

The practice of mediation to resolve clinical, bioethical, and medical malpractice disputes

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ABSTRACT

Mediation is a voluntary process whereby a neutral and impartial third party—the mediator—is present to facilitate communication and negotiation between the disputing parties so that amicable settlements can be agreed. Being confidential and non-adversarial in nature, the mediation process and skills are particularly applicable in clinical practice to facilitate challenging communications following adverse events, to assist bioethical decision making and to resolve disputes. Mediation is also a more effective and efficient means of dispute resolution in medical malpractice claims when compared with civil litigation. Health-care mediation teams should be set up at individual facilities to provide education and consultation services to frontline staff and

patients. At a community level, the Government, the mediation community, and the health-care professionals should join forces to promote mediation as a means to settle medical malpractice claims outside of the courtroom.

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Introduction

With rapidly developing technology and ever-increasing patient expectations, frontline health-care professionals face immense challenges. Disputes and conflicts are common in clinical practice. Health-care disputes are invariably related to patient dissatisfaction with a health-care practitioner or the treatment outcome. Although most of these disputes may be able to be resolved adequately at an early phase, some may evolve into formal complaints or even litigation. In most common law jurisdictions including Hong Kong, victims of medical malpractice (claimants) can seek redress through the formal legal system under the tort of negligence. The journey to a successful negligence claim, however, is usually long and arduous. Claimants do not usually get what they want and deserve as the process is expensive and inefficient.

Mediation is an alternative means of dispute resolution where a neutral and impartial third party (the mediator) is present to facilitate communication and negotiation between the disputing parties so that an amicable settlement can be agreed. Mediation has been widely used worldwide to resolve commercial and family disputes outside the courtroom. The use of mediation to settle medical malpractice disputes was pioneered in the US in the mid-1980s after a crisis in malpractice claims.¹ Aside from preventing lawsuits, bioethics mediation has also been practised in some states to help patients and their families make difficult clinical decisions, for example, with regard

to end-of-life treatment.² This article aimed first to give an overview of the practice of mediation, and describe the relevance of mediation to our clinical practice. Second, a critical appraisal of the current medical malpractice litigation is submitted with a view to explain why mediation is a better alternative means to settle malpractice claims. Finally, this article offers some suggestions for the provision of mediation services at a facility level and at the wider community level.

What is mediation?

Mediation means different things to different stakeholders. In a nutshell, mediation is a voluntary process whereby the disputing parties come together, with the assistance of a neutral third party—the mediator, systematically isolate disputed issues in order to develop options and alternatives, and reach a consensual settlement that both parties can abide by.³ It may take place in different forms or on different scales, ranging from informal community or domestic mediations to large-scale multi-party international mediations. Apart from its obvious application in disputes or conflict resolution, transactional mediation is also commonly used to facilitate commercial negotiations when making business deals. In a medico-legal context, mediation may be used to resolve disputes and difficult communications that arise in clinical practice, to prevent and settle malpractice lawsuits outside the courtroom, and to enable patients and their families

to make difficult bioethical decisions.

Alexander⁴ introduced a ‘meta-model’ to describe different mediation practices: settlement mediation, facilitative mediation, transformative mediation, expert advisory mediation, wise counsel mediation, and tradition-based mediation. Depending on which model is adopted by parties and the mediator, mediation may be interactional (eg traditional mediation) or interventional (eg expert advisory mediation) in nature. In Hong Kong, the facilitative (interest-based) mediation model is commonly employed. In this mode of mediation, the mediator will assist and coach the disputing parties to adopt an interest-based negotiation rather than positional-based bargaining. Of note, the mediator will not advise or adjudicate on any matters related to the dispute. In this sense, parties will be more likely to accept and honour their own settlements. In Hong Kong, potential mediators are assessed and accredited based on the facilitative mediation model by the Hong Kong Mediation Accreditation Association Limited.⁵

Why mediation for health-care disputes?

Maintaining confidentiality and a collaborative attitude between parties are important values that underlie facilitative mediation and render this mode of mediation particularly suitable for resolving health-care-related disputes.⁴ For obvious reasons, health-care professionals and their institutions care about professional image and reputations. Likewise, patients do not usually want social stigma attached to their disease or suffering. Notably, there are express provisions in the new Mediation Ordinance (Cap 620, Laws of Hong Kong) to protect the confidentiality of mediation communications. Even in the worst case scenario where parties fail to reach a settlement, neither party can use any information obtained during the mediation for litigation purposes, except in a few circumstances. Also, in the facilitative mode of mediation, opposing parties can communicate, negotiate, and decide a settlement among themselves with the assistance of the mediator. Conceivably, the doctor-patient relationship will largely be preserved after health-care mediations.

Apart from mediation process training, almost all accredited mediation training courses provide some training in communication and negotiation skills. Most of these skills—for example, active listening, reframing, acknowledgement of feelings, etc—are relevant to our daily clinical practice where different (or difficult) human interaction is inevitable. Health-care professionals who have attended communication training courses find the learning experience fruitful, regardless of whether they complete the accreditation examination.⁶ Most

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李偉雄、賴寶山

調解是在爭議雙方自願的情況下進行。調解員作為公正中立的第三方會就爭議事宜促進雙方互相溝通和談判，從而達成和解協議。調解性質為非對抗性和過程絕對保密，因此可應用在醫療事故發生後，透過調解程序及技巧來促進醫患之間的溝通，以解決爭端；調解也可以協助對生命倫理臨床問題作出決定。與民事訴訟相比，調解能更快更有效地解決醫療事故的賠償爭議。有見及此，醫療機構應成立調解工作小組向前線員工和病人提供教育和諮詢服務。在社區層面上，政府、調解界和醫護界應合力推動使用調解服務，讓醫療糾紛訴訟可以庭外和解。

also enjoy improved communication and a better relationship with their patients, even in the absence of a dispute.⁷ In 2013/14, the Hospital Authority took the initiative to sponsor 120 and 600 health-care staff to participate in accredited mediation courses and applied mediation skills training, respectively.⁸

A number of landmark studies have confirmed that when patients complain or resort to litigation, it is most likely related to miscommunication between themselves and health-care professionals.^{9,10} Frequently, the perception of lack of care offered by health-care professionals is the trigger for complaints or litigation, rather than genuine professional negligence in the delivery of care.¹⁰ Communication between the patient and the health-care professional becomes even more challenging when there are adverse or unanticipated outcomes. Whilst patients and their relatives legitimately expect truthful explanations and honest apologies where appropriate following adverse events, health-care professionals are, more often than not, either not ready or comfortable to communicate with them in the aftermath.¹¹ In addition, in Hong Kong it is common practice for legal advisors to advise front-line clinical staff to avoid direct communication with patients or relatives following an adverse medical event in case they inadvertently admit liability. Thus patients or relatives become suspicious when no one responds to their enquiries and an initial wall of silence becomes the prologue to a formal complaint or even a lengthy legal battle.¹²

In a broad sense, the mediation process and skills can play a vital role in difficult communications following a medical adverse event. First, mediation (communication) skills can be employed by front-line staff to calm the emotions of patients and their relatives. Acknowledgement of feelings, active listening, and expression of empathy are important and useful skills for frontline staff to handle

emotionally charged patients and their relatives. It has been proven that effective communication following adverse events can reduce the number of patients who initiate legal proceedings against their doctor.¹³ At the very least, an open and direct dialogue prevents escalation of parties' emotion and allows healing of a broken relationship at a much earlier phase.¹⁴ Second, with the assistance of a mediator, the mediation process can provide a safe and protected environment for patients and health-care professionals to communicate directly and frankly without the fear of being prejudiced. Early and honest disclosure of medical events or errors (if any) has been regarded as an important risk management strategy worldwide to prevent escalation of tensions between parties.¹³ As aforementioned, the Mediation Ordinance stipulates that 'things that were said or done' during mediation must remain confidential, and in general, mediation communications will not be admissible as evidence in any subsequent court proceedings. Thus, it is envisaged that mediation can provide an appropriate avenue for health-care professionals to offer truthful explanations and apologies without the fear of admitting liability. Hitherto, there is no Apology Legislation in Hong Kong although a public consultation is underway.¹⁵ Unless and until such legislation is enacted in Hong Kong, mediation represents an effective mechanism to bridge the legal gap in the context of medico-legal dispute resolution.

Apart from claims and complaints management, there is growing interest in the use of health-care mediation to assist patients or their relatives to make bioethical decisions such as those that concern end-of-life treatment. Health-care professionals and patients often hold conflicting views on sensitive issues such as withholding or withdrawing treatment, Do-Not-Resuscitate orders, and medical futility.¹⁶ Although doctors believe their decisions are based on what is in the best interests of the patient, the relatives may not agree. During mediation, a neutral mediator (someone who is not a member of the management team) can help explore the interests and goals of both parties and address them in a collaborative manner. Patients feel respected if they are given the opportunity to express their views and opinions freely. They will also hear first-hand the difficulties or dilemmas faced by health-care professionals during the two-way dialogue. Any treatment plans formulated in such a cooperative atmosphere and on a level playing field will be more likely to be accepted by both the patients and their families.

Why mediation is preferred to litigation?

English common law provides a robust system—the

tort of negligence—that enables aggrieved patients to assert their legal rights in malpractice claims. Nonetheless it is extremely difficult to win such cases. In order to be successful in a claim of negligence against a doctor, the patient (claimant) must prove, on a balance of probability, that the doctor breached his or her duty of care to the patient, and that the doctor's act or omission materially caused physical and/or psychological damage to the patient.¹⁷ It is well known that civil litigation involves complicated and lengthy procedures such as 'discovery of evidence' and 'exchange expert reports'. Any uncooperative party can introduce delaying tactics to increase both the financial and psychological burden on the opposing party. It is not uncommon to see cases dragging on for years before they reach court and the trial stage.¹⁸

In addition, patients may not find what they want or deserve in a court of law. Beckman et al¹⁰ identified the following reasons that explain why patients took legal action against their doctor(s): doctors' unavailability, discounting patient or family concerns, poor delivery of information, lack of understanding, and perceived lack of caring and/or collaboration in the delivery of health care. Most patients initiated legal proceedings following an adverse medical event because they wanted an honest explanation, and individual and organisational accountability; they also looked for strategies to prevent recurrence of mishaps.¹⁹ Regrettably these non-monetary remedies are not available under the current litigation system. Similarly, respondent doctors always suffer from different degrees of emotional disturbance—shame, fear, self-doubt, isolation, difficulty concentrating, etc—regardless of whether or not they believe an adverse medical event is due to their error.²⁰ They also demand quick resolution of any potential claims associated with the events. Unfortunately, litigation will not give doctors any quick relief or reassurance. Even assuming the respondent doctor is exonerated, the psychological stress associated with litigation may irreversibly damage the doctor's professional life.

On the other hand, mediation is usually flexible and less formal in procedural matters, and hence time and cost-saving.¹⁸ Unlike litigation, non-monetary issues such as explanations, apologies, or even future strategies to enhance patient safety can be discussed during mediation.²¹ Apart from monetary compensation, early resolution also relieves parties' psychological stress, especially that of doctors. Doctors can resume their normal clinical work without any fear or pressure arising from the claims or, sometimes, the media. In the UK, the National Health Service Litigation Authority (NHSLA) has been asking their representative lawyers to consider and offer mediation in appropriate cases since 2000.²¹ The NHSLA's findings suggest that claims may be

settled by mediation directly although settlement may not be achieved on the same day of mediation. In a recent survey conducted by the European Hospital and Healthcare Federation, mediation was also widely used in health-care disputes in 10 European member states.²² In Hong Kong, with the joint effort of the Hong Kong Medical Association and the Hong Kong Mediation Council, the first successful malpractice mediation was reported in 2006.²³ In 2009, the Hong Kong Judiciary introduced Civil Justice Reform with a clear objective to facilitate settlement of civil disputes fairly, effectively, and efficiently.²⁴ Under the new Practice Directions, legal practitioners need to inform their clients of the availability of mediation, and to sign a 'mediation certificate' before they can file a claim in court. In addition, the courts may now impose an adverse costs order on any party who unreasonably fails to engage in mediation even if that party subsequently wins the case.²⁵ It is envisaged that all these judiciary measures will further enhance the use of mediation to settle medical malpractice claims.

The way forward

At a facility level, a health-care mediation team comprising different mediation-trained staff members such as nurses, doctors, allied health professionals, administrators, psychologists, and social workers, could be established to provide education and consultation services to front-line staff, and to assist them in handling difficult communications.²⁶ At times, a formal mediation process can be conducted at the facility when the disputing parties volunteer and agree to do so. The facility should provide a list of in-house accredited mediators for the process from which parties can select. Equally, if parties wish, they can use external accredited mediators.¹⁶ At the moment, there is no additional requirement for general mediators to mediate health-care-related disputes. It is well known that health-care disputes usually involve complex professional issues. It would thus be easier and desirable for mediators to have a medical knowledge base when dealing with health-care disputes.²³ In any event, early access to mediation may save transaction costs (eg time, money, emotional energy, opportunities lost) in relation to the dispute resolution.^{1,27}

Health-care professionals should be more receptive to malpractice pre-trial mediation. Mediation aims to help opposing parties to understand their respective interests and goals, to restore a broken relationship, and most importantly to work out a consensual settlement without taking the dispute to the courtroom. Peeples et al²⁸ observed that the term 'settlement' might be viewed negatively as 'admitting fault' in the eyes of the medical profession during mediation. Nonetheless,

the same term is commonly used among the legal profession in dispute resolution processes, and does not have negative connotations. Thus, it is important to rectify this conceptual misunderstanding before health-care professionals come to the mediation table. Equally, legal practitioners need to transform their practice during mediations. Traditionally, lawyers are trained to take an adversarial approach to fight for their clients in court. Mediation requires a different mindset and negotiation skills. Lawyers who take part in mediations should assist their clients on legal matters and be responsive to clients' interests and goals during the negotiations rather than being focused on purely winning the case.²⁹ It is thus vital that all parties who participate in the process understand the underlying fundamentals and values of mediation in order to achieve the maximum benefit.

Despite various judiciary measures, the use of mediation to resolve medical malpractice disputes has received much less attention compared with commercial disputes. The Hong Kong SAR Government has supported the setting up of the Financial Dispute Resolution Centre to assist appropriate clients in financial disputes. Hitherto, there is no similar medical dispute resolution centre to coordinate such services although the Steering Committee on Mediation has reported its initiative to devise a medical mediation scheme to support the use of mediation in medical disputes.¹⁵ It remains to be seen how much resources the Government is willing to allocate to this 'new' means of medical dispute resolution. On the other hand, mediation stakeholders should be mindful of the current situation: while there are alleged advantages to the use of mediation to settle medical malpractice disputes, more empirical research data are needed to support its real effectiveness and efficiency.

Conclusion

The mediation process and associated skills may be applied in our daily clinical practice to facilitate challenging communications, to assist bioethical clinical decision making, and to resolve disputes. Individual health-care facilities should set up their own mediation teams to coordinate the service to patients and frontline staff. Whilst victims of medical mishaps might assert their legal rights through litigation, it is an ineffective and inefficient way to get what they want and deserve. Nowadays, the Judiciary's Practice Direction requires parties to participate in meaningful pre-trial mediations in order to settle disputes outside the courtroom. Apart from judiciary measures, the Government and the mediation community should put more effort into promoting the use of mediation to settle medical malpractice claims in the community in order to save time and public resources.

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