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The Extremities of Mediation and the Importance of Process

Tony Allen*

Solicitor, Mediator and Senior Consultant to CEDR

Abstract

Based on the author's unrivalled experience of mediating clinical negligence and personal injury claims in England, Ireland and South Africa, coupled with his fifteen years of writing about the place of mediation in civil justice, this article discusses the nature and objectives of mediation in the context both of clinical negligence and right-to-life claims. He sets his views against his own redefinition of mediation as 'a confidential complex conversation facilitated by a skilled neutral', centred on his argument that engagement in the mediation process is as important for participants as achieving settlement outcomes. This both justifies its regular use in right-to-life claims and explains the growth of mediation as a particularly appropriate process for progressing clinical negligence claims and meeting the needs and objectives of claimants and clinicians in such disputes, even where one party seeks to persuade the other that their claim or defence is without any merit.

1. Introduction

The UCLan conference is entitled 'Is mediation the best medicine?' This question was anticipated and given an answer of sorts as long ago as Dyson LJ's judgment in *Halsey v Milton Keynes NHS Trust*,[1] in which he asserted that 'mediation and other ADR processes do not offer a panacea',[2] a view that was repeated by Jackson LJ in his costs review, when he said (without obvious evidence cited in support): 'I accept that mediation is not, of course, a universal panacea'.[3] Forgiving the tautology (after all, 'panacea' means 'universal cure-all'), mediation's possible status as a panacea (or not), especially when compared with other civil justice processes is a very proper topic for consideration.

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1 [2004] EWCA Civ 576.
2 At para. 16.
3 R. Jackson, *Review of Civil Litigation Costs: Final Report* (Norwich: The Stationery Office, 2010), 361.

2. Delivering Rights and Interests

2.1. The Importance of Distinguishing Rights and Interests

When mediation was first introduced in the UK for non-family civil disputes, in around 1989-90,[4] mediation trainers used to recount the famous metaphorical story of the orange to trainee mediators so as to illustrate the concept of 'win-win', said to be the hallmark of mediation. Two children are scrapping over an orange in the family kitchen. Both want it all and do not just want half each. Their mother says –'but what do you really want it for?', only to discover that one wants just the peel to zest for icing a cake, and the other just wants the juice for a drink. The win-win outcome is achievable if you concentrate on interests and needs, rather than rights and positions. There it resides in the classic negotiation text, *Getting to Yes* by Fisher and Ury,[5] and has ever since been embraced by mediation enthusiasts. Does 'win-win' really define mediation? Or putting the converse, if 'win-win' is unattainable, does this undermine the value of mediation as a dispute resolution process?

We turn to the law and courts to define our rights – whether in contract, where a relationship was once chosen, or in tort, where regulation of neighbourly relationships is defined. Court judgments though are always backward looking. What went wrong in the past? Who was to blame? This is decided in the light of weighing evidence of past actions and standards and also based on past legal precedent, enabling a rational assessment by a skilled neutral over whether those in dispute were right or wrong. Party interests are not really relevant to outcomes in an arena delivering rights-based judgments.

Negotiation enables people to bring their underlying interests to the table to set beside their rights. If they are honest and perceptive enough to identify them (sometimes people need help by way of reminder), they can try to secure benefits which enhance their positive interests – a renewed but renegotiated business or personal relationship; enhancement of reputation; improved finances; the neutralisation of lurking risks; a better future.

Steps can also be taken to avoid or minimise damage from negative interests – avoiding business failure; irreparably damaged personal relationships; loss of reputation; lost costs; and adverse precedent, which might open floodgates to future challenges.

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4 ADR Group was founded in 1989 and CEDR (Centre for Effective Dispute Resolution) was founded in 1990.

5 R. Fisher & W. Ury (with B. Patton), *Getting to Yes: Negotiating an Agreement Without Giving In* (London: Random House, 2012), 59.

These are the interests that underpin settlement discussions, which, if they turn out to be compatible (as with the orange), will perhaps produce that ideal of a win-win. And mediators – perhaps especially American mediators[6] – have suggested that it is their ability to shift party perspectives within a dispute that enables them to discern that win-win – to transform what was contentious into a compatible outcome with benefits for both or all. Conflict is converted into comradeship and co-operation to the good of all, in this rather Disneyish vision. No wonder sceptics have delighted in writing mediation off as 'touchy-feely'[7] for many years. Are such outcomes feasible when it comes to medico-legal disputes? How do *interests* play out in cases where parties are taking positions to establish their rights in relation to alleged clinical error or when challenging clinical judgments?

For the purposes of this paper, let us look at two very different types of dispute in the light of the dichotomy between rights and interests. Firstly, we look at clinical negligence claims, where a patient has suffered significant harm thought to have been inflicted by a healthcare professional or body like a hospital. Secondly, we look at right-to-life cases, like Charlie Gard, ironically where *rights* are decided by the civil courts by taking a view over the 'best *interests*' of a child.

The *rights* are clearly articulated in each type of case. The claimant has almost certainly suffered a degree of harm, and seeks to have it defined and vindicated. The healthcare provider defends the claim by denying breach of professional standards, usually seeking support from experts to articulate that a reasonable body of professional opinion justifies the act or omission alleged (the *Bolam* principle[8]). However, establishing breach is not enough.

2.2. Clinical Negligence Cases

In clinical cases, except in relation to most birth injury cases and some elective procedures,[9] the patient was not in perfect health before the clinical intervention. There was a degree of pre-existing naturally caused harm, such as cancer (even if it was diagnosed late) or a fracture (even if initially un-

6 First articulated by R.A. Baruch Bush & J.P. Folger in: *The Promise of Mediation: Responding to Conflict Through Empowerment and Recognition* (San Francisco: Jossey-Bass, 2004), *passim*.

7 An oft-repeated albeit largely historic dismissal that cannot be attributed to any one commentator in particular.

8 As enunciated in *Bolam v Friern Hospital Management Committee* [1957] 2 All ER 118, as slightly modified by *Bolitho v City and Hackney Health Authority* [1998] AC 232.

9 Mothers are pregnant but not ill; nor are cosmetic surgery patients usually ill before surgery, just dissatisfied with their body image.

detected or badly aligned). So breach of duty may be made out, but sometimes a significant reduction or even complete eradication to the asserted right to damages emerges, made to reflect the pain and suffering that would have happened anyway. This classical causation argument frequently takes up more airtime at mediations of clinical disputes than breach of duty. So compensation is sought as a right in response to a breach of duty which caused measurable harm. This is defended by denying breach or asserting that breach did not cause any damage or as much as alleged.

So focusing on interests again, what underlying interests can be discerned in clinical claims? First, what are the *positive interests* for a typical claimant patient?

- **Recovery of health** for a living patient who suffered trauma is not always, perhaps rarely attainable, and only through further healthcare rather than by negotiation alone.
- **Compensation** may be sought to fund care and treatment caused by the health deficit: this is really a rights-based interest, perhaps only satisfied by seeking vindication of those rights.
- **Belief in the competence of future healthcare**, if and when needed – that belief will certainly have been shaken by past events, and comes close to the more negative interest of needing not to fear that future healthcare might again be substandard.
- **Acknowledgment or even apology** are often sought by claimants, although again this comes close to a rights-based need.
- Having suffered, they may want to know **why things went wrong and that there is less chance of it happening** to someone else, an altruistic interest which can do little to correct what has happened to them: what one grieving family described in a mediation about the death of their adult child following elective surgery as 'a small comfort, but a comfort nevertheless'.
- It may be strange to describe this as a 'positive' interest, but the strong emotions generated by feeling that negligent harm has been done may lead to a desire for **retribution or revenge** – disciplinary action and public blame for the wrongdoer – or at least the pleasure of winning a civil claim, with society's disapproval of substandard care being encapsulated in an award of damages. This again is close to a rights-driven approach.

Patients could be forgiven for just cursing their own misfortune, and the incompetence of others (if this can be proved). For the family of patients who have died, there is little discernible positive interests other than the right and opportunity to express strong feelings – grief, anger, loss and depression. For the family of babies suffering birth defects through oxygen starvation, hope, however forlorn, may be the only positive interest – that somehow the nightmare of disability and deficit will dissipate, and a happy family life will emerge. Such

a hope is readily coupled with the first negative interest defined below – namely fear over what the future may hold.

So what are the *negative interests* underlying such disputes for claimants which they might wish to avoid or minimise?

- **Fear for the future**, which needs to be assuaged – perhaps of declining health or life's challenges proving overwhelming, or of financial challenges.
- **Anger and mistrust of healthcare providers**, with claimants needing to be reassured that they can seek treatment in the future.
- Where litigation is commenced, claimants may **fear losing what a win might have offered** by way of satisfaction, and (perhaps equally) the unknown financial and personal consequences from losing altogether. They have to engage in an obscure claims process against clinical professionals, once again having to place their prospects of success into the hands of another professional, this time a legal team. Clinical negligence lawyers are brave if they assume that they are immune from some of the suspicion of professionals that their clients inevitably harbour for doctors.

Such negative interests are magnified even more when felt vicariously over the damage to a new-born child hoped and expected to be healthy, or the irrevocable death of a loved one.

Also, we should not overlook the interests of the healthcare professionals. When on the receiving end of an allegation of sub-standard care, it is hard to discern anything positive for them. It is a brave doctor – certainly a rare one – who views a mistake as a really positive opportunity to learn and improve, even if this might turn out to be the best way to deal with a really painful allegation. Every instinct will press towards denial and defence of something that goes to the heart of their professional principle – 'Do No Harm' and peer pressure towards professional perfection – and yet such allegations may lead to distraction, de-motivation, and even depression.

Maybe the most significant mutual interest for both claimants and clinicians is in securing that overworked but still cogent concept, **closure**, although each will welcome it for slightly different reasons and from somewhat different perspectives. For both, closure probably means a move out of a negative life view to a more positive life view. Claimants will have to cope with whatever physical or psychological deficit continues, yet a sense of relief that the process of claiming is over may well help, coupled with any benefits conferred by the way settlement and closure were achieved. The end of a claim for clinicians may be a different kind of relief from a burden, 'the finishing of unfinished business', as one surgeon put it to me, after a mediation had enabled him to explain his decision-making to a former patient after five years of litigation had

kept them apart. Clinicians may still have to tackle how to cope with having been accused of substandard care and skill, or with having a claim settled for something which they felt was not their fault. But attaining a sense of closure remains a powerful objective, especially where years have so often passed since the index event.

It will be rare for there to be a sense of 'win-win' at the end of an orthodox clinical claim; more a sense of endured pain, an acknowledgement that both parties have contributed and made concessions to enable settlement to be reached, and realisation that 'it's over at last'. Perhaps closure is ultimately the highest interest to be served by settling clinical claims.

2.3. Right to Life and Other Bioethical Cases

Looking then at right-to-life and other bioethical cases, the gap between rights and positions on the one hand and interests and needs on the other for each party is small. Close family members of a loved one described as being in a permanent (or, worse, semi-) vegetative state desperately want it not to be true. They want healthcare professionals to be wrong when it is said that a condition is irreversible and end of viable life inevitable, or when told that an apparent sign of response is nothing more than a neural reflex. So they fight for their rights,[10] as that fight corresponds exactly with their interests. 'We should have the say over whether life support is withdrawn, not medical professionals. The continued existence of our relative is in the best interests of both us and our loved one, because our love overrides all other considerations'. What other choice is there but to fight, if necessary up to the Supreme Court or the European Court of Human Rights, as not to do so means surrendering any positive right or interest still possessed, however unlikely.[11] There is no other interest to be asserted or captured. For clinicians, there is the pain of accepting that they can do no more for their patient, and that, again, contrary both to their caring professional instincts and their fundamental ethic 'Do No Harm' – withdrawing life support will lead to inevitable death, the very opposite of what both clinician and family of their patient want, and in violation of all their efforts to be alongside the family in a caring therapeutic relationship.

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[10] E.g., asserted inherent parental rights or rights under Articles 2 and 8 of the European Convention on Human Rights (ECHR).

[11] See *Great Ormond Street Hospital v Yates, Gard and Gard* [2017] EWHC 1909 (Fam) which went to the Court of Appeal, the Supreme Court and the European Court of Human Rights, all of which ruled substantively against the family; and *Alder Hey Children's NHS Trust v Evans* [2018] EWHC 818 (Fam), where again the family lost, led to refusal of permission to appeal by the Court of Appeal, Supreme Court and the European Court of Human Rights.

Where is the win-win in all this? What could even conceivably be described as 'closure' in such cases? How can mediation produce anything that could be described as 'success' in such an environment, when the outcomes available are difficult to relate to a co-ordination of mutual interests, and where every outcome seems rooted in grappling with negatives, rather than mobilising positives? How can mediation be used to split some kind of clinical orange in a way that satisfies all parties? If mediation is all about helping people to achieve mutually acceptable outcomes and transforming dispute into consensus simply by exchanging and modifying perspectives between disputants, then mediation seems not to fit into this particularly dark area.

But that is to misunderstand what mediation truly is, writing as one who has seen the early slow growth of mediation in the clinical sector in this country in the mid-1990s turn into its recent gratifyingly rapid growth, and not in any way based upon romantic or transformative models of mediation. Having tried to persuade judges and lawyers over many years that mediation is worth mobilising, I have been clear that to do so by relying on its allegedly transformative powers would not work. The 'touchy-feely' write-off would be deployed swiftly to rubbish such an idealistic pitch. But the fact that win-win is far less obviously available from mediating clinical claims does not in any way disqualify it as a process, so long as its true nature is understood. If we investigate the answer to this conundrum through pragmatism rather than principle, I hope that the sheer proven effectiveness of mediation in helping parties through the challenges that clinical disputes throw at them, whether in relation to substandard treatment or right-to-life decisions, will demonstrate its huge benefits, especially as contrasted with what engagement with the conventional civil justice process offers.[12]

3. The Essence of the Mediation Process

So what is the essence of the mediation process? It is a *confidential complex conversation facilitated by a skilled neutral*. By 'confidential' is meant a secure conversation without legal or personal risk of subsequent adverse consequences, either over the use or misuse of what is said, or over being criticised for exiting from the process without needing to say why. 'Complex' connotes a series of inter-connected multi-lateral conversations between the central stakeholders to the dispute, some with all parties present, chaired by the neutral; some private unilateral conversations between each party and the neutral; and

[12] At least, following the Supreme Court decision in *An NHS Trust and Others v Y (by his Litigation Friend, the Official Solicitor) and Another* [2018] UKSC 46, permission will no longer be needed from the Court of Protection to withdraw treatment or feeding from patients with disorders of consciousness when the family and the hospital agree this course of action.

some conversations without the neutral, especially private conversations within teams, and even some multilateral conversations between individuals from different parties. 'Conversation' is a word that exactly captures the tone that a good mediator seeks to generate for the mediation process. 'Facilitated' characterises the neutral's job as being to assist parties towards self-determination of their rights and interests and not to make decisions for them. A 'skilled neutral' is an independent person trained and experienced in the demands of bringing people into constructive conversations, who has no interest or bias (nor is perceived as having such) concerning the parties and the dispute, or as to where that conversation might lead.

The idea of the confidential conversation conveys the essence of mediation. Significantly, this definition makes no mention of 'settlement' or 'success' or 'outcome', unlike the classic CEDR definition of mediation, for instance, first created in 2007, as:

'a flexible process conducted confidentially in which a neutral person actively assists the parties in working towards a negotiated agreement of a dispute or difference, with the parties in ultimate control of the decision to settle and the terms of resolution.'[13]

More than half this definition is about working towards an outcome, though of course underlining that the parties retain control over whether to settle. I do not challenge that objective, as mediation must have some utility and must help to take disputants somewhere. Its emphasis on party self-determination is also very important. But if you set this definition against the notorious, even mischievous, aphorism produced with rhetorical glee by Professor Dame Hazel Genn in her Hamlyn Lectures of 2008,[14] you begin to see my point:

'Mediation is not about *just* settlement: it is *just about* settlement' (emphasis added).

My response to that is that 'mediation is *not necessarily about settlement at all*' (emphasis added). It cannot and does not and should not always produce settlement, and does not have to produce settlement to justify its use and existence.[15] Indeed one of Professor Genn's criticisms of mediation was that it deprives the common law of the oxygen of publicly available precedent, added to

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13 See CEDR, 'Model Mediation Procedure' (2018 edition) para. 1, www.cedr.com/about_us/modeldocs/?id=21.

14 See H. Genn, *Judging Civil Justice (The Hamlyn Lectures 2008)* (Cambridge: Cambridge University Press, 2010), especially her second lecture on 'ADR in Civil Justice: What's Justice Got To Do With It?', 78-125.

15 T. Allen, 'Judging Civil Justice? A Critique of the 2008 Hamlyn Lectures Given by Professor Dame Hazel Genn QC: Part 1', www.cedr.com/articles/?item=Judging-civil-justice-a-critique-of-the-2008-Hamlyn-Lectures-given-by-Professor-Dame-Hazel-Genn-QC-Part-I.

which that it risks parties accepting outcomes that are somehow 'unjust'.[16] So she should welcome the fact that mediations do not always settle, allowing parties to find their way back into litigation and the courts. In a branch of justice which is elective at the behest of the claimant, claimants must be allowed to choose their outcomes by discussion with their opponents, leaving them free to decide whether they ultimately prefer to have that outcome decided for them. Similarly, defendants must be able to choose to settle rather than submit to the risks of an imposed outcome. Each party will of course weigh their options in the light of what they hope or fear a judge may decide, and justice and the common law always enter the private debate by that route.

4. Distinguishing Process and Outcomes

I used the phrase 'mediation process' above deliberately, as it seems to me essential to distinguish process from outcome. We need to examine the utility of engagement in the process as well as the utility of outcomes. This is another way of debating what constitutes 'success' in measuring the value of mediation as a process.

So what is the utility of convening a mediation (as defined above) in an extremely painful clinical claim, say a life-changing disaster like cauda equine syndrome from an unscanned and undiagnosed spinal injury; or the death of an adolescent child from self-harm when a psychiatric in-patient; or failure to diagnose a recurrence of cancer in a claimant who has now been given a terminal prognosis; or the death of a loved spouse with a chronic condition being treated at a tertiary centre who had a weekend flare-up and whose death resulted from inadequate treatment by a satellite hospital; or the death of a desired child shortly after birth, giving rise to significant depression in the mother; or learning that a child has suffered hypoxic brain damage and that future family life will be very different from what was expected? I am thinking of specific cases of each of these types which I have mediated, and I ask myself 'what did the mediation process achieve for these parties?' In my view, it achieved the bringing of key decision-makers together to talk about what had happened in a secure environment, in a way that had not been done previously, at least not to good effect.

Some of those claimants will of course have needed compensation where they can establish a right to it, especially the families of children with cerebral

16 See H. Genn, 'Why the Privatisation of Civil Justice is a Rule of Law Issue', 36th F.A. Mann Lecture, Lincoln's Inn, 19th November 2012.

palsy, and those who can never work again as a result of what went wrong. It is good that the lottery of huge compensation for negligently caused cerebral palsy as opposed to State Benefits for those where the CTG[17] trace exonerates the clinical staff from breach of duty may be ended by the Rapid Resolution and Redress Scheme[18] for birth injury without fault being proven currently under discussion and design. Some will have felt that payment of compensation was a kind of acknowledgement or admission. But what was common to all these cases and almost all other clinical cases I have mediated is the value placed upon the key encounter between claimants and families and clinical and non-clinical staff from the NHS Trust or other clinical body involved. It enables acknowledgements and even apologies to be given, and what is more appreciated and accepted, even four or five years or more after the event. It enables long-held guilt to be assuaged by reassurances from a clinician, for instance as to whether the mother of a brain-damaged child now aged nine had been partly responsible for her child's disability by declining a foetal blood sample at a crucial stage. She had unnecessarily harboured a sense of guilt for eight years. To see a family taking strength from hearing from senior clinicians at a Mental Health Trust that extensive steps had been taken since the death of their child from self-harm to minimise the risk that it would happen to any other patient in future is extremely moving and undoubtedly delivered what both 'sides' wanted – an effective reconciliation out of an immensely painful episode for both. That hour and a half meeting during the mediation was enormously appreciated by the family who heard these assurances then, but had not heard them at the inquest and would have been extremely unlikely to have heard anything like this at a civil trial. The clinicians too appreciated the candour and openness of the family and gained their own benefits from being able to listen and talk with them.

So what are the deliverables at a mediation of a clinical claim? At the most basic level, the most important for many claimants and (if they are courageous enough to attend to have their say) clinicians, is to provide an opportunity to have your say, unfettered by any rules of evidence as to relevance or embarrassment that such words are underpinned by strong feelings. For a claimant to put things firmly into a human context in a late cancer diagnosis by looking the defendant team in the eye and saying 'because of your failure I shall not be a grandparent or see my children graduate from university' is a shocking thing

17 The cardiotocograph, or EFM (electronic foetal monitor) which is used to monitor foetal heartbeat and maternal contractions during labour.

18 See Department of Health, 'A Rapid Resolution and Redress Scheme for Severe Avoidable Birth Injury: Government Summary Consultation Response' (November 2017), www.gov.uk/government/consultations/rapid-resolution-and-redress-scheme-for-severe-birth-injury.

to hear and receive, but when I saw this happen, there is no doubt about the release of tension for the claimant or the proper account taken of it by the defendant team. It produced an empathetic response that was bravely and constructively received by the claimant and the soon-to-be bereaved spouse.

The next level of productive engagement is the face-to-face provision of acknowledgement or even apology; an explanation of what went wrong and why; reassurance that steps have been taken to prevent a recurrence, both locally and more widely within the NHS; sometimes even an invitation to participate in planning improved service delivery using the insights and experience gained by the claimant and family; and a reassurance that making a claim against the NHS does not place someone on a secret blacklist which might result in slower and less sympathetic treatment in future. These are all valued elements for discussion in the mediation process and are frankly not within the gift of a civil trial judge. They have little necessarily to do with negotiating outcomes to litigation.

There is one more possible deliverable outcome, which it is unwise for any mediator to expect and although in the long run it may emerge to the benefit of both claimants and families and clinicians, neither of them can ask for it or promise it. It is best described by Henry Marsh in his moving book *Do No Harm:*

'Doctors need to be held accountable, since power corrupts. There must be complaints procedures and litigation, commissions of enquiry, punishment and compensation. At the same time if you do not hide or deny any mistakes when things go wrong, and if your patients and their families know that you are distressed by whatever happened, you might, if you are lucky, receive the precious gift of forgiveness'.[19]

This is a generous opinion. It is the more powerful because he expresses it after telling the story of a grieving mother who could not forgive hospital staff over the sudden but probably non-negligently caused death of her adult son, adding:

'I fear that if she cannot find it in her heart to forgive the doctors who looked after her son in his final illness she will be haunted forever by his dying cry'.[20]

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19 H. Marsh, *Do No Harm: Stories of Life, Death and Brain Surgery* (London: Weidenfeld & Nicholson, 2014), end of Chapter 15.

20 *Ibid.*

So the benison of forgiveness can probably be found only in a two-way street, when it will benefit both giver and receiver. I have never even dared to propose the giving or receiving of forgiveness between claimants and defendants at a mediation, but it is perhaps a sign of the strength of the mediation process (in contrast to the powerlessness of the mediator in relation to raising such a matter) that I have seen the mediation process make forgiveness possible. This is transformative indeed, but it seems to me that a much more pragmatic approach is what mediators and those who utilise the mediation process must take, though taking quiet pleasure if the process they utilise goes in such a creative direction.

Besides meeting these interests for claimants, in the huge preponderance of clinical mediations, the outcome to litigation claims is also successfully negotiated, besides capturing the non-monetary values of participation in the process described above. Clinical negligence litigated claims are probably the least easy to bring home. Breach may be difficult to establish, with contrary expert opinion. Causation may defeat or reduce the potential value of a claim even if breach is proved or admitted. Another way of putting it is that there are always significant litigation risks swirling around such cases. If a claim is obviously hopeless from the start, most good clinical negligence lawyers will weed them out, especially if when funding is by a no-win-no-fee conditional fee agreement. If a case is clearly indefensible, sensible defendants will use every effort to settle it quickly, though they should still not overlook that non-monetary benefits may also help to enhance early settlement. Those that remain unsettled at the end of the pre-action protocol period and continue into litigation will have contentious issues within them, and the outcome at trial will be hard to predict. So risks stalk the litigation arena and buying up those risks by seeking a compromise settlement figure occupies much of the later stages of clinical mediations. Having a neutral to assist with this kind of bargaining helps parties move on from positional and confrontational bluffs and threats, trying to rubbish an opponent's case, with which round table meetings (RTMs) often start and sometimes continue. RTMs almost always involve only face-to-face discussions between the senior lawyers for each team, with the lay parties out of the way and with clinicians rarely present at all. This greatly reduces the possibility of delivering non-monetary extra-legal value for parties from the process, which I am arguing is the fundamental benefits of the mediation process.

The outcomes negotiated at a mediation (or indeed an RTM) will rarely mirror what a judge would award. It is extremely rare for either party to persuade the other that their own case is wholly right, persuading the claimant to discontinue (but I have very occasionally seen that happen, when coupled with non-monetary benefits) or the defendant to pay in full (rare because a litigation risk discount almost always is conceded). What happens is that the parties reach unspoken adjustment on issues of breach, causation and heads of damages

claimed, and settle at a figure which each feels is acceptable as a means of reaching the end of litigating. The risk discounts leading to the agreed settlement figure are generated against the background of what each party thinks a judge will do, so in that sense they bear a relationship to the law as it stands and can be argued to be a 'just' outcome, at least one measured against what justice might say or do if asked at trial, and reached on good legal advice about where the risks and benefits lie.

I hope that this account of such mediations will end any misconception that mediation is 'touchy-feely' in a derogatory sense. They are very often sad, tough and emotionally charged occasions. Tears are shed, anger is expressed, grief emerges, depression and fear are signalled in both rooms, though only rarely acted out. Emotional vocabulary is required, and the mediation process has an ability to cope realistically with deep feelings in a constructive and un-frightened way. In fact, I claim 'touchy-feely' as a badge of honour rather than dishonour, for the mediation process, especially when contrasted with the way underlying emotions are often ignored or suppressed at RTMs and trials. What could be a greater driver for lay participants in such cases – than the way they feel about what has happened, so what is more in need of sensitive handling? Just trying to trump feelings with rationality is fraught with risk.

5. Objectives in Right-to-Life Mediations

I turn to bioethical life and death cases now, and ask again – 'What is the utility of mediation in such cases?' when it is self-evident that 'settlement', as we think of it, is extremely unlikely. Clinicians who have stepped painfully over the line from recommending and implementing life-prolonging treatment into seeking authority to withdraw it will be very reluctant to concede on reflection that they are wrong. And who can be surprised that parents might be utterly resistant to the withdrawal of treatment for their child, perhaps conceived by IVF after a struggle with fertility, with the inevitable consequence of early death and maybe even the destruction of prospects of parenthood? Of course, there are many cases where families do accept clinical advice and agree to withdrawal. It is the cases where they do not that hit the headlines.

I believe that it is the words of Francis J in both of his judgments at the end of the two hearings before him in *GOSH v. Yates, Gard and Gard*[21] that give us

[21] *Great Ormond Street Hospital v Yates, Gard and Gard* [2017] EWHC 972 (Fam) at para. 130 and also [2017] EWHC 1909 (Fam) at para. 20.

the clue here, especially the words in italics. At the end of the first hearing he said:

'I end with this procedural note: I have already expressed the opinion that I believe that it would, in all cases like this, be helpful for there to be some form of Issues Resolution Hearing or *other form of mediation where the parties can have confidential conversations to see what common ground can be reached between them. I believe that that type of hearing, be it Judge led or some other form of private mediation, would have led to a greater understanding between the parents and the clinical team in this case. I am not saying that it would necessarily have led to a resolution, but I think in many such cases it would and I would like to think that in future cases like this such attempts can be made'*.[22]

In his second judgment he said:

'I want to mention, again, the subject of mediation. Almost all family proceedings are now subject to compulsory court led dispute resolution hearings. This applies in disputed money cases, private law children cases and in all cases involving the welfare of children who might be the subject of care proceedings. *I recognise, of course, that negotiating issues such as the life or death of a child seems impossible and often will be. However, it is my clear view that mediation should be attempted in all cases such as this one even if all that it does is achieve a greater understanding by the parties of each other's positions.* Few users of the court system will be in a greater state of turmoil and grief than parents in the position that these parents have been in and anything which helps them to understand the process and the viewpoint of the other side, even if they profoundly disagree with it, would in my judgment be of benefit and I hope that some lessons can therefore be taken from this tragic case which it has been my duty to oversee'.[23]

These words seem to me to recognise the force of my approach to the definition of mediation, as the offering of a *confidential complex conversation facilitated by a skilled neutral* to those facing the agonies of a situation of this kind. It enables both families and clinical teams actually involved in the situation to sit down in neutral territory (very important in such cases) so as to have a risk-free, embarrassment-free, no-holds-barred conversation about what matters. It is the presence of an entirely neutral facilitator that makes it possible. Mistrust and frustration and all sorts of other emotions would be likely to colour any direct unfacilitated conversation, so having a person to chair and ease parties through such extremely painful discussions is vital. Just occasionally perhaps, the conversation might reveal an unexpected way forward. Maybe a different line of

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22 Para. 130 (emphasis added).
23 Para. 20 (emphasis added).

treatment or case as yet untried might emerge. Or maybe even a provisional conversation about the nature of palliative care will prove possible, if ever agreement to withdraw treatment is reached. But the important fact for Francis J and his fellow judges is that they will be able to know that such a conversation has taken place, that all avenues of compromise have been privately explored without an agreed outcome, and maybe that will ease the burden of having to make a life-or-death decision in 'the best interests' of the child.

So win-win is by no means a necessary component of useful and successful mediation. Its essence is the protected conversation giving the parties the best chance of making progress and contemplating resolution of their differences. Even if the process has to help parties grapple with sorting out what is likely to be an irredeemably negative set of interests against an uncertain background of where a court might find that their respective rights and duties truly lie when looking back on the past, its emerging track record of high settlement rates and high satisfaction levels[24] shows that it is delivering what participants want. Sadly, profiling its successes is significantly hampered by the confidentiality that lies at its heart and which is one of the reasons that the mediation process works. Recent relaxations on publicising the fact and terms of settlement may help with this, though never at the expense of exposing what happened on the mediation day, especially in cases which did not settle. If win-win is not possible then maybe gain-gain is.

6. Mediations Where Total Concession is Sought

Occasionally, one party proposes a mediation to seek to persuade the other that their position is untenable and that they should concede completely. Doubtless this hope is fostered by claimants who have been advised about the monetary value of their claim which has been embodied in a schedule of loss with a statement of truth endorsed on it as to its accuracy and validity. They will hope that the defendant will accept and offer to pay their claim and the various heads of loss completely. At the mediation, arguments will be firmly deployed to persuade defendants that this is what the outcome should be. In practice, however, there is very little litigation which is entirely free from risk. So during settlement discussions (whether at a mediation or in any other settlement process) claimants are very often advised to accept discount off their best case to buy up the risk of failing to establish a particular head of damage, or

[24] See e.g. L. Mulcahy *et. al.*, *Mediating Medical Negligence Claims: An Option for the Future?* (London: The Stationery Office, 2000), especially Chapters 2, 6 and 8; and T. Relis, *Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties* (Cambridge: Cambridge University Press, 2009), especially Chapters 6 and 8.

even accepting an overall risk discount to reflect the risk of not succeeding in establishing breach of duty in proving causation of loss at all.

Defendants too are alive to litigation risk and will offer more than they had initially hoped to achieve an agreed outcome by risk-discounting upwards. Finality, certainty, and the end of continuing legal costs on both sides is thus achieved, made more attractive to defendants since April 2013 since the Civil Procedure Rules (CPR) were amended to disentitle them from claiming costs from a claimant in the event that the claimant loses.[25]

It must be borne in mind that a strikingly high proportion of clinical claims do not succeed in generating damages. In the year 2016-17, NHS Resolution closed just over 17,000 cases. Of these, just over 44% were settled or tried without payment of damages. Only 121 (0.7% of the total cases) reached trial and, of those, 72 were successfully defended and 49 were won by claimants.[26]

So there is a significant failure rate in clinical claims, and defendants will occasionally want to argue that a claim is wholly misguided and doomed to failure, perhaps especially as they will have to fund their own costs of defending it even if they are right. They want to confront the claimant and their legal team with this view in the hope that good sense, as they see it, will prevail. Of course, they can simply run the claim to trial in the hope of being vindicated by the judge, but QOCS makes that an expensive option.[27]

So mediations are occasionally convened at which defendants attend with the acknowledged intent of *not* making monetary offers to settle. It is still wise for defendant to indicate a willingness to listen to any persuasive argument to the contrary, and authority to change their mind. But even so they may indicate that it is up to the claimant to persuade them to change their view, and one outcome may still be that they remain of the view that the claim is without merit and make no offer of compensation. They may propose non-monetary benefits to the claimant personally, such as a platform to describe what happened

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25 See CPR 44.13 to 44.17. Called 'qualified one-way costs shifting' (abbreviated to QOCS) by Jackson LJ in his *Review of Civil Litigation Costs*, loss of the defendants' former right to claim costs if they defeated a claim was the price paid for no longer having to pay substantial success fees and litigation insurance premiums as well as the claimants' base legal costs whenever damages were awarded or agreed. Under QOCS, defendants can only recover costs from damages they would otherwise have had to pay where the claimants fail to beat a Part 36 offer, or where the claim is struck out or found to have been an abuse of process or dishonestly framed.

26 See NHS Resolution, 'Annual Report and Accounts 2016-17' (2017), 16, https://resolution.nhs.uk/wp-content/uploads/2017/07/NHS-Resolution-Annual-report-and-accounts-2016_17.pdf.

27 See footnote 25.

or involvement with the design of changed practices. Very occasionally a claimant will find this satisfying and accept such non-monetary benefits in lieu of compensation.

Claimants and their lawyers will privately hope that they can and will persuade the defendant to buy up their risk of losing, even if heavily discounted. Indeed a claimant's lawyer who has advised that a claim is worth pursuing and has backed that judgment by agreeing to run the claim on a no-win-no-fee basis has a significant financial interest in being vindicated in that judgment. If they fail to do so, they must decide whether to undertake the risk of fighting on to trial in the hope of winning there in the teeth of firm opposition by way of defence. The alternative is to file and serve a notice of discontinuance, which would mean (assuming the usual no-win-no-fee funding arrangement) that the claimant's legal team must go unpaid as the claimant has not won, although the claimant will normally not be liable for any of the defendant's costs, since QOCS applies.

Claimant lawyers in particular who fail to elicit an offer from a defendant at a mediation will often get very angry, perhaps thinking that the defendant's proposing or agreeing mediation had signalled an unexpressed willingness to compromise which has been withdrawn. They feel embarrassed in front of their client not to have succeeded in persuading the defendant to settle, and they may fear the travail of having to fight to win. They will certainly express the view that a mediation in such circumstances was a 'waste of time'. Such an outcome for mediation is as far from a 'win-win' as almost all 'right-to-life' mediations with their inherent likelihood of non-settlement, perhaps even more so because one party predicted in advance that they would not pay damages. So are such mediations worth convening at all?

If mediation is truly a *confidential complex conversation facilitated by a skilled neutral*, with no necessary implication that it will lead to consensus as to settlement terms, then surely such a conversation is worth convening at some point before a judicial determination is imposed upon the parties. If the defendant's assertion that there is no valid claim is right, a safe occasion to explain why they believe this to be so may be valuable. The claimant will usually be present in person to hear this, and it is just possible that an acknowledgement of the claimant's adverse experience (while not conceding liability for it), coupled perhaps with some kind of acceptable non-monetary benefit may be devised as a satisfactory substitute for damages, however dismaying for the claimant's lawyers. But the defendant may turn out to be persuaded that there is a risk worth buying up, just as it is possible that a right-to-life mediation might lead (albeit rarely) to consensus. It might emerge that the claimant is willing to give a much larger risk discount than had been expected in the wish to get out of the chances of litigation. Mediators can only report that they have seen huge

gaps between parties closed as a result of engagement in the mediation process that no one, especially the parties and even the mediator, would have predicted were capable of closure.

The question is whether it is worthwhile assembling parties to discuss even what one disputant regards as a hopeless case. Logically it is worthwhile, especially if my definition is accepted, as parties should always be expected to sit down and discuss their differences before they seek a third party ruling on them, especially when litigating them creates distance, entrenchment, misunderstanding and broken communication. Financially and emotionally it will seem not to be worth it to parties and lawyers who believe they are right, and may suffer financial penalty if they are wrong. As to whether a civil justice system requires parties to engage in a *confidential complex conversation facilitated by a skilled neutral*, so as to ensure that parties hear each other in an informal and neutrally enabled process which can have no adverse outcome for either party if resolution does not emerge, this is an important question of policy, which has been answered differently in different jurisdictions.[28] This question is briefly debated in Section 7 of this paper.

7. Wider Implications: Is Mediation a Civil Justice Panacea?

This section goes on to raise a question of general application to the civil justice system and its views about mediation, not confined to clinical and ethical claims. If mediation truly is 'a confidential complex conversation facilitated by a skilled neutral', then where is the harm in requiring litigants to engage in it at some time in *any* claim before they over-burden the over-stretched civil justice system with cases or trials? It cannot be asserted that to do so hinders their right to a trial under Article 6, as there is no compulsion to settle. It is arguably simple common sense to get people to check their intentions, especially when litigants take every opportunity to conceal feared weaknesses from their opponent where possible. A safe conversation to which no adverse inference can be attached, which gives the best possible chance of settlement – as experience has repeatedly showed – can only help the judiciary in taking cases out of

[28] Many US, Canadian and Australian common law jurisdictions have explicit or implicit requirements to mediate in any case, sometimes before issue and sometimes before trial. There is a huge literature on the subject of mandatory mediation, which has never been favoured by the English judiciary. See the current debate encapsulated in Civil Justice Council, 'ADR and Civil Justice', CJC ADR Working Group Interim Report (October 2017), www.judiciary.gov.uk/wp-content/uploads/2017/10/interim-report-future-role-of-adr-in-civil-justice-20171017.pdf.

the justice system as early as possible where parties discover that they want to settle, or, conversely, that a case really does require a judge to decide it.

This is not only a concern for clinical claims, though such cases, once issued, do occupy a considerable proportion of judicial case management time, even if it is rare for them to reach trial. The case is more easily made out for requiring or organising mediation for clinical claims, as most of the things that mediation can deliver to parties, and which research has repeatedly shown are of considerable importance to parties,[29] are simply not available from a judge.

So is mediation a panacea? If a definite rights-based outcome one way or the other – a guaranteed cure, in other words – is an essential feature of any panacea, then it is not, although those who lose at court would be unlikely to regard judicial decision as a panacea or a cure for their ills. But the medicinal administration of mediation can properly be viewed as requiring parties to take a necessary moment to review and obtain mutual delivery of otherwise undeliverable interests, while never excluding access to rights-based considerations. In ingesting it, they can review and, if they so choose, to value and try to buy up the risks they face in not achieving all their objectives. That all sounds like a pretty sensible form of treatment.

This paper has looked at the mediation process when used in extreme situations, in particular concerning ethical issues such as treatment choices and the right to life, but also in those extremely painful human situations that typify clinical claims for both claimants and clinical staff, and also where orthodox monetary settlement seems a remote possibility, or is even declared to be unlikely or impossible in advance. Mediation needs to make sense in all these extremes as well as in more orthodox settlement discussions in which compromise seems easier to attain. Surely in any modern society with a correspondingly sophisticated civil justice system there remains the need to ensure that civilised and safe conversation, free from adverse outcome if it leads nowhere, is a norm, to be encouraged and perhaps even required of all who find themselves in dispute.

29 See references in footnote 24.