

The role of mediation in present day practice: illustrations from case studies

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Arguments are mounting against litigation as the appropriate oversight mechanism for medical errors due to costs, time spent and a one-sided system in which the “winner takes all”.

In this case series, the role and potential benefits of mediation over litigation are discussed. In the cases discussed, mediation has the potential to decrease costs and time spent in conflict resolution when compared with litigation. Furthermore, mediation may provide psychological wellness benefits to the parties over litigation. A strong case can be made to pursue mediation initially in all patient-practitioner conflicts where possible.

Keywords: arbitration, mediation, medico-legal

Introduction

According to the Health Professions Council of SA (HPCSA) analytic report Jan 2015 to October 2018, anaesthesia practitioners (specialists and general practitioners) received the highest number of complaints compare to other medical disciplines [Personal communication – T Mohlamonyane, November 12, 2019]. Many of these complaints are non-clinical in nature and can be attributed to miscommunication,¹ lack of public awareness and the ever-changing expectations of the public.¹ This “fertile soil” and the growing medico-legal service industry has resulted in an increase in litigation.

HPCSA trend analysis report of complaints against anaesthetists
from January 2015 – October 2018

Items:	Description	Quantity
	Accounts	31
	Excessive fees	28
	Incompetence	27
	Insufficient care	11
	Reports	6
	Refusal of assistance	4
	Professional secrecy	3
	Putting patient in danger/at risk	3
	Bad communication	3
	Over service ²	2
	Impaired practitioner (Section 51)	2
	Advertising	2
	Operation performed without consent	1
	Improper relationship	1
	Colleague's reputation	1
	Total complaints	125

Mediation is a **structured, voluntary, non-binding, non-prejudicial** and **confidential** process, commencing after an **agreement to mediate** has been signed, and in which participants with **settlement authority**, assisted by a **neutral** person (the mediator), **self-determine** a negotiated outcome.³

Litigation is a process where public officials decide cases by applying the law to their understanding of the facts and proclaim who is ‘right’ and who is ‘wrong’; the process of taking legal action; the term used to describe proceedings initiated between two opposing parties to enforce or defend a legal right.³

As of 2016, the Medical Protection Society had reported a five-fold increase in total claims over a ten-year period, and the number of claims in excess of R5 000 000 had increased nine fold.⁴

By 2017, medical negligence liabilities reached R55 billion, and this was just short of one third of the entire public healthcare budget for 2016/2017.^{5,6} The extent of these medical negligence claims is unsustainable in South Africa. Secondly, a further unfortunate consequence is that this is resulting in a diminishing provision of specialist health care in South Africa. The number of practising specialists in fields such as paediatric neurosurgery and obstetrics is decreasing at an alarming rate.⁶ This is due to perceived unacceptable risk associated with continued substantial medical litigation in those sectors.

Two case studies serve to demonstrate the potential place and role mediation could play in present day practice.

Case studies

Case study 1: Gynaecology

In March 2014, a 20-year-old patient was booked for a laparoscopic ovarian cystectomy commencing at 08h00. The patient's mother signed the informed consent form on behalf of the patient. The start of the operating slate was delayed because the anaesthesiologist, Dr K, had been requested by the same treating gynaecologist, Dr G, to insert a labour epidural in another, actively labouring patient. Dr G, concerned about the delay in the operating time, asked for the patient to be brought directly to the theatre. Dr K considered the patient to be of appropriate age and maturity to consent for themselves and a preoperative assessment was done outside the theatre.

Co-payments were discussed with the patient but not with the family, who were not present at the time of this consultation.

The procedure was uneventful, although it took longer than anticipated and the patient was discharged home seven hours later. Dr K did not see the patient after the operation.

An invoice was submitted to the patient's medical aid. There were two communications between the patient and Dr K's billing company, and one error on the invoice was rectified. The outstanding balance of the account was paid by the medical aid within three months and the family of the patient did not have to make any co-payments to Dr K. The administrative issues were dealt with by Dr K's billing company without his knowledge.

In November 2014 Dr K received a communication from the HPCSA, of a complaint from the patient's father against Dr K, alleging that:

1. There was over-servicing, in that theatre duration time was 72 minutes, and Dr K's time billed was 85 minutes.
2. Excessive fees were charged. This despite all outstanding balances being paid by the medical aid in accordance with the required regulations.
3. The charging of the 10 to 20-minute preoperative visit fee of R821.20 was inappropriate, as according to the complainant, a preoperative visit was not performed.

After the case was escalated to the Preliminary Committee of the HPCSA, Dr K was presented with a final charge sheet which stated:

"You performed a procedure on the complainant's daughter whilst you failed and/or neglected to obtain informed consent in respect of your fees. You are guilty of professional misconduct for not disclosing the fee and/or obtaining such consent in an improper manner and a guilty fine was imposed."

Until 2019, this case has been postponed more than ten times and has not yet been heard. The insurers of Dr K estimate that approximately R200 000 has been spent on legal fees. Mediation has been denied on the advice of the defendant's lawyers.

Case study 2: Orthopaedics

In January 2013 Dr A, an orthopaedic surgeon, performed a right total knee replacement on a patient under combined general anaesthesia and femoral and sciatic nerve blocks. The procedure went well.

One day postoperatively, the patient complained of severe pain over the right knee and paraesthesia under the right foot. The orthopaedic team assessed the patient and concluded that the symptoms could be due to complications of the nerve blocks. A neurologist performed nerve conduction studies and a diagnosis of a posterior tibial nerve neuropraxia, unrelated to the nerve blocks, was made. The patient was discharged one week later with corticosteroid and anti-inflammatory medication and returned to her home on the coast.

Three weeks later, the patient's complaints had intensified and a report from the treating physiotherapist noted that *"the leg looks crooked and the foot has bad sensation and is painful to touch"*. The patient attempted several times to contact Dr A, who was out of the country, although e-mails and telephonic conversations were exchanged. The final advice given to the patient was that if she was unable to return inland to consult with Dr A, she should consult an orthopaedic surgeon in the coastal area.

A senior orthopaedic colleague, Dr B, in the coastal area, assessed the patient and in his opinion, he felt that her leg was in an acceptable alignment. He reassured her that the nerve symptoms should recover spontaneously.

By March 2013, the patient complained of a sudden increase in her knock knee appearance and increasing pain in the right foot. She consulted with the third orthopaedic surgeon, Dr C, who thought it might be complex regional pain syndrome. X-rays of the right knee revealed a valgus deformity of the knee with spin-out of the whole tibial insert, which is a rare complication of knee replacement.⁷

Immediately following this consultation, the patient consulted a lawyer and instituted a negligence and malpractice claim of several million rands against Dr A, who was instructed not to contact the patient again. The case dragged on, without progress being made, between 2013 and 2018. At this stage one of the expert witnesses suggested that the case go through mediation. Three weeks prior to the first court appearance, the defendant's legal team reluctantly agreed to mediation.

On the day of the mediation the defendant (Dr A) was shown plaintiff and defendant's expert reports for the first time. Both reports were of the opinion that there was no negligence on the part of the primary treating surgeon but rather due to a rare but well-described complication of knee replacement surgery.⁷

Mediation of this case took four hours (compared to the five years and counting of the medico-legal case), and a settlement of about R200 000 was reached, a fraction of the initial demand. The insurers of Dr A estimated that the medico-legal fees, prior to the mediation, had cost them approximately R500 000.

Discussion

The current litigation system for addressing and dealing with complaints against medical practitioners is time-consuming, expensive and flawed. The "winner takes all" approach means that cases are often pursued without considering all the facts. The second case study presented provides a good example in which the defendant's lawyers were confident of a large settlement for negligence, which proved to be unfounded.

Mediation is one of the primary processes of alternative dispute resolution. In mediation, a neutral third party (the mediator) mediates (acts as a go-between, facilitates) the conflict between the patient and the doctor/s to reach a conflict resolution (a mutually acceptable agreement). This agreement may take the

form of a settlement and the settlement may be made an order of the court, if the parties agree to do so.

There were some similarities between the two case studies that were identified during the interviews.

1. Psychological disturbances

All individuals experience stressful life events, and up to 84% of the general population will experience at least one potentially traumatic event. In some cases, acute or chronic stressors lead to the development of posttraumatic stress disorder (PTSD) or other psychopathology. However, most people seem to be resilient to such effects.⁸

- Re-experiencing symptoms: examples are flashbacks and bad dreams. The defendants, in both cases, experienced similar symptoms during their daily clinical routine.
- Avoidance symptoms: Dr K (anaesthesiologist) started avoiding any white A4 registered envelopes in his postbox. He mentioned that he would wait a few days before opening any correspondences from HPCSA. Dr A (orthopaedic surgeon) would avoid talking about the case with others.
- Arousal reactivity symptoms: Their main complaint was difficulty in sleeping. Both practitioners described feeling tense at times, "on the edge" and irritable.

Dr A's personal quote-

"this is tearing up my life... I could not sleep... It affected my soul."

- Cognitive and mood symptoms: Both had distorted guilty feelings, loss of interests in their normal enjoyable activities. Both practitioners lost time spent with their families.

2. Time-consuming

These cases dragged on for more than five years and Dr K's is still ongoing because mediation was denied. All the psychological disturbances described above persisted throughout that time. Dr A described the relief he had when mediation was concluded in less than four hours and the 'first good night of sleep' after five years of emotional trauma. When cases do go to trial, they are lengthy with average trial lengths of five years and have less than 10% success rates for the plaintiff. Even when successful, the majority of the awards go to the attorneys, not the plaintiffs.⁹

3. Lack of communication

Both practitioners were not allowed to speak to their patients after the complaints/litigation were lodged due to the clause "obstruction of justice". Dr A also had minimal communication from his lawyers over the period of five years.

4. Dignity violation

Both experienced a dignity violation. Dr K's complainant called him a 'fraudster'. Dr A had a chance to reconcile with the patient at the end of mediation.

5. Costly exercise

Both practitioners were indemnified by the same insurance company. Mediation expenses were about R30 000 for Dr A's case which saved millions of rands. The cost of litigation must not only be considered in terms of time and money; the

damage to the quality of life of both the defendants and the doctor involved is significant. The mediation cost structure is approximately one tenth of the litigation costs, considering both the financial and time cost.^{6,10} If the second case were to go to mediation, the costs would likely be similar.

"An ounce of mediation is worth a pound of arbitration and a ton of litigation."

Joseph Grynbaum¹¹

6. Reputational damage

Litigation is publicity prone whereas mediation is private and confidential. A well-known and respected orthopaedic surgeon's career was at risk if it was not for mediation. The anaesthesiologist could not enrol for fellowship internationally because his case is still ongoing which resulted in their certificate of good standing being listed as "pending".

In general, over 90% of all disputes never reach court, and some 95% of those that do, are resolved without going to trial.¹² Is there any point spending a large amount of money, much anguish and years in litigation, only to have cases resolved by negotiation?¹² Spending years litigating only to settle the case by negotiations, has been described as the equivalent of travelling from Johannesburg to Cape Town via London. You will have reached your destination but is it worth it?

Conclusion

The concept of mediation, as opposed to litigation, is a product of significant social and political changes in both society and in the medical and legal professions. The authoritarian illusion of exclusive control as exemplified by the current regulatory institutions such as the courts and the HPCSA are still appropriate in certain circumstances but, instead of occupying this space exclusively, courts should share this space with communities and provide resources for them to act wisely on their own behalf.¹²

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