Mediating Medical Negligence Claims In Malaysia: An Option For Reform?

by

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Abstract

The present tort system has been criticised as not being a suitable mechanism for compensating victims of medical negligence. The deficiencies of the system has been identified and proven as not being able to fulfill objectives such as providing fair and adequate compensation, maintaining equity between injured victims with similar needs, providing deterrence and incentives to accident reduction. Alternatives to the tort system have been advocated, particularly in employing various methods of alternative dispute resolution to reach a settlement between disputing parties. Such methods can be seen to do away with the rigours of litigation by offering settlement through a fairer, cheaper and more helpful approach. Compared to other methods of alternative dispute resolution, mediation seems to offer a costless process of integrative bargaining. It does not emphasize on who should win or lose, who is right or wrong. Rather, it focuses on goals of reconciliation and personal transformation. In mediation, parties participate directly in what is thought to be an informal and voluntary dispute resolution process that may offer a novel and promising approach in resolving claims. In handling medical negligence claims, mediation can be seen as the main form of dispute resolution, which provides speedy, economical and trauma-free alternative to litigation. Experiences from countries that have employed mediation for medical negligence disputes such as England and Australia can offer valuable lessons to Malaysia in assessing whether this alternative can be a viable option in solving the problems inherent in medical negligence litigation in Malaysia.

I. Introduction

The spur of litigation is often caused by absence of information and explanation given to patients. Not all patients want financial compensation. Some of them merely want to know what happened, why it happened, be assured that it will not happen again and to receive an apology for what had happened. Litigation under the tort or fault based system has never been able to offer such non-legal remedies or even provide fair and adequate compensation for all types of medical negligence victims. From the patient's point of view, the costs of trying a medical negligence case and length of time required have adverse effect on the amount of compensation received, as damages awarded must be reduced by the costs of bringing the suit. On the other hand, from a doctor's point of view, the system cannot justify the large damage awards given for intangible losses such as pain and suffering. Instead of having a deterrent effect, a large damage award causes an increase in doctor's medical insurance premiums causing them to move away from high-risk specialties. Alternatives to litigation have been advocated by many quarters to solve the inherent difficulties faced by doctors and patients in the present tort or fault-based system.

II. The Tort or Fault-Based System

Presently, the tort system or fault-based system is used to regulate medical negligence litigation in Malaysia. Generally, this system provides for compensation only when a doctor or any other medical personnel assisting in the treatment of a patient is negligent. The heart of negligence is the element of fault. However, it can be seen that fault is not a satisfactory criterion for liability due to difficulties of adjudicating on it.[1] Litigation demanding proof of fault is notoriously protracted and complex, particularly, where the behaviour being challenged is that of a professional.

III. Problems with the Tort or Fault-based System

a. *Adversarial in nature*

The tort system, being adversarial in nature requires the litigating parties to determine the subject matter of the controversy between them and supply the court with the evidence on which they wish the court to decide. The task of the court is to do justice based on the available evidence and the law. In reality, it sometimes happens that litigation fails to achieve real justice between the opposing parties as a result of inherent weaknesses in the adversarial system and practical disadvantages, which obstruct the proper functioning of such a system. These weaknesses are equally applicable to medical negligence litigation in much the same way as other types of litigation, which include issues of judicial impartiality and competencies, disadvantages of the tactical manoeuvring, partisanship and unreliability of witnesses and the unfairness that can result in such hearings when there is inequality of legal representation.[2]

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[1] See, Cane, P., (1993), *Atiyah's Accidents, Compensation and the Law,* London : Butterworths, at Chapter 7 on the "Appraisal of the Fault Principle".

[2] In many medical negligence cases, the defendant (doctors) are usually represented by insurance companies, which possess large resources, a lot of experiences in personal injury litigation, skilled negotiators and clear expectations of the outcome of claims brought against them. This inequality has a direct effect on the respective abilities of the parties to construct convincing cases.

b. ***Unreliability of expert witnesses***

The crucial part in medical negligence litigation is obtaining the expert medical witness views on whether the particular act or omission concerned constituted a breach of duty. Once the patient has decided to engage a lawyer, the first step is usually to obtain medical records and engaging a medical expert to examine them and provide a preliminary report. The concerned medical expert must be willing to give oral evidence at the later part of the proceedings and prepared to be challenged on cross-examination. However, in the event that "the case does not proceed to a contested hearing, the expert evidence on both sides is still likely to be instrumental in the bargaining process leading to an out-of-court settlement, or even to a decision by a claimant to abandon proceedings."[3]

Undeniably, there is much difficulty faced by legal practitioners in obtaining expert evidence for claimants in medical negligence cases. This may be due to various reasons. Firstly, there is generally a strong reluctance of doctors to testify against each other. Some doctors feel that they owe a greater duty to their professional colleagues rather than to a member of the public who suffers damage as a result of negligent treatment. The Supreme Court of California in *Salgo v Leland Stanford Jr. Univ. Bd of Trustees*[4] commented:

> "Gradually the courts awoke to the so-called "conspiracy of silence". No matter how lacking in skill or how negligent the medical man might be, it was almost impossible to get other medical men to testify adversely to him in litigation based on his alleged negligence. Not only would the guilty person thereby escape from civil liability from the wrong he had done, but his professional colleagues would take no steps to insure that the same results would not again occur at his hands."[5]

The unwillingness to testify by doctors could be due to psychological as well as economic reasons. Being subjected to testifying in court and grilled during cross-examination may not be a memorable experience. At times, it may be considered as traumatic. Furthermore, it may be unpleasant to be involved personally with the doctor who is a defendant in a medical negligence proceeding as there is a possibility of ostracism by the same members of the group. Thus, it is understandable that doctors try to avoid the risk of professional isolation. A more persuasive explanation for the refusal to testify is economic. The so-called "conspiracy of silence" is quite prevalent among doctors who are members of the same medical insurance company. This is due to the pressure that is being applied by insurance companies whose motivation in silencing doctors for their own financial well being. The insurance companies have the power to cancel or refuse to renew the professional liability insurance of a doctor who breaks the rule and offers testimony.

b. ***The lengthy period in pursuing a claim***

The tort compensation system has been known to be cost-inefficient. Administrative costs are high due to the nature of the two principal criteria for compensation, namely, case-by-

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[3] Philips, A.F., (1997), *Medical Negligence Law: Seeking a Balance*, Aldershot: Dartmouth Publishing Co Ltd, at p. 77.

[4] 317 P 2d 1093 (1960).

[5] *Ibid.*, at p. 1095.

case determinations of fault and lump sum findings of damages under indeterminate guidelines. The main contributor to the costliness of the tort system is the delay involved in the pursuit of a claim. Delay may occur at different stages in the litigation process and for various reasons. In medical negligence cases, delay occurs for instance, before the plaintiff seeks legal advice, while waiting for information from the opposing side, while the parties wait for experts to investigate and produce their report, while the parties seek and exchange documentary evidence and while waiting for the trial date. These delays clearly contribute to the length of time required for the case to be settled. For instance, in the case of *Dr Chin Yoon Hiap v Ng Eu Khoon & Ors and other appeals*[6], litigation was initiated on 23 December 1981 whereas the judgment was delivered on 7 November 1997. Altogether, the case took about 16 years to conclude. If the time considered was when the cause of action accrued, that is, 7 January 1976, then the duration would be 21 years. Further, in *Foo Fio Na v Hospital Assunta & Anor*[7], the cause of action accrued on 19 July 1982 whereas judgment by the High Court was given on 8 October 1999[8] whereas the decision of the Court of Appeal[9] was given on the 5th of April 2001. An application for leave to appeal to Federal Court against the decision of the Court of Appeal in *Dr Soo Fook Mun v Foo Fio Na & Anor*[10] was made in November 2001[11] and the Federal Court finally delivered its judgment on the 29th December 2006[12], after a delay of over four and a half years from when the application for leave to appeal was made. Thus, the total number of years the case took to conclude from the High Court to the Federal Court was 24 years. It can be seen that the entire litigation process for medical negligence case requires an average of about a minimum period of 15 to 20 years, from date of injury to the conclusion of the case.

c. *Effect of a Medical Negligence Claim on the Defendant Doctor*

Doctors not only fear of losing a lawsuit but the lawsuit itself. If the injured patient files a complaint against the doctor, this already has a detrimental effect on the doctor's reputation and practice even if the matter does not go to trial. This is due to the fact that the publicity which a claim entails is sufficient to cause a loss of reputation which might have adverse effects on their practice regardless of whether the doctor wins in court or not. Furthermore, by bringing legal action, the patient assaults the doctor's credibility, insinuating faulty judgment and treatment. Self esteem and status as a successful practitioner may suddenly be jeopardized overnight. In a way, a medical negligence suit challenges professional reliability and authority. Such development may not only cause the adoption of defensive medicine but also deter doctors from opting for high-risk specialties. The threat of litigation also subtly changes doctors' relationships with all patients, not just those who initiate claims against them. This is because the threat of medical negligence claims compels the doctor to view his patient as a future adversary in

[6] [1998] 1 MLJ 57.
[7] [1999] 6 MLJ 738.
[8] An application for leave to appeal to Federal Court against the decision of the Court of Appeal in *Dr Soo Fook Mun v Foo Fio Na & Anor* [2001] 2 CLJ 457. The Federal Court delivered its judgment on the 29th December 2006, after a delay of over four and a half years.
[9] The judgment can be found in *Dr Soo Fook Mun v Foo Fio Na & Anor* [2001] 2 CLJ 457.
[10] *Ibid.*
[11] This can be found in *Foo Fio Na v Dr Soo Fook Mun & Anor* [2002] 2 MLJ 129.
[12] [2007] 1 MLJ 593.

a courtroom proceeding. Even if the negligence claims is settled out of court, there is still an effect on the doctors as settlements out of court leave them with no chance of vindicating themselves. At the end of the day, they still feel that there is a cloud hanging over their head.

d. ***Rise in medical insurance premium rates***

Frequency of medical negligence suits and the amount of awards against doctors can lead to sharp increases in the cost of doctor's liability insurance as has occurred in the United States, Australia and the United Kingdom. Significant increases in subscriptions paid by doctors to the medical defence organisations can have an impact on the patients in the form of increased fees.[13] Ultimately, this may raise the cost of medical attention.

e. ***Defensive medicine***

Litigation has the tendency of developing defensive and confrontational attitudes. The rising number of medical negligence cases may lead to doctors adopting "defensive medicine." In *Whitehouse v Jordan*[14], Lawton J. said that defensive medicine consists of "adopting procedures which are not for the benefit of the patient but safeguards against the possibility of the patient making a claim of negligence."[15] Mr Justice Gopal Sri Ram reiterated this point in *Dr Soo Fook Mun v Foo Fio Na & Anor Appeal*[16] by stating that:

> "…if the law played too interventionist a role in the field of medical negligence, it will lead to the practice of defensive medicine and the cost of medical care for the man on the street would become prohibitive without being necessarily beneficial."[17]

Defensive medicine can be considered to be positive as well as negative. Positive defensive medicine involves undertaking extra procedures to eliminate any risk inherent in a treatment. For instance, the doctor may subject the patient to additional tests, which in his professional judgment is clinically unnecessary but necessary to ensure that nothing goes wrong. This procedure is considered to be a waste of time and resources and subjects the patient to unnecessary medical intervention. Negative defensive medicine, on the other hand, deprives the patient of treatments that are beneficial to his health as there are some risks attached to the treatment. For instance, a doctor may refuse to carry out a treatment as the risks inherent in the treatment is rather high and therefore, the risk of medical negligence suits if things go wrong is likely to be high too.

IV. Alternatives to Litigation

A radical solution to the problems faced by litigants in medical negligence claims is to move away from the fault-based system towards a "no-fault" based system of liability. However, it is not easy to design a no-fault scheme for medical accidents which is simple

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[13] For instance in Australia, due to the failure to retain adequate funding to compensate large number of claims between 1995 and 2005, average medical indemnity premiums increased by 221 per cent (averaging 13 per cent per annum), with the largest average premium increase of approximately 50 per cent in 2002. See further; 'No cure-all in this crisis', *The Australian*, 8/10/03, p 11.

[14] [1980] 1 All ER 650.

[15] *Ibid*., at p. 659.

[16] [2001] 2 CLJ 457.

[17] *Ibid.* at p. 472.

to run, straight forward in operation and acceptable in costs.[18] Other alternatives to litigation merit consideration in order to overcome the difficulties facing both doctor and patient in the present fault-based system. Alternative dispute resolution (ADR) methods have the advantage of preserving doctor-patient relationship and offer an alternative for those who lack the stamina to see through the litigation process. While litigation is lengthy, complex, expensive and produce unjust results, alternative dispute resolution, by contrast, is faster, simpler and creates an opportunity for both parties to play a major role in resolving the dispute at an affordable cost. *Flaxman*[19] opined that:

> "[Alternative dispute resolution] gives the parties the satisfaction of 'their day in court'; the chance to express their views, their frustrations, their sense of outrage or disappointment.... [and for those who are] unable to risk the uncertainties and financial reefs of litigation, it [is] an increasingly acceptable alternative."[20]

Thus, the potential use of various methods of alternative dispute resolution in resolving medical negligence cases has to be considered seriously as it may provide the long awaited solution faced to the problems faced during the medical litigation process. There are various methods of alternative dispute resolution such as negotiation, arbitration and mediation. Compared to other methods of alternative dispute resolution, mediation seems to offer a costless process of integrative bargaining. It does not emphasize on who should win or lose, who is right or wrong. Rather, it focuses on goals of reconciliation and personal transformation.

V. Mediation

In mediation, parties participate directly in what is thought to be an informal and voluntary dispute resolution process that may offer a novel and promising approach in resolving claims. Lord Woolf in his *Access to Justice Final Report 1996*[21] has singled out medical negligence as requiring special attention because it has become increasingly obvious that it was in the area of medical negligence, that the civil justice system was failing most conspicuously to meet the needs of litigants in a number of respects. His Lordship further recommended alternative dispute resolution mechanisms, particularly mediation, to be used for medical negligence claims, which may be better suited than litigation to the needs of both patients and doctors. His Lordship identified the needs of patients as wanting "impartial information and advice, including an independent medical assessment, fair compensation for losses suffered, a limited financial commitment, a

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[18] Many lessons can be learned from the New Zealand, Swedish and Danish Compensation Schemes. There are many factors that may inhibit Malaysia from adopting a no-fault compensation scheme for medical injuries. See Puteri Nemie, J.K. (2003). "Adopting a No-Fault Compensation Scheme for Medical Injuries in Malaysia: A Myth or Reality?" in *Issues in Medical Law and Ethics.* Kuala Lumpur *:* Harun Hashim Law Centre; Puteri Nemie J.K. (2002) "Is No-Fault the Answer to Dilemmas Facing Victims of Medical Negligence?"Vol. 4 *Malayan Law Journal.* pp. x1ii – x1viii.

[19] Flaxman, C., (1992).Technical Director of the Solicitor's Indemnity Fund Limited, in Bevan, A.H., *Alternative dispute resolution: a lawyer's guide to mediation and other forms of dispute resolution*, London: Sweet & Maxwell.

[20] Ibid., at p. v.

[21] Lord Woolf MR, *Access to Justice: The Final Report to the Lord Chancellor on the Civil Justice System in England and Wales,* London: HMSO, 1996, at paragraph 18.

speedy resolution of the dispute, a fair and independent adjudication; and (sometimes) a day in court."[22] Doctors, on the other hand, want "a discreet, private adjudication, which some would prefer to be by a medical rather than legal tribunal, an expert of their own or their solicitor's choice and an economical system."[23]

Mediation provides an early opportunity for patients' needs to be reviewed and addressed in a positive light. Unlike arbitration or court litigation, no resolution can be reached save by the consent of the parties and mediator's decision is not binding. All discussions are without prejudice and parties can walk away at any stage. In other words, the parties should be free to continue or opt out. Settlement achieved should be on terms acceptable to all parties after each side assesses and balances the risks involved. If after a session of information-sharing and good faith negotiations the parties cannot agree, settlement will not and should not result. Levels of compensation offered must be realistic.[24] However, for successful mediation, the role of the mediator must be clearly defined. The mediator is not to make a decision, as that is the function of the judge or the arbitrator. The role of the mediator is simply to establish an atmosphere in which the parties work to settle a situation themselves. The good mediator constantly points out to the parties the practicalities of negotiations and the advantages and disadvantages of various approaches. Necessarily, mediators should have fair knowledge of the subject matter. This can be achieved by having independent scientific experts advising mediators on aspects of medical issues. With sufficient knowledge, mediators should be able to propose settlement terms, with compensation being assessed for losses or previous temporary impairment and loss of income suffered and the effects of continuing impairment. By probing strengths and weaknesses of each side, the mediator can facilitate settlement or help to narrow the issues in dispute. The strength of evidence on one side can be brought to the attention of the other side at an early stage and this may prompt early settlement. Substantial costs and expenses can be saved. The appointment of the mediator should be at the discretion of both parties. Impartiality should be the main assessing criteria in choosing the mediators. Mediation should be conducted without prejudice and the mediator should have the power to choose the procedure, which he thinks fits and considered to be the most efficient, speedy and cost effective. The mediator cannot be called upon to act as an advocate adviser or witness to a litigation proceeding or be in a position that requires him to disclose information about any matter arising from the mediation.[25] This is to ensure the confidentiality of the proceedings.

VI. The United Kingdom Experience

There are many similarities between medical negligence claims in the UK and Australia. The size and number of medical negligence claims in both countries has been rising. In the UK, in 1974/75, annual NHS clinical negligence expenditure in 2002 terms was £6.33

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[22] *Ibid.*

[23] *Ibid.* at paragraph 19.

[24] See, Llewellyn, K., "Ask About Mediation", (May 2000) *Dispute Resolution Journal,* at pp. 33-38; Varma, A. & Stallworth, L.E., "Barriers to Mediation", (February 2000) *Dispute Resolution Journal*, at pp. 32-40.

[25] For the do's and the don'ts of mediation in medical negligence cases, see Galton, E., "Mediation of Medical Negligence Claims", (2000) *Capital University Law Review*. Vol. 28 : 321.

million.[26] By 2001/02, it had increased to £446 million. The cost of medical litigation in the UK is equivalent to 0.04% of Gross Domestic Product.[27] Increases in the incidence of medical negligence and the size of claims led to the launch of the medical negligence mediation pilot scheme.[28] The pilot scheme[29] aimed to test whether mediation could improve satisfaction with claims management. By the end of a third year of the scheme, 12 cases had been mediated and settlement was reached in 11. The cases covered a range of medical specialities and took an average of seven hours to settle. The average settlement was just over £34,000 although one case settled for £80,000. The official evaluation of the scheme conducted by *Linda Mulcahy*, the research leader and the report concluded that mediation had considerable potential for medical negligence cases.[30] Mediation proved to be much more sensitive to the non-financial needs of the parties and provided an opportunity for the parties to meet in person, discuss the details of medical treatment and participate in settlement negotiations. Other than providing an explanation for claimants to understand why something had happened, the flexibility of mediation allowed the claimants to fully explore such issues with the clinical staff before launching into a discussion of legal precedent and the value of the claim.[31] However, the evaluation report stated that not all kinds of cases are suitable for mediation. Cases that are suitable for referral to mediation are cases where non-legal remedies such as apologies and explanations are being sought. It is also suitable for cases where parties wanted greater involvement in case management, where speedier resolution is required and where parties have established a long-term relationship with the healthcare provider.[32] Cases that are not suitable for mediation are cases that lacked settlement potential such as cases where there was a desire to set precedent, where the claim value is high and insufficient information on which to base settlement negotiations.[33] Thus, mediation may not be suitable for all medical negligence cases but it certainly has the potential to encourage more appropriate and effective resolution of disputes. It clearly provides an opportunity

[26] United Kingdom, Department of Health, Making Amends: A consultation paper setting out proposals for reforming the approach to clinical negligence in the NHS, A report by the Chief Medical Officer, June 2003. A copy of the report is available from www.doh.gov.uk/makingamends/pdf/cmomakingamends.pdf

[27] *Ibid*. at p. 11.

[28] *Ibid.* The concept of ADR crossed from the US to England in the 1980s and the Centre for Effective Dispute Resolution (CEDR) (the main mediation body in the UK and now one of the largest in Europe) was founded in 1990. However, prior to 1999, there was resistance to using ADR amongst the majority of legal practitioners and their clients. Possible reasons for this reluctance include strong adversarial legal culture in England, a perception that suggest some form of ADR might be seen by the other side as a sign of weakness and a general lack of court encouragement.

[29] The pilot study in two NHS regions, namely, Anglia and Oxford and Northern and Yorkshire was launched in 1995 with the aim of analysing up to 40 mediations over two years. But the low referral rate meant the study had to be extended for a third year, and only 12 cases were completed at the end.

[30] Mulcahy, L. with Selwood, M., Summerfield, L. & Netten, A., (2000). *Mediating Medical Negligence Claims – an option for the future?* An evaluation of the Department of Health's Mediation Pilot Scheme, The Stationery Office, Norwich; See further Burns, S & Mulcahy, L. (1999) "Civil Justice Reforms, ADR and Mediation", in M Powers and N Harris (eds), *Medical Negligence* (3rd edn), Butterworths, London.

[31] *Ibid.* at p xvii.

[32] *Ibid.*

[33] *Ibid.* at p. xv.

to explore all aspects of the claim rather than just those elements on which the legal system focuses.[34]

Further, in the wake of the Woolf reforms of the UK civil justice system court annexed mediation schemes and judicial pressure to mediate are becoming more common. Lawyers are being compelled to discuss settlement at an earlier stage of litigation and to consider alternatives to the courts. In 1995 and 1996, Lord Woolf conducted a large-scale inquiry into improving access to justice in English courts. The Final Report proposed a new civil justice landscape, which would avoid litigation wherever possible; involve less adversarial and less complex litigation; and provide stricter case management by judges.[35] A unified Code of Procedural Rules (the CPR) provided the centrepiece of the programme of reforms that followed Lord Woolf's inquiry. The Rules came into effect on 26 April 1999 and apply to High Court and County Court proceedings in England and Wales. There is now a duty on courts to actively case manage by encouraging the parties to co-operate and to use ADR.[36] The Rules specifically provide a window of opportunity early in proceedings for parties to request a stay to attempt ADR.[37] The CPR have also introduced the possibility of cost sanctions if a party does not comply with the court's directions regarding ADR. In particular, a court when assessing costs can have regard to efforts made by the parties both before and during proceedings to settle the dispute.[38] Since the introduction of the CPR, there has been a dramatic decline in the number of proceedings instituted and also an increase in the number of settlements at an early stage of proceedings. It is hoped that, with mediation, the cost of NHS compensation, costs and legal fees, currently amounting to £4billion, will be reduced by at least 5% over the next two years. [39]

[34] Subsequent to this pilot scheme, a clinical negligence pre-action protocol was developed to provide a code of good practice to be followed in clinical negligence litigation. The protocol lists a range of alternative mechanisms for resolving clinical negligence disputes, including mediation, early neutral evaluation, expert determination and arbitration. See the *Civil Procedure Pre-Action Protocols Clinical Negligence Protocol*, available at http://www.open.gov.uk/lcd/civil/procrules.

[35] Lord Woolf, Access to Justice: Final Report, July 1996, *supra*, at pp. 4-9. See also Nesic, M. (2001) Mediation - on the rise in the United Kingdom? (2001) 13(2) *Bond Law Review* 20.

[36] Code of Procedure Rules, rule 1.4(2).

[37] Code of Procedure Rules, rule 26.4(1).

[38] Code of Procedure Rules, rule 44.5(3). In *Frank Cowl v Plymouth City Council* [2001] EWCA Civ 1935, Lord Woolf stated that sufficient information should be known about ADR to make the failure to adopt it, in particular where public money is involved, indefensible. Although this was a public law case in the context of judicial review, Lord Woolf's disapproval of parties who do not properly address ADR options in the course of litigation has general application. Further, in *Dunnett v Railtrack* [2002] EWCA Civ 302, the Court of Appeal refused to award costs to the successful litigant (Railtrack) as it had refused to mediate when it was proposed at an earlier stage in the proceedings. The Court stated that the parties and their lawyers should be aware that it is one of their duties to consider ADR, especially when the court has suggested it. This is the first case in England where the judges have actually withheld costs from a successful party on account of a failure to mediate.

[39] See Nesic, M, (2001) Mediation - on the rise in the United Kingdom? *supra*

VII. The Australian Experience

Efforts towards establishing mediation in Australian states started in the early 1980s. Also known as the "legislative avalanche"[40], the process of adopting mediation before trial by the courts to tackle the backlog of cases started in Australia's most populous State, that is, the New South Wales (NSW). In 1980, the Community Justice Centres (Pilot Projects) Act was introduced in which the appropriate infrastructure was established for the mediation of small civil and criminal disputes by specially-trained mediators.[41] These Centres are used for the resolution of neighbourhood, family, environmental and employment disputes. In 1998, the State of Queensland had 28 different Acts or Regulations which provided for ADR, typically mediation.[42] Victoria, which is Australia's second-largest State, was only slightly behind NSW in adopting mediation as a central plank of its legal system. In June 2003, the Victorian Department of Human Services commissioned the Centre for Public Health Law, at the School of Public Health La Trobe University, to conduct a research project examining the use of Alternative Dispute Resolution (ADR) techniques within regulatory schemes registering health professionals.[43] The survey found that most participants viewed ADR techniques as useful, flexible and desirable, as a good alternative to the existing complex, expensive and intimidating system of dispute resolution, and saw it as a beneficial mechanism for handling consumer complainants as well as those involving health practitioners. Many participants perceived ADR, particularly mediation, as a commonsense part of good management.

Mediation is also a key form of private dispute-resolution at the federal level in Australia. For instance, under the Family Law Act 1975, section 16A provides that "the court must, if it considers it is in the best interest of the parties or their children to do so, direct or advise either or both parties to attend counselling. Further, under the Federal Court of Australia Act 1976, section 53A provides that "the court may order a proceeding, or any part of a proceeding, to a mediator for mediation, with or without the consent of the parties to the proceeding." In 1991, the Courts (Mediation and Arbitration) Act was introduced to facilitate court-sponsored mediation and arbitration in the courts of federal jurisdiction, namely the Federal Court and Family Court.[44] Mediation in Australia has

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[40] Wade, J., "Current Trends and Models in Dispute Resolution, Part II", (1998) 9 *Australian Dispute Resolution Journal* 59, 61.

[41] This experiment in state-sanctioned private mediation, designed to reduce the number of proceedings filed in the lower NSW courts, was subject to a sunset clause giving it a three-year opportunity to demonstrate its worth. In 1983 the project was made permanent. Significant investment was undertaken in the establishment and maintenance of Community Justice Centres to facilitate the greater emphasis given to mediation in the NSW justice system.

[42] Wade, J. "Current Trends and Models in Dispute Resolution, Part II", *supra.*

[43] Report and Recommendations for Victoria Centre for Public Health Law entitled "The use of Alternative Dispute Resolution in Australia and New Zealand" by Health Practitioner Registering Bodies conducted by School of Public Health La Trobe University, October 2004. In this survey, 13 authorities participated in the interviews, including 12 Health Practitioner Registration Boards and the Office of the Health Services Commissioner (OHSC). A total of 28 interviews were conducted. These interviewed included the Health Services Commissioner and Presidents, Chief Executive Officers, Registrars, Legal Practitioner members and Managers of the participating bodies.

[44] In the Federal Court, forms of "assisted" dispute resolution such as mediation are typically undertaken with the involvement of a Registrar or Justice of the Court, and if a mediation is successful, the outcome is

undeniably been very successful in resolving disputes. In particular, the Victorian Supreme Court's "Spring Offensive" produced a success rate of 54%. A recent study conducted by the Building Lists of the State courts indicates a settlement rate above 75%.[45] Further, the Federal Court reports that the cases settled after court-annexed mediation between 1994 and 1999 averaged 55%, but this figure excludes cases that were privately mediated where parties are not required to inform the Court.[46] The Supreme Court of Australia has successfully tackled backlogs in civil cases between 1992-1993 by implementing mandatory mediation in this way.[47] However, the adaptation of some of the principles of ADR processes such as mediation, negotiation and conciliation into the health regulatory disciplinary boards has only slowly begun to be incorporated into legislation such as in reforms to the Medical Act in Western Australia.[48]

Despite the high rate of success in employing mediation, doubt has been expressed in some quarters about the effectiveness of mediation in relieving the caseloads of traditional courts and providing a cheaper recourse to justice. Critics maintain that ADR processes remain expensive in Australia, especially for the more skilled commercial mediators.[49] Concern has also been expressed that the eagerness of courts to refer matters to mediation may be preventing important cases from adding to the body of Australian law.[50] Nevertheless, mediation will undoubtedly continue to establish itself as an indispensable part of the Australian legal system.

VIII. Is Mediation an option for reform in Malaysia?

Although at present, Malaysia is not experiencing the kind of "malpractice crisis"[51], there is certainly a rise in the number of negligence claims and the size of awards.[52] These factors are sufficient to cause alarm for future implications and generate serious thoughts for reform of the present system. Rising number of medical negligence claims is not considered healthy for a country as it leads to a reduction in the amount of money

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reflected in orders of the Court. The Court has reported that between 1994–95 and 1998–99, an average of 220 matters were referred to mediation each year, with 347 matters referred to mediation in 1998–1996.

[45] Supreme Court of Victoria, 2002-04, *Judges' Annual Report*, 19.

[46] Australian Law Reform Commission, Managing Justice ─ *A Review of the Federal Civil Justice System*, Report No. 89 (2000).

[47] Bartlett, C., "Mediation in the Spring Offensive 1992" (1993) 67 *Law Institute Journal* 232.

[48] The Medical Act 1894 did not provide for the use of alternative dispute resolution (mediation, conciliation) in handling complaints against medical practitioners. The 1991-1993 Review of the Western Australian Health Practitioner Legislation recommended that a possible option available to a CAC (complaints screening committee) could be for referral for conciliation of the matter by the Office of Health Review and dealt with under the relevant Act.

[49] See http://www.mallesons.com/publications/article/2005, accessed on 9th April 2008.

[50] See A DeGaris, "The Role of Federal Court Judges in the Settlement of Disputes", (1994) 13 *University of Tasmania Law Review* 217.

[51] A country is said to be experiencing "malpractice crisis" if the number of malpractice cases has risen dramatically in the last 10 to 15 years in terms of medical malpractice suits by the patients. Other symptoms include dramatic rise in medical malpractice insurance premiums, rise in the amount of courts' awards and settlements whether for economic or non-economic damages and greater availability of punitive damages.

[52] In the year 2000, the amount of compensation paid by the Malaysian government to medico-legal cases was RM219,508 whereas in the year 2001 was RM 430,502, whereas in 2002 was RM951,889. (Source: Medical Practice Division, Ministry of Health Malaysia)

available for patient care. A single large award can distort the amount government or private hospitals can use to enhance healthcare.

As a compensatory mechanism, the tort or fault based system may prove to be efficient to successful claimants as the damages received may represent quite a generous compensation. This is because the principle of restitution requires the courts to place the successful plaintiff in a position he or she would have been, had the defendant had not injured him, so far as it is possible through monetary damages. This means that all economic loss resulting from past, present and future interruptions to work as a result of the injury are incorporated into the award as well as any expenses involved in the care of the plaintiff. Further, the system also compensates non-economic losses as well such as pain and suffering and loss of amenities. However, the problem lies with the fact that not many can successfully claim compensation as the difficulties faced by patients in overcoming the substantive law of negligence are insurmountable. As a result, only a small proportion of patient suffering medically related injuries obtain compensation. Furthermore, the present fault-based system seems ill equipped to provide non-legal remedies such as an explanation and investigation of what has occurred to claimants. The emphasis on establishing fault destroys the proper relationship of mutual trust between patient and doctor by introducing a confrontational element.

Thus, mediating medical negligence cases has much to offer to claimants as well as health providers in Malaysia. The main advantage of mediation would be to settle monetary and personal issues arising from medical negligence which litigation may not allow. As mentioned earlier, most of the time, patients want to know what actually happened, why it happened and be assured that it will not happen again. They need an avenue where their grievances can be made known and resolved. Through mediation, parties may speak openly in order to relieve the non-monetary stresses, which would not necessarily be relieved during pre-trial preparations or even at trial.[53] The health care providers interests can also be effectively addressed during mediation even if the doctor admits that he had made a mistake in treatment by apologizing to the claimant. This is due to the fact that unlike trial, mediation forum are confidential and the doctor may feel more at ease in admitting that he had committed a human error.[54]

Although the Malaysian Mediation Centre was set up in November 1999 under the jurisdiction of the Bar Council's Alternative Dispute Resolution Committee, the centre has yet to receive any medical negligence disputes.[55] The Centre has its own rules for purpose of accreditation of Mediators. All Mediators of the Centre must be a practising member of the Malaysian Bar of at least 7 years standing. He or she must have completed

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[53] See Galton, E. *et al*.(1994). *Representing Clients in Mediation*. Americal Lawyer Media : Texas; Sheila M. Johnson, "Medical Malpractice Litigator Proposes Mediation", (1997) *Dispute Resolution Journal*. Vol. 52 : 42.

[54] Gitchell, R. L. & Plattner, A., "Mediation: a viable alternative to litigation for medical malpractice cases" *DePaul Journal of Health Care*. (1999), Volume 2 :. 421 citing Galton, E. *ibid*. at p. 122.

[55] The Centre is open to public and firms and is available for all kinds of dispute but according to the Secretariat for the Malaysian Mediation Centre, majority of cases that have come to the attention of the Mediation Centre are on family matters.

at least 40 hours of training conducted and organised by the Centre and must also pass a practical assessment conducted by the trainers.[56] On application to the Centre, the Mediation Agreement provides for the parties to appoint a suitable Mediator of their choice or if not, the Mediator selected by the Malaysian Medical Council. The Agreement also provides that the Mediation will be conducted under the Mediation Rules of the Centre.[57] The Rules provide the process of initiating mediation, appointment of Mediators, disqualification of Mediators, vacancies, representation, authority of Mediator, mode of settlement agreement, confidentiality, termination of Mediator and the interpretation of the Rules.[58]

Nevertheless, for mediation to be successful in overcoming problems inherent in medical negligence claims, there is a need for it, as a form of dispute resolution, to be an integral part of the litigation process. Thus, the recent announcement by the Malaysian judiciary[59] that there is a proposal for a Mediation Act to allow for court-annexed mediation is very much welcome. Court-annexed mediation is when a judge refers the matter to a mediator with or without the consent of the parties involved. This will ensure speedy disposal of all pending civil cases as of July last year, there were 319,862 civil cases pending in the high courts and the subordinate courts which were registered from 1st January 2000.[60] If mandatory mediation is to be implemented during pre-litigation stage, claimants should file a written request for mediation within two to three weeks of filing their malpractice claim. Mediation panel should consist of three members; a lawyer who chairs the panel, a doctor or health professional with some expertise in the area of the claim and a layperson. It does not matter if they do not have previous experience but some brief mediation training may be required. The lawyer is to assume the role of a legal expert, the doctor as a neutral medical expert and lay member as an advisor. Panels are to meet within the prescribed period for mediation and parties involved must attend the mediation session.[61] These sessions are to be informal and non-binding. No records are to be kept and nothing said in a session is admissible in a subsequent court action. In theory, panels do not render decisions but if mediation does not produce agreement, panel members are then free to advise parties on their projections of the likely outcome should the case proceed to trial. This will enable them to initiate the processing and settlement of small claims that might not otherwise be able to proceed due to high transaction costs of

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[56] Kuthubulzaman Bukhari, *Arbitration and Mediation in Malaysia* at http://www.aseanlawassociation.org, accessed on the 11th April 2006. The Mediators of the Centre are now trained by either the Accord Group or LEADR of Australia. Presently, there 300 Mediators at the Centre.

[57] The Agreement also requires that the parties must act in good faith. Parties are not to disclose any information of document given to them during the dispute resolution process. Parties that attend the mediation sessions must be cloaked with authority to settle and in the event they do not have the full authority to settle they must disclose to the Mediator.

[58] *Ibid.*

[59] See Prime News in News Straits Times, Monday, June 18, 2007, at p. 6.

[60] *Ibid.* According to Kuthubulzaman Bukhari *supra*, the ADR Committee of the Bar Council has recommended to the Statutory Rules Committee to incorporate Mediation in the Rules of the High Court during the stage of case management. The Statutory Rules Committee is in the midst of finalising the same.

[61] See Boomer, R.G. "Making the Most of Court Ordered Mediation", (March 1994) *Dispute Resolution Journal*, at pp. 17-22; Spencer, D & Brogan, M, *Mediation Law and Practice*, Melbourne: Cambridge University Press, 2006, at pp. 263-304.

litigation. In this way, unmeritorious claims can be removed from the courts as soon as possible.

VIII. Conclusion

Mediation, undoubtedly, offers a solution to the difficulties of tort litigation. It has many features that make it an attractive and a viable alternative in the context of medical negligence. In particular, the goals of litigation have absolutely nothing to do with healing whereas the goals of mediation appear entirely consistent with the paramount goals of medicine such as enhancing communication, increasing understanding, easing the exchange of information, focusing on the human side of a dispute, giving an opportunity for conciliation and restoration of relationships, an opportunity for healing, and an opportunity for a cost-effective and timely resolution. The flexibility of the mediation process will also make it possible to design remedies that are not only compensatory, but prevent future occurrences of medical negligence.