

8-1-2002

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Recommended Citation

Emanuel, Lisa and Mills, Michael (2002) "Medical negligence, litigation and mediation," *ADR Bulletin*: Vol. 5: No. 4, Article 2.
Available at: <http://epublications.bond.edu.au/adr/vol5/iss4/2>

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ADR responding to the insurance crisis

Medical negligence, litigation and mediation

Lisa Emanuel and Michael Mills

The recent collapse of United Medical Protection (UMP), Australia's largest medical defence insurer, has heightened the already widespread perception of a crisis in liability insurance.

Media reports of medical practitioners forced to leave their profession in the face of a constant threat of litigation and escalating insurance premiums have become commonplace in the past 18 months. The very survival of highly specialised fields such as obstetrics and neurosurgery is said to be endangered, particularly in regional communities.

Insurers claim that burdensome litigation, unpredictable court decisions and steep indemnity awards have drained the profitability from medical malpractice insurance policies and have caused the current crisis. Figures released by UMP in 2000 show that the number of medico-legal claims against doctors had more than doubled in the preceding 10 years, with the number of claims made rising from 20 per 1000 members in 1990 to 50 per 1000 members in 2000.¹

More worrying than the increase in the number of claims made, which according to some commentators is not as significant as is often suggested,² is the knowledge that the number of people who seek compensation for injuries actually caused by medical negligence is far smaller than the number who might be entitled to compensation.

It is thought that as few as 5 per cent of people who suffer iatrogenic, or doctor caused, injuries where negligence may be implicated actually choose to sue, and more than half of those either lose the case at hearing or give up the claim before it gets to court.³ If the situation is critical when only a small percentage of those who might sue actually do so, what will

happen if all of those who might have a negligence claim take action?

Informed commentators agree that a number of factors have contributed to the current problems in medical indemnity, most of which have little to do with any real or imagined 'litigation explosion'. However, the fact remains that if disputes can be satisfactorily resolved without litigation, this is desirable for all the parties involved — the public, doctors and claimants.

For the public, litigation against medical practitioners has contributed to the growth in insurance premiums, extensive and stressful delays in the processing of claims, and spiralling costs to the public and private sector.

For medical practitioners, the costs of litigation are very high and often include substantial financial costs, stress, reduced career satisfaction and diminished professional reputation.

For claimants, litigation is often an unsatisfactory way of dealing with what, in most cases, involves a perceived breach of trust between the medical practitioner and the injured patient. Litigation normally cannot and does not address the emotional issues concerning the doctor/patient relationship, which are often a critical aspect of the dispute for one or both parties. In many cases, the potential monetary award is not the patient's only or even primary motivating factor. Patients may be seeking, first and foremost, an acknowledgment of wrongdoing from the institution or medical practitioner involved, an apology, and/or reassurance that procedures or policies have been put in place to prevent what happened to them from happening to others. Sometimes patients simply want their concerns properly listened to and their questions fully answered, yet because of its adversarial nature, litigation is

often not the best method of achieving these outcomes.

This is not to say that there is not a role for litigation, or that litigation (or for that matter, lawyers) is the cause of the current medical malpractice and public liability insurance crises. Rather, this article proceeds on the basis that if disputes can be satisfactorily resolved prior to litigation (or at least trial) then that is highly desirable for both the parties and the public generally.

Solution involves ADR

The complex, entrenched nature of the current medical malpractice crisis in this country necessitates multifaceted solutions and the involvement of a number of players, including government, insurers, medical practitioners, the legal profession and the community. Legislative reform, improvements in the provision of health services and changes to the way defendants and their insurers respond to claims are all part of the solution. In addition, a significantly increased emphasis on ADR, and particularly mediation as an alternative to the litigation process, is a necessary component of any comprehensive solution.

Federal Government Minister for Revenue and Assistant Treasurer Helen Coonan has emphasised the role of ADR in resolving the current problems in public liability insurance as follows:

I would like to see a comprehensive analysis by the legal profession of the suitability of alternative dispute resolution systems including early neutral evaluation and their capacity to offer much cheaper justice and fewer delays. There needs to be a much better thought out system for contact between those acting for plaintiffs and insurers with early and frank exchange of information. The present 'cat and mouse' litigation game between plaintiff



and defendant may be forensically defensible but is surely no longer affordable.⁴

Some ADR initiatives are already under way, with courts in some jurisdictions pursuing ADR options vigorously and a good percentage of the legal community now looking to these processes. There are also efforts being made to encourage insurers to implement processes that promote communication, openness and the early resolution of disputes, with government and courts actively advocating and supporting the change of culture.

However, current progress seems too slow, certainly for many doctors and patients, if not the public generally. It also ignores a fundamental problem in medical negligence litigation, namely that most medical professionals are understandably reluctant to express sympathy for or make an apology to a patient where there is a risk of liability, for fear that such communications may be treated as admissions of liability and/or prejudice their insurance cover. This is so, despite the medical practitioner often empathising with the patient's plight and concerns. Conversely, recent US trials indicate that expressing such empathy significantly decreases the number of claims made and raises the morale of both patients and staff.⁵

Mediation and medical negligence claims

The use of ADR in the context of medical negligence claims involves numerous processes, including mediation, facilitation, early neutral evaluation and negotiation. ADR models vary considerably and different approaches may be more appropriate in different circumstances. Generally, however, mediation processes are particularly well suited to medical malpractice claims — being informal, confidential, speedy, enforceable, cost effective and consensual as opposed to determinative.

In mediation, parties will ideally voluntarily elect to engage in negotiations facilitated by an independent third party to reach a satisfactory agreement for all parties. The aim is for the parties themselves to participate towards reaching a

mutually acceptable arrangement, with the neutral third party merely conducting the procedural aspects of the deliberations through the use of constructive negotiation and problem solving techniques. The power to agree on a solution lies with the parties rather than with the mediator, who cannot impose a decision upon them.

Medical negligence claims are well suited to mediation for the following reasons.

- Mediation is a confidential process and therefore avoids unwanted and unnecessary adverse publicity for the medical professional or institution involved. In many Australian jurisdictions, legislation requires that any admission made or anything said in a mediation conference will not be admitted as evidence in court.⁶
- Mediation is quicker and more cost efficient than the usual forms of litigation. It is also much more informal and therefore patient (if not party) friendly.
- The parties to mediation retain a greater degree of control over the process and outcome than in litigation or arbitration.
- The process of mediation is much more likely than litigation to leave the doctor/patient relationship intact. Failing that, the process is generally less acrimonious than litigation.
- If a negotiated solution is not sufficient, mediation can be supplemented by other forms of ADR, such as early neutral evaluation, a minitrial or expert advice.
- Mediation can take into account remedies not capable of being granted by the courts, not least of which can be an apology, explanation or exploration of the best treatment and remedy for the patient going forward.

As mentioned above, the mediation process tends to be far less damaging to relationships than litigation. Patients often find that when they commence litigation, all useful dialogue with, if not treatment from, the medical practitioners involved ceases. This is often because the practitioners fear that any show of compassion or acknowledgment of wrongdoing on their part will weaken their legal

position in the ensuing litigation. Even the fear of being sued can be enough to prevent doctors from responding openly to their patients' questions and concerns in the aftermath of adverse treatment outcomes. This is the fundamental inadequacy of litigation in the area of medical negligence: while the threat of litigation remains, it promotes a defensiveness and lack of empathy from doctors, while it is commonly dialogue and compassion that the patient is seeking above all else.

In contrast, mediation can: address the human side of dispute settlement; often preserve or improve relationships between the parties; focus on and seek to maximise the parties' underlying interests, rather than simply deciding between their positional claims; provide a forum and atmosphere whereby the parties can express their concerns and engage in a dialogue which may lead to an acknowledgment of the problem — sometimes in the form of an apology; and often produce an emphasis on the parties' future needs rather than past facts, which aids both an amiable reconciliation, rather than an adversarial court battle, as well as possibly the patient's recovery.

NHS medical negligence mediation pilot scheme

In April 1995 the UK National Health Service (NHS) launched a medical negligence mediation pilot scheme in response to criticisms of the way claims were managed and concerns about their increasing incidence. Critics had focused on five main issues: the defensiveness encouraged by existing procedures; dissatisfaction among plaintiffs with the process and outcome; the inaccessibility of the civil justice system; delays in the management of claims; and the cost to the public purse of claims management.

Plaintiffs felt that health authorities and solicitors were overly defensive in their management of medical negligence cases and wanted greater openness and more frequent meetings. Many plaintiffs found that the outcome of litigation left them unable

to put the matter behind them or to come to terms with what had happened. In particular, plaintiffs felt that many of their questions remained unanswered. Further, certain remedies sought by plaintiffs, such as the prevention of recurrence, apologies and opportunities to talk issues through with the other side, were not readily forthcoming.⁷

The pilot scheme was relatively small in scale. Over a three year period, only 12 cases were mediated, with settlement reached in 11 of them. However, five main successes of the scheme were identified by participants: heightened awareness of mediation among medical negligence specialists; increased participation among clients in the settlement process; flexibility in process and the potential for involving nonlegal remedies in the settlement; privacy; and efficient case disposal facilitated by the concentrated negotiations.⁸

The heightened participation allowed by mediation was particularly important for claimants. Participation took several forms, including visibility of the process, the opportunity to put across one's case, catharsis, and the opportunity for personalised explanations and apologies.⁹ Mediation facilitated a very flexible approach to settlement, with flexibility of process, role, timing and remedies.¹⁰

ADR pilot program

The time is right for an Australian pilot program involving dispute resolution processes in the area of medical negligence.

Such a program could take many forms. Frankly, if gauged by overseas experience, any additional efforts to encourage mediation in medical malpractice disputes are likely to be welcomed by the parties involved, as well as the public.

A scientific pilot program will require the identification of a suitable trial area and the participation of a large number of practitioners in the identified area (including specialists, general practitioners and institutions such as hospitals). Insurers would need to agree to process all claims in the trial area in accordance with the trial

initiatives to encourage early mediation and resolution of disputes.

Developing a useful pilot program and/or initiatives to encourage greater use of mediation should involve a coalition of interested parties, including insurers, practitioners, institutions and dispute resolution trainers. LEADR, a not for profit membership organisation established in 1989 to promote the use of consensual resolution processes in Australia and the region, is currently investigating the possibility of an Australian trial of ADR processes in the area of medical negligence. LEADR has also indicated its willingness to take a co-ordinating role in such a trial or initiative. If need be, funding may be obtained from State or Federal health departments.

The purpose of a trial would be to ascertain whether ADR processes work in the Australian medical malpractice cases. It would initially involve a small number of claims and would operate on an 'opt-in' basis, in that the parties would need to agree to be involved. If successful, the program could potentially be extended.

Conclusion

ADR processes may not prove suitable for all medical negligence claims. Certainly, they are not the solution to all the current problems surrounding the provision of medical malpractice insurance. However, ADR processes, and specifically early intervention and mediation, can potentially encourage more appropriate, effective and cost efficient dispute resolution. Given the current community and political climate, a trial of ADR processes in the context of medical negligence should receive serious consideration from, and hopefully the support of, government, industry players, the legal profession and the wider community. ●

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Endnotes

1. Information kindly provided by Scott Pettersson, Chief Executive Officer of LEADR, in the LEADR background paper for the Royal College of General Practitioners (Australia) Conference 2000. According to UMP figures, the number of *reported* incidences of potential claims in 2000 was 120 per 1000 members, while only 50 claims per 1000 members were actually made. Obviously these figures do not take into account unreported incidences.
2. Madden B 'Myths of explosion prevent solutions to indemnity crisis' *Sydney Morning Herald* 2 May 2002 p 13.
3. Hirsch D 'Medical negligence: a litigation crisis?' (1994) 2(9) HLB 105 at 106.
4. Coonan H 'Balance key to end blame game over public debt' *Australian Financial Review* 22 April 2002 p 63.
5. Information kindly provided by Scott Pettersson, Chief Executive Officer of LEADR, in the LEADR information sheet *Mediation and*

Medical Indemnity May 2002.

6. The position varies depending on the sort of ADR process and the applicable legislation. For example, s 53B of the *Federal Court of Australia Act 1976* (Cth) provides that evidence of anything said or any admission made at a mediation referred under the Act is not admissible in any court. Evidence of anything said or done at a mediation conducted under the *Administrative Appeals Tribunal Act 1975* (Cth) is not admissible in any proceedings, except before the Tribunal where the parties otherwise agree (s 34A(7)). This provision is replicated in s 110P(4) of the *Supreme Court Act 1970* (NSW), r 50.07(6) of the *Victorian Supreme Court Rules* (s 24A of the *Supreme Court Act 1986* (Vic) is to the same effect), and s 65(6) of the *Supreme Court Act 1935* (SA).
7. NHS Executive *Mediating Medical Negligence Claims: An Option for the Future?* 2000 p xiii <www.doh.gov.uk/mediation>.
8. Above note 7 p xvii.
9. Above note 7 p xvii.
10. Above note 7 p 79.