Clinical negligence:  
The issues and options for reform  

A response to the CMO’s working party  
from  
the Centre for Effective Dispute Resolution 

1 The current position 

There is no doubt that, from CEDR’s perspective as a not-for-profit mediation provider of dispute resolution services for over 10 years, the Civil Procedure Rules 1998 (the CPR) have made a major difference to the litigation climate. The combined effect on clinical negligence litigation of the pre-action protocol, case management, and costs sanctions for unreasonable or disproportionate conduct of litigation, has transformed for the better many of the unsatisfactory features of old-style combative litigation in this field, particularly commented upon by Lord Woolf in *Access to Justice*. Perhaps also the development of other forms of effective dispute resolution through the initiatives of CEDR and others has helped.

Similarly, reforms such as the establishment of expert panels for both claimant and defendant lawyers, the input of such organisations as Action for Victims of Medical Accidents (AVMA) and the Clinical Disputes Forum (CDF), and the reforms of funding involving the Legal Services Commission (LSC) and the NHS Litigation Authority (NHSLA) and new approaches to risk management and funding of litigation have already changed the landscape and continue to do so.

CEDR itself has contributed to the reform debate and supported such initiatives as the NHS Mediation Pilot for which it was one of the approved nominators of mediators, and very much welcomes the broad conclusions of the Mulcahy Report. This is so even though in some respects its conclusions on the key question of increased cost of mediation were regarded as surprising in the light of CEDR’s market experience of mediation in the commercial sphere, where there has been a general perception of added value from use of the process. Attached is a copy of an article by Tony Allen, a Director at CEDR and its most experienced mediator of clinical negligence claims, which discusses some of those issues.

The first question for the CMO will be as to timing in relation to what has already been done. There is obviously substantial public and political frustration about the cost of litigating clinical negligence claims, highlighted by the National Audit Office (NAO) Report of May 2001. Legal and expert costs are the particular target for concern. However, from a close reading of that report, much of the data relates to the old existing liability scheme (ELS) cases, and there seems a general feeling that cases dealt with under the combined effect of the Clinical Negligence Scheme for Trusts (CNST), the pre-action protocol, the CPR and the other developments identified above will have made an appreciable improvement as against what the NAO has highlighted, based on historical data.

The argument runs that it is too early to make wholesale changes to the system as extensive as contemplating the introduction of no-fault compensation or tariffs for claims. So much remains to bed down in relation to the existing recent reforms that there is a risk in reforming what is actually already
improved. CEDR can see some force in that viewpoint. However, in response to the CMO’s call for ideas, the rest of this paper assumes tentatively that there must be change even this soon after the Woolf reforms. This is CEDR’s attempt to make a contribution to that debate from the viewpoint of a provider of effective dispute resolution services and consultancy both in the UK and across Europe.

It is worth specifically mentioning that CEDR Solve, the services arm of CEDR, is already involved in partnership with the British Council for the Department for International Development (DFID) in design and consultancy of welfare benefit dispute resolution systems in Russia, and in working on the theory and development of dispute resolution systems internationally with the United Nations (through UNCITRAL), and in the European Union through Project Grotius. CEDR’s perspective is thus by no means limited to mediation. It consults and provides services in other types of effective dispute resolution as well, both adjudicative as well as facilitative, and through standard processes and also through special processes made available through schemes in both public and private sectors.

CEDR’s submission will focus on the narrower issue of effective dispute resolution more than the question of no fault compensation systems in theory, since this is its natural remit. CEDR’s past involvement has mainly been in the resolution of clinical negligence claims shortly before issue of litigation proceedings or at any time after the issue of proceedings. Several CEDR Directors and Consultant Mediators have brought input to CEDR’s thinking from their perspective as conciliators in the NHS complaints system, though like most mediation providers CEDR has not hitherto been much involved in the resolution of complaints. CEDR’s contribution to the debate needs to be understood in that light.

2 The needs of patients

There is much research and common sense available to define what patients want when confronted with an adverse outcome to clinical care. CEDR’s experience within mediations of such case over the last 6 years or so confirms the primacy of such matters as:

- explanation
- apology
- reassurance that lessons have been learned
- compensation
- arrangements for future treatment
- acknowledgement of mistake
- speedy resolution
- an opportunity to say what is felt about what happened to key people unconstrained by formality

Mulcahy suggests that compensation is by no means the top priority in that list, but whether or not that is the case, there must be provision in any credible and accessible system for delivering monetary remedies, as part of full and final settlement of claims. The challenge is to ensure payment “of the right sum to the right person at the right time”, as the Chief Executive of the NHSLA has frequently said. It is these needs that the panoply of the complaints, regulatory and litigation systems seek to meet, and which are subject to scrutiny.

CEDR observes that the patient needs listed above are all deliverable outcomes within the single process of mediation, which exists outside but alongside both the existing complaints and litigation systems. This
is not just theory: besides the corroboration found in the Mulcahy research, CEDR's own experience of clinical negligence mediations bears out the delivery of all these remedies, though the need for confidentiality as to its mediations makes detailed accounts difficult. Neither the litigation or complaints systems can yet deliver (in theory at least) all of those outcomes in one process. The NHSLA’s perception from its own data collection may well reinforce these points.

The one further aspect which remains highly important is the accountability of clinical staff through the regulatory process by which clinicians and nursing staff are disciplined within their professions. Mediations of clinical negligence claims to date have not delivered disciplinary outcomes, though there has occasionally been debate about whether a GMC referral would be made. It is worth mentioning, however, that CEDR has for the last 18 months been advising the Financial Services Authority on the use of mediation within its statutory regulatory framework, and is now its appointed provider for the scheme which starts in December 2001. Once tested in that context, there may perhaps be seen to be an extended role for mediation within other regulatory systems, even those of the healthcare professions.

Is a one-stop process such as mediation a model to adopt when considering the review of the formal systems being undertaken for the benefit of claimants?

3  The needs of clinicians and the NHS

These cannot be overlooked too. They are bound to include:

- a fair and effective forum for dealing with criticism
- the chance to show that criticism is actually unjustified
- a fair opportunity for clinicians and organisations to learn where things have gone wrong - within “an organisation with a memory”
- speedy resolution
- processes which are proportionate in time and expense

It will always be the case that criticism of a healthcare professional will be upsetting and undermining from the moment it is made, and vindication (or the reverse) through a rigorous litigation process may be the preferred method to achieve an outcome. Hence the formality of trial and professional tribunal has held some attractions for clinicians, though the slowness and legal technicality of the litigation process probably has not. The BMA has for some time welcomed the possibility of a no-fault system for compensation as preferable to litigation, though when this was apparently ruled out late in 2000, it adopted a policy of interest in what mediation might offer.

Mediation and other non-binding dispute resolution processes cannot deliver authoritative outcomes: they lead to settlement, not precedent. They do however allow parties to craft their own solutions which can go beyond what a court or tribunal can order, and they do offer to clinicians and others under scrutiny the opportunity for direct access at a human level to claimants and their families to endeavour to deal with the past and find an acceptable way to deal with future clinical relationships. Thus the benefits that mediation can offer in meeting the needs of defendants in clinical negligence claims are substantial, and CEDR has frequently seen mediated settlements which produce highly acceptable outcomes for both defendants and claimants, both as to the terms agreed and the spirit in which the matter is concluded.
4  The challenge

The challenge is to define ways of meeting and reconciling the various needs of those who become engaged in clinical disputes in a cost-effective yet principled and acceptable way respected by all those involved, particularly the individual parties involved - the claimants and healthcare professionals - but also reflecting the needs of society at large. It must be remembered that the National Health Service is the chief funder of all such litigation, and the Legal Services Commission, at present at least, makes possible through public funding the bringing and financing of many such claims.

5  The contribution of mediation to date

Little if any mediation of clinical negligence claims occurred in the UK before the NHS Pilot was far-sightedly set up in 1995. The NHS Mediation Pilot was founded on four basic tenets:

- it should be entirely voluntary
- it should not be expected to be a panacea for the problems of clinical negligence claims
- not every case can be expected to settle
- success may involve narrowing of issues and not merely full settlement

Against those criteria, the limited number of cases which went through the pilot performed remarkably well. All settled, eleven with payment and one being withdrawn. The level of satisfaction among both lay and professional participants was very high. Clinical professionals were recorded as being less enthusiastic, but CEDR’s own experience found great satisfaction among doctors who attended pilot mediations. High settlement and satisfaction rates continue to characterise at least CEDR’s experience of mediating clinical negligence cases since the Pilot ended. Setting that against the high (70%) dissatisfaction rate found among those polled with the pre-CPR litigation system, even where they had been compensated, the research findings about mediation are impressive, even despite the small sample.

The remaining issues identified by Mulcahy are those relating to cost, to the fact that the outcome is not binding unless parties reach agreement and also (linked perhaps with both those points) the quality of the mediator. CEDR has continued to look at these issues, ensuring so far as possible that best practice is developed and practised.

6  Mediation as an adjunct to the litigation system

Mediation is symbiotic with the litigation system. Before issue of proceedings, if settlement negotiations are ineffective, litigation is the alternative to mediation, and they remain alternative to each other during litigation. CEDR’s experience since the Pilot is that a number of cases have been mediated
successfully quite late in the life of the litigation, as an alternative to an impending trial. These are the
cases which are intractable, and the true measure of savings is to set the cost of mediation against the
cost at least of court door settlement, if not of trial as a whole.

The savings at this stage are still likely to be substantial against that measure, even if much of the cost
of preparation has been incurred. There remains a sense among experienced lawyers of needing to have
full understanding of the range of each side's case before settlement can be safely considered. There
remains a fear of under-settling, which might give rise to a claim for negligence against a claimant
lawyer, or over-settling which might jeopardise its position on the NHS Panel for a defendant lawyer.
These are not however issues exclusive to mediation: they characterise any settlement negotiations.
The responsibility for just and acceptable outcomes remains with each party and their legal adviser.

It has been argued that mediation creates pressure to settle which somehow subverts its validity as a
process. Mediation is basically a compression of the settlement negotiation process at which all relevant
people (including claimant and defendant) attend, almost always with legal advice. Settlement is not
compulsory: either side can leave without finality (again sometimes a criticised feature of the process). It is
illogical to criticise the process for both reasons. It cannot be forgotten that mediation is still relatively new
in this field, and much is expected of it, which, if not immediately delivered, gives rise to criticism. Only the
most experienced mediators can relax about whether disputes settle or not. With greater acceptance of the
process and greater experience of it among both mediators and lawyers, these pressures should balance
out. The pressures and cost of the traditional litigation trial should not be forgotten by comparison.

As experience grows of what mediation can achieve at earlier stages of claims, it may well be possible to
bring settlement dates earlier and thus make greater savings of costs through earlier information assembly
and exchange and earlier risk assessment and appraisal of likely prospects of success.

7 Mediation and other forms of dispute resolution in the complaints system

The relevance of mediation in this area is illustrated by the fact that local resolution embodies a
conciliation process not unlike mediation, bringing the main parties together to see if apology,
explanation and similar non-monetary outcomes can satisfy the complainant. Currently, though, there
no official power to offer any compensation, and complaints procedures may end without knowing
whether the complainant intends to progress into litigation. Conciliation and independent review
followed by Health Service Ombudsman procedures are clearly not one-stop solutions as they stand
unless a complainant is prepared to accept them as such.

As to quality in the conciliation process, funding, training and quality is variable between healthcare
providers in local resolution. There are undoubtedly some very good schemes in place which achieve
the aims of the complaints system by delivering apology, explanation and the other non-monetary
outcomes sought by claimants. Though practices vary, it is understood that a number of Trusts do make
ex gratia payments as part of their response to complaints, though this is by no means universally done
nor clearly authorised.

The Clinical Disputes Forum is understood to be consulting about a proposal that Trusts be able to make
compensation payments of up to £10,000, as well as being able to deliver the non-monetary benefits
which the process has always tried to make available. The hope must be that a larger number of lower
value complaints which would otherwise become claims would be settled at that stage, with
independent legal and (if necessary) expert advice paid for at low cost to the claimant and/or
defendant, which in turn would “purchase” a full and final settlement excluding further litigation. The limit corresponds with the level at which the Legal Services Commission is reluctant to fund litigation.

To work, the process must be independent and inquisitorial, relieving parties of the need immediately to seek legal advice, though providing for it before the process and the amount of any settlement figure is finalised. If local resolution fails, the proposal is for referral to a Regional Tribunal (instead of independent review, as we understand the proposal) to review the case and make findings and an award if felt appropriate, of up to £10,000. If more is sought, then litigation would be the route to take.

Cases with up to £10,000 at stake will include a number of very emotive matters, such as claims for the death of new-born babies, where, even if an inquest is held, feelings will be high and yet compensation for bereavement and funeral costs low. Claims can however be made for psychological and physical trauma to mother and father which may increase even higher the potential value if the emotional issues are not properly dealt with early.

8 Making costs savings in delivering outcomes in complaints and claims

8.1 In principle

There is a direct clash of principle and practice when dealing with smaller claims. Numerically they form the bulk of complaints and claims actually or potentially made. Conduct by lawyers of such cases is perceived to be too expensive. It is thus said that reducing the costs of legal representation in complaints and claims settlement in lower value cases is the only way for wide access to justice to be achieved. On the other hand, how can justice be fairly made available if restrictions are placed on the calibre and extent of legal advice and representation to claimants? The same debate characterised the establishment of the Small Claims jurisdiction up to £5,000 in the County Courts, though the lowest claim there for personal injury was for £1000, and clinical negligence cases are almost always placed in the multi-track because of their complexity.

The NAO report observed that in 65% of claims worth up to £50,000, process costs exceeded damages. Bearing in mind the complexity of many such cases in the clinical negligence field, are these statistics entirely surprising, or necessarily unacceptable? In the USA, with lawyers operating on a contingency fee basis, the damages would presumably be much greater, so as to allow claimant lawyers to slice off their success percentage fee. It so happens that the system here separates damages from costs, and it is through the costs jurisdiction that the CPR have introduced extra levels of discipline into litigation conduct. Research would be needed to see if the net outlay of paying parties in the UK and the USA is markedly different.

But is it self-evidently always wrong for process costs to exceed compensation awards? CEDR believes not. Economy is obviously important and will be a very significant touchstone especially where there is public funding on both sides of the process, as is the case here. Best value is undoubtedly the test, but this includes other quality matters besides cost. The criteria for good process were identified by Lord Woolf in Access to Justice and these remain important. These include such considerations as being fair and just, proportionate, speedy, understandable and responsive to users. CEDR found itself setting out very similar principles in its design work for the Russian Government’s social dispute resolution system - authority and respect, accessibility, independence and fairness. The Mulcahy research showed how
unattractive the old system in England & Wales was to 70% of its users, even where compensation was paid. There is therefore a case for ensuring that the process is right in the broadest sense, rather than necessarily the cheapest.

It is also worth noting that the CPR have now created powerful cost controls, backed with sanctions, ever imposed through the costs jurisdiction. Courts can penalise both unreasonable and disproportionate conduct, whether before or after litigation is commenced, and have the benchmark of the pre-action protocol against which to measure these matters. The NHS is of course always acutely aware of relativity of cost issues in deciding whether to give expensive treatments in given cases, and there must undoubtedly be both controls and priorities to be exercised. Every step should be taken to minimise process costs, but if they are justified they need not necessarily be assumed to be less than the compensation and the other important non-monetary benefits which they generate.

8.2 Claims of up to £10,000 in value

At present, the LSC will rarely fund such claims, in effect expecting complaints procedures to be mobilised instead, despite the fact that, as has been seen, these can often be very traumatic cases on the facts. The CDF proposal for complaints - of permitting limited compensation to be agreed or awarded by a Tribunal on a simplified Bolam test - might well meet the problems of this band. Certainly the proper authorisation of the “package” approach commended in the NAO Report, with limited compensation duly authorised together with other non-monetary outcomes, would seem to CEDR to be a good way forward, leaving mediation to offer additional help where a package is rejected and a simple tribunal or independent review decision is not seen as likely to be satisfactory. Trusts will need to deploy trained (but not necessarily legally qualified staff) to handle the package approach, and should offer to pay for advice to a claimant before a final figure is accepted. If these claims are found to be unsatisfactorily handled, the Health Service Ombudsman can deal with them, including (since 1997) complaints about clinical matters. This jurisdiction would presumably be augmented to deal with monetary compensation, if allowed in such cases, which is at present outside the Ombudsman’s powers.

As a means of addressing the balance that is required to be struck here between the cost of dispute resolution and its benefits, it is right to observe that CEDR’s fees a mediator and associated administration for a time-limited mediation for say four hours are not substantial of themselves. However, with legal representation on both sides for preparing and attending the mediation, the global figure can soon approach or exceed the amount at stake, and still (it is observed) with no certainty of a binding conclusion. CEDR sees independent tribunals or bodies such as an Ombudsman with inquisitorial powers as being a feasible solution to the cost issue, provided that sufficient independence can be guaranteed to make participants comfortable about participating without legal representation.

One option instead of setting up Regional Tribunals to replace Independent REVIEW panels might be to extend the Ombudsman’s powers on a regional basis. Whichever form of dealing with small claims is adopted, however, one of the powers exercisable might well be for the body to be able to refer cases to mediation. We refer the CMO to the Independent Housing Ombudsman’s mediation scheme, where a number of cases are referred to CEDR for mediation to deal with the practicalities of reconciliation between landlord and tenant on the ground, so to speak. This has in our view useful parallels for healthcare disputes.

As we observe below, another way of adding credibility and answering criticism of a system which minimises separate legal advice will be to develop a cadre of specially qualified mediators capable of winning the trust and confidence of all participants.
Whether the proposals of RESOLVE are a feasible alternative, with capped costs of investigation on small value cases, is not yet clear. We have not seen the proposal in detail, but understand that in principle this will provide cheap basic advice and opinion for settlement discussion, but does not further the process by which this is concluded. Will this address the non-monetary outcomes seen as saving or sidelining the priority of compensation?

8.3 Claims of up to £50,000 in value

This is the next band of concern as defined by the NAO Report, largely because of the statistic that in 65% of clinical negligence claims for £50,000, costs exceeded the damages (at least based on the ELS data, which is quite old). Can (indeed, should) lawyer activity be limited in that band of case? The principles behind this are discussed above.

If steps are taken to reduce lawyer involvement in these medium sized cases, perhaps simply to counter the NAO statistic, the need to ensure that claimant and clinicians’ voices are heard is perhaps all the greater. Both have human rights which must be ultimately protected, especially under Article 6. Principled settlement is an appropriate way to resolve disputes, and here the availability of mediation, especially if conducted by mediators drawn from a cadre of particularly well trained and experienced mediation practitioners, may offer real benefits.

CEDR is in discussion with AVMA and the NHSLA about developing such a cadre, and are seeking funding to do research and design work to develop these ideas. Their joint proposal goes further in suggesting that this cadre should also have a gate-keeping role in clinical negligence cases, acting as process consultants to assist parties to adopt the best way towards resolution of claims, and negotiating between the players to achieve the best outcome as soon as possible. Thus an independent grouping of those whose sole job it is to help parties get to the end of any claims process as quickly as possible might assist with choices between complaint, litigation and even the timing of mediation or other forms of effective dispute resolution most suited to the case in hand.

8.4 Cases over £50,000

These are by definition likely to be complex and to belong naturally in the multi-track under the CPR. Cost benefit analysis of legal costs and expenses involved in a mediation tends to be easily justifiable. Here case management, the costs and proportionality provisions of the CPR, and the growing use of single joint experts, plus funding discipline from the LSC and NHSLA are still having an impact in cost saving also. In CEDR’s view, it is early days to be doing wholesale reform here.

CEDR would like to see:

- mediation and other forms of EDR being specifically referred to in the Clinical Negligence pre-action Protocol, as has happened in all the later protocols annexed to the CPR. Two-thirds of the NHS Pilot cases were mediated before issue of proceedings, and this should be the first moment at which parties are required to consider mediation. Mediation might not be appropriate if it is too early, perhaps because expert evidence is unavailable or prognosis cannot be certain.
- better systems for information exchange and opinion being considered at the protocol stage: it should be not necessary for proceedings to be issued simply to provide the machinery for this. Where a refusal to mediate or negotiate before proceedings are issued is flagrant, the Court currently has full discretion to impose penalties, as instanced by the case of Paul Thomas Construction v Hyland Ltd.

- mediation being considered as a matter of course at some appropriate point before trial in complex cases. This is not to say that it will always be utilised; but arguments need to be canvassed and assessed, if necessary by a procedural judge, who can decide whether reasons tendered for not mediating by either party (or both parties) are adequate: CEDR certainly has had experience of successful mediations where a stay for mediation has been ordered even in the teeth of one party’s opposition.

The availability of an independent gatekeeper mediation group, possibly with a key to the court door by being able to liaise with the procedural judge, becomes more significant in such cases.

CEDR does not accept the proposition that mediation is unsuited to large value claims. The process is used for multi-million pound commercial disputes of equal or greater complexity, and while it is true that a clinical negligence claimant is seeking the cost of continued tolerable or improved living rather than a satisfactory commercial deal of less personal significance, the complexity and value are little different in themselves. CEDR has conducted mediations in cases involving paraplegia, personal injury and clinical negligence claims for over £1 million involving complex issues of causation and quantum.

9 No fault compensation

Mediation and other forms of effective non-adjudicatory dispute resolution obviously start within the framework of the system which allocates blame. Claims are made to establish whether liability exists, and mediation will usually involve debate of the prospects of success in establishing liability or the risks of not doing so. Equally, mediations deal on occasions simply with issues of causation and or quantum of damage.

Yet in practice, mediation quite frequently enables parties to go beyond allocation of fault to seek a mutually acceptable resolution which rarely requires the finding or admission of actual blame. Acknowledgement and even apology (usually given confidentially within the mediation process itself) is usually all that is sought and given. Of course no payment would be offered without the defendant perceiving a risk of being found to blame by a court decision, but CEDR mediators of clinical negligence disputes are all familiar with a final conclusion in which the parties shake hands, agree that a reasonable outcome has been negotiated and come close to mutual celebration of that fact, without any continuing sense of recrimination.

Does this enable consideration to be given to a no fault system? Society starts off into the claims process with blame very often in mind, and there may be even more unjustifiable distinctions to be drawn with a no fault system. Would it mean that any person who leaves a hospital worse off than predicted will have a claim? What about causation, often more contentious than liability in the current system? What about accountability? What about the need for a “day in court”? What will the level of compensation be, either in terms of capital payments or periodic payments (the latter being another flexible remedy of which CEDR approves)? Can a no fault system possibly be afforded by a nation of 60 million potential
claimants, as opposed to New Zealand and Sweden, both much smaller? There are lessons from other jurisdictions to be learned, and CEDR is not really in a position to make representations of any authority on these points.

Even in a no-fault system, however, it seems to us that mediation may well have a major role to satisfy some of the continuing disputes in a way which respects both sides and produces a sound and acceptable closure. In the final analysis, mediation is a process for settling disputes, and there will be a place for it even if a no-fault system is introduced.

10 Summary of CEDR’s responses to the CMO’s questions

CEDR believes that mediation has much to offer for the better resolution of clinical negligence claims, whether within the existing broad structure of pre- and post-proceedings litigation, or as an adjunct to reformed or new processes as a result of the reforms which may emerge.

In the existing system, it has great potential for conferring high quality flexible remedies, good party experience and transaction cost-saving.

Two alternative models which the CMO might consider for lower value complaints/claims are:

• a dedicated tribunal for such claims, with an inquisitorial approach, perhaps unifying the complaints and claims procedures, and with power to encourage or refer cases into mediation or other dispute resolution processes

• an extension of the Ombudsman system, which embodies its special advantages, namely:

  ◊ public understanding the concept and recognition of ombudsman independence
  ◊ the inquisitorial approach, which minimises legal cost
  ◊ ability to deal with small claims and grievances after exhausting internal procedures
  ◊ offering a wider range of remedies than currently available through the courts or complaints system
  ◊ a publicly published (yet anonymised) annual review, enabling internal confidential review and reporting to improve the quality of clinical care
  ◊ ability to encompass a range of different processes including mediation and adjudication.

Whichever model is adopted, mediation can offer added value to the process of reaching conclusions and ensuring that the voice of the individuals in any case is adequately heard.

As to larger claims, perhaps above £50,000 in value CEDR supports a number of the concepts canvassed in the “call for ideas” by the CMO, in particular:

• imposed structured orders
• rehabilitation initiatives
• reform of s.2(4) of the 1948 Act
• indemnities
It is hoped that the AVMA/CEDR approach to process management by a cadre of mediators can add value to either of those systems, certainly through the availability of an identified group of high quality mediators to whom cases can be referred, and perhaps also through the use of the process management/gatekeeper role.

Matters about which CEDR is less persuaded at present are:

- no fault compensation
- tariffs for certain types of case - the JSB benchmark approach should continue to be adequate, as disputes on valuing general damages are relatively narrow. If by tariff the concept of a cap is intended, this is much more contentious if it is intended to limit recoverable special damages in any way

On the general question of costs savings, CEDR’s firm view is that earlier mediation of claims will overall lead to a reduction in overall expense in larger claims by bringing earlier the dates on which claims are settled. On small and medium sized claims, there may need to be an inquisitorial conduct of claims by tribunal or ombudsman with a mediation arm to try to generate the benefits of non-monetary remedies for claimants and clinicians alike.

Attached:

Copy article: The cost of mediating clinical negligence claims by Tony Allen

Summary of Paul Thomas Construction Ltd v Hyland

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This above paper is the work of Dr. Karl Mackie, William Marsh and Tony Allen, all Directors of the Centre for Effective Dispute Resolution, Exchange Tower, 1 Harbour Exchange Square, London, E14 9GB, telephone 020 7536 6000, to whom any questions may be addressed, initially through Tony Allen at that address. His direct line is 020 7536 6016, fax 020 7536 6060 and his e-mail is tallen@cedr.co.uk