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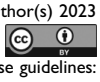
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Navigating conflict: The role of mediation in healthcare disputes

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Abstract

Navigating conflict in healthcare settings can be challenging for all parties involved. Here, we analyse disputes about the provision of healthcare to patients, specifically exploring how mediation might be used to resolve disputes where healthcare professionals may disagree with the patient themselves or the patient's family about what healthcare is in the patient's best interests. Despite concerns about compromise over the patient's best interests, there is often room for the parties to come together and think about how the dispute might be resolved in a way that is acceptable to all. It is in this space where mediation might step in. We set out the potential benefits and risks of mediation in this article, and argue that there is a need for clearer, empirically grounded evidence on the use of mediation in healthcare disputes.

Keywords

Bioethics and medical ethics, clinical ethics, minors, mediation, mentally disabled, legal aspects, philosophical aspects

Introduction

Navigating conflict in healthcare settings can be ethically, emotionally and interpersonally challenging. Moreover, the need to maintain continued working relationships and the ongoing provision of care can create further challenges. The conflict that we analyse here relates to disputes about what, and whether, healthcare treatment should be provided to individual patients. In these scenarios, healthcare professionals (HCPs) may disagree with the patient themselves or the patient's family about what healthcare is in the patient's best interests. Yet where there is a dispute about the provision of healthcare, this conflict can have consequences for everyone involved, impacting upon the day-to-day care that must continue. The patient can be impacted by not having their views listened to or acted upon, family members or parents of children can feel excluded from the decision-making process[1] and all parties may experience moral distress,[2,3] including when they are not able to do what they think is best for the patient. All parties may feel pressured by the other to compromise in the interests of resolution, even where they think there is no compromise to be had. Of course, most instances of dispute that arise in healthcare are resolved informally. Furthermore, ways forward can often be agreed upon that balance the different perspectives of everyone involved. Yet there are circumstances where agreement cannot be reached, and resort to the courts may be necessary.[4] It is these challenging circumstances that may result in legal proceedings that this article explores, considering the role of mediation as an alternative to the use of the courts for disputes that cannot be resolved in other ways.

Healthcare disputes can cover a range of issues, from the everyday such as personal hygiene and feeding and drinking to serious medical treatment such as invasive ventilation and CPR. These disputes also include various issues in between, including the more 'routine' ongoing medical interventions, such as vaccinations and contraception, as well as serious but 'one-off' matters such as childbirth. Despite many involved in healthcare disputes appearing to adopt a firm line as to their interpretation of the patient's best interests, as Huxtable[5] rightly explains, there is often room for compromise over ethically difficult positions. It is in this space where mediation might step in – being more informal than courts but having a clear process and structure for moving forward. Mediation can provide a place, time and space for reflection on difficult ethical issues that arise, allowing all parties to better understand

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each other and to identify shared interests from which agreement may emerge. However, mediation is not without risks; some of which are quite particular to healthcare. Moreover, it is problematic to advance mediation as a solution to conflict when its empirical evidence base is not strong.[6]

In this article, we start by outlining the legal framework in England and Wales relating to consent and capacity for adults and children to highlight the legal complexity of navigating the decision-making framework where patients are unable to make their own decisions. We then move on to consider the role of mediation to provide an insight into how and why mediation might be an appropriate alternative to litigation. Finally, we consider the possible benefits and risks of using mediation in these cases. We argue that there is a need for clearer, empirically grounded evidence on the use of mediation in healthcare disputes, from which to formulate a more robust framework to govern mediation's use in this ethically challenging and legally complex landscape.

The law and healthcare disputes

Disagreements about the provision of health and care to patients can arise for numerous reasons: there may be a breakdown in trust between HCPs, patients and family members, there may be differing values underpinning different perspectives on which treatment is necessary and there may even be resource factors at play.[7–12] When disputes arise, they operate within a legal framework, which acts as the backstop to this conflict. Those who work outside of law or healthcare are often surprised to learn that patients themselves, or their family members, do not always have the right to decide whether and, if so which, healthcare is provided. Different legal frameworks apply depending on whether the patient is an adult or a child, and the rights of different parties vary depending on the patient's capacity or competence to make their own decision. However, the common theme is that where a patient is unable to make their own decision, the law requires a decision to be made on their behalf in their best interests. Recourse to the courts may not always be necessary where disagreement arises but, if conflict cannot be resolved in the patient's best interests, then the court will be the final arbiter.

We turn first to the law on adults (those over the age of 16). The Mental Capacity Act 2005 (MCA) operates to determine whether a person lacks the mental capacity to make a specific decision using a diagnostic and functional test. If, in accordance with the criteria set out in section 3 MCA, a person is unable to make a specific decision about their healthcare, then where they have an impairment of or disturbance in the functioning of the mind or brain that causes that inability, a decision about their healthcare can be made in their best interests. Best interests decisions can be made by the Court of Protection (CoP), subject to the statutory provisions regarding advance decisions, lasting powers of attorney and deputyship,[13] as well as the provisions set out in section 5 MCA regarding acts in connection with the care or treatment of the person. Whether a person is able to make a decision is analysed by reference to whether they are able to understand the information relevant to the decision, retain that information, use or weigh the information or communicate their decision. They must also be able to understand the reasonably foreseeable consequences of the decision, or of not making one. For decisions to consent to or refuse medical treatment, relevant information generally encompasses understanding the treatment, its risks and benefits, reasonable alternatives, the consequences of accepting or refusing the treatment and the likely outcome of the treatment or refusal. Where an adult is found to lack the mental capacity to make their own decision about the provision of healthcare, they must still be involved in the process of decision-making on their behalf. This theoretical safeguard is not always borne out in practice, as indicated by numerous criticisms of the lack of a participatory approach in the CoP and mental capacity law more generally.[14–17]

Adolescents aged 16–17 are at the intersection of legal frameworks affecting adults and children, being governed by both the MCA and the Family Law Reform Act 1969 (FLRA). Section 8(1) FLRA makes clear that 'the consent of a minor who has attained the age of 16 years … shall be as effective as it would be if he were of full age'. This means that a 16- or 17-year-old can give consent to healthcare, provided that they do not lack capacity under the MCA. However, the FLRA is silent on consent refusal, meaning that if a 16- or 17-year-old wishes to withhold consent, then that choice can be overridden if someone else consents on their behalf, typically those with parental responsibility or through a court order.

For children in mid-childhood, whether or not they can consent to their own healthcare depends on whether they are *Gillick* competent.[18] This now well-known test considers the developmental maturity of the child to understand the seriousness of the decision, requiring an appreciation of the consequences, side effects and risks of failure to treat.[19] For younger children who are not *Gillick* competent, others will have to make decisions about their healthcare on their behalf. Most often this will be the parents (or, more specifically, those with parental responsibility) under ss 2–4 Children Act 1989. Despite the parental power to make decisions for their children, the court retains a residual power to act in the child's best interests under the inherent jurisdiction of the High Court. The best interests of the child is the paramount consideration, whether it is the parents or the court making the decision.[20] It is important to remember that best interests is a broad concept, not solely focusing on medical factors. In the case of Charlotte Wyatt, Wall LJ summarised the approach[21]:

> The term 'best interests' encompasses medical, emotional, and all other welfare issues. The court must conduct a

> balancing exercise in which all the relevant factors are weighed and a helpful way of undertaking this exercise is to draw a balance sheet.

While the best interests tests relating to adults and children are not identical, they do have a number of commonalities. It is particularly important that for older children, the best interests approach of the MCA is considered, more so the closer the child gets to adulthood.[22] Furthermore, both adults and children ought to have their views adduced and taken into account at all stages of the decision-making process. In addition to the domestic legal framework, there are various international standards that govern this area and require the patient's involvement in decision-making. For children, Article 12(1) of the UN Convention on the Rights of the Child (UNCRC) requires that the child have 'the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child'. A similar concept is mirrored in the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which, under Article 12(1) provides that disabled people 'have the right to recognition everywhere as persons before the law' and in relation to access to justice includes a requirement that disabled people are facilitated to play an 'effective role as direct and indirect participants'.

The law is not the end of the matter though. To add further complexity, HCPs must also operate within the bounds of their own professional standards, which vary slightly depending on their discipline. For example, the General Medical Council (GMC) and Royal College of Paediatrics and Child Health (RCPCH) both have guidance on how HCPs should approach decision-making.[23] The GMC guidance broadly reflects the MCA framework and emphasises that to assess the overall benefit for the patients, it is necessary to weigh the benefits, risks and burdens of each option, and it is not only clinical considerations that should be included. With regard to children, the RCPCH starts with the assertion that children are individuals with rights that must be respected. Doctors have a duty to protect their health and well-being and to listen to their views. The RCPCH guidance importantly emphasises that in most cases, decisions are made by consensus, which can be inferred by the fact that the case law represents only a tiny portion of the numbers of healthcare decisions made on a daily basis. Yet the guidance acknowledges that disagreements do arise between HCPs, patients and family members, which may stem from miscommunication or differences in genuine and deeply held beliefs.[24] Interestingly, mediation is one of the options suggested as a possible way forward by both the GMC and the RCPCH, before the case is referred to a court. It is one of the potential steps to help resolve disputes without going to court, but mediation has not received sustained academic attention, and it is the role of mediation to which we now turn, aiming to help fill this gap.

The role of mediation

The above section signals how complex healthcare decision-making can be where disagreement arises. HCPs, family members and patients have to navigate often perplexing legal criteria, against a backdrop of ongoing ethical and emotional challenges. Conversely, the fact that the vast majority of healthcare decisions are made without express recourse to the law or courts suggests that agreement is possible despite the challenges faced. For example, Brierley *et al.*'s empirical analysis of end-of-life decision-making for children over a three-year period on a Paediatric Intensive Care Unit (PICU) found that[10]:

> In 186 of 203 cases in which withdrawal or limitation of invasive therapy was recommended, agreement was achieved. However, in the 17 remaining cases extended discussions with medical teams and local support mechanisms did not lead to resolution …

They go on to explain that 11 of the unresolved 17 cases involved religious issues, which made it difficult to reach agreement. They further explain[10]:

> Five of the 11 cases were resolved after meeting religious community leaders; one child had intensive care withdrawn following a High Court order, and in the remaining five, (…) no resolution was possible due to expressed expectations that a 'miracle' would happen.

This article highlights that the small number of cases that are difficult to resolve informally may be those where there is a conflict of values between HCPs, family members and, in some cases, the patient themselves. Albeit not all cases of conflict of values will lead to disagreement or a best interests determination by a court. Kong *et al.*[25,26] have written about the difficulty in weighing values that are not commensurate; if the starting positions of HCPs, patients and family members are so fundamentally different in nature, then it can be difficult to see how any principled approach can reconcile those values in ways that can satisfy all parties. However, approaching the issue from the perspective of trying to reach consensus on the substantive issue, the patient's best interests, is not the only way of approaching healthcare disputes. Mediation may provide a different way of framing the dispute, which focuses on a process of bringing people together and prioritising communication to begin to resolve those seemingly unresolvable cases.

What is mediation?

Mediation has been suggested as an alternative way to address healthcare and medical treatment disputes, one that is non-judicial and non-adversarial. It can take place alongside or even following court proceedings, but can also take place at an early stage in the conflict process to try and resolve matters before relationships break down further. The practice of mediation can vary depending upon the subject matter of the dispute and the mediator's own style, but it generally involves a mediator acting as an independent third party to work with the individuals in dispute to help them to come to a mutually agreed resolution.[27–29] Of course, while resolution is one of the aims of mediation, a key feature of mediation that distinguishes it from litigation is that the parties themselves decide whether to reach an agreed way forward; it is the parties, not the mediator, who are the decision-makers. Mediation may, therefore, be deemed to be 'unsuccessful' if it does not lead to an end to the disagreement. This is not necessarily a fair reflection of the potential benefits of mediation, however, as other outcomes and benefits can materialise, such as improved communication, greater shared understanding of the facts, narrowing of the issues or better understanding of the other party's perspective.[8,24,30–33] Furthermore, mediation can lead to agreement at a later date well beyond the timeline of the mediation if, for example, it gives parties the space to reflect upon their differences and their own perspectives. These benefits of mediation are well established in the literature, albeit there is little evidence specifically about mediation's use in relation to medical treatment disputes.[9,30,32–35]

In contrast to litigation, mediation is meant to be a non-adversarial process. Mediation does not lead to one side 'winning' and the other 'losing'. Instead, the aim is to encourage the parties to collaborate and, if possible, to reach agreement that they can all accept. No party is compelled to accept a mediated agreement. The role of the mediator is important, but it is not a quasi-judicial role; mediators are expected to facilitate the discussion between everyone involved but to remain impartial as to the outcome. It would be inappropriate, according to facilitative mediation theory (which is the approach dominantly practised in this area of dispute), for the mediator to express a preference for a particular outcome. Furthermore, the mediator ought not to give advice to the parties or an opinion on the merits of the dispute. However, the extent to which this is reflective of mediation practice in this or related areas is debatable. For example, in an analysis of CoP mediation, it was noted that[30]:

> The legal representatives clearly acted as gatekeepers in this mediation … For example, there was evidence in this mediation of a legalised approach, with an adversarial culture being clear. This was apparent through the mediator's own style, being a practising barrister in addition to a mediator … This was also surprising considering the mediation literature which points towards facilitative mediation being the norm rather than a more evaluative approach. It appeared that the mediator in this case study drew on his own legal experience to even provide an opinion at one stage. Yet, interestingly, this was responded to positively by the parties and they requested his opinion at one point.

Despite this, facilitative mediation is still the type of mediation most commonly used in civil and family justice. However, the way in which it is operationalised in the healthcare context requires further empirical insights. From our experience of speaking to mediators in this area as part of our ongoing empirical work, mediation of healthcare disputes rarely operates along the commercial model. Instead of confining the mediation to a one-off meeting, mediators in healthcare disputes tend to take more time over the process and have mediation meetings over a number of days, weeks or months, with the amount of flexibility determined to some extent on the factual confines of the case.

In addition to this ability to design the process to suit the case and the parties, the key features of mediation are the voluntariness of the process; the impartiality and independence of the mediator; the empowerment of the parties to decide the outcome themselves; confidentiality; and the flexibility for the parties to explore their underlying interests and reach creative settlements. In mental capacity law mediations concerning adults, some of these features have been shown to be present. For example, mediation does fulfil the requirement of flexibility, voluntariness and mediator independence.[14,30] There is, however, less evidence to support the empowering potential of mediation for the parties involved, with Lindsey[14] arguing that mediation in mental capacity disputes 'privilege[s] legal notions of justice' as legalism dominates, meaning that the mediations are heavily shaped by lawyers, and the lay participants are marginalised in the process.

What does the law say about mediation?

Given that mediation is taking place in healthcare disputes, it is perhaps surprising that there is very little guidance on when and how it should be used. Looking at the law on adults first, the MCA is silent on mediation, and while case law in the CoP does sometimes refer to mediation, it is generally rarely discussed.[14] Chapter 15 of the Code of Practice to the MCA does provide some general information about the use of mediation, with some specific types of case considered. However, none of the examples provided relate to medical treatment, although the provision of care to an adult with dementia is considered as a possible dispute for mediation. There is no statutory or similar guidance on the use of mediation in healthcare disputes concerning children, with the Children Act 1989 briefly referring to

mediation but in relation to section 8 child arrangements orders in family proceedings only.[36]

Interestingly, human rights treaties also do not refer to mediation explicitly, and it has not been the subject of intensive reflection by international human rights bodies. For example, the Human Rights Committee, in the General Comment on the right to fair trial, only briefly mentions mediation in the context of juvenile criminal justice, and the UNCRPD does not mention mediation at all.[37] Nevertheless, mediation has been discussed by the UN Committee on the Rights of the Child (CRC Committee) and various organs and expert groups within the Council of Europe (CoE). Both the UNCRC and the CoE[38] insist that the two fundamental principles of the Convention on the Rights of the Child (CRC), that is, the best interests principle and the right to be heard, should be respected and safeguarded in the mediation process 'to the same extent' as in court proceedings.[39] The best interests principle is a substantive right and a procedural requirement: whenever a decision is to be made that will affect a child, 'the decision-making process must include an evaluation of the possible impact (positive or negative) of the decision on the child or children concerned. (…) the justification of a decision must show that the right has been explicitly taken into account'.[40] The child capable of forming his or her views should also be heard when a decision is made 'in all matters affecting him or her'.

Yet international sources provide rather limited advice on how to ensure respect for patients' rights in the context of mediation. Access to information and independent legal representation is clearly relevant.[41] Some sources are neutral as to benefits of mediation for children, with some concerns also present about the potential to limit access to justice. The law, both domestically and internationally, therefore appears to be unwilling to directly engage with mediation's use in this challenging area, instead emphasising that recourse to a court may offer more guarantees of protection.[42]

What are the benefits and risks of mediation?

Even though many in healthcare law have suggested that mediation may be a better way forward compared to litigation, there has been very little independent or academic data to justify this point of view, and it is, in our view, premature to recommend mediation as a better way forward for resolving healthcare disputes. This is despite Mr Justice Francis noting about the Charlie Gard case 'it is my clear view that mediation should be attempted in all cases such as this one even if all that it does is achieve a greater understanding by the parties of each other's positions'[43] and the Charlie Gard Foundation recommending 'access to medical mediation where there are differences of opinion'.[44] However, we do think that mediation has some potential to provide benefits for those involved in healthcare disputes. Here we consider what evidence exists of mediation's potential in related areas of dispute.

In a qualitative interview study[14] analysing mediation in CoP disputes (albeit none of these concerned medical treatment), the key positive findings included that mediation can provide greater flexibility in the resolution of disputes and it can offer greater respect for the individuals involved (particularly the patient), for example by tailoring the process to individual needs and being more responsive to those needs. In areas that similarly involve vulnerable parties such as family law, evidence shows that mediation can be seen as a more effective way to resolve disagreements due to its focus on improving communication and developing co-operation.[45]

One of the advantages of mediation is that it allows for participation of all parties, including the patient, in more creative ways than litigation might allow. Working with the parties, the mediator tailors all aspects of the mediation process to the needs of all those involved and ensures each voice is heard. Getting the appropriate people to the mediation is important so that questions can be answered, interests explored and, where appropriate, consensual agreements reached on ways forward. Mediations are often highly emotive meetings, and no more so than in this context. Crucially, any outcomes are ones the parties themselves have decided on, and in that way they are active participants reaching collective decisions. However, the evidence so far suggests that participation has not been effectively secured in CoP mediations. For example, less positive findings from the mental capacity law mediations study included that the patient is unlikely to participate or give voice.[14]

It is possible that, if participation is facilitated effectively, mediation could help patients and family members come to terms with the issues at the heart of the dispute and help HCPs fully understand the perspective of others involved. The realisation as a parent that you are not legally the final decision-maker for your own child can be shocking and lead to a feeling of powerlessness. It can take time and careful discussion to digest the realities when faced with your seriously unwell or dying child. Conversely, HCPs may benefit from hearing directly from the family, in a neutral venue, over a period of time, away from the realities of the hospital ward. Furthermore, in cases concerning older children or adults who may lack the capacity to make their own decisions, even unwell patients may be able to indirectly participate in a mediation process, for example, by an attendee reading out a statement of their wishes or playing a video of them during the mediation. For all parties, then, mediation might provide an opportunity to hear from and be heard, in a way that is not possible in the ordinary course of the provision of healthcare. Of course, in some cases the patient will not be able to participate as fully as in others. We explore further in this section how to ensure that the best interests (and the wishes and preferences) of such patients are the foundation of any resolution.

An interesting comparator is perhaps special educational needs and disabilities (SEND), where mediation is part of the statutory framework in England (the Children and Families Act 2014) for resolving disputes about the provision of support for disabled pupils, including health provision. The Act bestowed on young people aged 16–25 the legal right to challenge a local authority decision on their support. Yet few young people attend a mediation involving their SEND support.[46] Mediation's use in SEND was researched as part of a review, carried out by the Centre for Educational Development, Appraisal and Research (CEDAR), of the effectiveness of disagreement resolution arrangements in this area, including information, advice and support services; mediation; complaints; and the First-tier Tribunal SEND.[47] The research found that use of mediation reduced the likelihood of an appeal to the tribunal. Although some mediated cases did go on to the tribunal, of the group who chose not to use mediation, 36% went on to appeal, compared to 22% of those who had been to mediation, a 14% point reduction in the likelihood of registering an appeal after mediation. It is important to note, however, that the fact a case did not proceed from mediation to tribunal does not necessarily mean the dispute was resolved.

Despite mediation's increasing use in the SEND context, earlier research noted concerns, particularly in relation to protection of children's rights and an inherent power imbalance between families and local authorities.[48] To some extent, these concerns apply not only to mediation but to any settlement mechanism in healthcare as well as in SEND. Non-judicial processes for resolving disputes involving the public sector risk being seen as individualised and privatised justice without reference to the need to respect fundamental rights and the public interest in open justice. Some of these concerns could be addressed by greater transparency of mediation outcomes, even though the discussion at mediation remains confidential. Concerns about power imbalances between parties could also be addressed by ensuring parties have access to independent legal advice.

The reason for confidentiality as a key feature of mediation is to encourage honesty and openness in the discussion, which facilitates improved communication. In practice this confidentiality raises important issues – both practically, when information must be shared with colleagues and with family members, and in terms of transparency of decisions made by public bodies that can have wider public interest. Often it is the discussion itself that is considered to be confidential, and the parties themselves can agree that any resulting settlement agreement or joint statement of outcome is in the public domain. This transparency in relation to any agreement is important where public bodies are involved, and there is the potential for learning to be had and a wider public interest in outcomes.

Concerns raised about mediation in disputes involving a public body such as an NHS Trust or local authority also include a perception that mediation involves compromise, and these disputes are not amenable to compromise.[49] We argue that mediation should not be seen as a route to compromise, something neither party in healthcare disputes could countenance when issues of life and death are at stake. In such contexts, the 'stereotypical image of a mediated settlement model, often characterised in terms of a confidential carve-up borne of an unseemly horse-trade, need not apply. Mediation is a flexible tool, in which the ground rules and outcomes can be dictated by the nature of the dispute and the priorities of the parties'.[50] Unlike in clinical negligence disputes, the remedy sought is not a financial settlement, requiring a different 'sensibility' of mediation than that commonly used in civil and commercial claims. It may be that certain aspects of the dispute are amenable to negotiation, such as aspects of particular treatments or where and how a patient receives end-of-life care. This is not necessarily compromise but instead it is a recognition that, at the periphery at least, there may be room for movement on the part of the HCPs once they better understand the patient or family's position. Mediation in these contexts can serve as an effective mechanism for information exchange, which may in turn lead to a change in each party's perspective as to what actually is in the patient's best interests, rather than compromising over best interests.

There is also a legitimate concern that mediation could be impacted by the imbalance of power between the parties. Power in mediation is a complex issue and is not simply about the power of an institution and the professionals who work in it versus the relative lack of power of an individual lay person. In disputes about medical treatment, power held by the parties includes professional expertise, the physical location of a patient, knowledge of the patient and her wishes and preferences, access to support and cultural and religious beliefs that inform decision-making. Mediators are expected to be aware of and address any power imbalances that might make mediation as a process unsafe for any party. They do this, for example, by allowing parties equal time and space in which to speak and be heard; by ensuring that technical language and acronyms are explained; and by facilitating the inclusion of supporters, advocates and legal advisers. However, these skills are dependent on mediator competence, and the uncertainty that parties might feel about that competence contrasts with the perception that judicial involvement secures parties' safety and redresses any imbalance of power. A further concern in relation to children's cases in particular might be that mediation is used as a tool to persuade parents to change their view and agree with the HCPs, rather than it being a genuine attempt at resolution from both sides. Whether this is indeed a

common experience of parents has not been empirically tested.

A final concern regarding mediation's use in healthcare and medical treatment disputes is that it could lead to delay and prolonged suffering for adults and children, particularly at the more extreme end of healthcare interventions involving life or death decisions. One of the difficulties with using mediation in such disputes is the need to ensure that any agreed outcome reflects the best interests of the patient, whether a child or adult. Any delay to a best interests decision caused by the parties taking time out to mediate could negatively impact upon the patient by prolonging their suffering. There are also questions about the ability of mediation to secure best interests at all, with concerns that it becomes about the parties' own wishes rather than the patient. It therefore may be necessary to include in the mediation an independent advocate (or legal representative) who can ensure that the patient's best interests, which might be different from the interests of parents/family and HCPs, is the foundation for any agreed outcome.

Conclusion

This article has provided an insight into the possible role of mediation in healthcare disputes concerning the provision of treatment to adults and children in England and Wales. While we have not looked at the legal context beyond this jurisdiction, there is certainly scope to consider whether mediation would be effective in other legal cultures, particularly those where informal resolution and reluctance to use the courts is already more embedded.[4,51] We have shown that the law is complex and does not effectively deal with the role of mediation as an alternative way of resolving these difficult cases. However, we do have emerging evidence about the benefits of mediation in cases concerning adults in the CoP as well as benefits from other areas of practice such as SEND. These benefits include flexibility, more creativity in solutions and potentially a more participatory approach. However, mediation is not without risk, particularly in relation to the potential delay it could have and the impact this might have on the patient. Moreover, there is a risk that inexperienced mediators may not be able to effectively manage the multi-faceted power imbalances in this sensitive arena. Overall we argue that mediation's evidence base requires strengthening before wholesale incorporation or regulation can be developed.

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