An Integrated Dispute Resolution System for NHS General Dental Practice: Is the Proposition Feasible?

By Gareth Rowland Thomas

Summary

The paper set out to examine whether it would be possible to integrate the complaints and compensation system for NHS general dental practice. To achieve the aims and objects set for the paper, it was necessary to examine the current position with regard to both the complaints and compensation processes as currently employed in NHS general dental practice. This involved an analysis of the tort of negligence as applied to clinical malpractice as well as analysis of the current NHS complaints system introduced in 1996 following the Wilson report. It was further necessary to examine the alternative dispute resolution processes that are available and may or may not have a role to play in settling NHS disputes.

Having established the background to the paper, the fundamental question of whether an integrated dispute resolution system was a feasible proposition was examined in light of the information contained within the first part of the paper. The proposition is a feasible proposition, but there are difficulties that need to be overcome before the principles could be put into practice. NHS general dental practice has two aspects to the complaints and compensation system, namely the NHS complaints system for which compensation is not as a rule available and the legal compensation system funded by the defence societies. These (the defence societies) would have to be included into any integrated dispute resolution system.

The alternative dispute resolution systems that were considered to be most appropriate for NHS general dental practice were adjudication and mediation.

The recommendations are that a pilot study be undertaken to test the efficacy or otherwise of the concept of an integrated dispute resolution system that should be in accord with section 1 of the Civil Procedure Rules 1999. The concept of an integrated dispute resolution system is feasible, but needs the necessary political will before it could be implemented as part of the NHS complaints and compensation procedures for dental patients.

Contents

Chapter 1
Introduction and Aims and Objects

Introduction

NHS general dental practice is no different to other parts of the NHS in that practitioners are complained about and sued for medical malpractice[1]. These dispute resolution processes can be a consequence of the provision of dental treatment. Complaints are about the failure to meet the standards expected of a dentist providing NHS dental health care and are resolved through NHS procedures whilst compensation is obtained from legal processes when the practitioner does not meet the accepted standards.

It needs to be clearly stated at this initial stage that the difficulties facing patients in obtaining NHS dental treatment are outside the scope of this dissertation. The focus of the dissertation is whether it is practicable to have an integrated complaints and compensation for NHS general dental practice. Whilst complaint and compensation systems are currently separate the dissertation will examine the question of whether patients would be better served by an integrated complaints and compensation system than by two separate dispute resolution processes.

The question that is addressed is whether the NHS complaints system would be better if it was integrated with a compensation system with scope for referral to the General Dental Council (GDC) for disciplinary proceedings if thought appropriate in the particular circumstances. It is not envisaged at this stage that an integrated complaints and compensation system would include a disciplinary aspect to the process. Discipline is the prerogative of the GDC, a statutory body that has been given the requisite powers through Act of Parliament to conduct the necessary disciplinary procedures. No integrated complaints and compensation system could usurp such powers without the approval of Parliament.

The NHS complaints system does however, have a number of aspects that can include disciplinary proceedings for failure to meet the NHS terms and conditions of service.[2] These include censures such as fines, but not the draconian powers available to the GDC. Compensation for wronged patients in all cases being provided by the defence organisations who whilst not insurance companies[3] act as insurers for the dental profession. General dental practitioners are expected to make their own arrangements for professional indemnity insurance in contrast to hospital appointments where indemnity cover is the responsibility of the Trust/Health Authority.

Integration, in the context of this dissertation is thus confined to the complaints and compensation procedures not the disciplinary procedures.

A question that needs to be considered is whether the compensatory procedures as currently practised meet the needs of patients and dentists let alone society in light of the Woolf Reforms and the Civil Procedure Rules 1998 (CPR). Part I of the CPR is so important both generally and to the theme of the dissertation, that it is set out in full.

The overriding objective

1.1 (1) These rules are a new procedural code with the overriding objective of enabling the court to deal with the cases justly.

(2) Dealing with a case justly includes, so far as is practicable-

(a) ensuring that the parties are on an equal footing;

(b) saving expense;

[1] See any standard medical text such as Kennedy and Grubb; Medical Law. London: Butterworths 2000; Part II for the general position with regard to the NHS and complaints and compensation procedures in general terms.

[2] See National Health Service Act 1977, National Health Service and Community Care Act 1990 together with the NHS terms of service as set out in the 1990 "New Contract" between NHS general dental practitioners and the NHS.

[3] Medical Defence Union v Department of Trade [1979] 2 WLR 686.

(c) dealing with the case in ways which are proportionate-

(i) to the amount of money involved;

(ii) to the importance of the case;

(iii) to the complexity of the issues; and

(iv) to the financial position of each party;

(d) ensuring that it is dealt with expeditiously and fairly; and

(e) allotting to it an appropriate share of the court's resources, while taking into account the need to allot resources to other cases.

The question is thus, "Is it possible to have an integrated complaints and compensation system for general dental practice that meets the needs of all the parties and if so what is the system?"

A word of caution needs to be introduced at this stage as to why the dissertation is limited to NHS practice and does not cover the full ambit of general dental practice. Within the dental profession there is an on going debate about private practice and the lack of a complaints system to meet patients needs[4]. Currently the only mechanisms open to "wronged" patients to obtain redress are either to sue the practitioner or to complain to the General Dental Council (GDC) about the conduct of the dentist. It is, however, generally recognised that the GDC will only deal with those cases that fall under the term "serious professional misconduct" with regard to the provision of private dental treatment.[5] There is no definition of serious professional conduct in the General Dental Council's guidelines, but examples of what may constitute serious professional conduct have been given. The guidelines would suggest that it is any conduct that is likely to bring the dental profession into disrepute. These include the following:[6]

- Non-compliance with Council guidelines on anaesthesia and sedation
- Failing to take proper precautions to prevent cross infection, for example HIV
- Failing to seek medical advice and supervision in the event that the dentist has an infection which can be transmitted to patients, for example HIV
- Unsafe disposal of clinical, hazardous waste
- Lack of consent to treatment by the patient because the dentist did not properly explain a procedure and the risks
- Dishonesty, violence, indecency or breach of confidentiality
- Criminal convictions such as fraud, theft, unlawful possession of controlled drugs or acts of indecency
- Failure to have set up a practice-based system for dealing with patients' complaints after 1996.

The more common complaints such as over-treatment are not specifically mentioned though arguably would come under the description of "conduct likely to bring the dental profession into disrepute".

The private patient position is such that any attempt to postulate about an integrated complaint and compensation system is dependent upon a fundamental change of legal concepts. This is the ability of a "non-interested" third party to introduce terms into a contract to the "benefit of one party" and to the perceived detriment of the other when both parties are of similar standing in the eyes of the law. This question of law is not within the parameters set as the terms of reference of the dissertation. Thus, the consequences flowing from the private dental situation are outside the terms of reference. As such by default a private complaints and compensation system cannot be dealt with until the first level situation of incorporating a third party agreement into a dental contract has

[4] The Dental Law and Ethics Forum International Centre for Dentistry, Grays Inn Road, London in May 2001 held a workshop and debate on the processes and forwarded the recommendations to the GDC who have been examining the whole process for a number of years.

[5] See Thomas GR, Private Patients' Complaints Systems: page 14; Dentistry 18th January 2001 for a discussion of contractual problems regarding the legal difficulties of incorporating a private complaints procedure into a contract against the wishes of a party.

[6] See Thomas GR, Dentistry 18th January 2001 ibid.

been clarified. The terms of reference drawn up for the dissertation thus limit the concepts of an integrated complaints and compensation system to NHS dentistry where the procedures can be incorporated into the contract between the NHS and the independent general dental practitioner for the benefit of the patient.

In summary, the NHS general dental services have a three pronged complaints and compensation procedure for "wronged" patients. These systems are:

1. the NHS complaints procedure;
2. the legal system for compensation following a wrong; and
3. complaints to the GDC concerning the unprofessionalism of the practitioner.

The terms of reference of the dissertation are to examine whether it is a feasible concept to integrate the present NHS complaints procedure and the legal compensation system into one system providing a fairer, faster, more efficient and less expensive alternative that would benefit both practitioners and patients. There is undoubtedly pressure for reform of the system governing the practice of dentistry. Any such reforms should be in accord with the Woolf Reforms and the subsequent developments that have followed including the Civil Procedure Rules 1998 (CPR rules). If the reforms do not meet these standards they could be outside the requirements of the civil law as it currently stands. The proposals, if any, that are suggested in this dissertation will take into account the current civil legal requirements.

The dissertation must thus integrate a number of diverse requirements and needs especially those of the dental profession and patients with the legal requirements of both the civil law and natural justice to produce a fair and just process. These requirements will determine whether it is possible to produce an integrated complaints and compensation procedure that meets the legal, ethical and philosophical requirements of both patient and dentist. This needs to be a system that engenders trust by being fair and equitable to all parties who are party to the provision of NHS dental services. This is the *raison de etre* of the dissertation.

Aims and Objectives

The aims of this dissertation are to analyse and answer the following questions:

1. Do the present complaints and compensation systems meet the needs of patients and dentists?
2. Are the alternative dispute resolution systems that are available capable of meeting the needs of an NHS complaints and compensation process for general dental practice?
3. Can an integrated complaints and compensation system be developed?
4. Would an integrated complaints and compensation system better serve NHS general dental practitioners and patients alike?

The objects of this study are:

1. To enable a critical analysis of the concept of an integrated dispute resolution system for NHS general dental practice to be developed.
2. To determine whether one or more of the ADR techniques and processes could fulfil the concept of an integrated process for dental complaints and compensation.

These are the central themes that will be examined and developed in the dissertation.

Background

NHS general dental practice as stated above clearly has three different components with regard to complaints, compensation and disciplinary aspects. The disciplinary aspect of the GDC is however, outside the terms of reference set for the dissertation. The complaints and compensation processes whilst as seen below can and do run in parallel to a certain extent (see chapter 2) and do overlap and if both processes are invoked then there is a duplication of process that is both inefficient with regard to time and other resources.

Clinical negligence claims are a major drain on health care resources as the following figures for the NHS as a whole in Wales demonstrate. The estimate for clinical negligence in Wales alone rose

from £145 million in 1998-99 to £214 million as at 31st March 2000[7]. These figures for Wales demonstrate how the problem of compensation claims is escalating. There are however, no figures available to show how those claiming compensation correlate with those patients who initially made a complaint rather than sought compensation for a perceived failure in the standard of treatment or in the manner in which the patient was treated. There has been much conjecture in the National Press that many people are frustrated by the complaints system and only then do they seek compensation though no reliable figures are available on this point only speculation.[8] This interesting point is however, outside the terms of reference of the dissertation, but needs to be mentioned as the dissertation is designed to examine the possibility of combining the complaints and compensation processes to give a fairer, faster resolution of a dispute.

With regard to general dental practice there are substantial restrictions on the information placed in the public domain by the defence organisations that fund the compensation process.[9] Therefore, data is severely limited as to aspects of malpractice in general dental practice. The information that is available is most certainly not correlated with the NHS complaints' procedures to give an overview of the whole process. This being the case no empirical data or other figures will be used in the dissertation to prove or disprove the financial efficacy of the systems currently in place and those, if any, that may be suggested to replace the current methods. Indeed, the dissertation will concentrate on the complaints and compensation processes and improvements, if any, that can be made by streamlining the systems as currently operated.

Both the complaints and compensation procedures are intended to resolve disputes that have arisen from the provision of dental treatments. One the compensation process is a strict legal procedure whilst the other, the complaint process, has more flexibility though it is carried out in accord with set procedures. The efficacy of adhering rigidly to such arrangements is open to question if an equitable and just settlement is to be obtained efficiently and economically. If a complainant follows both procedures then there is much duplication of process and even worse a different result can be obtained from each procedure; that is, a party can have a **win-lose** result from the same case on the same facts.[10] This situation clearly leaves something to be desired.

It has become recognised that there are alternative methods of dispute resolution to those that are currently practised that may better meet the needs of parties in civil disputes such as those that arise from dental practice. These are not new methods, but processes that have been in existence for many a long year and certainly from well before the birth of Christ.[11]

The various alternative dispute resolution processes have in recent years made a comeback. The legal systems that have held sway for so long have come to be recognised as not fulfilling all that is required of them when the needs and wants of the parties are examined against the results that are produced. It is these alternative dispute resolution processes and their usage that are going to be tested when the processes of integration of the complaints and compensation system for NHS general dental practice are examined in depth in the course of the dissertation.

[7] National Assembly for Wales: Audit Committee Report 00-04 13th July 2000.
[8] Christina Lambert, Dental Law and Ethics Forum, Hempsons Solicitors, London, 11th June 2002.
[9] The defence organisations publish their annual reports, but these do not contain the information necessary to make an independent analysis of the information contained therein. The defence organisations have the information, but are not prepared to place it in the public domain.
[10] Christina Lambert, Dental Law and Ethics Forum, Hempsons Solicitors, London, 11th June 2002.
[11] See the works of Aristotle

Chapter 2
Present Systems of Complaint and Compensation

Introduction

In the context of the dissertation, it is necessary to set out the current position with regard to both the complaints' procedures and the legal systems of recompense. The reasoning behind this is that without the basic knowledge of the present situation it is impossible to compare and contrast and make recommendations later in the dissertation. The object of this chapter is to provide a reasoned account of the present systems and an overview that adds to the overall focus of the work. To achieve this, the complaints system will be described in broad details and the fundamentals of the legal system discussed and finally to identify where difficulties arise between the two if a patient uses both procedures to make a complaint and seek compensation.

The Complaints Procedures

The NHS complaints' procedures for NHS general dental practitioners is based upon the standard NHS complaints procedures.[12] The dissertation's terms of reference are based on the relationship between patient and dentist not on the relationship between the dentist and the NHS.

NHS Complaint

The current NHS complaints' procedures were introduced on 1st April 1996.[13] NHS general dental practitioners were included in the processes as were hospital doctors and general medical practitioners. This followed a report of a review committee[14] and the Government's response[15]. The efficacy or otherwise of the procedures in general are outside the scope of the dissertation, but the procedures have been evaluated for their efficacy by the Department of Health[16]. The procedures are not regarded as being a success in their current format.

"The main causes of dissatisfaction among complainants are operational failures: unhelpful aggressive or arrogant attitudes of staff, poor communication and a lack of information and support. The most important structural failure is the perceived lack of independence in the convening decision and in the review process generally."[17]

The failure of the procedures however, does not mean that the system can be ignored. It is still necessary to describe the process in broad terms. Complaints should be made within six months of the incident or within six months of discovering the problem provided that this is within twelve months of the incident.

NHS Complaints Procedures

The complaints system has the following main stages:

1. Local resolution
2. Independent review
3. Health Service Ombudsman

1. Local Resolution : Local resolution can be divided into two:

- Minor complaints
- More Serious Complaints

[12] The disciplinary aspects of the NHS procedures are outside the terms of reference of the dissertation. For further information see: Rhodes-Kemp R, A Remedy for Medical Complaints. London: Sweet & Maxwell 1998.
[13] National Health Service (Clinical Negligence Scheme) Regulations 1996 as amended by the National Health service (Clinical Negligence Scheme) Amendment Regulations 2002 No 1073.
[14] The report of the Review Committee on NHS Complaints Procedures, chaired by Professor Alan Wilson: *Being Heard*, May 1994.
[15] The Government's Proposals in Response to "Being Heard": *Acting on Complaints*, March 1995.
[16] NHS Complaints Procedure – National Evaluation: Published by Department of Health © Crown Copyright 2001.
[17] Ibid. page 2.

(a) Minor Complaints

Minor patient complaints can be dealt with immediately. This may be either verbally or in writing by the dentist or anyone else in the dental practice. Provision is however, made for complainants to be able to complain to the complaints manager at the local health authority if the complainant is worried about the consequences of complaining.[18] The concept being that these complaints as a rule are regarded as being part of the normal day to day problems of running a health care practice (they are not confined to dentistry) and can be resolved "on the spot" quickly and efficiently. There should be no need to invoke the more formal procedures for these types of complaints. If the person to whom the complaint is made is unable to deal with the complaint then that person should ensure that the complaint will be dealt with by the appropriate person; that is, the complaints manager. This may be another dentist or practice manager. This person should inform the complainant how the complaint is going to be dealt with and if a failure of care is alleged whether a meeting is to be arranged to discuss the matter and if so the arrangements for the meeting. A minor complaint can be made either orally or in writing with the response either being orally or in writing depending upon the seriousness of the complaint. The complainant is entitled to advice from the community health council (CHC), but this is rare for minor complaints.[19]

(b) More Serious Complaints

Dental surgeries should have leaflets and information concerning how complaints can be made. This information should be readily available for patients. The form that the investigation will take is dependent upon the seriousness of the complaint. If the complaint cannot be resolved immediately then the complainant should have acknowledgement of the complaint within two days or a response within five days and whenever possible either a written response within ten working days or a meeting arranged within that time period to resolve the dispute. If a response is going to take longer than ten days then the complainant should be informed of this. The health authority may arrange a meeting between the dentist and the patient and provide a conciliator to attend if it is felt appropriate to aid resolution of the dispute.

A written response should be within ten working days and will include:

- An explanation of what occurred;
- Notification that a meeting is going to be called; and
- If applicable, advice that the investigation may take longer than ten days and why it is going to take longer than ten days.

2. Independent Review

This is the second stage of the process and is invoked if a complainant is not satisfied with the results of the local resolution stage of the process. The complainant should write to the health authority/NHS Trust convenor and the convenor must **receive** the request within twenty working days of the complainant receiving the results of the local resolution process. The complainant must ask for an independent review. The request to be acknowledged within two days. The convenor needs the following information from the complainant in statement form setting out:

- Remaining grievances; that is, those points of dispute not resolved at the local resolution stage; and
- Why the complainant is dissatisfied with the outcome of the local resolution process.

There is however, no automatic right for an independent review for the complainant. Thus, it is very important that the complainant provides as much information as possible and obtains advice on

[18] Ibid. page 2 "7. Patient interest groups draw attention to the fact that some potential complainants are deterred by the fear that services will be withdrawn. This is more likely where the provider has a personal relationship with the patient and where a complaint may be thought to signal a breakdown of trust. Some complainants have been removed from a practice list on this basis, although the concern is not restricted to primary care services."

[19] There are no definitions of what constitutes a minor complaint or a major complaint, but the complaints are assessed on their merits.

the process and its requirements. A convenor for a health authority must make a decision within ten working days whether to refuse or agree to the request.

(a) Refusal of a request

A refusal of a request needs to include:

- An explanation as to why the request has been refused. This may include reasons such as in the convenor's opinion all the grounds have been covered in the initial stage at the local resolution level or an independent review could not take the matter further or provide a different answer.
- Advice about the complainant's right to approach the Health Service Ombudsman.

(b) Agreement to an Independent Review

The agreement to independent review should include details of what aspects of the complaint the panel will be investigating. This is a second stage procedure and some of the aspects should have been resolved at the first stage namely local resolution.

An independent review panel is regarded as being both costly and time consuming and given the discretion that is available to the convenor, one where a significant proportion of such requests are refused.[20] Appeal being to the Health Service Ombudsman. If the convenor does decide that independent review is appropriate then the convenor has ten working days to convene a panel to review the case.

Independent Review

If it is agreed by the convenor that there should be an independent review of the complaint, the complainant is informed that a panel will be established. The panel is empowered to talk to everyone involved and to get specialist advice as appropriate. The complainant is also informed of the terms of reference for the panel. The panel consists of the following:

- An independent lay chairperson;
- The convenor
- An independent lay person
- At least two independent clinical assessors (for clinical complaints only)

The way that the panel conducts itself is the prerogative of the chairperson though the panel meets in private and is confidential. The complainant is however, entitled to have an observer from the community health council present at the meeting.

If the complainant is called for an interview by the panel, then if the chairperson agrees, the complainant can be accompanied by a person to speak on his behalf. If the claimant's representative is legally qualified, he cannot act as an advocate even though he can speak for the claimant. The claimant is also entitled to have "moral support" from a second person. This is usually a friend or member of the family.

The panel is entitled to have access to all relevant documents including the complainant's health records. The complainant in contrast does not have an automatic right to see the papers, but can make such a request of the panel.

The panel, prepare a report in draft form setting out the results of the investigation including the conclusions, suggestions and comments. This draft needs to be completed within thirty working days of the panel being established. The complainant is entitled to comment on the first draft report and a final report should be sent to the claimant within fifteen working days of the draft report.

The aim is that the review should be completed within three months of the complainant's request for independent review.

The final report is also sent to the chief executive of the health authority who will inform the complainant in writing of what action will be taken as a result of the final report. The complainant

[20] Rhodes-Kemp R: A Remedy for Medical Complaints. London,:Sweet & Maxwell 1998

at this stage is also informed of the right to refer the complaint to the Health Service Ombudsman if still dissatisfied with the outcome.

3. The Health Service Ombudsman

The Health Service Ombudsman is the final stage of the complaints' procedures.[21] The Ombudsman may be involved at a number of stages in the process, examples being the refusal to establish a review panel or dissatisfaction with the outcome of the review. The Ombudsman is totally independent of the NHS and is empowered to investigate complaints about the following:

- Poor service;
- Failure to purchase or provide a service that a patient is entitled to receive;
- Administrative failures – avoidable delays, not following the proper procedures, rudeness or discourtesy, not explaining decisions, not answering a complaint within the time limits set down in the new procedure, etc;
- Care and treatment provided by a doctor, nurse or other trained professional – if the event happened after the 31st March 1996;
- General medical practitioners, dentists, pharmacists or opticians providing NHS services – if the event happened after the 31st March 1996; or
- Failure to provide information under the Code of Practice on openness in the NHS.

A complainant needs to write to the Ombudsman outlining the complaint. And should include the following:

- A description of what happened, where and when and who was involved;
- An explanation as to why the complainant is complaining and that he has already been through the local complaints procedures; and
- All the available evidence, including copies of letters and other papers relevant to the case.

The complainant must make a complaint to the Ombudsman within twelve months of realising that he has a complaint. It is possible however, for the Ombudsman to extend this period in exceptional circumstances. A complainant should not however, rely on this discretion being exercised.

The Ombudsman has the power to decide whether to investigate a complaint or not. It would be most unusual for the Ombudsman to investigate a complaint that has not been through the NHS complaints' procedure. If the Ombudsman refuses to investigate he is expected to give his reasons.

If the Ombudsman does decide to investigate the complaint, the complainant will be informed of those aspects that will be investigated. The investigation will include examination of the medical records and possibly interviews with the parties to the dispute whether the complainant or health care staff including the dentist. The Ombudsman is also empowered to make site visits.

The Ombudsman prepares a report and this is sent to the complainant. If all or part of the complaint is upheld the complainant will be informed of what action the NHS authority has agreed to take in respect of the Ombudsman's findings.

There is no appeal against the Ombudsman's decision.

The NHS complaints' procedures have been examined in some detail, but there is a flaw in their workings and that for the most part compensation cannot be awarded.[22] This has been highlighted as one of the failures of the system.

"**Compensation:** The panel has no power to discipline anyone, award compensation or even to recommend such action. Disciplinary action may be taken after a complaint has been made but this

[21] See Harpwood V, The NHS Commissioner, An Extended Role in the New NHS, European Journal of Health Care, Spring 1997.

[22] Compensation payments are the prerogative of the defence organisations, not the NHS. Though in some medical situations, it is possible that some compensation can be awarded.

is considered under a different procedure."[23] The compensation point is important as it leads into the next section of this chapter namely the compensation systems that are available to NHS dental patients for malpractice.

The Compensation System for Dental Malpractice

The legal system is used for redress/compensation for alleged dental malpractice rather than the complaints' procedures. The terms of reference of the dissertation are such that it is necessary to set out the law as regards obtaining compensation for dental malpractice.

To reiterate, the complaints' procedures do not, compensate patients for dental malpractice. The complaints' procedures result in measures **against the dentist** rather than actions **for the patient**. If the patient requires financial redress for an alleged wrong then the only processes currently available are legal ones. NHS and private patients need to be differentiated.

Private patients have a contract with the individual dentist. The terms of the contract depend on the relationship between patient and dentist. By contrast, the NHS patient does not have a contract with the dentist. The contract that the dentist operates under is a *contract for services* with the NHS and in particular the appropriate health authority. Therefore, NHS patient claims are limited to the law of tort for a civil wrong. Private patients, however, have the right to claim redress both in the law of tort or the law of contract depending on the circumstances of the case and the chances of a successful outcome using one instead of the other.

The Importance of the Law of Tort in Dental Malpractice Cases

The importance of the law of tort cannot be overstated in dental malpractice cases. This is because the majority of dental patients and dental treatments undertaken in the United Kingdom come under the auspices of the NHS.

NHS patients who require redress are limited primarily to the law of tort and in particular the tort of negligence. Whilst, there have been difficulties in certain parts of the United Kingdom regarding access to NHS general dental services, the NHS general dental services are still a major provider of dental treatment for the public at large.

The Law of Tort

Given the limitations on space, it is only possible to briefly outline the law of tort and the relevant individual torts. Under English law, tort has been defined as:

"[being] concerned with the redress of wrongs or injuries (other than breaches of contract) by means of a civil action brought by the victim. This redress most commonly takes the form of damages, that is to say monetary compensation."[24]

The law of tort is not one specific law, but is made up of a number of individual torts. There are a number of torts that are relevant in dental malpractice cases. Included in these are the tort of trespass to the person (which includes assault and battery) and negligence. Both these torts are common law torts and have developed through precedent.

In English law any civil case is decided on a balance of probabilities in an adversarial system of judgement. In an adversarial system of judgement both sides: that is, the claimant and the respondent will attempt to prove their case and disprove the arguments of their opponents. In this respect, the law of tort is no different to other civil laws in the English Legal System and it is for the court to decide where the balance of probabilities lay in these cases.

(i). Trespass to the Person

Trespass to the person, is the umbrella term encompassing the three separate torts of assault, battery and false imprisonment. It is the first two that will be outlined and not the last as false

[23] http:www.howtocomplain.com/cgi-bin/complain1. The disciplinary point is outside the terms of reference of this dissertation.
[24] Rogers W.V.H.: Fundamental Principles of Law: The Law of Tort 2nd Ed. London: Sweet & Maxwell 1994 p.1.

imprisonment is not appropriate to the dental malpractice cases. It is generally accepted that assault and battery occur together, though they can exist separately, but for convenience they will be coupled together. A further point needs to be made, though not elaborated on and that is, all three of the torts are also criminal offences under English law.

Battery is the simplest form of trespass to the person and is "committed where the defendant intentionally and directly applies unlawful force to the plaintiff's body".[25] In England the law would appear to give credence to the assumption that the defendant's interference with the plaintiff must be intentional and direct for a claim in battery to succeed. Thus, any non-consensual contact can and does raise the prospect of a claim in battery.

Assault is an "apprehended battery"; that is, the fist raised to strike or the blow that misses. Unlike battery, neither contact nor harm is required, but like battery it is a tort of "intention" and even the spoken word can be considered to be an assault. Assault is however, tempered by the fact that there must be an immediate risk of battery.

It is a general rule that most batteries are preceded by assaults, though in the case of an unconscious patient this need not be the case, here the battery can occur without the assault.

(ii). Negligence

Negligence is the tort that is most used in dental malpractice cases by NHS patients. The important elements of the tort will be outlined, but out of necessity this will be a brief resume of the tort of negligence in the English Legal System rather than a comprehensive and in-depth analysis of the tort of negligence. Negligence may be a part of other actions, but it is the separate tort of negligence that will be discussed here, not its application to other torts.

"Negligence as a tort occurs when the defendant (1) owes a "duty of care" to the plaintiff, (2) breaks that duty by failing to come up to the standard of care required by law and (3) thereby causes some legally recognised damage to the plaintiff."[26]

The individual requirements of the tort of negligence will now be discussed.

(a). The Duty of Care.

In negligence for a case to succeed, the claimant must prove that the respondent owed him a "duty of care". The idea of a duty of care can be broken down into two questions. The first, was the claimant's loss or suffering of a type to be covered by the tort of negligence? If, affirmative, the second question being was a duty owed to the claimant? Or

"Was it foreseeable that the plaintiff would be harmed by the defendant's act?".[27] The "neighbour principle" was developed by Lord Atkin in **Donoghue v Stevenson**.[28]

"You must take care to avoid acts or omissions which you can reasonably foresee would be likely to injure your neighbour. Who, then, in law is my neighbour? The answer seems to be persons who are so closely and directly affected by my act that I ought reasonably to have them in my contemplation as being so affected when I am directing my mind to the acts or omissions which are called in question."

Dental practitioners have a readily defined relationship with their patients so no difficulty exists in demonstrating that dentists owe a duty of care to their patients. Failure to establish this relationship on the part of the claimant would render the case untenable from the onset. The neighbour or proximity test has allowed new categories of duty of care to be established in negligence and for actions to proceed against respondents when a civil wrong had occurred.

[25] ibid. p.145
[26] ibid. p. 41
[27] ibid. p. 42
[28] [1932] A.C. 562

(b). Breach of Duty.

The standard of care demanded in negligence cases is an objective rather than a subjective standard. The standard being one of reasonableness in the given situation; that is, the reasonable man test. Negligence being defined as[29]:

"[T]he omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs would do, or doing something which a prudent man would not do."

The standards of reasonableness are set by the courts, "Neglect of duty does not cease by repetition to the neglect of duty"[30], and not by the professions. The failure to meet the recognised standard is thus a breach of duty.

However, considerable deference is given to the practices of the medical professions as established by expert evidence and if it can be shown that the respondent complied with the prevailing professional standards the court is likely to find for the respondent. It is expected though that professionals should keep up to date with modern developments.[31] In trying out new techniques and/or treatments the respondent is not necessarily negligent,[32] but it places the onus on the respondent to prove that he was not negligent rather than for the claimant to prove negligence.[33]

In dental cases, there may not be a "general and approved practice" as to what is proper. The law being that the respondent is not negligent if he acts in accordance with an accepted practice at the time as approved by a responsible body of professional opinion skilled in that treatment, even though another body of opinion might adopt another technique. This is commonly known as the **Bolam Test**.[34]

(c). Causation and Remoteness of Damage.

A claimant must establish that a respondent's act or omission; that is, a breach of duty of care, was a possible cause of the harm claimed for.[35] It need not be the sole cause of the damage, but needs to be one of the causes and this process is given the legal title of "causation". Failure to establish causation renders the case invalid and the claimant would lose his claim. Establishing causation permits the next stage of the legal process; that is, remoteness of damage to be considered.

Causation being established by the "but for test", being described by **Rogers** "If the results would not have happened but for a certain event then that event is a cause; contrariwise, if it would have happened anyway, the event is not a cause."[36]

It is not for every breach of duty that a claim can be made by a claimant. The respondent's liability must be within reasonable bounds and the consequences claimed for by the claimant must not be too remote from the respondent's act or omission.

The two accepted approaches to the remoteness of damage principle are either the respondent is liable if the harm suffered by the claimant as a "direct" consequence of the respondent's "wrong":[37] or the respondent is responsible to the claimant for the "foreseeable" consequences of his wrong. The point that needs to be established is the "wrong" the claimant is claiming for must not be too remote from the incident that is said to be the negligent act or omission.

[29] Blyth v Birmingham Waterworks Co. (1856) 11 Ex. 781 at 784.
[30] Bank of Montreal v Dominion Guarantee, etc. Co. Ltd. [1930] A.C. 659 at 666 per Lord Tomlin.
[31] Thompson v Smiths Shiprepairers (North Shields) Ltd. [1984] Q.B. 405.
[32] Hunter v Hanley 1955 S.C. 200.
[33] Clark v MacLennan [1983] 1 All E.R. 416.
[34] Bolam v Friern Hospital Management Committ [1957] 1 WLR 582 at 587.
[35] Wilsher v Essex Area Health Authority [1988] A.C. 1074.
[36] Rogers W.V.H., Winfield & Jolowicz on Tort 14th Ed., Sweet & Maxwell, London 1994.
[37] Re Polemis [1921] 3 K.B. 560.

(d). Proof of Negligence.

The burden of proof in negligence cases rests with the claimant. He must prove what the respondent's acts or omissions were and that this caused the claimant's loss and in law it amounted to negligence; that is, it is decided on a balance of probabilities with the claimant proving the facts of his case. Conformity to an accepted practice is usually taken as evidence that reasonable care has been taken, for medical cases the test is the **Bolam test,** but the courts retain the power to rule that the whole procedure involved is not acceptable. This can be a complex process and the court to a great extent is guided by expert witness opinion.

Given the obvious difficulties with the above approach, English law has developed the *res ipsa loquitur* maxim (the thing speaks for itself). The maxim is a rule of evidence used by the claimant who is unable to explain how the incident occurred and the claimant asks the court to make a "prima facie" finding of negligence and it is then up to the respondent to rebut it if he can. Three things are required to establish the maxim:

- there must be an absence of explanation as to how the accident occurred;
- the "thing" which caused the accident must be under the control of the respondent; and
- the accident must be such as would not ordinarily occur without negligence.[38]

The respondent can rebut the maxim by showing how the accident occurred and that the explanation is consistent with a lack of negligence, or secondly, how the accident could have occurred without negligence. It must be a reasonable explanation not a theoretical explanation.

In summary, there must be a duty of care owed, that duty has been breached and the damage is a result of the breach and for which the claimant is entitled to be compensated. Even if the claimant meets these requirements, he will not necessarily win his case, the respondent is permitted to raise defences to the claim of negligence.

Defences

In English law, two common defences are raised even if the elements of negligence can be proven. These are contributory negligence and *volenti non fit injuria*.

Contributory negligence is regarded as meaning that the incident claimed for was partly caused by the negligence of the respondent and partly by the claimant's failure to take reasonable care of his own safety in the given circumstances. The appropriate legislation being **The Law Reform (Contributory Negligence) Act, 1945**, part of section 1 being quoted below:

"...[W]here any person suffers damage as the result of his own fault and partly of the fault of any other person or persons, a claim in respect of that damage shall not be defeated by reason of the fault of the person suffering the damage, but the damages recoverable in respect thereof shall be reduced to such an extent as the court thinks just and equitable having regard to the claimant's share in the responsibility for the damage."

The onus is placed on the respondent to prove that the claimant's actions were a cause of the injury suffered. It would be unusual if contributory negligence was raised as a defence to most clinical negligence actions.[39] The standard required of the claimant is usually that of the reasonable prudent person; "In practice the courts take into account the relative causative force of the conduct of both parties and their comparative blameworthiness."[40]

Volenti non fit injuria [that to which a man consents cannot be considered an injury].

[38] Scott v London & St. Katherine's Docks Co. (1865) 3 H& C 596.

[39] It can be expected however, that in certain circumstances patients have failed to follow the instructions of the dentist and contributory negligence could be raised as a defence. Similarly, the patient may have requested inappropriate treatment and accepted the consequences of the treatment prior to commencement of the treatment by the dentist.

[40] Rogers W.V.H., Fundamental Principles of Law: the Law of Tort 2nd Ed. page 81. London: Sweet & Maxwell 1994.

In English law, no act or omission is actionable as a tort if the claimant has expressly or impliedly assented to it and no one can enforce a right that he has voluntarily waived or abandoned; that is, the claimant has consented to the actions taken.

Any consent must be real and "given without force, fraud or fear". Fraud negates consent. Knowledge of the risk however, does not amount to consent. Consent in medical cases in English law is a contentious issue and given the limitations imposed, will not be dealt with further except to state that if the defence of consent is successful, it is a complete bar to the recovery of damages.

Remedies and Limitations

In the vast majority of tort cases, the remedies pursued are an action for damages. Indeed, in very many cases it is the only remedy as the deed has already been done and is unlikely to be repeated. Damages are intended to compensate for injury, see below.[41]

"[W]here any injury is to be compensated by damages, in settling the sum of money to be given for reparation of damages, you should as nearly as possible get at the sum of money which will put the party who has been injured, or who has suffered, in the same position as he would have been in if he had not sustained the wrong for which he is now getting his compensation."

In tort, as in other areas of English law a case cannot be pursued after a period of time, known as the "limitation period". Within this period, a statement of claim must be issued, though not necessarily served. The trial itself may be delayed a long time after the issue of the statement of claim. The basic periods of limitation are three years for personal injury claims except trespass to the person which is, six years.[42] In non-personal injury cases there is a six years limitation period.

In personal injury cases, under **The Limitation Act, 1980**, time will start to run from the "date of knowledge" of the person injured. This basically means from the time that the claimant should reasonably have known that he had a significant injury that could be attributed to an identifiable respondent. Failure to proceed within the limitation period can result in the loss of the claimant's claim however valid that the claim may be. It would fail for want of prosecution.

Summary of the Present Complaints and Compensation Procedures

There is little doubt that similarities do exist between the two sets of procedures. There is also little doubt that many patients when they become claimants invoke both sets of procedures. The hypothesis has been asserted that patients use the complaints' procedures to test the merits of their case before proceeding to legal action.[43]

This being the case, the obvious solution to the difficulties is to consider whether the two processes can be integrated into one complaint and compensation procedure. The present systems unfortunately are incapable of meeting these requirements. Neither the legal system nor the complaints' procedures as currently employed have the necessary flexibility to meet these needs.

This being the case alternatives need to be examined and these alternative dispute resolution procedures will be examined in the following chapter.

[41] Per Lord Blackburn, Livingstone v Rawyards Coal Co, (1880) 5 App. Cas. 25, 39.
[42] Stubbings v Webb [1993] A.C. 498.
[43] Presentation to the Dental Law and Ethics Forum, London, 11th June 2002, Hempsons solicitors by Christina Lambert and discussion on the proposition.

Chapter 3
Alternative Dispute Resolution Procedures

The aims of this chapter are to outline potential methods of dealing with disputes that can arise from the practice of dentistry in the United Kingdom. At this stage the concept of integration will not be dealt with only the available dispute resolution processes and how they may be adopted for dental usage. In furtherance of these aims the following format has been adopted.

1. Introduction
2. What is a dispute?
3. Types of dispute
4. Types of dispute resolution processes
5. Issues affecting dental dispute resolution
6. The substantive law of dispute resolution
7. Litigation
8. Arbitration
9. Expert determination
10. Adjudication
11. Mediation
12. Conclusions

1. Introduction

The question needs to be asked, "Why should both dentists and patients be concerned with dispute resolution?" Indeed, it is the sort of subject which neither dentists nor patients wish to know about until a dispute arises. As a rule of thumb, it is a subject best left to the lawyers, defence societies and those directly responsible for settling disputes. There is much to be said for patients and dentists ignoring the subject of disputes and their resolution and carrying on with the business of everyday life, however, there are compelling reasons for dentists to understand disputes and their settlement. The time, effort and resources spent on dental disputes may well outweigh the "value" of the dispute to either patient or practitioner.

It is accepted that many legal actions commence because of patient dissatisfaction with the complaints' procedures currently in operation and the lack of involvement of the patient in the procedures. The role of the patient is minimised so amongst other things, to obtain satisfaction the patient engages a lawyer. The scale of the dispute then escalates with duplication of the procedures; that is, both the complaints' and compensation procedures are invoked by the patient in an attempt to seek "justice".

2. What is a Dispute?

There is little doubt that neither the patient nor dentist wish to enter into a dispute with each other. Discussions over treatment should be the norm. In many respects this is a bargaining process based on the expert knowledge of the dentist and the perceived needs of the patient as identified by the dentist. The end of the process should be the patient's consent to the proposed actions of the dentist. The niceties of consent are outside the terms of reference of the dissertation, but consent is more than agreement to the proposed treatment.[44]

The dentist and patient may not initially be in agreement about the requirements of dental treatment. The differences between the parties may be such that no agreement is reached; that is, there is no consent. This, however, is not a dispute as there are no "rights" at stake. If no agreement is reached then the proposed consent simply fails to materialise. The parties can walk away from each other with no obligations between the parties.

In contrast, a full-blown dispute is different. Apart from the obvious stress, expense and inconvenience involved, there is the added ingredient of an assertion of harm done to a legal right or obligation. Disputes detract from the real business and that is the practice of dentistry with the objective of providing dental treatment for patients by qualified practitioners. However, unwelcome as disputes are, (apart from adopting good practice to minimise the possibility of disputes arising between patient and dentist), once a "bone of contention" arises between the parties, there is no option, but to address and resolve the differences. There is little point in ignoring the

[44] For a fuller discussion of the topic see Rahn and Gillen, Philosophical Medical Ethics. Chichester: Wiley 1986.

issue hoping that it will go away. If the dispute is significant or perceived to be significant then the aggrieved party will pursue the matter.

The professional value of the claim may be such that the dispute process will proceed even though the monetary value is small. Thus, even with relatively minor disputes a great deal of stamina and determination may be required to successfully assert and enforce one's rights albeit patient or practitioner who are enforcing the rights.

3. Types of Dispute

The range of treatments performed in general dental practice can give rise to disputes. The types of dispute may be divided into two distinct legal forms of action, namely Contract and Tort. Whilst the dissertation is concerned with NHS general dental practice, in the context of this chapter, contract as well as tort considerations need to be considered.

Disputes involving the performance or non-performance of private dental practice agreements are founded in Contract Law and amount to allegations of breach of contract. Private dental practice in common with other business relationships is one based on the supply of goods and services. Contract disputes have until recently been limited to the two parties to the contract even though the patient / dentist contract may be part of a chain of interrelated contracts.[45]

When the parties, here patient and dentist, make a contract there is the opportunity at this stage to set out in advance the way that any future dispute between the parties in relation to the agreement will be resolved. Agreement being reached when consent is given to the proposed treatment. It is possible for the parties to agree the process for the settlement of any other type of civil dispute that may arise between them in the future, including tortious claims of clinical negligence and malpractice.

The parties may subsequently agree to a different process, but whilst under European consumer regulations, the patient has the right to pursue the matter in court, the dentist cannot unilaterally decide to ignore the agreed dispute resolution process and use a different method or process to resolve the dispute. However, if after the dispute arises the patient consents to submission to the ADR process, then ADR becomes a condition precedent to litigation.

Disputes can involve contractual and tortious matters at the same time. Both types of claim can be dealt with together so there is no need to engage in separate dispute resolution actions for the different types of claim.

4. Types of Dispute Resolution Processes

There are four principal dispute resolution processes available to the parties to a civil dispute, namely:

a. mediation;
b. adjudication;
c. arbitration; and
d. litigation before the courts.

There are a number of variations on each of these mechanisms for dispute resolution. A dispute may be resolved by a combination of these processes such as mediation / arbitration or arbitration / litigation. The process ends as and when the dispute is resolved. In respect of dentistry, as stated earlier, there is an NHS complaints system for NHS patients, with the potential to complain to the General Dental Council as well as the possibility of litigation. In contrast, at present, the only avenues open to private patients who have complaints are either a complaint to the General Dental Council or litigation. There is no formal complaints' procedure in place for private patients. There is also no integrated system of dispute resolution in place to meet the diverse needs of patient and dentist.

5. Issues affecting dental dispute resolution

The practice of dentistry has undergone a "revolution" since the introduction of the "New Contract" in 1990 for general dental practitioners. There are now numerous providers of private dental health

[45] Dental Law and Ethics Forum, London May 2001.

care, patients who pay privately for their dental treatment and the NHS which nominally permits the mixing of private and NHS dental treatment.[46]

One of the first hurdles in any potential dispute should be to determine who the parties to the dispute are. In most cases it will obviously be the patient and dentist, but there is no guarantee that these will be the parties to the dispute. The parties need to be identified as does the problems that have occurred and form the basis of the dispute.

The parties to a dispute have to rely on the NHS complaints procedures, the substantive law or the rules and regulations of the General Dental Council as being fair, impartial and expeditious giving a creditable outcome to a dispute without accusations of bias in the proceedings.

6. The substantive law of dispute resolution

Whatever process is chosen for the resolution of a dispute, there will still be the necessity to establish the procedures and the substantive law of the dispute. The General Dental Council has the same regulations for the whole of the United Kingdom, but there are three legal systems in operation. These are the English legal system for England and Wales, the Scottish legal system for Scotland and the legal system in Northern Ireland. The NHS rules and regulations whilst broadly similar also have to take into consideration the changes that have occurred in administration following devolution in Scotland and Wales.[47]

There is also little integration between the legal systems and the rules and regulations of the NHS. The consequence of this is that it is possible to have both litigation and an investigation by the NHS with results that are incompatible on the same "evidence". An integrated system could be the solution to the conflicts that exist at present between the two systems. The third aspect of the complaints and compensation procedures is the General Dental Council, a statutory body that is responsible for “discipline” of dentists.

The General Dental Council is a statutory body established to regulate the dental profession. The relevant statute is the ***Dentists Act 1984***. The two main functions relevant to this dissertation being:
a. Maintenance of the dentists register - the right to practice being conferred by the Council by registration and this right may be removed by the Council; and
b. Regulating the professional conduct of dentists and their fitness to practice.

Under **section 27, Dentists Act 1984**, the General Dental Council has the right to remove dentists' names from the register for serious professional misconduct. The Council's jurisdiction is restricted to considering matters of serious professional misconduct or of serious impairment to health. **The General Dental Council does not operate a complaints procedure as such**.

There is no definition of serious professional misconduct, but the examples given by the GDC suggest that it is conduct that is likely to bring the dental profession into disrepute. Examples of such misconduct being:
(i). non-compliance with GDC guidelines on anaesthesia and sedation
(ii). failure to take proper precautions to prevent cross-infection
(iii). failure to seek appropriate medical advice in the event that the dentist has an infectious disease which can be transmitted to patients
(iv). lack of consent to a treatment because the dentist did not properly explain the procedures and risks involved
(v). dishonesty, violence, indecency or breach of confidentiality

This is not an exhaustive list, but one used to show the scope of what is considered to be serious professional misconduct.

[46] Audit Commission 19th September 2002. HMSO. These points were contained within the Audit Commission’s Report into the provision of dental treatment.
[47] The process of devolution being May 2000 with elections to the Welsh Assembly and Scottish Parliament and subsequent formation of democratic assemblies for the Celtic countries of the United Kingdom.

It needs to be noted that the list does not include the most common complaints that patients would make, namely reference to over treatment; that is treatment which cannot be clinically justified nor to the standard of treatment undertaken. Therefore, in the majority of cases the following options are the ones that in the absence of an amendment to the ***Dentists Act 1984***, are available to resolve disputes between patients and dentists.

7. Litigation

In the absence of choice or perceived choice, a dispute will find itself "before the courts". This may be very good news for the lawyers, but not such good news for either the patient or the dentist. The services of lawyers are expensive and even with the best will in the world, the judicial system tends to be slow and laborious.

The courts do enjoy a great deal of power and have the full majesty of the law to uphold their decisions. Confidence in the judicial system is the greatest asset of the courts. The legal knowledge and understanding of the judiciary are highly valued by parties to a dispute. Judges are perceived as being dispensers of justice. The concepts of negligence have been dealt with earlier in the dissertation.

8. Arbitration

As a general statement, arbitration has several advantages over litigation as a dispute resolution process. Arbitration is private so the dispute does not end up being discussed in the papers. A major advantage for a profession that relies on public confidence to provide its services. If the court's role is kept to a minimum, the process can be conducted relatively quickly. In practice it should take no more than six months to reach Arbitration, whereas two years or more is not unusual for the commencement of a trial. The difficulty with these time spans is that the patient may need “urgent” treatment to rectify the problems that he is claiming for, but is unable to fund the remedial works until he has received compensation for the malpractice claimed for. Even a six months period as envisaged for arbitration may be too long to meet the needs of the patient.

The time aspect went somewhat awry in the eighties and early nineties, but arbitration has now regained the time advantage over the courts - due to new regimes that encourage less formal arbitral procedures. Arbitration tends to be less expensive than litigation. However, an inefficient arbitral process could result in excessive discoveries and argumentation that can result in costs reaching an exorbitant level. To a certain extent, the parties, get the arbitral process they want, so there is little ground for complaint about the process.

Despite the legal expertise of judges the parties frequently feel that a judge does not understand the commercial and technical realities of either the profession or the patient’s complaint. The lawyers can do their best to explain to the judge, but the judge is unlikely to have great understanding or empathy with the profession or to respect the patient’s complaint about the treatment received.

Arbitration can solve this problem in that many arbitrators begin their professional life as architects, surveyors, mariners or other professions before converting to "*legal practice*".[48] There is less need to explain to an arbitrator with relevant professional experience where the processes went wrong and what the correct procedures should be. The arbitrator can make decisions of fact reinforced by his personal experience, expertise, knowledge and understanding of the profession. This reduces the possibility of the parties being dissatisfied with the outcome of the arbitration.[49] Dentistry is no different to other professions in this matter.

9. Expert determination

Frequently, the only issue to be settled in a dispute is "How much is this worth?" or "Has the duty been undertaken?" Questions of law and legal interpretation may have little or no role in the settlement of such a dispute. An expert may be better suited to deciding the issue than a judge.

[48] Chartered Institute of Arbitration publicity materials.

[49] CIArb materials though no supporting figures are quoted whereas for mediation in the USA satisfaction rates of 80% plus are quoted by organisations such as the ABA and NADR Inc.

There is no reason why an expert cannot be employed to settle factual questions. The expert applies his own knowledge and understanding without recourse to legal submissions. The process is one of evaluation rather than judicial in concept. The judicial aspect being performed by others rather than the expert. The process is extremely quick and inexpensive. Judges and arbitrators may perform the same function, but the costs involved are far greater. Expert determination these days is used far less than previously. It was very popular at one time, but has sadly fallen into disuse as lawyers rarely advise their clients of the service.

10. Adjudication

What is adjudication and who or what is an adjudicator? Whenever someone who is empowered to do so makes a decision affecting somebody else's legal rights they adjudicate over that person's rights. Expert determinators, judges and arbitrators often perform an adjudicatory function. Here adjudication refers to another process. A new form of dispute resolution process has developed in the United Kingdom, known as Adjudication. By virtue of ***The Housing Grants Construction and Consolidation Act 1996***, (subsequently referred to as the ***Housing Grants Act***), construction industry disputes may be subject to an adjudication process.

Adjudication has much to commend it and has proved very valuable in the settlement of construction disputes. However, there is no reason why parties to any civil dispute cannot adopt an adjudication process for the resolution of their dispute. Voluntary adjudication processes can be adopted by those responsible for both the complaints procedures as well as the compensation processes that accompany NHS general dental practice giving the benefits currently enjoyed by the construction industry in the United Kingdom.

The distinct features of adjudication are that it is a private, immediately enforceable, non-binding process and is carried out very, very quickly.[50] The process is also inexpensive. It tends to be carried out on a documents only basis, though it is possible to have oral hearings and pleadings. The role of the lawyers in the process is kept to a minimum.

Under the ***Housing Grants Act*** the process takes twenty-eight days from reference to determination, but a voluntary system could extend or limit the time scale at the request of the parties or the adjudicator. Adjudicators being drawn from the appropriate profession, here dentists in a similar manner to those who are expert determinators. They do not have to be qualified lawyers.

The words "immediately enforceable" and "non-binding" appear to be mutually exclusive and need to be explained. The award is immediately enforceable on the due date, often seven days after the award. In the event of non-compliance the courts will enforce the award. There is scope to challenge the scope of jurisdiction and judicial review is available to supervise the conduct of the process, as with any other legal decision making process, but that apart the successful party will receive his award.

The great value of this is that within a short period of time the parties receive an authoritative statement of what their respective positions are. In comparison arbitration can take months and litigation even longer before an outcome is reached. Experience indicates that most disputes end at the award stage. The parties usually are satisfied with the outcome.[51]

"Non-binding" refers to the right of either party to take the dispute forward to arbitration or litigation. The subsequent process will take place without reference to the adjudication process. However, since the parties are required under the adjudication process to gather evidence and prepare witness statements to present to the adjudicator much of the preparation work for trial will already have been done. The arbitrator or judge will make an award without reference to the adjudication. The arbitrator or judge will be aware of the party which prevailed at the adjudication, but will not know the details of the award and should not be influenced by the adjudication award

[50] See Association of Independent Construction Adjudicators materials.

[51] AICA, RICS and other bodies all make the claim that the parties settle at this stage and are satisfied with the outcome. No figures are readily available as the process is confidential.

when making his own. However, as with a payment into court or settlement offer, the judge can take the adjudication award into account when making an award on costs. Therefore, it can be a risky business challenging an adjudication award and a party would need to have compelling reasons to take the matter to court or arbitration.

11. Mediation

At the present time, mediation is virtually unheard of with regard to the health care professions outside the United States, although various schemes have been piloted in the United Kingdom.[52] However, mediation has much to commend it and hopefully within the near future will have an important role in settling health care disputes.

Mediation, in common with adjudication is a private, quick and relatively inexpensive process when compared to the legal system.[53] The parties themselves maintain control over the decision making process rather than handing it over to a third party. There is an obligation to participate in the process, but no obligation to reach a settlement. If no settlement is achieved the parties are free to proceed to adjudication, arbitration or litigation. However, having canvassed the issues thoroughly in advance pre-trial preparation will be at an advanced stage and many side issues will have been resolved resulting in a quicker and more efficient process.

At a mediation, the mediator acts as a go-between, exploring issues with each of the parties in turn, facilitating them to reach an agreement. The process has much to offer when the parties realise that a settlement is necessary and are prepared to broker a settlement. Many legal cases settle on "the steps of the court", mediation achieves a similar result, but involves the parties directly and leads to far more satisfactory settlements than are brokered through the auspices of the lawyers.

Mediation has less to offer in situations where one party simply refuses to recognise any liability or responsibility or refuses to pay or perform a service or put something right. If a party takes a stance of infallibility with regard to the dispute and attends a mediation out of duty rather than of a mind to settle the dispute then the process cannot succeed. Even here though, participation in the process can result in the recalcitrant party realising that their stance is unrealistic, paving the way for a settlement. Apart from being relatively inexpensive, mediation is a valuable tool for repairing damage to relationships.

Mediation is a serious process and has been successfully used to settle disputes involving large sums of money. Indeed, mediation agreements are readily enforceable before the courts if the mediation agreement is breached.

12. Conclusions

Litigation has a valuable role to play in the future of dental dispute settlement, but so has arbitration as well as the newer processes of mediation and adjudication. The dental profession as a whole will be well advised to take a close look at what is presently available in the form of dispute resolution systems. The NHS is widely acknowledged as suffering from an excess of litigation for clinical negligence. The alternative dispute resolution processes have the ability to remedy the present position.

Dentistry and the dental profession is continually evolving, the same is true of the dispute resolution industry. There is no reason why the dental profession and dentistry cannot evolve with the dispute resolution systems. These are points that will be brought out in subsequent chapters of the dissertation.

The dispute resolution processes would, however, have to be incorporated into the contract between the patient and the practitioner if they are to form the basis of the dispute resolution procedures governing the dentist - patient relationship. This can either be achieved voluntarily or made compulsory if it is thought desirable to do so. The integration of the processes forms the second part of the dissertation.

---

[52] Mulcahy, L: Mediating Medical Negligence Claims: An Option for the Future?: The Stationery Office: 2000.

[53] See ADR providers such as NADR, CIARb, AICA materials who all stress this point.

Chapter 4
What Does ADR Have to Offer Dentistry?

Introduction

From the preceding chapters, it can be recognised that the dental compensation procedures for NHS patients are based on clinical negligence procedures with regard to legal processes and similarly the complaints system is a standard NHS procedure. There are advantages and disadvantages for patients and practitioners alike with the two processes.

Problems arise from the fact that whereas they are two diverse systems, they can overlap in their usage. At the same time however, they can fail to meet the needs of patients who believe that they have suffered a wrong at the hands of the dentist. The dentist in contrast can feel frustrated that his best endeavours have resulted in stress and patient dissatisfaction with what in his opinion is perfectly reasonable and acceptable treatment.[54] The patient is further frustrated in that under both systems the patient is a minor player rather than a major participant in the dispute resolution processes.

It is much speculated upon in both the specialist press and the National Press that patient frustration with the NHS complaints system and the lack of personal input of the patient can and does lead to an unacceptable number of patients pursuing their grievances through the courts. This is thought in some quarters[55] to be because the patients have failed to obtain satisfaction through the complaints procedures.

In contrast to this, the dentist does not have the same rights regarding the complaints' procedures. The dentist's options are limited to removal of the patient from his NHS list or the pursuit of non-payment for services rendered through the court system if there is a problem between the dentist and the patient and it is the dentist who is dissatisfied with the position.

The questions that will be addressed in this chapter therefore are:

1. How to rectify the complaints and compensation procedures that fail to satisfy the needs of patients and dentists?
2. Can an integrated dispute resolution system be developed?
3. Would an integrated resolution system better suit the needs of patients and dentists alike?
4. Can the accepted alternative dispute resolution systems serve the needs of patients and dentists?

1. How to rectify the complaints and compensation procedures that fail to satisfy the needs of patients and dentists?

As stated above, there is little doubt that the present systems do not meet the expectations of patients or the needs of dentists. Whilst the legal system is well established as a means of settling disputes, it has undergone fundamental changes in recent years following the Woolf reforms. Clinical malpractice has not undergone the radical changes that other branches of personal injury claims have, but even dental malpractice claims have radically altered in recent years. There is a firm of specialist solicitors where the principals are doubly qualified who have established a solicitors' practice out of pursuing claims against dentists.[56] The usual method of financing the claim is by a "conditional fee agreement", these were first permitted under the **Courts and Legal Services Act, 1990** as amended by the **Access to Justice Act, 1999**.

The nature of a conditional fee agreement is such that it provides that the legal costs or some part of them are only payable in the event of success in the litigation. A conditional fee arrangement must be in writing and comply with the current requirements as set out in the **Conditional Fee**

[54] DLEF London 11th June 2002.
[55] See earlier chapters with reference to Christina Lambert and DLEF 11th June 2002.
[56] The Dental Law Practice based in Nantwich, Cheshire. The two partners are doubly qualified as dentists and solicitors.

Agreements Regulations 2000 (SI 2000/692). A conditional fee arrangement can be used in all types of civil litigation other than family matters. Conditional fees are not limited to pure legal actions, but can be used in other procedures that resolve disputes. These include arbitration and mediation.

These agreements permit the financing of actions by patients that may not otherwise have proceeded. The claimant is expected to purchase insurance in case the action is lost and the respondent is successful and claim his fees from the claimant. The selection process is such though that the hopeless cases are filtered out at an early stage. There are no statistics available to confirm the efficacy of the conditional fee agreements or otherwise, but the explosion in medical malpractice claims has corresponded with the introduction of these arrangements.

The growth of clinical malpractice claims and processes have not been controlled, but has developed in an *ad hoc* manner that can justly said to fail both patient and practitioner. Legal representation is not part of the complaints' procedure and unless the patient pays for his own legal representation at the preparation stage the lawyer cannot bring his skills to the table. These skills are however, used in the compensation procedures. It is also widely believed that the complaints' procedure is used to prove the efficacy of the case[57] as well as to bring out the necessary evidence to succeed with a claim in negligence.

These failures of the systems have led to dissatisfaction with the processes currently employed and there is pressure for reform of the current systems from various sources including patient organisations and practitioner bodies.

2. Can an Integrated Dispute Resolution System be Developed?

An integrated dispute resolution system for NHS general dental practice is a proposition that requires the co-operation of two distinct entities. Unlike NHS hospital practice where there is crown indemnity for NHS employees; that is, the funding of any compensation awarded is the responsibility of the NHS either through the appropriate Trust or through the NHS, NHS general dental practice has external suppliers of professional indemnity insurance. The two separate and very diverse entities would have to be brought into the system if it is to be integrated.

To date there is little doubt that the defence societies have done a creditable job in providing indemnity cover for general dental practitioners. There is no reason why this should not continue into the future.[58] The foreseeable difficulties arise from the fact that there is little doubt that an integrated dispute resolution system can be developed.[59] The difficulties with such a system are focused on the need to attribute responsibility to the partners to the proposed NHS scheme. This does not mean that the two partners to the process can bind their fellow partners in the process to courses of action that they would not have followed if they had been given the choice. This is important. The NHS complaints system cannot be given *carte blanche* to decide to give compensation to a "wronged patient" if they are not responsible for providing the compensation. Similarly the defence organisations are unable to give an undertaking that they will modify NHS practices if a patient so desires and this forms part of the complaint.

There is little reason to doubt that an integrated dispute resolution system for NHS general dental practice can be developed. The first step is to examine the successes and failures of the current NHS complaints system for patients. These have been criticised, but the criticisms can lead to a better system both for patients and dentists. One of the major criticisms of the system is the lack of role that the complainant has once the procedures have started. It has been postulated by some that this is a reason why patients need to go to law to establish their rights. If an integrated system is to

[57] See above Christina Lambert and DELF 11th June 2002

[58] St Paul's Insurance of the USA have withdrawn from the indemnity market in the United Kingdom, but following this withdrawal the other providers have emphasised their commitment to their members.

[59] DENPLAN, the private dental health provider has an integrated system for its patients and dentists with local resolution being the initial stage and arbitration being the final stage of the process.

be developed then it must respect the rights of those who take part in the process. Both patient and practitioner have rights that need to be respected and any system needs to consider the rights of all parties to the process.

An integrated system would have to be built up and consist of various stages to the process. It may be such that the defence organisations may not be brought into the process until a fairly late stage, but their entry would be automatic if compensation was sought. Any system would have to have preliminary procedures and stages in its function.

An initial local resolution stage could well eliminate many of the disputes at a very early stage in the proceedings. This is something that the present NHS complaints' procedures can achieve. The failure of the present system is with the more serious complaints when a stage two investigation is undertaken. It is not possible to award compensation, or to discipline the dentist at this stage. In many respects it becomes a paper exercise that cannot give satisfaction to the complainant or the health care practitioner.

If the complainant is successful in his complaint, he still has to pursue the matter through litigation for compensation. If the complaint is, however, not upheld the claimant still has the option to use the litigation system to try to obtain compensation even though he has lost his case at the one level. Similarly, if the dentist is exonerated, he cannot say that the matter has been closed as it is still open to litigation. This clearly illustrates the difficulty with the complaints' procedure, it does not give closure of the dispute. In many respects it prolongs the process. An integrated system should be able to give closure subject to a review process.

3. Would an Integrated Dispute Resolution System Better Suit the Needs of Patients and Dentists?

This question is a direct follow on from the above section. The two fold present systems neither lead to a swift closure of the system nor a guaranteed cohesive result from both when they are used. As stated above they do not allow closure of the procedures. An integrated system would allow for closure of the dispute. This would have benefits for both patient and dentist.

The advantages for a patient are:

- One process to resolve the dispute
- If a legal process, legal assistance could be available, possibly under a contingency fee agreement
- Active participation in the resolution process

The advantages for a dentist are:

- Early resolution of a dispute
- One process not two
- Closure of the dispute

Advantages for a Patient

The advantages of one integrated process, with the possibility of legal assistance to prepare the case has its obvious attractions as does the possibility to take an active part in the dispute resolution process. By its very nature, this does not mean that the patient has all the advantages to the detriment of the dentist. The advantages to the patient can also be of benefit to the practitioner. The concept of an integrated process in which the patient has a role has advantages for both parties to the dispute. There is only one procedure even though it may well consist of a number of different stages. This would give a faster, more efficient process with no duplication of procedure. An integrated process would allow a patient to have an input into the process and believe that his complaint is about himself rather than about the dentist and the complaints procedures. This would focus the dispute, allow the patient to have his say and remove patient resentment at the procedures. These are all failures attributed to the current NHS complaints' process.

The availability of legal assistance for the patient would also permit a more efficient process to be developed. Lawyers are trained in the procedures and processes that are used for dispute resolution. This training if brought into the equation at an early stage would permit identification of the problems that the patient is complaining of. This would be before the dispute had meandered into dissatisfaction with the complaints system by the patient and as a consequence use of litigation to achieve satisfaction.

Advantages for a Dentist

The advantages of an integrated system for the dentist are that only one procedure would be involved that should permit early resolution of the dispute with closure at the end of the dispute resolution process.

The advantages that these give the dentist can be described in terms of those that are non-measurable such as reduction of stress from a prolonged litigation process and knowing that closure should follow the end of the procedures used for the dispute resolution process. There are also those gains that are measurable such as the saving in time and costs associated with the two fold processes that are currently employed.

There are obvious advantages to both parties from having an integrated dispute resolution process. There are also advantages to other bodies from an integrated system. The defence organisations would be part of the process at an earlier stage before the possibility of resentment had become established between the parties. This would permit easier resolution of the dispute. Once resentment has been created between the parties, resolution of the dispute becomes more difficult. Similarly the complaints system would not be in a vacuum, but part of the whole complaints and compensation system.

It is possible to develop a system that would benefit both patients and dentists and these systems and what they have to offer will be developed in the next section.

4. Can the Accepted Alternative Dispute Resolution Processes meet the Identified Needs of an Integrated Dispute Resolution System?

The identified alternative dispute resolution processes all have advantages and disadvantages when compared to litigation. The concept of this dissertation also needs the systems to be integrated with the NHS complaints system rather than being a stand alone dispute resolution process.

The NHS complaints system as described previously can use a conciliator, but one of the identified difficulties with this is that the NHS cannot give compensation for the complaint. Therefore, there is no guarantee of recompense for a wronged patient even if it is justified. Unless the dentist is prepared to fund the compensation claim himself then the defence societies need to be involved if compensation is to be awarded at the conciliation process.

The accepted alternative dispute resolution systems are:

- Arbitration
- Adjudication
- Mediation
- Conciliation

The above dispute resolution processes may be backed up by other types of dispute settlement procedures. These can be a combination of two or more of the accepted ADR procedures. Mediation / arbitration and mediation / adjudication are gaining in popularity though certain safeguards have to be considered when they are used in combination.[60]

[60] Glencot Development and Design Co. Ltd v Ben Barrett & Son (Contractors) Ltd Technology and Construction Court 2 and 13 February 2001.

"Summary judgment would not be given automatically where an adjudicator had also acted in a mediation role between the parties, as there could be an arguable case of perceived bias of the adjudicator" per Humphrey Lloyd.[61]

There is also the need to consider expert determination when alternative dispute resolution systems are discussed.

A previous chapter has examined the accepted alternative dispute resolution processes in general terms, but their suitability to dentistry and in particular NHS general dental practice has not been considered until now.

Conciliation

The first ADR process to consider must be conciliation. This is not because it is considered superior or inferior to the other processes, but simply because the NHS already has the facility to use a conciliator as part of the complaints process if the panel thinks that it may help to resolve the complaint that has to be investigated.

Conciliation has advantages and disadvantages when its application to dental practice is considered. There are, however, limitations when applied to the current NHS complaints' procedures. Conciliation is not used to settle litigation claims, but is part of the complaints' procedures. There is currently no overlap between the two processes. Conciliation has the potential to settle cases as long as all parties can be "brought to the table".

The difficulty with this approach is that whilst all parties have an interest in settling the dispute each party may have a different agenda that prevents settlement of the dispute. The NHS representatives are remote from the problem in that the disputes that arise are practice based between the dentist and the patient rather than between a Trust and a patient. This renders the investigation panel remote from the problem and it is only after they have investigated the claim that conciliation becomes a viable option. At this stage, it is arguable that both sides have become entrenched in their positions and they will not compromise for fear of being regarded as the party that has caused the wrong rather than the wronged party.

The concept of conciliation if introduced at an early stage may well assist in a dispute, but after the parties have established their respective positions it becomes far more difficult. A further difficulty is that whilst conciliation is an informal process, the parties need to be represented if it is to work. Under the present regulations, a patient is not entitled to legal representation at any of the stages of the NHS complaints' procedures.

The complaints' processes also fail to consider the need to have a representative of the defence organisations present who can authorise compensation payments if needed to settle the dispute. Conciliation if it is to be considered as part of an integrated dispute resolution system would have to be considered at an earlier stage with all prospective parties represented at the conciliation.

There is little doubt that conciliation can play an important part in a NHS dispute resolution process especially if analysis of the original complaint would suggest that the problem would not require compensation to settle the dispute.

Mediation

Mediation in many respects is regarded as the alternative dispute resolution process. Arbitration and adjudication are judgmental in operation. Mediation is a negotiated settlement process. Mediation has been considered as a dispute settlement process for the NHS. It has not however, been considered as part of the complaints' process.

The NHS medical negligence mediation pilot scheme was launched in April 1995.[62] The scheme was set up to deal with clinical negligence claims rather than to deal with complaints and compensation. The medical negligence pilot scheme was set up in response to a number of

[61] ibid

[62] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999.

criticisms that had been levelled at the management of clinical negligence claims in the NHS. Some of the problems that had been identified included the following:

- The defensiveness encouraged by existing procedures;
- Dissatisfaction amongst claimants with process and outcome;
- The inaccessibility of the civil justice system
- Delays in the management of claims; and
- The cost to the public purse of claims management.[63]

The study identified characteristics for clinical negligence cases that suggested that they could be settled by mediation. Amongst the characteristics identified were the following:

- Small and medium cases[64]
- Those cases with an emotional overlay
- Where non-legal remedies such as apologies and explanations were sought[65]
- Claims where the parties wanted greater involvement in case management
- Claims where a speedier resolution was required
- Claims where the patient had a long-term relationship with the healthcare provider.[66]

The pilot scheme also identified the types of cases that were not considered suitable for mediation. These were identified as falling into three categories:

- Cases that lacked settlement potential[67]
- Cases where the claim was high
- Cases where there was insufficient information on which to base settlement negotiations.[68]

An interesting observation that arose from the pilot scheme was that the identified information threshold for referral to mediation was the point where expert evidence on the claim had been received by either one or both of the parties.[69]

The pilot scheme also identified problems with the scheme itself. These were split into two different types of problem:

- Those concerning the creation of a supportive policy environment that led to a reluctance amongst gatekeepers to refer cases; and
- Those that concerned the procedures and practices adopted in the mediated cases.[70]

There were also problems associated with the administration and operation of the scheme that adversely affected its efficacy.[71] These negatives can be contrasted with the positives that emerged from the scheme. Five main successes were identified:

---

[63] Ibid page xiii

[64] Complex and large cases were not thought of as being suitable for mediation as they could involve a large amount of evidence together with greater reliance being placed on the courts' judgements in cases involving substantial claims for compensation.

[65] It was not explained why these matters were not first dealt with by the complaints' procedures rather than through the litigation process.

[66] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page xv.

[67] Examples being cases where there was a desire to set a precedent.

[68] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page xv

[69] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page xvi.

[70] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page xvi.

[71] Those involved in the pilot scheme formed the opinion that the NHS Executive did not adopt a sufficiently strong approach to the management of the scheme. The NHS Litigation Authority was also considered not to have been sufficiently proactive in supporting the scheme and directing cases to the scheme to be mediated. There was also concern about how the mediations were conducted with last minute ambushes and "unnecessarily defensive stances adopted by solicitors".

- Heightened awareness of mediation amongst medical negligence specialists
- Increased participation amongst clients in the settlement process
- Flexibility in process and the potential for involving non-legal remedies in the settlement
- Privacy
- Efficient case disposal facilitated by the concentrated negotiations.[72]

The above list is great surprise in that these are some of the standard claims made for mediation as a means of settling disputes. The results of the pilot scheme reinforced the claims already made for the efficacy of mediation. The one advantage that the pilot scheme had when compared to the proposed integrated complaint and compensation system for NHS general dental practice is that the parties representing the NHS had full authority to settle the dispute with regard to financial recompense. There were no third party bodies (the defence societies) responsible for this aspect of the claim. This was important for the success of the scheme.

The concluding remarks of the executive summary certainly sum up the position with regard to mediating health care disputes.

"Mediation may not be suitable for all medical negligence cases and it is certainly not a panacea for the problems of medical negligence litigation, but it clearly has the potential to encourage more appropriate and effective resolution of disputes."[73]

The concept of mediating health care disputes has many advantages as well as potential pitfalls. NHS general dental practice can benefit from mediation and as stated in the trial scheme, the potential for settlements that involved non-standard responses was one of the successes of the scheme. The ability to explore avenues of settlement that could not be considered under other dispute resolution schemes is one of the great advantages of mediation.

An important consideration that was identified in the pilot scheme was the role of the gatekeeper in identifying cases that were suitable for mediation or should proceed to litigation. The present systems for dental complaints and compensation do not readily permit the transfer from one procedure to the other process. Early identification of cases that can be mediated would greatly enhance the efficacy of the complaints procedures as well as permitting patients to have a greater say in the dispute resolution process.

Mediation is also a "buzz word" since the Woolf Reforms and the courts have pushed the concepts in their judgements.[74] Mediation can be one of a number of techniques that can be used to settle disputes and these are applicable to dentistry. Mediation can permit better management of health care disputes.

The American experience of mediation in health care dispute management is such that mediation has been a great success. ADR providers such as the NADR[75] are confident that their mediation models can be successful for most cases as long as the initial sifting process has been carefully performed. Other organisations such as CPR Health Disputes Project[76] are devoted specifically to develop ADR programmes to meet the needs of society. They have developed specific packages for the health industry that have proved successful in practice and satisfies the needs of both health

[72] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page xvii

[73] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page xvii.

[74] See Cowl v Plymouth City Council 16th November 2001 The Times, where Lord Woolf in his judgement encouraged the use of ADR techniques to settle disputes with a public law aspect.

[75] National Association of Dispute Resolution, Dallas, Texas claim a success rate of seventy-five per cent plus for health care mediation settlements.

[76] The CPR Legal Program is a non-profit alliance of more than five hundred global corporations and leading law firms, together with select law teachers and public institutions, organised to develop alternatives to the high costs of litigation.

professional and patient[77]. There are however limitations as to what mediation can achieve.[78] Not all disputes can be mediated as has been stated previously. There are other alternative dispute resolution procedures that may be adopted that can meet the needs that cannot be achieved by mediation.

An advantage of mediation that has not been touched on which is important is that it is a process that can be swift. This may be the deciding factor when the claim is made. The claimant may wish to have a swift ending to the dispute to enable him to repair the damage that has been caused. The speed of resolution is important and that factor is one that favours other forms of ADR over litigation. The American experience of mediation can best be summed up by the following:

"Mediation has singular potential in the health field. It has the ability to preserve ongoing relations and to broaden avenues of communication and resolution in hospitals and other complex institutions. It focuses parties on their interests instead of only their rights and helps them search for viable practical solutions to problems. In addition, it can be used early in disputes and its non-binding nature induces participation. These qualities can be crucial in health care institutions, which consist of heterogeneous but interdependent groups of physicians, administrators, patients and others."[79]

Arbitration

Arbitration is a judgmental process that has been used to settle disputes for centuries.[80] Denplan[81] has adopted an arbitration procedure as the final stage in its dispute resolution process. The arbitration is usually conducted by a person who has specialist knowledge of the requisite discipline. This gives an in-sight into the difficulties that can be expected from the procedures that are being complained of.[82] A major advantage of arbitration is that it may give a swifter result than litigation. A time span of six months is regarded as being the norm following the **Arbitration Act 1996**.

The speed of resolution is important if the claimant needs early settlement of the dispute to enable remedial work to be undertaken. The difficulty with the procedure is that it does not have the flexibility of mediation to allow the parties to explore solutions that are not normally available from the judgmental processes. Arbitration could not be the first stage in any complaints and compensation procedure for general dental practice because by its very nature it is a decision making process as is a court judgment.

A gatekeeper role would have to be established if arbitration were to be used as a means of settling dental disputes. There is however, nothing to prevent the NHS incorporating an arbitration clause in the contract between dentist and NHS.

The concept of arbitration is one that is not usually associated with the resolution of NHS health care disputes in the United Kingdom as it is not a process favoured by the NHS Litigation Authority. This does not mean however that because it is not used that it does not have a role to play in dispute resolution. The use of arbitration by Denplan is proof that on commercial grounds it is a viable proposition. The great advantage of arbitration over litigation is that it is a private process.[83] This is undoubtedly a major consideration for a profession that relies on reputation for its

[77] Health Industry Dispute Resolution: Strategies and Tools for Cost-Effective Dispute Management CPR Legal Program 1993 pp 24-25.
[78] Health Industry Dispute Resolution: Strategies and Tools for Cost-Effective Dispute Management CPR Legal Program 1993 p 40
[79] Health Industry Dispute Resolution: Strategies and Tools for Cost-Effective Dispute Management CPR Legal Program 1993 p 40
[80] See Aristotle and other Classical Greek literature.
[81] Denplan is a private health care provider of dental treatment in the UK. The patient pays a regular monthly premium to ensure that he has access to treatment and the routine costs of the treatment are covered by the insurance premiums.
[82] Denplan use a dentally qualified fellow of the Chartered Institute of Arbitrators to settle disputes.
[83] See The Arbitration Act, 1996

status in the opinion of the public. Keeping disputes private has advantages in that the dentist's competence is not brought into question. The prospect of other claimants "jumping on the band wagon" will have been eliminated. From the patient's perspective a swifter resolution of the dispute would have positive consequences enabling him to "carry on with the rest of his life".

The nuances of arbitration are outside the scope of the terms of reference, but arbitration is not just one set process. There are variations to arbitration that could well be of great use in settling NHS general dental service complaints if they have reached the stage where the dispute needs to be litigated. Arbitration can be either in its traditional form, fast track or even paper only. Arbitration can be used as a stand alone process or part of other processes such as the second stage for mediation giving a mediation / arbitration process.[84]

Arbitration undoubtedly can have a role to play in NHS general dental service dispute resolution processes, but it is not the only judgmental process that can be used. Adjudication has been used successfully in other areas and there is no reason why it cannot be developed for dentistry as can be seen below.

Adjudication

Adjudication in the United Kingdom is based on the **Housing Grants Construction and Consolidation Act 1996**. This Act set up a new form of dispute resolution system for the construction industry that was judgmental in operation.[85] The adjudication process has found great favour in the construction industry as in its usage it has proved itself to be an effective means of settling disputes.[86] As stated previously a decision is given within twenty-eight days of referral to an adjudicator.[87]

The adjudicator is usually a person who has specialist knowledge that enables him to make a decision on the dispute in question. The process is swift and economical. Many of the legal niceties are omitted from the process, but the dispute is swiftly resolved allowing both parties to be in a position to carry on with their main activities rather than being side tracked by the litigation process.

In the absence of a specific Act of Parliament or appropriate Statutory Instrument, adjudication would have to be on a voluntary basis if it was to be incorporated into the NHS general dental practitioner – patient relationship. There is a scope for the use of the system as part of the complaints and compensation procedure. Adjudication can be part of a second stage dispute process as can arbitration. Mediation – adjudication is gaining in popularity and whilst there are concerns over the same person being mediator and arbitrator or adjudicator.[88] These concerns arise from the fact that mediation is a facilitated negotiation with the parties encouraged to provide the mediator with confidential information in the private sessions that they would not supply to a "court". This is done to enhance the dispute resolution process. If the same person who was the mediator then becomes the adjudicator or mediator he has information to make a judgmental decision that would not be available to a new adjudicator or arbitrator though such a person would have greater insight into the case than a "newcomer". These concerns are part of the second stage considerations of an integrated complaints and compensation system and do not form part of the primary considerations.

---

[84] For a fuller discussion of the role that arbitration can play in settling disputes see *A Practical Approach to Arbitration Law, Tweedale & Tweedale,* Blackstone 1999.

[85] Buckett J, 1997 Alternative Dispute Resolution. In Campbell P (ed) *Construction disputes – avoidance and resolution*. Whittles Publishing pp 41-64.

[86] Kennedy P & Milligan J 2002, *Research analysis of the progress of adjudication based on returned questionnaires from adjudicator nom,inating bodies (ANBs') and on questionnaires returned by adjudicators.* Report No. 4 June Glasgow Caledonian University.

[87] Housing Grants Act 1996 and enacting legislation.

[88] Glencot Development and Design Co. Ltd v Ben Barrett & Son (Contractors) Ltd Technology and Construction Court 2 and 13 February 2001.

Adjudication could play a valuable role in dispute settlement as a second stage process if local resolution of a dispute has failed to achieve patient satisfaction. Patient satisfaction is the prime consideration in any dispute resolution process. The dentist is the professional and as long as a system is in place that ensures "justice is not only done, but seen to be done"[89] then the dental surgeon would have to accept the outcomes of the dispute resolution process. The difficulty is that the patient needs to be satisfied with the process at all stages; that is, he has had a fair hearing and justice will have been "seen to be done", in the patient's eyes even if he is dissatisfied with the outcome.

Adjudication can achieve these outcomes in a swift resolution of the dispute. Adjudication has a great deal to offer as a NHS dispute resolution process. The use of resources is efficient, the short time scale concentrates minds on to what needs to be achieved rather than allowing the dispute to procrastinate to a decision that because of the time interval may no longer be strictly acceptable to either party.

Adjudication may give a "rough and ready answer",[90] but it is an answer that is swift. This is important. If the complaint is about failed dental treatment then the patient may need a swift resolution of the dispute so he can be placed in a position where he can have treatment to remedy the wrongs claimed for.

The ability to settle disputes quickly and economically is very important when dental disputes are considered as the financial outlay of preparing the case may be out of proportion to the damages that will result from the claim. This is important when the Civil Procedure Rules 1998 are considered.

1.1(2)(c) dealing with the case in ways which are proportionate-

(i) to the amount of money involved;
(ii) the importance of the case
(iii) to the complexity of the issues; and
(iv) to the financial position of each party

Adjudication could and would enable these objectives to be met if it is used as part of the dispute resolution process for NHS general dental practice. This is true whether it is a stand alone system or as part of an integrated complaints and compensation system.

There is also expert determination to be considered as a dispute resolution process. This can be very important if it is agreed that a wrong has occurred and the only thing that cannot be agreed is the quantum of damages. This undoubtedly can have use in settling dental disputes. This is true where the facts of the case are not in dispute, but the amount of damages claimed for may far exceed those that the respondent is prepared to pay. The expert would determine the amount that would be fair and equitable in the circumstances.

There is little doubt that each and every one of the dispute resolution processes can have a significant role to play in settling dental complaints and awarding compensation. The question that remains to be considered and the one that will be asked in the next chapter is whether an integrated system can be developed from the various dispute resolution processes.

[89] Often repeated maxim regarding the concept of justice though originally attributed to Aristotle.
[90] Bessey J; Rough Justice is Enforceable: Construction News 17th August 2000

Chapter 5
Discussion and Analysis

Introduction

If the concept of an integrated complaints and compensation is to be developed then the following questions needs to be asked: What is expected of such a system? and What do the parties want from the system? These two questions are not synonymous. The first question places the requirements of the system into the larger picture of society. The second question is concerned with the wants and needs of the individuals.

The Needs of Society

The needs of society is an open ended question, but one that needs to be reduced in a work such as this to a more realistic focus. The first aspect of this question in the context of this dissertation, is what is the concept of society that is under discussion?

The nature of the NHS and its complaint system by definition restricts the concept of the society under discussion here to the NHS. The considerations are thus, what is expected from the NHS by the population at large as well as other interested parties, chiefly the Government and as a matter of course Parliament. These "political" considerations are of the utmost importance when the concept of an integrated complaints and compensation system is discussed, but one that for the most part is outside the terms of reference of the dissertation.

The development of any integrated complaints and compensation system would, however, have to fit into the developments of NHS systems whilst also permitting participants to have recourse to mainstream NHS systems if they are not completely satisfied with the integrated complaints and compensation system. The development of such a system would have to provide procedures that would be in accord with the Woolf Reforms and other developments. The rationale behind such developments is that they are there to provide just and equitable systems that meet the needs of society to the detriment of no party to the dispute. It is possible to develop dispute resolution systems that fall outside the concepts of mainstream NHS practices, but they need to come under the broad umbrella of what should be expected of such a system.

The Parties Needs

The needs of the parties are not actually paramount in setting up a system for dealing with complaints and compensation. This is a bold statement to make, but there is no standard format for deciding what the parties want from a system. Different parties to different disputes will want different things from the system. It is not possible to tailor a system to meet each and every dispute as it arises, but what can be achieved is to establish a system that meets the broad needs of the parties within the format expected of an NHS dispute resolution process. It is however, possible in broad terms to set out what should be the requirements of the dispute system for both dentist and patient.

The Patient

The patient needs a system that is easy to understand, swift, cost effective and one which is capable of dealing with the complaints made and the disputes that arise from NHS general dental treatment. Legal assistance should also be permitted in the processes. The system also needs to be able to give the patient a "result", in that the patient must be satisfied that the process has been fair and equitable in settling the dispute even if the outcome does not favour the patient.

The Dentist

The identified needs of the patients also apply to those of the dentist. The dentist requires a swift, cost effective system that is capable of dealing with patient complaints if they have gone past the local resolution stage. The dentist requires a system that is not going to impinge on his professional practice and his "good name" and equally important a system that will give "closure" of the dispute in a reasonable time period.

Having set out what both society and the individuals require from the dispute resolution system, regard has to be made to the type of dispute that can arise. As stated previously, not all disputes are similar though they can have characteristics in common. The first stage is to differentiate those disputes that can be settled "in-house" and are relatively minor from those that are more serious and cannot be successfully resolved by the parties themselves. It is not possible to state categorically that one type of dispute is minor and another is more serious and needs outside parties to resolve the matter in question. What can be discerned is that an integrated system will need to consist of a number of distinct stages. The stages of dispute resolution that are apparent are:

- local resolution of the dispute
- referral to local NHS authority if unable to be resolved at the local level
- direct access by patient to the gatekeeper if the patient believes that he cannot approach the dentist directly or is unhappy with the treatment and has already either engaged a lawyer and / or seen another dentist who recommends that the patient seek satisfaction from the original dentist
- NHS gatekeeper to decide whether it is a dispute that is suitable for resolution at the authority level by mediation or conciliation and if unable to be closed at mediation or conciliation to be settled by adjudication or arbitration
- if the gatekeeper is of the opinion that the dispute may be better settled by arbitration or adjudication to advise the claimant accordingly and to advise claimant of the options.

At this stage of the discussion the above is a big statement to make, but with regard to developing an integrated dispute and compensation system, the stages in the dispute resolution process need to be identified at this stage.

Local Resolution

The present system for resolving minor disputes at the local level has merits and as such can and does form an integral part of any dispute resolution process. As long as there are acceptable lines of communication between the parties or the dispute is one that can be resolved at the local level then local resolution has much to commend it. This format is both cost effective, reduces the stress on the parties and avoids adverse publicity for the dentist. General dental practice is a business as well as being a profession and so from the dental perspective a private dispute resolution process has much to commend it as the dispute can be resolved without adverse publicity. This is a consideration that can be applied to all the dispute resolution processes that have been discussed previously. Local resolution of the dispute is generally regarded as being an informal process.

Referral to Appropriate Health Authority if Unable to be Resolved at the Local Level

Referral to the appropriate health authority is an important stage in the dispute resolution process. If a dispute is not to escalate into a situation where the parties are more concerned with "scoring points" off each other rather than resolving the dispute a swift referral is of great importance. This removes the "heat" from the situation and allows a third party to look at the dispute in a dispassionate manner. It must be remembered that a dentist cannot contract his defence organisation to pay compensation to a patient. This is the prerogative of the defence organisations. An individual dentist can, however, pay compensation himself without utilising the resources of his defence society if he so wishes.[91]

At this stage of the process, it is possible for the appropriate health authority to look at the dispute and if need be contact the parties and see if the dispute can be settled. This could be described as an informal mediation or conciliation process. There are however, going to be disputes that most certainly do not lend themselves to this type of relatively informal resolution. These require a more formal resolution.

[91] From the very nature of the concept there cannot be any figures available as this would be a private process between patient and dentist.

There is little doubt that at present, litigation of dental malpractice disputes will not cease. There is little likelihood of the Government introducing new laws regarding clinical negligence. This does not mean that an integrated dental dispute resolution system cannot be introduced on a voluntary basis with the parties given the option of using the procedures that are available or pursuing litigation through the courts. It would however have to be made clear that if a patient opts for arbitration or adjudication then the litigation option is not feasible.

Direct Access by the Patient to the Gatekeeper

The gatekeeper could perform the function of being a filter for disputes. There are a number of reasons why direct access to the gatekeeper stage should bypass the local resolution process. These include the following:

- the relationship between patient and dentist has broken down to such a degree that there are no channels of communication between the two parties;
- the patient or the patient's representative considers the nature of the complaint to be so serious that local resolution is not possible;
- the patient has been seen by another dentist and advised to make a formal complaint.

The above are demonstrations of where the gatekeeper can expect complaints to come from. The role of the gatekeeper is thus paramount in the process as envisaged.

The gatekeeper would have the role currently done by the convenor under the present NHS complaints' procedure. The gatekeeper (or convenor) would be central to the efficacy of the system. However, it would have to be accepted that under any system such as the one proposed the gatekeeper could not refuse permission to allow the case to proceed. He would have to determine in his opinion what would be the best way of proceeding with the problem. If he refused to deal with the case, then the patient would have no option but to resort to litigation. This would negate the concept of an integrated system to deal with complaints and compensation.

Choice of Dispute Resolution Mechanism

The choice of the appropriate dispute resolution mechanism is the key to settling disputes. Some cases can be considered to be suitable for mediation or conciliation whilst others may be thought to be more appropriate for one of the other dispute resolution mechanism processes.

Mediation can be a very good way of settling disputes, but the difficulty with this type of process when applied to NHS general dental practice is that the defence organisations would need to be party to the mediation process. There is in theory no reason why this cannot occur. The defence organisations would be responsible for preparing the case for the defendant whilst the claimant could have his own legal representation to meet his needs. There is little doubt that mediation can achieve good results in the health care field, but a major consideration would have to be cost. There are other dispute resolution mechanisms that are cheaper. Adjudication is a prime example of one of these systems.

There is nothing to stop mediation being a first stage process that is backed up by arbitration or adjudication as the second stage resolution procedure. The choice of mediation can be dependent on whether the patient wants "his day in court". A balance does however, have to be drawn between upholding patient's rights and the cost effectiveness of the dispute resolution system. The patient may want to have "his day in court", but if he is not willing to pay for it then it is not a practical proposition.

"In particular mediation appears to add to the legal costs of defending cases. The costs of mediation form a much higher proportion of the total legal costs for the defence than for the claimant (whose legal costs are higher overall). If there are any savings to be had from introducing mediation they are most likely to accrue to claimants' legal costs through reducing the length of cases and costs involved in those few cases that would otherwise have reached the court. But for the defence, mediation would seem to cost more because it brings case preparation forward and involves the medical profession more directly. The increased participation of doctors may increase satisfaction

amongst claimants and facilitate greater accountability. A more proactive and speedy preparation of defences may also be desirable. However, both are achieved at a cost."[92]

Mediation can however, offer alternatives that are not available under other dispute resolution processes, but this would have to be determined by the gatekeeper at an early stage. It should however, be possible for the claimant to voice a preference as to what he wishes. As stated previously, if the dispute does not settle at mediation then it can go to arbitration or adjudication. The concept of the same person being the mediator and the arbitrator or adjudicator will not be discussed here except to say that there are advantages and disadvantages to the same person being both mediator and adjudicator / arbitrator with regard to the efficacy and fairness of dispute settlement.[93]

Arbitration or Adjudication

The choice of arbitration or adjudication is one that needs to be balanced against what the realistic value of the claim is. For the most part dental claims are not for large sums of money[94] and hence the costs involved must be proportionate to the claim. There is little doubt that adjudication can be a cheap, fast and efficient means of settling disputes. Whilst arbitration is relatively quick and an efficient means of settling disputes, it cannot be considered to be cheap when compared to adjudication. The anecdotal evidence from the Chartered Institute of Arbitrators suggests that six months is the norm for settling a dispute through arbitration, compared to twenty-eight days for adjudication. Arbitration whilst cheaper than litigation can and does incur legal costs as well as arbitrator's costs and the costs of the venue. These may be substantial.

Whilst adjudication may lack the subtleties of either arbitration or litigation it is cheaper and unless there are very good reasons to use another system would make an excellent method of settling dental disputes. Indeed, it is possible to place the argument that all disputes that cannot be resolved at the local level would be better adjudicated on than using one of the other dispute resolution mechanisms that are available.

If the NHS is to develop fast efficient dispute resolution mechanisms then adjudication should be at the forefront of any such development. Adjudication meets all the needs that are asked of it. Adjudication has proved its worth in the construction industry in cases both large and small. There is no reason why the same success cannot be achieved for the dental profession.

Adjudication could form the valuable second stage if local resolution has proved inconclusive; that is, instead of the present system of the convenor determining whether a panel should be convened and who should be part of the panel. The convenor could advise the patient of the adjudication option and suggest that this would be a suitable way to proceed with the dispute. Adjudication being a legal process, the defence societies would have to comply with the adjudicator's decision and meet the compensation, if any that would be awarded.

Thus, it is possible to develop an integrated dispute and compensation system for dentistry, but a number of initial requirements would have to be met before such a system could be introduced. These will be developed in the next chapter when the conclusions and recommendations are advanced.

[92] Mulcahy L et al, Mediating Medical Negligence Complaints: An Option for the Future? The Stationery Office, 1999. Page 99.

[93] See Glencot Development and Design Co. Ltd v Ben Barrett & Son (Contractors) Ltd., Technology and Construction Court 2 and 13 February 2001 and the reference to p 54 of the dissertation.

[94] The Judicial Studies Board Guidelines p 51 provide figures that form the basis of settlement. These range from loss of one front tooth £1,000 to £2000 to loss or damage to a back tooth, £525 to £900. Similarly the tariff for dental treatment as employed by the Dental Law practice reveals that the majority of treatment per tooth is less than a thousand pounds.

Chapter 6
Conclusions and Recommendations

Introduction

The original question posed was, "An Integrated Dispute Resolution System for NHS General Dental Practice: Is the Proposition Feasible?" The foregoing chapters clearly demonstrate that it is possible to develop an integrated complaints and compensation system for general dental practice.

The theory behind an integrated system is one that on close examination is sound. It is possible to develop a system that can respond to the needs and wants of both patients and dentists whilst avoiding the duplication and frustrations associated with the current systems.

As stated previously, it is recognised that patients and their representatives now use the NHS complaints procedures both to test their case and to obtain evidence before proceeding with legal action. It is also apparent that patients are dissatisfied with the complaints system in many instances. This is for a number of reasons, but a prime reason amongst those recognised is the failure of the system to permit the patient to take part in the process as well as the feeling that the system is for the benefit of the professionals rather than the patients.

There is little doubt that litigation is a major problem for health care providers both in terms of financial resources allocated to deal with problems as well as stress on the individuals who are concerned with litigation. The present system has the potential to stretch the process an inordinate amount of time whereas alternative methods of dispute resolution can reduce the time needed to settle a dispute. The commencement of action may be three years after the event and even with the Woolf Reforms there are delays in preparing cases that can stretch the time span out given the need to accommodate the various parties and their prior appointments.

It is also possible for both parties to the dispute to fail to recognise that they actually have a dispute when a complaint is made. It is possible to streamline the complaints and compensation system to achieve a fair and equitable result for all parties to the dispute.

Conclusions

The original objectives of the dissertation were to:

- To enable a critical analysis of the concept of an integrated dispute resolution system for NHS general dental practice to be developed.
- To determine whether one or more of the ADR techniques and processes could fulfil the concept of an integrated process for dental complaints and compensation.

The dissertation has in broad terms achieved the objectives set for it though the need for an integrated dispute resolution system for NHS general dental practice has yet to be agreed and implemented by those parties that have a legitimate interest in the process.

The major drawback is that the complaints and compensation systems for general dental practice as they have developed have no coherent structure. The complaints system for the most part cannot compensate patients and the compensation system cannot deal with patients' complaints.

An integrated dispute resolution system would be able to achieve the aims of being able to both compensate and deal with complaints. The difficulty at present is that the NHS does not have Crown Indemnity for NHS general dental practitioners. Patient compensation is paid by the defence organisations. Unless there is a fundamental change of direction with regard to NHS general dental practice and compensation with practitioners given Crown Indemnity, then the defence organisations would have to be brought into the proposed compensation system and their approval would be a prerequisite for settlement.

A voluntary system that would include an input from the defence organisations would be able to circumnavigate these problems. This would provide the advantages that an integrated system would have with regard to dispute settlement and the savings in costs, stress and time for the parties as well as preserving the relationship, if any, between the parties. A voluntary system would have to be the focus of such a system and to date there have been no published plans to establish such a system. Indeed, even in ***NHS Dentistry: Options for Change***[95] this concept not been developed. There are however, proposals by CEDR (Centre for Effective Dispute Resolution) in conjunction with the NHS Litigation Authority (NHSLA) and the Legal Services Commission (LSC) to explore the possibility of increasing the use of mediation in settling NHS disputes.[96] The concept being to use "expert" mediators to settle disputes.

If such a system is developed for dentistry, however, it would be a prerequisite to include the defence organisations' as they are the bodies who fund the compensation process.

The advantage of an integrated complaints and compensation system is that alternative methods of dispute resolution can be explored as part of the settlement procedures rather than as part of the litigation process.

For the most part, dental disputes are for relatively small amounts of recompense.[97] There are a number of alternative dispute resolution techniques that can be used as a basis for an NHS dispute resolution system. The processes that would lend themselves most successfully to dentistry given the financial constraints are mediation where the patient can play a major role in the process and adjudication where the benefits that have been achieved by the construction industry are obvious.

There is no one type of dispute and there is no one specific solution to the dispute, but there are methods that can be employed to settle disputes once they have arisen. The Civil Procedure Rules that were introduced following the Woolf Reforms establish the requirements of what a dispute resolution mechanism must achieve. The appropriate rules are so important that they have again been incorporated here as they were in the opening chapter. The Civil Procedure Rules 1998 state that:

The overriding objective

1.1 (1) These rules are a new procedural code with the overriding objective of enabling the court to deal with the cases justly.

(3) Dealing with a case justly includes, so far as is practicable-

(a) ensuring that the parties are on an equal footing;

(b) saving expense;

(c) dealing with the case in ways which are proportionate-

(v) to the amount of money involved;

(vi) to the importance of the case;

(vii) to the complexity of the issues; and

(viii) to the financial position of each party;

(d) ensuring that it is dealt with expeditiously and fairly; and

(e) allotting to it an appropriate share of the court's resources, while taking into account the need to allot resources to other cases.

The position is such that to meet these objectives greater use should be made of the alternative dispute resolution procedures. This is in accord with Lord Woolf and his judgments.[98]

[95] August 6th 2002 available at: www.doh.gov.uk/cdo/optionsforchange

[96] Allen T: Increasing the use of mediation in clinical negligence disputes: Legal Week 1st August 2002.

[97] See The Judicial Study Guidelines and from personal knowledge of settlement where the order for settlement is of the range £2,000 to £3,000 for a front tooth including provision for replacement of the same.

[98] See Cowl v Plymouth City Council: The Times 16th November 2001.

The appropriate conclusion to draw is that the alternative dispute resolution processes can be adapted to NHS general dental practice and if these processes are used in the future they can achieve the aims set for them by the Woolf reforms. The use of such systems by themselves would however, not constitute an integrated complaints and compensation system. It would not imply the holistic approach that would come from the adoption of an integrated system for dealing with patients' complaints and claims for compensation. Piecemeal adoption of ADR processes, without any other substantive changes, would merely add another procedural hurdle to the dispute resolution process. This would be to the benefit of no-one.

There is an undoubted need for a swift resolution dispute mechanism for NHS general dental service complaints and compensation. The question is what system or systems of alternative dispute resolution mechanisms best suit the purpose for general dental practice.

Recommendations

The recommendations are:

- to undertake a pilot study to determine the efficacy or otherwise of the proposals, namely an integrated complaint and compensation system with a gatekeeper to decide the most appropriate method of dispute settlement in accord with the principles of section 1 of the Civil Procedure Rules 1998;
- to ensure that the defence societies are prepared to willingly participate in a full scale version if the pilot study proves successful;
- to introduce by voluntary means the concept of an integrated complaints and compensation process;
- to train appropriate qualified personnel to be gatekeepers, mediators and adjudicators for the proposed integrated system; and
- to determine whether adjudication and mediation can be effectively used to settle dental disputes.

There is little doubt that there is need for reform of the present systems of dealing with patient complaints and awarding compensation. The difficulty is that there is no obvious mechanism of introducing reforms when the problems with the current mechanisms have not been identified as existing.

For reform of the systems to occur political pressure needs to be applied. To date there has been no pressure even though there is consensus the present systems are failing both practitioner and patient.

Given Lord Woolf's reforming crusade it can only be a matter of time before alternative dispute resolution mechanisms are proposed for dealing with NHS complaints. The next step is a fully integrated complaints and compensation mechanism. The concept as shown above is feasible if the political will is present.

Bibliography

Access to Justice (Woolf Reforms) 1997 HMSO

Allen T: Thoughts from the NHS Mediation Pilot: The Personal and Medical Injuries Law Letter 13 (9): 1997 p71-72

Brown H and Simanovitz A: Alternative Dispute Resolution and Mediation: Clinical Risk Management, British Medical Association Publishing Group 1995.

Civil Justice Council Annual Report September 1999

Daurer E and Marcus L: Adapting Mediation to link resolution of medical malpractice disputes with health care quality improvement: Law and Contemporary Problems 1997 60(1): 185-218.

Department of Health: Modernising NHS dentistry: Implementing the NHS Plan 2000 –Department of Health: www.doh.gov.uk/dental/strategy

Department of Health: Dentistry Modernisation Steering Group _ CDO Digest February 2002 :

- Quality and Regulation www.doh.gov.uk/cdo/qualityandregulation.htm
- Dental Education Continuum www.doh.gov.uk/cdo/education.htm
- Inequalities of Oral Healthcare www.doh.gov.uk/cdo/imequalities.htm
- Empowering Patients www.doh.gov.uk/cdo/empower.htm

Department of Health Shifting the Balance of Power July 2001 www.doh.gov.uk/shiftingthebalance

Dyer C: Lawyers slow to turn to mediation in medical rows: Health Service Journal March 1998: 35

Gill E A: The Law Of Arbitration 4th Ed. London: Sweet & Maxwell: 2001

House of Commons Health Select Committee: March 2001 – HMSO Publications Centre London

Journal of Personal Injury Litigation (1998) Report on the APIL/ FOIL Conference

Kennedy I and Grubb A; Medical Law 3rd Edition. London, Butterworths 2000.

Meschievitz C: Mediation and medical malpractice: Problems with definition and implementation: Law and Contemporary Problems 54(1) 1991 p 196-215

Montgomery J: Health Care Law 2nd Ed. OUP 2002.

Mulcahy, L: Mediating Medical Negligence Claims; An Option for the Future? The Stationery Office; 2000.

Medical Negligence and Clinical Risks: Trends and Developments 1998

National Assembly for Wales Audit Commission 6th April 2000

Pearson Commission (1978) CMND 7054

Rahn and Gillen; Philosophical Medical Ethics. Chichester: Wiley, 1986.

Rhodes-Kemp R; A Remedy for Medical Complaints. London: Sweet & Maxwell 1998.

Rogers WVH: Fundamental Principles of Law; The Law of Tort 2nd Ed 1994. London: Sweet & Maxwell.

Thomas G R & Spurin C H: Dentistry, A Suitable Case Study for ADR: 3rd International Congress on Dental Law and Ethics London 1-3 October 1998

Tweeddale K & Tweeddale A: A Practical Approach to Arbitration Law. London: Blackstone, 1999

Wilson Report, "Being Heard", DOH May 1994

Winfield & Jolowicz on Tort 14th Ed. London: Sweet & Maxwell, 1994.

Table of Cases

Bank of Montreal v Dominion Guarantee, etc., Co. Ltd. [1930] A.C. 659

Blyth v Birmingham Waterworks Co. (1856) Ex. 781

Bolam v Friern Hospital Management Committee [1957] 1 WLR 582

Clark v MacLennan [1983] 1 All E.R. 416

Cowl v Plymouth City Council, The Times 16th November 2001

Donoghue v Stevenson [1932] A.C. 562

Glencot Development and Design Co. Ltd v Ben Barrett & Son (Contractors) Ltd, Technology and Construction Court 2 and 13 February 2001.
Hunter v Hanley 1955 S.C. 200

Livingstone v Rawyards Coal Co. (1850) 5 App. Cas. 25
Medical Defence Union v Department of Trade [1979] 2 WLR 686

Polemis: Re [1921] 3 K.B. 560
Scott v St. Katherine's Docks Co. (1865) 3 H&C 596
Stubbings v Webb [1993] A.C. 498
Thompson v Smiths Shiprepairers (North Shields) Ltd. [1984] Q.B. 405
Wilsher v Essex Area Health Authority [1988] A.C. 1074

Table of Statutes

Access to Justice Act 1999

Arbitration Act 1996

Court and Legal Services Act 1990

Dentists Act 1984

Housing Grants Construction and Consolidation Act 1996

Law Reform (Contributory Negligence) Act 1945

Limitation Act 1980

National Health Service Act 1977

National Health Service and Community Care Act 1990

Table of Regulations

Conditional Fee Agreements Regulations 2000 (SI 2000/692)

National Health Service (Clinical Negligence Scheme) Regulations 1996

National Health Service (Clinical Negligence Scheme) Amendment Regulations 2002