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# Observations on conciliating medical disputes

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# ADR bulletin

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## ADR in health complaints

# Observations on conciliating medical disputes

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Diary and happenings

The Office of Health Review (OHR) was established in Western Australia in 1996 under the *Health Services (Conciliation and Review) Act 1995* (the Act). In 1999 Part 6 of the *Disability Services Act 1993* was amended to expand the OHR's jurisdiction to include complaints about disability service providers. The OHR has a similar role and function to health complaints bodies in other States and Territories in Australia. The main objective of these agencies is to resolve health complaints through conciliation.<sup>1</sup>

### Conciliation – WA Model

Conciliation at the OHR is the formal process outlined in Part 3, Division 3 of the Act (similar provisions exist in Part 6 of the *Disability Services Act 1993*). The Act generally outlines the process to be followed when conciliating a complaint. It is not prescriptive and allows considerable scope to the conciliator. The role of the conciliator includes: arranging for the parties to hold informal discussions about the complaint; assisting in the conduct of those discussions; and assisting the parties to reach agreement.

The conciliator must make a final report to the Director of the OHR once the conciliation process has been completed. This report must include details of any agreement reached and, if no agreement has been reached, the conciliator may make certain other recommendations, including investigation of the matter.<sup>2</sup>

The parties to the conciliation process are bound by the confidentiality provisions contained in the Act. Also, evidence of anything said or admitted during the conciliation process is not admissible in proceedings before a court or tribunal.<sup>3</sup>

Consistent with the NADRAC definition of conciliation,<sup>4</sup> the conciliator plays a more active role than a mediator would. Conciliators encourage settlement and provide advice on resolution of complaints, but at the same time they try to ensure that their independence is not compromised. Conciliators have no determinative role.

Although the process is designed to facilitate direct resolution between parties to the dispute, in reality there can be as many as four parties involved in the process: the consumer/complainant, their legal adviser, the provider, and their legal adviser (or insurer). The number of parties involved increases where the complainant is not the consumer, or when they wish to have a support person or advocate involved in the process.

The OHR does not provide advocacy services as such, but is rather an impartial statutory agency. This is a fact that sometimes needs to be heavily reality-tested with the provider and the consumer, both parties occasionally viewing the OHR as a consumer advocacy agency. The OHR works with both parties to explore all available evidence with a view to identifying and agreeing on options for the resolution of complaints.

The process can be increasingly complex to manage where there are two or more

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providers involved; for example, a private specialist at a private hospital, where there are concerns about the provision of services by each of these parties.

Complaint agencies receive a wide variety of complaints ranging from complaints about rudeness by the service provider through to medical negligence. The majority of these complaints are amenable to resolution by a less formal process of conciliation. However, where preliminary enquiries suggest that the issues are more complex, a more formal process is used to conciliate the complaint.

When the issues have been clarified during preliminary enquiries and the available evidence suggests that the consumer has suffered an adverse event or consequence from the treatment, the consumer/complainant will generally be asked to draft a submission outlining what they want in order to resolve the matter. They are also advised that they may wish to prepare their submission with the assistance of their legal adviser or advocate. The submission is then given to the provider or his or her representative.

The conciliator then manages the negotiations between parties in as timely a fashion as possible, using either negotiation by correspondence or face to face meetings. When organising face to face meetings it is important to ensure that all parties are available for the relevant date, that the meeting place is acceptable to all parties (wherever possible we try to use our office as a neutral venue) and that the parties are aware of who will be attending at the meeting and the role they will play in discussions. The conciliator should also ensure that all parties are fully prepared (for example, have copies of all relevant documentation) and have authority to negotiate (for example, they can put firm offers to the other party for consideration).

The matter then progresses until a settlement is reached. Where a settlement involves payment of compensation, reimbursement of out of pocket expenses or payment as a gesture of goodwill, the parties often want a deed of settlement to be signed, which is usually prepared by the providers' representative. We

recommend to both parties that legal advice be obtained before signing any documentation evidencing settlement. The OHR does not provide legal advice and makes this clear to the parties.

There are often occasions where the conciliation process does not result in the resolution of the complaint. On those occasions both parties are given a detailed explanation of what information has been gathered and the reasons why the matter cannot be resolved. Sometimes the provision of such an explanation may be sufficient to allow the parties to move past the dispute.

### **Can all health disputes be resolved through conciliation?**

It is sometimes useful for a conciliator to consider the broad source of the conflict, before embarking on the formal conciliation process. Dr Moore<sup>5</sup> as early as 1986 isolated a number of different types of conflict relevant to the mediation process, each of which requires a different response from mediators. In our experience, this can also apply to the conciliation process. The sources of conflict that are evident from complaints can be grouped into four main categories, namely conflict involving:

- (1) data mismatch
- (2) resource issues
- (3) emotional or values based issues
- (4) communication.

The examples outlined below are very broad, and we recognise that conflict is not usually comprised of simply one type, but more likely a number. However, the following examples are presented for explanatory purposes.

#### **Data mismatch conflict**

Many health complaints arise from a data mismatch. This refers to conflict where the same set of facts, documents or health issue have been interpreted differently by the parties. Resolution of such conflicts in the health arena can often be achieved by a third party or peer reviewer examining the document, records or symptoms, and then, without necessarily knowing the outcome, providing their comments and opinion. This approach minimises the impact of

hindsight bias. Where this approach does not resolve the matter (for example, where the reviewer presents a third interpretation), the conflict may be resolved by the original two interpretations and the actual outcome being presented to the reviewer, which usually elucidates explanations of why the different interpretations may have arisen. Sometimes, the reviewer may interpret the data in a different way to the original health provider. Once again, this could mean an adverse event arose from a misinterpretation by the original provider, or that a number of different interpretations are available. This type of dispute is generally amenable to the conciliation process.

### **Resource issues conflict**

Some health complaints are resource based or arise from the existing structure of the health system. For example, complaints involving waiting times and access to services often involve resourcing issues. Unless there has clearly been an inadequate allocation of resources, there is often little that can reasonably be done by health complaint commissions to resolve individual complaints of this nature. They can and often do take the approach of establishing that the particular consumer was treated similarly to other consumers in similar circumstances. It may also be that broad systemic recommendations arise from these complaints. Generally, there would not be a comprehensive role for conciliation in such complaints.

### **Emotional or values based conflict**

Disputes arising from a complaint based on emotional issues, differences of opinion or values, such as an issue about the manner in which a service was provided, can be difficult to resolve. This is because, in the absence of other witnesses or information, they often come down to differing versions of the same event. Sometimes, an emotional issue or value-based conflict can be linked with a resource issue, such as a decision to decline to perform surgery on a person who continues an activity that is causing the condition. It is important in such situations to validate the party's emotions but also maintain focus on the facts and control

the resolution process tightly so as not to wander into value differences and judgments. That is, to focus on the relevant facts and also to ensure the consumer has been treated as others in similar circumstances.

### **Communication conflict**

By far the majority of health complaints, as with many other types of complaints, involve communication problems. This is where written or verbal communications have been misinterpreted or are lacking; for example, misunderstandings or lack of information about risks or medication errors. There is a wide range of examples involving communication issues along the health dispute continuum. In trying to resolve these issues, the root cause needs to be isolated. Once this has been done the cause can be discussed with the provider and consumer, peer reviews obtained on the matter, and often quality improvements made at the end of this process. The latter may benefit not only this consumer but also have a system wide impact. Complaints of this type are amenable to conciliation, and at the end of the process we would usually provide feedback on quality improvements to organisations such as professional medical bodies, or the Office of Safety and Quality within the Department of Health.<sup>6</sup>

## **What, from the perspective of a health complaints agency, may assist in resolving complaints in a timely and effective fashion?**

### **Networks**

Access to other complaints networks facilitates an exchange of information, better understanding of different systems and practices used elsewhere, and the development of best practice in complaint handling and resolution methods.

### **Participation**

Encouraging the relevant parties to participate actively and resolve the complaint. Responses to a complaint can often be formulated by a person who has not been involved in the direct care of the consumer (particularly in

large provider organisations). Problems often arise because the person preparing the response interprets records or information differently from how the original service provider intended and letters can go out to consumers that may not be entirely accurate. This often compounds the original concerns of the consumer, resulting in the feeling that no one had listened to their original concerns, or worse still, that there has been some sort of 'cover up' by the service provider.

### **Accuracy**

A response to a complaint needs to be accurate. In the first instance, the original clinical staff should prepare, or have significant input into, the response to the complaint. This gives them the opportunity to have feedback on the way their treatment was perceived, and also gives them the opportunity to present their recollection of events and identify any documentation/information that may be relevant. The response coordinator can then bring together all relevant information and documentation and ensure that a cohesive and accurate reflection of the circumstances is presented.

### **Understanding**

The initial complaint should be read carefully by conciliation staff and, if not completely understood, checked back with the consumer regarding the points of concern. Even where a complaint seems clear, initial contact with a consumer can clarify the matter further. This also provides them with an opportunity to ask questions about the complaints resolution processes, which then facilitates better communication of the issues of complaint to the provider and a more accurate and comprehensive response.

### **Timelines**

Ultimate responsibility for the timely resolution of complaints rests with the conciliator, but control often rests with the parties. Maintaining ongoing contact with consumers and providers encourages timely resolution. This does not mean that complaints need to be closed speedily, although a faster closure can assist complete resolution of matters. However, where a fast closure may mean a less accurate response, or a



less than thorough resolution process, the best way forward is usually to ensure the parties are kept advised of progress. In this way they know something is being done on their matter but understand the reasons why it is taking longer than expected.

### **Acknowledgment**

Where a consumer or provider or a particular staff member from a large organisation has been helpful in bringing a matter to resolution, always acknowledge that contribution.

### **Truth**

Providers should be encouraged to tell consumers the truth about what happened to lead to the circumstances of the complaint. This may be enhanced by the Open Disclosure Standard currently being promoted in Australia.<sup>7</sup> This standard encourages the approach that when an adverse incident occurs an apology or expression of regret is useful in assisting the resolution process. In addition, the provision of an accurate factual explanation of what happened, the potential consequences of the event and any remedial action taken by the provider as a result of the incident can assist resolution.

### **Content**

Providers should be encouraged not to be defensive or use complex terminology or jargon in a verbal or written response to a complaint. This often increases the frustration and concerns of the consumer. Clear explanations in plain language are likely to enhance the chances of positive resolution.

### **Duplication**

Try to avoid duplication of the resolution process. For example, a hospital and a complaint agency may perform similar enquiries to try to resolve a complaint. Before proceeding towards formal resolution through conciliation, it is wise to check what enquiries have previously been made, by whom, and what was the outcome. Also, one should check whether or not the consumer knows about those enquiries and their views on any

outcomes achieved to date. This might reduce the number of issues to be resolved and allow the conciliation process to focus on outstanding issues.

### **Summary**

Conciliation can be an effective dispute resolution process in health complaints. It can be complex and difficult but, notwithstanding this, many types of disputes or conflicts are amenable to such a process. Simple things can be put in place both before and during the conciliation process to streamline resolution of the matter and to ensure the conciliator remains in control of the dispute process. This helps to resolve the issues of concern in an impartial and effective manner, while at the same time encouraging resolution of the issues of concern. ●

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