JOURNAL OF CULTURAL ANALYSIS AND SOCIAL CHANGE

Journal of Cultural Analysis and Social Change,
2025, 10(2), 3733-3746
ISSN: 2589-1316

Restorative Justice as Cultural Practice in Medical Malpractice: Face-Work, Institutional Trust, and Social Learning in Healthcare Organizations

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Citation: Limijadi, E. K. S., Sulchan, A. and Devi, K. S. (2025). Restorative Justice as Cultural Practice in Medical Malpractice: Face-Work, Institutional Trust, and Social Learning in Healthcare Organizations, *Journal of Cultural Analysis and Social Change*, 10(2), 3733-3746. https://doi.org/10.64753/jcasc.v10i2.2180

Published: November 21, 2025

ABSTRACT

This article examines restorative justice as a cultural practice within healthcare, focusing on how apology, accountability, and institutional learning are shaped by context, norms, and trust. Drawing on a scoping review of nineteen studies across different jurisdictions, it analyzes Open Disclosure, Communication and Resolution Programs, and clinical mediation as post-incident frameworks that extend beyond liability management toward moral and relational repair. The findings show that similar procedures operate through distinct cultural scripts: in some systems, apology is protected by law, while in others it is grounded in social legitimacy and mediated harmony. Success is most likely when clinicians participate, claims are moderate, and dialogue occurs in psychologically safe environments. By contrast, cases involving severe harm or contested standards of care require hybrid models that combine restorative and formal legal processes. The analysis integrates the concepts of face work, legal consciousness, and institutional trust to explain how openness and empathy can transform defensive institutions into reflective ones. When embedded in cultural and legal systems that safeguard candor, restorative practice enables not only fair resolution but also sustained social learning within healthcare organizations.

Keywords: Restorative Justice; Medical Malpractice; Face-Work; Institutional Trust; Healthcare Organizations.

INTRODUCTION

Adverse events that harm patients still occur in healthcare. After such incidents, many organizations continue to prioritize rules and liability management over relational needs (Dijkstra et al., 2022; Wailling, 2022; Rathnayake et al., 2025). These needs—acknowledgment, explanation, apology, support, and assurance of improvement—often go unmet, which slows organizational learning and quality improvement. A restorative approach offers an alternative: those affected are placed at the center, facts are clarified, accountability is affirmed, and plans for repair and prevention are jointly designed through safe dialogue rather than adversarial processes (Farrell, Alghrani, & Kazarian, 2020; Kirkwood, 2022; Nickson & Neikirk, 2024; Rathnayake et al., 2025). This shift, driven by ethics and transparency, has led to open disclosure policies, communication and resolution programs (CRP), and the use of mediation to prevent prolonged disputes.

The need for nonadversarial pathways is evident across jurisdictions. In China, rising medical disputes and declining public trust prompted national regulations and the creation of People's Mediation Committees with trained mediators and expert panels to stabilize expectations and maintain service continuity (Shen et al., 2024). Court based mediation shortens resolution times, reduces uncertainty, and lowers costs through judicial facilitation and forensic clarification before parties decide whether to settle or proceed to trial. In New Zealand, system level restorative initiatives place listening circles and facilitated dialogue at the core, enabling shared identification of

impacts, needs, and obligations for redress with those responsible (Wailling, 2022). Key conditions include person centered design, collaborative leadership, and procedural adaptability, so that relational repair advances alongside organizational learning.

Although policies exist, implementation is uneven; some initiatives have become compliance checklists, shifting attention to risk management rather than relational recovery (Farrell, Alghrani, & Kazarian, 2020; Kirkwood, 2022; Nickson & Neikirk, 2024). As a result, dignity, validation, and accountability often do not materialize, and public trust is slow to return. A restorative approach is therefore relevant not only for faster and more cost efficient resolution but also for moral repair, improved perceptions of justice, and a clearer link between factual transparency and system level quality improvement (Jenkins, Barclay, & Simmons, 2017; Li et al., 2018; Wailling, 2022; Shen et al., 2024). In this article we treat restorative practice as a cultural practice that connects human needs with tangible organizational improvement.

The main gap in the literature concerns implementation oriented mapping. We need a clear account of the types of restorative or communicative approaches used, the process components applied (acknowledgment, apology, investigation, face to face meetings, follow up), and the outcomes reported (resolution status; clearly defined start to end timelines; compensation mechanisms and costs; system level prevention; and perceptions of justice). Without shared definitions, cross context learning is fragmented and strategy selection becomes unclear. This scoping review addresses that gap by mapping post incident communicative and restorative approaches across legal regimes and levels of care, focusing on how programs are framed and implemented, and on what is restored rather than on legal verdicts alone. We also present a harmonized measurement framework: defined start to end markers for resolution time, clear denominators for resolution rates, and distinctions between compensation mechanisms and amounts, enabling fairer cross context comparisons and supporting both policy decisions and practice improvement.

METHODS

Study Design and Reporting Standard

We conducted a scoping review to map restorative/communicative approaches used after clinical incidents in healthcare (e.g., open disclosure [OD], CRP], clinical/court-annexed mediation, people's mediation, and related policies such as duty of candour and apology laws). We followed the PRISMA-ScR reporting guideline and drew on the Arksey & O'Malley framework (Arksey & O'Malley, 2005). We did not seek to estimate causal effects or comparative efficacy; our aim was conceptual and contextual mapping of what has been reported, how it has been studied, and where the knowledge gaps remain.

PCC Framework

Using PCC (Population–Concept–Context), our review addressed:

1. **Population (P):** patients/families, healthcare workers, hospitals/health systems, payers/insurers, mediators/regulators involved in post-incident resolution.
2. **Concept (C):** restorative/communicative approaches after alleged malpractice/medical errors (OD/CRP, clinical or court-annexed mediation, people's mediation), their core process elements (acknowledgement, apology, RCA/investigation, face-to-face meetings, follow-up/prevention), and reported outputs (resolution status, time to resolution with operational definition, compensation types/values when present, costs, system prevention, perceptions of justice/closure).
3. **Context (C):** jurisdictions with fault-based vs no-fault regimes, different care levels (primary–tertiary), and country/state variations.

Research Questions

1. **RQ1.** What forms and core process elements of restorative/communicative approaches have been reported in healthcare services?
2. **RQ2.** Where and by whom were these approaches implemented (jurisdictions/regulatory backdrops; provider types; actors)?
3. **RQ3.** What outputs were reported (e.g., resolution status, time, compensation/costs if any, system prevention, perceived justice/closure)?

Eligibility Criteria

Eligibility was framed using the PCC logic to capture service-level implementations of restorative/communicative approaches while excluding legal-only or policy-only records. The full inclusion and exclusion rules appear in Table 1.

Table 1. Eligibility criteria

No	Inclusion	Exclusion
1	Empirical, peer-reviewed studies published in 2015–2025	Litigation-only datasets (closed-claims audits, court judgment summaries) reporting duration/compensation from pure litigation.
2	English-language and full-text available	Policy/legal frameworks (pre-suit, mediation, duty of candour) without service-level implementation data.
3	Healthcare delivery settings	Experience-only qualitative studies on litigation, or internal open disclosure focused on organizational communication without dispute resolution.
4	Reports ≥1 relevant output: resolution status; time to resolution (with start–end definition); compensation/costs (if any); system-level prevention; perceived justice/closure.	Criminal-law vignettes using "RJ" not involving healthcare dispute resolution.
5	Addresses at least one approach: OD/CRP, clinical mediation, court-annexed mediation, people's mediation, or related policy as implemented in practice.	

Information Sources and Search Strategy

We searched PubMed/MEDLINE, EMBASE, and Scopus from 1 January 2015 to 20 October 2025 (search closed: 20 Oct 2025). We additionally used Google Scholar for citation tracking (forward/backward snowballing) on included records and key reviews. Full, database-specific search strings (MeSH/Emtree/subject headings + free text) are provided in Supplementary File S1. As an example, the PubMed string was: ("restorative justice" OR "open disclosure" OR "communication and resolution" OR mediation OR apology) AND ("medical error" OR "adverse event" OR malpractice OR "patient harm") AND (hospital* OR healthcare) AND (english[lang]) AND ("2015/01/01"[dp]: "2025/10/20"[dp])**.

Study Selection (Screening)

Records were de-duplicated and screened in two stages (titles/abstracts, then full-texts) by two independent reviewers. Disagreements were resolved by discussion or a third reviewer. We calculated inter-rater agreement on a random 20% subset: Cohen's $\kappa = 0.81$ (titles/abstracts) and 0.84 (full-texts), indicating substantial agreement.
Figure 1 summarizes the study selection process. During the identification phase, records retrieved from database searches and other sources were screened for relevance. After duplicate removal and full-text assessment, only studies meeting the inclusion criteria were retained. The final set of included studies formed the basis for the thematic synthesis presented in the next section.

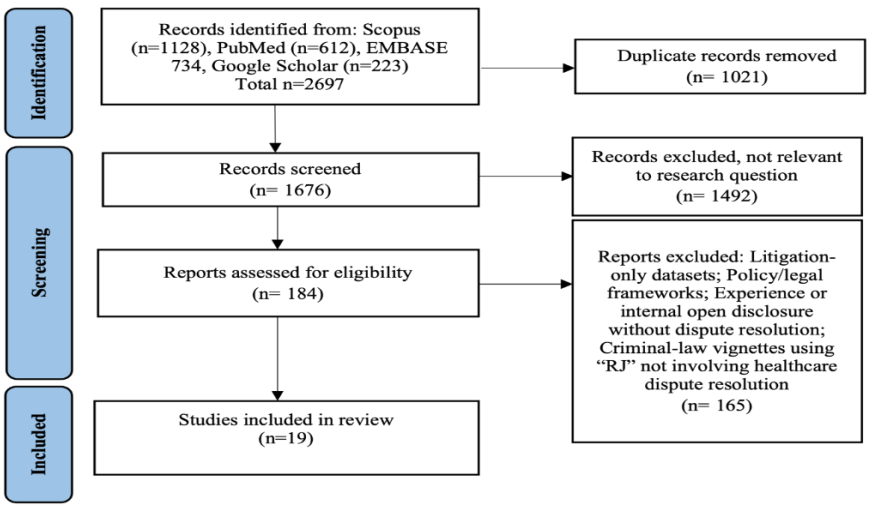

Figure 1. PRISMA Flow Diagram

Data Charting

We used a piloted data-charting form (Supplementary File S2). Across 19 studies (2016–2025; peak 2022), settings were predominantly hospital-based and geographically concentrated in the United States with expanding coverage in Asia (e.g., China, Indonesia, Singapore, Taiwan, Hong Kong, Malaysia) and selected sites in Europe, Oceania, and South Africa. We extracted study identifiers (author, year), country/jurisdiction/regime, design, and setting. We coded the approach type (OD/CRP; clinical mediation; court-annexed mediation; people's mediation; other; multi-label allowed) and the dispute type. We captured core process elements (acknowledgement, apology, RCA/investigation, face-to-face meeting, follow-up/prevention). Reported outputs included resolution status; pre-litigation settlement proportion with a clear denominator; time to resolution with a defined start–end point and unit; compensation mechanism (fault-based, no-fault/ACC, ex-gratia/bill-waiver) and amounts; costs with component definitions; system-level prevention/QI; and perceived justice/closure. We also logged author-stated definitions, denominators, and limitations.

RESULT

The geographic distribution of study sites is dominated by the United States, followed by growing contributions from Asia, particularly China and Indonesia, together with Singapore, Taiwan, Hong Kong, and Malaysia (see Figure 2 for the location distribution). Consistent clusters are observed in New Zealand, while Europe is represented by the Netherlands, Germany, and Switzerland; Australia and South Africa complete the coverage. Several studies use a multicountry design (for example, the United States, Australia, the Netherlands, and Germany; or China, Indonesia, Singapore, and Hong Kong), enabling cross jurisdictional comparisons of policy and practice. This pattern shows that most evidence comes from high income systems, alongside a growing research ecosystem in Asia and Oceania that adds diversity to regulatory frameworks and implementation models. Most studies were conducted in hospitals, with limited representation from academic medical centers, private surgical services, clinics (including primary and oral care), and community services.

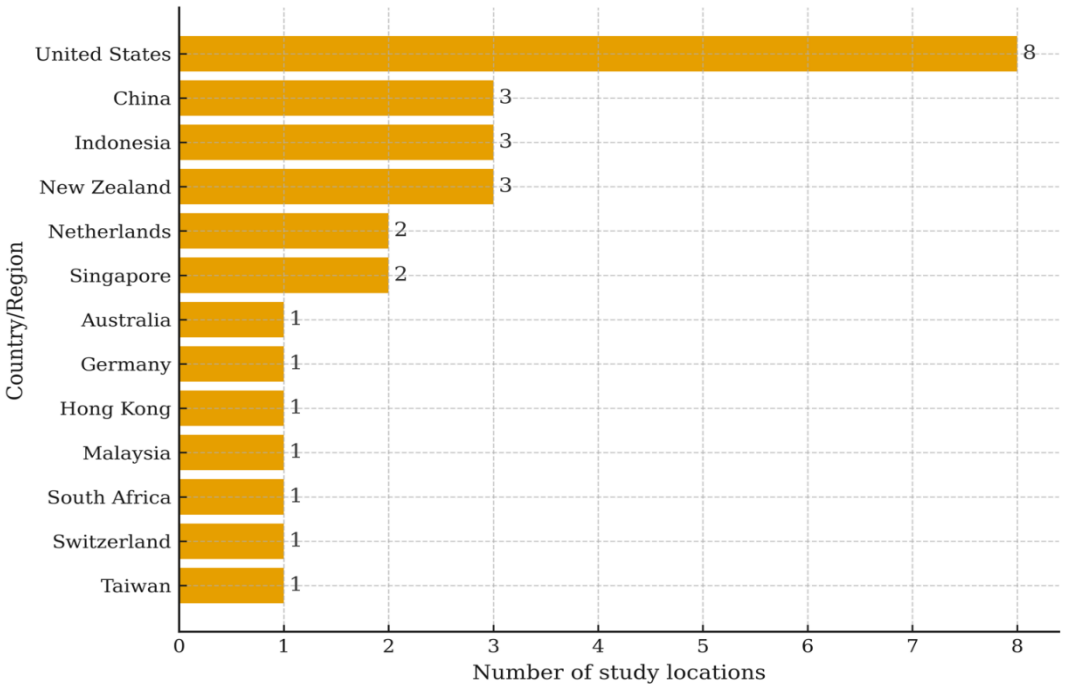

Figure 2. Country/region distribution

The publications cover the period from 2016 to 2025, with a peak in 2022 (4 of 19). Research activity remained relatively stable between 2018 and 2023, indicating a concentration of evidence within the past five to seven years. You can see the distribution of publication years in Figure 3. Retrospective designs dominate, accounting for 10 of 19 studies (53%), including qualitative retrospective (6 of 19; 32%) and observational retrospective (4 of 19; 21%) designs. Other categories include qualitative narrative studies (2 of 19; 11%) and one study each (5%) classified as a scoping review, a systematic review, a quasi-experimental study, an observational comparative study using court records, an observational cohort study with a retrospective approach, a qualitative case study, and a mixed methods study.

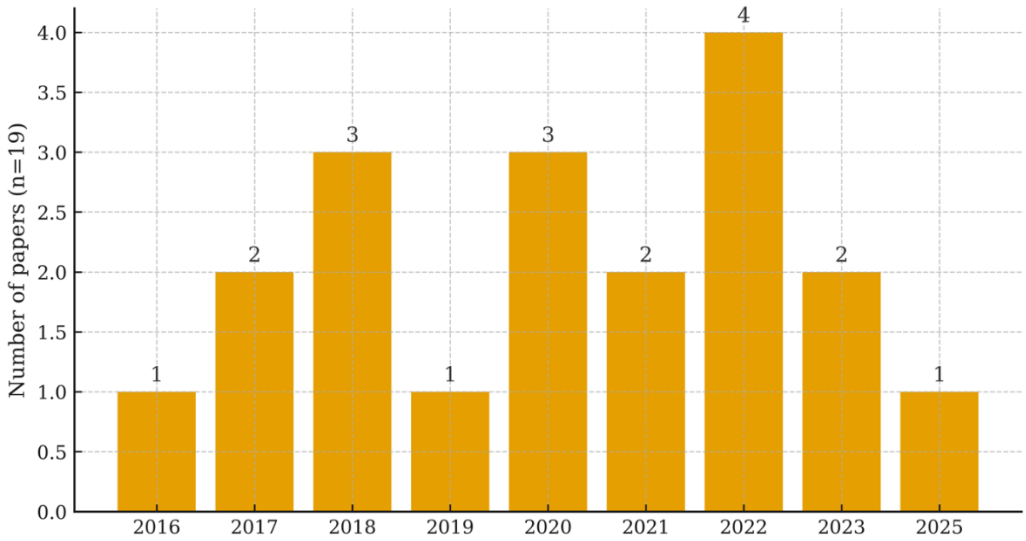

Figure 3. Distribution of publication years

Dispute Types

Most disputes originate from clinical processes in hospitals. Procedural or surgical cases are the most common, followed by those related to therapy or treatment, diagnosis, and obstetrics and gynecology. Other categories, including medication error, emergency care, anesthesia, and nursing, appear less frequently. Less common categories also include falls, monitoring, medical devices, informed consent, internal medicine, and distinctions between negligent and non-negligent actions. This pattern aligns with the overall hospital centered setting, while primary care, community services, and specialist clinics are represented in smaller proportions. You can see the distribution of dispute types in Table 2.

Geographically, procedural, diagnostic, and medication error disputes are reported most often in the United States, with additional clusters in Asia (particularly China, Indonesia, Singapore, Taiwan, Hong Kong, and Malaysia) and in Europe and Oceania (the Netherlands, Germany, Switzerland, New Zealand, and Australia). This cross-country coverage indicates that restorative approaches are most often applied to disputes arising from procedural actions and acute care in hospital settings, with variation in policy context and implementation across jurisdictions.

Table 2. Dispute types

Dispute type	Count (n/19)	Percentage
Surgical / Procedural	15	79%
Treatment / Therapeutic	11	58%
Diagnostic	10	53%
Obstetric / Gynecologic	10	53%
Medication error	5	26%
Emergency care	5	26%
Anesthesia / Perioperative	3	16%
Nursing care	2	11%
Falls	1	5%
Monitoring	1	5%
Device / Equipment	1	5%
Consent	1	5%
Internal medicine	1	5%
Negligent vs. non-negligent adverse events	1	5%
Medical injury (general) / Doctor–patient disputes	1	5%

Notes: Counts reflect mentions across studies; one paper may include multiple dispute types (multi-label). Percentages use 19 papers as the denominator.

Process Elements

Across the included studies, restorative approaches appear as a staged sequence. The process begins with early clarification to patients and families, continues with a structured investigation or Root Cause Analysis, proceeds to a face-to-face meeting to present findings and hear expectations, and concludes with a remediation package that includes any compensation offers, together with documented preventive actions and follow up. The most frequently reported elements are apology, investigation or Root Cause Analysis, face to face meetings, and early

acknowledgment. You can see the proportions in Table 3. This tiered pattern is reported most often in hospitals in the United States, with consistent clusters in Aotearoa New Zealand and strong contributions from Asia, particularly China, Indonesia, Singapore, and Taiwan, as well as from Europe, especially the Netherlands, and from South Africa. This suggests a common core of process elements across jurisdictions despite differences in regulatory frameworks.

Table 3. Core process elements

Process element	Count (n)	Papers
Apology	17	Dijkstra et al. (2021); Dijkstra et al. (2022); Triana and Sulistyorini (2021); Jenkins, D'Alesio, and Gann (2021); Hung, Lin, Chen, and Huang (2023); Jenkins et al., 2017; Kachalia et al., 2018; LeCraw et al. (2018); Li et al. (2018); Mello et al., 2016; Schulz (2025); Widihastuti, Hartini, & Kusdarini, (2017); Mononyane (2020); Wailling, Marshall, and Wilkinson (2019); Wailling, Wilkinson, and Marshall (2020); Wailling et al., 2022; Wang et al., 2020
Investigation / RCA	15	Dijkstra et al. (2021); Dijkstra et al. (2022); Triana and Sulistyorini (2021); Jenkins, D'Alesio, and Gann (2021); Hung, Lin, Chen, and Huang (2023); Jenkins et al., 2017; Kachalia et al., 2018; Li et al. (2018); Lim et al. (2022); Mello et al., 2016; Schulz (2025); Widihastuti, S., Hartini, S., & Kusdarini, E. (2017); Mononyane (2020); Wailling et al., 2022; Wang et al., 2020
Face-to-face meeting	10	Dijkstra et al. (2022); Triana and Sulistyorini (2021); Jenkins, D'Alesio, and Gann (2021); Hung, Lin, Chen, and Huang (2023); Jenkins et al., 2017; Kachalia et al., 2018; LeCraw et al. (2018); Lim et al. (2022); Mononyane (2020); Wailling et al., 2022
Early disclosure	5	Dijkstra et al. (2022); Kachalia et al., 2018; LeCraw et al. (2018); Lim et al. (2022); Wailling et al., 2022

Elements are ordered by Count (n) from highest to lowest. Setting and country are described in the narrative.

Outcome Metrics

The studies describe tangible remediation packages, primarily compensation through refunds or fee waivers, follow up care or rehabilitation, and monetary payments. These findings are consistent across hospital networks in the United States and in comparative summaries that include the United States, Australia, the Netherlands, and Germany, as well as in reports from China and Indonesia. Resolution times tend to be faster than in full litigation, with a higher share of pre litigation settlements observed in Open Disclosure and Communication and Resolution Programs and in clinical mediation. This trend is most evident in the United States and New Zealand, both operating under no fault regimes. Several studies also report reductions in defensive or total costs when resolution occurs earlier. See Table 4 for summary of outcome metrics, citations, and study settings.

Nearly all reports complete the cycle with system level improvements, such as revisions to standard operating procedures, quality or communication programs, and registries or complaint channels, which are documented as follow up actions. Justice and satisfaction outcomes are strongly reflected in qualitative findings: patients and families report validation, clarity, and psychosocial support, while healthcare professionals gain peer support and a learning environment without stigma. Numerical values, such as compensation amounts, median resolution times, pre litigation percentages, and costs, vary across jurisdictions, but the overall direction is consistent: earlier resolution at lower cost, accompanied by documented organizational learning.

Across comparable reports (Florida pre-suit mediation, Beijing court-annexed mediation, and China People's Mediation Committees), time-to-resolution ranged from ≈87 days (~3 months) to ≈13 months; Florida programs typically closed within ≤6–<9 months, Beijing mediation averaged ≈13 months versus ≈27 months for judged cases, and China PMC averaged ≈87 days. Resolution outside trial ranged ≈74–90% (≈74.3% settled/dismissed/withdrawn in Florida pre-suit; ≈90% non-judicial closures in China PMC), while cost reporting was heterogeneous and not directly comparable across jurisdictions (see S2)

Table 4. Outcome metrics

Outcome family	Metric / value (direction)	Example metric (if reported)	Papers	Locus / Setting	Denominator / notes
Settlement before court (%)	Higher share resolved pre-filing/ pre-judgment	n/r (direction consistently ↑ across US CRP; explicit % varies by study)	Mello 2016; LeCraw 2018; Jenkins 2017; Jenkins 2021;	US hospitals (Florida CRP/pre-suit mediation); Europe (NL	Denominators differ (all claims vs eligible cases). Some studies report 'successful

			Dijkstra 2022; Hung 2023	complaint bodies); Taiwan (court mediation)	mediation' not strictly 'no filing'.
Time to resolution	Shorter than full litigation; court mediation faster than judgment	n/r (often reported narratively as faster; medians not harmonized)	Mello 2016; LeCraw 2018; Jenkins 2017; Jenkins 2021; Li 2018	US hospitals (CRP/pre-suit mediation); Beijing court mediation	Time definitions vary (incident→closu-re vs claim→closure).
Costs (defense/t otal)	Lower defense/total costs with early resolution	n/r (direction ↓; numeric values vary by network/year)	Mello 2016; LeCraw 2018; Jenkins 2017; Jenkins 2021	US hospitals (Florida networks)	Some report defense cost only; others total cost. Specify when citing study-level numbers.
Compensat ion (type/valu e)	Refund/fee waiver; continued care/rehabilitati on; monetary payment	n/r (values reported in several single-site studies; not standardized across jurisdictions)	Mello 2016; LeCraw 2018; Jenkins 2017; Jenkins 2021; Dijkstra 2022; Li 2018; Wang 2020;Widihastuti 2017; Maulana 2023; Lim 2022; Hung 2023	Hospitals & AMCs (US, NL/DE); China (Guangdong/Beiji ng); Indonesia; Singapore; Taiwan	Some list package components rather than amounts; cross-study currency/PPP not harmonized.
Prevention & system change	SOP updates; quality/commu nication training; registry/compl aints channel established	n/r (mostly narrative implementation, not quantified)	Dijkstra 2022; Mello 2016; Jenkins 2021; Wailling 2019; Wailling 2020; Wailling 2022; Lim 2022; Hung 2023	US; Europe (NL/EU); Aotearoa New Zealand; Singapore; Taiwan	Indicators of implementation rate seldom reported; treat as qualitative outcome.
Perceived justice & satisfaction	Patients: validation, clarity/closure, psychosocial support; Clinicians: peer-support and learning	n/r (qualitative themes; few standardized scales)	Jenkins 2017; Jenkins 2021; Mello 2016; Wailling 2019; Wailling 2020; Wailling 2022; Dijkstra 2022; Triana & Sulistyorini 2021	US; Aotearoa New Zealand; Europe (comparative); Multi-country review	Primarily thematic analysis; specify sample and method when citing.

Directional synthesis across included studies; example metrics marked n/r where not harmonized across jurisdictions.

Factors Associated with Mediation Success Across Studies

The success of mediation and restorative justice programs is shaped by several key factors. Physician participation in mediation sessions has a significant positive effect on the likelihood of resolution. Case severity also matters: nonfatal cases are far more likely to settle through mediation than cases involving death or serious injury. Hospital level influences outcomes as well, with primary and secondary hospitals showing higher success rates than tertiary hospitals. Claim size is another determinant; larger claims generally reduce the chances of success, whereas moderate claims increase them. Longer case processing times likewise reduce the likelihood of successful mediation. See Table 5 for summary of these determinants and their directional effects.

Process factors are critical. Confidentiality, together with the use of certified mediators, creates a safe space for open discussion and increases the likelihood of early settlement. Facilitator neutrality and the presence of independent expert panels further enhance fairness and credibility, contributing to success. By contrast, cases involving severe harm, such as disability or death, are seldom resolved through mediation because they often require formal legal proceedings to ensure accountability.

Overall, restorative programs are more likely to succeed when physicians are involved, claims are moderate, cases are nonfatal, and neutral mediators operate within a regulatory framework that supports transparency and openness. Conversely, large claims, prolonged proceedings, and severe harm reduce the probability of success and may warrant formal legal action. These factors apply broadly across countries, although contexts such as the United

States, China, Taiwan, and New Zealand differ in regulatory frameworks and policy implementation, which can shape mediation and dispute resolution outcomes.

Table 5. Factors associated with mediation success across studies

Driver	Impact Direction	Effect Size / Detail	Locus/Setting	Papers
Presence of doctor in the session	Positive impact on success	Odds of success approximately 39 times higher (95% CI 3.05–499.32; p=0.005)	Taiwan; hospital mediation	Hung et al., 2023
Severity of harm: non-fatal vs fatal	Positive impact on success (non-fatal)	Odds Ratio (OR) approximately 2.53 (non-fatal cases more likely to be mediated)	Guangdong, People's Mediation Committee (PMC)	Wang et al., 2020
Hospital level	Positive impact on success (primary/secondary > tertiary)	OR approximately 1.84 (primary) & 2.09 (secondary) compared to tertiary	Guangdong, PMC	Wang et al., 2020
Claim amount (value of claim)	Negative impact on success for high claims	Success likelihood decreases by approximately 7% for every increase of 10,000 CNY in claim value	Guangdong, PMC	Wang et al., 2020
Duration of case handling (days)	Negative impact on success with prolonged resolution	Success likelihood decreases by approximately 0.2% for every additional day	Guangdong, PMC	Wang et al., 2020
Severe harm (disability/death)	Negative impact on success	All severe harm cases failed to be mediated	Taiwan; hospital mediation	Hung et al., 2023
Mediation confidentiality/ privilege & certified mediator	Positive impact on success (safe space for disclosure, higher chance of early resolution)	Evidence from comparative programs of pre-suit mediation/CRP	Florida, US; hospitals/networks	Jenkins et al., 2017; Jenkins, D'Alesio & Gann, 2021; LeCraw et al., 2018; Mello et al., 2016
Neutrality of facilitator & independent expert panel	Positive impact on success (trust, fairness, neutrality, timeliness)	People's Mediation Committee design with independent mediators (legal/medical/psychological background) and expert panel support	Guangdong, PMC	Wang et al., 2020
Court mediation vs judgment	Mediation: faster and lower payment; some cases still end in judgment	Comparative findings on court-annexed mediation	Beijing, court-annexed mediation	Li et al., 2018
Complexity & type of dispute (diagnostic, obstetric, therapeutic)	Negative impact on success when highly complex or standards are contested	Higher likelihood of judicial decision rather than mediation settlement	Beijing, court mediation	Li et al., 2018
Regulatory support (apology law, duty of candour, no-fault scheme)	Positive impact on success (enables early disclosure, safe dialogue)	Synthesis across multiple countries	US, NZ, NL/EU	Dijkstra et al., 2022; Wailling et al., 2019/2020/2022; Mello et al., 2016

Conditions Limiting Restorative Suitability and Recommended Pathways

Based on the mapping of 19 studies, several conditions make the restorative approach less suitable and more appropriately handled through ethical, regulatory, or judicial channels. You can see Table 6 for a consolidated

summary of these conditions and the recommended pathways. First, in cases involving severe harm, such as permanent disability or death, the likelihood of successful mediation drops sharply. In several studies, all cases involving severe harm failed to reach mediation, indicating that formal accountability through legal proceedings is more appropriate. Second, when facts and standards of care are heavily disputed, or when cases involve multiple defendants and require extensive evidentiary review, they tend to conclude with court judgments. More complex medical disputes, for example those concerning diagnosis, obstetrics, and therapy, frequently end in legal decisions rather than mediation. Third, when there is suspicion of gross negligence, malice, or recurring patterns of misconduct, the restorative approach is inadequate without formal investigation and sanctions. Confidentiality in mediation and the use of certified mediators are essential to ensure a safe and open process, as shown in cases from Florida, United States.

Fourth, significant conflicts of interest or power imbalances, especially in the absence of an independent facilitator, can undermine trust and reduce the likelihood of agreement. The success of mediation depends heavily on the neutrality of facilitators and the presence of independent expert panels to maintain fairness and avoid bias. Overall, the restorative approach is not suitable when harm is severe, when evidence and standards are highly contested, or when there are indications of malice or recurring negligence. In such circumstances, ethical, regulatory, or litigation pathways are more appropriate, although restorative processes may still operate in parallel to support transparency and psychosocial recovery.

Table 6. Conditions limiting restorative suitability and recommended pathways

Condition for Inappropriate Use	Explanation	Locus/Setting	Papers
Severe harm (disability or death)	Mediation is less likely to succeed when the harm is severe, such as permanent disability or death. These cases require formal accountability through legal channels.	Taiwan, Guangdong, Beijing	Hung et al., 2023; Wang et al., 2020; Li et al., 2018
Disputed facts or standards of care	When facts or medical standards are heavily contested or involve multiple defendants, the likelihood of mediation success decreases.	Beijing	Li et al., 2018
Gross negligence or malicious intent	In cases where gross negligence or malicious intent is suspected, restorative processes may be inadequate without formal investigation and sanctions.	Florida, Guangdong	Mello et al., 2016; Wang et al., 2020
Power imbalance or conflict of interest	Mediation may fail when there is a significant power imbalance or conflict of interest without a neutral facilitator, or when a key party, such as the lead doctor, is absent.	Guangdong	Wang et al., 2020
Lack of legal protections (e.g., apology law, duty of candour)	Without legal protections for disclosures (such as apology law or mediation privilege), restorative processes may be inappropriate or counterproductive.	Various settings, including the US and China	Dijkstra et al., 2022; Li et al., 2018

Stakeholders and Oversight in Restorative Medical Dispute Resolution

In the context of restorative justice, particularly for medical dispute resolution, oversight and legal frameworks play a crucial role in ensuring accountability and transparency. Multiple stakeholders have defined roles to keep restorative processes effective, including clinical teams, patient safety units, insurance companies, ethics committees, and regulatory bodies. You can see Table 7 for a summary of stakeholders, their roles, and the associated oversight mechanisms.

Clinical teams present factual information and implement service improvements, while patient safety units ensure compliance with standard operating procedures, the quality of Root Cause Analysis, and the adoption of preventive measures. Facilitators or mediators maintain balanced participation and psychological safety, ensuring fair dialogue. Insurance companies help assess and implement compensation but do not dominate clinical decisions. Ethics committees evaluate conflicts of interest and oversee follow up actions, and regulatory bodies or complaint commissions intervene when external oversight or formal reporting is required.

Geographically, practices in Southeast Asia show hospital based adaptations, including the use of interpreters and culturally sensitive facilitation techniques. For example, in Indonesia, caucus sessions are used in mediation to surface hidden interests, whereas Singapore and Taiwan emphasize structured disclosure to enhance transparency.

Clear authorization is essential regarding who may offer an apology and compensation, along with proper documentation of timelines and follow up registries to ensure accountability. A hybrid model that integrates restorative pathways such as Open Disclosure, Communication and Resolution Programs, and clinical mediation with ethical and regulatory obligations and options for litigation is the most realistic approach. This model enables

earlier resolution while ensuring that compensation and system improvements are implemented promptly, and, when necessary, it can operate in parallel with formal litigation.

Operationally, well prepared organizations have established procedures for Open Disclosure, Communication and Resolution Programs, and mediation, as well as consent forms, ground rules, and lists of accredited mediators. Regular training in empathic communication, difficult disclosure, negotiation, and bias awareness is also necessary to ensure fairness in practice. Performance is monitored using indicators such as resolution time, the proportion of pre litigation settlements, the type and value of compensation, defensive costs, and perceived fairness and satisfaction.

However, restorative approaches do not replace formal investigation or legal enforcement in cases involving gross negligence, malice, or recurring misconduct. In such circumstances, ethical, regulatory, or judicial pathways must take priority, while elements of transparency and psychosocial support may proceed in parallel to assist the process.

Overall, hybrid models that combine restorative practices with formal legal and regulatory processes tend to close cases earlier and at lower transaction costs than full litigation, where reported. Their effectiveness is supported by apology protections, mediation confidentiality/without-prejudice privilege, and neutral facilitation. For illustration, Florida's pre-suit mediation (confidential) resolves a large share of matters within ≤6–<9 months with ≈74% settled/dismissed/withdrawn and markedly lower defense costs (≈USD 5,205 per claim) relative to state/national benchmarks; in Beijing, court-annexed mediation has been documented to resolve disputes faster (≈13 vs ≈27 months) and with lower mean payments than judgments; China's People's Mediation Committees report ~90% non-judicial closures with ≈87-day average duration. These patterns reflect earlier fact-sharing and structured dialogue rather than any generalized no-fault legal design, and cross-jurisdiction cost figures remain not directly comparable.

Table 7. Stakeholders and oversight in restorative medical dispute resolution

Element	Description	Context/Example	Papers
Role of Clinical Team	Clinical team provides facts and service corrections.	Involvement in ensuring service quality and responding to patient harm.	Widihastuti, Hartini & Kusdarini, 2017; Maulana, Praja & Hakim, 2023; Li et al., 2018
Patient Safety/Risk Management	Ensures compliance with SOPs, RCA quality, and follow-up prevention.	SOP adherence and systematic risk management practices.	Dijkstra et al., 2022; Triana & Sulistyorini, 2021
Facilitator/ Mediator	Maintains balance of voices and psychological safety during the mediation process.	Facilitates communication and ensures fair dialogue in restorative sessions.	Wailling, Marshall & Wilkinson, 2019; Wailling et al., 2022
Insurance/Insurer	Involved in assessing and realizing compensation without dominating clinical decision-making.	Involved at the compensation stage, ensuring fairness while respecting clinical decisions.	Mello et al., 2016; LeCraw et al., 2018
Ethics Committee	Assesses conflicts of interest and ensures appropriate follow-up.	Ensures impartiality and fairness, and evaluates ethical dilemmas.	Wang et al., 2020
Regulatory Bodies/Complaint Committees	Involved when cases need external oversight or must be formally reported.	Oversight from external bodies to ensure legal and regulatory compliance.	Dijkstra et al., 2022
SOP and Cultural Sensitivity in Asia	In Southeast Asia, hospital SOPs adapted to include interpreter/assistant support and culturally sensitive session techniques (e.g., caucus for hidden interests in Indonesia).	Adaptations based on cultural and linguistic needs in Southeast Asian countries.	Widihastuti, Hartini & Kusdarini, 2017; Maulana, Praja & Hakim, 2023
Authorization of Apology and Compensation	Clear guidelines on who is authorized to apologize and offer compensation.	Important for transparency and clarity in restorative practices.	Triana & Sulistyorini, 2021; Dijkstra et al., 2022
Operational Governance (OD/CRP/Mediation)	Includes accredited mediator lists, consent forms, ground rules, and ongoing training on communication, negotiation, and bias awareness.	Ensures fair processes in all restorative practices.	Mello et al., 2016; LeCraw et al., 2018

Performance Monitoring	Performance is measured by indicators like resolution time, pre-litigation settlement rates, defensive costs, compensation types, and fairness metrics.	Regular assessments of mediation effectiveness and process improvements.	Jenkins et al., 2017; Mello et al., 2016
Restorative Process Limitations	Restorative practices do not replace formal investigations when there is gross negligence, malicious intent, recurring patterns, or forensic reporting obligations.	When restorative processes are insufficient, regulatory/legal actions must be prioritized.	Li et al., 2018; Mello et al., 2016
Hybrid Model	A hybrid model combines restorative practices with regulatory and litigation options in a parallel-controlled manner, allowing for dual tracks of resolution.	Triaged at hospital level with potential litigation if restorative processes fail.	Wang et al., 2020; Dijkstra et al., 2022
Legal Protections and Confidentiality	Confidentiality is maintained through written agreements or legal protections (e.g., apology protection and mediation privilege).	Florida, USA example: Mediation confidentiality facilitates open dialogue.	Mello et al., 2016; Jenkins et al., 2017
Examples of International Practices	The role of apology law, mediation privilege, fault-based tort, and regulatory guidelines are crucial to effective restorative justice systems.	In Florida, USA, pre-suit mediation enhances early disclosure and reduces defensive costs.	Dijkstra et al., 2022; Triana & Sulistyorini, 2021
Decision-Making in Compensation	Insurance involvement in determining compensation, while clinical decisions remain within the clinical team.	In Aotearoa New Zealand, no-fault schemes streamline compensation while ensuring regulatory compliance.	Wailling, Marshall & Wilkinson, 2019; Wailling et al., 2022
Case Escalation	Restorative justice can escalate to litigation or regulatory pathways when necessary, especially in severe cases or when negotiations fail.	Hybrid model: processes begin with restorative steps but shift to litigation when required.	Wang et al., 2020; Li et al., 2018

DISCUSSION

In healthcare, restorative approaches such as OD, CRP, and clinical mediation often appear procedurally similar, involving early acknowledgment, apology, RCA, face-to-face meetings, and follow-up. However, the meaning and effectiveness of these steps are shaped by cultural scripts that guide how actors discuss error, shame, and responsibility. In jurisdictions that uphold apology laws and mediation privilege, candor becomes a legally protected norm. In no-fault systems, the focus shifts from individual blame to relational recovery and system improvement, while in people's mediation, the socially and culturally legitimate mediator provides a neutral space that helps preserve the dignity of all parties. In short, practices that appear identical on the surface operate through different norms, power relations, and conceptions of justice in each context.

Cross-national findings show that the success of these approaches depends not only on procedural tools but also on a shift in interaction norms. The face-to-face forum moves communication away from legal documentation toward the lived experiences of patients and families. Validation and acknowledgment replace defensiveness as the initial response. Legal protection for apologies transforms risk calculation into a habit of early truth-telling, which in turn strengthens institutional trust and reduces adversarial escalation. When RCA findings are shared openly, personal experiences become evidence for revising standard operating procedures, linking relational repair directly to prevention and measurable organizational improvement.

Theoretical perspectives help clarify these mechanisms. Drawing on Goffman's concept of facework, apology functions not merely as a moral statement but as a strategy to maintain professional honor while restoring the dignity of those harmed (Goffman, 1967). This explains the relevance of mediators and techniques such as caucus in societies that value harmony. The legal consciousness framework proposed by Ewick and Silbey (1998) suggests that apology and privilege not only regulate behavior externally but also shape legal awareness, making candor an expected social norm. Within Zehr's restorative justice framework, the sequence of acknowledgment,

responsibility, and repair transforms individual dispute resolution into social learning (Zehr, 2002). Institutional trust, as discussed by Luhmann and Hardin, emerges as both the outcome and the precondition for sustaining openness (Luhmann, 1979; Hardin, 2002). Together, these dynamics mark a shift in organizational culture, as described by Schein (2010), from a defensive mindset to a reflective one.

Contextual factors define the boundaries of effectiveness. The strongest outcomes occur in nonfatal cases with clear post-RCA findings, moderate claim values, physician participation in dialogue, and policy frameworks that protect openness. In such contexts, the cultural script of saving face while admitting fault allows apologies to be offered without undermining professional dignity, while patients receive validation and credible plans for improvement. The results include faster resolution, lower defensive costs, and higher rates of pre-litigation settlement. Conversely, in cases involving gross negligence, malice, recurring patterns, or highly contested standards of care, restorative forums risk becoming ritualized apologies that provide cultural comfort but fail to ensure forensic accountability. In these circumstances, hybrid models that combine restorative forums with ethical, regulatory, or judicial channels are more legitimate and effective.

The Indonesian and Southeast Asian contexts demonstrate how cultural adaptation can strengthen the connection between relational healing and institutional change. The use of caucus provides a safe space to manage emotions and clinical hierarchies, consistent with the value of harmony. However, for social change to be sustainable, the apology script must be standardized, specifying who speaks, when, and in what language, while legal protections and operational guidelines should institutionalize openness as an organizational norm. Mediation outcomes should also be linked to system reform through clear deadlines, indicators, and traceable audits.

Current evidence, which remains hospital-centered and largely observational, highlights important research gaps. Further studies are needed in primary and community care to assess how cultural scripts mediate between policy and outcomes such as time, cost, trust, and system learning. Harmonizing definitions of start and end times and adjusting purchasing power parity for cross-country comparisons of compensation will strengthen inference and improve transferability.

By framing OD, CRP, and mediation as cultural practices rather than simple liability-management tools, this discussion illustrates how restorative justice can drive social change within healthcare organizations. It does so through linguistic scripts that enable apology without loss of face, institutional protections that normalize openness, and learning loops that translate experience into reform. This framework integrates facework, legal consciousness, restorative justice, and institutional trust to explain the transition from individual dispute resolution to organizational cultural transformation—an empirically grounded and theoretically relevant foundation for plural societies such as Indonesia.

CONCLUSION

This scoping review identifies how restorative approaches in healthcare—encompassing Open Disclosure, Communication and Resolution Programs, and clinical mediation—move beyond procedural frameworks to operate as cultural practices shaped by context, norms, and institutional trust. Their effectiveness depends on early acknowledgment, legal protection for apology, clinician participation, and facilitation within psychologically safe environments. However, restorative forums remain limited in cases of severe harm, contested standards of care, or recurring negligence, where formal investigation and judicial accountability are required. Evidence also remains concentrated in hospital based, high income settings and relies largely on observational data, restricting causal inference and transferability. Future studies should expand to primary and community care, apply comparative and theory informed designs, and integrate quantitative indicators such as resolution time, cost, satisfaction, and trust with qualitative insights on cultural scripts and institutional learning. Strengthening cross national measurement frameworks will enable fairer policy comparison and evaluation. Overall, the findings suggest that when openness is legally protected and culturally supported, restorative practice can bridge moral repair and organizational improvement, transforming disclosure from a defensive procedure into a reflective, trust building process within healthcare systems.

ACKNOWLEDGEMENT

The authors are sincerely grateful to the anonymous reviewers for their insightful and constructive comments, which significantly strengthened this manuscript. The authors also acknowledge the use of ChatGPT (OpenAI, GPT-4) to assist with language polishing, editorial refinement, and proofreading during manuscript preparation. All interpretations, revisions, and the final text are the sole responsibility of the authors, who critically reviewed and approved the complete manuscript.

Conflict Interest
The authors declare that they have no conflict of interest.

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