Mediating clinical negligence claims

by Tony Allen

Solicitor, accredited mediator and Senior Consultant to CEDR

This paper looks at how mediation is particularly appropriate as a dispute resolution process for claims made against healthcare professional and institutions, and the special demands that such mediations make on those involved.

The potent mix in clinical claims

Claims against healthcare professionals (whether as individual clinicians in their own medical practice or, more often, within an entity like a public hospital) involve a potent and characteristic mix of complication, which to an extent spills over into mediation of such claims. The facts emerge from an occasion when a person placed trust in the hands of experts to care for their health, an essential part of their being, and alleges they were professionally let down. Such situations inevitably engender strong emotion, felt either directly or vicariously where the patient was a close relative. This perceived failure may have led to permanent damage to health, to a failure to prevent shortening of life or even to death, and such sad outcomes are hard to accept without uncertainty, disappointment, anger and fear .

The test for negligence and the need for expert opinion

Yet frustration often results when complaints and claims of clinical negligence are made. They are technical, and, when tried in the courts, dependent for success on expert opinion, since the leading test (in England and Wales at least) for whether negligence is made out against a healthcare professional depends on whether what was done or omitted would have been in accordance with the opinion of a "reasonable body of practitioners" – in other words the healthcare profession sets its own standards. Claimants will, except in self-evidently disastrous cases like operating on the wrong limb or organ or administering the wrong drug dose, have to enlist supportive expert opinion before their claim can be advanced at all. Defendants will also have to mobilise contrary expert opinion to succeed. Furthermore, unlike some other negligence claims, there is almost always an additional hurdle to overcome even when breach of duty is proved or admitted, in that to prove what damage was caused by that breach, or the extent of the damage as claimed, can be difficult. If a patient was doomed anyway, a late diagnosis of disease may have done little to delay the inevitable. Besides these special difficulties, there remain the ordinary ones typical of all injury claims of proving the heads of damage.

The challenges for healthcare professionals

Distress and upset are not the exclusive preserve of claimants in clinical claims, however. As any professional who has been accused of negligence will testify, such allegations are extremely painful and distracting, disturbing sleep and endangering concentration on continuing work. Affected claimants may have little sympathy for this aspect of the clinical claims equation, but mediators who ignore it will be overlooking their responsibility to all parties, as well as missing a normal personal dynamic which exists in most cases, even if it quite often does not emerge because of the absence of the relevant healthcare professional from the mediation itself, or the professional chooses to adopt an aloof or defensive attitude.

The need for careful preparation of clinical mediations

This background gives a strong steer to the importance of preparing properly for such mediations. Prior contact will normally be with the lawyers for each party, and apart from the usual questions about their previous mediation experience, any explanations to supplement their knowledge and checking practical matters like venue, time, the terms of the mediation agreement, and what settlement attempts if any have been made so far, it is always important to look at the human factors behind each claim. Checking what contact there has been hitherto between claimant and family and the healthcare professionals is important. Was any formal complaints procedure invoked and how did that turn out? Is there any unfinished business? Has there been any explanation of what went wrong, or any reassurance of changed practice? Has anyone apologised, and if not would this still be appreciated? If so, who needs to attend the mediation? Who does the claimant need to hear from, if this can be set up? Is the mediation the best place for this to happen? Will the claimant and family feel able or want to encounter relevant healthcare professionals, or conversely will they be angry if those professionals do not propose to attend? Careful consideration by the mediator from the earliest stage to these issues is needed and careful diplomacy to achieve what each party wants or fears. Special arrangements may be necessary to enable professional to escape from their busy schedule. It may be necessary to offer to talk to the doctor in advance, in the event of any reluctance on the doctor's part to meet.

Managing the encounter between claimants and defendants

So if it is appropriate and acceptable to all for healthcare professionals to attend such mediations, how should it be managed on the day? There is an inescapable risk of an outburst during such an encounter. But it is rarely inauthentic, and may well be an integral part of the value of the mediation. I have seen many honest and painful expressions of feeling on both sides when they meet, leading eventually to a sense of closure for both claimant and defendant. Often this will have been the first meeting of patient and family with the professional involved since the events which led to the initiation of claim, litigation being the distancing force that it always is. So the opening meeting must be carefully prepared and managed on the mediation day. Time spent in each room gauging the mood of each party is essential, remembering that each party is entitled to have their emotional state treated confidentially as much as their assertions of fact or opinion. It is important for a mediator both to suggest conveying the strength of feeling on the part of one party to the other, and also essential to obtain specific permission to do so.

The ensuing encounter normally will then normally (but not necessarily) take place at a joint meeting relatively early on the mediation day, so as to provide an opportunity to clear strong feelings about the past out of the way early, and allow cooler appraisal of the issues and risks in seeking to find acceptable settlement terms. However, if the parties cannot cope with an early meeting, this can be postponed until later or even shelved. I have seen doctors keen to meet their erstwhile patient but who had to wait until late in the day before the claimant could bring themselves to come together. However, my repeated experience is that there is enormous potential value in facilitating and managing a face to face meeting between claimants and defendants to exchange views, information and feelings, or simply to be

together and acknowledge each other's presence. Not infrequently, there is a real sense of resolution on both sides by the end of the mediation.

Needless to say such encounters need very careful chairing and managing by the mediator. Both lay parties will feel vulnerable as well as angry, aggressive (if claimant) and defensive (if defendant). It would be easy for mis-communication or non-communication to continue or be aggravated. The mediator must therefore create an atmosphere in which parties are prepared to communicate honestly and also to listen respectfully and attentively, each being open to the possibility that their view might possibly be modified by what the other says to them. They will only do this if they believe that the environment in which they are called upon to meet is entirely safe and controlled, which is one of the cardinal principles of mediation.

The usual mediation process

Mediation is by its very nature a very flexible process. The normal model for a mediation day in England and Wales adopts the following format:

- Private meetings with each party in their separate rooms, mainly to settle them in, to sign the mediation agreement, to assess readiness for a joint meeting with the defendant team and to encourage preparation for this
- A joint meeting chaired by the mediator in which each full team meets and, after the mediator has framed the process and the principles on which it is founded (of confidentiality and mediator neutrality), each party makes a presentation to the other of where they want to start discussions within the confidentiality of the process. The claimant's team usually goes first, but sometimes the defendant team seeks the claimant's agreement (negotiated by the mediator) to speak first so as to tender an apology for what went wrong, hoping to start the day off well. Sometimes this meeting will be extended to map out an agenda and timetable for the day, but most often the parties will wish to take a break from what has usually been the first time that patient and family and clinician have met since things were perceived to have gone wrong. Variations on this template include conducting virtually the entire mediation in joint meeting to go through the medical notes line by line, right through to never having a joint meeting involving all parties.
- A series of private meetings between the mediator and each party in turn, during which the mediator helps each party to explore their case in private, identifying and authorising arguments and material to be conveyed either directly between team members or (more usually) through the medium of the mediator which might influence the other in its approach to settlement.
- There may be further joint meetings chaired by the mediator (and some=times just individual encounters with out the mediator) between the two complete teams, or more often between individual members of each team, such as each lawyer or sometimes patient and doctor or hospital manager
- Once the arguments have been exchanged, the parties will usually start to make settlement proposals to each other, either across the table or conveyed by the mediator from room to room, until acceptable terms emerge or it becomes clear that settlement cannot be reached.
- Agreed terms are then put into writing by lawyers and signed to make them binding (a requirement of CEDR mediation agreements to ensure certainty): these terms are not confined to what a court would have ordered at trial, and may include future steps as

between claimant and healthcare provider such as treatment, consultation over reformed practice or further conversations with identified personnel. Alternatively discussions as to next steps take place if no agreement is reached, with the mediator usually offering to keep working between the parties.

- Where proceedings have been commenced, a court order to end these appropriately will be drafted and lodged.

Coping with technicality

What of the technicality of clinical claims? This too requires preparation by the mediator. It is necessary to understand the medical as well as the legal and medico-legal issues involved. Access to anatomical diagrams, medical dictionaries and learned articles is easily arranged. Lawyers in this sector are usually specialists and do such preparation work themselves and are often extremely well informed. They expect any mediator to cope with both the relevant concepts and vocabulary, understanding the implications of the expert reports which lie at the heart of such cases. There is also the question of understanding how damages are calculated. Guidelines or reported decisions on damages awards are the usual source of assistance in quantifying damages for pain and suffering if they are comparable and analogous. Damages for past and future loss broadly follow the same pattern as for personal injury claims, so understanding these specialist topics so as to follow the arguments in an informed way will be daunting for a mediator inexperienced in these sectors.

Unlike in the commercial sector, there is a degree of specialisation among the legal profession in clinical negligence in England and Wales. Solicitors' firms almost always only act for claimants or defendants, and this can colour their approach to their own clients and to their opponents, though because both specialist groups are relatively small, there is a good deal of respect for each other as well among top law firms. But there can be suspicion of opponents and defensiveness and protectiveness for clients as well. Many barristers do both claimant and defendant work, though some only act for one or the other. A Google search will usually reveal all that needs to be known.

Assessing risks

Clinical claims are inevitably technical. They are also not easy to establish. In England and Wales, the easiest types of negligence claim to prove are road traffic accidents, followed by employers' and public liability claims. Clinical claims have the lowest overall success rate in litigation, probably in the region of 40% of all claims notified. Breach of duty (negligence) mist be established, usually dependent on expert medical opinion that the clinician or hospital concerned fell blow any reasonable standard of competence. Additionally, expert opinion has to be mobilised to prove that any such negligence resulted in damage over and above what would have been suffered anyway by the claimant, - not always easy to show. If a claim based on whether informed consent was given or was sufficient to excuse the damage that did occur, there can be painful and chancy discussions of what was said to a patient by a clinician orally, at a time when there was not corroborative witness available, and it is the patient's word against the doctor's. So there are inherent difficulties in suv9ccessfully establishing a clinical claim, especially where a doctor is anxious to preserve clinical reputation intact in a profession where perfection seems to be expected at all times.

In cases where there is chance of not succeeding, discounting the full value of a claim to reflect those risks becomes a serious consideration. As to whether breach of duty or causation is made out sufficiently on the facts of a given claim to justify a full or discounted offer, this will frequently entail discussion of the relative merits of each expert opinion in order to assess the risks that each side faces on this before being able to decide whether to settle or the appropriate level of settlement. An under-used option is to try to get the experts to attend at the mediation and have the debate that they are ordinarily required to have under CPR Part35 with the parties present to assess the respective persuasiveness of each. But the mere fact that a claim involves a dispute over whether breach of duty or causation of damage can be made out does not disqualify it from being successfully mediated. If parties are prepared to take a view on the strength of otherwise of their expert evidence on the risks of not succeeding in either brining home or defending a claim, then risk-discounted settlements are perfectly possible to achieve, often (in England and Wales at least) incidentally saving huge sums in legal costs, which can dwarf the damages in lower value claims.

Success rates and satisfaction levels in mediating clinical claims

Clinical negligence mediations have a high rate of settlement, at least 90% in my experience, and they can even be settled before issue of proceedings, much earlier than is usual in litigation, and before high legal costs have been racked up. Where they do not settle on the day, it may prove necessary to adjourn or decline to settle until further evidence is sought. Then at a later stage further discussions very often lead to settlement after adjustment of each side's risk analysis, usually through direct discussions, though the mediator is almost ready to help further. If an unsettled case proceeds to trial, one or other party finds that their assessment of their prospects of success was seriously wrong.

Clinical mediations also very often lead to a sense of business done at a personal level for both claimant and clinician, hard to obtain if a claim is settled by the arms-length acceptance of a Part 36 offer with its threat of costs sanctions if rejected and misjudged. The mediator's role from start to finish is to enable difficult conversations to take place, both face to face and in private, about both (literally) painful past events and also the chances of success for each side and the risks of failure. The mediator is there to prolong discussions rather than allowing parties to make a dramatic withdrawal, and to coach the parties in what offers might attract the other party towards possible settlement (though in clinical cases with the extra element of both monetary and non-monetary outcomes). Above all, the mediator is there to promote the lay parties back into the centre of their case, when so often excluded by the nature of the litigation process, and indeed by the joint settlement meetings chosen frequently as the settlement process by lawyers in the clinical sector.

The take-up of mediation of clinical claims

Despite the positive views taken of mediation in clinical negligence claims which emerged from the Mulcahy Report in England & Wales the late 1990s, mediation has not been taken up in this sector as much as might have been expected, despite occasional positive opinions being expressed by practitioners. It is said that claimant lawyers may feel unhappy at the prospect of having to compromise their client's genuine needs for damages within a mediation. But if ever there was a risky area of law with uncertain prospects of success it is clinical claims. Is going to court and losing preferable to settling at a sensible discounted value and getting something, even if not everything? Maybe claimant lawyers somehow fear surrendering

control over their client's case to a neutral. As this is what initiating proceedings at all involves (to an adjudicative judge) it is hard to understand this fear, especially as mediators emphatically value the expert representation and advice which lawyers tender to their clients at a mediation. On this and the earlier objection, it must be remembered that no one is compelled to settle at mediation, The lawyers are there to advise whether a better outcome at trial is worth pursuing, and if so and the client agrees, they can walk away from the mediation without penalty.

Recent developments in the UK and elsewhere

In recent months, the NHS Litigation Authority, which conducts all litigation claims on behalf of all hospitals In England (but not Wales) has initiated a mediation scheme, designed particularly to deal with lower value/ high emotion claims , such as infant and elderly deaths and more modest claims, in which the legal costs tend to dwarf the damages at stake. Claims against general practitioners and consultants in private non-NHS practice are represented by one of the medical defence organisations such as the Medical Defence union or the Medical Protections Society (which is very strong in South Africa) who enter into quasi-insurance arrangements with medical practitioners to represent them if in any civil or regulatory proceedings brought against them. Mediation of clinical claims is familiar in Australia and the USA, though complicated in the US by the fact that any doctor on whose behalf damages of any amount are paid in a claim has to have this fact entered on a national database which is available to patients and future healthcare employers. Clinical mediations are beginning to take place in South Africa: indeed the writer actually mediated one of the first of these in Cape Town in 2014, producing a mutually acceptable conclusion to a three year dispute in three hours of mediation.

Conclusions

Mediation undoubtedly has a valuable role to play in providing a safe environment in which the actual parties to a clinical dispute can meet, communicate, discuss ways forward, and find solutions of a wide-ranging nature to the strong feelings that arise when it is thought that professional care has led to an unexpected and distressing result. Parties can negotiate the extent to which any outcome moves into the public domain. Usually both parties are content to keep the dispute, the resolution process and its outcome private. But sometimes there are lessons of a wider nature to be learned. Usually a confidential mediated outcome to a civil claim will not prevent a significant learning issue for healthcare generally from being considered by other routes, such as complaint management, regulatory action and so on. Certainyl mediation should never be used deliberately to hush up a matter of general importance, and claimant lawyers will doubtless attend to those considerations. Nevertheless such issues only arise rarely, and for the vast majority of those engaged in healthcare disputes, mediation provides just the right kind of environment for parties to achieve what they really need and want.