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HRESTOMATIJA HRVATSKOGA MEDICINSKOG PRAVA

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Recommendation on alternative dispute resolution in medical liability in Council of Europe member states[1]

1. INTRODUCTION

There is almost no sector in such a need for the development and application of dispute resolution techniques and processes as is the healthcare sector. Incorporation of negotiation, mediation, facilitation, and dialogue techniques with emerging issues such as patient safety, healthy clinical environments, labor shortages, bioethics, technological advances, public health emergencies, health professions education, and access to health services could provide the necessary infrastructure for the evolution of the culture of healthcare[2].

We can ask ourselves are we ready to bring the Recommendation on alternative dispute resolution in medical liability in Council of Europe member states, or perhaps there is yet no need for such a Recommendation? Or is the situation in healthcare sector so chaotic that we should even pass additional Protocol to the Convention on human rights and biomedicine. But, as Nys concluded in the Report on medical liability in Council of Europe member states[3], „there are the procedural aspects of medical liability such as the burden of proof, causality and so on. There are marked differences between the countries studied….it will be very difficult to harmonize these differences because they derive from general rules regulating civil and criminal liability." If we look on common problems, maybe the Recommendation could help solve those problems: „Such a Recommendation could encourage member states to provide alternatives to court procedures in medical liability cases and to ensure that information and advice as to these options was already available to citizens. It would build on existing standards concerning, among other things, patient safety and reporting system…. It could also deal with systems of risk management, and cover appropriate compensation, indemnity and guarantee mechanisms aimed at ensuring funding is available for meeting claims[4]." One argument pro alternative dispute resolution is undisputable: speed and cost-effectiveness is important both to the patients as health care users and to the health care providers. If member states of Council of Europe decide

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[2] http://www.decision1.net/id7.html

[3] Nys, H. 2005. A Comparative Study of the Legal and Factual Situation in Member states of the Council of Europe. Council of Europe. March, pg. 28.

[4] Kilby, E. 2008. General rapporteur oft he Conference. The ever-growing challenge of medical liabilty: national and european responses. 2. - 3. June. Council of Europe. Proceedings, pg. 234.

to bring such an instrument, it should satisfy all interested parties (states, health care providers, physicians and patients) and meet their common concerns in applying alternative dispute resolution in medical liability. We have to bare in mind that some legal systems have already developed so-called "no-fault" compensation models (Scandinavian countries, partially France (ONIAM), Belgium[5]) and that possible future Recommendation should not be in collision with their alternative dispute solutions *(herein and after: ADR)*. However, we should bare in mind that even if parties make use of some alternative dispute resolution techniques in health sector, their access to court as described in article 6. of the European Convention of human rights should not be denied[6].

2. THE BENEFITS OF ADR IN MEDICAL LIABILITY CASES – STARTING POINTS FOR THEIR IMPLEMENTATION

The exact number of adverse events[7] in health care sector is not easy to determine. The studies revealed that 2.9% to 16.6 % of patients in acute care hospitals experienced one or more adverse events and that in 5% to 13% of the adverse events patients died. Approximately 50% of the adverse events were considered as preventable[8]. Errors are happening in the health care sector worldwide and once we identify them, we have to start solving them finding the best and most economical way possible, taking into account that patient safety and quality management are priorities[9].

Unfortunately, although the goal of providing health is the most noble one, the tensions between patients as health care users and physicians or hospitals as health care providers are often arising and leading sometimes to a long and expensive court proceedings. The challenge of addressing error in medicine demands also a thourough reconsideration of the legal mechanism currently available to deal with harms in health care. Regardless whether the health sector belongs to civil or common-law legal system, the problem of expansion of court cases was (is) everywhere the same, already at its peak or slowly climbing towards

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5 From May 15. 2007.

6 Article 6. proscribes „In the determination of his civil rights and obligations or of any criminal charge against im, everyone is entitled to a fair and public hearing within a reasonable time by an independent and impartial tribunal established by law…."

7 Adverse event refers to An *injury related to medical management, in contrast to complications of disease.* Medical management *includes all aspects of care, including diagnosis and treatment, failure to diagnose or treat, and the systems and equipment used to deliver care. Adverse events may be preventable or non-preventable*. *Preventable* adverse event refers to *An adverse event caused by an error or other type of systems or equipment failure* (World Alliance for patient safety, Who Draft guidlines for adverse event reporting and learning systems, From inforamtion to action, Who, 2005). Adverse event can be defined as *an unintended injury that results in disability at the time of discharge, death, or prolonged hospital stay and is caused by healthare management rather then by the patient's underlying disease process* (see footnote 3.), as *an injury caused by medical management–rather than by the underlying disease–which prolongs hospitalization, produces a disability at the time of discharge, or both etiology drug effects, wound infections, technical complications, negligence, diagnostic mishaps, therapeutic mishaps, and events occurring in the emergency room.* (http://medical-dictionary.thefreedictionary.com/adverse+event)

8 Nys, H. 2008. The factual situation of medical liability in the member states oft he Council of Europe, report, Conference: The evergrowing challenge of medical liability: national and european responses. 2 June. Council of Europe. Proceedings/Actes. pg. 18.

9 For more information regarding adverse events and statistical data, see Ćepulić, E.; Roksandić Vidlička, S.; Babić, T. 2008. Scandinavian model of insurance from medical errors – Can it live in framework of Croatian legislative. Civil liabilty in medicine. Croatian Academy of Science and Art, pg. 125-133.

it. Consequently, the use of alternative dispute resolution in increasing in cases arising from health care rendering. It is not only due to the fact that litigation lasts longer and it is more expensive, but it is due to the fact that health sector is very emotional field. "Anger and the court system shows slow docket, openness to public view, layers of appeal, and lack of means for the grievant to speak out personally and have his or her sense of wrong clearly and directly addressed. Because parties value speed, confidentiality and finality in the resolution of their disputes, as well as a forum suitable for sorting out many technical and complex details, many parties turn to alternative dispute resolution to resolve their legal, financial and emotional disputes"[10].

ADR methods have many advantages comparing to trials at courts. This is especially true for medical liability cases. Since these methods enable patients to report cases of medical malpractice without involvement of police, public prosecutors and courts they create more friendly reporting environment as well as more friendly environment for resolving such cases. As we know, long and expensive judicial procedures often discourage patients from reporting. However, reporting and resolving medical malpractice cases is of utmost importance to avoid reappearance of avoidable adverse events. Also, the physician who made mistake, or to whom adverse event happen, after elaborating it through ADR, would be in position of avoiding it in the future. Furthermore, discovering of those adverse events would prevent mistakes from happening to other health care providers. In addition, detection of mistakes will help to set up a better control mechanisms in health sector. A valuable source of information on potential ways to avoid malpractice mistakes might be a database of such cases.

Media coverage of court proceedings is often impartially written thereby causing deterioration of patient-physician relationship leading to the erosion of trust in the healthcare system. By avoiding media attention, ADR contributes to protection of the relationship between patients and physicians. Of course it is important to inform the public about health care rights and situation in health sector, but everyday's pompous headlines about mistakes doctors make, even before conviction, are contra productive if we would like to build (have) quality patient-safety and reporting system. Therefore, it is important to constantly improve the trust between patients and healthcare providers. ADR could certainly contribute to this.

It is also crucial to improve and support communication between providers and users of health services. Physicians often fear that disclosing too many information regarding the patient's medical treatment could actually expose them to litigation and unfortunately they even begun to use defensive medicine in certain cases, although professional and regulatory agencies promote disclosure[11]. The possible consequences of being sued are quite significant: physicians can loose their reputation already during the trial and suffer a great financial loss. Other reasons for not disclosing information to patients include a lack of training in how to disclose, their own emotional shame, and discomfort with difficult

[10] Craig, D. J.; Cook, J. A. 2002. Healing thyself. ADR in health care industry. Michigan Bar Journal. December, pg. 16

[11] Liebman, C. B. & Hyman, C. 2004. July/August. A mediation skills model to manage disclosure of errors and adverse events to patients. *Health Affairs*. 23, pg. 22-32.; Balcerzak, G. A. & Leonhardt, K. K. 2008. July/August. Alternative Dispute Resolution in Healthcare: A Prescription for Increasing Disclosure and Improving Patient Safety. Patient Safety & Quality Healthcare. http://www.psqh.com/julaug08/resolution.html

conversations[12]. According to the sources in the USA, one of the most frequent reasons for suing physicians is ineffective communication[13]. After an unanticipated outcome, adverse event, patients want to engage in open and honest communication with their physicians,[14] who are often unwilling. Patients want "basic information about the event; assurances that they won't suffer financially because of it; an apology; and prevention of similar events or errors in the future[15]."

Disclosing errors is beneficial to patients, providers, and the healthcare system at large. Even physicians believe that disclosure is morally and ethically the "right" thing to do[16] but sometimes they do not know how to approach the patient. By improving communication, the enhanced relationship between patient and provider can potentially avoid or minimize the impact of lawsuits.[17] If mediation or other ADR method is introduced in health care sector, or more used, the communication will become mandatory. As the consequence, once an event is disclosed, a more open discussion can occur among the members of healthcare team as well. As we have underlined above, this allows the ability to learn from medical errors and to make changes in the system, to reduce or eliminate errors and ultimately improve patient safety[18].

In resolving medical malpractice cases, according to Council of Europe 2008 research[19], patients' preferences are the following[20]:

1. Future prevention (deterrence effect)
2. Restoration of a violated right
3. Financial compensation
4. Explanation
5. Apology

The research has demonstrated that financial compensation, which is primarily provided by the courts, is not the most import for patients. Future prevention and restoration of violated rights come before financial compensation. Explanation of why the adverse event

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12 Berman, S. 2002, April. Reporting outcomes and other issues in patient safety: An interview with Albert Wu. Journal on Quality Improvement. 28. pg. 197-204.; Gallagher, T. H.; Waterman, A. D.; Ebers, A. G.; Fraser, V. J. & Levinson, W. 2003. February 26. Patients' and physicians' attitudes regarding the disclosure of medical errors. *Journal of the American Medical Association*. 289(8), 1001-1007.; Gallagher, T. H.; Garbutt; J. M., Waterman, A. D.; Flum, D. R.; Larson, E. B.; Waterman, B. M. et al. 2006. August 14/28. Choosing your words carefully: How physicians would disclose harmful medical errors to patients. *Archives of Internal Medicine*. 166. pg. 1585-1593.

13 Joint Commission on Accreditation of Healthcare Organizations (JCAHO). 2007. Disclosing medical errors: A guide to an effective explanation and apology. Oak Park. IL: Joint Commission Resources.

14 Liebman & Hyman. 2004. ibid. pg. 22-32.; Berman. 2002, ibid., pg. 197-204.

15 Liebman & Hyman. 2004. ibid. pg. 22-32.; Gallagher. 2003, ibid., pg. 1001-1007.

16 Mazor, K. M.; Simon, S. R. & Gurwitz, J. H. 2004. August 9/23. Communicating with patients about medical errors: A review of literature. Archives of Internal Medicine. 164, pg. 1690-1697.

17 JCAHO. 2007.

18 JCAHO. 2007

19 Essinger, K. 2008. Medical liability: alternative ways to court procedures. Conference: The ever-growing challenge of medical liability: national and european responses. 2 June. Council of Europe. Proceedings/ Actes. pg. 55. The research was about the factual situation of medical liability in the member states of the Council of Europe.

20 Response to the question: *From the list please classify following a decreasing priority order what patients in your country want through medical claims?* Ibid. pg. 55.

has occurred and apology score high in patients' expectations, however they are hardly provided through court proceedings[21].

The deterrent effect is possible only in cases that are brought to court, but in cases where the patient was not able to sue (e.g. because of financial reasons), there will be an opposite effect because a health provider (physician) will not even think (or admit to himself) that he did something wrong. Therefore, alternative mechanism for resolving cases should be provided.

The restoration of violated rights is definitely something that could be much faster resolved through mediation then court proceedings. Court proceedings are time-consuming, while in a mediation process the restoration of violated rights can be immediately addressed through direct communication between patient, health management and physician. Often only a quick medical treatment can restore a violated health right thus possible health complications caused to patients by a physician need to be revealed as soon as possible.

It is often difficult for patients to prove in front of the court that deterioration of his/her health was caused by fault of the physician, or that there is a casual link between physicians' misconduct and a damage patient has suffered. Furthermore, the expert witness often explain the medical treatment in a language which is unfamiliar to the patient. Patients are in a very difficult and unjust position comparing with health care providers (physician or even hospital), as their opponents also when it comes to cross-examination of expert witnesses.

As opposed, the use of ADR methods opens a possibility to form a true partnerships between patients and healthcare community – integrating diverse interests and needs of those providing services and those seeking them.

Expenses are another huge problem in court proceedings related to medical cases since financial costs of medical malpractice cases could be enormous. The cost of litigation is a barrier to access to justice for those who may need it the most. On the other hand, as the life and the health are the most precious values, the financial costs of hospitals that have lost the case in front of the court could be enormous. It might be more useful to spend that money for direct compensation to patients and for improving conditions in the hospital rather then for paying court fees, attorney's fees etc.

The question of time also favors ADR. Medical malpractice litigations are among the most complicated cases. In order to prove all the necessary facts by the court, procedures are usually long, which is unacceptable. In countries where the jury has the key role in trials outcome, submitting the case to ADR body seems to be an excellent alternative to the sometimes incompetent jury, having neither legal nor medical knowledge.

3. OBSTACLES TO IMPLEMENT ADR IN MEDICAL LIABILITY CASES

If we want to enhance the use of ADR in medical liability cases, especially mediation, it is important to be aware of the potential obstacles related to the use of ADR. The main

[21] In Europe, apart of financial compensation, other aspects of the redress sought by complainants, were particularly stressed at the conclusions of the conference The ever-growing challenge of medical liability: national and European responses. Kilbi, E. 2008. Conclusions of the Conference, report, Conference: The ever-growing challenge of medical liability: national and european responses. 2 June. Council of Europe. Proceedings/Actes, pg. 233.

obstacle is that the parties (patients and physicians), not aware of the advantages of ADR can refuse to participate in mediation although it might be beneficial to them. Therefore, strong public campaign would be needed in promoting ADR. In addition, to make ADR an attractive alternative, it must be easy for interested parties to initiate it.

Success of mediation requires effective communication between the parties. Therefore, training of health providers, hospital management, lawyers and mediators is needed. This requires additional resources. Recent research in Europe has demonstrated in some European countries the communication between patients and medical staff is ineffective (e.g. Armenia, Georgia, Italy, Lithuania, Portugal and Ukraine)[22].

The Council of Europe research demonstrates that in "ADR countries" the number of accepted/paid claims is about 5 times higher than in "court countries". In spite of that, the statistics show that the costs per inhabitant are not higher[23]. The fact that more adverse events are solved by implementing ADR leads to better quality management and increased patient safety which on the other hand contributes to decreasing of adverse events in rendering health care resulting in overall cost reduction.

In considering introducing ADR mechanisms we must be aware that „there are the procedural aspects of medical liability such as the burden of proof, causality and so on. There are marked differences between the countries studied….it will be very difficult to harmonize these differences because they derive from general rules regulating civil and criminal liability[24]". In our opinion, mediation will not interfere with the existing legal systems, however it will take a while to be in full implementation due to the fact that people are accustomed to resolving disputes through litigation.

4. SELECTION OF APPROPRIATE FORM OF ADR IN MEDICAL LIABILITY CASES

Alternative dispute resolution is a generic term that describes a variety of processes used to resolve these disputes as an alternative to litigation (negotiation, mediation, facilitation, dialogue techniques, arbitration, "no-fault" systems). When defining the best optimal system in dealing with medical malpractice, we agree with Studdert and Brennan[25] in determining the following 5 key goals:

1. The system should encourage physicians and other health care providers to report errors, especially those that cause medical injury (data should be studied to understand key structural determinants of common errors, as well as risky, persistent behavioral patterns that cause them);
2. The system should strive to make quality improvements;
3. In rare case, patients are harmed by physicians who are incompetent, dangerous and malevolent. Even a system of compensation that is not focused on fault must have mechanisms in place to deal with such practitioners (criminal, offence or disciplinary liability);

[22] Nys. 2009, p. 25.
[23] Essinger. 2008, pg. 50.
[24] As Nys concluded in the Report on medical liability in Council of Europe member states.
[25] Studdert, D. M.; Brennan, T. A. 2001. *No-fault* compensation for medical injuries. *The prospect for error prevention*. JAMA. July 11. Vol. 286. no. 2, pg. 219.

4. System, or compensation programme should reinforce the honesty and openness of patient-physician relationship ("ideally, physicians would be able to inform their patients that an injury has occurred due to medical management and that there is a possibility that the injury may have been preventable.");
5. Whenever appropriate, patients should be compensated in a manner that is speedy, equitable, affordable and predicable.

Mentioned authors concluded that a no-fault system of compensation based on enterprise-liability, as an alternative method, would be well positioned to accomplish each of mentioned five goals[26]. Our aim in this article is not to present the best version of so called "no-fault" compensation models[27]. However, we would like to emphasize that introduction of no-fault system might generate additional costs which might be off-putting for countries in making decision to introduce it. On the other hand, implementation of mediation does not incur great additional costs for the countries. Still, "no-fault" system in any of its versions[28], can be very good alternative solution. By introducing no-fault "…the disadvantages of tort law as a mechanism of compensation for victims of medical malpractice should be overcome if such alternative compensation system were to be introduced.[29]" We can state the same for mediation.

According to Essinger, a system that would enforce the patients' right to get compensation for a medical injury must include the following general components[30]:

a) special legislation based on patients' rights;
b) enterprise liability (hospital liability) instead of personal liability for the doctor;
c) compensation systems should be *no blame* for the doctors –economic compensation to patients should be separated from finding physicians' liability (if physicians need to defend themselves it is more difficult for patients to get compensation);
d) to compensate avoidable injuries regardless of negligence, error or omission on the part of a physician (that would reduce the need for court procedures);
e) using an alternative system for claims handling instead of going to court in order to lower costs and shorten decision time;
f) set minimum threshold below which there is no compensation;
g) use the information from claims in order to learn how to avoid future adverse events (confidentiality rules must be respected).

Essinger warns, on the basis of the earlier studies in Canada, that it is not possible to entirely copy one system of resolution of medical malpractice disputes from one country to another: Each country has its own welfare and healthcare systems as well as legal culture (for example the Scandinavian systems are based on welfare systems that may not exist to the equal extent in other countries).

In the questionnaire about the factual situation of medical liability in the member states of the Council of Europe[31], there was a question on the percentage of claims that are

[26] Ibid, pg. 219-223.

[27] The The Scandinavian systems are called *no-fault* which is wrong, because the main rule is to compensate only medicla injuries that could have been avoided by an experinced specialist (Essinger. 2008. ibid. pg. 42).

[28] For *No-Fault* Compensation in the Health Care Sector. *Tort and insurance law*. 2004. Eds. Dute, J., Faure, M. G., Koziol H. vol. 8. European Centre of tort and Insurance law. Springer Wien New York.

[29] Ibid, pg. 1.

[30] Essinger. 2008., ibid. pg. 48.

[31] Nys, H. ibid, pg. 21.

resolved through mediation techniques. Since only 16 out of 47 member states of Council of Europe responded, we can not state that we have final and complete data on the situation in Europe, but that was sufficient to have the following findings: "Three distinct categories of member state can be distinguished from the perspective of resolving claims through mediation techniques: In the first category of member states mediation techniques are not (yet) used because one is not familiarized with this kind of techniques (for instance the Slovak Republic) or because of another particular reason (in the United Kingdom the main barrier to the use of mediation is lack of awareness as well as some opposition from the legal profession). In a second category of member states mediation techniques are not used to settle claims because other mechanisms exist to resolve medical claims. The Danish reply to the questionnaire states: "mediation techniques are not used to solve claims that are brought before the administrative instances". Comparable replies came from Finland and Sweden, also countries with a patient compensation scheme. Third, in some other member states experiments have been set up with mediation techniques to settle medical claims (Austria, Germany, Netherlands, Spain, France (ONIAM), United Kingdom)."[32]. According to the report, in Armenia, Georgia, Iceland, Italy, Lithuania, Moldova, Portugal, Slovak Republic, Switzerland and Ukraine, the use of mediation techniques to settle medical liability claims in these countries is either not known or they are non-existent[33].

In his final conclusion, Nys stated that in order to deal efficiently with the challenge of medical liability one should:

- Invest in restoring confidence of the citizens in the safety of the healthcare system and trust in the medical profession;
- **Lift barriers and obstacles to obtain compensation by offering alternative means of compensation in stead of a procedure through court** and
- Take initiative to ameliorate the mutual understanding between the medical and legal profession[34].

In USA, the arbitration and mediation are two of the most common ADR processes used[35]. In USA the principal organizations that provide ADR services are the American Health Lawyers Association[36] and the American Arbitration Association[37]. American Health Lawyers Association's ADR Service features national and regional panels of trained dispute resolvers that are drawn entirely out of lawyers who are specialized in health care law and business practice[38].

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32 Nys, H. ibid. pg. 22. The percentage of claims solved through mediation techniques is the following: Sweden (99.9%), Finland (99.9%), Denmark (99.3%), France ONIAM (98%), England NHSLA (96%), Iceland (93%), Germany (60%), France insurance (40%), Italy (14%), Essinger. 2008. ibid, pg. 50.

33 Nys, H. ibid, pg. 27.

34 Nys, H. ibid, pg. 28.

35 Reffers to USA data. Craig, D. J.; Cook, J. A. 2002. Healing thyself. ADR in health care industry. Michigan bar Journal. December, pg. 14.

36 For more information about ADR: http://www.healthlawyers.org. Also see Health Care Dispute protocol: A due process protocol for mediation and arbitration of health care disputes.

37 For more informtion about ADR: http://www.adr.org/

38 Craig, D. J.; Cook, J. A., pg. 18.

4.1. Recommendation of Mediation

In this article we focus on mediation as, in our opinion, the most suitable ADR method in health sector. For the purposes of drafting future Council of Europe Recommendation on ADR methods in healthcare, it might be beneficial to compare figures from the European countries using mediation with those in the USA. Besides mediation, or instead of it, arbitration[39] can be alternative to court proceeding.

Mediation in civil matters is defined in Recommendation Rec (2002) 10[40]of Council of Europe. There mediation refers to dispute resolution process whereby parties negotiate over the issue in dispute in order to reach an agreement with the assistance of one or more mediators. As the Recommendation states[41], mediation may be particularly useful where judicial procedures alone are less appropriate for the parties, especially owing to the costs, the formal nature of judicial procedures, or where there is a need to maintain dialogue or contracts between the parties. That is exactly what happens in the health care sector.

Mediators should "act independently and impartially and should ensure that the principle of equality of arms be respected during the mediation process. The mediator has no power to impose a solution on the parties. Information on the mediation process is confidential and may not be used subsequently, unless agreed by the parties or allowed by national board.[42]" Of course, the aim of ADR is to find appropriate solution in dispute matter and that the matter is solved in best interest of both parties: "In order to define the subject-matter, the scope and the conclusion of the agreement, a written document should usually be drawn up at the end of every mediation procedure, and the parties should be allowed a limited time for reflection, which is agreed by the parties, after the document has been drawn up and before signing it. Mediators should inform the parties of the effect of agreements reached and on the steps which have to be taken if one or both parties wish to enforce their agreement. Such agreements should not run counter to public order"[43]. Mediators used in health disputes should have knowledge of the health care issues and be skilled in health law in order to give maximum in dispute resolution. If the lawyer serves as mediator the "key to his success in mediation is shifting his role from advocate to counselor[44]" The same applies to mediators coming from other professions.

It is very important to educate the public, patients' associations, political parties, health care providers and professional associations (e.g. chambers and associations) that the use of ADR, primarily mediation, in heath sector is needed and crucial in restoring good physician-patient relationship. It should not be forgotten that ADR is closely linked to patient safety policy in hospitals as well as to quality risk management. An optimal system must address the need to prevent medical errors and ways to efficiently compensate medical injuries once they occur[45].

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39 Arbitration results in final and bining award.

40 Recommendation Rec. 2002. 10. Mediation in civil matters adobped by the Committee of Ministers on 18. September 2002. at the 808th meeting oft he Ministers' Deputies.

41 Recommendation Rec. 2002. 10. II. (i) Scope of application.

42 Recommendation Rec. 2002. 10. IV. Mediation process.

43 Recommendation Rec. 2002. 10. VI. Agreements reached in mediation. Even if parties make use of mediation, access to the court should be available as it constitues the ultimate guarantee for the protection oft he rights oft he patient (III. Organization of mediation. para 3.).

44 Craig, D. J.; Cook, J. A., pg. 18.

45 Also see Studdert, D. M.; Brennan, T. A., pg. 219.

Talking about mediation as one of the means of fulfillment of the goal of quality improvement and patient safety, we should address Council of Europe Recommendation Rec (2006) 7 on Management of patient safety and prevention of adverse events in healthcare[46]. This Recommendation underlines the following: it must be accepted that people will make mistakes and that processes and equipment will sometimes fail. It must be accepted that under specific circumstances and for various reasons individuals can make errors[47] (such as[48]: time-pressure for health care providers, frequent "handig-over" of patients from one healthcare professional to another, shortage of staff, pressure on health-care professionals to quickly discharge a patient from hospital, introducing commercial elements in healthcare and side-effects of competing commercial insurance companies). Also, the Recommendation emphasizes that at all levels, problems and errors should be treated openly and fairly in a non-punitive atmosphere. The response to a problem must not exclude individual responsibility, but should focus on improving organizational performance rather then on individual blame[49]. All staff should be trained in team-work based problem solving and encourage to use root-cause analysis to learn how and why incidents happen[50]. This is where we also see the role for mediation in health care disputes.

Rec (2006) 7 requires legal framework related to patient's rights should ensure that: complaints made by patients or their representatives are taken seriously and handled appropriately, patients who have been harmed by a patient-safety incident are entitled to receive financial compensation, etc[51]. In order to reduce and prevent patient-safety incidents, health professional must understand their own behavior patterns, their decision-making process and their ability to cope with challenging situations in daily activities[52]. This is where we see important role for mediation, trying to get both parties to find best possible solution and to cooperate.

Even if parties make use of mediation, access to the court (Article 6. Of European Convention of Human Rights) should be availabe as it constitutes the ultimate guarantee for the protection of the rights of the patients[53]. But, if the patients through mediation would gain what they expect[54], we believe that they would not consider going to court.

5. CONCLUSION

The literature has noted that malpractice claims are more likely to be triggered by "maloccurence" (bad outcome) than "malpractice" (bad medicine) and that many patients who have suffered consequences of negligent care never file suits for malpractice[55]. If we introduce ADR that will change. The restoration of violated rights is definitely something

46 Adopted by the Committee of Ministers on May. 24th. 2006 at the 965th meeting oft he Ministers' Deputies. Council of Europe.

47 In Appendix to Recommendation, B. Culture of safety/enviroment. 2.b.

48 Underlined by authors, according to Appendix to Recommendation. A.5.

49 Appendix to Recommendation. B. Culture of safety/enviroment. 3.g.

50 Appendix to Recommendation. B. Culture of safety/enviroment. 3.g., last para.

51 Appendix to Recommendation. J. Legal framework.

52 Appendix to Recommendation, F. human factor. 1.

53 Reccommendation. 2002. 10. II.

54 See above under Title 4.

55 Fraser, J. J. 2001. Technical Report: Alternative dispute Resolution in Medical Malpractice. *Pediatrics*. vol. 107. No. 3. March, pg. 605

that can be much faster resolved through mediation, or some other ADR technique. It should not be forgotten that ADR is closely linked to patient safety policy in hospitals as well as to quality risk management. An optimal system must address the need to prevent medical errors and efficiently compensate medical injuries once they occur. This is exactly the case with mediation.

As we have previously elaborated, ADR methods have many advantages comparing to trials at courts, which is especially evident in medical liability cases. First of all, these methods support patients to report cases of medical malpractice without involvement of police, public prosecutors and courts. They also help to prevent mistakes from happening in the future. They represent a good bases for setting up an efficient control of health providers and avoiding adverse events. It should not be forgotten that ADR is closely linked to patient safety policy in hospitals as well as to quality risk management. An optimal system must address the need to prevent medical errors and ways to efficiently compensate medical injuries once they occur[56].

It is very important to educate the public, patients' associations, political parties, health care providers and professional associations (e.g. chambers and associations) that the use of ADR, primarily mediation, in heath sector is needed and crucial in restoring good physician-patient relationship.

We would recommend to introduce mediation in member states of Council of Europe as an alternative method for dispute resolution, since it does not requires changing legal and health systems. Mediation would only improve the quality of health care rendering and patient safety and it will hopefully restore trust between patients and health care providers, mainly physicians. Anyhow, patient-safety, quality improvements and avoidability of medical errors (including collection of data on errors) are prerogatives in finding best possible alternatives to court proceedings.

[56] Also see Studdert, D. M. Brennan, T. A., pg. 219.