Look who's (not) talking: The use of mediation in medical negligence claims in Ireland

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Abstract

This paper looks at why mediation is not more widely used in medical negligence claims in Ireland. It is based on research, undertaken in connection with an MA in Mediation and Conflict Intervention at Maynooth University, during which eight solicitors working in the field of medical negligence shared their experience and perspectives on the use of mediation in this area. The research finds that mediation is in use but only as part of the convoluted litigation system and the style used is focused on the legal interests of the parties rather than any emotional needs. The Irish State has introduced some measures to facilitate the use of mediation but there is no coherent strategy and low public awareness. Legislative changes to streamline the litigation system are on the way, but if the parties' needs and interests are to be served, a more facilitative, people-centred mediation style should be adopted, supported by a coherent, government sponsored, restorative justice strategy.

Key words

Medical negligence, mediation, restorative justice.

Introduction

This paper presents findings from research undertaken in connection with an MA in Mediation and Conflict Intervention at Maynooth University. The focus of the research was to gain insight into the use of mediation in medical negligence claims in Ireland and to understand whether there were opportunities for a more restorative approach to the settlement of such claims.

Background

The literature indicates that globally hundreds of thousands of people are injured in healthcare settings every year and that the majority of these injuries can be attributed to negligence on the part of healthcare professionals. Medical negligence contributes to more deaths each year in the US than motor accidents, breast cancer or AIDS (National Academy of Sciences, 2009). Medical negligence is described as ". . . the failure to provide a standard level of care or, in other words, the delivery of substandard care." (Sohn, 2012:50)

When injury occurs, patients and/or their families, may seek (and sometimes need) financial compensation. However, often they just want an explanation as to what happened, an apology and some reassurance that what happened to them will not happen to someone else (Liebman, 2004; Robbennolt, 2009; Regis, 2010; Helo, 2017). Medical errors have consequences not just for the injured party but also for their families and the healthcare professionals involved (Helo, 2017). Medical professionals say that when things go wrong they want to be open and say sorry but the fear of litigation and worry about the impact on their reputation and insurance premiums prevents disclosure (Mazor et al. 2006; Robbennolt, 2009).

Frustrated with the lack of communication and openness from the healthcare provider, injured patients often turn to litigation (Bismark et al.,2006; Helo, 2017). Medical negligence litigation places an increasing financial burden on healthcare systems and leads to a defensive approach to medicine (Boothman, 2016; Helo, 2017; Lin et al., 2018). Cases run for years exposing the injured party, and often the healthcare professional, to ongoing distress as the details of the incident are pored over again and again.

Some jurisdictions have disclosure mechanisms which allow medical practitioners to apologise when something goes wrong without it being seen as an admission of liability (Boothman, 2016: Helo, 2017). Doctors can talk to patients directly without the fear of litigation — this offering a more restorative outcome. There is a focus on the needs and interests of all the parties involved and it avoids the

adversarial nature of the legal world (Gunther, 2015). In Michigan open dialogue between patients and doctors, without any legal intervention, reportedly cut claims by more than 50% per year and also reduced resolution time (Helo, 2017).

A number of injured patients in New Zealand, when presented with easily accessible monetary and/or non-monetary remedies, chose the non-monetary route (Bismark et al., 2006). Jenkins et al. (2017) describe significant savings in terms of legal fees, time and emotional distress derived from the mandatory pre-suit mediation model introduced by a group of hospitals in Florida. Data from the eight-year programme showed an 87% reduction in legal expenses compared to traditional litigation and an average receipt-to-resolution time of less than six months. With legal claims against the UK's National Health Service hitting £1.7bn in 2017, what was the National Health Service Litigation Authority has now become NHS Resolution, signalling an ambition to cut litigation and fast track resolution using tools such as mediation (Dyer, 2017).

In Ireland, the State Claims Agency (SCA) reported 3,196 active clinical claims at the end of 2018, an estimated outstanding liability of €2.33 bn and year-on-year increases in the numbers of claims and associated legal costs (National Treasury Management Agency, 2018). It states that 98% of its cases are resolved through negotiated settlements either with the plaintiff's legal advisors or through a process of mediation. No further breakdown is offered, but the year-on-year increase in legal fees, as shown in the report, would not suggest a widespread use of mediation or other dispute resolution mechanisms, particularly at the early stage of proceedings where legal costs can be minimised. This is in spite of various legislative and policy changes which allow for disclosure and apology without the risk of such an apology being construed as an admission of liability.

Since the Mediation Act 2017 became law in Ireland, all solicitors are required to advise their clients of the option of mediation. If the client decides to litigate, the documentation initiating the proceedings must be accompanied by a statutory declaration from the solicitor stating that they have performed their obligations with respect to mediation (Mediation Act, 2017). However, it seems that even if

the majority of cases are settled outside the court room, claimants are still forced to access traditional litigation routes with their 'justice' being delivered on, or near to, the steps of the court after a lengthy pre-trial process.

Method

Given the important 'gate-keeping' role that solicitors play with respect to the world of litigation and mediation, it was decided to focus the research on this population. Semi-structured interviews were conducted with eight solicitors (some who acted on behalf of the healthcare provider/insurers and some who represented the injured party) in 2019. The interviews were transcribed and coded to allow for a meaningful narrative to be elucidated.

Findings

All participants agreed that the way that medical negligence claims are currently handled in Ireland is less than satisfactory for all the parties involved. They echoed the literature — people who have been injured or families who have lost loved ones in healthcare settings want to know what happened, why it happened and that something will change to avoid it happening to someone else. They also want an acknowledgment of what happened, an admission of liability and an apology.

Those injured tend to first seek answers from the doctor involved in their care or through a hospital complaints procedure and only turn to a solicitor when no satisfactory information is forthcoming. As one participant said, generally speaking patients do not want to sue their doctors or their healthcare providers. The erstwhile patient, now the 'potential plaintiff', enters into what can be a very lengthy legal battle with the healthcare provider, the defendant, in an attempt to understand what went wrong with their care.

The participants described the lengthy and costly process that is medical negligence litigation. Legal aid is not available to medical negligence claimants so some solicitors fund the pre-trial work in anticipation of getting their costs

covered if the claim is successful. Years may elapse before the legal teams even engage with each other to discuss the merits of the case and how best to proceed.

Most medical negligence claims in Ireland do not get to trial. Trials are risky; the loser pays the winner's legal costs which could run to hundreds of thousands of euros. If the uninsured plaintiff loses, they will be liable, not only for their own legal costs, but also those of the defendant. If the court finds for the plaintiff, the defendant loses control of the amount of damages they might become liable for. In addition, court proceedings are stressful and attract publicity which may be unwelcome for both sides.

It appears that most cases are settled out of court. Settlement meetings can happen any time during the litigation process but the majority happen within weeks of the scheduled court hearing date, meaning that all of the expensive pre-trial work has already been done. Settlement meetings involve a conversation/negotiation between the legal teams about money; the plaintiff and the healthcare insurer, rather than the provider, may be present but they tend not to meet.

One participant said that plaintiffs had little appetite for seeing their doctor at this stage —too much time had passed and an apology can often seem too little too late. Some participants indicated that it was very difficult to get an admission of liability and an apology — the very thing that the clients articulate as being important to them at the outset. In some cases, compensation is paid but the healthcare provider will refuse to admit liability or to offer an apology. One participant said that they explained to their client that the payment of money was in effect an admission.

It was suggested that the current system does not best serve the needs of the medical practitioners either. The case is taken over by the healthcare providers, the insurer or indemnifier and a settlement reached even though the practitioner may feel that they have done nothing wrong.

Where mediation was used it was described as a 'glorified settlement meeting' by a number of the participants. Three participants had not used or been involved in mediation. All but one said they were advocates for the use of mediation. The participants indicated that mediation would be used as an alternative to a settlement meeting in complex and sensitive cases where someone external to the parties' legal teams was needed to bring home a nuance or help facilitate a conversation between them. One participant said they had used it in time-sensitive cases where the life expectancy of the plaintiff was limited. Another participant said it was very necessary where an injured party had to be heard.

Mediations typically happen just before the trial date — participants said they need to know the strengths and weaknesses of each other's case before considering mediation. The cast of the mediation meeting is the same as that of a settlement meeting except that a mediator, who is almost always a senior counsel, is now engaged. According to the participants the mediator in these cases needs to understand how the legal process works in order to be able to manage the parties' expectations about the outcome and the potential risks of not arriving at an agreement and ending up in court. One participant said that in essence mediation in these cases is an 'assisted negotiation' where apology rarely features. The healthcare provider is generally not in attendance but it was acknowledged that mediations where a clinician was present were satisfying and liberating not just for the patient and their family but in some cases for the healthcare provider as well.

Two barriers to the more widespread use of mediation were voiced. Plaintiff solicitors do not tend to request mediation — it might suggest a lack of confidence about the strength of their case. They generally wait until the defence team invite them to mediate and these invitations tend to arrive quite late in the day when all of the preparatory trial work has been done and they are on 'a war footing psychologically'. A mediation at this point can be a distraction and can delay a trial, although it can also be seen as an opportunity to see what the other side might argue at trial. Mediation also introduces an additional cost, that of the mediator and the venue, on top of all of the expensive, time-consuming

preparatory work that has already been done. A settlement meeting may well serve the same purpose as a mediation at this point.

The term restorative justice was not used unprompted by any of the participants.

Discussion and Recommendations

Three themes, that is the system, the style and the state, emerged from the discussions with the participants about the use, or lack thereof, of mediation in medical negligence claims in Ireland. These themes are discussed below.

The System

All of the participants agreed that the current court-based system for handling medical negligence does not best serve their clients' needs. The patient waits years hoping to learn more about what happened to them and to hear someone say sorry. The treating doctor is excluded from the system, their case being taken over by the insurer who may decide from an economic perspective to settle, even though the doctor may believe that they have done nothing wrong.

The absence of legal aid means that many solicitors fund cases in anticipation of winning for the injured party — one participant said that they were not going to be paid unless they win. By the time both sides have completed their investigations and are ready to proceed one participant described being on the 'warpath psychologically'. They need to protect their investment as well as doing a good job for their client. An offer of mediation from the defence at this point can be seen as a distraction — an unnecessary delay. Mediation can be seen as an unnecessary added cost and unless it is a particularly difficult case, where there are several points in dispute, the interviewees did not seem all that keen to invest. They might consider it if was offered but invariably the plaintiff team will not request it. They seem instead to favour a settlement meeting where the two legal teams can hammer out an agreement. As one participant said: it is all about the money.

The elapsed time takes its toll on the parties' appetite to meet with each other. The participants suggested that often, because of the 'wringer' effect of the legal process, the plaintiff never wants to see the doctor involved again. They suggest that the relationships are beyond repair and that a financial settlement, in *lieu* of an admission or apology, is sufficient. This is not necessarily borne out in the literature — one medical negligence claimant said that even after eight years of litigation they still regretted not getting an apology (Naessens, 2017).

It seems then that time and cost are two factors that act against the more widespread use of mediation in medical negligence cases. Because it takes so long for the legal teams to understand the strengths and weaknesses of each other's case, they are very far into the litigation process and the traditional route of out of court settlement, without the added cost of a mediator, seems to be preferred. Time can also impact the attitude of the parties and dampen their need to hear, and be heard by, the person who caused them harm.

The Mediation Act 2017 requires all solicitors to advise their clients to consider mediation prior to issuing proceedings. If mediation was to be taken up when the client first consults the solicitor, it would negate the two barriers described above. This point is most relevant for those solicitors who act on behalf of the plaintiff. If time and money invested in a case creates a reluctance to offer to mediate late on in the litigation process what are the barriers to seeking out mediation before litigation? One interviewee, when asked this question, raised the issue of who would pay. Since there is no financial support for plaintiffs in these cases it is easier to cover costs, such as the cost of a mediation, as part of a litigation process where there is an insurer involved. When the researcher probed about there being too much at stake in terms of loss of earnings from litigation for lawyers one response was that the lawyers are versatile and would be able to make up for the loss of money from lengthy trials by being able to handle more cases. One interviewee was asked about the specifics of their conversations with their clients about mediation. The participant said that they would talk their client through the pros and cons of mediation but that they would not necessarily

advocate for it. Further research into the possibilities of pre-litigation mediation would seem to be of merit.

The Style

The terms 'glorified settlement meetings' or 'assisted negotiations' were used by the participants to describe the style of mediations used in medical negligence cases — the focus is on the money. An 'evaluative' style (Zumeta, 2018) where the parties sit in separate rooms and the mediator shuttles between them carrying offers and counter-offers was described. Rarely, if ever, does a plenary session take place where all the parties are in the same room. The medical practitioner is not seen to have a role to play — they are instead represented by their insurer or indemnifier.

The mediator is usually a senior counsel because, according to the participants, it is important to have someone who is able to understand the pros and cons of the arguments being used and how they might be viewed by a trial judge. This in effect is a forum where lawyers talk to lawyers through a lawyer. It is consistent with the explanation used by Zumeta (2018) to explain evaluative mediation — there is more interest in the legal rights than in the needs and interests of the disputing parties. One participant commented that even if nothing comes of it, at least the sides have had a chance to rehearse their arguments before the trial. The mediator is bringing their professional knowledge and experience to help smooth the dialogue between the professionals.

But what about the patient? Typically, the patient is present and sits with their legal team listening to the arguments about how much their injury is worth. On occasion, as a condition of the mediation, the healthcare provider is present and sits with the defence legal team until the deal has been done. The mediator will then facilitate a brief meeting between the patient and the healthcare provider. Two of the participants described being involved in mediations where this has happened and both talked about how satisfying and worthwhile it was for their clients.

The style of mediation used seems to offer little more than a settlement meeting. There does appear to be an awareness that the patient's, or indeed the clinician's, needs and interests are not best served by the style utilised in these cases. One participant reflected that it might be more 'advantageous' if there was more talking by the non-lawyers and the lawyers were just there to oversee the deal. If, as the literature suggests, oftentimes the parties just want to have their voices heard (Liebman, 2004; Robbennolt, 2009; Regis, 2010; Helo, 2017) mediation would seem to be the perfect vehicle to allow for this.

A number of the participants seemed open to the possibility of adopting a more facilitative style where the parties had a greater voice and there was as much focus on their needs and interests as there is on the legal arguments and quantum. This merits further conversation and investigation.

The State

The high cost of medical negligence claims is driving people to look for alternatives to the way things have been handled up until now (Murphy, 2018). A plethora of legislative and policy changes have been introduced by the Irish State over the last few years, but these could hardly be described as signalling a coherent strategy. So, is there more that the State can do?

Pre-action protocols for instance, which one interviewee suggested would transform their work, are still geared towards streamlining the existing legal system. The Mediation Act (2017), requires solicitors to advise their clients about the availability of mediation as an alternative to litigation but no one appears to be policing the relatively low uptake. Even though the State indemnifier, the SCA (State Claims Agency), appears to be moving from a 'deny and defend' approach to earlier engagement with the plaintiff, it seems that most of the mediations, when they take place, are happening too late in the day to make any conversation, or apology that might be offered, meaningful to the patient or their family. Even if one leaves aside the emotional needs and interests of the parties, earlier use of mediation may reduce the not insignificant legal bills associated with medical

negligence claims which, according to the SCA, are in excess of €63m for 2018 (National Treasury Management Agency, 2018).

Successful alternative schemes such as those described earlier have been introduced in other jurisdictions but do not appear to be on the horizon in Ireland. Restorative practices, the aim of which is to give back control to the parties involved to engineer their own settlement and arrive at an agreed resolution, would seem worthy of further investigation for medical negligence cases. The creation of a restorative justice strategy similar to that scripted by Marder et al. (2019) in relation to the criminal justice system would seem like a great place to start.

It would seem that there is low public awareness around mediation. Solicitors are obliged to advise their clients about the option of mediation but once the patient seeks the advice of a solicitor the scene may be set for litigation. In order to increase the uptake of mediation, a public education programme, where alternatives to litigation were explained, may result in would-be litigants seeking out a more restorative resolution method, without having to submit to the vagaries of the traditional court-based redress system. The question of who pays would need to be addressed — the SCA's annual legal budget would seem to be a good place to start when looking for funding for an alternative approach. More research is needed into the impact of raising the awareness and accessibility of mediation with patients and medical practitioners.

Conclusion

The research suggests that the number of cases benefiting from mediation is on the rise. However, far more cases are following the more traditional route of a High Court hearing or a settlement meeting typically just before the trial date. The current system not only creates barriers for the use of mediation, but it works against itself in terms of efficiencies and effectiveness. The style of mediation used is focused on legal arguments and process rather than the needs and interests of the parties.

The Irish State, while it has introduced a number of measures that could facilitate the more widespread use of mediation, does not have a coherent approach or strategy to promote it. One of the participants commented that it was important not to throw the baby out with the bathwater. Thousands of patients and their families benefit from the existing approach to medical negligence claims, at least financially. There is a huge commitment from the legal profession to their clients and perhaps mediation and litigation can work hand in hand to achieve the best outcome.

It is clear that there are opportunities to improve the existing system by removing some of the sources of frustration and introducing a greater focus on the emotional needs and interests of those who are unfortunately harmed. Brazier (2005: 414) talks about finding a resolution method that avoids 'the transformation of private tragedy to public spectacle' — mediation with a focus on restoration, which allows for the parties to have a voice in a confidential and supportive setting, could do the job.

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