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ARTICLE

Delay and settlement: The disposition of medical negligence claims in Ireland

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Abstract

Reflecting the international experience, statistics show that most medical negligence cases in Ireland settle. Less is known, however, about the duration of these cases, though anecdotal evidence suggests that they are protracted in nature. Procedurally focused reforms, aimed at reducing costs and facilitating more expedient resolution of these disputes have been proposed in Ireland, yet await implementation. As such, the pace of litigation is largely determined by the parties to the dispute. Drawing on the findings of an empirical study (an analysis of closed case files and qualitative interviews), this article explores two questions: first, how long do medical negligence cases take to resolve; and secondly, what contributes to delay in this context. Whilst causes of delay may vary by case, it is important to attempt to identify and explore common factors which contribute to delay. If these factors can be problematised and understood, possible solutions may be reached. In doing so, the article contributes to the debate on medical negligence reform across common law jurisdictions, evidencing the broader considerations, in addition to procedurally focused reforms, which are required when considering the issue of delay.

Keywords: civil justice; medical negligence; delay; litigation; Ireland

'I often explain to clients that [litigation] is the legal equivalent of lying in a hospital trolley, except it won't kill you.'

(Barrister 10)

1 Introduction

Concern in relation to delay[1] in civil litigation has been expressed in multiple jurisdictions over the past number of decades (Dyson 2015; Reda 2011; Van Rhee 2004; Fenn and Rickman 1999). Similarly, in Ireland, the duration of medical negligence litigation[2] in Ireland is often condemned by the media, although statistics in this area are limited. The question of whether delay exists,[3] and

I would like to express my sincere thanks to Professor Mary Donnelly for her comments on an earlier draft of this paper. I would also like to thank the two anonymous reviewers for their helpful feedback which has improved this work.

[1]Nelken has highlighted the issues in using the term 'delay' as a 'self-evident fact'. This is recognised, however, it is outside the scope of the current discussion. See D Nelken (2004, pp. 1, 3).

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

[3]Two types of delay may exist in medical negligence proceedings: delay between the event complained of and the issuance of proceedings, and/or delay once proceedings have been commenced. The focus of this article is on delay once proceedings have been issued.

what contributes to delay in medical negligence litigation, is an important one. This is because, delay, whilst generally considered undesirable, is particularly problematic in a medical negligence context due to its potential to further compound harm, limit access to justice, and its role in increasing costs. For example, where an individual suffers loss and/or harm and needs recompense to cover the cost of care, any delay in providing redress will have a significant impact (Shuman, 2000).[4] While litigation is ongoing, plaintiffs typically bear all injury-related expenses and therefore, their quality of life, as well as their health, may be significantly impacted.[5] The issue of delay also raises access to justice concerns. Reda (2011, p. 1085) notes that delay in civil litigation can threaten access to justice 'as delaying tactics or merely inefficient processes lengthen the time before a plaintiff gets her day in court'. Similarly, O'Mahony (2015, p. 25), noting the protracted nature of medical negligence litigation in Ireland has asserted, 'while justice delayed may not always be justice denied, it usually means justice diminished'. Within the broader civil justice literature, parallels have long been drawn between cost and delay (frequently referred to as the 'cost-delay narrative') (Reda, 2011). Arguably, the most cited implication of delay in civil litigation is financial, as prolonged litigation usually correlates with an increase in legal costs. As the number of years before trial increases, often so do the legal fees, given the amount of time that practitioners may dedicate to the case (Genn, 1995). Where cases are protracted in nature, associated costs may be prohibitive for litigants and/or law firms who can afford to litigate the case. As such, cases are usually pursued on the basis of the commercial decision made by lawyers (Hyman and Silver, 2006).[6] Thus, in some instances delay might compromise justice by eliminating the option of recourse to litigation altogether.

Whilst the impact of delay is important, this article is not focused on this aspect of the debate. The focus, rather, is on whether or not delay exists in medical negligence cases and what contributes to delay in this context. Despite anecdotal reports of the protracted nature of medical negligence disputes in Ireland, data is sparse. As such, exploring the duration of medical negligence claims and the causes of delay is important if we are to understand how best to respond, particularly in the context of proposed reform in this area. The article will first contextualise medical negligence litigation in Ireland. An overview of the methodological approach of the research will then be provided. The article will then explore, with reference to the research findings and the literature, factors which contribute to delay in these disputes. Finally, proposed measures which seek to address the protracted nature of these disputes will be discussed.

2 Medical negligence litigation in Ireland

The court system is the primary mechanism for the resolution of medical negligence disputes in Ireland.[7] The adversarial system closely mirrors that in England and Wales, and other common

[4]The Irish healthcare system has been described as 'an eclectic mix of elements of the private and national service models ... Services are delivered through a combination of private, public and voluntary organisations and the system has been criticised for being fragmented' (Brady and O'Donnell, 2010' p. 9). Public healthcare is not universally free, although means tested medical cards are available. There is also a long-term illness card scheme as per s.59(3) of the Health Act 1970. Those availing of private healthcare generally require health insurance.

[5]For example, aids and appliances may be required as a result of the injury. Similarly, the plaintiff's home may need to be adapted. Whilst these may ultimately be compensated for upon resolution of the claim, until the claim reaches resolution the plaintiff will have to bear these expenses themselves.

[6]In Ireland, legal fees are generally based on the number of hours worked and complexity of the case. See Legal Services Regulation Act 2015, part 10.

[7]The state, via the State Claims Agency who manages the clinical indemnity scheme provides indemnity to all clinical staff in public hospitals. There are approximately forty-seven public hospitals, twenty-two voluntary and nineteen private hospitals in Ireland. For a detailed discussion on liability arrangements in Ireland see S Mills and A Mulligan (2017), *Medical Law in Ireland*, 3rd edn. Bloomsbury Professional, Ch. 8.

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law jurisdictions.[8] Notwithstanding the commonalities in the substantive principles which govern these disputes, procedural differences exist. As the focus of this article is on the existence and causes of delay in medical negligence claims, the phenomenon is examined through the lens of procedure, rather than the substantive law. The procedural steps involved in litigating a claim of this kind in Ireland have been outlined elsewhere (Brassil and Hourigan, 2021; Tumelty, 2021) and so it is not proposed to discuss them here. Nonetheless, it is useful to briefly note that medical negligence litigation in Ireland is adversarial and the procedural rules which govern the process are measures or 'steps' which are predominantly focused on getting a case ready for trial. The Civil Liability and Courts Act 2004 is the central governing piece of legislation in this respect. Unlike some other common law jurisdictions, for example England and Wales, at present in Ireland, there are no pre-action protocols, which outline the steps parties are required to take before proceedings are commenced in an attempt to encourage earlier resolution of claims, in force. Nor is there any formal case management process for these disputes. Procedurally focused reforms, with the aim of reducing costs and enhancing the expediency of this type of litigation, have been proposed in Ireland. Namely, the introduction of pre-action protocols, periodic payments and case management (High Court Working Group on Medical Negligence Litigation and Periodic Payments, 2010–2013). Mediation, as a method of alternative dispute resolution, has also been promoted by the judiciary and the legislature, and in 2018, a statutory framework for its integration into the civil justice system was introduced (Mediation Act, 2017). More recent proposals have been made by an Expert Group appointed to review the law of torts and the system for the management of clinical negligence claims. Recommendations included the introduction of a dedicated High Court list to deal with the management and hearing of medical negligence claims. A no-fault approach was also considered, though ultimately rejected (Expert Group 2020: 11). Reform measures are further discussed later in this article, nonetheless, it is noteworthy that despite the recommendation of the introduction of pre-action protocols in 2012, they await implementation. Furthermore, no formal case management system is in place. As such, the pace of litigation largely remains at the discretion of the parties to the dispute.

3 Research methods

The aim of this study was to investigate the duration of medical negligence litigation and to critically explore the factors which contribute to its length. Socio-legal research methods (Bradney, 2012) were employed and included an analysis of closed medical negligence case files in order to gather data on the length of these claims (Webley, 2010), and secondly, interviews with legal practitioners (Barristers) to gain insights into the causes of delay were conducted. A mixed-methods approach was identified as appropriate, for reasons of 'completeness', which through engagement with a variety of approaches provides a more comprehensive picture of the phenomenon under study (Greene *et al.*, 1989) and 'offsetting weaknesses' which provides that the weaknesses of a single approach can be minimalised, while strengths are built upon thereby providing more accurate data (Bryman, 2006). Institutional ethics approval was gained prior to the commencement of the research.

3.1 Analysis of closed case files

Given the absence of data in relation to the duration of medical negligence cases in Ireland it was necessary to identify a suitable site whereby access to closed medical negligence case files could be

[8]Cases involving diagnosis and treatment are governed by the principles established in *Dunne v. National Maternity Hospital* [1989] IR 91 and the standard to be applied in cases concerning informed consent is set out in *Geoghegan v. Harris* [2000] 3 IR 536. A similar approach can be seen in *Bolitho v. City and Hackney Health Authority* [1996] 4 All ER 771 and *Montgomery v. Lanarkshire Health Board* [2015] UKSC 11 in the UK and in *Crits v. Sylvester* (1956) 1 D.L.R. 2d 502 (Ont. C.A.) and *Reibl v. Hughes* [1980] 2 S.C.R. 880 in Canada.

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gained.[9] The Medical Negligence Unit (MNU) is a specialised unit within the Legal Aid Board which deals solely with cases of medical negligence and was, therefore, identified as a suitable research site.[10] The MNU deals with medical negligence claims from those who are eligible for legal aid. Whilst this only represents a small subset of medical negligence claims in Ireland, as it does not capture data from private litigants and therefore cannot be definitively said to be representative of medical negligence litigation in Ireland, it was anticipated that through an analysis of its closed case files, the average length of these claims could be ascertained providing an insight into the duration of these cases for the first time in an Irish context.[11] The MNU consented to its representation in this research, so concerns surrounding anonymity in this regard did not arise.[12]

The data extrapolated during the analysis of closed case files was subjected to quantitative data analysing techniques in order to ascertain the average duration of a claim. It was necessary to delimit the parameters from which a sample for the study was drawn to ensure consistency and accuracy. This research analysed medical negligence cases which were litigated by the MNU, i.e. cases in which proceedings had been issued and had reached resolution through settlement, ADR or trial, during the period of 2006 to 2015. A total of fourteen claims met this criterion. The small sample size of this study is recognised as a limitation of this research. However, it is maintained that the findings are nonetheless instructive given the dearth of statistics in this area in Ireland. In order to minimise the limitation of the small dataset, the research findings from the MNU were tested during the qualitative stage of the research, detailed below.

3.2 Interviews

The quantitative findings were tested during the qualitative phase of the research (Weiss 1995), where perceptions on the causes of delay in medical negligence cases were also explored. The sampling framework involved Barristers (junior and senior counsel) who specialised in medical negligence litigation. Participants were purposively sampled based on their expertise in this area (Patton, 2014), namely their ability to provide insights into the dynamic of medical negligence litigation in Ireland as a whole, including the issue of delay. To minimise the potential for bias, random purposive sampling (Schreier 2018) was employed. This sampling strategy is useful where there is no apparent reason to select one participant who meets the criteria over another. Thus, from a sample identified on the Bar Council of Ireland website (34), Barristers were chosen at random using a generator tool and invited to participate in the study. A total of twelve Barristers were interviewed. Anonymity was guaranteed, which was achieved by assigning each participant an alpha-numeric code, e.g. B1 = Barrister 1 and by removing any identifying details. Once the data was collected, it was subsequently analysed and coded and a narrative informed by the literature was formed.

[9]One source of information in relation to medical negligence claims in Ireland is the National Treasury Management Agency (NTMA), which publishes Annual Reports, including data on the Clinical Indemnity Scheme. However, information relating to the duration of claims is limited. A Freedom of Information (FOI) request was made seeking further information, however, this request was denied.

[10]The MNU is one of thirty Legal Aid Law Centres in Ireland. Legal Aid Board, *Value for Money and Policy Review of the Legal Aid Board* (October 2011) wherein it is noted that in 2006, all existing medical negligence files in individual legal aid board law centres were transferred to the MNU. This analysis includes transferred case files.

[11]In order to obtain legal aid for civil matters in Ireland a prospective client must have an annual disposable income not exceeding €18,000 and disposable assets of less than €100,000. Therefore, it should be noted that this element of the study does not capture data from plaintiffs who accessed private legal advice, as access to such data was unavailable. For further detail see, Civil Legal Aid Act 1995, s 28; FLAC, *Report on Civil Legal Aid in Ireland Forty Years On* (2009).

[12]It was recognised that potential ethical issues surrounding anonymity and confidentiality may have arisen in relation to the content analysis conducted at the MNU as the closed case files accessed belonged to individual litigants. However, to surmount this issue, no record was taken of these individuals' names or files and only data relating to the length of the claim was noted, namely the date the claim was initiated (proceedings filed) and the date the claim was resolved

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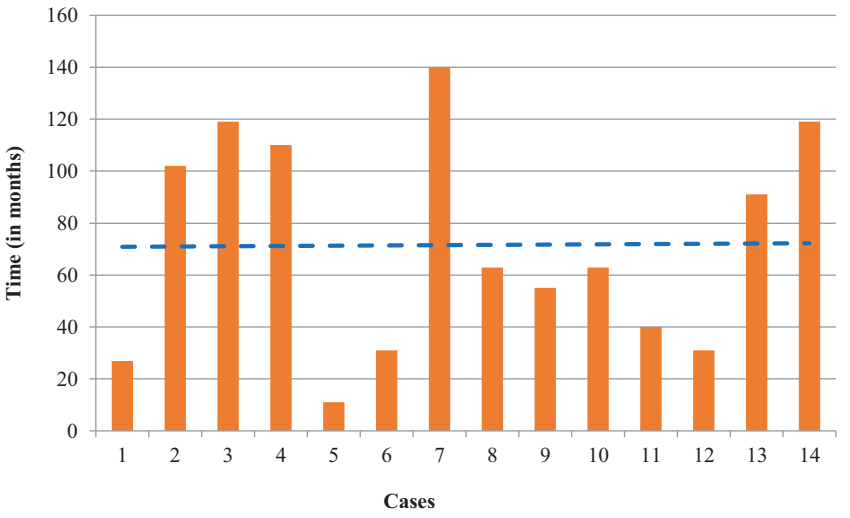

Figure 1. Analysis of closed case files: duration of litigation.

4 The existence and causes of delay in medical negligence claims

This section of the paper critically discusses and explores the research findings from both the quantitative and qualitative studies. What comes across most powerfully is the protracted nature of these disputes.[13] Notwithstanding the procedural complexity inherent in these claims and often complex subject matter, broader issues contributing to delay were identified. The findings are presented as follows: first, the duration of medical negligence litigation is discussed and analysed; then, perceptions on the causes of delay in this context are explored.

4.1 The duration of medical negligence litigation in Ireland

The analysis of the data extrapolated from the closed case files revealed that the average time to litigate a medical negligence claim in Ireland is five years, eleven-and-a-half months. The case with the quickest resolution time was eleven months; in contrast, the case with the longest resolution time was eleven years and eight months. As previously detailed, in order to surmount confidentiality and anonymity concerns, no identifying details were recorded during the analysis of the closed case files. It is therefore not possible to comment on the subject matter or relative complexity of these cases which may help explain their duration. Figure 1 (above) illustrates the duration of these cases.

It is submitted that given the criteria for inclusion in this study (i.e. cases which had been commenced and reached resolution), this figure is conservative, as it does not capture time expended on the case prior to the initiation of proceedings nor does it account for circumstances where, for example, an appeal is lodged. Save in circumstances where there is a concern over a claim being statute-barred with proceedings being lodged on a precautionary basis to 'stop the clock', during the initial phase of investigation time will be spent reviewing the case which will include obtaining the plaintiff's medical records (Boylan, 2022) and supportive medico-legal

[13]It is worth noting that delay is not an issue unique to medical negligence cases, however, a broader discussion on delay is outside the scope of this article. See, for example, Courts Service, *Annual Report* (2021). Available at: https://www.courts.ie/annual-report, which provides an overview of the average length of proceedings in a variety of cases including commercial, judicial review and employment, in first instance courts in Ireland from issue to disposal. The average length of proceedings is reported in days, however, it is unclear from the Report whether this reflects working days or calendar days and, therefore, it is difficult to definitively interpret the figures provided.

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expert evidence.[14] Equally, while a majority of these claims are resolved via settlement negotiations, plaintiffs who proceed to trial may face the prospect of an appeal.

In the context of the present research, in line with national and international statistics in this area, 92.8% of these cases settled before trial. Interestingly though, there was no attempt at settlement in the earlier stages of litigation with an analysis of the closed case files revealing that settlements occurred in thirteen out of the fourteen cases only when a trial date had been obtained. Boylan (2012, p. 67) has similarly reported that liability frequently remains in dispute 'until shortly before trial', thus preventing earlier resolution of these disputes. It can be said that this speaks to the contentious nature of medical negligence disputes in Ireland, which McKeever (2021, p. 80) has recognised 'can be slow, frustrating and not fit for purpose'.

There was no discernible relationship between the award of damages and the duration of the claims. For instance, some of the longest claims had settlement awards under €100,000. In contrast, some claims which had a shorter timeframe for resolution had higher awards. Whilst it is accepted that not all cases will be suitable for early resolution, at present, given that one of the first steps both parties to the dispute take in the litigation process is obtaining the opinion of a relevant medico-legal expert, and relevant information is available at an early stage in the proceedings, it is conceivable that settlement discussions could take place at an earlier stage in the process. However, the often highly contentious nature of this type of litigation appears to inhibit opportunities for settlement, something which was further explored during the qualitative phase of the research and discussed later in this article.

It is difficult to situate the findings in a broader, comparative context, as statistics and analysis on the duration of claims in medical negligence disputes are limited. Recent studies have instead focused on analysing the cost of claims relating to individual medical specialties (Hansrani *et al.*, 2021; Machin *et al.*, 2018). Some recent reports from England and Wales, however, provide some insight into the duration of clinical negligence claims. For example, a House of Commons Health and Social Care Committee on NHS Litigation Reform in England and Wales considered the issue of the duration of clinical negligence claims in 2021 and recognised the length of time that such claims take to resolve as significant: '[o]ver the course of our inquiry we heard an abundance of evidence that the clinical negligence process fails patients and the families of those who have been harmed because it takes far too long to resolve cases' (p. 16). The average duration of a clinical negligence claim has recently been reported in the NHS Resolution Annual Report and Accounts (2022), which notes that the duration of claims has been reduced from '80 months to 18 months'. However, the Report (2022, p. 34) further clarifies that 'there can be a significant time-lag between an incident occurring and a claim being made – on average three years'. Additionally, it is noted that some claims take longer than the average clinical negligence claim, most notably, birth injury cases.

Given the limited sample size, the quantitative findings were tested during the qualitative phase of this research. Barristers were presented with the finding that as deduced from the MNU data, on average, from date proceedings are issued to the date the claim is resolved, medical negligence cases take five years, eleven-and-a-half months to resolve and were asked on the basis of their own professional experience whether or not they felt this finding was representative. Whilst solicitors are involved with the day-to-day running of the case, Barristers are frequently involved from the stage of initiation to the conclusion of the claim. These insights were particularly important as Barristers could also speak to the duration of medical negligence litigation from the perspective of private litigants, thus addressing the issue of the representativeness of the findings. Out of the

[14]Supportive medical evidence is required before proceedings are commenced. See, for example, *Reidy v. National Maternity Hospital* [1997] IEHC 143, at 24, wherein Barr J stated, 'It is irresponsible and an abuse of the process of the court to lodge a professional medical negligence action against institutions such as hospitals and professional personnel without first ascertaining that there are reasonable grounds for so doing. Initiation and prosecution of an action in negligence on behalf of the plaintiff against the hospital necessarily requires appropriate expert evidence to support it.'

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twelve participants, two felt that based on their own experience, cases were resolved within a slightly shorter time frame and two felt that based on their experience, cases took longer. The majority (eight) agreed that this finding (an average duration of five years, eleven-and-a-half months) was representative of medical negligence litigation in Ireland, based on their own experience:

> [That finding is] [p]retty accurate, they're very slow and I have to say that there can be significant periods of inactivity, particularly by plaintiff solicitors either waiting for expert reports or just finding it difficult to cope, and no defendant is going to push it because they hope it will go away. (Barrister 9)

> You wouldn't get a huge proportion of cases that would be resolved within that time frame and many medical negligence cases are much longer than that ... I mean I'm aware of several cases which are ridiculously long, over 20 years ... so [that average] wouldn't be surprising at all. (Barrister 10)

The limitations of the data notwithstanding, it is argued that these findings are instructive given the dearth of statistics on these claims in Ireland. The findings of this research suggest that medical negligence litigation in Ireland is typically protracted. Given the problematic nature of delay in cases of medical negligence, it is now necessary to explore the causes of delay through a discussion of the research findings and the literature.

4.2 Causes of delay

Scholars such as Church *et al.* (1978), who have explored the causes of delay in criminal and civil cases, uncovered that delay cannot be explained by factors such as increased caseloads or jurisdictional size in isolation. Instead, they argue that 'speed and backlog are the result of a stable set of expectations, practices and informal rules of behaviour' by legal practitioners (Church *et al.*, 1978, p. 41). Priest (1989, p. 529) has argued that 'the sources of litigation delay are far more subtle' and can often be attributed to 'a jurisdiction's "local legal culture"'. Kritzer and Zemans (1993, p. 538) explain that 'local legal culture' exists where 'local patterns of practice reflect in part informal norms and expectations that regular players in the system (lawyers and judges) have developed and have come to accept as "how we do things"'. Though conceptualisations of 'legal culture' within the literature vary (Engle-Merry, 2012), for the purposes of this research, Nelken's (2004, p. 1) definition, '[l]egal culture, in its most general sense, is one way of describing relatively stable patterns of legal oriented social behaviour and attitudes. The identifying elements of legal culture range from facts about institutions ... to various forms of behaviour such as litigation ... and, at the other extreme, more nebulous aspects of ideas, values, aspirations and mentalities', is adopted, with a specific focus on litigation behaviour.

In this research, factors contributing to the duration of these claims were identified during the qualitative data analysis phase. The overarching theme of the research findings related to the contentious nature of medical negligence litigation and the existence of a 'local legal culture' and this was identified as a contributing to the duration of proceedings. Within the broader existence of this 'local legal culture', other issues emerged, namely: the absence of enforced timelines; difficulties in sourcing medico-legal experts and challenges in determining quantum. These findings provide new insights into the causes of delay in this type of litigation. Though some of the factors identified are specific to the Irish context, other more fundamental issues were identified and as such, the research provides more broadly applicable lessons in this context. In doing so, the article aims to provide insights into 'the way the law is conceived and lived rather than to establish universal truths about the nature of the law' (Nelken, 2004).

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4.2.1 Adversarialism and the contentious nature of medical negligence litigation

Litigation in Ireland is adversarial. Whilst the court system is well-respected, the contentious nature of litigation was recognised as contributing to the protracted nature of these claims. Despite the fact that the majority of medical negligence claims resolve prior to trial via settlement negotiations (NTMA, 2021, p. 52), the findings of this research indicate that settlement discussions typically take place once a trial date has been obtained. At this stage significant time and costs are likely to have been expended. Though it is recognised that it may not be feasible to resolve every medical negligence case at an early stage in the dispute, the findings suggest that the contentious nature of this type of litigation is not conducive to earlier exchanges of information, for example, which may facilitate more expedient resolution. In exploring Barrister's perceptions of the causes of delay, the contentious nature of these disputes was recognised as preventing earlier settlement talks or attempts at resolution:

> '[litigation is] so aggressive, it's so aggressive in medical negligence actions, there's no need for it.' (Barrister 1)

> 'Once litigation commences ... once the papers arrive at the barrister's desk, game on.' (Barrister 3)

This reference to litigation as a 'game' reflects the contentious and positional nature of these disputes at present, which are often focused on 'winning'. The procedural rules which currently govern these disputes are focused largely on the preparation of the case for trial. Thus, although the majority of these cases settle, the procedural steps are focused on the refinement of the issues and arguments to prepare the case for an adversarial court hearing. As Sourdin and Castles (2020, p. 492) explain 'the focus is on making a case ready for hearing rather than resolving a matter'. This can result in an often-positional approach to negotiation, which they suggest, is unsurprising. Further evidence of 'legal culture' emerged in this context in the research findings. Barristers spoke of the adversarial nature of medical negligence litigation, which also emerged in negotiation:

> 'Quite frankly, the plaintiff figures are always over exaggerated, and the defence figures are traditionally always low-balled, and there's some kind of a sense to it ...' (Barrister 7)

This positional approach to resolution, which occurs where 'each side sets extreme aspiration levels and makes a series of strategic offers and counter-offers intended to result in a resolution as close as possible to that side's initial aspiration' (Lande 2007, p. 626) often has the effect of increasing rather than de-escalating conflict. Arguably, such an approach contributes to the length of these claims. In addition to concerns in relation to the protracted nature of these claims, it should be noted that an approach focused on positions rather than broader interests may not be aligned with the goals of the plaintiff in the dispute (Tumelty, 2022).

The existence of a 'local legal culture' and the role of adversarialism therein also emerged in the context of information exchanges and the disclosure of medico-legal reports. Barristers noted that in certain instances such exchanges may result in a tactical disadvantage:

> 'There is also a concern as well that if you disclose at a very early stage for example, when you've notice of trial and now you make a disclosure, and you don't get a trial date for four months, you could actually well end up being faced with a slew of [medico-legal] reports subsequently.' (Barrister 6)

> 'There is no way that you will exchange reports unless it's absolutely contemporaneous ... you won't do it in a medical negligence action ... and that's a traditional suspicion and I would really love if that suspicion wasn't there.' (Barrister 1)

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Condlin (1992, p. 8) has argued within the adversarial system 'every disclosure is viewed as ... potentially a concession' and lawyers will be 'cautious and circumspect, revealing as little and defending as much as possible until the other's intentions are known'. Similarly, the findings of this research further highlight these concerns and this approach was identified as sometimes inhibiting earlier resolution. Although the exchange of expert reports in medical negligence disputes are governed by the Rules of the Superior Courts in Ireland, which aim to ensure an 'equality of arms' between parties in the exchange of reports, issues remain. For example, although the Rules require disclosure of a schedule which lists all reports from expert witnesses who will be called at trial (Order 39, r46(1)), disclosure of medico-legal reports by experts who are not listed for trial is not required. Mills and Mulligan (2017) note that this enables the 'cherry-picking' of reports which are supportive, whilst unfavourable reports may go undisclosed. The use of medico-legal experts as adversaries and the partisan way in which experts are typically engaged was also noted:

> 'What happens is that even though an expert is supposed to be objective in the process, and the expert has a duty to the court to remain objective, everybody knows that plaintiff experts bat for the plaintiff and the defence experts bat for the defence.' (Barrister 7)

> 'I had a case ... they were all the same type of doctors ... [they] had all written a paper together ... and here they were all quoting it to suit themselves and you were thinking "this is tug of war stuff".' (Barrister 1)

The use of medico-legal experts as adversaries is not an issue unique to Ireland, with similar difficulties reported in other common law jurisdictions. For example, in the context of civil justice reforms in England and Wales, Lord Woolf noted the 'polarisation' of experts (1996). In Ireland, although expert witnesses owe duties to the court (Rules of the Superior Courts, Ord 39, r57(1)), including a duty of independence and impartiality, the findings of this research suggest that in practice, the impartiality of experts may not be so absolute. This is something which has been recently recognised by the Courts in *Patrick Duffy v. Brendan McGee t/a McGee Insulation Services & Anor.*[15] Although not a case involving medical negligence, Collins J's observations are relevant to the current discussion, where it was noted that '[f]ar too frequently, expert witnesses appear to fundamentally misunderstand their role and wrongly regard themselves as advocates for the case of the party by whom they have been retained. It may be said that this is an established part of litigation culture in this jurisdiction. If so, the culture is unacceptable and it needs to change'. It is also noteworthy that in contrast to the position in England and Wales (Devaney, 2012), in Ireland expert witnesses currently enjoy immunity from suit (*E O'K v. K & Others*, [2001] 3 IR 568). Case law suggests that immunity will only be lost in cases of malicious and irrelevant statements, or flagrant abuse of the privilege. It is not clear whether or not the fact experts currently enjoy immunity from suit contributes to the contentious approach in which they are engaged, however, given the central role experts play in medical negligence litigation, further consideration could be given to this issue. Reform measures in this context are discussed later in this article.

Though not every case will be suitable for early resolution, and notwithstanding the broad acknowledgment of the contentious nature of these claims, participants recognised that opportunities for a more expedient resolution of these claims could be embraced. However, the adversarial process can inhibit this. One barrister reflecting on their experience, and recognising the potential for earlier resolution of these claims and the problematic nature of adversarialism in this context, reflected:

[15][2022] IECA 254, para. 24.

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> 'Perhaps what we should be doing is looking at disclosure much earlier on in the proceedings ... rather than the game that we play, and it is a game ...' (Barrister 4)

This comment again highlights both the contentious nature of this type of litigation, referred to here again as a 'game', and also alludes to the potential of protocols to facilitate earlier resolution of medical negligence disputes. Pre-action protocols and other proposed reforms are discussed later in this article. However, it is worth noting that the experience in other jurisdictions, such as that in England and Wales is instructive in this regard. For example, in Lord Jackson's 2010 review of the Woolf reforms it was noted that pre-action protocols had led to the 'front-loading' of costs. As such, these measures have been described as a 'contentious element of law reform' (Greer, 2014, p. 167). The findings of this research provide insight into the current legal culture which exists in this jurisdiction. As can be inferred from the preceding discussion, delay in medical negligence litigation is multifactorial. The current aggressive approach to medical negligence litigation in this jurisdiction is one element of 'legal culture' which it is argued contributes to the length of these cases. Thus, within the broader existence of a 'local legal culture', specific factors were also identified as contributing to the duration of these claims. These can also be considered to be facets of legal culture in medical negligence litigation in Ireland. Although some are specific to the Irish context, others are more broadly applicable and therefore, offer insights into the phenomenon of litigation delay generally.

5 Timelines

As previously noted, at present in Ireland, the pace of litigation is largely determined by the legal teams handling the case. The inherent challenges with the absence of timelines have long been recognised. For example, in 2007, the Irish Supreme Court in *Payne v. Shovlin*,[16] a case concerning the interpretation of statutory provisions relating to the disclosure of reports from expert witnesses intended to be called at trial, observed, 'there is no separate division of the High Court for medical negligence cases nor any effective case management system whereby procedures can be simplified and costs be kept to a minimum'. As previously noted, pre-action protocols, similar to those in operation in England and Wales, are not currently in force in Ireland, despite the recommendation for their introduction in 2012 by a High Court Working Group on Medical Negligence and Periodic Payments.

In exploring Barristers' perceptions of the causes of delay in these disputes, the absence of timelines was identified as a contributing factor to the duration of medical negligence proceedings. Whilst it is recognised that legal practitioners (acting for the plaintiff and defendant) must be afforded an adequate opportunity to formulate their clients' case, the findings of this research indicate that at present, the lack of imposed timelines in medical negligence litigation contributes to the length of these cases.

> 'I mean, we don't have strict timelines here, not really, not that are pushed. We do have timelines, but they are not rigidly adhered to. So that is probably why this is geared to drag on, and sometimes does drag on for a long time.' (Barrister 2)

> '[To go to trial] you need to have everything prepared, and it's just a simple fact of life that that actually doesn't happen without very significant pre-action protocols or case management processes where things have to be done by a certain time, and people actually abide by them, and where people don't abuse the disclosure system in order to gain a tactical advantage.' (Barrister 6)

[16][2007] 1 I.R. 114, at 124–125.

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Delay as a phenomenon in medical negligence disputes is not unique to Ireland. A number of countries internationally have introduced pre-action protocols to maximise efficiencies. Lord Woolf (1996), in the context of his review of the civil justice system in England and Wales highlighted concerns in relation to delay in medical negligence litigation. Following the recommendations of the Woolf Report, pre-action protocols were introduced with the aim of reducing claim resolution time. Singapore have also introduced greater case management for medical malpractice disputes to encourage earlier resolution of these disputes (Quek Anderson, 2021). In the context of their evaluation of the impact of pre-action protocols in South Australia, Sourdin and Castles (2020, p. 489) note that 'the proximity of the court door ... is perceived to be a critical factor in terms of settlement behaviour ...'. Thus, the absence of timelines or the propensity towards settlement only once a trial date has been obtained cannot be said to be unique to Ireland. The broader legal culture here influences the resolution of these disputes and as a consequence, their expediency. The failure to introduce pre-action protocols in Ireland is regrettable. Although the relevant legislative provision is in place (Legal Services (Regulation) Act 2015, s219), it is yet to be commenced and the regulations to introduce pre-action protocols are still awaited. Reforms will be further considered in Section 6 of this article.

6 Difficulties in obtaining medico-legal witnesses

In addition to the wider causes of delay discussed above, this research revealed other factors which participants reported as contributing to delay in medical negligence disputes. Whilst these factors cannot explain the problem of delay in a general sense, they provide useful insights into the unique legal culture which exists in Ireland, as well as the additional factors which contribute to delay in medical negligence disputes in Ireland. The first of these related to difficulties in obtaining medico-legal expert witnesses.

In most common law jurisdictions, the role and necessity of the medico-legal expert in medical negligence litigation is long-recognised. During the phase of investigation of the plaintiff's case, once medical records have been obtained, a suitable expert may then be engaged to prepare a report to support or rebut the allegations of negligence. This is a long-established practice in medical negligence cases, as previously noted, a supportive medico-legal report is required before proceedings can be initiated.[17] This is important as professional negligence cases can have serious consequences for a physician and/or a healthcare institution.[18]

In addition to the important role of the medico-legal expert in the period before the initiation of a claim, several medico-legal experts may typically be required at various stages of the litigation process. For example, in order to formulate the claim for damages, a plaintiff may need to be examined by a number of experts in order to obtain reports in respect of various issues. Additionally, a plaintiff may need to be assessed by a medico-legal expert in respect of aids, equipment and appliances and/or future care (Boylan, 2022).

Despite the necessity of the medico-legal expert in medical negligence claims, their involvement in medical negligence litigation was identified as a factor contributing to both cost and delay. A large majority of legal practitioners noted that particular challenges existed in sourcing an appropriate medico-legal expert within Ireland and it was frequent necessary to source experts who were based internationally. This is thought to be primarily attributable to the small size of the jurisdiction and the unwillingness of doctors to examine the work and potentially testify against their colleagues (O'Mahony, 2015, para 3.11). Noting these issues barristers commented:

[17]RSC Ord 1A II, r 6. provides an exception to this is in rare circumstances where a solicitor may institute proceedings to prevent a claim from becoming 'Statute barred'.

[18]*Mangan v. Dockery & Ors* [2019] IECA 45.

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> 'Most plaintiffs will usually source experts from outside the jurisdiction for obvious reasons, because it's very difficult to get Irish doctors to swear up against Irish doctors, it's too small a community . . . ' (Barrister 7)

> 'The issue is it's a very small community here. Ireland is very much like a village . . . a lot of these guys would simply know each other as well, so I think it has to do with the smallness of the community.' (Barrister 6)

In addition to the issue of delay in this context, there are also likely financial implications. Notwithstanding the fact that the majority of these cases settle, both the findings of this research and the literature suggest that settlement frequently occurs only when a trial date has been obtained. In such circumstances, considerable expense and time may already have been expended on organising medico-legal expert witnesses, who frequently will have to travel to testify. Issues in sourcing medico-legal experts does not explain delay in a general sense, however, it does provide insights into some of the nuances inherent in this type of litigation, which must be considered when proposing reform in this area.

7 Challenges in determining quantum

Although expedient resolution of these disputes is desirable from both the perspective of the plaintiff and defendant given the often financial and emotional impacts of these cases, the legal representatives of both the patient and the healthcare professional and/or organisation must be afforded sufficient time to prepare their client's case. Equally, the principle of *restitutio in integrum,* which applies in several other jurisdictions including the UK, aims to place the plaintiff back in the position they would have been in had the negligent act or omission not occurred. In certain cases of injury, determining quantum may be challenging when an injury has not reached a definite prognosis.

Historically, in Ireland, a plaintiff could only be awarded a lump sum. However, the assessment of same has been recognised as an 'enormously difficult task' particularly in cases of catastrophic injury (Boylan, 2022, p. 241). The challenge of ascertaining the true nature and extent of an injury was recognised as a contributing factor to the length of medical negligence cases. Such is often more accurately ascertained following the passage of time. Corbett (2018, p. 23) has observed that lump sum payments essentially require the Court 'to peer into a crystal ball'. Determining quantum can therefore, oftentimes, be difficult and thus, may contribute to the length of litigation in this context. The absence of a framework which would facilitate periodic payments in this jurisdiction and thus help address the length of these claims, has been widely lamented. As Irvine J observed in *Gill Russell (a minor) v. Health Service Executive*,[19] a case involving catastrophic injury:

> 'To state that the current law in this jurisdiction which requires the Court to award a lump sum intended to compensate a Plaintiff for all past and future losses and particular future pecuniary loss is inherently fallible and unjust cannot be disputed. It is grossly outdated by reference to the approach now adopted by the Courts in other common law and civil law jurisdictions . . . '[20]

Two difficulties with lump sum payments can be said to arise in medical negligence disputes. First, the adequacy of a lump sum payment as a means of compensation where a plaintiff has suffered severe and life-long injuries. Secondly, where a periodic payment is unavailable, the delay in the resolution of these disputes may have a significant impact on the quality of life of the plaintiff in

[19][2015] IECA 236.
[20]*Russell (A Minor) v. The Health Service Executive* [2015] IECA 236, para. 5.

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circumstances where the injury is on-going. In the context of this research, barristers spoke of the difficulties inherent in quantifying these claims, particularly where an injury was on-going:

> 'Whilst there's a lot of complaints about it being long, it's not necessarily because one side or the other is to blame ... people might ... want to see how much damage has been done or particularly in the case of a child, you want to wait a few years until they see the extent of the damage. For a child of 2 or 3 you will have no idea about how much damage is done and that's why most claims are when the child is 7, 8, or 9, so you can see what their capabilities are.' (Barrister 2)

> 'I genuinely believe that in most cases it's just that the quantum hasn't been resolved or the condition and prognosis hasn't really reached a pattern significantly quickly enough to bring about a settlement.' (Barrister 7)

Given the importance of financial redress in cases of life-long and severe injury, the delay in quantifying these claims is likely to be appropriate. Failure to properly quantify a claim, resulting in under compensation, may have severe implications for the quality of life of the plaintiff. However, whilst a claim is ongoing, the plaintiff will have to bear all injury-related expenses. This may also have health and quality of life implications. Periodic payments have the capacity to address both the issue of appropriate compensation and delay. Although proposed in 2012 in Ireland (High Court Working Group on Medical Negligence and Periodic Payments, Module 2, 2013) and introduced by virtue of the s51(I) of Part 2 of the Civil Liability and Courts Act 2004, as inserted by the Civil Liability (Amendment) Act 2017, in 2018, problems remain. Most notably, with its current indexation. This issue is explored in further detail in the final section to this paper, which considers mechanisms to address delay in medical negligence disputes.

8 Dealing with delay

Having discussed the duration of these claims and identified factors which contribute to delay in this context, this section of the paper considers measures proposed to help ensure the expedient resolution of medical negligence claims in Ireland. Article 6 of the European Convention on Human Rights, which applies to both civil and criminal matters, provides the right to a fair and efficient trial, with Article 6(1) specifically referring to the issue of 'reasonable time'. Redress, by way of damages, for a breach of Article 6(1) is feasible in accordance with Article 41 ECHR. Part of the purpose of this requirement is to protect parties from excessive delays. A full discussion on Article 6(1) and the relevant jurisprudence which considers the 'reasonable time' requirement is outside the scope of the present discussion and is documented well elsewhere (Cox, 2012; O'Donnell, 2004). However, it is noteworthy that although parties in Ireland are currently responsible for the expediency of the interlocutory steps taken to get the claim to trial, as part of its obligations under the Convention, the state has a responsibility to address delay.[21]

In light of criticisms levelled at the current dynamic of medical negligence litigation in Ireland, a number of review and expert working groups have been established over the past two decades. Proposals for reform, including reforms aimed at targeting delay, have been suggested. A package of procedurally focused reforms were recommended by the High Court Working Group on Medical Negligence Claims and Periodic Payments (2010–2013). More recently, an Expert Group on Tort Reform and the Management of Clinical Negligence Claims (2018) was convened. Whilst this Group considered more significant reforms such as the introduction of no-fault compensation and the establishment of a Medical Injuries Assessment Board (MIAB), they ultimately did not recommend their introduction. Instead, the group recommended the introduction of procedurally

[21] *Price & Lowe v. UK* [2003] ECHR 409.

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focused reforms. These reform proposals and their potential impact on addressing the issue of delay in light of the research findings will now be considered.

8.1 Pre-action protocols

The proposal to introduce pre-action protocols in medical negligence actions has largely been viewed as a response to the perception that the length of time required to resolve medical negligence claims is excessive.[22] The aim of pre-action protocols is to reduce the time associated with these claims through the imposition of strict time limits. These protocols will apply to all medical negligence actions prior to the commencement of proceedings.[23] Whilst these recommendations have been put on a statutory footing by virtue of the Legal Services Regulation Act 2015 which amends s219 of the Civil Liability and Courts Act 2004; this is yet to be commenced. Additionally, the regulations surrounding the provisions are still awaited.[24] This notwithstanding, it is envisaged that the protocols will facilitate early exchanges of information which will encourage earlier resolution of these disputes.[25]

Whilst the introduction of pre-action protocols in medical negligence litigation has been heralded as a major step towards remedying the current temporal burdens (Sheikh, 2016), Lord Jackson, in his review on civil litigation in England and Wales in 2009, reported that pre-action protocols have resulted in parties 'front-loading' costs, whereby a significant amount of time is spent working on the claim (and therefore, costs accrued) in the pre-action period. Thus, although pre-action protocols may reduce the length of a medical negligence claim from date proceedings are issued to date of resolution, they are unlikely to have a major impact on the current dynamic in terms of cost (Campbell-Tiech, 2001). Interestingly, in their report, the Department of Justice Legal Costs Working Group (2005, p. 56) noted in a general context, 'no amount of amendment to procedural rules is likely to be effective in the absence of a change in the attitude by practitioners to adherence to prescribed time limits, and in the approach by the courts in applying those time limits with rigour'. More recently, Boylan (2022, para. 19.10) has observed that 'there is an endemic culture of non-cooperation, foot dragging and reluctance to openly communicate which bedevils the system ... it is important to bear in mind that pre-action protocols will only work efficiently if they are underpinned by significant investment and resources, and a willingness on the part of the plaintiff and defendant to be open, transparent and cooperate'. The findings of this research also suggest that a cultural change amongst the legal profession is required in addition to the introduction of the protocols, if such measures are to be effective.

9 Periodic payments

The challenges in determining quantum in cases of life-long and catastrophic injury have already been discussed and identified as a contributing factor to delay in medical negligence cases. Periodic payments have been identified as preferable to a lump sum for reasons discussed previously, namely the importance of appropriate compensation and also, expediting the

[22]See, for example, A O'Keffee, 'Time to cut out delays in cases of medical negligence' *The Irish Times* (Dublin, 20th May 2018); Roger Murray, 'The lessons from Scally: How we can correct our system' *The Journal* (Dublin, 2nd October 2018).

[23]The Legal Services Act 2015, s32B(2)

[24]The Legal Services Act 2015, s32B(3).

[25]To help achieve this, the statute of limitations for medical negligence actions will be extended from two years, to three years; Legal Services Regulation Act, s221 (1) 'The Statute of Limitations (Amendment) Act 1991 is amended – (a) in section 3, by substituting the following subsection for subsection (1): "(1) An action, other than one to which section 6 of this Act applies, claiming damages in respect of personal injuries to a person caused by negligence, nuisance or breach of duty (whether the duty exists by virtue of a contract or of a provision made by or under a statute or independently of any contract or any such provision) shall not be brought after the expiration of – (a) in the case of a clinical negligence action within the meaning of Part 2A of the Civil Liability and Courts Act 2004, 3 years ...".'

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resolution of these disputes. Periodic payments are available in many common law jurisdictions, including England and Wales. Following the recommendation of the High Court Working Group in 2012, legislation was enacted, which enabled the courts to make periodic payment orders. In addition to providing for PPOs, the Civil Liability (Amendment) Act 2017 which inserts Part IVB in the Civil Liability Act 1961, sets out principles regarding the security of payments of PPOs and provides that PPOs will be subject to yearly indexation.[26] Whilst this legislation was enacted and commenced, evidence has since emerged that PPOs linked to the Harmonised Index of Consumer Prices (HICP) would result in under-compensation. This was highlighted in *Jack Hegarty (A Minor Suing by his Mother and Next Friend Jacinta Collins) v. The Health Service Executive*,[27] a catastrophic birth-related injuries case, wherein Murphy J noted that '[i]n its current form therefore, the legislation is regrettably, a dead letter'.[28] In particular it was noted that the indexation provision introduced by the PPO scheme would not meet the future needs of those with catastrophic injuries.

Although PPOs will not deal with the overall issue of delay medical negligence litigation, their introduction should help mitigate the current delay where there are concerns about the quantification of a claim for a lump sum payment. Additionally, they should ensure that plaintiffs receive compensation which will meet their needs throughout their lifetime thus better supporting the principle of *restitutio in integrum*. It is disappointing therefore that the legislation introduced is a 'dead letter'. It has been reported, however, that the Department of Justice has reconvened a Working Group to take account of the decision in *Hegarty* and to make recommendations to the Minister (NTMA, 2021).

10 Case management

As previously noted, there is no formal framework for the case management of medical negligence disputes in Ireland. Case management is well-established in other common law jurisdictions. Benefits associated with formal case management include the early identification of issues in dispute, further embedding mediation as a step in the process and the streamlining and thus, expedition of the case. Although considered by the High Court Working Group in 2013, who drafted a set of court rules to facilitate same, the group ultimately concluded that the 'blanket application' of a case management to medical negligence cases was 'simply not feasible' due to a lack of available resources. Instead, it suggested that case management should be available on application of the parties or the court's own initiative where the case meets certain criteria, for example, complex cases (2013, p. 13). More recently however, the Expert Group appointed to review the law of torts and the current system for clinical negligence disputes, noted that case management is 'an essential part of any reform' (Expert Group, 2020, p. 21). The aggressively adversarial nature of these disputes was also acknowledged, with the Expert Group of the view that the introduction of case management would help to ameliorate the currently contentious nature of

[26]Civil Liability (Amendment) Act 2017, pt 2, s51J provides: (1) A court may make a periodic payment order where it is satisfied that continuity of the payments under the order is reasonably secure. (2) In considering whether continuity of the payments under a periodic payments order is reasonably secure, a court shall have regard to the following matters: (a) whether the payments under the order are guaranteed under the Clinical Indemnity Scheme or the General Indemnity Scheme; (b) whether the payments under the order are eligible for payment from the Insurance Compensation Fund; (c) whether continuity of the payments under the order can be guaranteed by other means. (3) In considering whether other means for guaranteeing payments referred to in subsection (2)(c) are such that continuity of the payments under a periodic payments order would be reasonably secure, a court shall have regard to whether the proposed means for guaranteeing payments under the order— (a) are such as to be capable of making the proposed payments to a plaintiff during his or her lifetime and (b) are capable of being adjusted in accordance with the Harmonised Index of Consumer Prices as published by the Central Statistics Office or such other index as may be specified by the Minister under section 51L

[27][2019] IEHC 788.

[28]*Ibid.*, at para 74.

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claims. In particular, the Expert Group noted that case management would encourage 'a spirit of cooperation between the parties and the avoidance of unnecessary combativeness which results in unnecessary additional stress to the parties, expense and delay' (Expert Group, 2020, p. 21).

The introduction of case management as a measure to mitigate against delay and adversarialism is to be welcomed, however, little progress has been made since the recommendations of these Expert Groups in 2013 and 2020.

11 Expert witnesses

Though the challenge of securing a medico-legal expert within Ireland may not be easily remedied given the size of the jurisdiction and the cultural context therein, the findings of this research highlight the need for a more fundamental consideration of the adversarial space in which experts are currently engaged. As previously noted, the use of medico-legal experts as adversaries is not an issue unique to Ireland. A recent case in England and Wales has highlighted the potential implications where expert witnesses are not cognisant of their objective duties to the court. In *Patricia Andrews and ors v. Kronospan Limited*[29] the consequences of non-compliance with that duty were seen where an expert was alleged to have acted as an advocate for the claimants. Whilst the case in question did not involve medical negligence, it provides interesting insights into how the courts regard and will treat a breach of the duty of independence to the court.

Notwithstanding the fact that experts owe their duties to the courts, this research, along with recent case law, suggests that in practice experts are typically engaged and report in a partisan manner. One way to mitigate against this may be through the appointment of joint expert witnesses. However, in Ireland, although s20 of the Courts and Civil Liability Act 2004 provides that the court may appoint an expert witness, Boylan (2022, p. 14.07) asserts that this provision has never been used in a medical negligence context. Thus, perhaps speaking to the wider culture which exists in this type of litigation.

Though the role of experts was considered by the Expert Group on Clinical Negligence and Tort Reform, issues and challenges with medico-legal experts were not explored in detail. The Expert Group did note however, that the introduction of procedural reforms such as case management and pre-action protocols would help minimise the issues in dispute and therefore, the testimony of the expert at trial would be less extensive. In addition, the Group (2020, p. 12) recommended the introduction of sanctions where 'a defendant files a defence containing matters in respect of which there is no supportive expert report'.

12 Mediation

Mediation, a facilitative, voluntary and confidential process, has been identified as a form of dispute resolution with the capacity to address the perceived ills of medical negligence cases (Meruelo, 2008; Shipley, 2018). In Ireland, a framework for the formal integration of mediation in the civil justice system has been introduced; the Mediation Act 2017 was commenced in January 2018. The intent of the Act is to increase the number of cases that are resolved via mediation. Section 14 of the Act contributes to this aim through the imposition of a requirement on solicitors to inform clients of the possibility of resolving their dispute via mediation prior to the issuance of proceedings. Other measures designed to encourage the uptake of mediation include the power of the court to suggest parties consider mediation (s16) with a further power to award costs where mediation has failed to be considered unreasonably following invitation by the court (s21).

[29](2022) EWHC 479

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Whilst the introduction of the Act can be recognised as a positive step in the integration of mediation in the civil justice system in Ireland, it is worth noting that mediation has long been an option to parties to medical negligence disputes. For example, under section 15 of the Civil Liability and Courts Act 2004, the court had the power to invite parties to consider mediation upon request of a party, with section 16 bestowing similar powers to award costs in cases where there was an unreasonable refusal to consider mediation. However, anecdotal evidence suggests that uptake of mediation in medical negligence disputes has been limited (Dowling-Hussey, 2016), reasons for which remain underexplored. It is perhaps too early to tell whether the 2017 Act will have a meaningful impact on the number of medical negligence claims resolved by mediation, however, given its capacity to resolve these disputes in an expedient, economical and holistic way it is argued that this form of dispute resolution should continue to be promoted amongst disputants with suitable cases.

13 Conclusion

Whilst medical negligence claims can be protracted, civil cases may be assumed to revolve only around money and accordingly, delay may be viewed as unlikely to cause harm in this context. However, it is submitted that delay in cases of medical negligence is particularly problematic in circumstances where individuals suffer a significant injury and need immediate financial support to cover the cost of care. Arguably, in such circumstances, delay will be intolerable and may have a devastating impact on their quality of life, as well as their health. Additionally, the stress and emotional turmoil often associated with ongoing litigation may be difficult for both the patient-plaintiff and the medical practitioner (Tumelty, 2021). The longer the case takes to resolve, so too, the longer the parties must live with the associated stress.

This article has provided insights into the duration of medical negligence claims for the first time in an Irish context and contributed to the discourse on causes of delay in the resolution of these claims offering some more broadly applicable insights. In Ireland, procedurally focused reforms have aimed to address and ameliorate delay. Their impact is yet to be ascertained. However, it is argued that any reform measures must be considered within the broader context of a jurisdiction's 'local legal culture'. As the findings of this research suggest, without a more fundamental engagement with the current legal culture, measures aimed at ameliorating the current dynamic of these disputes will be limited.

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