Encouraging Resolution

mediating
patient/health services disputes
in Scotland

a report produced by

The Royal Society *of* Edinburgh

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Foreword

In many countries, mediation, and other methods of alternative dispute resolution, are encouraged, recognised and used as means of resolving disputes, rather than resorting to litigation. Mediation is also being used in Scotland, but not to the same extent, and its use in relation to resolving disputes between patients and the health services is negligible. Against that background, and taking into account the conclusions of a recent Symposium held by the Royal Society of Edinburgh, the Society saw it as timely to establish a Working Group to examine the scope of using mediation to resolve patient / health services disputes in Scotland, and in particular medical negligence disputes.

All litigation is stressful, and this is especially true of medical negligence cases. It is also widely recognised that litigation should be the last resort, but in Scotland it is still the route used more often than not. Can a greater use of mediation bring about an improvement to that? The Working Group believes it can. As is made clear in this Report, resorting to mediation instead of litigation should produce a number of benefits, of which reduction of stress can be one. Another is that it may enable a claimant to obtain some remedies not otherwise available in litigation. But mediation is not a panacea, and will not be appropriate in all cases.

A greater use of mediation will not take place unless there is a change in attitudes, culture and education. This applies to all stakeholders, but above all there must be political will for change. There must also be co-operation and action by all the organisations to which the recommendations in this Report have been addressed. I hope that politicians, these organisations and the public will study the Report, and that those who are able to do so will give effect to its recommendations. It would be unfortunate if Scotland was to continue to lag behind other countries in recognising that there is a place for mediation in the field of medical negligence claims.

The Society is most grateful to all those who agreed to serve on the Working Group, to every person and organisation that took the time to provide evidence, and to everyone who attended the Group's evidence discussion seminar held in November 2001. In particular, the Group would like to thank those individuals who were prepared, throughout the Group's work, to share with it their personal experiences. Without all of these contributions this report could not have been produced.

Finally, the Group wishes to express its gratitude to its indefatigable secretary, Graeme Herbert, for the sterling work he has performed during the Group's deliberations and in the preparation of this Report.

Donald M Ross PC, FRSE
Vice President

The Royal Society of Edinburgh

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Chapter 1

Introduction

The group's origins

1.1 On 15 June 2000, the Royal Society of Edinburgh (RSE) hosted a symposium which considered medical practice and the growth of litigation in the United Kingdom. The event identified, among other things, a need for a more detailed examination to be made of mediation as a possible means of improving the resolution of disputes between patients and health services in Scotland. In June 2001 the RSE, with the support of the Scottish Executive and the Medical and Dental Defence Union Scotland, established an independent group of medical, legal and public health experts to undertake such an examination. The group was chaired by RSE Vice-President, Lord Ross, PC, FRSE; its membership is shown at Annex A.

Terms of reference

1.2 Our terms of reference were:

- To explore the scope for using mediation as a process for resolving patient disputes involving the health services in Scotland.

- To make recommendations on any actions considered appropriate and necessary.

- To report by end January 2002.

In carrying out our work we had regard to evidence from relevant sources, including evidence from other jurisdictions.

Our focus

1.3 Our main focus was on mediation in the context of medical negligence[1] disputes. For the most part, this report therefore considers and discusses that, but not to the complete exclusion of non-clinical disputes involving the health services. These are also discussed within the report.

The issue

1.4 Much public concern is voiced about how medical negligence disputes are currently handled in the United Kingdom. The concerns are both quantitative, in terms of rising costs; and qualitative, in terms of the effect on patients, their families, healthcare providers, and morale and public confidence in the health services.

1.5 We examined the extent to which litigation and healthcare complaints procedures meet the needs and serve the interests of those involved in medical negligence disputes and whether mediation could and should be used as a more constructive means of resolving such disputes. In doing so we did not examine issues relating to the prevention of negligent incidents happening. That did not fall within the scope of our work.

1.6 We recognised that the merits, or otherwise, of mediation cannot be completely divorced from costs and sought to establish the potential financial impact of it. Some suggest it would have a cost saving impact; others suggest the opposite. But insufficient data exists on which we could reach a fully conclusive and objective view, one way or the other. We do, however, discuss throughout the report cost issues that need to be borne in mind by those who set and implement the policies governing the resolution of medical negligence disputes.

[1]For the purposes of this report the term "medical negligence" is defined as also covering the term "clinical negligence".

1.7 Medical negligence is the term given to a breach of duty of care by healthcare professions in the performance of their duties towards patients. Healthcare professions include medical, dental, nursing, midwifery and other professions allied to medicine. Put simply, a duty of care is breached if a healthcare practitioner takes a course of action that no practitioner of ordinary skill in the same situation would have chosen, had he or she been taking reasonable care. Disputes arising from alleged medical negligence often involve delicate, difficult and emotional issues. They can be protracted, antagonistic and stressful for all concerned. Elements of trust and care which are a vital part of a doctor / patient relationship can easily be lost, and publicity – which can be unbalanced – may cause unnecessary damage to the parties. The dispute resolution process influences all of this.

1.8 Where patients consider that a duty of care has been breached they can have recourse to a civil legal remedy through litigation and / or the Complaints Procedures[2]. In some situations the matter may be dealt with through various disciplinary processes, for example, those regulated by the General Medical and Dental Councils, or through other legal procedures, for example, criminal proceedings or fatal accident inquiries.

1.9 Most disputes concerning an alleged breach of a duty of care follow the litigation and / or the Complaints Procedures route. From the outset, many disputes move to litigation, but some may begin, and end, through the procedures. Some may also begin there and subsequently move to litigation. The procedures can be the pivotal element of a dispute. We have therefore considered mediation in the context of both of these resolution avenues. In doing so we recognise the potential interaction with disciplinary processes and other legal procedures and touch on this in chapter 6.

Our evidence

1.10 In collecting our evidence we:

- Sought and received oral and written evidence from a wide range of sources from both within and out-with the Scottish jurisdiction. These sources of evidence are listed at Annex B.

- Sought and received oral and written evidence from members of the public and individual members of the medical and legal professions, including those with personal experiences of medical negligence disputes.

- Held a discussion seminar which was attended by around 70 participants comprising representatives from the legal and medical professions, the health services, patient interests, and the Scottish Executive. This also included patients and practitioners with personal experiences of medical negligence disputes. A separate Executive Report of this seminar has been published[3].

1.11 We are extremely grateful to all those who took the time to provide evidence and to attend the seminar. Without this we could not have undertaken our examination properly. We are particularly grateful to those individuals who were prepared to share their personal experiences. Their evidence was crucial in enabling us to reach a fully reasoned judgement before making our recommendations.

[2]For the purposes of this report the term "the Complaints Procedures" or "the procedures" cover both the NHS and Private Healthcare Sector procedures.
[3]Royal Society of Edinburgh: "Mediating patients and health services disputes in Scotland" - 19 November 2001, fifth report in "Scotland's Wellbeing" Public Policy Seminar Programme 2000-2001.

Chapter 2

Conclusions and recommendations

< main

conclusions

2.1 This chapter summarises our main conclusions and our recommendations.

Main conclusions

2.2 Litigation has and must continue to have a place in resolving medical negligence disputes, but should be used only as a last resort. We believe that litigation should be avoided unless absolutely necessary, and all those involved in medical negligence cases should work to reduce the number of cases that follow this route – (paragraphs 6.2, 6.12 and 6.13)

2.3 There is a need to improve the Complaints Procedures. Mediation offers a possible means of achieving that improvement – (paragraph 6.23)

2.4 In considering mediation against a quantitative (i.e. number of medical negligence claims and financial costs) background, there is a reasonable argument that says there is no pressing need for it. Also, in the absence of sufficient data, we cannot reach an objective conclusion on the financial savings, or otherwise, that mediation would add. In that respect, a lot will depend on the stage at which it is used. It is, however, important not to be guided by quantity alone. There is an equally important qualitative dimension; a need for qualitative improvement in how medical negligence (and non-clinical) disputes are resolved, seeking outcomes that have a more encouraging impact on attitudes, culture, perceptions and relationships – (paragraphs 6.27, 6.28 and 6.30)

2.5 Mediation confers a number of advantages and may create some disadvantages. We believe that the advantages clearly outweigh the disadvantages. Mediation is a process that would add qualitative value – (paragraphs 6.24, 6.28, 6.39 and 6.41)

2.6 We can identify no cogent argument that supports a rejection of mediation, and consider that it offers the potential to achieve the qualitative improvement needed. But it is not a universal panacea, its potential lies in being an option to litigation and / or the Complaints Procedures, not a replacement for them – (paragraph 6.38)

2.7 Mediation or agreements reached through it should not restrict the scope of regulatory bodies, criminal proceedings or Fatal Accident Inquiries – (paragraphs 6.42 – 6.45)

2.8 Compulsory mediation that removes any recourse to litigation would be inconsistent with Article 6 of the European Convention on Human Rights. There is no question of making it compulsory – (paragraph 7.12)

2.9 We do not argue against the general principle that very few cases are unsuitable for mediation at some stage, and see no reason why the starting presumption for the resolution of all medical negligence (and non-clinical) disputes cannot be that mediation is appropriate. However, there will be cases for which mediation is inappropriate. We suggest it is unlikely to be suitable for resolving a dispute if: – (paragraphs 7.18 and 7.19)

- Either party is not willing or able to participate.
- Doing so would not be within the public interest.
- Doing so would not enable legal or other precedent that needs to be set.
- Publicity is sought.
- Regulatory proceedings of professional bodies are ongoing.
- Criminal proceedings are ongoing.

2.10 To be most effective, mediation should happen at the earliest possible stage of a dispute, and once both parties are sufficiently prepared. It can also be effective and can be used at all stages prior to resolution – (paragraph 7.22)

2.11 Mediation will not become a practical option, or be used as a resolution process more regularly, simply by advocating its merits and the potential it offers. For that to happen, issues of culture, education, funding and process need to be addressed – (paragraph 8.1)

2.12 To encourage the greater use of mediation, existing cultures and attitudes need to change. Raising awareness about mediation would make a major contribution to this – (paragraphs 8.18 and 8.20)

2.13 Mediation must be a credible service that can meet demand – (paragraph 9.1)

Summary of recommendations

Process

2.14 The Scottish Executive should, in conjunction with the National Health Service Scotland Central Legal Office (CLO), undertake a fully researched mediation project mirroring that being undertaken by the National Health Service Litigation Authority (NHSLA) in England – (paragraph 8.5)

2.15 The Medical Defence Organisations (MDOs) should undertake appropriate mediation projects that, like the recommended CLO project, require mediation to be offered wherever appropriate and suitable – (paragraph 8.7)

2.16 The Scottish Executive should work closely with the MDOs in developing its research into the CLO project to achieve, as far as is possible, an integrated research outcome – (paragraph 8.8)

2.17 The courts in Scotland should consider adopting the principles which are outlined in the pre-action protocol for the resolution of clinical disputes in England (see Annex C) which has been promoted by the Clinical Disputes Forum – (paragraph 8.10)

2.18 The courts should consider the introduction of appropriate rules of court to encourage parties to consider the option of mediation – (paragraph 8.13)

2.19 Statutory protection, similar to that which already exists for mediation in family matters, should be provided regarding the admissibility of evidence – (paragraph 8.17)

Culture and education

2.20 The relevant professional and patient representation bodies, supportive of mediation in medical negligence (and non-clinical) disputes, should issue public statements of policy intent. In support of the CLO project, the Scottish Executive should also provide a statement of policy intent to NHS Trusts and Boards – (paragraph 8.23)

2.21 The Scottish Executive should give active consideration to encouraging "NHS Education for Scotland", in partnership with all interested stakeholders, to promote mediation training and awareness. In doing so, five specific steps the partnership should consider are: – (paragraph 8.25)

- Providing public and patient guidance.
- Promoting education through undergraduate training in medicine, nursing, and law (e.g. the law, medical and dental schools, incorporating the role and process of mediation within their core curricula).
- Promoting a programme of Continuing Professional Development (CPD) training for lawyers, judges and health care practitioners.
- Promoting a programme of education and training for health services administrators (e.g. Complaints Managers / Officers).
- Facilitating the development and implementation of mediation.

< summary of recommendations

2.22 Some of these matters can and should also be addressed directly by law schools, medical and dental schools, judicial training bodies and others, such as professional institutions and patient representation organisations. These bodies should take the necessary steps to achieve this in keeping with the partnership approach recommended – (paragraph 8.26)

Funding

2.23 In granting legal aid in medical negligence cases a condition(s) to consider the use of mediation at a particular stage or stages, should be built into the process by the Scottish Legal Aid Board (SLAB) – (paragraph 8.34)

2.24 SLAB should have a promotional and training role in relation to raising the awareness and understanding of both solicitors and legal aid applicants as regards mediation in medical negligence disputes – (paragraph 8.35)

2.25 Where appropriate, the defence gateways (CLO and MDOs) should consider meeting the costs of the mediation process – (paragraph 8.37)

Complaints procedures

2.26 The Scottish Executive, in its current review of the NHS Complaints Procedures in Scotland, should consider mediation as being an integral option in the process of resolving non-medical negligence disputes – (paragraph 8.42)

2.27 The Health Services should take steps to enable and encourage a greater and more effective use of conciliation within the Complaints Procedures, with a view to avoiding the need for any further Alternative Dispute Resolution (ADR), including mediation – (paragraph 8.43)

Service provision

2.28 Four general principles should be considered in establishing mediation service provision: – (paragraph 9.3)

- The provider must be, and be seen to be, wholly independent of both parties and the systems. If the mediator is not independent the credibility of mediation will diminish.
- Encouraging the growth of an indigenous mediation service in Scotland. This will build confidence in the service and allow it to meet the particular needs of Scottish health services while recognising the specialities of Scots law and procedure. But we should not be parochial. We should, if need be, draw on the experience of mediation providers from elsewhere in the United Kingdom.
- The creation of any new service provision body would be inappropriate at the present time. There are insufficient medical negligence claims in any one year to justify that. We also do not see a single body as being conducive to what we say about independence.
- The most important attribute of an effective mediator should be excellence in the skills required in the process of mediation. It is not a prerequisite of mediating medical negligence disputes to have knowledge of medical terminology and issues.

Setting and maintaining standards

2.29 There should be set and regulated national standards for mediators who are engaged to mediate medical negligence disputes, or non-clinical disputes in a clinical context. In the meantime, the minimum competence criteria should include: – (paragraph 9.5)

- A programme of mediation training (lasting a minimum of 3-4 days).
- A separate assessment and accreditation stage with set competence criteria.
- A regular CPD programme for accredited mediators to maintain skills (2-3 days per annum).
- Confidential debriefing following mediations.

2.30 In the intervening period those mediators who are accredited by recognised mediation and legal bodies in the United Kingdom, and who have fulfilled the minimum competence criteria, should be recognised as being potentially acceptable to mediate – (paragraph 9.7)

2.31 The Scottish Executive should establish a Medical Disputes Forum (MDF) comprising relevant stakeholders to consider, develop and implement quality standards relevant to mediating medical negligence (and non-clinical in a clinical context) disputes – (paragraph 9.8)

2.32 Service providers should adhere to good practice standards for delivering mediation services. The setting and implementation of these should fall to the MDF. The standards that should be included are: – (paragraph 9.9)

- Handling pre-mediation inquiries and offering objective advice about suitability of cases for mediation.
- Providing literature about the mediation process.
- Arranging the venue for the mediation.
- Handling the exchange of information prior to the mediation.
- Providing an appropriate form of agreement to mediate.
- Conducting such pre-mediation meetings as may be necessary.
- Providing appropriate post-mediation advice and follow up.
- Binding all mediators to a published Code of Conduct, covering confidentiality, ethics, equal treatment and independence.
- Ensuring all mediators have professional indemnity cover.
- Providing a consistent pricing policy.
- Providing adequate administrative arrangements.

2.33 In the longer-term there should be clearly defined monitoring and evaluation arrangements in place. This should be a matter for the MDF to consider and implement – (paragraph 9.10)

< summary of recommendations

2.34 The mediation process must ensure, as far as is reasonable, that a balance of power exists throughout between patients and the health services. This should be built into the Code of Conduct – (paragraph 9.12)

2.35 No one should be excluded from using mediation. It must be an option available to all. Ensuring equality should be built into the Code of Conduct – (paragraph 9.13)

< summary of recommendations

Chapter 3

What is mediation?

3.1 This chapter puts mediation into context in relation to Alternative Dispute Resolution (ADR) and provides a working definition of it and its core features. In doing so it does not provide any absolute definitions, or exhaustive descriptions. Its purpose is to provide readers with a better understanding of what it is, its features and the background against which we took forward our considerations.

Putting it in context

3.2 Mediation is one method of ADR. There are many other forms, for example, arbitration, administrative tribunals, ombudsman, and in the case of the subject under consideration, the Complaints Procedures. All are methods of resolving disputes without using the court system, but each has its own unique structure and process. Mediation differs fundamentally from most other methods in that it does not result in a determinative adjudication and seeks a solution that is determined by and satisfies all parties. It is part of a wider movement towards a more co-operative and consensual approach to conflict. At an international level, mediation and other forms of ADR to prevent the escalation of conflict and to manage conflict are well recognised. In commerce and industry, much more attention is now given to managing staff relations and disputes with consumers on a co-operative basis. Many organisations and businesses now include statements of policy designed to promote co-operative dispute resolution. Mediation as a process to resolve disputes is growing and encouraged in many countries.

A definition

3.3 Proponents of mediation offer numerous definitions of it. These definitions vary markedly and may conflict depending on who the provider is, the ideology, style, and practice of the mediator, and the characteristics of the dispute. Metzloff[4] argued that it is "one of the most overused and misunderstood terms in the ADR lexicon".

3.4 There is no absolute definition of mediation that can be lifted from the shelf. However, for purposes of our considerations we define it as being:

"A non-judicial, informal forum for the voluntary settlement of disputes, in which an impartial third party is used to facilitate communication between parties to promote reconciliation and understanding among them and settlement of the dispute. The primary responsibility for the resolution of the dispute rests with parties, not the mediator." [5]

[4]Metzloff, T. (1992) Alternative dispute resolution strategies in medical malpractice, Alaska Law Review, 9(2): Pg. 440.
[5]Alma Saravia, (1999) Overview of Alternative Dispute Resolution in Healthcare Disputes, Vol. 32, No. 1, HOSPLW Pg. 139.

Its core features

3.5 While a variety of definitions exist, the process of mediation is underpinned by a number of core features. These are:

- Unless both parties in dispute decide otherwise, it is a private and confidential process.
- It operates within a flexible framework, determined by the nature of the matter in dispute and the needs of the parties. There are no set procedures that must be followed, or outcomes that must be reached. The setting is less adversarial than court.
- The mediator is entirely independent of the parties and his or her authority derives from appointment by the parties and his or her ability to gain the trust of the parties. He or she has no power to issue a decision or make a ruling.
- All discussions are without prejudice and non-binding unless and until a settlement is achieved. All legal and other rights are reserved.
- Mediation works best when parties are well prepared and have the desire and authority to achieve a mutually acceptable resolution.
- Parties are free to leave the process whenever they wish and resort to other resolution processes, including litigation.

Chapter 4

The Scottish context

4.1 We mention in our introduction that there is much public concern voiced about a rising number of medical negligence cases and rising costs. But to what extent are these quantitative concerns justified in Scotland? How many cases are there? How much is it costing?

4.2 Our specific remit was to "explore the scope for using mediation". But what is the existing field of activity in Scotland? To what extent is it already being used?

4.3 This chapter considers these questions. It looks at medical negligence and the use of mediation in the context of litigation and the Complaints Procedures, and the use of mediation in a wider context.

Litigation: claims, costs and incidence

Claims

4.4 Claims arising in Scotland are dealt with in one of two ways. Those made against a NHS health body are handled by the National Health Service Scotland Central Legal Office (CLO) which on average deals with around 65 – 75% of all medical negligence claims made in Scotland in any one year. Those made against General Dental Practitioners (GDPs) General Medical Practitioners (GPs) and Private Healthcare Practitioners are handled by the Medical Defence Organisations (MDOs) – the main player in Scotland being the Medical and Dental Defence Union of Scotland (MDDUS), which represents the vast majority of GDPs, GPs and Private Practitioners in Scotland. The CLO and the MDOs assess the likelihood of a claim being successful and advise defenders on whether to seek a settlement or defend any resulting litigation.

4.5 For reasons of commercial confidentiality, the MDDUS was unable to publicise figures relating to the number of claims it handles, and against that background we saw no value in seeking figures from the other MDOs. We cannot therefore provide a complete picture for Scotland. We have however, provided figures on the number of medical negligence claims lodged with the CLO over the period 1997-2000. This is shown at figure 3.1.

FIGURE 3.1[6]
The number of medical negligence claims lodged with the CLO over the period 1997 - 2000

'97-'98 **520**

'98-'99 **524**

'99-'00 **482**

4.6 The number of claims has remained consistent in recent years, with a downward trend showing in 1999-2000, but they do not provide a parameter for the future. Medical negligence is unpredictable in terms of claim numbers in any one year. We understand from MDDUS that over the same period the rate of rise of claims it handles has decreased, although there has been a small increase in actual claim numbers.

4.7 The number of claims lodged with the CLO are markedly different to those actually settled. On average, 70% of all claims lodged are, for a variety of reasons, abandoned or dismissed at different stages. Of the remaining claims, around 25% are settled out of the Court and less than 5% ultimately go to trial. A similar picture emerges as regards MDDUS claims, with, on average, 65% of claims being abandoned or dismissed and less than 5% going to trial.

[6]Source: Scottish Executive response to Scottish Parliament Audit Committee hearing on 23 January 2001.

4.8 How long does it take those that are not abandoned or dismissed to settle? That varies according to the circumstances and complexity in each case, but the CLO estimate the average length of time of a formal claim to the date when compensation is paid to be 3.5 years; the MDDUS 4.5 years.

Costs

4.9 There are four different elements that make up the full cost picture, and it is important to draw a clear distinction between them. Firstly, there is the value of claims, which is the assessment of the financial liability of all outstanding and potential claims, i.e., what theoretically might have to be paid out to claimants, not what is actually paid out to them. Figure 3.2 shows the values over the period 1997-2000.

FIGURE 3.2[7]
The value of claims over the period 1997 - 2000

'97-'98
CLO **£45.7m**
MDDUS **£?m**
TOTAL **£?m**

'98-'99
CLO **£61.4m**
MDDUS **£37.0m**
TOTAL **£98.4m**

'99-'00
CLO **£84.1m**
MDDUS **£36.0m**
TOTAL **£120.1m**

4.10 As can be seen, the total overall value of claims has markedly increased over the period, with a 22% increase between 1998 and 2000; and what would undoubtedly be an even greater percentage increase between 1997 and 2000. Such an increase does not of course sit with the reduction in the number of CLO claims lodged, or the decrease in the rate of rise of MDDUS claims. It is, however, partly explained by fluctuating values, whereby a higher likely settlement value is attached to existing claims against a background of case law. This pushes the calculation of damages in an upward direction. Two recent decisions in England (*Wells v Wells*[8] and *Heil v Rankin*[9]) had a specific effect on increasing the values of claims. *Wells* by applying a 3% discount rate to the calculation of future losses, so as to produce a substantial increase in the multipliers used by the court; and *Heil* by determining that, in cases of significant value, claims have been undervalued by the courts and an increase on past awards of about one-third is justified. The increase may also be partly explained by the reporting of new claims that occurred some years ago.

4.11 The value of claims does not represent a sum of money that could otherwise be used for healthcare provision. Trusts, Boards, GDPs, GPs and Private Providers do not set aside resources to cover this. Instead, they pay risk indemnity premiums, which in the case of Trusts and Boards is to a central NHS scheme known as the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS); and for GDPs, GPs and Private Providers is to the MDOs. But the amount of premium paid is influenced partly by the values of existing claims. It therefore follows that the higher the value, the higher the premium.

FIGURE 3.3[10]
Money paid to claimants by the CLO over the period 1997 - 2000

'97-'98 **£4.1m**

'98-'99 **£4.4m**

'99-'00 **£3.5m**

4.12 The second cost element is the amount of money actually paid out to claimants in respect of claims successfully made. As with claims, the MDDUS was unable, because of commercial confidentiality, to provide figures. Figure 3.3 therefore only shows the amounts paid out by the CLO over the period 1997-2000. These include not only the amounts of damages paid, but also the adverse costs paid, i.e., the legal costs of the claimant where these have been awarded against the defenders.

4.13 While the value of claims has risen significantly, the actual money paid out to claimants has remained relatively constant over the period. These costs are small in comparison to the values set, equating to less than £1 per head of population. We understand from MDDUS that over the same period the amount it has paid out has also remained fairly constant, although has been subject to a small rise.

[7]Sources: "Overview of the NHS in Scotland 1999/2000" – Audit Scotland; and MDDUS.
[8]Reference: Wells - [1999] 1 A.C. 345.
[9]Reference: Heil - [2000] 2 W. L. R. 1173.
[10]Sources: "Overview of the NHS in Scotland 1999/2000" – Audit Scotland.

4.14 The third element is claimants' costs. Funding for this has to be arranged to enable a claim to be pursued. In some cases the costs are met entirely privately. In such cases there is no call on taxpayers' money. But in other cases, costs are covered through legal aid, which, subject to eligibility tests, can be made available through advice and assistance, which covers matters that do not go as far as court proceedings; and civil legal aid, which covers representation at proceedings. In either case, if a claimant succeeds in his or her claim, the costs are normally recovered from the defenders (CLO and MDOs).

Legal aid

4.15 The Scottish Legal Aid Board's (SLAB) civil legal aid system contains no separate classification for medical negligence; it is subsumed within a far larger reparation category. Detailed information on civil legal aid applications, grants and costs is not therefore available. However, a broad analysis done by SLAB estimates that in 2000-2001 the number of applications relating to medical negligence was around 310; the number of applications granted was around 160.

4.16 A small sample of final accounts received for cases granted in the last three years showed varying costs, ranging from £50 to more than £12,000. Using the average cost of the sample, and the estimated number of grants in 2000-2001 as indicators, SLAB estimate the gross cost (including VAT) to the public purse as being around £450,000 per year. The net cost to the public purse would, however, be lower as a result of being offset by any financial contributions from applicants and awards of expenses or damages in successful cases.

4.17 SLAB's analysis showed greater activity as regards advice and assistance, with around 1300 relevant intimations of advice and assistance being received for 1999-2000; and around 1400 for 2000-2001. By June 2001, 664 accounts were submitted for intimations received in 1999-2000. Payments ranged from £0 to £1,600. The total sum was just over £170,000. The total cost to the public purse will increase once all accounts are submitted, but not all intimations result in an account. The costs of some cases are wholly covered by financial contributions from applicants. Also, if a case is resolved under advice and assistance and a financial award is made, it is, as in civil legal aid, used to cover the costs.

4.18 The fourth and final element is defence costs. The cost of each claim or action varies. It is dependent on a number of factors, including complexity, the cost of independent experts, the cost of Counsel – if required, the number of procedural hearings and whether a proof is in fact ever heard. As a broad indicator the CLO estimates the average cost of a claim as incurring charges of £500; and a Court of Session action £6,500. Again, the MDDUS was unable to provide figures regarding its defence costs.

Incidence

4.19 A large number of people receive healthcare treatment in Scotland each year. In 1999-2000, NHS hospital activity accounted for around 8 million cases and there were around 16 million general practitioner consultations[11]. The potential for medical negligence disputes arising is therefore considerable. The reported incidence is, however, low. Using the

[11]Source: NHS Hospital Activity - Office of National Statistics; GP Consultations - 2000-2001 estimate, Information and Statistics Division, NHS Scotland.

1999-2000 NHS hospital activity figure as a broad illustration over any given year, in each year over the period 1997-2000 only around 0.007% of cases resulted in litigation claims (figure 3.1) of alleged medical negligence.

4.20 Of course the figure only provides a very broad illustration. It does not, for example, account for any claims that, for whatever reason, patients chose not to make. No information is available regarding this. Nor does it account for claims handled by the MDOs. Claims often also relate to cases in an earlier year, so activity in any one year cannot be reconciled against the number of claims in that year. Nevertheless, they do put the extent of incidence into some context, and even allowing for what they do not account for, the overall level of incidence is very low.

Complaints procedures: complaints and costs

4.21 The NHS and Private Healthcare Providers operate complaints procedures that differ in terminology, but broadly comprise the same three stages – local resolution, independent review / appeal and the involvement of an external adjudicator, which in the case of the NHS is the Health Service Commissioner.

NHS and GP complaints

4.22 Information available on NHS complaints categorises them as covering: staffing issues; procedural issues; waiting times; treatment; delay; transport; environment / domestic; and others. Figure 3.4 shows the total number of NHS complaints over the period 1997-2000 – which has remained fairly constant; and GP complaints over the same period – which show a rising trend, with a 79% increase between 1997-1998 and 1999-2000. Like litigation claims these figures cannot necessarily, however, be used as parameters for the future.

4.23 Very limited and variable information is available on the proportion of complaints directly or indirectly attributable to medical negligence or, for example, of cases beginning in the Complaints Procedures and subsequently moving to the litigation process. The extent of medical negligence cases being handled through the Complaints Procedures cannot therefore be meaningfully shown.

Private healthcare complaints

4.24 Procedures set by the Independent Healthcare Association (IHA) govern the handling of complaints in around 95% of the acute and mental healthcare private sectors in the United Kingdom. Information on the total number of complaints received by that sector in Scotland in the period 1997-2000 is not available, but figure 3.5 provides some indication of the numbers that arose, and of the % of complaints that became negligence claims.

4.25 We did not obtain any statistical information regarding complaints made within the remainder of the private health care sector, such as private nursing homes.

FIGURE 3.4[12,13]
The total number of NHS complaints and GP complaints over the period 1997 - 2000

	NHS	GP	Total
'97-'98	10,993	177	11,170
'98-'99	11,251	268	11,519
'99-'00	10,813	316	11,129

FIGURE 3.5[14]
The numbers of complaints made to Scottish independent hospitals and the % that became negligence claims over the period 1997 - 2000

	Number of complaints	% that became negligence claims
'97-'98	88 (42% of hospitals had no record)	2.3
'98-'99	193 (28% of hospitals had no record)	1.5
'99-'00	302 (all recorded)	3

[12]Source: Information and Statistics Division, NHS Scotland.
[13]Source: Medical and Dental Defence Union Scotland which indemnifies more than 90%, but not all GPs in Scotland.
[14]Survey by Scottish Independent Hospitals Association - October 2001; based on 77.8% response.

Patient costs

4.26 The Complaints Procedures do not impose any financial costs on patients, and in many cases, particularly those concluded at the local resolution stage, there are no costs – save sundry costs such as post and travel. But there are cases where patients may incur costs, for example, to obtain expert or independent advice. No information is available to show the financial costs that fall to patients who lodge complaints. Nevertheless, it is important in setting the context to recognise that a cost element can exist for patients.

Healthcare provider costs

4.27 Healthcare providers incur administrative and staffing costs. These vary significantly in each case and depend on the complexity of the issue of complaint, and the stage of the procedure the complaint has reached. NHS Trusts and Health Boards do not maintain detailed records of costs. Nor have we been able to obtain information on costs in the private healthcare sector. A detailed or complete cost picture cannot therefore be given. However, a recent survey[15] indicates that the cost of an NHS complaint can range anywhere between £200 and £3,000.

Use of mediation

4.28 In Scotland little use has so far been made of mediation to resolve medical negligence disputes. We are aware of only one case in which it has been used.

4.29 The current NHS Complaints Procedures do not include mediation per se, but do offer conciliation, arguably mediation by another name, as a voluntary option available to both patients and healthcare providers – both parties having to agree to the process. Its aim is to help the resolution of a complaint at local level, but fairly minimal use is currently made of it. A recent survey[16] showed that during 1 April 2000 – 31 March 2001, 19 Trusts had used it on 30 occasions and 10 Health Boards had used it on 17 occasions. Extrapolating the average to all Trusts (29) and Health Boards (15) would give a total of around 71 conciliations over the period. Using the 1999-2000 complaints figure as an illustration of the total number of complaints over a given year, conciliation was used in less than 0.7 % of the cases during 2000-2001.

4.30 These figures provide part, but not the whole, of the picture on conciliation. They do not account for the number of cases when it was offered by a Trust / Health Board and refused by the patient – and in turn the reasons for the refusal, or the number of cases where it was not necessary or appropriate. Information on that is not available.

4.31 While the IHA Code of Practice for Handling Patients' Complaints offers the option of employing mediation at the local resolution stage, we understand that it is not something that has so far been widely used in Scotland (or indeed elsewhere in the United Kingdom). But the IHA perception is that the use of mediation as part of its complaint procedures is slowly growing.

[15] Scottish Executive enquiry of Trusts and Health Boards - August 2001.
[16] Scottish Executive enquiry of Trusts and Health Boards - August 2001.

Use of mediation in a wider context

4.32 The CLO has been involved in two mediations arising out of the contract of employment of an employee. In Scotland, there have also been mediations in a number of other matters, including IT and computers, employment, commercial contracts, construction projects, partnership, landlord and tenant, professional services and alleged professional negligence of other professionals. The Citizens Advice Bureau has operated a mediation scheme for a number of years through Edinburgh Sheriff Court. Neighbourhood mediation is promoted and encouraged by local authorities and SACRO (Safer Communities and Reducing Offending). Family mediation has been well established for a number of years, having developed from disputes involving children to the full range of matters arising in matrimonial disputes, including financial provision.

4.33 The Scottish Legal Aid Board has for a number of years allowed the costs of family mediation to be paid under advice and assistance or civil legal aid. In March 2001 it extended the coverage to include non-family cases. The response to that has, however, been negligible, with only one request, which did not relate to a medical negligence case, having been received.

4.34 Despite these various different activities, a survey[17] into the experiences of ordinary citizens dealing with problems that could ultimately end in the civil courts, suggests that in Scotland, at the date of the survey and in the areas surveyed, the use of ADR processes such as mediation is negligible. It offers probable reasons for this as being lack of knowledge about ADR services among the general public and to some extent among advisers and the legal profession; and also principled objections to the compromise of legal rights and entitlements. On the other hand it shows that 80% of respondents prefer to resolve disputes by agreement.

[17] Paths to Justice Scotland: What People in Scotland Do and Think About Going to Law: ISBN 1-84113-040-0.

Chapter 5

Position in other jurisdictions

5.1 This chapter discusses medical negligence disputes in other United Kingdom jurisdictions, and the use of mediation in these and in the jurisdictions of Australia, New Zealand and the USA.

Drawing comparability with Scotland

5.2 Different legal environments, organisational arrangements, aggregated information, types of claims – and in the case of the international jurisdictions, differences in other fields such as social security etc, make it impossible to provide a like-with-like comparison to the position in Scotland. We have not therefore attempted to do this. We have, however, gathered evidence that puts the litigation position in other United Kingdom jurisdictions into some context, and enables very general comparisons to be made with the position in Scotland. We have not done likewise as regards the international jurisdictions. For these we focus solely on the role mediation is playing.

Medical negligence: claims, costs and incidence in other United Kingdom jurisdictions

England

Claims and incidence

5.3 In 1999-2000 around 10,000[18] new medical negligence litigation claims were received. In the same period, NHS hospital activity accounted for around 74 million cases and there were around 200 million general practitioner consultations[19]. Using the NHS hospital activity as a broadly illustrative figure (as we did in Chapter 4 for Scotland) suggests that the incidence of alleged medical negligence in relation to cases in a given year is not significantly different to the incidence in Scotland.

Costs[20]

5.4 In 1997-1998 the provision to meet outstanding claims was £1.7 billion. In 1999-2000 it was £2.6 billion; a 65% increase.

5.5 In 1997-1998 the amount paid as settlement totalled £144 million, or around £3 per head of population. In 1999-2000 the settlement total was £373 million, or around £7 per head of population[21]. These upward trends show an increase of around 159% in total costs; and an increase of around 133% per head of population. The settlement costs include the amount of compensation paid to patients and the total amount paid to lawyers for both the NHS and claimants, but no information is available on the proportions that relate to compensation and legal costs (which are, we understand, usually significantly higher than in Scotland). Information is also not available on claims administration and staffing costs, which are excluded from the settlement total.

[18]Source: "Handling Clinical Negligence Claims in England" – Report by the Comptroller and Auditor General – 3 May 2001: Does not include claims handled by Medical Defence Organisations.
[19]Source: Office of National Statistics. GP Consultation based on 1998 figures which showed average of 4 consultations per head of population over the year.
[20]Source: "Handling Clinical Negligence Claims in England" – Report by the Comptroller and Auditor General – 3 May 2001.
[21]Source: House of Commons Parliamentary Answer – 20 July 2001: Col 735W.

5.6 These figures show a marked rising trend in England. They cannot, however, be taken solely at face value. They must be considered against the background of the unpredictability of claim numbers, when / if they are settled, fluctuating values and the distortion to the overall picture that can be brought by a single large settlement in any one year. This is borne out by the fact that the total settlement cost for 1996-1997 was £235 million[22]. Which, when looked at against the 1997-1998 cost, would show a downward trend; and against the 1999-2000 cost would show a lower percentage increase, but a continuing rising trend nonetheless.

5.7 The average time taken from the date of a formal claim to the date when compensation is paid is estimated to be 5.5 years.

Wales

Claims and incidence

5.8 In 1999-2000 over 700[23] new medical negligence litigation claims were received. In the same period, NHS hospital activity accounted for around 4 million cases and there were around 18 million general practitioner consultations[24]. Using the NHS hospital activity as a broadly illustrative figure suggests, as in England, that the incidence of alleged medical negligence in relation to cases in a given year is not significantly different to the incidence in Scotland.

Costs[25]

5.9 In March 1997 the provision to meet outstanding claims was £70 million. At March 2000 the provision was £93.7 million; a 34% increase.

5.10 In 1999-2000 the amount paid as settlement was £26.9 million, or around £9 per head of population. This represents a 42% increase on the previous year. The settlement costs exclude the claims administration and staffing costs. The limited information available regarding this estimates that these costs totalled around £1.5m in 1999-2000. As in England, these figures show a marked rising trend, but for the same reasons there, they cannot be taken solely at face value.

5.11 The average time taken from the date of a formal claim to the date when compensation is paid is estimated to be 2.5 years.

Northern Ireland

5.12 The Northern Ireland National Audit Office has undertaken a medical negligence audit similar to its counterparts in England & Wales. At the time of completing our work it had not been published.

[22]See note 21
[23]Source: "Clinical Negligence in the NHS in Wales" – Report by the Auditor General for Wales – 23 February 2001: Does not include claims handled by Medical Defence Organisations.
[24]Source: NHS Hospital Activity – Office of National Statistics; GP Consultations National Assembly for Wales – 1999 estimate.
[25]Source: "Clinical Negligence in the NHS in Wales" – Report by the Auditor General for Wales – 23 February 2001.

Medical negligence: role of mediation in other United Kingdom jurisdictions

England and Wales

5.13 Lord Woolf's *Access to Justice Report* in July 1996, which covered all types of civil actions in England & Wales, recommended that patients and their advisers should work more closely together to try and resolve disputes co-operatively, through non-litigious solutions, rather than proceeding to litigation. It specifically recommended a pre-action protocol for medical negligence cases. The purpose of the protocol being to: encourage greater openness between parties; encourage parties to find the most appropriate way of resolving a dispute; reducing delay and costs; and reducing the need for litigation.

5.14 A pre-action protocol[26] was introduced in April 1999 (shown at Annex C). New Civil Procedure Rules of court and practice directions were also implemented. These enabled the courts to treat the standards set in the protocol as the normal reasonable approach to pre-action conduct. If proceedings are issued it is for the court to decide if there has been compliance with the protocol. If it determines there has not, it can impose cost sanctions and penal interest payments sanctions. The protocol does not prescribe mediation, or any other method of dispute resolution that parties must or should follow, but does reinforce the message that the increasing expectation of the courts is for parties to have tried to settle their differences by agreement before issuing proceedings.

5.15 That expectation is being driven by judges who are increasingly encouraging the use of mediation and other methods of ADR. The Court of Appeal in England has recently stated that the courts should use their powers under the new Civil Procedure Rules to ensure that disputes between public authorities and members of the public are resolved with the minimum involvement of the courts. The Lord Chief Justice said "Without need for the vast costs that must have been incurred, the parties should have been able to come to a sensible conclusion as to how to dispose of the issues which divided them. If they could not do that without help, then an independent mediator should have been recruited to assist." He added "Today, sufficient should be known about alternative dispute resolution to make failure to adopt it, in particular when public money is involved, indefensible."[27] There is also some evidence of more pro-active approaches being taken by the Assigned Masters of the Queen's Bench Division, who handle all High Court medical negligence actions in London. Both Masters are becoming increasingly interested in discussing mediation with parties at case management conferences.

5.16 It is too early to assess properly the impact of the Woolf reforms and limited information is available regarding this. However, mediation is being used increasingly in a wide range of disputes.[28] An early evaluation of the overall reforms by the Lord Chancellor's Department[29] also reports a drop in the number of civil claims since the introduction of the reforms, in particular in the types of claims where the new Civil Procedure Rules have been introduced. Anecdotally, the pre-action protocol is also said to be having an encouraging effect on settling cases before the issue of proceedings.

5.17 Between 1995-1998 a medical negligence mediation pilot operated in the NHS regions of Anglia and Oxford and Northern and Yorkshire. This was in response to criticisms made of the way negligence claims were handled and concerns about increasing incidence. It anticipated up to 40 cases would be mediated, but realised only 12 cases. A report by the House of Commons Health Select Committee on its inquiry into adverse clinical incidents and outcomes in medical care[30] considered scepticism and ignorance on the part of the legal profession; a lack of awareness by patients, clinicians and trusts; and an absence of formal support of the process by the NHS, as reasons why only a small number of cases were referred to mediation.

5.18 In publishing the pilot report[31] ("The Mulcahy Report") in February 2000, the Department of Health reinforced a drive to use mediation by stating that it expected NHS Trusts and Health Authorities, in line with the pre-action protocol, to consider the use of mediation as a method of resolving clinical disputes. Evidence shows that this drive initially achieved only a minimal impact. Only 2% of Trusts in England usually offer mediation[32]. In Wales, responses to a survey[33] showed that, as a whole, NHS Trusts rarely offer mediation to patients. Two Trusts did usually offer it, but nine have never done so. The position on the remaining four is not recorded.

[26]Produced by the Clinical Disputes Forum.
[27]Cowl & Others v Plymouth City Council 14 December 2001 – The Times 8 January 2002.
[28]Centre for Effective Dispute Resolution reported a 141% increase in 1999-2000.
[29]Emerging Findings: An early evaluation of the Civil Justice Reforms, Lord Chancellor's Department, March 2001.

5.19 That impact is further demonstrated by the initial results of a pilot exercise being run by the National Health Service Litigation Authority (NHSLA). Since June 2000 it has required its solicitors to offer mediation wherever appropriate and suitable. During the first year of the exercise, the NHSLA offered mediation in 106 medical negligence cases; claimants requested it in 31 cases. But during the period only 9 cases actually proceeded to mediation. The primary reasons for this very low uptake being rejection based on no response by claimants' solicitors, cases being concluded by other means, or considered by the NHSLA and claimants' solicitors to be unsuitable or at too early an investigative stage to proceed to mediation. The most common reason given by claimants' solicitors supporting the latter being a need for further expert input.

5.20 Because of the low uptake the NHSLA has continued the exercise for a further year. During the period June 2001 to end September 2001 it had offered mediation in 49 cases; claimants had requested it in 10 cases. Over that same period there was an increased uptake, with 9 cases proceeding to mediation and reaching a settlement. That marked increase indicates a shift, albeit slow, towards a greater use of mediation. This appears to be driven by changes in culture and understanding, with the NHSLA finding that it is dealing mostly with repeat players as regards the legal profession and mediation providers. It may also be influenced by the other initiatives we mention below, in particular that of the Legal Services Commission (LSC) that are aimed at making mediation an important element of the dispute resolution procedure.

5.21 ADR, of which mediation is one process, has also been widely promoted by the Lord Chancellor. In a statement on 23 March 2001 he announced that Government Departments and Agencies would consider and use ADR in the resolution of disputes involving them. They are committed to the Court being used only as a last resort, with Government legal disputes being settled by "mediation or arbitration" whenever suitable and whenever the other party accepts it. This commitment is being monitored by performance measures in each Department and Agency, but similar to Woolf, it is much too early to properly assess its impact.

5.22 On 7 December 2001, the Lord Chancellor also launched a new mediation scheme at the Birmingham Civil Justice Centre. Anyone who makes a claim at the centre, which includes every form of civil case from County Court to High Court, will be encouraged to make use of the mediation service the scheme offers.

5.23 In June 2001, the LSC introduced a funding code and guidance in relation to medical negligence cases that encourages, but does not force, the wider use of ADR. This ensures that the option of mediation and other forms of ADR are properly considered in all medical negligence cases funded by the Community Legal Service. When introduced it was seen by some to be controversial and too directive, although not by all, and was supported by some solicitors firms.

5.24 Since its introduction the LSC believe there has been a growing use of mediation and has received very few complaints regarding how the guidance is operating in practice. It is optimistic that when it evaluates the position more fully next year, mediation will be shown to have an important role to play in the resolution of medical negligence disputes.

[30]Procedures Related to Adverse Clinical Incidents and Outcomes in Medical Care: 1998-99: HC 549-I ISBN 0 10 556490 7.
[31]Mediating Medical Negligence Claims - An Option for the Future?: ISBN 011 322268 8.
[32]Source: "Handling Clinical Negligence Claims in England" – Report by the Comptroller and Auditor General – 3 May 2001.
[33]Source: "Clinical Negligence in the NHS in Wales" – Report by the Auditor General for Wales – 23 February 2001.

Use of mediation in international jurisdictions

5.25 At an international level, mediation and other interventions to prevent the escalation of, and to manage conflict, are considerably more recognised and used than in the United Kingdom. It is a means through which medical negligence disputes are being settled in international jurisdictions, particularly in the United States. But evidence specific to this is difficult to gather and for the most part patchy. While there is much assertion about mediation being used, there appears to be a dearth of empirical evidence that evaluates the impact it is making, or substantiates its value and effectiveness. That perhaps reflects the overall usage of it to resolve medical negligence disputes. It also perhaps reflects the complexities involved in such disputes. Against that background we are able to provide no more than a general picture of what is happening internationally, mentioning what meaningful evidence we have gathered regarding mediation in the field of medical negligence.

5.26 We have looked at three jurisdictions – Australia, New Zealand and the United States. Here is what we found.

Australia

5.27 The use of ADR in relation to civil claims has grown over the past 20 years. An early milestone was the establishment of Community Justice Centres (CJCs) in New South Wales, from which the development of the mediation process in Australia can be traced. The success of the CJCs, which cater principally for neighbourhood disputes, showed that mediation could be successfully deployed and that there was a high level of community acceptance and support for it.

5.28 The use of mediation outside the court system initially grew slowly, but through increasing awareness – particularly amongst the legal profession, and Government encouragement, the use of it has gained momentum. The courts encourage mediation outside the court system to the extent that they will usually allow a pause in the litigious process while parties try to resolve matters by mediation.

Provision is in place to support this. Various legislation and Federal and State court rules and Practice Directions enable referral through choice, or can order the use of mediation. The specific provision varies according to different States. There have also been different mediation schemes and initiatives:.

examples of schemes and initiatives

In 1992 there was a mediation "blitz" in the Supreme Court of Victoria where all matters were called over and a large number of cases were sent to mediation and successfully resolved. The Supreme Court of Western Australia did similar in 1993 with a "blitz" on its court lists.

In 1991 and 1992 the Supreme Court and Law Society in New South Wales held "settlement weeks" during which a significant number of cases were mediated; with approximately 70% being settled.

Following on from this was the introduction of a continuous programme of referral to mediation from various courts through the Law Society. The Society scheme does not force a party to mediate and depends upon all parties accepting the Law Society's invitation. But, the Society acts as a facilitator to encourage such agreement.

5.29 A number of organisations exist through which mediation services are provided. These also cater for the training of people to be mediators, and serve to encourage the use of mediation and other forms of ADR. Mediators in Australia are typically retired judges, practising lawyers, or non-lawyers usually with professional expertise in the area involved in the mediation.

New Zealand

5.30 As far back as 1974 New Zealand stopped medical negligence litigation. It introduced an Accident Compensation Act that provides for compensating persons who suffer personal injury by accident – which includes medical misadventure, and bars lawsuits for damages arising directly or indirectly from such accidents. The Accident Compensation Corporation, which executes this legislation, decides whether a person has in fact suffered personal injury by accident. Its decision is conclusive. There is therefore little, if any, need and place for mediation in resolving medical negligence matters in New Zealand.

5.31 More generally, mediation continues, especially in commercial disputes, to grow in popularity. Guided by a High Court Case Management practice note, the courts actively encourage parties in civil disputes to seek settlement through negotiation or the use of ADR techniques, including mediation, but parties are not ordered to mediate against their wishes. To support that practice, court registries hold contact numbers of umbrella ADR organisations in New Zealand.

United States

5.32 From a general perspective, mediation plays a prominent role in the resolution of all civil disputes in the United States. The Alternative Dispute Resolution Act of 1998 requires that federal agencies weave it into the fabric of their daily operations. Many States have done so, and indeed had already done so prior to 1998 – with the federal, county and district courts generally demonstrating an understanding of the process, and a sensitivity to its core values and principles.

5.33 Its use varies depending on the jurisdiction. It is used more often in some States than others. Some apply it to all civil disputes; some to only certain types of civil dispute; it is used at differing stages of disputes. In some states it is mandatory, with sanctions for failing to do so, and for failing to do so in good faith. For example Alabama, California, Florida, Indiana, Louisiana, Maine, Montana, Nevada, North Carolina, Texas and Wisconsin all have different degrees of court mandated mediation and can impose different sanctions.

Courts in Michigan have started mandating mediation in medical malpractice cases. Medical Negligence mediation schemes / programmes also operate and have operated in a number of States, for example, Florida, Indiana, Massachusetts, North Carolina and Wisconsin.

5.34 Some States require individuals to complete training and attain certain practical skills before being allowed to mediate. For example, in Illinois some Judicial Circuits, along with some private organisations train and certify mediators. Each State that certifies mediators deals with it in its own way. Florida certifies attorneys, mental health professionals and accountants as mediators. Kentucky's mediation statute is based on the principle that as long as all mediators go through the same certification process, nothing indicates that judges or lawyers will serve their clients better in mediation than other professionals.

Chapter 6

A need and role for mediation?

6.1 There is a developing health services climate which is seeking to encourage more openness, better communication and improved systems – aimed at better serving the needs and interests of patients and providers. It is therefore timely to consider if there is a need to change or improve how we resolve medical negligence disputes in Scotland. In this chapter we discuss the extent to which litigation and the Complaints Procedures currently meet the needs and serve the interests of those involved, and support the developing climate; and whether there is a role that mediation can play. We also consider its interaction with regulatory and other legal procedures.

Resolution through litigation

6.2 Litigation provides claimants with a means to exercise, if they so wish, their rights under Article 6 of the European Convention on Human Rights (see Annex D). It provides a forum that best serves the resolution of issues that involve matters of precedent or public interest. It has and must continue to have, a place in resolving medical negligence disputes. There is no cogent argument against that. There is, however, a strong argument which says it should be a last resort. That argument is based on the nature of the litigious process and its overall impact.

6.3 As a process it indisputably achieves outcomes, but not in an informal or co-operative manner. By its very nature it is adversarial. It compels parties to set out their case in the most effective way in order to achieve a decision in their favour; to present and acknowledge only one side. This adversarial approach tends to promote polarisation. For example, medical experts often find themselves adopting divergent and entrenched positions, based on different factors and approaches.

6.4 The adversarial culture can result in negotiations between parties and their representatives being antagonistic. Willingness to acknowledge error or show concern about the other side can be interpreted as a sign of weakness. Disclosure of information or expressions of regret may be discouraged in case they are used to establish, or viewed as admission of, liability. Negotiations may often fail or take a long time because of lack of communication, the adoption of inflexible positions, or lack of preparation in advance. Negotiations may also often take place at "arms length" involving only the representatives, not the parties themselves. This discourages face to face contact between the parties, which can, in some cases, be a crucial element in achieving a mutually acceptable and satisfactory outcome. In the cases where face to face contact is a crucial element, the negotiations do little to support a patient / health services climate of greater openness and improved communication.

6.5 Litigation cultivates a culture where defensiveness is a main feature – which in turn can serve to cultivate the "blame" culture which the developing health services climate is seeking to remove. It is invariably stressful for all involved and can be, and frequently is, lengthy. The nature of medical negligence means that patients and families are often unaware of what has gone wrong in events leading to a claim and are keen to have their "day in court" to have the opportunity to meet and hear from those responsible. But very few claimants actually achieve their "day". As we show in Chapter 4, most cases never cross the door of the court; many are settled just before the door is opened, having gone on for a considerable period at considerable cost – often years, during which uncertainty and trepidation over the process serve to heighten the stress. It can also be financially expensive and out-with the means of many – particularly those in the middle income bracket.

6.6 All of this makes litigation a process that many patients and families have to, prefer to, and often do avoid. The *"Paths to Justice"* survey[34] showed that those who experienced problems relating to medical negligence were amongst the least likely to take action to resolve the problem. That is fairly telling and arguably says much about the extent to which litigation is best serving patient and family interests and providing for proper access to justice for all in relation to medical negligence.

6.7 Litigation can also affect clinical judgement. Empirical research has shown that clinicians perceive the possibility of it as affecting their decisions. One study[35] of GPs' responses to the threat of complaints and legal claims found that 50% of 300 respondents surveyed *sometimes worried* about being sued and 30% *often worried*. A further study[36] showed that litigation, or even the threat of it, had an adverse effect on clinicians; subtly changing their relationships with all patients, not just those who may have initiated a claim.

6.8 In terms of wider impact the process can serve to damage relationships between patients, their families and healthcare practitioners. It can also damage morale and public confidence in the health services.

6.9 The Mulcahy Report[37] shows that a successful court case, or a financial settlement prior to proceedings, does not necessarily produce the outcome which patients and families seek. They may seek a range of outcomes. This includes, explanation, apology, assurance – perhaps in the interests of others in the future, a review of procedures, implementation of a future treatment plan, payment of compensation / damages, or any mix of these and other non-monetary outcomes which may be appropriate as a result of the event which has triggered the dispute.

6.10 The cases mediated through the National Health Service Litigation Authority (NHSLA) pilot exercise in England & Wales, discussed in Chapter 5, produced monetary and non-monetary outcomes. In its first year the average settlement figure was £336,000; in the second year the average was £177,000. The non-monetary outcomes included fast-tracking a particular hospital procedure, arrangements for the claimants to meet at a later date with a consultant for further explanation, the defusion of mistrust between Trust and claimant, and expressions of apology.

6.11 The remedy of damages is, however, generally the only outcome possible in the event of a medical negligence litigation claim being brought successfully. The litigation route can therefore provide an outcome, but can leave patients and families with a continuing sense of frustration and grievance once all is said and done.

6.12 The report by the House of Commons Health Select Committee on its inquiry into adverse clinical incidents and outcomes in medical care[38] concluded that litigation should be avoided, except where absolutely necessary and all those involved should work to reduce the number of cases that follow this route. We strongly agree with that conclusion.

6.13 Other than the reasons we will mention in paragraph 7.19, we can identify no convincing argument to support the use of litigation in resolving medical negligence disputes except as a last resort. It has and must continue to have a place in resolving such disputes, but it should not be the main route used. For that to happen, other means of resolving disputes need to be available. Mediation is one possible means.

Resolution through complaints procedures

6.14 Many medical negligence disputes move directly to litigation and do not touch upon the Complaints Procedures, but some may begin, and end, through the procedures. Others may begin with them and subsequently move to litigation – which they are compelled to do if a legal remedy is sought, with the procedures automatically stopping should that be the case. One cannot therefore consider how medical negligence disputes are resolved without also considering the role of the procedures in the overall process.

6.15 As a process, the purpose of the procedures is to provide simple, flexible, impartial and easily accessible routes for the resolution of patient complaints, as well as being fair to practitioners and staff. The procedures handle complaints on a wide range of issues and medical negligence issues can and do feature, although as mentioned in Chapter 4, limited and variable information is available regarding the extent to which they directly or indirectly do.

[34] See note 17.
[35] Summerton, N. (1995) Positive and negative factors in defensive medicine: A questionnaire study of general practitioners, *British Medical Journal*, 310 (7 January): 27-9.
[36] Ennis, M and Vincent, C (1994) The effects of medical accidents and litigation on doctors and patients, Law and Policy, 16(2): 97-121.
[37] See note 31.
[38] See note 30.

6.16 By their very nature the procedures are intended not to be adversarial. In principle they are conducive to consensual resolution, to handling the human dimension of medical negligence (and non-clinical) disputes, but does how they operate in practice reflect their intended purpose?

6.17 A recent report[39] on a review of the NHS Complaints Procedure suggests that by and large it is serving to meet the interests of the health service and those within it, but not the interests of the patients. It shows that many complainants expressed a high level of dissatisfaction with the operation of the current procedure. Only 33% of individuals whose complaint was dealt with locally believed their complaint had been handled well. A majority thought the procedure to be unfair or biased; a high proportion found the process stressful or distressing. Of those who sought an Independent Review, 25% believed their complaint had been well handled; 10% were satisfied with the time taken to resolve the complaint; and 13% were satisfied with the outcome. Almost 75% believed the procedure to be unfair or biased; a significant majority found the process stressful or distressing. The main causes of dissatisfaction amongst complainants were operational failures; unhelpful, aggressive or arrogant attitudes of staff; poor communication; and a lack of information and support. The most important structural failure was a perceived lack of independence in the convening decision and in the review process generally.

6.18 In stark contrast the views of those complained against are markedly different. The majority thought that complaints against them had been handled well; they were generally satisfied with the outcome; and they thought the process to be fair and unbiased. The only consistent source of dissatisfaction concerned failures in lines of internal communication. By way of further contrast, most Chief Executives believed that the local resolution stage worked well and, in response to the proposition that the procedure needed a radical overhaul, only around 31% of those operating the procedure in Scotland agreed.

6.19 The complainants picture that has emerged is entirely consistent with our evidence, most notably in relation to matters of independence, poor communications and a generally defensive attitude adopted by healthcare providers. The marked difference between that and the views of the providers does not indicate the procedure as being efficacious. Rather it suggests a procedure, which is often, although not always, adversarial – a "them and us" culture. That in turn generates the same adverse impacts that we have rehearsed in relation to litigation.

6.20 A recently completed annual review by the Independent Healthcare Association (IHA) of its procedures also highlighted a similar type contrast in the views of those representing patients' interests and those representing the practitioners.[40] We have not obtained any evidence to show a meaningful picture of the handling of complaints by the other private sector providers who are not members of the IHA.

6.21 It is not within our scope to consider and recommend the steps needed to address the issues highlighted by the Complaints Procedures reviews we have mentioned. But if the procedures are to play a more constructive role in helping to resolve medical negligence (and non-clinical) disputes and to best serve the interests of all involved, they must be, and be seen to be, non-adversarial.

6.22 The procedures are a form of ADR and ideally should serve to encourage people not to go down a litigation route. By and large they do not achieve this in relation to medical negligence disputes. They do provide greater potential than litigation to achieve the non-monetary outcomes we mentioned in paragraph 6.9, but for the most part do not provide for a monetary outcome, although in a few cases they can result in ex-gratia payments being made. Nor do they allow for any legal involvement at any stage. This can and invariably does serve to force patients to choose between the procedures and litigation. There is no bridge between them. It is either one or the other. Many patients and families simply choose to bypass the procedures knowing that they are not an option for resolving their dispute. They choose in the knowledge that taking the wrong route can leave them without a remedy. For example, if a complaint is brought and is subsequently stopped as a result of legal involvement, and later advice / investigations show litigation to be inappropriate, or out-with the patient's means, it may be too late to reopen the complaint.

6.23 There is a clear need to improve a process that arguably encourages the use of litigation and forces people to choose a route which even at the outset they know is unlikely, although not in all cases, to provide the outcomes sought. Mediation offers a possible means of achieving that improvement.

[39] NHS Complaints Procedure National Evaluation Report: York Health Economics Consortium and NFO Systems 3 Social Research.
[40] Source: Independent Healthcare Association.

Mediation as an option

6.24 Most of the evidence we received was supportive of the principle that mediation can play a role in enabling more constructive resolution of disputes. It confers a number of advantages and may create some disadvantages, which we discuss later in this chapter. We believe that the advantages clearly outweigh the disadvantages.

6.25 The House of Commons Select Committee report[41] encouraged the use of mediation. It specifically recommended that the Government review, clarify and improve the funding and other arrangements relating to mediation, and should act on the findings of the NHS Pilot. Given the small number of cases (12) the pilot handled over the period, it must be treated with some degree of caution. However, it demonstrated the qualitative benefits of mediation for both the claimants and healthcare professionals involved. All 12 cases were settled; 11 with payments and non-monetary outcomes conferred to claimants, and 1 withdrawn, but with a significant non-monetary outcome conferred. It substantiates the importance of non-monetary outcomes.

6.26 The NHSLA pilot exercise is demonstrating similar benefits. All but one of the mediated cases reached a settlement within a few months. Two cases settled on the day of the mediation; two settled within a few days of the mediation beginning. Those settled arrived at both monetary and non-monetary outcomes. The perception of NHSLA is that most of those who attended a mediation felt they had got something from it.

6.27 The claim numbers, costs and level of incidence shown in Chapter 4 suggest that in terms of size, medical negligence in Scotland is not a major issue; there is no major crisis or impending crisis that needs fixing. Against that quantitative background, there is a reasonable argument that says there is no pressing need for any change or improvement. It is, however, important not be guided by quantity alone. There is the equally important qualitative dimension, including the need to recognise the developing climate change within the health services, and to produce better outcomes for all involved. Simply maintaining the status quo is not therefore, in our view, a pragmatic option. There is a need for qualitative improvement in how medical negligence (and non-clinical) disputes are resolved.

Qualitative value

6.28 Our evidence clearly demonstrates that the vast majority of people have little difficulty with the principle of mediation being a process that should be used. It is seen to be, and we agree, a process that would add the qualitative (indirect cost) values we set out in paragraph 6.39. The empirical evidence from its usage in other jurisdictions is strongly supportive of this and we have identified no substantive evidence to support a contrary view. It is a means by which those involved can be encouraged to seek and reach mutually acceptable solutions. A consequence of that being, outcomes that have a more encouraging impact on attitudes, culture, perceptions and relationships.

6.29 Mediation can remove the process anomaly that currently exists, whereby litigation and the Complaints Procedures offer different remedies, but neither of them offers all possible remedies. That seems to us to be a fundamental flaw in the overall resolution process and is wholly inconsistent with the "one-stop shop" approach that is the linchpin of government policy in other areas. Mediation could in some circumstances be a "one-stop shop", but it is important to stress that it may also be complementary to litigation and the Complaints Procedures.

Quantitative value

6.30 Proponents of mediation often cite direct cost savings as one potential advantage which mediation can offer. Others take the opposite view; often arguing that it would not be cheaper and may create more cost through encouraging and generating more cases.

Limited data exists on which an objective judgement can be made on this matter, and the argument will continue until more substantive evidence is available. In the absence of such evidence we cannot offer any objective conclusion on the question of costs. A lot will depend on the stage at which mediation is used.

6.31 The Mulcahy Report[42] provides a general picture of the possible cost impact of using mediation, but must be read with a degree of caution – describing its cost comparisons as "extremely tentative". It sought to compare the

[41] See note 30.
[42] See note 31.

costs of the 12 cases it mediated, against non-mediated cases and found there to be no appreciable difference in the average cost to claimants. The comparison did not, however, include the costs of the small number of cases that went to trial; if the costs of those were factored in, the average cost of non-mediated cases would undoubtedly have risen. The cost picture that emerged as far as complainants were concerned was therefore positive in terms of encouraging and supporting greater use of mediation.

6.32 A different picture emerged as regards defence costs. This showed that the costs of mediated cases up to the point before any trial were greater than the costs of non-mediated ones. The reasons for this being the bringing forward of case preparation involving the medical profession more directly; increased participation by the profession in the actual process at that stage; and mediator's fees. Like claimants' costs, the comparison did not factor in the costs of non-mediated cases that went to trial. The more trial cases, the more likely there would be an equalisation of the costs and possibly a swing towards mediation being cheaper. That needs to be considered against a background that very few cases actually go to trial. On the other hand, it may only take the costs of a few to alter the comparison.

6.33 In looking at the comparisons it is also worth noting two further points. Firstly, the pilot operated within a climate of reluctance, borne out by the fact that it got only 12 cases in 3 years. That may have seen the cases being mediated further down the line than they would have been had there been more encouragement to do so. Had that happened, earlier mediation might have seen a reduction in both claimant and defence costs. Secondly, they do not touch upon the overall case costs. If, as some opponents suggest, mediation generates more cases, the potential for a rise in overall case costs and indeed settlement costs increases. On the other hand, if mediation allows parties to focus on non-monetary outcomes, as it appears many claimants seek, the converse may be true. Only experience will tell.

6.34 The report concluded that any direct savings to be had from mediation were most likely to accrue to claimants' legal costs through reducing the length of cases and costs of the few cases that would otherwise have reached the court. It recognised qualitative benefits, such as the greater direct participation by doctors, increasing satisfaction amongst claimants and facilitating greater accountability; and a more proactive and speedy preparation of defences, but saw these as being achieved at a cost to the defence.

6.35 It is too early to draw any meaningful cost conclusions from the NHSLA Pilot exercise, but initial impressions given by the NHSLA suggest that defence costs in cases up to the point before any trial have not been less but perhaps more when mediation is used. That is consistent with what the Mulcahy Report[43] suggests, but like the findings of that report, other things need to be factored in before a true cost comparison can be demonstrated.

6.36 The LSC holds the view that if used effectively, through occurring at the earliest possible stage, mediation has the potential to reduce costs. On the other hand, it recognises that if used ineffectively there is potential for a cost increase. The LSC is not in a position to illustrate the cost benefits or disbenefits of mediation as opposed to traditional litigation; and, given the impossibility of knowing with any certainty that whenever a case settles through mediation, if and at what stage it might have settled without it, considers it unlikely that definitive objective evidence can ever be provided which quantifies accurately cost savings. It will, however, be seeking to evaluate its new funding and guidance approach (discussed in Chapter 5) during 2002.

6.37 In the absence of any other meaningful evidence or data, the Pilots and the LSC evidence provide a useful general picture of potential cost impacts, but do no more than that. More than anything they serve to reinforce the point that the question of whether it does add a quantitative value is unanswered. The question is very much "chicken and egg" and is likely to remain so unless there is greater use of mediation – against which a truer cost assessment can be made, and a more reasoned judgement can be reached. A cost assessment would also of course require an accurate starting baseline of litigation and complaints procedures costs, on which comparisons can be made. As far as we can tell from our evidence gathering, such information is not easily or readily available in Scotland.

6.38 While the question of added quantitative value remains unanswered and must be recognised, we do not consider it to be a compelling reason to reject mediation. Indeed, **we can identify no cogent argument that supports a rejection of it, and as we have said, consider that it offers the potential to achieve the qualitative improvement needed. But it is not a universal panacea, its potential lies in being an option to litigation and/or the Complaints Procedures, not a replacement for them**.

[43]See note 31.

Advantages

6.39 What are mediation's advantages? As a process it undoubtedly offers a less adversarial setting in which to resolve matters, and to better serve the collective interests of all involved. We see the potential advantages in comparison to litigation and the Complaints Procedures as being:

- Scope for flexible, more creative solutions which look forward rather than back – including monetary and non-monetary outcomes, such as explanations, expressions of regret or apology – without a health practitioner necessarily being held to have admitted liability or found liable in law – future care arrangements, and an alteration in procedures. It can offer a "one-stop shop" for all involved.

- Providing appropriate preparation has been completed, it can be a faster process. Most mediations can be arranged within weeks, or quicker if necessary, and most are completed quickly – avoiding the detrimental effect of delay which can arise within the litigation process. Available evidence[44] shows that the average length of a mediation to be 1.25 days.

- A better prospect of dealing with the emotional element involved: of achieving more honesty and openness in a private setting; of mitigating the stress involved; reducing antagonism; and maintaining and repairing professional and personal relationships.

- Scope to promote a greater understanding of the complexities and uncertainties of medical science and the difficulties faced by the healthcare profession. More productive use of health professionals' time.

- Greater opportunity for patients and families to express feelings and anger as part of the process of healing – the response to which can create a more positive setting for agreement.

- More opportunity for parties actually affected on all sides to play a role in resolving a dispute and to help to promote a more co-operative approach in health disputes.

6.40 Many practical examples exist of mediation successfully resolving medical negligence disputes. Figures 6.1 and 6.2 provide two such examples.

figure 6.1

case study

While giving birth to her first child at her local hospital, Ms X experienced complications and was left with a serious long-term injury. The Trust admitted liability at the time and apologised.

Following legal advice, Ms X opted for mediation and the Trust agreed to enter into the process. It was arranged quickly and took place shortly after the event. She attended the mediation with her solicitor. The Trust allowed her to suggest attendees from their side and both the chief midwife and the gynaecologist responsible attended. The Trust's insurers were not present.

During the mediation, Ms X met face to face and spoke to those directly responsible for her injury. This enabled honest dialogue about the event and provided for a direct apology to Ms X.

The parties agreed a settlement figure (the amount in dispute was £90,000) to compensate for the injury and both sides agreed a structure for the Trust to re-evaluate its procedures for the future.

The time between referral and mediation was 2 weeks. The mediation lasted 1 day.

[44]Source: Centre for Effective Dispute Resolution – based on its experience of mediating commercial disputes. CEDR expectation in medical negligence disputes is for mediation to be completed within 10 hours, although there are exceptions to this.

figure 6.2

case study

A case involving a bereaved man and his two children. His wife had died in hospital following a routine operation. Questions arose about the nursing regime and the decisions made by the supervising doctor. These included questions about the procedures which had been used and the extent to which either the nursing staff or the doctor were responsible for a failure to diagnose the patient's true condition and to treat it effectively. Further questions arose about the causal link, if any, between the alleged failures and the death. The case was proceeding towards a court hearing six and a half years after the death of the patient.

Mediation took place over one day. Following a series of private meetings between the parties (and their solicitors and other representatives) and the mediator at a neutral venue, the case was resolved. It was agreed that payment of a sum of money would be made to the patient's husband and children. Allocation of liability for payment was agreed, separately, between the hospital and the doctor. It was agreed that the husband could discuss current procedures further with the hospital. The hospital and the doctor reinforced their desire to maintain a working relationship.

Mediation brought closure and certainty for each of the parties and avoided what could have been a lengthy court hearing, along with the continuing stress, additional expense and possibility of unwanted publicity.

Disadvantages

6.41 We have identified a number of potential disadvantages attached to mediation in the context of resolving medical negligence disputes, although, as we say in paragraph 6.24, we believe the advantages clearly outweigh these. We have set out below the disadvantages that we have identified. We have also discussed reasons why we consider they should not serve as inhibiting factors that prevent mediation from taking place.

- Creating expectations that a willingness or offer to mediate is in some way an acceptance of wrong doing, a likelihood of there being a monetary outcome, or easy and quick-fix solution, in turn resulting in reluctance on the part of all involved to offer or enter into mediation. However, experience in England shows that, especially with court encouragement, recourse to mediation is not seen as a soft option or concession any more than a willingness to consider negotiation in the normal way.

- Creating an additional layer of quasi-bureaucracy, which may serve or be seen to elongate an already lengthy process; and, through disclosure of information, potentially weaken a case that may subsequently go to litigation. Generally, the earlier mediation can take place, the better, and the more quantitative benefits accrue; it can be quick and easy to organise and is totally confidential – no party is compelled to disclose more than they wish to disclose.

- Increasing the time commitment on healthcare practitioners. This is set against the need to prepare for a mediation and the greater likelihood of having to attend that, rather than court proceedings, given the small number of cases that actually progress that far. On the other hand, much time is spent in preparation and investigation of cases even if they do not reach court and there are other qualitative benefits from involvement in the mediation process.

- Generating an over-powerful climate; bringing pressure on those involved to settle and potentially producing over or under value monetary outcomes. If parties are well prepared and legally represented, mediation offers an opportunity to resolve matters without the pressure of the court door and in a forum in which true needs and interests can be taken into account; in any event, parties are free to leave a mediation at any time.

- Lacking in accountability and a demonstrable protection of rights. As in any negotiation, parties can be protected by legal representatives; and proper standards of performance by mediators should ensure protection and equality.

- Cannot deliver a precedent or public outcome, which may be, or amongst, the outcomes sought. If these are sought, the case is unlikely to be appropriate for mediation.

Interaction with regulatory and other legal procedures

6.42 There is clear scope for medical negligence disputes to raise issues which are of concern to professional regulatory bodies such as the General Dental and Medical Councils. Mediation or agreements reached through it should not in any way restrict the scope for the regulatory bodies to take actions they consider necessary. For example, it should not prohibit patients from participating in any regulatory investigations. Doing so would, we consider, conflict with effective regulation and would run counter to the public interest.

6.43 Where regulatory procedures have formally begun, we do not consider it appropriate for parties in dispute to enter into mediation. In any event, we consider it unlikely that all involved would be willing or suitably disposed to do so. On the other hand, the possibility of a regulatory investigation should not preclude mediation from happening. In such circumstances we can see no reason why mediation cannot be entered into if it is in the interests of both parties to do so.

6.44 There is also potential for medical negligence disputes conflicting with criminal proceedings. Mediation should not in any way restrict the scope of these proceedings and should not be entered into while such proceedings are ongoing.

6.45 The position is slightly different as regards Fatal Accident Inquiries (FAI) which arise as a result of an alleged medical negligent act or omission. As in the other scenarios, mediation should not restrict the scope of an FAI, but there is no reason why it cannot be entered into before or while an FAI is ongoing, if it is in the interests of both parties to do so. However, we recognise that there are cases where it will not be in the interests of either party to enter into a mediation when an FAI is imminent or ongoing.

Chapter 7

Mediating medical negligence disputes

7.1 It is not appropriate to try and mediate if either party is insufficiently prepared and has insufficient information in relation to the dispute in question and the mediation process, including how it differs in process and possible outcomes to other means of resolution – notably court action. That will result in a meaningless process where one or both sides are not in a position to take matters towards or reach an outcome, or may result in one side achieving a lesser outcome because of a weakened position. Before entering into mediation it is therefore vital that both parties are properly and fully prepared to do so.

How does the process work in practice?

7.2 In Chapter 6 we provided examples of mediation successfully resolving medical negligence disputes. But how does the process actually work in practice? This depends on the procedure and approach adopted, for example, issues such as the experience of the mediator; the wishes of the parties; and the dynamics of the dispute will all have a bearing.

7.3 There are different models of delivery, although most have a common emphasis on flexibility, and different approaches can be adopted depending on the dynamics and needs of the dispute in question. Models may include the use of sole or co-mediators and face to face or private meetings, or both. They may involve the use of different evaluative or facilitative techniques. An evaluative technique does not provide a mediator with any decision or rule-making powers – as is mentioned within the core features in Chapter 3, but can be seen to be, and can be, the use of indirect influence on participants. A technique that is wholly facilitative does not carry that baggage. We favour the facilitative approach as the best way to achieve a co-operative solution to a dispute, and understand it to be the approach taken by most leading mediation providers. The extent to which the pure facilitation of a settlement is achievable has, however, been the subject of debate amongst researchers and practitioners – with some[45] arguing that the impossibility of a non-evaluative, non-interventionist approach should be recognised. Evaluation or facilitation is therefore an important component of the overall process, and must be borne in mind.

7.4 Given the variation, there is no definitive model of how the process works in practice. For the purposes of this report we have provided a model example based on the general pattern of mediations that typically took place during the NHS Pilot in England & Wales (discussed in Chapter 5). All of the mediators involved subscribed to a facilitative mediation practice, although it is worth noting that there were incidences demonstrating some movement from this non-evaluative approach. We do not offer this model as the method that should be used in relation to mediation in medical negligence disputes, but as a demonstration of a method that can and has worked well in practice.

[45]Dingwall, R. and Greatbach, D. (1993) Who is in charge? Rhetoric and evidence in the study of mediation, *Journal of Social Welfare and Family Law,* 17 (2).

Phase 1 preparation	• Once case referred to mediation agency, case manager contacts the parties to fix a date. • Parties and mediator speak before the mediation. • Each side provides relevant documents for exchanging in advance, and a short statement outlining the crux of their case. • Mediation contract confirming the confidentiality of the negotiations and any fee to be paid signed in advance of the process beginning.
Phase 2 process begins	• Parties assemble in private rooms. The mediator meets with them and their representatives to explain the process, his/her role, and to establish views on the issues in dispute. • Mediation begins in shared room when both parties are ready. Mediator explains ground rules. Parties briefly present the position as they see it and may ask factual questions of each other.
Phase 3 considering, understanding and negotiating the issues	• Parties retire to private rooms and engage in confidential discussions with mediator. This concentrates on information-giving, clarification and exploration of respective arguments, concerns, feelings, needs and aspirations. • Mediator moves between parties with a view to sharing information that the parties have authorised can be shared, enabling parties to understand the other side's position, to find and look at all possible options; helping parties to negotiate on the issues raised with a view to achieving constructive, mutually-acceptable solutions. • Where appropriate, mediator meets in private with parties or representatives of both sides together. For example, with the claimant and doctor, or with solicitors to discuss complex legal arguments or detailed quantification of claims. Joint meetings of all concerned may take place.
Phase 4 reaching an agreement	• Parties agree, or fail to agree, whole or part settlement. This phase can, but need not, involve parties meeting again in a shared room. • This phase may see a continuation of phase 3 actions, or a need to move in and out of phases 3 and 4. • Parties sign a written agreement that reflects any settlement reached.

What if there is no agreement?

7.5 Mediation does not guarantee agreement. It can end without this, either before or during any of the phases. If that happens, the parties have recourse to other forms of resolution, including litigation. Lack of a full settlement does not, however, necessarily signify failure. If the parties have narrowed the issues in dispute or resolved some matters, full settlement can often occur shortly after. Sometimes in complex cases (such as cerebral palsy), the mediation is continued to enable parties to meet again when new developments take place or when a better understanding of the effects can be ascertained.

How long does it take?

7.6 The time required to move from the point of dispute arising to it being resolved through mediation varies according to the preparation and understanding of the parties, and the number and complexity of the issues. For example, if parties are highly emotional, or do not easily understand their rights or obligations, things may need to move along at a slower pace. No time-scales can therefore be set or defined.

7.7 As a general rule, no less preparation time is needed than would be required to take a medical negligence dispute to the stage when written pleadings are finalised (the Closing of the Record). Beyond that mediation offers the potential to be considerably quicker than other processes. As mentioned in Chapter 6, available evidence[46] shows that the average length of a mediation (phases 2-4 in the model example) is 1.25 days. Furthermore, it can be arranged speedily.

Who supports the parties?

7.8 There is no prescription on who attends a mediation to support the parties involved in a dispute. Each case is treated on its own circumstances and is informed by the issues at stake. It is likely that in most medical negligence cases there will be a need for both parties to have legal representation – particularly where issues of individual rights are at stake, but there is no hard and fast rule that dictates that there must be a legal presence. Expert opinion is more often than not the key component of a dispute. Those providing that may also therefore attend, but again there is no prerequisite to them doing so. In some cases, resolving disagreements between experts can be done at arms length without including them in the process; in others, including them within the process may be the best way forward.

7.9 Legal and medical experts are not the sole means of support for patients. They may need support and perspective at a personal level. It might be provided by partners, relatives, close friends, and/or patient advocacy groups from across the voluntary sector. There is also a need for support to address equality issues, which we discuss in Chapter 9.

7.10 Equally, the defending healthcare provider is not limited to legal and medical experts. Representatives of medical defence organisations and insurers may be present. The healthcare professional under challenge or a more senior healthcare professional may also attend, although the attendance of the healthcare professional who provided the care within a complaint or litigation is, in our view, fairly critical to mediation, providing the qualitative improvement we consider it offers. Personal support may also be helpful.

7.11 Whatever the composition of either party, it is of fundamental importance to the process that it includes someone with authority to settle any possible outcomes that may be reached.

Compulsory or voluntary?

7.12 Compulsory mediation that removes any recourse to litigation would be inconsistent with Article 6 of the European Convention on Human Rights. It is not therefore an option, and no evidence we received has argued for that. There are, however, different degrees of persuasion / direction that can be applied to encourage its use and to address any antipathy and lack of awareness, while retaining recourse to other avenues. For example, within the litigation process, mediation could be a mandatory requirement before any case is considered for trial; alternatively it could be an option that had to be considered and used where appropriate.

7.13 These approaches would certainly lend themselves to a greater use of mediation; and would help to address any reluctance – either through lack of awareness or antipathy on the part of patients, healthcare and legal practitioners to use it. Making it a mandatory requirement may, however, simply serve to create a culture whereby little more than lip service is paid to the process, which in turn gives rise to the additional layer of quasi-bureaucracy, identified as a potential disadvantage. Considering it as an option may also do little more than create a lip service culture, unless it was cemented by other arrangements.

7.14 A number of medical negligence mediation pilot schemes in international jurisdictions relied on compulsion. This highlighted concerns that it placed an over-emphasis on mediators as case managers and turned mediation more into a mini-trial than an alternative option.[47]

7.15 **Although mediation must be a voluntary process, it does not rule out some degree of direction that helps to encourage its use and to address any antipathy and lack of awareness. Without that, we believe mediation would remain as a worthwhile option promoted by many, but would be unlikely to develop significantly to achieve its full potential. We recommend, in Chapter 8, steps to achieve this.**

[46] See note 44.
[47] Source: Genn, H. (1998) Final Report to the Lord Chancellor on the County Court Pilot Scheme. London: Lord Chancellor's Department.

When would it be appropriate?

7.16 No clear rules or definitions exist concerning the type of cases that are suitable for mediation. Differing views exist and are influenced by whether mediation is seen only to be part of another process, or a process itself. Regardless of that, some mediation proponents argue that very few cases are inherently unsuitable at each and every point of their life cycle. On the other hand, others consider there to be a range of case types and characteristics that are unsuitable. Some common examples suggested to us being cases of high cost value, cases requiring precedent or of high public interest, cases with unwilling participants, and cases where the cost of mediating is disproportionate to the likely outcomes.

7.17 Mediation does not lend itself to a set of rule boxes into which each different case will fit neatly. Identifying when it is appropriate is not therefore a straight black or white process, but without greater clarity and direction than currently exists it is unlikely to become an integral part of the overall dispute resolution process.

7.18 We do not argue against the general principle that very few cases are unsuitable for mediation at some stage, and see no reason why the starting presumption for the resolution of all medical negligence (and non-clinical) disputes cannot be that mediation is appropriate. But there will be cases for which mediation is inappropriate.

7.19 In identifying cases that are inappropriate, it is important to avoid any rigid or overly detailed criteria such as quantum sought, or nature and complexity of the issues at stake. A pigeon-holed approach such as that would not reconcile with the flexibility that mediation offers. Moreover, it may serve to exclude some cases that might in fact achieve a constructive resolution through mediation. We suggest that mediation is unlikely to be suitable for resolving a dispute if:

- Either party is not willing or able to participate.
- Doing so would not be within the public interest.
- Doing so would not enable legal or other precedent that needs to be set.
- Publicity is sought.
- Regulatory proceedings of professional bodies are ongoing.
- Criminal proceedings are ongoing.

When should it take place?

7.20 Case timing is of as much importance as case characteristic or type. As we say in the opening paragraph of this chapter, it is not appropriate to try and mediate if either party is insufficiently prepared.

7.21 Having identified a case as appropriate for mediation, the next important step is assessing its state of readiness and to set the mediation date accordingly. The date can generate the momentum needed to bring parties to a state of readiness.

7.22 For mediation to be most effective it should happen at the earliest possible stage of a dispute, and once both parties are sufficiently prepared. In the case of litigation we see that as being the stage before court proceedings have started; in the case of the Complaints Procedures, before any independent review panel meets. That does not mean that it would be ineffective at later stages. Once litigation has commenced there is no reason why mediation cannot be an option at any time up to trial, or between judgement and any appeal. Similarly, in the Complaints Procedures there is no reason why it cannot be an option at any stage. In essence, it is an open door option that only closes once the dispute has been resolved by another means.

Chapter 8

Making mediation an option

8.1 It is easy to assert that mediation has a role to play in improving the resolution of medical negligence (and non-clinical) disputes. It is considerably harder to bring that about. If it was easy, one suspects, not unreasonably, that it and other forms of ADR would already be more commonly and regularly used in Scotland. Mediation will not therefore become a practical option, or be used as a resolution process more regularly, simply by advocating its merits and the potential it offers. For that to happen, issues of culture, education, funding and process need to be addressed. None of these issues is likely on its own to take mediation any further forward from its current position of being a good concept that has a potential role to play, but collectively, and supported by appropriate actions, we consider they can bring about making it an option.

8.2 In this chapter we discuss these issues and make recommendations that we consider will make mediation a viable option. In doing so we recognise, as we have stated in chapter 6, that it is not a panacea, and that we believe that what is appropriate is a step change, not a sea change which effects a major and immediate shift from how disputes are currently resolved.

An option to litigation

8.3 The litigation route leads into three legal gateways. For the healthcare providers it is the National Health Service Scotland Central Legal Office (CLO) or the Medical Defence Organisations (MDOs); for the patients and their families it is their solicitors. These gateways exercise the major influence over how a dispute is resolved and, as such, influence significantly the extent to which mediation is an option and is used. As well as being the legal gateways, they are also therefore the mediation gateways. If mediation is to be a viable option it must therefore become part of the fabric of the business of these gateways. If it does not, it will continue to be no more than a good concept. So how does it become part of the fabric of their business?

Process

8.4 The starting point is establishing a process which directs, encourages and promotes the use of mediation. No such process currently exists in Scotland; for mediation to become a viable option it needs to be established. We recommend three specific actions to achieve this:

CLO Project

8.5 **The Scottish Executive should, in conjunction with the CLO, undertake a fully researched mediation project mirroring that being undertaken by the National Health Service Litigation Authority (NHSLA) in England,** discussed in Chapter 5. That would enable the use of mediation now in appropriate and suitable cases across the whole of Scotland, not just those in particular health areas. It would also provide a body of evidence from which more fully informed decisions on the longer-term role of mediation can be made. What it would not do is tie the CLO, NHS healthcare providers, patients or their families to a particular resolution route during the project, or beyond it.

recommendations

8.6 The project should not at the outset be time limited, but should be flexible in terms of its completion. Its life-time should be driven by the generation of sufficient output to support the research study which, based on the experience of the NHSLA, is likely to see it needing to run for a minimum of 2-3 years. We also see it as important that, unless the emerging evidence is incontestably against the future use of mediation, the general ethos underlying the project should continue when the project formally ends and while the research study is being concluded. That would provide for a consistency of approach until such times as future decisions are made.

MDO Projects

8.7 While a CLO project will provide valuable evidence to inform about the future use of mediation and offer mediation as an option now, it will exclude cases involving General Dental Practitioners, General Medical Practitioners and Private Health Care Practitioners. We therefore see it as important for there to be similar type projects undertaken by the MDOs. Through similar projects a more complete body of evidence covering the whole panoply of disputes can be established. Through them can also be avoided the creation of a situation whereby the possibility of patients and their families using mediation markedly differs according to the defence gateway. That seems to us not to best serve the interests of patients, families or healthcare providers; either now or in the longer-term. **We therefore recommend that the MDOs should undertake appropriate mediation projects that, like the recommended CLO project, require mediation to be offered wherever appropriate and suitable.**

rec

8.8 These projects should also be fully researched and will deliver a clearer and more composite picture if integrated in some way with the research into the CLO project. **We also therefore recommend that the Scottish Executive works closely with the MDOs in developing its research into the CLO project to achieve, as far as is possible, an integrated research outcome.**

ommendations

Court Direction

8.9 It is clear from what we say in Chapter 5, that elsewhere, judges have played, and are playing, a significant role in raising awareness of and encouraging mediation. We therefore see the courts in Scotland as having a fundamental role to play in mediation becoming established here. We recommend three separate steps to enhance that role:

recommendations

A Pre-action Protocol

8.10 **The courts in Scotland should consider adopting the principles which are outlined in the pre-action protocol for the resolution of clinical disputes in England (see Annex C) which has been promoted by the Clinical Disputes Forum.** We recognise that this protocol reflects developments in England where there are new civil procedure rules. However, the underlying encouragement of a climate of openness and a timed sequence of steps for patients and health care providers, and their advisors, to follow when a dispute arises seems eminently sensible.

8.11 We are aware that there have been recommendations to improve Court of Session procedure generally. We consider that the general aims of the protocol, together with its specific objectives, would help to promote a more open and earlier resolution of medical negligence disputes in Scotland.

This would be consistent with the thrust of the proposals for reform of court procedure in Scotland. We note that specific steps such as the obtaining of health records, the submission of letters of claim and letters of response, and the approach to expert witnesses will all require consideration in a Scottish context and will need to reflect current legislation governing data protection.

8.12 While it may be argued that Scottish Rules of Court have tended not to focus on specific causes of action, we believe that, for the reasons set out in this report, Scottish courts should make specific provision for medical negligence disputes in the manner suggested by the pre-action protocol.

recommendations

Rules of Court

8.13 Rules of Court already provide for sheriffs to refer commercial matters to ADR – Sheriff Court Rule of Court 40.12 (3) (m). Specific provision to refer to mediation also exists in family matters – Sheriff Court Rule of Court 33.22 and Court of Session Rule of Court 49.23. In addition to the pre-action protocol, specific powers in the Rules of Court to refer medical negligence actions to mediation would enable the courts to encourage parties to consider this option. **We recommend that the courts in Scotland consider the introduction of appropriate rules.**

8.14 Assuming it is competent to do so, an order referring a case to mediation or encouraging the parties to try mediation could be pronounced at any stage during the case. However, it may be helpful if the court can identify a point in time when the parties are likely to be most receptive. This may be after some preparation has been carried out and the prospect of escalating costs becomes clear. For example, the availability of expert or other reports may help to focus minds. Generally, however, mediation may be tried as soon as the action has commenced, at a particular stage in proceedings such as the Options Hearing in the Sheriff Court or the proposed Case Management Conference, or after finalising of the written pleadings (Closing of the Record), or before proof – for example at the pre-trial meeting proposed in a recent Working Party on Court of Session Procedure.[48]

8.15 It should be borne in mind that, in mediation, a broad approach may often be taken to the facts and formal proof is not required. Thus, while the parties need to be able to make a realistic assessment of their position, they do not need to gather all the detailed information which might be required for proof. Gathering of information can be weighed against the need for a cost-effective resolution. Even where a formal court order is not available, the court may still encourage the parties to mediate while other court procedure continues, or pending the next formal court hearing.

8.16 When contemplating making an order for (or encouraging) the use of mediation, the court may wish to consider the following:

- Whether or not to sist the proceedings meantime and, if so, for how long. (Note that a sist may not be required, as mediation can be arranged and completed within three to four weeks, or less if necessary.)
- The administration of the mediation: the court may wish to refer the parties to one or more accredited mediation providers who meet, in the first instance, the minimum competence criteria we recommend in Chapter 9; and thereafter, the set national standards we recommend in the chapter. (The court may wish to consider compiling a booklet which might be provided to the parties, explaining mediation, how to make arrangements and who to contact.)
- Questions of expenses in the event of unreasonable refusal to participate in mediation or other procedure.

Protection of confidentiality

8.17 There is a need to provide protection to (a) the confidentiality of the mediation process and (b) the mediator, to avoid the mediator being compelled to attend court to give evidence of what has occurred in the mediation. The parties will normally have signed a contract providing contractual protection and we consider that, in accordance with public policy, courts would confer on mediation the same protection that is given to other extra-judicial negotiations. However, specific statutory protection would remove any doubt. **We therefore recommend that statutory protection should be provided.** Such protection already exists in relation to family mediation through the Civil Evidence (Family Mediation) (Scotland) Act 1995 – Chapter 6, which sets down the provisions governing the inadmissibility as evidence in civil proceedings in Scotland of information as to what occurred during family mediation. Similar provisions should be established governing the inadmissibility as evidence in civil proceedings in Scotland of information as to what occurred during medical negligence mediation.

recommendations

[48] The Coulsfield Report on Court of Session Procedure.

Culture and education

8.18 One of the most common threads running through all our evidence was the need to change existing cultures and attitudes to ones that are more accepting and encouraging of mediation. We strongly agree. Without that, other actions are likely to achieve very little. All involved – legal gatekeepers, health administrators and practitioners, and patients and families – need to be accepting of it as part of the fabric of the dispute resolution process. It is of course easier to assert that than to achieve it. Achieving it without there being some degree of continuing intransigence on the part of some players is probably an unrealistic expectation, but that should be the target.

8.19 Like the question on quantitative value, culture and attitude concerning mediation is "chicken and egg". As it is used more often and positive benefits are seen to be gained, it will inevitably impact on and change cultures and attitudes, but existing cultures and attitudes tend not to promote it being used more often. In particular, reluctance on the part of the legal profession is frequently suggested as a stumbling block, although we found a number of lawyers positively supportive of mediation as an alternative to more adversarial approaches. The general defensive culture, thought to be prevalent within the health services, is another frequently suggested block. But again, those who understand the potential for mediation tended to be supportive of it.

8.20 Raising awareness about mediation, what it is, what it offers and how it works was another of the most common threads running through all our evidence. It would make a major contribution to the changing of cultures and attitudes. It would also play a vital role in making mediation more accessible and in setting the expectations of those involved. For example, it would help to address concerns over false expectations where a willingness or offer to mediate is construed in some way as being an acceptance of wrong doing, a likelihood of there being a monetary outcome, or an opportunity for an "easy fix".

8.21 Awareness will only be raised through a concerted and continued programme of education and training, the benefits of which are likely to be more medium to long term. So what needs to happen to change cultures and attitudes? What should an education and training programme involve and who should deliver it?

8.22 Clear statements of policy intent by legal and medical professional bodies and patient bodies supporting and encouraging more use of mediation would represent a major overarching step forward. In December 2000, the British Medical Association made the following policy statement:

"BMA Council recognises the value of mediation in terms of benefits conferred on claimants and clinicians by both the process itself and the flexible outcomes which it makes possible and supports a campaign to raise awareness of the benefits of mediation across the medical profession and to supporting its use by clinicians and their legal representatives, wherever possible, to resolve clinical negligence and other disputes."

recommendations

8.23 This top-down demonstration of support sits with the projects we have recommended in paragraphs 8.5 and 8.7. It is also a vital step in changing cultures and attitudes. Similar demonstrations of support are therefore required from other bodies. **We do not think it appropriate for us to specify or prescribe what shape or form these might take, but do recommend that the relevant professional and patient representation bodies, supportive of mediation in medical negligence (and non-clinical) disputes, issue public statements of policy intent. We also recommend that in support of the CLO project, the Scottish Executive provide a statement of policy intent to NHS Trusts and Boards.**

8.24 We do not propose prescribing an exhaustive list of specifically what a continuing programme of cultural change or concerted education and training should involve. Others are better placed to do this – particularly as any programme will concern a wide range of interests. But for these issues to move forward beyond what is said in this report, a future focus is essential.

recommendations

8.25 An opportunity exists to provide this focus with the creation of "NHS Education for Scotland" as a new special health board in April 2002. **We recommend that the Scottish Executive gives active consideration to encouraging this new health board, in partnership with all interested stakeholders, to promote mediation training and awareness. In doing so, five specific steps that we recommend the partnership should positively consider are:**

- Providing public and patient guidance.
- Promoting education through undergraduate training in medicine, nursing, and law (e.g. the law, medical and dental schools, incorporating the role and process of mediation within their core curricula).[49]
- Promoting a programme of Continuing Professional Development training for lawyers, judges and health care practitioners.
- Promoting a programme of education and training for health services administrators (e.g. Complaints Managers / Officers).
- Facilitating the development and implementation of mediation.

8.26 Clearly, some of these matters can and should also be addressed directly by law schools, medical and dental schools, judicial training bodies and others, such as professional institutions and patient representation organisations. **We therefore recommend that these bodies take the necessary steps to achieve this in keeping with the partnership approach recommended above.**

8.27 There is also no reason why the partnership's work should be restricted to mediation. It could also, for example, be a source of advice or promotion in relation to other forms of ADR in the context of patient / health services disputes.

Funding

8.28 Patients and families will have no access to mediation unless the costs of it are met either by themselves or through other means, such as legal aid. It is no different a position to those who follow the litigation route, and there is no reasonable argument to support any change in that general funding framework.

[49] Several law schools have already introduced teaching in mediation into the Diploma in Legal Practice.

8.29 If someone is financially ineligible for legal aid and funding is not available through another means, they will need to meet the costs of mediation themselves, as they would do under existing arrangements. Issues surrounding the financial eligibility tests applying to legal aid featured often in our evidence, with many voicing access to justice concerns – particularly in relation to those in the middle income brackets. It is, however, out-with our scope to bring forward recommendations concerning the eligibility tests that apply to the availability of legal aid. It would therefore be inappropriate for us to do so.

8.30 The costs of medical negligence disputes fall broadly into two distinctive stages. Stage 1 being the period of preparation and gathering evidence prior to a trial or a mediation; stage 2 being the trial or the mediation itself. The process gone through in stage 1 is broadly similar, should the option at stage 2 be trial or mediation. The significant differences being that if mediation is the stage 2 option it can and is likely to be reached sooner and mediation once embarked upon is likely to take less time than a trial. Moreover, while, as we say in Chapter 7, preparation is essential, the same rigorous approach to proof is not necessary, therefore the costs of detailed investigation and preparation for an inquiry by a court into the facts and the law is not required.

8.31 All this impacts on the legal costs incurred by claimants – including those who are legally aided and required to pay a financial contribution towards this, and the defence. Encouraging people to mediate at the earliest practicable point offers more potential to reduce the legal costs involved. That in turn can serve to widen public access to justice. There is therefore an important role to be played by the Scottish Legal Aid Board (SLAB) and the defence gateways.

SLAB

8.32 As we mention in Chapter 5, the Legal Services Commission (LSC) for England & Wales has introduced a funding code and guidance encouraging wider use of ADR and, in particular, mediation. The code requires solicitors and their clients to consider the use of mediation at various stages during a case, and if it or another form of ADR is not pursued, to present the decisions and reasons for this. This informs decisions taken by the LSC regarding extensions of legal aid which have been awarded. If it considers in all the circumstances of a case that there is no good reason for avoiding ADR it can impose a limitation on the legal aid so that it only covers participation in ADR. It can therefore exercise powerful influence over the dispute resolution process.

8.33 SLAB has already moved one step towards encouraging more use of mediation by extending the availability of legal aid to cover it in non-family cases. But that itself offers very little in terms of impact, with solicitors being able to ignore the availability as they wish. Without further steps being taken, we consider that legal aid is unlikely to act as a mediation catalyst. These further steps need to address issues of process and culture and awareness.

recommendations

8.34 The legislative framework within which SLAB operates does not enable it to mirror the process adopted by the LSC. The framework does, however, enable it to build into its process of granting legal aid, conditions which are required to be met. **We therefore recommend that in medical negligence cases a condition(s) to consider the use of mediation at a particular stage or stages, be built into the process.** This cannot force people to use mediation, but it would serve to encourage greater usage of it by becoming part of the fabric of the legal aid process. Such a step is wholly consistent with what we recommend in paragraph 8.13 concerning Rules of Court. We recognise of course that attaching a condition(s) to the grant of legal aid creates additional workload for SLAB in monitoring observance, but given the relatively small number of medical negligence cases that it estimates it deals with each year – 160 (see Chapter 4) and the large numbers of those – around 70% (see Chapter 4) that are subsequently abandoned or dismissed, the extent of the increased workload would appear to be manageable.

8.35 **In terms of culture and awareness, we recommend a promotional and training role for SLAB in relation to raising the awareness and understanding of both solicitors and legal aid applicants as regards mediation in medical negligence disputes.** This might take the shape of guidance notes or leaflets, or specific training events. SLAB is best placed to determine what its role might involve and in doing so should clearly bear in mind its wider mediation and ADR interests. It should also bear in mind, and seek to be part of, any activities that emerge as a consequence of our recommendations regarding a future focus through a partnership approach under the auspices of NHS Education.

Defence gateways

8.36 We see the funding role of the defence gateways as only being in stage 2. Stage 1 is entirely for the claimants to fund either through legal aid, other means, or themselves. Where mediation has been chosen in stage 2 there are two possible approaches to funding it. Firstly, that both parties agree at the outset a cost split, which tends to be in practice, but not exclusively, 50 / 50. Given the flexibility offered by mediation that split could change as a consequence of outcomes reached. Alternatively, one side agrees to bear the costs, in most cases the defence; something we understand already happens in practice in some cases. There are therefore different options open to the defence gateways.

recommendations

8.37 The defence gateways agreeing to bear the costs may serve to encourage, but not force, people down the mediation route – particularly those who are legally aided and required to pay a financial contribution and those who are not legally aided (further widening access to justice). It may also serve defence cost interests through resolving matters earlier and avoiding costs associated with trial. **For these reasons, bearing the costs represents a sensible approach, and we recommend that the defence gateways consider adopting it where appropriate.** It makes particular sense as regards the taxpayer where CLO cases are concerned, and the claimant is legally aided and not required to pay a financial contribution. In that scenario the taxpayer would be no worse off, although we fully recognise there are different individual budgetary considerations – not least it would in effect be more money out of the health services "pot" which is cash limited and less out of the legal aid "pot" which is not.

An option to and within the complaints procedures

8.38 As mentioned earlier in the report some medical negligence disputes begin, and end, through the Complaints Procedures. Some also begin there and subsequently move to litigation. For those that begin and end it would appear, on the face of things, that there is no need for something different, such as mediation. That of course makes no recognition of the findings of the recent Complaints Procedures reviews which we mention in Chapter 6. It also assumes that the disputes have ended with the most constructive outcome and have not, for example, petered out as a result of being dropped by a patient or family because litigation was not an alternative option for them. There are undoubtedly cases like that, and cases that will have reached an outcome, but perhaps not the best possible for all involved.

8.39 Something different is required for disputes that have begun in the procedures and subsequently moved to litigation. The procedures should never prevent anyone involved from moving to litigation, but should not help encourage it being used – as they arguably do at present through "closing the door" as soon as a legal remedy and compensation is sought or suggested; leaving people with a litigation route as the only way forward.

8.40 Like the litigation gateways, the procedures can also be a gateway through which cases can be diverted to mediation. In considering this it is important to recognise that there are two different types of dispute that may need to be resolved. The first is the dispute where the person is seeking a monetary outcome and/or a legal remedy; the second where the person is not seeking a monetary outcome or legal remedy. There is also a third type of dispute where a person is complaining about a non-clinical matter arising in a clinical context.

8.41 So long as the procedures do not enable payments to be made for some, or all, claims and do not enable legal involvement – as is usually required as a consequence of the legal rights involved – mediation cannot be an integral part of the process for the purposes of resolving disputes which seek a monetary outcome or have legal involvement. It can, however, be a complementary option to the process and can serve to divert such disputes towards mediation or other forms of ADR at the earliest possible stage. We see the pivotal role in achieving that as resting with Complaints Managers / Officers. Not as mediators themselves, but as avenues through which advice and information on the other resolution options, including mediation, available to claimants can be provided. Such a role could not and should not be taken on without appropriate education and training for the staff concerned, and needs to be part of the concerted programme we mention earlier in this chapter.

recommendations

8.42 The position is different regarding the other types of dispute. In such cases, **we can see no reason why mediation cannot, and should not, become an integral part of the NHS Complaints Procedures** (as it is already in relation to the Independent Health Care Association's Procedures). **We therefore recommend it does and that the Scottish Executive in its current review of the NHS Complaints Procedures in Scotland gives consideration to this.**

8.43 We mention in Chapter 4 the use of conciliation in the procedures, which we described as, arguably, mediation by another name. If there is notable distinction between the two, it lies in how they are structured, with, in our view, mediation being more of a structured process. We do not therefore see mediation as being a direct replacement for conciliation. That should continue to be an integral part of the process. It encourages the same non-adversarial, more open climate that mediation offers; and is a complementary ADR option at a stage when a more structured option, such as mediation, may not be needed or appropriate. **We therefore recommend that the Health Services should take steps to enable and encourage a greater and more effective use of conciliation where appropriate, with a view to avoiding the need for any further ADR, including mediation.** Grampian University Hospitals NHS Trust is in the process of taking such steps. It is aiming to establish, early in 2002, what it calls an independent "Mediation Service Project" on site at the Royal Infirmary, Aberdeen. Through this, people with complaints and grievances will be able, if they choose, to try and resolve matters at the earliest stage to avoid serious conflict, perhaps negligence claims and complaints, and breakdown of relationships. It is, we consider, more an example of a conciliation process, rather than what we have defined as being mediation. Nonetheless, it is very similar, founded on the same principles and is to be commended, and the results of it should be considered widely.

8.44 For the most part, we see the more structured mediation process fitting in before any Independent Review Panel takes place, but there is no reason why, if a dispute lends itself to it, mediation cannot take place at another stage. It should be a step within the process that Complaints Managers / Officers and Independent Panel Convenors should be able to offer if they consider it appropriate and suitable. A key to its success will be the independence of the mediator from the health providers systems; a commonly raised issue amongst our evidence.

8.45 Disputes also need to be looked at on their own merits, not packaged rigidly within the process. A decision to mediate should not mean that if it fails, or does not settle the whole dispute, the procedure door is closed. Mediation should be one possible step in the process and a person's right of recourse to other steps within it should not be removed. That is consistent with people's right of recourse to litigation from the procedures and indeed mediation – if either of these are routes they choose to take.

Chapter 9

Providing a mediation service

9.1 Mediation must be a credible service that can meet demand. In this chapter we discuss service provision; setting and maintaining standards of service; the need to ensure power balances between patients and healthcare providers; and the need to ensure equality.

Service providers

9.2 Scotland does not have a wealth of providers with experience of mediating medical negligence disputes. Indeed, as we mention in Chapter 4, we understand that there has so far only been one medical negligence case mediated in Scotland. That does not mean that none exist with sufficient experience in that field – they do; or with considerable experience in mediation more generally, which could perhaps be effectively used in that field and certainly in the field of non-clinical disputes.

recommendations

9.3 **We do not see it as appropriate for us to prescribe who the service providers should be. That is a matter for those who actually commission any service. Rather, we have recommended four general principles to be considered in establishing service provision. These are:**

- The provider must be, and be seen to be, wholly independent of both parties and the systems. One of the most common issues raised throughout our evidence was the need for this. If the mediator is not independent, the credibility of mediation will diminish.
- Encouraging the growth of an indigenous mediation service in Scotland. This will build confidence in the service and allow it to meet the particular needs of Scottish Health Services, while recognising the specialities of Scots law and procedure. It will enable individuals in Scotland with experience of either or both of the medical and legal systems to develop as mediators. It is likely to prove to be a cheaper option than bringing in mediators from elsewhere and to create a more accessible service. The scope for Scottish provision is likely to increase if and when more usage is made of mediation. But we should not be parochial. We should, if need be, draw on the experience of mediation providers from elsewhere in the United Kingdom. In doing that we would be better placed to address the question of unknown demand, a position we are currently in.
- The creation of any new service provision body would be inappropriate at the present time. There are insufficient medical negligence claims in any one year to justify that. When the number of other disputes is added there is perhaps more of an argument, but we do not see a single body as being conducive to what we say about independence.
- The most important attribute of an effective mediator should be excellence in the skills required in the process of mediation. It is not a prerequisite to mediating medical negligence disputes to have knowledge of medical terminology and issues. While such knowledge is undoubtedly helpful, it can be acquired as part of preparation by skilled mediators.

recommendations

Setting and maintaining standards

Quality Standards

9.4 A number of mediation and legal bodies in Scotland, and elsewhere in the United Kingdom, accredit mediators to practice, and require them to maintain their skills by undertaking a programme of continuing professional development. An example of this is in the field of Community Mediation, where a stringent system of service accreditation is operated by the national umbrella body Mediation UK, and is recognised by, among others, the Legal Services Commission for England and Wales. Another example is the Association of Mediators, which has a Code of Practice. Regulation of individual mediators is also advancing through the introduction of National / Scottish Vocational Qualification in Mediation – set at Level 4 in recognition of the complexity and degree of autonomy involved in the mediator's task.

recommendations

9.5 Despite all this there are no nationally accepted mediation quality standards in the United Kingdom and little regulation of mediators in Scotland. **Following on from that there are no set and regulated national standards for mediating medical negligence disputes, or non-clinical disputes in a clinical context. We recommend that, in due course, there should be.** The success and credibility of mediation depends on the competence of the mediators. They must meet a minimum standard of competence and be able to show that they are properly trained and accredited. **In the meantime, while mediation is being established we recommend that the minimum competence criteria should include:**

- A programme of mediation training (lasting a minimum of 3-4 days).
- A separate assessment and accreditation stage with set competence criteria.
- A regular CPD programme for accredited mediators to maintain skills (2-3 days per annum).
- Confidential debriefing following mediations.

9.6 Those commissioning mediation should take these factors into account.

recommendations

9.7 In recommending the creation of set and regulated standards we do not propose that medical negligence cases in Scotland cannot be mediated until such times as they are in place. That would create what was described to us as "paralysis by analysis". It would simply serve to delay the projects we have recommended in Chapter 8. On the other hand it does not mean we see it appropriate for anyone to mediate. That may serve to diminish the credibility of mediation. **In the intervening period we therefore recommend that those mediators who are accredited by recognised mediation and legal bodies in the United Kingdom, and who have fulfilled the minimum criteria set out in paragraph 9.5, be recognised as being potentially acceptable to mediate.** The criteria set out above should help to determine the bodies and mediators worthy of recognition. Allowing that will enable mediation to be used now where it is appropriate and suitable. It will also provide valuable evidence to help inform the competency standards that need to be set.

9.8 Who should set the national standards? We see the Scottish Executive as being best placed to take this forward in partnership with others. There exists more than one single mediation stakeholder with a vested interest, and as such there is a need for a collective pulling together of all these interests to ensure that all concerns are fully and properly taken on board. **We therefore recommend that the Executive establish a Medical Disputes Forum (MDF) comprising relevant stakeholders to consider, develop and implement quality standards relevant to mediating medical negligence (and non-clinical matters in a clinical context) disputes.** The Forum might also serve as the focus for monitoring, and, as appropriate, helping to take forward, other recommendations we make in this report.

recommendations

Service Provision Standards

9.9 Of equal importance to the mediators' competence is the setting of service provision standards. Each provider must have a clearly defined and transparent set of policies and procedures that govern their activities. That will help to ensure an appropriate and consistent quality of service exists. **We therefore recommend that, in due course, there should be established a set of good practice standards to which service providers must adhere in medical negligence (and non-clinical matters in a clinical context). We recommend the setting and implementation of these should also fall to the MDF. The good practice standards that we recommend be included are:**

- Handling pre-mediation inquiries and offering objective advice about suitability of cases for mediation.
- Providing literature about the mediation process.
- Arranging the venue for the mediation.
- Handling the exchange of information prior to the mediation.
- Providing an appropriate form of agreement to mediate.
- Conducting such pre-mediation meetings as may be necessary.
- Providing appropriate post-mediation advice and follow-up.
- Binding all mediators to a published Code of Conduct, covering confidentiality, ethics, equal treatment and independence.
- Ensuring all mediators have professional indemnity cover.
- Providing a consistent pricing policy.
- Providing adequate administrative arrangements.

recommendations

Monitoring Standards

9.10 Having set quality and service provision standards it is vital that performance monitoring and evaluation tools are in place. These are fundamental to maintaining, and where necessary improving, the competencies and standards that have been set, and to issues of accountability. Initially at least, if the quality and service standards set out above are met, we consider that those commissioning mediators will be well placed to monitor the provision and provide information on what other steps may be taken. But, in the longer-term there should be clearly defined monitoring and evaluation arrangements in place. **We recommend this as being a further matter for the MDF to consider and implement.**

Power balance and ensuring equality

9.11 It is inevitably easier for the Health Services to assemble a team of legal, medical and other experts than for patients and their families. That presents a danger of there being a power imbalance in the mediation process in terms of support and advice. A defence that considerably outweighs the claimant may not be conducive to creating the necessary setting in which mediation needs to take place. Moreover, it has the potential of leading to poorer outcomes – particularly where patients and families are concerned. None of that would support the credibility and value of mediation as an option.

recommendations

9.12 It is important to recognise that the same principle applies no differently to the resolution of disputes through other means, such as litigation. It is therefore recognised that, so far as possible, there must be "equality of arms", that is, a fair balance between the opportunities afforded the parties involved. Each party must be given a reasonable opportunity to present their case under conditions that do not place them at a substantial disadvantage vis-a-vis their opponent. In the same way, the mediation process must ensure, as far as is reasonable, that a balance of power exists throughout. **One way of helping to cement the principle of balance of power is to build this into the Code of Conduct we have referred to above, and we recommend that this should happen.**

9.13 No one should be excluded from using mediation. It must be an option available to all. To achieve that, the process must, where necessary, allow for and enable the provision of services for different groups. For example, services to support those with a disability; those from minority ethnic groups; and those who, for a variety of reasons, would require patient advocacy or carer support. **As with a balance of power, we recommend that the issue of ensuring equality be built into the Code of Conduct.**

Chapter 10

Wider considerations

10.1 Our report has focussed on disputes involving patients and the health services in Scotland – primarily medical negligence disputes. Our terms of reference do not require us to look beyond that scope, but we have identified other areas in which we consider mediation has the potential for improving the resolution of disputes in the health sector. For example, disputes concerning employees, building projects, information technology provision, land and property, partnership issues and service provision. In all of these areas, mediation has resulted in resolution of disputes in other sectors. As we mention in Chapter 4, in Scotland the CLO has been involved in two mediations in difficult employment matters, and in England mediation has been used, for example, in disputes on major building projects involving Trusts. Commercial disputes may, in particular, often be well suited to mediation, especially when there are or may be ongoing contractual relationships between parties.

10.2 We have not considered these areas in any detail. We do not therefore provide any detailed discussion on them. We have, however, provided below practical examples of when mediation has been successful in resolving disputes in some of them.

figure 10.1

employee dispute

Over a period of approximately four years, a Trust and Mrs Z had found it more and more difficult to work together, and in particular to find a suitable working environment. She had initially been moved after complaints by her colleagues, but had not found the move to be congenial, and sought to return to a post similar to the original job she had held. Attempts to return to that type of job were hampered by her ill health, which accounted for substantial absences; and she reached a point where she found any dialogue with Trust management unacceptable. She raised a large number of grievances, which were upheld by a panel of the Trust.

By this point, it was apparent that there was a serious breach in the relationship between employer and employee. She remained on long term sick leave. A number of unsuccessful attempts were made to arrange other employment. Mediation was proposed in order to explore the issues and to see if a satisfactory resolution could be achieved.

The mediation took from 10am to approximately 6.30pm. The mediator met separately with both parties at the outset, to go over the written submissions which had been tendered, and then moved between the two rooms to which the parties had adjourned. After lengthy discussions, in which the mediator was able to crystallise the arguments in an objective and unemotional manner, a settlement was achieved. The mediation agreement, a compromise agreement and a reference were all typed up and signed that day, and indeed the employee was able to leave the Trust premises with a cheque for the full settlement figure.

figure 10.2

building project dispute

A Trust had entered into a contract for a major extension and refurbishment of a new hospital wing. The value of the contract was £2.7 billion, but there were cost overruns and a dispute arose with the contractor making an additional claim for a further £1.2 million.

Throughout the contract the contractor had generated a large number of technical queries and building work had necessitated unforeseen changes. The contract had, however, provided for such changes by incorporating contingencies. Payments were made monthly throughout the contract, but as work proceeded disputes arose about the value of the work undertaken. None of this came to the Trust's attention as the "client" until very late in the contract; the Trust being reliant on its design consultants to manage the contract on its behalf. In doing so the consultants maintained a position of the contractor not being entitled to additional payments being demanded.

There then followed a series of aggressive meetings between the contractor and the design consultants, and a lot of acrimonious correspondence. This went on for about two years and ended in deadlock with the contractor deciding to take the Trust to arbitration. At that point the Trust suggested mediation. The contractor was initially suspicious of this, but agreed. A crucial factor in his decision being his right to arbitration not being prejudiced if the mediation failed.

The mediation lasted two days. It began with both parties presenting their case; the Trust case by their solicitor, the contractor's case by a contract expert who had been engaged. Each party then went into its own room and there followed a series of separate meetings between the mediators and the parties. At the end of day one there was no sign of agreement, but the Trust Chief Executive commented that the dispute was nothing like as clear cut as he had been led to believe; the contractor did have one or two points that ought to be considered, but the advice he had received to that point was that there was no justification for paying more.

Day two followed a similar pattern with no sign of improvement until after lunch when things came together. The mediator had narrowed the gap between both parties to the point at which the Chief Executive and the contractor's chief negotiator met in another room and struck a deal that both parties could live with.

figure 10.3

service provision

dispute

A supplier of porterage and domestic services to an NHS Trust under a 30 year Private Finance Initiative contract claimed on invoices worth over £400,000 for services provided above the contractual level to meet the Trust's needs. This was disputed by the Trust on the grounds that the contract did not permit payment for the work done in the absence of formally agreed variations. A continuing relationship was inevitable, bearing in mind the enormous length of the contract, but the inter-party commercial relationship was very bad. After a very lengthy mediation day, running into the evening, during which one side nearly withdrew from the process, an agreement was reached to pay a proportion of the claim, and to establish fresh operating and review procedures between the parties. The parties both later commented that the business relationship had been significantly improved by the communication restored through the mediation, even though relationships continued to be strained for much of the mediation day.

ANNEX A

Group membership

The Rt Hon Lord Ross PC, FRSE	Vice-President, Royal Society of Edinburgh – Chairman
Dr David Blaney	Director of Post Graduate GP Education, South East Scotland
Miss Maggie Boyle	Chief Executive, North Glasgow University Hospitals NHS Trust
Mr Tom Divers	Chief Executive, Greater Glasgow Health Board
Mrs Pat Dawson	Head of Policy, Royal College of Nursing (Scotland)
Mr Hugh Donald, OBE	Partner, Shepherd & Wedderburn WS
Dr John Garner	Chairman, British Medical Association Scotland
Mr Ranald Macdonald	Legal Adviser, National Health Service Scotland Central Legal Office
Dr William Mathewson	Deputy Chief Executive, Medical & Dental Defence Union of Scotland
Mr Grant McCulloch	Partner, Drummond Miller, Solicitors and Estate Agents
Lord Patel, FRSE	Chairman, Clinical Standards Board for Scotland
Mrs Anne Smith, QC (now the Hon Lady Smith)	Faculty of Advocates
Professor John Sturrock, QC	Director, Core Mediation Ltd
Dr Charles Swainson	Medical Director, Lothian University Hospitals NHS Trust
Ms Helen Tyrrell	Development Co-ordinator, Voluntary Health Scotland
Mr Graeme Herbert	The Royal Society of Edinburgh – Group Secretary

ANNEX B

Sources of evidence

Academy of Medical Royal Colleges in the UK
Association of Personal Injury Lawyers
Action for Victims of Medical Accidents
Centre for Effective Dispute Resolution
Clinical Disputes Forum
Core Mediation Ltd
Faculty of Advocates
Family Mediation Scotland
General Medical Council
General Dental Council
Grampian University Hospitals NHS Trust
Health Service Ombudsman
International Bar Association
Independent Healthcare Association
Legal Services Commission
Lothian Health Board Complaints Officers
Medical Defence Union
Medical and Dental Defence Union of Scotland
Medical Protection Society
National Health Service Litigation Authority
NHS Complaints Association Scotland
North East Perthshire Post Graduate Education Group
The Patients Association
Royal College of Physicians of Edinburgh
Royal College of Surgeons of Edinburgh
Royal College of Physicians and Surgeons of Glasgow
Royal College of General Practitioners – Scottish Council
Royal College of Midwives – UK Board for Scotland
SACRO
Scottish Consumer Council
Scottish Independent Hospitals Association
Scottish Legal Aid Board
The Scottish Executive
Voluntary Health Scotland

ANNEX C

Pre-action protocol for the resolution of clinical disputes in England

This protocol is not a comprehensive code governing all the steps in clinical disputes. Rather it attempts to set out **a code of good practice** which parties should follow when litigation might be a possibility.

The **commitments** section of the protocol summarises the guiding principles which healthcare providers and patients and their advisers are invited to endorse when dealing with patient dissatisfaction with treatment and its outcome, and with potential complaints and claims.

The **steps** section sets out in a more prescriptive form, a recommended sequence of actions to be followed if litigation is a prospect.

Good practice commitments

Healthcare providers should:

- ensure that key staff, including claims and litigation managers, are appropriately trained and have some knowledge of healthcare law, and of complaints procedures and civil litigation practice and procedure;
- develop an approach to clinical governance that ensures that clinical practice is delivered to commonly accepted standards and that this is routinely monitored through a system of clinical audit and clinical risk management (particularly adverse outcome investigation);
- set up adverse outcome reporting systems in all specialties to record and investigate unexpected serious adverse outcomes as soon as possible. Such systems can enable evidence to be gathered quickly, which makes it easier to provide an accurate explanation of what happened and to defend or settle any subsequent claims;
- use the results of adverse incidents and complaints positively as a guide to how to improve services to patients in the future;
- ensure that patients receive clear and comprehensible information in an accessible form about how to raise their concerns or complaints;
- establish efficient and effective systems of recording and storing patient records, notes, diagnostic reports and X-rays, and to retain these in accordance with Department of Health guidance (currently for a minimum of eight years in the case of adults, and all obstetric and paediatric notes for children until they reach the age of 25);
- advise patients of a serious adverse outcome and provide on request to the patient or the patient's representative an oral or written explanation of what happened, information on further steps open to the patient, including, where appropriate, an offer of future treatment to rectify the problem, an apology, changes in procedure which will benefit patients and/or compensation.

Patients and their advisers should:

- report any concerns and dissatisfaction to the healthcare provider as soon as is reasonable to enable that provider to offer clinical advice where possible, to advise the patient if anything has gone wrong and take appropriate action;
- consider the full range of options available following an adverse outcome with which a patient is dissatisfied, including a request for an explanation, a meeting, a complaint, and other appropriate dispute resolution methods (including mediation) and negotiation, not only litigation;
- inform the healthcare provider when the patient is satisfied that the matter has been concluded: legal advisers should notify the provider when they are no longer acting for the patient, particularly if proceedings have not started.

Protocol steps

The steps of this protocol which follow have been kept deliberately simple[50].

Obtaining the health records

Any request for records by the patient or their adviser should:

- provide sufficient information to alert the healthcare provider where an adverse outcome has been serious or had serious consequences;
- be as specific as possible about the records which are required.

Requests for copies of the patient's clinical records should be made using the Law Society and Department of Health approved standard forms adapted as necessary.

The copy records should be provided within 40 days of the request and for a cost not exceeding the charges permissible under the Access to Health Records Act 1990 (currently a maximum of £10 plus photocopying and postage).

In the rare circumstances that the healthcare provider is in difficulty in complying with the request within 40 days, the problem should be explained quickly and details given of what is being done to resolve it.

It will not be practicable for healthcare providers to investigate in detail each case when records are requested. But healthcare providers should adopt a policy on which cases will be investigated.

If the healthcare provider fails to provide the health records within 40 days, the patient or their adviser can then apply to the court for an order for pre-action disclosure. The new Civil Procedure Rules should make pre-action applications to the court easier. The court will also have the power to impose costs sanctions for unreasonable delay in providing records.

[50] The protocol is accompanied by an illustrative flowchart showing the likely sequence of events in a number of healthcare situations.

If either the patient or the healthcare provider considers additional health records are required from a third party, in the first instance these should be requested by or through the patient. Third party healthcare providers are expected to co-operate. The Civil Procedure Rules will enable patients and healthcare providers to apply to the court for pre-action disclosure by third parties.

Letter of claim[51]

If, following the receipt and analysis of the records, and the receipt of any further advice including from experts if necessary, the patient/adviser decides that there are grounds for a claim, they should then send, as soon as practicable, to the healthcare provider/potential defendant, a letter of claim.

This letter should contain a clear summary of the facts on which the claim is based, including the alleged adverse outcome, and the main allegations of negligence. It should also describe the patient's injuries, and present condition and prognosis. The financial loss incurred by the plaintiff should be outlined with an indication of the heads of damage to be claimed and the scale of the loss, unless this is impracticable.

In more complex cases a chronology of the relevant events should be provided, particularly if the patient has been treated by a number of different healthcare providers.

The letter of claim should refer to any relevant documents, including health records, and if possible enclose copies of any of those which will not already be in the potential defendant's possession, e.g. any relevant general practitioner records if the plaintiff's claim is against a hospital.

Sufficient information must be given to enable the healthcare provider defendant to commence investigations and to put an initial valuation on the claim.

Letters of claim are not intended to have the same formal status as a pleading, nor should any sanctions necessarily apply if the letter of claim and any subsequent statement of claim in the proceedings differ.

Proceedings should not be issued until after three months from the letter of claim, unless there is a limitation problem and/or the patient's position needs to be protected by early issue.

The patient or their adviser may want to make an offer to settle the claim at this early stage by putting forward an amount of compensation which would be satisfactory (possibly including any costs incurred to date). If an offer to settle is made, generally this should be supported by a medical report which deals with the injuries, condition and prognosis, and by a schedule of loss and supporting documentation. The level of detail necessary will depend on the value of the claim. Medical reports may not be necessary where there is no significant continuing injury, and a detailed schedule may not be necessary in a low value case. The Civil Procedure Rules are expected to set out the legal and procedural requirements for making offers to settle.

[51] Accompanying the protocol is a template for the recommended contents of a letter of claim.

The response[52]

The healthcare provider should acknowledge the letter of claim within fourteen days of receipt and should identify who will be dealing with the matter.

The healthcare provider should, within three months of the letter of claim, provide a reasoned answer:

- If the claim is admitted the healthcare provider should say so in clear terms.
- If only part of the claim is admitted the healthcare provider should make clear which issues of breach of duty and/or causation are admitted and which are denied and why.
- If it is intended that any admissions will be binding.
- If the claim is denied, this should include specific comments on the allegations of negligence, and if a synopsis or chronology of relevant events has been provided and is disputed, the healthcare provider's version of those events.
- Where additional documents are relied upon, e.g. an internal protocol, copies should be provided.

If the patient has made an offer to settle, the healthcare provider should respond to that offer in the response letter, preferably with reasons. The provider may make its own offer to settle at this stage, either as a counter-offer to the patient's, or of its own accord, but should accompany any offer by any supporting medical evidence, and/or by any other evidence in relation to the value of the claim which is in the healthcare provider's possession.

If the parties reach agreement on liability, but time is needed to resolve the value of the claim, they should aim to agree a reasonable period.

[52]Accompanying the protocol is a template for the recommended contents of a letter of response.

ANNEX D

European Convention on Human Rights

Article 6 – right to a fair trial

1. In the determination of his civil rights and obligations or of any criminal charge against him, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law. Judgement shall be pronounced publicly but the press and public may be excluded from all or part of the trial in the interests of morals, public order or national security in a democratic society, where the interests of juveniles or the protection of the private life of the parties so require, or to the extent strictly necessary in the opinion of the court in special circumstances where publicity would prejudice the interests of justice.

2. Everyone charged with a criminal offence shall be presumed innocent until proved guilty according to law.

3. Everyone charged with a criminal offence has the following minimum rights:

   (a) to be informed promptly, in a language which he understands and in detail, of the nature and cause of the accusation against him;

   (b) to have adequate time and facilities for the preparation of his defence;

   (c) to defend himself in person or through legal assistance of his own choosing or, if he has not sufficient means to pay for legal assistance, to be given it free when the interests of justice so require;

   (d) to examine or have examined witnesses against him and to obtain the attendance and examination of witnesses on his behalf under the same conditions as witnesses against him;

   (e) to have the free assistance of an interpreter if he cannot understand or speak the language used in court.