

# Alternative dispute resolution and mediation

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Doctors and patients are not natural enemies. On the contrary, there is commonly a special relationship between them, with vulnerability and trust on one side and caring and professional expertise on the other.

A medical dispute can create turmoil of that relationship, particularly if it is conducted in the traditional adversarial procedure. Depending on how it develops, the patient may see the practitioner as uncaring and evasive and the practitioner may see the patient as threatening and ungrateful. Legal considerations, the requirements and strategies of indemnifiers, and the language and approach of litigation all serve to fuel antagonism on both sides. Any experience of hospitals or practitioners closing ranks to prevent access to "the truth" may heighten suspicion and hostility.

Currently, most medical disputes follow an adversarial path. This entails pursuing a formal claim for damages, through the courts by way of litigation if necessary. The initiation of litigation serves various functions: it signals a serious intention to prosecute a claim; it leads to the use of procedures enabling fact gathering and eventual verification to take place; it is a vehicle for providing an outlet to anger, frustration, and other feelings; it interrupts the limitation period; and, incidentally, it provides a potential framework within which settlement negotiations can eventually take place.

However, litigation also has shortcomings, both for patients and practitioners. For patients, the public perception is that the most serious failings are cost and delay. With the reduction in availability of legal aid very few ordinary families can afford to undertake medical negligence litigation. Although the move towards conditional fees, which is a form of "no win, no fee," may seem superficially attractive, it will have little effect in medical negligence while the plaintiff remains at risk of paying the huge costs of the defendants in the event of the action failing. Furthermore, solicitors are likely to undertake only cases with high probabilities of success, which are very difficult to identify in medical negligence cases. Although delay, unlike cost, may not actually deny justice to patients, it causes immense distress and hardship. The average time before a medical negligence case is resolved is about four years. Meanwhile the patient and any dependants may suffer considerable privation, and expensive care which may be urgently needed could be denied. For practitioners the years of delay while an allegation of negligence, often unjustified, hangs over them can cause untold distress.

As serious an issue for patients is the need to prove negligence and the difficulty in doing

so. Not only does this involve finding a medical expert prepared to criticise a colleague robustly but the burden of proof is so difficult to discharge that only a minority of medical negligence claims succeed at trial.

The more important shortcomings for patients and practitioners, and indirectly for health authorities and trusts and their managers, are, however, that the wrong issues are addressed because everything has to be reduced to pounds and pence and that the adversarial procedure turns patients into enemies of the healthcare providers. Although financial compensation may be important to claimants, that is by no means universal. The financial claim may often have little more than symbolic value for people seeking accountability – who, for example, wants £7500 or indeed any sum when they have lost a young child?

Accordingly, in common with other fields of activity, there have been moves to seek alternatives to litigation for medical disputes by using processes which effectively serve many of the functions of litigation but with the opportunity to avoid some of its negative consequences, and with the additional dynamic of constructive neutral intervention (see, for example, Kellett,<sup>1</sup> Leone,<sup>2</sup> and Reeves<sup>3</sup>).

## Alternative dispute resolution (ADR) processes

This paper examines alternative dispute resolution processes with particular reference to the medical context. These processes have a common thread – namely, the use of a neutral who impartially helps the parties to resolve their dispute. There are two fundamentally different ways in which the neutral can do so: by *adjudication*, in which the neutral makes a decision which is binding on both sides, and through various forms of *non-adjudicatory alternative dispute resolution*, in which the neutral has no authority to make any binding decision but instead helps the parties to arrive at their own binding agreement as to the terms of resolution.

Adjudicatory forms of alternative dispute resolution in the medical context are primarily arbitration or expert determination, though any other process involving decision making that was binding would fall into this category – for example, the way of dealing with disputes within the health standards inspectorate proposed by Action for Victims of Medical Accidents (AVMA) and the Association of Community Health Councils in England and Wales (ACHCEW). There is a view that adjudicatory processes should not be classed as alternative dispute resolution but in this paper they will be viewed as such.

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Non-adjudicatory alternative dispute resolution processes entail the neutral using various skills in facilitating a settlement of the dispute by agreement between the parties. Some of these processes may entail an examination of the merits of the dispute and an attempt to provide a non-binding opinion to help guide the parties in their settlement attempts, but because of the non-binding element these processes remain non-adjudicatory. Others do not consider the merits of the dispute, leaving the parties and their professional advisers to place their own weight on the factors relevant to settlement. In the absence of agreement the parties reserve the right to have the issues resolved by adjudication, whether by litigation or by an adjudicatory form of alternative dispute resolution. These non-adjudicatory, or consensual, forms include mediation, the mini-trial, and neutral fact finding experts.

This paper will focus primarily on mediation, as the form of non-adjudicatory alternative dispute resolution most widely used or considered by various authorities, as it can be used without any need for legislation or formalisation, and also as it addresses more than the formal allegations by the patient and therefore seems to be more suited to disputes between doctor and patient.

In several countries outside the United Kingdom, some forms of alternative dispute resolution are available through the courts as an alternative to the strict litigation process, known as "court attached" processes (for example, court attached arbitration, court attached mediation, judicial settlement conferences, and settlement weeks, also the concept of a "multi-door courthouse" used in the United States, under which cases are screened by an appointed court official to help decide which kind of process to use; see Brown and Marriott<sup>1</sup>). Although some of these processes are under consideration in the United Kingdom, they are not yet in effect and will not be mentioned further.

### **Adjudication of medical disputes**

Several alternatives to litigation exist where adjudication is required, as follows.

#### **ARBITRATION**

Arbitration is a privately arranged and confidential process by which a third party neutral, selected by the parties or through some agreed selection procedure, hears and determines the issues, and whose decision is binding. The arbitrator's approach may be judicial in its quality, but the procedures and rules of evidence may be simplified from the traditional court process, and special rules may be applied by agreement. So, for example, the arbitrator may be helped by an expert medical assessor; the way in which expert medical evidence is adduced can be specified; and extensive oral submissions can be largely replaced by written submissions. Arbitration in the United Kingdom is regulated by a statutory regimen, which provides a framework, with some freedom to move outside it.

Towards the end of 1991 the Department of Health issued a consultation paper on proposals for the arbitration of medical negligence claims.<sup>1a</sup> Based on ideas first put forward by Lord Griffiths at a conference of the Action for Victims of Medical Accidents in June 1991, its main proposals were for adjudication by a lawyer and two doctors with evidence restricted to documents and with no cross examination of witnesses. In early 1995 no decision had been made by the department on the proposals nor had the comments of the consultees been published. It is known, however, that there was little enthusiasm for the proposals from patients' or practitioners' representatives and it is unlikely that the proposals will be taken any further.

Arbitration services are available for medical claims (for example, the Chartered Institute of Arbitrators has developed an arbitration scheme for medical negligence claims within the National Health Service), but as arbitration is seen by many patients' groups as a watered down version of litigation which, save perhaps for cost and speed, is less fair to patients it is not generally considered an attractive proposition.

#### **EXPERT DETERMINATION**

Expert determination differs from arbitration in that the expert's functions and authority arise from the contract of appointment, subject to which a determination binding upon the parties is generally required to be made. There is no statutory framework (for an overview of the use of expert determination see Kendall<sup>5,7</sup> and cases of *Campbell versus Edwards*,<sup>8</sup> *Nikko Hotels versus MEPC plc*,<sup>9</sup> and *Jones versus Sherwood*<sup>10</sup>). Provided that there is no fraud or collusion and the expert makes a decision within the terms of his or her brief, which may not necessarily involve hearing oral or written submissions, there is not usually any basis for reviewing or appealing the decision.

There may be circumstances in which an expert determination is appropriate, but many disputants may prefer, if they seek an adjudication, to have the benefit of court procedures and appeal and review possibilities.

#### **MEDICAL INSPECTORATE**

As mentioned, the idea of dealing with disputes between patients and doctors within the context of a health standards inspectorate has been proposed by the Action for Victims of Medical Accidents and Association of Community Health Councils in England and Wales. There would be four separate commissions to deal with claims, complaints, disciplinary matters, and administrative problems. The advantage for patients would be that all issues would be addressed by one body whose different sections would be interconnected and thus able to share information. Practitioners would benefit because not only would considerable time be saved but once the issues were dealt with by the inspectorate, this would be finally conclusive as between practitioner and patient.

Claims would be investigated formally by the inspectors and most would be dealt with

administratively. When disputes did arise a tribunal under the High Court would adjudicate, using the inquisitorial approach of the inspector for establishing the facts but allowing the parties or their representatives to challenge them.

Although the proposals do not specifically include arrangements for mediation, the framework would readily allow for referral to mediation. The proposals are under continuing discussion and the idea of an inspectorate has been taken up by some of those concerned with the issue of risk management.

#### OMBUDSMAN

An ombudsman is usually an independent person whose role is to deal with public complaints against administrative injustice and maladministration and who has the power to investigate, criticise, and make issues public, and in some instances to make compensatory awards (see Mills<sup>11</sup>). As these functions comprise the examination and resolution of grievances outside the judicial system (see Birkinshaw<sup>12</sup>), and may include investigation and mediation, many alternative dispute resolution organisations view the ombudsman as properly coming under the broad heading of alternative dispute resolution.

Health service commissioners have been appointed for England and Wales pursuant to the National Health Service Act 1977 and the Health Services Act 1980. They may investigate complaints relating to alleged failures by health authorities or trusts to provide services or complaints of injustice or hardship suffered as a result of action taken by a health authority or trust. However, the limitations of their investigative powers do not give them significant relevance to individual medical negligence disputes. For example, they may not investigate complaints in which the person has a right of appeal or review to a tribunal or a remedy by way of court proceedings, nor in which the action of the health authority or trust was taken in connection with diagnosis, care, or treatment of a patient solely in consequence of the exercise of clinical judgment.

#### Mediation and other non-adjudicatory processes

##### SHARED ATTRIBUTES

Non-adjudicatory alternative dispute resolution processes including mediation share several characteristics. They are generally all conducted on a confidential and evidentially privileged basis, with the right reserved to go to trial (or to some other form of adjudication) if agreement cannot be reached. Compared with adjudication, they are generally relatively low risk, low cost, and expeditious. They tend to heal rather than exacerbate differences; and their success rate in most fields is relatively high. On the other hand, these processes do not constitute a panacea; there are situations in which their use would be inappropriate and in which a third party adjudication is necessary and proper; and they need to be handled with care and skill.

In risk management terms, these consensual processes are obviously more effective than litigation and other forms of adjudication. This is because in adjudication significant decisions are taken out of the hands of the parties, who become dependent on lawyers, expert witnesses, and an adjudicator. However, in non-adjudicatory alternative dispute resolution such as mediation, all decision making remains in the hands of the parties (and with the managers of health authorities or trusts when there is an obligation to indemnify) and there can be no outcome which is unacceptable to them (apart from reverting to adjudication). Inevitably, this is the most effective way to try to manage the risk of a dispute. Another significant factor is that these processes offer a forum in which parties can communicate more freely and can express concerns and offer explanations, and even apologies, if appropriate. They afford the opportunity for patients to understand the considerations that may have made a clinical decision more problematical and for practitioners to understand the feelings and concerns of the patient.

Traditional lawyers and negotiators sometimes query the value of impartial intercession, pointing out that they are capable of conducting a case and negotiating a settlement without this process. This view certainly has some validity. When constructive discussions and negotiations result in parties arriving at an agreed settlement there is no need for neutral intervention as offered by alternative dispute resolution processes. Unfortunately, in a significant majority of cases this is not the reality, at least until a very late stage, when time has passed, costs and risk have escalated, and both sides have had to experience much anxiety and emotional distress. Mediation and other forms of alternative dispute resolution can bring a new dynamic into the situation at any stage, with established procedures and skilled practitioners to help in those cases which cannot easily be settled by way of ordinary bilateral negotiations.

#### MEDIATION (CONCILIATION)

Mediation may be defined as a process by which disputing parties voluntarily engage the help of an impartial mediator, who has no authority to make any decisions for them but who uses certain skills to help them to resolve their dispute by negotiated agreement without adjudication (for details of the mediation process see Brown and Marriott,<sup>4</sup> Acland,<sup>13</sup> and Bevan<sup>14</sup>).

The term "mediation" is sometimes understood to be more proactive than "conciliation," entailing a higher level of mediator intervention, but sometimes the reverse usage is used. There is no consistency, but increasingly the trend is to regard these terms as interchangeable. Mediation is used here to include conciliation. This is not, however, to be confused with the conciliation which forms part of the present family health services authority complaints procedures. Although this form of conciliation is often helpful, in many cases it does not address all the issues worrying the

patient and specifically does not deal with compensation. The patient may “resolve” the complaint without being aware of all the facts and implications. That can mean that the matter is not finally laid to rest.

There is a broad framework for all kinds of mediation, but within this there is no single universal model that applies to all situations. Various factors may influence the way in which the mediation is conducted, as follows.

- (1) Different alternative dispute resolution organisations may follow different rules or codes of practice. Generally, these provide practical and ethical ground rules, and there is likely to be a broadly consistent approach.
- (2) Mediation may be *interest based* or *facilitative*, in which the parties are helped to explore their mutual interests and to try to arrive at a settlement which is in their respective best interests. Alternatively it may be *rights based* or *evaluative* in which event the mediator, personally or with other professionals or experts, may help the parties to assess their respective strengths and weaknesses with a view to their agreeing a resolution which has due regard to their respective rights, so far as these can be evaluated. Some mediators will work only in a facilitative mode, regarding evaluation as having no place in mediation; but even those who will work evaluatively are likely to do so only after exploring mutual interests facilitatively, because once a mediator evaluates, his or her impartiality may be regarded as suspect by one side or the other. If mediation is to be developed for medical disputes and be beneficial for risk management and to patients, an interest based model may need to prevail. Although a rights based process may be of interest and may have some relevance, there is a risk that this approach could perpetuate some of the problems and the attitudes of practitioners, managers, and patients that are inherent in litigation. It is unlikely that continued emphasis on rights would be capable of resolving all the issues between the parties. To take just one example, a patient may wish to continue to be treated in the same hospital or it may clearly be to his or her benefit for that to happen: whereas an interest based process could make this feasible, that may not be the case where the focus is on rights.
- (3) Management styles and practice and levels of intervention will vary from one mediator and model to another. Some mediators may adopt a minimal intervention approach, providing a forum and facilitating communications and negotiations between the parties. At the other end of the range mediators may tend towards greater intervention and directiveness; but in no case are parties compelled to accept a mediator’s views. Most mediators fall somewhere in between, using their skills and management authority to help the parties towards resolution without imposing any personal preferences.

- (4) Although many models of mediation involve a mediator working alone, there is also a model of co-mediation in which two mediators work together as a team. Although this may be more costly than sole mediation, it does offer various advantages including the possibility of having mediators from different disciplines – for example, a doctor and lawyer – working together.

Mediation applicable to medical disputes might proceed as follows.

*Stage 1* – Once appointed by both parties, the mediator (or the mediation organisation concerned) liaises with the parties (or, if desired, their solicitors) in order to arrange a meeting and a timetable for the delivery and exchange of documents. The period to be set aside for the mediation meeting would depend on the complexity of the matter, but two days would not be an unreasonable initial estimate in many cases. If more time was found to be needed it could by agreement be extended beyond the initial period. The mediation venue would, if possible, be neutral, and two separate rooms should be available if required.

*Stage 2* – Within an agreed period the parties’ lawyers provide preliminary details of the dispute to the mediator and to one another, in the form of written submissions and a bundle of documents, which would be likely to include medical reports and other relevant documents available to both parties, including those relevant to quantum. If legal proceedings have started copy pleadings are also furnished. Mediation cannot be started too early once proceedings have started. There is a view that mediation should await the close of pleadings and the conclusion of discovery, but most practitioners of alternative dispute resolution would probably regard that delay as unnecessary as the machinery for the definition and clarification of the issues and for the furnishing of relevant documents can be framed within the mediation process itself.

*Stage 3* – Where the issues are complex the mediator may have a preliminary meeting with the parties or their respective lawyers to agree the timetable and ground rules for the mediation.

*Stage 4* – The substantive mediation meeting is then held. The mediator is likely to meet together with the parties and their solicitors, with counsel if required, to discuss and explain the process. Each party (or more usually, though not necessarily, their lawyer) will then be given the opportunity to make an oral presentation of their case. Witnesses are not usually called, though the presentation might outline the broad nature of the evidence to be adduced if the matter were to go to trial. However, there is no reason why parties should not be able to agree with the mediator for expert witnesses to outline certain aspects in support of a presentation if this is considered helpful. There is no cross examination, but if the mediator approves, questions to clarify aspects may be asked.

*Stage 5* – After the parties have met in joint session and respectively presented their cases

negotiations then take place, facilitated by the mediator, either continuing in joint session, chaired by the mediator, or, more usually, in a series of separate meetings (called "caucuses") which the mediator has with each party. By assuring each party as to the confidentiality of matters discussed in the caucuses, except as the party may agree to have disclosed; by using the overview gained by this process; by shuttling from one side to another; and by using various skills and techniques the mediator helps the parties to narrow and resolve their differences and to arrive at mutually acceptable settlement terms.

*Stage 6* – The mediator may during this process use any other strategy which he or she may consider helpful. For example, the mediator may wish to see the parties together without their lawyers, or vice versa; or may allow an opportunity for explanations or discussion if appropriate; or discuss the matter with respective experts, either separately or, if so agreed, together; or seek additional information; or adjourn the mediation to enable the experts to consider certain aspects or for any other reason. The mediator is responsible for managing the process, which may be done in consultation with the parties; but the parties remain responsible for agreeing the outcome (subject to the parameters stipulated by the defence organisations, insurers, or indemnifying authorities when relevant).

*Stage 7* – If a settlement is reached it will usually be recorded immediately as a binding agreement or, when court proceedings are pending, as a consent order.

Defence organisations, insurers or indemnifying authorities (or the Central Fund if and when applicable) will need to give authority for the mediation to be conducted and for a binding settlement to be recorded. (In March 1994 the National Health Service Executive issued a consultation document *Clinical negligence: proposed creation of a central fund in England*. Under the accepted proposal, a fund would be established to which affiliated trusts would make contributions from which the larger compensation payments would be made. The fund would be administered by a special health authority; and the proposal specifically provides that "fund managers should be consulted before a claim is settled and should seek to dissuade trusts from settling at an early stage cases which properly could be defended" and that they may at their discretion take over the management of any claim.) As when authorising settlement negotiations, they may provide parameters for acceptable levels of settlement. Their representative may attend the mediation meeting or may make alternative arrangements for the settlement terms to be confirmed while the mediation is under way. It is not usually acceptable to conduct a mediation, with its preparation and perhaps some days of meetings, if either side does not have the authority to record a binding settlement if it is reached.

The qualities, skills, qualifications, and attributes needed for effective mediation of medical disputes are considered below.

#### MINI-TRIAL

The mini-trial is not a "trial" at all, but rather another kind of assisted negotiation: it may be seen as a form of evaluative mediation (see Brown and Marriott,<sup>4</sup> Green,<sup>15 16</sup> and Wilkinson<sup>17</sup>). In the mini-trial the parties have the case presented to them by their respective lawyers on an abbreviated non-binding basis, to enable them to assess the strengths, weaknesses, and prospects of the case. In effect, the parties themselves become a tribunal informally hearing the case (resulting in the United Centre for Dispute Resolution in the United Kingdom calling this process the "executive tribunal"). With the benefit of these insights the parties with their legal representatives have an opportunity to enter into settlement discussions on a realistic basis.

A key figure in this process is a neutral adviser, who is usually someone with authority in the field of the dispute, and who may chair and manage the process, asking questions of the presenters and clarifying points for the parties. If required, the neutral adviser may give a non-binding opinion on the case. The adviser may also adopt a facilitative or mediatory role in any settlement discussions which may follow.

The case is usually presented in accordance with an agreed procedure and timetable. Ordinarily no witnesses are called, but expert witnesses might explain technical aspects or key witnesses may explain parts of the case. Other devices may be used to illustrate the case, such as charts, photographs, or films. The neutral adviser helps the parties to understand and form their own views on the case before they rejoin their respective lawyers to consider and discuss what they have observed and learnt.

#### OTHER FORMS OF ALTERNATIVE DISPUTE RESOLUTION

The various other alternative dispute resolution processes include, for example, the *neutral fact finding expert*, in which the parties jointly appoint a neutral expert to investigate facts and form a legal or technical view either about certain specified issues or about all issues generally and to make a non-binding report to the parties which helps to inform any settlement discussions that may then take place. "*Med-arb*" is a process in which the neutral attempts to help the parties to settle their dispute through mediation; but if this is unsuccessful, he or she then makes a binding determination as arbitrator. "*Med-arb*" has dangers as well as advantages and needs to be selectively and carefully chosen and applied; it would not seem to be appropriate in the ordinary course of medical disputes. Goldberg *et al*<sup>18</sup> quote Professor Lon Fuller as questioning whether if the same person acts as mediator and then as arbitrator, in addition to damaging his efficacy as a mediator, he would not have "fatally compromised the integrity of his adjudicative role." Alternatives have been devised in the United States – for example, allowing parties the option of either proceeding with the arbitration if the mediation fails or of

opting out of it (Goldberg *et al*<sup>19</sup>) or treating the mediator as an advisory arbitrator whose opinion is authoritative but non-binding.

Another alternative dispute resolution neutral role that has been successful in the United States is the *early neutral evaluator*, who is appointed by the court at an early stage. He or she considers the documents, meets the parties and hears oral presentations, and then expresses a non-binding view on an off the record and evidentially privileged basis. This is followed by helping the parties to consider how to conduct the litigation more expeditiously and economically, devising plans for conducting the discovery of documents, sharing material data and expediting procedures, and helping the parties to explore settlement possibilities and alternative dispute resolution processes which might be suitable for the resolution of the issues (see Levine<sup>20 21</sup>).

### No fault compensation

No fault compensation is not usually regarded as an alternative dispute resolution process, but it needs to be mentioned because many see it as an attractive alternative to adversarial litigation (see Spastics Society<sup>22</sup> and Royal College of Physicians<sup>23</sup>). Its basic premise is that when a medical "accident" takes place the patient is entitled to compensation without having to prove negligence. In many of the more straightforward cases this is an enormous advantage and leads to many claims being settled quickly and without lawyers. The major problems with such a procedure are, firstly, that the definition of an accident remains with practitioners; secondly, the potentially high cost of compensating all accidents; and, thirdly, the fact that other issues such as accountability are not dealt with.

Sweden, Denmark, and Finland operate compensation systems which purport to be of this type; however they are not truly "no fault" systems. In effect, as the accident must not have been foreseeable, they are fault based, and the arbitrary selection of accidents which merit compensation is wholly unsatisfactory. In New Zealand a no fault system existed for many years, covering all accidents, including medical accidents. A major drawback from the patients' viewpoint, and indeed risk management generally, was that accountability was ignored. In 1994 because of the cost the government totally emasculated the system, leaving many claimants without remedy as the right to go to court had long since been abolished.

### Mediator's role, attributes, skills and qualifications

#### ROLE AND FUNCTIONS

Mediators combine several roles and functions, which may overlap. These include the mediator as manager of the process, with responsibility for maintaining order and regulating the proceedings; as information gatherer, receiving information both directly through open and confidential proceedings and also by watching for non-verbal signals and by getting data from third parties; as reality tester and evaluator, helping parties to appreciate whether their

ideas, perceptions, or proposals are realistic; as scribe, if required, helping the parties to record any settlement terms; and as settlement supervisor, if required, ensuring that terms of settlement are properly implemented and resolving any issues arising during the course of implementation.

#### ATTRIBUTES

Attributes, the inherent personal qualities and traits, rather than learned skills and techniques, required of mediators include the following.

- Sensitive understanding of issues and a respect for parties' concerns
- Sound and judicious judgment
- A creative and constructive response to problems
- Integrity and trustworthiness
- Flexibility and an ability to cope with changing circumstances
- An empathetic approach
- Authority to manage the process and an ability to work autonomously.

#### SKILLS

Skills may be learned or intuitive, and those of mediators include the following.

- Communication skills, which include listening to the parties and appreciating their views; observing non-verbal communications; helping the parties to hear and understand one another; asking questions effectively; reframing when necessary, by changing a frame of reference to give events a different yet correct meaning or perspective; and summarising properly
- Managing conflict and allowing the opportunity for parties to ventilate their emotions without damaging the prospects of negotiating an effective outcome
- Encouraging negotiation and developing a problem solving mode
- Managing the process in a firm, sensitive, impartial manner
- Facilitation of communications, discussions, and negotiations with a view to achieving an agreed outcome
- When working in an evaluative mode, expressing personal views without undue pressure and enhancing rather than damaging the prospect of agreed resolution.

#### QUALIFICATIONS

There are no formal qualifications to act as a mediator, but it is generally accepted that special training is necessary and this is provided by several alternative dispute resolution organisations, most of which will provide mediator accreditation and some of which may maintain a panel of approved neutrals.

Mediators bring into the process their personal attributes and skills; their specialised training; their experience as neutrals; and, of course, their own individual professional, business, or personal backgrounds. There are mediators from a wide range of occupational backgrounds, including law, medicine, accountancy, management, industry, social and community work, and counselling and other mental health fields.

Two kinds of expertise can be brought into the mediation process: one is substance expertise, which is the specialist knowledge of the subject matter of the dispute, and the other is process expertise, which is proficiency in and understanding of the mediation process itself. Given the choice, process expertise must be the more important in choosing a mediator as a competent expert in mediation can generally adapt to dealing with different kinds of disputes; but if a mediator has both process and substance expertise, that might be an ideal combination.

**Conclusion**

The present response to a patient’s misgivings about any particular treatment or an assertion of professional error, as well as the whole system of managing and resolving any disputes that may then arise, require a fundamental re-examination. This system lends itself to an adversarial and potentially hostile confrontation.

There are several contributory reasons, as shown in the box.

**Reasons for adversarial nature of disputes**

Need to establish negligence by the practitioner transforms a clinical occurrence with negative implications into a compensatable claim.

Claims may be asserted, or be perceived as being made, in a contentious way.

Professional culture does not prepare practitioners for the possibility of lapse or error or how to respond.

Finding of negligence could have adverse professional implications for practitioners.

No opportunity to consider the clinical event in an impartial and objective way.

Economics often control the strategy of litigation, which commonly requires the claimant to overcome many obstacles to establishing a case.

Lawyers have established strongly partisan approaches and are grouped into those supporting claimants and those defending practitioners, with little room for middle ground.

Often medical experts too develop strongly partisan approaches.

The language and approach of litigation have an effect of spiralling mutual antagonism upwards.

Emotions may understandably run high on both sides.

These and other factors all combine to create a situation in which the mere hint of “negligence” may lead to a knee jerk reaction of determined defence.

This situation could be reviewed at different levels. At a fundamental level the whole question of negligence and causation could be re-examined. This has already been mooted with the notion of no fault compensation and the proposals of the Action for Victims of Medical Accidents and Association of Community Health Councils in England and Wales for a health standards inspectorate; and the last word may not yet have been spoken on

these basic issues. At another level the adversarial procedure could be re-evaluated and new procedures developed to improve the conduct of medical disagreements and claims, from their inception to their conclusion. There is no reason why representatives of medical groups, patients’ groups, and other interested groups should not be able to consult with one another and devise improved procedures to replace or supplement existing ones. To some extent this is already happening. This could widen and enhance resources for resolving issues constructively while respecting the concerns of all parties and preserving all existing safeguards, such as the right to trial where other options fail.

Meanwhile, practitioners, patients, and managers do not need to wait for fundamental organisational changes before they start implementing ways of widening their resources for dealing with medical disputes. As indicated here, processes already exist and are available in appropriate cases to allow parties to try to resolve their differences without proceeding to litigation or to supplement an adjudication with a parallel procedure for mediation, dispute management, or other third party assistance (box).

**Some alternative dispute resolution organisations and practitioners**

The Chartered Institute of Arbitrators, International Arbitration Centre, 24 Angel Gate, City Road, London EC1V 2RS (tel 0171 837 4483) offers an arbitration scheme with a mediation option.

The Centre for Dispute Resolution (CEDR), 100 Fetter Lane, London EC4A 1DD (tel 0171 430 1852) has a specialist medical sector working party for medical negligence and other healthcare disputes.

ADR Group, Equity and Law Building, 36–38 Baldwin Street, Bristol BS1 1NR (tel 01179 252 090), network of lawyer mediators in the UK, provides mediators for various kinds of disputes, including medical negligence.

The British Academy of Experts, 90 Bedford Mansions, Bedford Avenue, London WC1B 3AE (tel 0171 637 0333) maintains a register of mediators.

Mediation UK, 82a Gloucester Road, Bishopston, Bristol BS7 8BN (tel 01179 241234) is an umbrella organisation whose members cover a wide range of mediation activities.

Mediation and other alternative dispute resolution processes are not intended to replace litigation, which continues under the present system to have an important role when a third party adjudication is necessary. They do, however, provide a much wider range of alternative processes than mere confrontation. It has been said of litigation that, “If the only tool you provide a person with is a hammer, you should not be surprised if all he can see are nails.” Alternative dispute resolution offers a toolkit which preserves all established options but allows other possibilities to be introduced

into the resolution of disputes. In medical disputes, in particular, it allows for the possibility of incorporating into agreed ground rules any permutation of fact finding, explanation and dialogue, facilitation with communications, assisted negotiation, neutral expert settlement guidance, accountability, and any other factor that parties might consider to be important. Settlement terms can, and sometimes need to, include not only financial aspects but also a form of words that parties find mutually acceptable, in a way that conventional litigation cannot achieve.

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