
Research report

Alternative mechanisms for resolving disputes: a literature review

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Foreword

I am delighted to welcome you to this monograph, the third in a series on research in regulation of the professions registered with the HPC. It is part of our commitment to building the evidence-base for regulation and being innovative in our approach. We will produce further publications over the coming years, each of which will explore different aspects of the regulatory landscape. We hope that over time these pieces of work will contribute not only to our own understanding of regulation in the health and social care sector, but also to that of a wider audience of stakeholders with an interest in this area.

Since the publication of the first of these research reports, we have recognised the need to further our understanding of complaints and complainants. In 2009 we commissioned Ipsos MORI to examine the expectations of complainants through a qualitative study. One of the recommendations of this work was to explore mediation as an additional methodology for resolving disputes. This monograph is in part a response to those recommendations. It is also a response to the Council's own expressed desire to explore innovative ways of approaching complaints and to reflect a wider movement towards listening and learning from concerns about practice.

I am grateful to the authors for providing such a clear overview of the literature on alternative dispute resolution and a commentary on its potential as a regulatory tool in handling certain types of complaints. We do not yet know how alternative dispute resolution will be used in our regulatory process but we are committed to undertaking further work to explore the use and value of mediation in an HPC context. The results of the pilot, together with this report, will undoubtedly contribute to the future direction of the Council and its approach to handling concerns about registrants.



Anna van der Gaag
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Executive summary

This literature review for the Health Professions Council (HPC) focuses on the use of alternative dispute resolution (ADR) in the resolution of complaints or disputes between professionals and their clients. It provides an overview of the field before turning to issues of policy and practice such as the relationship between complaints handling and professional regulation; the 'public interest'; apologies; and confidentiality. It reviews the use of ADR in a number of settings worldwide. Many of these studies show that initial responses to mediation are at best hesitant and at worst dismissive. However, once established, mediatory processes were judged by those involved to be both beneficial and effective.

The literature indicates that a mediatory approach in a regulatory setting could add value to current processes for dealing with fitness to practise allegations. Certain conditions apply: for example, mediation needs to be offered early in the process, with an emphasis on face-to-face communication between the complainant and registrant, to facilitate explanation, apology (where appropriate and genuine) and plans for future learning and prevention. A 'mediation manager' plays a significant part in the success of those schemes that have been widely used, effectively acting as 'champion' during the introduction of an approach that may be unfamiliar or even regarded with suspicion by potential participants. The review also highlights two potential mechanisms for ensuring that mediated outcomes align with the HPC's duty to protect the public: to refer these back to the Investigating Panel for ratification, and / or to have an HPC partner (with direct knowledge of the profession concerned) as part of the mediation process.

The HPC's current statutory framework also provides for mediation to occur after an allegation has been upheld. This has much in common with a process known as 'restorative justice' where the emphasis is on acknowledging and apologising for harm, allowing the person harmed to describe how they were affected and to participate in the discussion of remedial steps. The review suggests describing such a step as a 'restorative meeting' and offering this as another opportunity for mediation, where appropriate.

Throughout the literature there is an emphasis on learning from past errors in order to improve the quality of future practice. This is positively linked to satisfaction with regulatory and complaints processes on the part of both complainants and professionals. Mediation's potential for face-to-face discussion and ability to deliver a range of possible outcomes suggest that it could help the HPC to deliver these desirable outcomes within its fitness to practise process. At the same time, the HPC would need to take active steps to ensure that any such scheme was clearly explained, publicised and utilised.

Introduction

The purpose of this study is to provide information for the Health Professions Council (HPC) on the use of mediation and other forms of alternative dispute resolution (ADR) in dealing with complaints against health and wellbeing professionals. ADR is a term that embraces a range of alternatives to adjudication or investigation, including mediation, conciliation and ‘frontline resolution.’¹ The HPC’s interest in these practices stems from a report prepared for it by Ipsos MORI² which indicated a lack of understanding of its fitness to practise process among members of the public and the professions.³ One of this report’s suggestions was that some form of mediation could prevent a proportion of complaints from reaching a formal investigation.⁴

The Health Professions Council was established in 2002 by the Health Professions Order 2001 enacted under section 60 of the Health Act 1999. Its function is to protect the public by ensuring high standards among fifteen professions working in the health and wellbeing arena.⁵ It enforces these standards via its fitness to practise process. While the main trigger for investigating a registrant is a complaint,⁶ the HPC is clear that its approach differs from other complaints processes. It is not designed to punish professionals for harm done, nor to resolve disputes between them and their clients: rather, its focus is on whether these professionals are fit to practise.⁷

¹ A term coined by the Scottish Public Services Ombudsman (SPSO) in *Consultation on a Statement of Complaints Handling Principles and Guidance on a Model Complaints Handling Procedure*, p. 13, available at www.spsos.org.uk. Referred to hereafter as SPSO (2010).

² Ipsos MORI, *Expectations of the Fitness to Practise Complaints Process: Research for the Health Professions Council: Final Report*, January 2010.

³ “One of the potential benefits identified in the discussion was fulfilling the expectations of complainants by providing a way of resolving issues or concerns which whilst important to the complainant, do not relate to impairment of fitness to practise.” From minutes of the HPC Fitness to Practise Committee, 25 February 2010, p. 3.

⁴ “Key stakeholders, complainants, registrants and members of the public all said they would be keen to see a mediation stage in the fitness to practise process. It was felt that often an explanation or apology would be enough to see a satisfactory resolution to many complaints.” Ipsos MORI, 2010, p. 21.

⁵ Arts therapists; biomedical scientists; chiropodists / podiatrists; clinical scientists; dietitians; hearing aid dispensers; occupational therapists; operating department practitioners; orthoptists; paramedics; physiotherapists; practitioner psychologists; prosthetists / orthotists; radiographers; and speech and language therapists.

⁶ Described in the relevant legislation as an ‘allegation’ (Health Professions Order 2001, S. 22).

⁷ “Fitness to practise proceedings are about protecting the public. They are not a general complaints resolution process, nor are they designed to resolve disputes between registrants and service users. Our fitness to practise processes are not designed simply to punish registrants for past mistakes they have made or harm they may have caused. Our processes allow us to take appropriate action to protect the public from those who are not fit to practise either at all or on an unrestricted basis.” *Fitness to Practise Annual Report 2010* (London: Health Professions Council, 2010), p. 4; see also www.hpc-uk.org/assets/documents/10002FD8FTP_What_does_it_mean.pdf

The distinction between professional regulation (where the focus is on the registrant's conduct, competence and fitness to practise) and complaints handling (where the emphasis is on the patient / consumer's experience), may lead to some confusion for members of the public who complain. If, for example, a registrant has made a mistake that caused harm to the complainant, but is unlikely to repeat it and is currently fit to continue practising, the HPC may choose not to impose any restrictions on that person. The complainant, however, may feel that their complaint has not been taken seriously. In these circumstances another potential benefit of ADR is the opportunity for face-to-face discussion,⁸ allowing complainants to receive an explanation and, where appropriate, an apology. It may also enable registrants to improve the quality of their practice in future through hearing first-hand about the impact of their actions on complainants.

The idea of learning from complaints in the interests of quality improvement chimes well with the priorities of the Council for Healthcare Regulatory Excellence: "As regulators review their standards and guidance, we consider that they should address issues raised by patients, service users and carers, through surveys and other research, as well as new statutory developments."⁹

This review considers whether existing research provides evidence that ADR could achieve these three purposes: to resolve appropriate cases without formal investigation, to enhance user satisfaction with the fitness to practise process and to support quality improvement and learning for registrants.

⁸ See Section 2.3 below.

⁹ Council for Healthcare Regulatory Excellence, *Improved Performance Through Regulation: Annual Report 2009 – 10*, (London: Council for Healthcare Regulatory Excellence, 2010), p. 12.

1 Alternative dispute resolution

1.1 Definitions and terminology

The brief for this Literature Review states that “mediation and ADR are only two mechanisms and that there may be other approaches that the HPC could adopt” to help it fulfil its wider goals in relation to fitness to practise.

This phrase highlights the need for clarity: strictly speaking mediation is just one form of ADR. Some historical background may be useful here.

While mediation is undoubtedly an ancient practice,¹⁰ the idea of alternative ways of delivering justice began to appeal to twentieth-century Western legal systems as courts grew busier, delays longer and costs greater. American legal academic Frank Sander is credited with coining the phrase ‘alternative dispute resolution’¹¹ in 1976. He also used the term ‘multi-door courthouse’; the idea being that an individual with a problem would find doors marked variously ‘arbitration’, ‘mediation’, ‘negotiation’ and ‘litigation’.

So, ADR describes alternatives to the formal, state-sponsored adjudication system. Mediation is the best known but ADR also includes arbitration and a range of innovations with titles such as Early Neutral Evaluation, Mini-trial, Med-Arb, Arb-Med, Collaborative Law and Restorative Justice.¹² Some have questioned the ‘otherness’ of ADR, suggesting that ‘Appropriate Dispute Resolution’ is a more suitable title.¹³ In this review we speak mostly of mediation, defined as: any setting where two or more people with a dispute or disagreement are helped to resolve it by a third person who does not impose a judgement.¹⁴ Where other practices appear useful we will try to describe them as accurately as possible. For example, the Scottish Public Services Ombudsman has recently issued a report which refers to ‘Frontline Resolution’, meaning: “‘On the spot’ apology, explanation, or other action to resolve the complaint quickly.”¹⁵ This is quite distinct from mediation, as no third party is involved, and may prove a useful first step in preventing some matters from entering formal processes.

¹⁰ Abel, R (1983) ‘Mediation in Pre-Capitalist Societies’ in *Windsor Yearbook of Access to Justice 175-185*, p. 181; Roebuck, D (2007) ‘The Myth of Modern Mediation’ in *73 Arbitration* (1) 105-116, p. 106.

¹¹ Sander, F (1976) ‘Varieties of Dispute Processing, Address Delivered at the National Conference on the Causes of Popular Dissatisfaction with the Administration of Justice’ (Apr. 7-9, 1976), in *70 F.R.D.* 111, 111.

¹² See Bingham, L, Nabatchi, T, Senger, J and Jackman, M (2009), ‘Dispute Resolution and the Vanishing Trial: Comparing Federal Government Litigation and ADR Outcomes in *24 Ohio State Journal on Dispute Resolution*.

¹³ Menkel-Meadow, C (2010) ‘Empirical Studies of ADR: The Baseline Problem of What ADR is and What It is Compared to’ in Cane, P and Kritzer, H (eds.) *Oxford Handbook of Empirical Legal Studies* (forthcoming); Sander, F and Rozdeiczer, L, (2005) ‘Selecting an Appropriate Dispute Resolution Procedure: Detailed Analysis and Simplified Solution’, in Moffitt, M and Bordone, R (eds.) *The Handbook of Dispute Resolution*, San Francisco: Jossey-Bass.

¹⁴ Alternatives to mediation are discussed at Section 4.2 below.

¹⁵ SPSO (2010), p. 13.

1.1.1 Conciliation or mediation?

The terms ‘conciliation’ and ‘mediation’ are often used interchangeably. In the early 1990s family conciliation services transformed into family mediation services without significantly altering their practice. Recently the UK Disability Conciliation Service became the Equalities Mediation Service.¹⁶ Nonetheless, subtle differences of meaning persist. Platt states:

“In the UK the Department of Health uses the word ‘mediation’ primarily in relation to clinical litigation and personal injury claims. In contrast, the term ‘conciliation’ tends to be reserved for the process used in relation to the complaints procedure.”¹⁷

As we discuss below,¹⁸ the HPC’s fitness to practise process is neither litigation nor a typical complaints process, with the HPC effectively a third party acting in the public interest. However, some additional characteristics are also said to distinguish conciliation from mediation: a longer timescale, no requirement for face-to-face meetings and a more “proactive or interventionist”¹⁹ approach than mediation.

This last quality may imply that the term is preferable for the HPC. Platt also suggests that the conciliator in some settings will ensure that the rights of one of the parties are reflected in any proposals, and that these rights (patients’ rights, for example) are non-negotiable.²⁰ This corresponds to the ‘norm-advocating’ style of mediation (see below). While Platt’s perspective is valuable, for the purposes of this review we use the term mediation owing to its wide international currency and broadly agreed meaning.

1.2 The HPC’s legislative framework

As noted above, the Health Professions Council is a statutory body.²¹ Its principal functions are “to establish from time to time standards of education, training, conduct and performance for members of the relevant professions and to ensure the maintenance of those standards”,²² with the main objective being to “safeguard the health and well-being of persons using or needing the services of registrants.”²³ The Council’s primary tool in achieving these aims is the Register.

¹⁶ See www.equalities-mediation.org.uk; for a thorough explanation of its work see www.adrnow.org.uk/go/SubPage_38.html

¹⁷ Platt, A. W. (2008) *Conciliation in Healthcare: Managing and Resolving Complaints and Conflict* (Oxford: Radcliffe Publishing), p. 7.

¹⁸ At Section 2.1.

¹⁹ Platt (2008) p. 10.

²⁰ *Ibid*, p. 11.

²¹ Health Act 1999, Section 60: Regulation of health care and associated professions
(1) Her Majesty may by Order in Council make provision –
(b) regulating any other profession which appears to Her to be concerned (wholly or partly) with the physical or mental health of individuals and to require regulation in pursuance of this section.

²² Health Professions Order 2001 s.3(2).

²³ *Ibid*, s.3(4).

To supplement this and assist the Council in its role, the Order creates four committees: the Education and Training Committee; the Investigating Committee; the Conduct and Competence Committee; and the Health Committee. These last three come within the Council's Fitness to Practise function, under which, the Council must:

“(a) establish and keep under review the standards of conduct, performance and ethics expected of registrants and prospective registrants and give them such guidance on these matters as it sees fit; and

(b) establish and keep under review effective arrangements to protect the public from persons whose fitness to practise is impaired.”

The Order provides a framework for complaints handling which concentrates on allegations that the professional's fitness to practise is impaired. This may be by reason of:

- misconduct;
- lack of competence;
- a conviction or caution;
- the physical or mental health of the Registrant;
- a determination by another body that fitness to practise is impaired;
- the person is on a barred list (within the meaning of the various Safeguarding Vulnerable Groups Acts); or
- that their entry in the Register has been fraudulently procured or incorrectly made.²⁴

Once an allegation has been made to the Fitness to Practise Department, the Investigating Committee first considers whether or not it concerns the professional's fitness to practise. If it does not, a ‘no case to answer’ decision will be made and the complaint dismissed. If there is a fitness to practise case to answer, the Investigating Committee has three options. It can:

- make an interim order (suspension or conditions of practice);
- refer the case to mediation; or
- forward it to a hearing committee.²⁵

The available outcomes for the Investigating Committee (which itself hears cases of incorrect or fraudulent entry to the Register) are:

- no case to answer; or
- amend or remove an entry in the Register.

For the Health or Conduct and Competence Committees the possible outcomes are:

- no further action;
- suspension order;
- conditions of practice order;
- caution order; or
- striking-off order (in lack of competence and health cases only available where a registrant has been continuously suspended for at least two years).

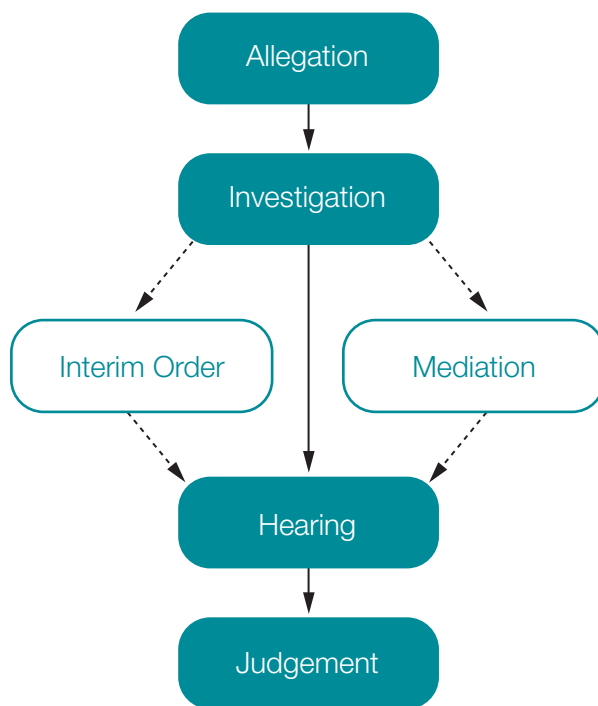
Mediation may also be used as a final outcome from these two committees.

²⁴ s.21(1) (a) Health Professions Order 2001.

²⁵ The Investigating Committee is the hearing committee for any allegations about a fraudulent or incorrect entry to the Register. The Health Committee deals with allegations about a professional's physical or mental health. The Conduct and Competence Committee deals with the other allegation types.

The current fitness to practise process is outlined below.

**Figure 1– Fitness to practise:
An overview of the process**



1.2.1 ADR within the Health Professions Order

Mediation appears at three points within the Order. First, it is an option for screeners (those who conduct the preliminary screening of allegations) to mediate prior to a hearing.²⁶ However, this can only be done at the request of the Practice Committee, a requirement which may work against screeners taking the initiative in offering mediation and the “aim of dealing with the allegation without it being necessary for the case to reach the stage at which the Health Committee or Conduct and Competence Committee, as the case may be, would arrange a hearing.”²⁷ Next, when the Investigating Committee finds there is a case to answer, it may mediate itself or refer the matter to screeners for them to mediate.²⁸ In this case, if the mediation is unsuccessful there is no provision to refer the case back to the Investigating Committee. Finally, the Order provides for mediation after an allegation has been investigated and declared to be well founded.²⁹ To date no mediations have taken place.

The fact that mediation has never been used may be the result of its ambiguous place in the fitness to practise process. In spite of the wide statutory mandate enabling its use throughout the process, the HPC’s Practice Note on Mediation seems to rule it out in all but the most minor cases:

²⁶ HPO S.24 (3) (d).

²⁷ HPO S.24 (3) (d).

²⁸ HPO S.26 (6).

²⁹ HPO S.29 (3).

“Panels need to recognise that certain disputes should never be referred to mediation. As mediation is a closed and confidential process, its use in cases where there are issues of wider public interest [...] where its use would fail to provide necessary public safeguards and seriously undermine confidence in the regulatory process [...] Mediation may (but will not always) be appropriate in minor cases that have not resulted in harm.”³⁰

1.3 Mediation

Mediation has undergone considerable expansion in the last twenty years, both as a practice and as a subject of academic study.³¹ It would be misleading to suggest that it is a homogenous practice: one form of mediation may be barely recognisable to another.³² Most official discourse on mediation in the UK anticipates a facilitative, non-directive process in which the mediator acts as a conduit to aid

the participants’ discussions and negotiations.³³ In this model, the content of any agreement reached is crafted by the parties themselves without the mediator voicing an opinion on whether the outcome is just, appropriate or fair.

Empirical evidence suggests that mediators in practice are more directive, manoeuvring parties into particular settlements.³⁴ Similarly, the mediation process may be more evaluative, where the mediator “focuses [...] on the legal claims, assesses the strengths and weaknesses of those claims [and predicts] the impact of not settling.”³⁵ Leonard Riskin adds a further dimension, suggesting that mediators within the justice system adopt a ‘narrow’ or ‘broad’ approach. A narrow orientation focuses on the legal and monetary issues, while a broader orientation looks at the parties’ relationship, longer-term interests and wider societal or public-interest issues.³⁶

³⁰ Health Professions Council, Mediation Practice Note, October 2009, p. 3, www.hpc-uk.org/assets/documents/10001DDCPRACTICE_NOTE_Mediation.pdf

³¹ For example, a recent review lists 91 monographs published in English since 2008: Brown, B (2010) *A Practical Bibliography of Books for the Mediation Practitioner (2010 Update)* www.mediate.com/articles/brownB1.cfm

³² While mediation may represent a simple negotiation process aided by a third party, as Carrie Menkel-Meadow suggests “[i]n its most grandiose forms, mediation...[may] achieve the transformation of warring nation states, differing ethnic groups, diverse communities, and disputatious workplaces, families and individuals, and to develop new and creative human solutions to otherwise difficult and intractable problems[...] it is a process for achieving interpersonal, intrapersonal and intrapsychic knowledge and understanding.” Menkel-Meadow, C, ‘Introduction’ in Menkel Meadow, C (ed.) (2001) *Mediation: Theory, Policy and Practice* (Aldershot: Ashgate/Dartmouth) at xiii-xiv.

³³ See, for example, the Civil Mediation Council’s definition of mediation, which adopts the European Code of Conduct for Mediators: www.cmcregistered.org/pages/3/european-code-of-conduct-for-mediators-

³⁴ See, for example, Dingwall, R and Greatbatch, D (2000) ‘The Mediation Process’ in Davis, G *Monitoring Publicly Funded Family Mediation* (London: Legal Services Commission), p. 251.

³⁵ McAdoo, B and Welsh, N, ‘Does ADR really have a place on the lawyer’s philosophical map?’ in *Hamline Journal on Public Law and Policy*, 18 (1997), pp. 376–393, at p. 389.

³⁶ See Riskin, L, ‘Understanding Mediators’ Orientations, Strategies and Techniques: A Grid for the Perplexed’ in *Harvard Negotiation Law Review*, 1, (1996), pp. 7–52.

Ellen Waldman has suggested an alternative typology based on the norms according to which mediation decisions are made. She names three styles: 'norm generating', 'norm educating' and 'norm advocating'.³⁷ Under the norm-generating approach, the parties themselves provide the norms according to which the outcome is judged. A norm-educating mediator goes further, providing information on applicable legal and societal norms, but still leaving it to the parties to decide which, if any, they choose to apply. And a norm-advocating mediator insists that any settlement reached reflects particular applicable norms: "In this sense, her role extended beyond that of an educator; she became, to some degree, a safeguarder of social norms and values."³⁸ The HPC's duty to protect the public interest may mean that this last approach is the most appropriate.³⁹ In the UK the Equalities Mediation Service is the clearest example of a norm-advocating approach, as this description indicates:

"The mediator must ensure that any agreement is in line with rights and responsibilities set out in the Disability Discrimination Act, or in other relevant discrimination legislation."⁴⁰

Finally, although most mediation can be described as settlement-oriented, another school, known as 'transformative mediation' insists that the process should focus on the relationship between the parties. Here the mediator's role is to 'support' party interaction, restoring to those in conflict a degree of competence or 'empowerment', which in turn leads to a greater capacity to recognise the perspective of the other.⁴¹ This approach has been controversial within the mediation community. It may, however, have much to offer in the HPC context, where 'settlement' is not the main aim and where, as we discuss below, supporting direct communication may be the most important benefit of mediation.⁴²

³⁷ Waldman, E, 'Identifying the Role of Social Norms in Mediation: A Multiple Model Approach' *Hastings Law Journal*, 48, pp. 703–770.

³⁸ *Ibid*, p. 745.

³⁹ Waldman gives the example of an end of life mediation where the mediator had to ensure that both legislative and professional ethical standards were taken into account in the final agreement.

⁴⁰ www.adrnow.org.uk/go/SubPage_38.html

⁴¹ See Bush, R A B and Folger, J P, *The Promise of Mediation: Responding to Conflict Through Empowerment and Recognition (2nd Edition)* (San Francisco: Jossey-Bass), 2005.

⁴² For a review of transformative mediation's use in an employment context see Bingham, L, Hallberlin, C, Walker, D, and Won-Tae Chung, 'Dispute System Design and Justice in Employment Dispute Resolution: Mediation at the Workplace' in *Harvard Negotiation Law Review*, 14 (1), pp. 1–50.

1.4 Critiques of ADR

The mediation process has been positively evaluated in a number of contexts.⁴³ Claimed benefits include speed (compared to the formal adversarial process); reduced cost; empowerment (in that parties retain decision-making power); creativity (going beyond the courts' "limited remedial imagination");⁴⁴ capacity to preserve relationships; and the power of a face-to-face encounter ("What pervaded disputants' talk on mediation agendas was their wanting to directly communicate their perspectives, be heard, seen, and understood").⁴⁵ It is also a commonplace that mediation attracts high satisfaction ratings from users.⁴⁶

There are however recognised concerns about the use of mediation.⁴⁷ These include the possibility that existing power imbalances may

be exacerbated; the abrogation of legal entitlements; concerns about procedural justice; and the lack of public pronouncement of decisions.

1.4.1 Power imbalances

Power imbalances between disputing parties can take many forms: for example, financial and legal resources, expert knowledge, prior experience, confidence and eloquence. This has been a source of particular concern in disputes between lay persons and both professionals and government agencies. And if the mediation process, to use Waldman's typology, is 'norm-generating', (ie where parties themselves choose the norms according to which the outcome is judged) then imbalances of power or resources could in turn lead to unfair solutions.⁴⁸

⁴³ For a thorough review of the field see Jones, T (ed.) (2004) 'Conflict Resolution in the Field: Assessing the Past, Charting the Future' in *Conflict Resolution Quarterly*, 22, 1 and 2, which has chapters on court connected, community, employment, victim-offender and environmental mediation as well as conflict education. In terms, for example, of settlement rates, user satisfaction and cost and time savings, see also Prince, S (2007) 'Institutionalising Mediation? An Evaluation of the Exeter small claims mediation pilot' *5 Web Journal of Current Legal Issues* available at <http://webjcli.ncl.ac.uk/2007/issue5/prince5.html>; Doyle, M (2006) *Evaluation of the Small Claims Mediation Service at Manchester County Court* (London: Department of Constitutional Affairs), available at www.dca.gov.uk/civil/adr/small-claims-manchester.pdf (accessed 31 August 2010); Ross, M and Bain, D (2010) *In Court Mediation Pilots: Report on Evaluation of In Court Mediation Schemes in Glasgow and Aberdeen Sheriff Courts* (Scottish Government, Courts and Constitution Analytical Team), www.scotland.gov.uk/Resource/Doc/310104/0097858.pdf. Evaluations of mandatory mediation have been less positive: see for example, Genn, H *et al* *Twisting Arms: Court Referred and Court Linked Mediation under Judicial Pressure* (2007: Ministry of Justice)

⁴⁴ Menkel-Meadow, C, 'Ethics in Alternative Dispute Resolution: New Issues, No Answers from the Adversary Conception of Lawyers' Responsibilities', *South Texas Law Review*, 38, 407, 1997, p. 452.

⁴⁵ Relis, T, (2009) *Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties*, (Cambridge: Cambridge University Press), p. 153.

⁴⁶ For example see Ross and Bain (2010); Doyle (2006).

⁴⁷ As a rule of thumb the criticisms gain greater potency the more that mediation is institutionalised and the less that parties exercise informed consent.

⁴⁸ One of the most cogent critiques of the handling of inter-party power dynamics in mediation was launched by Trina Grillo in Grillo, T, 'The Mediation Alternative: Process Dangers for Women', *Yale Law Journal*, 100 (6), 1991, pp. 1545-1610; see also Delgado, R *et al* (1985) 'Fairness and Formality: Minimizing the Risk of Prejudice in Alternative Dispute Resolution' *Wisconsin Law Review* 1359.

Given mediation's commitment to impartiality, it can be argued that there is little the mediator can do to alleviate the impact of one party's superior resources, leading to potential injustice for the weaker party.⁴⁹ On the other hand, some of these imbalances can be addressed where both parties have access to legal representation or the mediation process is more explicitly 'norm educating' or advocating.⁵⁰ Even standard facilitative mediation may alleviate power imbalances, for example, by the impact of mediators' treating both parties with respect, listening with care, and such matters as controlling how both parties are greeted, seated and addressed.⁵¹ It is also important to acknowledge that such imbalances can persist in formal adjudicatory settings.

1.4.2 Mediation, the abrogation of legal entitlements and 'justice'

Another critique holds that mediation may lead to a denial of justice.⁵² It argues that, in contrast to adjudication where an authoritative neutral judge renders a decision based on relevant legal norms, in mediation claims are reframed through a 'harmony'⁵³ lens into non-legal disputes to be resolved through discussion and compromise.⁵⁴ Leaving aside the nuanced issue of the imperfect application of law,⁵⁵ such arguments squarely equate justice with the law and rule out other considerations and norms as barometers of justice. Yet justice is not the monopoly of the law; in fact, parties may not regard legal outcomes as just.

⁴⁹ As Professor Dame Hazel Genn colourfully remarked recently, "[t]he outcome of mediation is not about **just** settlement, it is **just about settlement**.", Genn, H, *Judging Civil Justice: The Hamlyn Lectures 2008* (Cambridge: Cambridge University Press, 2010) at p. 117.

⁵⁰ Albeit that such an approach by the mediator may appear biased and lead to a lack of perceived impartiality – see for example Kovach, K K, 'Mapping Mediation: The Risks of Riskin's Grid' *Harvard Negotiation Law Review*, 3, 71, 1998, pp. 71–110. For a discussion of the issue of power imbalances in mediation, see Irvine, C (2009) Mediation and Social Norms: A Response to Dame Hazel Genn' in *Family Law* 39, 2009, pp. 352–57.

⁵¹ See Davis, A, and Salem, R, 'Dealing with power imbalances in mediation of interpersonal disputes' in Lemmon, J (ed.) *Procedures for Guiding the Divorce Mediation Process* (San Francisco: Jossey-Bass, 1984); Subrin, S (2002) 'A traditionalist looks at mediation: It's here to stay and much better than I thought' 3 *Nevada Law Journal*, pp. 196–231.

⁵² See generally Auerbach, J. S (1983) *Justice Without Law? Resolving Disputes Without Lawyers* (New York: Oxford University Press; Abel, R (1984) *The Politics of Informal Justice* New York: Academic Press.

⁵³ Nader, L, 'Controlling Processes in the Practices of Law: Hierarchy and Pacification in the Movement to Re-Form Dispute Ideology' in *Ohio State Journal of Dispute Resolution*, 9, 1993, pp. 1–25.

⁵⁴ See, for example, the discussion in Genn (note 49 above) at pp. 114–21; Brunsdon-Tulley, M 'There is an 'A' in 'ADR' but Does Anybody Know What It Means Anymore?' *Civil Justice Quarterly*, 28 (2), 2009, pp. 218–36.

⁵⁵ For an illuminating discussion see Subrin (2002).

Recent research indicated that parties regarded lawyers' focus on legal tactics as trivialising issues of importance to them.⁵⁶ They may be seeking something entirely different from mediation, such as apology or explanation.⁵⁷

1.4.3 Procedural justice

Substantive or distributive justice concerns outcomes: procedural justice refers to the process by which those outcomes come about. Procedural justice literature focuses on participants' perceptions of the fairness of decision-making procedures.⁵⁸ Parties' perceptions of procedural fairness have consistently been found to impact on their overall assessment of encounters with decision-making bodies, independent of outcomes. Citizens are more likely to view outcomes as fair if they judge that the process

by which those outcomes have been arrived at was in itself procedurally fair.⁵⁹ While the bulk of research in the area has focused on criminal justice,⁶⁰ it has more recently become influential in the study of administrative justice in the UK.⁶¹ Three primary factors contribute to assessments of procedural fairness: voice (the opportunity to present views, concerns and evidence to a third party), being heard (the perception that the "third party considered their views, concerns and evidence")⁶² and treatment (being treated in "a dignified, respectful manner").⁶³

Procedural justice norms have been brought to bear in the scrutiny of mediation.⁶⁴ It seems that mediation's promise of party empowerment and self-determination may be largely meaningless if the process does not exhibit the key characteristics of procedural justice.

⁵⁶ Relis (2009).

⁵⁷ Research conducted in Scotland in 1997 found that, while around half of disputants surveyed wanted financial compensation, 43 per cent wanted an apology and 41 per cent wanted an explanation – Scottish Consumer Council, *Civil Disputes in Scotland: A report of consumers' experiences* (1997). See also McFarlane, J (2009) *The New Lawyer*, chapter 6; Clark, B (2009) 'Mediation and Scottish Lawyers: Past, Present and Future' in *Edinburgh Law Review*, 13, pp. 252–74.

⁵⁸ "three decades of socio-legal research have demonstrated that citizens also care deeply about the process by which conflicts are resolved and decisions are made, even when outcomes are unfavourable or the process they desire is slow or costly" MacCoun, R (2005) 'Voice, Control, and Belonging: The Double-Edged Sword of Procedural Fairness' in *Annual Review of Law and Social Science*, 1, pp. 171–201, at p. 172.

⁵⁹ Lind, A and Tyler, T, *The Social Psychology of Procedural Justice* (New York: Plenum Press, 1988) pp. 66–70.

⁶⁰ See, for example, Tyler, T and Huo, Y *Trust in the Law: Encouraging Public Cooperation with the Police and Courts* (New York: Russell Sage Foundation, 2002); Tyler, T *Why People Obey the Law* (Princeton, NJ: Princeton University Press, 2006)

⁶¹ Genn and others, 2006; Adler, M (ed.) (2009) *Administrative Justice in Context* (Oxford: Hart Publishing); Halliday, S and Scott, C (2009) 'A Cultural Analysis of Administrative Justice' in Adler (ed.) (2009).

⁶² Welsh, N, 'Making Deals in Court Connected Mediation: What's Justice Got to Do With It?' *Washington University Law Quarterly*, 79, 2001, pp. 788–858 at p. 820.

⁶³ *Ibid*, p. 820; Welsh suggests that a fourth factor, neutrality, might be expected to feature, but people seem to have been more influenced by the third party's attempts at even-handedness and attempts at fairness.

⁶⁴ See Welsh, N (2002) 'Disputants' Decision Control in Court-Connected Mediation: A Hollow Promise Without Procedural Justice' in *Journal of Dispute Resolution*, 1, pp. 179–192; Welsh, N (2001) 'Making Deals in Court Connected Mediation: What's Justice Got to Do With It?' in *Washington University Law Quarterly*, 79, pp. 787–865.

There is some evidence that people perceive greater procedural fairness when decisions are made on their behalf by an authoritative third party.⁶⁵ However, Welsh suggests that a more nuanced reading of the literature reveals the importance of embedding procedural justice norms in all types of dispute resolution.⁶⁶

1.4.4 Lack of public pronouncement

Another critique of mediation holds that it privatises dispute resolution, leading to the suppression of public norms. Formal adjudicative processes fulfil a democratic function concerned with “reinforcing values and practices.”⁶⁷ They exist not simply to resolve citizens’ disputes but to cast a shadow over society by providing rulings on acceptable and unacceptable behaviour. According to this argument, dispute resolution measures such as mediation, cloaked in confidentiality and privacy, may stifle the prospect of such ‘lesson-learning’ and lead to the “erosion of the public realm”.⁶⁸ In the HPC’s context, it could be argued that any attempt to divert some allegations to mediation prior to a determination prevents the Council from fulfilling its public role of upholding standards and norms.

1.5 Conclusion

We began by clarifying the meanings of ADR and mediation. We then considered the statutory backdrop to the HPC’s fitness to practise process. The current legislation is ambiguous as to when mediation should be undertaken, by whom, and with what purpose, and this may be a contributing factor to its non-use to date. We set out a typology of mediation and suggested that, given the HPC’s duty to protect members of the public and act in the public interest, it might consider a ‘norm educating’ or ‘norm advocating’ approach (where the mediator ensures that the parties take appropriate social or legal norms into account in arriving at an outcome). At the same time, the transformative approach may provide the clearest focus on those aspects of the fitness to practise process that have led complainants to ask for a mediation step: the desire for explanation, apology and reassurance that ‘it won’t happen to anyone else’. Mediation has also been subject to cogent critiques: its capacity to deal with power imbalances, potential to deliver less than formal legal entitlements, lack of an authoritative third party decision and privatisation of disputes have all come under fire. It would be wise for those adopting a mediatory approach to be conscious of these concerns and to take steps to address them.

⁶⁵ MacCoun (2005) p. 175.

⁶⁶ Welsh (2002).

⁶⁷ Genn, see note 49.

⁶⁸ See Luban, D (1995) ‘Settlements and the Erosion of the Public Realm’ *83 Georgetown Law Journal*, pp. 2619–62. For a counter view of such matters, see Menkel-Meadow, C (1995) ‘Whose dispute is it anyway?: A philosophical and democratic defence of settlement (in some cases)’ in *83 Georgetown Law Journal*, , pp. 2663–96.

2 Issues for the HPC

2.1 Consumerism v professionalism – complaints and the role of a regulator

As noted above, the HPC is a regulator rather than a complaints handling organisation.⁶⁹ Its fitness to practise process exists to “protect the public from those who are not fit to practise either at all or on an unrestricted basis.”⁷⁰ However, a significant proportion of the cases it deals with are initiated by a complaint from a member of the public.⁷¹ Below we consider the implications of the distinction between professional regulation and complaints handling.

There is a considerable body of literature on the subject of complaints and complaints handling, much of it relating to administrative justice – complaints by the citizen about actions or decisions of the state.⁷² Brewer traces the influences on complaints handling models, from traditional ideas of citizenship to more recent consumerist perspectives.⁷³ The consumerist model frames complaints as learning opportunities leading to improved services. This creates an incentive for organisations and bureaucracies to ‘harvest’ complaints in the interests of quality improvement. According to Davis, however: “Misconduct, by comparison,

goes to the heart of what it traditionally means to be professional and draws into question the suitability of the practitioner to remain in practice, either at all or without additional safeguards.”⁷⁴

Even though some professions have in recent years lost the privilege of self-regulation, a framework of professional discipline rather than complaints handling can still be seen as a mark of status. It effectively processes the public’s dissatisfaction with professionals on the professions’ terms: ‘lay’ members of the public are not deemed to have the necessary skills and knowledge to determine whether a professional was acting competently. Davis acknowledges that this may depend on the issues at stake: “a matter which goes to the heart of a professional’s competence or suitability to practise can be very different from a complaint that the service wasn’t quite what the client expected.”⁷⁵

The HPC’s primary focus is not on complaints (which generally concern past conduct) but rather with a professional’s current and future fitness to practise. The results of the 2009 Ipsos MORI study of complainants’ expectations suggest that complainants themselves do not necessarily understand or accept this distinction.⁷⁶ Some had hoped for

⁶⁹ See note 7.

⁷⁰ *Health Professions Council Fitness to Practise Annual Report 2010*, p. 4.

⁷¹ 31 per cent in 2010, compared to 33 per cent from employers and eight per cent from other registrants or professionals, *ibid*, p. 11.

⁷² See for example Adler, M, ‘Tribunal Reform: Proportionate Dispute Resolution and the Pursuit of Administrative Justice’ in *Modern Law Review*, 69, 6, 2006, pp. 958–85; Boyron, S ‘The rise of mediation in administrative law disputes: experiences from England, France and Germany’ in *2006 Public Law*, pp. 319–44; SPSO, 2010.

⁷³ Brewer, B (2007) ‘Citizen or customer? Complaints handling in the public sector’ in *International Review of Administrative Sciences*, 73 (4), 2007, pp. 549–56.

⁷⁴ Davis, M (2010) The demise of professional self-regulation? Evidence from the “ideal type” professions of medicine and law’ in *Professional Negligence*, 26 (1), pp. 3–38, at p. 25.

⁷⁵ *Ibid* (at note 97).

⁷⁶ Ipsos MORI (2010).

remedial action, some sought an informal, mediation approach and one said “I think I thought the HPC were going to sort the whole thing out, really.”⁷⁷ The former Chief Medical Officer for England referred to a shift in society as a whole, with less deference to institutions: “Informed by access to health information that was once the sole preserve of the professions, the public are more likely to challenge received opinion.”⁷⁸

The potential mismatch between complainant expectations and the reality of a fitness to practise process raises important questions for this review.

- Can mediation’s claimed creativity regarding solutions⁷⁹ open up alternative and desirable possibilities for fitness to practice cases?⁸⁰
- Can the HPC endorse proposed outcomes from mediation that it deems useful but which go beyond its current remit?

- At what stage in the fitness to practise process is mediation most usefully placed?
- Is there a place for a regulator to deal with non-fitness to practise matters?

2.2 The public interest

One of mediation’s principal claims is that it supports party self-determination.⁸¹ This raises issues in relation to the public interest, as such an approach within the HPC’s fitness to practise process would seem to place decision-making responsibility in the hands of complainants and registrants. Even if a decision is acceptable to both, it does not absolve the HPC from its duty to protect the public. How might a regulator strike an appropriate balance so that the public interest is protected without losing one of mediation’s most distinctive benefits (self-determination)?

⁷⁷ *Ibid*, p. 32.

⁷⁸ Donaldson, L ‘Introduction’ in *Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century*, 2007, p. 17, available at www.official-documents.gov.uk/document/cm70/7013/7013.pdf

⁷⁹ Menkel-Meadow (1995) (cited at Note 68 above) at pp. 2687–94. Carrie Menkel-Meadow contrasts the law’s limited remedial imagination with mediation’s capacity for a range of creative outcomes.

⁸⁰ The Equalities Mediation Service suggests at least nine potential mediation outcomes: “Apologies; explanations; compensation; changes in policy or procedures; arrangements for return to work or resume a course; references; staff training in disability awareness or equalities and diversity; information being made available in accessible formats; improvements and arrangements for future communication.” See www.adrnow.org.uk/go/SubPage_38.html

⁸¹ For example, the Scottish Mediation Network’s Code of Practice states: “Voluntary participation and self determination: A mediator shall recognise that mediation is based on the principle of voluntary participation and that it is the parties, rather than the mediator, who determine the outcome.” See www.scottishmediation.org.uk/downloads/CodeofPracticeforMediationinScotland.pdf For a fuller discussion of the issues raised by this term see Irvine, C., ‘Mediation’s Values: An Examination of the Values Underpinning Mediation’ (unpublished masters dissertation, University of London, Birkbeck College, 2007), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1686195 ; Welsh, N., (2001) ‘The Thinning Vision of Self-Determination in Court-Connected Mediation: The Inevitable Price of Institutionalization in *Harvard Negotiation Law Review*, 6 (1), 2001, pp. 1–95.

The Health Professions Order 2001 effectively defines the public interest for the HPC:

“The main objective of the Council in exercising its functions shall be to safeguard the health and well-being of persons using or needing the services of registrants.”⁸²

The report *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* provides further detail.⁸³ First and foremost is the “overriding” interest of patient safety and quality of care. Next is impartiality, as the HPC must show that it is “independent of government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare.” Then a balance must be struck between fulfilling the tasks of “sustaining, improving and assuring the professional standards of the overwhelming majority” and “identifying and addressing poor practice or bad behaviour”. Actions need to be proportionate. And finally there is a holistic requirement that the regulatory scheme does all of the above while working to protect the strength and integrity of health professionals within the United Kingdom. Many of these seem to come down to trust: an effective regulator needs to be trusted by the public, employers and the regulated.

Some writers argue that ADR can actually do more to meet the public interest than traditional litigation, which “does not promote effective communication, information

exchange, or learning to improve performance in health care delivery. Importantly, it induces silence by one party who has significant knowledge of direct and indirect factors surrounding the events.”⁸⁴ While the HPC’s hearing system is not the same as litigation, and efforts are made to ensure openness and transparency, its power to ‘strike off’ means it still risks inducing just such a silence in the registrant. Nonetheless, we recognise a significant issue for the HPC: if an allegation is referred to mediation, and if the mediator follows a traditional model seeking to support party self-determination, how can the HPC be assured that its duty to protect the public is also taken into account in the outcome?

One option would be to train mediators in Waldman’s ‘norm-advocating’ style of mediation, where the mediator’s role clearly includes advocating for particular norms: “the mediator not only educated the parties about the relevant legal and ethical norms, but also insisted on their incorporation into the agreement. In this sense, her role extended beyond that of an educator; she became, to some degree, a safeguarder of social norms and values.”⁸⁵

This may be challenging for existing mediators or health professionals trained in a facilitative style of mediation. There is, however, a parallel in the UK: mediators working for the Equalities Mediation Service ensure that outcomes comply with relevant legislation.⁸⁶

⁸² Health Professions Order (2001) Article 3(4).

⁸³ *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* Department of Health, February 2007, paragraph 6, www.official-documents.gov.uk/document/cm70/7013/7013.pdf

⁸⁴ Liang, B, and Small, S (2003) ‘Communicating About Care: Addressing Federal-state Issues in Peer Review and Mediation to Promote Patient Safety’ in *Houston Journal of Health Law and Policy*, 3, pp. 219–64.

⁸⁵ Waldman (1995) p.745; see Section 1.3 above.

⁸⁶ See www.equalities-mediation.org.uk

We encountered another model that may balance safeguarding the public interest with a mediatory process. In Alberta, Canada, the Health Professions Act⁸⁷ requires a representative of the college / profession to which the practitioner belongs to be present during mediation. While this person may be the mediator, they may also act as a separate party. For example, the College of Registered Nurses states:

“The College representative is present to discuss the nursing practice standards, code of ethics or any other nursing information necessary for the process and to assist with appropriate performance improvement based on the nature of the complaint and the admitted behaviours of the registered nurse. As well, the College representative ensures that the public interest is not overlooked in the agreement between the complainant and the registered nurse.”⁸⁸

It is conceivable that a representative of the HPC could fulfil the same role, ensuring that any agreement is in the public interest. The presence of such an individual would also remove the need for the mediator to adopt a ‘norm-advocating’ role, leaving him or her free to facilitate the discussion without a further agenda.

Another way to ensure that the public interest is taken into account would be to require that any agreement reached through mediation be ratified by the regulator. A similar system already exists in relation to ‘Disposal by Consent’, where a registrant agrees to the same kind of measures that a fitness to practise panel would impose, without the need for a hearing. The HPC can only accept such a step, however, where it is satisfied “that:

- the appropriate level of public protection is being secured;
- and doing so would not be detrimental to the wider public interest.”⁸⁹

A similar standard could be applied to mediated outcomes, thus ensuring that the public interest is protected while still avoiding the need for a full hearing.

This discussion raises wider policy questions for the HPC. Liang and Small note that “to continuously promote safe and effective health care, both providers and patients must be active partners and participants in the system of delivery”.⁹⁰ It could be argued that, when the healthcare system fails to meet the highest standards, the public interest will be best served by empowering both deliverers and recipients to participate in steps to learn from such failure and ensure it does not recur.

⁸⁷ Discussed further at Section 3.8 below.

⁸⁸ www.nurses.ab.ca/Carna/index.aspx?WebStructureID=859

⁸⁹ See HPC practice note ‘Disposal of Cases by Consent’, p. 1. Available from www.hpc-uk.org/assets/documents/10002473PRACTICE_NOTE_ConsentOrders.pdf

⁹⁰ Liang and Small (2003) p. 221.

2.3 Face-to-face encounters

An important theme throughout the literature is the significance of a face-to-face meeting between the two people most affected by the problem. In their study of US ADR schemes, Szmania et al noted that “a relatively high importance is placed on open, in-person communication for all the administrators we spoke with”.⁹¹ The Scottish Legal Complaints Commission’s Mediation Manager stated: “when face to face with the person they wanted to ‘beat up’ they realise that this is just another person”.⁹²

2.3.1 Open communication

A study into patient expectations of complaints committees in the Netherlands⁹³ found that only 18 per cent of patients thought that the opportunity to “tell what happened personally” was not important, with 53 per cent rating this as very / most important.⁹⁴ Richardson and Genn note that: “The oral hearing, when well executed, gives the citizen the opportunity to be heard and to observe that they have, indeed, been heard by the tribunal.”⁹⁵

Mediation in the fitness to practise process would aspire to achieve the same result, ensuring that complainants are heard, and know they have been heard, by the registrant about whom they are complaining. It would also help to fulfil the elements of procedural justice:

- ‘voice’ (in that both complainants and registrants would have the opportunity to explain their views, concerns and evidence);
- ‘being heard’ (in that the mediator would be seen to consider these views concerns and evidence); and
- ‘fair treatment’ (in that, assuming mediators follow their own ethical codes, all parties will be treated in a “dignified, respectful manner”).⁹⁶

Procedural justice studies consistently find that citizens’ experience of a procedurally fair process enhances their respect for, and compliance with, the wider justice system,⁹⁷ and it is to be hoped that a similar impact would be seen within the HPC’s fitness to practise process.⁹⁸

⁹¹ Szmania, S, Johnson, A and Mulligan, M ‘Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices’ in *Conflict Resolution Quarterly*, 26, 2008, pp. 71–96 at p. 79.

⁹² Interview with Marjorie Mantle, August 2010, see Appendix.

⁹³ Friele, R, and Sluijs, E, *Patient expectations of fair complaint handling in hospitals: empirical data* (NIVEL, Netherlands Institute for Health Services Research, 2006). Available from BMC Health Services Research, www.biomedcentral.com/1472-6963/6/106

⁹⁴ *Ibid*, Table 1.

⁹⁵ Richardson, G, and Genn, H, ‘Tribunals in transition: resolution or adjudication?’ in *Public Law*, 2007, pp. 116–41; See also Ross and Bain (2010), p.78: “A sense of unfairness or dissatisfaction arose when parties did not get a chance to speak about the merits of the claim early in the case.”

⁹⁶ See discussion in Section 1.4.3 above.

⁹⁷ MacCoun (2005), p. 178.

⁹⁸ This could also have a bearing on an issue identified by the Council for Healthcare Regulatory Excellence on sharing a registrant’s response to the initial complaint with the complainant. See Council for Healthcare and Regulatory Excellence *Performance review report 2009/10 Enhancing public protection through improved regulation July 2010*, available at www.chre.org.uk/_img/pics/library/100806_Performance_review_report_2009-10_tagged.pdf The HPC’s response to this report can be found at www.hpc-uk.org/aboutus/council/councilmeetings_archive/index.asp?id=523

2.3.2 Face-to-face communication

Face-to-face meetings also allow a ‘real time’ interaction:

“[[face-to-face] meetings increase the chances that each party will clearly understand all the points at issue in the case. We know of situations in which, until a face-to-face meeting was held, the parties simply did not understand the opponent's arguments. We must create a climate where there are more opportunities for genuine interaction between the parties. Clarity is the key.”⁹⁹

Genuineness is also important: “all of the issues can be talked through in depth and a resolution may be possible at this stage.”¹⁰⁰

The Medical Protection Society recognises the benefits for all parties – registrant, complainant and regulator:

“Arranging a face-to-face meeting will allow you to clarify the issues from the complainant's point of view [...] You will then have an opportunity to discuss what the complaints process can and can't deliver if the complainant seems to have unrealistic expectations.”¹⁰¹

Relis's study of Canadian medical malpractice mediation forcefully underlines the importance of face-to-face encounters to both ‘sides’: “What pervaded disputants' talk on mediation agendas was their wanting to directly communicate their perspectives, be heard,

seen and understood.”¹⁰² This positive view of direct communication was shared by both plaintiffs and defending physicians.

2.3.3 Conclusion

The evidence suggests that open, in-person communication is one of the most popular features of mediation for its participants. For a proportion of complainants, the opportunity to tell their story and receive an explanation or apology may be all they seek from the fitness to practise process. As well as delivering a procedurally fair process, the use of ADR early in the progress of an allegation may allow some matters to be dealt with swiftly and directly, thereby avoiding the need for further investigation. The HPC, however, would still need to ensure that the public interest is protected and it may be that a ‘triage’ system is advisable,¹⁰³ allowing an early assessment of the likelihood of significant risk to the public if the registrant continues to practice.

Another, related, issue for the HPC to consider is the location of an ADR process, chronologically and geographically. Our review of ADR schemes around the world¹⁰⁴ illustrates that they are mostly used early in the progress of a complaint or problem. The HPC may wish to consider the practical ramifications of local dispute resolution, for example at the point of care. Is this something it could deliver, or might a partner organisation be better placed to intervene at this stage?

⁹⁹ Evans, D, ‘LMAA arbitrations: observations of a user’ in *Arbitration*, 76(3), 2010, pp. 399–404.

¹⁰⁰ Healthcare Commission, *Complaints Toolkit: Handling complaints within the NHS*, March 2008, paragraph 5.6.2, Available at www.chi.gov.uk/_db/_documents/Complaints_Toolkit.pdf

¹⁰¹ The Medical Protection Society, *Guide to Resolving Complaints: The Wider Picture*, p.10. Available at www.medicalprotection.org/adx/asp/adxGetMedia.aspx?DocID=23768,129,127,9698,22,11,Documents&MediaID=6657&Filename=MPS+Resolving+Complaints+booklet_web.pdf

¹⁰² Relis (2009), p. 153.

¹⁰³ Similar to that used by the Scottish Legal Complaints Commission. See Section 3.1 of this report.

¹⁰⁴ See section 3 of this report.

2.4 Apologies

Apologies feature prominently in the complaints handling literature, as well as in the HPC's own research.¹⁰⁵ This section looks at the need for apology, how and where it can fit into complaints-handling procedures and its application to the HPC. While there is considerable discussion about the definition of apology, for present purposes a common-sense (and borrowed) definition is useful:

“an expression of sympathy or regret, a statement that one is sorry or any other words or actions indicating contrition or commiseration, whether or not the words or actions admit or imply an admission of fault in connection with the matter to which the words or actions relate.”¹⁰⁶

2.4.1 Do complainants need an apology?

Harris and Riddell note some controversy about this:

“In terms of what people want, some might merely want an apology whereas some will want an authoritative decision; and some will want formal resolutions, while others have a preference for informal resolutions.”¹⁰⁷

¹⁰⁵ SPSO (2010), p. 12; Ipsos MORI (2010), p.21.

¹⁰⁶ British Columbia, Canada: Apology Act 2006 s.1.

¹⁰⁷ Harris, N, Riddell, S, and Smith, E, *Special Educational Needs (England) and Additional Support Needs (Scotland) Dispute Resolution Project Working Paper 1: LITERATURE REVIEW*, Centre for Research in Education, Inclusion and Diversity, University of Edinburgh, 2008, available from <http://www.creid.ed.ac.uk/adr/index.html>; See also *What do people want? From Transforming Public Services Complaints, Redress and Tribunals* (Department for Constitutional Affairs, 2004): “The outcome that people are looking for will vary considerably from case to case and person to person. A key question will be the extent to which people are looking (just) for a legal remedy, like an award of a disability benefit. Or whether they might really be seeking something else, like an apology or a clear explanation.”

¹⁰⁸ Ipsos MORI (2010), p. 21.

¹⁰⁹ Relis (2008), p. 142.

¹¹⁰ See Galanter, M, ‘The Vanishing Trial: An Examination of Trials and Related Matters in Federal and State Courts’ in *Journal of Empirical Legal Studies*, 1, 3, 2004, pp. 459–570. This highlights the stark contrast, in the USA at least, between public perception of a ‘litigation explosion’ and the reality of a steady decline in the number of trials.

¹¹¹ Vines, P, ‘Apologies and civil liability in the UK: a view from elsewhere’ in *Edinburgh Law Review*, 12, 2, 2008, pp. 200–30 at p. 204.

However, other studies have found apology frequently featuring as both a goal and outcome of ADR programmes, suggesting it must have some importance to those involved. The HPC's own report on complainants' expectations lists apology as one of the hopes expressed for mediation.¹⁰⁸ Relis' study found that 94 per cent of medical negligence plaintiffs sought an admission of fault in mediation, with 88 per cent specifically wanting an apology.¹⁰⁹

2.4.2 Why (not) apologise?

The apology appears to have suffered from the increase and (more significantly) the perceived increase in litigation,¹¹⁰ insurance contract clauses and the associated fear of liability. Vines uses the term ‘mischief’ to describe the assumptions leading to the fear of, and therefore avoidance of, apologising. This has a “significant and unwelcome impact on civil society.”¹¹¹ Vines summarises the impact as follows.

- We now live in a litigious compensation culture, a “culture of blame in which people no longer take responsibility for themselves”.

- Apologies amount to admissions, deemed to create liability by the courts and resulting in insurers having to pay claims.
- Apologies can still void an admissions / compromise clause in an insurance contract, rendering the person apologising liable without recourse to insurance.
- Apologising is seen as a mistake – “apologies are so prejudicial that they automatically tend to attract liability.”

However, Vines also notes that apologies are a “social mechanism”, with a “healing and re-balancing function for both victim and relationship, and often for the offender as well.”¹¹² Apologies may thus have a corrective role in transferring the humiliation of harm from the harmed to the apologiser. Schneider describes this as the “exchange of shame and power”.¹¹³ In contrast, Jesson and Knapp present a more instrumental view of apologies, potentially robbing them of their sincerity and therefore value.¹¹⁴ It is clear that not all apologies are the same, so we now turn to the question of their quality.

2.4.3 What makes a ‘good’ apology?

The General Dental Council’s Principles of Complaints Handling includes the advice to “Offer an apology and a practical solution where appropriate. Remember that an apology does not mean you are admitting responsibility.”¹¹⁵

This somewhat contradictory advice suggests the making of a ‘non-apology apology’. In Vines’ view: “An apology does not exist unless the person who is expressing regret is also taking responsibility for a wrong which they have committed.”¹¹⁶ Anything less is only a ‘partial apology’ and there is some evidence that these are counter-productive, negatively affecting the complainant’s view of the dispute.

The elements of disclosure, apology, lesson-sharing and implementing may be expressed without using the term apology. For example, the Australian Commission on Safety and Quality in Healthcare’s ‘Open Disclosure Standard’ talks of:

- an expression of regret;
- a factual explanation of what happened;
- the potential consequences; and
- the steps being taken to manage the event and prevent recurrence.

¹¹² Vines (2008), p. 206.

¹¹³ Schneider, C, ‘What it Means to be Sorry: The Power of Apology in Mediation’ in *Mediation Quarterly*, 17 (3), 2000. Available at www.mediationmatters.com/Resources/apology.htm

¹¹⁴ Jesson, L and Knapp, P, ‘My Lawyer Told Me to Say I’m Sorry: Lawyers, Doctors, and Medical Apologies’ in *William Mitchell Law Review*, 35, 4, 2009, pp.1410–56 at p. 1421.

¹¹⁵ www.gdc-uk.org/NR/rdonlyres/DC7DE443-B616-437E-B13B-0C014B9F5D73/0/ComplaintsHandling.pdf, p. 10.

¹¹⁶ Vines, P, ‘The Power of Apology: Mercy, Forgiveness or Corrective Justice in the Civil Liability Arena?’ in *Public Space: The Journal of Law and Social Justice*, 1.5, 2007, pp. 1–51 at p. 8. This article highlights the difficult overlap between a moral and legal wrong.

This standard provides a 40-page guide for what is essentially the mandated way to apologise in order to support the overarching aim:

“In working towards an environment that is as free as possible from adverse events, there is a need to move away from blaming individuals to focussing on establishing systems of organisational responsibility while at the same time maintaining professional accountability.”¹¹⁷

The NHS’s National Patient Safety Agency’s ‘Being Open: Saying sorry when things go wrong’ guidelines offer similar advice:

“‘Being open involves:

- acknowledging, apologising and explaining when things go wrong;
- conducting a thorough investigation into the incident and reassuring patients, their families and carers that lessons learned will help prevent the incident recurring;
- providing support for those involved to cope with the physical and psychological consequences of what happened.”¹¹⁸

And finally, the NHS Education for Scotland (NES) practice note ‘The Power of Apology’ provides simple advice using ‘three Rs’:

- “Regret – Meaningful, real, acknowledge wrongdoing; Just say sorry; Accept responsibility
- Reason – Be honest – doesn’t mean you will be sued; Unintentional and not personal; Trying hard to do the right thing
- Remedy – Next steps – who will do what; Investigate to find out why; Provide feedback”¹¹⁹

A number of countries have considered the potential of apologies in rectifying past wrongs. The National-Audit-Office-commissioned document, *Handling Complaints in Health and Social Care: International Lessons for England*,¹²⁰ looked at the healthcare regulatory regimes of ten countries including England. It found that approaches ranged from placing apology centre stage to no mention at all.

¹¹⁷ [www.health.gov.au/internet/safety/publishing.nsf/Content/B892340AE79ACA88CA25775B00005B0F/\\$File/OD-Standard-2008.pdf](http://www.health.gov.au/internet/safety/publishing.nsf/Content/B892340AE79ACA88CA25775B00005B0F/$File/OD-Standard-2008.pdf); This is echoed in some US schemes for dealing with ‘adverse events’. See, for example, Michigan University Health Service, as described in Boothman et al (2010); Kaiser Permanente’s MedicOm scheme, described in Houk, C., and Edelstein, L. (2008) ‘Beyond Apology to Early Non-Judicial Resolution: The MedicOm Program as a Patient Safety-Focused Alternative to Malpractice Litigation’ in *Hamline Journal of Law and Public Policy*, 29, Fall 2007, pp. 411–22; See also Moody in www.roughnotes.com/rnmagazine/2005/november05/11p124.htm

¹¹⁸ NHS National Patient Safety Agency, *Being Open: Saying sorry when things go wrong*, 2009. Available from the National Reporting and Learning Service at www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=65172&type=full&servicetype=Attachment

¹¹⁹ NHS Education for Scotland ‘The Power of Apology’ in *Focus*, Spring 2010, Available at www.nes.scot.nhs.uk/media/649655/apology%20spring%20focus%202010.pdf

¹²⁰ Lister, G, Rosleff, F, Boudioni, M, Dekkers, F, Jakubowski, E and Favelle, H, *Handling Complaints in Health and Social Care: International Lessons for England*, National Audit Office, 2008). Available at http://www.nao.org.uk/publications/0708/learning_from_complaints.aspx

2.4.4 The place of apology in ten healthcare regulatory regimes

(references are to Lister et al, 2008)

Northern Ireland	Local Resolution, followed by Independent Review and finally referral to an Ombudsman with apology encouraged, but fear of apology evident (pp. 5–6)
Scotland	In Health and Social Care Complaints apology more obviously encouraged, as part of redress and response to complaints (pp. 8 and 10)
Wales	Apology is similarly part of response and redress (p.12)
Australia	Open Disclosure standard and statutory exclusion of liability means apology is heavily encouraged and protected. Local Resolution, followed by referral to the complaints agency for assessment, investigation and / or further review, means ample opportunity for apology to come in (pp. 14–15)
Canada	Processes include mediation, giving space for apology with particular focus on explanation of lessons learned (pp. 17 and 19)
Denmark	Processes of aided local resolution followed by arbitration supports the opportunity for apology (pp. 20–22)
Germany	Fragmented system, so that “Apology is one outcome of complaint procedures that is difficult to achieve” (p. 25)
New Zealand	Outcomes from assessment and investigation include apology with focus of learning lessons from the incident (pp. 26–28)
The Netherlands	Complaints Committees with transparent hearings highlighting lessons that should be learned. Apology was not overly evident (pp. 29–31)

2.4.5 Apology in the HPC

The HPC's own approach to apologies is likely to influence the possibility of their occurrence. If panels view them as evidence against a professional (framing them as an admission of wrongdoing or poor practice) then the culture may work against apology even in a mediatory process. If, on the other hand, they look on professionals' apologies favourably (as illustrating that the registrant has shown insight into his or her part in the problem, explained it, apologised for it and recognised lessons that can be learned) apologies may be more readily offered. The HPC's Indicative Sanctions Policy is helpful:

"6. Even if a Panel has determined that fitness to practise is impaired, it is not obliged to impose a sanction. In appropriate cases, a Panel may decide not to take any further action, for example, in cases involving minor, isolated, lapses where the registrant has apologised, taken corrective action and fully understands the nature and effect of the lapse."¹²¹

This supports the possibility of full apology. An early face-to-face encounter, as in mediation, may also make an apology more likely to occur and be perceived as genuine.¹²²

Recent hearings provide evidence of hearing committees' attitudes to apologies. For example, in a hearing for a radiographer, the lack of an apology was an aggravating factor in the sanction discussions: "the registrant has neither provided plausible explanation for the phone call nor offered any apology for the upset caused to Patient A."¹²³

The case of a biomedical scientist indicated that panels can recognise partial apology and its limitations: "While the registrant has made a general type of apology, she has qualified this by stating 'she finds it difficult to apologise for something which she cannot remember'. The Panel find that this demonstrates a lack of insight into how inappropriate her conduct was about a professional colleague."¹²⁴

A full apology by another radiographer was seen as a mitigating factor: "The Panel was satisfied that she has shown clear insight into these incidents, has expressed her regrets and has made an unqualified apology."¹²⁵

¹²¹ HPC Indicative Sanctions Policy, 2009. Available at www.hpc-uk.org/assets/documents/10000A9CPractice_Note_Sanctions.pdf

¹²² SLCC's Marjorie Mantle believes a later apology is of less value: "If an apology hasn't been made by either party by then, I feel it would be unlikely to be genuine if made post-investigation", Mantle, 2010, p. 4.

¹²³ Monday 16 August 2010.

¹²⁴ Thursday 15 July 2010.

¹²⁵ Thursday 12 February 2009.

2.4.5 Conclusion

The National Patient Safety Authority states: “It is important to remember that saying sorry is not an admission of liability and is the right thing to do.”¹²⁶ It may be helpful for the HPC similarly to recognise apology as a first element of local resolution. If, in response to a complaint, the registrant can acknowledge the harm caused, express regret and take steps to prevent it recurring, it is likely that a proportion of complainants will wish to take no further action. This corresponds closely to ‘frontline resolution.’¹²⁷ It also chimes well with the HPC’s existing emphasis on ‘insight’ as a key indicator of a registrant’s capacity to address failings.¹²⁸

2.5 Confidentiality and privilege

One of the perceived benefits of the mediation process is its confidential nature. Yet, despite often glib assertions by mediators, the issue of confidentiality and privilege is complex and uncertain.

The legal term ‘privilege’ refers to evidence that is not available for use in court proceedings, and applies to communications between lawyer and client. In Scotland there is no suggestion that this principle will apply to mediators,¹²⁹ while in England and Wales the question remains very much open.¹³⁰ However, it seems that the courts will treat mediation discussions as confidential in the same way as contractual negotiations, but subject to the same limited exceptions that apply to other ‘without prejudice’ negotiations.¹³¹

At the same time, recent case law from England and Wales suggests that mediation’s confidentiality can no longer be assured. In order to tackle the perceived increase in the ‘tactical’ use of mediation some cases have ruled that where parties behave in an unreasonable fashion within mediation, thus stifling opportunities for settlement, evidence to this effect may be led in court to allow cost sanctions to be applied.¹³²

¹²⁶ National Patient Safety Agency, *Being Open*, 2009. Available at www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=65170&type=full&servicetype=Attachment

¹²⁷ See Section 4.2.1 below.

¹²⁸ HPC practice note on Disposal of Cases by Consent, p. 1.

¹²⁹ See the discussion in: Scottish Law Commission, *Discussion Paper No. 92*, 1991, paragraphs 1.3 and 2.1.

¹³⁰ *Brown v Rice & Patel* (ADR Group intervening) unreported, [2007] EWHC 625, per Deputy Judge Isaacs QC at para [20]. The limited evidence for such a common law principle led the Scottish Law Commission to propose statutory intervention in the area of family mediation, manifest in the Civil Evidence (Family Mediation) (Scotland) Act 1995.

¹³¹ Including unequivocal admissions or statements made – see *Cutts v Head* 1984 Ch. 290; *Daks Simpson Group Plc v Kuiper* 1994 SLT 689 or where fraud, impropriety or misrepresentations in the negotiations are alleged – see *Unilever v Proctor and Gamble* [2001] 1 AE 783.

¹³² *Earl of Malmesbury v Strutt and Parker* [2008] EWHC 424 (QB); *Carleton v Strutt & Parker (A Partnership)* [2008] EWHC 616 (QB). This view is consistent with Civil Procedure Rule 1.4(2)(f) which states that parties and their representatives must “ensure that their conduct within proceedings assists the court in furthering the overriding objective, or rather that aspect of it which require to court to help the parties settle the whole or part of their case.”

Similarly, parties to mediation were ordered to disclose to the court certain documents furnished in the course of mediation discussions to allow the court to assess the level of damages in a subsequent case.¹³³ Finally, in the case of *Brown v Patel*¹³⁴ the court allowed evidence of parties' conduct at a mediation to ascertain if the case had settled or not.

These decisions represent something of an about face on the part of the judiciary: English judges in the past took the view that the court should not enquire into the reasons why mediation had failed.¹³⁵ There is a risk that rendering mediation more porous in this way will undermine parties' faith in the process.¹³⁶ The situation may be clarified shortly, however, as the recent European Directive on Mediation requires the UK to clarify its arrangements regarding the confidentiality of the mediation process.¹³⁷

Given the current uncertainty regarding confidentiality, it may be helpful for the HPC to clarify the position with regard to mediation within the fitness to practise process.¹³⁸ This may require it to seek an extension of its statutory powers. Nonetheless, we consider there to be significant benefit from a clear statement by the HPC that the contents of a mediatory process shall be confidential. It would also be useful to clarify for registrants the HPC's attitude towards apologies.

¹³³ *Cattley v Pollard* 2007 Ch. 353.

¹³⁴ 2007 EWHC 625.

¹³⁵ *Fusion Interactive v Venture Investment Placement* [2005] EWHC 736.

¹³⁶ For a useful discussion see Wood, W., 'When Girls go Wild: The debate over mediation privilege' in online publication *The Mediator Magazine*. Available at www.themediatormagazine.co.uk/features/13-expert-briefings/46-mediation-privilege (accessed 30 August 2010).

¹³⁷ Directive 2008/52/EC, 2008 OJ L 136/3, article 7. This Directive places a number of obligations on member states to support cross-border mediation. These include taking measures to ensure: the quality of mediators, the enforceability of mediation outcomes and the confidentiality of mediation proceedings.

¹³⁸ See, for example, the Equalities Mediation Service's assurance about confidentiality: www.equalities-mediation.org.uk/faq/#24

3 Comparative perspectives

Here we consider a range of models. The HPC hoped to find rigorous evaluations of the use of ADR in the regulation of health professionals. Looking around the world these seem rather rare.¹³⁹ We have therefore expanded this review to include both parallel processes; the use of ADR in other settings, and in parallel subject areas (ie other facets of complaints-handling in healthcare). The ADR literature contains considerably more description than evaluation and we have referred to these studies where appropriate. We also echo Menkel-Meadow's recent note of caution when she identified four difficulties in assessing empirical studies of ADR processes:

- lack of clarity about what each process actually is;
- problems in developing comparable cases;
- the virtual impossibility of using true experimental design where the same dispute is subject to different conditions; and
- “the continually changing and open nature of the field itself (through innovations, hybridization and locations in different legal systems and cultures)”.¹⁴⁰

Subject to these caveats, we describe below some of the settings where ADR has been embraced.

3.1 Scottish Legal Complaints Commission

Disquiet with self-regulation by the Scottish legal profession led to the setting up of the Scottish Legal Complaints Commission (SLCC).¹⁴¹ Something of a half-way house, SLCC acts as the gateway for all complaints about legal practitioners while the relevant professional bodies retain disciplinary responsibility for professional misconduct.¹⁴² Its first stage involves sifting the complaints and rejecting those that are frivolous, vexatious or late.

Its second step involves a further sift. One of the scheme's innovations is to subdivide complaints into two types, each pursuing a different route. 'Service' complaints relate to “the quality of work a practitioner has carried out, or which you think should have been carried out, during the course of a transaction”.¹⁴³ 'Conduct' complaints concern “a practitioner's behaviour, their fitness to carry out work and how they have behaved either in carrying out a transaction or outside of business.”¹⁴⁴

¹³⁹ Linguistic limitations on the part of the researchers have contributed to a strong focus on English-speaking and European examples. There may be examples from further afield of which we are unaware.

¹⁴⁰ Menkel-Meadow, C, 'Empirical Studies of ADR: The Baseline Problem of What ADR is and What It is Compared to' in Cane, P, and Kritzer, H (eds.) *Oxford Handbook of Empirical Legal Studies* (forthcoming 2010 at time of writing), p. 2.

¹⁴¹ Legal Profession and Legal Aid (Scotland) Act 2007.

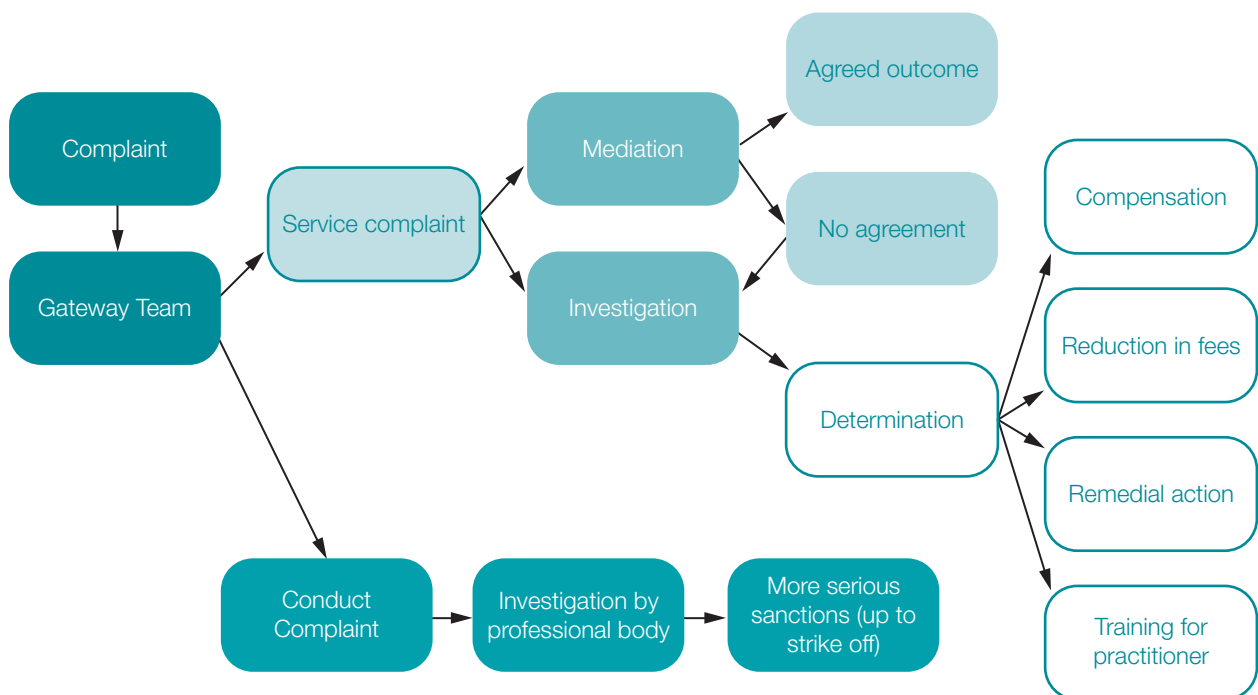
¹⁴² The Law Society of Scotland and the Faculty of Advocates.

¹⁴³ www.scottishlegalcomplaints.com/how-to-complain.aspx#Service%20Complaint See also the Law Society of Scotland's definition: “the service a client can expect from a firm of solicitors or an individual solicitor. Typically these include service issues such as delivering on commitments and using clear language to communicate.” From the Standards for Scottish Solicitors, available at www.laws Scot.org.uk

¹⁴⁴ *Ibid.* The Law Society's definition refers to “the behaviour of the individual solicitor. These include acting with integrity and honesty and not working for two or more clients where there is a conflict between those clients”.

The ‘Gateway Team’ thus plays a critical role in dealing with complainants and in signposting the mediation scheme.¹⁴⁵ If a complaint is deemed to concern ‘conduct’ SLCC has little further involvement and an investigation is carried out by the relevant professional body. However, for complaints about ‘service’, SLCC offers both mediation and investigation. The process is illustrated in the diagram below.

Figure 2 – Complaints Process: Scottish Legal Complaints Commission



Prior to formal investigation, both complainants and practitioners are offered the option of mediation. The motivation for this was to encourage local resolution of complaints while preventing matters that could be resolved from going on to formal investigation.¹⁴⁶ The Act also created the position of Client Relations Partner within solicitors’ firms to strengthen and improve internal complaints procedures.

While not a health regulator, SLCC is one of the few bodies across the Western world to have made mediation a **default** step in its complaints process. And although it only came into being on 1 October 2008, it has begun publishing statistics on the uptake and effectiveness of mediation. We therefore conducted a face-to-face interview with its Mediation Manager, Marjorie Mantle.¹⁴⁷

¹⁴⁵ Similar to the ‘triage’ idea suggested at Section 2.3.3 above.

¹⁴⁶ Scottish Executive, *Reforming complaints handling, Building consumer confidence: Regulation of the Legal Profession in Scotland*, 2005. Available at www.scotland.gov.uk/Publications/2005/05/09103027/30369 .

¹⁴⁷ Reproduced in full in the appendix to this Report, cited as Mantle, 2010.

Mantle raises a number of issues of importance to the HPC. The first is of great practical significance: how to ensure that mediation is used or at least considered with an open mind by both or all parties. This is an issue that has dogged the ADR movement since the revival of interest in mediation in the 1970s.¹⁴⁸ SLCC's own statistics tell a typical story. Participants tend to hold very positive views once they have experienced mediation¹⁴⁹ and yet a large proportion reject it.¹⁵⁰ Mantle stresses the importance of the coordinator role in addressing this issue: "This is not just a matter of sending out letters, but of conveying the values of mediation, particularly to the Client Relations Partners. Of course I also have to convey that even-handedness to the complainers."¹⁵¹ She also tells of a slow start, followed by a more recent increase as the legal profession comes to believe that mediation is even-handed, or perhaps simply gets used to the idea. However, she acknowledges that the bulk of her promotional efforts have been targeted at the legal practitioners, in spite of the fact that it is complainants who reject

mediation in higher numbers, citing the simple impracticality of educating all of the public. It is possible that the HPC is better placed to accomplish the latter task given its size and profile.

A second, related, issue concerns complainants' motivations. In contrast to some findings from the health and education sectors,¹⁵² Mantle believes that a majority of those who complain about legal practitioners "want the solicitor 'punished'. A minority want the problem solved with the minimum of fuss."¹⁵³ It might be expected that mediation would disappoint this group, but Mantle was upbeat about its effects: "However, and this is the benefit of mediation, when face to face with the person they wanted to 'beat up' they realise that this is just another person."¹⁵⁴ The key phrase 'face-to-face' runs like a thread through the literature we reviewed.¹⁵⁵ This suggests that, even where people enter a complaints process with little expectation or desire for reconciliation, the force of a direct encounter with the other person should not be underestimated.

¹⁴⁸ See the consideration of 'Benign neglect' at Section 4.3 below.

¹⁴⁹ 31 out of 34 respondents said they would recommend mediation to others, and 26 rated it as excellent (15) or very good (11). See Mantle, 2010.

¹⁵⁰ Out of 141 cases where mediation was suggested, it had been rejected in 98 (by both parties – 8; by practitioner – 28; by complainant – 62). See Mantle, 2010.

¹⁵¹ *Ibid.*

¹⁵² Harris and others, cites both Genn (1999) and Gulland (2007) in asserting that "people simply wanted to solve the problem rather than secure any punishment, revenge or an apology and so they wanted routes to redress that were quick, cheap and stress-free", Harris and others (2008), p.33.

¹⁵³ Mantle, 2010.

¹⁵⁴ *Ibid.*

¹⁵⁵ See Section 2.3.2 above. In one US scheme 'face-to-face meeting' was listed as a form of ADR, see Szmania, S, Johnson, A and Mulligan, M, 'Alternative Dispute Resolution in Medical Malpractice: A Survey of Emerging Trends and Practices' in *Conflict Resolution Quarterly*, 26, 2008, pp. 71– 96 at p. 73; see also Moody, M, (2005) www.roughnotes.com/rnmagazine/2005/november05/11p124.htm

A third insight from Mantle concerned speed. In her view mediation works best when the face-to-face encounter happens relatively quickly after the events leading to the complaint. This would confirm conventional wisdom that sees a mediatory approach as a first and early step in a complaints resolution process.

Finally, Mantle discusses the success of mediations. Settlement was achieved in 21 out of 35 cases (60%). When asked what forces might work against settlement she speculated on the lack of a ‘down side’ for the complainant. While the costs to legal practitioners increase the further into the investigation process they go, there is no cost to complainants. If their goal is punishment there is little incentive to resolve matters at mediation. Charging complainants for an unsuccessful investigation may modify this effect, but could have the unwelcome consequences of dissuading complainants with a valid complaint and limited resources.

This touches on the goals of a mediatory approach. It seems well suited to allow the following to take place: explanation, apology, a chance to talk about the impact of the event and plans to prevent its recurrence.¹⁵⁶ However, when outcomes are framed in more instrumental terms, such as diversion or settlement, it can look less successful. It is therefore important to resolve in advance the criteria by which a mediation scheme will be judged.

The above outcomes may be particular to complaints against lawyers,¹⁵⁷ with their understandable focus on adversarialism and monetary outcomes. The HPC’s fitness to practise process focuses on the registrant’s “health and character, as well as the necessary skills and knowledge, to do their job safely and effectively”.¹⁵⁸ Such matters can be discussed in a mediation process, but the list highlights the potential importance of having a representative of the HPC present to ensure that the public interest is protected in any agreements that are made. It should be noted that SLCC’s scheme, with its distinction between ‘service’ and ‘conduct’ complaints, does not provide an exact comparison with the HPC.

The SLCC scheme raised some useful questions for the HPC.

- Could there be some equivalent for the HPC of the distinction between ‘service’ and ‘conduct’ complaints?
- Would the HPC wish to reserve mediation for less serious matters? What would be the benefits and disadvantages?
- What is the most useful point in the fitness to practise process for mediation to take place?
- If the HPC favours a mediatory approach, how can it ensure that this option is properly considered by both complainants and registrants, as in the SLCC model?

¹⁵⁶ Szmania et al, 2008, p. 73.

¹⁵⁷ See Relis, T, *Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties* (Cambridge: Cambridge University Press, 2008).

¹⁵⁸ *Health Professions Council Fitness to Practise Annual Report 2009*, p. 4.

3.2 Disciplinary processes for other UK professions

It is also helpful to consider other UK professions. ADR is rather rare in dealing with complaints against members, with most adopting more traditional disciplinary proceedings following breaches of a code of conduct. Some examples are described below.

The Chartered Institution of Building Services Engineers¹⁵⁹ complaints procedure focuses on their code of conduct. A disciplinary panel determines whether there is a cause for sanction, with the power to censure, suspend or expel its members.

The Chartered Institute of Arbitrators¹⁶⁰ focuses strictly on misconduct. Complaints in the first instance are made to the legal department, which then offers the practitioner an opportunity to comment before the Professional Conduct Committee adjudicates.

The Institute of Chartered Accountants in England and Wales (ICAEW)¹⁶¹ has embraced ADR as part of the process when the “professional and ethical standards of our members and firms do not meet the reasonable expectations of the public and other members.” Complainant led local resolution is preferred as a first stage, with the ICAEW stepping in where this fails. Cases are sorted initially, with 60 per cent proceeding.

Cases closed at this stage mostly seem to be fee disputes, for which a voluntary arbitration scheme is suggested. If a case is not a disciplinary matter, the ICAEW will suggest independent mediation or, again, arbitration. Disciplinary cases are dealt with in one of two ways. Conciliation is offered where the firm or member could do something to address the complaint, ie return withheld records. If unsuccessful or rejected, an investigation allows the ICAEW to take disciplinary action itself.

The Civil Mediation Council’s Complaints Resolution Service¹⁶² is, perhaps unsurprisingly, based on informal mediation by the member him / herself. If this fails, the matter may be referred to the CMC for resolution by mediation.

The General Medical Council’s (GMC) complaints resolution procedure strictly follows the fitness to practise model.¹⁶³ There is a preference for first contact to be locally made, but if this is unsuccessful the complaint may be escalated by approaching the GMC. Cases are screened to determine if they are relevant to fitness to practise then, if considered serious enough for a hearing, adjudication is made.

¹⁵⁹ www.cibse.org/index.cfm?go=page.view&item=1058

¹⁶⁰ www.ciarb.org/information-and-resources/membership-rules-and-regulations/how-to-make-a-complaint/

¹⁶¹ www.icaew.com/index.cfm/route/139178/icaew_ga/en/Home/Protecting_the_public/Complaints_process/Complaints_process

¹⁶² www.civilmediation.org/page.php?page=2

¹⁶³ www.icaew.com/index.cfm/route/139178/icaew_ga/en/Home/Protecting_the_public/Complaints_process/Complaints_process

3.3 USA

The USA has one of the most developed ADR sectors in the world.¹⁶⁴ Since coming to prominence in the 1970s ADR, and in particular mediation, is being used in numerous settings such as family, neighbourhood, employment, environmental disputes, education, business and civil court.¹⁶⁵ A recent survey found that 140 out of 151 US law schools offered courses in ADR.¹⁶⁶ And in 2008 Relis could say that lawyers in America were “at an advanced stage of acceptance of mediation per se during formal legal processes”.¹⁶⁷

Medical malpractice has provided ripe territory for the use of ADR, and we review a number of schemes. When it comes to the regulation of professionals, however, we were unable to locate any US reference to the use of mediation. Litigation is the default way to hold healthcare professionals accountable. This has one advantage for our study: improvements brought about by the introduction of ADR schemes are readily measurable in terms of litigation rates or settlement rates. While it might be thought that these schemes would focus largely on fault and financial liability,

organisations also stress the contribution of an ADR approach to improving patient safety through systemic quality improvement. For example:

“Saving litigation costs was a side-effect rather than a motivating cause for Kaiser Permanente’s leadership [...] the program was put in place [...] to help ensure that their members’ quality-of-care concerns are addressed in a timely, empathetic and honest manner.”¹⁶⁸

Szmania et al¹⁶⁹ studied a number of organisations offering medical malpractice ADR. They found a broad range of ADR processes in use, most frequent being “opportunity to tell one’s story”, followed by facilitating apologies, facilitating explanations, mediation, assurances that the error would not happen again and face-to-face interaction.¹⁷⁰ Typical ADR programme goals were: early intervention, diffusion of anger, reduction in costs, untangling entrenched positions, preserving doctor-patient relationships and ‘early settlement’.¹⁷¹ Most frequent outcomes included explanation and apology, with monetary settlement somewhat less common.

¹⁶⁴ Although China claims to have 4.9 million mediators. Chinese Ministry of Justice (<http://english.sina.com/china/2010/0828/336569.html>)

¹⁶⁵ For a review of the field see Jones (ed.) ‘Conflict Resolution in the Field: Assessing the Past, Charting the Future’ in *Conflict Resolution Quarterly*, 22 (1&2), 2004.

¹⁶⁶ Lande, J, and Sternlight, J, ‘The Potential Contribution of ADR to an Integrated Curriculum: Preparing Law Students for Real World Lawyering’ in *Ohio State Journal on Dispute Resolution*, 24 , 2010, pp. 249–96, note 101.

¹⁶⁷ Relis (2008), p. 82.

¹⁶⁸ Houk and Edelstein (2008) p. 422; See also Dauer and Marcus, E, (1997) ‘Adapting Mediation to Link Resolution of Medical Malpractice Dispute with Health Care Quality Improvement’ in *Law and Contemporary Problems*, 60, pp. 185–218; Szmania and others (2008); Boothman and others (2009).

¹⁶⁹ Szmania and others (2008).

¹⁷⁰ *Ibid*, p. 79.

¹⁷¹ *Ibid*, p. 79.

The success rate of the schemes was around 90 per cent.¹⁷² The authors made a comparison between medical malpractice ADR and victim-offender mediation,¹⁷³ suggesting that in both settings victims can find a way to gain control of their vulnerability. Significant cost savings were also noted when hospitals introduced an “interest-based, collaborative approach to claims management” with one reporting savings of \$52,000 per case.¹⁷⁴

Boothman et al studied one institution’s efforts to manage the apparently inexorable rise in medical malpractice claims. The University of Michigan Health Service sets out to deal with potential claims by being transparent with patients and their families, apologising immediately if fault clearly lay with the healthcare team, always offering an explanation while robustly defending ‘medically reasonable’ decisions. Every potential claim is reviewed by an experienced member of staff. While not strictly speaking a form of ADR, the scheme does provide evidence that an open, transparent approach to complainants can pay dividends: from 2002 to 2007 the number of open claims dropped from 220 to 83, the average claim processing time had dropped from 20.3 months to under eight and litigation

costs had halved.¹⁷⁵ The study also reports significant medical improvements as a result of the scheme, hypothesising that a move away from ‘defend and deny’ allowed hospitals to understand and act on insights from unexpected incidents.

The USA Medicare system had an annual budget of \$486 billion in 2009.¹⁷⁶ A substantial quality improvement programme was initiated in 2004¹⁷⁷ and one of its innovations was to enable Quality Improvement Organizations (QIO’s) to offer mediation in place of the traditional review process.¹⁷⁸ In proposing the use of mediation in Medicare one writer suggested it would rest upon a “basic assumption of patient competency and personal power.”¹⁷⁹ In common with a number of mediation schemes, there is a preliminary sift so that the more serious matters go straight to investigation. Those designated “no substantial improvement opportunities identified” or “the care could reasonably have been expected to be better” can go on to mediation.¹⁸⁰ The process is outlined over the page.

¹⁷² *Ibid*, p. 81.

¹⁷³ Now known in the UK as restorative justice; see Section 4.2.5 below.

¹⁷⁴ Szmania and others (2008), p. 77.

¹⁷⁵ Boothman and others (2009), p. 144.

¹⁷⁶ President’s Fiscal Year CMS 2009 Budget Request. Available at www.hhs.gov/asl/testify/2008/02/t20080214a.html

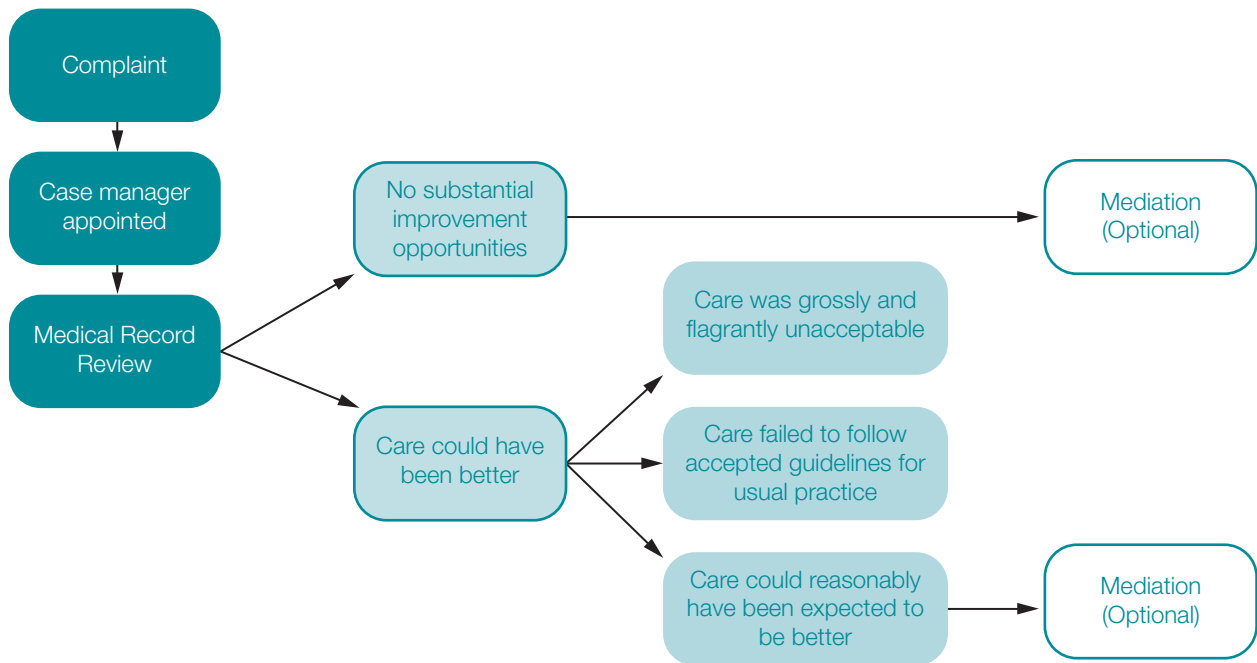
¹⁷⁷ *Medicare’s Quality Improvement Organization Program: Maximizing Potential (Series: Pathways to Quality Health Care)*, 2006. Available from www.nap.edu/catalog/11604.html

¹⁷⁸ *Ibid*, p. 308.

¹⁷⁹ Bernard, P ‘Mediating with an 800 pound gorilla’ in *Washington and Lee Law Review*, 60, 2003, pp. 1417–59 at p. 1450.

¹⁸⁰ *Medicare’s Quality Improvement Organization Program* (see note 177), p. 308. See also *Mediation: A New Option for Medicare Beneficiaries* Available from www.cms.gov/BeneComplaintRespProg/Downloads/3a.pdf

Figure 3 – Complaints process for Medicare beneficiaries



Although mediation was not evaluated separately from changes to the overall case review programme (which now includes a mediation step), taken as a whole, user-satisfaction with the outcome of a case review had gone from 39 per cent to 60 per cent in the course of one year.¹⁸¹

A number of private insurers have also incorporated mediation into their complaints processes, most notably Kaiser Permanente (KP).¹⁸² KP is a not-for-profit healthcare organisation, providing hospitals, physicians and health insurance, and its preferred model has been to appoint ‘medical ombudsman / mediators’.

As the title suggests, these full-time employees have a role in dealing with difficulties as soon as an ‘adverse event’ occurs, sometimes meeting patients and their families the same day. They can spend several weeks preparing for a mediation and when it occurs they have a mandate to include a wide range of parties including physicians, hospital administrators, risk managers and insurers as well as patients and their families. If a mistake has been made compensation will be offered, but the emphasis is very much on continuous improvement, incorporating lessons learned into future provision.¹⁸³

¹⁸¹ *Ibid*, p. 320. The survey compared the traditional case review system with a new system which included a mediation option. From April 2003 to July 2004, there were 3,378 beneficiary complaint cases, of which 357 entered the mediation process.

¹⁸² Houkand Edelstein (2008).

¹⁸³ Private conversation with Lois Kaye, medical ombudsman / mediator with Kaiser Permanente in Oakland, CA, on 4 September 2010.

The ‘medical ombudsman / mediator’ has much to commend it. However, its focus on wider systemic learning may render it less applicable in the HPC context, where the principal focus is on individual registrants’ competence.

3.4 UK clergy discipline provisions

Both the Church of England and the UK Methodist Church have inserted a mediatory step into their disciplinary process, with a particular emphasis on the importance of restoring the pastoral relationship.

3.4.1 Church of England

The Church of England’s Clergy Discipline Measure 2003¹⁸⁴ applies only to those ‘Allegations of Misconduct’ about:

- doing any act in contravention of or failing to do any act required by the laws ecclesiastical;
- neglect or inefficiency in the performance of the duties of the office; or
- conduct unbecoming or inappropriate to the office.¹⁸⁵

The overall purpose of the measures is to “deal with clergy who are found to have fallen below the very high standards required and expected of them.”¹⁸⁶

In common with most schemes there is an initial scrutiny of complaints, carried out by the registrar on behalf of the Bishop to whom the complaint was sent. Once the complaint has been accepted ‘conciliation’ is among the actions open to the Bishop.

The reasons given for choosing conciliation are: “to restore the pastoral or personal relationship between the clergy and complainant”, and that “the complainant seeks an apology.”¹⁸⁷

Conciliation is not used for any complaint which, if proved, would require a penalty of prohibition. Any agreement that is made during the conciliation must be later ratified by the Bishop, and this can only be done if the agreement suggested is within his powers as laid out by the Measure.¹⁸⁸ If conciliation is unsuccessful, there is an investigation process, then a tribunal, which makes a determination. If the tribunal finds there has been misconduct it may impose a prohibition for life, a suspension, removal from office, revocation of license, an injunction or rebuke.

3.4.2 Methodist Church

The “imperfect nature of human beings” as part of the Methodist Church’s “fallible community” requires there to be a robust complaints procedure.¹⁸⁹

¹⁸⁴ www.cofe.anglican.org/about/churchlawlegis/clergydiscipline

¹⁸⁵ S.8 Clergy Discipline Measure 2003.

¹⁸⁶ Church of England Clergy Discipline Measure 2003 Code of Practice, paragraph 4. Available at www.cofe.anglican.org/about/churchlawlegis/clergydiscipline/codeofpractice.pdf

¹⁸⁷ *Ibid*, paragraph 127.

¹⁸⁸ *Ibid*, paragraph 137.

¹⁸⁹ Bellamy, C, *Complaints and Discipline in the Methodist Church: A Step by Step Guide to the Standing Orders on Complaints and Discipline [3rd Edition]*, 2008. Available at www.methodist.org.uk/downloads/cd-guide-to-complaints-and-discipline-bellamy-091208.pdf

The initial sorting stage is: “a critical appraisal of the significance of the relationship between the standing of the person complained of in relation to the Church and the words, acts or omissions complained of.” Complaints may be made about any member of the Methodist Church.

The first stage encourages local, informal resolution, by “whatever steps are appropriate” including mediated settlement.¹⁹⁰ This is done in all except sufficiently serious cases, which go directly to the Connexional Complaints Panel. The second stage is described as being ‘formal resolution’. If neither informal nor formal resolution is successful the complaint goes to the Connexional Complaints Panel. A disciplinary hearing may be called for serious breaches of discipline, disregard to the church or if they “have or might have seriously impaired the mission, witness or integrity of the Church by his or her words, acts or omissions.”¹⁹¹ There are many disposals and penalties available, ranging from expulsion to a rebuke. Mediation may be used as part of the reconciliation process, as with the Church of England measures, when personal or pastoral relationships are at issue.

3.5 The Netherlands

The Dutch Individual Health Care Professions Act (Wet BIG)¹⁹² regulates the provision of care by dentists, doctors, healthcare psychologists, midwives, nurses, pharmacists, physiotherapists and psychotherapists. The aim of the Act was to replace an ineffectual statutory regime and provide greater scrutiny of the medical professions. It was also intended to strengthen the position of complainants, as there had been a perception that the previous regime had enabled professionals to protect one another.¹⁹³ This in turn required additional safeguards, with the over-riding purpose of the Act to “foster and monitor high standards of professional practice and to protect the patient against professional carelessness and incompetence.”¹⁹⁴

The complaints process under this Act has two streams: disciplinary measures and fitness to practise measures. Disciplinary measures aim to “guarantee proper standards of professional practice in order to protect the interests of those for whom care is provided.”¹⁹⁵ Two norms apply: ‘due care’, and all other activities which conflict with proper practice.

¹⁹⁰ *Ibid*, paragraph 2.6.

¹⁹¹ *Ibid*, paragraph 5.3.

¹⁹² Ministerie van Volksgezondheid, Welzijn en Sport (Ministry of Health, Welfare and Sport, the Netherlands), *The Individual Health Care Professions Act International Publication Series (number 10)*, The Hague, October 2001, pp. 1–69. Available from http://english.minvws.nl/includes/dl/openbestand.asp?File=/images/big-eng_tcm20-107817.pdf

¹⁹³ Hout, E, *The Dutch disciplinary system for health care: an empirical study*, 2006, p. 9. Available from http://dare.uvu.vu.nl/bitstream/1871/9194/1/binnenwerk_proefschrift_Hout.pdf This thesis pays particular attention to the application of a professional disciplinary regime (already applied to the ‘old professions’ of medicine, dentistry and pharmacy) to the ‘new professions’ of psychology, physiotherapy and nursing.

¹⁹⁴ *Ibid*, p. 5.

¹⁹⁵ *Ibid*, p. 10.

Complaints may be brought by patients, their relatives or other professionals. The Public Health Inspector may also institute proceedings. Following a written complaint, a preliminary investigation takes place. At this stage, both parties are given an opportunity to state their views, and an “amicable agreement” is offered.¹⁹⁶ If accepted, this is recorded and implemented and the disciplinary process is terminated. If not, the complaint continues to a hearing. Sanctions range from a warning, reprimand, fine, suspension or conditions on practice, to striking off.

Fitness to practise means literal fitness: cases cover only unfitness as the result of a mental and / or physical condition or of habitual misuse of alcohol or drugs.¹⁹⁷ Only the Public Health Inspector may bring such a case and a board will assess the practitioner’s fitness with possible sanctions including putting conditions on practice or striking off. There are, in addition, penal provisions under the act, all of which would be otherwise covered by criminal law.¹⁹⁸

The division of case types mirrors that of the HPC, with the Dutch Fitness to Practise cases running in line with those that go to the HPC’s Health Committee. While the disciplinary scheme covers most other issues, by bracketing norms of due care and “against proper practice” it excludes some ‘consumer-type’ complaints.

The opportunity for “amicable agreement” is an interesting variant on ADR, but like a number of innovations in this field there is little evidence of its use.¹⁹⁹ While the methodology is not mentioned, it could work as mediation or simply as a third-party proposed agreement which the parties are free to reject.

There has been some criticism of the scheme. A further legally qualified person was added to the five-person disciplinary boards with the intention of strengthening the position of complainants, but in fact the number of complaints upheld has reduced.²⁰⁰ Professionals were also critical where the panel did not contain someone from the same profession.²⁰¹

3.6 France

The French Médiateur de la République (MDLR) fulfils a similar role to an ombudsman in other countries, helping citizens in their disputes with the state and administration. In 2009, following almost 40 years’ experience since the post was established in 1973, the Médiateur declared that: “We no longer have to manage a case but accompany a person to help him overcome a problem. Receiving is respecting, accompanying and reconstructing.”²⁰²

¹⁹⁶ *Ibid*, p. 11.

¹⁹⁷ *Ibid*, p. 12.

¹⁹⁸ *Ibid*, p. 13.

¹⁹⁹ An evaluation of the disciplinary system makes no mention of amicable settlement occurring in its 180 pages – Hout (2006).

²⁰⁰ From 19 per cent to 15 per cent, *Ibid*, p. 130.

²⁰¹ *Ibid*, p. 130.

²⁰² Mediator of the French Republic, Annual Report 2009, www.mediateur-republique.fr/fic_bdd/pdf_fr_fichier/1271756115_Rapport_2009_ANGLAIS.pdf

This seems to suggest a parallel with the HPC's work. The role of 'accompanying' could conceivably included a face-to-face mediatory meeting with the practitioner, modelling the three pillars of procedural justice described above – a chance to tell one's story, a sense that this is being taken into account and respectful treatment by a representative of authority.

The MDLR has now extended his role into the healthcare sector following the recognition that, even though the complaints system may be effective, those making complaints often experience a sense of powerlessness. He also identifies benefits for the healthcare system: "Physical mediation, in particular, has an educational value for professionals: it does not seek to hold somebody responsible, but to use the error positively".²⁰³ This highlights a difficulty for mediation: does it run counter to the idea of 'holding somebody responsible'? If so, it will be difficult for a regulator representing the public interest to countenance. In the case of the HPC, the mediatory step would need to combine the ideas of accountability and learning from mistakes. The MDLR notes a rise in the phenomenon of dissatisfied complainants going on to raise court actions against medical practitioners. Acknowledging that this is part of an international trend, he suggests that it "maintains and escalates deadlock situations".²⁰⁴

Finally, he raises the issue of what he terms 'ordinary maltreatment' in hospitals. This includes poor hygiene and insufficient attention to the patient's pain or other characteristics, and may often stem from factors beyond the control of the practitioner. The MDLR acknowledges that health practitioners are under pressure and may become the object of insults and even violence. One in five health related referrals come from the practitioners themselves and therefore his role is also to "take care of the healthcare workers, without criticising them, and to strive, together with them, for a 'good-treatment' policy".²⁰⁵

The example of the MDLR suggests that the HPC may wish to consider 'mediators with power'.²⁰⁶ This term was coined by US mediation writer Bernard Mayer, who asserts that mediation's credibility can be enhanced when conducted by someone who commands high respect and authority within society. It may be that in the UK too complainants and practitioners could find mediation more acceptable if it were provided by such a figure (for example the Health Service Ombudsman).²⁰⁷

²⁰³ *Ibid*, p. 6.

²⁰⁴ *Ibid*, p. 6.

²⁰⁵ *Ibid*, p. 7.

²⁰⁶ Mayer, B, *Beyond Neutrality: Confronting the Crisis in Conflict Resolution* (San Francisco: Jossey-Bass, 2004), pp. 108–110.

²⁰⁷ However, Kaiser Permanente in the USA see it as more important for the ombudsmen / mediators to be health professionals (private conversation with Carol Houk, founder of the Kaiser Permanente MedicOm scheme, on 11 September 2010).

3.7 Belgium

In August 2002 Belgium passed a law creating a mediation function within the health service. Its purpose is to “prevent queries and complaints through the promotion of communication between patient and professional practitioner.”²⁰⁸ The Act also sets out a general standard for health professionals: “Everyone should receive from the health professionals the most appropriate care to prevent, listen, evaluate, consider, process and relieve pain.”²⁰⁹

The scheme seems to have had positive results, with the most common subject matter being the therapeutic regime. However, the technical details mattered much less than the poor quality of the patient / carer relationship. By 2008 the scheme was still “too little known”.²¹⁰ As noted below,²¹¹ Delvaux found that the scheme was completely invisible in hospital leaflets.

In 2008 the Belgian Fondation du Roi Baudouin published a study of hospital mediation schemes in seven countries: Canada (Quebec), Finland, France, Germany, the Netherlands, Norway and the United Kingdom. Its findings were as follows.

- Some countries gave frontline complaint handling to general managers, others to mediators; two combined the two approaches; four countries provided support to patients in bringing complaints.
- Mediators tended not to have senior positions in the hospital hierarchy; if they were non-medical, they tended to be full-time mediators.
- While there was not unanimity about the appropriate qualifications for mediators, there was a strong emphasis on continuing professional development. In the future it is likely that some sort of benchmark standard will develop.
- Six of the seven countries allowed access to medical records.
- Six of the seven integrated complaints handling into the quality system of their local hospital. The UK was the only one to integrate local complaint and litigation management into its national risk management strategy.

Interestingly the author found that, overall, the UK’s system was strongest, taking account of common-sense values and integrating complaints-handling into a systematic and dynamic vision of healthcare.²¹²

²⁰⁸ Law of 2 August 2002, Article 11 § 2 See www.ordomedic.be/fr/avis/conseil/la-fonction-de-m%E9diation

²⁰⁹ *Ibid*, Article 11a.

²¹⁰ Delvaux (2008).

²¹¹ At Section 4.3.

²¹² Jacquerye, A., *Exploratory study of hospital mediation* (Fondation Roi Baudouin, 2008). See www.kbs-frb.be/uploadedFiles/KBS-FRB/05_Pictures,_documents_and_external_sites/14_Summary_publications/MediationHospitaliere_Resume_FR.pdf

3.8 Alberta, Canada

Mediation and other alternatives to formal complaints processes are being used in a number of jurisdictions, and the term 'Alternative Complaint Process' (ACP) has been coined.²¹³ The Alberta Health Professions Act 2000 covers 28 health professions.²¹⁴ The Act creates, for each profession, a college to govern and regulate its members. The focus is on protecting and serving members of the public and includes enforcement and regulation of a standard of practice and ethics. Only complaints about professional conduct may be considered.

Complaints are made in writing to the Complaints Director who has eight options for action, as follows.

- Encourage parties to communicate and resolve the complaint.
- Attempt to resolve the complaint with the parties' consent.
- Make a referral to the 'Alternative Complaint Process' (ACP).
- Request an expert to provide an evaluation of the subject-matter of the complaint.
- Investigate the complaint.
- Dismiss the complaint if vexatious or trivial.

- Dismiss the complaint if there is insufficient or no evidence of unprofessional conduct.
- Make an incapacity order on grounds of mental or physical health (includes a treatment order and / or suspension).²¹⁵

ACP can only go ahead with the agreement of both complainant and professional. The person conducting the ACP must be impartial, and act impartially. A member of the professional's college must conduct or participate in the ACP. While mediation is not referred to by name, the function of the person conducting the ACP is to assist in settling the complaint. Any settlement reached must be reported to the complaints review committee to be ratified, amended (with consent of both parties) or refused. In these two requirements the scheme shows both norm educating and norm advocating characteristics.²¹⁶

If ACP does not achieve settlement, the complaint will return to the Complaints Director. An investigation is likely to follow, then a re-investigation or hearing if the complainant does not agree with a dismissal of the complaint. The hearing can make a wide-range of orders including: caution, reprimand, impose conditions, make a treatment order, suspend or cancel registration, or order to pay costs or fines.

²¹³ Province of Alberta, Canada: Health Professions Act 2000, SS 58–60 (www.qp.alberta.ca).

²¹⁴ Acupuncturists; chiropractors; combined laboratory and X-ray technicians; dental assistants; dental hygienists; dental technologists; dentists and denturists; hearing aid practitioners; licensed practical nurses; medical laboratory technologists; medical diagnostic and therapeutic technologists; midwives; naturopaths; occupational therapists; opticians; optometrists; paramedics; pharmacists; physical therapists; physicians, surgeons and osteopaths; psychologists; registered dietitians and registered nutritionists; registered nurses; registered psychiatric and mental deficiency nurses; respiratory therapists; social workers; and speech-language pathologists and audiologists. See schedules 1–28 of the HPA 2000.

²¹⁵ HPA 2000, S.55(2).

²¹⁶ See Section 1.3 above.

4 Observations for the HPC

4.1 ADR – what are its goals?

It is clear that ADR schemes are diverse and motivated by varied considerations. A key question for the HPC concerns purpose: what could an ADR scheme deliver that the current fitness to practise process does not? If this question does not have a clear affirmative answer then it is unlikely that a mediation scheme will be used, however well-intentioned.²¹⁷ This links to the related question of beneficiaries. Would such a scheme benefit complainants (whether members of the public or not), registrants, the HPC in its public protection role, the health service or the wider public? We set out below some of the possibilities and their implications.

4.1.1 Diversion

One of the key drivers for the growth of ADR has been dissatisfaction with existing dispute-resolution processes. This may be because they are slow, expensive and inaccessible, or to free-up formal adjudication for more serious cases. Previous research for the HPC has indicated some misunderstanding of the existing fitness to practise process on the part of members of the public who complain, leading to possible dissatisfaction.²¹⁸ However, this does not in itself make the case for diversion. The HPC has a duty to protect the public and we see no indication that, for example, cost savings are a motivation for introducing ADR.

On the other hand, the investigation process requires an investment of time and resources from both the HPC and the registrant and one of the respondents in the Ipsos MORI research thought mediation could resolve matters more speedily.²¹⁹ It may also be that a number of complaints concern matters not pertaining to fitness to practise: a mediation meeting may allow these to be resolved to the satisfaction of the parties without involving other agencies.

4.1.2 ‘Reinstatement of the care relationship’

This term comes from an evaluation of the Dutch regulatory system.²²⁰ It highlights one of the claims consistently made for mediation: that it can enable parties to resolve disputes without terminating their relationship. While a complaint to the HPC may indicate that the care relationship is already fatally damaged, for a proportion of complainants a continuing or improved relationship with a valued carer will be important. Some may have complained because it is the only way they can highlight a difficult issue, or because they have been advised to do so. If a mediation meeting were to be offered early in the fitness to practise process it would present an opportunity to address such concerns while allowing the professional relationship to continue (and perhaps strengthening it).

²¹⁷ See Section 4.3 below.

²¹⁸ Ipsos MORI (2009), p. 12: “Attempting to resolve problems can be stressful and a lack of common understanding of the complaints procedure can be a source of dissatisfaction among users.”

²¹⁹ *Ibid*, p. 31.

²²⁰ Hout (2006), p.138

4.1.3 Settlement

Mediation has also been characterised as a 'settlement ritual'. It provides a forum for people in dispute to arrive at a settlement that satisfies their interests, a quality which accounts for much of its appeal to the justice system. However, this motivation may be problematic for the HPC. While a complainant has an indisputable interest in the outcome of a fitness to practise process, she or he does not have the only interest. The HPC has a duty to consider the wider public interest, including such matters as whether the registrant presents a potential danger in future. In a sense, once the complaint has been made, the complainant no longer 'owns' it: she or he may be called as a witness, but ultimately the regulator's decision about proceeding is governed by the duty to protect the public. This is spelt out in the case of the Irish Pharmaceutical Society:

"If a complaint is withdrawn, the committee considering it may, with the Council's agreement,

- (a) decide that no further action is to be taken, or
- (b) proceed as if the complaint had not been withdrawn."²²¹

Relis' 'parallel worlds' findings tell us that settlement does not feature strongly in most (non-legal) parties' perspectives on mediation.

For them a face-to-face encounter held out the promise of a chance to be heard, leading to explanation, apology, future prevention and, in some cases, vindication and shaming the practitioner.²²² We discuss below the implications of this for the style of mediation, but it appears that settlement may be simultaneously over-optimistic (because some complainants will not want to withdraw their complaints even after a positive mediation experience) and under-achieving (because mediation has the potential to deliver more than a simple settlement, particularly future learning, a restored relationship and / or closure).

4.1.4 Learning

A number of commentators have noted the potential of ADR to deliver longer-term learning as parties to a conflict are forced to reconsider their points of view and scrutinise the events that led to the conflict.²²³ To quote the French Médiateur de la République again: "Physical mediation, in particular, has an educational value for professionals: it does not seek to hold somebody responsible, but to use the error positively."²²⁴

One of the limitations of the current fitness to practise process is its concentration on the individual registrant: the HPC has no remit to sanction entities like hospitals or health centres, nor to recommend wider systemic improvements.

²²¹ Pharmacy Act 2007, S.44 (Republic of Ireland).

²²² Relis, 2008.

²²³ For example the French Médiateur de la République (see Section 3.6 above; in the USA Dauer and Marcus (1997), Boothman et al (2009), Szmania et al (2008) and both the Medicare and Kaiser Permanente schemes cite learning as a key objective.

²²⁴ Médiateur de la République, *Annual Report 2009*, p. 6; see also Donaldson in *Trust, Assurance, Safety* (2007) (see note 78).

A mediatory meeting could, however, assist the HPC and the registrant to make greater use of the learning from complaints, particularly if the complainant and registrant participate in a discussion about possible remedial steps. The presence of a representative of the particular profession could also enable that profession to learn from errors by disseminating the agreed outcomes of mediation.

4.1.5 Customer satisfaction

This factor should not be underestimated. While evaluation of outcomes is problematic, because of the difficulty in attaining true experimental conditions,²²⁵ the popularity of mediation with its users is almost universal.²²⁶ The Scottish Legal Complaints Commission, for example, found that mediation was rated as 'Very Good' or 'Excellent' by 72 per cent of its users, while 86 per cent said they would recommend it to others.²²⁷ Mediation's high client-satisfaction ratings have been dismissed by critics asserting that people simply enjoy the attention of an interested professional. However, as the literature on procedural justice illustrates,²²⁸ parties' positive views of their treatment in one setting seems to enhance their respect for the whole system.

This review was commissioned at least in part because of disquieting concerns about the current fitness to practise process: it is possible that a mediatory approach, as part of an integrated approach to complaints, could contribute to improved user-satisfaction.²²⁹

4.1.6 Other goals

Other goals for mediation could be: faster, cheaper case-processing; the reduction of conflict; and a commitment to party self-determination. However, the critiques highlighted above suggest that it may be less likely to deliver definitive judgements and the public pronouncement of norms (although this may be tempered by allowing publication of anonymised mediated outcomes). It may also not be suitable where one party holds considerably more power than another, although much will depend on the skill of the individual mediator.

4.2 Alternative methods of resolving disputes

Alternative Dispute Resolution, as the name implies, is not limited to one technique. We have discussed mediation in detail, largely because it remains the most common approach to the resolution of disputes. We now consider alternatives to mediation.

²²⁵ See Menkel-Meadow (2010) (see note 13).

²²⁶ See, for example, Jones (ed.) (2004); Doyle (2006) (see note 43); Urwin, P and others, *Evaluating the use of judicial mediation in Employment Tribunals (Ministry of Justice Research Series 7/10)*, 2010 (www.justice.gov.uk/publications/judicial-mediation-research.htm); Ross and Bain (2010) (evaluation of a small claims mediation pilot in Scotland) (see note 43).

²²⁷ See Mantle (2010). See appendix.

²²⁸ *Ibid.*

²²⁹ With wider systemic benefits for the health and wellbeing sector – see Houk and Edelstein (2008); Szmania and others (2008).

4.2.1 'Frontline resolution'

This term was coined by the Scottish Public Services Ombudsman (SPSO)²³⁰ and forms part of his Model Complaints Handling Procedure. It is targeted at “issues that are straightforward and easily resolved, requiring little or no investigation” and refers to “on the spot apology, explanation, or other action to resolve the complaint quickly”.²³¹ The principle of acting quickly has much to commend it: memories are fresh and attitudes have not yet hardened. However, by the time a complaint comes to the attention of the HPC the time for such action may already be past.²³² It could nonetheless issue guidelines, akin to those contained in the SPSO consultation, setting out best practice in frontline resolution. This may be beneficial to both complainants and professionals and have significant preventative potential.

At the present time healthcare professionals may be reticent about apologising.²³³ In some instances a complaint will concern actions which the registrant will consider quite appropriate. Clearly s/he will not apologise in such cases. However, an explanation, clearly setting out how the decision was arrived at, may still be important to the complainant and may in fact reduce stress for registrants.²³⁴

Registrants may also be wary of apologising because they fear that it will amount to an admission of guilt. HPC guidelines would have to make a clear statement about its attitude to such early apologies in subsequent fitness to practise hearings.²³⁵

SPSO's guidelines place particular stress on organisational action to correct errors. Other members of staff should intervene promptly to deal with problems as soon as they become apparent. In contrast the HPC can only focus on the individual registrant and his or her actions and decisions. It cannot compel other workers to take actions it considers advisable. However, another feature of frontline resolution is that the details of complaints are 'harvested' for systemic improvement. It is conceivable that the HPC could have a role in this, but it would require coordination with local health providers and hospitals. Many registrants are sole practitioners and here the onus will be on them to learn from mistakes and make improvements.

4.2.2 Disposal of cases by consent

The HPC already has a structure for dealing with cases by agreement. This provides

²³⁰ Scottish Public Services Ombudsman, *Consultation on a Statement of Complaint Handling Principles and Guidance on a Model Complaints Handling Procedure*, 2010 (www.spsso.org.uk/files/webfm/Publications/Newsletters%20and%20Guides/2010_06_16_SPSO_Consultation.pdf).

²³¹ *Ibid*, p. 12.

²³² See Mantle (2010).

²³³ See discussion on apologies at Section 2.4 above.

²³⁴ Boothman and others (2009), p. 146. 98 per cent of physicians in the University of Michigan Health System approved of the change from a policy of 'defend and deny' to one of transparency and explanation.

²³⁵ For example, British Columbia's Apologies Act 2006 ensures that an apology does not constitute an admission of liability. For further discussion of statutory exclusions of liability, see Vines (2008) (at note 111).

“a means by which the HPC and the registrant concerned can seek to conclude a case without the need for a contested hearing, by putting before a Panel an order of the kind which the Panel would have been likely to make in any event.”²³⁶

Where there is a ‘case to answer’, the registrant accepts the allegation in full and the proposed remedial action is similar to what would occur after a hearing, the matter can be resolved by consent.

This procedure bears some similarities to a mediatory approach. It is described as a “case management tool” which will reduce the “time taken to deal with allegations” and “the number of contested hearings”.²³⁷ Any admission made is treated as a “without prejudice” settlement offer. However, the procedure as currently set out does not envisage a role for the complainant: disposal by consent is negotiated between the registrant and the HPC.

We wonder whether elements of this ‘Disposal by Consent’ procedure could be adapted to enable a mediatory approach. Similar standards of confidentiality and HPC scrutiny could apply. There would be two major differences. Firstly, the complainant’s perspective would be taken into account in arriving at the proposed outcome. The mediator could assist in preparing the proposal for presentation to a Panel. Secondly, the requirement that the registrant admit liability may not be appropriate in some instances. This would require a change in the HPC’s practice and procedures, but may be regarded as worthwhile if it enables a larger group of cases to be dealt with by consent.

A mediatory approach could thus broaden the existing disposal by consent mechanism to incorporate the complainant’s perspective. The mediator could also assist the HPC in ensuring that the public interest is protected, by being familiar with both the HPC’s code of conduct and the range of disposal options available to it. At the same time the face-to-face dimension would enhance complainants’ sense that their views are taken into account in fitness to practise decisions.

4.2.3 Recorded concerns

This suggestion comes from the HPC’s project brief for this review, the idea being to create learning points for registrants where fitness to practise panels have found ‘no case to answer’ but nonetheless identify an issue of concern. In one sense this follows best practice in complaints handling by ‘harvesting’ the information for future learning. It would also accord well with Donaldson’s sentiments when he asserts that the recent huge expansion in knowledge and techniques places great pressure on health professionals. As a consequence “the system of regulation needs to put in place mechanisms that deal with honest mistakes fairly, supportively and sympathetically”.²³⁸

We would, however, highlight two concerns with this approach. The first is that it lacks the ‘face-to-face’ element which we identified earlier as being of great significance in the early resolution of complaints.²³⁹ Even if a written report is thorough and reflective, it is likely to lack the nuance and richness of a dialogue.

²³⁶ HPC practice note on Disposal of Cases by Consent. Available from www.hpc-uk.org/assets/documents/10002473PRACTICE_NOTE_ConsentOrders.pdf

²³⁷ *Ibid*, p. 1.

²³⁸ Donaldson in Trust, Assurance and Safety (2007), p. 16.

²³⁹ Szmania and others (2008); Moody (2005).

The professional's response to a particular statement by the complainant, and the back-and-forth, fine tuning that occurs in real-time conversation, are likely to lead to greater insights and more thorough lessons. These are, of course, potentially risky conversations for registrants and the presence of an impartial 'honest-broker' such as a mediator may be necessary to ensure that they do not revert to what Boothman et al describe as the 'deny and defend' approach.²⁴⁰ More fundamentally, the relational dimension of complaints should not be forgotten. In one US study, 71 per cent of those who decided to litigate against a physician cited a problem in the physician / patient relationship, clustered around four themes: "deserting the patient" (32%), "devaluing patient and / or family views" (29%), "delivering information poorly" (26%), and "failing to understand the patient and / or family perspective" (13%).²⁴¹

The second concern relates to the earlier discussion about the contrast between consumer complaints and professional regulation.²⁴² The 'learning point' proposal keeps the focus on the professional rather than the patient or client.

We therefore recommend that the HPC consider the possibility of a mediatory meeting both prior to and following determination by a fitness to practise panel. Prior to a panel the purpose is diversion – as SLCC puts it, mediation is an "opportunity for the parties to have each other's undivided attention as they try to resolve the complaint together".²⁴³ After a panel has determined that there is 'no case to answer' but has identified an issue for the registrant, the focus of mediation will be on explanation, acknowledgement and future learning, both for the individual registrant and the wider health system.²⁴⁴

One useful refinement may be to have a representative of the particular profession (this could be an HPC Partner from the same part of the Register) attend the mediatory meeting.²⁴⁵ His or her role would be to ensure that any plans or proposals comply with best practice within that profession, as well as providing background information for both parties.²⁴⁶ The HPC Partner could also play a role in recording the 'learning points' and ensuring that they are disseminated within the profession in question.

²⁴⁰ Boothman and others (2009), p. 143: "The deny and defend approach is mutually exclusive to the honest introspection necessary to true identification of errors, and to the will to correct them." See also the concept of 'reactivity' in which doctors respond to regulatory pressure by behaving defensively, described in McGivern, G. and others, *Statutory Regulation and the Future of Professional Practice in Psychotherapy and Counselling; Evidence from the Field*, (London: Kings College London, 2009) www.kcl.ac.uk/content/1/c6/06/35/90/StatutoryRegulation1.pdf

²⁴¹ MacCoun, R., 'Voice, Control and Belonging: The Double-Edged Sword of Procedural Fairness' in *Annual Review of Law and Social Science*, 2005, pp. 171–201 at p. 179.

²⁴² See Section 2.1.

²⁴³ SLCC Mediation Information Sheet (available from www.scottishlegalcomplaints.com).

²⁴⁴ McGivern and others (2009) talk of an "'amber zone' of potential malpractice [where mediation] may be a more effective way of tackling poor practice without practitioners being turned into either a patient or a criminal", p. 6.

²⁴⁵ As in the Albertan Health Professions Act, see Section 3.8 above.

²⁴⁶ Fisher, Ury and Patton, in their classic text *Getting to Yes*, suggest that negotiators "insist on objective criteria" in order to arrive at principled outcomes. This proposal would assist any HPC mediation scheme to achieve this goal. Fisher, R, Ury, W and Patton, B *Getting to Yes: Negotiating Agreements Without Giving In* (London: Random House, 1991).

It is important to re-state the principle of voluntariness here. The complainant may not wish a face-to-face meeting with the registrant if the panel has declared 'no case to answer', and the HPC clearly cannot compel attendance. However, if the Ipsos MORI findings are replicated throughout the UK it is likely that a significant proportion of complainants would appreciate the opportunity to hear an explanation or apology from the person who they have complained about.

4.2.4 Facilitated resolution / conciliation

For some complainants the idea of sitting in the same room as the person who they believe has harmed them is inconceivable. It may nonetheless be possible for a third party to assist. Platt claims that meeting face-to-face is not essential within healthcare conciliation, saying: "It is possible for a healthcare complaint to be resolved satisfactorily without the need for the parties to meet".²⁴⁷ Medicare, the US federal provider of support for medical costs, describes this as 'facilitated resolution'.²⁴⁸ This model provides flexibility and caters for particularly high-conflict situations. However, as well as losing some of the benefits of face-to-face meetings, 'shuttle' meetings can add considerably to the time taken. Platt suggests something akin to the commercial mediation standard model (one full day) or a series of meetings of one-and-a-half to two hours in length, spread over several weeks.²⁴⁹

4.2.5 Restorative justice

Complaints that have a bearing on competence are often robustly defended by the professional involved. The allegation that they have been incompetent or lacking in judgement goes to the heart of their professional identity and, for many people, requires to be rebutted. In these circumstances 'early' mediation, prior to a formal investigation, is probably inappropriate. If facts are disputed, how can the complainant and registrant arrive at a shared understanding? While mediators often need to work to balance power (which can ebb and flow from one party to the other during the session) most would be wary of offering mediation where one party holds considerably more power than the other. It could be argued that a health professional, in their area of professional expertise, wields considerably more power than a patient or client.

However, after determination, when the facts have been established and a fitness to practise concern identified, one of the range of disposal options currently available to a panel is mediation. This may not be the most useful term. At this stage in the proceedings the closest parallel is a process known as 'restorative justice'. Restorative justice brings the perpetrator of a crime face to face with the person they have harmed. Its purpose is to allow the person harmed to explain the impact of the crime and to give the perpetrator the opportunity to make amends (including offering an apology).

²⁴⁷ Platt (2008), p. 10.

²⁴⁸ Centers for Medicare and Medicaid Services 'Frequently Asked Questions for Medicare Beneficiaries': "Other forms of dispute resolution might be less formal than mediation. For example, a mediator may talk to each party separately to resolve the conflict. This is known as facilitated resolution. The goal of facilitated resolution is to help guide the two parties to a resolution. The difference is that with facilitated resolution you would not speak directly with the doctor or provider". Available from www.medicare.gov/Publications/Pubs/pdf/11348.pdf

²⁴⁹ Platt (2008) p. 72.

Its proponents forcefully distinguish it from mediation: it is “motivated primarily by the need to address the harm done: it does not take place unless and until the person who has caused the harm has fully and freely admitted to their actions and is willing to take responsibility for them”.²⁵⁰ They suggest that mediation in the context of harm done would be a mistake:

“Worse still, a person harmed would (and should) be outraged by the suggestions that their primary need is to sort out their ‘difference of opinion’ with the person who has harmed them, so as to create a ‘win-win’ outcome. This is no place for that kind of moral neutrality.”²⁵¹

It could be argued that any mediatory approach taken after a finding against the professional, even if the disposal falls short of removal from the Register, ought more properly to be described as ‘restorative justice’. Menkel-Meadow suggests the following characteristics of this process.

- 1) Describing the act and the harm it has done.
- 2) Explanation by the perpetrator of what was done and why.
- 3) Acknowledgement and acceptance of fault by the perpetrator (and apology, if not coerced).

- 4) Chance to understand why the act occurred.
- 5) Consideration of appropriate outcomes, not just for the victim but the wider community.
- 6) Reintegration of the perpetrator into the wider community, via apology and restitution.²⁵²

It is useful to consider the parallels with a fitness to practise process. First, if the panel considers the allegation well-founded, it is no longer appropriate for the practitioner to dispute the circumstances. The complainant is then in a position to describe the impact of the act or omission on her / him. This could help to bridge the gap identified by Gulland between the causes of a problem and its effect.²⁵³ The panel (and presumably the practitioner) will bring expert knowledge to bear in diagnosing the **cause** of the problem and, if appropriate, attributing blame. However, it is the complainant who has direct, first-hand information about the **effect**. A ‘restorative meeting’, after a finding of blame, could supplement the step in the current complaints procedure when the panel invites submissions from the registrant and the HPC (but not the complainant) about what action they should take.²⁵⁴ This would remedy one drawback of the current fitness to practise process, ie the complainant has no voice in deciding the best way for the practitioner to remedy the harm caused.

²⁵⁰ Brookes, D and McDonough, I, *The Differences Between Mediation and Restorative Justice/Practice* (Scottish Centre for Restorative Justice, November, 2006), p. 4. Available at www.restorativejusticescotland.org.uk/MedvsRJ-P.pdf

²⁵¹ *Ibid*, p. 6.

²⁵² Menkel-Meadow, C, ‘Restorative Justice: What Is It and Does It Work?’ in *Annual Review of Law and Social Science*, 3:10, 2007, pp. 10.1–10.27 at p.10.4 (Available at <http://lawsocsci.annualreviews.org>).

²⁵³ Gulland, J, cited in Adler, M, ‘Tribunal Reform: Proportionate Dispute Resolution and the Pursuit of Administrative Justice’ in *Modern Law Review*, 69 (6), 2006, pp. 958–85 at p. 968.

²⁵⁴ Health Professions Council, *How to make a complaint about a health professional*, p. 7. Available at time of writing at www.hpc-uk.org/assets/documents/10002C24Howtomakeacomplaintaboutahealthprofessional.pdf Recently revised (2010) and republished as *How to raise a concern*.

The HPC still needs to ensure that the public interest is taken into account. This could either be the role of the mediator or the HPC Partner.

Returning to Menkel-Meadow's list above, such a meeting could achieve the following.

- Allow the complainant to describe the impact of the action or omission complained about.
- Allow the registrant to explain how it happened and what factors led to the problem.
- Allow the registrant to acknowledge the harm done, to accept her or his fault and to apologise for it (although apologies must be 'genuine' to be of value).²⁵⁵
- Give the complainant the opportunity to understand why the harm occurred.
- Discuss possible steps by the registrant to remedy the harm and / or improve her or his competence (the presence of a representative of the particular profession would be useful in giving guidance).
- Consider the wider lessons that may be learned for the registrant, the employer, other health institutions and the NHS.

Restorative justice is not without its critics, however, and there are problems with such an approach. First, in the criminal justice setting, some consider restorative justice to be a 'soft option' offering offenders a meeting rather than more conventional punishments like imprisonment. Second, some see it as 'going through the motions'. As discussed above,

apology is unlikely to be valuable unless it is perceived to be genuine. Mantle saw no place for a post-determination meeting within the SLCC's procedures as the parties would have no continuing relationship. She added: "If an apology hasn't been made by either party by then, I feel it would be unlikely to be genuine if made post-investigation".²⁵⁶

Finally, there is a persistent critique that victims will be "re-victimized in their retelling of pain or injury suffered".²⁵⁷ Some complainers may not wish to go through the possibly traumatic experience of repeating their story to the person who caused them harm. Restorative justice practitioners have therefore developed careful protocols to ensure that the perpetrator is clear about the purpose of the meeting and willing to take responsibility for the harm.

Redefining mediation after a complaint has been upheld as a 'restorative meeting' would be an innovative approach, drawing on experience in the criminal justice system and recognising the HPC's role in acting on behalf of the wider society. A pilot project, with a thorough evaluation of outcomes for complainants, registrants, the profession and the public, would be beneficial.

4.3 Benign neglect

One phenomenon that emerged from the literature might be described as benign neglect or 'withering on the vine'. This occurs where a regulatory scheme, presumably with the best of intentions, contains a provision for referral to mediation which is rarely or never used. It applies to the HPC itself where, to date, no mediations have taken place.²⁵⁸

²⁵⁵ See Section 2.4 above.

²⁵⁶ Mantle (2010), p. 4.

²⁵⁷ Menkel-Meadow (2007), p. 10.12.

²⁵⁸ See Section 1.2.1 above.

In Alberta, Canada, the Health Professions Act sets out a thorough, integrated 'Alternative Complaints Resolution' (ACR) process.²⁵⁹ And yet the College of Physical Therapists of Alberta (one of the colleges created by the Act) omits all reference to ACR in its guidance to the public about complaining, and its 2009 annual report refers simply to investigation, with dismissal or guilt the only outcomes.²⁶⁰ And while the Alberta College of Speech-Language Pathologists and Audiologists clearly lists ACR among the functions of its Complaints Director,²⁶¹ its 2009 annual report names dismissal or resolution as hearing outcomes without reference to ACR.²⁶²

In Ireland the Pharmacy Act 2007 enables the Council of the Pharmaceutical Society to devise a scheme for resolving complaints by mediation.²⁶³ To date no mediations have taken place.²⁶⁴ In Belgium the Law of 22 August 2002 created a duty on all hospitals to set up a mediation scheme to deal with patient complaints. A 2008 article summed up the

scheme as "too little known", describing how mediation was almost completely unknown to patients and invisible on hospital leaflets.²⁶⁵ The Church of England Disciplinary Measure appears to have fallen victim to the same phenomenon with just one case out of sixty three dealt with by conciliation in 2008.²⁶⁶

Similar results are not uncommon in the ADR world, as the title of one recent article illustrates: "Faster, Cheaper, and Unused: The Paradox of Grievance Mediation in Unionized Environments".²⁶⁷ It contrasts striking cost and time savings vis-a-vis arbitration with very low uptake for mediation. Further investigation revealed hidden barriers, including union identity in a highly adversarial labour relations setting, meaning that the language of collaboration and reasonableness had little appeal. Similar factors seem to have been at play during the Northern Ireland Police Ombudsman's mediation pilot,²⁶⁸ with disappointing results and very low take-up.

²⁵⁹ Province of Alberta, Canada: Health Professions Act 2000 SS 58-60 www.qp.alberta.ca

²⁶⁰ College of Physical Therapists of Alberta, *Annual Report 2009*, www.cpta.ab.ca/sites/default/files/CPTA_AR09_web.pdf, p. 6.

²⁶¹ See [www.hearlife.ca/public/data/documents/complaints_director\[1\].pdf](http://www.hearlife.ca/public/data/documents/complaints_director[1].pdf)

²⁶² Alberta College of Speech-Language Pathologists and Audiologists, *Annual Report 2009*, www.acslpa.ab.ca/public/data/documents/2009_Annual_Report_-_Final.pdf

²⁶³ Ireland – Pharmacy Act 2007 S.37, www.pharmaceuticalsociety.ie/Home/upload/File/Pharmacy_Act_2007/Pharmacy%20Act%202007.pdf

²⁶⁴ Confirmed in a private conversation with Ciara McGoldrick, Head of Fitness to Practise and Legal Affairs, in August 2010.

²⁶⁵ Delvaux, J, 'La médiation hospitalière: trop peu connue' in *En Marche*, 2008. Available at www.enmarche.be/Sante/Sante_publique/mediation_hospitaliere.htm

²⁶⁶ *General Synod Clergy Discipline Commission Annual Report for 2008*. Outside the statistics page the report makes no mention whatever of the conciliation option, referring instead to investigation, discipline, penalty by consent or dismissal. See www.cofe.anglican.org/about/gensynod/agendas/july09/gsmisc924.pdf

²⁶⁷ Monahan, C, 'Faster, Cheaper, and Unused: The Paradox of Grievance Mediation in Unionized Environments' in *Conflict Resolution Quarterly*, 25 (4), 2008, pp. 479–96.

²⁶⁸ www.policeombudsman.org/Publicationsuploads/mediation.pdf

Both complainants and police officers regarded the scheme as potentially disadvantaging them because of its lack of formal adjudicatory power: “Most of them [police officers] viewed any acceptance on their part to engage in mediation as tantamount to admitting that they had in fact done something wrong and formal investigation in their minds would protect them better than mediation.”²⁶⁹ All of these examples illustrate that conciliation or mediation may seem like a good idea to those drafting regulations, while in practice the idea of formal determination is almost irresistible because the stakes are so high or people are already locked into an adversarial system where the only alternatives are upholding or rejecting the complaint.

And yet in other schemes, in spite of similar early scepticism, those who have participated in mediation tend to be almost uniformly positive about the experience.²⁷⁰ So why does this ‘benign neglect’ occur in some settings? One explanation may be simple resistance to change: mediation schemes seem to need to attain a certain critical mass before they are widely accepted. Another possible explanation emerges from Relis’ study of medical malpractice mediation. Her findings suggest that parties and their legal advisors spoke of

mediation in such different terms that they could be described as occupying “parallel worlds”.²⁷¹ Parties spoke of wanting explanations, reassurance that fault would not happen again, acknowledgement, apology and even vengeance; their advisors characterised mediation in tactical and strategic terms, such as making parties more ‘realistic’, illuminating case strengths and weaknesses and saving money. While parties to the HPC’s fitness to practise process may not routinely take legal advice, such sentiments are likely to have influenced the advice given by professional bodies and possibly perceptions in the wider culture too.

If the HPC does conclude that mediation ought to be more widely used within its fitness to practise process, the following suggestions from other mediation schemes may help prevent such ‘benign neglect’.

- Mediation to occur as early as possible in the process.²⁷²
- Provide information on the process in all leaflets, websites and publicity regarding complaints.²⁷³
- Proactively explain the process to registrants and others with whom they work.²⁷⁴

²⁶⁹ *Ibid*, p. 24.

²⁷⁰ See Mantle (2010); Jones (ed.) (2004); The US Medicare Mediation Program states: “A major reason for the growing use of mediation as a way of dealing with conflict is the satisfaction that many individuals experience when they find that they have the opportunity to communicate directly with the responding party.” From Centers for Medicare and Medicaid Services, *Mediation: A New Option for Medicare Beneficiaries* (available at www.cms.gov/BeneComplaintRespProg/Downloads/3a.pdf)

²⁷¹ Relis (2009), p. 8: “the parallel worlds of understanding and meaning inhabited by legal actors versus lay disputants, reflecting materially divergent interpretations and functions ascribed to case processing and dispute resolution”. Relis describes how legal actors, whether acting for the plaintiff or defendant, view mediation in entirely different terms from their clients.

²⁷² Delvaux (2008); SPSO (2010).

²⁷³ Delvaux (2008).

²⁷⁴ Delvaux (2008); Mantle (2010).

- Appoint a ‘mediation coordinator’ with the specific role of ensuring that the mediation option is fully considered in all cases.²⁷⁵
- Ensure independence from health service management.²⁷⁶
- Assure confidentiality.²⁷⁷
- Mediators need to be credible as well as well-trained and accredited.²⁷⁸

4.4 Who should mediate and how?

If the HPC were to choose some form of mediation, it is vital that the mediators be of high quality. This Review has highlighted the daunting range of issues and personalities that they will have to deal with, and because of the novelty of this approach their practice is likely to come under considerable scrutiny. While there are some UK schemes to accredit mediators, none is universally accepted, and different settings apply different standards. The Civil Mediation Council operates a system of registration for workplace mediators.²⁷⁹ In Scotland the Scottish Mediation Register is a self-certified quality assurance system, covering a wide range of mediation types.²⁸⁰

When SLCC recruited mediators to deal with complaints against solicitors it invited applications from experienced mediators and then provided in-house training. It may be thought that those who work for the Equalities Mediation Scheme, already accustomed to working in a ‘norm advocating’ setting, would readily be able to adapt to a fitness to practise context.

In contrast, the Kaiser Permanente MedicOm scheme recruits those with a thorough grounding in healthcare, and trains them to be ombudsmen / mediators. The reasoning of the scheme’s founder was that a healthcare professional could be taught ombudsman / mediation skills in three weeks, but that a deep understanding of the healthcare system required many years of experience.²⁸¹ Professional mediators may object to this characterisation of their education, but the HPC may also find it useful to look to those who already have significant experience of the activity complained about. It may be that HPC Partners, trained as mediators, are the people most likely to be seen as credible and acceptable.

²⁷⁵ Mantle (2010) states: “I think my own ‘mediation coordinator’ role has been significant. This is not just a matter of sending out letters, but of conveying the values of mediation, particularly to the Client Relations Partners. Of course I also have to convey that even-handedness to the complainers”; See also Doyle (2006), pp.117–19 for a description of the role of the ‘mediation officer’ in promoting a new mediation service.

²⁷⁶ In Belgian hospitals the role of mediator can no longer be filled by a director, chief clinician or head of department (Delvaux, 2008).

²⁷⁷ Delvaux (2008); Boothman and others (2009).

²⁷⁸ Delvaux (2008).

²⁷⁹ www.cmcregistered.org

²⁸⁰ www.scottishmediation.org.uk/mediators/index.asp

²⁸¹ Private conversation with Carole Houk, 11 September 2010.

5 Conclusion and recommendations

The regulation of health and wellbeing professionals touches on important issues for individual patients and society as a whole. We rightly expect high standards from those in these professions. At the same time, it is plain that they are placed under greater pressure than ever before, both by new scientific developments and rising public expectations. Any system that deals with allegations about such professionals has to balance a number of considerations. It needs to be fair, and be seen to be fair. It needs to take account of the needs and perspectives of those who complain and those it regulates. It needs to ensure that those who are not fit to practise are prevented from harming the public, while ensuring that those who need short term support receive it. And it needs to provide a process that encourages learning and improvement for individual practitioners and the wider health service.

We have reviewed a range of both complaints and professional regulatory processes. Some are adjudicatory, focussing on investigation and sanctions. Others insert a mediation step into the process in the hope of diverting suitable cases away from investigation and determination. Still others focus on learning, tackling adverse events as soon as they arise and taking a holistic approach to complaints, which includes explanation, apology, acknowledgement, advocacy, investigation, facilitation and mediation. This last approach is probably beyond the remit of the HPC, which must consider the conduct of individual registrants. At the same time the HPC's own research suggests that the adjudicatory approach leaves some complainants with a sense of dissatisfaction. For this group a mediatory approach may offer greater engagement, more information and closure.

There are also potential difficulties with a mediatory approach. It may not reach a conclusion. It may facilitate an outcome unacceptable to the HPC, even though both parties agree to it. Its critics say it can allow the stronger party to dominate, leading to unfair outcomes. It also lacks the public face of adjudication, with its capacity to publicly pronounce rules and guidance.

Having said this, steps can be taken to remedy each of these objections. The growth in mediation schemes around the world and the early findings that they are effective and appreciated suggest that a mediatory approach may have something to offer the HPC. There would appear to be two points in the fitness to practise process at which such a step could be more widely employed.

- **Immediately after an allegation has been received.** There would need to be an initial sift, or 'triage', to ensure that mediation is only offered in appropriate cases. Where there is a potential risk to the public if the registrant continues practising, the case will need to proceed to investigation. Where, however, the registrant appears to have made a mistake or omission that is unlikely to be repeated, a mediatory meeting will allow the complainant to explain how it has affected him or her, and the registrant to give an explanation and apology (if appropriate) and agree steps to prevent the problem happening again. This could avoid the need for full investigation in a proportion of cases.

- **Following an investigation, where an allegation about fitness to practise has been upheld.** Mediation is already among the disposal options open to a panel. We would suggest that this could be re-named a ‘restorative meeting’. Borrowing from the restorative justice field, the intention of such a meeting would be to allow the registrant to acknowledge the harm caused to the complainant, to explain what happened and to apologise. The complainant and the registrant would then participate in a discussion about the appropriate remedial steps to restore the registrant’s fitness to practise.

In both of the above scenarios the outcome of mediation would still have to be endorsed by the investigating panel (much as currently happens under the Disposal by Consent guidance).²⁸²

If the HPC wishes to make greater use of the mediation option, at either of the stages outlined above, the following observations may help to ensure that it is used and effective.²⁸³

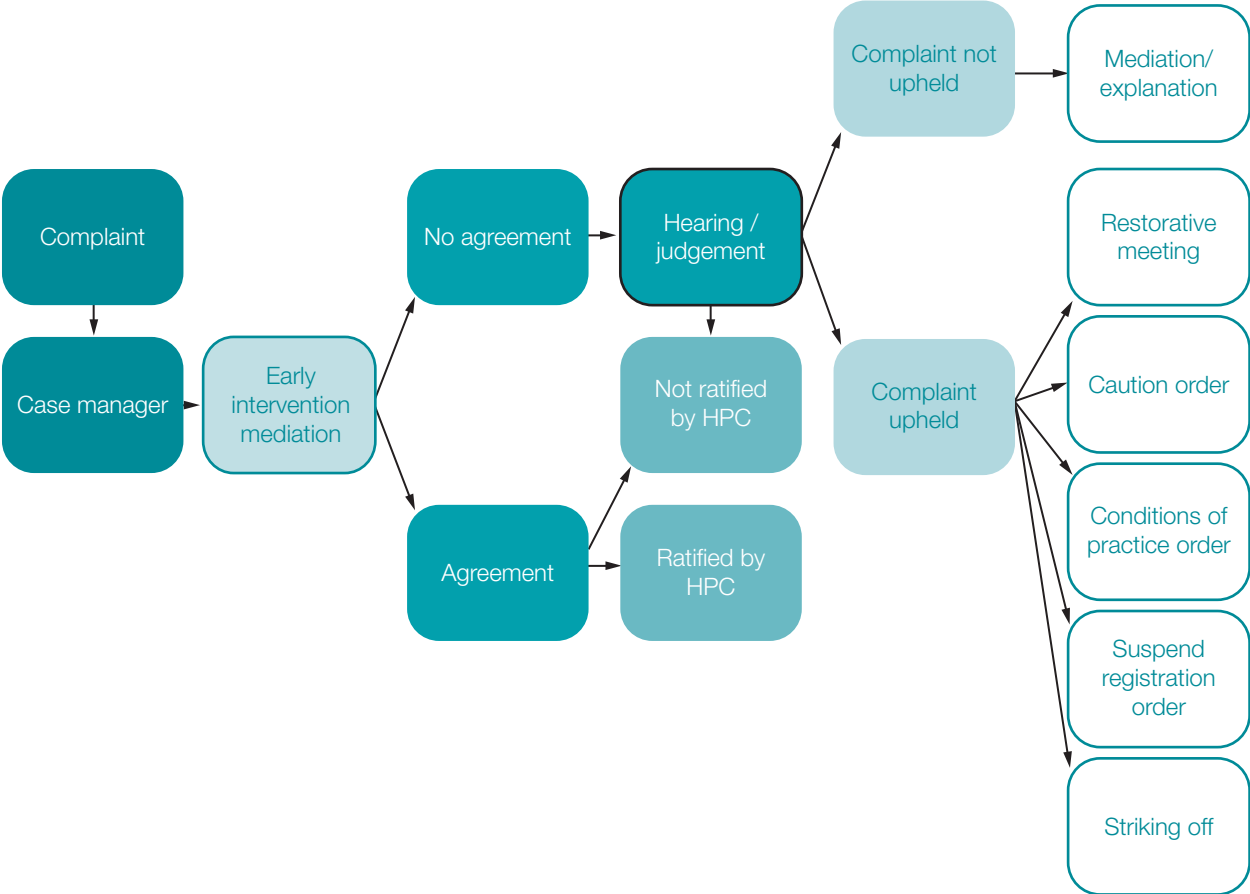
- Appoint a ‘mediation manager’ with the role of setting up a mediation scheme, recruiting the mediators, and ensuring that both registrants and complainants make an informed decision about whether to use it.
- Early intervention mediation should be a default step in the fitness to practise process, with both parties having the option to refuse it. A triage system could help to ensure that unsuitable cases are not mediated (ie where there is an ongoing risk to the public).
- Agreements arrived at in early intervention mediation should be ratified by the HPC. Those which are not should be remitted back for hearing and judgement.
- The mediators should be highly experienced practitioners. A mix of those with a background in the health service and those who do not is probably appropriate (bearing in mind that members of the public may have concerns about a mediator who is a health professional ‘siding’ with the registrant).
- Mediators should be encouraged to take a broad approach, allowing for explanation, apology, remedy and future learning as well as withdrawal of the complaint.
- One option would be to follow the Alberta model in having a representative of the particular profession present in the mediation. This person would provide normative guidance within the mediation as well as ensuring that mediation insights are shared with the wider profession. Because the benefits and disadvantages of this approach are not clear from the literature we would recommend that it be piloted in a small area and evaluated.
- The mediation discussions should be confidential, but with the possibility of the outcome being more widely publicised where both parties consent.
- Any new scheme needs to be widely publicised through leaflets and the HPC’s website, and supported by appropriate policies and procedures.

²⁸² See Section 2.2 above.

²⁸³ This list should be read in conjunction with the suggestions for preventing ‘benign neglect’ at Section 4.3 above.

We have outlined below a possible revised fitness to practise process, designed to encourage the use of a mediatory approach at the two distinct stages described above. It is also conceivable that mediation would be appreciated where an allegation has not been upheld but where the complainant still seeks an explanation for the action that led to the complaint. We have reflected this in the diagram.

Figure 4 – Possible modifications to the HPC’s fitness to practise process



This study raises fundamental issues about the role of a fitness to practise process. It has highlighted the often difficult role of health regulators in balancing the needs of complainants and the public interest, as well as the need to deal with past harm and future risk. Whatever the merits of 'frontline resolution', it seems most appropriate for service providers. The HPC, on the other hand, does seem to be well-placed to re-visit its existing statutory mandate to mediate. The reasons for this could include diversion of some cases away from investigation, to maximise the learning opportunities, to enhance procedural fairness and to insert a face-to-face element into the fitness to practise process. While we have highlighted some significant practical hurdles, most of the literature indicates a high degree of enthusiasm and commitment for such an approach, particularly once people have experienced it.

Appendix

Interview with Marjorie Mantle, Mediation Manager, Scottish Legal Complaints Commission

Note: This interview took place on Thursday 12 August 2010 in the offices of SLCC. The interview was not recorded and the following record is based on handwritten notes taken at the time. C is Charlie Irvine, Visiting Lecturer, the Law School, University of Strathclyde and M is Marjorie Mantle.

C How long has the SLCC mediation scheme been operating?

M Since 1 October 2008.

C Tell me about numbers.

M So far we have conducted 35 mediations, out of 141 where it was suggested. However, if you look more closely at the figures we experienced a slow start and take-up has definitely increased recently.

C What factors have contributed to the increase in use of the service?

M First of all, word of mouth among professionals – once a few had tried it they must have heard that it's worth trying. Secondly, I think my own 'mediation coordinator' role has been significant. This is not just a matter of sending out letters, but of conveying the values of mediation, particularly to the Client Relations Partners. Of course I also have to convey that even-handedness to the complainers. I think a third factor has been genuine goodwill on the part of solicitors, who say 'We don't want an unhappy client'. I think they feel their personal integrity is at stake.

C When do lawyers hear about the complaint?

M Once the complaint is accepted as an eligible complaint. There is a sifting process by our Gateway Team. The SLCC has a legal requirement to serve notice on the complainer and the practitioner, setting out what the complaint is, who will investigate it or, if appropriate, why it is not being investigated.

C How is mediation explained?

M The same explanation is given to both complainer and solicitor. The Gateway Team sends out information. I send it again, in case they didn't read it the first time. The terms of the explanation are that mediation may help to achieve 'resolution' of the complaint. I describe it as 'a solution that you can both live with'.

C Would you use the term 'redress' rather than resolution?

M No. I don't think that would be helpful.

C What is the role, if any, of financial compensation within the scheme?

M There is no set amount for specific types of cases but there is a tariff to which we would normally expect Investigators and Determination Committees to adhere. But I explain to complainers that the amounts involved are generally pretty small, say, £50 or £100.

C Are you 'anchoring' their expectations?

M Very much so. It's important that they are realistic. If they have paid fees of two and a half grand and are expecting to have them waived, it may not happen.

C One of the documented strategies that mediators use, particularly in court settings, is ‘reality testing’. That is, they say to the clients ‘Here’s what you’re likely to end up with, after X months of delay and hassle and Y pounds of legal costs. You might want to take that into account when considering what is a fair settlement.’ Having done some of this work, it strikes me that there is no equivalent for SLCC mediators, and so complainers’ expectations may remain unchallenged. Are you intending to do anything about this?

M Some stats are beginning to appear. I dare say mediators could use them in their discussions with clients.

C [I showed Marjorie a quote from Harris et al (2008) which picked up on Genn’s (1999) finding that success of dispute resolution strategies depended on the type of case. It states that “people simply wanted to solve the problem rather than secure any punishment, revenge or an apology and so they wanted routes to redress that were quick, cheap and stress-free”. Gulland similarly found that in Scotland some people bring a complaint in respect of their community care “with reluctance, hoping their problem can be sorted out with minimum of fuss”.] Do you think these comments apply to people who complain about legal professionals?

M In my experience a number of complainers want the solicitor ‘punished’. A minority want the problem solved with the minimum of fuss. However, and this is the benefit of mediation, when face-to-face with the person they wanted to ‘beat up’ they realise that this is just another person. Of course, this is just my personal view.

C Can you comment on the role of apologies?

M It could be helpful in some sense for a solicitor to apologise without it being held against them by a professional body or insurer if that is the case.

C [I then showed Marjorie a list on p.39 of Harris et al setting out a variety of reasons why mediation works in a Special Educational Needs setting. These are:

- “Allows communications to take place freely
- Overcomes deadlock
- Assists negotiations
- Focuses on important issues and needs
- Gets the right people and information together at the same time
- Makes everyone part of the solution
- Rebuilds trust
- Restores and safeguards relationships
- Explores options for mutual gain”

I asked Marjorie which of these apply to the SLCC mediation scheme]

M They all apply, with the reservation that mediation may rebuild trust and may restore relationships. In addition to these I think it enables people to draw a line under the episode. It’s better than a determination because they have both been involved in the process, so they can kind of say, ‘I still disagree with you but...’

C What are the goals of mediation?

M To seek early resolution of problems that can be sorted out between the people most immediately involved.

C Is diversion from investigation a specific goal?

M Yes, in a sense. We want to help parties resolve matters quickly. If appropriate, mediation can be a useful option for them to consider.

C Have the cases delivered those goals?

M Yes, even though only 21 out of 35 settled. [Marjorie then described her sense that one of the problems with mediation in this context is that there is ‘no down side for the complainer’. In other words, there is little incentive for the complainer to withdraw their complaint because it costs them nothing to continue on to investigation. In contrast the professional has a great deal to lose in terms of time, cost and reputation.]

C How might the SLCC mediation scheme be improved?

- M – More information for Client Relations Partners (CRPs).
 - An education exercise for professionals, telling them what they can expect from mediation. Ideally I would have an education exercise for the public too, but they are in the nature of things harder to identify.
 - Perhaps it would create a more level playing field if complainers were charged a fee if they go to investigation and their complaint is not upheld. However the legislation we work under does not allow for this.

C Who rejects the offer of mediation more, complainers or legal practitioners?

M Out of 98 where mediation was rejected:

Both said ‘no’:8

Complainer said ‘no’:62

Practitioner said ‘no’:28

C How would you account for these numbers?

M I think there is a range of factors:

- Complainers have nothing to lose by continuing to investigation.
- Someone else will make the decision for them.
- Some are genuinely too nervous to sit in the same room as the practitioner even though I do provide two separate rooms and advise the parties that they don’t have to meet face-to-face if they don’t wish.
- Some complainers may be ‘vexatious’ complainers.

C Could you say more about the actual feedback you have received to date?

M The most significant finding, for me, is that, of 34 responses to this question [a return rate of 98%] 31 said they would recommend it to others, and three said they would not.

Overall evaluation of mediation:

Excellent	15
Very good	11
Good	9
Poor	1

These are roughly the same for complainers and practitioners.

C Could you see a role for mediation post-investigation, in the same way that restorative justice operates after a finding of guilt in the criminal justice system?

M That doesn’t sit comfortably for me. Why would they? They will have no continuing relationship.

C I guess that’s true in restorative justice as well, but it does offer a chance for an apology to be made.

M If an apology hasn’t been made by either party by then, I feel it would be unlikely to be genuine if made post-investigation.

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