SAMLA GUIDELINES AND PROTOCOL FOR MEDICAL MEDIATION – V11

1. INTRODUCTION – NEED FOR MEDICAL MEDIATION AND A SET OF GUIDELINES AND PROTOCOL FOR SOUTH AFRICA

1.1. It is well-known that South Africa is faced with a medical negligence crisis. Since the beginning of 2015 concerted efforts have been directed at finding solutions for this problem. These efforts have been guided by the Minister of Health of South Africa, the Honourable Dr Aaron Motsoaledi.

1.2. Organisations and institutions of which the authors are aware, which have contributed to the development of solutions or reducing the harm associated with this crisis, have included the South African Medico-Legal Association (SAMLA), Mediation in Motion (MiM), Conflict Dynamics (CD), the South African Society of Obstetricians and Gynaecologists (SASOG), the Society of Neurosurgeons of South Africa (SNSA), The South African Spine Society (SASS), the South African Orthopaedic Association (SAOA), the National and Provincial Health Departments, the ANC Legal Research Group, the Medical Protection Society (MPS), Natmed Medical Defence and Constantia Ethiqal Insurance Company.

1.3. As much as the term “medical negligence” is in widespread use, claims for compensation are not confined to allegations related to treatment by “medical practitioners”. Many claims are lodged on the basis of alleged negligence by health care professionals who are registered in categories other than “medical practitioner”. For this reason all instances of the term “medical negligence” in this document should be taken as synonymous with the term “clinical negligence”.

1.4. It has become abundantly clear to the authors, and is now widely accepted in the public health sector, private health sector and health insurance industry, that mediation of medical disputes is a crucial and central element of any viable solution. Mediation is intended to be an informal, voluntary, confidential, consultative and without prejudice process of assisting the parties to reach a mutually satisfactory resolution of their dispute.

1.5. In addition, mediation is a flexible process. This means that mediators may adapt the process to suit the issues and needs of the parties.

1.6. Against this background the following practical circumstances pertain : -

1.6.1. There is a great need for medical mediation in South Africa, and there are many existing medical disputes that would benefit from mediation.

1.6.2. Mediation of medical disputes has been implemented with success in other countries.

1.6.3. Parties to medical disputes and their legal representatives are unsure about where to find and how to identify safe and reliable medical mediators.

1.6.4. There are sound mediator training- and accreditation organisations in South Africa.

1.6.5. An ever increasing number of South African professionals, from a variety of medical-, legal- and other disciplines, have already been trained and accredited as mediators.

1.6.6. Newly accredited mediators, despite a desire to mediate medical disputes, are often insecure about how to get going in the real world and in any event do not receive referrals.

1.6.7. There are different kinds of medical disputes, some of which have challenging conceptual, scientific and legal issues at their very heart.

1.6.8. Introduction of mediation for medical disputes in large scale will “upset some apple carts”, as it is perceived to be, at least in the short-term, to the disadvantage of certain role players in the litigation of medical disputes.

1.6.9. There is a substantial body of opponents to mediation, some of whom may be opposed out of concern for the challenging conceptual, scientific and legal issues, while others may be opposed out of concern for their personal interests.

1.6.10. If mediation of medical disputes is initiated without properly considering and addressing the conceptual, scientific and legal issues, such mediation will be at risk of failure and is likely to become the target of attack by those opposed to mediation.

2. STYLES OF MEDIATION

2.1. Different styles of mediation are recognised and practiced internationally. In view of significant inherent differences between these styles, it is important to be clear which style is being referred to in any discussion about mediation. Parties to any dispute may accept one or more styles and reject others, and adverse experience with a particular style should not prevent a party from considering a more suitable style.

2.2. In brief these styles are : -

2.2.1. Adjudicative Mediation. This process is similar to an arbitration, in that the jointly appointed mediator makes a ruling on the issues in dispute, but differs in the sense that the parties are then free to accept or reject the ruling.

2.2.2. Evaluative Mediation. The mediator assists the parties to reach a solution by evaluating their respective cases, by having regard to their legal rights, and by making recommendations. The mediator controls the structure and influences the outcome of the mediation.

2.2.3. Facilitative Mediation. The mediator facilitates a process of communication between the parties, through questioning and active listening, by having primary regard to the interests and needs of the parties, and by assisting the parties to craft their own unique solution based on information and understanding. The mediator controls the structure and the parties determine the outcome of the mediation.

2.2.4. Transformative Mediation. The mediator facilitates a process of empowerment of the parties, seeking recognition by each of the other's needs, interests, values and points of view. This process seeks primarily to transform the long-term relationship between the parties, with or without reaching agreement on the index issue in dispute. The mediator and the parties control the structure of the mediation together, while the parties determine the outcome.

2.3. Whereas the above-named styles of mediation are seen as adjacent parts of a continuum from most interventionist to least interventionist, and whereas parties to any mediation are free to elect the style of their choice, the authors do not recommend the use of Adjudicative Mediation or Evaluative Mediation for resolution of medical disputes in South Africa.

2.4. The recommendations in this document refer to Facilitative Mediation and/or Transformative Mediation. As is clear from the above, Facilitative Mediation and Transformative Mediation have much in common. In practice the authors have found benefit in combining these two styles in the same mediation, usually commencing with the Transformative model and, after the fires have settled, moving seamlessly to the Facilitative model.

3. EVOLUTION, PURPOSE, SCOPE AND AUTHORITY OF THESE GUIDELINES AND PROTOCOL

3.1. Mindful of the above issues, the authors, who have been closely involved with the efforts of organisations and institutions referred to above, have taken the initiative to fill a void by drafting a plan to assist the introduction of safe and effective medical mediation in South Africa.

3.2. Further to their training and accreditation in mediation, the concepts and recommendations incorporated herein are based on the experience of the authors in medico-legal litigation in South Africa, as well as extensive discussions with experienced mediators and with lawyers and medical experts who are experienced in the litigation of clinical negligence disputes in South Africa.

3.3. The plan, which is offered as a public service, subject to review, constructive engagement and improvement with experience, consists of : -

3.3.1. A proposed Guidelines and Protocol for Medical Mediation (this document).

3.3.2. One or more pilot projects to be conducted by senior experts (separate documents).

3.3.3. The establishment of a Register of Medical Mediators (separate documents).

3.4. This document is intended for use by accredited mediators who wish to contribute their professional services to the mediation of medico-legal disputes and/or other disputes that occur in a medical environment.

3.5. It is assumed that accredited mediators are already suitably trained in the styles (see below), procedures, art and skills of mediation. The guidelines and protocol are intended to be used in addition to existing standard mediation guidelines, procedures and protocols, and makes no attempt to duplicate the well-known principles or procedures of mediation in general.

3.6. The authors are mindful of the fact that the introduction of mediation for medical disputes in South Africa is an exciting and pioneering venture, filled with the promise of great cost-saving- and other benefits to both public- and private health services and embattled medical specialists, as well as the promise of personal satisfaction to all participants.

3.7. At the same time the authors are mindful of potential resistance from parties and their representatives, as well as potential pitfalls and risks to parties and mediators.

3.8. The document is intended to assist mediators in maximising the potential benefits of medical mediation and minimizing the potential risks. It also seeks to re-assure parties and their representatives by acknowledging and addressing their concerns.

3.9. To facilitate the achievement of these aims, the guidelines and protocol provide for the introduction of pre-mediation meetings, recognizes that there are different types of medical dispute, provides separate recommendations in relation to each type, and addresses particular issues that form part of many medical disputes.

3.10. As a further safety measure the guidelines and protocol recommend that, at least in the beginning, Technical Medico-Legal Mediations (see below) should be conducted by two suitably qualified and experienced Technical Medico-Legal Co-Mediators (see below).

3.11. The guidelines and protocol are intended to be a dynamic instrument, subject to amendments that are expected to occur over time on the basis of lessons learned, as well as constructive suggestions that may be offered to the authors.

3.12. The guidelines and protocol have no authority. It is merely a set of recommendations based on the experience and understanding of the authors. Specific recommendations contained herein may be adapted in any particular case, depending on the circumstances of the case, by any legal agreement between the parties and the mediator/s. In line with the voluntary and flexible nature of mediation, it should be borne in mind that the only true authority in mediation derives from agreements between the parties.

4. TYPES OF MEDICAL/CLINICAL MEDIATION

4.1. It is necessary to appreciate that there are two fundamentally different types of medical/clinical mediation, and that the second type has two subtypes.

4.1.1. The first type of mediation that arises in the health sector may be called “Health Sector Commercial Mediation”(HSCM). This type of mediation concerns disputes that are unrelated to scientific knowledge and expertise, but more related to conflicting interpersonal relationships between health carers, hospital staff and/or management or any financial improprieties allegedly committed. Although disputes of this type may arise in a medical setting, such as at a hospital or between a health carer and a patient, they do not require particular scientific knowledge and expertise to reach resolution through mediation.

4.1.2. The second type of mediation may be called “Technical Medico-Legal Mediation”(TMLM). This type of mediation concerns medical- and other issues where scientific knowledge and expertise are required to enlighten the parties. Technical medico-legal mediations include two distinct subtypes : -

4.1.2.1. Subtype A may be called “Technical Medico-Legal Mediation – Clinical Negligence” (TMLM-CN). These relate to disputes which include allegations of clinical negligence and damages brought about by the alleged negligence. They require appropriate expertise to enlighten aspects of negligence, outcome, causation, apportionment and/or quantum of damages.

4.1.2.2. Subtype B may be called “Technical Medico-Legal Mediation – Personal Injury”(TMLM-PI). These are less complex in that they do not require considerations of negligence, and in that the “merits” of these claims are typically resolved without any need for expert evidence. Claims of this nature do, however, require appropriate expertise to enlighten aspects of outcome, causation, apportionment and/or quantum of damages.

5. REGISTER OF MEDICAL MEDIATORS

5.1. At the time of compiling this document, in June/July 2017, competent and confident medical mediators are in very short supply in South Africa. Additionally, many trained and accredited mediators, who wish to mediate medical disputes, do not know how to get started.

5.2. These guidelines and protocol seek to address these problems by recommending the compilation of a Register of Medical Mediators, and providing guidelines for their use. It is recommended that the names and other details of mediators should be entered into such register in the appropriate one of three categories, namely : -

5.2.1. Health Sector Commercial Mediators. The qualifications for this category are a suitable professional in good standing who (a) is an accredited mediator AND (b) has certified that he or she abides by the DISAC Code of Professional Conduct for Mediators, AND (c) commits to contributing his or her professional services to the mediation of medical disputes.

5.2.2. Technical Medico-Legal Co-Mediators. The qualifications for this category are all of the above plus (d) a senior health care practitioner with considerable medico-legal experience which includes experience in litigation of medical/clinical negligence disputes, OR (e) a senior legal practitioner with considerable medico-legal experience which includes experience in litigation of medical/clinical negligence disputes OR (f) a senior mediator with extensive experience in various types of mediation, whether medical or non-medical. Health care- and legal co-mediators should have an adequate understanding of the medico-legal concepts of negligence, outcome, causation, apportionment, quantum of damages and legally privileged peer review meetings.

5.2.3. Technical Medico-Legal Sole Mediators. The qualifications for this category are all of the above plus (g) sufficient experience in co-mediation of Technical Medico-Legal Mediation – Clinical Negligence (see above) matters to achieve

the necessary self-confidence and peer recognition to mediate technical negligence disputes on their own. Technical Medico-Legal Sole Mediators should have an advanced understanding of the medico-legal concepts of negligence, outcome, causation, apportionment, quantum of damages and legally privileged peer review meetings.

5.3. The Register of Medical Mediators, although established in Gauteng, will be open to accredited mediators in all provinces who wish to contribute their professional services to the mediation of medico-legal disputes and/or other disputes that occur in a medical environment. It is anticipated that this Register will develop into a National South African Register of Medical Mediators.

6. INITIATION, DEVELOPMENT AND TRANSFORMATION OF MEDICAL MEDIATION IN SOUTH AFRICA

6.1. It is considered that all Health Sector Commercial Mediators are already suitably trained in the nature, procedures, art and skills of mediation, to be able to conduct satisfactory Health Sector Commercial Mediations. Parties to such disputes are advised to refer their disputes to Health Sector Commercial Mediators whose names appear on the register.

6.2. It is considered that, at least in the beginning, Technical Medico-Legal Mediations should be conducted by two suitably qualified and experienced co-mediators from the fields of medicine and law or mediation, at least one of whom should have an adequate understanding of the medico-legal concepts of negligence, outcome, causation, apportionment and quantum of damages. Parties to such disputes are advised to refer their disputes to Technical Medico-Legal Co-Mediators whose names appear on the register.

6.3. In the interests of transformation and development, the guidelines and protocol recommend the inclusion of keen Health Sector Commercial Mediators as observers at Technical Medico-Legal Mediations, for the purpose of in-service exposure to, and training in, the complexities of Technical Medico-Legal Mediations.

6.4. It is envisaged that, by adherence to their training in mediation, their professional ethics, the spirit of mediation and these guidelines and protocol as they evolve over time, observer Health Sector Commercial Mediators will develop into safe and effective Technical Medico-Legal Co-Mediators, and that Technical Medico-Legal Co-Mediators will develop into safe and effective Technical Medico-Legal Sole Mediators.

7. PRE-MEDIATION MEETINGS

7.1. Prior to any agreement between parties to enter into medical mediation (rather than to arbitrate or litigate or appoint a single referee), they should agree to attend a pre-mediation meeting chaired by an accredited mediator. It is recommended that the chairing of pre-mediation meetings be offered free of charge as a public service by accredited mediators.

7.2. The first task to secure a successful medico-legal mediation, is for all participants to understand the nature of the dispute required to be resolved.

7.3. The purpose of the pre-mediation meeting will include properly informed consent, to be confirmed in an agreement to mediate, as well as determination of the issues in dispute and the participants in the mediation.

7.4. Please refer below to the agenda for medico-legal pre-mediation meetings, which sets out issues to be discussed and agreed in such meetings.

8. MEDIATION OF TECHNICAL MEDICO-LEGAL DISPUTES

8.1. Caution

8.1.1. It is important to ensure proper consideration of legal- and medical issues, and to level the playing fields between the disputants.

8.1.2. The recommendations set out below have been designed inter alia to remedy any imbalance that might exist between an uninformed and lay patient on the one hand and a skilled and knowledgeable healthcare practitioner, manager and/or insurer on the other.

8.1.3. Disputes of this nature may not be capable of resolution at a single sitting. Mediators faced with such disputes should consider the specific issues, and should discuss these with one another and the legal representatives of the parties.

8.2. Mediators

8.2.1. Parties to the dispute should agree on the appointment of two Technical Medico-Legal Co-Mediators or one Technical Medico-Legal Sole Mediator (see above).

8.2.2. Such appointments should be guided by whether the dispute is of the Clinical Negligence subtype or Personal Injury subtype (see above), and also by the availability of suitably qualified Technical Medico-Legal Co-Mediators and Technical Medico-Legal Sole Mediators.

8.2.3. In the case of Technical Medico-Legal Co-Mediators, one should be a suitably qualified medical practitioner (see above) and the other should be either a suitably qualified legal practitioner (see above) or a suitably qualified mediator (see above).

8.2.4. At least one of the co-mediators should have an adequate understanding of the medico-legal concepts of negligence, outcome, causation, apportionment and quantum of damages.

8.2.5. The medical co-mediator need not belong to the same medical field as the accused medical practitioner, and it may be preferable if the medical co-mediator belongs to a different medical field. This recommendation relates to potential perceptions of bias by complainants. The purpose of employing a suitably qualified medical co-mediator relates to his or her capacity to understand and analyse the expert evidence, and to ask suitable questions to promote understanding thereof by the lay persons at the mediation. The medical co-mediator should not provide, and therefore does not need to be able to provide, any expert evidence in the matter.

8.3. Legal representatives

8.3.1. Each disputant should appoint his/her own legal representative to attend the mediation process, purely in a capacity as advisor to his/her client on the understanding that the mediator/s are in charge of the mediation proceedings and not the legal representatives.

8.3.2. It is recommended that legal representatives who assist parties in medical mediation should be experienced in the specialist field of medico-legal litigation.

8.3.3. As much as it is the right of every individual to choose his or her own legal representatives, the recommendations in the guidelines and protocol are aimed at a high standard of mediation, for which suitably qualified legal representatives, experts and mediators are required.

8.3.4. Legal representatives are necessary in order to advise parties, inter alia in relation to the selection of mediators and experts, appropriate reality checks, risk assessments of BATNA (best alternative to a negotiated agreement) and WATNA (worst alternative to a negotiated agreement), evaluation of expert reports and evidence, questioning of experts, and reducing agreements between the parties to writing.

8.3.5. The reality is that mediation of these disputes will occur “in the shadow of litigation”, i.e. if the mediation does not succeed the matter will probably proceed to court.

8.4. Issues in dispute

8.4.1. Mediators, assisted by the legal representatives of the parties, should determine whether the issues in dispute relate to allegations of negligence, causation, apportionment and/or quantum of damages. Any or all of these aspects that are relevant to the dispute should be properly dealt with in the mediation.

8.5. Appointment of experts

8.5.1. Parties should appoint appropriate medical- or other experts to investigate, analyse and report on aspects that are relevant to the agreed issues in dispute. In making these appointments the parties should be advised by their legal representatives.

8.5.2. In order to limit the number and costs of experts to those necessary to facilitate properly informed mediation, and more importantly to reduce the risk of subconscious bias by experts, parties are urged to find agreement on the joint appointment of a single independent expert in each necessary field.

8.5.3. This goal may not be possible, for example cases in which opposing experts have already been appointed prior to any agreement to mediate; cases in which the parties are unable to agree on the joint appointment of a single independent expert; and cases in which either party loses confidence in a jointly appointed expert. In such cases the parties will naturally be entitled to appoint opposing experts of their choosing.

8.5.4. If the scientific issues in dispute relate to a single field of medical expertise, a single relevant expert should suffice. If these issues span more than one field, it will probably be necessary to appoint an expert in each relevant field.

8.5.5. Experts should be supplied with relevant medical records, reports and other relevant materials that are already in existence.

8.5.6. Experts should ensure that they are objective and unbiased. It must be made clear to appointed experts that their functions are to investigate, analyse and inform the parties, based on their expertise, experience and medical knowledge; to render explanatory medical reports that explain scientific matters in understandable lay language; and to make no attempt to take sides or to make judgments or decisions obo either party.

8.6. Merits experts

8.6.1. Experts appointed to address issues of negligence, outcome, causation and/or apportionment should consult independently with each disputant, i.e. both the patient and the health care provider.

8.6.2. Expert/s appointed only to address issues of causation should be guided by the legal representatives and mediators in relation to whether it is necessary to consult with the patient and/or the health care provider.

8.7. Quantum experts

8.7.1. In the event of the parties' mediated agreement requiring quantification of damages, provision for future treatment and care, or some financial- or other benefit, the parties will jointly appoint one or more quantum experts.

8.7.2. Quantum experts may be required in one or more of the fields of medicine, surgery, nursing, occupational therapy, physiotherapy, clinical psychology, neuropsychology, educational psychology, industrial psychology, or any such field as may be deemed appropriate to the facts of the dispute/s, to investigate the dispute/s and render independent and impartial expert reports in accordance with the above recommendations.

8.7.3. Once the necessary quantum expert reports are available, it may be necessary to appoint an actuary.

8.8. Observer mediators

8.8.1. Mediators are urged to seek consent from parties to allow the attendance of observer mediators (Health Sector Commercial Mediators who are training to become Technical Medico-Legal Co-Mediators).

8.8.2. Observer mediators will not be paid for their attendance, and will be held to the same duty of confidentiality as the mediator/s.

8.8.3. The purpose of this recommendation includes transformation and development of medico-legal practice in South Africa (see above).

9. MEDIATION OF HEALTH SECTOR COMMERCIAL DISPUTES

9.1. It will usually NOT be necessary to appoint co-mediators, as a single experienced and qualified mediator from either a legal-, commercial-, labour- or medical background should suffice.

9.2. It may or may not be advisable for each disputant to appoint his/her own legal representative, to attend the mediation process purely in an advisory capacity to the client on the understanding that the mediator is in charge of the mediation proceedings. Mediation is intended to be an informal, flexible, voluntary, confidential, consultative and without prejudice process of assisting the parties to reach a mutually satisfactory resolution of their dispute. In any given case the mediator should advise parties in relation to the advisability or otherwise of legal representation.

9.3. Depending on the nature of the HSCM dispute, and in the event that the mediated agreement arrived at requires quantification of damages or some financial or other benefit, the parties may appoint an expert or experts in any appropriate field, adhering to the above recommendations relating to appointment of experts.

10. PAYMENT OF THE COSTS OF MEDIATION AND POSSIBLE NEED FOR CONFIDENTIALITY

10.1. Professional fees for legal representatives will be agreed between each party and his/her legal representative, who will also agree whether these fee agreements are to remain confidential. This type of agreement should preferably be concluded prior to the pre-mediation meeting. The chairperson of the pre-mediation meeting will not inquire into the nature or details of the fee agreements, but may enquire into the existence of such agreements and whether they are satisfactory to the parties.

10.2. Costs for the venue, catering, transport, accommodation, translation services and any other necessary services or facilities will need to be agreed with the provider/s thereof.

10.3. Professional fees for the mediator/s and expert/s will need to be agreed with the individual professionals.

10.4. The standard principle is that the parties share the costs of mediation equally. In particular cases it may be in the interests of both parties that the costs are shared on a different basis, or even that the costs are fully paid by one party. In other cases it may be possible to obtain funding from an outside benevolent source.

10.5. In cases where agreement is reached between the parties and their legal representatives that the costs will not be shared equally, this agreement should be kept confidential and should not be disclosed to the mediator/s or expert/s. This is to guard against the risk of subconscious bias.

10.6. An undertaking to pay the mediator, mediators and experts for their professional services must, however, be signed by the person who has agreed to make the payments, without disclosure of the source or sources of funds.

11. AGENDA FOR MEDICAL PRE-MEDIATION MEETINGS

11.1. Chairperson

11.1.1. Identity and qualifications of the chairperson of the pre-mediation meeting.

11.2. Parties and their respective representatives

11.2.1. Identity of the parties to the dispute. Home language of each party. Settlement authority of each party. Identity of translator/s (if necessary). Identity of the 3rd party payer/insurer with settlement authority (if necessary). Identity of the legal representative of each party.

11.3. Confidentiality

11.3.1. The discussions at the pre-mediation meeting will remain confidential and take place on a without prejudice basis.

11.4. The dispute

11.4.1. Nature and type of the dispute (as stated in agreement or separately by the parties and legal representatives). Whether the dispute includes allegations of negligence, causation and/or quantum of damages (agreement by parties and legal representatives).

11.5. Introduction to informed consent to mediate

11.5.1. Explanation by the chairperson of the pre-mediation meeting of the nature, aims and procedures of mediation; the potential benefits of mediation over litigation, including the capacity to explore interests rather than rights; and the retention by the parties of their legal rights. Mediation is intended to be a flexible, informal, voluntary, confidential, consultative and without prejudice process of assisting the parties to reach a mutually satisfactory resolution of their dispute in a safe environment.

11.6. Purpose of the pre-mediation meeting

11.6.1. Explanation by the chairperson of each of the items on the agenda for the pre-mediation meeting.

11.7. Peer-review

11.7.1. Has a peer review process been held? If not, will such process be held before the commencement of mediation? Is the peer review process legally privileged or not? Will the anonymized evidence and outcome of the peer review process

be provided (or has it been provided) to an appropriate health care training authority? (Each of these questions should be answered by the legal representative of the accused healthcare practitioner).

11.7.2. In the public sector the Health MECs may instruct their legal representatives to conduct a peer review process, and require their health care employees to participate in the process. In the private sector the indemnity insurers may instruct their legal representatives to conduct a peer review process, and require their insured practitioners to participate in the process.

11.7.3. The purpose of these recommendations is not to enquire into any confidential evidence or findings in the peer review process, but importantly to encourage the accused healthcare practitioner and his or her legal representative to engage in a peer-review process in view of the major benefits that such process is likely to confer on the further conduct of the dispute, whether by mediation or litigation, and more particularly in view of the major benefits that such process is likely to confer on the upstream issues of patient safety and prevention of future negligent harm to patients.

11.8. Documents

11.8.1. Exchange between the parties of existing correspondence, statements, pleadings or expert reports (on the advice of their respective legal representatives) and the provision of such documents to the mediator/s.

11.9. Fields of expertise required

11.9.1. Whether settlement of the dispute between the parties requires an expert report or reports; the components of the dispute (negligence, causation and/or quantum of damages) that require expert investigation, analysis and explanation; and the necessary field or fields of expertise (agreement by parties and legal representatives).

11.10. Selected experts

11.10.1. Identity of selected expert or experts to be jointly appointed (agreement by parties and legal representatives) OR Identity of separate expert or experts to be appointed (if no agreement can be read by parties and legal representatives in relation to joint appointments).

11.11. Selected mediator/s

11.11.1. Identity of selected Health Sector Commercial Mediator, Technical Medico-Legal Co-Mediators or Technical Medico-Legal Sole Mediator, to be appointed (agreement by parties and legal representatives), on the basis of the nature, issues and complexity of the dispute, as well as the availability of suitably qualified mediators.

11.12. Costs

11.12.1. Confidential or non-confidential agreements in relation to payment of the costs of mediation.

11.13. Observer mediators

11.13.1. Consent by the parties for the attendance at the mediation of observer mediators (Health Sector Commercial Mediators who are training to become Technical Medico-Legal Co-Mediators). Observer mediators will be held to the same duty of confidentiality as the mediators.

11.14. Confirmation of informed consent to mediate

11.14.1. Following the above, and prior to signing an agreement to mediate, the chairperson should address any outstanding concerns and answer any further questions the parties, legal representatives and/or 3rd party payer/insurer may have.

11.15. Agreement to mediate

11.15.1. Should the parties agree to submit their dispute to mediation, an agreement to mediate should be signed by both parties, any translator, both legal representatives, any 3rd party payer/insurer, the chairperson of the pre-mediation meeting and the agreed mediator or co-mediators. All signatories should confirm acceptance of the duty of confidentiality, both within and outside of the mediation.

11.15.2. Any of the above participants at the mediation, but who were not present at the pre-mediation meeting, should sign the agreement to mediate, and confirm acceptance of the duty of confidentiality, prior to or at the commencement of the mediation.

11.15.3. The mediation agreement should include an indemnity clause that provides that the mediator/s shall not be liable for any loss that the parties may suffer (whether such loss is recoverable by a claim based on contract, delict or any other basis) as a result of any act or omission directly or indirectly connected to the mediation.

11.16. Signed confidentiality agreements by other participants

11.16.1. All experts and trainee medical mediators will need to sign separate confidentiality agreements prior to their participation in the mediation.

11.17. Location and practical arrangements

11.17.1. The location or venue where the mediation is to be conducted should be inexpensive and easily accessible to all parties involved. If the parties cannot agree on such a venue the mediator/s in their view will decide on the best location. Arrangements should also be put in place for aspects such as transport, accommodation, catering etc.

12. FURTHER ASPECTS TO BE ADDRESSED IN FUTURE GENERATIONS OF THE GUIDELINES AND PROTOCOL

12.1. Additional items from standard mediation checklist.

12.2. Curatorship for individuals with mental handicap.

12.3. Protection of funds, either by curatorship or in a trust with suitable securities.

12.4. Provisions for case management, accommodation and care of handicapped individuals.

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