Mediation in Doctor-Patient Dispute Resolution

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Unexpected and adverse events are common in healthcare settings. When patients' expectations are not managed in a professional and appropriate manner, especially after an unexpected medical event, patients often turn to lawyers to seek redress.

International studies and experience indicate that the majority of malpractice claims and professional complaints are not due to negligence, but rather, motivated by insensitive handling and poor communication after an adverse outcome. One pivotal study in 1994 identified four themes: deserting the patient (32%), devaluing patient and/or family values (29%), delivering information poorly (26%), and failing to understand the patient and/or family perspective (13%).[1]

Another pivotal study in the same year found that the decision to take legal action was determined not only by the original injury, but also insensitive handling and poor communication after the original incident.[2] It identified four themes as reasons for litigation: concern with standards of care – both patients and relatives wanted to prevent similar incidents in the future; the need for an explanation – to know how the injury happened and why; compensation – for actual losses, pain and suffering, or to provide care in the future for an injured person; and accountability – a belief that the staff or organisation should have to account for their actions. Patients who took legal action wanted greater honesty, acknowledgement and empathy for the severity of the trauma they had suffered, and assurances that lessons had been learnt from their experiences.

The adversarial approach of the court process makes it an especially unsatisfactory forum to settle disputes arising from such communication breakdown. It is costly, not just financially, but also relationally, in that it is skewed to the rupture of relationships.

On the other hand, the approach of mediation is a conciliatory one. Facilitative mediation is a process of negotiation that involves a neutral third party who does not judge but assists the parties to communicate and mutually agree on how to settle the dispute. The process involves asking the parties how they would like to settle the dispute. A patient may merely wish to obtain an apology or explanation, or, of course, might additionally seek compensation from the healthcare institution. Whatever recourse offered can be confidential and without prejudice basis. The process is designed for mutual respect, building trust and cooperation between disputing parties and the solution is negotiated between them. The pivotal role of the mediator is one of facilitation. Court proceedings involve a judge who will adjudicate the dispute based on its merits and the presenting evidence. Most importantly, it is based on the adversarial nature of the law. It requires the judge to deem one party right and the other wrong, which would inevitably accentuate or even create animosity.

Restorative mediation is based on the concept of restorative justice, which is a way of dealing with disputes and conflicts. A process is said to be restorative when three events occur. First, the parties are able to acknowledge that a dispute exists and are able to share how they experienced the dispute with each other. Second, the parties are able to talk about how to make things as right as possible between themselves. Third, the parties talk about the future to prevent the dispute from occurring again and to rebuild trust.[3] Such programmes incorporate the potential to proactively review severe adverse outcomes and acknowledge fault, with an offer for proper apology and restitution when appropriate.

A number of apology or restorative justice programmes primarily dealing with medical error claims in the US have demonstrated the cost effectiveness and satisfactory resolution of claims. This process allows the parties to meet with a facilitator to talk about what happened and for the parties involved to take responsibility for their actions. Where appropriate, the responsible party has an avenue for compensation and restitution. Different variations of such programmes have demonstrated significant cost savings in claims. COPIC Insurance Company's 3R programme was estimated to have saved approximately 33% of the cost of the traditional adversarial process, with 98% of claims resolved without litigation. Other examples of such programmes emanating from US include the apology programme of the Veterans Administration Medical Center in Lexington, Kentucky, where the average payout was estimated to result in cost savings of 84%. There were only two lawsuits that have gone to trial during a ten-year period. The University of Michigan Health System apology programme reduced malpractice claims by an estimated 50%, reduced average time to process a claim from about 20 months to about eight months, and reduced the cost per claim by about 50%.[3]

More commonly in Singapore, many healthcare institutions have clinical incident management programmes. A senior doctor will usually be asked to review and address concerns relating to complaints. This is an important service that could be further enhanced by using clinicians skilled in mediation, who can not only rebuild relationships and clarify miscommunications, but also focus on and achieve conciliatory solutions when necessary.

In considering how best to promote the various types of mediation as the preferred method of resolving medical disputes, a compulsory mediation clause in the event of dispute can be incorporated into all healthcare contracts before a patient is seen by the doctor or in the healthcare institution.

An alternative is to appoint a neutral medical ombudsman to review all disputes, and make recommendations on negotiation, mediation or a referral for a formal dispute resolution, like arbitration or litigation, if necessary. An ombudsman has the potential to not just review doctor-patient disputes but also manage interprofessional disputes within a healthcare organisation. SMA

References

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