

*An Alternative Approach to Settling Medical Negligence Disputes*¹

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Introduction

The aim of this paper is to set out the anatomy of a medical negligence dispute, displaying its special features, and then inquire into whether a particular combination of alternative or assisted dispute resolution mechanisms, if utilised by the parties, would be likely to provide greater benefits and better outcomes for the parties than if they simply stuck to the conventional path of adjudicative litigation.

For the purposes of this analysis I will restrict myself to looking at the current practice and procedure of the Supreme Court of New South Wales³ as defining the conventional path of adjudicative litigation in medical negligence disputes – i.e. “the court system” for resolving such disputes.

The particular alternative or assisted dispute resolution mechanisms which I will be advocating as a means of providing a better, more efficient, less costly and less confrontational or adversarial means of attaining early settlement of medical negligence disputes are a combination of *Neutral Evaluation* and *Mediation*. Whilst it is acknowledged that either of these ADR mechanisms alone might be capable of

¹ This paper was first presented at the SLC in 2000. Whilst it continues to be as relevant in 2005 as it was in 2000 please note that it has not been updated as yet to take into account any practice and procedure changes brought about by the commencement of the *Civil Procedure Act NSW* on 15th August 2005.

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³ For the rest of the paper I will simply refer to it as ‘the Supreme Court’.

assisting an early resolution of the dispute, it is submitted that the highly technical nature of medical negligence disputes, combined with the clash of interests of the three entities involved (plaintiff, defendant and insurer), create a high risk of failure when the parties resort to just one or the other of them. This paper will look at how an effective blend of the two different mechanisms might produce a better success rate in early resolution of such disputes.

Before going any further I wish to immediately acknowledge that there have been some recent major changes in the practice and procedure in the Supreme Court in dealing with medical negligence disputes which in my view significantly improve the mechanisms for managing such disputes once they are channeled into the 'litigation system'. These improvements are all part of the new 'professional negligence list' in the Supreme Court.⁴ The special features of this list will be outlined later in the paper.

However, even with this acknowledgement, which is properly due, I will endeavour to put forward a case that the interested parties in a medical negligence dispute may be even better served if they give consideration to particular scheme for dispute resolution advocated in this paper. The scheme is not in opposition to the present professional negligence list in the Supreme Court, but complementary to it.

The chief sources, which I have drawn upon to formulate the views expressed in this paper, are listed in the attached bibliography.

⁴ The List is governed by Part 14C of the Supreme Court Rules and Supreme Court Practice Note No. 104. Together, the rules and the practice note provide a scheme for management of professional negligence cases in the Supreme Court.

Before we can begin to consider any new, and possibly better approach, to resolving medical negligence disputes, we need to understand the current regime and the features which underpin it. We need to understand both the macro and microelements of the current regime.

By “current regime”, I mean seeking a resolution of the dispute via traditional litigation. This means serving a notice of claim on the intended defendant, inviting the intended defendant and his/its insurer to consider the possibility of settlement, pursuing direct settlement negotiations to the extent possible, and if no settlement eventuates, filing court proceedings to commence formal litigation.

By “macro” I mean looking at and understanding –

- i. what constitutes a medical negligence dispute;
- ii. the different interests and expectations involved in such a dispute;
- iii. the key features inherent in conventional litigation.
- iv. the psychology of conventional litigation
- v. the limitations of conventional litigation.

By “micro” I mean looking at and understanding –

- a. what happens when a medical negligence dispute is filed in court;
- b. what alternatives or options are offered to the parties;
- c. what pressures or constraints are created or removed by the case management system applied to the dispute once it enters the doors of the court;
- d. how efficient the regime is;

- e. how economic the regime is;
- f. how just the regime is;
- g. the parties level of satisfaction with the regime.

The Anatomy of a Medical Negligence dispute

The essential ingredients of a medical negligence dispute can be summarised as follows-

1. There has to be a Claimant –

This is the person who ultimately becomes the “plaintiff” if court proceedings are commenced. This person alleges that a doctor, hospital or other health service provider has, by some act or omission, been negligent and thereby caused him or her injury and consequential damage. In short, it is alleged that the health care provider breached his, her or its duty of care to the patient. The act/s or omission/s relied upon complained of might be in any of the following areas –

- i. the failure to give appropriate advice or warnings to the patient;
- ii. the failure to provide an appropriate standard of treatment to the patient;
- iii. the failure to manage the patient’s care appropriately after an operation;
- iv. doing something to the patient contrary to the patient’s instructions, wishes or without the patient’s informed consent.

2. There has to be an alleged Offender –

This is of course the doctor, hospital or other health care provider accused by the Claimant of doing wrong or acting negligently and thereby causing the Victim some kind of harm. This is the entity which becomes “the defendant” if court proceedings are ultimately commenced.

The Claimant and the Offender together become “the parties” to the dispute. If court proceedings are commenced they become the parties to the litigation.

3. The Lawyers –

The parties seek advice from their chosen lawyers.

The Claimant seeks legal advice as to whether he or she has a viable cause of action against the Offender with reasonable prospects of success. Translated this means “Can I win and obtain compensation?” It may also mean – “Can I win and get justice?” The “justice” part may simply equate to fair and just compensation for the harm done. However, it may also mean getting some level of retribution against the doctor or hospital in order to compensate for the subjective sense of grievance and anger being experienced by the Claimant.

The Offender usually refers the complaint, once received from the Claimant, or the Complainant’s lawyers, to his, her or its Medical Defence Union, which is backed by a large Insurer Underwriter. The Defence Union in turn seeks legal advice from its Lawyers. The advice sought is “Can we successfully defend this Claim and avoid paying any compensation?” If the Claim cannot be successfully defended, the question is “How can we pay as little as possible to get rid of this Claim?”

The Claimant's lawyers may or may not have special expertise in medical negligence disputes. The practice of medical negligence law is highly specialised and if a potential claimant ends up in the hands of lawyers who are not adequately experienced in this field this may seriously compromise or prejudice the claimant's prospects of success. It may also significantly add to his or her financial and psychological burden during the course of the dispute.

The Offender's lawyers are invariably one of the big city law firms and invariably have a high level of expertise in dealing with medical negligence disputes.

4. The Medical Insurers –

These are big and well resourced Underwriters. They are a business and are run on usual business principles. They have shareholders. Their aim is to make a profit not a loss. This objective is best satisfied by employing whatever strategies are necessary to avoid paying compensatory damages to the Claimants, or if liability is conceded or considered a likely possibility if the claim went to trial in a court of law, to settle the case for as little as possible.

5. The Courts –

Once the Claimant files a formal Claim in the Court, the Claim becomes a "legal proceeding" or "case" and is thereafter subject to the Court's practice and procedure

in managing the progress of the case from filing through to final adjudication by a judge, or by a judge and jury, of the Court. Once a Claim has been filed in a Court there is “litigation” between the Claimant and the alleged Offender, now called the Plaintiff and the Defendant. This litigation becomes subject to and controlled by the Court’s case-management system. The case management regime in the Supreme Court for medical negligence suits is currently provided by the “Professional Negligence List”.

Ultimately, if the parties are unable to find a way to settle their dispute through direct negotiation or some other means, the case will run its course through the Court’s case-management system and end up being assigned to a judge, or judge and jury, for adjudication and determination. This is known as a “hearing” or a “trial”. The judge, or a jury⁵, will hear the evidence and decide which party wins and which party loses. This will bring the dispute to an end subject to the losing party’s right to lodge an appeal.

The Plaintiff is the winner if the judge or jury decides that the Defendant was negligent and thereby caused harm and loss to the Plaintiff. The Defendant is the winner if the judge or jury decides that the Defendant was not negligent, or if the Defendant was negligent, that negligence was not responsible for causing any damage to the Plaintiff.

If the Plaintiff wins, the Defendant will be ordered to pay the Plaintiff a sum of compensation, the quantum of which will be determined by the Court. The Defendant will also be ordered to pay the Plaintiff’s legal costs and disbursements. If the

Defendant wins, the Court will order the Plaintiff to pay the Defendant's legal costs and disbursements.

6. The Appeal Rights –

The losing party has a right to lodge an appeal to the Court of Appeal provided that it can identify appropriate “grounds of appeal”. If the appeal is maintained and proceeds to a hearing, the Court of Appeal will decide whether the “Court of First Instance” reached the right decision or not. If it did, then the Court of Appeal will dismiss the appeal. If it did not, the Court of Appeal will allow the appeal and deliver its own decision. In which case, the original “winner” may now be the “loser”. If this happens to be the Plaintiff, the Plaintiff/Victim will usually be ordered to pay the Defendant/Insurer's legal costs and disbursements of both the appeal and the original trial. This outcome could be quite devastating to the Plaintiff.

7. “Costs follow the Cause” –

This applies in most Australian Courts, including the Supreme Court. Put bluntly, it means “loser pays”. If you bring a dispute to Court, and lose, you will be ordered to pay the costs of the winner. These costs will often be very substantial. The Plaintiff could end up losing his or her house in order to pay those costs -a frightening prospect for many plaintiffs or would-be plaintiffs. In fact, this rule creates such a threat in the minds of potential plaintiffs that many meritorious cases are never taken to Court. The Claimant limits his or her instructions to the lawyers to “try and settle the case out of court”. If this fails to produce any result, the Claimant accepts defeat then and there.

⁵ To have a jury one of the parties must “requisition a jury”. The Supreme Court Rules govern when

The special features which underpin this Macro of the current regime

For the purposes of this paper I would like to highlight the following features which are inherent in the above anatomy of a medical negligence dispute –

1. There are three different stakeholders and hence three different sets of interest – that of the complainant/plaintiff, that of the defendant - health care provider (doctor/hospital) and that of the medical insurer;
2. The plaintiff is often under-resourced and/or poorly resourced, whilst the defendant is usually backed and funded by a large insurer and a large legal firm;
3. The principle of “loser pays” operates as a threat only to the plaintiff. For the defendant it is simply a “commercial consideration” to be taken into account.
4. A medical negligence dispute can often be highly technical – both medically speaking and legally speaking;
5. A medical negligence dispute, if not resolved early, can be very time consuming, labour intensive and costly;
6. The plaintiff’s interests might embrace any of the following –
 - i. to win;
 - ii. to be fairly compensated;
 - iii. to punish the defendant for a perceived wrongdoing;
 - iv. to ‘get justice’;
 - v. to be understood;

and how a jury can be requisitioned by a party.

- vi. to tell his story in open court;
- vii. to be heard;
- viii. to have the defendant apologise and accept that he did wrong;
- ix. to expose serious negligence to the public eye – so that it will not happen again;
- x. to know the true facts in order to understand how a medical mistake came about.

7. The defendant's interests and the insurer's interests are not the same and in some instances are not even compatible –

- the defendant's interest (especially for a doctor) might include the following –
 - i. to vindicate himself;
 - ii. to safeguard his professional reputation;
 - iii. to avoid unnecessary and unwelcome publicity;
 - iv. to protect his integrity;
 - v. to avoid any financial penalty or commercial damage to his practice;
 - vi. to explain his actions to the plaintiff, and if possible, mend the fence with the plaintiff;
 - vii. resolve the matter as quickly as possible.

- the insurer's interests might include –
 - i. avoid liability if at all possible;
 - ii. contain compensation payouts which can drive medical insurance premiums up;
 - iii. make no admissions of any kind which might increase the risk exposure;
 - iv. if plaintiff has good prospects of success, try and settle the case out of court without any admission of wrongdoing;
 - v. make use of other medical experts to try and win the technical medical issues;

- vi. make use of the best lawyers to try and win the technical legal issues.
 - vii. delay payment of compensation to plaintiff as much as possible (profit motive).
8. Once the complainant files his case in court, the court's timetable and rules and procedures govern the future management of the dispute. The court's objective is to drive the dispute to a conclusion as quickly as possible. From the point of filing the claim the court process dominates the parties focus and all further attempts at settlement are done under the 'shadow of litigation'.

The Key Features of Conventional Litigation

The principle objective of the court system is to bring a dispute to finality. The 'system' includes the following features –

- i. It has Rules that govern the way in which a dispute can be brought into the court system. The dispute must be reduced to writing – called a 'statement of claim' which complies with the 'rules of pleading'. Medical evidence to support the plaintiff's claims must be obtained before the Claim can be filed in the court's registry. A filing fee must be paid. This filing fee is no longer insubstantial and can place a burden on many plaintiffs.
- ii. Once the Claim has been filed, it becomes subject to the Court's case management system. In the Supreme Court it is entered in the Court's 'Professional Negligence List' and is thereafter managed in accordance with the Rules of that List. The List is controlled and supervised by two of the Court's judges.

iii. The Dispute, once in the Professional Negligence List, must be made ready for hearing as soon as possible. By use of what are called 'directions hearings', where the lawyers of the parties must appear before the List Judge, a timetable is set which requires the parties to do certain things by certain deadlines. If a plaintiff fails to adhere to the timetable he can suffer serious penalties. The worst penalty is having his case struck out. Some plaintiffs can be exposed to serious financial and psychological stresses in endeavoring to adhere to the Court's timetable. At the final directions hearing, if all is in order, the Court fixes a date to hear and determine the dispute by formal adjudication. In some cases a jury will be requisitioned. The jury's function will be to decide what are the facts and to apply the law, as instructed to them by the judge, to the facts in order to decide who wins and who loses the dispute.

iv. At the formal hearing, the plaintiff and the defendant will have to enter the witness box to give sworn evidence as to what they say are the facts. They will have to be prepared to undergo cross-examination and be tested on what they have earlier said to be true. The judge or jury will have to decide who they believe. Attacks on credibility and personal integrity are quite common in such disputes.

v. Once the formal hearing is over, and if the adjudication was done by a judge alone, the parties may have to wait many months before the judge hands down his decision. This 'waiting' can be a very stressful time for the parties. There is fear of the unknown and how an adverse outcome might impact on the litigant's life.

vi. The Court gives judgment. In the formal justice system the law decides what is just and appropriate. It does this according to how it finds the facts and how it applies the relevant legal principles to those facts. The parties may agree or disagree with

how the Court found the facts or applied the law. However, unless the losing party can, with legal assistance, identify “errors of law” (a highly technical exercise) in the judgment, or in rulings made by the judge during the trial, he or she must accept the outcome. For better or worse, the formal justice system provides some kind of objective standard with regard to rights, entitlements and obligations which the disputants are required to accept. They understood this when the decision was taken to submit the dispute to the Court for formal adjudication.

The Psychology of Conventional Litigation

The psychology of Conventional Litigation is driven by the need to have winners and losers. But even the technical ‘winner’ may end up being a loser. In which case instead of there being a win/win outcome, there could very well be a lose/lose outcome.

For instance, a plaintiff might be technically the ‘winner’ but still suffer a financial set back because the compensation awarded to him or her is inadequate. Or, even if the compensation is generous, he or she might still feel aggrieved and negative about the whole experience because of the manner in which the case was handled, the insensitivity of the lawyers and/or the judge, or because he knows that the doctor never ended up making any concession that he did something wrong and never offered any apology.

On the other hand, a defendant doctor, who technically ‘wins’ the case, might still feel a loser because of the bad publicity he got during the case which tarnishes his good reputation and possibly causes financial harm to his practice.

The psychology of conventional litigation is therefore one of fear, anxiety, confrontation, opposition, struggle, war, anger, retribution, ego, victory, defeat, loss of control, vulnerability and so on. Negative emotions rather than positive ones dominate it. This is borne out of the adversarial character of litigation.

The Limitations of Conventional Litigation

Conventional Litigation is limited by the scope of its objectives. The system it offers is an adversarial one. The dispute is treated as a contest in which the court is asked to accept the job of final arbiter. The Court's ability to investigate the facts, in order to elicit the truth, is very limited. It generally has to depend on the parties and their lawyers to place the facts before it. Those facts may be less than the full facts. The Court has to do the best it can with what it is given. A judge also has to apply the law as it is rather than what he or she would like it to be. Even if that results in an outcome that personally offends the judge, he must still render that decision if the law requires it.

It is not the Court's function to mend fences between the plaintiff and the defendant. As far as the Court is concerned such issues are not relevant. The only facts which are relevant are those which have a bearing on the issues of the dispute as defined by the court pleadings.

Once a defendant doctor receives notice of a claim he or she must place it in the hands of his or her insurer and thereafter be guided by the advice of the insurer's lawyers.

As can be seen above, the insurer's interests do not necessarily coincide with those of the doctor. Once a claim is notified the doctor and patient must be kept apart and not allowed to 'talk it over'. The system ends up polarising and isolating them. They

become pawns controlled by ‘the game’ of litigation that has only one objective – to produce one winner and one loser. However, as pointed out above, because the interests of the doctor and the insurer may be quite different, a ‘win’ by the doctor might end up only being a real win for the insurer because the other interests of the doctor were never considered relevant.

Therefore, whilst the conventional system of delivering ‘justice’ via the courts may be doing a very fine job judged according to criteria such as –

- i. efficiency;
- ii. reduced costs;
- iii. cases disposed of within a set period

the limitations inherent in the system may not be producing good results judged by alternative criteria such as –

- a. participant satisfaction;
- b. self determination;
- c. emotional healing;
- d. free choice;
- e. reducing emotional stresses;
- f. reducing financial stresses;
- g. increased understanding;
- h. restoration of respect;
- i. satisfying collateral underlying interests and needs;
- j. improving relationships;

k. enhancing community understanding and perceptions of the ‘justice system’.

and so on.

Solutions to overcome these Limitations

It has been accepted for some time now that ADR⁶ needs to be an essential component of the formal justice system for resolving disputes in order to overcome the serious limitations inherent in the conventional litigation system.⁷ The purpose of this paper is to consider whether the current regime offered by the Professional Negligence List of the Supreme Court goes far enough in making use of ADR processes to resolve medical negligence disputes in a way that will offer the greatest potential benefits to the three sets of interests that are involved in such disputes –that of the complainant, the defendant and the insurer.

ADR embraces all methods of resolving disputes other than court-based adjudication. However, for the purposes of this paper, I am only concerned with two of them – Early Neutral Evaluation (ENE) and Mediation.

ENE has been defined as meaning –

the process of evaluation of a dispute in which the evaluator seeks to identify and reduce the issues of fact and law that are in dispute. The evaluator’s role includes assessing the relative strengths and weaknesses of each party’s case and offering an

⁶ Alternative Dispute Resolution or Assisted Dispute Resolution.

⁷ See for instance “Contemporary Developments in Mediation with the Legal System and Evaluation of the 1992-3 Settlement Week Program”, a report prepared on behalf of the Law Society of New South Wales in April 1994; and “Managing Justice – a Review of the Federal Civil Justice System”, Australian Law Reform Commission, Report No 89.

*opinion as to the likely outcome of the proceedings, including any likely findings of liability or the award of compensation.*⁸

Mediation has been defined⁹ as follows –

A structured negotiation process in which a neutral third-party, the mediator, who is independent of the parties, assists them to agree on their own solution to their dispute by assisting them systematically to isolate the issues in dispute, to develop options to assist the parties to the dispute to achieve their own resolution of the dispute in an agreement which accommodates the interests of all the disputants as much as possible.

The Supreme Court sets a new standard for civil procedure

On the first day of term in the year 2000 the Chief Justice announced amendments to the *Supreme Court Rules* intended to inaugurate a new standard for civil procedure.

The basic principle is identified in a statement of overriding purpose in Part 1 rule 3(1) namely the “just, quick and cheap resolution of the real issues” in civil proceedings. Some might have preferred a different word to “cheap”, but no doubt it is meant to convey the need for the mechanisms for dispute resolution to be effective and efficient, and for the costs of litigation to be kept as low as possible without the overriding principle of “just” resolution being eroded or compromised.

Making use of ADR is an integral part of this new standard for civil procedure. So much so that it has led to the emergence in a new rule of practice for New South Wales barristers. Barristers are required to adhere to their own practice rules. Rule

⁸ This definition is provided by the UTS (LLM) Dispute Resolution Course Materials for 2000.

17A makes express an obligation on barristers to consider alternatives to a full contest. Mediation will be a frequent means of satisfying the Rule but of course there are other alternatives.

The Supreme Court's jurisdiction is shared between certain "divisions" and "lists". A senior judge supervises each division and list. It is part of that judge's duty to ensure that the new standard is reflected in the specific rules of practice and procedure in that division and list.

It is the Professional Negligence List that determines the practice and procedure that governs all medical negligence suits filed in the Court.

The Professional Negligence List

Cases in the List are subject to their own Rules – contained in Part 14C of the Supreme Court Rules. They are also subject to recent amendments to Part 36 of the Rules that commenced on 1 March 2000. A new Part 39 also has direct relevance to the Professional Negligence List. Finally, there are the new case management Rules contained in Part 26 rule 3.

Part 7B of the Rules is also of direct relevance to the List. This Part is headed "Mediation and Neutral Evaluation". Its purpose is to enable the Court to refer matters for mediation or neutral evaluation "if the parties to the proceedings concerned have agreed to that course of action."¹⁰ However, the Part does not prevent the parties to

⁹ UTS Dispute Resolution Course Materials (LLM)

¹⁰ Section 110H(1).

the proceedings from agreeing to and arranging for mediation or neutral evaluation of any matter otherwise than as referred to in the Rules.¹¹

The Rules make it clear that resort to either of these ADR mechanisms is entirely voluntary. The Court's duty is simply to identify matters arising in cases before it which are suitable and appropriate for mediation or neutral evaluation. If the parties also agree then it is up to the parties to also agree upon who should be the evaluator or the mediator. If the parties elect to proceed this way then they must also be responsible for the costs payable to the mediator or evaluator in equal shares.

To assist litigants in finding an appropriately qualified evaluator or mediator the Chief Justice has compiled a list of persons considered to be suitable to perform those roles. However, the parties are not bound to select someone from that list.

With respect to the use of ADR, I would like to quote direct from Justice Abadee who at the time of writing this article was the judge in charge of the List. When speaking about the new Professional Negligence List at a recent Scientific Meeting of the Medico-Legal Society of New South Wales he made the following remarks¹² -

In the List great emphasis has been placed on the matter of mediation and consents to mediation. The importance of consent mediation is emphasised from the inception of the proceedings. Indeed in the initial "Notice of Conference Hearing" it is a matter particularly emphasised. Mediation need not wait until the final preparation stage and should be considered at every List Conference held by the Court. The recent increase in the consent mediations shown by the December 1999-February 2000 figures reflects I believe Court's active case management of cases in the List from

¹¹ Section 110H(2)(a).

April 1999 onwards. This in turn has impacted on their state of preparation and readiness for hearing or referral to mediation. The statistics also show a pleasing number of settlement of actions in the Professional Negligence List – many clearly attributable to mediation. A point to be made is the high level of consensus as to the desirability for consent mediation under the consent mediation provisions of section 110K Supreme Court Act (NSW).

A small specialised group of mediators has emerged as acceptable to the parties. This I regard as highly desirable. They bring accumulated experience and expertise to bear in the mediation process. Reports and results suggest that in respect of matters the subject of the mediation process a high level or rate of success has been already achieved. Medical and legal insurers, and the plaintiffs and their advisers have come to recognise the real merits of mediation.

I have frequently expressed the view in the Court that ‘generally speaking there is no such thing as a useless mediation’ and I am becoming more and more convinced that this is correct. Even a failed mediation may bridge differences and identify or limit the real issues for trial. A failed mediation may cause the parties to pause, reflect and later settle before trial so that if the matter proceeds to trial the parties will be able to concentrate resources on the real controversies between them.

Mediation is a parallel course to preparation for trial in the Court. Trial preparation continues. Mediation gives privacy and helps protect reputations. Mediation is attractive on a ‘referral’ out under s.110 of the Act since there is the perception that the case remains under the Court’s overall umbrella and is not placed outside the

¹² Volume 17, No.1, Medico-Legal Society of NSW Journal.

Court. The fact that many of the “few” specialist mediators are ex-judges is also helpful to the process.

In respect of ADR I have generally favoured the mediation approach, as have the party litigants. I still do so. Experience has confirmed such as a very good way to go in respect of cases in the List.

Where is the Potential for Improvement?

I would venture to say that both the plaintiff/claimant and the defendant/doctor involved in a medical negligence dispute will have a number of common objectives, such as –

1. achieve a resolution of the dispute as quickly as possible;
2. resolve the dispute as economically (cheaply) as possible¹³;
3. have the other party better understand his own point of view or position¹⁴;
4. maintain control over their own lives and destiny in the management of the dispute if possible;
5. achieve a fair and just outcome without causing personal harm to each other¹⁵;

¹³ ‘Cheaply’ for the plaintiff means keeping his or her legal costs and disbursements as low as possible. ‘Cheaply’ for the doctor, who is generally covered by insurance, means trying to keep his medical insurance premiums from blowing out.

¹⁴ From the plaintiff’s perspective, even if the doctor will not make any formal admission of liability or accept responsibility for what happened (for legal and insurance reasons) it would still make a huge difference if he could just say he did make a mistake and is sorry for what has happened to the plaintiff. From the doctor’s perspective, he or she might like a chance to sit down privately with the plaintiff to explain how a medical misadventure can sometimes happen even when the utmost care is taken. He or she might like to say ‘sorry’ and express sympathy and support but at the same time making it clear that there was no carelessness or breach of professional standards owed to the patient. Because of the nature of our adversarial system and doctors obligations under their insurance policies as soon as a medical mishap occurs and litigation is threatened the doctor is literally prohibited from having any direct personal contact with the former patient. The system requires that they be alienated and distant from each other. This fuels mutual distrust and antipathy causes the plaintiff and defendant to view each other as enemies.

¹⁵ This is excluding the rare cases where the defendant has not just been careless, but has been guilty of gross neglect or deliberate neglect of the patient. In those type of cases plaintiffs’ sense of justice often does demand that the defendant be publicly exposed and suffer personal disgrace.

6. achieve some level of reconciliation even if a decision is made to pay the plaintiff compensation.

These are a set of objectives that may find little accommodation by the other stakeholder – the medical insurer.¹⁶ It is submitted that a better system of resolving medical negligence disputes is one which is designed to achieve a better integration of these common objectives of the plaintiff and defendant with those of the insurer.

The former Chief Justice of the Supreme Court of New South Wales, The Honourable A.M Gleeson, now the Chief Justice of the High Court of Australia, wrote an article entitled “*Individualised Justice – The Holy Grail*”.¹⁷ This article analysed the trend in modern law towards a preference for individualised, discretionary solutions to disputes as against the principled application of general rules. The article noted that this trend is largely a function of a societal expectation that looks to the law to provide redress for an increasing number, and an expanding scope, of grievances, in a manner tailored to the justice of a particular case. But it points out that to achieve individualised justice there must be a give and take. For instance, an expectation for a swift resolution of a dispute will be in tension with an expectation of an exhaustive inquiry into the merits of the opposing positions in the dispute.

The introduction of ADR into the practice and procedure of the Supreme Court is a reflection of this trend. It is part and parcel of the serious review of the resources that are made available to the system of administration of justice. It is an integral part of the solution to a justice system whose process involved a profligate use of time and money. As Chief Justice Gleeson put it in his article, “The interest that is now being

¹⁶ The insurer’s agenda and objectives have already been canvassed earlier on in this paper.

shown through Australia, and in England and the United States, in alternative dispute resolution is a case of invention responding to necessity.” He also remarked that recent experience is utilizing ADR in the court system is that “many litigants are willing, and even anxious, to find a means of submitting their disputes for resolution by some reasonably fair and impartial process which does not involve the costs, and in many cases the agony, of a court case.” He made the point that “increasing ingenuity is being devoted to ensuring that people do not get caught up in the machinery developed to comply with those standards.”

The best solution to achieve these objectives and to satisfy the needs of the parties as expressed above, lies in the hands of the parties themselves together with their legal advisors. The best solutions can be devised and implemented even before the dispute ends up in the Professional Negligence List. Therefore, the proposals I am about to outline in this paper are chiefly being put forward as a dispute resolution mechanism to be considered and implemented before the dispute is fed into the formal court system. However, they can equally be considered for use in and incorporation into the Professional Negligence List practice and procedure.

An important point to make at the outset is that as soon as the parties permit their dispute to be entered into the formal court system, whether or not they chose to avail themselves of ADR thereafter, their ability to contain their overall costs is vastly reduced. This is because, as stated by Justice Abadee in his speech quoted above, if the parties agree to pursue Mediation they must still keep preparing their case for final court adjudication in the event that ADR does not produce a settlement. This continues to expose the parties to stresses of the conventional litigation system – to

¹⁷ (1995) 69 A.L.J., 421.

the psychological stress and the financial stress. It may also deter some from agreeing to try ADR in case it fails to resolve the dispute and simply adds to the financial burden.

The Proposed ADR Mechanism to promote early resolution of medical negligence disputes –

As I stated at the start, it involves a combination of two mechanisms or processes of dispute resolution – *Early Neutral Evaluation* and *Mediation*, which terms have already been defined above.

Whilst both these ADR processes are provided for by the Supreme Court Rules they are put forward as alternatives to choose from rather than promoted as a combined two part mechanism for resolving such disputes.

My thesis is that a combined use of these two mechanisms might be particularly beneficial to achieve early resolution of medical negligence disputes prior to entering such disputes into the professional negligence list of the Supreme Court or as soon as possible after a dispute enters the list.

The proposed mechanism takes account of two key factors –

1. The timing of the parties resort to the mechanism; and
2. The power of ‘scoping’ of the dispute first, by use of ENE, before moving to mediation. This is particularly so when the dispute contains highly technical legal issues. It is more within the province of a highly qualified neutral evaluator than

of a mediator to help the parties crystallize the real issues and to ‘reality test’ their respective stances in the dispute.

Timing in my view is a critical factor not to be underestimated. Once legal proceedings have been formally commenced in the Court positions of the parties tend to have become entrenched and their attitude towards each other more combative. Settlement negotiations will have come to an unfruitful end. Financial issues will have been raised, discussed and resolved. A decision will have been made to proceed with litigation. Emotions will have hardened. All this creates a mind-set that is attuned to litigation and final court adjudication and less receptive to ADR.¹⁸

The advantage of ENE before Mediation

The Hon. Justice Murray Kellam, a Judge of the Victorian Supreme Court, in an address he gave to the Royal Australasian College of Surgeons¹⁹, on the topic of ADR, said with reference to ENE, “This is a hybrid process sometimes called outcome prediction. Much of the overseas growth in ADR has been in processes that combine mediation with some form of technique designed to prod the parties into settlement if mediation fails. The technique was created by a US federal trial court. It involves a lawyer who is knowledgeable in the substantive area considering the facts and the legal arguments and attempting to predict the probable range of outcomes at a time well before the consumption of the parties of substantial time and money in trial preparation.”

Once again, key factors are –

¹⁸ There is an alternative viewpoint that commencement of proceedings, with their inherent uncertainty and delay, and the risk of an adverse outcome, provides a good incentive for both parties to mediate the dispute. This is called ADR “in the shadow of litigation”.

- a. Timing;
- b. Cost reduction or conservation;
- c. Stature, reputation, skills etc of the Evaluator;
- d. Analysis of each party's case by the independent Evaluator;
- e. Scoping of the issues;
- f. Objective evaluation leading to reality checking by each party on their respective positions.

This process, in my view, will be of immense utility to the disputants in a medical negligence case. A skilled Mediator, as opposed to an Evaluator, may not necessarily be highly knowledgeable about the legal issues involved. Also, it is not the Mediator's true function and utility to express any view on the legal issues and the respective merits of each party's case as a matter of legal principle. The particular value of the Mediator's role will be discussed later.

Some of the specific goals of ENE would be –

- I. Resume, re-focus and enhance direct communication between the parties about their claims and supporting evidence;
- II. Provide an assessment of the merits of the case by a neutral expert²⁰;

¹⁹ 30 October, 1998, RACS Bulletin, November 1998.

²⁰ An issue arises as to whether the neutral expert necessarily has to be a lawyer. It might be argued that the role of neutral evaluator should not be confined to lawyers, but should include medical experts of high repute. This view was recently put to me by members of the Medlaw Association of NSW (all doctors) after I delivered this paper to them informally on 15th March 2001. If the evaluator was a lawyer it would most likely be a lawyer (and possibly a former judge) who had a significant past involvement with medical negligence litigation. He or she would therefore have enormous experience in reading and evaluating expert medical opinions. If the neutral evaluator was to be a medical practitioner, that person would conversely have to have the capacity to understand and evaluate the legal issues involved, not just the medical ones. Such a medical person would be rare although there are now a number of former doctors practising as lawyers. It might be possible however, in suitable cases,

- III. Provide a ‘reality check’ for clients and their lawyers;
- IV. Identify and clarify the central issues in dispute;
- V. Assist with discovery by informal exchange of relevant information ²¹;
- VI. Facilitate settlement discussions between the parties.

The process to achieve these goals might be as follows –

- ◆ Each side, via their lawyer, presents the relevant evidence (including all the relevant expert medical opinions) and arguments supporting his, her or its case (without regard to the rules of evidence and without any direct cross-examination of witnesses.)
- ◆ Witness evidence can be provided in the form of signed statements;
- ◆ The evaluator will identify areas of agreement, clarify and focus the issues;
- ◆ The evaluator will then, after hearing the evidence and the arguments, and discussing same with the lawyers, will write an evaluation opinion. This opinion will include –
 - i. an estimate, where feasible, of the likelihood of liability and the dollar range of damages;
 - ii. an assessment of the relative strengths and weaknesses of each party’s case;
 - iii. the reasoning that supports these assessments.

This evaluation opinion will then be presented to the parties.

for the Neutral Evaluation to be conducted by a lawyer and a medical practitioner chosen and accepted by the parties.

After the parties have considered the evaluation they will then be encouraged by, and if requested, assisted the evaluator to resume their settlement negotiations and reach a resolution of the dispute. If settlement does not occur, then the evaluator's last step will be to meet with the parties one further time in order to ascertain whether enough progress has occurred to make it a further worthwhile use of their time and money to move immediately to stage 2 of the ADR process, which is *Mediation*. However, if the parties can see no potential benefit in doing this they can elect to take their case to court, or if already in the professional negligence list, to advise the court that ENE has not resolved the dispute and that they wish to proceed to adjudication by the court. As part of this final stage of ENE the Evaluator can also assist by helping the parties realistically assess future litigation costs.

In my view, if such a process were to be available and regularly made use of in medical negligence disputes it would lead to the early settlement of many such disputes before the parties start to commit themselves to the much higher cost of pursuing the path of conventional litigation. Although Rule 72 of the Supreme Court Rules provides for parties to request a referral to ENE, it is less satisfactory than the mechanism I have put forward for the following reasons –

1. The parties must already have commenced court proceedings before the referral can occur;
2. The 'process' of ENE as outlined in the Rule is less comprehensive than what I have proposed;
3. The Evaluator's role is not defined to include the final stage of involvement which is contained in my proposal.

²¹ It may even provide a low cost substitute for formal discovery and avoid costly pre-trial interlocutory

Stage two - Mediation of Medical Negligence Disputes - Background

As stated at the outset, the Mediation option has now become an essential part of the court system in managing personal injury claims, including medical negligence suits. It is all part of the significant review of the way in which courts undertake litigation that has been taking place over the last 5 years or so. This is so in all Australian jurisdictions and mirrors overseas experience in the United Kingdom, the United States and Canada. Mediation is now a regular option in most case management systems. As Justice Kellam, of the Victorian Supreme Court, remarked in his address²² to the Royal Australasian College of Surgeons, regarding the apparent success rate of mediation in medical negligence cases, “it does appear that practitioners, both those acting for plaintiffs and those acting for defendants, are willing enough to use it (mediation). This is a substantial cultural shift in a period of approximately five years. Before then, mediation in medical cases was unheard of.”

The driving force behind this cultural shift is clearly the concern felt by all participants in the tort system about the significant delays and cost and uncertainty of proceeding with a claim in that system, and the consequential impacts of this on both the individual and the whole community.

It is vital that the parties ‘grasp the ADR nettle’ early – either pre-filing of the claim in court or soon thereafter. This will help the achievement of the following objectives-

motions to resolve disputes over further and better particulars, discovery and interrogatories.

- (a) Cost savings;
- (b) Time savings;
- (c) Conservation of valuable court time and resources;
- (d) More effective use of judicial resources;
- (e) Quicker reduction of court back-logs of cases which ultimately have to go to trial;
- (f) Improvement of Court's public image, and indeed of the whole 'justice system'.

How can Mediation benefit the parties in a medical negligence dispute?

This topic has been much written about and there now seems to be a widespread consensus that the mediation option has much to offer those engaged in litigation, including medical negligence litigation. One writer has referred to mediation as the “adjustable spanner in the dispute resolution tool box.”²³ It does not really matter what is the nature of the dispute, provided that certain criteria are met. This would include –

- The parties have a real and sincere desire to negotiate and resolve their dispute themselves;
- The timing is ripe for the mediation process to assist the parties in their efforts to resolve their dispute;
- Both parties are committed to the process and are ready and willing to commit the time and money to properly prepare for the mediation and to attend the mediation;
- All parties have reality tested their respective positions on liability and damages and crystallised the issues for resolution;

²² See reference already given in footnote 18.

²³ AF Ackland, *A Sudden Outbreak of Common Sense – Managing Conflict Through Mediation*, Hutchinson Business Books, London, 1990, pp.2,29.

- All relevant and admissible evidence has been disclosed and objectively evaluated;
- The applicable law has been accurately identified and applied to the facts which each party truly believes can be proved if the case went to trial.

It is submitted that the last three criterion will often not be satisfied if the parties have not first submitted their dispute to ENE. This is particularly so in the context of medical negligence disputes. The chances of a successful outcome from mediation will therefore be reduced. Conversely, if there has been ENE, the chances of a successful outcome from mediation will be greatly enhanced, particularly if a highly skilled mediator whose credentials are acknowledged by both sides is conducting the mediation.

The goal of mediation is to reach a mutually satisfactory agreement resolving all or part of the dispute. The mediator's job is to facilitate this happening by skillfully managing the process of negotiation and interaction between the participants.

Mediation is a flexible, non-binding, confidential process in which the mediator manages the process in order to maximise the parties ability to negotiate their own outcome to the dispute.

The mediator need not be a lawyer. It is not his or her function to communicate any view on the law or the quality of each side's evidence. The mediator's key function is to –

- Improve communication between the parties;
- Resolve impasses;

- Clarify key underlying interests and to promote deeper understanding of each participants needs and interests;
- Identify areas of agreement;
- Identify concessions;
- To help generate more options to broaden the base for possible settlement.

It can be readily appreciated that these key functions of the mediator are entirely different to those of the neutral evaluator. If a mediator attempted to incorporate the role of evaluator it would have the potential to corrupt and weaken the true role of the mediator.

If no prior ENE had taken place, there would be a legitimate argument that a mediator of a medical negligence dispute should preferably be a lawyer with expertise in medical negligence litigation. Otherwise it would be extremely difficult for the mediator to manage the impasses and blocks which inevitably arise in the negotiations due to differing views over what the law is and how the law applies to the facts. This is why I am strongly advocating prior ENE before a medical negligence dispute proceeds to mediation.

If there has been prior ENE, in my view the Mediator, as part of his or her preparation for the mediation, should be given a copy of the neutral evaluator's opinion. This may give the mediator a valuable insight into the issues that are causing the impasse to settlement. It will assist the mediator to devise his or her strategies to close the gaps and broaden the territory to allow settlement to occur.

The final key role of the mediator in such disputes is to skillfully reconcile the special interests and needs of the plaintiff, the defendant and the insurer. In the majority of such disputes the medical insurer takes over the conduct of the defence. It appoints the lawyers to mount the defence for the doctor or hospital. If doing so insurance interests come to the forefront and often overrides the needs and interests of the doctor. Conventional litigation, without ADR, has no means to deal with this issue. For all practical purposes the court system treats the insurer and the defendant as one entity.

As previously stated, this aspect of the traditional tort litigation system promotes alienation, lack of understanding and a negative emotional divide between the doctor and his aggrieved patient. It promotes the antithetical 'us v them' attitude between the victims and the alleged transgressors. In the end both patient and doctor are left feeling misunderstood and frustrated by the system which keeps each of them confined to their corner of the boxing ring whilst their intermediaries, the lawyers, fight each round of the match until the match is over and the court delivers the verdict.

This culture not only has negative repercussions for the litigants, it has negative repercussions for the whole society. It creates 'war camps' which rally around the protagonists. The victims war-camp accuses the doctor/insurance war camp of misuse of power and resources and of trying to use their greater resources to avoid accountability. The doctor/insurers war-camp accuses the victim's war camp of abusing the tort system for unmeritorious financial reward.

Mediation has the potential to evade this culture and over time to dissipate it. But to do so it is essential that the interests of the doctor and the interests of the insurer be separately represented at the mediation. The doctor and his patient, if they wish it, need to be given the chance 'to talk'. The skills of the mediator will permit the ventilation of personal feelings and statements between former patient and doctor without jeopardising the resolution of the dispute over liability and compensation. Everyone knows that confidentiality will be ensured.

Permitting the ventilation of personal feelings and a direct dialogue between the doctor and former patient may very well be the very factor that opens the door to settlement of the legal dispute. Hearing the doctor say 'sorry', with genuine remorse and empathy for the patient's current predicament, may be the very thing needed to help the patient say 'yes' to a settlement outcome which his lawyers were recommending but which up until then the patient had been resisting because of his unresolved feelings towards the doctor.

For the doctor, being permitted to say 'sorry', but without any admission of wrong doing or moral culpability, and seeing with his own eyes that the plaintiff accepts his apology and no longer views him as a bad or evil person, may be the very thing needed to persuade the doctor to agree to a settlement outcome being advocated by the insurer and its lawyers, but which up until then the doctor had been resisting because he felt maligned by the plaintiff's claims against him.

Conclusion

The message in this paper is that a skilful blend of ENE with Mediation, employing the abilities of highly skilful Evaluators and Mediators, not only has the potential to

significantly increase the number of medical negligence disputes being resolved without a need to go to trial, but also to –

- ◆ Save cost both to the plaintiff, the insurer and the community;
- ◆ Reduce the burden on the finite resources of the courts;
- ◆ Reduce the tensions between war-camps representing the vested interests in conventional tort litigation;
- ◆ Promote the healing of damaged relationships;
- ◆ Improve the public image of the ‘justice system’;
- ◆ Restore the personal integrity of those who find themselves unintentionally injured and who seek just compensation;
- ◆ Restore the personal integrity of those who carry out a noble profession and provide great benefits to their community who had the misfortune to cause injury by mistake or inadvertence.

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