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CLINICAL CLAIMS AND THE USE OF MEDIATION AS AN ALTERNATIVE DISPUTE RESOLUTION BY THE IRISH AND BRITISH HEALTH SYSTEMS – A MULTIPLE-CASE STUDY OVER THE LAST FIVE YEARS.

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Master of Arts (MA) in Dispute Resolution

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Initially, I want to thank myself for being persistent and not giving up on my dreams, even of the most difficult ones that were to leave my country and to start all over as a professional and student again.

This research is a proof to a future me to look back and understand that I am capable and strong enough to achieve my goals and see myself with more self-esteem and confidence in my abilities and knowledge.

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Abstract

This dissertation was done as a mandatory conclusion project of the MA in Dispute Resolution completed in Independent College Dublin in November 2022.

This research aims to explore how the governments of Ireland and England have been dealing with clinical claims in their health public system, using mediation as an alternative dispute resolution in the last five years.

The objectives to guide this research were:

To explore how the Irish and British governments have been managing complaints from their health public system involving health professionals, hospital or other healthcare service providers and their patients and/or families who allege medical negligence.

To identify the use of mediation as an alternative dispute resolution practice in cases of clinical claims occurred in Ireland and England in the last five years.

This research constituted of a multiple case study comparing systems in both countries, using a documental review as source for a quantitative and qualitative analyses.

Among the main findings, it was possible to conclude that both countries have been using mediation in cases involving clinical claims occurred in their health public system over the last five years. However, it has been applied in different ways and approaches, meeting the necessities and resources in each country.

The author concluded that just this research it is not enough to deeply comprehend the system of management of clinical claims in Ireland and England and their outcomes using mediation as alternative dispute resolution. Nonetheless, it is expected that this research can provide reliable source of information to the study of mediation in the health area, mainly to the use on clinical claims.

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Abbreviations

ADR – Alternative Dispute Resolution

CMC – Civil Mediation Council

EDR – Early Dispute Resolution

GMC – General Medical Council

HSE – Health Service Executive

MPTS – Medical Practitioners Tribunal Service

NHS – National Health Service

NHSR – National Health Service Resolution

NHSLA – National Health Service Litigation Authority

NMBI – Nursing and Midwifery Board of Ireland

NMC – Nursing and Midwifery Council

PHSO - Parliamentary and Health Service Ombudsman

PPC – Preliminary Proceedings Committee

USA – United States of America

UK – United Kingdom

Chapter 1 – Introduction

1.1 Overview

Healthcare professionals experience a range of stressors and unpredictable setbacks in the course of a long day at work. These stressors added to the pressure of having someone under their care will certainly affect those professionals in many ways, and create a perfect combination for conflicts to arise.

Considering how complex it is to work with ill people in a high pressure environment, having to cope with conflicts nearly every day, it is expected that some mistakes and misunderstandings will happen, generating formal complaints to hospitals and organizations. But in case of complex issues, when consequences are serious and affect patients' safety and integrity, how should the conflict be handled by professionals and organizations?

Cases of malpractice and medical negligence have taken special attention in courts and tribunals, for their complexity, time consumption and costs involved, and they can generate in claimants and healthcare professionals a mix of uncomfortable feelings. Many claimants, their families, and medical professionals must loathe the thought of appearing in court proceedings or even just having their case discussed in public. It is hardly significant how they feel about the treatment they believe to have been subpar. Healthcare workers who are under inquiry would dread cross-examination meant to show that they were careless as much as, if not more than, they will welcome the chance to clear their reputation. (Allen, 2018, p. 24)

Studying Alternative Dispute Resolution - ADR teaches people about? different approaches to cope with all kinds of conflicts, avoiding litigation process and having in mediation a fast and cheaper way of conflict resolution that presents great outcomes, even in cases involving medical negligence claims.

The Directive 2008/52/EC of the European Parliament and of the Council describes mediation as a cost-effective and quick extrajudicial alternative of dispute resolution in civil and commercial cases tailored to the needs of the parties, in which agreements are more likely to be fulfilled, preserving a more friendly and stable relationship between those involved.

Because mediation is founded on a cooperative conflict model rather than the win-lose mentality of the adversarial legal system and because it actively and directly involves the parties in seeking a resolution to their differences as opposed to imposing one on them, mediation's supporters claim that it should produce better results. It is asserted that this active engagement should result in

psychological commitment to the agreements made as well as lasting accords that accurately reflect the demands and circumstances of the disputants. (Deutsch, Coleman and Marcus, 2006, p.727)

Above are the reasons why public healthcare systems should be using mediation as ADR to solve conflicts that might arise among patients and/or families and healthcare professionals or organizations from cases of malpractice and/or clinical negligence. So, that was the beginning of this research , wondering how public health service has been dealing with clinical claims, and if mediation has been considered to cope with this kind of conflicts in their system.

1.2 Research Question and Objectives

The research question which delimited this study is:

How have Ireland and England governments been dealing with clinical claims in their health public system, using mediation as an alternative dispute resolution in cases occurred in the last five years?

As objectives for this research, these were expected through documentation review:

1) To explore how the Irish and British governments have been managing complaints from their health public system involving health professionals, hospital or other healthcare service provider and their patients and/or families who allege medical negligence.
2) To identify the use of mediation as an alternative dispute resolution practice in cases of clinical claims occurred in Ireland and England in the last five years.

1.3 Research Roadmap

This study is divided into 6 main chapters as described below:

Chapter 1 – introduction with a brief overview, definition of the research question, objectives, roadmap, justificative, scope and limitations of this research.

Chapter 2 – a literature review about the research subject in clinical claims and mediation, considering the peculiarities in the Irish and British health system.

Chapter 3 – the methodology of this research, describing the author's approach choice.

Chapter 4 - the presentation of findings and data analysis over the record review from both countries.

Chapter 5 – discussion of the research findings and analysis.

Chapter 6 - conclusion of this research with a brief reflection from the author.

1.4 Justificative and Limitations

Conflict has been studied over the last decades with a myriad of approaches in order to find the best ways to resolution. One can easily find numerous authors and research in that field, with different views and beliefs. At the same time, conflicts in the health field perspective are also well known and addressed by some specialists, mainly discussing the consequences for the health staff – mentally and physically. However, the study of mediation as conflict solving to that field does not seem to be used frequently and it's not widely known by health professionals.

So, there are many reasons to evaluate mediation as practice of conflict resolution involving health workers and patients in case of clinical claims. The healthcare environment is surrounded by different types of stressors such as insufficient number of professionals, ethical dilemmas, lack of materials, high pressure environment, shift work and others. All these factors can be challenging and contribute to the development a range of conflicts which can result in some cases of malpractice.

For Schweitzer (2008), health services can be translated in a field where ethical and moral judgments are constantly made in the daily practice of professionals, namely clarification, evaluation and decision-making involving situations where norms of conduct, values and beliefs can conflict. The health professionals have to find a balance among patient and hospitals interests maintaining ethic and practical efficiency as basement to their work.

Additionally, mediation as ADR solution can represent a reduction of high costs and time consumption of clinical claims in courts, providing fast resolution compared to the litigation proceedings. Therefore, it is relevant to identify the use of that in health public system considering all benefits that it can result and the confidentiality of the process, which gives patients and healthcare professionals the opportunity to express their explanations and apologies.

As ADR are a confidential process among the involved parties and considering also the confidentiality of clinical claims information, this research had as limitation the material and documents published to the public by official organizations, councils and representative organizations from both countries - Ireland and England. Also, the skills and knowledge of the author, including the short time to analyze the findings in depth, reason why the timeline of five years from 2017 to 2022 was chosen to delimit the data collection for this study.

Chapter 2 – Literature Review

2.1 Considerations About Clinical Claims

The field of healthcare corresponds to one where moral and ethical judgements are made, including clarification, evaluation, and decision-making that involve circumstances in which moral and ethical norms, values, and beliefs may clash. Always based on ethical and practical efficiency, health professionals seek to strike a balance between the interests of the patient and the institution where they work. (Schweitzer, 2008)

Patients often encounter medical professionals when they are emotionally distraught, mentally weak, or both. They are compelled to rely on the professional because they are unable to assert their own scientific knowledge. In this way, the connection, which is prone to being paternalistic, starts to be structured and dominated by professional norms. In recent years, patient advocacy organizations and medical sociologists have asserted that patients' and their families' expert understandings of sickness are also possible. Their skill is said to be both holistic and practical. The dominance of scientific discourse has made it hard for such accounts to be given the same level of legitimacy as those provided by doctors. But when patients claim a doctor's fitness to practice, they assert a different point of view. They question the veracity of the idea that there is a hierarchical agreement between the expert and the client. (Mulcahy, 2000)

When patients or family members write about inadequate care or other problems, complaints are frequently viewed as a bad experience in the medical field. These challenges that arise could be minor or significant. Patients and healthcare professionals could view things differently. For instance, healthcare professionals can be unaware of the degree to which patients' dignity was upheld, whether they encountered delays, or how they were treated. However, patients are aware of all of these facts. It is well established that patient input into their treatment can benefit medical care. These observations might not be valued as greatly as staff evaluations of the care's quality and safety, though. (O'Dowd et al., 2022)

In regard to fitness to practice in the healthcare field, it is important to define malpractice as, any professional misbehaviour, egregious incompetence or disregard for professional obligations, or illegal or unethical behaviour. Malpractice is a type of negligence, which is defined in legal terminology as either the doing of something that a reasonable and wise person would not do or the omission of something that a reasonable person, guided by the common factors which ordinarily regulate human affairs, would do. It is a term for poor, incorrect, or careless professional treatment

of a patient; it causes harm, needless suffering, or patient death in the context of medicine, nursing, and allied health professions. Even if the doctor or other medical professional acted in good faith, the court may possibly find that malpractice occurred. Omitting to take action when it is necessary might result in malpractice and neglect. While negligence can be described as in law, a person acting in a way that they would not ordinarily do or failing to act in a way that they would ordinarily act in a certain situation. When there is a legal obligation, such as the responsibility of a doctor or nurse to give patients reasonable care, and when the negligence causes harm to the patient, negligence may become the basis for a clinical claim. (Keane, 2003)

So, a demand for financial restitution for alleged injury brought on by inadequate clinical treatment is known as a clinical negligence claim or clinical claim. Incorrect treatment or failure or delay in diagnosis are frequent causes of claims. In practice, inadequate communication is the root of many allegations. (Medical Protection Society, 2015, online)

2.2 Mediation as an Alternative Dispute Resolution

There are numerous definitions of what mediation is, however, most academics, legislators and other professionals agree that mediation is a form of negotiation involving a neutral third party intervention who has no power or limited power of decision, considering that involved parties hold this power. The third party or mediator have the main role of helping the parties to mutually identify and reach an agreement of any issues in dispute. (McRedmond, 2018)

Debell (1997, p.2) defines mediation as a reasonable discussion between parties, led by an outside person who has the expert knowledge of the technical matter in dispute. It can result in an agreement accepted by both parties as a final position and a status of legally binding under the guidance of the mediator.

In Europe, the practice of mediation as ADR was first established in 1998 during the Council of Europe for a Recommendation on Family Mediation. In 2000, the European Council introduced the basic principles of ADR for civil and commercial law in order to simplify and improve access to the justice. Some other changes have been happening since that and nowadays, the attention to the internal market and consumers rights across the European Union, could be improved by using of ADR and the regulation of online platforms on dispute resolution. The practice of mediation in England has grown and has been supported by the court after the introduction of the Civil Procedure Rules 1998, that requested of either party or on the court's own initiative, remain proceedings while parties try to conclude the case using ADR – including mediation. In 2003, the Civil Mediation Council

– the CMC was created by different professionals and government departments, turning into the recognised authority in England and Wales for all matters related to mediation. While in Ireland, the turning point for the use of mediation happened in 2017 with the Mediation Act, that had as primary aim to integrate mediation into the civil justice system reducing legal costs, time consumption and effectiveness in dispute resolution. But mediation as a professional activity became visible in the mid to late 1980s, and in 1992 the Mediation Institute of Ireland was created intending to regulate and professionalise mediation in the country. Mediation until then was being carried out informally in the Irish society. Currently, the adoption of mediation laws and policies by European institutions reflects the growth of mediation as an effective form of ADR and even more so as an accepted practice of an integrated justice system. (McRedmond, 2018)

McRedmond (2018) describes that some mediation models were developed mainly based on their types of approaches that follow different goals in the process. The problem-solving models has the aim of reaching an agreement and it is possible to identify two basic approaches – facilitative and evaluative. Whereas, the relationship based models, exemplified as transformative and narrative mediation, intend to assist people with their relationships and personal growth while settlement is being reached, being the process of mediation as important as any agreement. According to McRedmond (2018), the four approaches can be summarized as:

Facilitative Mediation: model based on the assumption that self-determination of the parties is paramount, that work together with the mediator to reach an agreement. The parties are assumed as intelligent and capable of understanding their situations better than anyone. The mediator focuses on developing parties' skills and capacities by in-depth questioning and listening, in order to help them to identify and explore interests and options to achieve a settlement.

Evaluative Mediation: in this approach, the mediator tends to assist the parties to identify their options providing some directions. The mediator will introduce their own assessment of the parties' options into the process, valuing their own knowledge, law and practice expertise as important part of their skill. In this process, it is believed that parties need detailed information about the case to reach the most successful decision-making. The mediator is usually an expert in the field, that is, in discussing among the involved parties.

Transformative Mediation: in this process, parties are guided to recognize their needs and capacities, focusing to promote empathy among them. It can foster personal growth and relational changes, having an agreement as a secondary outcome into the process. The mediator in this approach will support the parties as where they want to go in their dispute, without intervening in

changes of the discussion subject, promoting shifts in empowerment and recognition between them, to reflect in their self-confidence and empathy during the mediation.

Narrative Mediation: the mediator in this approach will conduct the parties to make sense of the world around them, deconstructing parties' primary idea of the case and creating a new story of their interaction, helping them to move towards in a new positive narrative. The mediator is very active in the process, breaking down the parties' stories and holding pieces of that for putting into examination by them, supporting their abilities to make new understanding and views of the case, without limit to legal or social norms believing that the parties decide what is fair in the resolution. The conclusion of a successful mediation may not be an agreement.

Allen (2019) defends mediation as an excellent way for dispute resolution, not only for enabling patients and their families to hear explanations and apologies, but also for giving them the opportunity to voice their concerns, which otherwise would not be possible in a meeting with lawyers. In truth, trials are conducted in the assumption that parties want someone to make a judgment for them, because they cannot make this by themselves. Their focus is not to provide parties satisfaction for the decision delivered or through the way that the process is driven.

However, for Deutsch, Coleman and Marcus (2006) mediation is not a "magic bullet" capable of solving all kind of conflicts. For the author, there are six factors which will possibly affect the success of mediation in dispute resolution, as following:

High levels of conflicts – the conflict intensity and severity are negatively correlated with difficulty in helping parties to reach a settlement. The anger, lack of trust and strong ideological and cultural differences affect the process.

Low motivation – if some of the parties do not have interest in resolving the conflict, the probability of agreement is low and mediation tends to fail.

Low commitment to mediation – both parties have to be interested in participating in the process, also trust the mediator skills.

Shortage of resources - resource shortage may reduce the range of mutually agreeable solutions that can be identified, as well as the parties' and mediator's motivation to look for them.

Disputes involving "fundamental principles"- for instance, international disputes when ideologies are at stake, labour disputes involving union recognition as opposed to wages, these kind of matter are specially difficult to resolve.

Unequal power – when some of the parties are much more powerful than the other, meaning more articulate, self-confident and so on, mediation becomes more difficult.

2.3 Conflicts in Health Field, Clinical Claims and Mediation

Conflicts regarding malpractice claims have a profound impact on healthcare workers as well as patients because of the issues they raise. Health professionals mention the embarrassment that is caused, the poor work atmosphere that is developed, which has an adverse effect on how roles are performed, and the fact that they are not satisfactorily remedied. Additionally, they exhibit worries about how to deal with what happened and avoid such circumstances in the future. (Claro and Cunha, 2017)

In hospitals, the potential for ADR appears to be almost limitless. Arbitration is a standard clause in hospital purchasing contracts, as evidenced by its widespread use in commercial disputes. Arbitrating or mediating financial disputes between hospitals and patients or third-party payers has also great potential. ADR, particularly mediation and arbitration, can be used to resolve disputes involving disciplinary measures and other human resource decisions. Professional service contracts should also include some form of ADR. However, because the parties typically have a significant relationship and interest in continuing that, mediation should be the first step in resolving disputes in this case, for it typically produces a win-win outcome rather than the win-lose outcome found in arbitration agreements or court cases. Also, mediating ethical questions may help to resolve disputes within families and caregivers about the care of a family member who has become incompetent. Issues may include the appropriate care required, end-of-life decisions, and the patient's intentions in terms of medical decisions. (Darr, 1994).

In clinical claims, patients and their families are not looking for monetary compensation as priority. They want apologies, admission of fault, investigation of their case, information and demonstration of their concerns and also prevention of recurrences. The mediation process allows them to speak up their feelings, facilitating dialogue and explanation, generating more satisfaction for the complaining parties. That is quite the opposite of what studies had shown for litigation process, which presented a high percentage of dissatisfaction between claimants even when there was monetary compensation. Whereas, when a case of negligence claim comes up to a healthcare professional, they experience a mix of different feelings such as fright, denial, shame, self-blame, anger, insecurity, low self-esteem and confidence. It is obvious that no professional wants to deliberately make a mistake, mainly those in the healthcare sector who deal with human lives on a daily basis and simply wish to improve the health of the people who are under their care. Hence, the deep reluctance displayed by some professionals when asked to participate in mediation, especially because they are aware they will confront the patients or their families face-to-face.

Alternatively, it may create acceptance by understanding it as a positive step to move towards to the claim resolution, also as an opportunity to express explanations of what happened, apologies and regret. (Allen, 2018).

In order to help patients and their families understand the actual situation in which they are involved, Liebman and Hyman (2004) claim that mediation provides a scenario of information exchange between medical professionals, patients, and families. Mediation also helps in the transmission of complex information about the uncertainties of medical treatments. Since the mediator will assist with information that is frequently lost or with more delicate questions regarding patients' opinions, which helps to an already-existing conflict resolution, the hospital can also gain additional information and introduce new standards with the help of mediation.

Conflicts that develop in the healthcare context are visible and observable in their concrete and physical forms. As it takes into account that each individual has certain requirements that are different from those of others, mediation can also help in building better relationships between medical professionals, patients, and their families. On the other hand, using mediation enables patients and their families to perceive that all healthcare teams, including doctors, nurses, and assistants, have restrictions on how they can perform their duties, which frequently fall short of what the patient expects. (Andrade, 2007).

Allen (2019), says that in a final analysis, all disputes arise between human beings, are developed and sustained entirely by their characteristics and deep feelings, whether or not this surfaces during whatever dispute resolution process is adopted. Mediation can assist people to reach outcomes beyond what court proceedings can award, considering their participation in the process, direct encounter and uncomfortable conversations among the parties into the process, providing considerable and underrated value for them. Even when the outcome mediated is something distance of what a judge would have ordered on a win/lose decision, what is negotiated follows in the shadow of the law and with due respect for the law, also attending the parties demands and concerns. But the mediation and justice system symbiosis is essential and inevitable. It improves efficiency and simplifies access. A court trial will always have a rational approach to decision-making. While in mediation, interpersonal contact will offer best opportunities to cope with disputes in a human and emotional level as well, being conducted in a safe and confidential process, and managed by a neutral and skilled third party.

Hospitals, healthcare institutions, and other healthcare facilities can use mediation to stop disputes before they start, lessen the chance of disputes growing, and save associated expenses. It also

enables early conflict intervention, frequently preventing the progression of the process to court, which reduces associated expenses. Additionally, it helps to develop internal dispute resolution techniques, which results in a more beneficial policy from an economical perspective. Finally, it enables the discovery and resolution of the dispute's core problem, ending the conflict and averting further occurrences. (Claro and Cunha, 2017)

2.4 Clinical Claims and Mediation Outside Europe

In the United States of America – the USA, Dubler and Liebman (2011) discussed a growing in conflicts involving patients, families, and health professional because of the current understanding of health as a business. They said that patients and families may not trust in what has been done to them, thinking that some exams or procedures may be a way to overprice a service. In addition, institution's administrators seeking for profitability have been increasing the productivity of their providers and the patients' discharge in acute care. At the end, all these factors cause the tension between nurses and doctor to increase, resulting in a conflict-prone work environment.

The authors also defend what they call "bioethics mediation", which consists in the introduction of clinical ethics perspectives combined with mediation techniques, in order to identify the parties involved in the conflict; understand their interests; minimize disparities among patients, families and medical professionals; define their interests and common consensus; maximize the options for a resolution and make it accessible to the health staff explaining the bioethics issues involved; follow the agreement implementation and conduct follow-up. For them, one of the main advantages of mediation into bioethical conflicts is the flexibility of the process. It can be altered to meet the patients and family's needs, as long as it respects the impartial position of the process.

Darr (1994) said that among all benefits such as low cost, fast outcomes and confidentiality, the latter is the major advantage in ADR. However, it makes studies difficult to determine how often alternatives resolutions are used in disputes involving health services.

Supported by policies and encouragement by the USA government, many mediation programs have been implemented in the country to attend to different types of conflicts from personnel to employment, including disputes to public conflicts in health care. The programs have been recognized as one of the most significant movements in the US law in the latter part of the 20th century. (Deutsch, Coleman and Marcus, 2006, p. 726)

Mediation process has been used in disputes involving health providers covering a variety of conflicts – disputes among nursing home residents and staff, medical care refunding, complaints of

medical care services and products, malpractice claims and bioethics disputes. It is not always successful like in other types of disputes such as divorces, commercial disputes, minor crimes and others. Also, understand bioethics conflicts as a subject full of complexity factors into the universe of providing care to individuals; it is paramount to understand the necessity for this process to reach a positive result, the clarification of medical facts developing solutions that attend the patient's values and satisfaction. Additionally, the increase visibility of popular movements as patient's right in society along consumer's movement also contributed to the mediation initiatives programs as a way to solve disputes in health services institutions (Dubler and Liebman, 2004).

Mamdani (2004), said that what differ malpractice cases from the USA to India is that in the latter the claims are handled by special consumer courts while in the former it is done in the state courts and compensation determined by a jury. In India, the idea of being against doctors, questioning their actions is something unlikely, even among wealthy patients. The author also mentions, the initiative of a fund to compensate patients who suffered an injury from negligence or malpractice cases in New Zealand.

In Brazil, for instance, there are some initiatives focused on increasing judicialization of social rights, which have been sought and implemented with the goal of reducing the number of claims involving the topic, particularly through institutionalized mediation. However, it is worth mentioning that mediation is also a technique heavily used by economic conglomerates to protect financial and industrial secrets. So, the careful use of mediation as a tool for promoting and gaining access to justice is crucial, making sure to exclude certain privileged interests (Ribeiro, 2018).

2.5 Mediation and Clinical Claims in England

In the United Kingdom - UK, the first mediation move focused on clinical claims was developed in the 1990s by the National Health Service Litigation Authority – NHSLA (nowadays, renamed as National Health Service Resolution or NHSR) but it had limited uptake for unknown reasons. Moreover, another pilot scheme started from middle of 2014 to end of 2015 and then promulgated a permanent mediation scheme in 2016. However, there have not been any studies on them yet, comparing both pilot schemes to analyze the positive and negative aspects, taking into consideration lessons learned, and advantages and disadvantages of using mediation to solve all types of clinical claims. Also, at that time lawyers in the UK did not know how to represent their clients into mediation process in cases involving clinical claims. (Allen. 2018, p. 2)

Nowadays, the National Health Service Resolution – NHSR in England has two providers who are

specialized in clinical claims related to personal injuries and clinical negligence incidents and claims against members of the NHS bodies, which are: the Centre for Effective Dispute Resolution and the Trust Mediation Limited. Apart from them, two other providers specialized in disputes involving the recovery of legal costs – but that is not the subject of this study. In addition to that, the NHSR provides a service called “assisted mediation”, which supports healthcare professionals to solve relationship issues between them, which in turn has a positive impact on the teamwork and on the care provided to all patients. (NHS Resolution, 2020a, online)

Sometimes, when a complaint to a hospital or healthcare provider is not solved, one may file a complaint using the Parliamentary and Health Service Ombudsman, which offer mediation among their services as a dispute resolution alternative providing a teamwork trained in that to support the parties involved in the situation. (Parliamentary and Health Service Ombudsman, n.d., online)

Summarizing the process in England, for a successful clinical claim the patient, relative or interested part has to demonstrate on the balance of probabilities that a breach of duty occurs when a treatment is provided, and also the causation – that breach or act of negligence which caused or contributed to the patient’s harm, injury or loss. To demonstrate neglect, it is necessary to pass both of these requirements. A pre-action protocol of ADR is established in England and Wales as an attempt to solve clinical claims without proceeding to court wherever possible. This protocol defines some steps among the parties and avoids stress, time and high costs associated with formal court proceedings. Even when formal legal proceedings are issued, most claims are discontinued, or settled by mediation or negotiation before going to trial. (Medical Protection Society, 2015, online)

For Allen (2019), the clinical negligence claims have been the major contributor of the growth in the use of mediation by the NHS scheme that was made permanent in 2016. In July of 2018, the NHS Resolution exceeded their 50 mediation target for the first year by more than three times, having confirmed a settlement rate of 75%. A relevant point to this result is the policy decision of NHS Resolution in effect to require solicitors to persuade claimant solicitors to participate in the process, expressing or implying warnings that unreasonable refuses to mediate, may lead to costs sanctions.

2.6 Mediation and Clinical Claims in Ireland

When someone was hurt as a direct result of medical malpractice or a lack of care, you may have a claim for medical negligence. The term "medical accident," "adverse incidence," or "patient safety incident" may also be used to describe this. It does not imply that the therapy was 'negligent' necessarily. While better care or safety precautions may have been able to prevent injuries, it's

possible that the incident itself was absolutely unavoidable. The Irish legal system acknowledges that medical negligence claims may be the most complicated subset of personal injury law. (Claims Ireland, n.d., online)

Looking into how clinical claims can be solved in Ireland, it is possible to identify that here the health system, known as Health Service Executive – HSE, in accordance with Part 9 of the Health Act 2004, establishes that any person – either patient or a professional, can raise a complaint by their website, telephone or email. However, there is no information available on the online page offering ADR as a way to solve conflict situations involving healthcare professionals, providers and patients. The process is detailed into three steps that involves firstly the point of contact for a written or verbal complaint; secondly an HSE formal investigation process; and finally the HSE internal complaint review. The HSE provides a list of complaint officers available in Ireland divided by hospitals, communities and primary cares, national ambulance service and national screening service. They inform that in case of no satisfaction about a complaint decision, the ombudsman service is available in that case. In no part of the process explained there is a mention of mediation as a conflict resolution service being available for the parties. (Health Service Executive, n.d.)

In 2010, the President of the High Court in Ireland created a Working Group in Medical Negligence Litigation and Periodic Payments to examine the system that handled claims resulted from medical malpractices to provide any kind of advice that may require to improve the system, to determine periodic payments to some kinds of injures, making recommendation to the president when necessary, and to supply the president with regulations, laws and rules drafts that may be required in order to implement the Working Group's recommendations. (Irvine, 2012, p. 3)

As defined by Kelly (2020, p.40) this group issued three reports between 2010 to 2013 that contained:

First report – recommendation of statutory provision empowering the courts to make some consensual and non-consensual period payments to compensate some injured victims of long-term permanent care as an alternative compensation way.

Second report – in 2012 proposed a model of pre-action protocol to attend clinical claims resulted from damages for negligence, breach of statutory duty or breach of contract arising from any act or omission. This report described benefits of the pre-action protocol to the current system and highlighted the potential of facilitating resources to mediation and other types of ADR in early stages of a case, to resolve some kind of clinical claims.

Third report – asking for new rules in order to facilitate the pre-trial in cases of clinical negligence

proceedings and providing new obligations related to the disclosure of evidence, having the operation of these new rules in conjunction with the pre-action protocol previously proposed.

Provisions to the pre-action protocols in clinical negligence cases were covered by Part 15 of the Legal Services Regulation Act 2015, with the Minister for Justice and Equality having the authority to prescribe them rather than the court rules committees, and periodic payment orders were covered by the Civil Liability (Amendment) Act 2017. The introduction of court rules to regulate management of clinical negligence actions await the prescribing of the pre-action protocol. The Law Reform Commission – LRC has also examined and recommended the use of mediation in cases involving clinical claims adhering to the Mediation Act 2017 that was brought into force in January 2018, and establish the obligations of practitioners to inform clients about the mediation as an alternative way to resolve their dispute before court proceedings. However, mediation has been underused in cases involving medical negligence claims, even showing a potential to minimize harm. (Tumelty, 2021, online)

In June 2018, the Irish Government created an Expert Group after many controversial cases related to the Cervical Checking Screening Program. The group met each month in the period between September 2018 to November 2019 to analyse clinical cases claims and they also recommended in their report the implementation of a pre-action protocol and some other actions that include a dedicated list in the high court to management and hearing medical negligence claims. (Meenan, 2020, pp. 3, 11)

Also in November 2021, a coordinated joint letter with a coalition of healthcare organizations was addressed to the Minister of Justice in Ireland signed by the Irish Hospital Consultants Association (IHCA), Irish Dental Association (IDA), Royal College of Surgeons of Ireland (RCSI), Royal College of Physicians of Ireland (RCPI), Irish College of General Practitioners (ICGP), Faculty of Dentistry RCSI, the College of Ophthalmologists in Ireland and the Medical and Dental Consultants Association (MDCA) emphasising the necessity of a regulation and introduction of a pre-action protocol to attend to clinical claims. (Medical Protection Society, 2022, online)

Despite all the attempts and work that have been done and described above, Ireland health system currently does not have an official ADR protocol to handle disputes involving medical negligence cases.

In Ireland, just 53% of claims are settled before going to court; whereas 70% of claims in England and Wales are settled out of court using pre-action protocols established over more than 20 years. Also, enormous expenses have an effect on the entire health system - according to the 2020 Annual

Report of the National Treasury Management Agency, legal and expert expenditures made up 24% of the overall cost of clinical claims (or €76.8 million out of €321.8 million). All this money would be better used for patient care. (Medical Protection Society, 2022, online)

Conversely, in the UK, between 2006-07 and 2016-17 the annual spending for NHS Resolution's Clinical Negligence Scheme increased from £0.4 billion to £1.6 billion, having a previous expectation to raise again by £3.2 billion in 2020-21. The pre-action resolution and mediation remain as the key strategy for the government to cut the high cost of clinical negligence claims. But they also recognize the importance of understanding and working on the root causes of clinical negligence claims in their health system. (Malla, 2018, online)

Chapter 3 – Methodology

3.1 Type of Research and Method

This research consists of an exploratory case study comparing the use of mediation in clinical claims cases as ADR in two countries – Ireland and England.

About case study, its ideally suited to the needs and resources of a small-scale researcher, that is focused on one to three examples which might be a place of work, an institution or organization. A case study usually describes issues or refers good practices, restricting the research to a detailed view, having as advantages to explore alternative meanings and interpretations, to provide data source for further analysis and to link actions to insights contributing to change practices. (Blaxter, Hughes and Tight, 2010)

By opting to study the mediation as ADR in clinical cases comparing practices in both Ireland and England, this study acquires a comparative design that entails the collection and/or analysis of data from two or more nations, and takes the form of a multiple-case study considering that it is examining more than one case. (Bryman, 2016)

A research design should include some components such as the study question's definition, propositions and the case – that can be individuals, groups, organizations, projects, decisions, etc. The establishment of these components will lead the researcher to identify data collection, define the logic linking the data to the propositions and the criteria for interpreting the findings. All that, will design the case study analysis. (Yin, 2018)

This case study is based on a mixed method research, combining quantitative and qualitative analysis based on documentation review of annual reports from official government bodies such as NHS, HSE, ombudsman, nursing and medical councils from Ireland and England issued in the period between 2017 to 2022 as inclusion criteria. Moreover, books, articles and news from reliable sources related to the main subject and the research question are also considered into this research. The period of time was defined by the author considering the time consumption and the deadline to submit the final research and also considering the complexity of a multiple-case study.

It can be said that multiple-case studies are complex and more compelling than single-cases, having as a disadvantage the requirement of extensive resources and time beyond the means of a single student or researcher. The mixed methods research combines quantitative and qualitative research techniques and approaches into a study, allowing researchers to address more complicated questions and collect richer and stronger evidence. (Yin, 2018)

As descriptors to this study, the following will be used: “mediation”, “healthcare providers”, “clinical claim”, “medical negligence”, “health professionals” and “alternative dispute resolution”.

3.2 Data Collection and Analysis

All data collected will be identified in a form previously made to facilitate the analysis. The form will collect information such as origin of source, authors if applicable, place and date of publication, main results and conclusion. Some other fields may be included in order to facilitate the process of identification and analysis of all material found. The analysis will be made through documentation and archival records review perspective.

As any type of source of evidence, documentation has its strengths and weaknesses, However, for the subject of this study, it has been the exclusive reliable source available in order to provide a more reliable answer to the research question considering the confidentiality of the cases involving clinical claims and the mediation proceedings. In the next figure, Yin (2018) explores the strengths and weaknesses of the six sources of evidence that can develop a research study.

Source of Evidence	Strengths	Weaknesses
Documentation	• Stable—can be reviewed repeatedly • Unobtrusive—not created as a result of the case study • Specific—can contain the exact names, references, and details of an event • Broad—can cover a long span of time, many events, and many settings	• Retrievability—can be difficult to find • Biased selectivity, if collection is incomplete • Reporting bias—reflects (unknown) bias of any given document's author • Access—may be deliberately withheld
Archival records	• *[Same as those for documentation]* • Precise and usually quantitative	• *[Same as those for documentation]* • Accessibility due to privacy reasons
Interviews	• Targeted—can focus directly on case study topics • Insightful—provides explanations as well as personal views (e.g., perceptions, attitudes, and meanings)	• Bias due to poorly articulated questions • Response bias • Inaccuracies due to poor recall • Reflexivity—e.g., interviewee says what interviewer wants to hear
Direct observations	• Immediacy—covers actions in real time • Contextual—can cover the case's context	• Time-consuming • Selectivity—broad coverage difficult without a team of observers • Reflexivity—actions may proceed differently because participants know they are being observed • Cost—hours needed by human observers
Participant-observation	• *[Same as above for direct observations]* • Insightful into interpersonal behavior and motives	• *[Same as above for direct observations]* • Bias due to participant-observer's manipulation of events
Physical artifacts	• Insightful into cultural features • Insightful into technical operations	• Selectivity • Availability

Figure1: Six Sources of Evidences (Yin, 2018, p.114)

For Yin (2018), documentation source consists of agendas, minutes of meetings, reports of events, administrative documents such as proposals and progress reports, formal studies and evaluations. While archival records, taking the form of data files, public use files, organizational records, maps and charts, or survey data produced by others. Emphasizing that in some studies, the archival records are so important that they become object of extensive and quantitative analysis.

As this research is a multiple-case study in which two different countries' systems are discussed, the analysis will consist of a cross-case synthesis that only applies in multiple-case studies.

The technique is to aggregate both findings from the different cases to produce a synthesis and all observations from that.

In a cross-case synthesis, the researcher's ability of recognize differences among the cases is essential, since no two cases are identical. Also, similarities in the material must be made to support the principles and interpretations from one case to another, being a challenge the development of strong and plausible arguments that are supported by the data. (Yin, 2018, p. 198)

Chapter 4 – Data Findings and Analysis

4.1 Ireland Data Findings and Analysis

As data collected to this study on Ireland, the author considered as source the reports made by Ombudsman Service, HSE, Medical Council and the Nursing and Midwifery Board of Ireland regarding the years of 2017 to 2022 years.

4.1.1 Ombudsman Ireland Reports

The Ombudsman roles' is to examine complaints of some public service providers as government departments, local authorities, the HSE, charities and voluntary bodies that deliver health and social service on behalf of the HSE, public hospitals, public and private nursing homes and third-level education bodies. (Ombudsman Ireland, n.d., online)

In regard to their data, the author has just considered the number of complaints received by the service and described in the reports issued from 2017 to 2022 in relation to the Health and Social Care Service, as well as Private Nursing Homes.

Ano	Number of Complaints of the Health and Social Care	Number of Complaints of the Private Nursing Homes
2021	796	83
2020	633	53
2019	708	65
2018	730	61
2017	608	63
Total	3475	325

Table 1: Number of Complaints from Ombudsman Report.

It is important to highlight that a number of complaints counted in their reports described in the Health and Social Care section, and also in the Private Nursing Homes section, were clearly not related to medical negligence cases, which is the focus of this research. The report also considered as clinical claims, complaints related to irregular charges claimed by patients and families from some healthcare providers. So, the author could not precisely identify the exact number of clinical claims just related to medical negligence cases.

However, analysing the private nursing homes complaints described in the reports, the author

should subtract the number of complaints due to the care and treatment offered to patients, as represented below:

Private Nursing Home Complaints		
Ano	Total of Complaints	Complaints Related to the Care and Treatment of the Elderly
2021	83	49
2020	53	29
2019	65	28
2018	61	07
2017	63	21
Total	325	134

Table 2: Private Nursing Home Complaints from Ombudsman Report.

Understanding that complaints related to the Care and Treatment of the Elderly is directly connected to the professional practice and assistance provided to the patient, the total number of 134 cases reflects in potential medical negligence cases and that could consequently turn into clinical claims in court.

Looking into the cases described in the reports, it was possible to find seven cases that can be related to clinical claims considering they involved patients and their families or relatives against health professionals or healthcare providers due to malpractice or situations that could affect patients' integrity or health. The examples of cases described in the Ombudsman reports that were related to the subject of this study are presented in sequence following a descending order of years from 2021 to 2017.

The first case in the figure below, presents a complaint from a woman against a private nursing home. Her mother, who has dementia, was a resident and left the home without anyone noticing, being later found in some street nearby, with some injures on her face. It happened in 2021 and by reading the report available one can infer that the nursing home did not know their obligation to provide information to family and to the Ombudsman. After being informed of that, the information was given to the service, however, to the family, a written report of the case was not provided by the nursing home.

Nursing home refuses to respond in writing to family's complaint about mother who left the home

Background

Norah complained to a private nursing home when her mother was found on her own, and with facial injuries, around three kilometres from her nursing home. Her mother was in her late 70s and had dementia. The nursing home initially refused to engage with Norah or her family saying that they could not make a complaint on behalf of her mother. Norah brought her case to the Ombudsman when the private nursing home refused to provide a written response to her complaint.

Investigation

The nursing home had initially told the family it could not discuss the case with them for a number of reasons including data protection provisions. It subsequently provided a verbal response to the family but refused to give a written reply.

When the Ombudsman sought information from the nursing home as part of his investigation, it said it was not obliged to respond to his Office. Once the Ombudsman clarified that under the Ombudsman Act 1980, the nursing home was obliged to provide his Office with the information, it provided the information, but continued to refuse to write to the family. The Ombudsman pointed out that the home was in breach of its own complaints policy by not responding in writing.

It became apparent to the Ombudsman that the nursing home had already carried out an investigation into the incident, and that it had made a number of recommendations aimed at avoiding the situation arising in the future. However, the nursing home's investigation was not carried out in accordance with its own complaints policy because of a:

- lack of documentation on the complaint file
- failure to initially accept the complaint from a third party
- failure to have the complaint independently investigated
- failure to provide a written response.

As a result of the Ombudsman's intervention the nursing home wrote to Norah apologising for the incident. However, it continued to refuse to respond to Norah in writing to the issues raised in her complaint.

Outcome

The Ombudsman provided a full written account of what had happened on the day of the incident to Norah, and her family.

He has also spoken with the Department of Health, with a view to having the requirement for private nursing homes to provide written responses to complaints put on a statutory basis.

Figure 2 – Case 1 (Ombudsman Ireland, 2021 p. 33).

The next case in figure 3, shows a complaint from a daughter that had her mother wrongly medicated in the emergency department of a public hospital in Dublin, Ireland in 2020. The hospital provided a written apology to the family and also an educational campaign about the importance of reporting incidents immediately.

4.1 Woman who had not consumed alcohol given medication for alcoholism

Background

Sarah complained to the Ombudsman after her late mother, Norah, who did not drink alcohol, was prescribed medication for alcoholism and alcohol withdrawal as part of her emergency cancer treatment.

Norah had attended the Emergency Department of the Mater Hospital with severe pains in her stomach and jaundice. While giving her medical history to the hospital, she made it clear that she did not drink alcohol. Norah had a previous history of cancer and the medical team admitted her to hospital for further tests. An ultrasound confirmed that Norah had liver cancer.

Later that night, Norah was given two medications that are commonly prescribed for individuals who have a history of alcoholism and for the treatment of acute alcohol withdrawal. Her family later noticed that she was drowsy and confused, and they spoke to the nursing team about their concerns. A doctor came to review the woman. The doctor noted that Norah had not drunk alcohol in 10 years and stopped the two medications.

Norah's family complained to the hospital that she had been wrongly prescribed medication. A short time later, Norah died, and the family felt that they had missed precious time with her because she was so drowsy from the side effects of the medication. They were also concerned that the hospital had made an assumption that Norah consumed alcohol.

The hospital acknowledged that Norah was wrongly prescribed the two medications but it was unable to identify the doctor who had written the prescription.

The prescription was initialled, but with no Irish Medical Council registration number. Norah's daughter, Sarah, made a complaint to the Ombudsman as she felt that the hospital should have been able to identify the doctor.

Examination

While the hospital had apologised to Norah's family it was unable to provide an explanation as to why the medications were prescribed as it had been unable to identify the doctor who wrote the prescription. Various efforts were made to try to identify the doctor, including speaking with the doctors that were working that day, completing a medication variance report form and comparing the initials on the prescription with the hospital's signature bank. An incident form was also completed. However, these actions were taken after receipt of a formal complaint from the family, as opposed to immediately after the medication error was identified. The only action taken at that stage was to stop the medication and provide the family with a verbal apology.

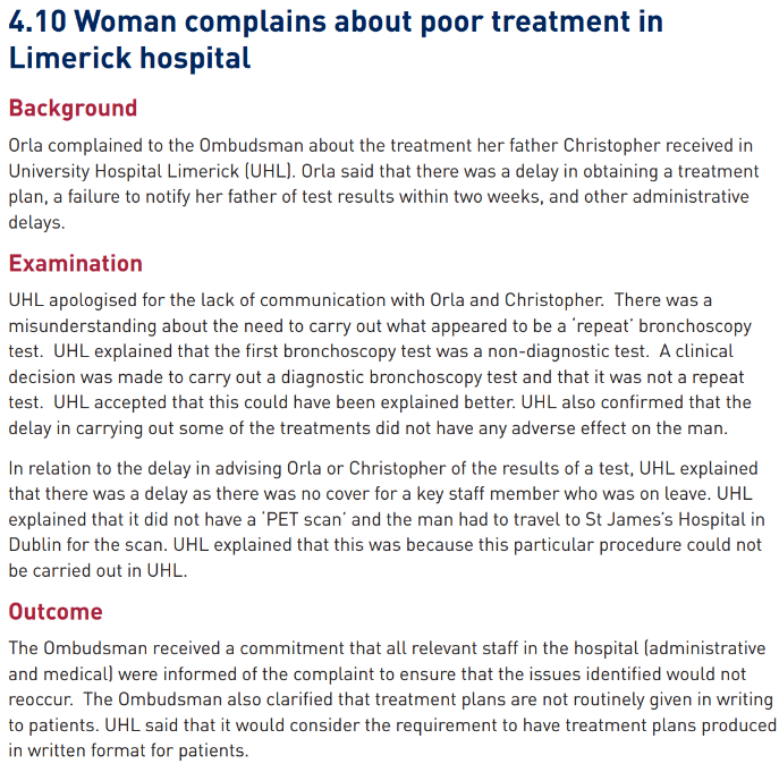
The Ombudsman said that the incident form should have been completed immediately, and greater efforts should have been made at that time to identify the doctor, as opposed to when the complaint was received.

Outcome

The hospital's CEO provided a further written apology to the family. The hospital is currently in the process of implementing an education programme for the multidisciplinary team in respect of the identification of prescribers and recording of the Irish Medical Council registration, which should be on all prescriptions. The hospital is also working on developing e-prescribing. A new electronic incident reporting system is also being introduced. This will be accompanied by an educational campaign, which will highlight the importance of reporting incidents as soon as possible.

Figure 3 – Case 2 (Ombudsman Ireland, 2020 p. 28).

The following case in figure 4, is also about a daughter that alleged a delay in her father's treatment and the disclosure of some exam results by a hospital in Limerick, Ireland in 2020. The hospital was committed to identifying issues and informing all staff so it would not reoccur.



4.10 Woman complains about poor treatment in Limerick hospital

Background

Orla complained to the Ombudsman about the treatment her father Christopher received in University Hospital Limerick (UHL). Orla said that there was a delay in obtaining a treatment plan, a failure to notify her father of test results within two weeks, and other administrative delays.

Examination

UHL apologised for the lack of communication with Orla and Christopher. There was a misunderstanding about the need to carry out what appeared to be a 'repeat' bronchoscopy test. UHL explained that the first bronchoscopy test was a non-diagnostic test. A clinical decision was made to carry out a diagnostic bronchoscopy test and that it was not a repeat test. UHL accepted that this could have been explained better. UHL also confirmed that the delay in carrying out some of the treatments did not have any adverse effect on the man.

In relation to the delay in advising Orla or Christopher of the results of a test, UHL explained that there was a delay as there was no cover for a key staff member who was on leave. UHL explained that it did not have a 'PET scan' and the man had to travel to St James's Hospital in Dublin for the scan. UHL explained that this was because this particular procedure could not be carried out in UHL.

Outcome

The Ombudsman received a commitment that all relevant staff in the hospital (administrative and medical) were informed of the complaint to ensure that the issues identified would not reoccur. The Ombudsman also clarified that treatment plans are not routinely given in writing to patients. UHL said that it would consider the requirement to have treatment plans produced in written format for patients.

Figure 4 – Case 3 (Ombudsman Ireland, 2020 p. 36).

The next case in figure 5, consists of a complaint from a woman who had a doctor discuss with her a medical condition that was hers, but from a different patient who had the same name as her. Later, the patient also discovered a medical letter mixed in the her medical chart. After this mistake, she decided to cancel her surgical procedure in Letterkenny University Hospital in 2019. The hospital apologised for their mistake, and also was committed to providing training to the staff and reviewing their policies in relation to medical records.

4.2 Records management improved after confusion over woman's medical file

Background

Deirdre complained to the Ombudsman after a doctor at Letterkenny University Hospital discussed her medical history with her but she realised it was not hers. She then discovered a letter on her file belonging to a different patient but with the same name as hers.

Deirdre had attended the hospital for a surgical procedure but she cancelled the procedure after the mistakes. Deirdre complained to the hospital but was unhappy with how it responded to her complaint.

Examination

The doctor had quoted the wrong medical history as he had read it from another patient's record, which was misfiled on Deirdre's medical chart.

A 'General Incident/Near Miss form' which should have been completed immediately after the incident was not completed until after Deirdre had complained to the hospital. In addition the details on the form were not entirely accurate.

There was also some confusion around the 'pre-assessment' prior to Deirdre's attendance at the Day Services department for her surgical procedure. The HSE said that the 'pre assessment' form was not signed by Deirdre as the pre-assessment was conducted over the phone, which is normal practice.

Outcome

The General Manager of the hospital apologised to Deirdre for the distress she had suffered.

In order to avoid a similar incident occurring the hospital:

- delivered refresher training to hospital staff on the correct filing of documents in medical record charts
- reviewed its policies in relation to medical records management and
- will be delivering training on the policies to staff.

The Ombudsman will be following up with the hospital in mid-2020.

Figure 5 – Case 4 (Ombudsman Ireland, 2019 p. 28).

The other case, in the next figure, is a complaint against Limerick University Hospital made by a daughter in 2018, reporting that her father had undergone surgery with the use of regional anaesthesia and could hear the loud surgical instruments, causing him distress. The hospital apologised for the situation and purchased earphones to avoid this occurrence in surgeries involving regional anaesthesia. Moreover, the hospital staff will have to register the offer of earphones and music to the patients in that situation.

4.5 Man distressed by the noise of his own surgery

Background

A woman complained that while her father underwent surgery in Limerick University Hospital, he could hear the noise of the instrument used for his surgery. This caused him distress.

Examination

As the man was not a suitable candidate for a general anaesthetic, he had surgery under a 'spinal block'. This meant that he was awake during the operation. The hospital said that staff offer ear phones and music to patients undergoing surgery under regional anaesthesia involving loud surgical instruments.

However, it could not say whether this offer was made to the patient during his procedure. Examination of the medical and nursing notes found no record of the patient being offered, or using, earphones.

Outcome

The hospital apologised to the patient for the experience. It acknowledged that the incident had increased the stress for the patient. The hospital purchased disposable earphones for use by patients during surgery involving regional anaesthesia.

In addition, staff have been documenting the offer of earphones and music, and the patient's response.

Figure 6 – Case 5 (Ombudsman Ireland, 2018 p. 31).

Another case is described below:

4.7 Medical staff unable to access patient records over the weekend

Background

A man had a procedure in Connolly Hospital. Two days later the man was experiencing chest pains so he went to the Emergency Department in Connolly Hospital. However the hospital staff could not access the medical records from the procedure the man had undergone two days before.

The man complained that there could have been serious consequences in an emergency as hospital staff were unable to access his medical records.

Examination

The man's procedure had taken place on Thursday. Following his procedure staff sent the man's medical records to the Hospital In-Patient Enquiry (HIPE) Department on Friday for coding.

His medical records remained in the HIPE Department over the weekend. Therefore, they were not accessible by the medical staff when he arrived in the Emergency Department on Saturday.

Speedy access to a patient's medical records is essential to assist hospital staff provide the best care to any patient and a lack of up to-date information can lead to the unnecessary duplication of tests or misdiagnosis.

Outcome

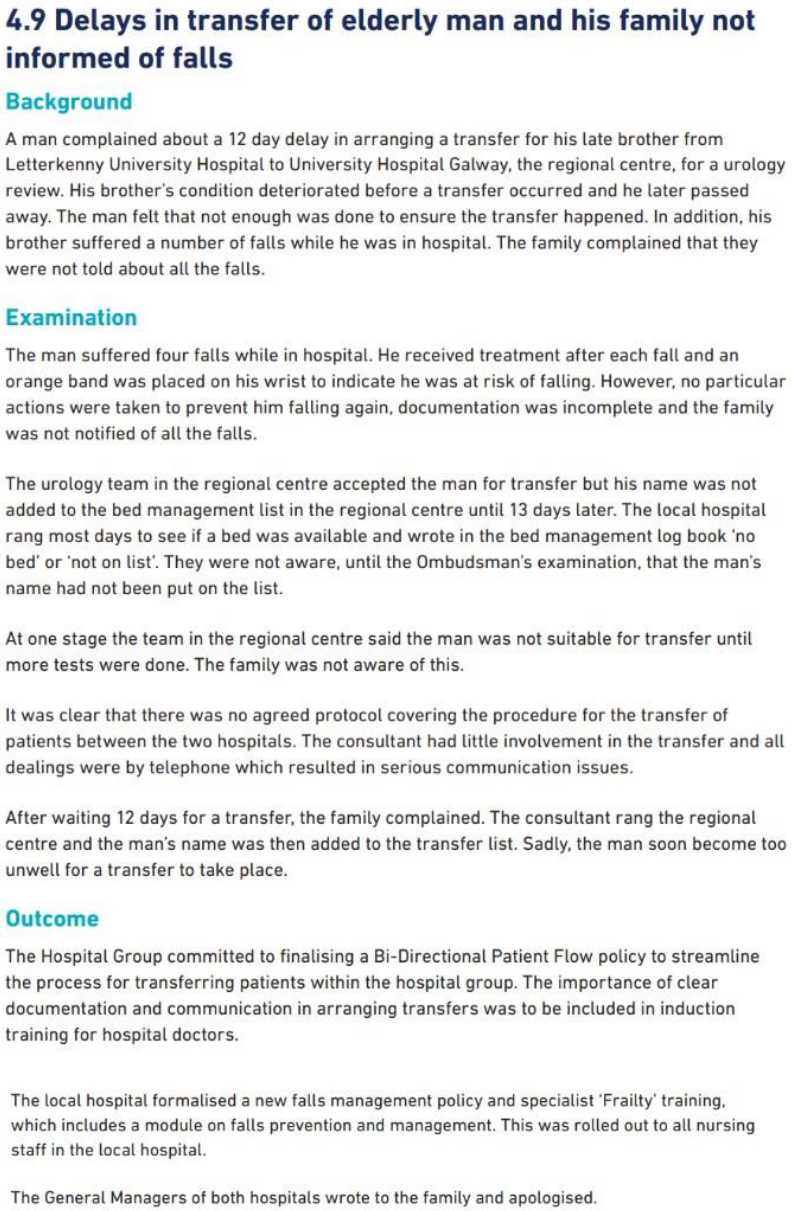
Following the complaint, the hospital introduced new protocols. These protocols facilitate the retrieval of charts out-of-hours. Security staff will now help Emergency Department staff to access the HIPE over the weekend and during out-of-hours periods.

In addition, the hospital undertook an audit to test the accessibility of healthcare records to clinicians, out-of-hours and at weekends. Finally, the hospital reassured the man that the lack of availability of his medical records on that occasion did not alter the clinical management of his condition.

The Ombudsman was satisfied that the hospital took the matter seriously, acknowledged there was a problem and took the necessary corrective action to address the issue.

Figure 7 – Case 6 (Ombudsman Ireland, 2018 p. 32).

The figure 7, shows a complaint reported by a man in 2018, who had undergone a procedure in Connolly Hospital in Dublin. Two days after being discharged, he had to come back because he was experiencing chest pains, but the Emergency Department could not access his medical records. The hospital introduced new protocols to guarantee the access of medical records to all people authorized and during all day – including weekends. An audit was carried out to test this accessibility of clinical records and the patient was reassured that the event did not affect the management of his clinical condition.



4.9 Delays in transfer of elderly man and his family not informed of falls

Background

A man complained about a 12 day delay in arranging a transfer for his late brother from Letterkenny University Hospital to University Hospital Galway, the regional centre, for a urology review. His brother's condition deteriorated before a transfer occurred and he later passed away. The man felt that not enough was done to ensure the transfer happened. In addition, his brother suffered a number of falls while he was in hospital. The family complained that they were not told about all the falls.

Examination

The man suffered four falls while in hospital. He received treatment after each fall and an orange band was placed on his wrist to indicate he was at risk of falling. However, no particular actions were taken to prevent him falling again, documentation was incomplete and the family was not notified of all the falls.

The urology team in the regional centre accepted the man for transfer but his name was not added to the bed management list in the regional centre until 13 days later. The local hospital rang most days to see if a bed was available and wrote in the bed management log book 'no bed' or 'not on list'. They were not aware, until the Ombudsman's examination, that the man's name had not been put on the list.

At one stage the team in the regional centre said the man was not suitable for transfer until more tests were done. The family was not aware of this.

It was clear that there was no agreed protocol covering the procedure for the transfer of patients between the two hospitals. The consultant had little involvement in the transfer and all dealings were by telephone which resulted in serious communication issues.

After waiting 12 days for a transfer, the family complained. The consultant rang the regional centre and the man's name was then added to the transfer list. Sadly, the man soon become too unwell for a transfer to take place.

Outcome

The Hospital Group committed to finalising a Bi-Directional Patient Flow policy to streamline the process for transferring patients within the hospital group. The importance of clear documentation and communication in arranging transfers was to be included in induction training for hospital doctors.

The local hospital formalised a new falls management policy and specialist 'Frailty' training, which includes a module on falls prevention and management. This was rolled out to all nursing staff in the local hospital.

The General Managers of both hospitals wrote to the family and apologised.

Figure 8 – Case 7 (Ombudsman Ireland, 2017 p. 30).

This last case (figure 8) selected from Ombudsman Report was made in 2017 by a man against Letterkenny University Hospital for delaying his brother's transfer to the University Hospital Galway to an urology review, and for many falls his brother had suffered during the hospitalization - which were not reported to the family until the patient passed away. The hospital reviewed their transfer policy within the hospital group and their falls management policy, including training the staff. Both hospital's managers provided written apologies to the family.

Although the Ombudsman website informs they do not examine complaints involving clinical judgements giving as example the diagnosis or treatment of a patient made by, or on behalf of, the HSE or private nursing home, some of their cases described in the annual reports might be an example of that. On their website, there is also a list of organizations that people can look for help in case they cannot handle their case. (Ombudsman Ireland, n.d.)

Considering problems involving healthcare providers, the Health Information and Quality Authority - HIQA can receive a concern from general public to hold an inspection in the service. In their last annual report of the Health Information and Quality Authority – HIQA informed that, in 2021, in Ireland there were 567 nursing homes offering a total of 31,842 beds, being 77% of them owned and operated by private providers. In the same year, they received 1,024 pieces of unsolicited information from public, that includes residents or relatives of residents, employees of nursing home and others. This information included concerns relating to the quality of care such as healthcare, falls and medication management, hygiene, nutrition and hydration, also communication, infection control measures, residents' rights, general welfare and development and others. (Health Information and Quality Authority, n.d., online)

4.1.2 HSE Reports

With respect to HSE, their Annual Report and Financial Statements issued over the period from 2017 to 2022, the number of complaints reported to the organization is quite expressive. The table below summarizes the number of complaints received in relation to HSE hospitals and services managed directly by HSE, also voluntary hospitals and agencies proving work to HSE in Ireland but managed by voluntary organisations. (Health Service Executive, n.d.)

Year	HSE	Voluntary Hospitals/ Agencies	Total Complaints
2021	5,415	9,820	15,235
2020	5,394	9,633	15,027
2019	5,938	12,160	18,098
2018	6,610	11,367	17,977
2017	8,281	11,356	19,637
Total	31,638	54,336	85,974

Table 3: Number of Complaints from HSE Annual Reports and Financial Statements (Health Service Executive, n.d.).

Looking into the reports, it is not clear how many of those complaints are directly related to clinical claims - the focus of this research. However, HSE also describes some issues contained in their complaints such as: access, dignity and respect, safe and effective care, communication and information, privacy, accountability, improving health, participation and some other topics. What is interesting about that description are points defined as safe and effective care, privacy, accountability and clinical judgement. These can suggest a direct relation to complaints involving malpractice and negligence in health service provider – by professionals or services considering they evoke professional and organizational standards and outcome of quality and safe care to patients. Thereby, it is relevant to detail the numbers of complaints for some categories found in the HSE reports over the years 2017 to 2021 as represented by the author's chart below:

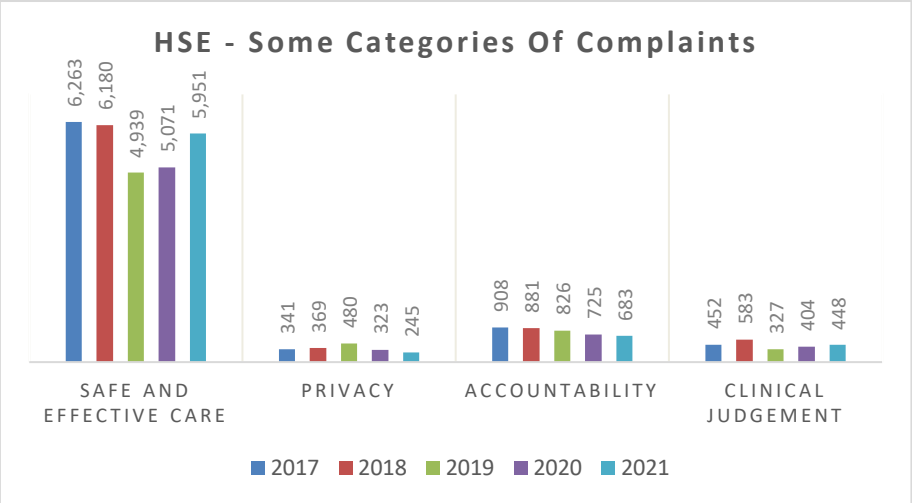


Chart 1: Number of Complaints from HSE Annual Reports and Financial Statements by Categories (Health Service Executive, n.d.)

The HSE reports clarify that a complaint can be considered in more than one category depending on what is being reported in that. So, those numbers do not reflect the total number of complaints received by them. Moreover, it is possible to notice that among a myriad of categories described by the HSE, the author's selection of what is related to the subject of this study: "complaints of safe and effective care" have the highest number compared to the other three categories, presenting a significantly lower number of complaints. (Health Service Executive, n.d.)

4.1.3 NMBI Reports

Analysing the annual reports issued by the Nursing and Midwifery Board of Ireland, four of them were found from the years 2017 to 2020. The report referred to 2021 was not available yet.

In 2020, the board of Nursing reported 95 complaints, being 41% of them from the public – usually patients and relatives, and 59% from employers, colleagues and other registrants. Among them, the allegations are spread generally in competency and clinical practise, behaviour and health issues, which may commonly include drug abuse, forging prescription and/or theft of drugs. Some other reasons were not related to professional, organization and patient interaction. The total of complaints generated a number of 11 sanctions applied to the board including cancelation, censure, suspension and advice. However, in 10 of these cases a final determination had not been made by the board or had not been confirmed by the High Court at the end of 2020; explaining that sanctions other than advice, an admonishment or a censure must be confirmed by the High Court. (Nursing and Midwifery Board of Ireland, n.d.)

With reference to the report of 2019, the board of Nursing registered 109 complaints involving the same allegations spread generally in competency and clinical practise, behaviour and health issues. In that year, they generated a total of nine sanctions applied to the board including cancelation, censure, suspension and admonishment, remaining 7 sanctions without a final determination by the board or the High Court. (Nursing and Midwifery Board of Ireland, n.d.)

Regarding the 2018 annual report, the board of Nursing presented 113 complaints, being 58% made by patients or families, 32% by employers and/or work colleagues and 10% by the board as complainant. From those inquiries the concerns made were mainly related to clinical practice and competence, failure to communicate appropriately with patients and families, behaviour and health issues, including verbal and physical abuse of patients. In that year, the board showed eight cases of sanctions, remaining five of them without a final determination by the board or by the High Court.

Additionally, in the 2018 annual report, the NMBI described a cost of €13,784 spent on mediation service. The report does not reveal whether the cost is related to one or more cases. However, it shows that mediation was used in a dispute resolution involving the board. (Nursing and Midwifery Board of Ireland, n.d.)

Concerning the year of 2017, the respective report described 127 complaints being 63% made by patients and relatives, 33% by employers and colleagues and 4% by the board. The allegations were related to clinical practice and competence, failure to communicate appropriately with patients and families, behaviour and health issues, including being on duty in an unfit state. In that year, the report presented 14 cases of sanctions, being 8 of them without a final determination by the board or by the High Court. (Nursing and Midwifery Board of Ireland, n.d.)

4.1.4 Irish Medical Council Reports

In regard to Medical Council reports, four annual reports and financial statements were issued from 2017 to 2022, due to the fact that the 2021 report has not been published yet. The protocol established by the Irish Medical Council when receiving a complaint is explained in the figure below extracted from the 2017 report, and it shows that they consider the use of mediation to solve some of the received complaints:

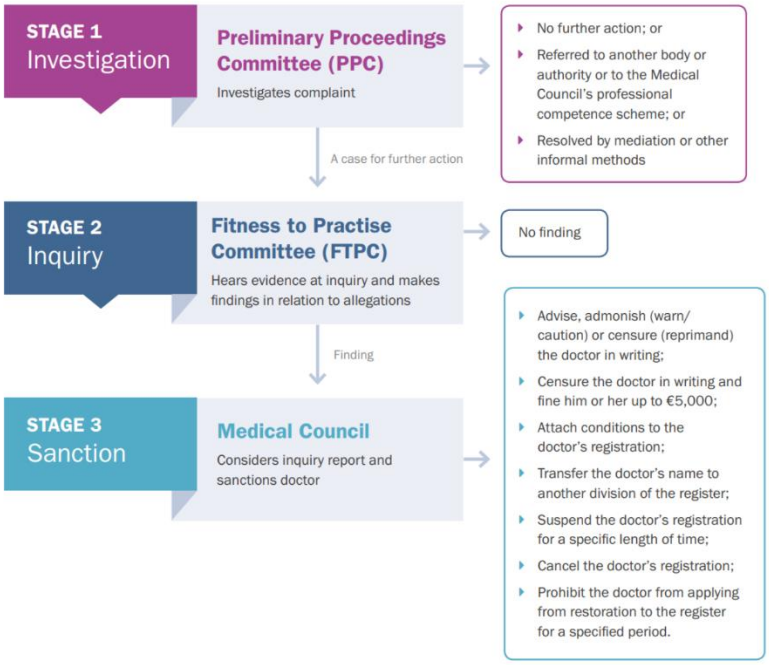


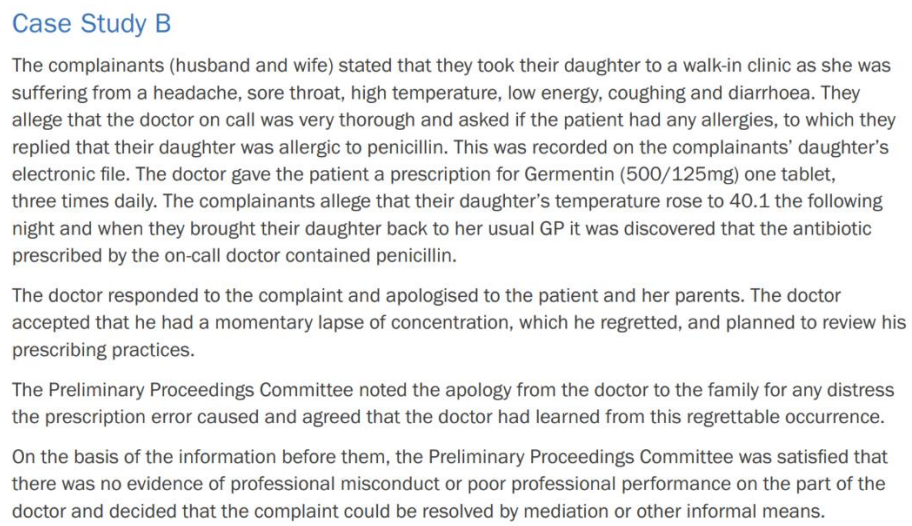
Figure 9: The Complaint Process in the Irish Medical Council (Medical Council, n.d. p. 11)

Analysing the 2020 annual report, it describes 279 complaints received in that year. The majority of complaints originated from the public, with a total of 219 complaints, followed by 27 of them made by the medical council and 21 made by healthcare professionals. The remainder was made by different types of sources, for instance, other organizations, hospitals and solicitors. The most frequent concerns in the complaints were related to doctor's responsibilities to patients, professional practice, treatment and professional conduct, being important to highlight that the highest number referred to communication issues among doctors and patients. The council issued 11 sanctions including advice, admonishment, cancelation, suspension, condition and censure. Moreover, the report did not show any use of mediation to the inquiries over that year. (Medical Council, n.d.)

On the subject of the 2019 annual report, it presented 431 complaints, being 83% of them made by the public, 6% by other members of the medical profession, plus 3% from the Medical Council either becoming aware of a patient safety issue through the media or through a notification by a relevant body in another state. Other complaints are spread among different types of sources. The majority of concerns were related to treatment, responsibilities to patients, professional practice and conduct, highlighting communication issues, clinical investigation and examinations, also diagnosis. There was no use of mediation in the inquiries held in that year, and 27 sanctions imposed including advice, admonishment, cancelation, suspension, condition and censure.

With respect to the 2018 annual report, 396 complaints were found, being 331 of them made by the public, 32 by the Medical Council, and 13 by healthcare professionals. The other origins of complaints are divided by different sources. The major reason of complaints in that year was related to communication issues between doctor and patients or their relatives. Another significant number is related to diagnosis, clinical investigations and examinations, follow up care and prescription, most of them classified in the categories of responsibilities to patients, treatment and professional practise. The report shows the use of mediation in 6 cases to resolve the conflict. In that year, the council imposed 22 sanctions including cancellation, conditions, suspension, and advise or admonish or censure.

This 2018 report contained a description of one case as an example when mediation could be used to solve a conflict happening between family and doctor. It can be seen in the next figure:



Case Study B

The complainants (husband and wife) stated that they took their daughter to a walk-in clinic as she was suffering from a headache, sore throat, high temperature, low energy, coughing and diarrhoea. They allege that the doctor on call was very thorough and asked if the patient had any allergies, to which they replied that their daughter was allergic to penicillin. This was recorded on the complainants' daughter's electronic file. The doctor gave the patient a prescription for Germentin (500/125mg) one tablet, three times daily. The complainants allege that their daughter's temperature rose to 40.1 the following night and when they brought their daughter back to her usual GP it was discovered that the antibiotic prescribed by the on-call doctor contained penicillin.

The doctor responded to the complaint and apologised to the patient and her parents. The doctor accepted that he had a momentary lapse of concentration, which he regretted, and planned to review his prescribing practices.

The Preliminary Proceedings Committee noted the apology from the doctor to the family for any distress the prescription error caused and agreed that the doctor had learned from this regrettable occurrence.

On the basis of the information before them, the Preliminary Proceedings Committee was satisfied that there was no evidence of professional misconduct or poor professional performance on the part of the doctor and decided that the complaint could be resolved by mediation or other informal means.

Figure 10: Case 8 (Medical Council, n.d. p. 17)

Considering the report of the year 2017, the Irish Medical Council declared receiving 356 complaints in that year. From that total, again most of them were made by public with a number of 293 complaints, 19 by healthcare professionals, 15 by the medical council as claimant and the other complaints had diverse sources as origin. The categories which presented a large number of complaints were: treatment, responsibilities to patients and professional practice, with many issues related to communication, diagnosis and clinical investigations and examinations. From all those cases, five of them were solved by mediation in 2017. Furthermore, 11 sanctions were imposed including cancellation, conditions, suspension and advise, admonish or censure.

4.2 England Data Findings and Analysis

In regard to the British organizations online reports, this research will show data collected from four different sources, namely: the Parliamentary and Health Service Ombudsman (PHSO), the NHS Resolution, the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC), from 2017 to 2022.

4.2.1 Parliamentary and Health Service Ombudsman Reports

The Parliamentary and Health Service Ombudsman in England is responsible for complaints have not been resolved by the NHS in England, UK government departments and other public organisations. The service is free and they just investigate complaints that were firstly made to the organisation but do not have a solution. Also, they can just accept a complaint against private health

provider if it was funded by NHS.

Analysing the Annual Report and Accounts 2017 – 2018, the service reported the receiving of 24,664 NHS complaints. From that number 5,545 were assessed by them, being 132 cases resolved without needing of full investigation and 2,232 cases accepted for investigation by the service. (Parliamentary and Health Service Ombudsman, 2018) However, the majority were handled in their first step analysis as explained in the picture below.

Figure 11: Complaint Handling in Detail (Parliamentary and Health Service Ombudsman, 2019, pp. 25)

In terms of the Annual Report and Accounts for 2018 – 2019, this described the total of 23,293 health complaints, having 1,722 cases gone under investigation by them. Moreover, the report detailed one of the medical negligence claim cases which occurred in that period for appreciation. (Parliamentary and Health Service Ombudsman, 2019)

Case study

Poor care and treatment led to a man losing an eye

Mrs F complained that the Trust's poor care and treatment of her husband's eye infection meant that he had to have his eye removed.

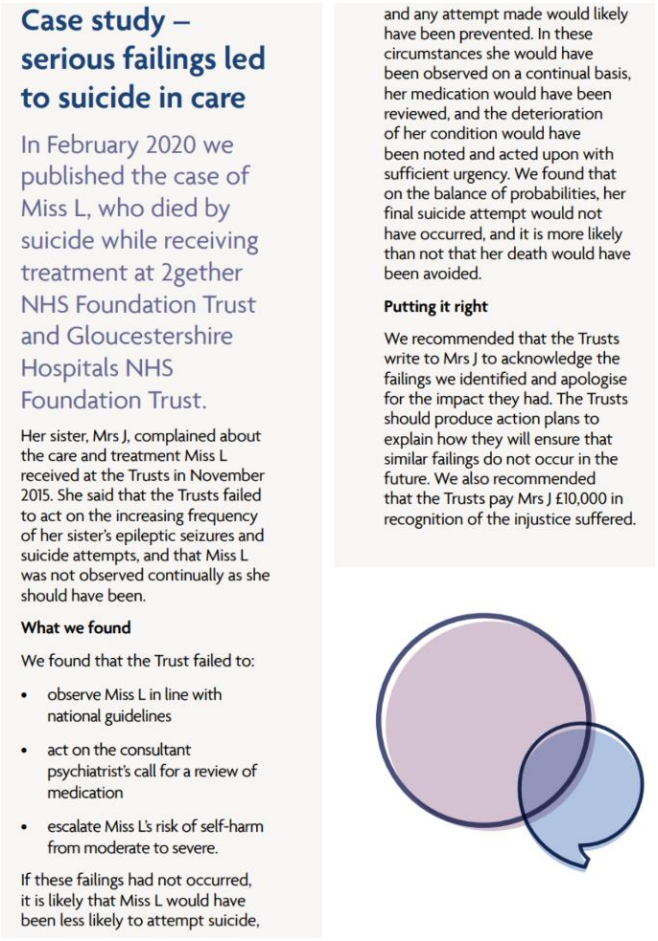
When Mr F began experiencing problems with his vision in his left eye, his GP referred him to the Trust's Ophthalmology Clinic. Over the course of four months he was wrongly given eye drops as well as steroid medication that likely made his eye worse. At his request, he transferred to another Trust. They found that he had a fungal infection that should have been identified much earlier than it was. Unfortunately it was too late to save his eye.

We found that if the correct treatment had been given, while Mr F's vision may have still deteriorated, it is more likely than not that he would have kept his eye. The care Mr F received was not in line with General Medical Council guidance, which was a failing.

At our recommendation, the Trust acknowledged and formally apologised to Mrs F for the failings in her husband's care and treatment. It also outlined what changes they have made to prevent this from happening again. The Trust made a payment to Mrs F of £1,000 in recognition of the injustice.

Figure 12: Case 9 (Parliamentary and Health Service Ombudsman, 2019, p. 37)

In regard to the 2019 – 2020 report, the organization opted to temporarily pause the presentation of the total health complaints received by them in that period, taking into consideration the Covid pandemic emergency in order to avoid placing additional burdens on the NHS. So, the number of complaints presented will not be used in this research due to the incapability of providing precise information about health complaints. Nonetheless, the report mentioned that 1,125 cases of NHS England had undergone investigation in that period. This report also included an Early Dispute Resolution pilot – EDR launched in July, 2019. Following accredited and professional training, the team uses mediation to resolve complaints received by the service, bringing claimants and organizations together by video or teleconference. Their intention is to achieve a right decision of individual cases without putting people under more time-consuming investigation when it is not necessary. Initially they presented an outcome of 14 successfully resolved complaints. However, it is not mentioned if that number is related to health complaints. Moreover, the medical negligence case below was detailed in a case study in the record. (Parliamentary and Health Service Ombudsman, 2020)



Case study – serious failings led to suicide in care

In February 2020 we published the case of Miss L, who died by suicide while receiving treatment at 2gether NHS Foundation Trust and Gloucestershire Hospitals NHS Foundation Trust.

Her sister, Mrs J, complained about the care and treatment Miss L received at the Trusts in November 2015. She said that the Trusts failed to act on the increasing frequency of her sister's epileptic seizures and suicide attempts, and that Miss L was not observed continually as she should have been.

What we found

We found that the Trust failed to:

- observe Miss L in line with national guidelines
- act on the consultant psychiatrist's call for a review of medication
- escalate Miss L's risk of self-harm from moderate to severe.

If these failings had not occurred, it is likely that Miss L would have been less likely to attempt suicide, and any attempt made would likely have been prevented. In these circumstances she would have been observed on a continual basis, her medication would have been reviewed, and the deterioration of her condition would have been noted and acted upon with sufficient urgency. We found that on the balance of probabilities, her final suicide attempt would not have occurred, and it is more likely than not that her death would have been avoided.

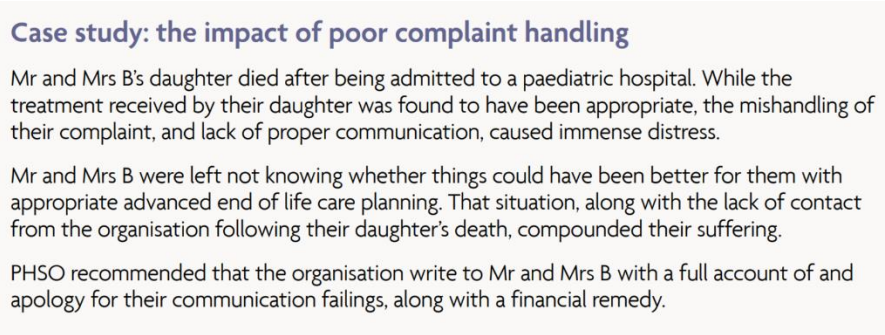
Putting it right

We recommended that the Trusts write to Mrs J to acknowledge the failings we identified and apologise for the impact they had. The Trusts should produce action plans to explain how they will ensure that similar failings do not occur in the future. We also recommended that the Trusts pay Mrs J £10,000 in recognition of the injustice suffered.

Figure 13: Case 10 (Parliamentary and Health Service Ombudsman, 2020, p. 40)

On the subject of the 2020 – 2021 report, although it mentions that there was a halt in reporting health complaints so the NHS could focus on managing the COVID pandemic, the data presented in the entire report does not specify the respective numbers of health complaints received after the reported break period finished. The same occurred in the report of 2021 – 2022. Based on that, the author decided not to consider the information about the number of complaints on both reports avoiding imprecise data to the subject of this study. However, both of them informed the use of mediation, 14 (Parliamentary and Health Service Ombudsman, 2021, p. 32) and 29 (Parliamentary and Health Service Ombudsman, 2022, p. 30) respectively, as successful alternative resolution in that number of complaints. Bear in mind that those numbers do not specify if the cases involved were related to medical negligence claims.

Furthermore, it is relevant to show in this research the case study related to the subject which was published in the 2020 – 2021 report, as seen below:



Case study: the impact of poor complaint handling

Mr and Mrs B's daughter died after being admitted to a paediatric hospital. While the treatment received by their daughter was found to have been appropriate, the mishandling of their complaint, and lack of proper communication, caused immense distress.

Mr and Mrs B were left not knowing whether things could have been better for them with appropriate advanced end of life care planning. That situation, along with the lack of contact from the organisation following their daughter's death, compounded their suffering.

PHSO recommended that the organisation write to Mr and Mrs B with a full account of and apology for their communication failings, along with a financial remedy.

Figure 14: Case 11 (Parliamentary and Health Service Ombudsman, 2021, p. 25)

Throughout the first three reports, the total costs of NHS England payments for financial loss or recognition of the impact of what went wrong made by NHS England organisations in relation to the complaints' recommendations managed by PHSO were described, and the respective costs are presented in the table below, made by the author as a way to summarize the information for a clearer analysis.

	2017 – 2018 Report	2018 – 2019 Report	2019 – 2020 Report
NHS England costs of payments done	£ 516,530	£ 236,038.18	£ 568,032.69

Table 4: NHS England payments made for financial loss or recognition of the impact of what went wrong .

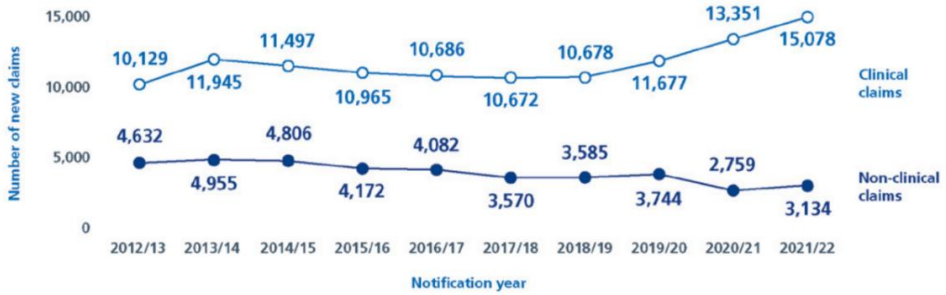
Over that period, it can be said that NHS England organisations spent the impressive amount of £ 1,320,600.87 covering clinical claims only delivered to the PHSO service, according to their official annual reports.

4.2.2 NHS Resolution Reports

With respect to the NHS Resolution data, the last annual report issued refers to 2021/2022 period and has presented a chronological comparison over the last few years of their service in England. Therefore, the author opted to consider these data in the research, even though some of them show a period prior to 2017.

The figure below shows the number of clinical negligence claims received by NHS Resolution per

year-period, comparing the number of other claims non-clinical related over the same period. It is relevant to highlight that this number represents the total of new clinical negligence claims and reported incidents reached by year, following what is described in the annual report. (NHS Resolution, 2022b, p. 36)



Graph 1: The number of new clinical and non-clinical claims reported in each financial year. (NHS Resolution, 2022b, p. 36)

Concerning their data information, obstetrics, orthopaedic surgery and emergency medicine services were responsible for the majority number of clinical negligence claims, having presented a percentage of 12% each, while other reasons not detailed in the report corresponded to 32% of the total claims among the total which includes some other reasons such as gynaecology, general surgery, general medicine, radiology etc. Moreover, a significant finding in the report is that obstetrics claims present an expressive number and financial cost into their budget system, having a specific scheme of compensation called Early Notification Scheme – EN, developed to tackle a more rapid caring response to support families involved in cases of specific brain injuries at birth, investigating and determining if negligence has caused the harm. Obstetrics claims were responsible in 2021/2022 for 62% of all clinical claims by value received in the year (equivalent to £6 billion), 60% of the total clinical negligence cost of harm (equivalent to £13.6 billion), and being responsible for 70% of their total clinical negligence provision, almost £128. 2 billion. It shows the negative effects on patients, families, and healthcare workers as well as the financial expenses of maternity indemnity payments. (NHS Resolution, 2022b)

About obstetrics claims, they were described in the reports of the years 2020/2021 and 2019/2020 as responsible respectively for 59% (£7.1 billion) and 50% (£4.8 billion) of their clinical claims by value received in the period, 60% and 69% of their total clinical negligence cost of harm, also 68% (£52 billion) and 72% (£77.6 billion) of their total clinical negligence provision. (NHS Resolution, 2021 and 2020b)

In relation to the total number of clinical claims reported, the organization accounted for the

following percentage of claims settled without and after proceedings in court started as demonstrated by their chart below:

Chart 2: Litigation rate for clinical claims. (NHS Resolution, 2022b, p. 38)

The NHS Resolution (2022b, p. 38) considers that the number of clinical claims that has been resolved without court proceedings has increased over the last five years, due to the development of dispute resolution techniques such as mediation and closely collaboration with claimants' lawyer, keeping a rigorous investigation of illegibility for compensation in the cases reported to them. Conversely, the NHS Resolution also works developing legal precedent, sending cases to trial and higher courts in areas of law which need to be challenged in the broader interests of them, managing the cases fairly and effectively . Considering that trials reflect in other similar cases, their outcomes can either provide an opportunity for others claims under similar circumstances or stop claims without merit.

4.2.3 NMC Reports

Collecting data from Nursing and Midwifery Council, they issue a specific report related to fitness to practice called Annual Fitness to Practice Report. For clarification, their reports present an overall analysis of the cases received from all countries in the UK. Although the report present a total number of cases received by them, in the detailing of the data worked by NMC, this division by countries is not made.

Looking into the report of 2017-2018 period, it presented a total of 5,509 concerns of nurses and midwifes fitness to practice, being 27% of them made by patients/public and 40% by employers; other concerns were made by different types of sources. From this total, 731 concerns were discarded because did not have enough information or identification of the professional involved in the case. England had a total number of 3,834 cases received by the council in that year. (Nursing

and Midwifery Council, 2018)

In regard to 2018-2019 report, the NMC received 5,373 concerns again the majority of them being issued by employers with 35%, following by 29% made by patient/public. In that period, the council discarded 1,020 cases for absence of enough information for proper identification. There were 3,475 concerns in England received by them. (Nursing and Midwifery Council, 2019)

Regarding 2019-2020 report, 5,704 concerns were received by NMC, being 33% of them made by patient/public and 32% by employers, as the majority sources. A number of 1,429 cases were disregarded considering identification issues or due to not enough serious issues reported. Also, a total of 3,365 cases were from England. (Nursing and Midwifery Council, 2020)

The table below summarizes the sanctions issued by NMC in the last three reports, as presented by them:

	2019–20		2018–19		2017–18	
Panel decision	Number	Percentage	Number	Percentage	Number	Percentage
Strike off	127	28%	162	25%	257	21%
Suspension	142	32%	231	35%	372	31%
Conditions of practice	69	15%	99	15%	165	14%
Caution	42	9%	57	8%	129	11%
FtP impaired – no sanction	0	0%	0	0%	0	0%
Sub-total	**380**	**84%**	**549**	**83%**	**923**	**77%**
Facts not proved	5	1%	17	3%	5	<1%
FtP not impaired	67	15%	95	14%	279	23%
Total panel decisions	**452**	**100%**	**661**	**100%**	**1,207**	**100%**

Table 5: Panel decisions 1 (Nursing and Midwifery Council, 2020)

It can be seen that suspension of nurses and midwifes presented the highest number of sanctions issued by the council over the period presented in the reports, having also a significant number of professionals who had their registration revoked by the council being unable to work in the UK.

In terms of the 2020-2021 report, it presented 5,547 concerns received in that period, having 35% patient/public as registrants and 25% employers, counting as majority sources. A total of 942 cases did not have proper identification of the nurse/midwife involved, and 784 did not present the registrant identification, having to be discarded. The total of 3,057 were from England in the UK. (Nursing and Midwifery Council, 2021)

In relation to 2021-2022 report, they found a number of 5,291 concerns being again public/patient

responsible for 38% of the total, followed by 24% from employers. 1,207 cases were not considered because of lack of information about the nurse/midwife identification, and 2, 856 cases issued were related to England. (Nursing and Midwifery Council, 2022)

The table below was presented in the last report, showing some of the sanctions issued by NMC to nurses and midwifes:

Panel decisions	2021-2022		2020-2021	
Panel decision	**Number**	**Percentage**	**Number**	**Percentage**
Strike off	109	26%	56	27%
Suspension	124	30%	86	41%
Conditions of practice	61	15%	27	13%
Caution	37	9%	14	7%
Sub-total	**331**	**80%**	**183**	**88%**
Facts not proved	22	5%	6	3%
FtP not impaired	61	15%	19	9%
Total panel decisions	**414**	**100%**	**208**	**100%**

Table 6: Panel decisions 2 (Nursing and Midwifery Council, 2022)

Again, it can be seen that suspension and strike off were the most commonly imposed sanction by the council over the period presented.

Other sanctions such as conditions, warnings and advice also were made by NMC. However, there were not represented in the data collected by the author to present in this research.

4.2.4 GMC Reports

On the topic of the General Medical Council, four annual reports issued in the years of 2018, 2019, 2021 and 2022 were found.

The 2017 annual report issued by GMC, informed a number of 8,546 concerns about doctors' fitness to practice, being just 1,485 of them considered serious and generating a full investigation on them due to risk to patients' safety. From the latter, 1,381 investigations were concluded in the same year, having the council presented the number of 195 outcomes of investigation concerns and their determination under the Medical Practitioners Tribunal Service – MPTS to the doctors involved as seen in the next figure. (General Medical Council, 2018, p. 27)

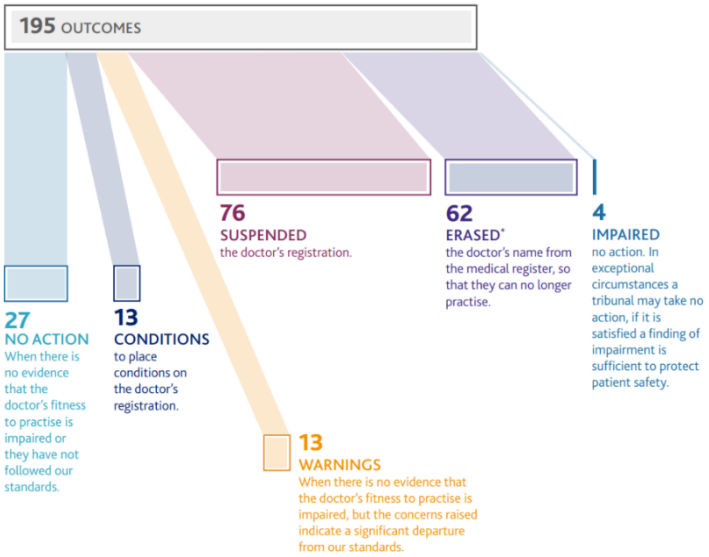


Figure 15: 2017 Outcomes from MPTS fitness to practice tribunals (General Medical Council, 2018)

For clarifications purpose, MPTS is a statutory committee of the GMC and are accountable to the GMC Council and the UK Parliament, having as role to run hearings and make independent decisions following the Medical Act 1983 and other statutory rules about doctors' fitness to practice medicine in the UK. Their outcomes can be appealed by GMC or by a professional involved. (Medical Practitioners Tribunal Service, n.d.)

Regarding the 2018 annual report, the council received 8,573 concerns of doctors' behaviours and performances, generating 1,544 cases to be fully investigated by them. From that number, they presented 1,208 concluded cases in that year, with 247 outcomes from their MPTS to the doctors involved showed in the figure 16. (General Medical Council, 2019)

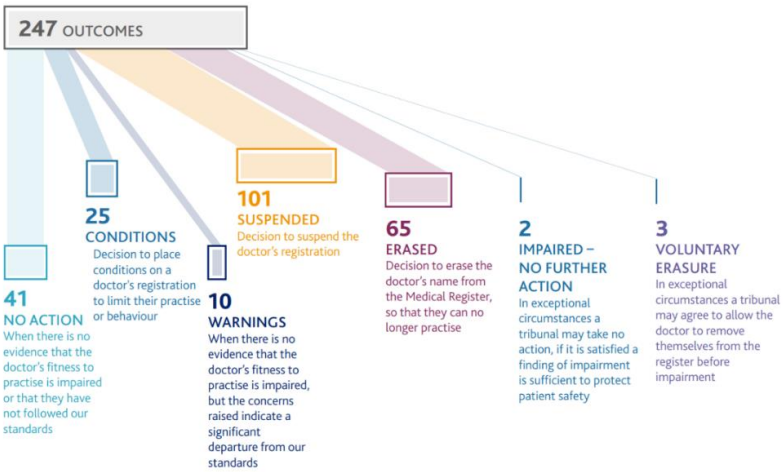


Figure 16: 2018 Outcomes from MPTS fitness to practice tribunals. (General Medical Council, 2019)

About the 2020 annual report issued by them, a number of 8,468 concerns were made about doctors' fitness to practice, the majority of that were raised by members of the public with 6,318 concerns of the total. Only 1,117 were considered serious under their criteria and followed to a full investigation, and from that number, 276 were referred to the MPTS so they decided what action to take against the doctor denounced. There were no descriptions of outcomes from their tribunal that year. (General Medical Council, 2021)

Analysing the 2021 annual report, GMC received 9,074 concerns being 74.8% of that raised by the public, having 925 cases gone under full investigation following their statutory threshold for investigation that consider cases which may be a risk to patients' safety or to public confidence in doctors. From that, 257 cases were referred to MPTS, which had a total of 269 outcomes in 2021 as shown in the next figure. This last number possibly reflects the fact that some outcomes were from cases which have taken more than one year to be concluded. (General Medical Council, 2022)

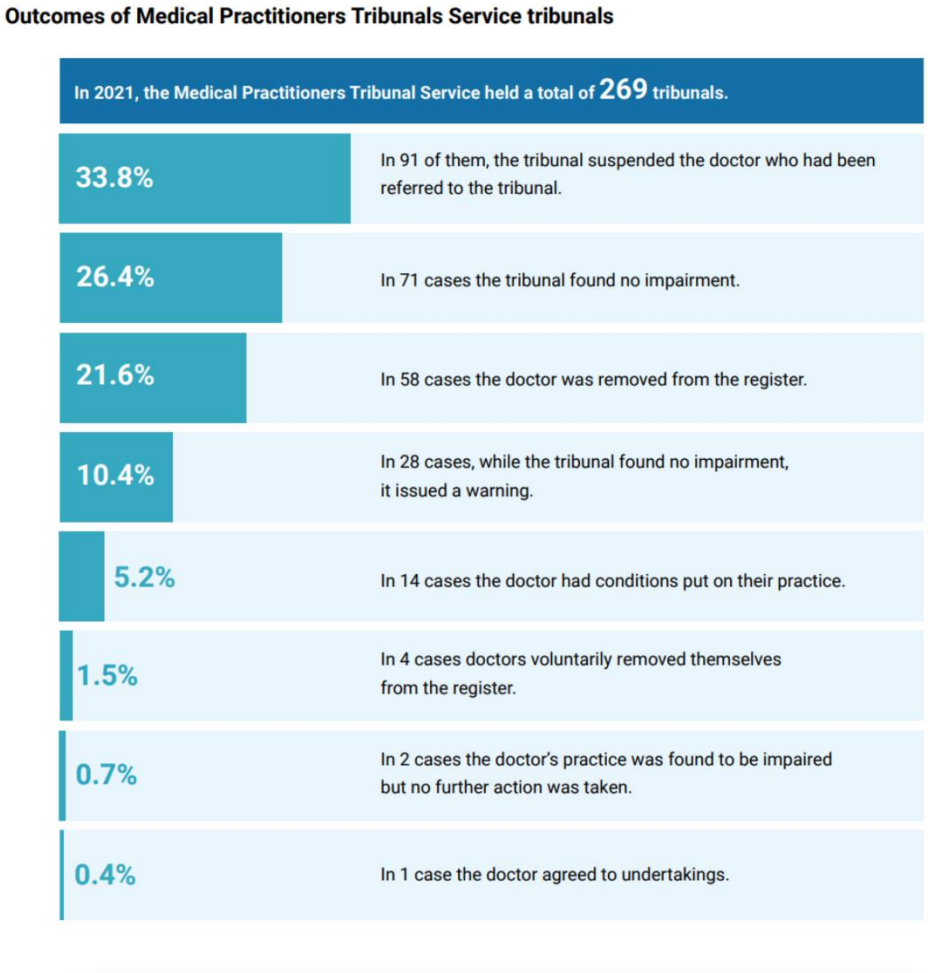


Figure 17: 2021 Outcomes from MPTS fitness to practice tribunals. (General Medical Council, 2022)

It is relevant to highlight that many cases are disregarded by GMC following the understanding that the concern raised require a local level action, a conversation with the professional or should be brought before another organization. Additionally, some cases investigated and concluded by the GMC were not referred to the MPTS, but also generated sanctions to the doctors involved, such as advice and warning by the council. However, for the cases submitted to MPTS, it can be seen a more expressive number of suspensions and erases of doctors' registers, banning those professionals from working in the UK.

The GMC 2019 annual report was not found on their website, not even any explanation about that whatsoever, what leads the author to infer the advent of the Covid-19 pandemic crisis as a possible reason to this absence.

Chapter 5 – Discussion

The first consideration into this chapter, has to be made about the population in both countries of this study. It is because, comparing the data collected among them, it is noticeable that England presents a higher number to Ireland. According to the latest Census provided by the Central Statistics Office (2022, online), Ireland has a population of approximately 5.1 million people nowadays, most of them concentrated in the capital, Dublin. While England, has an estimated population of almost 56 million people, showing at least 8.5 million people just in the capital - London - which alone outnumbers the entire population in Ireland.. (UK Population.Org, n.d., online). Hence the importance to clarify that all data presented from Irish sources will have a considerable discrepancy in terms of number in comparison the data collected from England sources.

Considering the Ombudsman service provided by both governments, what is noticeable is that in England this service does not accept complaints against social care services and private healthcare sector with exception to the ones funded by NHS, while in Ireland the organization receives complaints against private nursing homes and social care services. The former, has an exclusive category in the Irish Ombudsman report as the latter is counted inside the health complains category. Moreover, it is relevant to highlight typical examples of medical negligence claims presented in their reports as study cases and replicated by the author in the figures 2 to 8 and 12 to

14 in the previous chapter. Although the Ombudsman in Ireland inform on their website they do not accept to investigate cases that involve clinical judgment (Ombudsman Ireland, n.d.), some of their cases in the reports exemplify claims in which clinical decisions made were being challenged. When a patient or a family are unhappy with the care provided and with medical decisions made at the point of raising a formal complaint, a claimant is assuming at least a superficial medical judgement from what happened should be different.

Also, cases involving wrong medication and delayed in diagnosis and treatment that can affect a patient deterioration as contained in their reports should be clearly understood as medical negligence requiring specialist clinical judgment.

Allen (2018, p. 70) describes that, in regard to clinical claims in England, a doctor is not guilty of negligence if he has acted in accordance with a practice which is properly applied by other medical practitioners or their body's opinion, in a way that a judge would rarely overrule a body of expert medical opinions. Thus, in clinical claims, a claimant will have to support their assumptions with a reasonable body of experts' opinion and a mediator will need the significance of the "Bolam principle or test[1]" in order to find a clinician breach of duty or negligence.

Besides, considering the complexity of clinical claims and the different levels of knowledge among healthcare professionals, patients and their families, it is paramount to think how challenging and important a mediator' role is in these cases. It brings to mind Deutsch, Coleman and Marcus's (2006) views that mediation might not solve some conflicts, and that the mediation process has to be guided by a very qualified and skilled mediator when inequality of power is affecting the process negatively.

Moving to the British Ombudsman records, the author could find a precise number of medical negligence claims, whereas in the Irish service, there were claims related to refund of taxes paid to health services, which is not the subject of this research. Although both services mentioned providing mediation as alternative way to resolve conflicts, in the British service it can be easily seen in their reports and website for anyone who looks for information about how to file a complaint and what is offered by them. Nonetheless, when analysing their records for the period here studied, it is unclear how often this option has been applied, in the same way that is unclear how many of

[1] Bolam Principle: "*A test that arose from English tort law, which is used to assess medical negligence. Bolam holds that the law imposes a duty of care between a doctor and his patient, but the standard of that care is a matter of medical judgement… The plaintiff seeking to prove medical negligence needs to show that there was a duty of care between the doctor or nurse and the patient, which is usually a straightforward exercise, and that the act or omission of the doctor or nurse breached the duty of care."* (Bolam Principle, 2011)

the raised claims were resolved without generating posterior proceedings in court. Consequently, the use of mediation as ADR is not realistically measurable in that service.

Comparing information from HSE in Ireland to NHS in England through to NHS Resolution, it is remarkable that in the UK the usage of ADR – mainly mediation, is highlighted for the general public users, workers and providers under the service provided by the organization. The NHS Resolution as a systematic scheme of pre-action protocol to cases involving medical negligence claims inside the NHS, appears to provide more opportunities for a solution between claimants, lawyers, healthcare professionals and healthcare providers without the necessity to proceed to the courts, defining what is demanded as evidence from both sides to achieve a settlement, promoting a more clear view of what can be expected in the cases, also slightly predicting sooner financial compensation or any kind of different outcome which cannot be achieved when taking legal actions. Also, considering their extensive background in the matter, they support and provide reliable information for the sides involved. (NHS Resolution, 2022a, online)

In Ireland, mediation has also been used through the Mediation Act 2017, which preconizes mediation has to be offered by lawyers as a primary option to everyone who intends to go into court proceedings. However, many organizations and professionals involved in clinical negligence cases believes that a formal pre-action protocol is essential and beneficial for cases involving medical negligence, allowing solicitors to require and provide specific information and medical records earlier in a way that could resolve the cases without going into court proceedings. It can promote early identification and communication of the issues in dispute between the parties also decreasing the cost and time consumption of those claims in tribunals and courts in the country, encouraging a more positive experience and outcome for claimants and health professionals involved. (Medical Protection Society, 2022, online)

Understanding the difference of how the information about the process is shared or not, and the existence of a formal organization focused on clinical claims resolutions and the establishment of a pre-action protocol to avoid court actions promoting mediation can relate to how many cases can be solved consuming less time and sources, also how it should economically affect the government and health systems in terms of saving claims in courts.

For NHS Resolution, the use of mediation and ADR remains the main strategy of England government to keep their legal costs of clinical claims in courts proceedings in decline as said by Malla (2018, online).

According to one of the organization's publication, the number of mediations carried out by them

has been increasing over the years, since the first pilot was run, as shown in the graph 2.

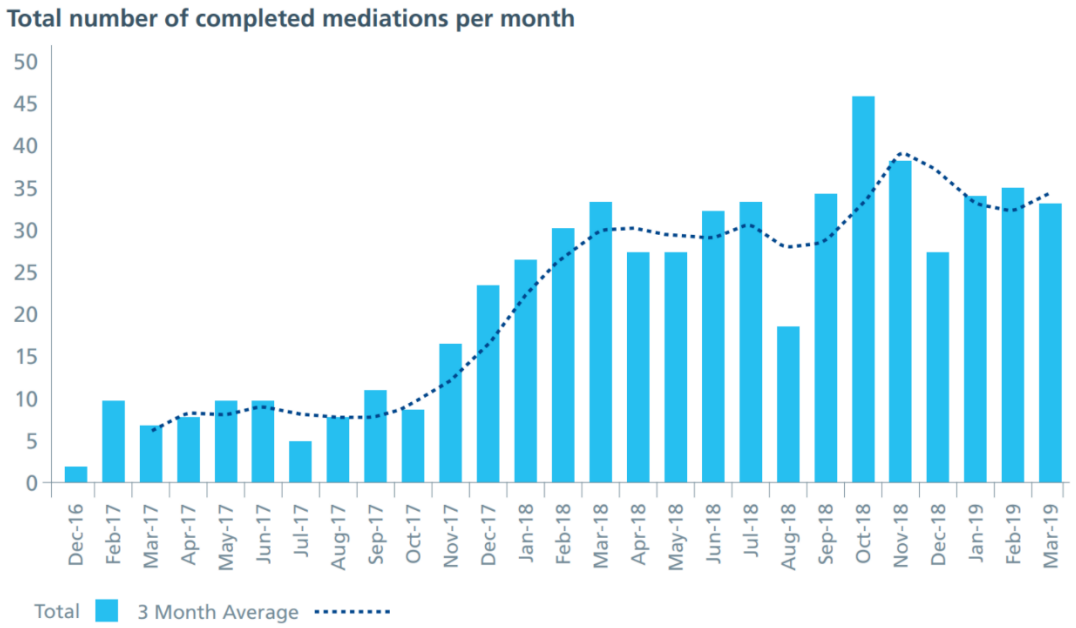


Chart 3: All types of mediations by month from 5 December 2016 – 31 March 2019. (NHS Resolution, 2020c, p. 7)

As outcomes for using mediation all over these years, the NHS Resolution (2020c, p. 4) describes that it has been proven effective in solving cases involving injured patients and/or their families, providing a chance to receive face-to-face explanations and apologies, promoting opportunity to articulate concerns that would not be addressed in other forms of ADR, and presenting mutual benefits to patients, families and NHS staff. Until now, a significant number of their mediations just took place after legal proceedings had commenced, making the cost invariably more expensive, detailing that mediation can be more effective and cheap as intervention in early stages of the claim's lifecycle.

A very interesting point of comparison is the number of complaints raised to HSE and to NHS Resolution being roughly similar despite the huge difference in total population in both countries. Even observing that HSE reports present a variety of complaints categories that do not necessarily reflect cases of medical negligence, looking into the categories of safe and effective care, privacy, accountability and clinical judgement selected by the author, the number of complaints in Ireland remains significantly high against what is shown by the NHS Resolution reports.

Unfortunately, the information provided to the public by the organization's records which used in this research do not allow us to have any solid reason or conclusion why Ireland, with a small

population, presents a significant number of health complaints - similar to a larger and more populated country like England.

Moreover, a serious and alarming fact noticed in the British data was the number of clinical claims related to obstetrics reasons, forcing the government to create a specific scheme of early notification and compensation to the families, demonstrating the severity of the problem in the country and their effort to reduce it. Cases of negligence and malpractice at birth such as brain injuries may permanently affect the baby and family dynamic, including their mental health. In these types of cases, consequences are not completely measurable in early years of life, creating a huge financial impact to the system having to wait for the child's development to conclude an assessment and determine the damage. It can be noticed by their expenses and cost predictions described in the previous chapter.

In an attempt to tackle it, NHS Resolution has been working tirelessly in partnership with other national organizations including the Royal College of Midwives, Royal College of Obstetricians and Gynaecologists, the National Maternity Safety Champions and NHS England and NHS Improvement through the Maternity Transformation Programme to support the Government's target of halving the rates of stillbirths, neonatal/maternal deaths and brain injuries associated with birth by 2025. Their scheme provides families with a detailed explanation of what happened wrong, apology, sign-posting to independent representation and where an entitlement to compensation has been identified, prompt financial support for clinical and respite care, in addition to psychological support. Before their scheme was launched, the length of a time between the incident and the compensation was almost 11 years with claims taking around five years to be notified to NHS Resolution. (NHS Resolution, 2019)

Crossing the information among the nursing councils in the two countries, both of them have the patient/family or public and the employers as the major source for raising concerns, which is expected since patient and family share the direct contact with nurses and midwifes while under care. They are the frontline workers in hospitals and healthcare providers, and usually the primary line when someone looks for sharing dissatisfaction with treatment. On the employer's side, colleagues can identify other professional who do not follow standards or ethical and proper professional behaviour, offering risk to patients' safety. When these cases happen, a report of the situation has to be made under their professional code and liability.

Looking into their number of complaints and the number of sanctions, the author could infer that many of the concerns are not characterized as a case of malpractice or breach of duty . In Ireland,

the majority of concerns of fitness to practice were related to communication issues and clinical malpractice and competence. But a few of them did generate cases of sanctions, which may include admonishment, advice, suspension and others. The use of mediation in the previous chapter was reported by NMBI in 2018 informing the cost of €13,784 with the service. However, they did not mention what kind of case required the use of mediation, or if it was related to a clinical claim case or not.

While in the British council for nurses and midwifes, although the number of sanctions were also relatively low in relation to the number of complaints received by them as occurred in Ireland, the number of revoked registrations was the second most applied sanction over the period of this study, outnumbered by suspensions only.

The same analysis can be done into the Medical Council in England regarding sanctions to doctors after investigation proceedings. Suspension in doctors' registration were the highest number of sanctions applied in the period, followed by revoked registrations.

However, the number of fitness to practice sanctions for nurses and doctors in England was significantly high compared to the number issued in Ireland. But it can be related to total number of concerns received by the boards in both countries, which differ too.

Again in 2018, the GMC like in NMC report, mentioned to use mediation to solve conflict disputes. The medical council reported the number of six mediations in the year, but did not mention the reason of the conflict dispute, thus it remains unclear whether they had any relation to clinical claims cases.

Summarizing all data collected, it can be seen that mediation has been used by both countries and their respective health systems and bodies organizations. Despite not being clear what mediation was used for in some cases, considering the matter of this research, it is evident that mediation has been considered by both governments and health organizations as an alternative dispute resolution including cases of medical negligence claims or clinical claims, as they are called in this study.

Chapter 6 – Conclusion

It is important to consider that unfortunately cases of medical negligence may happen anywhere affecting patients, families and healthcare professionals negatively. Consequences are not only

physically impacting claimants' functional lives, but also the psychologically for all people involved in the case. They will also affect organizations, health public systems and governments in terms of costs and public confidence in the service provided.

Thinking about these occurrences it is noticeable that the British government and the National Health System - NHS have a more developed protocol to manage clinical claims, also offer and see mediation for their professionals, organizations and patients as a positive alternative way of dispute resolution, investing in schemes of pre-action protocol to avoid litigation and the costs and longtime of actions in courts and tribunals. It must be emphasized that England is an immense country compared to Ireland, and it makes a difference not only in financial matter but also in the necessity of quality strategies to delivery information to general public and health professionals.

In regard to Ireland, mediation has also been introduced and also used in cases involving clinical claims, considering their justice system maturity and the Mediation Act 2017. But the idea of using mediation in cases of clinical negligence appears not widely diffused and recognized inside the health public system. This assumption may have been wrongly made due to the lack of a formal organization such as "NHS Resolution" to manage claims from their public health system as the one created by the British government. In fact, comparing the population number of Ireland and England, such structure might be completely unnecessary.

The fact is that this study alone is not enough to reach a conclusion and declare whether the clinical claims management in course is efficient or not for both governments. For this research, time and resources were limited, therefore not achieving such consistent results to precisely determine how successful the British and Irish public health systems and governments have been in the management of clinical claims, or if mediation has been primarily considered as ADR for that cases. However, the author could achieve basically how each country deals with clinical claims and that mediation has been used even if not widely diffused among healthcare professionals in both countries.

Managing and investigating clinical claims can show hospitals and health public system what is not in compliance with the rules and what needs to be implemented in order to avoid negligence and malpractice cases. Additionally, by using mediation in a structured way, a reliable evaluation of the outcomes will be available, enabling researchers in this field to quantify the gains as ADR in spite of courts and tribunals proceedings.

Understanding hospitals, community clinics and other types of health facilities as places where people having an illness go to find a treatment or cure to their problems, it is reasonable to say that

those places may present a huge variety of different personalities, perspectives, attitudes, feelings and beliefs. Many scenarios of distress between patient or clients and health professionals are possible, just focusing on their interaction.

On top of it, one has to think of those places as a company, surround by everyday problems that will be found in any other type of business, involving management of staff, products and materials, customer's dissatisfaction, absenteeism and everything that involves making the business work. Thus, considering health facilities as a company allows us to see them from a different perspective - a place where other issues should arise, not only those directly related to the patient versus professional interaction.

Nowadays, with the increase of the privatization and commercialization of health services, the perspective view of the patients has changed, as well as the way of serving the patient, and also the professionals and organizations managers' view. So, when thinking about clinical claims and mediation we have to assume that the parties involved can be patients and their families, healthcare professionals and providers.

Expanding this analysis into other countries' realities, the development of mediation as alternative dispute resolution as a strategy for clinical claims might appear discreet compared to England and Ireland, due to many other issues and lack of people's knowledge and access to the justice system, including the lack of incentive for this type of practice by governments.

In conclusion, it is expected that the present research is perceived as a fruitful contribution to the study of the use of mediation in the health area, through a constructive vision, working as a basis for future research aimed at the management of conflicts related to clinical claims.

6.1 Reflection

Throughout my professional experience as a nurse in Brazil, the number of conflicts of different natures surrounding the work environment was remarkable. Most of the team clearly struggled to work in such an environment, having many issues to solve daily while trying to keep high standards of care and not affect patients. Unfortunately, healthcare professionals are not prepared for many of the conflicts that will occur in a healthcare environment, let alone how to manage conflict resolution.

As student of the Master in Dispute Resolution course, I have learnt many new concepts that I had never heard before, and an example of that is ADR. Mediation for me, even during the course is a challenge, because it requires of me skills that I do not feel I possess. So, as clinical claims are a

chronic problem in many societies nowadays, for me learning mediation was a breakthrough, making me aware of what can be done to avoid these cases in court and try to provide a faster outcome for patients and families who were affected by some medical negligence.

This research was really challenging to conduct considering many factors such as: my limited knowledge of Irish and British health systems and their medical laws and justice system; the time and resources available to develop the topic since many articles and materials about health field are not available in search tools provided by the college; the methodology of the college to provide orientation to students, and the confidentiality of mediation processes and clinical claims.

Despite all the difficulties mentioned above, a great effort was put into it and I believe this research will shed a light on how those cases are managed in both countries. In my particular case, I can say I have learnt a lot about public health systems in Ireland and England doing this research, which will definitely contribute to my profession as nurse in Europe.

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