Mediation and Arbitration in Healthcare Dispute Resolution

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DISPUTES IN healthcare can arise from a variety of reasons. While failure to provide proper care resulting in patient harm is one such reason, adverse outcomes can arise even with the best clinical care. A lack of good communication following adverse outcomes, whatever the cause; or indeed poor communication or rupture of the doctor-patient relationship, even when no adverse outcome has occurred; is often at the root of patient dissatisfaction. This has been discussed in an article that was published in the January 2013 issue of *SMA News* that focused on basic aspects of mediation.[1]

Mediation is a dispute resolution process with conciliatory communication at its heart. It contrasts with the conventional adversarial court or disciplinary process, which serves to further widen the chasm between disputing parties. The potential that mediation has to amicably resolve disputes is not confined to those arising from communication failure, but is also pertinent to disputes where clear substantive issues are involved.

Whether in the State Courts, Singapore Mediation Centre or in private mediation settings, I have seen mediation successfully resolve disputes for a wide range of scenarios, be it sales of goods between dealer and distributor, construction contractor and subcontractor, sibling disputes over property rights and of course, healthcare disputes, to name but a few. Short of a serious criminal offence or disciplinary lapse, or when one of the parties to the dispute (or the lawyer) is clearly unreasonable and refuses to be otherwise, just about every dispute can be successfully mediated.

Therefore, healthcare providers should consider utilising mediation as the "first-pass" method to resolve disputes. This can be achieved by including a clause in healthcare contracts stating that mediation should be attempted in the event of any dispute. All other conventional routes like the courts, arbitration or complaints to Singapore Medical Council (SMC) remain open should this process fail. Lawyers representing parties in mediation should ideally be mediation advocates or collaborative practice lawyers who understand the conciliatory approach to dispute resolution.

Mediation for SMC disciplinary issues

Section 42(4)(b)(ii) of the Medical Registration Act allows for the SMC Complaints Committee, upon review of the issuer, to refer the matter for mediation between the registered medical practitioner and complainant.[2] It will be useful for SMC to consider whether all but the most serious disciplinary issues are better resolved by mediation. If there are technical medical issues involved, it would be beneficial to employ doctors trained and experienced in mediation to conduct the process.

Confidentiality

Two major advantages of mediation are the conciliatory nature of the process and cost savings. Confidentiality is another very important feature, which is common to both mediation and arbitration. The rest of this article will examine how mediation can be coupled with arbitration to provide an alternate dispute resolution process that affords the benefits of mediation as an opportunity to be realised and minimises the threat of unwanted publicity.

Arbitration-mediation model

A documents-only arbitration is performed for the disputing parties, with the agreement that it will only be enforced if subsequent mandatory mediation attempts fail, and that they will be otherwise bound by any mediation agreement. The arbitral award can be sealed in an envelope,

and opened only if mediation fails to resolve the issues. The arbitrator is a co-mediator in the mediation process.

This mediation model allows for a conciliatory agreement in the face of a potentially adversarial outcome. The arbitrator acts as a co-mediator but can be excused if necessary, for example during the individual caucus when more personal and sensitive issues are discussed. The arbitrator, who sits as co-mediator, is particularly effective in reminding parties about BATNA (Best Alternative to a Negotiated Settlement) and WATNA (Worst Alternative to a Negotiated Settlement), and the potential for a lose-lose outcome in the event of non-resolution. Lawyers need not be present during the mediation as the legal arguments have already been made for the arbitration.

Mediation-arbitration model

This is the conventional model where mediation is potentially coupled with arbitration for dispute resolution. Arbitration is the agreed modality to resolve the dispute if mediation fails. In this context, arbitration is conducted in the conventional manner, with full court hearings and lawyer representation. The mediator is usually also the arbitrator. Detractors fear lack of objectivity once the unfettered story has been given to the mediator-arbitrator, along with concerns that parties will not be open during mediation. One possible solution to this is that the arbitrator could take on the role of co-mediator and be excluded from the individual caucus, with parties retaining the right to confidentiality from this potential arbitrator for specific portions of the discussion with the other mediator.

A potential advantage of getting the arbitrator to be a co-mediator as well, is that parties are less likely to be unreasonably obstructive during the mediation process, knowing the final arbiter is privy to their actions.

Challenges to mediation in the healthcare community

The present system of dealing with potential and actual disputes is usually highly dependent on the advice of the lawyer consulted. Even as mediation's immense potential to better resolve disputes is recognised nationally, with plans for a Singapore International Mediation Centre currently under way, there are lawyers who are either unfamiliar with and ill-equipped for it, or are obstructive to it perceivably for their own vested interests.

The selection of appropriate mediators is also essential. Lawyers and the lay public, including doctors, sometimes mistakenly believe that judges, retired or otherwise, or senior members of the legal profession, make the best mediators. While there are such people from these categories who are indeed highly effective mediators, being a good mediator requires a different skill set altogether.

Some key attributes to look for in a mediator are excellent communication skills, including empathy, strong problem-solving ability and mastery of the mediation process. A wide breadth of life experiences and sound technical understanding of the substantive issues of the dispute, along with a basic understanding of legal principles, further enhances the effectiveness of the mediator.

When plans are made to implement a mediation scheme in healthcare, we must ensure due diligence to ensure that those leading it have a proper understanding of healthcare and the challenges we face, are experienced practitioners in Medicine and mediation, and have the interest of our profession and society at the heart of it all. Failure to do so could undermine the potential of mediation to better resolve disputes and save costs.

Conclusion

The healthcare fraternity should consider including the option of mediation into contracts as the main legal dispute resolution mechanism. This of course can still be waived upon the agreement of both disputing parties, should the prevailing sentiment be that mediation would not be helpful.

Where arbitration is desired, whether or not it is the contractually agreed final dispute resolution mechanism, the mediation-arbitration model can be utilised for bigger claims. The threshold can be set at the $250,000 level which normally requires action in the Supreme Court. The documents-only arbitration-mediation model can be utilised for claims below $250,000.

As healthcare professionals, we should take better charge of how disputes in our arena are resolved. We must equip ourselves to understand how each dispute resolution mechanism works, and only employ the adversarial approach, like disciplinary hearings and court action, in the few circumstances where it is clearly necessary.

In most cases, we will then see that the decision to opt for mediation is the logical first step to trying to resolve a dispute. No lawyer should stand in the way of such decisions we have made. As medical practitioners, we are the ones who truly understand our profession, so we must be charged to set up and implement a viable mediation scheme. ■

References

1. *Loke P. Mediation in doctor-patient dispute resolution. SMA News 2013; 45(1): 14-5. Available at: http://goo.gl/6cg8j3. Accessed 22 April 2014.*
2. *Attorney-General's Chambers. Medical Registration Act (Chapter 174), Section 42(4)(b)(ii). Available at: http://goo.gl/5DXAM. Accessed 22 April 2014.*

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