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Healthcare Disputes: Why Mediation is the Best Medicine

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Abstract

This article compares and contrasts conventional litigation with the benefits of mediation. Reflecting on his vast experience in clinical negligence cases, the author draws attention to some of the main disadvantages of litigation like the delays and costs involved as well as the lack of flexibility and creativity in the outcomes. To illustrate the value of mediation, he discusses its fruitful use in the two government inquiries which he chaired at the beginning of the 21st century. The work concludes by recommending a more extensive use of mediation, and a correspondingly lower use of litigation, for the resolution of healthcare disputes.

1. Introduction

Abraham Lincoln once said, "[d]iscourage litigation. Persuade your neighbours to compromise whenever you can. As a peacemaker the lawyer has superior opportunity of being a good man. There will still be business enough".[1] Subsequently he went further and said, "Never stir up litigation. A worse man can scarcely be found than one who does this".[2] He clearly had some form of alternative dispute resolution in mind. This article argues that it is apt to apply this advice to healthcare disputes. With this in mind, the discussion below will firstly highlight some of the main disadvantages of clinical negligence litigation. It will then draw attention to the benefits of mediation, before concluding by recommending its higher uptake in the resolution of these claims.

2. The Perils of Clinical Negligence Litigation

Civil litigation in clinical negligence cases can be difficult to access, costly, lengthy, and stressful. Further, since litigation produces a win or lose result within an adversarial system, it can result in the parties being even further apart at the end than they were at the outset. By using examples from real cases, including those where I represented the claimants, the discus-

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1 A. Lincoln, *Collected Works of Abraham Lincoln Volume 2* (Michigan: University of Michigan Digital Library Production Services, 2001) p. 82.

2 *Ibid*.

sion below will illustrate the negative impacts which these can have on the litigants.

2.1. Access to Justice

It is interesting to begin by seeing how civil litigation has developed from the 1980s.[3] At that time, cases worth £5,000 and above were heard by a High Court Judge. Leading counsel would frequently attend court with several briefs, the majority, if not all, of which settled at the door of the court. This led to detailed investigation as to the wastage of judicial time. Many claimants were funded by Legal Aid and successful claimants contributed 10% of the costs to Legal Aid which was largely self-funding. Alternatively, there were legal aid schemes from unions, it being an attraction to employees to join a union with the benefit of a free legal aid scheme. Friendly societies and other organisations also operated legal aid schemes and proper funding was generally available to investigate and run cases from the outset to conclusion.

In the 1990s, the government Legal Aid Scheme was under scrutiny in an effort to reduce the burden on government finances. There was ever increasing control of the procedural aspects of litigation and there was an outcry against the cost of litigation generally.[4]

In the 2000s, the availability of Legal Aid was becoming more restricted save for cases involving children and those lacking capacity.[5] Conditional fee agreements replaced Legal Aid. There was a percentage uplift on success as compensation for those cases which were lost and no fees were recovered. The conditional fee uplift was abolished in 2013.[6] Legal Aid is currently difficult to obtain even for minors and those lacking capacity.[7]

Cost budgeting is restrictive of the claimant's preparation for trial and is a blunt instrument dealing inadequately with unexpected changes in a case, the obtaining of new information possibly involving a new case, the manner in which cases move on and different situations which can occur and the ability to deal with unexpected events. Self-funding defendants and those protected by insurance can have as many conferences as they wish particularly with experts

3 For discussion, see S. Moore & A. Newbury, *Legal Aid in Crisis: Assessing the Impact of Reform* (Bristol: Polity Press, 2017) pp. 21-22.

4 *Ibid.*

5 For discussion, see A. Flynn & J. Hodgson, 'Access to Justice and Legal Aid Cuts: A Mismatch of Concepts in the Contemporary Australian and British Legal Landscapes', in: A. Flynn & J. Hodgson (eds.), *Access to Justice and Legal Aid: Comparative Perspectives on Unmet Legal Need* (London: Bloomsbury, 2017), Chapter 1.

6 Law Society, 'Conditional Fee Agreements Guidance'.

7 For the current eligibility criteria, see 'Legal Aid', available at https://www.gov.uk/legal-aid/eligibility (accessed 1 November 2018).

as they are paying whereas the claimant is restricted to conferences provided for in the cost budget.

All these factors created a fertile field for detailed consideration of mediation and alternative dispute resolution. This is notwithstanding the fact that since the 1970s and 1980s, lawyers had developed particular skills in settling cases. I am aware of one case which settled for £30,000 and where the parties' solicitors met shortly after the settlement. The claimant's solicitor boasted that his client would have taken £20,000 but the defendants had paid £30,000. The defendant's solicitor replied that he had authority up to £40,000 but the claimant accepted a mere £30,000. In the end, both parties felt unhappy about the settlement which perversely indicated that it was a good settlement.

From these beginnings evolved joint settlement meetings (JSMs).[8] These usually take place late in the course of litigation and shortly before trial. The reason, it is said, is that the JSM should not take place until all the evidence has been obtained, expert evidence analysed, joint meetings between experts have taken place, schedules of loss and counter-schedules have been exchanged and no further evidence is to be garnered.[9] While JSMs are useful in saving trial costs, they do not have the benefit of avoiding delay and its concomitant consequences. Combined with the issue of how access to justice is becoming more and more restricted, alternatives must therefore be considered.

2.2. Delays and Psychological Distress

The normal clinical negligence litigation process imposes stresses and strains upon both parties but more so for claimants who have the burden of proving their case. Delay produces inordinate stress, there is uncertainty as to outcome, the need for procedural acuity, slow disclosure, lack of communication, attrition and even ill-will between the parties. Claimants have to deal with tactical strategies by defendants, slowness of expert witnesses to inspect or examine and report, delay in waiting for experts to meet and prepare joint statements, the lateness of joint settlement meetings, the potential of interlocutory applications and hearings and the overall worry, concern and stress of huge adverse costs consequences if the case is lost.

An important corollary of delay is that in birth asphyxia cases, by way of example, the claimant is without funds for the necessary care, treatment, accommodation and equipment until the claim is concluded. The availability of interim payments depends on the defendant's response to the issues of liability and causation. The family is riven with concern and the unremitting burden of

8 Lord Justice Jackson, *Review of Civil Litigation Costs: Final Report* (London: The Stationery Office, 2010) p. 355.

9 This is an accepted practice where there is a will to settle.

proving liability, valuing the claim and the overriding pressure of caring for the claimant. Doctors, in the meantime, labour under reputational issues and specific criticisms of their actions. Life may be on hold until the claim is concluded by settlement or judgment. Even after the first instance decision, there is always the risk of appeal and further adverse costs consequences.

In cerebral palsy cases for instance, often the mother feels guilty about the damaged outcome of her child at birth. Doctors, midwives and health professionals feel imperilled pending the outcome of a case and probably beyond.[10] The process is adversarial with its attendant problems of slow release of information, protectionism, denial, distress and a full range of human emotions to attack and defend. Justification for delay in cerebral palsy cases runs along the lines that the investigation has to be in great detail both as to breach of duty, causation and quantum.[11] So much depends upon how the child develops and sometimes it is necessary to wait and see the condition of the child on full maturation. Early settlement could result in a professional negligence claim on the grounds of incomplete investigation of breach and causation resulting in the claim being lost or more particularly under settled on apportionment of liability and also quantum. These factors featured in the extreme case of Urbanski where the claimant was 33 years of age before an award of £3m was approved by the Court in the late 1990s.[12]

Delay is therefore to be deprecated and a more expeditious dispute resolution process, such as mediation, must be considered.

3. The Value of Mediation

Mediation can be defined as a confidential, voluntary, non-binding process in which an independent third party, the mediator, assists the parties to a dispute to find a mutually satisfactory outcome.[13] Outcomes can be monetary but also include apology, restoring relationships, full and frank explanations as to what went wrong and why, re-training, new standard operating procedures, some form of memorial, contribution to a charitable cause, new research and many more opportunities to avoid litigation. Early openness and transparency, particularly from doctors and hospital authorities, with full and

10 NHS Resolution, '*Five Years of Cerebral Palsy Claims: A Thematic Review of NHS Resolution Data*' (September 2017) p. 20.
11 *Ibid.*, p. 19.
12 This case was settled but not reported.
13 J.M. Conley & W.M. O'Barr, *Just Words: Law, Language and Power* (Chicago: University of Chicago Press, 2005) p. 39.

frank communication have demonstrably been shown to avoid or reduce the volume of litigation.[14]

The use of mediation techniques has proved productive both in the Royal Liverpool Children's (Aldey Hey) Inquiry and the Redfern Inquiry into Human Tissue Analysis in UK Nuclear Facilities. They also have application in clinical negligence claims.

3.1. The Use of Mediation Techniques in Government Inquiries

The Alder Hey Inquiry related to a 15-year period in which there was extensive retention of children's organs which came to light in 1999. The Inquiry took place in 2000/1. The Report was submitted to Parliament in January 2001.[15]

One family had to contend with the death of a 5-year-old male twin. For several days following his death in hospital they were unable to locate or see the body. They were unaware of the extent of organ retention. In the end all the immediate family attended the mortuary and were refused entry. The mortuary attendant was persuaded to allow them in but only to view the body from the right-hand side because of the work that was being carried out on the left. The surviving 5-year-old twin was with them. When the body was exposed he ran around to the left and planted a kiss on his dead brother's lips. The psychiatrist who was advising the Inquiry said what the surviving twin had done was the best method of assuaging grief.

Throughout the Inquiry the behaviour of the families was exemplary. They had faith that the Inquiry would reveal the mischief as to what had been going on and make vigorous recommendations to prevent recurrence. That is precisely what happened. It led to a new Human Tissue Act[16] and a substantial reform of coronial practice and procedure. However, all the evidence obtained from Liverpool University was first vetted (quite properly) by their solicitors whereas there was full unencumbered access to all documents at Alder Hey Hospital. The contemporaneous documentation was devastating. Nevertheless, many witnesses challenged the content of that documentation and steadfastly denied knowledge that the first Chair of Foetal and Infant Pathology, Professor Van Velzen had systematically retained deceased children's vital organs over a prolonged period of time.

There was mistrust between the families, the medical profession and their managers. Attitudes had hardened and there was a general failure on the part of the hospital and the university to confess or satisfactorily explain documented

14 P. Kumar & M. Clark, *Clinical Medicine* (London: Elsevier, 2012) p. 7.
15 *The Royal Liverpool Children's Inquiry: Report* (London: The Stationery Office, 2001).
16 The Human Tissue Act 2004.

facts. Each chapter in the report contained relevant recommendations many of which were taken up.

The government has consistently failed to implement the recommendation for a standard consent form across the country so that whichever hospital a patient attends the consent form would be the same. The reason given was that each Hospital Trust is autonomous and can decide for itself the content of its consent form. What can be said is that in the outcome the days of medical paternalism are dead. Doctor no longer knows best. Consent is a two-way process with the patient and his or her family having equal standing and expectation from the consent process.

The Redfern Inquiry into Human Tissue Analysis in UK Nuclear Facilities was presented to the House of Commons on 16th November 2010[17] having commenced in March 2007. The Inquiry related initially to the circumstances in which between 1961 and 1992 organs/tissues were removed from 64 individuals and were sent to and analysed at Sellafield. It quickly became apparent that bodies other than British Nuclear Fuels Ltd (BNFL) employees alone were involved and the terms of reference were amended to inquire into the circumstances in which, from 1955, organs/tissues were removed from individuals at National Health Service or other facilities and sent to and analysed at nuclear laboratory facilities. This was the first in-depth analysis of research in the nuclear industry involving the use of human organs.

The Inquiry considered a number of research projects involving analysis of organs taken, largely without consent, from more than 6,500 bodies. Organs were removed at post mortem from employees of the nuclear industry, test veterans who had attended nuclear weapons tests, random individuals who had lived close to nuclear facilities and the general population with no occupational or geographical links to the nuclear industry. There was a random survey across the UK for Strontium 90 in human bone and the food chain from atmospheric testing of nuclear weapons. The work was carried out into the 1990s and involved radiochemical analysis of organs for the following purposes:

i. scientific purposes as to the amount of radiation present in each organ and the effect of radiation exposure;
ii. evidence on the cause of death for coronial purposes;
iii. evidence in litigation cases for compensation from deaths of individuals potentially exposed to radiation.

The stakeholders involved included the United Kingdom Atomic Energy Authority, British Nuclear Fuels Limited, the Atomic Weapons Establishment,

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17 *Redfern Inquiry into Human Tissue Analysis in UK Nuclear Facilities* (London: The Stationery Office, 2010), Reference HC571-1.

the National Radiological Protection Board and the Medical Research Council. Other interested parties included NHS Trusts, pathologists, Coroners, trade unions and families. Evidence was received from more than 100 witnesses including Coroners, pathologists, hospital staff, stake holder management and employees, experts and families.

It is readily understood that those who had worked in the nuclear industry for 20 or 30 years, exposed daily to plutonium, represented a scarce commodity for analysing the effects of radiation on human organs.

An extraordinary range of organs was removed for analysis. The largest retentions included liver, lungs, vertebrae, sternum, ribs, mediastinum/lymph nodes, spleen, kidneys, femur, testis, brain, heart, patella and tongue. The analytical process was destructive. Information from the analytical results from 51 nuclear workers at Sellafield was sent to the United States Trans Uranium Registry. Individual names were disclosed and, in the majority, medical and occupational information were also provided which amounted to an obvious breach of confidence.

None of the families were asked for permission to remove organs from the deceased whether for research or use in litigation. They were unaware of what post mortem examination involved. They received little or no information from Coroners, Coroners' officers, treating clinicians, pathologists, solicitors or the nuclear industry. None had been made aware at the time that organs had been removed. They discovered that a body, which they thought had been buried or cremated intact, was in fact missing an extraordinary number of internal organs. They had suffered shock and distress by the perceived lack of dignity and respect shown to the body. Had they been asked many would have agreed to the organs being removed and analysed.

One person said "*My family and I have been absolutely devastated as a result of what has gone on. I believe that my father's organs were taken under the instruction of Dr. L for research ... They were clearly not taken to assist in identification of the cause of death and no consent was obtained. I believe they showed severe disrespect of my father's body and I find this mutilation very disturbing*".

In light of what had been removed from the body there was evidence that bone was replaced with broomstick handles to give the appearance of normality of the body at the funeral. This finding was based on sight of purchase invoices. The Report led to the passing of the Coroners and Criminal Justice Act 2009 which addressed long overdue reform to the coronial system. It is easy to imagine the distress suffered by families when these matters came to light and the fact that they did not receive a proper explanation as to what had happened until November 2010.

In both inquiries and with each party involved, mediation principles were used in order to elicit information, obtain explanations, identify documents, ascertain each parties' interests and priorities with a view to repairing relationships and making findings to improve accountability and working practices in an attempt to prevent recurrence with the concordance of those involved.

Families found the process of telling their stories and sharing their grief particularly helpful. One mother wanted me to look at her photograph album of her deceased child which I did slowly with dignity and respect. She was greatly relieved at sharing her experience.

3.2. Mediating Clinical Negligence Claims

Mediation is well suited to clinical negligence as well as a range of Inquiries. It is informal, speedy, enforceable with consent, cost effective and consensual as opposed to being purely judgmental.[18] Medical confidentiality can be preserved, the process is quick, cost effective, informal, patient friendly and the parties retain a greater degree of control. It can preserve the doctor/patient relationship intact and is certainly less acrimonious than litigation.[19] More particularly there is a greater range of remedy including apology, explanation and remedy for a patient going forward including reform, re-training or some form of memorial.

Following a hearing at a Coroner's Court three years ago, in a clinical negligence case, the parties agreed that in light of what the deceased had suffered by way of his presenting condition and the doctor's failure to treat it correctly the doctor took early retirement. Re-training for treatment of the condition was undertaken and a specialist ward was named after the deceased which led to the family achieving closure. There was no claim for financial compensation. It is surprising that in-depth analysis of the mediation process demonstrates that monetary compensation is surprisingly low down the list of priorities.

Mediation is reality testing of each parties' publicly stated position and argument by an impartial mediator in a private meeting. The issues are much more likely to be taken seriously than when ventilated in a public hearing. The mediator focuses on interests and not rights. Mediation has the ability to bring disputes to a head timeously with significant costs savings.[20] It is collaborative, flexible and a constructive alternative focusing on the future by seeking creative solutions in a trusting, non-threatening environment.[21]

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18 M. Pauknerova & M. Pfeiffer, 'Act on Mediation – Significant Step on a Long Way to Make Mediation Work in the Czech Republic', in: C. Esplugues & L. Marquis (eds.), *New Developments in Civil and Commercial Mediation: Global Comparative Perspectives* (Switzerland: Springer, 2015) pp. 227-228.

19 P. Brooker, 'Court-Connected Construction Mediation Practice in England and Wales', in: A. Agapiou & D.A. Ilter (eds.), *Court-Connected Construction Mediation Practice: A Comparative International Review* (Oxford: Routledge, 2017) p. 20.

20 M. Wells, *et. al.*, 'Medical Mediation', in: M. Liebmann (ed.), *Mediation in Context* (London: Jessica Kingsley Publishers, 2000) p. 201.

21 F. Strasser & P. Randolph, *Mediation: A Psychological Insight into Conflict Resolution* (London: Continuum, 2004) p. 119.

A court cannot directly enforce modification of working practices, enhance standards, order re-training or even the making of an apology. The potential for a satisfactory outcome is far greater with mediation than any potential conclusion in the litigation process.

Mediation incites creative options for resolution. The mediator listens, empathises, encourages ventilation of complaints when deemed productive and urges parties to face facts, listen and praises efforts to accommodate the purpose of the mediation.[22] It has much to offer in the restorative process of healing and on the principle of distributive justice in that it attempts to evenly distribute benefits and burdens between the parties.[23]

STADA is the acronym for 'sit down, tell me about the patient, admire, discuss and ask'.[24] The purpose is to mend the imbalance of power. An aggrieved patient and his family can set out their opinions and concerns openly. This facility has to be recognised, appreciated and discharged with respect to the patient, family, doctors and medical staff with the mediator at all times maintaining an impartial stance as to the outcome. The mediation process can clarify misconceptions, defuse emotion, identify common interests and encourage creative thinking.[25] The aim at all times must be to equalise the bargaining power between the parties.

Family members knew the deceased best. They knew what the deceased person would have wanted. Their input is vital. The mediator must provide a caring, respectful and communicative environment in order to explore disputes and for the parties to identify interests and then priorities hopefully leading to dispute resolution. The means available to a mediator in this process are considerable.

There are a number of questions to consider in looking to develop and expand mediation as an even better alternative to litigation.

i. Do only weak cases go to mediation?
ii. Is there a distrust of mediation in clinical negligence cases?
iii. Is the outcome likely to be better with a non-Court appointed mediator?
iv. To what extent can a case be investigated in order to obtain an early resolution?
v. Should the mediator be a doctor or a lawyer qualified to mediate?
vi. Does the trained mediator usually have a higher success rate than a non-medically or legally qualified mediator?

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22 O. Shapira, *A Theory of Mediators' Ethics: Foundations, Rationale, and Application* (Cambridge: Cambridge University Press, 2016) p. 171.
23 N.N. Dubler & C.B. Liebman, *Bioethics Mediation: A Guide to Shaping Shared Solutions* (New York: United Hospital Fund of New York, 2004) p. 37.
24 *Ibid.*, p. 75.
25 C. Chern, *The Commercial Mediator's Handbook* (Oxford: Routledge, 2015) p. 382.

vii. Should there be an evaluative element in mediation in clinical negligence cases?
viii. Is the retention of lawyers to represent the parties at mediation an impediment or encouragement to resolution?
ix. What benefits occur from early explanation as to why the adverse events occurred?
x. Can mediation occur when there is distrust between the parties?
xi. What is the full range of non-monetary outcomes available in mediation?
xii. Can mediation address institutional and professional cultures?
xiii. Is there a perception that defendants fare badly at mediation?
xiv. Is there an optimal model for mediation in clinical negligence cases?

These and many other questions fall for careful consideration in order to improve mediation and make it more attractive to the parties. The tort system remains expensive, slow, painful, stressful with outrageous costs consequences to the losing party.

It is important to remember that there is inherent risk to any surgery and that complications can arise without fault of the surgeon. Sifting these cases in early course from cases which deserve monetary compensation is vital and by no means easy. In any event in mediation the patient/family learn exactly what happened earlier, appreciate the complexities and uncertainties of medical care which can often lead to a healing of the doctor and patient relationship. There is much to commend the range of outcomes in mediation. There is also the opportunity to consider monetary compensation.

The legal profession might well object to mediation on the basis that early mediation leads to resolution before all the relevant facts have been investigated. There is an inherent risk that a lawyer might be sued for mediating the outcome before all the evidence has been identified, examined, reported upon and discussed jointly between each party's experts. Defeat or under-settlement is the overriding argument with a concomitant risk of being sued for failure to prepare properly the issues of breach, causation or the assessment of quantum. Might the continuing earning of fees during the currency of the claim be a factor against mediation?

The alternative argument is why does it take on average 11 years in the tort system to resolve in these cases.[26] In cerebral palsy cases it is quite wrong to keep a child waiting for compensation until the outcome of litigation when the child needs help with regard to resolution and treatment of his/her condition, adapted accommodation, care, equipment, transport, case management and medical review and medication from birth.

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26 This is based on the author's personal experience.

It is often said that the bigger the case the easier it is to value. Resolution of cerebral palsy cases within a year or two of birth, particularly by way of reduced lump sum and periodical payments, means that the child greatly enhances his/her opportunity of recovery, rehabilitation and independent lifestyle rather than waiting for the average of 11 years for the claim to be resolved by litigation. In particular the family will have received money at least nine years earlier than the average litigated case. This should assuage any fear of under-settlement particularly if periodical payments, which last a lifetime, are the order of the day. They are index linked, tax free and guaranteed. Is there a better safe investment?

Mediation has much to offer, is capable of immense development and has support from the government, Ministry of Justice, the Courts, insurers and other interested parties. The court can order adverse costs when mediation is not implemented when it would have been reasonable to do so.[27]

4. Conclusion

My purpose in this article has been to compare and contrast conventional litigation in clinical negligence cases with the benefits of mediation. There is much to commend mediation for the avoidance of delay in bringing the parties together and the availability of a battery of outcomes which might include monetary outcomes on the same or similar bases as those awarded by the Courts. All parties have much to gain from mediation as this article has endeavoured to demonstrate. Work needs to be done to encourage parties and their insurers/funders towards mediation. It is essential that all parties consider mediation. Discussions are underway in the insurance industry[28] to include mediation as a contractual term in order to facilitate early dispute resolution. Ordering of mediation is also a power available to Judges.

What is needed is a cost-efficient mechanism for early resolution of legal disputes with mutual gains and limited financial risk. Mediation is a system to reduce delay, improve communication with openness and transparency being paramount. It is an intriguing opportunity to speed up settlement and minimise costs. It is an impressive vehicle which has a longstanding and established record of success in other jurisdictions.

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27 *Laporte & Anor v The Commissioner of Police of the Metropolis* [2015] EWHC 371 (QB).

28 D. Richbell, *How to Master Commercial Mediation: An Essential Three-Part Manual for Business Mediators* (West Sussex: Bloomsbury Professional, 2015) p. 200.