INTRODUCTION

Healthcare is one of the primary needs of human life. The delivery of health services sometimes ends with disagreements, conflicts even disputes between the health professionals and patients. Many disagreements, conflicts or disputes lead to a judicial process, either civil or criminal judicial process (Cottam et al, 2007).1

One of the disputes in the delivery of healthcare is malpractice. In Indonesia, the regulations on malpractice cannot be explicitly found in healthcare regulations. Law regulating healthcare in Indonesia can be found in Act No. 36 of 2009 on Health of State Gazette 2009 no. 144, Supplement No. 5063 (Health Act), Act No. 44 of 2009 on Hospital of State Gazette 2009 No. 153, Supplement No. 5072 (Hospital Act), and Act No. 29 of 2004 on Medical Practice of State Gazette 2004 No. 116, Supplement No. 4431 (Medical Practice Act). These three provisions do not provide regulation on malpractice at all.

Legal practice shows that malpractice term is used very broad definition. One of the cases referred to as malpractice in 2013, which becoming quite interesting attention, was the case of Ayu, MD Supreme Court Decision No. 365K/Pid/2012 dated September 18, 2012 annulling Manado District Court Decision No. 90/Pid.B/2011/PN.MDO dated September 22, 2011. Mass media and public, even among medical doctors refers the case as malpractice. Another case also referred to as malpractice case was Misran, a Nurse, in violation of Article 82 paragraph (1) point d in conjunction with Article 63 paragraph (1) of Act 23 of 1992 regarding Health by means of storing and dispensing G list drugs to patients without a doctor's prescription in March 2009.

From 2004-2005 there were 122 cases on medical disputes which was reported to the Council of Medical Ethic Code (Purwadianto, 2007).2 As of the establishment of the Indonesian Medical Disciplinary Council (MKDKI), in 2006, until October 2013, MKDKI received 231 reports. It does not matter how many reports are received and how many cases are resolved in court if there is no clear definition and the criteria of medical malpractice.

Article 58 paragraph (1) of Health Act states that "Everyone is entitled to claim for compensation against a person, health professionals, and/or healthcare providers who cause losses due to errors or negligence in relation to the healthcare services received". The process to settle the disputes by means of court claim is called litigation.

In the United States the cost of disputes resolution through the courts (litigation) has increase the cost of healthcare costs. The long period and the costs incurred during the process of litigation has made the litigation costs expensive (US Congress, 1993)3 (GAO, 2003)4. In addition to the high cost of this litigation process, the time required for a verdict to become a final and binding verdict as well as to enforce the final and binding verdict was long enough. In Indonesia, the litigation process from First Instance Court to Supreme
Court to become final and binding verdict will normally take 3 to 4 years, not included Judicial Review process that can take 2 to 3 more years.

In addition to the high cost and long time, from the aspect of confidentiality, litigation process reveals the entire story of the case. Almost all litigation proceeding in court is open for public. It means that there is no more secret in the relation to the disputes. This frequently becomes an obstacle to create and deliver justice for all parties concerned and involved with the delivery of healthcare (Hennes, 2004) (Shurtz, 2010). In relation to this matter, in the United States, people are thinking to resolve disputes in healthcare, including malpractice, through alternative dispute resolution institution (Morreim, 2011). This effort to resolve dispute has gain attention from existing arbitration institute (National Arbitration Forum, 2005) (Benesch, 2011). Subsequent research showed that the use of alternative dispute resolution institutions got well supports from many actors of health care sector, either medical professionals or patients (Holman, 2011). In Indonesia, the provision on alternative dispute resolution is regulated in Act No. 30 of 1999 on Arbitration and Alternative Dispute Resolution of State Gazette 1999 No. 138, Supplement No. 3872 (ADR Act). However, according to Article 5 and Article 66 of the ADR Act, ADR is valid only to resolve disputes in commercial field. The ADR Act does not regulate at all the alternative dispute resolution in healthcare field, including malpractice.

Research on other related legislation shows that Article 58 paragraph (3) of Health Act, Article 60 point f of Hospital Act and Article 67 of Medical Practice Act, although it is not explicitly stated, there is a possibility to settle healthcare disputes including malpractice disputes through Alternative Dispute Resolution institutions. It should be recognized that the lack of clarity with respect to the definition of malpractice in the health sector has somehow also made the in clarity in resolving malpractice problems in the health sector.

There are two objective of this research. The general objective is to obtain a good understanding on the definition, restriction, criteria, causes, types of malpractice, and malpractice dispute resolution in healthcare through alternative dispute resolution institution. While the specific objective is to know the definition, restriction, criteria, causes, types of malpractice, the kinds of evidences that can be used in order to settle malpractice disputes in healthcare, and to know kinds of alternative disputes resolution that can be used to settle malpractice disputes in healthcare.

THEORETICAL REVIEW

Health today is one of the basic human needs (Maslow, 1943) (van Wagner, n.d.). More than that, according to Nordenfelt in Understanding the Concept of Health, "health is now considered to be one of our most important values" (Ronnow-Rasmussen, Peterson, Josefsson & Egonsson, 2007, p.2). Today health has become one of the world's central concern. Since 1947, World Health Organization (WHO) has defined health in a broad definition, namely as "a state of complete physical, mental, and social well-being, and not merely the absence of disease and infirmity" (WHO, 1947, p.3). Abraham Maslow (1943) describes health as one of the basic human needs after physiology needs. The concept of healthy, derived from the concept and meaning of health, can be viewed from two perspectives: healthy which is free social and cultural value, and healthy which contains social and cultural values. In this concept, the definition of “sick” can also be seen from two points of view, those are sick which is free of social and cultural value and sick which contains social and cultural values.

At the beginning, people believe that every human being has the same views and value of what is meant by being healthy and being sick. It can be generally seen on the biological function of the human body. When the human body functions normally, when a person can perform his normal activities, then the person is said to be healthy. Any forms of deviation from body function are considered as sick. These are the view of naturalist. However, along with the development of human life, socio-cultural values are perceiving people with the meaning of healthy or sick. So, it comes the normative view, linking the sick or healthy condition with the socio-culture environment (Bloomfield, 2001).

Scientists and physicians would easily call a state as disease by analyzing various functions of organs of the human body and seeing whether each organ is still functioning properly (Boorse, 1997). Thus, being sick (Bilton, et.al., 2002) is an organic condition; that in temporary and can be changed by a medical intervention; experienced by people who are sick; handled after symptoms appear; and handled in medical environment.

Jennings (1986) in one of his writings expresses the difference between disease and illness. It is said that illness is an experience and it is only disease of which it can be conducted research using biomedical research. A person can be exposed to disease without even feeling ill as one can feel ill without exposure to a specific disease. Through biomedicine, someone can distinguish between medical illness originating from disease and non-medical illness originating outside the disease. Thus, the definition of disease given by Jennings is purely on biomedical issues, related to pathophysiology and pathochemistry. While illness is subjective phenomenon experienced by someone.

Perception differences on sick (in the form of illness and disease) can be easily explained in Health Belief Model (HBM) theory. HBM theory was first developed in 1950s by a group of social psychology scientist worked at US Public Health Service to find out why
many people did not want to participate in the activities of public health programs at that time, particularly tuberculosis (Rosenstock, 1974).19

The provision of health services requires a trust between health services providers and patients, which is called fiduciary relation (Hui, 2005)20 (Zilber, n.d.)21, which in the end resulted in obligations called as fiduciary duty. Fiduciary relation is a trust relation (Francis, 2010).22 Fiduciary duty in relation to the provision of health services essentially reflects a wide range of obligations that exist as a result of the fiduciary relation between health professionals and patients, which become the basis to create health care relation between health professionals and patients. This obligation, called as fiduciary duty, is inherent in health professionals.

Stewart and Roter (1989, p.21) suggests the existence of four types of doctor-patient relation as follows23:

| Patient Control | Doctor Control |
|-----------------|---------------|
| Low             | Default       |
| High            | Consumerist   |
|                 | Paternalism   |
|                 | Mutualty      |

Kath Maguire (n.d., p.1-2) describes the relation as follows24:

a. **Paternalistic** - typified by a doctor centered style.

b. **Consumeristic** - here the patient knows exactly what they want and forces the doctor into a patient centered approach.

c. **Default** - this is where the patient centered style fails. The doctor is trying to relinquish control but the patient is unwilling to accept it. The result is an impasse.

d. **Mutuality** - the doctor uses open questions to encourage the patient to talk about his complaint. This approach relies on taking time to listen and trying to understand the patients' point of view.

By taking the definition of agency according to Black's Law Dictionary, as (Garner, 2004, p.67) "fiduciary relation created by the express or implied contract or by law, in which one party (the agent) may act on behalf of another party (the principal) and bind that other party by words or actions," we can see that, in principle, fiduciary relation can exist because of a contractual relation or because of an obligation imposed by law.25

In carrying out the functions of the fiduciary relation, disputes can happen. The disputes can be divided into ethical dispute, disciplinary dispute and legal dispute. With respect to legal dispute, people used to settle it in the form of litigation through public court; or in form of alternative dispute resolution, including Arbitration in lieu of public courts.

(Shamir, n.d., p.2) Alternative Dispute Resolution (ADR), sometimes also called "Appropriate Dispute Resolution" is a general term, used to define a set of approaches and techniques aimed to resolve disputes in a non-confrontational way.26 It is said further that (Shamir, n.d., p.2) “It covers a broad spectrum of approaches, from party-to-party engagement in negotiations as the most direct way to reach a mutually accepted resolution, to arbitration and adjudication at the other end, where an external party imposes a solution.”26 It is again said that (Shamir, n.d., p.2) “Somewhere along the axis of ADR approaches between these two extremes lies “mediation,” a process by which a third party aids the disputants to reach a mutually agreed solution.”26

**RESEARCH METHODS**

This is a qualitative research, with descriptive analytical approach. This research uses secondary data and in-depth interviews (Creswell, 2009).27 This study tries to construct a definition of medical malpractice and to find out the appropriate alternative dispute resolution to settle disputes in healthcare malpractice. The research process was conducted by collecting secondary data in the form of primary, secondary and tertiary legal materials and in-depth interviews with experts in the field of health law to obtain expert judgment. From the study results of literature review and interviews, it was then analyzed through content analysis.

This research was conducted in several phases:

a. Collecting secondary data, in the form of primary and secondary and tertiary legal sources, by doing web search via keyword, among others: medical, malpractice, physician-patient relation, Health Belief Model, communication, alternative dispute resolution, arbitration;

b. Conducting the process of selecting data and information and grouping them based on subject matters in accordance with the material to be analyzed;

c. Performing content analysis of secondary data collected;

d. Determining informants to be interviewed;

e. Conducting interviews with informants, for data triangulation;

f. Performing further content analysis to draw conclusions.

**RESULTS AND DISCUSSION**

Malpractice according to Black's Law Dictionary is “the failure to exercise that degree of skill and learning commonly applied under all the circumstances in the community by the average prudent reputable member of a profession with the result of injury, loss or damage to the recipient of the professional’s services or to those entitled to rely upon them” (Black, 1990, p.959).28 Vukmir (2004) argues that the concept of malpractice is rooted in the law theory developed in the 18th century, introduced by Sir William Blackstone.29 In 1768, he suggests the term "mala praxis" in which the loss due to negligence or acts that do not have the skills of a surgeon or apothecary because he or she violates the
trust given by the patients and has been detrimental to the patient.”

Law on medical malpractice, rooted in common law, developed through the law of tort, which regulates civil compensation as a result of injury or loss to others (Buditti & Waters, 2005). It should be understood that historically the main focus of common law tradition is to resolve disputes rather than creating legal norms, which are recorded and subsequently used to regulate the daily life of people as the civil law tradition. This means that common law tradition is developed through case verdict that is used continuously (precedent) based on the principle of *stare decisis* (O’Connor, n.d.).

Thus, to determine the meaning of medical medical malpractice, it should be seen from court decision passed from time to time. These court decisions ultimately establish legal norms, which are summarized and used in other verdict in the future.

Conceptually, medical malpractice as part of tort law in the common law tradition has its place in a form of negligence. The concept of negligence expects everyone to be cautious in doing things. If they do not act carefully and cause harm to or injure others, the person who is in negligence is obliged to provide compensation to the injured party (Buditti & Waters, 2005). In the common law tradition, tort is “civil breach of a non-contractual duty” (McNaught, Alpaugh & Hicks, 2012, p.2).

Based on the concepts, many definition of medical malpractice has been formulated by legal experts. Bal (2009, p.340) defines medical malpractice as "any act or omission by a physician during treatment of a patient that deviates from accepted norms of practice in the medical community and causes injury to the patient". Dearmon (n.d, p.472) defines medical malpractice as "negligence on the part of a professional only while he or she is acting in the course of professional duties." Tan (2006, P.23) gives the definition of malpractice as "an act, by commission or omission, by a healthcare professional that departs from an accepted healthcare standard, where the departure causes an injury to the patient". It is further said that it is not accurate to say that "medical negligence means an adverse outcome, a wrong judgment, or even a medical error or mistake" (Tan, 2006, P.23). It should be defined case by case. In http://medical-malpractice.com/know.htm, medical malpractice is defined as "simply a health care provider not doing what he is supposed to do or doing what he is not supposed to do." Thrumoorthy (2011, p. 12) says that "medical malpractice or negligence is defined as the failure or deviation from medical professional duty of care – a failure to exercise an accepted standard of care in medical professional skills or knowledge, resulting in injury, damage or loss".

In the Civil Law tradition, Stauh (2011) states that health problems in Germany can be flash back to the era of Otto van Bismarck in 1880s. In malpractice disputes in healthcare, according to the applicable Germany Code of Civil Law (*Bürgerliches Gesetzbuch* - BGB), the patient can file a civil lawsuit for the loss suffered through contractual lawsuit or tort or both. Previously, a civil lawsuit related to compensation, can only be prosecuted based on one type of lawsuit, either in the form of contractual breach (sourced from agreement) or based on non-contractual tort. Nevertheless, with the change of BGB in 2002, malpractice suit in healthcare can be carried out either in the form of a lawsuit for breach of the contractual or non-contractual relation in the form of tort (Stauch, 2011).

Article 276 of BGB regulates the lawsuit for compensation caused due to a contractual relation. While the basis for the tort lawsuit is provided in Article 823 (1) BGB. Patients can use one or two of this article as a basis for filing a lawsuit related to medical malpractice (Stauch, 2011).

If in Germany it is possible to have contractual and non-contractual lawsuit at the same time for medical malpractice, in Netherland, the legal relation between doctor-patient is specifically regulated in Book 7 on the Special Agreement of Title 7 on Services of Section 5 on the Agreement Related to Health Care, regulated from Article 446-468 of Dutch Civil Code (*Nieuwe Burgerlijke Wetboek* - NBW). From these provisions it can be seen that the doctor-patient relation is a contractual relation that is based on an agreement, which should fulfill the condition for a valid agreement.

From the provisions of Article 446 paragraph (1) of NBW, it can be seen that the agreement related to health care is (Warendorf, Thomas & Curry-Summer, 2009, p.831-832). “Contact whereby one natural or legal person, the provider of care, binds himself in the exercise of a medical business or profession, as regards another person, the client, to performs acts in the field of medicine, directly concerning the person of the client or a specific third person.”

From the formulation of the legal relation of above, it can be said that all matters relating to medical malpractice is a breach of the contractual relation.

There are four things that must be met in order to have legal and valid contractual relation. The first is the matter of “agreement”, described in the form of informed consent, as something that should exist. The second relates to the capability to make and provide the consent. Society requires that each person who makes a decision to relate him or herself to the law should already have the minimum knowledge, ability and intelligence. This person is considered as adult and competent to act within the law. Therefore, the law provides age limit. Currently, in Indonesia, according to Article 47 and Article 50 of Act No. 1 of 1974 on Marriage, State Gazette No. 1974, 1, Supplement No. 3019, either a person has reach the age of 18 years old.
or he or she has been married although he or she has not yet reached the age of 18 years old, is considered an adult. Of those considered as incapable to act within the law, like an adult, a principle of representation will be applied. This representation may exist either because of laws or because of a court decision. What is interesting is the provision in Article 465 of NBW stating that doctors or other health professionals are considered to be and to act as representatives of those who are considered incapable to act, in condition that he or she does not have another person as his/her representative. *Zaakwaarneming* principle set forth in Article 1354 of Indonesian Civil Code applies in this case. Any act in violation of *zaakwaarneming*, if it causes injuries to patient, then the injured patient has the right to demand compensation for the loss. It can be done according to Article 1365 and Article 1366 of Indonesian Civil Code as tort. In such conception, a doctor or health professional who does not act in accordance with his or her obligations as a party representing patients who do not have representatives may also be sued as tort.

In addition to the two things mentioned above, the third condition of the validity of a contractual relation is the "information" that becomes the basis of giving the "consent" on medical service or action to be taken or made by the medical doctor or other healthcare professionals. Any changes in the information that may result in different actions to be taken, or causing significant changes to the circumstances shall require a new consent from the patient. In the perspective of law the old contract based on the old consent, given by the old information are no longer valid. This means that the old contract is already no longer relevant or no longer possible to be implemented with all the legal consequences. What happens is no new consent. It answers question that it is not patients who withdraw the consent but a new consent has not been given.

In relation to the consent "withdrawal" of the patients, it is necessary to note that the contractual relation between medical doctors or other health professionals and patients, in the perspective of law, is a real contract. It is said as real contract because the rights and obligations derived from the contractual relation only exist at the time the medical doctors or health professionals take medical actions. Without any actions taken, informed consent will not have any meaning for both sides, the medical doctor or health professional on one side and a patient on the other side. This means that, at any time prior to medical or health actions taken, the patients have the right to "withdraw" the consent. Article 408 paragraph (1) of NBW under the title of service provision states that "The client may terminate the contract at any time." It can happen considering that the contractual relation of service provision is a real contractual relation.

One other important note is that in the contractual relation of service, it is not a matter of the result; but it is person who does the work or who provides the services is more important. This differs from the contractual relation of goods. This explains also why in the relation between medical doctors or health professional and patients. Sometimes the outcome is not the main. A person goes for treatment because he or she knows the reputation of the medical doctor; it is not only to have treatment. Trust is the main basis of the contract formation.

The last thing becoming the basis of the validity of contractual relation in the medical relation in providing healthcare services is that the medical actions taken or made is something not against the law, morals or public order, in accordance with the provisions of Article 1337 of Indonesian Civil Code. For example, euthanasia is something prohibited by law. Contract, approval or consent given to have abortion, cloning and various things prohibited by the law, morality or public order do not make the consent. Doing things contrary to law, morals or public order, acts violating the law will not create legal consent. If these acts, violating the law, harming the patients, will result in the right of the patient to sue the medical doctors or health professionals performing the acts contrary to the law, morals or public order, for the compensation.

This means that the medical malpractice is a legal term, particularly in private law, with an emphasis on the obligation to provide compensation in the form of loss, costs and interest. Any violation of discipline and ethics is simply not medical malpractice. However, violation of discipline, as long as it arises losses to patients, can be used as a basis to file a malpractice suit in healthcare.

Janes suggests that there are three things becoming form the basis of medical malpractice of a contractual relation (Janes, 2011).  

a. Injuries caused by the negligence of a health professional to follow the standard of care;  
b. The health professionals promise to the patient or his representative, that the injury will not occur;  
c. The injuries have not obtained approval from the patient or his representative.

From the description and explanation given above it can be seen that each medical action undertaken must meet the following criteria:

a. Every medical action requires informed consent from the patient and or party legally representing the patient;  
b. The medical actions are undertaken in accordance with the expertise and professionalism competence (standard of care);  
c. The duties and obligations have been carried out with caution, and it has been has taken all necessary steps to ensure the best results;  
d. No error or negligence is made, either in a medical act performed alone or together with other health professionals;  
e. The occurrence of pain or loss in the patient as a
result of action taken incorrectly mentioned above.

Below is presented the table of analysis results:

| No | Types of Malpractice | Criteria | Causative Factors | Proving | Dispute Resolution |
|----|-----------------------|----------|------------------|---------|--------------------|
| 1  | Contractual Relation  | a. No informed consent; b. Breach of contract, including standard of care; c. Good faith; d. No error; e. Injury or loss | a. Problems of competence; b. Errors or negligence in implementing the standard of care; c. Differences in perception; d. Less or inappropriate communication; e. Promising something medically or clinically not a sure thing | Patients proving | Court or Alternative Dispute Resolution |
| 2  | Not Contractual Relation | a. No informed consent; b. Breach of standard of care; c. Good faith; d. No error; e. Injury or loss | a. Problems of competence; b. Errors or negligence in implementing the standard of care; c. Differences in perception; d. Less or inappropriate communication | Patients proving or Health Profession als proofing | Court |

CONCLUSIONS

1. Medical malpractice is private law relation, particularly in the legal field of wealth. Medical malpractice is a wrong practice, either because of errors or negligence made by the medical doctors or other health professionals, whether derived from consent or not, which occurs during or as a result in providing medical professional services in accordance with his or her expertise and ability, and if it is violated and results in injury or loss for the patients, it is obliged to provide compensation to the patients.

In the context of Indonesian law it can be said that the medical malpractice is a contractual relation; with exceptions for specific things, explicitly stated by law that it can take the form of non-contractual relation.

2. An action is called as medical malpractice if it meets the following criteria:
   a. The medical action performed is not based on informed consent;
   b. The medical action performed is not in accordance with the standard of care;
   c. The medical action is not performed based on the precautionary principle;
   d. There is error or negligence the in medical action;
   e. The medical action causes direct loss in patients.

3. Medical malpractice can be divided into:
   a. Medical malpractice as a breach of a contractual relation;
   b. Medical malpractice as a breach of fiduciary relation protected by law (tort).

4. Medical malpractice may occur due to:
   a. No competence;
   b. Error or negligence in implementing the standards of care;
   c. Differences in perception between the doctor or health professional and the patient about the process of providing health services performed;
   d. Less or inappropriate communication;
   e. Promising something medically or clinically it is not a sure thing.

5. Proving in medical malpractice is the burden of patients as a plaintiff. Evidence that can be used are:
   a. Written evidence;
   b. Witness;
   c. Expert testimony;
   d. The local inspection.

6. As tort, malpractice dispute resolution in healthcare is carried out through the courts. Meanwhile, as a contractual relation, malpractice dispute resolution in healthcare can be carried out through the district courts, alternative dispute resolution, and arbitration. Choice of disputes resolution through alternative dispute resolution, and arbitration will (in absolute terms) cease the right of court to handle and settle the case. With the existence of these clauses in the contractual relation, the disputes resolution of medical malpractice can be better, faster, more professional, confidential, not publicly exposed, and appreciated by the disputing parties, including the medical doctors or health professionals and patients.

SUGGESTIONS

1. For the Ministry of Health, Indonesian Medical Doctor Association (IDI), Indonesian Dental Association (PDGI) and all related professional institutions, to make the relation between medical doctor or other health professionals and patients as a contractual relation that allows the settlement of malpractice disputes in healthcare out of court.

2. For Universities, both State Universities and Private Universities, to provide “communication” subjects in their curriculum.

3. For medical doctors and health professionals providing health care services, to avoid giving promise in providing medical care, especially for something which is clinically cannot be proven.

4. For related stakeholders, to create and establish Institute, Agency or Center for Alternative Dispute Resolution and Arbitration to resolve malpractice disputes in healthcare.

5. For the Government and the House of People’s Representatives, to insert the rules of medical
malpractice and its alternative resolution in Health Act, Medical Practice Act and Hospital Act through amendment, or make new Acts that can unify the entire profession of health professionals with malpractice rules in healthcare including its resolution firmly.

6. For other researchers, to conduct further research on alternative dispute resolution in medical malpractice among various options, i.e. negotiation, mediationconciliation or arbitration.

Further promotion to stakeholders is need in the form of seminars and similar events in order to obtain a better understanding of medical malpractice.

REFERENCES

1. Cottam, Daniel. et.al. 2007. “Medicallegal Analysis of 100 malpractice claims against bariatric surgeons, Surgery for Obesity and Related Diseases 3”, (n.p), 60-67.
2. Parwadianto, Agus. 2007. “The More Transparent Health Regulation in Indonesia”, power point presented in Phitsanulok Meeting of 22 June 2007.
3. U. S. Congress, Office of the Technology Assessment. 1993. Impact of Legal Reforms on Medical Malpractice Costs. OTA- BP-H-119. Washington DC: U.S. Government Printing Office.
4. GAO-03-836. 2003. Medical Malpractice and Implications of Rising Premiums on Access to Health Care. Washington: US GAO.
5. Hennes, Katherine. 2004. “The Effects of Malpractice Tort Reform on Defensive Medicine” Issues in Political Economy. Vol. 13.
6. Shultz, Ity. 2010. “The Impact of Malpractice Litigation on Physician Behavior: The Case of Childbirth, UC Berkeley”.
7. Morreim, Haavi 2011 "Medical Liability Reform in Oregon: A Legal Analysis of Oregon’s Medical Practice Act and Hospital Act through Regulation in Indonesia”, power point published as web resource 22 Januari. 2007.
8. National Arbitration Forum. 2005. Mediating And Arbitrating Healthcare Disputes, Includes Practical Tips And Model Ad/Language.
9. Benesch, Katherine. 2011. “Why ADR And Not Litigation For Healthcare Disputes?”, Health Care, August/October 2011.
10. Holman, Mirya. et.al. 2011. “Most Claims Settle: Implications For Alternative Dispute Resolution From A Profile Of Medical-Malpractice Claims In Florida”. Law And Contemporary Problems, Vol. 74:103 Summer, 103-133.
11. Maslow, A.H. 1943. “A Theory of Human Motivation”. Psychological Review, 50, 380-381.
12. Van Wagner, Kendra. “The Five Levels of Maslow’s Hierarchy of Needs”. about.com.
13. Ronnow-Rasmussen, T., Petersson, B., Josefsson, J. & Egonsson, D. 2007. (Eds.) Hommage a Wlodek: 60 Philosophical Papers Dedicated to Wlodek Rabinowicz – published as web resource only. Lund University, Department of Philosophy.
14. World Health Organization. 1947. “Constitution of the World Health Organization”. Chronicle of the World Health Organization, 1/1–2.
15. Bloomfield, P. 2001. Moral Reality. New York: Oxford University Press.
16. Boorse, C. 1997. “A rebuttal on health,” in J. M. Humber and R. F. Almeder (Eds.), What is disease?, Totowa, NJ: Humana Press, 3–143.
17. Bilton, T. Et al. 2002 Introductory Sociology. 4th edition. Basingstoke: Palgrave Macmillan.
18. Jennings, D. 1986. “The confusion between disease and illness in clinical medicine.” Can Med Assoc J, 135: 865-870.
19. Rosenstock, IM. 1974. “Historical origins of the Health Belief Model”. Health Educ Monogr, 2:328-335.
20. Hui, EC. 2005. “Doctors as fiduciaries: a legal construct of the patient physician Relationship”. Hong Kong Med Journal, Vol 11 No 6 December.
21. Zilber, Claire. (n.d.) “Ethics And The Doctor-Patient Relationship”.
22. Francis, Leslie Pickering. 2010. “The Physician-Patient Relationship and a National Health Information Network.” Journal of Law, Medicine and Ethics, Spring: 36-49.
23. Stewart M, and Roter D (eds). 1989. Communicating with medical patients. London: Sage.
24. Maguire, Kath. (n.d.) “Doctor/patient relations”, Sociologies of HealthIllnessE-Learning Databank www.medgraphics.cam.ac.uk/shield/.
25. Garner,Bryan A. 2004. Black’s Law Dictionary (8th ed.). St. Paul: West Publishing Co.
26. Shamir, Yona. (n.d.) “Alternative Dispute Resolution Approaches and Their Application.” UNESCO Report.
27. Creswell, John W. 2009 Research Design: Qualitative, Quantitative and Mixed Methods Approaches. California: Sage Publication Inc.
28. Black, Henry Campbell. 1990. Black’s Law Dictionary (6th ed.). Mine: West Pub.
29. Vukmir RB. 2004 “Medical Malpractice: Managing the Risk”. Med Law 23:495-513 quotes Blackstone W. (1768) Commentaries on the Laws of England. Vol.3. Oxford, England: Clarendon Press, 122.
30. Buditti, Peter P. and Teresa M. Waters. 2005. Medical Malpractice Law in the United States. California: Kaiser Family Foundation.
31. O’Connor, Viviene. (n.d.) “Common Law and Civil Law Traditions”. INPROL.
32. McNaught, Joseph, Amy Alpauagh and David Hicks. 2012. “Medical Liability Reform in Oregon: A Legal Analysis of Several Alternatives under Oregon Law.” Oregon DoJ, 6 Januari.
33. Bal, B. Sonny. 2009. “An Introduction to Medical Malpractice in the United States.” Clinical Orthop Relat Res, 467:339-347.
34. Dearmon, Valerie. (n.d.) “15 Risk Management and Legal Issues.” Jones and Bartlett Pub. LLC, 470-493.
35. Tan, SY. 2006. Medical Malpractice. Singapore: World Scientific Publishing.
36. Thirumoorthy, T. 2011. “Understanding Medical Negligence and Litigation – Basic for the Medical Professional.” BMA News, 12-13.
37. Stauoch, Mare S. 2011. “Medical Malpractice and Compensation in Germany.” Chicago-Kent Law Review, Vol.86:3, 1139-1168.
38. H. Warendorf, R. Thomas en I. Curry-Sumer. (2009). Civil Code of the Netherlands. Deventer: Kluwer.
39. Janes, Carol Sue. 2011. “Chapter 8 Medical Malpractice Liability.” Washington Health Law Manual, 3rd ed. WSSH.