
Is there any role for health care professionals at the mediation of clinical negligence claims?

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It is unusual to see health care professionals present at the mediation of a clinical negligence claim which involves them. Many legal representatives could count on one hand the number of times they have either seen or taken a health care professional to mediation. This is a departure from classical mediation practice, where the parties to the dispute play the primary, if not dominant, role at mediation, including in deciding whether to mediate, making opening statements, identifying issues, developing solutions and deciding whether to resolve the dispute. Although there are a variety of reasons why a health care professional's presence at mediation may not be beneficial, will a health care professional's absence increase the prospects of resolving a dispute? Are there are situations where a health care professional should be present?

HOW DO CLINICAL NEGLIGENCE MEDIATIONS LOOK?

In clinical negligence claims, legal representatives for both the patient and the health care professional, together with the health care professional's insurer representative/s, play the dominant roles. In a litigated dispute, the court has the power to order mediation "if it considers the circumstances appropriate".¹ It will invariably do so with a consent application by the parties' legal representatives and will often do so when it considers mediation to be in the best interests of the parties. Some courts have a practice of ordering mediation (usually involving larger damages claims) unless one or more parties demonstrate special reasons why mediation should not take place.

Once ordered, or otherwise agreed, the parties' legal representatives arrange mediation. In New South Wales, there is no requirement for the parties to attend in person (unless stipulated otherwise in a mediation agreement). However, mediation is essentially pointless unless the relevant decision-makers attend or, less desirably, are available by telephone.

A health care professional's role is usually confined to being asked whether they agree to mediation. Generally, they are not asked to attend mediation. The health care professional's legal representatives (on instructions from the health care professional's insurer) will prepare mediation documents, including a position paper setting out the defence of the claim in legal terms. This establishes that the health care professional's insurer and its legal representatives will play both the primary and decisive roles in mediation.

At mediations, legal representatives usually play the dominant role. Although the patient is invariably present, their role is usually restricted to giving a short insight into their emotions and alleged suffering, following their legal representative's opening statement. The insurer's legal representative makes an opening statement in reply. Both opening statements are usually a summary of position papers. This sets the tone for a mediation which, following the opening session, transforms into "shuttle mediation", siting the different parties in separate rooms, with the mediator facilitating, and the parties' legal representatives conducting, positional-based negotiation. Other than being given advice and giving instructions, the patient generally plays little role. The parties generally only meet face to face again once the dispute is resolved, or there is agreement that the dispute cannot be resolved at mediation. The final meeting is merely an opportunity for the mediator to close the mediation and thank both the parties and their advisers.

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¹ *Civil Procedure Act 2005* (NSW), s 26.



WHY ARE HEALTH CARE PROFESSIONALS USUALLY ABSENT FROM MEDIATION?

There are a variety of reasons why health care professionals are generally absent from mediation.

In determining whether to resolve a clinical negligence claim, the health care professional generally does not make the final decision. The decision is normally made by an insurer. In many jurisdictions, medical and allied health practitioners are required to hold professional indemnity insurance which covers their negligent acts and omissions in the course of their practice.² Generally, other health care professionals, such as nurses, are employed by hospitals which maintain their own professional indemnity cover for their employees. Once a patient claims damages arising out of allegedly inadequate care and treatment, it is an indemnifying insurer which will cover the health care professional for any damages awarded and decide (usually with health care professional input) on whether to settle the claim prior to hearing. Although medical indemnity policies usually include clauses providing for resolution of disputes between an insured health care professional and insurer on whether to settle a claim or proceed to hearing by an independent barrister, either the insured health care professional is required to abide by the barrister's decision or the insurer will only cover the health care professional up to an amount which it agrees to settle. While the health care professional will sometimes question an insurer's decision, it is extremely rare for them to not ultimately abide by it. Generally, the only situations in which the health care professional's views govern whether and when to resolve a claim are where they lack insurance cover. Depending on the terms and conditions of an insurance policy, bases for denial of indemnity can include claims or circumstances outside the period of cover, sexual or criminal misconduct, failure to disclose circumstances which may give rise to a claim and/or delayed notification of a claim.

Within the confines of the current clinical negligence mediation model, there is limited scope for a health care professional to participate in, and make a substantial contribution to, mediation. Their absence facilitates the "shuttle model". Although it is beyond the scope of this article to critique that model, it does not work in every dispute, particularly where compensation is not the only thing a patient seeks.

Both health care professional insurers and legal representatives are commonly concerned about any forensic advantage a health care professional's presence will give to the patient. Mediation may provide an opportunity for the patient's legal representative to assess how a health care professional will present before a court and to goad them into making unfavourable admissions. Although Baer suggests pre-mediation discovery should mean there are no surprises at mediation,³ there may be a considerable amount of pertinent information which is not revealed in pleadings, factual documentation and expert evidence.

A health care professional's presence, particularly where the patient (and/or the health care professional) is highly emotional and/or irrational, can inflame passions, impede negotiations and hinder resolution. The risk increases where the health care professional has a particularly strong view about the appropriateness of their conduct and/or the patient's supposed lack of entitlement to compensation.

Some question what a health care professional can add to mediation, at least within its present form. The dominant issue in clinical negligence mediations is generally about entitlement to, and the amount of, compensation. There are now thresholds for claiming of damages for pain and suffering and gratuitous care.⁴ There are fewer claims in which compensation is not the main issue, creating less scope for health care professionals' input. As many mediations take up to a day, involving considerable cost, it tends to be larger compensation claims which are mediated, involving significant injuries and/or ongoing problems.

² See eg *Health Care Liability Act 2001* (NSW), ss 19, 25; *Health Care Liability Regulation* (NSW), reg 6.

³ Baer R, "Occupational Therapists as Mediators in Personal Injury Compulsory Conferences" (2007) 18 ADRJ 44 at 48.

⁴ *Civil Liability Act 2002* (NSW), ss 15, 16.



CONSIDERING PATIENT INTERESTS

The patient's interests are crucial in determining the utility of a health care professional's presence at mediation.

One study showed the same patient motivations in disciplinary complaints as in suing medical practitioners, namely punishment, regulation, compensation and accountability.⁵ Only about a quarter of the patients named compensation as their primary motivation for suing, with an even spread among the remaining three factors.⁶

Although compensation is usually a patient's primary motivation where they have suffered a serious injury and/or significant long-term effects, health care professional insurers and their legal representatives must consider a patient's non-compensatory interests. If not considered, resolution may be impeded. For example, a patient may seek a significant award of damages but also an explanation for what happened and an apology from the health care professional.⁷ Absent explanation and apology, the patient may be unwilling to settle for a reasonable sum. However, where there is a dispute over what happened during the course of care and treatment and/or the appropriateness of the care and treatment provided, the health care professional's explanations for what happened may agitate the patient, and any apology may seem insincere, impeding negotiations and resolution.

A health care professional's presence could empower the patient and enhance their participation. In disciplinary complaint conciliations, Lines observed that many legal representatives are "well-versed in primary dispute resolution processes", altering dynamics, which may prevent a patient from offering their own insight and identifying what is important to achieve resolution.⁸ Where the patient is the only party present at mediation who is inexperienced in the process, they may "go into their shell", relying on their own legal representatives to represent their interests and to determine what should be sought. By contrast, a health care professional's presence may encourage the patient to become more involved if the patient feels he or she can interact with that person. The degree to which this would occur would very much depend on the respective personalities of both the patient and health care professional.

Where a health care professional is absent, the plaintiff patient may assume that the health care professional did not consider the dispute sufficiently important to be present. This may affect the patient's willingness to negotiate and resolve the dispute. It may be necessary to emphasise to a patient that it is not the health care professional who makes the decision about whether to resolve the dispute.

THE HEALTH CARE PROFESSIONAL'S INTERESTS

A health care professional's absence from mediation can also be detrimental to the professional, causing a sense of disempowerment and a lack of closure. He or she can only vicariously participate in case presentation, issue development and decision-making. This may lead the professional to feel undervalued and/or ignored, in turn causing considerable frustration and disenchantment with the legal system. Baer suggests that, in the context of personal injury mediation generally, defendants facing allegations require closure of a dispute for their own peace of mind.⁹ However, many health care professionals do not want to participate in mediation, either in order to avoid confrontation with an aggrieved patient and their legal representatives, or through disinterest.

⁵ Daniel AE, Burn RJ and Horarik S, "Patients' Complaints about Medical Practice" (1999) 170 MJA 598, citing Vincent C, Young M and Phillips A, "Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action" (1994) 343 *Lancet* 1609.

⁶ Niselle P, "Angered Patients and the Medical Profession" (1999) 170 MJA 576 at 577, citing Vincent et al, n 5.

⁷ In New South Wales, an apology does not constitute an admission of liability: *Civil Liability Act 2002* (NSW), s 69.

⁸ Lines J, "Something's Happening Here: Resolving Complaints in the NSW Health Conciliation Registry", paper presented to the National Mediation Conference, Perth, September 2008, p 5.

⁹ Baer, n 3 at 48.



SHOULD HEALTH CARE PROFESSIONALS PARTICIPATE IN MEDIATION?

Whether a health care professional's presence at mediation would be beneficial is a complex question, depending on a variety of issues.

The various personalities are important. A vocal, domineering patient and a reticent, quiet health care professional are unlikely to be a combination facilitating resolution. The patient may feel the health care professional fails to answer their concerns, and the health care professional may become defensive due to dislike of the patient. By contrast, a coherent and composed patient and an insightful health care professional may combine well. Similarly, a domineering patient's legal representative may seek to exploit the perceived hesitation of an anxious health care professional, or confront a strong-minded health care professional. However, a patient's legal representative who is focused on resolution, not showing off to their client or exploiting a forensic advantage, may render a health care professional's presence beneficial.

There is more likely to be scope for a health care professional to contribute to mediation if it takes place early in a dispute, particularly where the parties have not adopted entrenched positions and/or litigation has not been commenced. At the same time, the parties' emotions may be rawer, increasing the risk that mediation will fail to resolve, and may even inflame, the dispute.

If the claim involves a number of health care professionals, too many may overwhelm the patient and it may be difficult to ensure the health care professionals adopt a coherent voice. However, confronting each professional involved may also be important to the patient and crucial to resolution.

If a health care professional's treatment allegedly resulted in catastrophic and long-term consequences for a patient, obtaining sufficient compensation may be far more important than any apology, reconciliation and/or systemic change. By contrast, a patient with a less significant injury with time-limited consequences may be focused on obtaining an apology, reconciliation and/or systemic change. If there is a dispute concerning whether the health care professional's care and treatment were appropriate, the professional's presence may be considerably less valuable than in situations where the professional and their legal representatives accept that inappropriate care was provided.

If health care professionals are to be present at mediation, their role should be more than token. Depending on the various factors set out above, it may be beneficial to allow them to address the patient's concerns, particularly if their contribution is likely to be measured, considered and insightful.

There is generally no right or wrong decision concerning whether health care professionals should be present at clinical negligence mediations. Determining whether they should be present can be quite difficult. However, it should involve careful consideration of the various factors and participants in the dispute, with a view to arriving at a decision which both protects the health care professional's position and provides the best chance of resolution for all parties involved.

