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UNIVERSITÀ DEGLI STUDI DI ROMA "FORO ITALICO"

Rivista scientifica trimestrale di diritto amministrativo (Classe A)

Pubblicata in internet all'indirizzo www.amministrativamente.com

Rivista di Ateneo dell'Università degli Studi di Roma "Foro Italico"

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Redazione
Carlo Rizzo

FASCICOLO N. 1/2025

Estratto

Iscritta nel registro della stampa del Tribunale di Roma al n. 16/2009

ISSN 2036-7821

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ISSN 2036-7821

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Beyond the courtroom: evaluating alternative dispute resolution in medical liability cases

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Sommario

1. Introduction: setting the stage for dispute resolution. – 2. Exploring alternative dispute resolution modalities. – 3. Global perspectives on dispute resolution practices. – 4. A comparative analysis of European dispute resolution approaches. – 5. Final reflections: the future of alternative dispute resolution in medical liability.

Abstract

In In recent decades, the burgeoning prevalence of professional medical liability litigation, initially within the United States and subsequently extending to Europe, has prompted a discernible shift towards alternative dispute resolution (ADR). This phenomenon is characterized not so much by the establishment of a prior error but rather by negative outcomes, inefficiencies, and inadequate documentation. Consequently, there has been an increasing interest in ADR as a means to facilitate out-of-court settlements between physicians and patients, thereby circumventing the traditional judicial process.

* *Il presente lavoro è stato sottoposto al preventivo referaggio secondo i parametri della double blinde peer review*

ISSN 2036-7821

1. Introduction: setting the stage for dispute resolution.

In In recent decades, the burgeoning prevalence of professional medical liability litigation, initially within the United States and subsequently extending to Europe, has prompted a discernible shift towards alternative dispute resolution (ADR). This phenomenon is characterized not so much by the establishment of a prior error but rather by negative outcomes, inefficiencies, and inadequate documentation. Consequently, there has been an increasing interest in ADR as a means to facilitate out-of-court settlements between physicians and patients, thereby circumventing the traditional judicial process.

The concept of ADR encompasses a variety of alternative mechanisms – including negotiation, mediation, conciliation, and arbitration – through which parties may resolve disputes amicably, without resorting to formal litigation[1].

The inception and evolution of ADR can be attributed to several factors, foremost among them the aspiration to establish a system that "resolves" rather than "exacerbates" disputes[2].

The adversarial nature of the judicial system, by its very design, instigates a direct confrontation between the parties involved. This approach is particularly ill-suited to the nuanced and often delicate relationship that exists between physicians and patients. Rather than facilitating understanding and resolution, traditional litigation frequently leads to a deterioration of trust, fostering animosity and defensiveness. In many instances, the experience of engaging in litigation can generate negative feelings and attitudes that complicate the potential for future interactions[3].

Moreover, the traditional adjudicative process offers little in the way of educational value for the parties involved. Instead of learning from their experiences, litigants often emerge with a reinforced sense of grievance and a defensive mindset, which can further strain their relationship. In stark contrast, ADR methodologies promote an environment where fairness and competence are prioritized – qualities that are frequently absent in judicial resolutions of medical disputes[4].

While ADR is often heralded as a panacea for a judicial system beleaguered by compensation claims, it is essential to recognize that the effectiveness and proliferation of ADR mechanisms are intrinsically linked to the efficiency of a

[1] J. S. AUERBACH, *Justice Without Law*, New York and Oxford, 1983.

[2] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, in P. TORTORANO (ed.), *ADR esperienze settoriali a confronto. Applicazioni, risvolti teoretici e prassi*, *Quaderni di Heliopolis*, no. 17, Artetetra Edizioni, Capua, 2023, pp. 335.

[3] A. DONALD, *Alternative Dispute Resolution: managing upsets and keeping people safe*, in *Evidence-Based Healthcare & Public Health*, 2004, p. 412.

[4] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., pp. 335-336.

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country's judicial system[5]. Indeed, the development of these alternative approaches appears to correlate strongly with cultural attitudes that favor conciliation over rigid, adversarial stances[6]. In societies where the judicial system is perceived as effective and equitable, there is a greater inclination among parties to seek amicable solutions through negotiation and mediation, rather than through contentious litigation. Thus, the evolution of ADR not only reflects a pragmatic response to the challenges posed by medical liability disputes but also embodies a broader cultural shift towards more harmonious conflict resolution practices[7].

2. Exploring alternative dispute resolution modalities.

The wide diversity in forms of ADR across different national contexts introduces a challenge in delineating the various scenarios[8], from which one can derive a coherent understanding[9] with ADR best conceptualized as a continuum.

At one extreme lies inaction on the part of the aggrieved party, while at the other, the recourse to formal legal proceedings[10].

Within this spectrum, as observed in the nations of the European Union[11], the United States, and Australia, one finds a broad array of ADR methods and techniques, each uniquely adapted to its respective legal and cultural environment. Despite this divergence, the fundamental and unifying characteristic of these mechanisms remains their "alternative" nature in relation to traditional litigation[12].

However, acknowledging the inherent definitional flexibility, it remains possible to categorize the different types of ADR, thus avoiding terminological ambiguity that

[5] On this point, M. TARUFFO, *Diritto e trattamento dei conflitti. Alternative al processo e nel processo*, in V. VARANO (edited by), *L'altra giustizia*, Milan, 2007.

[6] A. SANTI, *Le A.D.R. nel contesto italiano ed europeo*, in www.risoluzioneconflitti.it, 2007. See also M. BOVE, *Le condizioni di procedibilità con funzione di prevenzione: problematiche processuali ed opportunità per la giustizia civile*, in *Il giusto processo civile*, 2018, p. 363 ff.

[7] Directive 2008/52/EC of the European Parliament and of the Council of 21 May 2008 on certain aspects of mediation in civil and commercial matters. Available at http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=CELEX:32 008L0052:EN:HTML. Last accessed on April 6, 2023.

[8] On the varying degree of appropriateness of different types of ADR or the judicial process with reference to sample cases see, A. B. LIANG, *Understanding and Applying Alternative Dispute Resolution Methods in Modern Medical Conflicts*, J. LEGAL MED., 1998, p. 397 ff.

[9] J. STUYCK, E. TERRYN, V. COLAERT *et al.*, *An analysis and evaluation of alternative means of consumer redress other than redress through ordinary judicial proceedings*, Final Report, A Study for the European Commission, Health and Consumer Protection Directorate-General, Leuven, 2007. Available at http://ec.europa.eu/consumers/redress/reports_studies/comparative_report_en.pdf. Last visited October 9, 2024.

[10] On this point, see M. ZULBERTI, *La consulenza tecnica preventiva ai fini della composizione della lite in materia di responsabilità sanitaria. Riflessioni a margine dell'art. 8 della l. n. 24/2017*, RIV. ARB., 2018, p. 97 ff., spec. pp. 105-106.

[11] Consumer Affairs Alternative Dispute Resolution (ADR), *Helping consumers seek redress*, Consumers Affairs. Available at http://ec.europa.eu/consumers/redress_cons/adr_en.htm#coop. Last visited April 5, 2023.

[12] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 336.

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could lead to substantive misunderstandings. Here, we shall focus on those forms most pertinent to resolving disputes in the healthcare sector.

Negotiation involves a direct engagement between the two parties, without the involvement of a third party, where each side progressively makes concessions until reaching a mutual agreement. This process can take two primary forms: "principled" negotiation, which centers on establishing shared normative or reference criteria for resolving the dispute, and "positional" negotiation, where the conflict revolves around the actual demands or concessions until a compromise is reached on the substantive issues[13].

The advantages of negotiation lie in the complete control both parties maintain over the process, its educational value – allowing each side to confront and understand the other's perspective – and the potential for it to serve as a foundation for later mediation[14].

However, negotiation is not commonly used in medical disputes, as the personal involvement of the doctor and patient often leaves lingering animosity, undermining the emotional detachment needed for a successful outcome. Instead, negotiation tends to be more effective in disputes involving large organizations, where representatives with expertise can engage without personal involvement, thereby fostering a more objective resolution[15].

While no universally accepted definition of mediation exists, it is generally understood as an advanced form of negotiation in which the parties are aided by a neutral third party, the mediator, who helps them strive toward a mutually agreeable resolution. The Council of Europe has defined mediation as a process in which the disputing parties negotiate their issues with the assistance of one or more mediators[16].

Mediation is inherently voluntary and non-binding, as the mediator has no power to impose decisions but rather facilitates dialogue, listening separately to each party's concerns – be it the grievance of the patient or the defense of the doctor – and then seeking to build a path toward reconciliation. A recent directive proposal within the EU resists imposing uniform qualifications for mediators, defining them broadly as

[13] V. PINCHI, *Alternative dispute resolution: esperienze a confronto*, RIV. IT. MEDICINA LEGALE E DIR. SANITARIO, 2009, pp. 580-581.

[14] *Ibid*.

[15] J. FRASER, *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, PEDIATRICS, 2001, p. 602.

[16] Principle I.1 Recommendation Rec (2002) 10, adopted by the Committee of Ministers of the Council of Europe on 18, September 2002 on Mediation in civil matters. J. STUYCK, E. TERRYN, V. COLAERT *et al*., *An analysis and evaluation of alternative means of consumer redress other than redress through ordinary judicial proceedings*, cit.

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any third party assisting in mediation, regardless of profession or appointment method[17].

Notably, in Roman law-based European countries, the terms mediation and conciliation are often used interchangeably, and both concepts will be examined in further detail.

As will become clearer through the examination of specific national experiences, the term "conciliation" presents significant definitional challenges and carries a broad generality[18].

Unknown in Anglo-Saxon legal traditions, conciliation cannot be considered entirely synonymous with mediation, despite their considerable similarities. Both processes involve the voluntary engagement of a third party to resolve disputes, yet conciliation is distinct, particularly in Roman-law countries, where it encompasses various forms of alternative dispute resolution (ADR)[19].

Often, conciliation is broadly applied to any effort by a third party to facilitate an agreement that avoids or shortens a confrontation. This definitional complexity is further muddied in jurisdictions, such as Italy, where conciliation may also refer to attempts made by a civil judge within a formal legal process. The dual application of the term at both judicial and extra-judicial levels complicates its classification as a true ADR mechanism. Consequently, on a supranational level, the term is not favored for definitional clarity. In fact, many prefer to use "mediation" as a catch-all term to cover conciliation and other forms of assisted negotiation. Nevertheless, some scholars argue that conciliation represents a specific subset of mediation, where the third party can offer expert opinions – legal or otherwise – on the dispute, a role not typically found in pure mediation, which excludes technical evaluations[20].

Within the spectrum of Alternative Dispute Resolution (ADR), arbitration stands as the most intrusive and binding method of dispute resolution, representing the extreme form of ADR just before resorting to judicial action. In Anglo-Saxon

[17] J. STUYCK, E. TERRYN, V. COLAERT *et al.*, *An analysis and evaluation of alternative means of consumer redress other than redress through ordinary judicial proceedings*, cit. In Roman legal systems the term conciliation is sometimes regarded to be broader than mediation and to include all possible forms of dispute resolution, whereas mediation is understood as a consensual form of dispute resolution, in which a third party is entitled to propose a solution to a dispute. The term is moreover also used in these jurisdictions to refer to settlement attempts performed by civil law judges themselves in the framework of civil law proceedings.

[18] Council of Europe, Recommendation Rec (2002)10. Available at https://rm.coe.int/16805e1f76. Last visited April 5, 2023.

[19] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., pp. 338-339.

[20] US doctrine with reference to the possibility of appealing an arbitral decision has noted «You've got to spend thousands of dollars to build a factual case to prove that the arbitration clause is denying you justice. It's a miracle that there have been as many successful challenges as there have been. […] You'd have to be rich or crazy». See J. STERNLIGHT, *Arbitration Pendulum*, ABA J., 2003, pp. 14-15.

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jurisdictions, arbitration is typically categorized into two types: "binding" and "non-binding". The binding form is the most prevalent, wherein the arbitrator's decision is final, subject only to limited appeals based on specific criteria outlined in civil codes—such appeals being intricate and rarely successful. Conversely, the recently introduced non-binding arbitration permits parties to engage in a process that merely provides recommendations, allowing them the discretion to accept or reject the arbitrator's guidance[21].

Due to its inherently binding nature, arbitration is often viewed as the least appropriate form of ADR, as it mirrors the adjudicative characteristics of traditional courts, sometimes lacking their fairness. A noteworthy variant in the United States is "pre-dispute" arbitration, wherein both physician and patient agree, prior to any dispute, to resolve conflicts through arbitration, typically overseen by a panel of three arbitrators, a practice endorsed by various professional associations, such as the Florida Medical Association[22].

This model necessitates that arbitrators be selected from a predefined list, thereby limiting the opportunity to challenge the decision on grounds of negligence or inconsistency.

Advocates argue that such binding pre-dispute agreements reflect individual autonomy and should be upheld within the framework of free-market principles. They contend that arbitration contracts are embodiments of personal choice, deserving of legal and ethical recognition, as individuals are believed to be best positioned to assess their interests. Proponents also claim that pre-dispute arbitration offers practical benefits, notably reducing both time and emotional investment in dispute resolution.

However, this form of arbitration is not without its criticisms[23]. Detractors highlight concerns regarding its lack of transparency, as proceedings can often occur without the full participation of the parties involved[24]. Moreover, the absence of negotiation and the tendency for outcomes to favor medical practitioners or associations may lead aggrieved parties to feel further marginalized. Legal scholars in the United

[21] On this point, K. A. DEVILLE, *The Jury is Out: Pre-Dispute Binding Arbitration Agreements for Medical Malpractice Claims, Law, Ethics, and Prudence*, J. LEGAL MED., 2007, pp. 333-395, 2007.

[22] D. T. CALDON, *Medical Malpractice dispute in the Age of Managed Care*, 1998. Available at http://www.mediate.com/articles/caldon.cfm. Last visited April 5, 2023.

[23] E. A. DAUER, *Alternatives to litigation for health care conflicts and claims: alternative dispute resolution in medicine*, HEMATOL. ONCOL. CLIN. N. AM.,2002, p. 1415.

[24] With regard to patients undergoing the arbitration procedure, it has been noted that they often «feel as if they have been hurt twice: first by their health care provider, then by the system that is supposed to resolve the problem». M. ANDREWS, *For Patients, Unpleasant Surprises in Arbitration*, N.Y. Times, Mar. 16, 2003, p. 8.

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States acknowledge these issues, noting the absence of regulatory oversight concerning mandatory pre-dispute arbitration agreements[25].

They advocate for Congressional action to empower states to regulate such contracts, thereby ensuring that both physicians and patients fully understand the implications of entering into binding arbitration.

Additionally, within Anglo-Saxon legal systems, there exist specialized procedures for resolving healthcare professional liability claims[26]. These procedures, while varying in structure and outcomes, are consistently "facilitative," meaning they remain non-binding. Often classified as hybrid or advisory ADRs, they involve a neutral third party who provides assessments, opinions, and non-binding resolutions, distinguishing them from the more conclusive nature of traditional arbitration[27].

3. Global perspectives on dispute resolution practices.

As suggested by the terminology used to define ADR prototypes, the most established practices originate from Anglo-Saxon countries, particularly the United States, Great Britain, and Australia. The increasing reliance on ADR in the realm of healthcare liability is often viewed as a symptom of the crisis facing the tort system, which underpins the principles governing damage compensation in traditional civil law procedures. This demand for reform in tort law is primarily linked to the staggering rise in costs associated with compensating damages stemming from healthcare practices, compounded by cyclical crises of uninsurability in medical professions and the added expenses linked to defensive medicine – such as the excessive prescription of diagnostic tests[28].

The hallmark reforms to the tort system undertaken in the US and Australia chiefly consist of imposing limits on compensable damages arising from medical activities (caps on damages). In Australia, various states have established caps for both pecuniary and non-pecuniary damages related to medical malpractice. In the United States, beyond these caps, the punitive damages awarded to patients against physicians have been abolished, and indirect reforms have been enacted, such as the

[25] J. FRASER, *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, cit., pp. 602-603.

[26] E. A. DAUER, *Alternatives to litigation for health care conflicts and claims: alternative dispute resolution in medicine*, cit., pp. 1416-1417.

[27] L. FEINBERG, *Medical Professional Liability Reform for the 21st Century: A Reveiw of Policy Options Report of the Advisory Committee on Medical Professional Liability*. Available at http://jsg.legis.state.pa.us/Med%20Mal.PDF. Last visited April 5, 2023.

[28] G. D. DALTON, X. F. SAMAROPOULOS, A. C. DALTON, *Effect of physician strategies for coping with the US medical malpractise crisis on healthcare delivery and patient access to healthcare*, PUBLIC HEALTH, 2008, p. 1051 ff. See also G. CALABRESI, *Concerning Cause and the Law of Torts: An Essay for Harry Kalven, Jr.*, U. CHI. L. REV., 1975, p. 69 ff.

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elimination of the tort law stipulation that mandates full compensation for plaintiffs, even when portions of their costs are covered by other means (like medical expense insurance)[29]. Other indirect reforms, such as linking legal fees to a predetermined percentage of awarded damages and converting future damage payments into periodic installments instead of lump sums, have yielded mixed results. The evolution of tort law has also seen significant legal and jurisprudential changes concerning the standard of "reasonable care," evidence derived from health system guidelines, and the "peer professional opinion" utilized in judicial proceedings. These matters, while important, are particularly relevant to litigation and thus lie outside the scope of ADR[30].

In contrast to the judicial compensation mechanisms defined by tort law, there exist primarily two systems for compensating damages resulting from healthcare activities: the no-fault system and ADR. The no-fault system is an administrative, non-judicial method of compensation that operates independently of establishing error, fault, or liability on the part of the healthcare provider or institution. Under this framework, predetermined types of adverse events occurring post-medical intervention are automatically compensated. The no-fault system, notably advanced in New Zealand[31] and to a lesser extent in Sweden, is less prevalent in the United States[32], Australia, and the United Kingdom[33].

Indemnities awarded through the no-fault system are typically lower than those provided through court-based compensation systems[34].

Proponents of the no-fault model argue that its streamlined and straightforward procedures, along with lower indemnities, contribute to the containment of healthcare liability costs. Conversely, critics contend that the accessibility of the no-

[29] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 341.

[30] D. KESSLER & N. SUMMERTON, *Effects of the medical liability system in Australia, the U.K. and U.S.A.*, Lancet, 2006, p. 240; C. SMITH, *Capping the Cap discussion. Alternate Solutions For Rising Medical Malpractice Insurance Premiums, Patient Safety and Alternative Dispute Resolution*. Available at https://www.amsa.org/hp/MedMal_AlternateSolutions.pdf. Last visited April 5, 2023.

[31] In New Zealand, medical professional liability compensation is provided by the Accident Compensation Corporation (ACC). In connection with the ACC operates the Heatlh Disability Commissioner, a full-fledged conciliation commission, which offers a series of non-monetary remedies after investigating the case according to a mediation procedure in which both the patient and the health professional play an active and participatory role. See M. BISMARK & E. A. DAUER, *Motivations for Medico-Legal Action Lessons from New Zealand*, J. LEGAL MED., 2006, p. 55 ff.

[32] Few data are available for the US, but facilities that introduced a no-fault indemnity system had similar costs to similar facilities that retained the tort system's indemnity route. C. SMITH, *Capping the Cap discussion. Alternate Solutions For Rising Medical Malpractice Insurance Premiums, Patient Safety and Alternative Dispute Resolution*, cit.

[33] In the UK, only certain specific types of damage are eligible for compensation through the no-fault system, such as neurological damage resulting from childbirth. D. KESSLER & N. SUMMERTON, *Effects of the medical liability system in Australia, the U.K. and U.S.A.*, cit., p. 260 ff.

[34] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 341.

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fault system leads to an increase in claims, ultimately raising overall expenditures in the sector. Furthermore, they assert that such a system fosters a diminished perception of negligence or disorder among healthcare providers, consequently reducing their commitment to preventive measures[35].

Regarding the broad domain of ADR, Anglo-Saxon countries differentiate between institutional ADRs, which are guaranteed and administered by recognized institutions, and private ADRs. A quintessential example of institutional ADR is found in the United Kingdom, where the Clinical Negligence Scheme for Trusts was established in 1994[36]. This scheme, administered by the National Health System Litigation Authority (NHSLA), oversees disputes between citizens and the national health service, encompassing hospital care, general medicine, and, more recently, dental care. The NHSLA employs a mixed compensation approach: neurological birth injuries[37] are compensated through a no-fault system; claims up to £30,000 are processed for rapid compensation via an expedited administrative fault-finding procedure followed by a settlement proposal, while claims exceeding this amount require a process to establish the fault of the healthcare provider, utilizing various forms of ADR (negotiation, mediation, etc.)[38].

Overall, 96% of the disputes managed by the NHSLA are resolved through negotiation, mediation, and other forms of ADR. The conflict and litigation management process is highly structured; guidelines were issued in January 2007[39] to govern conflict management from its inception through documentation preparation, preliminary examination, potential expert opinion, and forecasting of case-related costs (including compensation and legal fees).

In the United States, certain states mandate institutional ADR for specific cases of healthcare liability. In Maryland[40] for instance, since 1976, a citizen alleging harm from a healthcare service must first seek arbitration through the Health Care

[35] On the degree of impact of ADRs on the extent of compensation and risk control of healthcare services provided by some hospitals in the UK, P. FENN, A. GRAY, M. RICKMANC, *Liability, insurance and medical practice*, J. HEALTH ECON., 2007, p. 1057.

[36] The National Health Service Litigation Authority, Report and Accounts 2007, London: The Stationery Office, 2007.

[37] For an in-depth look at the system of guidelines and audit procedures with the NHSLA in obstetrics and gynaecology to which 60-70% of annual medical liability payments are due, see L. BUSH & S. ARULKUMARAN, *Clinical Negligence Scheme for Trusts for maternity services (CNST)*, in *Current Obstetrics & Gynaecology*, 2003, p. 373 ff.

[38] P. FENN, A. GRAY, N. RICKMAN, *The economics of clinical negligence reform in England*, in *The Economic Journal*, 2004, p. 272 ff.

[39] Clinical negligence reporting guidelines, Fourth edition – January 2007. Available at www.nhsla.com/NR/rdonlyres. Last visited April 5, 2023.

[40] M. AHEARN, *Medical Malpractice Arbitration*. Available at http://www.adrlawinfo.com/medmal.html. Last visited April 5, 2023.

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Alternative Dispute Resolution Office, resorting to court only if the opposing party consents and an expert opinion affirms a deviation from the standard of care. This precaution is intended to deter unnecessary litigation for non-liability cases. The arbitration process is conducted before a panel selected by the parties from a list, comprising a physician, a lawyer, and a citizen representative. This panel determines whether negligence occurred and assesses damages arising from inadequate medical services. Decisions made by the arbitration panel may be appealed in the Circuit Court[41].

Similarly, in Michigan and Wisconsin, citizens must first present their grievances to a commission of five mediators before proceeding to court, although this phase is not truly one of mediation or conciliation; rather, it serves to filter out claims deemed "frivolous," ensuring that only well-founded cases advance to judicial consideration.

In the United States, while ADR, particularly mediation, is acknowledged for its potential to amalgamate the advantages of arbitration with the merits of litigation, its application in resolving medical disputes is not widespread, and comprehensive data is scarce. The limited adoption of ADR can be attributed mainly to the tendency for judicial outcomes to be more favorable to physicians[42] compared to those resulting from ADR mechanisms. Moreover, all compensation payments for medical liability, even those achieved through ADR, must be reported to the National Practitioner Data Bank (NPDB)[43]. The records of each medical practitioner in the NPDB are permanent and are referenced by insurance companies during contract negotiations and by medical organizations prior to offering employment, which often leads physicians to prefer litigation over ADR, despite its greater emotional cost and investment[44].

This tendency is underscored by data from insurance agencies, revealing that in the United States, no more than 2% of health disputes are resolved through mediation, even though mediation is widely regarded as less expensive, more effective, and more satisfying for both parties. Although judges can appoint neutral third parties to conduct mediation outside the courtroom, the data regarding court-related

[41] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., pp. 343-344.

[42] J. FRASER, *Technical Report: Alternative Dispute Resolution in Medical Malpractice*, cit., p. 603 ff. In this sense, D. W. HORAN, *Trials, settlements and arbitration: the plaintiff's perspective*, CLIN. PLAST. SURG., 1999, p. 93, emblematically notes that the judicial route does not favour the plaintiff. In fact, the author states that «[m]ost plaintiffs do not favor arbitration because of the element of uncertainty − a jury − combined with the element of exclusivity, usually favoring a defendant».

[43] Alternative Despute Resolution. Available at http://www.ama-assn.org/ama/pub/category/6074.html. Last visited April 5, 2023.

[44] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 344.

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mediations indicate low success rates[45] and minimal impact in alleviating the volume of court disputes.

4. A comparative analysis of European dispute resolution approaches.

Within the European context of out-of-court negotiations[46] Germany occupies a significant position, particularly as its healthcare system grapples with a notably high volume of disputes. This is underscored by the fact that, according to estimates from 2001, Germany had the highest per capita access to healthcare services globally[47]. The fourth decade of operation of the Conciliation Chambers, which were established under two distinct models—the Gutachterkommissionen (GutK) and the Schlichtungsstellen (SchlSt)[48] – is now drawing to a close.

In Germany, healthcare documentation is acquired ex officio, offering probative value primarily for the party receiving assistance. Initially, the healthcare case undergoes examination by a Commission of Experts, appointed according to the relevant medical discipline. This commission prepares a report to ascertain the presence or absence of medical error and the general liability of the healthcare

[45] In North Carolina, court-ordered mediations were unsuccessful in 56% of the cases and had no influence on either the number of disputes that reached the court or on the outcome of compensation judgments, to the extent that mediation resulted in a substantial overlap with a settlement conference (counselling operations carried out in the court). The mediated conference, «in most instances, is "usually'" nothing more than a structured traditional settlement conference conducted by a neutral third party. The parties themselves participate only infrequently and creative solutions are rarely considered. Lawyers talking about money is the norm». Robert Wood Johnson Foundation, *Evaluation of Court Ordered Mediation in Medical malpractice Cases*. Available at http://www.rwjf.org/reports/grr/032057.htm. Last visited April 5, 2023.

[46] For a critical reconstruction of the Community regulatory requirements and impulses that have led to the current state of Italian-Community sources on the alternative system of justice E. CAPOBIANCO, *Dai sistemi di risoluzione alternativa delle controversie nell'ordinamento italo-comunitario alla mediazione in materia civile e commerciale: analisi e prospettive*, VITA NOT., 2012, p. 155 ff; V. VIGORITI, *Superabili ambiguita`. Le proposte europee in tema di Adr e di Odr*, NUOVA GIUR. CIV. COMM., 2012, p. 313 ff; R. CAPONI, *La conciliazione stragiudiziale come metodo di ADR («AlternativeDispute Resolution»)*, FORO IT., 2003, 165 ff; C. CAMARDI, *Metodi "alternativi" di soluzione delle controversie: diritto, spazio e tempo nell'ambiente delle tecnologie informatiche*, EUR. DIR. PRIV.,2004, p. 549 ff; F. P. LUISO, *La direttiva 2013/11/UE, sulla risoluzione alternativa delle controversie dei consumatori,* in RIV. TRIM. DIR. E PROC. CIV., 2014, p. 1299 ff; T. ROSSI, *Effettivita` della tutela nella recente regolamentazione europea di ADR e ODR,* RASS. DIR. CIV., 2014, p. 831 ff.

[47] The number of admissions to the national health system in Germany in 2004 was 18.4 million, Expert Commission and Arbitration Boards at Chambers of Physicians, German Medical Association, Berlin, 2007.

[48] For extensive references on the subject S. WINLKLER, *Alternative Dispute Resolution. Risoluzione extragiudiziale delle controversie mediche*, DANNO RESP., 2003, p. 1041 ff. The GutK, which is run exclusively by the Medical Association, is the most widespread form of conciliation commission at a national level and is composed of doctors with various specialisations as well as a jurist with a licence to practice as a judge. Only the patient and the doctor may appear before the Gutk, possibly assisted by their respective lawyers. The SchlSt was created by an agreement between the Medical Association and the guild of insurance companies and has a commission with a composition similar to that of the GutK, but insurance companies may also participate in the conciliation procedure.

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facility. Subsequently, the Conciliation Commission intervenes, finalizing the facts and circumstances and formulating a written settlement proposal based on the expertise provided. While the Medical Expert Commission assesses the doctor's conduct from a technical and scientific standpoint, the Conciliation Commission focuses on proposing a settlement informed by the medical report and grounded in civil law principles[49].

The Commission confines its opinion to the technical and scientific aspects of liability, deliberately avoiding issues of informed consent or any potential defects therein. The Commissions conclude by issuing an opinion regarding the possible existence of liability on the part of the doctor, without evaluating damages, which remain a matter for direct negotiation between the injured party and the insurance company. In the SchlSt, the liability opinion is accompanied by a conciliatory recommendation presented to the involved insurance company[50].

The data reflecting the work of these Commissions is particularly revealing[51], indicating that, on average, only one-third of the appeals presented are well-founded (i.e., genuinely characterized by medical liability). Among those accepted, the Commission's opinion successfully averts continued litigation in approximately 90% of cases. The widespread acceptance and strong credibility that the German commissions enjoy at the national level are the fruits of a long-term commitment to the principles of competence, independence, and transparency[52].

Moreover, the procedures of the German conciliation commissions offer the dual benefits of being gratuitous and non-binding while also promoting educational opportunities for both parties. For the patient, the conciliation process allows them to voice their grievances, comprehend the events surrounding their healthcare experience, and bridge communication gaps. For the physician, it provides a chance to restore effective communication with the patient, address any technical or scientific uncertainties encountered, and convey the legal and medico-legal

[49] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 346 ff.

[50] *Ibid*. This procedure is voluntary for both the physician and the patient, and the opinion of the Conciliation Commission does not constitute an arbitration award, is non-binding, and does not preclude the possibility of court proceedings. The core activity of the Commissions revolves around medical expertise, which in the case of GutK is conducted by an internal commission member, with costs borne by the Medical Association. Conversely, in the SchlSt, external medical consultants typically perform this task, with expenses covered by the insurance company. Furthermore, the process incurs no costs for either the physician or the patient, aside from any legal fees that the parties may choose to incur.

[51] See J. NEU, K. D. SCHEPPOKAT, H. VINZ, *Medical risk and iatrogenic injury "accident reports" from the North German Schlichtungsstelle (expert panel for extrajudicial claims resolution)*, Z. ARZTL. FORTBILD. QUALITATSSICH., 2004, p. 567; K. D. SCHEPPOKAT & K. HELD, *Results of 903 settlement proceedings in internal medicine*, DTSCH. MED. WOCHENSCHR., 2002, p. 253 ff.

[52] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 347-348.

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implications of specific behaviors in a more "persuasive" manner than through traditional adjudicative processes.

In France[53], the establishment of the Hospital Conciliation Commission and the Regional Conciliation and Compensation Commission was initiated first by a decree in 1998[54], followed by Act No. 303 of March 4, 2002, titled "*Relative aux droits des malades et à la qualité du système de santé*", and further regulated by Act No. 806/2004[55]. The former Commission is primarily tasked with the initial acceptance of disputes, whereas the Regional Commission conducts the actual conciliation procedure. This latter body comprises various representatives, including physicians (both employed by the national health service and independent practitioners), healthcare facilities, insurance companies, and experts in biological damage assessment[56].

If the Regional Commission identifies medical liability in a given case, it issues a proposal for conciliation, which the injured party may either accept or reject in favor of traditional legal recourse. In instances where biological damage exceeds 24%, but no evidence of professional error is found (as may occur in cases of complications), the case is forwarded to O.N.I.A.M. (the National Organisation for Adverse Medical Events), which formulates a conciliation proposal that nonetheless ensures compensation. Thus, even in France, there appears to be a delineated no-fault compensation system, albeit confined to the aforementioned adverse circumstances where professional liability is not established[57].

In Italy, article 8 of Law No. 24/2017 instituted the requirement to pursue a negotiated pathway prior to initiating actions for damages resulting from healthcare liability in state courts. Specifically, this provision offered an alternative between the pathway delineated by Article 696-bis of the Code of Civil Procedure and that governed by Legislative Decree No. 28 of 2010. It further stipulated a clear preference for the procedural route dictated by Articles 702-bis et seq. of the Code of Civil Procedure in instances where the parties fail to reach a negotiated resolution, although a transition to the ordinary procedural route remains permissible should a summary instruction prove unfeasible[58].

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[53] For an analysis of the French system C. JARROSSON, *Les modes alternatifs de règlement des conflits: présentation générale*, REV. INT. DIR. COMP., 1997, p. 325 ff.

[54] On this point *Décret no 98-1001 du 2 novembre 1998 Relatif à la commission de conciliation prévue à l'article l. 710-1-2 du code de la santé publique et modifiant ce code (deuxième partie: Décrets en Conseil d'Etat)*.

[55] *Loi n. 2004-806 du 9 ao"t 2004 relative à la politique de santé publique*.

[56] V. PINCHI, *Alternative dispute resolution: esperienze a confronto*, cit. p. 588. On this point, it must be stressed that only disputes concerning events occurring after 5 September 2001 may be submitted to the Commission.

[57] P. TORTORANO, *Alternative Dispute Resolution.Comparing experiences of medical liability*, cit., p. 348 ff.

[58] For an anlysis see M. MARINARO, *In materia di responsabilità medico-sanitaria serve la figura professionale dell'in33mediatore*, in *Guida al Diritto*, Milan, 2012; M. BOVE, *Responsabilità sanitaria ed esperimento di ADR come condizione di procedibilità: su alcune questioni aperte*, RIV. ARB., 2019, p. 587 ff.

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Notwithstanding the fact that the aforementioned provision does not delineate the relationship between mediation and litigation, nor clarifies the terms of the alternatives between the cited pathways, certain application nuances persist that warrant further examination, even following previous reflections on the subject[59].

Through Law No. 24/17, the legislator introduced a novel instance of conditional jurisdiction within the realm of healthcare liability reform. Article 8, in particular, imposes an obligation to undertake the preventive technical consultancy procedure stipulated in Article 696-bis of the Code of Civil Procedure, which serves not only to facilitate preliminary investigative activities but also to promote conciliatory settlement attempts through a court-appointed technical consultant[60].

A central issue addressed by the 2017 legislature pertains to the nature of liability for healthcare professionals and facilities. Initially categorized as contractual liability, opinions diverged post-Law No. 189/12, with some asserting it as non-contractual while others maintained its classification under contractual liability[61].

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[59] V. PINCHI, *Alternative dispute resolution: esperienze a confronto*, cit. p. 588. See also G. TRISORIO LIUZZI, *La riforma della responsabilità professionale sanitaria. I profili processuali,* in *Il giusto processo civile*, 2017, p. 649 ff, spec. pp. 675.

[60] There is an extensive literature on the institution, to which we refer for a general review. Above all C. BESSO, *Consulenza tecnica preventiva ai fini della composizione della lite*, in S. CHIARLONI (ed.), *Le recenti riforme del processo civile*, II, Bologna 2007, p. 1316 ff; M. MONTANARI, *Brevi note sulla consulenza tecnica preventiva in funzione di composizione della lite (art. 696 bis c.p.c.) e sulle relative conseguenze d'ordine applicativo*, GIUSTO PROC. CIV., 2012, p. 701 ff; A.A. ROMANO, *Il nuovo art. 696 bis c.p.c. tra mediation e anticipazione della prova*, in CORRIERE GIUR., 2006, p. 405 ff; L. SALVANESCHI, *I procedimenti di istruzione preventiva*, in C. CONSOLO, F.P. LUISO, S. MENCHINI, L. SALVANESCHI, *Il processo civile di riforma in riforma*, Milan, 2006, p. 113 ff; A. TEDOLDI, *La consulenza tecnica preventiva ex art. 696 bis c.p.c.*, RIV. DIR. PROC., 2010, p. 805 ff; V. ANSANELLI, *La consulenza tecnica preventiva ai fini della composizione della lite*, in M. TARUFFO (ed.), *La prova civile*, Milan, 2012, p. 1070 ff; G.N. NARDO, *La consulenza tecnica preventiva ex art. 696 bis c.p.c. tra conciliazione della lite ed anticipazione della prova*, in *Studi in onore di Carmine Punzi*, III, Turin, 2008, p. v339 ff; F. COSSIGNANI, *La consulenza tecnica preventiva ai fini della composizione della lite*, in A. CARRATTA, (ed.), *I procedimenti cautelari*, Bologna, 2013, p. 723 ff; F. CUOMO ULLOA, *voce Consulenza tecnica preventiva ai fini della composizione della lite*, DIG. IT., disc. priv., sez. civ., agg., II, Turin, 2007, p. 273 ff; M. ADORNO, *La funzione "conciliativa" della consulenza tecnica preventiva ex art. 696-bis c.p.c.*, GIUSTO PROC. CIV., 2015, p. 869 ff; R. BONATTI, *Un moderno dottor Jekyll: la consulenza tecnica conciliativa*, RIV. TRIM. DIR. PROC. CIV., 2007, p. 247 ff.; M. SCALAMOGNA, *Alcune questioni controverse in tema di consulenza tecnica preventiva con funzione conciliativa*, RIV. TRIM. DIR. PROC. CIV., 2010, p. 957 ff; V. SCIBETTA, *Il nuovo art. 696-bis c.p.c.: la consulenza tecnica preventiva ai fini della composizione della lite*, GIUR. MERITO, 2006, p. 267 ff.

[61] The doubts stemmed from the unfortunate wording of Article 3, Law No. 189/12, which, after excluding criminal liability for slight negligence on the part of the healthcare professional who follows guidelines and good practices accredited by the scientific community, added that in such cases, the obligation set forth in Article 2043 of the Civil Code remains in force. The ensuing debate concerned the nature of such liability which, according to one view, outside of the hypotheses in which the service was performed under a contract concluded directly between the patient and the healthcare professional, was exclusively extra-contractual, while, according to another view, despite the reference to Article 2043 of the Civil Code, the contractual action, based on the theory of so-called social contact, which jurisprudence had developed over more than a decade, remained available. On this debate, see, among the many contributions, R. BREDA, *La responsabilità civile dell'esercente della professione sanitaria alla luce della c.d. legge Balduzzi: ipotesi ricostruttive a confronto*, RIV. IT. MED. LEG., 2013, 751 ff; A. VALLINI, *L'art. 3, 1 comma della legge Balduzzi: reazioni, interpretazioni, applicazioni*, GIUR. IT., 2014, 2057 ff; M. L. RUFFINI GANDOLFI,

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Law No. 24/17 clarifies this matter in Article 7, stating that facilities bear contractual liability for damages, whereas healthcare professionals are liable on a non-contractual basis unless a contract with the patient exists—an important distinction impacting burdens of proof and statutes of limitations, which differ depending on the type of liability involved[62].

Article 9 subsequently establishes that both private and public facilities that have compensated the injured party – through judicial or extrajudicial means – possess the right, within specified limits, to pursue recourse against the healthcare professional, or to assert damages within the administrative liability judgment brought forth by the public prosecutor at the Court of Auditors[63]. Both recourse actions must be initiated within one year of payment[64].

Furthermore, Article 9, paragraph 3, excludes the effectiveness of decisions rendered in legal proceedings where the practitioner was not a party, while paragraph 7 expressly limits the evidence's applicability against practitioners who did not participate in the proceedings. Additional principles concerning the appointment of court-appointed technical consultants in healthcare liability cases are established under Article 15[65].

In tema di responsabilità medica: tra incertezze giurisprudenziali e dubbi suscitati dalla Legge Balduzzi, RAGIUSAN, 2014, 176 ff.

[62] M. ZULBERTI, *La consulenza tecnica preventiva ai fini della composizione della lite in materia di responsabilità sanitaria. Riflessioni a margine dell'art. 8 della l. n. 24/2017*, cit., pp. 97-98.

[63] *Ibid*. On the one hand, it is required that the health care practitioner has acted with malice or gross negligence, and on the other hand, in cases of gross negligence, maximum limits are set within which the practitioner is liable for recourse or administrative liability. The question arises as to whether the private structure can already act against the practitioner in the action brought by the injured party when the latter has not sued him. In fact, Article 9 states that if the healthcare professional has remained outside the proceedings, the action of "recourse" can be brought only after the compensation has been paid. In favour of a negative solution to the question, see A. D'ADDA, *Solidarietà e rivalse nella responsabilità sanitaria*, CORRIERE GIUR., 2017, p. 775 ff. However, it does not appear that the provision is intended to derogate from the general rules on the subject of joinder of parties, as it seems to refer to the hypothesis in which the healthcare professional was not a party to the lawsuit, regardless of whether he became a party as a defendant by the plaintiff, summoned by the defendant facility or voluntarily intervened in the lawsuit. In this order of ideas, see M. VACCARI, *Le condizioni dell'azione di rivalsa nella legge Gelli-Bianco*, RIDARE, § 2; G. RICCI, *L'azione di rivalsa della struttura sanitaria*, in A.D. DE SANTIS (ed.), *I proifili processuali della nuova disciplina sulla responsabilità sanitaria*, Rome, 2017, p. 66 ff. The previous framework is confirmed, given that the damage suffered by the public structure was deemed to be claimed in the context of administrative liability proceedings. See P. MARIOTTI & A. SERPETTI, *Danno erariale da responsabilità sanitaria*, Milan, 2014.

[64] According to a part of the doctrine, the forfeiture would not apply to the action for damages, but only to the action for recourse of private healthcare facilities. See M.A. ZUMPANO, *Profili proceduali della nuova legge sul rischio clinico*, NUOVE LEGGI CIV. COMM., 2017, p. 491. This interpretation, however, clashes with the letter of the provision that refers to both actions the forfeiture period. In this sense, A. D'ADDA, *Solidarietà e rivalse nella responsabilità sanitaria*, cit., p. 775 ff.

[65] M. ZULBERTI, *La consulenza tecnica preventiva ai fini della composizione della lite in materia di responsabilità sanitaria. Riflessioni a margine dell'art. 8 della l. n. 24/2017*, cit., p. 99.

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The disputes subject to the mandatory attempt under Article 8 encompass all actions for compensation, condemnation, or mere ascertainment related to healthcare liability, whether arising from negligent or intentional actions of the healthcare professional or from the facility's breach of the medical care contract[66]. However, it remains contentious whether the term "compensation disputes" extends to claims involving rights other than the right to compensation but closely connected to it. A restrictive interpretation is preferred in cases where provisions temporarily curtail the right of action[67]. However, it remains contentious whether the term "compensation disputes" extends to claims involving rights other than the right to compensation but closely connected to it. A restrictive interpretation is preferred in cases where provisions temporarily curtail the right of action[68].

5. Final reflections: the future of alternative dispute resolution in medical liability.

The establishment of Conciliation Commissions or Chambers, alongside a broader implementation of Alternative Dispute Resolutions (ADRs) within the realm of healthcare liability, is unequivocally suggested as a beneficial strategy for mitigating the costs associated with medical malpractice litigation. This approach aims to alleviate the often exasperating nature of the adjudicative process, reduce the inclination towards criminal proceedings – which recent scholarly perspectives frequently regard as ineffective for the injured party and overly punitive towards healthcare practitioners – and ultimately facilitate swifter, fairer, and less costly access to compensation for the aggrieved patient. However, a preliminary

[66] On this point A. BARLETTA, *Il tentativo obbligatorio di conciliazione nell'art. 8 della legge Gelli-Bianco*, RIDARE, 2017. In contrast, V. AMIRANTE, *La consulenza tecnica preventiva e la nuova condizione di procedibilità: disciplina, tempi, soggetti*, RIDARE, 2017, who considers that the compensation disputes would only be those in which a request for condemnation is formulated, considering the expression more limited than that used by legislative decree no. 28/10 which imposes compulsory mediation in relation to compensation disputes, which would instead also include those of mere ascertainment. Of the same opinion, see M. ADORNO, *Il nuovo "filtro" dell'art. 696 bis c.p.c. in materia di responsabilità sanitaria*, in A.D. DE SANTIS (ed.), *I profili processuali della nuova disciplina sulla responsabilità sanitaria*, Rome, 2017, p. 107 ff.

[67] Case law has enumerated the obligations to which the healthcare facility is bound under the contract of hospitalisation, which consists of a complex service, which does not end with the provision of medical and surgical treatment, but extends to a series of other services, such as the provision of auxiliary medical and paramedical staff, medicines, and all the necessary technical equipment, as well as the hotel services in a lato sensu. See, *inter alia*, Cass. 30 September 2015, no. 19541

[68] Article 12 in fact does not affect the provisions of Article 8, *i.e.* those relating to the mandatory nature of the conciliation attempt. See G. OLIVIERI, *Prime impressioni sui profili processuali della responsabilità sanitaria (legge 8 marzo 2017, n. 24)*, in www.judicium.it, § 3; F. SANTAGADA, *Il tentativo obbligatorio di conciliazione*, in G. ALPA (ed.), *La responsabilità sanitaria. Commento alla l. 8 marzo 2017, n. 24*, OSPEDALETTO, 2017, p. 357 ff; G. BUFFONE, *Un ruolo centrale per la consulenza tecnica preventiva*, GUIDA DIR., 2017, p. 78 ff; M. HAZAN, *Alla vigilia di un cambiamento profondo: la riforma della responsabilità medica e della sua assicurazione (DDL Gelli)*, DANNO RESP., 2017, p. 89 ff; A. MEI, *Responsabilità sanitaria e risoluzione stragiudiziale, dopo la c.d. riforma Gelli approvata in via definitiva*, in *La nuova procedura civile*, 2, 2017; M. ADORNO, *Il nuovo "filtro" dell'art. 696 bis c.p.c.*, cit., p. 108 ff.

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examination of both international practices and our national experience reveals that a significant cultural gap must be bridged to effectively plan for and adopt systems that favor the out-of-court resolution of disputes.

To begin with, the measures that aim to establish potential bodies, organs, and commissions at the local-regional level for the extrajudicial management of health-related disputes must employ terminology (such as conciliation, arbitration, mediation, etc.) with precision and clarity. This is crucial, as the terms frequently draw from other sectors—such as finance and corporate law, particularly within Anglo-American jurisdictions—where a notable diversity in procedural realities already exists. Moreover, in various European contexts, different terminologies supplement these terms, notably the word "conciliation".

The mechanisms and modalities of conciliation are often misaligned with the judicial process. The plaintiff, having chosen the litigation path, typically structures their grievance based on expert opinions; hence, a withdrawal towards a settlement might not adequately address their concerns. Furthermore, judicial conciliation is hampered by the inherent limitations posed by the conciliator's institutional role, which can inhibit the parties' transparency – essentially, the mutual openness necessary to comprehend the underlying reasons for the grievance and the corresponding offers or requests, which form the bedrock of any potential settlement.

Consequently, extrajudicial conciliation in the sphere of healthcare professional liability necessitates that medical examiners, specialists, and legal practitioners cultivate conciliatory skills previously unrequired. The urgency to develop proficiency in conciliation techniques may soon emerge, particularly if the current legislative momentum surrounding mediation and conciliation culminates in the establishment of dedicated bodies or individuals tasked with addressing disputes in medical professional liability. In anticipation of this evolution, legal and medical professionals could seek guidance from established guidelines and standards – such as those adopted by certain health mediation bodies internationally (e.g., in the United States) – while it remains imperative for national scientific societies to promptly tackle this issue by proposing targeted training programs and operational models tailored specifically for the conciliatory processes instituted within our jurisdiction.

In conclusion, while the potential for ADRs and conciliation in healthcare liability is significant, realizing this potential demands a concerted effort to overcome cultural barriers, refine terminological precision, and enhance the skills of those involved in the conciliation process. The development of stable structures for conciliation will be crucial, necessitating a proactive approach from both legal and healthcare professionals to foster an environment conducive to effective dispute resolution.

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Only through such efforts can we aspire to create a more efficient, equitable, and supportive framework for addressing grievances within the healthcare system.

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