VILNIUS UNIVERSITY

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PATIENTS' RIGHTS TO QUALITY IN HEALTH CARE AND HEALTH DAMAGE COMPENSATION

Summary of Doctoral Dissertation
Biomedical Sciences, Public Health (10 B)

Vilnius, 2010

The doctoral dissertation was prepared at Public Health Institute of Vilnius University in 2004-2009

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The summary of the doctoral dissertation was sent on 30 March of the year 2010.
There is the possibility to get familiar with the dissertation in the library of Vilnius University. Address: Universiteto 3, LT-01122, Vilnius, Lithuania.

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PACIENTO TEISĖS Į KOKYBIŠKĄ SVEIKATOS PRIEŽIŪROS PASLAUGĄ IR ŽALOS SVEIKATAI ATLYGINIMĄ

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“Understanding and respecting patients’ values, preferences and expressed needs is the foundation of patient - centered care.” – Harvey Picker http://www.pickerinstitute.org/

RELEVANCE OF THE DISSERTATION

Over the past ten years, the health system in all countries is undergoing a patients' rights "revolution". Various human rights‘ initiatives demonstrate exceptional focus on the fundamental human right to health and life. Also significant and important become other patients' rights: the right to information, informed consent, choice, the right to be heard, the right to affordable health care and health care of good quality, privacy, confidentiality, the right to complain and claim for compensation for health damage. Increasingly stronger patient position in health care is particularly actively developing the principle of the patient's autonomy and their right to participate in the decision making regarding their care.

The patients' rights policy is closely linked to the reorganization of the health sector in the country. Inefficient implementation of health care reform may prevent securing and actually implementing many of the patients' rights. In the management of the process of the achievement of goals and objectives of health care reform, the Lithuanian health politicians pay particular attention to the improvement of accessibility of services in all levels of health care, ensuring the patients' rights and the quality of service. Research projects are being focused on the situation analysis of the patients' rights, and activation of the public. Ensuring the realization of the patients' rights reflects the performance of the state health care system.

It is notable that two of the patients' rights presenting a comprehensive discussion today have been selected out of this wide set of patients 'rights: right to quality in health care and health damage compensation. Exclusive media coverage to so-called medical malpractice, patient complaints about poor quality of health care, rising number of claims for medical malpractice, staggering rates of malpractice suits show that there are disruptions in the assurance and implementation of these rights in practice.

THE AIM OF THE DISSERTATION: to examine and evaluate the opportunities of patients treated at in-patient healthcare institutions to realize their right to health care of good quality and opportunities of patients who have filed a malpractice claim in the court, to realize their right to health damage compensation.

To achieve this objective of the work, the following tasks were initiated:

1. To analyze the statutory regulation of the patient‘s rights to health care services of good quality and health damage compensation in Lithuania, and to compare their basic principles with international and European patients' rights legislation.
2. To examine and assess the patients' opinions on the quality of health care provided to them at in-patient healthcare institutions, to identify the shortcomings in the quality of health care from the patient's perspective and to provide legal and managerial assumptions to improve the quality of services.
3. To analyze the medical malpractice litigation cases of general jurisdiction courts of the Republic of Lithuania in terms of the principles of health damage compensation,

procedural characteristics and efficiency, by revealing the problem aspects and to provide possible decisions of regulatory and practical implementation.

SCIENTIFIC INNOVATION OF THE RESULTS

This work is a scientific assessment of the implementation of the patients‘ rights to quality in health care and health damage compensation in Lithuania, where the functioning of two patients' rights is assessed in a systematic and integrated manner, both in the medical and the legal aspect. This provides assumptions to propose harmonized legal and management trends for the improvement of the implementation of the patients' rights.

This paper scientifically assesses the quality of health care from the patients perspective through the use of biomedical and social science methodologies. It contains the adapted questionnaire of Picker Institute used in scientific research in many countries for patients treated in in-patient facilities, which can be successfully applied for future research in Lithuania, comparing the national and the European experience in terms of quality in the health care.

Legal relations pertaining to the provision of health care services constitute a separate health law institute; therefore this research work is important to the theory and practice of the health law science. One has to admit that in Lithuania the health law institute lacks the science of law. It is underdeveloped and creates assumptions for different interpretation of the statutory content of patients 'rights, including the disadvantages for the implementation of the patients' rights. For this scientific research the author has chosen the first five years of the malpractice litigation cases in settling disputes on the health damage compensations. This is the first continuous scientific assessment of medical civil liability in Lithuania.

DISSERTATION STATEMENTS TO BE DEFENDED

1. Legislative patients' rights regulation provides a mechanism for their implementation.
2. In-patients realize their right to quality in health care services.
3. The judicial protection of the violated right to quality in health care is ensured, which helps patients realize their right to health damage compensation.

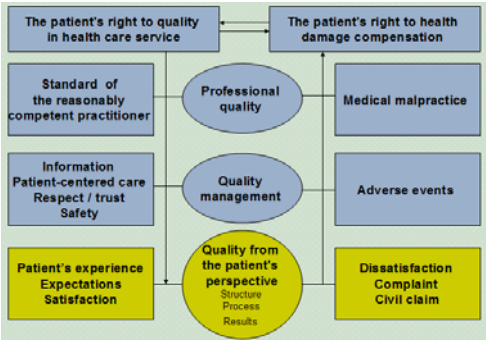

Figure 1 . Theoretical model of patients' rights implementation

REVIEW OF RESEARCH LITERATURE

Search of scientific literature covered the period from 01-01-1998 till 31-12-2009 and was carried out in electronic databases: Medline (PubMed), Embase, PsychINFO, EBSCO, Web of Science, Medline/Ovid, Cochrane Library. In the initial stage the search of literature was carried out in Medline and Embase databases using the two key word groups:

1. *Patient rights, Medical law & legislation, quality of care, in-patient questionnaires, patients experience and perspective*
2. *Patient rights, Medical law & legislation, personal injury compensation, medical malpractice litigation, no-fault compensation*

In addition to the sources of literature received from databases, the work contains the analysis of the Lithuanian and foreign legislation on patients' rights to quality in health care services and health damage compensation. The author, recognizing the legal research priority, however intending to present a comprehensive view on the patients' rights institute, also used provisions and statements of health policy, since the health reforms directly affect the patient's legal situation. Literature review covered 371 foreign and Lithuanian sources.

MATERIAL AND METHODS

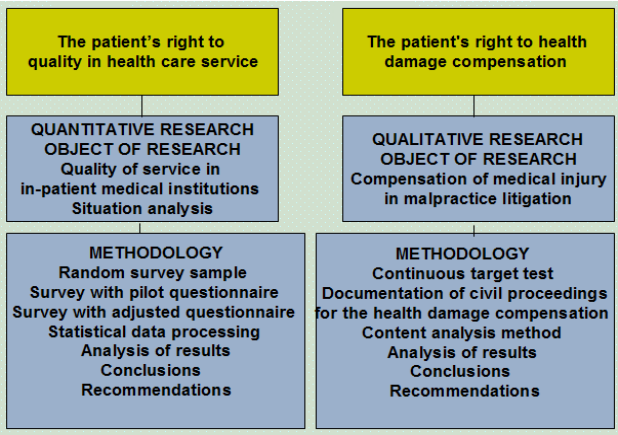

Figure 2. Research scheme

PATIENT'S RIGHT TO QUALITY IN HEALTH CARE SERVICE

Research sample. The research was conducted in 22 general inpatient health care institutions (thereinafter - HCI). The sampling was construed on the basis of the stratified multistage probability method. Depending on the service level, general hospitals were divided into homogeneous strata: university hospitals, county (city) hospitals and district hospitals. Random sampling of in-patient HCI was carried out

within each strata. Thus, the sampling included four university, six county (city) and twelve district in-patient HCI. Sample size is calculated by applying the confidence intervals of the general sample characteristics according to the forecasted hospital morbidity. The number of questionnaires was distributed among homogeneous strata on the basis of the hospital morbidity ratio (1:1.6:1.3), which is calculated in accordance with the statistics of the Lithuanian Health Information Centre of 2005. In the case of the research group of patients – respondents who were discharged from hospital, the sample included each leaving patient who received treatment in an in-patient HCI internal and surgery departments for more than 24 hours. The applied principle: the patient completes the questionnaire on the day of discharge from hospital to home, if his health allows him to do it himself.

Study participants. 2060 questionnaires were distributed. 2006 patients returned the questionnaires, i.e. 97.38 percent of the surveyed patients. 1917 questionnaires or 93.06 percent of the distributed questionnaires were suitable for the statistical analysis. The study included 43.7 percent of men (n = 837) and 56.3 percent of women (n = 1080). The largest age group (42.5 percent of respondents) was between 51 and 70 years old, slightly smaller (37.8 percent) – from 31 to 50 years old. In all age groups, the distribution between men and women is very similar except the age group above 70 years (81 men and 118 women). More than half of the respondents had secondary or college education (54.3 percent n = 1040). 29 percent of respondents were retired (n = 555), 17.6 percent – employees of state-owned enterprises (n = 337), 17.5 percent of employees from the private sector (n = 335). The largest group consisted of the respondents whose income was from LTL 500 to 1000 per month (41.7 percent of all respondents). In this group the ratio of men and women was similar (42.8 percent of men and 40.9 percent of women).

More than half of respondents (61.9 percent, n = 1186) came to the HCI as a matter of urgency, the hospitalisation of 38.1% of them was scheduled. More often respondents were admitted to the therapy departments (58.3 percent, n = 1117).

Method of the investigation. Anonymous survey-questionnaire was used to interview patients.

Tool of the investigation. The modified Picker Institute‘s questionnaire was used for the scientific research of patients treated in hospital. Questions with regard to national health care quality program were collected from the Picker Patient Experience Questionnaire. On 20-02-2006 – 28-02-2006, a pilot study was conducted at Vilnius University Santariškės Hospital on the day of patient's discharge from the hospital. The survey with pilot questionnaire was conducted in a direct interview method. 32 patients were interviewed. The questionnaire was adjusted and approved by the Institute of Public Health of Vilnius University. The modified questionnaire of the Picker Institute Europe applied in this study consisted of 34 closed-end questions, which reflected the patient opinion in the assessment of their health care quality services. Additionally, basic data on socio-demographic characteristics of respondents were collected. The survey with modified questionnaire was carried out in November 2006 – February 2007.

Statistical data processing. Statistical data analysis was performed on a personal computer using the version 15 of SPSS software for statistical analysis (Statistical Package for Social Sciences), Microsoft Office Excel 2003, JMP version 7 (SAS / Statistical Analysis System version), Chernoff Faces program. Answers to questions were encoded, and data was entered into the SPSS statistical package program tables for

statistical data processing and analysis. The encoding of data complied with the general principle: the minimum value was assigned to the worst answer, the highest value – to the best answer. In patient questionnaires the answer "very good" was coded as 5, "good" – 4, "satisfactory" – 3 "bad" – 2, "very bad" – 1. To sum up some of the research results and comparing with similar surveys in other countries, respondent answers were dichotomised, i.e. evaluations "very good" and "good" were summed up and regarded as a positive assessment, and evaluations of "bad" and "very bad" were summed up and considered as a negative assessment. For the evaluation of reliability of the questionnaire, the Cronbach alpha was calculated – 0.79. With the purpose of grouping the questions provided in the questionnaire so that each of them individually exploratory reflects a certain dimension of service quality measurement, the factor analysis method was applied. Adequacy of the correlation matrix of selected variables to the factor analysis was assessed by calculating the Bartlet's test of sphericity – 6487.156, df=136; $p<0.0001$. Kaiser-Meyer-Olkin (KMO = 0.81) measure of sampling adequacy showed that the variables are adequate for factor analysis. The factor analysis method allowed to identify four factors (the quality measurement dimensions): the first factor included the patients' and doctors' communicative relationship, the second – organization and coordination of health care services. The third factor consisted of the questions on the procedure of discharge from hospital. The fourth was the physical environment and comfort rating. The fifth and the sixth dimensions of quality measurement were obtained by grouping the questions which in itself marked a clear and undeniable dimension: the fifth dimension – access to a scheduled hospitalization, the sixth – patient safety (questions on the experience of the fact of damage to health). The dimensions and indicators' scheme of the health care quality assessment was drafted (Fig. 3) which the author followed in presenting the patient attitudes on health care quality assessment.

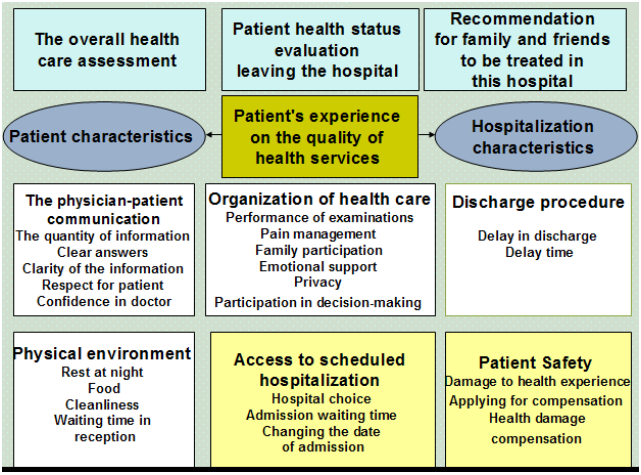

Figure 3. Dimensions and indicators scheme of health care quality assessment

When applying the binary logistic regression approach, three general categories of quality assessment were selected as dependent variables (the overall health care

assessment, own health status assessment leaving the hospital and recommendations for treatment in this hospital for family and friends.) They were re-coded in the two values: 1 and 0 (“*positive assessment“* and *“assessment otherwise*"). Evaluations of these key quality indicators were linked to factors / dimensions isolated through the factor analysis. All three regression equations were statistically significant according to the general criterion of regression coefficients (omnibus test), $p < 0.001$. In order to statistically justify what quality indicators or other factors mainly influenced positive or negative patients‘ assessment of the quality of service, crosstabulations were applied. Chi-square test (χ^2) of associated variables was used. Differences between particular indicators are considered statistically significant when the calculated statistical significance is $p \leq 0.05$. Spearman's rank correlation coefficient showing the direction and strength of the statistical relation was used for the search of the statistical-correlation relationship between variables.

RESULTS

The research results are presented in accordance with the above-mentioned scheme of health care quality assessment dimensions and indicators (Fig. 3).

Key characteristics of health care quality assessment.

When assessing the quality of the overall health care provided, 47.4 percent of respondents assessed hospital services as good, 44.5 percent – very good (Fig. 4)

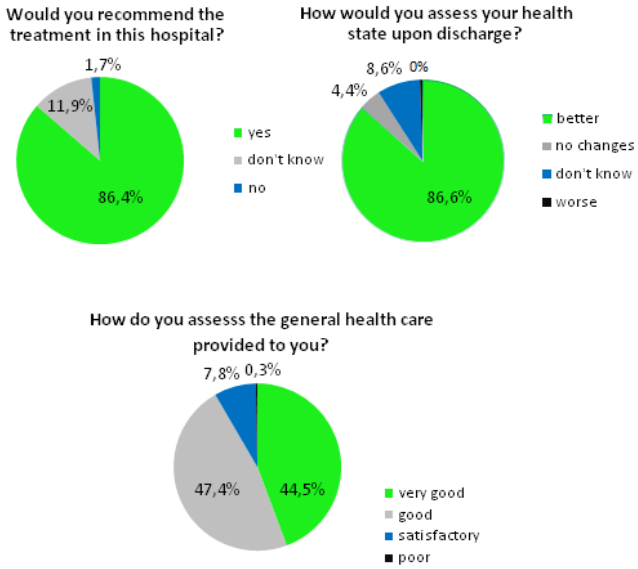

Figure 4. Distribution of the key characteristics of the health care quality assessment

A statistically significant correlation between patients' assessment and the type of HCI in which the services were provided, was determined ($p = 0.002$). The survey shows that

patients treated in district hospitals most often were assessing overall health care services as good or satisfactory, and services in the county health centres were evaluated very well by every fourth patient. In university hospitals, patient assessments divided equally between satisfactory, good, and very good.

For 86.6 percent patients' health status, in their opinion, was better when leaving the hospital compared to the arrival at hospital. 13 percent of respondents consider their health state did not change after treatment on the moment of leaving the hospital or they had difficulties in judging their health status changes. A statistically significant relationship was found between opinions of respondents about their health status before leaving the hospital and the type of HCI ($p = 0.001$). Better health state before departure was more often indicated by patients who were discharged from county hospitals. Worse evaluation results of health status in university hospitals could result of the fact that university hospitals generally treat patients with more severe health condition.

The intention to recommend the service provider to other patients suggests that the patient positively evaluates his or her health care. The survey data show that 86.4 percent of respondents would recommend their family and friends the medical treatment in the hospital where they have received treatment. A statistically significant association between the intention to provide recommendations for medical treatment in particular hospital and the type of HCI was determined ($p < 0.000$). Less frequently the recommendation would be given by patients treated in district hospitals, more often – by patients who were treated in the county or city hospitals.

Health care quality assessment by the dimensions of the services provided.

Patients' opinions on the quality of health care services were assessed on a scale (0-100) according to the quality dimensions.

Table 1. Descriptive statistics of the health care quality dimensions

		Communication	Organisation	Discharge	Physical environment	Accessibility
Number of respondents:	responded	1917	1917	1917	1917	734
	not responded	0	0	0	0	1183
Average		**91.64**	**77.68**	**83.46**	**75.03**	**87.80**
Standard mean error		.34	.36	.59	.37	.59
Median		100.00	80.00	100.00	77.78	100.00
Mode		100.00	95.00	100.00	72.22	100.00
Standard deviation		14.90	15.90	25.91	16.23	16.00
Minimum		9.09	15.00	.00	16.67	28.57
Maximum		100.00	100.00	100.00	100.00	100.00

By analogy, the evaluation of quality dimensions was made separately for respondents who have been treated in university, county or city and district hospitals. Comparison of the assessment of quality dimensions by the type of HCI was done by applying the *Chernoff Faces* method.

Doctor-patient communication was very similar in university and county hospitals (92.29 and 92.66), but was valued worse in district hospitals (90.07). It is noted that he

organization / coordination of health care is best assessed by patients treated in county hospitals (79.31) and worse by patients from district hospitals (75.68). In the assessment of hospital discharge procedure, there were slight differences in estimates among respondents from university and county or city hospitals, the lowest score was obtained from the respondents treated in district hospitals (82.09). Physical environment and comfort was a quality dimension which in all types of hospitals was rated the worst. When comparing the survey results by the type of HCI, the physical environment and comfort services were assessed worse in university hospitals (72.31). Availability of scheduled hospitalizations was best evaluated by the respondents from county or city hospitals (89.53).

Health care service quality assessment by indicators.

Dimensions of the quality of health care consisted of the indicators (questions) that analyzed how they were every single time assessed by respondents. Assessment results of all dimensions of quality indicators are presented in Table 2.

Table 2. Assessment of health care services quality from patients' perspective

Dimensions / Indicators	Positive assessment (good and very good)		Negative assessment (poor and very poor)	
	n	percent (PI)	n	percent
Key characteristics of quality				
Overall quality assessment	**1761**	**91.9 (90.6-93.1)**	5	0.3
Health state upon discharge	**1660**	**86.6 (85.1-88.1)**	9	0.5
Recommendation for family/friends to be treated in this hospital	**1657**	**86.4 (84.9-88.0)**	32	5.2
1. Physicians and patients' communication				
1.1. Quantity of information	**1739**	**90.7 (89.4-92.0)**	162	8.5
1.2. Clear answers of doctors	1462	76.3 (74.4-78.2)	24	1.3
1.3. Clarity of information	**1646**	**85.9 (84.3-87.4)**	47	2.5
1.4. Respect for patient	**1690**	**88.2 (86.7-89.6)**	25	1.3
1.5. Confidence in doctor	**1704**	**88.9 (87.5-90.3)**	18	0.9
2. Organization / coordination of care				
2.1. Family member / relative participation in the treatment process	1277	66.6 (64.5-68.7)	40	2.1
2.2. Analyses and tests	1509	78.7 (76.9-80.5)	31	1.6
2.3. Pain management	**1577**	**82.3 (80.6-84.0)**	19	1.0
2.4. Emotional support	**1620**	**84.5 (82.9-86.1)**	47	2.5
2.5. Privacy	1012	52.8 (50.6-55.0)	**192**	**10.0**
2.6. Participation in decision-making	878	45.8 (43.6-48.0)	**285**	**14.9**
3. Discharge procedure				
3.1. Delay of discharge (was / was not on hold)	1297	67.7(65.6-69.8)	**620**	**32.3**

4. Physical environment, comfort				
4.1. Noise at night	1508	78.8 (76.8-80.5)	**368**	**19.2**
4.2. Cleanliness of ancillary premises	**1747**	**91.1 (89.9-92.4)**	147	7.7
4.3. Food	1208	63.0 (60.9-65.2)	120	6.3
4.4. Reception room waiting time	1076	56.1 (53.9-58.4)	**282**	**14.7**
5. Access to scheduled hospitalization (743 respondents)				
5.1. Hospital choice	490	66.8 (62.5-69.4)	**141**	**19.2**
5.2. Waiting time for scheduled admission	580	79.0 (75.1-81.0)	32	4.4
5.3. Changing the date of scheduled admission	**684**	**93.2 (90.1-94.0)**	5	0.6
6. Health damage compensation / safety				
6.1. Damage to health experience	**1795**	**93.6 (92.5-94.7)**	122	6.4

Note: patient assessment "satisfactory", "no opinion“, I do not care," "somewhat," "sometimes" are not presented in the table.

Comparing the answers of patients who took part in this study on their communication with doctors and the results of other quality dimensions, the communication of patients and physicians was assessed the best. Even 90.7 percent respondents believe that they were given sufficient information, which was both understandable (76.3 percent), and clear (85.9 percent). 88.2 percent of respondents think that doctors treated their patients respectfully. It could be assumed that this resulted in patients' confidence in the physicians (88.9 percent). Percentage distribution of the communication indicators of physicians and patients is presented in Figure 5.

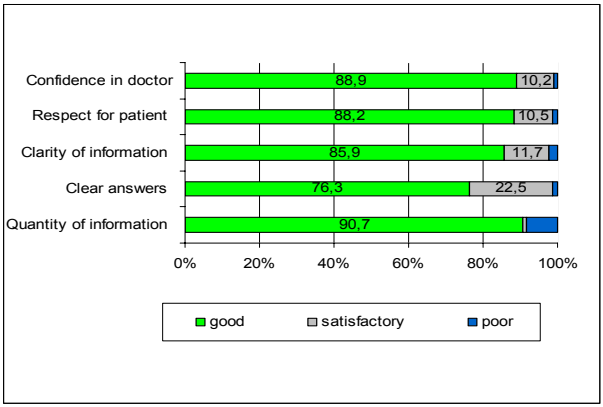

Figure 5. Respondents opinion about their and doctors' communication

The results show that individual aspects of care and organization were evaluated differently by the respondents. Percentage distribution of indicators is presented in Figure 6.

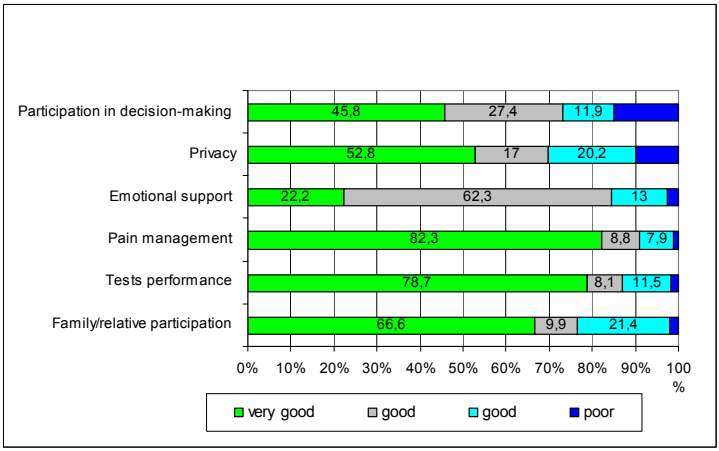

Figure 6. Respondents opinion on health care organization and coordination

The absolute majority of patients felt that the staff did everything possible to reduce pain (82.3 percent), to nearly every ninth patient the pain was relieve only partial (8.8 percent). The survey data shows that respondents also appreciated timely analyses and tests. As much as 78.7 percent of respondents noted that analyses and tests were always carried out in time, 8.1 percent respondents noted that tests were not always carried out at the time scheduled by a doctor.

Two-thirds of respondents indicated that their family members wanted to and had every opportunity to participate in the discussion of his health state and care (66.6 percent). 23.5 percent of the respondents either did not want themselves or did not wish their family members to participate in the treatment process, 9.9 percent of participants in the survey said that their family members were not provided all opportunities to talk with doctor. When responding to a question about privacy, 20.2 percent of respondents indicated that privacy generally was not important to them. For every tenth respondent, privacy was not guaranteed when discussing his health state and treatment (10.0 percent). 52.8 percent of respondents said that there was sufficient privacy when discussing their condition or treatment. 45.8 percent respondents indicated that they indeed participated in decision-making, 27.4 percent of the respondents were more sceptical about their potential to participate in this process (they were somewhat involved), 11.9 percent of respondents generally did not want to participate, while 14.9 percent of respondents indicated that they were not able to participate as far as they wanted. In the treatment process, emotional support of medical staff is very important for patients. 22.2 percent of the respondents stated that the emotional support was provided to them by doctors and nurses. 47.4 percent of the patients were reassured by doctors, 14.9 percent – by nurses (62.3 percent). 13 percent of respondents indicated they had no worries during their hospital treatment.

Physical environment and comfort have a significant impact on the assessment of health care quality Assessment of each indicator of this dimension from the patients‘ perspective is illustrated in Figure 7.

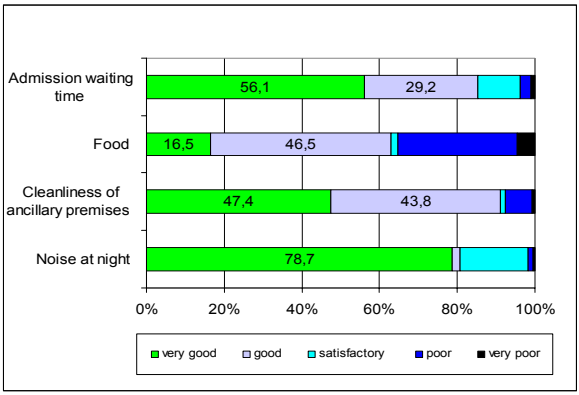

Figure 7. Respondents opinion on the physical environment and comfort at the hospital

Although very good and good rating of hospital food was 63 percent, a third of the respondents considered it to be satisfactory (30.7 percent), 4.5 percent of respondents assessed the food as poor (1.8 percent did not eat the hospital food). Toilet and bathroom cleanliness was evaluated by 91.2 percent of respondents very good and good, 7.7, percent stated that the facilities were not very clean or completely dirty. 78.7 percent of respondents were not bothered about noise at night, others noted that at night they were bothered by the noise from other patients (17.4 percent). During the survey respondents were asked how much time, after their arrival to the hospital, they waited until they got to the ward. 56.2 percent of the participants in the survey were admitted to the ward immediately or after waiting less than 20 minutes, 6.3 percent of respondents waited for up to one hour, but as many as 13.8 percent of patients were only admitted to the ward after waiting in the department for 1 to 4 hours.

The survey results showed that respondents positively assessed the availability of scheduled hospitalization. Percentage distribution of answers is presented in Figure 8.

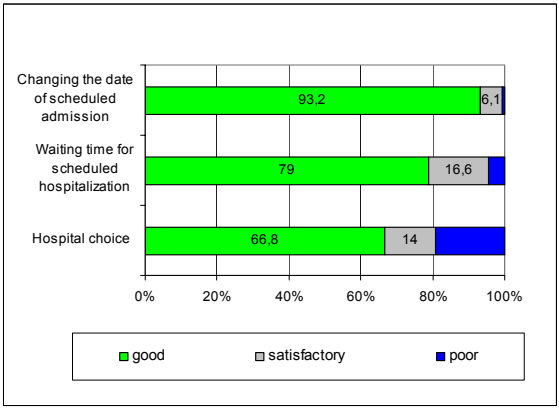

Figure 8. Respondents opinion on the accessibility of scheduled hospitalization

In the opinion of 79.0 percent of respondents, they have been hospitalized as soon as they thought it was necessary, 16.6 percent feel they had to be hospitalized a little faster. The right to choose HCI has been implemented by 66.8 percent of respondents, but 19.2 percent of respondents indicate that this right has been violated: they could not choose the hospital for scheduled treatment. In as many as 93.2 percent of cases, the scheduled hospital admissions date has not been changed, in 6.1 percent cases, it has been changed, once, and only in 0.6 percent of cases, patients had to travel to hospital three or more times.

Assessing the discharge procedure, the delay time and the reason for the delay of patients in the hospital were analyzed in detail. 32.3 percent of respondents were held on the day of discharge from hospital. One-third of held patients had to wait for doctor's statement, almost a fifth – for a prescription from the doctor. In most cases patients were hold up to one hour (58.1 percent), but there were cases where the procedure of discharge would last for more than four hours (2.6 percent, n = 16). Hold-up of patients being discharged from therapeutic divisions was more frequent than in surgical divisions.

The patient questionnaire included questions aimed at evaluation of one of the most important dimensions of quality of health care services – the patient safety. The vast majority of patients surveyed indicated that they did not experience health damage when receiving health care services (93.6 percent, i.e. 1795 respondents). Only 6.4 percent of respondents (n = 122) noted that in general they have suffered malpractice in the past. The results showed that the majority of affected patients (90.2 percent, n = 110) did not seek for the compensation for medical injuries and did not contact any institutions. Of the twelve respondents who sought health damage compensation, only four respondents received partial or full reimbursement for damage to health. Almost half of respondents who have suffered damage indicated that they are frustrated about the system of health damage compensation in Lithuania and seeking compensation, in their view, would not bring any results (49 cases out of 110). A third of respondents believe that the desire to be compensated for health damage would have negative consequences in their further relationship with a doctor or a medical institution, and therefore, in their view, it is not worth seeking compensation. Every sixth respondent would have sought compensation, if he / she knew what institution to contact.

Factors influencing the assessment of quality in health care services.

The *binary logistic regression* was established between the key assessment characteristics and quality factor dimensions and social demographic indicators. Three regression equations resulted. The regression model enabled to predict the values of dependent variables with two values (overall evaluation, health state upon discharge and the recommendation for family/friends) from the values of independent variables (quality dimensions and patient socio-demographic characteristics). Risk factors for key health care quality evaluation characteristics are displayed graphically in Figure 9.

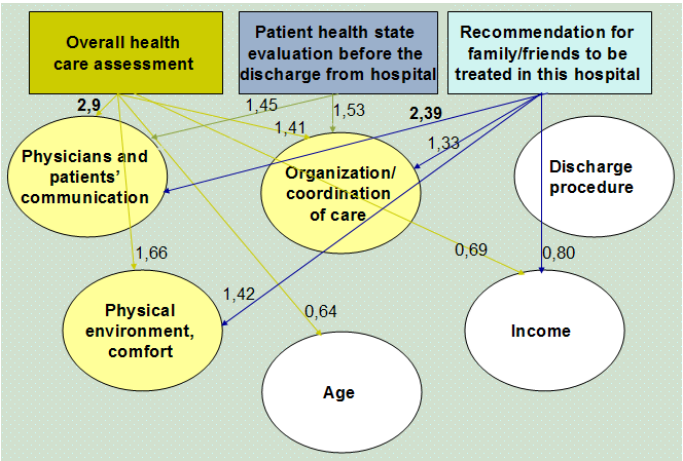

Figure 9. Risks of the key health care quality evaluation characteristics (scheme of binary logistic regression)

The first two dimensions are statistically significant ($p < 0.002$) in each regression analysis equations: with improving patient and doctor communication, as well as improving organization and coordination of health care services, increases the likelihood that the patient generally assesses the service quality, health improvement well, and recommends treatment for family/friends (if necessary). Delay of the discharge procedure is not significantly related with any of the key characteristics of quality assessment. With improving physical environment, statistically significantly ($p < 0.001$) increases the likelihood that patients will better assess the quality of services and will recommend the treatment to relatives, however environment is not statistically significantly related with improvements in physical health state of patient. Age significantly affects only the overall quality of service assessment: with increasing age, the probability of good estimate decreases.

Income is significantly associated with the evaluation of quality of service as such (higher income reduces the likelihood of good evaluation of services, $p = 0.003$, and the likelihood that patient will recommend treatment to relatives, $p = 0.013$).

The study analyzed how much each service quality indicator influenced the key characteristics of the assessment, which reflected the patient's opinion about the quality of services provided. Therefore, the statistical correlation relationships of each of the quality indicators of health care services to the three key evaluation characteristics of the quality of health care services, was assessed. Link of quality indicators with the major evaluation characteristics of the quality of health care services, by calculating the Spearman‘s correlation coefficients, are presented in Table 3.

Table 3. Relationship between the key characteristics of quality assessment and quality indicators from the patient's perspective (Spearman's correlation coefficients)

Quality indicators	Key characteristics of the assessment		
	Overall rating	**Health condition**	**Recommendation treatment in this hospital**
1. Physicians and patients' communication			
Quantity of information	0.273	0.140	**0.300**
Clear answers	**0.348**	0.134	0.296
Clarity of information	0.271	0.104	0.260
Respect for patient	**0.380**	0.205	**0.374**
Confidence with doctor	**0.405**	0.184	**0.457**
2. Organization / coordination of care			
Family/relative participation in the treatment process	0.203	0.133	0.147
Tests performance	0.219	0.158	0.217
Pain management	0.285	0.150	0.269
Emotional support	0.173	0.104	0.097
Privacy	0.230	0.126	0.207
Participation in decision-making	0.282	0.110	0.202
3. Discharge procedure			
Delay in discharge	0.267	0.026**	0.144
Delay time	0.289	0.035**	0.157
4. Physical environment, comfort			
Noise at night	0.232	0.051*	0.192
Cleanliness of ancillary premises	**0.375**	0.083	0.207
Food	**0.372**	0.144	0.225
Admission waiting time	0.228	0.066*	0.141
5. Accessibility of scheduled hospitalization			
Hospital choice	0.213	0.070**	0.194
Waiting time for scheduled hospitalization	**0.320**	0.082*	0.290
Changing the date of scheduled hospitalization	0.116	0.031**	0.067**
6. Safety			
Health damage experience	0.081	0.094	0.090

Statistical significance level p <0.001 of Spearman's correlation coefficients (ρ) except
*- *p<0.05 but >0.001*
**- *p>0.05*

After summarising the data presented in the table one can see that the patients' opinions on the quality of health services was mainly affected by the confidence with doctors, doctors' respect for patients, understandable information, cleanliness of auxiliary premises, food and the waiting time for scheduled hospitalization. Patients who felt more confidence with doctors, were shown respect and who received enough information about their health state and treatment, are more likely to recommend to their family/relative to receive treatment in the same hospital.

Patient characteristics (age, sex, education, occupation, income) and hospitalization characteristics (treatment profile and hospitalization type) are the factors that also may affect the patient's views on health care quality. The correlation method was applied to determine whether the socio-demographic characteristics affect individual indicators of the service quality evaluation. No statistically significant gender differences were defined in the assessment of quality of services by indicators, but the patient age statistically significantly correlated with a number of quality indicators, although with a low strength: the timely tests and analysis (ρ =- 0.131, p <0.001), cleanliness assessment (ρ=-0.102 p<0.001), waiting time in the admission department (ρ =- 0.118, p <0.001) and emotional support (ρ =- 0.161, p <0.001).

The study analysed also other factors which may influence the patient's views on the quality of health care services. This is the treatment profile and hospitalization type. Patients treated in therapeutic divisions indicate that pain control was worse (ρ =- 0.39, p <0.001). Upon hospitalisation to the therapeutic division, the patient was less likely to choose HCI (ρ =- 0.48, p <0.001). Therapeutic divisions often take more time for the discharge procedure than surgery (ρ =- 0.04, p <0.001).

PATIENT'S RIGHT TO HEALTH DAMAGE COMPENSATION

Time of research: September-November 2006.
Object of research: right in health damage compensation, as one of the remedies of violated patients‘ rights and a constituent of the patients' rights institute
Subject matter of research: international and national legislation governing health damage compensation, practices of courts of general jurisdiction and the Lithuanian Supreme Court.
Number of cases: 32
Research method: general and specific legal research methods, statistical analysis
Method of the investigation: continuous research of medical malpractice litigation documents during the period of 2001-2005.
Research was carried out in the Civil Division of the Lithuanian Supreme Court.

The author, on the basis of the principles of qualitative research, described and interpreted the content and meaning of investigated lawsuits documents, applied detailed descriptions, classifications, examples of case episodes in the courts practice in other countries. Statistical data analysis was performed on a personal computer using the version 15 of SPSS software for statistical analysis (Statistical Package for Social Sciences), Microsoft Office Excel 2003, JMP version 7 (SAS / Statistical Analysis System version). The descriptive statistics are submitted according to the course of legal civil court procedure. Chi-square test (χ^2) of associated variables was used to assess statistical relations. Differences between particular indicators are considered statistically significant when the calculated statistical significance is $p \leq 0.05$.

The study analyzed the medical malpractice lawsuit cases in Lithuania during the period of 2001-2005. The Lithuanian Supreme Court administration contacted in writing the general jurisdiction courts of 54 district and 5 regional courts, requesting to submit all malpractice litigation cases examine during the period regarding health damage compensation, where court decisions were passed. A total of 8 district and 3 regional

courts submitted 32 cases of the category in question. 20 civil lawsuits at first instance were settled in district courts, 12– at regional courts.

In more than two thirds of the cases, defendants in the case for the compensation of injury to health were public inpatient HCI. The distribution of cases by type of institution is given in Table 4.

Table 4. Distribution of cases by year and type of health care institutions

Type of treatment facility	Year										Total	
	2001		2002		2003		2004		2005			
	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent
outpatient	0	0.0	0	0.0	3	42.9	0	0.0	6	40.0	**9**	**28.1**
inpatient	2	100.0	1	100.0	4	57.1	**7**	100.0	9	60.0	**23**	**71.9**
TOTAL	2	100.0	1	100.0	7	100.0	7	100.0	15	100.0	**32**	**100.0**

Nearly half of civil claims were filed against hospitals providing services of secondary level. The study shows that in 2005 the number of patients seeking compensation for damages has doubled compared to 2003 or 2004. This could result from the new version of the Law of the Health damage compensation to Patients of the Republic of Lithuania of 1 January 2005 which widely informed the public about the rights of patients and, of course, the right to health damage compensation. The three main characteristics were chosen for the assessment of the implementation of patient right to the reimbursement for health damage:

1. Court decision (in plaintiff's / defendant's favour)
2. Case duration (in months from the claim filing to the decision)
3. Compensation amount in litas (total damages, pecuniary and non-pecuniary)

The scheme of fundamental evaluation characteristics and factors likely to influence them is presented in Figure 10.

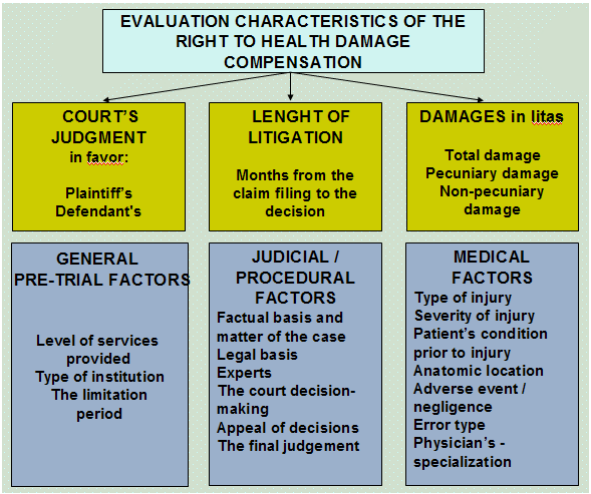

Figure 10. Civil case investigation scheme

RESULTS

Characteristics of the claim.

In most cases patients complained against medical actions, indicating that the doctor incompletely investigated their health state, made the wrong diagnosis, treated with negligence, improperly performed operation or other procedure, did not consult with his colleagues, did not inform the patient about methods of treatment, alternatives and possible consequences. The distribution of cases by factual base of claim is given in Figure 11.

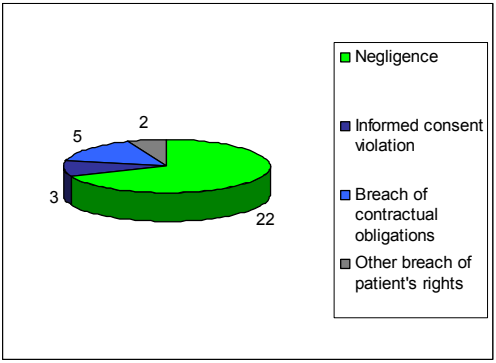

Figure 11. Distribution of cases by factual base of claim (number of cases)

In recent years, particularly active aspiration to seek non-pecuniary damages is observed in patients. In total, as many as 78 percent of plaintiffs (25 cases) required to compensate non-pecuniary damage. The average limitation period of the civil claim filing is 32.22 months.

Legal proceedings, their length of time.

Analysis of civil cases showed that as many as in 93.8 percent of cases the court hearings were attended by experts (30 cases of cases). The distribution of cases by participation of experts is given in Figure 12.

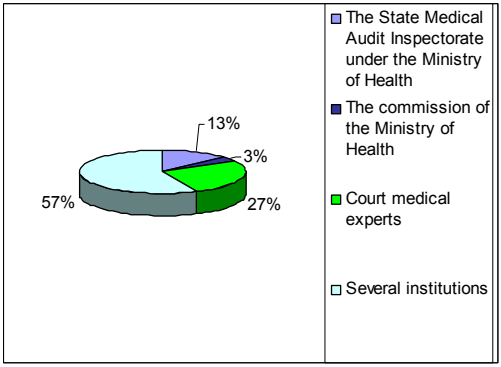

Figure 12. Distribution of cases by participating experts

More than half of the cases involved the participation of several expert bodies and the appointment of additional or complementary re-examinations. The largest number of examinations was carried out by forensic experts, they provided clear conclusions on the violation of the standard of the doctor's actions. The stringiest assessment of the legitimacy of doctor actions was done by the State Medical Audit Inspectorate under the Ministry of Health, in 77.8 percent of cases, determined violations of standards of conduct by doctors.

Important criterion of the evaluation of the patients right to compensation for damage to health is the length of time during which the patient defends his/ hers violated right to the quality in health care. The results of the carried out case analysis showed that the average time between filing a claim and the decision is 20.31 months. In 87 percent of cases of the civil procedure took up to three years. The results of the research showed that the average civil case length of time without the presence of experts is 4 months, and with the participation of experts – 22.3 months.

Table 5. Distribution of the number of expertises by length of civil litigation

Litigation length months	Number of expertises								Total	
	No expertise		One expertise		Two expertises		Three and more		n	percent
	n	percent	n	percent	n	percent	n	percent		
up to 12	2	18.2	**7**	**63.6**	2	18.2	0	.0	11	100.0
13-36	0	.0	4	23.5	5	29.4	8	**47.1**	17	100.0
more than 36	0	.0	3	**75.0**	1	25.0	0	.0	4	100.0
Total	2	6.3	14	43.8	8	25.0	8	25.0	32	100.0

χ^2=14,690, ll=6, p=0,023, Kendall's tau-c test 0,290, p=0, 032

Although in 2005 the number of civil cases has doubled compared with 2003, the average proceedings length in this year was reduced by more than twice (up to 14.8 months). Distribution of litigation length by years is presented in Figure 13.

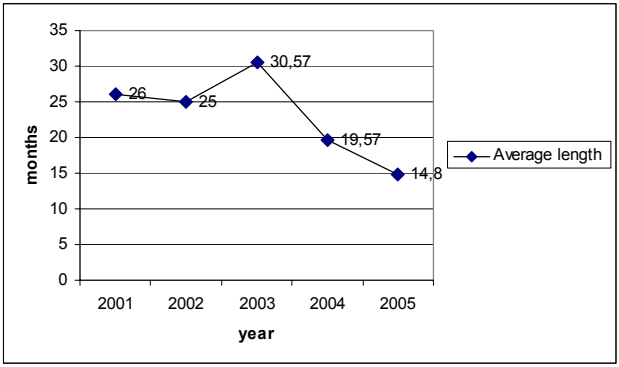

Figure 13. Average length of civil litigation by the year

In 2003, the first "peak" of malpractice litigations was observed in Lithuania, this could explain the longest average length of civil proceedings (30.57 months).

Court judgments and their control.

Table 6. Characteristics reflecting the court's judgment

Characteristics	Number of cases, n	Percentage
Court's judgment		
1. claim is fully satisfied	**5**	**15.6**
2. claim is satisfied in part	**14**	**43.8**
3. peace treaty / case closed	2	6.2
4.case left unheard (pre-litigation procedure was not followed) or the claim was rejected	11	34.4
The court decision-making		
1. first instance	8	25.0
2. appeal	11	34.4
3. cassation	**13**	**40.6**
Appeal against the judgment		
1. yes	**24**	**75.0**
2. no	8	25.0
Appealed decision was changed		
1. yes	11	45.8
2. no	**13**	**54.2**

In a total of 59.4 percent cases, the claim was fully or partially meet. In two cases, Šiauliai and Kaunas regional courts approved the peace treaty with the mandatory provisions of law or public interest, and the parties have reached agreement on compensation of damage to patient's health. In three cases, the dispute could not be examined in the court, because the plaintiffs failed to comply with the pre-litigation dispute settlement procedure, in eight cases, the courts dismissed the claim in the absence of evidence of the requirement statement in the proceedings.

The scientific work has examined whether *legal procedural actions* in the health damage compensation cases affects the court's decision in favour of the plaintiff-patient. No statistically significant relationship between the decisions in favor of the patient and legal and factual basis of the claim were found (χ^2 = 1.586, df = 3, p = 0.663, Fisher's test 1.360, p=0.921) (χ^2=5.987, ll=9, p=0.741; Fisher's test 7.327, p=0.696). Possible influence of *medical factors* to the decisions was analysed as well. Statistical analysis using the precision Fisher's test revealed that neither the severity of injury nor the extent of the bodily injury, nor health state before the referral to a health care institution had statistically significant effect on the court's judgment in favor of the plaintiff-patient.

Despite the low number of cases of civil cases in the statistical analysis, the court's decision significantly dependent on the type of injury, which was defined by the patient's health disorder cause: A) health disorder exists, but not because of adverse event or breach of the doctor's standard of care, B) health disorder was caused by adverse event, C) patient injury was due to medical malpractice. Statistical relation was assessed using Fisher's exact test's Freeman and Halton summary version (exact Fisher's test = 28.422, p <0.000). Court decisions showed that 37.5 percent of claims submitted in the absence

of adverse event whatsoever or the adverse event occurred not cause of the breach of the doctor's standard; in 62.5 percent cases adverse event was caused by doctor's negligence. In all cases where the court found medical malpractice cases, the judgment was made in favor of the plaintiff: the action was satisfied in full (5 cases) or in part (13 cases). In eight cases with adverse event, but in the absence of medical negligence, court decisions did not meet the plaintiff's claims for the compensation of damage. In four cases with the absence of adverse event, in one case the damage compensation for injury has been awarded to the plaintiff, where the court found involuntary hospitalization procedures of the mentally ill patient.

The results of the study show that the majority of cases were brought against doctors for errors in making diagnosis of the disease, and less often – for incorrect treatment or following up with health state of the patient. In evaluating whether the physician acted reasonably and prudently, the courts apply the current standard of care on a moment of causing the damage. The court takes into account the doctor's specialization and assesses in particular those requirements which are applied in the medical norm of this specialty. As many as 56.2 percent of civil claims were instituted against surgical doctors (surgeons, traumatologists, and gynaecologists).

Determination of the amount of compensation for damage to health.

In each case of damage, the court must calculate as accurately as possible the amount of damage compensation and take into account the full compensation principle. Compensation is usually for real damage, although the damage in this category of cases is very specific.

Compensation for health damage was asked by 31 plaintiff (in one case – only periodic payments), the damage was compensated in 19 cases (61.3 percent). Compensation of pecuniary damage was claimed by 21 plaintiffs (compensations were awarded in 12 cases, that is 57.1 percent), and non-pecuniary damages were claimed by 25 plaintiffs (awarded were 15 compensation cases, i.e. 60 percent). The largest requirements for pecuniary and non-pecuniary damages have been made in a civil case *R.V., D.L.V. v Kaunas 2nd Clinical Hospital, Kaunas Clinical Infectious Hospital* (No.3K-3-1180/2003)for the death of the eighteen year old female patient to whom doctors incorrectly diagnosed the disease and applied incorrect treatment. However, the biggest health damage compensation was awarded to plaintiffs in a civil case *L.Z., M.Z., V.Z., G.Z M.Z. v PI Marijampole hospital* (No.3K-7-255/2005) for medical negligence and injuries to newborns. The maximum pecuniary damages, namely LTL 12 527, was awarded by the Lithuanian Supreme Court to parents in the civil case *J.R., Z.R. v PI Vilnius University Santariskės Hospital* (No.3K-3-206/2005) for expenses incurred for their 14 year old daughter's death after heart surgery.

Possibilities of the implementation of the patient's right to health damage compensation were assessed according to relative amounts of the compensated and claimed damages. Average ratios of damages awarded to damages sought are presented in Table 7.

Table 7. Average ratios of damages awarded to damages sought

Injury type (number of cases)	Average amount of damage LTL ±St. deviation
Total damages (n = 31)	
Plaintiffs sought	**266553**±462478
Damages awarded	**48872**±103562
Ratio of damages awarded to sought	**0.18**±0.22
Pecuniary damages (n = 21)	
Plaintiffs sought	**63589**±159790
Damages awarded	**2581**±3911
Ratio of damages awarded to sought	**0.04**±0.02
Non-pecuniary damages (n = 25)	
Plaintiffs sought	**277112**±394777
Damages awarded	**58433**±112533
Ratio of damages awarded to sought	**0.21**±0.28

The results showed that in the analyzed group of 32 civil liability cases plaintiffs were awarded 18 percent of the overall pecuniary and non-pecuniary damages claimed. Compensation for non-pecuniary damages amounted to 21 percent of the required in the claim, the pecuniary damages– 4 percent of the damages request at by plaintiffs. Extremely low rates of reimbursement of pecuniary damages were determined by three unjustifiably high requirements of the compensation for lost revenue.

CONCLUSIONS

1. Statutory regulation of patients 'rights to quality in health care services and health damage compensation in Lithuania meets international and European patients' rights protection principles.
2. While in regulating patients' rights in Lithuania we observed the greatest progress of the health reform, and patient rights are provided for in many different levels of national legislation (Constitution, Civil Code, Law on the rights of patients and compensation of the damage to their health, Health insurance law), but they still lack the systematic legal approach and harmonization between them.
3. The special Law on the rights of patients and compensation of the damage to their health of the Republic of Lithuania regulating the essential health care service quality items and arrangements of reimbursement of damage to health is recognized as a he key instrument in realizing the rights of patients. The rapidly changing social dialogue between doctors and patients creates presumptions to a systematic evaluation and update of patients' rights regulation. The version of the Law on the rights of patients and compensation of the damage to their health of the Republic of Lithuania that became effective of 1 March 2010 shows the regulatory progress in patients' rights protection.
4. The research showed that the vast majority of surveyed patients (nine out of ten) realized their right to quality in health care service in the hospital: their rating of quality of health care services provided to them was good and very good. The best rated by patients was their communication with physicians, provided information about their

health state and care, the respect shown by staff and expressed confidence with treating doctors.

5. However, more than a third of respondents indicated the time-consuming procedure of the discharge from hospital, one-fifth of patients were irritated by noise during the night and nearly every seventh respondent was waiting in the reception room for more than an hour.

6. Nearly a third of respondents did not participate in the decision-making process about their health state and care (not been able or willing to). Every fifth respondent hospitalized according to schedule was unable to choose a health care institution. One out of ten stated that there was no privacy in discussing his health state or treatment, to every fifth respondent, privacy in general was not important. Thus, the changes in culture of medical facilities based on the principle of patient autonomy and patient's ability to know and exercise their rights create the managerial background to improve the quality of health care services.

7. During the first five years the Lithuanian Supreme Court adopted principal decisions on the interpretation and evaluation of patient health damage compensation in medical malpractice litigation cases. A statistically significant correlation between the doctor‘s negligence and the court judgment in favor of the plaintiff ($p < 0.001$) confirmed the principle of application of legal liability – the liability is limited to illegal activities. In the event of doctor‘s fault, in all cases the damage was fully or partly compensated for the plaintiff.

8. Six out of ten plaintiffs received the health damage compensation. Plaintiffs were awarded nearly a fifth of the requested overall pecuniary and non-pecuniary damages, as well as fifth of the amount of non-pecuniary damages stated in the claim. Extremely low rates of reimbursement of pecuniary damages were determined by unjustifiably high requirements of the compensation for lost revenue.

9. The following problems were identified in the practice of the courts: although with the increasing number of cases the length of judicial process reduces in time, judicial proceedings are still a time-consuming process (with an average hearing period of 20.3 months); numerous examinations and contradictory expert opinions can be a serious barrier for injured patients to realize their right to health damage compensation.

10. Results of this scientific research and good practice examples provided in the literature overview on the health damage compensation indicate that in Lithuania it is worth to implement alternative mechanisms for the medical injury compensation.

RECOMMENDATIONS

In view of the scientific assessment and the above conclusions the author provides specific theoretical and practical recommendations and suggestions to improve the realization of patients' rights.

1. Recommendations to improve national legislation:

- To concentrate the regulation of patients' rights in the Law on the rights of patients and compensation of the damage to their health of the Republic of Lithuania. To align the provisions of the Civil Code of the Republic of Lithuania and the Health Insurance Law of the Republic of Lithuania unreasonably attributing patients' rights to individual groups of patients, in accordance with the

Special Law on the rights of patients and compensation of the damage to their health.

- To establish in the Law on the rights of patients and compensation of the damage to their health a definition of high-quality health care services as an integral right.
- To develop a national diagnostic and treatment protocols, not only to assess the quality of services, but also to apply in the judicial practice solving the legal disputes between doctors and patients. To refuse from local protocols approved by managers of health care institutions since it violates the patient's right to receive quality in health care services, in line with medical and nursing science achievements, and raises many doubts to the courts in addressing the patient-doctor dispute.
- To define and regulate the standard of reasonably competent professional in the Medical Practice Law of the Republic of Lithuania, as the "maximum efforts" criterion, worded in the Lithuanian Supreme Court practice, brings a lot of uncertainty and confusion in both medical and judicial practice.
- To add the provisions of law on doctors' rights and responsibilities of patients, providing the equivalent partnership of doctor and patient.
- Additionally regulate specific physician requirements – to legal expert participating in medical malpractice litigation cases, to ensure its objectivity and impartiality. To supplement the professional code of ethics with the provision on impeccable and conscientious conduct of a doctor – a court expert.
- Upon setting on the concept and design of medical injury compensation, to create a regulatory framework for no-fault health damage compensation and the registration and management of adverse events.

2. Recommendations to health care quality improvement:

- Create a system of health care quality evaluation and dissemination in health care facilities: for ongoing monitoring and evaluating of the quality of service to use the European Picker Institute questionnaires to help easily identify the health care gaps, formulate problems and their solutions, and compare the dynamics of the quality of health care between health care institutions at national and international levels.
- Based on foreign experience, to develop a national quality assessment resource base from the scientific results of the assessment of quality of health care services, patient questionnaires, examples of good practice. Create a follow-up monitoring system of quality of health care services that would allow single and continuous dynamics monitoring of the quality of service on patients perspective.
- Encourage patients to participate in decision-making that are important to their health and quality of treatment (e.g., information for patients, providing examples of good practice on physician-patient partnership). Establish the organizational-managerial preconditions for the realization of the principle of patient autonomy (right of choice, privacy assurance).

3. Improve the current mechanism of the compensation for patients' health damages in Lithuania in the following areas:

- Ensure the functioning of the patient complaints system, thereby reducing the number of unsubstantiated claims (e.g., introduce the positions of patient advocacy / or risk manager in health care institutions).

- Develop alternative means of pre-trial dispute settlement: health care institutions and / or physicians malpractice liability insurance, mediation, arbitration, etc.
- Organize a public debate, inviting the public, physicians, and health policy makers to discuss the no-fault health damage compensation mechanism, which would allow patients to receive compensation of damage quickly, at lower cost and for a greater number of them.
- Promote a culture of the disclosure of errors in public and in the medical community, through the development of the concept of patient safety in Lithuania (e.g., organize the medical staff and patient forums to discuss adverse events, medical errors and malpractice).
- Recommend medical education institutions, professional medical organizations to include in the study / training programs the training on adverse events, errors in medical anatomy and error risk management.
- Organize special training for medical professionals promoting a culture of patient safety in health care institutions.

Publications on the Topic of Dissertation

1. Daiva Brogienė, Romualdas Gurevičius. Factors determining inpatients opinion about quality of care. Visuomenės sveikata. 2008;3(42):36-45.
2. Daiva Brogienė, Romualdas Gurevičius. Inpatients' opinion on quality of health care. Medicina. 2009;3(45):226-237.

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PACIENTO TEISĖS Į KOKYBIŠKĄ SVEIKATOS PRIEŽIŪROS PASLAUGĄ IR ŽALOS SVEIKATAI ATLYGINIMĄ

Disertacijos reziume

„Į pacientą orientuotos sveikatos priežiūros pagrindas - suprasti ir gerbti paciento vertybes, pirmenybę ir išreikštus lūkesčius.“ - Harvey Picker...

Darbo aktualumas. Pastaruosius dešimt metų sveikatos sistema visose valstybėse išgyvena pacientų teisių „revoliuciją“. Įvairios žmogaus teisių iniciatyvos demonstruoja išskirtinį dėmesį prigimtinei žmogaus teisei į sveikatą ir gyvybę. Reikšmingos bei svarbios tampa ir kitos pacientų teisės: teisė į informaciją, informuotą sutikimą, pasirinkimą, teisė būti išgirstam, teisė į prieinamą ir kokybišką sveikatos priežiūrą, privatumą, konfidencialumą, teisė skųstis, reikalauti žalos sveikatai atlyginimo. Stiprėjanti pacientų pozicija sveikatos priežiūroje ypatingai aktyviai formuoja paciento autonomijos principą ir jo teisę dalyvauti sprendimų dėl jo sveikatos būklės ar gydymo priėmime.

Pacientų teisių politika glaudžiai susijusi su valstybėje vykdomomis pertvarkomas sveikatos sektoriuje. Neefektyviai įgyvendinant sveikatos apsaugos reformą, daugelis pacientų teisių gali būti realiai neužtikrintos ir neįgyvendintos. Sveikatos priežiūros reformų tikslų ir uždavinių įgyvendinimo proceso valdyme Lietuvos sveikatos politikai ypatingą dėmesį atkreipia į paslaugų prieinamumo visuose sveikatos priežiūros paslaugų teikimo lygiuose gerinimą, pacientų teisių užtikrinimą ir paslaugų kokybės gerinimą. Moksliniai projektai orientuojami į pacientų teisių situacijos analizę ir visuomenės aktyvinimą. Pacientų teisių užtikrinimas ir realizavimas atspindi valstybės sveikatos apsaugos sistemos efektyvumą.

Moksliniam darbui plačioje pacientų teisių aibėje neatsitiktinai pasirinktos dvi labiausiai šiandieną diskusijų keliančios kompleksinės pacientų teisės: teisė į kokybišką sveikatos priežiūros paslaugą ir žalos sveikatai atlyginimą. Išskirtinis žiniasklaidos dėmesys į vadinamąsias gydytojų klaidas, pacientų skundai dėl nekokybiškos sveikatos priežiūros, didėjantis ieškinių dėl žalos sveikatai atlyginimo skaičius, stulbinantys civilinių ieškinių dydžiai rodo, kad praktikoje egzistuoja trukdžiai šių teisių užtikrinimui ir realizavimui.

Darbo tikslas: ištirti bei įvertinti stacionarinėse asmens sveikatos priežiūros įstaigose gydytų pacientų galimybes realizuoti teisę į kokybišką sveikatos priežiūros paslaugą ir pacientų, pateikusių žalos sveikatai atlyginimo ieškinį teisme, galimybes įgyvendinti teisę į žalos sveikatai atlyginimą.

Siekiant darbo tikslo buvo iškelti šie uždaviniai:

1. Išanalizuoti paciento teisių į kokybišką sveikatos priežiūros paslaugą ir žalos sveikatai atlyginimą įstatyminį reglamentavimą Lietuvoje, palyginti jų pagrindinius principus su tarptautiniais ir Europos Sąjungos pacientų teises apibrėžiančiais teisės aktais.
2. Ištirti ir įvertinti pacientų nuomonę apie jiems suteiktų sveikatos priežiūros paslaugų kokybę stacionarinėse asmens sveikatos priežiūros įstaigose, nustatyti sveikatos priežiūros paslaugų kokybės spragas paciento požiūriu ir numatyti teisines bei vadybines prielaidas paslaugų kokybės tobulinimui.

3. Išanalizuoti LR bendrosios kompetencijos teismų civilines bylas dėl žalos sveikatai atlyginimo, vertinant patirtos žalos sveikatai kompensavimo principus, procesinius ypatumus bei efektyvumą, atskleisti probleminius paciento teisės į žalos sveikatai atlyginimą įgyvendinimo aspektus ir pasiūlyti galimus reglamentavimo bei praktinio įgyvendinimo sprendimus.

Darbo mokslinis naujumas. Šis darbas - pacientų teisių į kokybišką sveikatos priežiūros paslaugą ir žalos sveikatai atlyginimą įgyvendinimo mokslinis vertinimas Lietuvoje, kuomet dviejų pacientų teisių funkcionavimas vertinamas sistemiškai ir integruotai, kartu tiek medicininiu, tiek teisiniu aspektais. Tai sudaro prielaidas siūlyti suderintas teisines ir vadybines kryptis pacientų teisių įgyvendinimo tobulinimui.

Šiame darbe, panaudojus biomedicinos ir socialinių mokslų sričių metodologijas, moksliškai įvertinta sveikatos priežiūros paslaugų kokybė pacientų požiūriu. Adaptuotas daugelyje valstybių moksliniuose tyrimuose naudojamas Europos Picker instituto klausimynas stacionare gydytiems pacientams, kuris gali būti sėkmingai taikomas tolimesniuose moksliniuose tyrimuose Lietuvoje, lyginant šalies ir Europos valstybių patirtį sveikatos priežiūros paslaugų kokybės srityje.

Teisiniai santykiai, susiję su sveikatos priežiūros paslaugų teikimu, sudaro atskirą sveikatos teisės institutą, todėl šis mokslo darbas svarbus sveikatos teisės mokslo krypties teorijai ir praktikai. Tenka pripažinti, kad Lietuvoje sveikatos teisės institutui trūksta teisės mokslo. Jis per mažai plėtojamas ir tai sudaro prielaidas įvairiai interpretuoti įstatymuose įtvirtintą pacientų teisių turinį, kartu ir nepalankias sąlygas pacientų teisių įgyvendinimui. Moksliniam tyrimui autorė pasirinko pirmuosius penkerius teismų praktikos formavimosi metus, sprendžiant ginčą dėl žalos sveikatai atlyginimo. Tai pirmasis ištisinis gydytojų civilinės atsakomybės (toliau – CA) bylų dokumentų mokslinis vertinimas Lietuvoje.

Ginamieji darbo teiginiai:

1.Įstatyminis paciento teisių reglamentavimas užtikrina jų įgyvendinimo mechanizmą.

2. Stacionarinėse asmens sveikatos priežiūros įstaigose pacientai realizuoja savo teisę į kokybišką sveikatos priežiūros paslaugą.

3.Užtikrinama pažeistos teisės į kokybišką sveikatos priežiūros paslaugą teisminė gynyba, kurios pagalba pacientai realizuoja teisę į žalos sveikatai atlyginimą.

Disertacijos struktūra ir apimtys. Darbą sudaro keturios struktūrinės dalys, 44 lentelės ir 33 paveikslai. Įvadiniame skyriuje bendrais bruožais aprašoma tiriamoji problema, darbo aktualumas, darbo rezultatų mokslinis naujumas. Įvardinti darbo tikslai ir iškelti uždaviniai, suformuluoti ginamieji teiginiai. Pirmojoje dalyje pateikiama literatūros apžvalga, kurioje aprašomi pacientų teisių užtikrinimo įstatyminiai pagrindai, teisės į kokybišką sveikatos priežiūrą sąvoka, turinys ir matavimo kriterijai paciento požiūriu, teisės į žalos sveikatai atlyginimą sąlygos ir mechanizmai. Antrojoje dalyje pristatoma pacientų apklausos tyrimo medžiaga ir metodai (tyrimo objektas, tyrimo imtis, statistinė duomenų analizė). Aprašomi gauti rezultatai, nurodomas jų statistinis patikimumas. Pateikiamas gautų rezultatų aptarimas ir palyginimas su kitų panašių mokslinių studijų rezultatais.Trečiojoje dalyje pristatoma civilinių bylų dėl žalos sveikatai atlyginimo tyrimo medžiaga ir metodai. Pateikiami gauti rezultatai. Aptarimo skyriuje, remiantis kokybinio tyrimo principais, aprašomas ir aiškinamas tiriamų bylų

dokumentų turinys, pateikiami detalūs bylų epizodų aprašymai, kitų šalių teismų praktikos pavyzdžiai. Išvadose ir rekomendacijose apibendrinami abiejų tyrimų rezultatai, pateikiami uždavinių, problemų sprendimai. Disertacijos pabaigoje pateikiamas literatūros sąrašas, kuriame yra 371 bibliografinis šaltinis.

Atlikus tyrimą ir išanalizavus rezultatus, padarytos šios išvados:

1. Paciento teisių į kokybišką sveikatos priežiūros paslaugą ir žalos sveikatai atlyginimą įstatyminis reglamentavimas Lietuvoje atitinka tarptautinius ir Europos Sąjungos pacientų teisių apsaugos principus.
2. Nors paciento teisių reglamentavime Lietuvoje stebima pati didžiausia sveikatos reformos pažanga bei pacientų teisės numatytos daugelyje įvairaus lygio nacionalinių teisės aktų (LR Konstitucijoje, LR CK, LR PTŽSAĮ, LR sveikatos draudimo įstatymuose), tačiau juose vis dar trūksta teisinio sisteminio požiūrio, jų tarpusavio suderinimo.
3. Specialusis LR PTŽSAĮ, reglamentuojantis esminius sveikatos priežiūros paslaugos kokybės elementus ir žalos sveikatai atlyginimo tvarką, pripažįstamas pagrindiniu teisės aktu realizuojant paciento teises. Sparčiai besikeičiantis socialinis dialogas tarp gydytojo ir paciento sudaro prielaidas nuolatos vertinti ir atnaujinti pacientų teisių reglamentavimą. 2010 m. kovo 1d. įsigaliojusi LR PTŽSAĮ redakcija rodo teisinio reguliavimo pažangą paciento teisių apsaugos srityje.
4. Tyrimas parodė, kad didžioji dauguma apklaustų pacientų (devyni iš dešimties) realizavo teisę į kokybišką sveikatos priežiūros paslaugą stacionare: gerai ir labai gerai vertino jiems suteiktų sveikatos priežiūros paslaugų kokybę. Geriausiai pacientai įvertino jų bendravimą su gydytojais, suteiktą informaciją apie jų sveikatos būklę ir gydymą, personalo parodytą pagarbą ir išreiškė pasitikėjimą gydžiusiais gydytojais.
5. Tačiau daugiau kaip trečdalis respondentų nurodė užsitęsiančią išrašymo iš stacionaro procedūrą, penktadalį pacientų vargino triukšmas nakties metu ir beveik kas septintas respondentas priėmimo kambaryje laukė ilgiau nei valandą.
6. Beveik trečdalis respondentų nedalyvavo sprendimų dėl savo sveikatos būklės ar gydymo priėmime (neturėjo galimybių arba nenorėjo). Kas penktas planine tvarka hospitalizuotas respondentas neturėjo galimybių pasirinkti gydymo įstaigą. Kas dešimtas nurodė, kad nebuvo privatumo, aptariant jo sveikatos būklę ar gydymą, kas penktam respondentui privatumas apskritai nebuvo svarbu. Taigi, gydymo įstaigų kultūros pokyčiai, pagrįsti paciento autonomijos principu, ir paciento gebėjimai žinoti bei pasinaudoti savo teisėmis sudaro vadybines prielaidas tobulinti sveikatos priežiūros paslaugų kokybę.
7. LAT per pirmuosius penkerius metus priėmė principinius sprendimus dėl žalos paciento sveikatai atlyginimo aiškinimo ir vertinimo gydytojų CA bylose. Statistiškai reikšmingas ryšys tarp gydytojo aplaidumo ir teismo sprendimo ieškovo naudai ($p<0,001$) patvirtino teisinės atsakomybės taikymo principą – atsakomybė galima tik už neteisėtą veiką. Esant gydytojo kaltei, visais atvejais žala pilnai arba dalinai buvo atlyginta ieškovui.
8. Šeši iš dešimties ieškovai gavo žalos sveikatai atlyginimą. Ieškovams buvo priteista beveik penktadalis prašytos bendrai turtinės ir neturtinės žalos dydžio:

21 proc. ieškinio pareiškime nurodytos neturtinės ir tik 4 proc. prašytos turtinės žalos atlyginimo. Mažą turtinės žalos sveikatai atlyginimo procentą sąlygojo ieškinio pareiškime nurodyti nepagrįstai dideli negautų pajamų reikalavimai artimo asmens mirties atveju.

9. Teismų praktikoje įžvelgtos šios problemos: nors didėjant bylų skaičiui teisminio proceso trukmė ir mažėja, teisminis ginčo nagrinėjimas vis dar išlieka ilgai trunkantis procesas (vidutinė bylinėjimosi trukmė - 20,3 mėnesio); gausus ekspertizių skaičius ir prieštaringos ekspertų išvados gali tapti rimta kliūtimi patyrusiems žalą pacientams realizuoti teisę į žalos sveikatai atlyginimą.
10. Šio mokslinio tyrimo rezultatai bei literatūros apžvalgoje pateikti geros praktikos pavyzdžiai dėl žalos sveikatai atlyginimo rodo, kad Lietuvoje verta diegti alternatyvius žalos sveikatai atlyginimo mechanizmus.

Atsižvelgdama į atliktą mokslinį vertinimą ir anksčiau išdėstytas išvadas autorė teikia konkrečias teorinio ir praktinio pobūdžio **rekomendacijas** bei pasiūlymus pacientų teisių realizavimui gerinti. Nacionalinių teisės aktų tobulinimui autorė siūlo suderinti tarpusavyje ir sisteminti teisines nuostatas apie pacientų teises, įtvirtinti kokybiškos sveikatos priežiūros paslaugos, kaip sudėtinės teisės, definiciją, reglamentuoti įstatymo nuostatomis protingai profesionalaus gydytojo elgesio standartą, detalizuoti gydytojų teises ir pacientų pareigas bei reikalavimus gydytojui-teismo ekspertui. Rekomenduoja rengti nacionalinius diagnostikos ir gydymo protokolus ne tik paslaugų kokybei vertinti, bet ir taikyti teismų praktikoje, sprendžiant klausimą dėl gydytojo veiksmų teisėtumo. Sutarus dėl žalos sveikatai atlyginimo koncepcijos ir modelio, kurti teisinę bazę, reglamentuojančią žalos sveikatai atlyginimą be kaltės ir nepageidaujamų įvykių registravimą bei valdymą. Sveikatos priežiūros paslaugų kokybės tobulinimui autorė siūlo sukurti sveikatos priežiūros paslaugų kokybės vertinimo ir sklaidos sistemą sveikatos priežiūros įstaigose, formuoti nacionalinę kokybės vertinimo resursų bazę iš mokslinių sveikatos priežiūros kokybės vertinimo tyrimų rezultatų, pacientų klausimynų, geros praktikos pavyzdžių. Būtina skatinti pacientus dalyvauti priimant sprendimus, kurie reikšmingi jų sveikatai ir gydymo kokybei, sudaryti organizacines-vadybines prielaidas paciento autonomijos principo realizavimui. Žalos sveikatai atlyginimo mechanizmui tobulinti tikslinga užtikrinti pacientų skundų sistemos funkcionavimą ir taip mažinti nepagrįstų ieškinių skaičių, tobulinti alternatyvius ikiteisminio ginčo sprendimo būdus.

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