greater responsibility” owed by doctors to patients justifies invalidation of medical malpractice exculpatory agreements. Without a more specific articulation, there is no obvious way to craft an agreement that could avoid a broad reading of the greater-responsibility justification and the *Creed* line of cases. The next Part puts forward a reason why the greater responsibility doctors owe to patients justifies invalidation of *some* agreements, but not all.

II

HOW SIGNALING EFFECTS CAN ENCUMBER THE DECISION TO SIGN A MEDICAL MALPRACTICE EXCULPATORY AGREEMENT

This Part uses a behavioral law and economics analysis of the patient’s decision to sign a medical malpractice exculpatory agreement to show why the simple presence of the doctor-patient relationship might justify invalidation of the agreement. Behavioral economic analysis is largely theoretical: It uses as a starting point the economic model of the purely rational, self-interest-maximizing decisionmaker and qualifies that model with the insights of behavioral psychology.

First, a caveat: Behavioral economic analysis is not the only way to illuminate patient decisionmaking. If it were possible, a case study or survey of patients or doctors actually involved in the decisions would be preferable as a replacement for, or supplement to, theoretical analysis. In cases like this, however, in which few examples of medical malpractice exculpatory agreements that could be used for

surveys or interviews exist,⁶¹ a methodology with predictive force is necessary. Thankfully, behavioral economic analysis provides that methodology, as it is designed to be a generalizable theory of micro-level decisionmaking.⁶²

The analysis in this Part, however, is not purely theoretical. It incorporates studies of the doctor-patient relationship generally to show that a behavioral economic analysis can describe actual decision-making that occurs within this relationship. It also provides some evidence—aneecdotal and otherwise—of how patients react when presented with medical malpractice exculpatory agreements.

The following Section shows that, in contracting over malpractice, a patient inevitably signals to her provider both her view of her provider's competence and her willingness to litigate. If this signal amounts to a cost, then it could influence the patient's decision to sign. Section B explains that, in general, signaling effects such as those posed by medical malpractice exculpatory agreements can be a cost to patients, for a variety of reasons both selfish and selfless. Thus, the analysis predicts (and some evidence corroborates) that, for many patients, signaling pressure is a cost that undermines the voluntariness of such agreements—even if they are nonadhesive and well crafted.

A. *Exculpatory Agreements and Their Signals*

Whenever an actor's choice of behavior gives private information to observers, that choice of behavior is said to have a signaling effect.⁶³ In accepting or rejecting her healthcare provider's offer of an

⁶¹ A survey of patients might probe their opinions of medical malpractice exculpatory agreements. Because very few agreements have been used, however, the best available sample would consist of prospective patients. Such a sample could provide, at most, a glimpse of how the patients think they would feel when presented with a medical malpractice exculpatory agreement. See Shari Seidman Diamond, *Reference Guide on Survey Research*, in REFERENCE MANUAL ON SCIENTIFIC EVIDENCE 229, 256–60 (Fed. Judicial Ctr. ed., 2d ed. 2000) (noting surveys of “consumer impressions have a limited ability to answer questions about the origins of those impressions” and outlining proper use of control groups in survey conduction).

⁶² See Jon D. Hanson & Douglas A. Kysar, *Taking Behavioralism Seriously: The Problem of Market Manipulation*, 74 N.Y.U. L. REV. 630, 636–37 (1999) (noting that behavioral qualifications to rational choice theory are systematic and able to be modeled); Robert A. Prentice, *The Case of the Irrational Auditor: A Behavioral Insight into Securities Fraud Litigation*, 95 NW. U. L. REV. 133, 135 (2000) (arguing that behavioral economics can improve law and economic analysis “across the board”). But see Gregory Mitchell, *Taking Behavioralism Too Seriously? The Unwarranted Pessimism of the New Behavioral Analysis of Law*, 43 WM. & MARY L. REV. 1907, 1909–13 (2002) (arguing that behavioral law and economics scholars, including Hanson and Kysar, make “incorrect and simplistic conclusions about human rationality” and fail to see their field's limitations).

⁶³ For example, one explanation for the observed status quo bias in contract law—the failure of actors to contract around apparently inefficient default contract terms—is that the decision to negotiate away from a contract term itself sometimes signals information

exculpatory agreement waiving negligence, a patient inevitably signals two things: her perception of her doctor's competence and her willingness to litigate if she is harmed. This is a fairly straightforward signaling effect. A patient who does not sign a negligence waiver is effectively saying, "I believe there is a significant chance that you will negligently commit an error in treating me for which I will seek and receive compensation, and the value of that prospective compensation outweighs the savings you have offered." The same is true of exculpatory agreements waiving punitive damages, except instead of signaling her perception of the likelihood of doctor error, the patient signals her perception of the likelihood of reprehensible behavior by the doctor.

The core of the theoretical argument in favor of medical malpractice exculpatory agreements is a standard freedom-of-contract argument: Because patients enter into agreements with their doctors to purchase medical services, the price of those medical services will inevitably include the estimated cost of any future liability imposed on either party by the law.⁶⁴ When the malpractice regime is mandatory (when exculpatory agreements are not enforced), the healthcare provider's fee will always include the provider's expected liability. If, however, the patient values the availability of a malpractice claim at less than its cost to the provider, then forcing the parties to include an undesirable contract term reduces the surplus created by the contract and can even discourage contracting altogether at the margins. Thus, if courts allow parties to contract around the system, overall surplus increases. This Note does not purport to settle the debate about the efficiency (or inefficiency⁶⁵) of medical malpractice exculpatory agreements; its primary focus is on the legality of these agreements.⁶⁶

that is in some way costly to the actor. Omri Ben-Shahar & John A. E. Pottow, *On the Stickiness of Default Rules*, 33 FLA. ST. U. L. REV. 651, 657-59 (2006).

⁶⁴ Richard A. Epstein, *Contractual Principle Versus Legislative Fixes: Coming to Closure on the Unending Travails of Medical Malpractice*, 54 DEPAUL L. REV. 503, 507 (2005).

⁶⁵ See generally Arlen, *supra* note 2, for a thorough argument explaining ways in which allowing medical malpractice exculpatory agreements would be harmful to some patients and create inefficiency.

⁶⁶ To the extent that the analysis herein contributes to the efficiency debate, it does so simply by identifying an additional cost of enforcing medical malpractice exculpatory agreements (the signaling pressure discussed in this Part) and proposes a potential solution that avoids these costs in some cases (the confidential contracts discussed in Part IV). The proposed solution, however, would not entirely cure all the inefficiencies created by contracting over liability. For example, if patients are heterogeneous in the risk of malpractice suit they pose (either because they are more likely to be harmed or because they are more likely to sue), only the riskiest patients will purchase the malpractice option, creating a problem of adverse selection. See Arlen, *supra* note 2, at 57 (discussing adverse selection created by medical malpractice exculpatory agreements); see also Mark Geistfeld, Note, *Imperfect Information, the Pricing Mechanism, and Products Liability*, 88 COLUM. L. REV. 1057, 1067-68 (discussing similar adverse selection problem in context of separate war-

A hypothetical can help illustrate the unavoidable signaling effect: If a healthcare provider offers an exculpatory agreement along with a fee reduction of \$200 and the patient rejects it, the doctor then knows that the patient values her right to sue for malpractice at greater than \$200. A perfectly rational patient calculates the expected value of malpractice availability by multiplying her estimated probability of recovery by her estimated recovery amount; her rejection of the fee decrease shows that the product of these two estimates is more than \$200. Thus, the patient thinks there is a significant chance that her provider will negligently cause her significant harm, and that she would successfully seek compensation for such harm.⁶⁷ This signaling effect is complicated—but not eliminated or necessarily diminished—by risk-averse patients⁶⁸ and the availability of insurance.⁶⁹

ranty pricing). Moreover, confidential contracting will not cure the inefficiencies of contracting arising from the fact that malpractice liability can be a collective good. *See* Arlen, *supra* note 4, at 247 (“Patients may benefit less from contractual liability than from tort liability because patients governed by malpractice liability do not benefit simply from liability imposed for their own injuries.”). For more on the efficiency implications of the argument in this Note, see *infra* note 79 and accompanying text.

⁶⁷ Pricing the right to malpractice is a difficult task. For one approach to the application of option pricing theory to legal rights, see generally IAN AYRES, *OPTIONAL LAW: THE STRUCTURE OF LEGAL ENTITLEMENTS* (2005).

⁶⁸ Risk-averse patients are those patients who would prefer a 100% chance of losing \$100 to a 10% chance of losing \$1000. *See, e.g.*, STEVEN SHAVELL, *FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW* 258–69 (2004) (discussing risk aversion and accident costs). Risk aversion would simply affect the hypothetical in the form of a multiplier on the expected award received through litigation (thus, rather than weigh the reduced price against the full benefits of a tort award, the patient would weigh the reduced price against some fraction of the benefits of a tort award). This would not change the fact that the patient must both foresee a significant chance of harm and be willing to litigate in order for the expected award to be relevant to her signing decision.

⁶⁹ The dynamics of the choice to sign a medical malpractice exculpatory agreement for an insured patient are slightly different than for an uninsured patient—the insured patient has both more and less incentive to sign the agreement. An insured patient has more incentive to sign because she would not be able to collect that portion of the tort award that went to medical treatment even if she retained the malpractice right—insurance companies usually claim a subrogation interest equal to the amount they have paid as a result of the plaintiff’s harm. *See generally* Kenneth S. Reinker & David Rosenberg, *Unlimited Subrogation: Improving Medical Malpractice Liability by Allowing Insurers To Take Charge*, 36 J. LEGAL STUD. 261 (2007) (discussing subrogation). However, an insured patient has less incentive to sign because if the insurance company pays a large percentage of the medical fee, it would see most of the resulting savings. Although a full analysis of the pricing dynamics under insurance is beyond the scope of this Note, it should be noted that insurance alters—but does not eliminate—the patient’s cost-benefit calculus. Accordingly, the signaling effect remains. Insured doctors retain an incentive to offer exculpatory agreements because claims against doctors lead to higher insurance premiums. Thomas H. Gallagher & Wendy Levinson, *Disclosing Harmful Medical Errors to Patients: A Time for Professional Action*, 165 ARCHIVES INTERNAL MED. 1819, 1819 (2005). Insurance companies may even request that doctors offer such agreements. Finally, for the forty-seven mil-

B. *The Costs of Signaling*

The fact that a patient who signs an exculpatory agreement inevitably signals something about her perception of her provider's competence (or, in the case of punitive damages, morality) and her willingness to litigate is interesting but not itself significant to the enforceability of the agreement. This signaling *effect* only becomes significant when it is viewed as a signaling *cost* to the patient—when the patient is afraid of revealing her perception of her provider's competence and acts accordingly. Only then does the presence of a signaling effect pressure the patient to sign and undermine the voluntariness, and therefore the enforceability, of the agreement.

The key question then becomes: Would a patient's decision to sign a medical malpractice exculpatory agreement actually be influenced by the signaling effect described in the previous section? Given how rare exculpatory agreements are in practice, it is difficult to obtain empirical evidence about the decisions of patients entering into these agreements.

This Section argues that patient decisionmaking would, in fact, be affected. It does this first by presenting a theoretical model of decisionmaking that is designed to describe behavior across contexts. It then shows that this model aptly describes the decisions of patients in the patient-provider relationship, making the circumstantial case that it would also describe the patient's decision to sign an exculpatory agreement. Finally, it presents some direct evidence.

1. *Fairness Costs in Theory*

In behavioral law and economics, "fairness" describes the experimentally observed behavior of actors who seem to consider the needs of others in making a decision⁷⁰ or retaliate against those who do not.⁷¹ Fairness-regarding behavior was first observed in an experi-

lion patients without health insurance and for patients receiving elective surgery not covered by insurance, this effect would be irrelevant. See Nan D. Hunter, *Risk Governance and Deliberative Democracy in Health Care*, 97 GEO. L.J. 1, 58 n.297 (2008) (discussing number of uninsured Americans).

⁷⁰ See Todd L. Cherry, Peter Frykblom & Jason F. Shogren, *Hardnose the Dictator*, 92 AM. ECON. REV. 1218, 1218 (2002) (attempting to devise game in which people would not treat others fairly); Elizabeth Hoffman et al., *Social Distance and Other-Regarding Behavior in Dictator Games*, 86 AM. ECON. REV. 653, 653-54 (1996) (arguing that fairness-regarding behavior depends on process and "social distance").

⁷¹ See Matthew Rabin, *Incorporating Fairness into Game Theory and Economics*, in ADVANCES IN BEHAVIORAL ECONOMICS 297, 298 (Colin F. Camerer et al. eds., 2004) ("The results demonstrate the special role of 'mutual-max' outcomes (in which, given the other person's behavior, each person maximizes the other's material payoffs) and 'mutual-min' outcomes (in which, given the other person's behavior, each person minimizes the other's material payoffs)."); see also, e.g., Richard A. Posner, *Rational Choice, Behavioral*

mental study known as the ultimatum game, in which researchers noticed that people went out of their way both to treat others fairly and to retaliate against those they perceived to be unfair.⁷² The fact that some people consider fairness in making decisions can induce fairness-regarding behavior even in individuals who do not otherwise value fairness. Such individuals, acting strategically, try to appear fair in order to avoid retaliation.⁷³ For both fairness-regarding actors and those behaving strategically, the “cost” of not acting fairly (for the former, a personal preference; for the latter, a cost measured by risk of retaliation) can be described as a “fairness cost.”

While the concept of fairness-regarding behavior seems rather intuitive, the suggestion that actors purposefully consider the needs and opinions of others challenges and qualifies the traditional economic notion that individual actors consider only their own utility when making a decision.⁷⁴ It is important to recognize how fairness-regarding behavior alters the economic, self-interested model because

Economics, and the Law, 50 STAN. L. REV. 1551, 1562–63 (1998) (discussing possible explanations for retaliation behavior).

⁷² This simple game involves two subjects: a Proposer and a Responder. The Proposer is given some amount of money (researchers have conducted tests with amounts ranging from very small to very large) and told to offer the Responder some portion of that money. See, e.g., Elizabeth Hoffman et al., *On Expectations and the Monetary Stakes in Ultimatum Games*, 25 INT'L J. GAME THEORY 289, 299 (1996) (finding results of ultimatum game did not change with higher stakes). If the Responder accepts, they both get the allocated amount. If the Responder does not, neither gets any money. Hoffman et al., *supra* note 70, at 653. In a world of perfect self-interest, the Proposer would be expected to offer the bare minimum, knowing that the Responder would rather have even a very small amount than nothing. But this is not what individuals do when playing the game: Instead, Proposers offer closer to 50% of the total, and Responders reject extremely low proposals (in apparent retaliation). E.g., Christine Jolls, Cass R. Sunstein & Richard Thaler, *A Behavioral Approach to Law and Economics*, 50 STAN. L. REV. 1471, 1489–90 (1998) (reporting contrast between results of ultimatum game and predictions of economic theory). This means not only that Responders would rather punish a Proposer they view as treating them unfairly than take money but also that Proposers are aware of this and tailor their proposals accordingly.

⁷³ Richard Posner describes this dynamic as follows:

To gain anything from playing the game, the proposer has to make an offer generous enough to induce the respondent to accept. As this necessity exists whether or not the proposer has any sense of fairness, there is nothing even remotely irrational—hence nothing that requires a concept of fairness to explain—about his offering more than a penny. So we can forget about the proposer and concentrate on the respondent, and ask, “Why won’t he take the penny?”

Posner, *supra* note 71, at 1564.

⁷⁴ See Colin Camerer et al., *Regulation for Conservatives: Behavioral Economics and the Case for “Asymmetric Paternalism,”* 151 U. PA. L. REV. 1211, 1216 & n.20 (2003) (“Some research in behavioral economics has focused on how people’s preferences are not what economists had supposed. For instance . . . people seem to have social preferences that cause them to care about more than merely maximizing their own material payoffs.”).

it can help to explain patient decisionmaking. Unsurprisingly, studies on fairness in the real world have documented behavior comporting with the predictions of fairness-regarding behavior theories.⁷⁵

The biggest difficulty in attempting to find fairness-regarding behavior in practice is determining what is “fair” and what is “unfair.” While this is a complicated and difficult question, for purposes of this Note it is enough to say that behavior is “unfair” if the actor believes the behavior represents a departure from the ideal norm of activity. This definition comports with that used by other scholars in similar studies.⁷⁶

Fairness costs (or benefits) that attach to an action often depend not on the action itself but rather on what the actor’s choice signals.⁷⁷

⁷⁵ See, e.g., Daniel Kahneman et al., *Fairness as a Constraint on Profit Seeking: Entitlements in the Market*, 76 AM. ECON. REV. 728, 728–29 (1986) (finding fairness costs constrained profit-maximizing firms). A number of studies show that businesses often present standard-form contracts to individuals in situations where social pressure will prevent them from reading them, such as when they are in the front of a long line at the car rental booth, so as to increase the likelihood that they will sign an entirely unfair contract. See Robert A. Hillman & Jeffrey J. Rachlinski, *Standard-Form Contracting in the Electronic Age*, 77 N.Y.U. L. REV. 429, 448 (2002) (describing use of this tactic).

⁷⁶ See Colin Camerer & Richard H. Thaler, *Anomalies: Ultimatums, Dictators and Manners*, 9 J. ECON. PERSP. 209, 216–17 (1995) (“The perceived norms of fairness . . . can be thought of as rules of polite business practice.”). It is true that this definition seems largely circular—something is unfair if people think it is unfair. Still, it at least suggests that what is fair can be gleaned from people’s behavior (that is to say, fairness is socially constructed), which provides some basis for identifying fairness in practice. It is also the best definition available. In any event, the exact source or form of the fairness cost is less important than its expressive function, as discussed in Part II.A.

⁷⁷ One study presented the dictator game (like the ultimatum game, except that the Responder has no power to reject the distribution) under double-blind conditions, ensuring that neither the opposing player nor the researchers would know what division the actor chose. Under these conditions, 64% of players gave nothing, and only 8% gave something approaching a “fair” price. Hoffman et al., *supra* note 70, at 653–54. In contrast, in a control group under the same study that was not double blind, only 18% gave nothing, and 32% gave a “fair” price. *Id.* at 654. This has been confirmed by others repeating the experiments. See, e.g., Catherine C. Eckel & Philip J. Grossman, *Altruism in Anonymous Dictator Games*, 16 GAMES & ECON. BEHAV. 181, 186–88 (1996) (presenting results and noting inability to reject hypothesis that results of authors’ study and Hoffman et al. study have same distribution); see also Gary Charness & Matthew Rabin, *Expressed Preferences and Behavior in Experimental Games*, 53 GAMES & ECON. BEHAV. 151, 154 (2005) (explaining that in two-player ultimatum game, second players are more likely to accept extremely low offer if they know that allocation of money was randomly assigned and not result of first player’s self-interested decision). In short, “[p]eople are less concerned with fairness than with the appearance of fairness.” John R. Hibbing & John R. Alford, *Accepting Authoritative Decisions: Humans as Wary Cooperators*, 48 AM. J. POL. SCI. 62, 64 (2004); see also Sally Blount, *When Social Outcomes Aren’t Fair: The Effect of Causal Attributions on Preferences*, 63 ORGANIZATIONAL BEHAV. & HUM. DECISION PROCESSES 131, 131–32 (1995) (arguing that attribution matters to fairness concerns); Camerer & Thaler, *supra* note 76, at 212 (“[T]he appearance of fairness is enough . . .”); Gary Charness, *Attribution and Reciprocity in an Experimental Labor Market*, 22 J. LAB. ECON. 665, 666 (2004) (finding employees worked harder when low wage was exogenously

This can be true whether the actor experiences fairness costs because he is fairness-regarding or merely because he is acting strategically.⁷⁸ When fairness costs take the form of signaling costs, fairness-regarding actors are concerned with the decisions that underlie their actions and what those underlying decisions signal about the actor to others.

The fact that fairness costs can be a function of signaling and not the underlying behavior itself makes it possible to avoid these costs by making the underlying decisions confidential. But confidentiality is a solution to the fairness problem only if a given patient's fairness concern arises from her discomfort with signaling to her doctor that she wants to sue. Confidentiality alone will not solve the fairness problem if a patient's sense of unfairness arises instead from her discomfort with voluntarily seeking the right to sue, whether or not her doctor knew she withheld the option. In such a case, the patient would still experience the distress of guilt even after signing a confidential contract. In this situation, there is an argument for taking the choice out of the patient's hands.⁷⁹ Confidentiality does redress problems arising from patients' concerns with appearing to be unfair or untrusting to their physicians, however. This is because when fairness costs depend on signaling, the "cost" of choosing to withhold the malpractice option is annulled by making the decision confidential.

2. *Fairness Costs in Patient-Provider Relationships*

The theoretical model of fairness costs that has been developed through laboratory experiments also aptly explains the patient-provider relationship. If patients are frequently fairness-regarding, such behavior might be at play in deciding whether or not to sign a medical malpractice exculpatory agreement.

Despite the difficulty in finding hard evidence of fairness-regarding behavior in the doctor-patient relationship, there are examples of patients making decisions they would rather not make simply

determined than when it was chosen by employer); Rabin, *supra* note 71, at 297–98 (noting that respect for “fairness” is actually dependent on motives of others).

⁷⁸ In the strategic case, retaliation has not been observed in games in which the Responder does not perceive the Proposer's action as intentional: It is the attribution of intentionality in the Proposer's unfair action, and not the action itself, that generates a retaliatory response. See, for example, Charness, *supra* note 77, and Blount, *supra* note 77, for discussions of “attribution.”

⁷⁹ In another paper, I elaborate on this rationale for mandatory rules, dubbing this form of argument—that a mandatory rule gives people what they would really want, if not for the cost of deciding they want it—“excuse paternalism.” Matthew J.B. Lawrence, Forcing Patients To Do What They Really Want To Do: The Case for Excuse Paternalism (Feb. 15, 2009) (unpublished manuscript, available at <http://ssrn.com/abstract=1343539>).

to avoid appearing untrusting or unfair to their doctor. One scholar, for example, reports an interview with a woman who claimed to avoid the subject of costs with her doctor for fear of being insulting or provoking retaliation.⁸⁰

A second example can be found in the puzzle surrounding mandatory second opinions. In another paper,⁸¹ I point out that patients assume a fairness cost—the result of expressed distrust of their doctors—in the decision to seek a second opinion that policy-makers do not, which helps explain the mysterious success of mandatory second opinion programs.⁸² The reasons proffered by patients who do not obtain second opinions under a voluntary regime suggest that (1) fairness costs indeed inhibit the decision to obtain a second opinion,⁸³ and (2) the fact that fairness costs are vitiated by removing the element of choice explains why patients who do not choose to obtain second opinions do not mind being forced to get them.⁸⁴

It is not surprising that patient decisionmaking is influenced by the desire to appear fair. As Mark Hall has shown, trust is an integral part of the doctor-patient relationship.⁸⁵ Patients want to trust their doctors and, moreover, to appear trusting to their doctors.⁸⁶ It is well documented that “[p]atients want a therapeutic relationship with their doctors, a relationship which produces and prospers on reliance, attachment, and mutual confidence.”⁸⁷ Thus, many, if not most, patients are concerned with appearing to be “model,” trusting patients—that is, they can be said to exhibit fairness-regarding behavior of a type that depends on signaling.

⁸⁰ Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 655–56 (2008).

⁸¹ Lawrence, *supra* note 79.

⁸² More patients obtain second opinions under a mandatory regime than under a voluntary regime. See David A. Hyman, *A Second Opinion on Second Opinions*, 84 VA. L. REV. 1439, 1458 (1998) (“The most striking fact regarding all voluntary [surgical second opinion programs] is that few people choose to use them.” (quoting Alan S. Friedlob, *Medicare Second Surgical Opinion Programs: The Effect of Waiving Cost-Sharing*, 4 HEALTH CARE FINANCING REV. 99, 104 (1982))). This success implies that many patients are made to obtain second opinions who would not choose them otherwise and that surveyed patients do not mind mandatory second opinion programs. Stephen N. Rosenberg et al., *Patients’ Reactions and Physician-Patient Communication in a Mandatory Surgical Second-Opinion Program*, 27 MED. CARE 466, 469–70 (1989).

⁸³ Lawrence, *supra* note 79, at 19–22 (asserting that patients do not voluntarily seek second opinions in part to avoid upsetting their doctors).

⁸⁴ *Id.* at 22–23.

⁸⁵ See generally Mark A. Hall, *Law, Medicine, and Trust*, 55 STAN. L. REV. 463 (2002) (discussing fundamental importance of trust to practice of medicine and to healthcare law).

⁸⁶ *Id.* at 510.

⁸⁷ Hall & Schneider, *supra* note 80, at 652.

3. *Fairness Costs in Malpractice*

If, as discussed above, patients are fairness-regarding with their medical providers, the question then becomes: Would a patient, by declining to sign an exculpatory agreement and thereby signaling a lack of confidence in her doctor's competence and a willingness to sue, be departing from an ideal norm?⁸⁸ Given that there are no examples of a patient being presented with a nonadhesive exculpatory agreement (those in reported cases are uniformly adhesive), the question is difficult to answer empirically.

However, there is evidence that a fairness-regarding patient would seek to avoid signaling distrustfulness of her doctor and a willingness to sue. First, it is no secret that malpractice suits are a sensitive subject among doctors,⁸⁹ and some doctors might even retaliate against patients they view as litigious by refusing to treat them or by practicing "defensive medicine."⁹⁰ Second, it is well documented that doctors have psychological difficulties with the prospect of error,⁹¹ and it is quite plausible that patients are aware of this. Third, studies show that patients sue their doctors very rarely, even when they have a valid cause of action.⁹² Moreover, the rate of malpractice suits declines even further if doctors simply apologize to their patients after making mistakes.⁹³ Superior evidence of fairness-regarding behavior in the real world would be difficult to find absent an empirical study. Thus, it seems likely that for many patients, the signaling effect associated with refusing to sign an exculpatory agreement would impose a

⁸⁸ This question derives from the definition of fairness presented in note 76 and accompanying text, *supra*.

⁸⁹ See, e.g., David Hilfiker, *Facing Our Mistakes*, 310 N. ENG. J. MED. 118, 121–22 (1984) ("Even the word 'malpractice' carries the implication that one has done something more than make a natural mistake; it connotes guilt and sinfulness. . . . [L]ittle wonder that we are defensive about our judgments . . .").

⁹⁰ Dorothy M. Allison, Comment, *Physician Retaliation: Can the Physician-Patient Relationship Be Protected?*, 94 DICK. L. REV. 965, 965, 967–68, 972 (1990).

⁹¹ See JOHN D. BANJA, *MEDICAL ERRORS AND MEDICAL NARCISSISM* ix (2005) (discussing how error "might assault the professional's sense of competency and adequacy" and therefore be "psychologically intolerable" for doctors); Cherri Hobgood, Armando Hevia & Paul Hinchey, *Profiles in Patient Safety: When an Error Occurs*, 11 ACAD. EMERGENCY MED. 766, 768 (2004) (pointing out that "ideal of error-free practice . . . permeates physician culture"). See generally INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn, Janet M. Corrigan & Molla S. Donaldson eds., 2000) (presenting comprehensive study of errors in healthcare system).

⁹² See PAUL C. WEILER ET AL., *A MEASURE OF MALPRACTICE: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION* 140 (1993) ("[O]ur analysis of malpractice litigation data demonstrates that the problem is not a litigation surplus, but a litigation deficit.").

⁹³ See Kevin Sack, *Doctors Start To Say 'I'm Sorry' Long Before 'See You in Court,'* N.Y. TIMES, May 18, 2008, at A1 (reporting that as result of doctors apologizing for medical errors, "hospitals are reporting decreases in their caseloads and savings in legal costs").

significant cost. For anyone concerned with appearing to be a trusting or fair patient, the signaling effect associated with the decision to sign an exculpatory agreement may be enough to render such a decision no longer truly voluntary. The next Part discusses how this problem may have influenced the inconsistent New York doctrine.

III

SIGNALING PRESSURE AS AN EXPLANATION FOR THE MEDICAL MALPRACTICE EXCULPATORY AGREEMENTS DOCTRINE

In Part II, this Note identified a new reason courts might treat medical malpractice exculpatory agreements as involuntary. What relevance does this new barrier to enforcement have to the doctrinal confusion surrounding these agreements identified in Part I? The answer to this question depends on who is asking. The easiest response is made to the patient seeking to sue despite having signed a medical malpractice exculpatory agreement: She could use the signaling-based argument to claim that her contract was involuntary and hence unenforceable.

The existence of this potential new sword for plaintiffs suggests a corollary response for the hypothetical defendant: In order to have his agreement enforced, he must eliminate the signaling pressures associated with the patient's decision to sign. Part IV discusses ways this may be accomplished, focusing on the use of a confidential contract. The harder question remains, however, as to whether the use of a confidential agreement would in fact increase the chances of enforcement.

A defendant could argue that the greater-responsibility strand of the doctrine—which, as discussed in Part I.C., is the most likely source of the categorical invalidation—might be motivated by signaling-pressure concerns. So understood, this doctrine would be entirely inapplicable to certain confidential agreements that eliminate signaling pressure associated with the decision to sign.

There are two arguments in favor of this understanding. First, the signaling-pressure explanation reconciles freedom-of-contract principles with the cases that seemingly apply a categorical rule, as I explain below in Section A. Second, this understanding can explain an exception to the void-for-public-policy test that is not easily justified otherwise.

Two counterarguments are worth noting. First, a natural objection is that a “new” theory cannot explain old doctrine. But as I will discuss in Section C, such an argument is not insurmountable: “New”

ideas may reshape the common law either because courts adopt them in the face of ambiguity and confusion⁹⁴ or because courts determine the old cases were decided in accordance with an underlying principle.⁹⁵ Second, the argument in this Part that the signaling-pressure explanation is an apt interpretation of the doctrine—and thus that a confidential contract would have a fair shot at enforcement—is not made to the exclusion of other contractual traits. For instance, it is true that many patients are not well informed⁹⁶ about the contracts they sign, thus presenting a separate and independent barrier to enforcement. The first generation of cases, in which exculpatory agreements were invalidated for lack of clarity, made this clear.⁹⁷ Therefore, an enforceable agreement must be worded such that it is clear to the patient what exactly she is signing. Additionally, *Ash* makes clear that an agreement must be nonadhesive.⁹⁸

*A. Reconciling Treatment of the Categorical Rule with
Freedom-of-Contract Principles*

Ash was ambiguous as to whether it created a categorical rule. It also departed from a long line of freedom-of-contract precedent that focused on a case-by-case analysis.⁹⁹ The ambiguity, however, can be resolved by understanding the greater-responsibility justification as being motivated by the signaling concern identified in the previous Part.

This opportunity for doctrinal coherence might be the best argument in favor of confidential medical malpractice exculpatory agreements: If courts can reconcile the categorical approach with both freedom-of-contract principles and the existing jurisprudence, they should. And, as I discuss in the next Part, if courts take signaling into account, a confidential contract—which would not raise signaling concerns—might be upheld. It is possible that some patients faced with

⁹⁴ See *Vodopest v. MacGregor*, 913 P.2d 779, 791 (Wash. 1996) (Talmadge, J., concurring) (“The rationale for our decisions in which public policy defeats a pre-injury release agreement has not always been particularly clear.”).

⁹⁵ See generally ALLAN C. HUTCHINSON, *EVOLUTION AND THE COMMON LAW* (2005) (discussing this view of common law).

⁹⁶ See, e.g., Mark A. Hall & Carl E. Schneider, *The Patient Life: Can Consumers Direct Health Care?* 41–44 (Feb. 29, 2008) (unpublished manuscript, available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1099054) (discussing limitations of patient information and choice).

⁹⁷ See *supra* note 27 and accompanying text (discussing invalidation through strict interpretation).

⁹⁸ *Ash v. N.Y. Univ. Dental Ctr.*, 564 N.Y.S.2d 308, 311–12 (App. Div. 1990). For a discussion of the adhesive considerations in the void-for-public-policy test, see notes 56–60 and accompanying text, *supra*.

⁹⁹ See *supra* Part I.B.

voluntary exculpatory agreements will sign for fear of offending their provider, as shown in Part II. But others might be unaffected by fairness costs and choose to sign (or not to sign) based solely on their uninhibited preferences. Freedom-of-contract principles dictate that without clear evidence in any given case that a contract was not signed voluntarily, consensual agreements should be enforced. At first glance, then, the recognition of signaling pressures in some decisions to waive malpractice might not justify a categorical rule such as the one applied by some courts.¹⁰⁰

But the case-by-case approach may not be capable of effectively determining whether the decision to sign was influenced by signaling pressures. Unlike analyzing the language of an agreement or the availability of alternatives, it is simply too difficult to know with certainty whether a given patient was worried about signaling distrust or unfairness to her provider when she signed an agreement.¹⁰¹ Given this fact, it is plausible that those New York courts applying a categorical rule have simply intuited that enough decisions would be affected by these signaling costs to justify categorical nonenforcement as a prophylactic. Thus, the categorical rule can be reconciled with the courts' long line of freedom-of-contract precedent when understood as a prophylactic test rather than a departure from its previous jurisprudence.¹⁰²

B. An Odd Exception

Further support for the signaling-pressure understanding is found in an otherwise strange exception to the categorical rule. According to this exception, certain exculpatory agreements are enforceable if they exculpate the doctor only for experimental, non-negligent treat-

¹⁰⁰ See *supra* notes 34–38 and accompanying text (showing void-for-public-policy test is sometimes applied as categorical rule).

¹⁰¹ The difficulty of separating individuals who are boundedly rational—including those who consider fairness costs—from those who are not is the motivating force behind the discussion in Camerer et al., *supra* note 74. Actually determining whether a given patient only consented because of fear of hurting her doctor's feelings would require assessing whether the consideration the patient received—the reduction in price that accompanied signing away negligence liability or punitive damages—was adequate. But pricing the “value” of malpractice liability or the availability of punitive damages is very difficult. See *supra* note 1 (discussing widely varying results of malpractice suits).

¹⁰² It is worth emphasizing again that without nonadhesive exculpatory agreements to study, it is not possible to determine precisely how many patients are actually affected by fairness costs such as the signaling that accompanies the refusal to sign an exculpatory agreement. However, given the significant amount of circumstantial evidence presented in Part II, some patients are surely affected. If enforcing exculpatory agreements between doctors and patients would lead to even a small minority of patients involuntarily waiving the right to sue, protecting that minority might justify a categorical rule when a case-by-case analysis is not possible.

ment.¹⁰³ Read literally, the categorical approach and the greater-responsibility justification would seem to apply with equal force to such a situation.

One possible explanation for this exception comes from understanding the greater-responsibility justification as being motivated by signaling effects. Much of what is signaled in the decision to sign a medical malpractice exculpatory agreement is removed when the agreement does not exculpate *negligent* treatment. A patient who refuses to sign and retains the right to sue for experimental, non-negligent treatment does not signal anything about her perception of the likelihood that her doctor will act negligently, but rather only signals that she is willing to accept the inherent risks of the experimental treatment. There is no reason to be concerned that a patient would sign for fear of signaling this fact because any informed patient who is unwilling to accept the risks of experimental treatment would simply forego the surgery entirely.

C. *Using New Ideas to Interpret Old Doctrine*

One could argue that an existing confused doctrine cannot be explained with a newly identified rationale. This is not necessarily the case. If one views the common law as simply a series of judge-made rules, the argument is not that the signaling-pressure explanation *actually* explains what the earlier cases were doing but rather that the signaling-pressure explanation lends coherence to the law espoused in past cases.¹⁰⁴ If one views the common law as judges' attempts to apply the rules in accordance with some underlying principle in new situations,¹⁰⁵ then, given that the underlying principle in contract law is freedom of contract, judges could have been intuiting the signaling-pressure explanation when overturning agreements without articulating precisely why those agreements violated freedom of contract. In any event, I argue that a confidential agreement would give the proponent a decidedly better chance of enforcement, even if it would not necessarily guarantee a safe haven.

¹⁰³ See, e.g., *Schneider v. Revici*, 817 F.2d 987, 993 (2d Cir. 1987) (citing proposition that exculpatory agreement waiving suit for experimental treatment will be upheld in New York courts as long as patient is fully informed).

¹⁰⁴ See, e.g., Joseph Raz, *Legal Principles and the Limits of Law*, 81 YALE L.J. 823, 839–40 (1972) (“There is a very strong presumption in most legal systems that . . . an interpretation which makes a law conform to a principle is to be preferred. . . . This role of principles is . . . a crucial device for ensuring coherence of purpose among various laws bearing on the same subject.”).

¹⁰⁵ See, e.g., Paul Craig, *The Common Law, Shared Power and Judicial Review*, 24 OXFORD J. LEGAL STUD. 237, 250 (2004) (using such analysis to explain development of judicial review).

IV CRAFTING A CONFIDENTIAL CONTRACT

Whether the signaling pressure discussed in Part II only represents a new weapon in a medical malpractice plaintiff's arsenal or also provides a shield defendants could use to argue in favor of enforcement, defendants seeking enforceable exculpatory agreements will need methods of contracting that do not create problematic signaling pressures. This Part describes the ways in which this might be done, introducing the idea of a "confidential contract," in which the offeror (the doctor) never finds out whether the offeree (the patient) accepts.

A confidential contract stands a better chance of enforcement—all things being equal—than an agreement in which the doctor knows the result of the patient's decision to sign or not, as confidentiality would help defeat attacks to agreements based on the greater-responsibility justification for the categorical rule. But first, any doctor seeking to craft an ideal agreement that maximizes the probability of enforcement must ensure that the recommendations of the Private Malpractice Symposium are met: The agreement must be clearly worded and must specifically mention negligence.¹⁰⁶ Moreover, the agreement must feature the two settled requirements previously discussed in order to avoid the clear pitfalls of *Ash*: It must be nonadhesive and it must not affect the quality of care given.¹⁰⁷

Next, there are two ways to avoid signaling pressures—either (1) contract for something that does not implicate signaling effects, or (2) find a way to remove signaling effects from the contracting process. The first option is relatively straightforward, and doctors and patients arguably already have found ways to do so. Arbitration agreements, which are widely enforced, may be viewed as one way patients can contract out of the malpractice system without signaling anything about their perceptions of their doctors' competence or their own willingness to litigate.¹⁰⁸ Agreements waiving non-negligent experimental treatment may be another.¹⁰⁹

But if the decision to sign does create a signaling effect—as an agreement exculpating negligence will¹¹⁰—the agreement can still be cured if the patient is assured that the doctor will never know whether

¹⁰⁶ See *supra* note 27.

¹⁰⁷ See *supra* notes 53–60 and accompanying text.

¹⁰⁸ See, e.g., LAW & POLAN, *supra* note 1, at 135 (describing such suggestion in arbitration context). *But cf.* Aaron-Andrew P. Bruhl, *The Unconscionability Game: Strategic Judging and the Evolution of Federal Arbitration Law*, 83 N.Y.U. L. REV. 1420, 1436–43 (2008) (discussing sometimes-contested enforceability of arbitration agreements).

¹⁰⁹ See *supra* note 103 and accompanying text.

¹¹⁰ See *supra* Part II.A.

or not she signed the agreement. This confidentiality would cure the signaling effect associated with the decision to sign, avoid the greater-responsibility problem, and thereby obviate the need for the accompanying categorical approach.

Confidential contracting would not necessarily be difficult to implement, especially given current institutional arrangements in the medical services field. There are two ways such a contract could be completed. First, an arrangement might utilize indirect contracting between patients and managed care providers in a way that would not signal to doctors which patients had signed agreements.¹¹¹

Second, a doctor and patient could enter into a traditional contract confidentially. Contract law leaves plenty of room for such an arrangement. The doctor could present and explain both fee arrangements—one including an exculpatory agreement, one not—as two separate offers. She could then invite the patient's acceptance of either offer confidentially, so as to remain in the dark about the patient's decision. Such an arrangement would be perfectly legal: the Restatement (Second) of Contracts makes clear that the offeror may invite acceptance by whatever reasonable means she designates in making the offer, be it performance or, in this case, acceptance delivered to a third party.¹¹² The Second Restatement also would not require that the doctor be aware of the patient's acceptance of the contract offer.¹¹³ Of course, even if the contract were formed confidentially, the patient may want a guarantee that her decision would remain confidential. Confidentiality and privacy clauses are common elements of contracts, and, in this case, both offered contracts need only include clauses that guarantee confidentiality, and perhaps provide some warranty in the event that confidentiality is breached. In addition, they might designate an independent third party—such as someone in the doctor's front office or the doctor's malpractice insurance company—to maintain the confidentiality of the agreement.

CONCLUSION

This Note has shown that previously unidentified signaling costs may explain courts' decisions regarding the enforceability of medical

¹¹¹ Several policy arguments have been made in favor of contracting with managed care organizations in this way. Arlen, *supra* note 2, at 23–24. This Note provides support for a new argument in favor of these arrangements.

¹¹² See RESTATEMENT (SECOND) OF CONTRACTS § 50 cmt. a (1981) (“Offers commonly invite acceptance in any reasonable manner . . .”).

¹¹³ Indeed, § 54 of the Second Restatement actually specifies that “no notification is necessary to make . . . an acceptance effective unless the offer requests such notification.” *Id.* § 54.

malpractice exculpatory agreements. If a court could be convinced that the greater-responsibility justification is driven by the signaling-pressure explanation, I argue that a tool that removes the signaling pressure may allow courts to uphold the contracts, and that a confidential medical malpractice exculpatory agreement that is also nonadhesive and clearly worded would likely be enforceable.

This Note has focused on signaling effects and confidential contracting in the context of medical malpractice exculpatory agreements, but these ideas might be generalized to other situations, especially where a “special relationship” between the two parties poses problems for the enforceability of nonadhesive, clearly worded contracts. For example, contracts in the workplace have been invalidated under the special-relationship prong of the void-for-public-policy rationale.¹¹⁴ Further research might usefully explore whether confidential contracts may be used in this way or, indeed, to cure any contract rendered problematic by signaling pressures.

¹¹⁴ *White v. Village of Homewood*, 628 N.E.2d 616, 619–20 (Ill. App. Ct. 1993).

