A New Way to Settle Old Disputes: Mediation and Healthcare

Mr Tony Allen

Solicitor and a Director of the Centre for Effective Dispute Resolution (CEDR)

The President: Well, once again good evening. Tonight we are venturing into the realms of dispute resolution by mediation and our speaker is Tony Allen, a Director of CEDR since 2001. Now, in my ignorance, I thought that CEDR stood for Comité Européen de Droit Rural, in other words the European Council for Agricultural Law, but I now know that the cognoscenti refer to it as the Centre for Effective Dispute Resolution, which is an independent non-profit organisation whose mission is to encourage and develop mediation and other cost-effective dispute resolution and preventive techniques in commercial and public sector disputes.

Now, Tony qualified as a solicitor in 1969 and practised primarily in the fields of personal injury and insurance (in which he acted both for claimants and defendants), clinical negligence, childcare, criminal and civil advocacy and general litigation, which I think you will agree with me is not exactly a narrow area. Now Chambers Guide to the Legal Profession of 2001/2002 said this: “He is universally considered to be clearly the best mediator in the UK for clinical negligence and personal injury”, and in previous editions it said “his humorous and affable style” counted for a lot in cases with a high emotional content.

So before calling on him to address us on A New Way to Settle Old Disputes I would remind you please to ensure that your mobile telephones are either set to silent or turned off altogether. Tony has agreed to take questions after his talk, so without further ado, Tony, please do go ahead.

Mr Allen: Thank you, Mr President. Good evening everyone.

Perspectives on the Role of Professionals in Mediation

Where do doctors and lawyers intersect, apart from the very convivial atmosphere of the Medico-Legal Society? (And may I say how much I have enjoyed this occasion and express my thanks to the Society for its kind hospitality and for dining with your President and for giving me the stimulus to reflect on what I spend a considerable proportion of my waking hours both thinking about and doing.)

In the afterlife, it seems to me, rarely will doctors and lawyers share the same space. Certainly in public folklore, there is the same dichotomy between doctors and lawyers as there is between saints and sinners. Heaven is where doctors belong and Hell is the place for lawyers. As a solicitor now technically non-practising, but for over 30 years in private practice, I belong to a profession of whom cruel jokes are made. What is the difference between a fatal road accident involving a dog and a lawyer? There will be skid marks leading up to the dog. Reflecting on this story, I realised that if you substitute the word doctor for lawyer, the joke wouldn’t work. What was slightly more depressing was that if I substitute the word doctor for dog, it seemed to work rather too well. An American colleague recently retold me the following story. A doctor went to see a solicitor about a legal problem. After two hours consultation he received a bill for £1,500. Outraged, the doctor phoned the lawyer and said “That’s ridiculous – it’s more than I charge as a consultant surgeon”, and the lawyer said, “Yes, it’s more than I used to charge as a consultant surgeon too.” (Laughter.) The fact that the original and much more likely version which I heard
of it was about a solicitor who called in a plumber whose hourly rate was more than it had been when he was a solicitor is of very little comfort to us.

What of public perception and the view of popular culture in the life of the here and now rather than the hereafter? Are there Press stories (whether in the British Medical Journal or the Sun) about fat cat doctors? Are there soaps dedicated to portrayal of infallibly competent solicitors in civil cases saving their clients from pain and ruin or worse by cool-headed miraculous professional intervention? There are of course the Rumpleis and the Kavanagh QC's of the criminal bar, but few TV idols have so far emerged from the Chancery Division or the Commercial Court, though Amelans (the Manchester solicitors) are trying rather hard in their “No Win, No Fee” programme on Channel 4. When NHS doctors are paid out of public funds there is no great surprise or challenge, and efforts are made to reduce the amount of unsocial hours they are required to work. When Legal Aid lawyers are paid out of public funds, there will be accusations of excessive spending and high living, even where Legal Aid lawyers may earn rather less than relatively junior doctors, and there is many a “24-hour Solicitor” sign to be seen up in the suburban areas of our cities. Of course, we do share the dubious status as professionals that sadly the public are on the whole somewhat reluctant and even afraid to come and see either of us in our professional capacities – in the one case fearing continued or (rather worse) fresh loss of money and in the other continued (but perhaps rarely) fresh loss of health. Even when consulted when things are going well, there is a superstitious restraint about going to see both of us – the patient fears a cataclysmic discovery of disease and the client fears that making a will is certain to give rise to imminent death. They hope for the best, certainly, but quite often fear the worst. But though some attitudes unite us in the public eye, mostly the public mind takes an oil and water approach to these different professions, viewing them very differently, or at least they pretend to.

That saint and sinner dichotomy continues reasonably comfortably in the public consciousness until something goes wrong, at which point doctors and solicitors move into sudden and close proximity. A road or industrial accident occurs – often the single worst event to have happened to an individual – and doctors treat and advise their patient, while lawyers claim for their client, mobilising the expertise of doctors to verify conditions and predict outcomes. Claimants may not harbour particularly warm feelings about the doctor instructed by the insurance company, especially if the examination mysteriously only occupies ten minutes of the doctor’s time, but that is no surprise – I mean of course the claimant’s feelings, not the ten minute examination. The emotions and the problems intensify when just occasionally a doctor is perceived by a patient to have delivered substandard care because of apparent error. The patient must find a lawyer and clinical expert who can work together to advise and seek a favourable outcome. Lawyers, especially when they act for the claimant, will probably be seen as a very unwelcome breed by the medical professional under scrutiny, and that same clinician under scrutiny will often attract little sympathy or, in extreme cases, little respect from the lawyers acting for the claimant.

Opinions on these topics are often heightened within the solicitor’s branch of the legal profession by the polarisation of practitioners into claimant and defendant camps. Perhaps, too, at moments when clinical negligence is alleged, sainthood and sinnerhood are swiftly reversed. Blame is readily imposed, occasionally to an irrational degree, and the respected professional clinician or hospital team becomes the villain who ruined or ended a life in the eyes of the patient and the patient’s circle. The fallout generated by the paediatric heart surgery undertaken in Bristol bears witness to the strength of feelings that can be aroused, and the retained organs litigation, in which I have been playing something of a part as a mediator, is another area where lay emotions ran high, and perhaps even professional ones too. In his closing submissions to the court in the national litigation counsel representing the claimants at one point accused the medical profession of a substantial wrong brought about by its paternalistic approach to consent to post-mortems, a view, I may say, not apparently wholly accepted by the judge, who noted also the sense of grievance felt by many pathologists at the criticism heaped upon them once the organ retention events came to light. Now, sadly, the public mythology has to accommodate not merely simple
alleged allegations of incompetence or negligence but even the dreadful spectre of that rare breed, the doctor who deliberately causes harm to the patient with no apparent therapeutic or palliative motive in mind. Hence the current painful fallout from the reports of Dame Janet Smith over the medical profession and its procedures and regulatory functions, closely observed by lawyers and doctors, in the aftermath of the activities of Dr Shipman.

It is at these very difficult points of intersection and interaction between doctors and lawyers that I spend quite a bit of my professional life. I hope that it may be of some interest to both lawyers and doctors here tonight if I share some of the insights that ten years of working as a mediator in this field has given me, in the primary hope that it will show that there is a spectrum of useful processes available for the resolution of medico-legal disputes, that parties have free choices to be made as to how disputes in this sort of field might be resolved and that intelligent questions need to be asked and answered more than once in the life of any significant dispute as to how best to progress it towards resolution. I also hope to look a little at the blame culture and what I choose to call the “blamed culture”, how this can be managed in practice through mediation and whether the mediation process might offer a channel to gradate and moderate issues of blame more subtly than the adjudicative outcome offered by the traditional litigation trial, by generating more appropriate psychological nuances and by delivering more than just monetary compensation.

Just a word about “Ground-rules”, if I may.

Frustratingly, mediation is an activity whose successes cannot readily be publicised because of the confidential framework within which it has to operate. Every mediation opens with the signature of a contract binding the parties to confidentiality as to what happens during the mediation and (unless varied by agreement) as to the outcome. It is not merely protected (as indeed it also is) by the privilege of “without prejudice” status. The parties and the mediator (for what that is worth) confer an enforceable right and duty of privacy on each other, which even in the absence of a mediation statute, which is perhaps currently visualised by the current EU Directive on mediation, the courts seem determined to protect.

I as a professional mediator would like to be able to identify and claim mediation successes, yet I cannot easily do so unless the parties choose to profile the outcome, or unless the details are heavily anonymised, or maybe they get into the public domain by some other means. Nevertheless, the colour of authenticity is required for people to assess and accept the worth of the process. So please assume that, when I give an account of mediations in which I have been involved tonight, I intend to respect the confidentiality level and anonymity which I know to be appropriate to each case, but I would appreciate your willingness to be discreet about sharing details outside this room, and as long as you accept that I will tell you all I can, but that I may not be able to tell you as much as I want, we shall proceed safely together.

So what are mediation and ADR (Alternative Dispute Resolution)?

I am going to assume that there are some in the audience who may not readily be able to answer that question in any depth, and they might be interested to hear an outline answer. The theory is best encapsulated by the modern definition of mediation which my organisation, CEDR, has recently promulgated:

A flexible process conducted confidentially in which a neutral person (a mediator) actively assists the parties in working towards a negotiated settlement of a dispute or difference, with the parties in ultimate control of the decision to settle and the terms of resolution.

So the point really that emerges from that is that it is non-adjudicative – the mediator does not make decisions but assists the parties towards finding their own resolution if they can, and if they can’t, then they will either initiate or proceed further with an adjudicative process such as litigation.

A flexible process in which the mediator runs that process and takes responsibility for the order of events and the combination of meetings either privately or together – I have already mentioned
the confidentiality of the process – and very much active assistance by the mediator of what goes on, an involvement with debate and discussion in order to work towards finding perhaps an outcome that both parties can live with, but with the parties remaining in ultimate control of that outcome.

Two words, or two phrases do not any longer appear in that definition. One is the word “voluntary”, and that word is omitted from the definition because there are now pressures from the judges, who are taking a view that putting some pressure on lawyers and parties to take part in the process is appropriate, albeit that doing so in no sense compels them to reach an outcome. Indeed, England and Wales is one of the very few common law jurisdictions where there is not a considerable element of judicial compulsion to secure participation in mediation. The other word that has now left the definition is the word “non-binding” because, although what is said within a mediation is off the record and does not bind anyone, any agreement reached at the end of the process will be a legally binding agreement if the parties so choose. If there are no proceedings afoot, there will be a binding contract which is enforceable as such. If proceedings have been started, then a binding consent order will be lodged to conclude the proceedings.

What Does a Typical Mediation Look Like?

Perhaps I can best answer this by describing one of the earlier mediations which occurred during the very far-sighted (in timing terms) Mediation Pilot Scheme between April 1995 and December 1997 sponsored by the NHS in two of its regions at that time. The findings of that report are published and available in “Mediating Medical Negligence Claims: an Option for the Future”, the lead researcher being Professor Linda Mulcahy. More of the pilot’s findings later. The template I am going to describe is broadly used most of the time, but because it is a flexible process there will be situations in which the mediator will choose to vary the practice in a given situation.

This was a case in which a patient had undergone a Roux-en-Y reconstruction to deal with repeated biliary reflux, and unfortunately for this patient he had to undergo six abdominal operations in three months, and perhaps it was a little unsurprising that he wanted to find out why. This was a surgeon, I think, whose view was that if there was any risk of an obstruction he would rather get inside and sort it out, rather than wait for the patient to die of peritonitis first, and he therefore opened up the incision when the patient failed to thrive on at least two occasions. Then non-negligently (as everyone agreed, but very much to his own chagrin) he nicked the small intestine and a faecal fistula formed, which he hoped to repair by using a few stitches. Eventually and finally an anastomosis was done and the patient was returned to bed at the end of a three month period, at which point, I think, the doctor went on a conference out of the country and returned to find the bed empty. Much relieved to discover this was not because the patient was in the mortuary, he was surprised to learn that the patient had been moved to another hospital without his knowledge and had there been treated conservatively and discharged a month later. He was then shocked to be served with proceedings alleging negligence in relation to his conduct of the surgery and the series of decisions that he had made in relation to that patient.

The mediation took place five years after the events in question and well into the litigation, and under the pilot there were two organisations that nominated mediators for these cases and I was nominated for that one. A neutral venue was found – in this case a convenient hotel – and position statements by each side were exchanged and a small bundle prepared with experts’ reports, with lofty exchanges of disagreement between the experts on each side. The very ordinary claimant and his wife came to the hotel where it was taking place and they were shown into their private room. Each party has a private room at a mediation, but there is also a joint room representing neutral territory where meetings of everyone can take place. After the hospital team and the claimant’s team had settled in their separate rooms, we moved into a joint meeting at which I explained how the process was going to work during the course of the day. Each team made a brief statement as to where they were coming from, all this being off the record, in
accordance with the mediation agreement that had been signed. We then briefly explored together what the issues were that we needed to talk about if we were going to make any progress and then the parties retreated to their private rooms. I as mediator began a process (if you like to call it that) of shuttle diplomacy between the rooms to find out what was really important for each team and where their strengths and weaknesses lay, each private meeting conducted confidentially with each team. It soon became very clear in this case that what was needed more than anything else was an opportunity for an exchange of information. The doctor felt that the clinical relationship had been violently ruptured five years previously. He wanted to explain very openly and frankly what he had done and why he had done what he did, and the patient wanted to hear what he had to say. So eventually, having discussed it with each team, it seemed right to suggest that we might all meet together again, when I would interview the doctor, as it were, objectively (perhaps rather like a television interviewer) as to his series of decisions, making sure that it was coherent in lay terms both to myself and also to the claimant and his wife. The doctor was very keen to do this openly. So we had a flip chart on which he drew pictures of the relevant parts of the claimant’s body to explain why he had done what he did. At the end of that process, the teams retreated to separate rooms to process what they had heard and discussed. I will come back to what happened in those meetings a little bit later on in my talk.

Thereafter, progress was made by proposals being made which were very rapidly accepted and a financial figure was hit upon in order to conclude the case. A written agreement was signed by both parties and a consent order was drawn up and lodged later with the court to bring the claim to an end.

So let me just review with you, if you like, the intrinsic nature of what went on and some of the sub-text. As I hope you understand, ADR (Alternative Dispute Resolution), which is an overarching phrase for mediation and other forms of process, is a term of art found in the Civil Procedure Rules. I want to think about the word “alternative” just for a moment, because the truth of the matter is that mediation and litigation are symbiotic. What goes on in a mediation is measured against what might happen at a trial subsequently, and similarly there may be moments during the course of litigation when the courts may say to parties “We think you should try mediation”. But they are not entirely separate streams. You do not, as it were, go off down the mediation track never to return. You are free to choose not to settle if the mediation process fails to produce an outcome that suits you, and face no sanction from the court for not having settled.

So what happened at that mediation?

The right people were brought together – the claimant and his wife (often the person who has suffered considerably as a result of what is said to have gone wrong) and their lawyer; the clinician under scrutiny came personally – clinicians do not always attend, but on this occasion he wisely did – the Trust Manager and the Litigation Authority, represented by their panel solicitor. A mediation is very frequently the only time before the trial itself when everyone who is needed to bring a case to a conclusion comes together in the same place. They can look at the whites of each other’s eyes and decide whether they like what they see – will someone be a powerful witness, will they not, and so on.

A safe environment was created in which people could discuss the issues off the record in private confidentially and decide whether they could find an appropriate outcome.

The parties had the opportunity to participate in a very appreciable way in their own case. The claimant and his wife were certainly pretty central to what went on. They were in the front row instead of at the back row of a courtroom and they were certainly there in the company of the “opposition” and able to both tell them what they felt about their case and to hear directly what the hospital’s views were, for better or worse. Each side thus had the chance to check and moderate the goals that were available and the risks of not achieving them.
Process Benefits

I draw an important distinction in mediation between *process* and *outcome*. Process benefits include the following:

- It guarantees a “day in court”. No litigation process guarantees a claimant, or indeed a doctor, a day in court. Many cases settle, thus depriving parties of their day in court. At a mediation there is a guaranteed occasion when the right people will gather together to exchange views.
- There is a degree of adequate informality, but balanced by a certain formality, involving a managed process which is respectful but reasonably accessible, making possible a simple explanation of the medical terms and the legal issues behind them; an informal venue, jackets off; a flipchart for drawing diagrams, and so on.
- Total flexibility of process, enabling it to be tailored to suit the needs of the particular parties involved in that dispute.
- An appropriate physical set-up, with separate rooms for private consultation, plus an area for a joint meeting.
- The restoration of communication and a quasi-restoration of the lost clinical relationship.
- A respectful acknowledgement in an ordinary room, facing each other, and not a judge or a decision-maker, in which there is scope for regret and apology to be expressed and to be received between the key players in a particular dispute without necessarily any admission of liability.
- And the opportunity to express feelings and to manage the expression of feelings in an honest and open way.

What Are the Outcome Benefits of the Process?

Firstly, risk-discounted financial settlements. Risk discount and risk analysis are the stuff of mediations, testing each team’s position on each issue against the chances that it will be accepted or not by a judge at trial.

Secondly, imaginative outcomes, beyond the gift of a litigated trial, where a judge can only really define past wrongs and rights and award compensation accordingly, with no real opportunity to provide for a future perspective.

What Are the Roles of Those Who Attend a Mediation?

The *patient or claimant* is usually there to express what they feel, which can be very strong feelings ranging from anger, grief, suffering, frustration, desire for revenge or retribution, if they feel permitted to do so. Mediation gives them that opportunity, but moderated and controlled by the judgment of the mediator as to what people can cope with and what they can’t.

Receiving the defendant’s considered responses personally, including things like apology, reassurance of change and explanation, and processing these into the personal attitudes and decisions of the claimant team.

Hearing the facts of life.

And I have seen mediations where the defendant team have said, “You have had a terrible experience...” – in fact, I have done it myself at mediations – “You have had a terrible experience, but we are not legally liable. Please explain to us, if you can, why you think we are, and we will take that into account and listen very carefully to what you have to say, but one of the possibilities is that we will not be prepared to accept that there is any risk to us and that we shall not have any proposals to make.”

The *doctor and defendant* will attend a mediation for a variety of reasons. They can be simply interpreters and a resource on technical matters, but they are, too, participants with needs: to accept or deny blame, or to seek closure. These are all important possibilities for doctors, but
beneath the way they behave outwardly at the mediation, they may well be seeking to preserve a sense of professional self-worth, to defend and vindicate their clinical judgment, to adjust to the possibility that their judgment is fallible (never a comfortable process) and to decide how to relate to their ex-patient on that day and, if appropriate, for the future, preferably in a way that is reasonably pain-free for everyone.

The role of the lawyers is to advise their clients and to make sure that in each case nothing is given away that should not be conceded, putting issues into the context of what would happen at trial; to review the risks in the light of what is learned as to facts and interpretation of facts; and to manage the presentation of that team.

The subplot, of course, is to do such things as retaining the client’s confidence, to have their advice vindicated, themselves to preserve their sense of self-worth too professionally, and doubtless to hope to keep them as a client or their friends.

And what of the mediator?

• Above all, the mediator is a process manager and facilitator – “facilitation” in the sense of making things easier for people.
• An enabler of honest communication.
• A promoter of the parties (without disempowering their legal representatives) – checking their involvement and their understanding throughout.
• A tester-out of issues with people, both in private or in joint meetings, either on the basis of material generated by the other team or occasionally matters that I myself might spot as being something that is significant which I might choose to raise with the person against whom it might be a matter of delicacy.
• A recipient of strong feeling – very much a lightning conductor sometimes.
• A re-interpreter of facts and positions – a holder up of mirrors to people’s cases to give them the opportunity to see if they want to re-evaluate it.
• A recipient of confidential information, a neutral listener.
• A negotiation consultant.
• But not, I emphasise, a therapist, and not a judge.

As a mediator I need to be trusted by all those I work with, because, frankly, mediators simply do not observe the rules of natural justice. They go from one room to another, having private conversations with each party. But I am not a decision-maker, so that breach of those rules is forgivable. Indeed it is the very fact that the mediator builds up an overall picture through such confidential communications with each team that assists the mediator to help the parties move forward towards a settlement, whereas each party might well be sitting in their own private room with less information than the mediator, thinking “Are we getting anywhere?”

I try to give permission for the honest expression of feelings and also to create the opportunity for people to change positions without too much pain. Very often positions have been very clearly articulated and formulated in schedules and counter-schedules and pleadings before the mediation, and unless there is a willingness to change, there will be no settlement. Helping people to consider how they might change without too much difficulty is a useful skill.

Who Are Mediators?

At CEDR Solve we have a wide range of professionals accredited as such. Many are barristers and solicitors, plus a few judges, even a Court of Appeal judge, and also quite a number of healthcare professionals – doctors, clinical directors, nurses, expert witnesses in therapeutic disciplines, local and national managers within the Health Service.

In the healthcare sector, we deal not only with clinical negligence claims, but also disputes between consultants within hospital firms, between clinical staff and Trusts, internal GP
partnership disputes, hospital property and service provision and building contracts, so the whole range of activities in the healthcare industry.

I just want to return for a moment to the research findings of the Mulcahy Report, because there is much in these that have proved prophetic and of lasting relevance to the development of mediation in this field since the pilot concluded six years ago, the report having been published four and a half years ago.

Part of that research involved looking at the levels of satisfaction among claimants with the old litigation system (pre-CPR, in the form that was castigated by Lord Woolf in his Access to Justice reports). Her report found, dismayingly, general dissatisfaction with the traditional litigation process among claimants surveyed. 70% of those surveyed were totally or very dissatisfied with what it had delivered, even where they had received damages. “The main sources of their dissatisfaction focused on the inability of the parties to come to an agreement they were both satisfied with and a feeling that the outcome of their legal action left them unable to put the matter behind them or to come to terms with what had happened. What seems to be at stake in these responses is a ritualistic closure of disputes and a desire for a more conciliatory process that does not result in a winner and loser.” She measured changes in objective for claimants before and after they had been through the claims process, and she found that the factor of increase in desire for a better outcome doubled or trebled or more in almost every category of outcome, except desire for money, which surprisingly increased by less than 30%, and those who started out by seeking nothing, where the desire for nothing unsurprisingly reduced hugely from 38% to 2%.

The pilot was set up as essentially a voluntary scheme, though as I have said, the law has been changing over recent years and there is far more judicial pressure now placed upon parties to mediate since and as a result of the CPR. This insistence on voluntary referral was seen as to some extent hobbling take-up. Other adverse factors were identified, such as reservations on the NHSLA about engaging in it (which has since been well overcome), doubt over whether Legal Aid was available for it (it became so and remains so) and indeed structural changes in the two NHS regions chosen to host the pilot, where suddenly people discovered that they were no longer working for the organisation that was supposed to be taking part, which was something of a disadvantage.

Twelve cases were fully evaluated: five obstetric, one gynaecology, three surgery, two oncology, one each in radiology, neurology, bacteriology and orthopaedics. Four cases have been issued at court, eight were pre-issue, and five out of twelve had been through complaints procedures. The settlement range was £5,000 to £80,000. They all took a day to conclude and there was a range of outcomes.

Despite the low take-up of twelve fully mediated cases (which was of course statistically insufficient to form an authoritative overall view) it was surprisingly successful when compared with other such pilots, for instance in the USA. All the cases settled – eleven with monetary settlements, one without monetary compensation at all (so in effect a withdrawal), but with a valuable non-monetary benefit given: it was to tell the claimant the whereabouts of the burial place of the foetus whose birth had been the cause of the claim, which the claimant had never been told and greatly appreciated when told as part of the mediation process.

Various significant successes were identified:

• efficient case disposal;
• party participation and catharsis, especially for the claimants;
• flexibility of process and non-legal remedies;
• there was a very high settlement rate.
The Inherent Value of the Mediation Process

There have been some florid experiences of people venting their feelings. I recall a woman who lost a child when a Caesarean scar ruptured, and the first 40 minutes of the mediation joint meeting comprised her, her husband, her mother and her father getting off their chest what they thought about the hospital’s care to the rather unfortunate medical director – in that case the obstetrician was not present – and then, having had a chance to receive and process that, responding in a way that was, I think, capable of being listened to by the family, who felt, once that had happened, that they were able to move on and debate things more rationally.

In a case of cerebral palsy, we got stuck on an issue relating to causation – was there a previous genetic condition that would have in any event caused damage to the child and reduce therefore the amount of damage? During the afternoon, the mother seemed to retreat into silence and disengagement. Spotting that and asking her to say why, she said, “I just have to tell someone what it is like to bring up a child about whom we have absolutely no possibility of being spontaneous in the way we live. We have to plan every change in routine like a military operation, we can’t even just get out to the pictures.” A very moving exchange where she and her husband told two youngish women managers acting for the defendant hospital, who responded magnificently to this intense outburst. There I have no doubt at all that that part of the process enabled the parties to free the log-jam in the negotiations which definitely was existing up to that time.

I return to the case I described to you earlier involving explaining the need for the six abdominal operations in three months. That explanation was undoubtedly enormously appreciated by the claimant and indeed of enormous benefit to the doctor who was at last given the opportunity to explain it. He said to me afterwards, “I find it very difficult to cope with unfinished business and I feel that I have had the chance today to finish off business five years on.” Even on initially going into his room after that joint session, it was palpably apparent that a huge burden had fallen off his shoulders now that he had been able to talk honestly and straightforwardly with his former patient and his wife.

In one mediation I was involved virtually the whole day with the parents questioning a surgeon about what had happened to their son, who had died shortly after having an operation for ulcerative colitis. We spent a long time going through the notes line by line, with the doctor explaining why he had done certain things, what changes he had made to his practice – “I don’t take the nasogastric tube out on day 2, I now do it on day 4. I always do it with an intensive therapy team under the same roof”. This procedure happened to have been undertaken at a private hospital. The answers given enabled the parents to say from time to time, “It’s a small comfort, but we do take comfort from the fact that steps have been taken to make sure that what happened to our son will never happen again.” At the end of that mediation I went into the hospital’s room and said, “For goodness sake, propose a financial settlement about which there need be no debate, because if we start haggling over money all the benefits of the process will be lost.” Happily, an acceptable monetary settlement was swiftly reached.

What Are the Outcomes of Clinical Negligence Mediation?

My own personal experience is that 85% of the cases that I mediate settle on the day or afterwards. Two cases did not settle and at trial it so happens that the claimant lost in each case.

I have had several cases with two defendants, where liability was accepted and some payment made by one defendant, and the other defendant was exonerated. So it does not necessarily mean that a defendant has to face making a compensation payment if they participate in a mediation.

A number of imaginative outcomes have emerged from mediations:

- fast-track IVF was agreed for woman who lost her child as a result of a ruptured Caesarean scar, where her ability to conceive was said to have been compromised;
an offer of future employment for the wife, soon to be a widow of a cancer patient, who used to work for the hospital that had failed to spot his lesion; involvement in the reviewing of departmental protocols and paperwork and risk analyses;

• participation in discussions over changes in procedure and departmental risk assessments;

• the chance to find out the real weaknesses in a case: it is very easy not to see the wood for the trees when you are involved in the detail of a case, and it certainly has been useful for parties sometimes to have a mirror held up by a mediator which enables them to think “perhaps our case isn’t quite as strong as one had hoped”.

Mediation is also deployed in some appreciable multi-party claims. I am glad to see my dear colleague Bertie Leigh here today and he will know what I have been involved in with him in relation to the organ retention litigation, which has been a fascinating but exceedingly difficult series of cases over a lengthy period of time. They were cases in which neither party was keen to make new law. Sometimes it is said that one of the reasons for not having a mediation is because you want to establish a precedent. I think Bertie will agree with me that neither in his tort text book nor mine was there a chapter on unlawful interference with the right to dispose of a body, and there could hardly be a more novel tort over which to litigate. One might have thought that lawyers would love to do so, and indeed in one of the two group actions in that litigation they did. The Liverpool case (which is topical because of the current General Medical Council hearing about Dr van Velzen) settled through mediation with a number of non-monetary outcomes, such as a public apology, a memorial, and support for amendment of legislation, which were critically valuable to those who were advising claimants in saying, “These are things that litigation cannot confer even if we win.” What happened with the national organ litigation perhaps is a rather longer and a sadder saga which I will not go into now, though maybe there is light at the end of that particularly long dark tunnel.

Risk and Blame

I want to look at two particular areas in which I believe mediation offers particular value to participants – risk and blame.

I have already talked a bit about the appraisal of risk and the reappraisal of risk, and maybe it helps to give an illustration, for those of you who are less familiar with mediation. Take a personal accident policy which would pay the insured £100,000 in the event of total disablement caused by a specific problem, say a holiday accident. The judge at trial has a simple choice: he either awards £100,000 plus costs to the claimant or zero to the claimant and (probably) orders the claimant to pay legal costs to the defendant insurer. He cannot choose to pay a discounted sum to the claimant reflecting any weakness or demerit in his argument. So is there any point in trying to mediate such an all-or-nothing claim? The answer is yes, and this kind of case is mediated, because settlement can build the reflection of risk into its terms in a way that a judgment cannot do. Typically and tellingly, such claims when mediated rarely lead to a simple 50/50 split. What happens is that the parties reach agreement over the risk assessment. If they agree that the insurer has a better chance of winning at trial than the claimant, the settlement figure might be somewhere around about £35,000. If they agree that the claimant has a better chance of winning at trial, then the settlement might be around £65,000. Both parties thus think they have got something out of settling: the insurer did not have to pay in full, and the claimant got something when there was a chance that nothing would be awarded. Hence some kind of acceptable compromise is reached, having debated the merits of the case and the chances of success for each side, both together and separately.

Of course, clinical negligence claims are all-or-nothing cases of a rather more complex kind than my illustration, with several points at which success may be prevented totally, and very rarely any element for contributory negligence. Either there is or is not a breach of duty or there is
or is not causation. What parties can do in mediation is to visit and conflate the various risks that lurk around the question of the chances of success on any given topic, see if agreement can be reached on those, discounting the full damages value (in the light of the risks on various issues – maybe life expectancy, residual earning capacity, promotion prospects but for the accident or the incident, and so on) in order to reach an acceptable monetary outcome, and those risks get expressed in monetary terms, often, in my experience, sweeping up different risks into a global figure. The mediation process is a very useful and easy medium within which to have this kind of debate. Parties are often very reluctant to reveal their willingness to compromise from a clearly argued position, and one of the things mediators can do (and I have done quite frequently now) is to receive confidentially changes of position in one room or another, not conveying them from one room to the other at that stage, so that I will know what the gap is, even if the other parties do not. Occasionally but increasingly, the gap gets to the point where I can ask in each room, “If the other side said they would settle for X, would you agree – yes/no?” In a large number of such cases where I have done that the answer has been “yes” on both sides, with the case settled by closing a gap when the parties hardly knew what the gap actually was before it was closed. Even where one or both parties say no, agreement usually follows swiftly on slightly amended terms.

The other topic I want to cover is the question of the culture of blame. Everyone except the Daily Mail and the Evening Standard is rather tired of the alleged compensation culture, the supposed urge to name, blame and claim and shame. So what does mediation contribute to this particular debate?

Certainly all the judicial and related statistics point to a drop in issued proceedings over the last ten years, especially since the Woolf reforms and the Civil Procedure Rules 1998. In particular, there has been a huge drop in proceedings in the Queen’s Bench Division, partly explained by redistribution of business. In 1992 there were 260,000 writs issued, whereas in 2003 there were 14,000 claim forms issued. There has also been a slow reduction in the number of county court proceedings issued. In 1990 there were 3.3 million claims issued, in 1999 it was about two million and in 2003 1.57 million. There is even a drop in the number of cases notified to the Compensation Recovery Unit, to whom compensators have to report before the issue of proceedings, making it another useful and interesting measure.

So there is no compensation explosion (at least, there is no litigation explosion), merely perhaps a culture – an instinct to blame others if at all possible, and perhaps, as a corollary, to deny personal responsibility for things that go wrong. The Better Regulation Task Force recently suggested that the real problem is a fear of a compensation culture and that this is pretty much as potent as if a compensation culture truly existed. If the main people to fear this are insurance companies, I suppose we can expect exponential rises in all liability insurance premiums, even to the extent that liability caps are being imposed contractually by professionals and employers are going out of business because they are unable to afford their compulsory insurance premiums.

The desire to blame and perhaps shame is often said to be what drives the compensation culture process. True, we ignore the dynamics of blame at our peril. The instinct or need for remedy is what underpins the civil common law.

A patient’s perception of fault and desire to blame someone will usually give rise to some of the emotions I have already discussed as typically emerging at mediations – anger, bewilderment, frustration, lack of understanding why (“Why me?”, “Why at all?”, “It isn’t fair”, and so on), coupled often with the stress that troubling to make a claim inherently generates – discomfort over the need to rely on professional advice, loss of control in having to participate in a highly technical arena, the financial pressures behind decision-making in wholly unfamiliar areas where dependence on a professional is almost inevitable and the associated worries about funding and outcomes. Anyone who has tried to understand or explain a Conditional Fee Agreement or to make decisions about the detailed implications underlying a decision of whether to accept or reject a Part 36 offer will know what I mean.
For healthcare professionals on the receiving end of potential blame, the effect is also pretty devastating. The Prichard Review in Canada identified several stages to this – initial denial, leading to a scrambling of recollection which can actually mask the truth that the act or omission was largely blameless anyway; then a mixture of anger, lack of professional and personal self-worth, hesitation, insecurity because of the uncertain outcomes, developing into stressful pressure on relationships with colleagues and family. These are extremely destructive feelings, and very likely to mar professional performance while felt. Research shows how physicians (and most other professionals, for that matter) are encouraged to believe in the perfectibility, or, rather, the perfection model of practice. Probably my own worst moments in private practice as a solicitor were when it appeared that I might negligently have let a client down professionally, and sleepless nights are a true and inevitable consequence. It was put in this way in a symposium on medical mishaps in 1999:

“There is a powerful emphasis on perfection, both in diagnosis and treatment. In everyday hospital practice, the message is equally clear: mistakes are unacceptable. Physicians are expected to function without error, an expectation that physicians translate into the need to be infallible. One result is that physicians come to view error as a failure of character – you weren’t careful enough, you didn’t try hard enough.”

Little surprise therefore that any allegation of conduct short of perfection is likely to be devastating in its psychological effect. As to what form that devastation takes, this depends, I suspect, largely on the individual who has been socially required to demonstrate that perfection – some will become depressed and feel devalued and unworthy, others will be defensively aggressive and angry. But however the stress manifests itself, this is not just a concern for the clinicians themselves, but also their employers. While Crown Indemnity has blurred the need to identify which part of a clinical team in the NHS is responsible for a medical mishap, employers of doctors need to take very seriously the effects of stress on the psychological health of their employees of whatever rank or seniority, in view of the risk that they may seek themselves to claim against the Trust which employs them in respect of actionable psychiatric injury which develops in the workplace for foreseeable reasons preventable by proper handling. One characteristic of blame is that it multiplies very readily in unexpected ways.

It is suggested that the threat of being sued leads (unsurprisingly) to defensive practices in medicine. Research seems not to show that such an approach to practice is clearly established here at least (arguably it might be said to lead to better medical practice). What is worrying is that it leads, unsurprisingly, to defensive attitudes. Professor Mulcahy in her recent book Disputing Doctors – she is clearly a film buff, if one looks at her chapter headings – has a chapter entitled “From Fear to Fraternity” in which she suggests that deflection of blame by clinicians takes two forms. Firstly, there is a collegial defensiveness of mutual support in which whistle-blowers are ostracised and colleagues supported. Secondly, and more worryingly, there is a readiness among doctors to return blame to complainants themselves. In a survey of 848 consultants looking from a socio-legal perspective at doctors’ attitudes over being called to account, of the 141 who troubled to respond and comment in detail on why people complained, only six were expressed in terms empathetic of patients. Characterisations such as “moaners”, “nasty”, “abusers” and “malcontents” abounded, and 21 doctors responding (of whom only twelve were psychiatrists) asserted that complaints were attributable to such conditions as personality disorder, paranoia and neuroticism. In another study of GPs, Allsop noted a shift of blame away from the professional’s clinical judgment to the uncertainty of the disease process or even to illness of the claimant whose sickness and essential laity gets in the way of understanding the scientific aspects of the issues at stake.

So if blame can be deflected or fault excused, it assists with well-being, especially if there is doubtful justification for its being laid at your door in the first place. Help has at times been at hand from the judiciary. There are undoubtedly fashions and circadian rhythms to legal liability
for professional services, whether under the tort of negligence or its associated liability in private practice for alleged breach of contract. One has only to go back to Lord Denning’s views expressed in Whitehouse v Jordan as recently as 1980, a decision which post-dated Bolam by 23 years. There he was entirely comfortable in drawing a distinction between an error of judgment, which might or might not attract legal liability, and negligence, which would. The test he propounded was to ask an average competent and careful practitioner the question “Is this the sort of mistake you yourself would have made?” and if he says “Yes, even doing the best I could, it might have happened to me”, then it is not negligence. That view didn’t survive the attentions of Lord Denning’s judicial colleagues long (like many of his opinions, at least in the short term), although the doctrine of justification by a reasonable body of medical opinion survived unscathed until Bolitho, 40 years after Bolam. But the point made is a valid one, and well highlighted by Alan Merry and Alexander McCall Smith (back to his day job after his holiday with the Ladies Detective Agency in Botswana) in their book Errors, Medicine and the Law. There they point out that there are debatable middle ground errors which may or may not be treated as giving rise to legal liability, but which certainly have a different moral feel to them. Courts, when judging the culpability of acts or omissions, tend to look at them in isolation from previous exemplary conduct spread over a career, or even over the minutes or hours leading up immediately to the act or omission complained of. Should a distractible human being (his very distractibility being the asset which makes a human agent preferable to a blinkered machine, enabling lateral thought to lead to imaginative solutions of unexpected problems) be castigated as subject to legal liability when this leads to damage? The answer is not easy to determine, as it is certainly not the patient’s fault that something went wrong. But is there a social contract entered into by those who are ill, usually through no fault of their own (if one leaves aside alcohol, smoking and obesity for the moment), which moderates others’ shortcomings or even forfeits their right to redress when what happens is no more than a human error?

The law and legal process are fairly uncompromising on this. As we have seen, claims for clinical negligence either succeed or fail – there is no percentage reduction for a minor level of fault within the gift of a judge. Even an isolated fault of omission in the middle of minutes, weeks, months or years of exemplary practice can easily be regarded as culpable by a judge. The problem is that courts often make surprising decisions, and the party, whether claimant or defendant, can often come away very puzzled, saddened or disappointed. Predicting what judges will do is a hazardous business, the difficulty of which has generated a good deal of income for the legal profession since it came into being as a civilised alternative to the days of trial by combat. But things have reached a startling pass, though, when one of Her Majesty’s High Court judges can himself openly state this on a public platform (actually at the AVMA conference in 2003):

“As in the case of trial by battle the overwhelming balance of negative considerations required the development and promotion by the State and the adoption by parties of alternative methods of resolution (namely trial by jury in place of trial by battle), so today the overwhelming balance of negative considerations in the case of modern litigation requires the development and promotion by the State and the adoption by the parties of ADR and most particularly the foremost method of ADR, mediation.”

Sir Gavin Lightman, in his 2003 lecture “Mediation the First and Litigation the Last Resort”, identifies uncertainty as the key problem, the changeability of the common law and the fallibility of advocates and witnesses.

But the point of this brief excursion into the wisdom of letting courts decide levels of blame is to suggest that there is indeed scope for building in such variables about blame, if sought and agreed, into a more pragmatic process, or within a pragmatic process such as mediation. Mediation deals, as we have seen, with discounting over the risk of winning and losing. It is extremely rare for a mediation to end with an utterly unequivocal outcome, reflecting that one
party has wholly achieved what they would have achieved from a judge. It is important that this should happen occasionally, otherwise entry into mediation will be seen as waste of resources for those who are genuinely unpersuaded that they have got no exposure. Full exoneration through the mediation process does sometimes happen and sometimes people walk away with no liability at all.

But no litigation can safely exclude some element of risk from the appraisal of a claim’s chances of success, even if this is only the usual conventional 10% discount for litigation risk. So if discounting for perceived risk is a familiar activity in mediation, is there any reason why such pragmatism should not encompass moderated outcomes which take account of the level of moral culpability or blame involved on a given set of facts? The normal comparator for valuing risk in a mediation is to test the offered outcome against the perceived risk of a more or less adverse outcome at trial. Parties are free to seek a settlement based on an agreed risk appraisal, moderated also by the value of other components of the settlement package. Claimants not infrequently, for instance, respond positively to respectfully devised apologies, explanations and reviews of practice by responding in a more concessionary approach to the actual sum of compensation, and they are just as free in a mediation context, it seems to me, to discount their approach to the terms of settlement, if they so choose, by reflecting that the error which led to damage was an inadvertent and atypical one which resulted from an understandable if technically blameworthy act or omission. When testing for breach of duty in a clinical negligence claim, there is little room for mitigation of damages comparable to the mitigation of sentence in a criminal trial. If a breach of duty caused damage, the damages are not reduced because it was only a little breach, atypical of the career of a doctor who had performed the same procedure or administered the same drug hundreds of times before without error. Of course claimants are free to reject such an approach because if properly advised it is not the approach the court would ultimately take. But it is their case and not their lawyer’s, and I can certainly recall instances of claimants saying to their lawyer, “Thank you for your advice that I might do better at trial: I choose not to try. What has been proposed feels acceptable to me”, and this is not fresh negligence on the part of the litigation lawyer, so long as such advice and the reaction to it is properly recorded. People are free not to continue to litigate, just as they were originally free not to start to litigate, and they are free to decide their own motivation and the terms and timing for doing so. I can well see that a claimant might take into account the apparent degree of culpability in deciding what feels right. It is just another factor that might in some cases be taken into account.

One of the issues that the Chief Medical Officer asked himself to reconsider in reviewing the clinical negligence field was whether a no fault system (as advocated then by the BMA) should be installed, and he decided against it – but why? Over 90% of cases settle anyway, whether by withdrawal (a high proportion compared with other sectors of claim) or by agreed compensation. An increasing but still relatively small number settle through mediation, something which the NHS Litigation Authority has made clear it encourages. The large majority settle through taking no further steps after the complaints procedure, telephone discussions, correspondence, meetings between solicitors, acceptance (often with a bad grace) of payments into court, settlement conferences and at the door of the court. But two points must be made about settlements:

- almost always the settlement deal is done off the record and without admission of liability: there is rarely any public statement of blame or imputation of fault, or open acknowledgement of the need to embed learning back in the organisation where things maybe went wrong; and
- except in mediated settlements, the parties themselves are rarely involved in the settlement process.

Money changes hands if so agreed, but we already know from the NHS Mediation Pilot report that this is no guarantee of satisfaction with the process for claimants. To quote one passage from the Mulcahy report:
“The money can’t completely resolve it. The money doesn’t make up for the person you love. Money can’t give you an explanation. That’s what you need. It settles your brain cells and you can get on with your life thinking ‘Yeah, they told me this and they told me that’. My solicitor didn’t understand my need to be told. Money won’t keep me from worrying and thinking ... thinking, thinking, thinking, will it?”

So is there really any escape from assigning blame and fault? Let us draft a statute which defines an average standard of amenity, lifestyle, income and health. In a no fault system, if anyone has the misfortune to fall below that standard, whether by medical or road accident or disease or heredity, the State shoulders the financial burden of bringing them up to that standard, using principles comparable to tortious restitution. Forgetting for the moment the impossibility of financing and administering such a scheme, if it existed, would a claimant (or society as a whole or the Press) mind or think it unjust when someone caused the less than perfect outcome in a blameworthy way but there was no distinction between outcomes for the wronged victim and the victim of chance or bad luck or heredity? I suspect they would. We are not a perfectly rational society and we don’t flinch from making emotional comparisons and judgments. There would still be a huge sense of dissatisfaction among the wronged population that they were entitled to no more than the innocently disadvantaged. Their sense of grievance would probably be far greater than among those who currently accept the outcomes of misfortune when comparing themselves with the victims of palpable negligence, be it at the hands of a doctor, another motorist or an employer.

So blame is where we will start, and indeed the vast majority of claims in the no fault system in New Zealand require proof to a tribunal of medical error, applying a remarkably Bolam-ish test. Very few claimants could bring themselves within those criteria for “medical mishap”. But though this may be where we inevitably start, it is not necessarily where we stay or finish.

At the risk of sounding maudlin and courting the temptation for the use of the dreaded adjective “touchy-feely” about the mediation process, I am happy to say that as more and more people experience the rigour and challenge of the mediation process, the less does the use of that characterisation seem appropriate. I will take the risk, in concluding, of mentioning the capacity of the mediation process to help people, both claimants and clinicians, to move on and to close an often long-standing piece of emotional and financial investment in a co-operative way. Leaving aside the unsatisfying aspects of an arms-length settlement without a settlement event (without the parties themselves coming together), the highest hope in a trial for a claimant is for the healthcare clinician to be pilloried in the witness box under cross-examination and then to be blamed by the judge, and this may be what a number of claimants want when they set out on the road of claiming, and what lawyers see the need to achieve without putting the judge’s back up in the process. Very rarely it may be achieved. Mediation takes the route of reconciliation much more readily, though by no means through denying or ignoring professional responsibility. It is a very tough process for those involved. But it is a creative, open and flexible process too, and one which accommodates and makes possible the concept even of reconciliation and forgiveness, often a very late arrival at the table during attempts to achieve the resolution of painful disputes and not one that anyone, including the mediator, is going to articulate without extreme care and sensitivity.

Desmond Tutu’s moving account of post-democracy South Africa’s Truth and Reconciliation Commission in his book No Future Without Forgiveness describes how amnesty for past wrongs liberated people from their past, and I quote:

“Forgetness means abandoning your right to pay back the perpetrator in his own coin, but it is a loss which liberates the victim. At the Commission we heard people speak of a sense of relief after forgiving. A recent issue of Spirituality and Health had on its front cover a picture of three US ex-servicemen standing in front of the Vietnam Memorial in Washington DC. One asks
Have you forgiven those who held you prisoner of war?” ‘I will never forgive them’ replies the other. His mate says ‘Then it seems they still have you in prison, don’t they?’

Finishing with just two more stories, I have a vivid recollection of the end of a mediation which had settled where a man dying of cancer was being bought a Scotch by the Clinical Director of the hospital whose department had failed to diagnose his cancer in time for it to be treated. In another mediation, a young woman claimed in respect of her Erb’s palsy. Her mother had not taken any steps to bring it in her minority, leaving the claimant to bring her own proceedings on attaining her majority. We spent the day debating the state of the art in midwifery 22 years previously over a period of four minutes when she had been stuck in her mother’s womb with shoulder dystocia, and I confess that at a moment when we seemed as stuck as she had been 22 years ago in the mediation debate I asked her, “Has it ever crossed your mind that the midwife saved your life?” I was afraid for a moment that she might hit me with her good arm, but she replied, “It’s funny you should ask that, because it only occurred to me for the first time three weeks ago, when I got the mediation submission from the hospital.” I suddenly thought to myself, without debating it with her, that this young woman had been allowed to believe a legend which demonised the midwife who had got her out of the womb in critical circumstances. Of course she had had a flail arm for 22 years, but she knew that life had been good for her despite her disability, and to just have a sense that for a moment or two she had taken a completely new look at the way her life was (and indeed that led quite swiftly to a settlement of the claim) was one of those magic moments that we occasionally enjoy as mediators and occasionally feel we can share with others.

I have been long enough now and you have been an extremely patient audience. I will stop there and give people an opportunity to ask questions.

Discussion

The President: Tony, thank you very much indeed for a very clear and succinct explanation of the process, the ethics, the human aspects and the results of mediation, which obviously is a very acceptable avenue for avoiding the courts, at least in the first instance.

One of my best friends was a mediator for many years, not in medicine but in property, and he kept us entertained at dinner very frequently with the stories of how attempts were made to influence his thinking, if you like. It was a lot of fun. I wonder, how do you manage to maintain your independence in the face of very obvious attempts by the parties concerned.

Mr Allen: Blandishments, as it were?

The President: Yes.

Mr Allen: It is funny, you spend 30 years of your life being a partisan, it is actually quite a relaxation not to have to represent one person’s point of view any more and to take a neutral stance and to be even-handed, and fortunately it begins to become instinctive, I hope. At the same time one needs to avoid the risk of just being rather flabby and not actually contributing anything to making progress and I think there, for me in my own personal practice as a mediator, and indeed I think in mediation as a whole, there is a continuing debate as to the extent to which mediators should be hands-on and hands-off and facilitative to evaluative spectrums of that kind, and we will continue to try and make sure that we do it right. But the one thing that we cannot do, of course, is to lose that neutrality. There have been times once or twice when I’ve got the sense that people have felt that I had. I truly hadn’t, but it is the most uncomfortable feeling one can have and you lose their trust and respect, and it’s devastating. So there is absolutely no alternative: neutrality and independence are absolutely fundamental to success and earning the trust of the parties.

The President: Thank you very much. Now, please, there must be some questions from the floor. Bertie.
Mr Bertie Leigh: Tony, if I can follow up on Neville’s question. Thank you for a fascinating talk; it was really interesting. It seems to me that there are two sorts of mediator, or there are two extremes of mediator. There are those who take the initiative and go in and tell each party “Look, you are going to lose because of this and because of that weakness in your case and the strength of the other side” and then go and do exactly the same with the other side, and do it perhaps in front of them in the preliminary session. I have dealt with mediation Court of Appeal cases and I tend to do that. And the other extreme is people who say “Well, what do you want me to say to the other side? How shall I do it, and what do you really want out of this?” Do you acknowledge there is an extreme, that there are two polarities?

Mr Allen: Oh, yes.

Mr Bertie Leigh: Do you think that one of them is necessarily better than the other, and how would you place yourself on the spectrum between the two?

Mr Allen: I place myself closer not to exactly the evaluative end of the spectrum. I mean, I don’t think I evaluate. I think the most awkward question I would ask you in a mediation room is “How many times out of 10 do you think a judge is going to find in your favour on that particular point?” So I want the responsibility for the advice to rest with the lawyer, and lawyers play an extremely important role in the mediation. They are the guardian of their client’s case and the person who can authoritatively contribute to the debate about risk analysis. I certainly don’t think it is much use to people to be kind of terribly, you know, “After you, Claude”, “After you, Cecil” about, you know, “Tell me what you would like me to say”. I mean, there are times when people do want questions raised and when someone says “I want you to go in there and I want you to ask ...” A, B, C and D, I’ve said “Well, okay, if you will allow me to choose when I ask it, I will do that, but I just want to give you a couple of warnings. One is they may not give me an answer, and the second is they might give me an answer but not allow me to tell you what it is. What I will do, though, is I will tell you that I have asked these questions. I will make sure that that has happened, and what you will have to do is to decide what effect they had by what they do.” But I certainly think it is part of a mediator’s job to ask the awkward questions. There are ethical considerations as to how you do it. For instance, I personally would never in front of both parties pluck out a weakness and, as it were, give it to one side publicly in the presence of the other. My preferred option would be to raise the weakness, if I can put it that way, in a private meeting with the person for whom it was a potential weakness, as I perceived it. I might well be wrong, you see, and they would hate me deeply if I raised a point of weakness in front of the other party, and probably hate me almost as much if I raised a good point in public. So I will do that in private. I think you should certainly raise these questions, but quite often I find that people would prefer to debate it on their own without me. I will say, “If you think that question is important, have a chat about it on your own.” I will leave them to agonise over it in private, and when you return, you find they have taken it into account and changed their position. That would be my own personal approach.

The President: My apologies for not reminding speakers from the floor, for the record, please to state their name and profession. Eddie.

Dr Josse: Edward Josse, medical practitioner. We did speak a little over dinner, but one question that really galvanised me to ask is that in the process of mediation both parties can put their points of view. Now supposing one party deliberately is fraudulent and produces fraudulent evidence that persuades the parties that his evidence is more persuasive and that he should be the beneficiary of the debate that is going on and in a year’s time it is discovered that that party had been fraudulent in the evidence and advice, and so on and so forth, that he produced, is there anything within the system that can, so to speak, go back a stage and assist the party that was wronged, or at the end of the day does that wronged party actually have to go to law to say “Well, we went to mediation. This was the situation: I was persuaded because of the false evidence that was produced”, and is there any penalty that can be brought on the individual that brought the false evidence?
Mr Allen: A nice little exam question there. Thank you, Eddie. What goes on at a mediation, as in any negotiation, is broadly speaking at the very least without prejudice; that is the status that it attracts automatically if it is a discussion which might lead to settlement, and it is intended to try to lead to settlement, and that is trite law. If someone misleads someone and it emerges later on that they did so, then I guess there are remedies in fraudulent or innocent or negligent misrepresentation which can be relied upon. The interesting and nice point is whether if that representation is made within the confidentiality of a mediation process it is less accessible. I mean, I hope it is rather difficult to conceive of either the circumstances or the personnel who would do a dastardly thing like this in the context of a clinical negligence mediation – I can certainly see that it might happen in a purely commercial case – and if there were issues that were really germane upon which one person essentially relied, then I think what I would seek to try to persuade everyone to do, without actually making it obvious that that is what I was asking them to do, is actually to recite the factual matrix upon which decisions are made in the settlement agreement, in effect as terms of that agreement, because the settlement agreement will actually be an accessible document to a judge. Once without prejudice discussions have led to an agreement, then even if you put “Without prejudice” on it a judge can look at it. So if therefore there were, as it were, recitals to a settlement which set out what proved later on to be fraudulent, then I think there would be access, but mediation can’t issue injunctions or, as it were, of its own motion raise equitable or legal remedies for things that go wrong in it. We have as little or as much authority as the parties choose to confer on us as mediators and they must go and seek their remedy in the courts if that arose.

Mr John Verdin Davies: John Davies, retired lawyer and former mediator. Tony, you have given us a very generous account of all this, taking terms of reference even somewhat wider than the subject compelled you to do, and we are grateful for it, but I should like to know do you have any feel for the appropriateness of mediation as compared with the progress of litigation in general? We are, I think, at a stage where litigation is on a falling curve (I hope so), and we all have our own ideas about the reasons for that, but how do you see mediation in comparison with litigation?

Mr Allen: Mediation has been going in this country for about fifteen years. The common law has been going for about 700 years, so there is a little bit of catching up to do. If you were to plot the graph you would certainly see the number of litigated cases dropping and the number of mediated cases going up. You then start looking at the numbers at the bottom of the graph and you see that you are talking about several million litigated cases and several hundred mediated cases, so it is still a smallish part of the dispute resolution industry and much more widely and commonly used in other common law jurisdictions than England and Wales. It is growing slowly in Scotland and Ireland. The delicious thing about training lawyers in Ireland is, as you discover very rapidly, that not to ambush the other party if you can is negligent in litigation, which is a wonderful idea. I remember those days 30 years ago when that was true in this country, but here now we have a “cards on the table” process where, if you do ambush someone, you are probably going to get some part of your anatomy removed by the judge. So I think there is undoubtedly a trend to encourage mediation which is slowly increasing. It is not an instinctive process for “red meat” litigators to engage in, and so there are changes in culture that are required for it to grow. But it seems to me to have an applicability far wider than simply litigation. For instance, I have been today at the Healthcare Commission debating whether they might build mediation into the complaints process at stages. It seems to me that the earlier disputes are handled properly and respectfully, the less likely they are to escalate and for entrenchment to take place, and I am very optimistic that ways will be found to put something appropriate in place there. The NHS Redress scheme is currently under consideration with the NHSLA. It has been mentioned in the Queen’s Speech and that is going to go ahead and there will be the need to look at both how you give redress to patients out of a quasi-complaints system and the best process for doing so. So there is a lot of imagination being applied to how and where it should develop, but I suspect that
mediation will never overwhelm the litigation process, and indeed we cannot afford for it to do so, because there must be a principled access to objectively established justice in the Queen’s courts, against which you measure whether you want to settle or whether you want to go to a judge for a decision.

Mr John Verdin Davies: Thank you.

The President: I will take one more question.

Ms Millard: I am Lizzie Millard, I am a lawyer. I am really interested in why mediations fail. Have you been able to identify any common theme to why mediations fail?

Mr Allen: Let me answer that simply in terms of clinical negligence cases, if I may. In certain commercial cases, greed could be the answer, and I do not want to spoil a more principled approach to the answer to that question. I think the answer is that one side gets their risk assessment badly wrong. There was one case, for instance, (perhaps this is illustrative) where mediation was suggested by the judge very late in the day. It was a claim about a vesico-vaginal fistula that had formed after a hysterectomy, and the amount at stake was relatively small. I think for the purposes of the trial quantum had been agreed at around about £28,000, because it had been repaired after a brief period. At the pre-trial review about two months before trial the judge said “Let’s have a mediation. I think you should”, and the parties said “We really don’t think it is going to be particularly helpful”, and he said “No, you go off and have a try”, so off they went. I turned up and the defendant team said to me “We really would be prepared to make a payment here if we thought it was a sensible business proposition. In other words, if we have got our risk analysis wrong – and our expert, who seems to be perfectly sensible and credible, says we haven’t and says we have got a good chance of fighting – if we see that we are actually at risk, we will reconsider our position.” I think they went very honestly and openly into the debate, and we all spent three or four hours poring over each expert’s opinion and could not find a chink in it. The case did not settle, and the problem was that to put one penny in the hand of the claimant by way of a compromise over damages you had to put £48,000 into the hands of her lawyer. The case went to trial for three days and at the end the judge said “I can see now why the mediation didn’t work”, and after reserving his judgment, he found for the defendants, and frankly everyone lost. The claimant got nothing, the claimant’s solicitor got prescribed rates of legal aid and then, having unfortunately gone on to a Conditional Fee Agreement for the trial, got nothing for the trial, as probably did the barrister, and the defendants really had virtually no chance of recovery. They hoped there might be an insurance policy to cover the cost of trial and they got nothing against the Legal Aid fund to claim for the rest of the case, so everyone lost. I have little doubt that if intelligent and well-informed expert panel solicitors had discussed this case at an early stage and said to each other “These cases can go either way. We can fight this to the death or is there a figure that is heavily discounted but which gives some acknowledgement to the client” that it might well have settled. So I think my answer to you is that in the cases that I can think of which did not settle (and they are relatively small in number) simply the risk analysis went badly wrong for one party, and it so happens in the cases that I have mediated, it was the claimant that got it wrong both times.

The President: Well, thank you very much, Tony, for a very instructive and interesting and, indeed, fascinating talk. We are very grateful to you, very grateful indeed, and here is a small token, a very small token of our appreciation, which we would like to show you now in the traditional way. (Applause.)