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Medical Law Review, 2023, **31**, 226–246
https://doi.org/10.1093/medlaw/fwac037
Advance access publication October 3, 2022
Original article

OXFORD

Plaintiff aims in medical negligence disputes: limitations of an adversarial system

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ABSTRACT

The adversarial nature of medical negligence litigation is subject to frequent criticism by the media, patient advocates, and scholars. In Ireland, reform of the medical negligence dynamic is often mooted, particularly in response to the high financial costs of this type of litigation; however, change in this area has been slow. Recently, the Irish courts have dealt with a number of high-profile, medical negligence disputes, including claims for those affected by the CervicalCheck controversy, which involved the failure to disclose the results of a retrospective audit to women who had developed cervical cancer. These cases have again highlighted the shortcomings of an adversarial system. This article explores the limitations of the tort system in the context of plaintiff aims in medical negligence disputes, drawing on empirical findings (qualitative interviews with patient support groups and barristers), and the literature. In doing so, the article argues that while financial compensation is necessary and appropriate in cases of medical negligence, the current system fails to recognise the often emotional nature of these claims, and the wider needs and aims of litigants involved in these disputes.

KEYWORDS: Ireland, litigation, medical negligence plaintiff aims

> The stark reality is that it's about compensation and there's nothing else that can be done for the person except compensate them . . . . (Barrister 10)

I. INTRODUCTION

Despite the emergence of the field of therapeutic jurisprudence and recognition of the role the law plays 'as a social force that impacts people's emotional lives and psychological well-being',[1] the adversarial system of litigation remains the predominant method for resolving

[1] William Schma and others, 'Therapeutic Jurisprudence: Using the Law to Improve the Public's Health' (2005) 33 Journal of Law, Medicine and Ethics 59.

Received: January 31, 2022. **Revised:** July 26, 2022. **Accepted:** September 12, 2022

civil disputes in many common law countries, including Ireland.[2] Medical negligence[3] is a branch of professional negligence, governed by the law of tort. Although it is estimated that in Ireland, 98% of claims are resolved without a contested court hearing,[4] 'the characteristics of the tort litigation system are ever present, shaping virtually every aspect . . .'.[5] Monetary damages are paid as a means of restoring the injured plaintiff to the position they would have been in had the negligence never occurred. The traditional view, therefore, is that when an individual has been injured, they are likely to have incurred financial loss and a monetary remedy is appropriate.[6] Although the theoretical underpinnings of negligence law have been questioned,[7] this article does not focus on this aspect of the debate, but rather, what the system delivers to plaintiffs and whether their aims are met. Whilst it is accepted that those who have suffered an injury may require and be entitled to financial compensation, an emerging body of international research in this area has established that 'patients and relatives are hoping for more than compensation when they embark on a legal action',[8] and may have a number of goals which they hope to achieve from the process of litigation.[9]

Research providing insight into the aims, expectations, and experiences of plaintiffs with medical negligence litigation in Ireland is non-existent. Evaluation of the dynamic of medical negligence disputes to-date has primarily focused on the expediency and costs associated with this type of litigation.[10] Consequently, debates about reform in Ireland have centred on these issues. Whilst the financial and temporal efficiency of medical negligence litigation is important, the evaluation of these concerns fails to provide insight into what the adversarial system actually delivers to litigants, and whether or not their aims are met. As a result, we lack context for evaluating both the current system and exploring suitable options for effective future reform.

This research was designed to elucidate the aims of plaintiffs in medical negligence litigation through an exploration of the perceptions of patient support groups and barristers of their litigation aims, based on their exhaustive professional experience.[11] This article critically explores the dissonance between plaintiffs' aims compared to the capabilities of the adversarial system, through an analysis and discussion of the research findings, and relevant literature. Subsequently, the article shows Relis' concept of 'system conditioning' at work.[12] This theory, which sits within the broader dispute transformation literature, is said to occur where legal practitioners 'condition' litigants on the limitations of the civil justice system.[13] The article begins by briefly contextualising medical negligence litigation as it operates in Ireland.

[2] Meanings of adversarial can include an action(s) which is contentious or combative in nature, or as a framework in a legal system, ie an adversarial system rather than an inquisitorial system. This article considers plaintiff aims in the context of an adversarial legal system.

[3] It is recognised that a variety of terms are used to describe this area of the law including 'clinical negligence' and 'medical malpractice'. For the purposes of this article, the term 'medical negligence' is adopted given its predominant use in Ireland.

[4] National Treasury Management Agency (NTMA), *Annual Report and Accounts* (2017) 43.

[5] Edward A Dauer, 'A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error' (2003) 24(1) Journal of Legal Medicine 37.

[6] Edie Green, 'Can We Talk?' in BH Bornstein and others (eds), *Civil Juries and Civil Justice: Psychological and Legal Perspectives* (Springer 2008) 241.

[7] For a discussion see, Steve Hedley, 'Making Sense of Negligence' (2016) 36(3) Legal Studies 491.

[8] Tamara Relis, 'It's Not About the Money!: A Theory on Misconceptions of Plaintiffs' Litigation Aims' (2007) 68 University of Pittsburgh Law Review 701.

[9] Hazel Genn and Sarah Beinart, *Paths to Justice: What People Do and Think About Going to Law* (Hart Publishing 1999).

[10] Doireann O'Mahony, 'Another Day, Another Dollar—Periodic Payment Orders for Catastrophic Injury Claims in Ireland' (2013) 19(2) Medico-Legal Journal of Ireland 107; Asim Sheikh, 'Clinical Negligence Litigation: A Need for Change Today' (2014) 20(1) Medico-Legal Journal of Ireland 2.

[11] The term litigation as used in this article is taken to include disputes which reach resolution via trial or negotiated settlement.

[12] Tamara Relis, *Perceptions in Litigation and Mediation: Lawyers, Defendants, Plaintiffs, and Gendered Parties* (CUP 2011).

[13] ibid 52. Relis' research encompassed a qualitative study of lawyers and disputant's understandings in litigation and mediation in Canada. She notes that 'by relying on their knowledge and experience, lawyers condition clients on civil justice system realities and direct them to aim for what they view as legally realistic.'

It then provides an overview of the methodology employed. The article then presents and analyses the research findings, and argues that the acceptance of damages as the primary mode of compensation has resulted in a limited understanding of the wider aims of medical negligence litigants in Ireland. In doing so, the article contributes to a broader understanding of the shortcomings of the adversarial system as it operates across common law jurisdictions, which, it is argued, is necessary when considering potential measures for reform.

II. MEDICAL NEGLIGENCE LITIGATION IN IRELAND

Medical negligence litigation in Ireland is adversarial. Medical negligence claims are a category of personal injury claims and actions are lodged in the appropriate court, i.e. the Circuit Court or High Court, depending on the value of the claim.[14] Medical negligence is governed by the law of negligence: a plaintiff must demonstrate that a duty of care existed, there was a breach of that duty, and that the damage suffered was caused by that breach. A body of jurisprudence on this branch of the law has developed, and in broad terms, Irish medical negligence is governed by similar principles to those in other common law jurisdictions, such as England and Wales. Space prohibits a detailed discussion on the law governing these disputes; however, it is worth noting that, in Ireland, the birth injury case of *Dunne v National Maternity Hospital*,[15] provides the relevant principles to be applied to cases of medical negligence involving diagnosis and treatment,[16] whilst the case of *Geoghegan v Harris*[17] established that the 'reasonable patient test' is the approved standard to be applied in cases involving informed consent.[18] In accordance with the principle of *restitutio in integrum*, which aims to 'restore' the plaintiff to the position they would have been in had the negligence not occurred, damages are the primary method of redress for these cases.[19]

Criticisms of the contentious nature of these disputes, and the temporal, financial, and emotional burdens associated with these claims are frequently made.[20] There have been a number of calls for reform in this area. Despite recommendations from a High Court Working Group on Medical Negligence and Periodic Payments established in 2010 to review the process of medical negligence litigation in Ireland,[21] at present, there are no pre-action protocols (similar to those in operation in England and Wales) in operation, which would introduce measures designed to facilitate the early resolution of these disputes.[22] Similarly, no

[14] In Ireland, the Circuit Court is restricted to hearing claims which do not exceed €60 000 in personal injury actions. The High Court may hear personal injury actions of a value of €60 000 and above.

[15] *Dunne v National Maternity Hospital* [1989] IR 91. A similar approach is adopted in *Bolitho v City and Hackney Health Authority* [1996] 4 All ER 771.

[16] For a full discussion see, Ciaran Craven, 'Medical Negligence and the Dunne Principles: What Do the First and Second Principles Mean' (2005) 1 Quarterly Review of Tort Law 1; Ciaran Craven, 'Medical Negligence and the Dunne Principles: The Third and Later Principles' (2005) 1 Quarterly Review Tort Law 12.

[17] *Geoghegan v Harris* [2000] 3 IR 536.

[18] This test was affirmed by the Supreme Court in *Fitzpatrick v White* [2007] IESC 51. A similar approach exists in the UK, see *Montgomery v Lanarkshire Health Board* [2015] UKSC 11.

[19] In some instances, a formal apology may be offered or negotiated.

[20] Michael Boylan, *A Practical Guide to Medical Negligence Litigation* (Bloomsbury 2015); Mary-Elizabeth Tumelty, 'Exploring the Emotional Burdens and Impact of Medical Negligence Litigation on the Plaintiff and Medical Practitioner: Insights from Ireland' (2021) 41(4) Legal Studies 633.

[21] High Court Working Group Working Group on Medical Negligence Litigation and Periodic Payment Orders (2010); High Court Working Group on Medical Negligence and Periodic Payments, *Report on Pre-action Protocols Module 2* (2012).

[22] Pre-action protocols may include a requirement for early and full disclosure of information, for example. Legislation for pre-action protocols has been enacted but the relevant section is yet to be commenced. See, Legal Services (Regulation) Act 2015, pt 15 which will amend s 219 of the Civil Liability and Courts Act 2004. For a full discussion on pre-action protocols, see High Court Working Group of Medical Negligence and Periodic Payments, *Report on Pre-action Protocols Module 2* (2012).

formal case management process for these disputes exists.[23] As such, the pace of litigation remains largely the responsibility of the parties involved.

In 2019, an Expert Group established to review the law of torts and the management of medical negligence disputes published its recommendations.[24] The Expert Group considered suggestions such as the introduction of a medical injuries assessment board or 'MIAB', similar to the personal injuries assessment board or 'PIAB' which was established in Ireland in 2004.[25] However, this was ultimately rejected by the Expert Group on the basis of a number of factors, including: the inherent complexity in many of these claims which frequently require expert evidence means that a paper-based process would be unsuitable; the challenges in providing a book of quantum for such claims; and the difficulty in delineating assessment of damages from liability and causation.[26] Similarly, the introduction of a no-fault system of compensation was not recommended by the Expert Group due to the potential unconstitutionality 'as it would restrict a person's right of access to the Courts and a person's right to General Damages in vindication of his/her right to bodily integrity'.[27]

Alternative dispute resolution mechanisms, as a means of resolving these disputes in a non-contentious manner, have also been mooted in Ireland. In particular, mediation, a voluntary, facilitative, and confidential dispute resolution process is available to litigants in medical negligence claims in Ireland.[28] There is limited data on the number of these disputes which are resolved via mediation; however, anecdotal evidence suggests that uptake remains low.[29] As such, the adversarial system remains predominant.

III. METHODOLOGY

The aim of this research was to explore the aims of plaintiffs involved in medical negligence disputes. Qualitative methods (semi-structured interviews) were identified as the most suitable data gathering instrument, as a means of gaining insight into the phenomenon under investigation from the lived perspective of the interviewee. Ethics approval was obtained before conducting this research.

Purposive sampling was employed, in order to select participants who were known to have knowledge and experience of the topic under study.[30] The purposive sampling framework included (12) barristers (junior and senior counsel) chosen at random, from all those who self-identified as specialists in medical negligence litigation on the Bar Council of

[23] High Court Working Group on Medical Negligence and Periodic Payments, *Report on Case Management* (Module 3) (2013).

[24] Expert Group, 'Report to Review the Law of Torts and the Current Systems for the Management of Clinical Negligence Claims' (2019) 33 <https://www.gov.ie/en/publication/ffb23-expert-group-report-to-review-the-law-of-torts-and-the-current-systems-for-the-management-of-clinical-negligence-claims/> accessed 27 January 2022.

[25] The Personal Injuries Assessment Board or 'PIAB' was established in Ireland in 2004 as an independent statutory adjudicatory body that deals with personal injury (PI) claims (excluding medical negligence). Before any PI claim can be lodged in the Irish Courts, the claim must be submitted to PIAB. If the respondent declines a PIAB assessment, the claimant can issue proceedings. For a full discussion see, Christopher Hodges, 'Ireland. The Injuries Board' in Sonia Macleod and Christopher Hodges (eds), *Redress Schemes for Personal Injuries* (Hart Publishing 2017).

[26] Expert Group (n 24).

[27] ibid 7. The Expert Group noted that medical negligence claims involve two competing rights under the Irish Constitution: the right to bodily integrity (art 40.3.1) and the right of a clinician and/or healthcare provider to their good name (art 40.3.2). The jurisdiction of bodies other than the Courts to resolve such disputes is limited.

[28] The Mediation Act 2017 provides a framework for mediation in Ireland, s 2 of the 2017 Act defines mediation as a 'confidential, facilitative and voluntary process in which parties to a dispute, with the assistance of a mediator, attempt to reach a mutually acceptable agreement to resolve the dispute.' The Civil Liability and Courts Act 2004 also provides for mediation in personal injury cases, including medical negligence. s 15 of the 2004 Act provides that any party can request the court to direct the parties to attend a 'mediation conference'. Under s 16, if the court is satisfied that a party failed to comply with the direction under s 15, cost sanctions may apply.

[29] Arran Dowling-Hussey, 'Irish Medical Professional Negligence Claims and ADR: Still Under-used?' (2016) 22(2) Medico-Legal Journal of Ireland 88.

[30] Tom Clark and others, *Bryman's Social Research Methods* (6th edn, OUP 2021).

Ireland website,[31] and patient representative groups (2).[32] Barristers were identified as having a valuable and unique perspective on plaintiff motivations as they are typically at the coalface when the matter reaches settlement talks or trial, where decisions to make resolution are made. Interviews were conducted with patient representative groups rather than individual patient–plaintiffs due to the wealth of experience these groups have in supporting individuals through the process of litigation, and also, due to the potential for distress to individuals given the subject matter involved.[33] This is recognised as a limitation of this research, as it is accepted that those who have direct experience of the phenomenon are best placed to provide insights. However, patient support groups were identified as being able to satisfy the research objectives given their significant knowledge and experience of the phenomenon under investigation.

Confidentiality and anonymity were guaranteed to the barristers who participated in this research, who were assigned alpha-numeric codes. As such, no distinctions between gender, level of practice (junior or senior counsel), or 'plaintiff/defendant' counsel are drawn in the discussion and analysis. Whilst these would have been interesting modes of analysis, due to the small nature of the jurisdiction, participants would have been potentially identifiable. The patient support groups chose to be represented in this research, and as such concerns relating to anonymity did not arise. Interviews lasted between 60 and 90 min and were subsequently transcribed. NVivo was used to assist with data coding and analysis.

IV. PLAINTIFF LITIGATION AIMS

Supporting the findings of other studies in this area,[34] this research found that plaintiffs in medical negligence disputes typically have several litigation aims, which were coded during the data analysis phase. Participants also spoke in general terms about the typical outcome(s) of litigation in this context. As such, the findings will be discussed in this section of the article from both the perspective of patient–plaintiff aims, and also, the capabilities and constraints of litigation in ultimately delivering these. Drawing on the literature, two categorisations of aims were recognised.[35] The concepts of 'realistic' and 'extra-legal' are used to reflect the constraints of the adversarial system within the context of plaintiff aims in these disputes. In presenting the findings in this way, both the broad aims a plaintiff may have in pursuing litigation, and the constraints of litigation in delivering these aims, are captured. Aims which

[31] The sampling framework involved junior and senior counsel who self-identified as specialists in medical negligence on the Bar Council of Ireland website. Participants were then chosen at random using a generator tool and sent an introductory e-mail inviting them to participate. Random purposive sampling was used as there was no apparent reason to select one participant who met the criteria over another. See, Rosaline S Barbour, 'Checklists for Improving Rigour in Qualitative Research: A Case of the Tail Wagging the Dog?' (2001) 322(7294) British Medical Journal 1115.

[32] An unanticipated finding of this research was the small number of patient representative bodies that provide support to individuals who are pursuing medical negligence claims in Ireland. Two representative bodies participated in this research: WHO Patient's for Patient Safety (https://patientsforpatientsafety.ie) and Patient Focus (www.patientfocus.ie). Patient Focus is a patient advocacy group who provide a wide range of supports, including support to individuals involved in litigation. The group, which was founded in 1999, moved to Sage Advocacy in 2018. WHO's Patients for Patient Safety also provide supports to individuals who are pursuing medical negligence claims.

[33] Thomas Hadhistravropoulos and William E Smythe, 'Elements of Risk in Qualitative Research' (2001) 11(2) Ethics & Behavior 163, 167; Jane Lewis, 'Design Issues' in Jane Ritchie and others (eds), *Qualitative Research Practice: A Guide for Social Science Students and Researchers* (Sage 2013); Barbara DiCicco-Bloom and Benjamin Crabtree, 'The Qualitative Research Interview' (2006) 40(4) Medical Education 314.

[34] Charles Vincent, Angela Phillips and Magi Young, 'Why Do People Sue Doctors? A Study of Patients and Relatives Taking Legal Action' (1994) 343(8913) The Lancet 1609; Relis (n 8).

[35] Relis (n 8), Relis has also used the term 'extra-legal' in this context. The term 'legally realistic' has also been used in other disputing contexts in the literature, see for example, William LF Felstiner and Austin Sarat, 'Enactments of Power: Negotiating Reality and Responsibility in Lawyer-Client Interactions' (1991) 77 Cornell Law Review 1447; Alison Diduck, 'Solicitors and Legal Subjects' in Jo Bridgerman and Daniel Monk (eds), *Feminist Perspectives on Child Law* (Routledge Cavendish 2000).

were identified as being readily achieved through the adversarial system were categorised as 'realistic legal aims', and included: (i) financial compensation and (ii) a desire for a day in court. In contrast, aims which were identified as incapable of being provided directly through litigation, although they may be provided to some extent through negotiated settlement, were categorised as 'extra-legal aims', and included: (i) an explanation; (ii) an apology; and (iii) prevention of recurrence.

A. Realistic legal aims

To date, measures aimed at reforming medical negligence disputes have largely been procedurally focused. Whilst reforms targeted at reducing costs and delay are important, it is argued that when thinking about reform in this area, we must consider the broader aims of litigants and what the system currently delivers. This section of the paper considers aims which are typically within the remit of the civil justice system to provide and therefore, are categorised as 'realistic'. Though aims such as the provision of financial compensation and a 'day in court' may seem 'realistic', they are more nuanced than they might first appear. For instance, although financial compensation is the primary form of redress for medical negligence, even in cases where damages were viewed as important, plaintiffs often held a wider range of aims. In the context of having ones 'day in court', statistics suggest that many will not achieve this aim due to the prevalence of settlement.[36] Thus, whilst these aims are categorised as 'realistic', as the following discussion will illustrate, dissonance remains between the 'realistic' aims of plaintiffs and the litigation process.

1. Financial compensation

Medical negligence litigation, if successful, typically results in an award of damages to the injured party (plaintiff) and this monetary award is sometimes viewed as a motivating factor for plaintiffs in pursuing a claim.[37] Financial compensation as a remedy for medical negligence is particularly important, as often times, individuals will suffer financial loss as a result of the negligent act or harm suffered, and therefore, it is right that this loss is addressed. This has long been recognised by the law of negligence, and although ultimately a plaintiff may not achieve actual restoration, this form of compensation has been described by Vines as 'both symbolic and real'.[38] Thus, in addition to damages serving as recognition of the harm and/or loss suffered, on a practical level, monetary compensation is often a real and urgent need. Similarly, participants in this research spoke of the importance of compensation in cases of medical negligence. The need for financial compensation was recognised as particularly acute in circumstances of severe injury, with a large number of legal practitioners and both patient support groups noting the importance of financial compensation for those with cases involving a severe and life-long injury. As such, it is suggested that the severity of the injury suffered may influence the goals of litigants and in such cases, financial compensation is likely to be a significant aim.[39]

[36] NTMA (n 4).

[37] John Tingle, 'Compensation culture encourages patients to sue' (2004) 13(16) British Journal of Nursing 938, although note several commentators question the existence of a 'compensation culture', see eg, Kevin Williams, 'State of Fear: Britain's "Compensation Culture" Reviewed' (2005) 25(3) Legal Studies 449.

[38] Prue Vines, 'The Protected Apology as the Modern Response to the Moral Question at the Heart of Donoghue v Stevenson: What if Stevenson had Apologised?' (2013) 3 Judicial Review 483, 489.

[39] International research also suggests that severity of injury is likely to influence motivations. See eg, David A Hyman and Charles Silver, 'Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid' (2006) 59(4) Vanderbilt Law Review 1085, 1116.

> [where there are] ongoing issues around, you know, needing special accommodation, needing equipment, of course you would be interested in the money. (Patients for Patient Safety)

> The client comes [to a solicitor] because the client is now left with a baby who has to be paid for . . . and the client doesn't have the wherewithal to pay for [the child]. (Barrister 1)

One barrister contributed their sense of the importance of financial redress, noting that whilst weight may be placed on other aims the most immediate need is often financial, and as such, is the primary concern.

> [Take for instance,] a child with cerebral palsy, a quadriplegic spastic, and [the parents] haven't had the money to look after this individual, [they have] given up their careers . . . you have to be quite sensitive to the actual need at the time. So in those situations a settlement fulfils that need: finance . . . there is an obvious and absolute need existing at that moment in time and that is "how will this victim be looked after for the rest of their lives?" (Barrister 3)

Similar to previous studies,[40] this research also suggests that the severity of the plaintiffs' injury is likely to be a factor in influencing litigation aims. Financial compensation where an individual has suffered damage and/or loss is important. However, the findings of this research revealed that even in cases of severe and life-long injuries, plaintiffs often have other motivations for pursuing a claim. International research has also evidenced that the motives of medical negligence plaintiffs' in pursuing litigation are not purely financial. For example, Genn and Beinart's study on plaintiffs involved in medical negligence actions in England and Wales, revealed that less than half of surveyed participants viewed financial compensation as a 'very important' objective.[41] Similarly, Relis has reported that, in the context of her research into medical negligence plaintiffs' litigation objectives in Canada, only 35% of litigants identified financial compensation as an objective at all.[42] The findings of this research revealed a perception that only a small minority of plaintiffs' pursued litigation with the sole objective of obtaining financial compensation. Two barristers argued that even in cases where compensation is vital, the aims of litigants are typically not purely financial:

> That's not to say [plaintiffs] are only [pursuing litigation] for finance, they're not. (Barrister 3)

> Medical negligence is such an uphill battle for everyone, that I don't believe that people start it on financial motivations . . . I don't think people are financially motivated . . . (Barrister 9)

The reference to these disputes as being 'an uphill battle' reflects not only the obstacles the plaintiff must surmount in terms of establishing breach of duty and causation, but also the often contentious nature of medical negligence litigation which is typically protracted and may also have a damaging effect on those involved.[43] To this end, a significant number of

[40] ibid 1135. See also, Marlynn L May and Daniel B Stengel, 'Who Sues their Doctors? How Patients Handle Medical Grievances' (1990) 24(1) Law and Society Review 105.

[41] Genn and Beinart (n 9) 412.

[42] Relis (n 8) 721.

[43] Tumelty (n 20); Thomas Gutheil and others, 'Preventing "Critogenic" Harms: Minimizing Emotional Injury from Civil Litigation' (2000) 28(1) The Journal of Law and Psychiatry 5.

barristers and both patient support groups asserted that for the majority of plaintiffs' 'it's not about the money':

> There are some people for whom it is not in any way about the money, it's about proving that they were wrongly injured, that they were damaged and they can't really get on with their life until they have proven that. And if they're right in that belief that can be very healing. (Patient Focus)

> I think a lot of litigation is not just motivated by money from the plaintiff's point of view . . . Often the claims are very small, despite what you read in the newspaper. For example, the death of a child is [worth maximum] €50,000 . . . (Barrister 9)

These findings highlight the shortcomings with damages as a primary, and sometimes, sole remedy for medical negligence disputes. Although damages may at an economic level 'restore' someone to the position they would have been in prior to the negligent act and/or omission, given the frequently intimate nature of damage of this kind, it is argued that it is a limited form of redress. Damages, for example, cannot reverse a catastrophic injury or replace the loss of a life. The inadequacy of financial compensation to meet the needs of plaintiffs in medical negligence disputes has also been recognised by the judiciary. For example, in *Kearney v McQuillan* which involved the performance of a clinically unnecessary obstetric procedure (symphysiotomy) resulting in lifelong pain, the Supreme Court took the view that 'an award of damages is an imperfect mode of compensation' as 'no award of damages can undo the damage done to the plaintiff's life'.[44] In this light, notwithstanding the importance of damages, it should be recognised that plaintiffs aims, even in incidences where compensation is vital, may not be 'exclusively financial',[45] as a monetary award cannot address social and emotional concerns. In this research, one patient support group poignantly highlighted the limitations of an award of financial damages to address harm and/or loss suffered:

> Sure, the sum of money doesn't exist that would equate to [losing a child]. That sum of money just doesn't exist . . . (Patients for Patient Safety)

Despite the fact that, for the majority of plaintiffs, 'it's not about the money',[46] the adversarial system is designed to provide financial compensation. The limitations of the adversarial system in this respect are considered further later in this article.

2. Desire for a 'day in court'

The findings of this research indicate that another realistic legal aim for some plaintiffs is a 'day in court'. Whilst both in Ireland and internationally settlement rates remain high,[47] litigation is traditionally thought to culminate with a judicial determination via trial. As such, the goal of a plaintiff to have their 'day in court' may be considered, at least initially, as realistic. Although the experience of a trial may be a source of stress for some plaintiffs,[48] for others, the desire to have their story heard by 'an authoritative yet sympathetic listener' can

[44] *Kearney v McQuillan* [2012] IESC 43.
[45] Vincent, Phillips and Young (n 34); Hyman and Silver (n 39) 1085.
[46] Relis (n 8).
[47] For a broader discussion on settlement rates, see Theodore Eisenberg and Charlotte Lanvers, 'What is the Settlement Rate and Why Should We Care?' (2009) 6(1) Journal of Empirical Legal Studies 111; Linda Mulcahy and Wendy Teeder, 'Are Litigants, Trials and Precedents Vanishing After All?' (2022) 85(2) The Modern Law Review 326.
[48] Genn and Beinart (n 9).

be a significant aim of plaintiffs.[49] As many associate the courts with the concept of 'justice',[50] it is perhaps unsurprising that some litigants want to have 'their day in court'. Procedural justice theorists such as Lind and Tyler have argued that amongst the factors which are important to the perception of procedural justice is an opportunity to be heard and listened to in a dignified manner.[51] Thus, the adversarial system provides a mechanism by which litigants can have their argument and supporting expert evidence heard, and be provided with reasons for any judgment issued.[52] Such opportunities for participation may, as Tyler argues, lead litigants to feel as though they have been more fairly treated.[53] In the context of the present study, a significant minority of participants spoke about the desire of the plaintiff to 'have their day in court'.

> Sometimes people want to get a sympathetic hearing, you've often heard the phrase 'get their day in court'. (Barrister 10)

> Sometimes the plaintiff wants their day in court, they want to vent, they want to go to the newspapers because they're angry. (Barrister 2)

> I've once or twice been involved in cases where somebody has [wanted their day in court] and they've rigidly stuck to that view, despite offers being made, cases have had to go on. (Barrister 8)

Although the findings of this research suggest that only a minority of plaintiffs want their 'day in court', it is noteworthy that the literature indicates that even those who achieve this aim may ultimately remain unsatisfied.[54] This is primarily due to the formality of litigation, and the complex medico-legal issues inherent in these cases, which may be difficult for those without legal or medical expertise to understand.[55] Furthermore, even in the event the plaintiff is given an opportunity to present their story to the court, it is likely that their story will be reframed to focus on the legal merits of the case rather than what they perceive to be important.[56] Accordingly, those who achieve their aim of a 'day in court' may remain unsatisfied. In this context, Relis observes:

> in using the legal system for empowerment, plaintiffs are inevitably disempowered by the state that they are confined to present their requests . . . in the language of the legal system, affecting how their cases are understood.[57]

Thus, plaintiffs may 'lose significant pieces of their story' during the litigation process as their story is reshaped to focus on the legal merits,[58] and this focus on the legal merits of the case in isolation may mean 'the fundamental problems will neither be understood nor

[49] John M Conley and William M O'Barr, 'Hearing the Hidden Agenda: The Ethnographic Investigation of Procedure' (1988) 51(4) Law and Contemporary Problems 181.

[50] Sally E Merry and Susan S Silbey, 'What do Plaintiffs Want? Re-examining the Concept of Dispute' (1984) 9(2) The Justice System Journal 151.

[51] Allan E Lind and Tom R Tyler, *The Social Psychology of Procedural Justice* (Springer Science 1988).

[52] Lawrence B Solum, 'Procedural Justice' (2004) 78 Southern California Law Review 181, 280.

[53] Tom R Tyler, 'Conditions Leading to Value-expressive Effects in Judgments of Procedural Justice: A Test of Four Models' (1987) 52(2) Journal of Personality and Social Psychology 333.

[54] Daniel W Shuman, 'The Psychology of Compensation in Tort Law' (1994) 43 Kansas Law Review 39; Robert J MacCoun, 'Voice, Control, and Belonging: The Double-edged Sword of Procedural Fairness' (2005) 1 Annual Review of Law and Social Science 171.

[55] Allan E Lind and others, 'In the Eye of the Beholder. Tort Litigants' Evaluations of their Experiences in the Civil Justice System' (1990) 24(4) Law and Society Review 953.

[56] Relis (n 8).

[57] Relis (n 12) 54.

[58] Mary W Steward and Steven M Wood, 'Civil Plaintiffs, Trauma, and Stress in the Legal System' in MK Miller and BH Bornstein (eds), *Stress, Trauma, and Wellbeing in the Legal System* (OUP 2013) 129.

resolved'.[59] The aim of the plaintiff to have a 'day in court' may also change during the process of litigation, as whilst litigants may expect a court hearing, in reality, the majority of cases settle before trial. As previously noted, in Ireland it has been reported that 98% of medical negligence cases are resolved without a court hearing.[60] Noting this fact, two barristers commented:

> You also have plenty of clients who . . . will start off [wanting their day in court] and then when a very good offer is made and they're being told "you know the offer that's made is the full value of the case, and in front of some judges you might get less than that" . . . all of a sudden they'll decide they're quite happy not to go into court. (Barrister 8)

> I mean you do have people who want [their day in court], although, my experience is if the price is right, they'll settle. They're not going to go through the court case for justice if the price is right. If they are being told they are not going to get any more than is on offer from any judge, no matter what they feel about the doctor, I think they'll generally settle. (Barrister 9)

It is interesting that those who set out with the aim of being heard in court, may ultimately not achieve this goal. However, it is also possible that the aims of the plaintiff are transformed from engagement with legal practitioners, as Relis explains, 'by relying upon their knowledge, experience and views on trial results, lawyers . . . condition plaintiffs on civil justice system realities and direct clients on how to view their disputes.'[61] Given the high costs involved with taking a case to trial and the prevalence of settlement, the fact that many plaintiffs do not ultimately receive their 'day in court' is unsurprising. Legal practitioners are required to act in the best interest of their client and in such circumstances, where trial is unlikely to result in a different outcome, and in circumstances where potential cost sanctions may apply, settlement is likely to be, strategically and from a financial perspective, in the best interests of the client.[62] Arguably, however, it also has the effect of limiting the plaintiff's voice. The findings of this research and the international literature suggest therefore that the legal system affords plaintiffs an opportunity to speak only in certain limited circumstances. Accordingly, instead of having to conform to the formulaic conventions of the courtroom, it is suggested that a form of dispute resolution such as mediation, which reflects the needs of plaintiffs, wherein individuals have the opportunity to be 'freely recount their stories' would be preferable.[63] It is therefore disappointing that, to-date, mediation has had a low uptake in this context in Ireland.

B. 'Extra-legal' aims

The traditional form of redress for medical negligence, as previously noted, is financial compensation. However, Vines notes that while financial compensation is clearly important in these disputes, 'it is also clear that when someone does something at fault that it also creates a different need, a felt moral need . . . in the individual.'[64] International research has

[59] Vincent, Phillips, and Young (n 34) 1611.
[60] NTMA (n 4) 43.
[61] Relis (n 8) 734.
[62] See eg, *Calderbank v Calderbank* [1875] 3 All ER 333; and the Legal Services Regulation Act 2015, s 169 (1) 'a party who is entirely successful in civil proceedings is entitled to an award of costs against a party who is not successful in those proceedings unless the court orders otherwise, having regard to the particular nature and circumstance of the case, and the conduct of the proceedings by the parties'; and s 169 (1)(f) 'whether a party made an offer to settle the matter the subject of the proceedings, and if so, the date, terms and circumstances of that offer.'
[63] Tamara Relis, 'Civil Litigation from Litigants' Perspectives: What We Know and What We Don't Know About the Litigation Experience of Individual Litigants' (2002) 25 Studies in Law, Politics and Society 151, 182.
[64] Vines (n 38) 489.

evidenced that plaintiffs involved in medical negligence litigation often have a number of aims, such as an apology, which are not typically within the power of a judge to provide.[65] As Lord Woolf seminally observed in the context of his review of the civil justice system in England and Wales, 'some victims want an explanation or apology rather than financial compensation, but are forced into protracted litigation because there is no other way of resolving the issues.'[66] Vincent et al. in the context of their research in England and Wales, found that other aims were viewed as equally, if not more important than compensation by medical negligence plaintiffs.[67] Similarly, in this research, both barristers and patient support groups reported that plaintiffs have a number of extra-legal motivations when pursuing litigation. In this context, three extra-legal aims were identified: an explanation; an apology; and prevention of recurrence.

1. An explanation

A body of research has illustrated the importance placed on an explanation in the context of medical negligence disputes. For example, Vincent et al.'s study of plaintiff's motivations in bringing a medical negligence claim in England and Wales found that 90% of plaintiffs reported that their decision to bring a claim was motivated by a desire to receive an explanation.[68] In Chiu's study of factors driving medical malpractice claims in Taiwan, a full explanation was identified as a key motivating factor in pursuing litigation.[69] These, and other studies, suggest that patient–plaintiffs and/or their families wish to fully understand what happened in the management of their care. In an Irish context, Boylan has also discussed the importance placed on an explanation, explaining:

> [P]atients often feel a sense of betrayal by the medical profession, shattered by the enormity of what has happened to them and their inability to do anything about it. Primarily, they want to know what happened and why. They want someone to own up . . .[70]

Since many of these studies, the open disclosure movement has grown, and open disclosure policies have been implemented in countries across the world. Whilst definitions of open disclosure vary, most emphasise open, honest, and timely communication with a patient (and/or their family) following a patient safety incident. Notwithstanding a general acceptance that open disclosure is the right and ethical approach to the management of patient safety incidents,[71] enhanced professional and ethical guidance, and the development of open disclosure policies, a commonly cited barrier to disclosure is fear of litigation.[72] In attempts to address this, a number of countries have introduced legislative protection for open disclosure

[65] Vincent, Phillips, and Young (n 34) 1611; Relis (n 8); Genn and Beinart (n 9); Jean R Sternlight and Jennifer Robbennolt, 'Good Lawyers Should be Good Psychologists: Insights for Interviewing and Counseling Clients' (2008) 23(3) Ohio State Journal on Dispute Resolution 437; Yu-Chan Chiu, 'What Drives Patients to Sue Doctors? The Role of Cultural Factors in the Pursuit of Malpractice Claims in Taiwan' (2010) 71(4) Social Science & Medicine 702.

[66] Lord Woolf, *Access to Justice: Final Report to the Lord Chancellor on the Civil Justice System in England and Wales* (HMSO 1996) para 14.

[67] Vincent, Phillips, and Young (n 34).

[68] ibid.

[69] Chiu (n 65).

[70] Michael Boylan, 'When Doctors are Bad for Your Health' (2002) 96(9) The Law Society Gazette, 11, 12.

[71] Rae Lamb, 'Open Disclosure: The Only Approach to Medical Error' (2004) 13(1) BMJ Quality & Safety 3; Angus JF Finlay, Cameron L Stewart, and Malcolm Parker, 'Open Disclosure: Ethical, Professional and Legal Obligations, and the Way Forward for Regulation' (2013) 198(8) Medical Journal of Australia 445.

[72] David M Studdert, Donella Piper, and Rick Iedema, 'Legal Aspects of Open Disclosure II: Attitudes of Health Professionals—Findings from a National Survey' (2010) 193(6) Medical Journal of Australia 351; Jane Pillinger, 'Evaluation of the National Open Disclosure Pilot' (Health Service Executive 2016). Available at: https://www.lenus.ie/bitstream/handle/10147/617915/OpenDisclosure16.pdf?sequence=1&isAllowed=y.

which is designed to prevent such disclosures from being admissible in subsequent litigation and/or complaints processes, and from invalidating professional indemnity insurance.

This research was conducted prior to the commencement of the Civil Liability (Amendment) Act 2017, which introduced legislative protection for open disclosure for the first time in Ireland. However, it is argued that the findings are still relevant and instructive given the existence of a previous Health Service Executive (HSE) Open Disclosure Policy (most recently revised in 2019) and the professional ethical guidance provided by the Irish Medical Council.[73] Notwithstanding the existence of a policy on open disclosure and the professional guidance in the area, in this research, a large majority of barristers and both patient support groups reported that a significant aim of plaintiffs in medical negligence litigation is to receive an explanation as to how the negligent act and/or omission occurred. Participants noted that plaintiffs wished to understand what had happened to them, and why. Furthermore, a large majority of participants in this research reported that plaintiffs often feel they have to rely on the adversarial process of litigation to get answers:

> [Litigation is] definitely motivated by the desire to get answers . . . a lot of [plaintiffs] want to know why it happened . . . (Barrister 9)

> We talk about open disclosure as a policy, policies are all very fine but if the people on the ground aren't operating out of those policies, well then they count for naught. (Patients for Patient Safety)

> The main issue with plaintiffs is that nobody will answer their questions, if they have questions, no-one will answer them . . . (Barrister 1)

Despite the existence of an open disclosure policy and professional and ethical guidelines at the time this research was conducted, the findings suggest a gap between policy and practice. Plaintiffs and/or their families may gain further information about their case and the circumstances that led to their injury and/or loss through the process of litigation, through information exchanges which take place in an adversarial framework, for example, during discovery. However, given the duration that medical negligence claims can take to litigate, such an approach is arguably undesirable. Whilst open disclosure has been discussed and adopted in a number of reports and policy documents in Ireland,[74] it was only in September 2018, that the Civil Liability (Amendment) Act 2017 was commenced, which introduced legislative protection for disclosure of patient safety incidents and associated apologies.[75] The impetus for the introduction of the legislation was largely due to political pressure following the CervicalCheck controversy, which highlighted shortcomings with the policy and practice of open disclosure in Ireland.[76] Scally's scoping inquiry into the CervicalCheck screening programme was commissioned when it emerged that the results of a retrospective audit of a group of women who had developed cervical cancer were not disclosed.[77] Scally was particularly critical of the language used in the then HSE Open Disclosure Policy which he viewed as providing 'no compelling requirement on clinicians to disclose'.[78]

[73] Health Service Executive, 'Open Disclosure: National Guidelines' (2013) <https://www.hse.ie/eng/about/who/qid/socialcareapplframework/open-disclosure-national-policy.pdf> accessed 27 January 2022; Medical Council of Ireland, *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (8th edn, 2016) <http://Guide-to-Professional-Conduct-and-Ethics-8th-Edition-2016-.pdf> accessed 27 January 2022.

[74] ibid.

[75] s 10.

[76] Gabriel Scally, 'Scoping Inquiry into CervicalCheck Screening Programme' (2018) <http://scallyreview.ie/wp-content/uploads/2018/09/Scoping-Inquiry-into-CervicalCheck-Final-Report.pdf> accessed 27 January 2022.

[77] Scally (n 76).

[78] ibid.

Although the Civil Liability (Amendment) Act 2017 introduced legislative protection for open disclosure, it is important to note that under this legislation, disclosure is voluntary. Additionally, the protections of this legislation only apply where the disclosure process as prescribed by the ministerial regulations attached to the Act, are adhered to.[79] These have been criticised due to their prescriptive and formulaic nature, with some commentators arguing that 'the regulations . . . fail to consider the complexity of the day-to-day provision of healthcare,'[80] as for example, the protections under the Act do not apply to bedside disclosures. Notwithstanding the fact that the legislation has only been in place for a short period, there has been increased public and political support for mandating open disclosure, and the Patient Safety (Notifiable Patient Safety Incidents) Bill 2019 will introduce the mandatory disclosure of certain notifiable patient safety incidents. The Bill contains a list of 'notifiable incidents' which will be subject to mandatory disclosure, and failure to disclose may result in a penalty.[81] Similar to the position with voluntary disclosure under the 2017 Act, the Bill provides protection to disclosure(s) from civil litigation, professional complaints processes, and insurance indemnification.[82] Given the relatively recent legislative developments in this area, a sea change may occur. However, as open disclosure is important not only from an ethical and patient safety perspective, but also in light of the aims of plaintiffs, it is argued that significant resources should be deployed to encourage a culture change in health care organisations. Whilst it is anticipated that statutory protection may assist with cultural change, studies in this area indicate that wider resources and measures such as training, mentoring, and support services are required.[83]

2. An apology

The second 'extra-legal' aim of plaintiffs identified by all barristers and both patient support groups in this research was an apology. Although theoretically different concepts,[84] apologies and open disclosure are closely linked as some commentators assert that a key feature of disclosure is an apology.[85] The aim of the plaintiff to receive an apology is somewhat unsurprising, given the fact that medical negligence disputes typically focus on harm, injury, and/or loss. An apology can have important therapeutic effects, by recognising the harm suffered whilst providing a foundation to make amends.[86]

Although the majority of barristers noted that the adversarial environment, by its nature, tends not to be conducive to apologies, there was an understanding of the importance of same from the perspective of the plaintiff. In recognition of the weight placed on an apology by some plaintiffs, and reflecting the then legal position whereby apologies were not protected by legislation, a number of barristers in this research suggested that expressions of regret were becoming more frequent in medical negligence litigation:

[79] Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018.

[80] Deirdre Madden and Mary-Elizabeth Tumelty, 'Open Disclosure of Patient Safety Incidents: Legislative Developments in Ireland' (2019) 25(2) Medico-Legal Journal of Ireland 76, 79.

[81] s 49.

[82] s 10.

[83] Marlynn Wei, 'Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws' (2007) 39(4) Journal of Health Law 107; Oliver Quick, 'Patient Safety and the Problem and Potential of Law' (2012) 28(2) Professional Negligence 78; Rick Iedema and others, 'What Prevents Incident Disclosure, and What Can Be Done to Promote It?' (2011) 37(9) The Joint Commission Journal of Quality and Patient Safety 409.

[84] Anna C Mastroianni and others, 'The Flaws in State "Apology" and "Disclosure" Laws Dilute their Intended Impact on Malpractice Suits' (2010) 29(9) Health Affairs 1611.

[85] Lucian L Leape, 'Full Disclosure and Apology—An Idea Whose Time Has Come' (2006) 32(2) Physician Executive 16; Martin L Smith and Heidi P Forster, 'Morally Managing Medical Mistakes' (2000) 9(1) Cambridge Quarterly of Healthcare Ethics 38; Aaron Lazare, *On Apology* (OUP 2005).

[86] Schma and others (n 1) 59; Susan Daicoff, 'Apology, Forgiveness, Reconciliation & Therapeutic Jurisprudence' (2013) 13 Pepperdine Dispute Resolution Journal 131.

> The apology is becoming more of a policy type thing now . . . . (Barrister 7)

Similarly, one barrister when referring to a case where an apology was provided stated:

> We did give an expression of regret . . . We were regretting that the [plaintiff] had ended up injured, not because we had done anything wrong . . . . (Barrister 2)

The significant shortcomings of expressions of regret were, however, highlighted by the patient support groups, with one noting:

> They are not the words you want to hear . . . You need to apologise for the outcome . . . for the conduct, the actual medical treatment . . . the behaviours, sending people away feeling discounted, dismissed, diminished . . . . (Patients for Patient Safety)

Both the existing and previous HSE Open Disclosure Policy and the Medical Council of Ireland professional guidance provide direction on apologies following a patient safety incident.[87] Despite this, and the reported increased frequency of expressions of regret, one barrister succinctly noted that:

> the legal system is not something that is capable of extracting apologies. (Barrister 6)

Whilst legislative protection for apologies has now been introduced by virtue of section 10 of the Civil Liability (Amendment) Act 2017, as previously noted, medical practitioners can only avail of the protections offered by the Act when the prescribed process as detailed in the ministerial regulations is adhered to.[88] This limits more natural or spontaneous interactions. Thus, although the recent introduction of protective legislation for apologies in Ireland has been heralded as a positive step, in that it may encourage apologies, Taft has argued that legislative provisions can transform apologies into a formulaic gesture.[89] The features or components of an apology which are deemed to be important have been discussed elsewhere, namely the format of the apology; who the apology is given by; and the timing of the apology.[90]

Notwithstanding an increased recognition of the importance of an apology in medical negligence disputes, and the introduction of legislative protection for apologies, the adversarial system of litigation arguably remains unconducive to apologies. Thus, whilst an apology or expression of regret may emerge during the litigation process, it is not within the traditional powers of the court to order an apology, and where an apology is offered, oftentimes it is 'an agreed form of apology' (Barrister 8). Such exchanges are unlikely to holistically address the aims of the plaintiff or the harm suffered.

3. Prevention of recurrence

Thus far the extra-legal aims of an explanation and an apology have been discussed. Although litigation may not be the most suitable vehicle to pursue these aims, it can in certain limited circumstances, achieve them. First, although the plaintiff may not receive an

[87] Health Service Executive (n 73); Medical Council (n 73).
[88] Civil Liability (Open Disclosure) (Prescribed Statements) Regulations 2018.
[89] Lee Taft, 'Apology Subverted: The Commodification of Apology' (2000) 109(5) The Yale Law Journal 1135, 1148.
[90] Allan D Slocum, Alfred A Allan, and Maria M Allan, 'An Emerging Theory of Apology' (2011) 63(2) Australian Journal of Psychology 83; Mary-Elizabeth Tumelty, 'Medical Negligence Litigation and Apologies: An Empirical Examination' (2020) 27(4) European Journal of Health Law 386.

explanation from the medical practitioner or health care provider directly, they are likely to achieve an understanding of what occurred through the investigation of their medical records by a medico-legal expert instructed on their case and details which emerge. Secondly, whilst the current shortcomings with apologies in litigation have been noted, the plaintiff may still ultimately receive an apology, albeit a 'partial' apology, delivered by a legal representative as part of a negotiated settlement. However, the third extra-legal aim identified in this research, 'prevention of recurrence', is not something which the traditional system of litigation is often capable of achieving directly.[91] Prevention of recurrence essentially refers to the aim of the plaintiff to ensure that the negligent act or omission does not occur to anybody else. Although in theory, prevention of recurrence or reform of practice could form part of a negotiated settlement, the findings of this research indicate that prevention of recurrence is an unlikely aim to be addressed through litigation. In recognition of this one barrister noted:

> I don't think we have the right learning from cases either. I think that there should be a much more cohesive approach, you know? (Barrister 2)

A large majority of barristers and both patient support groups spoke to the importance placed on prevention of recurrence by plaintiffs in medical negligence disputes. Participants noted that the majority of plaintiffs wanted the health care provider and/or medical practitioner to learn from the event, and to review the issues which led to the substandard care. These findings support Boylan's contention, who has noted that in the Irish context, 'more than anything . . . [plaintiffs] want to know that it will never happen again to anyone else.'[92] Similarly, noting the importance placed on this extra-legal aim, one patient support group commented:

> . . . time and time again, when you see people exiting the High Court, it's almost like a mantra, from each and every one of them: 'all we wanted was that it wouldn't happen to anybody else'. Most people accept that what happened is now unchangeable, they are distressed because it happened, but it is very important to them that it wouldn't happen to somebody else. (Patients for Patient Safety)

Despite the importance placed on this aim, the majority of barristers noted that it was something that the traditional adversarial system was incapable of addressing. This was highlighted by one barrister who stated:

> Unfortunately, the person that says 'I want to go into court because I want to ensure that this never happens to anyone else' . . . I mean you have to explain all the judge is doing is determining what damages you're entitled to, judges don't have an ability to dictate how surgical practice follows over the next 20 years or anything like that and sometimes cases do highlight a particular problem, but in most cases they're simply about liability and about damages. (Barrister 8)

Furthermore, whilst it was recognised that healthcare providers can use medical negligence litigation to learn from and improve the healthcare system, it was noted that due to the

[91] In some limited circumstances, instigation of litigation may prompt a review of practice or protocols, or a review of practice may be part of a negotiated settlement agreement. However, system change is not a usual remedy in the adversarial process.

[92] Boylan (n 70) 12.

current structure of the adversarial system learning from these incidences is not the primary concern in litigation. In this regard, one barrister explained:

> Once litigation commences . . . the first issue that I look at is not 'let's have a look at the learning points here, let's look at the circle of learning'. That may come, but it will come much further down the line. (Barrister 3)

Prevention of recurrence is also an important aim from a patient safety perspective. Learning from negligent events is of critical importance if medical protocols, procedures, and policies are to be improved. Open disclosure is therefore also essential in the context of prevention of recurrence, as whilst open disclosure does not guarantee prevention of recurrence, it would encourage a commitment to finding out how and why the negligent outcome resulted. As Vincent succinctly argues, in order to learn from the event which led to the litigation, 'it is necessary to look back to the "error-producing conditions"' or 'the decisions made by management and others that may have had a bearing on the outcome'.[93] Given the increasing importance placed on patient safety, consideration should be given to how the adversarial system of litigation and the move towards achieving a 'just culture' can align. [94]

The findings of this research suggest that at present, the current dynamic of medical negligence litigation is failing to address the extra-legal aims of plaintiffs. Having explored the litigation aims of plaintiffs in medical negligence disputes, it is now necessary to further discuss the limitations of an adversarial system in achieving these goals. In doing so the article considers how plaintiff aims are shaped by legal professionals and the adversarial system. Medical negligence litigation operates within the framework of the civil justice system. As such, legal practitioners litigate disputes in accordance with the governing legal framework. However, in doing so, the aims of plaintiffs may be transformed or reconstructed into what is viewed as 'legally realistic'.[95]

V. LIMITATIONS OF AN ADVERSARIAL SYSTEM

It should be noted at the outset that this article does not argue that the adversarial system is without merit, and the important role of the courts in this context is acknowledged. The traditional model of civil justice, where cases are litigated before a judge who ensures fair rules of procedure and evidence are adopted, and each party is afforded the opportunity to argue their position, is well-respected. Additionally, the observations offered should not be seen as a criticism of barristers, who are skilled legal professionals and litigators. Rather, the article posits that although certain aspects of litigation may have 'therapeutic side effects',[96] such as achieving an appropriate award of damages and/or having one's case heard before an independent adjudicator, there are limitations to the adversarial framework. As such, it argues that when conceptualising medical negligence litigation in the broader context of civil justice reform, it is important to recognise the limitations of the current system in the context of what it actually delivers to those involved, so that any potential reform measures can effectively respond. This section of the article explores the limitations of an adversarial system in

[93] Charles Vincent, 'Understanding and Responding to Adverse Events' (2003) 348(11) The New England Journal of Medicine 1051.
[94] HSE, 'Patient Safety Strategy 2018-2024' (2019) <https://www.hse.ie/eng/about/who/nqpsd/patient-safety-strategy-2019-2024.pdf> accessed 26 July 2022.
[95] Relis (n 8).
[96] Schma and others (n 1) 59.

light of the discussion on plaintiff aims above and the research findings. In doing so, barrister's own perceptions of the role of litigation in achieving plaintiff aims and its limitations emerge. What comes across most powerfully is the need for a broader form of resolution, and as Woolf noted in the context of the civil justice reforms in England and Wales over two decades ago, the need for the law to be 'responsive to the needs of litigants'.[97]

Despite a keen awareness of the broader aims of medical negligence plaintiffs, barristers spoke of the capabilities and constraints of the adversarial framework. The recognition of the limitations of what litigation can ultimately achieve often results in the formulation of medical negligence disputes in terms where financial redress is the primary (and sometimes sole) focus. Accordingly, what is significant to the plaintiff (and conversely, what is important to the defendant) is not necessarily going to be the focus of the claim. In this way, disputes can be said to be 'transformed', a phenomenon largely recognised in the civil justice and dispute resolution literature.[98] Dispute transformation occurs where despite the stated aims of the plaintiff, legal practitioners formulate the dispute in line with the procedural norms of litigation and the substantive law.[99] According to Riskin, dispute transformation is as a result of legal practitioners' 'standard philosophical map'.[100] He argues that first, legal practitioners believe disputants are adversaries; and secondly, that disputes are resolved by the application of the law to the facts.[101] As a result, legal practitioners 'put people and events into categories that are legally meaningful'.[102] In many ways, this is what the adversarial system requires. The law of negligence is designed to provide redress for a successful claimant in the form of monetary compensation. However, and as has been discussed previously, the principle of *restitutio in integrum* in practice, particularly in a medical negligence context, can be difficult to achieve. Whilst an alternative dispute resolution process such as mediation may provide an appropriate forum for the resolution of disputes in a way that has the capacity to meet the extra-legal aims of the plaintiff, litigation is less malleable.[103] Thus, it is perhaps somewhat unsurprising that despite awareness of the wide range of aims held by plaintiffs in these cases, barristers were also cognisant of the limitations of litigation. Arguably, in litigated cases both the substantive law and the procedural rules require this. In the present research, barristers spoke of the need to manage client expectations, recognising the limitations of litigation in the broader context of plaintiff aims:

> I think once the [client] understands the limitations of the exercise they are easier to manage, they understand what's capable of being achieved, they understand what's not capable of being achieved, and it just makes life much easier. (Barrister 6)

Whilst legal practitioners work from client instruction,[104] the legal practitioner is usually viewed as the expert, as the plaintiff will typically be inexperienced with the intricacies of the

[97] Woolf (n 66) para 10.

[98] See eg, William LF Felstiner, Richard L Abel, and Austin Sarat, 'The Emergence and Transformation of Disputes: Naming, Blaming, Claiming . . .' (1980) 15(3) Law and Society Review 631; Lynn Mather, 'Social Construction and Transformation of Disputes' in Neil J Smelser and Paul B Baltes (eds), *International Encyclopedia of the Social and Behavioral Sciences* (Elsevier 2001); Carrie Menkel-Meadow, 'The Transformation of Disputes by Lawyers: What the Dispute Paradigm Does and Does Not Tell Us' (1985) 4 Journal of Dispute Resolution 25.

[99] Relis (n 8) 705.

[100] Leonard L Riskin, 'Mediation and Lawyers' (1982) 43 Ohio State Law Journal 29, 44.

[101] ibid.

[102] ibid 45.

[103] However, given that a high number of these cases are resolved via settlement negotiations it is also noted that there is scope for legal practitioners to negotiate a wider range of outcomes.

[104] Law Society of Ireland, *A Guide to Good Professional Conduct for Solicitors* (3rd edn, Law Society of Ireland 2013); Bar Council of Ireland, 'Code of Conduct for the Bar of Ireland' (2021).

law and litigation. Therefore, the plaintiff's case is formulated by and construed through their legal advisors, and is generally focused on the substantive merits and/or demerits of the claim and the procedural running of the case. However, there are often 'sharp contrasts' between the goals of plaintiffs and the capabilities of litigation.[105] Evidence of dispute transformation emerged in the present research, with the findings of this indicating that although there are implicit understandings of the wider aims of the plaintiff in litigation, as illustrated throughout this article, the majority of legal practitioners 'transform' the aims of the plaintiff to focus on damages, which are viewed as the principal, and sometimes, sole remedy which litigation can provide.

> . . . in most cases they're simply about liability and about damages . . . Sorting out money to actually pay for people's care and needs . . . for the rest of their lives is the main thing that's important. (Barrister 8)

Another barrister argued that as financial compensation is the most obvious and immediate need in medical negligence disputes, particularly in the context of catastrophic injuries, tending to other needs is a secondary concern.

> sitting around the table to talk about your emotions is not seen as necessary, because the absolute essential need to be fulfilled here is an award of damages to enable the looking after of [the injured person]. (Barrister 3)

Interestingly, even legal practitioners who displayed an explicit awareness of the extra-legal needs of plaintiffs', still translated these aims into narrower objectives, as extra-legal aims are 'not the object of the exercise' (Barrister 6). Similarly, whilst Barrister 8 recognised that an apology is 'high on their list of priorities', they concluded that 'most cases are about sorting out what damages somebody is entitled to'. Felstiner and Sarat have commented on this, noting that although legal practitioners may be initially sympathetic, they are likely to persuade clients to view their case in 'legally realistic' terms.[106] However, in doing so, legal practitioners reinforce the concept that litigation is solely about money, and encourage plaintiffs to accept the 'realities' of litigation. This approach frames the dispute process and means that the extra-legal aims of the plaintiff and alternative dispute resolution processes such as mediation, which may be able to accommodate those aims, may not be readily embraced by legal practitioners. Relis has identified this phenomenon as 'system conditioning', which may occur as part of dispute transformation, where:

> By relying upon their knowledge, experience and views on trial results, lawyers then condition plaintiffs on civil justice system realities and direct clients on how to view their disputes. In so doing, they attempt to persuade clients to aim for what they view as legally realistic as opposed to plaintiff's initial desires.[107]

In an Irish context the concept of 'system conditioning' was evidenced by a large majority of legal practitioners, wherein notwithstanding their understanding of plaintiff motivations and goals, they emphasised the limitations of the litigation system.

[105] Relis (n 63) 157.
[106] William L Felstiner and Austin Sarat, 'Enactments of Power: Negotiating Reality and Responsibility in Lawyer-Client Interactions' (1991) 77 Cornell Law Review 1447.
[107] Relis (n 8) 734.

> The stark reality is that it's about compensation and there's nothing else that can be done for the person except compensate them, even though they may be emotionally traumatised and not have got over it. (Barrister 10)
>
> I like to see clients very early on in the process so that I can tell them precisely what's going on. I can give them some kind of a time estimate, I can explain to them the limitations of what I can and cannot do . . . I simply tell them at a very early stage that [extra-legal aims] is not what the litigation process is about . . . it's about damages and damages is a fancy word for compensation, and it is artificial and it doesn't make any sense. How can you compensate somebody for a loss - for a loss of a limb, a loss of an eye or a loss of a husband or loss of a brother? I mean it's all quite odd, but what we can offer them is really very, very limited . . . all I'll be able to do is to get them damages if we're successful. (Barrister 6)

Due to the formulaic and adversarial nature of the litigation process, legal practitioners typically focus solely on the legal merits of a case; however, as plaintiffs are unlikely to view their experience as a series of 'legal events', litigation and its remedies may bring little satisfaction if it fails to deal with the issues they consider to be important.[108] Menkel-Meadow has argued that whilst it may be easiest to formulate an agreement based solely on damages, it is likely to result in an unsatisfactory result for the plaintiff who frequently has extra-legal goals or objectives, as evidenced throughout this article.[109] Similarly, Bumiller argues, in transforming the dispute into legal formulae, legal practitioners are 'transforming lives . . . into cases' and this 'takes away from their stories the meaning behind their circumstances and unique identities.'[110] It is argued that by converting the extra-legal litigation aims of the plaintiff to focus on a 'legally realistic' outcome, i.e. a financial remedy, legal practitioners accept the limitations of litigation too readily, miss opportunities for more creative settlements, and contribute to the adversarial environment of medical negligence disputes.[111] As a result, plaintiffs who inevitably must accept the limitations of the litigation system are likely to leave the process feeling disempowered and unsatisfied with the outcome even in instances where they 'win' and have been awarded damages.[112]

A. Reform efforts

It is outside the scope of this article to explore reform measures in detail; however, as previously noted, over the past number of decades, several measures aimed at reform of the current dynamic of medical negligence litigation in Ireland have been proposed, and some have been introduced.[113] Reforms targeted at ameliorating the costs associated with these cases, as well as the duration such claims can take to reach resolution, have been proposed, although the substantive elements of the relevant legislation await commencement.[114] Whilst procedurally focused reforms, largely targeted at reducing costs and the duration of these claims, are to be welcomed, such measures do not fully address the aims of plaintiffs in these disputes. Other measures, which could be said to facilitate 'extra-legal' aims such as an explanation and apology, have been introduced. Concerns such as the desire to prevent recurrence may be addressed through, for example, a mediation process. The Mediation Act 2017, which

[108] Hazel Genn, *Hard Bargaining: Out of Court Settlement in Personal Injury Actions* (Clarendon Press 1987).
[109] Carrie Menkel-Meadow, 'Toward Another View of Legal Negotiation: The Structure of Problem Solving' (1983) 31 UCLA Law Review 754.
[110] Kristin Bumiller, *The Civil Rights Society: The Social Construction of Victims* (JHU Press 1992) 69.
[111] Carrie Menkel-Meadow, 'When Winning Isn't Everything: The Lawyer as Problem Solver' (2000) 28 Hofstra Law Review 905, 906.
[112] Relis (n 8).
[113] See generally, Section II.
[114] Legal Services (Regulation) Act 2015 (n 22).

was commenced in January 2018, was introduced with the aim of 'integrating mediation' into the civil justice system. The 2017 Act applies also to medical negligence cases. Thus, it could be said that given the relatively recent introduction of these measures, time must be afforded to see their impact on the dynamic of these disputes and in delivering the aims of plaintiffs. However, it is argued that broader consideration must also be afforded to the framework within which these disputes operate and until there is a more fundamental engagement with adversarialism, the impact of reform measures will remain limited. For instance, while at the time that this research was conducted the Civil Liability (Amendment) Act 2017 and the Mediation Act 2017 were not in force, both the Irish HSE and the Medical Council of Ireland had policies relating to open disclosure in place.[115] This notwithstanding, the findings of this research indicate a gap between theory and practice.

> We talk about open disclosure as a policy, policies are all very fine but if the people on the ground aren't operating out of those policies, well then they count for naught. (Patients for Patient Safety)

Conclusions about the impact of the adversarial system on the implementation of open disclosure from this research cannot be drawn. However, it is suggested that further research into the alignment of broader patient safety goals with the current operationalisation of these disputes would be valuable.

Similarly, whilst the Mediation Act 2017 had not commenced at the time this research was undertaken, mediation has long existed as an option to Irish litigants, and section 15 of the Civil Liability and Courts Act 2004 provides that on application of one party the court may direct parties to consider mediation, with the possibility for cost sanctions where one party 'unreasonably refuses' to engage in mediation. Whilst this provision is dependent on one party applying to the court, mediation was also feasible outside the framework of the 2004 Act. However, the findings of this research indicate that the dominance of the adversarial system in this type of litigation has influenced the success of such measures, with one barrister commenting:

> I mean we're an adversarial system. Regardless of mediation it's still going to be an adversarial system when they come out of that room. (Barrister 4)

It is argued therefore, that if traditional conceptions of litigation are to evolve, a more fundamental engagement with adversarialism is required when thinking about reform in this area.

VI. CONCLUSION

The findings of this research contribute to our understanding of the aims and expectations of plaintiffs involved in medical negligence litigation in Ireland, and suggests that a large majority of medical negligence plaintiffs commence litigation in pursuit of aims which are currently beyond the traditional remit of litigation. This research also highlights the current dissonance between plaintiff aims, legal practitioners' formulation of disputes, and the capabilities of litigation. In seeking justice by means of litigation, plaintiffs are forced to formulate their dispute in terms of legal rights, as opposed to interests. This can be problematic as Engle Merry notes, litigation and formal legal language can give effect to some compelling arguments, but

[115] Health Service Executive (n 73); Medical Council of Ireland (n 73) para 67.1.

can silence others.[116] Thus, medical negligence litigants may remain dissatisfied, even if it results in an award of damages.

As reform debates in Ireland to-date have focused primarily on financial concerns and the expediency of this type of litigation, it is argued that many fundamental issues within the medical negligence dynamic are at present, going unaddressed. Policy makers need to understand the broader issues within medical negligence disputes in its current operationalisation. Therefore, an understanding of the aims of litigants in this context is essential, not only in order to evaluate the current medical negligence dynamic, but also when considering reform in this area. The question as to how we better align plaintiff aims and redress remains. However, it is suggested that the empirical findings and analysis offered here provides some more generally applicable lessons on the need for a more holistic approach to civil justice reform in the sphere of medical negligence disputes. First, although procedurally focused reform discussions and proposals are helpful, unless there is a more fundamental engagement with adversarialism, it is argued that the impact of such reforms will remain limited. Secondly, there is a need to consider how the adversarial process impacts other policy and reform measures in this area.

ETHICS

I confirm that ethics approval was received from the Research Ethics Committee, Faculty of Arts, Humanities, and Social Sciences, University of Limerick, in respect of this research.

FUNDING

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of interest statement. None declared.

ACKNOWLEDGEMENTS

This article has benefitted from discussions with Prof Mary Donnelly, School of Law, University College Cork, whom I would like to thank. Sincere thanks also to the two anonymous referees for their comments which helped me refine my argument.

[116] Sally E Merry, *Getting Justice and Getting Even: Legal Consciousness Among Working-class Americans* (University of Chicago Press 1990) 9.