AGORA International Journal of Juridical Sciences, http://univagora.ro/jour/index.php/aijjs
ISSN 1843-570X, E-ISSN 2067-7677
No. 1 (2016), pp. 1-9

THE MEDIATION IN THE MEDICAL MALPRAXIS

L.D. Rath Boșca, M.M. Marinescu, O.T. Roman, M.O. Botea

Laura-Dumitrana Rath - Boşca
Law and Economics Faculty, Social Sciences Department
Agora University of Oradea, Oradea, Romania
*Correspondence: Laura-Dumitrana Rath - Boşca, Agora University of Oradea,
8 Piaţa Tineretului St., Oradea, Romania
E-mail: dumitra1970@yahoo.com

Mariana-Mihaela Marinescu
University of Oradea, D.P.P.D. department
E-mail: marinescum54@yahoo.com

Ovidiu Teofil Roman
Clinical Recovery Hospital Băile Felix
Student of Faculty of Medicine and Pharmacy
University of Oradea
E-mail: romanovidiu22@yahoo.com

Mihai Octavian Botea
University of Oradea
Faculty of medicine and pharmacy
E-mail: drmob78@yahoo.com

Abstract

The conflict has been defined over time in many forms. Dispute, disagreement, fight, litigation, divergence are common terms that we hear every day and that talk about the existence of conflict situations. When there is a clash of interests, concepts or egos of people, we are dealing with a conflict.

The medical malpraxis is a topic that throughout the last years has raised many controversies.

Keywords: **malpraxis, law, mediation, measures, justice, victim, controversies, insurance company, doctor,**

Introduction

The malpraxis complain is undoubtly the worst accusation which can be addressed to healthcare staff which is working in the health protection and public health promotion. This is why is a sensible subject for the medical staff, although, is quite important to specify that in our country were very few people being found guilty for malpraxis.

The medical malpraxis is a topic that throughout the last years has raised many controversies. Obviously we are dealing with many parties involved in these controversies.

One side is certainly represented by the medical staff which is complaining on the environment where they have to exert their work, sometimes with doubtful gear or short staff.

Even more, often being harassed by many criminal complaints and being continuously under the public opinion collimator and not the least under prosecutors' attention as possible law breakers.

On the other side are positioned the patients which are more and more unsatisfied by the way they are treated in this medical system. These patients are criticizing the slowness or,

from other points of view, the defiant way in which the abilitated institutions are managing in doing justice.

The malpraxis victim can is addressing to the Commission of motorization and professional competency. This Commission is having the competence to clarify the malpraxis accusation in a three months' period from the complaint submission day, based on an expertise report.

If either victim, the physician or the insurance company or any other person involved in this case is dissatisfied with the solution, then after can summit a disagreement attacking the report in a 15 days' deadline. If the Experts Commission establishes a case of malpraxis, the injured party can ask the court for indemnification.

The procedure under the Commission expertise is not really mandatory. The victim involved can apply directly the justice court, civil or criminal, upon the gravity of situation, which will give a solution based un a forensic medical expertize report.

Instead, only the court can force the persons found guilty of a malpraxis act to pay indemnification. Obviously the victim of a malpraxis must prove to the court that he suffered a moral or a material prejudice, and to show the period of time being prejudiced.

If the material prejudice could be easily proved to the court, in what concerning the moral prejudice, this can't be quantified. So, the court must grant compensations for the moral prejudice, which has to be fair and satisfactory, compensations proportional to the victim suffering, not available any mathematical or economic criteria to be applied for quantification.

An important role in a malpraxis case is played by the insurance company. This can pay indemnifications to those persons they have being subject of medical negligence and also can cover costs of the civil trial fees.

"The indemnifications will be granted wherever the place of medical assistance has been given"[1].

The Article 17th from the same normative act show that: *"(1) The indemnifications will be granted from the insurance company for the harm caused and for the trial costs also, to the person or the persons injured from the medical negligence, which can lead to body injury or even death; (2) In a death case, the indemnifications will be granted to the patient's successors in title, those who initiated ascertainment actions regarding provided unsuitable medical assistance; (3) The indemnification is grated also when the medical assistance was not provided, despite the fact that the medical condition would have been imposed an intervention for the person or the persons who asked for or for whom was required"*[2].

According to the Law no. 95/2006, regarding the reform in the healthcare system, with the modifications and further addendums, *"the malpraxis is the professional error made during a medical or a pharmaceutical-medical action, leading prejudices to the patient, implying civil responsibility of the medical staff or of the ware supplier or from the medical, sanitary or pharmaceutical services provider."* Therefore, when we are talking about malpraxis we are talking about a professional error, a medical activity error, made by the physician's duty, which can lead to a health or a body integrity injury, or even worst to the patient death.

The Romanian language dictionary gives the following definition for the malpraxis term: "*an incorrect or negligent treatment applied from a doctor to a patient, which produces to him any prejudice, in relationship with the degree of physic or psychological capacity harm*[3]*"*.

[1] Art. 16, alin (2) Law of medical malpraxis;
[2] Art. 17, Law of medical malpraxis;
[3] *https://dexonline.ro/*;

The British Universal Encyclopedia defines the term of malpraxis as being "*negligence, incompetence practice, lack of training or breaking job duties from the professional point of view, which cause a patient prejudice in any nature*[4]*".*

Before presenting a case study, assuming to be iconic for this article topic is important to make a distinction, when we are going to analyze a malpraxis, between a mistake and an error. The mistake consists in failure to follow the rules of good professional behavior from the physician, and the error is raising when the physician is aware that the illness progress towards a complication and he is not taking proper actions to avoid the worst.

The medical staff, well all those who are providing medical services are responsible when they evolve an effective medical activity but they responsible also in case of not acting according to the expectations.

The doctor has the obligation to provide to the patient good and competent care, according to the evidenced based medicine and following updated guidelines and protocols.

So that person designated to prove or not a malpraxis accusation must clear up if the care provided was according to the standards as stated in the medical guidelines and has or not scientific proves.

The article 14 from the malpraxis law show that: "*During providing medical assistance, the medical staff has the duty to apply therapeutically standards set through practice guidelines in that specialty, approved by a national body, or in absence, by recognized standards of that medical specialty comunity"*[5].

It is well known that after many years of studies and specializing, after many years of hardworking for the general and particular wellbeing of the people, that doctor who is accused of malpraxis is suffering and emotional stress, not only for the fact that his skills and professionalism are in doubt but also for the fact that after building a patient-doctor relationship, he is feeling that his trust is broken.

A doctor can be charged of malpraxis either on civil or criminal background. Usually these patients choose the criminal complaint to prosecution body, just because there are no fees to be paid or no costs to obtain a forensic medical report and the prosecutors obtain the medical documents in a very short deadline of 30 days. When a harmed party choose for the criminal grievance, the doctor is under a criminal investigation, this being quite hard to be proved in intention, and as in many cases, the prosecutors decide do not open a criminal investigation.

On the civil side the doctor is sued only for the prejudices the patient suffered. This is asking for indemnizations on this background.

The practice shows there are higher chances to win a civil trial for malpraxis than a criminal one, because is easier to prove the victim suffers from a medical error or negligence in the medical activity. If the victim believes the medical act was causing prejudice, that hedge his daily activities, can ask for indemnizations to the court.

The fact that many patients are choosing to sued under a criminal complaint is because through a civil action the patient has to pay different fees, cost that are really considerable.

Is desirable that the victim, the insurance company and the insured person to have an agreement to avoid the court, agreement on the guiltiness, to set the quantum and the procedure to pay the prejudice caused by a malpraxis act. In fact, when the insured person liability is questioning and all the parties have an agreement regarding all the aspects concerning the malpraxis act, the insurance company will grant indemnizations on an amiably way.

[4] *www.litera.ro/.../col-enciclopedia-universala-britannica;*
[5] Art. 14 Law of medical malpraxis.

Ideally, just saying ideally, the doctor in a position of a malpraxis accusation should recognize the fact that he was committed a mistake and to accept that he should pay for this without the implication of the insurance company. But obviously hard to put on practice.

As a person who has suffered from the medical errors should receive compensations for the prejudices created, so the person responsible for a malpraxis act should be sanctioned for his deed.

For this reason, the mediation is an advised solution in malpraxis cases, in the way that the benefits from approaching this option to break down conflicts are far the most preferable. Unfortunately, the mediation was not enough promoted through the doctors, in hospitals or to the insurance companies, fact that means a big loss from our point of view, because the procedure of the mediation could easily create opportunities of all parties' agreement, reduces significantly the costs generated by a call into a court, and why not, could lead o a practice of trust for the medical institutions.

Through the mediation, both parties are going to ask a third party, the mediator, a person specialized which is impartial and neutral and committed to help the conflict parties to negotiate to reach a final agreement.

The mediation is having multiple advantages.

The first, but not necessary the most important, is that the patient will receive his indemnification in a shorter time than throughout a court procedure (here could take even years). Extremely important that here is not necessary to bring proves, all that needs would be a common sense from everybody willing to reach an easy and fast agreement. These are all arguments why the mediation could be a challenging and an attractive option in a situation of malpraxis accusation.

For settleling the malpraxis cases through mediation is very important to gain all parties trust. If this could be happening, would be an enormously benefit for the doctors, hospitals, insurance companies and all the peoples that might be involved in a way or another in a malpraxis situation.

In practice, the doctor's layers are motivating their clients' absence in the mediation procedure by their busy schedule or by the fact that they want to protect against any verbal or physical assaults that might be raised from the patients or their families. These „excuses" made by the layers are making the gap deeper between the doctor and the patient. Sometimes, the simple presence of the doctor during the mediation procedure could satisfy the patient needs, because in this way the doctors is showing the respect and compassions for his patient sufferance. In this way through a real communication, the doctor and the patient are creating the opportunity for a "moral recovery", sometimes an honest excuse could be sufficient and enough for a conciliation.

The confidentiality is one of the most important principles of the mediation procedure, what actually remove any fear from the doctor's side regarding that his statements could return against him and so, his reputation might be questioning.

In other countries the mediation in a malpraxis case is mandatory, that not meaning the free acces to the justice is fenced or brooking the principal for the voluntary option to the mediation. On the contrary, here is provided and supported a higher interest for difficulties and needs in communication of the people. The parties in a mediation process are not looking to gain or to lose something. These parties are not looking to make the other one to loose, they are trying to communicate, to settle their problems.

It is necessary in a mediation process, to sit to the negotiation table, also an insurance company representant. His biggest concern will be the value of the insurance prime, because medical malpraxis insurances are usually made on quite small amounts. In a real situation this could be high likely to be insufficient to cover the harm requested by the patient. The mediation procedure is preferred even by the insurance because the indemnification amount is not imposed by a court, and will be about a negotiated amount by the both involved parties which should be realistic, justified and possible.

The mediation procedure is not looking to establish any guilty or unguilty feature of the parties, instead is looking to set advantageous bilateral agreement.

Case study

1.Case history (Ioana's Case)

Ioana is 24 years old and is a mother of a 1.8 years old child with neuromotor disability. She is living together with her husband and his parents in low, and she is now on a maternity leave. Her past job was worker in a wood factory.

A. *Main complains*

Five years ago, because of the final high school exam failure, Ioana was complaining of migraines headache. She was taking but not regularly Extraveral pills, an anxiolytic drug. She would have been desired to follow some university studies, but she wasn't able to reach her dreams. Ioana was admitted together with her child under a neuromotory rehabilitation clinic. There, her baby was following a treatment being diagnosed with neuromotor retard. This is the first admition in a hospital. She had presented symptoms of depression and anxiety, reason for being referred to a psychologist.

a) The history of the present disorder

After Ioana getting married, she moved to her parents in low, not far from her parents. She gave birth to a child, who during the delivery time presented some perinatal sufferance. The child was delivered after a caesarian section. She is telling the fact that because of the delivery complications her access to the child was not permitted. Because the child was aspirated meconial amniotic liquid, suffered a perinatal asphyxia, after being resuscitated, was given oxygen and presented isolated seizures. She wasn't informed by her child sufferance in those early days. This triggered some suspicions and concerns on her baby health. The fact she wasn't let to have a contact with the child after giving birth, and without being informed properly about what was going on, all these lead to a deep concerns and fear.

After 5 days, finally the mother found the reality about the child, without being offered details and explications about the situation what caused this disorder. Meeting the reality, the mother started to develop more anxiety and even panic symptoms on a high emotional stress background, followed by a period of deep sadness and even some crying episodes. All these emotional symptoms prouved a high psychological tension. The doctor proposed her an „injection" for improving her emotional condition but not having big effect on her. She was thinking that her child has a serious trouble, with no big chances for recovery, feeling not much could be done and feeling helpless on this situation (cognitive symptoms). It is obvious the catastrophic feeling. She started to look for lonlyness, her auto isolation was always coming with crying episodes (behavior symptoms).

The mother left the maternity hospital after 6 weeks without having a clear diagnose of her baby, without having been told what to expect regarding the outcome of this disorder. After 6 months from the hospital discharge, the mother observed no progress of development and so, she has been booked a neurology follow-up. There she has been told that her child is suffering of cerebral palsy, spastic tetraparezis post encephalopathy and moderate/sever neuromotor retard.

Since then, they started a neuromotor rehabilitation program in different children neurology clinics from Cluj-Napoca, and after that in Oradea. In between being at home and constantly applied the rehabilitation activities learned during the previous sessions. Ioana's parents in low and her husband were not happy with the diagnostic, and furthermore they were considering unjustified these rehabilitation procedures for the baby, too much stressful for the little one. Even more, because Ioana she was caring on the rehabilitation program, her unsupportive family made accusations as an insensible mother and not able to care a baby. Ioana ended to lose her self-confidence and lost her trust on facing the reality.

Despite all these issues, she carried on her child daily exercises, when no other members of the family were around. Ioana recognize that during that period of feeling not supported by her husband and her parents in low, she had thoughts of leaving her husband and that house and move back to her parents. During this period, she was visiting some religious confessors, even following religious fasting and joining some religious service in Deva, dedicated to her child cure.

Ioana was feeling overwhelmed about this situation, about rehabilitation activities, about living in a family which is not accepting and is not aware about the health issues of her child. She was sad because her husband was not listening to her, and more than that he was accusing her. He was denying his child health problems.

b) The personal and social history

Ioana grew up in a family with an authoritatively father but a very kind and a supportive mother, opened and keen for discussions, well empathic. She and her mother were quite reserved to share problems with the father and the husband. Ioana, she had a very good friend from a neighbor family, friendship which was ongoing for long time. She is describing herself a very obedient daughter. She was a pupil in-between mediocrity.

As a teenager she was not having any boyfriend. She married her husband, meeting him at the job. He is 11 years older than Ioana. She says that she loves her husband but she is expecting him to accept the reality and to be more supportive. She would be happy to see her husband being involved in caring on together this situation. She is gurdging him that he is to bound to his parents, especially to his mother and his two sisters and is too much apprehensive in relationship with his family to whom is offering much more attention despite his wife. She is also saying that all the decisions in this house are taken without her implication and her husband is following to tide his parents' opinions on the child health problems. Her husband is a fire stoker in a wood processing factory, working in two rotations, offering short time to his child and his family. He is avoiding interactions with his baby (he is not feeding him, is not washing him, is not holding in his arms only in his wife presence).

Between Ioana's family and his husband family are religious and cultural discrepancies. Ioana being of Romanian ethnicity and orthodox religion, and his husband being oh hungarian ethnicity and reformed religion. Ioana she is considering herself a religious person, she is keep quite closed to this, praying often, following every Sunday the church service, and respecting the religion fasting periods typical of the orthodoxies doctrine.

B. *Medical history*

From the history we find that she was fit and well before, not having important contacts with the medicine before.

C. *Mental status/Tools used*

The patient is alert and oriented having a obvious anxiety disposition. The clinical investigations pretest, to which Ioana has been submissed, after giving her formal consent, where the following:

For the subjective-affective level: Hamilon scale of depression (17 items) – the preintervention score 18 points (moderate depression); Hamilton anxiety scale (14 items) - preintervention score 17 points (subclinical anxiety); Profile of a dysfunctional emotional distress (PDE) – 29 points – high level of dysfunctional negative emotions associated with a low level of functional negative emotions (18 points); Self-esteem scale (Rosenberg) – second class – low level of self-esteem (28 points).

For the cognitive level: The automatic thoughts questionnaire (ATQ) – she is obtaining 32 points, which can be assumed as high level of dysfunctional automatic thoughts (4^{th} class); irrational cognitive scale (IRCS) – total score (obtained through totaling all the scores from the component subscales) 97 points – high level of global irrational thinking.

D. *Diagnostic DSM –IV Tr*

The 1st Axis (clinical disorders): Distimic disorder with late onset; the patients presents generalized anxiety with a subclinical intensity without meeting criteria for no one of anxiety disorder. Throughout the disease history it was not recorded any major depressive episode, manic, hypomanic or mixt and she had no medication so far for these depression symptoms.

The diagnostic was established fallowing the investigations based on the Structural Clinic Interview (SCID I) for clinical disorders on the Axis 1, in conformity with de diagnostic criteria of the DSM IV Tr.

The 2nd Axis (personality disorder): no clinic abnormalities. The pacients shows some of the features of the dependent personality, but not meeting the full diagnostic criteria of the dependent personality disorder.

The 3rd Axis (somatic disease or general medical conditions): no clinical significant abnormalities.

The 4th Axis (psychosocial stressors): a presence of a child with cerebral palsy, inadequate social support (living in a new family, quite different from her own one, low involvement of her husband in the child care and treatment, multiple hospital admission) for her child diagnostic and treatment.

The 5th Axis (general functioning index – GFI): GFI 70 (current).

The case conceptualization

A. *Ethyologic factor*

As triggering factor of Ioana's problems we are mentioning the birth of disability child, on a background of social skills lack and assertiveness feature (favoraising factors). All these added to social environment changing by moving to her husband family and parents in low cohabitation. We are also mentioning in the triggering factors category the absence of her husband support and upsets from her parents in low in what concerning her skills in raising the child. All these factors lead to an overwhelming feeling. Her expectations related to the happiness in the marriage and child birth were so different from the reality she is passing through now.

B. *Assessment of cognition and actual behaviors*

Ioana came to the hospital admition for her child symptoms, and she was explained the rare and severe condition of her baby, condition that need long term treatment with lots of other admition in the future. Now she had an emotional break-down because she was afraid she will not be able to face this situation, basically she was giving herself to small chances to go through. After the psychological assessment of the baby she was expecting all the information received to confirm her hypothesis that her child health status is really bad, because her baby psychological progress was deeply delayed. At that moment she was phoned by her husband, but due to the fact that he was showing irritability on the conversation, she decided to cut off the call abruptly. Following that she regretted doing this. Her hospital room mates noticed her sad disposition. They tried to get chatting her, but she refused telling them she wants to sleep.

To the psychologist she came quite suspicious. She didn't know what was going on to be, but being confident that someone should do something for her, to help her to pass through this low emotional disposition.

C. *Longitudinal assessment of cognition*

Ioana throughout her life developed focused believes, growing up in a family with an authoritatively father and hyper protective mother. Her focused believes are:

The first irrational believe is related to the affiliation: "I have to be accepted and approved by the others; otherwise I am feeling of no value. Is terrible bad that my ideas are not considered".

The second irrational believe is concerned to personal achievement: "I just can't afford to fail, could be so bad".

The third irrational believe is related to situational control: "If the other are not on my side I will not be able to face the reality and I will not be able to manage the important challenging of my life".

D. *Aspects and strong features of the patient*

Ioana is a fit and healthy woman, with a strong desire for changing and to find a balance in her family relationships; she wants to achieve progress aside of her husband and for this she is ready to put all the efforts in. She really wants to see her child recovered and she is looking to find her happiness together with her husband. Coping mechanisms used by her: in an initial phase to deny the problems, substantial unhappiness from her husband compensated with more dedication to the child. Ioana accepted the psychologist to offer her the help she need it, despite the fact that he will not be able to prescribe medication.

E. *Work hypothesis*

From the Ioana history, we notify her failure on the desire of following some university learning. This was probably the moment, she started to feel incapable and unapt, leading to a low self-esteem and a negative attitude on self-assessment. On the fail from the professional development were added marriage disillusions. Her move in a new house and a new family and her mother separations were triggering factors for her depression. Her believes focused on personal achievement, affiliations and situational control (predisposing factors) all these contributed to the onset and the manifestation of Ioana's depression. As well, as the asertivity lack and decreased social interaction skills, shown by a social environment with a very narrow role of the personal support.

Intervention plan:

A. *Problems panel*

- Ioana's depression disposition and anxiety
- Her relationship with her husband and his family in what concerning support
- Low self-esteem, lack of asertivity and of the social skills

B. *Therapeutically aims*

- Depressive disposition and anxiety amelioration
- Improving the negative distortional thinking with the impact on the depression and anxiety
- Stimulation of assertivity and social skills for amelioration and building a better relationship with her husband and his family

C. *Therapy scheduling*

The treatment plan was focused, in the early phase, on decreasing depressive disposition and general anxiety. Afterwards, we intervened on the asertivity stimulation and on improving self esteem and social skills.

For fulfilling the first aspects from the issues panel, the patient depression and anxiety amelioration, we were using: cognitive restructuring techniques, for the automatic thinking central believes changing. For the assertively increasing and for improving the social skills, we were using the assertive training. As well, we used techniques of solving problems related to searching and implementing practical solutions to the issues on the living with her husband family, for becoming less dependent.

For changing of the automatic thinking, of the catastrophic interpretations and of the central believes, the patient was taught cognitive restructuration techniques. We were focused on the modification of the assessment cognitions and corrections of cognitive errors from the patients thinking.

For stress and anxiety amelioration, Ioana has learned a procedure of stress inoculation, which will help her to better control the distress level and the anxiety. We were focused on the restructuring the way in which she is giving interpretation to her child diagnostic and of course on her negative predictions related to the child health status progress.

She was taught to replace her dysfunctional dialogue (autodistructive) with a functional one (auto encouraging), through a roll play.

The assertive training and problems solving were used for improving the patient social relations and her skills of solving problems at a personal and intrafamiliar level.

Therapy obstacles

Ioana hasn't had a high educational level, reason for approaching a reduced complexity level through the conversation. As well, testing her depression and anxiety was assuming observation and scales terms explaining

Results

Ioana's treatment was lasting 3 weeks, the entire period she was admitted under the neuro rehabilitation Clinique. There were in total 9 appointments, 3 for each week.

The posttest results of the testing were the followings:

a. For the subjective-affective level: Hamilton scale of depression – post intervantion score 14 points (mild depression); Hamilton scale of anxiety – post intervention score 12 points (subclinical anxiety); The profile of the dysfunctional emotional distress (PDE): 18 points – low level of negative dysfunctional emotions, associated with raising the functional negative emotions – 26 points; Rosenberg scale of self-esteem – 32 points (3^{rd} class) – moderate level of self-esteem.

b. For the cognitive level: The automatic thoughts questionnaire (ATQ): 18 points (2^{nd} class), meaning a low level of dysfunctional automatic thoughts.

c. Irrational cognition scale (IRCS): 49 points (global), low level of irrationality.

Ioana's emotional disposition was remarkably improved, seen also by rehabilitation doctor, from her hospital room mates and of course recognized by Ioana herself. She said that she is ready to go home and to put into practice what she learned during the psychology follow-up. She is determined to talk to her husband more seriously about their child rehabilitation issues, and even about their relationship disfunctionalities. She also wants to tell her husband about her plans for more psychologist treatment in the following period.

This case report is not by random, on the contrary, the message showed up is that a wrong or delayed medical intervention can easily destroy life, can destroy dreams, as we saw in this case, Ioana's dreams.

Conclusions:

The doctor has to choose the mediation because through the perspectives of the profession nature they are healers. The mediation could be "*a healing seen from another perspective".*

Another important message from this case is that medical staff should approach with more empathy, to provide more attention and care, to discuss all the aspects of the disease with their patients. The reality is that more and more patients are complaining about an impersonal and careless treatment from their doctors. "*The compassion and empathy is not regulated by the law! But can easily generate avoiding problems from the doctors"*

This article is not only a modality to promote the mediation as a more efficient backup to set conflicts, this article is also a way to raise awareness among those people to whom we are giving our lives. Do not forget the moment when they made the Hipocrate oath when they said "*the patients' health will be for them a sacred obligation".*

Bibliography:

1. Law no. 95/2006;
2. Law of medical malpractice;
3. www.litera.ro/.../col-enciclopedia-universala-britannica;
4. *https://dexonline.ro/*