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Patient Autonomy And Patient Safety-Based Medical Disputes Mediation

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ABSTRACT

Medical dispute mediation is an effort to resolve alternative dispute resolution models that contribute to improving patient safety by encouraging more honest and comprehensive risk reporting. Medical disputes and patient safety must be viewed through a new perspective, namely patient autonomy. Patient autonomy is a basic principle in medical ethics and must be respected. Patient autonomy is the freedom of patients to decide what should and should not be done with their bodies. Mediation can help reframe medical disputes from the footing of war between doctors and patients, and help maintain the relationship between doctors and patients. The implementation of medical mediation cannot be avoided from difficulties and obstacles, but at least the first step is to make a commitment to genuine mediation, not mediation as a means or guise to test if it fails to use litigation.

Keywords: mediation, medical disputes, patient autonomy, patient safety.

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INTRODUCTION

In general, medical disputes are triggered by unexpected events when the doctors performs their profession. The unexpected event raise the opinion that every expected event was generalized as a malpractice[1]. According to Tempo's daily data, there were 182 cases of medical negligence or malpractice in the time span from 2006 to 2012, which were proven by doctors throughout Indonesia. From the 182 cases, 60 cases were performed by general practitioners, 49 cases by surgeons, 33 cases by obstetricians, and 16 cases by pediatricians, while usually under 10 types of cases were reported[2]. Medical disputes are disputes involving patients and doctors when there is an error / negligence / omission of the doctor in performing medical actions against his patients, leading to a malpractice and resulting in harm to the patients[3].

According to Peter Salim Daris, in "The Contemporary English Indonesia Dictionary", the term “malpractice” is interpreted as an act or action that is wrong, which shows in any wrong action attitude. Meanwhile, according to John M. Echols and Hassan Sadily in the Indonesian English Dictionary, "malpractice" means the wrong way of treating patients. The scope includes the lack of ability to perform professional obligations or based on trust. So malpractice was one of the causes of medical disputes, which involved disputes between doctors and patients[4]. Medical dispute resolution in Indonesia, can be reached through two ways, namely litigation (court) and or non-litigation (out of court), but usually the cases of medical malpractice suits through litigation always fail in the middle of the process because the obstacle is the proof difficult given by the patients. Therefore, most cases of medical malpractice are resolved amicably performed outside the litigation path because the doctors did not want theirs reputation damaged if it was published negatively[5].

If the court way is chosen, there is certainly a separate mechanism in accordance with the dispute resolution mechanism with the consequence that the resulting decision will be a win-lose solution but in terms of certainty of law enforcement in accordance with the existing positive law will be stronger because it will be facilitated by a judge. Whereas in an out-of-court resolution the resulting agreement will be a win-win solution with a slight rule out of the legal process because what is sought is a consensus agreement[6].Disputing parties are given the freedom to determine the preferred mechanism of dispute resolution, whether to be settled through litigation (court) or through non-litigation (out of court), as long as it is not specified otherwise in the laws and

[1] Setyo Trisnadi. (2017). Perlindungan Hukum Profesi Dokter Dalam Penyelesaian Sengketa Medis. Jurnal Pembaharuan Hukum. (4) 1, 24-40.
[2] Benny Afwadzi and Nur Alifah. (2019). Malpraktek dan Hadis Nabi: Menggali Pesan Kemanusian Nabi Muhammad saw. dalam Bidang Medis. Al Quds (3) 1, 1-20.
[3] Wahyu Wiriadinata. (2014). Dokter, Pasien Dan Malpraktik. Mimbar Hukum. (26) 1, 43-53.
[4] Ibid
[5] Sri Ratna Suminar. (2006). Alternatif Penyelesaian Sengketa Antara Dokter Dengan Pasien Dalam Malpraktek. Syiar Hukum: Jurnal Ilmu Hukum, (8) 3,166-183.
[6] Bayu Wijarnako and Mudiana Permata Sari. (2014). Tinjauan yuridis Sahnya Perjanjian Terapeutik Dan Perlindungan Hukum Bagi Pasien. Privat Law, (2) 4,1-14.

regulations. Dispute resolution out of court usually takes the concept of alternative dispute resolution[7].

Indonesia's positive law also regulates these alternative dispute resolution (ADR) institutions as stipulated in Law Number 30 of 1999 concerning Arbitration and Alternative Dispute Resolution (AAPS Law). The AAPS Law states dispute resolution institutions which included in alternative dispute resolution (ADR) includes the consultation, negotiation, mediation, conciliation, or expert judgment.

So far, in medical practice that if the medical dispute occurred, it will be resolved through the following ways:

1. Dispute mediation: by using the medical term of peace resolution, which is performed by the hospital as an institution where doctors work with patients and their families;
2. Filing complaints to the Indonesian Medical Disciplinary Board (MKDKI), in accordance with the provisions of Article 66 of Law Number 29 Year 2004 concerning Medical Practices;
3. Through the court using the procedure according to the Civil Code Procedure and criminal suit through the Criminal Code Procedure[8].

Complaints to MKDKI have been performed by many patients and / or families over alleged violations of medical discipline, but the lack of socialization of the existence of MKDKI is felt to be ineffective. In resolving medical disputes by applying a suit to MKDKI, it will be difficult for patients in the area because their place of residence is only in Jakarta. If the patient's way out for the resolution of medical disputes through the court, then this method has the obstacles that are not light, namely the burden of proof lies with the patient, the proceedings require a long time, and the cost is not cheap. The possibility of a counter suit for defamation is a risk faced by patients in the future. Therefore, the method of resolution out of court by making peace is the most effective effort to resolve a medical dispute with the least risk for both parties, which in the legal concept, better known as negotiation which then develops into part of the resolution effort alternative dispute resolution. However, the existence of mediation institutions as a form of medical dispute resolution can be seen in Law No. 36/2009 on Health in particular Article 29 and its Explanation[9] which states that "in the case of health personnel suspected of negligence in performing their profession, such negligence must be resolved first through mediation." While in the Explanation, the reasons and objectives of mediation are performed, namely that mediation is performed when a dispute arises between health workers and patients, where the mediation is performed with the aim of resolving disputes out of court conducted by the mediator agreed by the disputing parties.

There are differences between negotiation and mediation as follows:

	Negotiation	Mediation
Purpose	Maximizing self interests	Creating new values
Framework	Negotiating the interests	Cooperative dialogue process
Perceptual framework	Static- no change	Changes flexibly
Points of conflict	Static- no change	Changes flexibly
Relationship	often worsens	Improve
Resolution	Win-lose	Win-Win

Alternative dispute resolution mechanisms can contribute to improve patient safety by encouraging more honest and comprehensive risk reporting. Medical disputes and patient safety must be viewed through a new perspective, namely patient autonomy. The relationship between doctors and patients has fundamentally changed, with more patients getting lots of information and being actively involved in decision making that affects their integrity and personal autonomy. One of the main causes of medical disputes is the patient's dislike that they are not given enough information to make their own decisions. The litigation resolution process is not only to get compensation or compensation but for patients to get more information about what actually happened to them. Therefore, it becomes important to outline patient safety questions in the context of resolving medical disputes.

The purpose of this study was to describe the concepts of patient autonomy and safety and analyze the basis of patient autonomy and patient safety in mediating medical disputes, so the legal issues are stated in this study, namely:

1. What is the concept of patient autonomy and patient safety?
2. What is the basis of patient autonomy and patient safety in medical dispute mediation?

RESEARCHMETHODS

This legal study used the legislative approach and conceptual approach. The legislative approach was performed by examining all laws and regulations relating to the legal issues raised in this study. Whereas the conceptual approach departed from the views and doctrines that have developed in the field of medical law and mediation as an alternative form of dispute resolution.

Patient Autonomy and Patient Safety

Most of the emergence of medical disputes was caused by medical negligence committed by doctors. The patients must prove that the doctors did not perform his obligations carefully and violated their professional obligations and even brought harm.

[7] Mahyuni. (2009). Lembaga Damai Dalam Proses Penyelesaian Perkara Perdata Di Pengadilan. Jurnal Hukum Ius QuiaIustum, (4) 16, 533-550.

[8] Evalina Alissa and Arrie Budhiartie. Eksistensi Lembaga Mediasi Sebagai Sarana Penyelesaian Sengketa Medis. Majalah Hukum Forum Akademika, 29-44 accessed on https://adoc.tips/eksistensi-lembaga-mediasi-sebagai-sarana-penyelesaian-sengk.html

[9] Toshimi Nakanishi. (2013). New Communication Model in Medical Dispute Resolution in Japan. Yamagata Medical Journal, (1) 31, 1-8.

However, each aspect of this negligence become more complex in medical malpractice suit. This related to the question of to whom the doctor is obliged, namely whether it is for patients, unborn infant, employers, parents; what is the scope of the obligation, namely whether it is to prevent physical injury, psychological damage, emotional distress, economic loss, loss of hope, loss of opportunity, or loss of patient autonomy.The next question is how the standard of care is determined. The relationship between the doctor and the patient occurs before there is a relationship between trust, vulnerability and hope. Medical options are unlimited and doctors must take into account not only the emotions, oddities and patien autonomy, but also the institutional culture of medical service providers and the practices and policies of insurance companies and managed care systems. The cause of medical negligence is very complex. The proceedings, which are hostile, are bound by stringent evidentiary rules and usually occur years after the event, are not the best mechanism for determining accountability, let alone understanding what actually happened[10].

Patient autonomy has dominated the discourse of medical negligence in the United Kingdom's Supreme Court decision, the Montgomery case versus the Lanarkshire Health Board, where infants suffered from cerebral palsy during childbirth. The mother, who has diabetes, has a child larger than usual. The mother itself was quite small, increasing the risk of shoulder dystocia during vaginal delivery, because the child's shoulder may not be able to pass through the pelvis. Risks manifest with tragic consequences. It was alleged that the doctor was negligent for failing to inform the mother about the risk of vaginal delivery and failing to perform an emergency caesarean. In discovering the doctor's responsibilities, Lady Hale, in her opinion, emphasized the importance of patient autonomy: that the interests protected by law regarding negligence are one's interest in their own physical and psychological integrity, what was important is their autonomous nature, namely their freedom to decide what the do's and don'ts to their bodies[11].

At the Thomson Medical Center, the Court of Appeals encountered with complicated questions about damages in "wrongful birth" cases. The plaintiff (husband and wife) has children through IVF. There was a mixture in the donor sperm due to the defendant's negligence, resulting in the conception of a baby who was biologically unlike her husband. The question was whether parents have the right to claim compensation for the costs of raising children. This raises complicated legal and moral questions with divided international jurisprudence: some countries allow such claims and others reject them. However, even in Britain, which denied the claim, the House of Lords acknowledged that in these cases, the interests of parental autonomy have been negatively affected, deserving compensation. Again, although from a different perspective, patient autonomy was central to the discourse of medical negligence. The Singapore Medical Council, in its revised guidelines released earlier this year, highlighted the importance of patient autonomy both in the preface and in the guidelines. Section C5 states explicitly, "Patient autonomy is a basic principle in medical ethics and must be respected[12]."

Nowadays medical malpractice was strongly influenced by patient autonomy. Patient autonomy must be taken into consideration both in medical dispute resolution and in developing patient safety protocols. The literature investigated doctor-patient relationships and physician professional attributes related to disputes. Communication has been found as a significant factor. Beckman et al. in 1994 analyzed the deposition of 47 plaintiffs in the United States and identified problematic relationship problems at 71%. The decision to sue the doctor was not always driven by adverse medical outcomes but was often more related to the doctor's communication behavior, because the problem mainly includes devaluing the patient's views, sending bad information, and lacking understanding of the patient's problem. Hickson et.al. in 1992 and Levinson et.al. in 1997 conducting a similar study in the United States further identified both positive (such as doctors' using more orientation statements, '' laughing and using humor, 'and' tend to use more facilitation ') as well as negative communicative attributes (such as doctors' not want to listen, '' don't want to talk openly, 'and' try to mislead them ') about doctors who influence the patient's decision to sue or not. Similar findings have been reported in East Asia, the study of Cho et.al in 1998 in South Korea and the study of Aoki et.al. in 2008 in Japan showed that miscommunication and bad attitudes were the main causes of patient dissatisfaction[13].

Medical dispute resolution through the courts has not been able to prove an increase in patient safety, but it is clearly an expensive and ineffective process. According to Kumaralingam Amirthalingam, that the answer to the question whether litigation increases professional standards and patient safety is most likely not. Anecdotal evidence shows that doctors both resolve claims by non-disclosure agreements and if they do not believe that they are personally wrong, taking their chances with litigation where they have a great chance of successfully defending actions. This does not encourage a culture of information sharing and learning from mistakes. Litigation was compensation that has no proven impact on patient safety, so separate strategies were needed to improve patient safety and to resolve medical disputes.Meanwhile, according to Sheila M. Johnson, that although litigation does not contribute to improving patient safety, it still needs to be because

[10] Kumaralingam Amirthalingam. (2017). Medical Dispute Resolution, Patient Safety, And The Doctor-Patient Relationship. Singapore Medical Journal. (58) 12, 681-684.

[11] Ibid.

[12] Ibid.

[13] Alex Jingwei He and Jiwei Qian. (2016). Explaining Medical Disputes in Chinese Public Hospitals: The Doctor-Patient Relationship and Its Implications for Health Policy Reforms. Health Economics, Policy and Law, (11) 4, 359-378.

individuals will have access to the court to seek justice, that is to provide procedural justice and legitimacy. However, for the most part, litigation may do more harm than good in resolving medical disputes and alternative resolutions for most disputes are preferred. Litigation is designed to produce win-lose results, illustrated by the metaphor of war: "litigation is based on a war model. The parties mobilized the forces (company), appointed a general (Lawyer), chose the battlefield (court), stockpiled ammunition (discovery) and engaged in battle (motion exercises), participated in the necessary peace efforts (pre-trial resolution conference), blows to each other (trial) and declares the winner (decision)[14] ".

Basis of Patient Autonomy and Patient Safety in Medical Dispute Mediation

Mediation was fit for disputes where the parties have an interest in an ongoing relationship. A classic example comes from family law, where divorced parents have a common interest in managing their relationships to deal with problems and preserve their children's rights. However, in medical disputes, often the relationship really ended, so there was no interest in continuing or correcting it[15]. Patients want explanations and compensation, while doctors and the institutions affiliated with them want to protect them, their reputation, and their financial interests. Mediation can help reframe medical disputes from the footing of war and help maintain relations. This can lead to better outcomes for doctors and patients, in terms of resolving disputes and improving patient safety[16].

Kumaralingam Amirthalingam suggested that medical disputes had unique features that made them very challenging for mediation. First, medical misery often involved complex medical facts and causal problems, making it difficult for untrained mediators. Second, medical disputes could involve various parties: around medical personnel from referring to doctors, to nurses, hospital management, as well as patients or close family and Lawyer. Each had a different perspective, based on professional training or institutional culture, made the mind meeting become challenging. Third, there was an imbalance of power in medical disputes between health care providers and patients. Fourth, the issues of confidentiality and privacy were not as in other disputes because of the sensitivity of the health record and the personal nature of the information.The biggest obstacle in medical dispute mediation came from the doctors and Lawyers[17]. American research on medical mediation showed that most mediations occurred without the presence of a doctor for a variety of reasons: they did not want to face their patients; they were too busy with their practice; or they just wanted to hand it over to their insurance company for the resolution. Oftentimes, defense lawyers told the doctors not to attend mediation in the fear that doctors may be too honest, making them vulnerable if mediation failed and patients continued with the litigation. In addition to prevent the doctors from attending mediation, some Lawyers disliked it because mediation affected their economic interests. Mediation was much faster, affecting the number of hours they can pay. One study in the US showed that a Lawyer spent an average of 3.5 hours preparing for mediation and more than 36 hours to prepare for a trial[18].

The followed difficulties of conducting medical mediation was unavoidable, but at least the first step was to make a commitment to true mediation, not mediation as a means or guise to test if it fails to use litigation. The essence of mediation was the assumption that the parties have a dispute and that they are willing to work together to achieve a mutually acceptable outcome. There are several basic principles for medical mediation to be successful:

1. Self-determination: this means that the disputing parties must be based on their own free will and volunteerism and they must be able to leave mediation at any time.
2. Impartiality: the mediators must be impartial so that the parties have trust and that the process has credibility. The mediator must protect the patient's interests while ensuring that he does not become an advocate for the patient.
3. Flexibility: the solution must be in accordance with the substance of the dispute and the expectations of the parties. Mediators need to be creative and parties must be willing to explore different solutions.
4. Confidentiality: it is very important that whatever is said during mediation remains confidential. If it does not maintain confidentiality it will be difficult to have a full and honest discussion, because the parties will worry that what they say can be used in court if mediation fails[19].

[14] Sheila M Johnson. (1997). A Medical Malpractice Litigator Proposes Mediation. *Dispute Resolution Journal*. (52) 2, accessed on https://arbitrationlaw.com/library/medical-malpractice-litigator-proposes-mediation-dispute-resolution-journal-vol-52-no-2

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[16] Chris Stern Hyman, Carol B. Liebman, Clyde B. Schechter and William M. Sage. (2010). Interest-Based Mediation of Medical Malpractice Lawsuits: A Route to Improved Patient Safety?. *Journal of Health Politics, Policy And Law,* (5) 35, 797-828.

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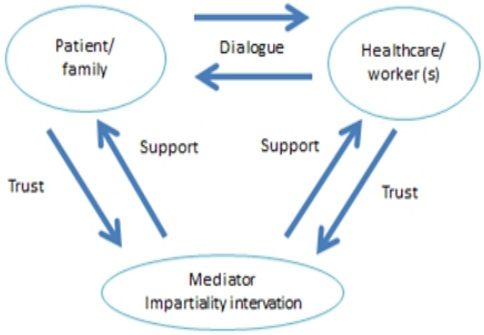
[19] Cris M Currie. (1998). Mediation And Medical Practice Disputes. *Mediation Quarterly*. (15) 3, 215-226. accessed on

Toshimi Nakanishi suggested that the facilitative mediation model was the fittest for disclosure and the initial stage of conversation in a medical dispute after a medical adverse event in which both parties acknowledge and evaluate the situation in different ways. Furthermore, it is recommended that the mediator conversation process is in-house (internal) as the first step in resolving disputes to be effective and useful in reducing emotional confusion, promoting information sharing and bringing a transformation of the perspective of the two parties caught with anger, anxiety and guilt. However, to fulfill this objective effectively in the regulation of medical disputes, a typical facilitative mediation model must be modified by adopting another theoretical perspective. The facilitative mediation model is described as follows



https://onlinelibrary.wiley.com/doi/abs/10.1002/crq.3890150306

The mediator acts as a neutral third party position on medical disputes, encouraging dialogue through empowerment, thereby enabling the opposing party to reach an agreement.

CONCLUSION

Respecting the patient autonomy and treating patients as equal partners in managing patient health was needed very much in the medical dispute resolution. Both sides involved in medical disputes were given the opportunity to convey their narratives in non-confrontational situations. Systemic strategies were always needed to improve patient safety. This personalized strategy to handle the medical dispute resolution was good and transparent communication. It was very important to identify the risks in the health care system and to maintain the inherent trust in the doctor and patient relationship.Obstacles in medical dispute resolution through mediation must be controlled by making the commitment of the disputing parties to perform a genuine mediation in the form of cooperation and agreements reached which was binding on the parties. The willingness to cooperate between the disputing parties, and the willingness to achieve mutually acceptable results was a realization of respect for patient autonomy and patient safety.

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