University of Reading

Economic and Social Research Council

Mediation of Medical Treatment Disputes: A Therapeutic Justice Model

End of Project Report




Jaime Lindsey, Gillian Francis, Margaret Doyle

Acknowledgements

We are grateful to all participants who took part in this research and shared their experiences with us. We also thank our research advisory board, who provided guidance and support from the start of the research in April 2022 until the end in September 2025. The research advisory group included: Jo Bridgeman, Victoria Butler-Cole KC, Mary Donnelly, Joan Goulbourn, Barry Lyons, Kate Mahoney, and Sophy Miles. We are also grateful to our project consultants: Margaret Doyle and Sarah Barclay. As well as previous research assistants who worked on the project: Katarzyna Wazynska-Finck and James Browning.

Finally, thank you to the ESRC for generously funding this research through a New Investigator Grant and to the University of Essex and University of Reading for supporting the hosting of the research.

Contents

Summary

The aim of this research was to understand whether and, if so, the extent to which mediation can and should be viewed as a form of 'Therapeutic Justice' in medical treatment disputes. These are disagreements that arise between patients, healthcare professionals (HCPs), family members and others regarding the provision of health and care to the patient. Usually these will be cases where there is some disagreement about what is, or was in the case of a complaint, in the patient's best interests, although the dispute will often also engage a much wider range of issues.

For this research we conducted an analysis of reported case law, theoretical analysis of 'Therapeutic Justice' and best interests, and empirical data collection. The research found:

- that mediation could be a therapeutic process where it was designed to be flexible, participatory, less adversarial, voluntary, collaborative and enhance participant communication and understanding and we suggest that mediation's use in health and care disputes should ensure these features are protected and promoted through mediation design;

- that some participants were closed to mediation and resolution, cynical about mediation and mediators (sometimes family members who distrusted the mediator's independence of the HCPs), and felt process coercion to participate (usually paediatric HCPs who saw it as a requirement from the court), attitudes which could be seen as anti-therapeutic;

- that mediation can cause delay in resolution, but that there was no evidence that mediation led to agreements that undermined the patient's best interests;

- that religious views of the parties were not a barrier to mediation and that, rather, religious support in mediation can be beneficial for parties.

1. Introduction

Mediation is a form of non-judicial dispute resolution which is increasingly being used (or at least recommended) to help resolve a range of medical disputes that might otherwise be subject to litigation. It generally involves 'a mediator acting as an independent third party to work with the individuals in dispute to help them to come to a mutually agreed resolution'.[1] Mediation is a party-led process in that the participants do not have outcomes imposed on them but instead aim to work together to reach agreed resolutions to take forward. The mediator is independent of the parties and does not determine the outcome but manages the process.[2] In this research we considered how the mediator can contribute to an environment which produces therapeutic or anti-therapeutic effects for participants.

Medical treatment disputes are cases in which there is a disagreement regarding a person's health and care provision, usually between the HCPs and the patient and/or patient's family members. These can often be tense and emotionally charged disputes about withdrawal of treatment at the end-of-life[3] but may also concern disputes about less serious medical interventions[4] or disputes about ongoing care issues for a patient in community or hospital settings.[5] Given the broad range of disputes that this research explored, we describe the focus of the research as 'health and care disputes' throughout this report and resulting publications.

One of the major challenges in researching mediation in health and care disputes has been the confidential nature of mediation. This means that it can be difficult to access

[1] Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck 'Navigating Conflict: The Role of Mediation in Healthcare Disputes' (2023) 19 Clinical Ethics 26, 29.
[2] For further discussion see Carrie Menkel-Meadow, 'Mediation, Arbitration, and Alternative Dispute Resolution' in *International Encyclopaedia of the Social and Behavioural Sciences* (UC Irvine School of Law Research Paper No. 2015-59, Elsevier Ltd, 2015); Carrie Menkel-Meadow (ed.), *Mediation: Theory, Policy and Practice* (Abingdon: Routledge, 2018).
[3] *Barts Health NHS Trust v Hollie Dance and others* [2022] EWHC 1435 (Fam); *Tafida Raqeeb v Barts NHS Foundation Trust* [2019] EWHC 2531 (Admin); *Alder Hey Children's NHS Foundation Trust v Thomas Evans and others* [2018] EWHC 308 (Fam); *Great Ormond Street Hospital v Constance Yates and others* [2017] EWHC 1909 (Fam).
[4] *A Local Authority v M* [2014] EWCOP 33; *North Yorkshire Clinical Commissioning Group v E* [2022] EWCOP 15.
[5] See for example *Imperial College Healthcare NHS Trust v MB* [2019] EWCOP 29; *Westminster City Council v Sykes* [2014] EWCOP B9; *A NHS Trust v G & Others* [2022] EWCOP 25.

mediation or its participants to gain a reliable understanding of mediation's potential. This research seeks to address this gap through empirical data collected directly from participants with experience of mediation and health and care disputes.

This project draws on existing research from the mediation and Therapeutic Justice[6] fields to consider whether, and to what extent, mediation might be a therapeutic form of dispute resolution. While we acknowledge that there are key differences in the legal frameworks that apply to cases concerning adults and children, we have analysed the cases together in this research because the areas have significant commonalities, which are worthy of synchronous consideration to advance understanding of the use of mediation. In most instances, the adult or child at the centre of proceedings is unwell and is unable to directly participate in them. However, the research does consider the ways in which adults and children at the centre of health and care disputes can be facilitated to participate. The disputes we explored mostly centred on a disagreement between the family members of the adult or child and the HCPs. In most of the instances discussed, the legal issue at the centre of the dispute was whether a particular healthcare

[6] Alexandra Crampton, 'Escape from the Laboratory: Ethnographic Methods in the Study of Elder and Family Court Mediation' (2016) 32 Negotiation Journal 191; Debbie De Girolamo, 'The Mediation Process: Challenges to Neutrality and the Delivery of Procedural Justice' (2019) 39 Oxford Journal of Legal Studies 834; Rachael Blakey, 'Cracking the Code: The Role of Mediators and Flexibility Post-LASPO' (2020) 32 Child and Family Law Quarterly 53, 55; Gary Paquin and Linda Harvey 'Therapeutic Jurisprudence, Transformative Mediation and Narrative Mediation: A Natural Connection' (2001) 3 Florida Coastal Law Journal 167; Omer Shapira 'Joining Forces in Search for Answers: The Use of Therapeutic Jurisprudence in the Realm of Mediation Ethics' (2008) 8(2) Pepperdine Dispute Resolution Law Journal; Varda Bondy and Linda Mulcahy with Margaret Doyle and Val Reid, 'Mediation and Judicial Review: An Empirical Research Study' (Public Law Project, 2009) <https://nuffieldfoundation.org/sites/default/files/files/MediationandJudicialReview.pdf>accessed 2 July 2025, pp 33–35; and in Varda Bondy and Margaret Doyle, 'Mediation in Judicial Review: A Practical Handbook for Lawyers' (Public Law Project, 2011) <https://publiclawproject.org.uk/content/uploads/data/resources/122/PLP_2011_MJR_handbook.pdf> accessed 2 July 2025, pp 45–47; David B Wexler and Bruce J Winick, 'Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research Essay' (1990) 45 University of Miami Law Review 979; BJ Winick 'The Right to Refuse Mental Health Treatment: A Therapeutic Jurisprudence Analysis' (1994) 17 International Journal of Law and Psychiatry 99; Michael L Perlin, '"The Ladder of the Law Has No Top and No Bottom": How Therapeutic Jurisprudence Can Give Life to International Human Rights' (2014) 37 International Journal of Law and Psychiatry 535; Anna Kawalek 'A Tool for Measuring Therapeutic Jurisprudence Values During Empirical Research' (2020) 71 International Journal of Law and Psychiatry 101581; Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck 'Securing Therapeutic Justice Through Mediation: The Challenge of Medical Treatment Disputes' (2025) 45 Legal Studies 40; Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck, 'Navigating Conflict', n1.

treatment or provision of care was in the patient's best interests;[7] however, we note that mediation often engaged much wider issues than the best interests question.

For this research we conducted an analysis of reported case law, theoretical analysis of therapeutic justice and best interests, and empirical research with mediation participants. This research highlights that mediation can be a Therapeutic Justice process where it was designed to be flexible, participatory, collaborative, less adversarial, voluntary, and to enhance communication and understanding.[8] Each of these features serves to secure and promote participant wellbeing.

In this report we also make the following recommendations:

- increased transparency surrounding mediated disputes;
- publication of anonymised details of mediated cases;
- representation of the child or adult subject in mediation;
- educational materials and information sessions about mediation;
- guidance about mediation's use in health and care disputes.

Finally, on 1 July 2025, we held our end of project conference to share our research findings, our short film about mediation and visual summary (see Figure 1 below) with key stakeholders. 35 people attended our in-person conference at the University of Reading, from a range of disciplines including academics, policymakers, lawyers, health and social care professionals, mediators, judges and people with lived experience.

Following an introduction to the conference by Dr Jaime Lindsey and the release of our short film on mediation in health and care disputes, the day was separated into three parts, with panels featuring a fascinating range of speakers, with a Q&A session following each panel. The first panel discussed the role of mediation in health and care

[7] For further discussion of the meaning and complexities around the best interests concept, see Cressida Auckland and Imogen Goold 'Re-evaluating 'Best Interests' in the Wake of *Raqeeb v Barts NHS Foundation Trust & Anors*' (2020) 83 Modern Law Review 1328; Mary Donnelly 'Best Interests, Patient Participation and The Mental Capacity Act 2005' (2009) 17 Medical Law Review 1; Camillia Kong, John Coggon, Michael Dunn and Alex Ruck Keene 'An Aide Memoire for a Balancing Act? Critiquing the 'Balance Sheet' Approach to Best Interests Decision-Making' (2020) 28 Medical Law Review 753.

[8] For further analysis of TJ in mediation see Jaime Lindsey, 'Mediation as Therapeutic Resolution for Conflicts about Patient Health and Care', (In Preparation).

disputes and included: Professor Carrie Menkel-Meadow, Victoria Butler-Cole KC, Mr Justice Hayden and Dr Louise Webster. In the second panel, members of the project team presented the research findings (Dr Jaime Lindsey, Margaret Doyle and Gillian Francis). The final session focused on what is next for the resolution of health and care disputes and drew on international perspectives. Speakers included: Shelina Begum, mother of Tafida Raqeeb and founder of the Tafida Raqeeb Foundation (Italy); Professor Mary Donnelly (Ireland); Dr Sarah Sivers (Scotland); and Professor Karl Harald Solvig (Norway).

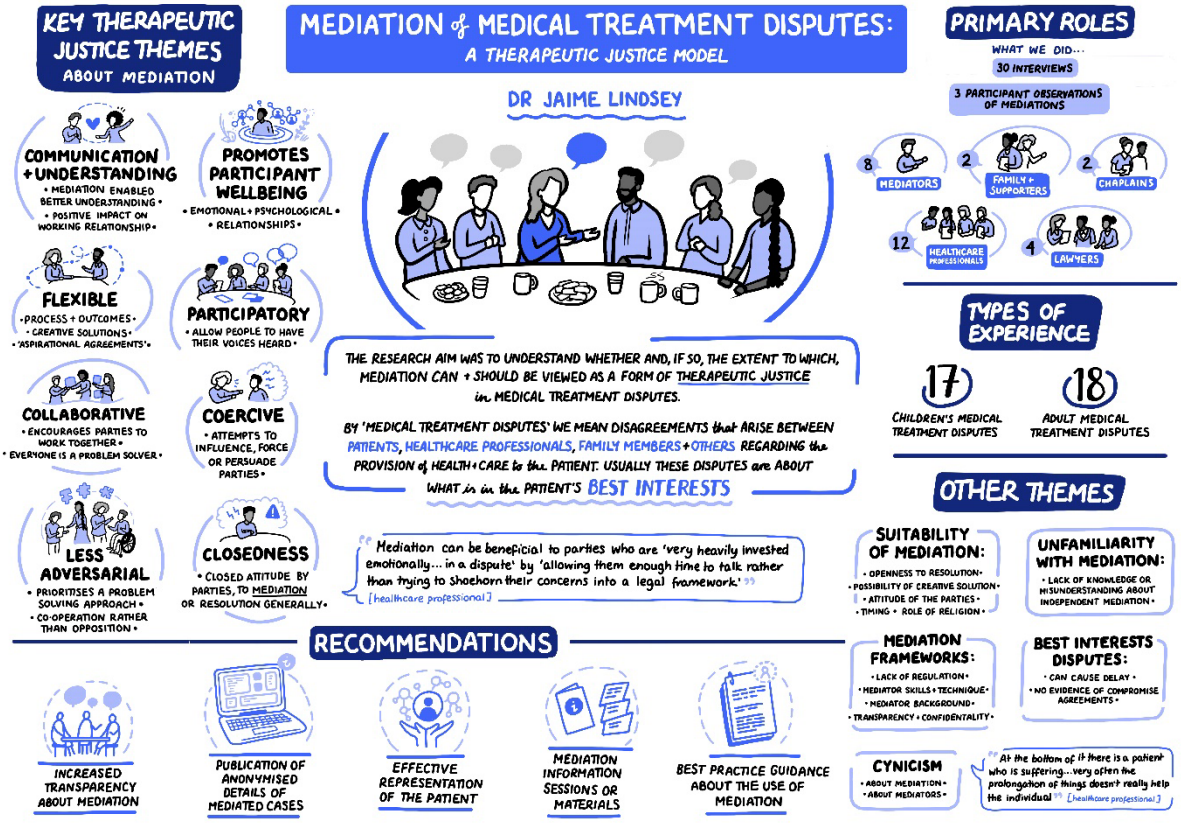

Figure 1: Visual summary of research findings. Designed by Amber Anderson, copyright Jaime Lindsey.

2. Background

End of life disputes

There is a history of high-profile conflict in adult and child end-of-life disputes in recent years in England and Wales.[9] Resolving these disputes can be difficult, and there has been much academic discussion regarding the best way to proceed, considering issues such as the test for best interests, the role of religion and the potential move to a significant harm threshold.[10] The best interests test is the guiding legal principle in cases concerning adults and children who are unable to make their own health and care decisions. It is a concept which can be difficult to define, engaging wider matters than clinical considerations[11] and has been criticised due to its perceived subjectivity and imprecision.[12]

Some studies have looked at the causes of conflict regarding end-of-life care. For example, Moreton for the Nuffield Council on Bioethics separated internal, relational and external causes of conflict in cases involving seriously ill children.[13] Internal causes relate to psychological reasons and differences in views and/or expectations between those involved. Relational causes are issues between the parties such as communication, behaviour, perspectives and attitudes towards each other. External causes refer to the role of third parties in the disputes and other external forces such as social media. Several of these factors can co-exist simultaneously in the same case and contribute to the breakdown in relationships. There has also been research into participant views on the

[9] See of *Great Ormond Street Hospital v Constance Yates,* n3*;* Kirsty Moreton, 'Literature Review: Disagreements in the Care of Critically Ill Children: Causes, Impact and Possible Resolution Mechanisms'(Nuffield Council on Bioethics, 2023); Nuffield Council on Bioethics, 'Disagreements in the Care of Critically Ill Children' (Nuffield Council on Bioethics, 2023) <https://www.nuffieldbioethics.org/publications/disagreements-in-the-care-of-critically-ill-children-2> accessed 30 June 2025.
[10] Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck, 'Securing Therapeutic Justice Through Mediation', n6; For further analysis see Cressida Auckland and Imogen Goold, 'Resolving Disagreement: A Multi-Jurisdictional Comparative Analysis of Disputes About Children's Medical Care' (2020) 28 Medical Law Review 643; Imogen Goold et al (eds) *Parental Rights, Best Interests and Significant Harms: Medical Decision-Making on Behalf of Children Post-Great Ormond Street Hospital v Gard* (Hart Publishing, 2021).
[11] *Aintree University Hospitals Foundation Trust v James* [2013] UKSC 67.
[12] Camillia Kong, John Coggon, Michael Dunn and Alex Ruck Keene, n7*;* Cressida Auckland, Imogen Goold and Jonathan Herring (eds), *'Parental Rights, Best Interests and Significant Harms',* n10.
[13] Kirsty Moreton, n9, 44.

causes of disputes, with HCPs tending to hold the view that conflict arose from breakdowns in communication, disagreements over treatment, and unrealistic expectations of family members.[14] Parents, on the other hand, expressed that conflict arose when their role was challenged or disregarded.[15] A review of case law also found that mediation might not be suitable in disputes with a religious element,[16] although our findings question that conclusion. There are similar studies on adult end-of-life care with some overlap between the findings on adults and children,[17] with some of the problems similarly concerning breakdowns in communication, trust[18] and interpretations of the patient's best interests.[19] While there has been extensive analysis of the causes of end-of-life disputes, there has been much less focus on how to effectively resolve them. Some studies have considered the use of mediation and clinical ethics committees,[20] but more empirical evidence is needed, and this research aims to help fill that evidence gap.

Health and welfare disputes

Not all disputes about health and care in this study related to end-of-life decisions. For both adults and children, disputes can arise regarding less serious forms of medical intervention, such as vaccination or the provision of ongoing care, whether that be at home or in a clinical setting. Moreover, disputes regarding the provision of healthcare can also arise in the context of complaints about treatment, an area which we have also explored for this research. A central feature of the scenarios that we considered in this

[14] Elie Azoulay et al, 'Prevalence and Factors of Intensive Care Unit Conflicts' (2009) 180 American Journal of Repository and Critical Care Medicine 853; Liz Forbat, Bea Teuten and Sarah Barclay, 'Conflict Escalation in Paediatric Services: Findings from a Qualitative Study' (2015) 100 Archives of Disease in Childhood 769.
[15] Emily Parsons and Anne-Sophie Darlington, 'Parents' Perspectives on Conflict in Paediatric Healthcare: A Scoping Review' (2021) 106 Archives of Diseases in Childhood 981; See also Giles Birchley et al, '"Best interests" in Paediatric Intensive Care: An Empirical Ethics Study' (2017) 102 Archives of Disease in Childhood 930.
[16] Veronica Neefjes, 'Can Mediation Avoid Litigation in Conflicts About Medical Treatment for Children? An Analysis of Previous Litigation in England and Wales' (2023) 108 Archives of Disease in Childhood 715.
[17] The literature which looks at conflict in adults cases includes Elie Azoulay et al, n14 and Kerry Knickle, Nancy McNaughton and James Downar, 'Beyond Winning: Mediation, Conflict Resolution, and Non-Rational Sources of Conflict in the ICU' (2012) 16 Critical Care 308.
[18] Elie Azoulay et al, n14.
[19] Harleen Kaur Johal, Giles Birchley and Richard Huxtable, 'Exploring Physician Approaches to Conflict Resolution in End-of-Life Decisions in the Adult Intensive Care Unit: Protocol for a Systematic Review of Qualitative Research' (2022) 12 BMJ Open e057387.
[20] Richard Huxtable, 'Clinic, Courtroom or (Specialist) Committee: In the Best Interests of the Critically Ill Child?' (2018) 44 Journal of Medical Ethics 471.

research was what lawyers would refer to as 'best interests' disputes, that is, what healthcare provision or treatment was in the patient's best interests. However, we acknowledge that in most cases there are many issues underpinning the conflict which go beyond the legal aspects of the dispute.

Adult health and care disputes in the Court of Protection (CoP) can cover a wide range of issues, from day-to-day welfare matters such as personal hygiene, diet, and living arrangements as well as more serious medical treatment issues such as ventilation or other life-saving procedures. There have been previous studies into the use of mediation in the CoP. One study showed that mediation had positive effects on the working relationship between the parties, could be a more flexible process and showed respect for the individual, but there were challenges in relation to securing the patient's participation in the process.[21] Another study similarly found that mediation can help to improve working relationships but there were challenges in securing effective participation and the best interests of the patient.[22]

Role of mediation and its evidence base

Disagreement between the parties in medical treatment disputes may be unsurprising given the sensitive and emotive issues at stake, but the level of relationship breakdown in several high-profile cases has raised concerns that these disputes are being resolved in ways that exacerbate conflict, rather than resolve it. One of the most high-profile disputes, *Great Ormond Street Hospital v (1) Constance Yates (2) Chris Gard (3) Charles Gard* [2017] EWHC 972 (Fam), led to calls from the judge for mediation to be used. In that case, the parents of an infant, Charlie Gard, disagreed with the HCPs treating him over whether he should travel to the US for potentially life-sustaining treatment. Mr Justice Francis recommended that 'mediation should be attempted in all cases such as this one, even if all that it does is achieve a greater understanding by the parties of each

[21] Jaime Lindsey, *Reimagining the Court of Protection: Access to Justice in Mental Capacity Law* (Cambridge University Press, 2022).
[22] Jaime Lindsey and Chris Danbury, 'Mediating Disputes Under the Mental Capacity Act 2005: Relationships, Participation, and Best Interests' (2024) 32 Medical Law Review 336.

other's positions'.[23] We have also seen mediation being used in other reported cases, including *Great Ormond Street Hospital v MX and FX and X* [2020] EWHC 1958, where the court was positive about the use of mediation as the parents were able to participate more effectively.[24] Other cases have engaged with mediation, including *Guy's and St Thomas' Children's NHS Foundation Trust v Pippa Knight and Paula Parfitt* [2021] EWHC 25, although there was uncertainty as to the benefits of mediation. Mediation has also been seen to cause delay in resolving disputes, for example in *The Newcastle Upon Tyne Hospitals NHS Foundation Trust v H* [2022] EWFC 14. Similarly, in the CoP there have been several reported cases where mediation has been discussed in both positive and negative terms.[25]

Despite calls for mediation, there has so far only been a very small number of studies looking at this.[26] There is an argument developing in the literature and legal practice[27] that mediation might be suitable for these disputes and even provide therapeutic benefits compared to litigation. As the use of mediation has not been widely tested through empirical research in the medical treatment disputes context, nor has a model of Therapeutic Justice been developed or applied to this field, this project sought to test those claims empirically through qualitative analysis of mediation in medical treatment disputes.

Mediation is not without risk and requires an evidence base to understand how, and in what ways, it can be beneficial. The benefits of mediation for dispute resolution more generally are well established, for example in community, employment and family disputes, but there is little evidence on the use of mediation in health and care disputes

[23] *Great Ormond Street Hospital v Constance Yates*, n3.
[24] For further discussion see Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck, 'Securing Therapeutic Justice Through Mediation', n6 and Jaime Lindsey, Denise Schuberg and James Browning, 'Medical Treatment Disputes and Children: An Empirical Analysis of Sixteen Years of Reported Judgments in England and Wales' (2025) 46 Journal of Social Welfare and Family Law 582.
[25] See *A Local Authority v M* [2014] EWCOP 33; *A Local Authority v PB* [2011] EWHC 2675 (Fam) 31; *North Yorkshire Clinical Commissioning Group v E* [2022] EWCOP 15; *North West London Clinical Commissioning Group v GU* [2021] EWCOP 59; *Imperial College Healthcare NHS Trust v MB* [2019] EWCOP 29; *Westminster City Council v Sykes* [2014] EWCOP B9; *A London Local Authority v JH* [2011] EWCOP 2420.
[26] Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck, 'Securing Therapeutic Justice Through Mediation', n6.
[27] Cressida Auckland, Imogen Goold and Jonathan Herring (eds), *Parental Rights, Best Interests and Significant Harms',* n10; David I Benbow 'An Analysis of Charlie's Law and Alfie's Law' (2019) 28 Medical Law Review 223; Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck, 'Securing Therapeutic Justice Through Mediation', n6.

in particular.[28] Some of the challenges in using mediation in this context include the risks of not securing the patient's best interests, mission drift into a wider range of areas beyond the initial confines of the dispute, and participant coercion into taking part in mediation or agreeing outcomes at mediation. For example, facilitative mediation is the main form of mediation practiced in healthcare disputes and in this style of practice, mediators are meant to refrain from providing an opinion on the dispute and act to guide the participants to reach their own resolution. However, an analysis of CoP mediation showed a case in which there was still an adversarial nature to the mediation with the legal representatives acting as gatekeepers and the mediator, who had a background as a barrister, providing their own opinion on the dispute.[29] Similarly, while it has been accepted that some of the key features of mediation that make it beneficial elsewhere are present in mental capacity law, such as flexibility, voluntariness and mediator independence, that research found that there was less evidence of mediation's participatory potential.[30]

As part of this research we analysed reported judgments regarding medical treatment of children.[31] While the focus of that work was not on mediation, we found that most cases are resolved in line with the public body's preferred outcome rather than the family. There is a relationship between the instigator of litigation and the outcome; and there is a relationship between the presence of religious factors and the outcome of the case.[32] This report, and other publications from this study, further contributes to the evidence base regarding mediation's use.

[28] Dominic Wilkinson, Sarah Barclay and Julian Savulescu, 'Disagreement, mediation, arbitration: Resolving Disputes About Medical Treatment' (2018) 391 Lancet 2302; Jaime Lindsey and Gillian Loomes-Quinn, 'Evaluation of Mediation in the Court of Protection' (2022) <https://repository.essex.ac.uk/33465/1/Evaluation%20of%20Mediation%20in%20the%20Court%20of%20Protection.pdf> accessed 27 May 2025; Varda Bondy and Linda Mulcahy with Margaret Doyle and Val Reid, 'Mediation and Judicial Review', n6; Mengxiao Wang, Gordon G Liu, Hanqing Zhao H et al, 'The Role of Mediation in Solving Medical Disputes in China' (2020) 20 BMC Health Serv Res 225; Rachael Blakey, 'Cracking the Code', n6 ; Tom R Tyler, 'The Psychology of Disputant Concerns in Mediation' (1987) 3 Negotiation J 367; Jaime Lindsey, Margaret Doyle and Katarzyna Wazynska-Finck 'Navigating Conflict', n1.
[29] Jaime Lindsey and Gillian Loomes-Quinn, ibid.
[30] Ibid.
[31] Jaime Lindsey, Denise Schuberg and James Browning, 'Medical Treatment Disputes and Children', n24.
[32] Ibid.

Challenges in researching mediation

There are several challenges to conducting empirical research on mediation. Mediation as a process is designed to be confidential and while this is beneficial in the sense that it can encourage parties' openness during mediation, the confidentiality means that it is difficult to research. Unlike judgments, which are now routinely published in the Family Court, mediation discussions are confidential and not recorded. Confidentiality of mediation discussions allows for participants to be open and frank within the mediation room, enabling them to express regret, share personal experiences, and propose settlement options, knowing that these are not shared with others outside the mediation. In that sense, it is a crucial ingredient for creating an environment in which the features of therapeutic justice, including participation, flexibility and collaboration, can thrive.

Yet there is an inherent problem with confidentiality of mediation, particularly in cases concerning public bodies, in which there is often a wider interest in holding government bodies to account. Although mediation discussions must remain confidential (aside from the exceptions outlined in mediation codes of conduct),[33] confidentiality need not, and arguably should not, apply to other aspects of the mediation when public bodies are concerned. These other aspects include the fact that the mediation has taken place and the outcome of the mediation, particularly actions agreed by the public body, such as an NHS Trust or a local authority.

The fact that a mediation has taken place, whether or not it prevents subsequent legal proceedings, can be important for accountability reasons.[34] It also assists researchers to shine a light on the extent to which mediation is being attempted. It is difficult to see the disadvantage to participants, or the risk to their privacy, by a public body holding and sharing quantitative and/or anonymised information on the mediations they have engaged with.

[33] See, for example, Medical Mediation Foundation Code of Conduct for Mediators: 'Code of Conduct' (Medical Mediation Foundation) <https://www.medicalmediation.org.uk/code-conduct/> accessed 28 May 2025.
[34] This is even more important in light of the emphasis placed on attempting what is termed 'alternative dispute resolution' in the revised Civil Procedure Rules (CPR 1.1, 1.4(2), 3.1(2), Part 28 & 29, and Part 44, revised in October 2024), which clarify the courts' power to order parties to mediate in civil claims and to impose sanctions for non-compliance. Although the CPR does not encompass most medical treatment disputes (as opposed to clinical negligence claims), public bodies like NHS Trusts may be involved in both medical treatment and civil disputes.

We know that mediation is being used in the CoP and in disputes about children, but the true number of mediations is likely to be underreported. There is no requirement for the judge to be informed that mediation was ever attempted before the case proceeded to the CoP and, while there is a question regarding mediation in the relevant family court application forms for children, this data is not always captured in reported judgments. Further, if an agreement is reached at mediation, then, depending on what stage the proceedings are at, there is no obligation for the parties to inform the court or obtain an order for the agreement. For that reason, successful mediations are rarely recorded. As we note below, we encountered several challenges in researching mediation, including reluctance from mediators to opening up their mediations to research, misunderstandings around confidentiality and difficulties in identifying when cases were mediated.

Summary of the legal position on regulation of mediation

There are different legal frameworks for adult and children cases, which are not discussed in detail in this report, but further information is available elsewhere.[35] Regarding mediation's regulation, there is no legal requirement to mediate in either child or adult health and care disputes in England and Wales.

The Mental Capacity Act 2005 (MCA) does not refer to mediation and it is also rarely discussed in reported judgments. Chapter 15 of the Code of Practice to the MCA provides general information about mediation and some case-specific examples are provided, including one which refers to the provision of care to an adult with dementia.[36] Similarly, there is no statutory guidance on the use of mediation in healthcare disputes concerning children. This is, perhaps, more surprising given that mediation is more

[35] Lucy Series, Adam Mercer, Abigail Walbridge, Katie Mobbs, Phil Fennell, Julie Doughty and Luke Clements, 'Use of the Court of Protection's Welfare Jurisdiction by Supervisory Bodies in England and Wales' (Cardiff University, 2015) < Local-Authorities-Use-of-the-CoP.pdf > accessed 30 June 2025; Rob George, *Wards of Court and the Inherent Jurisdiction* (Bloomsbury, 2024); Jaime Lindsey, Denise Schuberg and James Browning, 'Medical Treatment Disputes and Children', n24; Alex Ruck Keene, Kate Edwards, Nicola Makintosh, Sophy Miles and Anselm Eldergill, *Court of Protection Handbook: A User's Guide* (LAG Education and Service Trust Limited, 2025).

[36] 'Mental Capacity Act Code of Practice' (Office of the Public Guardian, 2013) <Mental-capacity-act-code-of-practice.pdf> accessed 28 May 2025.

widely embedded in family law in other areas. The Children Act 1989 does refer to mediation but in relation to section 8 child arrangements orders in family proceedings.[37]

We considered elsewhere the role of international law regarding mediation's use and highlighted that international human rights treaties also do not refer to mediation explicitly.[38] Importantly, the UN Committee on the Rights of the Child (CRC Committee) and the Council of Europe (CoE)[39] make clear that the best interests principle and the right to be heard must be safeguarded in mediation.[40] The 1998 CoE Recommendation on family mediation does reference 'the protection of the best interests and welfare of the child as enshrined in international instruments' and, in fact, encourages mediations to '(…) have a special concern for the welfare and best interests of the children, [and to] encourage parents to focus on their needs'.[41] The 2007 CoE guidelines on family and civil mediation[42] also recognize 'the importance of child's best interests' and recommend that there should be the establishment of common evaluation criteria to serve the best interests of the child, including the possibility of children taking part in the mediation process. There is no mention, however, of the weight children's views are meant to hold in mediation and their contribution to resolution. Overall, then, the law provides very little guidance about mediation's use in this area of practice.

[37] Children Act 1989; Children and Families Act 2014, s10.
[38] Jaime Lindsey, Margaret Doyle and Katarina Wazynska-Finck, 'Navigating Conflict', n1.
[39] 'Guidelines of the Committee of Ministers of the Council of Europe on Child-Friendly Justice (Adopted by the Committee of Ministers of the Council of Europe on 17 November 2010) and Explanatory Memorandum' (Council of Europe, 2011)<https://search.coe.int/cm?i=090000016804b2cf3>accessed 2 July 2025.
[40] Ibid, 27; UN Committee on the Rights of the Child (CRC), 'General Comment No 12 (2009) The Right of the Child to be Heard', (CRC/C/GC/ 12, 20 July 2009),<https://digitallibrary.un.org/record/671444?v=pdf#files> accessed 2 July 2025, para 32; UN Committee on the Rights of the Child (CRC), 'General comment No. 14 (2013) On the Right of the Child to Have His or Her Best Interests Taken as a Primary Consideration (art. 3, para. 1)' (CRC/C/GC/14, 29 May 2013) <https://www.refworld.org/legal/general/crc/2013/en/95780> accessed 2 July 2025, para 27.
[41] Council of Europe Committee of Ministers, 'Recommendation No. R (98) 1 of the Committee of Ministers to Member States on Family Mediation (Adopted by the Committee of Ministers on 21 January 1998 at the 616th Meeting of the Ministers' Deputies)' (Council of Europe, 1998) <https://search.coe.int/cm?i=09000016804ecb6e> accessed 2 July 2025.
[42] 'Guidelines for a Better Implementation of the Existing Recommendation Concerning Family Mediation and Mediation in Civil Matters' (2007) <https://rm.coe.int/european-convention-on-the-exercise-of-children-s-rights/1680a40f72> accessed 28 May 2025.

University of Reading

Economic and Social Research Council

3. Research Design & Methods

The guiding research question was to explore whether and, if so, the extent to which mediation can and should be viewed as a form of therapeutic justice in medical treatment disputes. This was conducted through analysis of the following detailed research questions:

1. Can, and should, a model of Therapeutic Justice be developed for use in litigation of medical treatment disputes? More specifically by:

    1.1. Analysing the extent to which Therapeutic Justice is an appropriate mechanism for analysing legal processes;

    1.2. Deductively analysing, through existing literature, which values are common between mediation, Therapeutic Justice and medical treatment environments;

    1.3. Determining which aspects of mediation have the potential to support Therapeutic Justice goals;

    1.4. Analysing what is characteristic of medical treatment disputes that makes Therapeutic Justice possible, or indeed challenging;

    1.5. Analysing to what extent Therapeutic Justice can be achieved with vulnerable participants in mediation.

2. What are the experiences of professional and lay participants (including healthcare professionals, family members, mediators and, in some instances, the subject of proceedings) in mediated medical treatment disputes under the Mental Capacity Act 2005? More specifically;

    2.1. How do participants feel about the use of mediation for their case?

    2.2. Does the experience of mediation support participants? If so, how and if not, why not?

    2.3. What are participants' post-mediation experiences?

    2.4. Does mediation provide any Therapeutic Justice benefits for participants in mediated medical treatment disputes?

3. What are the experiences of professional and lay participants (including healthcare professionals, family members and, in some instances, children) in mediated medical treatment disputes that arise in relation to children? More specifically;

3.1. How do participants feel about the use of mediation for their case?

3.2. Does the experience of mediation support participants? If so, how and if not, why not?

3.3. What are participants' post-mediation experiences?

3.4. Does mediation provide any Therapeutic Justice benefits for participants in mediated medical treatment disputes?

What we did

We conducted 30 semi-structured interviews involving a range of participants who had experience of disputes in the context of adult and/or child health and care cases. 17 participants had experience of child disputes and 18 participants had experience of adult disputes. Participants included HCPs (n=12), mediators (n=8), lawyers (n=4), chaplains (n=2) and one family member (a mother) and one family supporter. Some participants had secondary roles. This information is shown in Tables 1 and 2 below;[43] see Appendix 1 for a more detailed record of the demographics of participants.

Depending on interviewee preference, interviews were conducted either online (n=26) or in person (n=4). Informed consent was obtained from all participants and their names were replaced with pseudonyms. The minimum interview length was 30 minutes and the maximum was 100 minutes. All interviews were audio recorded and the recordings were uploaded to a secure server and transcribed. The transcriptions were then uploaded into NVivo for data analysis. Interviews with HCPs and mediators were stopped once we reached saturation but we were unable to reach data saturation for the category of family members as we were only able to recruit one family member and one family supporter to interview.

[43] Table 2 highlights all types of experience the participant had and therefore the totals exceed the total number of participants (i.e. some participants had experience of adult and child cases and/or complaints).

Participants were recruited through snowball and purposive sampling from our existing network of contacts. These participants were contacted via email and social media. We also circulated requests to participants of mediations we were aware were taking place; some were the mediations we observed and others were mediations we were made aware of through mediators. We also circulated requests to participate to NHS Trusts through the National Institute for Health Research portal where the research project was listed, and we asked participants and interested stakeholders we were in contact with to distribute our request to anyone they thought might be interested in taking part.

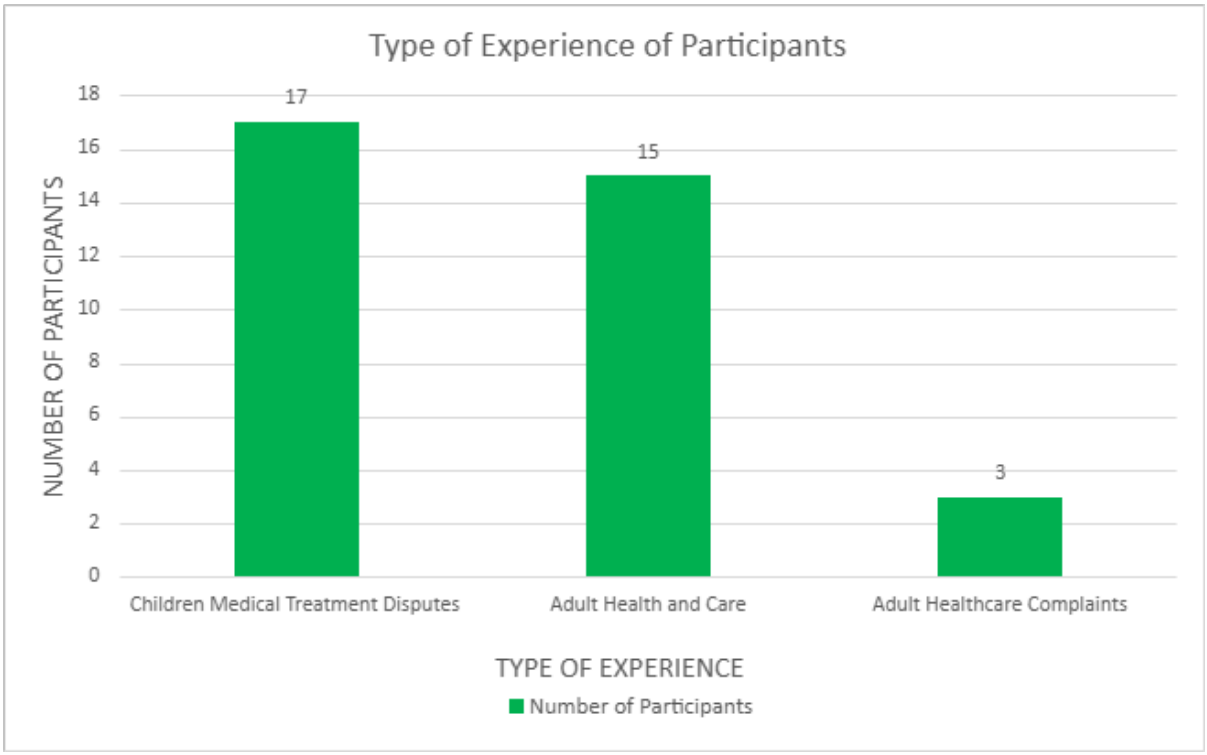

Table 1: Type of experience of interview participants

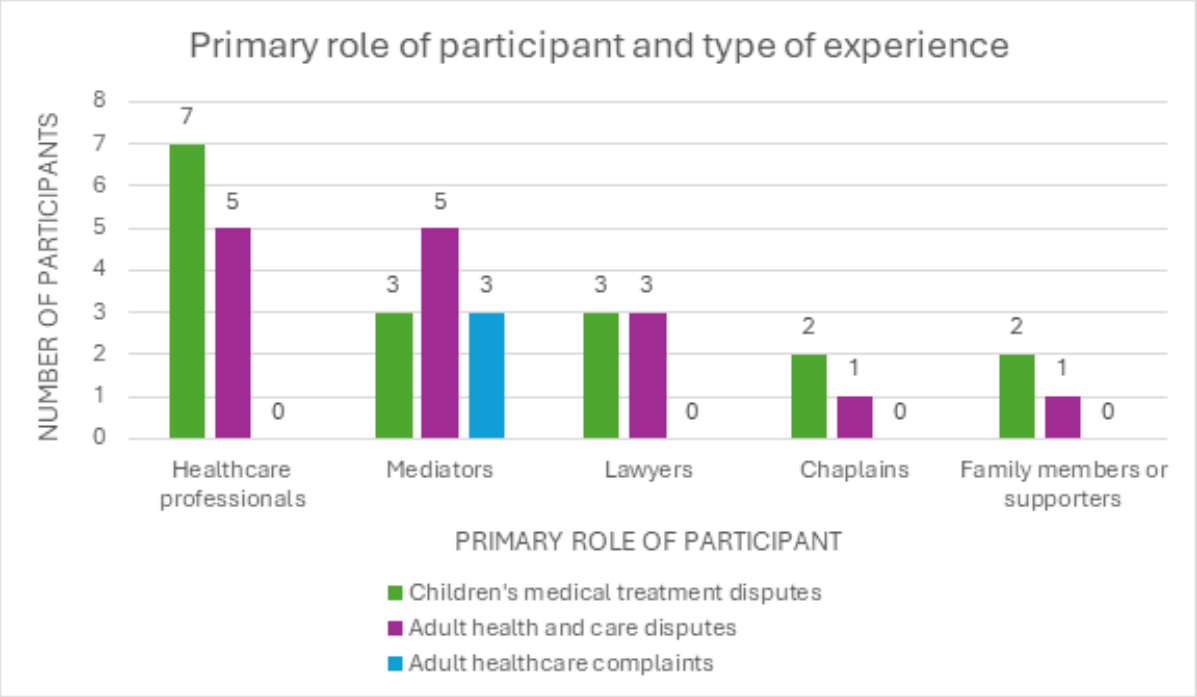

Table 2: Primary role of interview participant and type of experience

We were also able to observe three mediations which concerned adult health and care disputes as set out in Table 3. Participant-observation was selected as one of the research methods as it allows for a closer analysis of what happens in mediations, which are normally confidential.[44] This access can help to improve our understanding of the real-world application of mediation and provide different insights from other methods. We had hoped to observe more mediations but we found several barriers to accessing mediations where they concerned a dispute regarding a child's medical treatment. We recorded details of when mediations were referred to us for observation and the outcomes, including the reasons why we were not able to observe. This data is contained in table 4 below and provides a useful insight into the types of cases that were mediated during this study.

Where mediations were observed but it was not possible to obtain the consent of the patient because they lacked capacity to participate in research, a consultee process was used, for which ethical approval was obtained from the Health Research Authority.

[44] Alexandra Crampton, 'Escape from the Laboratory' and Debbie De Girolamo 'The Mediation Process', n6.

We also intended to gather data using a questionnaire from participants in the observed mediations, however, due to the very small numbers these data have not been used to inform this study.

The data analysis started with a therapeutic justice theoretical framework, followed by thematic analysis. The analysis was carried out by two researchers (JL and GF) who began by first familiarising themselves with the data before then identifying specific codes that reflected the key themes that were emerging from the data. These themes were then broken down into subcodes to provide a more granular analysis of the themes; these subcodes were checked against the data for accuracy. The final stage of analysis was the interpretation of the findings, which have been written up for several peer-reviewed publications, and a summary of these findings is contained in this report.

Limitations

Limitations of this study include that the findings are not generalisable due to the qualitative focus of the research and instead the focus was on capturing detailed participant experiences. While we reached data saturation for HCPs and mediators, we did not for family members and therefore our findings may not reflect the views of family members involved in mediations. We were able to observe three mediations concerning adults but were not able to access mediations concerning children's medical treatment. Therefore the findings may be less reliable in relation to children compared to adults. Despite these limitations, the study is still an important contribution to the literature because there has been no independent empirical research into mediation in relation to children's medical disputes, and only a small number of studies concerning adults (also conducted by one of the authors of this study).

	Observation One	Observation Two	Observation Three
Number of participants (including mediator and excluding observer)	7 (2 family members, 4 HCPs, 1 mediator)	Pre-meeting 1 with Local Authority: 4 Pre-meeting 2 with P's Carer: 2 Pre-meeting 3 with Local Authority: 3 Pre-meeting 4 with P & Carer: 3 (8 different participants)	8 (3 from P's family, 3 from the NHS Trust, 2 mediators)
Mediator interview participant name (anonymised)	Elizabeth	Elizabeth	Brenda (an assistant mediator was also present but not interviewed)
Other interview participant names (anonymised)	Amanda, Adela, Maxwell, Lailah	None	None
Location of mediation	In person at solicitor offices	Online via Zoom	Online via Teams
Key issues	Health and welfare	Health and welfare	Healthcare and best interests complaint
Number of mediation meetings	2 joint sessions	2 pre-mediation sessions with each party. Did not proceed to joint meeting	1 joint session
P presence	P not present at mediation	P present for part of the second pre-meeting	P not present (deceased)

Table 3: Observed mediation summaries

	Who notified us	Did it progress to mediation	Parties consent to observation	Issue in dispute	Outcome	Virtual or face to face
1	Mediator	No - parties decided not to mediate		Adult care - CoP case	Unknown	Unknown
2	Mediator	No - parties decided not to mediate		Unknown	Unknown	Unknown
3	Mediator	Unknown	No	Adult care - CoP case	Unknown	Unknown
4	Mediator	Yes	No - situation too tense	Child - medical treatment	Unknown	Unknown
5	Mediator	Yes - 2 mediation meetings	Yes (to second mediation meeting)	Adult care - CoP case	Agreement	Face to face
6	Mediator	Yes	Yes	Adult healthcare complaint	Partial agreement	Virtual
7	Mediator	Yes	No - last minute	Child - end of life medical treatment	Unknown	Unknown
8	Mediator	Yes	No – too tense	Child - end of life medical treatment	Unknown	Unknown
9	Mediator	Yes	No - too tense - originally agreed but mediator felt unable to raise again	Child - medical treatment	Unknown	Face to face
10	Mediator	Yes	Yes	Adult - care CoP case	Partial agreement	Virtual
11	Mediator	Yes	No – public body declined to participate due to sensitive and confidential issues	Child - medical treatment	Unknown	Face to face

Table 4: Observation referral data

4. Research Findings

Transparency and Understandings of Mediation

We recognise that there are many concerns about confidentiality which inhibit transparency of mediation. As discussed earlier in this report, confidentiality of

mediation outcomes might not be desirable in cases concerning public bodies, and indeed there may be benefits in sharing outcomes more widely. In health and care disputes, unlike other areas such as clinical negligence claims, the outcomes agreed are generally not financial settlements, but they might be outcomes that impact policy and practice. Some parties are seeking outcomes that will improve practice or communication and have a potentially wider benefit for others. The actions agreed by an NHS Trust or local authority in a health or care dispute might require sharing information within the public body or with the wider patient public, or they might be ones that require public consultation, such as a change to a policy. One mediator, Maya, described outcomes from a mediation that involved systemic changes and a change to NHS Trust guidelines. Another mediator, Brenda, discussed the mediation outcomes as involving 'service improvements', which enabled mediation to be used as a way to hold the organisation to account and presumably to benefit other patients.

Other potential benefits accrue to public bodies who, by sharing information on mediation outcomes, demonstrate they are open to collaborative ways of resolving disputes and to systemic change. Potential benefits to the wider public include a better understanding of how mediation can be used, and what mediation can, and cannot, achieve. One mediator, Ed, noted that a rigid approach to confidentiality 'does make it difficult to for us to tell the tale' of mediation and that 'we can't really tell convincingly real-life stories about mediation other than with very careful circumspection'.

There are ways in which the concerns about data sharing can be mitigated while greater transparency is promoted - for example, through providing accessible and anonymised summaries and/or requiring courts to include in the reported judgment where a case was previously mediated. Mediators could ensure that the boundaries of confidentiality of each mediation are established early on and agreed by the parties, or, if that is not possible, be revisited after the mediation to establish if and how outcomes could be shared. According to one of the mediators we interviewed, the organisation she works with, which provides mediation of healthcare complaints, has embedded in its intake process that the organisation is able to share its mediation casework in the same way it does other areas of its work. Despite this commitment, the logistics of publishing

case studies is still being worked on, as one participant explained, 'Because a lot of them are so personal, it's like how do you anonymise those?' At a minimum, a public body should be required to keep a record of the mediation having taken place and whether it resolved the issue or proceeded to court. Mediators could also be under an obligation to seek agreement at the start that the fact of the mediation taking place can be shared and an anonymised summary of the issues and outcome will be prepared by the mediator for agreement by the parties, which can then be used as a public statement.

Confidentiality is not the only barrier to empirical research on mediation. It can be difficult to gain consent from participants to have researchers observe a mediation and to interview participants, particularly family members, for reasons that have less to do with confidentiality and more to do with personal circumstances and the need to have time to reflect on a mediation. The process we used to gain consent to participate in the research involved sending a participant information sheet explaining the research and the confidentiality of personal data. The researchers also offered to speak with any participants who had questions about the research. In all of our observed mediations, we obtained consent from all participants for the observation, and consent for interviews from some participants, including family members. The participants in those observed mediations, and the mediators, welcomed the researcher's presence. None of the family members in those mediations ultimately agreed to take part in interviews, but other participants did, and they appeared willing to discuss the mediations they had taken part in. Similarly, the mediators we interviewed were willing to discuss their mediation cases while maintaining the confidentiality of the individuals' identities.

Reluctance to participate in research could also be attributed to the emotional nature of the disputes. In three of the mediations we were told about, all involving a child's medical treatment, either the mediator or the participants (we were not always clear when consent had been sought and declined, and when a mediator decided not to seek consent) considered the situation 'too tense' to involve an observer. In another, the public body declined to consent to observation on the basis that the information involved was too sensitive and confidential. This may reflect an anxiety about mediation on the

part of participants who are unfamiliar with the process and who anticipate that introducing another person might add stress and uncertainty.

It can also be difficult to get agreement from mediators to discuss their cases anonymously. The mediators who agreed to be interviewed appeared comfortable discussing their cases with us anonymously. However, we were told by one mediator, who declined to be interviewed, that he could never discuss his mediations, citing the confidentiality of the process. Despite reassuring him of the ethical guidelines covering confidentiality of personal data, we were unable to persuade him to tell us even the nature of the cases he had mediated. We believe that this may reflect a misunderstanding of the role of researchers. It may also reflect rigidity of mediator codes of conduct, which usually specify that mediators cannot disclose anything about a mediation without the consent of all participants. We encourage all mediation providers to consider adopting an approach that promotes information sharing, such as anonymised case summaries, while protecting the personal data of participants.

Another difficulty we encountered was misunderstanding the process of mediation. Some interviewees were unsure whether or not they had taken part in a mediation, which could suggest that unfamiliarity with the process leads to blurring of lines between in-house processes such as roundtable meetings or local resolution and independently facilitated mediation. One mediator, Georgia, said that the health bodies she works with were unfamiliar with mediation: 'a lot of them are still confused, "But we've already done the meeting. Why would we want to do another meeting?" And then it can be sort of explaining how mediation is different to a local resolution meeting.' Furthermore, participants who are cynical about a proposal to mediate, perhaps distrustful of its independence or because they believe they have already tried mediation, might not be engaging openly in a mediation process, as discussed above in relation to closedness and cynicism. Having more information in the public domain about actual mediations that have taken place can help address such misconceptions and concerns and contribute to informed choices to mediate or not.

Is Mediation a Form of 'Therapeutic Justice'?

The research identified several features of mediation that align with Therapeutic Justice (hereafter 'TJ'). This analysis will be published in more detail elsewhere and so only a summary of the key findings is included here.[45] TJ emerged as a movement from the mental health courts and problem-solving criminal justice courts, focusing on parties' emotional and psychological wellbeing rather than other aspects of the justice process. TJ can be defined as 'the use of social sciences to study the extent to which a legal rule or practice promotes the psychological and physical wellbeing of the people it affects'.[46] The rationale behind it is the premise that legal rules and procedures, and the actions of the individuals involved, are 'social forces that can have both therapeutic and anti-therapeutic consequences'.[47] There is no clear definition of 'therapeutic'; scholars have left it intentionally vague to allow researchers to interpret according to their own judgment and intuition, in response to the specific circumstances of each case.

This research highlights that there are several features which indicate that mediation can be a TJ process, and we suggest that mediation's use in health and care disputes should ensure the following features should be protected and promoted through mediation design: flexibility, participatory, collaborative, less adversarial, voluntary, and enhanced communication and understanding.[48] Each of these features serves to secure the overarching aim of promoting participant wellbeing.

Flexibility

The most prominent theme to emerge from the research was flexibility of process and outcome. The mediation processes were not rigid but allowed for a process to be designed that was sensitive to and flexible for participant needs:

[45] Jaime Lindsey 'Mediation as Therapeutic Resolution', n8.
[46] Christopher Slobogin 'Therapeutic Jurisprudence: Five Dilemmas to Ponder' (1995) 1 Psychology Public Policy, and Law 193, 196; David B Wexler and Bruce J Winick, 'Therapeutic Jurisprudence as a New Approach', n6.
[47] Ibid.
[48] For further analysis of TJ in mediation see Jaime Lindsey 'Mediation as Therapeutic Resolution', n8.

> *the process now is working well. The communication is much better. Visits are going better. The guy himself seems happier, which is not surprising really. If visits are going and there's less of an atmosphere, then … everyone's in agreement that … things are going better, people are working well together. (Maxwell, social worker)*

Outcome flexibility was important to enable parties to agree creative resolutions. For example, in observation one, the parties worked together to resolve matters through creative ways forward, including the care providers giving the family access to training, agreements to procure dental hygiene tools and agreements to practice haircutting. Examples of flexible outcomes were identified across the data and gave the parties some common ground on which to move forward. Further examples of flexibility in outcome are indicated in the outcomes section below.

Participatory

Participatory refers to a process which allows the parties to participate by providing them with the space, opportunity and support to freely express their views, contribute to the

discussions and have their voice heard.[49] The data indicated that there was a strong focus by mediators on trying to involve all participants and include their voices. Mediators emphasised the importance of creating a 'safe space' (Philip, mediator) in which each party has the opportunity have their voice heard and their experience acknowledged. Participants also described ways in which the mediator would sense-check how the parties were feeling and ensure that every participant understood what had been said:

> *If something was said that particularly somebody didn't feel was explained properly, she would re-word that in a way that made it more personal and approachable. (Lailah, care provider professional)*

Patient participation was more limited, in that the adult or child patient did not generally participate directly in mediations. Some mediators did encourage indirect participation. For example, they used photographs of the adult or child patient, asked the other participants to talk about the patient or refocus their discussion on the patient, and made adjustments/accommodations to enable the adult or child patient to participate in a limited capacity, as we saw in observation two.

Collaborative

Collaborative refers to a process where parties work together, valuing each other's expertise and making everyone a 'co-designer' of solutions. There were examples of HCPs working together with parents to draw up care plans for the child receiving treatment, offering training to the family members who had adult loved ones in care and even examples of parties working together to narrow the issues in dispute. In mediation it is the parties who come up with and agree solutions, but there were examples of the mediator creating a collaborative space, for example in observation one, the mediator invited each party to write ideas on post-it notes, which were then placed on a flipchart

[49] 'Council of Europe Recommendation On The Participation of Children and Young People Under the Age of 18' (CM/Rec (2012)2, Council of Europe, 2012) <https://rm.coe.int/168046c478> accessed 2 July 2025, 6; See also the work of Laura Lundy, ''Voice' Is Not Enough: Conceptualising Article 12 of the United Nations Convention on the Rights of the Child' (2007) 33 British Educational Research Journal 927.

and used to guide discussions and show commonalities which led to collaboration. There were also examples of the mediator adding to ideas generated by the parties, such as a mediator asking an NHS Trust if they use a 'patient passport', reflecting the parties' joint concern about effective communication. Another mediator explained that sometimes people need coaching on how best to participate in the mediation and that can include learning how to undertake 'collaborative dialogue' (Elizabeth, mediator). We saw this kind of coaching work in pre-mediation meetings between a mediator and one party. Similarly, mediators can work to create a collaborative environment which can 'slow the flow of information' (see Figure 1 below) and enable a collaborative space to develop which works for a range of participants and their individual needs (also reflecting the flexibility of mediation processes).

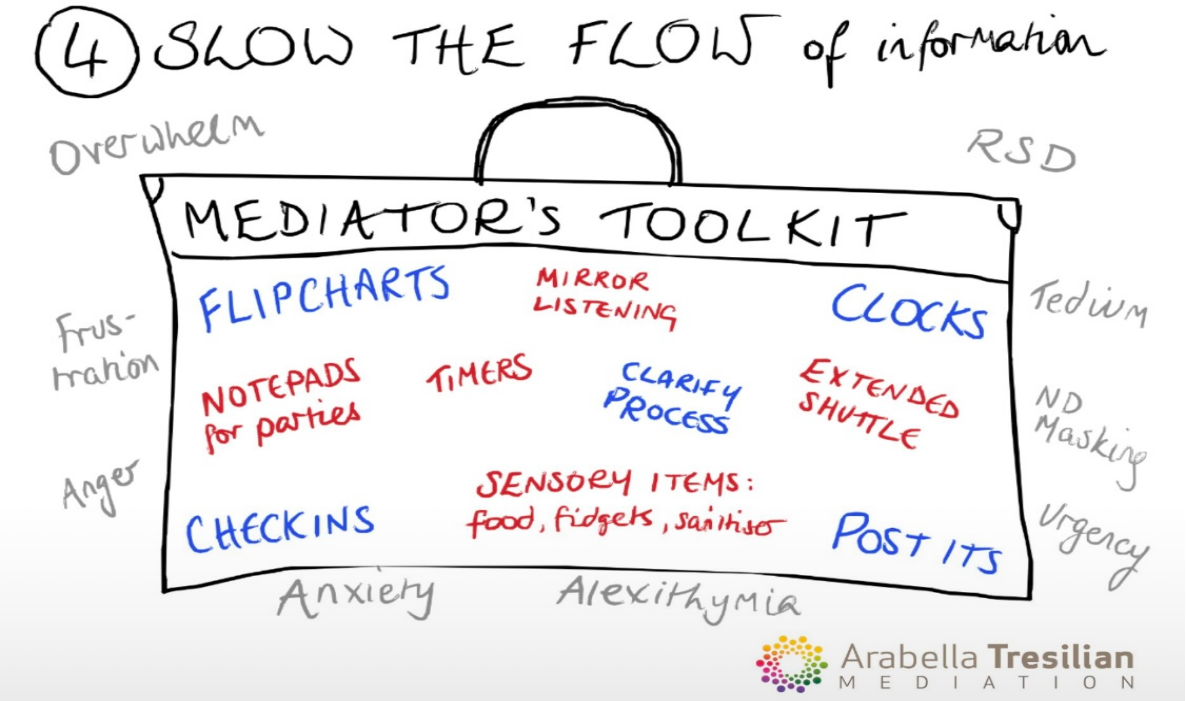

Figure 2: Arabella Tresilian Mediation (Source: LinkedIn)

Mediators also facilitated collaboration by promoting equality of arms between the parties. Some examples included the use of neutral venues, the use of first names for all participants and providing each party with equal access to the mediator. One participant

(Katherine, mediator) shared that, when one party in the mediation is represented and the other is not, she makes attempts to level the playing field by asking the represented party to explain things further to the unrepresented party so they have similar information. However, the research included several instances in which there was a lack of neutrality in the mediation. For example, the mediation from observation one was held in the offices of one party's solicitor, and in some interviews the mediation was described as taking place within the hospital, neither of which would be a neutral venue, albeit we note that parties would have consented to this.

Less Adversarial

We saw that mediation takes a problem-solving approach focused on co-operation rather than opposition. One participant explained that the success of mediation was not always dependent on a resolution being achieved but, rather, she considered that if the parties are able to have a different quality of conversation and 'see each other as humans' rather than enemies then she considered that to be a step forward. She felt that, even if the parties decided to proceed to court, mediation had helped them reduce the acrimony:

> *We've tried to see each other as human and be kind, and considerate, and empathetic, and thoughtful, and reflected, and we still cannot agree... If they get to this place, I think that can be softer, gentler, it's more healing.* (Abigail, mediator)

Another mediator described how valuable it is for family members to hear the perspective of HCPs and to understand:

> *…what it was like for that clinician on the day of the treatment. And you know, help the complainant to see what, you know, the clinician's day was like. How they kind of walk through their job and to help them understand you know, that these people are also human. They've also got*

> *feelings and they—you know, they try their best to do their job.* (Brenda, mediator)

Not only can this approach improve the relationship between the parties, but it can make the process less distressing for those involved.

Enhanced Communication & Understanding

We saw examples in which parties were able to communicate more openly with each other during and following mediation and examples in which people had learned how their actions or words had impacted others when they had previously been unaware. This was predominantly seen for HCPs who seemed to have their guard up when it came to disputes:

> *they have to have this barrier up because they cannot be emotionally in touch with everyone all the time. Because otherwise they'd become overwhelmed. You know, it's a safety guard.* (Georgia, mediator)

For some participants, such as family members, the mediators helped to break down these barriers to open up communication between the parties. This then allowed family members in particular to gain a clearer understanding of the clinical information regarding their relative. For example, in observation one we saw that the communication between the parties had improved since the first mediation, with the parties reporting positive feedback and remarking that the agreements from the first mediation resulted in agreements and the parties were communicating better. Similarly, mediation worked to improve understanding of the other party's point of view, even if this did not ultimately lead to resolution. Discussing an end-of-life case which she had mediated, one participant explained:

> *I think from what I remember we did have a session at the end with everyone in the room, just sort of saying where we'd got to and all of that.*

> *And there were some questions that the family had, I think, which were responded to by the doctors about sort of practicalities and things. And my recollection of it is that we also spent a bit of time talking about, if treatment was withdrawn, what would that actually look like? And how would it work in practice? It wasn't a successful mediation because by the end of it the family said, "Well, we understand why you've said all of that and we understand that if it goes to court that's going to be the answer but—and we still don't want to be—we still don't feel able to agree to it. And so, it'll—there'll have to be a court hearing anyway."* Nadine (lawyer and mediator)

This quote illustrates that for several participants, they saw benefits in the mediation process working to enhance communication and understanding between the parties, which in itself could be therapeutic even where it did not lead to resolution.

Voluntary

Participants should have the choice to engage in mediation and to reach agreed outcomes. This is important as there is some criticism of TJ in the literature for its potential to be coercive. Despite mediation being a voluntary process, there is still concern that there may be elements of coercion in mediation such as attempts to influence, force or persuade parties to act in a certain way or do things they are unwilling to do. This was present in two ways – process coercion and outcome coercion.

Process coercion refers to instances in which parties may have felt pressured or obligated to participate in mediation, whereas outcome coercion refers to concerns that mediation may be used by HCPs to coerce family members into an outcome with which they would not be comfortable or agree with, thereby potentially undermining the patient's best interests.

The data showed that participants rarely experienced any pressure to agree outcomes at mediation against what they believed were in the adult or child's best interests. However, there was some evidence of process coercion in children's cases, as

several paediatric HCPs expressed feeling obligated to engage in mediation despite thinking that it would be futile or not suitable for the case. Several paediatric HCPs described mediation as a 'box-ticking' exercise they were expected to go through before issuing legal proceedings and that the pressure to mediate comes from the courts:

> *We're in the position today where clinical teams are expected to have gone through a mediation process by the time they end up in court. But I think ... it's still at the moment more of a tick box exercise at the end of that pathway. (Caleb, paediatric intensive care consultant)*

Several mediators expressed that mediation requires an openness and willingness to engage. If HCPs are approaching mediation only because they feel pressured to, this is unlikely to be conducive to the spirit of collaboration and participation that is expected of mediation. Some HCPs did feel positive about engaging in mediation though, albeit only two of the seven paediatric HCPs expressed strongly positive views (see Kai's reflection below). Social workers or care provider professionals who worked in the adult health and care context were more positive about mediation than HCPs in paediatric cases, although four out of five of these participants interviewed were all involved in the same mediation process (observation one) and therefore may not reflect wider experiences of adult health and care mediation.

> *And that is why I feel mediation can play a significant role. It has got its… you know—and I wouldn't want to say downsides; I think unintended consequences as a result of that—going down that route. But I think if you were to take the whole picture into account, you know, and I think it's a positive thing more than, you know, a negative thing. (Kai, neonatologist)*

Closedness

Some participants, particularly HCPs, expressed a sense of closedness towards mediation and were hesitant to attempt mediation or had pessimistic views about it. Several

paediatric HCPs (four out of seven interviewed) were closed to mediation's use as they struggled to see its utility. For some, as noted above, mediation was perceived as a box-ticking exercise under pressure from the courts to attempt mediation. As well as HCPs being closed to mediation, some participants recounted instances in which family members appeared closed to mediation too, either because they were closed to the idea of resolution or closed to the process itself. The reasons for closedness were mixed and included that HCPs and family members were emotionally drained and exhausted from the dispute process, a lack of trust towards the mediator and sometimes, particularly for HCPs, that they believed they were already communicating effectively and so there was nothing further to be achieved at mediation.

Should Mediation be Used as a Form of Therapeutic Justice?

In most of the health and care disputes we explored in this research, the paramount legal consideration is the best interests of the individual at the centre of the dispute. However, there have been concerns expressed elsewhere as to whether mediation can adequately protect an individual's best interests.[50] The concern is that the mediation process, which has limited accountability to the court and is not subject to any external scrutiny, lacks sufficient safeguards to ensure the patient's best interests are being protected and prioritised, even if there may be other therapeutic benefits to mediation. To answer the question of whether mediation should be a form of TJ, we identified that it must still be able to secure the patient's legal rights and, in most instances, this should be viewed through the prism of their best interests. We conclude that mediation has the potential to secure a patient's best interests,[51] but more transparency of mediated outcomes would contribute to our understanding of whether and how it does so.

[50] For further discussion see n7.
[51] For further detailed discussion about this see Jaime Lindsey and Gillian Francis, 'Compromise, Coercion and Delay: Best Interests Decision-Making in Mediation of Paediatric Medical Treatment Disputes' (Under Review).

Compromise

There was little evidence in this research to suggest that mediation led to compromised agreements which undermined the patient's best interests. For example, one parent we spoke to expressed acceptance of the decision and she said that she felt the decision was in her child's interests:

> *Interviewer: Okay. And did you think that the agreement reached, that care plan reached, did you feel that was in your son's interests? Were you happy that it was the right thing for him?*
>
> *Lola: Yes. Yes, it was. Yes … It was. It was. And I felt like that coming, the mediator being involved, was the best thing that could have happened to us in that moment.* (Lola, patient's mother)

Several HCPs explained that for a dispute to reach the point of mediation, it is usually because the clinicians are convinced that their position would be in the best interests of the adult or child. Further, by the time the parties have approached mediation there will already have been several attempts at (mostly internal) dispute resolution so many participants, particularly HCPs, feel that there is not much left for them to give at this stage because they are not willing to compromise on what they view as the patient's best interests:

> *The mediation process is on to a loser there from the outset … because the clinical teams aren't left with anything to give.* (Caleb, paediatric intensive care consultant)

He further explained:

> *And by that time, you know, everybody's written their statements, which, because of the – the legal structure we have to work with it, are very black*

> *and white. And, you know, we don't have anything to give at that stage because, you know, the only decision is ... whether the treatment is in the child's best interests or not, and everybody is completely entrenched at that point. Any compromising suggestion has been beaten out of people's opinions by the time they get there, so the only time that – that we have something to give from the clinical side is at the outset in the early weeks and months.* (Caleb, paediatric intensive care consultant)

While there was no evidence from the participants we spoke to that HCPs were willing to compromise on their view of best interests, there was evidence that the process of mediation may still help to support all involved to move away from entrenched positions and to explore where there may be room for other ways forward which might not have been possible before because of the impact of the dispute on all involved.

Delay

Delay appeared as the biggest challenge for using mediation in best interests disputes, particularly for paediatric end-of-life cases, but delay was also a theme identified in cases concerning adults. One participant explained 'at the bottom of it there is a patient who is suffering… very often the prolongation of things doesn't really help the individual' (Rowan, paediatric intensive care consultant), and another said, 'it [mediation] definitely does prolong it [the case]' (Nadine, lawyer). However, the exact detrimental effect of delay is subjective, linking with wider criticisms of the best interests test itself which has a degree of subjectivity within it. Delay can be seen as beneficial in end-of-life cases in the sense that it gives families more time with their family member. Also, as one participant remarked, having families in agreement with the decision can be in the best interests of the patient. Further, mediation can sometimes help parties come to terms with an agreement, lead to partial agreements or help people address the underlying issues which may be preventing them from reaching agreement. As one party noted, it is an important decision and so it can be beneficial to take the time to ensure the decision is given due consideration. However, delay can also risk prolonging suffering for the

patient. The decision whether to attempt mediation must balance the risk of delay and its impact on the individual at the centre of the dispute and the potential benefit of reaching an agreement via mediation.

Other Research Findings

The role of religion

Another theme that emerged from the research was the role of mediation in disputes with a religious dimension. This theme was more prominent in paediatric disputes than disputes concerning adults. Key findings included: the impact of religion on best interests disputes, religion and entrenched views in mediation, and the role of religious support for families in mediation.[52]

> *I was slightly dubious at that point as to whether it [mediation] would be of any benefit, because this family's views were ... very clearly based around their religious views um, and the sanctity of any life.* (Jack, paediatric intensive care consultant)

The impact of religion in best interests disputes

Despite concerns that religion was a contributing factor to the initial breakdown of relations between parties, the research showed no evidence of religious views alone being a barrier to mediation. An emerging issue was that some participants had felt as if their religious views were being weaponised against them:

> *[the parents] felt that their religious views were being kind of used against them and they were being regarded … almost as a sign of mental ill health… they were feeling that [their views] were sort of being weaponised against them.* (Abigail, mediator)

[52] For further analysis of the role of religion see Jaime Lindsey, 'Mediating Religious Disputes About Children's Medical Treatment: A Qualitative Study' BMJ Paediatrics Open (accepted).

In fact, we found no instances of religious beliefs leading to agreements which obviously undermined the child's best interests. In most cases where there was a religious element to the dispute, family members who held religious beliefs either agreed and accepted the recommendations of the HCPs or they refused to accept them and proceeded to a court hearing; but there was no data to suggest that HCPs were reaching agreements due to pressure stemming from the family's religious perspectives.

Religion and entrenched views in mediation

The data showed some overlap between parties who held entrenched positions during the dispute and those who also held religious beliefs. However, this was not to say that disputes in which there was a religious element were necessarily not suitable for mediation; in many cases, it was the attitude of the parties that contributed to the entrenchment of the dispute rather than the fact they held religious views. Several HCPs, both chaplains and the family member we spoke to expressed the view that disputes which had a religious element could still be mediated because there can be nuances to faith and religious beliefs that allow room for discussion between the parties.

> *I think it's probably wrong to say that because somebody's got very strong faith-based views they are unlikely to change their mind ... Because I think within all faith communities there are a range of viewpoints.* (Marcus, chaplain)

The role of religious support for families in mediation

We found that participants whose religious beliefs played a role in the dispute may benefit from religious support throughout the mediation process. This means that including religious supporters in the mediation can help provide family members with emotional and spiritual support throughout the mediation process, advise on religious doctrine, and provide spiritual direction on how to move forward in ways which can be achieved through mediated agreements:

> *The family have got themselves stuck in a place based on a faith claim that's not quite right, and our own chaplains are perceived to be a bit of the hospital and then you get someone in from their life er, and that can be super helpful*. (Rowan, paediatric intensive care consultant)

Which cases are suitable for mediation?

The research identified several factors which can help to identify which cases are suitable for mediation. This is not an exhaustive list, as this was not the focus of the research. However, these questions may be helpful in assisting mediators and other professionals to identify which health and care cases may benefit from mediation.

Are the parties open to mediation?

Whether the parties are open to mediation is a key indicator of suitability. The parties should be open to engaging in the mediation and willing to follow the process, ground rules and agenda that they have agreed with the mediator. For example, one mediator explained that she refused to mediate a case on the basis that she did not feel she had 'full buy in from all the parties' (Elizabeth, mediator). The important feature to identify here is whether the parties are taking part in the mediation voluntarily and do not feel coerced or pressured into doing so.

> *There's got to be some sort of openness to the experience of participating and engaging in mediation. If somebody is literally just so angry, so wound up that they just can't—they're—you know, they are literally, like, "A judge has got to, like, beat these people up because I hate them," and therefore there's just no piercing that hostility, then that's hard to imagine that that party is going to be able to do anything other than act out in a mediation sphere*. (Katherine, mediator)

Are the parties open to resolution?

The suitability of mediation depends on the parties' openness to reaching a resolution. This does not mean that parties should come to the mediation with an agreed resolution, rather, that they are open minded about reaching one. This was illustrated in some comments by mediators regarding which disputes they would not be willing to mediate:

> *Because there is one I think I would refuse… It's something where with the person says 'I only want this and nothing's gonna change my mind', then I might say 'I'm not… I don't think I'm not sure there is territory for mediation'. So, I've had situations like that and uhm although of course generally people come to mediation saying 'I only want this', so again I try to distinguish between*. (Abigail, mediator)

As this mediator notes, most parties will come to mediation with a view of what they want as their preferred outcome. However, this is distinct from one or both parties being expressly unwilling to reach any resolution at the mediation. For example, where the parties do not desire a resolution, mediation is unlikely to be suitable. This was seen in instances where a patient's family members felt unable to make the decision to withdraw treatment and they wanted the decision to be taken out of their hands and made by the court:

> *You know, the family hugged our barrister afterwards, because they just wanted a resolution … it was a faith-based situation where they didn't feel they were ever allowed to stop until someone in authority could say stop. Which isn't a doctor it's a court*. (Rowan, paediatric intensive care consultant)

Is a creative resolution possible?

Mediation may be well suited in a case where there is the possibility of a creative resolution. This does not have to be a complete legal resolution of the issue but can

involve agreements that nonetheless benefit the participants and the patient. In end-of-life cases, parties might collaborate on agreements about visits, where care takes place, and communication while remaining in disagreement about proposed withdrawal of treatment. Creative outcomes are also possible where the parties are seeking further information, acknowledgement or even an apology. Typically, where parties were completely polarised in their opposing views with no possibility of creative resolution, the case was deemed by mediators and other participants in the research as less suitable for mediation. For example, one participant (Nadine, lawyer) explained that mediation may be easier in adult welfare cases where the person is going to be living in that care arrangement for the future so it is in everyone's interests to 'figure out a way of making this work'.

Are there any safeguarding concerns?

There were concerns from some participants in the research that mediation may not be suitable in cases of extreme hostility between the parties. It is common that parties in mediation will have some hostility towards each other due to the nature of the conflict. However, mediation may not be suitable where there are safety concerns which go beyond general hostility into concerns about whether the mediator can safeguard the parties within the mediation space.

One mediator explained that she had ended mediation in cases where she felt that 'the parties weren't able to engage in a successful manner and where there were safeguarding issues' (Elizabeth, mediator) that she felt were not being addressed. This was also identified in observation two in which the mediator decided not to continue mediating the dispute. Another participant (Nadine, lawyer) suggested that there are some cases where the family, for example, may have been 'really unpleasant to the doctors and kind of accused them of being murderers and … behaved really badly towards them', and those cases may be 'too late to try and salvage'.

Is there time pressure to resolve the dispute?

Timing was another key factor in mediation suitability. While some mediators believed there is never a situation where it is too early or too late to mediate, most participants mentioned the importance of mediation taking time and needing to take place over more than one meeting through several mediation sessions, making it more difficult to mediate in highly time-pressured scenarios. Several participants raised the importance of bringing in mediation early before the situation deteriorates as, if too much time has passed, it may be too late for mediation as the parties become too polarised in their positions.

This is also linked to the finding above regarding delay, namely that mediation may not be suitable in circumstances where it may cause unnecessary delay in reaching a decision. For example, some participants pursued mediation because they felt process coercion (as noted above) to do so, even where they believed that the mediation had no prospect of success. As the participant expected, the mediation did not lead to a resolution and they recounted it as a waste of time as the parties still had to pursue legal proceedings. In circumstances such as this, where parties expect from the start that mediation will not be helpful based on the particular facts of the case at hand and consider that they need a decision from the court instead, then it makes little sense to delay this decision by attempting mediation.

5. Outcomes of Mediation

We saw a wide range of outcomes from mediation, including:

- agreements to withdraw treatment;
- agreements to make tentative or temporary agreements;
- agreements to test ideas and resolutions and return to mediation to discuss their suitability;
- improved communication pathways between the parties;
- agreements for the parties to procure/provide further information;
- agreement shortly after the mediation;

- no agreement.

Agreements to withdraw treatment were seen in four of the interviews, (Kai, Lola, Abigail, Marcus) and there was one case in which there were partial agreements regarding the continuation of life sustaining treatment (Philip). In some of the adult health and care cases, as in observation one, we saw participants collaborating to reach agreements and testing them over the course of the mediation process before returning to provide their feedback on how well they worked. In the first observed mediation, we heard that the parties had previously agreed several outcomes in their first mediation session. At the second joint session, the parties fed back that those agreements had been working well and they expressed satisfaction with them. They then built on these in the second session; for example, the parties had previously reached an agreement regarding monthly meetings, and after testing this out, they were pleased with them and wanted to continue them:

> *Communication across the board and between me and [father]. Monthly meetings – I've enjoyed them and like hearing [father's] input. Want [ZB's] support plans to be reviewed by everyone and everyone's point of view taken into account. ZB is very happy and having good interactions with family*. (Participant from Observation 1)

A common outcome was improved communication between the parties. In all three observed mediations, we saw examples of how communication between the parties had improved. The mediation processes had facilitated open dialogue between the parties who left with an open channel of communication between them. In observation two, for example, even though the parties did not proceed to a joint mediation session, the mediator explained that the pre-mediation process was still useful as it facilitated effective communication between the parties, so much so that the parties were able to reach an agreement after she withdrew from the mediation. In the interviews, there were several examples in which the parties described having tense relationships prior to the

mediation which were improved following the mediation process. Another example where mediation improved communication was where it resulted in an agreement to provide further information; for example, in observation three, the HCPs agreed to provide more information to the family and acknowledged the need to improve on poor communication:

> *We're aware that we don't communicate well. Lots of reasons – the busyness of the place, and sometimes we're a little afraid and want to avoid having difficult conversations … we need to get the team to be more effective … Sorry. We need to do better. If in future you feel you're not being told, please challenge us on it. I don't want to put the burden on you. But it's important to let us know.* (HCP, Observation 3)

We also saw the use of creative outcomes in mediation. Some examples included the family members being allowed to conduct prayers for their loved ones in the hospital, family members and HCPs collaborating to draft a care plan for the patient. In observation one, the HCPs offered to provide training to the patient's family members so they could better understand the care that was being provided:

> *You know, Dad would like to know more training, have more training. So that's been sourced … we are gonna compromise and some of the workshops for his, his individual team, we're gonna invite Dad to those. They're kind of part training, part kind of person-centred working. So we'll have dad and either nan or the daughter there as well.* (Amanda, care provider professional)

Finally, there were examples where no agreement was reached at mediation. However, there may still have been therapeutic benefits for some participants (although we were also provided with examples where no benefits were believed to have accrued).

> *It became clear that … the trust and the family were not able to agree. But what they were able to agree on was that there was no need for oral evidence from the clinicians at the final hearing …. And so, the various clinical witnesses were able to be stood down. They didn't have to come to the final hearing. And the evidence at court was simply the evidence from the family members … So that was some benefit.* (Laurence, lawyer)

6. Recommendations

Drawing on the research findings, we make the following recommendations regarding mediation in health and care disputes.

Increased Transparency Surrounding Mediated Disputes

- We recommend that there is increased transparency about the use of mediation in disputes which reach court proceedings. We suggest this can be achieved in three ways:
    - Including a question regarding whether mediation has been attempted on the relevant court application forms.[53] We recommend that all court forms relating to health and care disputes concerning children or adults should include a clear question regarding mediation's use which will enable court data to be collected to identify when mediation has been used. We recommend the wording:

[53] In adult cases under the Mental Capacity Act 2005 there is no question on the application form (COP1) which asks about whether mediation has been considered or attempted. In children's cases issued either under the Children Act 1989 (form C100) or through the inherent jurisdiction of the High Court (form C66) there is already a question which asks whether the parties have attempted family mediation. It is unclear whether this is intended to capture mediation between family members and HCPs or only mediation within families (as the questions refer to 'family mediation'). We also note that there is a lack of clarity over whether the inherent jurisdiction of the High Court or the Children Act ought to be used in these cases, for further discussion and a strong case for using the Children Act see, Rob George, *Wards of Court and the Inherent Jurisdiction*, n35.

> 'Has mediation or any other form of non-court dispute resolution process been attempted? If 'Yes' please provide details of the process and why you are still seeking the above order. If 'No' please provide reasons as to why this has not been attempted'.[54]

- Once the above has been incorporated into court forms, we recommend that this data is published in the Family Court Statistics by breakdown of case, to show how many and which type of cases have been mediated.[55]
- We recommend that judges record in published judgments when they are aware that the case has been mediated.

Publication of Anonymised Details of Mediated Cases

- We recommend that public bodies (specifically NHS Trusts, primary care organisations and local authorities) should publish anonymised details of mediated cases they are involved in.
    - This could be done in case study format or as a list of features of the mediated dispute, including subject matter and outcome. Publishing details of mediated cases may help address some of the misconceptions around mediation and allow professionals to understand when mediation is used effectively.
- Mediation providers should consider publishing anonymised data regarding their mediations.
    - Some mediation organisations such as the Medical Mediation Foundation publish anonymised case studies on their website. It is

[54] This recommendation relates to data gathering only and is not intended to imply the court should take any role in judging whether or not the parties should have attempted mediation.
[55] We have reviewed the statistics which do not break down the number of health and care cases concerning adults and children and which have been mediated and so this data is not currently accessible.

important that publication occurs for all mediations, not just those that have successfully been resolved through mediation.[56]

Representation of the Child or Adult Subject

- We recommend that the adult or child who is the subject of the mediation should have their views represented at the mediation either through direct or indirect participation.[57] We note that this is more challenging to achieve in cases which are mediated at the pre-issue stage.
- We recommend that there is an obligation on all parties to the mediation to consider whether representation of the patient's views can be secured (even at pre-issue stage) before proceeding with mediation. This need not be a formal representative under the Mental Capacity Act 2005 or a children's guardian under the Children Act 1989.[58]
- We recommend that, in any best practice guidance, there should be a specific obligation on the mediator to ensure that the patient's wishes are represented at the mediation.

Educational Materials and Information Sessions

- We recommend the development of educational materials regarding mediation which can be shared with potential participants in advance of mediation's use.

[56] We note that the MMF Code of Conduct states at 3.1(i) that the mediator will not disclose 'the fact that a mediation between the participants is taking place or has taken place'. We suggest this is too onerous and inhibits proper transparency regarding mediation.
[57] We note there may be objection to this where the person at the centre of the dispute is unwell or too young to clearly express views verbally, however, there are ways to ascertain the views (past or present) in those cases, see Laura Lundy, ''Voice' Is Not Enough, n49; Mary Donnelly, Ursula Klikelly, 'Child-Friendly Healthcare: Delivering on the Right to Be Heard' (2011) 19 Medical Law Review 27; Anita Franklin and Patricia Sloper, 'Listening and Responding? Children's Participation in Health Care within England' (2005) 13 International Journal of Children's Rights 11, 12– 4.
[58] Children Act 1989, s 14A.

  - There are some guidance materials provided by the NHS regarding mediation,[59] and by individual mediation organisations,[60] but a centrally commissioned authoritative source of information about mediation would be helpful.

- We recommend that the Ministry of Justice implements a scheme for Mediation Information and Assessment Meetings (MIAM) for health and care disputes, similar to those provided in other areas of the family courts. However, this ought not be mandatory as it would undermine the benefits of the voluntariness of mediation.
- We have developed an information film about mediation as part of this project which provides information about adult and children health and care disputes, which we recommend is shared with interested parties.

[59] Public Participation Team at NHS England, 'Guide 12: A Bite-Size Guide to Mediation Between Patients, Carers and the NHS' (NHS England, 2016) <https://www.england.nhs.uk/wp-content/uploads/2016/07/bitesize-guide-mediation.pdf> accessed 27 May 2025.
[60] 'Medical Mediation: A Guide for Parents' (Medical Mediation Foundation) <https://www.medicalmediation.org.uk/resources/Parent-guide-V1.pdf> accessed 2 July 2025; 'Preparing for a Mediation' (Medical Mediation Foundation) <https://www.medicalmediation.org.uk/resources/Preparing-for-a-mediation.pdf> accessed 2 July 2025.

Guidance published about mediation's use in health and care disputes

- We recommend the development of best practice guidance on mediation for health and care disputes for adults and children:[61]
    - The Family Justice Council, or a comparable organisation in the CoP, may be best placed to commission this. While we do not go so far as to recommend statutory regulation and accreditation of mediators, we do recommend that there should be best practice guidance aligned to secure the TJ benefits of mediation alongside an expectation that mediation training and practice would operate in line with that guidance.[62]
- We recommend that any best practice guidance sets out expectations of training and practice that demonstrate the following features:
    - that the patient must have adequate representation of their views at the mediation to secure their direct or indirect participation;
    - that mediation should not be mandatory and all parties take part on a voluntary basis;
    - that flexibility of the mediation process is maintained to meet different participant needs.
- We recommend that cases should not be mediated where:
    - parties are not open to mediation;
    - parties are not open to resolution;
    - there are safeguarding concerns;

[61] The code of conduct published by the Medical Mediation Foundation on their website would be a useful point of reference in developing best practice guidance, although as noted at n56 above, their position on confidentiality and transparency is too onerous and ought to be amended to allow greater transparency of mediation. Their code includes guidance on how mediators should handle conflicts of interest, how to conduct the process (including ensuring that parties are participating freely and voluntarily), how to protect the welfare of the patient (including taking appropriate steps to ensure their wishes and feelings are considered during the mediation), how to process the agreements reached in mediation and more. Available at: Code of conduct | The Medical Mediation Foundation.

[62] There are practice standards, accreditation requirements, and national registers of accredited mediators in some mediation fields, such as family mediation and special educational needs and disabilities. Mediation is a self-regulated profession in England and Wales, with some government input into requirements in some specific fields, but it is not regulated in the same way as the legal or medical professions are.

- mediation would be likely to cause delay undermining the patient's best interests, or;[63]
- where parties have not been given the possibility of accessing independent legal advice.

[63] This ought to be an obligation on the mediator to consider as part of their decision whether to proceed with mediation.

APPENDIX 1: Anonymised Demographic Data of Participants

	Participants	Primary Role	Secondary Role	Sex	Direct Experience of Mediation (Y/N)	Type of Experience
1	Ed	Mediator	Lawyer	M	Y	Children medical treatment disputes
2	Elizabeth*	Mediator	N/A	F	Y	Children medical treatment disputes; adult health and care
3	Philip	Mediator	HCP	M	Y	Adult health and care
4	Abigail	Mediator	HCP	F	Y	Children medical treatment disputes; adult health and care
5	Rowan	HCP (paediatric intensive care consultant)	N/A	M	Y	Children medical treatment disputes
6	Francesca	Chaplain	N/A	F	Y	Children medical treatment disputes
7	Georgia	Mediator	N/A	F	Y	Adult healthcare complaints; adult health and care
8	Maya	Mediator	N/A	F	Y	Adult healthcare complaints; adult health and care
9	Jack	HCP (paediatric intensive care consultant)	N/A	M	Y	Children medical treatment disputes
10	Marcus	Chaplain	N/A	M	Y	Children medical treatment disputes; adult health and care
11	Amanda	HCP (care provider professional)	N/A	F	Y	Adult health and care

12	Adela	HCP (clinical commissioner and mental health nurse)	N/A	F	Y	Adult health and care
13	Laurence	Lawyer	N/A	M	Y	Adult health and care
14	Maxwell	HCP (social worker)	N/A	M	Y	Adult health and care
15	Yasmin	HCP (paediatrician)	Mediator	F	N	Children medical treatment disputes
16	Lailah	HCP (care provider professional)	N/A	F	Y	Adult health and care
17	Katherine	Mediator	Lawyer	F	Y	Adult health and care
18	Rachel	Lawyer (children's cases)	N/A	F	N	Children medical treatment disputes
19	Kai*	HCP (Neonatologist)	N/A	M	Y	Children medical treatment disputes
20	Lola	Family (Mother)	N/A	F	Y	Children medical treatment disputes
21	Tamara	HCP (consultant paediatrician)	N/A	F	Y	Children medical treatment disputes
22	Laura	Family Supporter	Lawyer	F	Y	Children medical treatment disputes; adult health and care
23	Brenda	Mediator	Lawyer	F	Y	Adult healthcare complaints; adult health and care
24	Nadine	Lawyer	Mediator	F	Y	Children medical treatment disputes; adult health and care
25	Sonny	HCP (consultant paediatrician)	N/A	M	N	Children medical treatment disputes

26	Josephine	HCP (adult critical care nurse)	N/A	F	N	Adult health and care
27	Oscar	Lawyer	N/A	M	Y	Children medical treatment disputes; adult health and care
28	Caleb	HCP (paediatric intensive care consultant)	N/A	M	Y	Children medical treatment disputes

* Two participants were interviewed twice. The first because she was subsequently involved in an observed mediation and we wanted to follow up specifically on that experience. The second because he had more to say about his experience of mediation than the initial interview permitted so a further interview was arranged.