

Modelling Contributing Factors of Judicial Judgment in Medical Negligence Cases

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Abstract. Medical negligence litigation poses significant challenges for healthcare systems, justice institutions, and patient safety. Yet the specific criteria shaping judicial judgment in such cases — and the differential weight assigned to them by distinct professional actors — have not been empirically modelled. This study addresses this gap by examining the criteria that contribute to judicial judgment in medical negligence cases in Greece, with particular focus on their relative importance in determining liability outcomes and the amount of compensation awarded. Using a structured questionnaire administered to a convenience sample of 71 professionals — judges, lawyers, and medical experts — the study empirically assesses the significance attributed to 27 predefined adjudication criteria. The study analysed data using descriptive statistics, correlation coefficients, and multiple ordinary least squares (OLS) regression models, using participant characteristics such as profession, court type, and years of experience as explanatory variables. Results indicate that severity, permanence, and extent of harm, along with the existence of a causal link between the medical act and patient outcome, are consistently rated as paramount across all participant groups. The regression models exhibit limited explanatory power ($R^2 = 7\text{--}35\%$), reflecting broad inter-professional consensus on criterion ranking. The study identifies cross-court inconsistency in adjudication and procedural barriers to access to justice as institutional deficiencies linked to SDG 3 (Good Health and Well-Being) and SDG 16 (Peace, Justice, and Strong Institutions). These failures carry direct implications for insurance markets, healthcare expenditure, and the practice of defensive medicine. To address them, the study advances two concrete reform proposals: introducing harmonised adjudication guidelines to standardise judicial decision-making across courts, and establishing a no-fault compensation mechanism for the Greek healthcare system.

Keywords: medical error, medical malpractice, court decisions, awarded amounts, sustainable development goals framework (SDG).

INTRODUCTION

Adverse events and medical errors within healthcare systems, over recent years, represent one of the principal causes of iatrogenic harm,

permanent disability, and mortality on a global scale, while simultaneously entailing a considerable economic burden that is ultimately

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borne by society at large (Bovbjerg & Raymond, 2003; Mello, 2002; QuIC, 2000; Vozikis & Riga, 2012; Arlen, 2013). Experts acknowledge that patient safety is closely linked to the provision of quality healthcare services. A considerable body of scholarly work contends that such instances of iatrogenic injury are predominantly attributable to the underlying weaknesses, omissions, and functional inadequacies inherent in the healthcare system itself (Vozikis & Riga, 2012). Systematic identification and analysis of these incidents can contribute to a more comprehensive understanding of systemic shortcomings, facilitating the development of policies and strategies and the implementation of targeted interventions to reduce the incidence of physical harm. The generation of knowledge about the medical errors and adverse events encountered by patients throughout their engagement with the Greek healthcare system constitutes a dependable means of enhancing the quality of healthcare services, safeguarding patient safety, and containing healthcare expenditures (Thomas & Petersen, 2003; Devine, Clayton, Dunford, Seying, & Pryce, 2001).

In the adjudication of a medical negligence case, the outcome of the trial and, consequently, the compensation awarded and the amount thereof, arise from the formation of judicial judgment and, specifically, from the judges, based on the assessment of all factual events and circumstances, of the evidence invoked by the two parties involved — patient and physician — as introduced and proven at trial by their legal representatives, as well as by the appointed medical experts and technical consultants of the parties involved. More generally, they arise from all those elements based on which it is ultimately judged whether there has been a breach of the rules of medical science and ethics and, by extension, of the rules of law to the detriment of the patient (Giesen, 1988; Vanezis, 2013). The judicial decision issued, in which the judicial judgment is reflected about the type and extent of the award and amount of civil compensation to the injured party and his or her relatives in cases of medical negligence, is reached through the assessment of certain basic criteria concerning the nature, magnitude and severity of the medical error. The liability of the physician in the exercise of his or her function, the damage caused to the patient/injured party and the causal link between the two preceding elements, as well as other important criteria for the

formation of judicial judgment included in our research, establish and determine the legal liability of the physician for medical errors and the amount of compensation and monetary satisfaction awarded due to non-pecuniary damage or mental anguish (Samanta et al., 2006; Kachalia et al., 2008).

The problem arising from this process, however, lies in the precise determination of the criteria that may influence the outcome of the trial, as well as in the importance attributed to those criteria by the parties involved and mainly by judges, their interaction, and the limitations, parameters and conditions provided by law as determining factors for the existence of medical error, the medical liability arising therefrom and the determination of the amount of compensation and monetary satisfaction awarded to the injured party or also to his or her relatives. Certain criteria are clearly of major importance for the outcome of judicial judgment in medical error cases, such as the severity, extent and permanence of the harm caused to the patient by the medical error, the existence and type of negligence of the physician, the existence of a causal link between the medical act or omission and the harmful outcome suffered by the patient, the impact of the medical error on the quality of the injured party's subsequent life, and the age of the latter. However, other criteria are also considered important in adjudicating cases of this kind (Hugh & Dekker, 2009; Edozien, 2001; Levin, 2017). In addition, these criteria are taken into account and assessed by all parties -judges, lawyers, experts, etc.- involved in the adjudication of each case, although each of them attributes the same or different weight to certain criteria (Deitschel et al., 2002; Wright, 2021; Sanbar & Pataki, 1978; Pergolizzi & LeQuang, 2024; McAbee et al., 2009; Paul & Narang, 2017).

These issues show that assessing certain criteria is difficult because perspectives on their importance vary by case, and because each case is individualised and particular. This results in different amounts of compensation and monetary satisfaction being awarded, even in cases of medical error that share, for the most part, similar characteristics. The difficulties arising from each party's prioritisation of criteria, as well as the inherent complexity of each medical error case, create uncertainty about the outcome of the relevant trial (Hugh & Dekker, 2009; Edozien, 2001). As a result, the correct and reasoned assessment of such a case becomes

difficult and, for this reason, the contribution of all parties involved is of utmost importance for a fair judicial judgment.

Within this framework, determining a common set of criteria is important. These criteria arise from theoretical review, court practice and case law. The parties should consider and follow them, each within the context of their own contribution, to ensure a fair trial and a correct judicial decision (Kampra & Vozikis, 2026).

In our research study, an attempt is made to determine all or most of the essential criteria that may influence the outcome of judicial judgment and the issuance of the relevant judicial decision in medical error cases, particularly in determining the amount of compensation and monetary satisfaction awarded in cases of liability arising from medical negligence, as well as to assess the degree to which each criterion influences that decision,

Initially, primary data were collected through a questionnaire and then empirically analysed to assess the contribution/significance of each criterion to the trial of medical negligence cases, both overall and for each group of involved parties.

This analysis uses graphical representations and empirical techniques, such as calculating correlation coefficients between the criteria, to determine whether relationships exist among the criteria themselves.

This analysis sits at the intersection of two pivotal United Nations Sustainable Development Goals. SDG 16 (Peace, Justice and Strong Institutions) calls on member states to promote the rule of law, ensure equal access to justice for all, and build effective, accountable, and inclusive institutions at every level (T. Campbell, 2023). SDG 3 (Good Health and Well-Being) requires not merely the provision of health services but the institutional scaffolding of quality, safety, and accountability without which those services cannot reliably achieve good outcomes (Kruk et al., 2018). Medical-liability adjudication stands at the nexus of both goals: it is simultaneously a justice-system function and a healthcare-quality accountability mechanism, and the quality of that adjudication has direct implications for the sustainability, equity, and effectiveness of both systems (Panagiotou, 2016).

From an SDG 16 perspective, the criteria Greek courts apply when adjudicating medical-negligence claims directly test whether the justice

system delivers equitable, predictable, and rights-protective outcomes for all parties. Where adjudication criteria are inconsistent or opaque, the system falls short of the SDG 16 standard of institutional coherence. It compromises meaningful access to justice for both patients seeking redress and healthcare professionals requiring legal certainty (Yamin & Lander, 2015). The governance-measurement literature underscores that sustainable institutions require transparent and measurable accountability frameworks, and that their absence erodes trust in legal institutions and undermines judicial legitimacy (Malito et al., 2020).

METHODS

For the determination of the most important criteria contributing to the adjudication of a medical error case and to the consequent award of compensation and monetary satisfaction, the data collected concern the quantitative and qualitative assessment of these criteria by the parties involved, who participate in the process of issuing the relevant judicial decision.

For this reason, we collected these data using a questionnaire, in which participants (from a convenience sample of related professions) were asked to assess the importance of certain key criteria that may contribute to the judicial outcome of a case of this kind.

This assessment was carried out in three stages/levels. In the first stage, participants declared their profession, total years of experience in that profession, participation in adjudicating medical negligence cases, the type of court before which the specific cases were adjudicated, and the total number of medical cases they had adjudicated. In the second stage, participants assessed the importance or non-importance of each criterion for issuing the judicial decision, about determining the amount of compensation and monetary satisfaction awarded. At the third and final stage, the criteria considered important in the previous stage were assessed again by the participants, this time about the Significance Level of each criterion, on a measurement scale from 21 to 100, according to which the criteria are classified into the following categories depending on their score:

21–40: Low Importance

41–60: Moderate Importance

61–80: High Importance

81–100: Extremely High Importance

The criteria that participants in the questionnaire were asked to assess amount to twenty-seven (27) and concern factors such as the severity and type of medical negligence, the type, extent and severity of the harm suffered by the injured party, the impact of the medical error on the social and professional life of the injured party, as well as other factors such as the age and sex of the injured party, the injured party's incapacity for work and whether it is permanent,

the monetary correspondence between the compensation awarded and the damage caused, the specialty of the physician, the evidence taken into account during the adjudication of the specific case, whether or not a medical expert report was conducted, and other factors that will be referred to in greater detail below.

Therefore, the assessment criteria considered for the present analysis are presented in the following Table 1:

Table 1. Assessment Criteria Regarding the Determination of the Amount of Compensation Awarded in Medical Negligence Cases

Criterion Number	Criterion Description
Criterion 1	The severity of the fault and the type of negligence of the physician or nurse — conscious or unconscious negligence — as well as the circumstances under which the harm occurred.
Criterion 2	The type, severity and extent of the harm suffered by the patient/injured party.
Criterion 3	The sex of the patient/injured party.
Criterion 4	The age of the patient/injured party, particularly in cases involving permanence of the harm.
Criterion 5	The type and consequences of the disability or disfigurement of the patient/injured party, particularly where it affects his or her future.
Criterion 6	The incapacity of the patient/injured party for work — permanent or temporary — particularly in cases involving permanence of the harm, for example limb amputation.
Criterion 7	The necessity of addressing the injured party's state of health.
Criterion 8	The certainty of the occurrence of future damage to the injured party and the determination of its extent.
Criterion 9	The correspondence between monetary satisfaction and the damage suffered by the injured party.
Criterion 10	Compliance with the principle of proportionality in relation to the damage suffered by the injured party, namely that the amount awarded should be neither trivial nor excessively high.
Criterion 11	Any contributory fault of the injured party in the damage suffered, namely the contribution of the injured patient himself or herself, through his or her own conduct, to the extent of the damage sustained.
Criterion 12	The existence of a specialty in the person of the physician, for example resident physician or specialist.
Criterion 13	The specific specialty of the physician, for example surgeon, internist, gynaecologist, anaesthesiologist, etc., and whether, on the basis of his or her personal abilities, knowledge, etc., he or she was able to foresee or avoid the punishable outcome.
Criterion 14	The financial, social/employment and personal situation of the parties involved, and mainly of the patient/injured party, for example employed or unemployed, single-parent family, with or without dependent members, etc.
Criterion 15	The care that the physician, nurse, etc. should and could have exercised, and whether he or she acted in the manner in which any average physician of his or her specialty would have acted and in accordance with the commonly recognised rules of science.
Criterion 16	The actions of the responsible physician or nurse after the tortious act, and the actions taken or not taken by him or her to address the harm sustained by the patient.
Criterion 17	The joint assessment of documents submitted and relied upon by the parties as independent evidence or for the drawing of judicial presumptions, including the assessment of sworn witness statements, medical opinions and expert reports, etc.
Criterion 18	A prior acquittal or conviction decision of a criminal court.

Criterion 19	The claims and evidence submitted by the parties before the judgment of the court.
Criterion 20	Whether or not an expert report was conducted where special knowledge of art or science was considered necessary.
Criterion 21	Whether liability arises from physicians or nurses serving in public nursing institutions, private clinics and diagnostic centres, or from private physicians.
Criterion 22	Whether the patient/injured party was adequately informed of the consequences of the intervention and whether his or her consent was obtained prior to each medical act.
Criterion 23	The type of cause giving rise to the medical error, for example underestimation of the patient's symptoms, incorrect diagnosis, lack of timely treatment, incorrect handling of a medical instrument, etc.
Criterion 24	Whether the medical error and its consequences were due to an act or omission of the physician or nurse, or to a fortuitous event.
Criterion 25	The life expectancy of the injured patient, in terms of the extent to which it affects the award of future compensation.
Criterion 26	The consequences for the quality of life of the injured patient, in terms of the extent to which they affect the award of future compensation.
Criterion 27	Previous judicial decisions and court case law in similar previously adjudicated cases of medical error.

Using simple descriptive statistics and graphical representations, the table provides a more detailed presentation of the sample. At the same time, the assessment of the importance of the selected criteria is carried out both for the sample as a whole and in subcategories, depending on specific characteristics of the participants, such as profession — judge, lawyer, medical expert, etc. — and the total number of cases in which the latter participated.

Subsequently, the relationship between these characteristics and the importance of the criteria is determined empirically by calculating correlation coefficients.

The aim is to determine the weight each party assigns to the criteria for adjudicating a case involving the award of compensation and monetary satisfaction due to medical negligence and, by extension, whether all participants consider any criteria equally important, regardless of status.

Finally, the importance of each criterion is examined in light of the participants' profession/capacity, the type of court — civil, military, administrative — in which they participated in the adjudicated medical negligence cases, the total number of cases in which they participated, their years of professional experience, and their years of experience in the adjudication of medical negligence cases, applying regression analysis using the least squares method.

The empirical methodology of the present study — comprising a structured questionnaire applied to a representative corpus of judicial decisions, statistical processing of case characteristics, liability outcomes, compensation awards, and causal patterns, together with graphical representation of distributional findings — is designed to generate policy-relevant metrics compatible with SDG indicator monitoring frameworks. The dataset of coded judicial decisions constitutes a national-level formal-sector sample of healthcare dispute resolution outcomes, providing the empirical base from which Indicator 16.3.3 estimates can be derived and validated. The compensation award and damage-classification data furnish cost-of-harm evidence that directly informs assessment of out-of-pocket financial burden under Indicator 3.8.2 and the institutional quality inputs relevant to UHC accountability under Indicator 3.8.1. By situating case-law patterns within this internationally recognised measurement framework, the study advances an integrated approach that links judicial performance evaluation to sustainable development benchmarks (United Nations, 2023a; United Nations, 2023b; United Nations, 2023c; WHO, 2025a; WHO, 2025b).

RESULTS

The sample consists of 71 participants, who are, as a rule, judges, medical experts and

lawyers and who have participated in administrative, civil and military courts.

The overwhelming majority of participants were judges or lawyers (51% and 34%, respectively), while only 13% were medical experts (see Figure 1).

Judges and lawyers are the core adjudicating actors in the cases examined. At the same time, medical experts fulfil an advisory role, assisting judges in assessing medical errors when specialist scientific or technical knowledge is required.

However, Greek case law also includes numerous medical negligence cases in which the court reaches its decision without a medical expert report, considering such a report unnecessary and the remaining evidence sufficient.

In addition, the sample included a minority of 3% of participants from the academic field who have been involved in cases of medical error and the consequent obligation to compensate the injured party or his or her relatives.

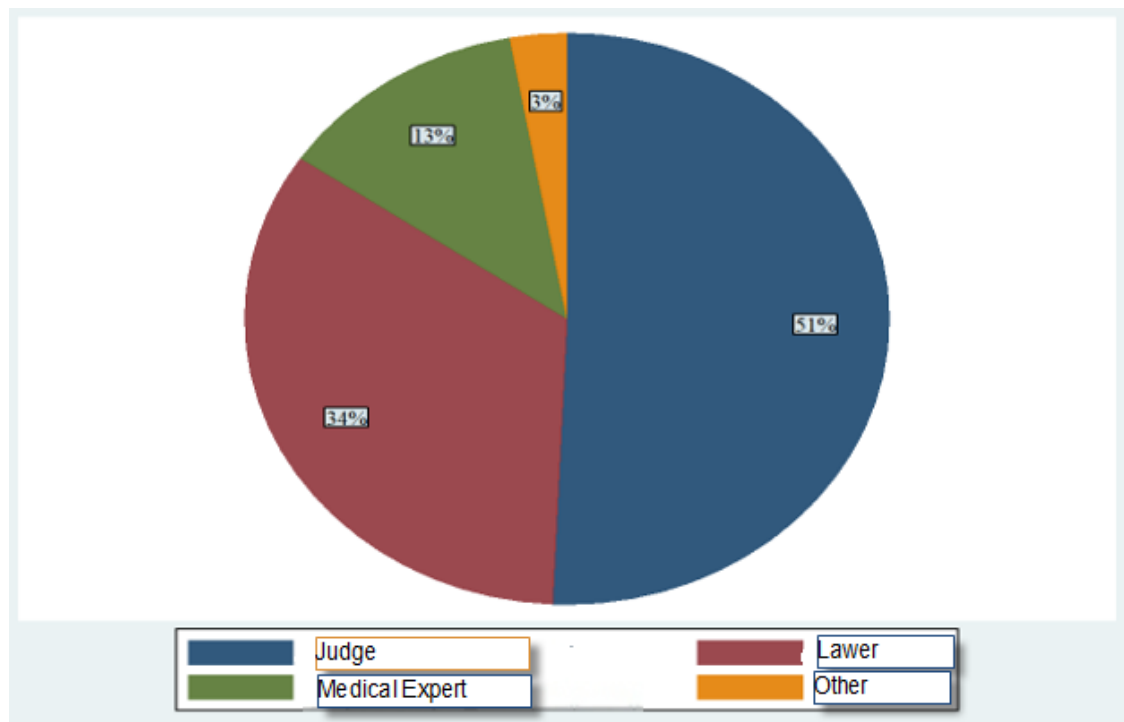


Figure 1. Professions of Participating Officers

Regarding the type and jurisdiction of the court in which the participants exercised their duties, three out of four participated in either a civil court (44%) or an administrative court (35%), while 10% participated in both.

Only 11% took part in a military court, as reflected in Figure 2.

Most cases in the sample involve liability attributable to physicians or nurses in public or private healthcare institutions, or to private practitioners. Military court cases represent a small minority, consistent with the proportionally limited population connected to military jurisdiction.

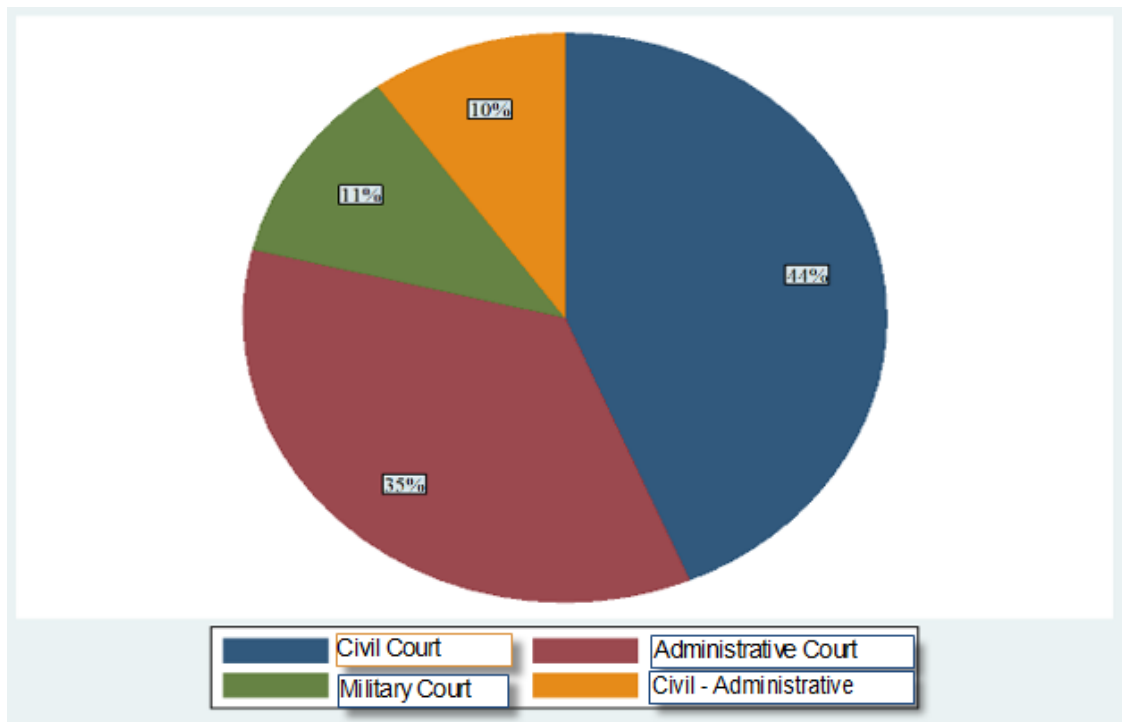


Figure 2. Type of Court of Participating Officers

In addition, Figure 3 presents the total number of medical negligence cases in which the sample participants took part.

Medical negligence cases remain proportionally limited within the Greek judicial landscape: 95% of participants had handled

fewer than 50 such cases throughout their career, and 70% fewer than 20. This pattern persists despite an increasing trend in recent years; Greece recorded approximately 5 new court cases per 100 inhabitants in 2022 (CEPEJ).

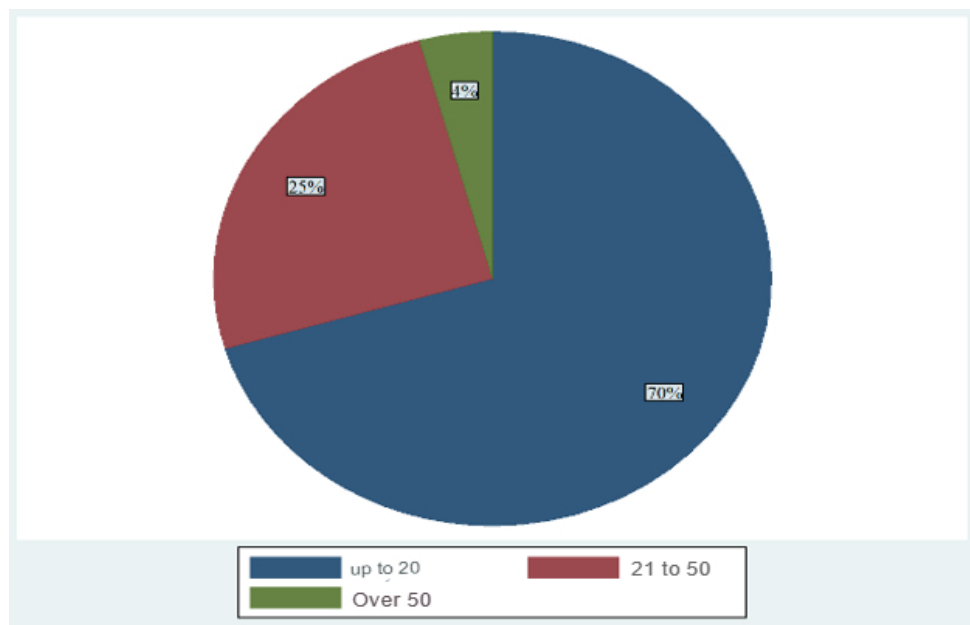


Figure 3. Number of Court Cases of Participating Officers

According to Table 2, the average overall experience of the participants in the sample is approximately 25 years, indicating extensive professional experience. In addition, judges and lawyers have, on average, 26 and 27 years of experience, respectively, while medical experts

and the remaining participants have less average experience, at 15 and 18.5 years, respectively, which nevertheless still represents a high total number of years.

These results are reliable, given that the variance also indicated values close to the mean.

Nevertheless, there was significant deviation among participants, since the minimum values by profession ranged from 1 to 6 years, while the

corresponding maximum values ranged from 21 to as many as 47 years of experience.

Table 2. Years of Professional Practice

Profession	Mean	Variance	Standard Deviation	Minimum Value	Maximum Value
Judge	25.55	26	7.52	1	35
Lawyer	27.04	30	11.19	4	47
Medical Expert	14.33	10	5.22	6	21
Other	18.5	18.5	4.94	15	22
Total	24.43	25	9.48	1	47

In addition, the overall average experience of participants in medical negligence cases reached approximately one decade, as shown in Table 3. As Table 2 also shows, medical experts had the least experience adjudicating medical error cases, at approximately 6 years.

These results showed a relatively high deviation at the individual level, as before, with the minimum years of experience by profession ranging from 1 to 5 years, while the maximum values ranged from 9 to 33 years.

Based on the above, the relative rarity of medical error cases compared with other court cases to date is apparent, given that most participants have dealt with up to 20 cases on this subject matter during their careers, and far fewer with up to 50. At the same time, their

overall professional experience and experience adjudicating such cases averaged more than one decade.

However, the assessment of these specific cases is of utmost importance, due to their seriousness and the impact — mainly financial and professional, but also moral — that they have on defendant/accused physicians, nurses, etc., and injured patients, with the bodily integrity and often the very life of the latter being at stake, as well as due to the great importance they present for the outcome of judicial judgment, which must be fair and based on the principle of proportionality in determining the amount of compensation and monetary satisfaction awarded.

Table 3. Years of Experience in Medical Negligence Cases

Profession	Mean	Variance	Standard Deviation	Minimum Value	Maximum Value
Judge	12.91	10	7.52	1	32
Lawyer	9.33	5	9.54	1	33
Medical Expert	5.77	6	2.22	2	9
Other	10.5	10.5	7.77	5	16
Total	10.73	7	8.98	1	33

The above data constitute characteristics that will be used further for the empirical study of the criteria under examination, which contribute to the adjudication of a medical error case.

More specifically, the results of the assessment of the criteria by the participants will be examined not only collectively, but also at subgroup level, based on the aforementioned characteristics.

However, greater weight will be placed on the assessment of the criteria by the participant groups, as these are formed based on their profession.

The purpose is to determine which criteria each group of participants and involved parties assigns greater weight to, according to their function in the adjudication of a case of this kind, and, by extension, whether some of these criteria are common among these groups.

In other words, the criteria considered to be of paramount importance by judges are compared with those considered most important by lawyers and medical experts and, in this way, any similarities and differences in the manner in which they assess them during the conduct of the trial are identified.

Initially, the results from the assessment of the criteria under examination by the

participants in the sample are presented as a whole in Figure 4.

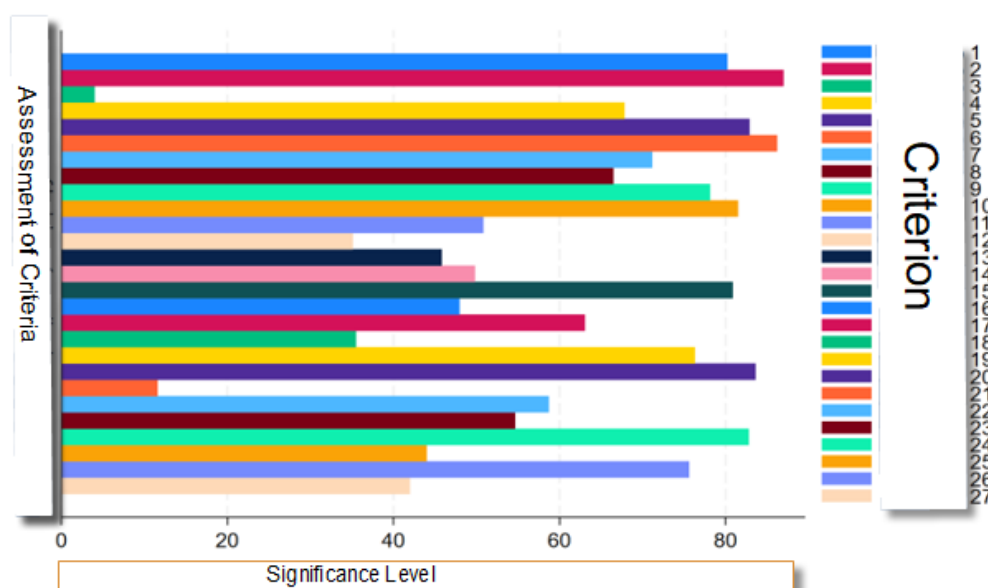


Figure 4. Assessment of Medical Negligence Criteria and Determination of the Amount of Compensation and Monetary Satisfaction Awarded

The criteria which are considered, on average, to be of extremely high importance, namely above 80%, by all participants without exception, are the following:

Criterion 1: The severity of the fault and the type of negligence of the physician or nurse;

Criterion 2: The type, severity and extent of the harm suffered by the patient/injured party;

Criterion 5: The type and consequences of the disability or disfigurement of the patient/injured party;

Criterion 6: The incapacity of the patient/injured party for work;

Criterion 10: Compliance with the principle of proportionality in relation to the damage suffered by the injured party;

Criterion 15: The care that the physician, nurse, etc. should and could have exercised;

Criterion 20: Whether or not an expert report was conducted where special knowledge of art or science was considered necessary; and

Criterion 24: Whether the medical error and its consequences were due to an act or omission of the physician or nurse, or to a fortuitous event.

Among the remaining criteria, the majority were assessed between the categories of low importance — 21–40 — and moderate importance — 41–60 — while a total of seven criteria were assessed as being of high importance — 61–80. These included elements

such as the age of the injured party (Criterion 4), the correspondence between monetary satisfaction and the damage suffered by the injured party (Criterion 9), and the evidence submitted by the parties before the court (Criterion 19).

To ensure reliable results, in cases where participants considered a criterion unimportant, we automatically assigned a value of zero (not important at all). In this way, possible extreme cases of participants who considered a criterion very important are offset against the cases of the majority, and the final result approaches more closely the true value of the criterion's importance.

In addition, there were only two criteria, Criterion 3 — the sex of the injured party — and Criterion 21 — whether liability arises from physicians and nurses serving in public or private hospitals or from private physicians — which were judged by all participants as not important for the assessment of medical negligence cases and for determining the amount of compensation and monetary satisfaction awarded.

In general, the ranking of the criteria under study, as shown in Figure 4, did not differ significantly among participants from different professions. However, there were marginal differences in assessing specific criteria, mainly those situated between the groups of high and extremely high importance (see Table 4).

The most decisive criteria for determining the compensation amount are the severity and permanence of harm, work incapacity, proportionality of award to damage, the conduct of an expert report when specialist scientific knowledge is required, and whether causation derived from a physician's act or omission versus a fortuitous event.

However, each of the above also examines and assigns weight to additional criteria in adjudicating the case in question.

For example, lawyers and judges also place great weight on criteria such as the evidence and claims the parties introduce at trial, as well as the effects of medical negligence on the injured party's quality of life. In addition, both lawyers and medical experts consider the severity of the fault and the type of disability suffered by the injured party to be of paramount importance, criteria which judges consider very important but of secondary importance compared with the aforementioned criteria.

Table 4. Assessment of Medical Negligence Criteria by Profession

Criterion	Total		Judges		Lawyers		Physicians	
	<i>Average</i>	<i>Assessment</i>	<i>Average</i>	<i>Assessment</i>	<i>Average</i>	<i>Assessment</i>	<i>Average</i>	<i>Assessment</i>
1	80.22	Extremely High	76.38	High	83.79	Extremely High	86.66	Extremely High
2	86.97	Extremely High	85.97	Extremely High	88.54	Extremely High	88.33	Extremely High
3	4.01	Not at all	1.38	Not at all	8.54	Not at all	0.00	Not at all
4	67.81	High	63.33	High	71.66	High	79.99	High
5	82.88	Extremely High	79.58	High	87.08	Extremely High	81.66	Extremely High
6	86.21	Extremely High	81.97	Extremely High	90.95	Extremely High	89.44	Extremely High
7	71.15	High	71.52	High	73.41	High	62.22	High
8	66.49	High	61.25	High	75.58	High	64.44	High
9	78.12	High	76.66	High	82.00	Extremely High	72.77	High
10	81.50	Extremely High	82.08	Extremely High	80.62	Extremely High	81.11	Extremely High
11	50.83	Moderate	53.05	Moderate	48.12	Moderate	41.66	Moderate
12	35.11	Low	26.55	Low	44.58	Moderate	38.88	Low
13	45.81	Moderate	43.91	Moderate	41.45	Moderate	57.22	Moderate
14	49.83	Moderate	46.16	Moderate	53.25	Moderate	57.77	Moderate
15	80.85	Extremely High	83.88	Extremely High	73.25	High	86.11	Extremely High
16	47.95	Moderate	42.75	Moderate	50.66	Moderate	57.77	Moderate
17	63.05	High	60.47	Moderate	66.79	High	58.88	Moderate
18	35.49	Low	30.94	Low	43.16	Moderate	32.22	Low
19	76.30	High	73.19	High	80.75	Extremely High	75.55	High
20	83.60	Extremely High	83.75	Extremely High	83.29	Extremely High	85.00	Extremely High
21	11.59	Not at all	7.55	Not at all	19.58	Not at all	9.00	Not at all
22	58.70	Moderate	43.91	Moderate	77.79	High	64.44	High
23	54.64	Moderate	52.22	Moderate	60.41	Moderate	46.66	Moderate
24	82.80	Extremely High	81.80	Extremely High	83.58	Extremely High	83.33	Extremely High

25	44.00	Moderate	37.36	Low	52.12	Moderate	42.88	Moderate
26	75.61	High	70.69	High	83.75	Extremely High	73.33	High
27	41.98	Moderate	34.88	Low	49.37	Moderate	43.88	Moderate

Interesting results emerged when the data were studied in relation to other characteristics, particularly regarding the importance of the criteria for assessing medical negligence cases and determining the amount of compensation awarded as a consequence.

Additionally, Table 5 presents tendencies in the importance of the criteria, depending on the number of medical negligence cases in which each participant from the aforementioned categories participated.

Indicatively, Criteria 1 — severity of fault, type of negligence of the physician and circumstances under which the harm occurred — and 5 — type and consequences of the disability or disfigurement of the patient — were characterised as being of extremely high importance by the groups of participants who had participated either in fewer than 20 cases or in more than 50 cases, whereas those who had

participated in 21 to 50 cases considered them less important.

Another case concerns Criteria 15 — the care that the physician should and could have exercised — 17 — the joint assessment of documents submitted and relied upon by the parties — and 23 — the type of cause giving rise to the medical error — whose importance increased markedly as the number of cases in which participants had participated approached 50.

By contrast, the importance of criteria such as Criterion 6 — the incapacity of the patient/injured party for work — and Criterion 24 — whether the medical error and its consequences were due to an act or omission of the physician or nurse, or to a fortuitous event — showed a downward trend as participation in medical error cases increased.

Table 5. Assessment of Medical Negligence Criteria by Number of Cases

Criterion	Up to 20 Cases		21–50 Cases		More than 50 Cases	
	Average	Assessment	Average	Assessment	Average	Assessment
1	81.62	Extremely High	75.55	High	85.00	Extremely High
2	87.80	Extremely High	83.61	Extremely High	93.33	Extremely High
3	5.70	Not at all	0.00	Not at all	0.00	Not at all
4	69.00	High	67.50	High	50.00	Moderate
5	85.20	Extremely High	76.66	High	81.66	High
6	87.76	Extremely High	83.38	Extremely High	77.33	High
7	69.84	High	74.16	High	75.00	High
8	66.88	High	69.16	High	44.00	Moderate
9	76.96	High	79.72	High	88.00	Extremely High
10	81.50	Extremely High	79.16	High	95.66	Extremely High
11	47.60	Moderate	57.77	Moderate	63.00	High
12	40.60	Moderate	20.33	Low	32.33	Low
13	46.50	Moderate	45.88	Moderate	34.00	Low
14	52.28	Moderate	44.16	Moderate	43.00	Moderate

15	78.76	High	85.27	Extremely High	89.33	Extremely High
16	45.78	Moderate	54.77	Moderate	43.33	Moderate
17	63.00	High	59.44	Moderate	85.66	Extremely High
18	35.16	Low	36.77	Low	33.33	Low
19	79.06	High	68.88	High	75.00	High
20	82.48	Extremely High	86.38	Extremely High	85.66	Extremely High
21	12.46	Not at all	11.11	Not at all	0.00	Not at all
22	63.44	High	45.83	Moderate	57.00	Moderate
23	55.50	Moderate	45.27	Moderate	96.66	Extremely High
24	81.62	Extremely High	87.77	Extremely High	72.66	High
25	44.74	Moderate	43.05	Moderate	37.33	Low
26	79.10	High	69.44	High	54.66	Moderate
27	43.56	Moderate	36.55	Low	48.33	Moderate

As regards the type of court before which actions for compensation and monetary satisfaction as a consequence of medical error were adjudicated, the assessed importance of the criteria was similar in cases adjudicated before civil and administrative courts (see Table 6).

With the exception of Criterion 1, which was considered more important in cases falling within the jurisdiction of civil courts than in administrative courts, and Criterion 15, for which the opposite was observed, all other criteria had corresponding degrees of importance between the two types of court.

In addition, the criteria characterised as extremely important in both cases were those considered of paramount importance in the sample as a whole, as shown in Figure 1.

In the case of military courts, according to Figure 13, the most important criteria that emerged were four, namely Criterion 1 — the severity of the fault and the type of negligence of

the physician or nurse — Criterion 2 — the type, severity and extent of the harm suffered by the patient/injured party — Criterion 20 — whether or not an expert report was conducted where special knowledge of art or science was considered necessary — and Criterion 24 — whether the medical error and its consequences were due to an act or omission of the physician or nurse, or to a fortuitous event.

Therefore, in a military court, the criteria that contribute decisively to the decision issued in cases of this subject matter mainly concern the severity and type of medical negligence, the damage caused to the injured party, and the causes giving rise to the medical error.

As shown in Table 6, the assessed importance of the criteria shows several similarities between civil and administrative courts, while differing significantly in military courts.

Table 6. Assessment of Medical Negligence Criteria by Type of Court

Criterion	Civil Court		Administrative Court		Military Court	
	Average	Assessment	Average	Assessment	Average	Assessment
1	85.51	Extremely High	70.80	High	86.87	Extremely High
2	90.32	Extremely High	84.00	Extremely High	80.62	Extremely High
3	6.61	Not at all	0.00	Not at all	0.00	Not at all
4	70.32	High	66.60	High	56.87	Moderate

5	86.29	Extremely High	79.20	High	73.75	High
6	89.77	Extremely High	84.44	Extremely High	72.50	High
7	67.64	High	75.80	High	57.50	Moderate
8	69.32	High	64.20	High	53.12	Moderate
9	78.48	High	81.40	Extremely High	61.25	Moderate
10	83.22	Extremely High	82.20	Extremely High	72.50	High
11	45.80	Moderate	60.80	Moderate	41.87	Moderate
12	42.74	Moderate	23.64	Low	21.25	Low
13	50.16	Moderate	41.60	Moderate	36.37	Low
14	51.87	Moderate	49.64	Moderate	27.62	Low
15	77.35	High	85.60	Extremely High	76.25	High
16	48.09	Moderate	44.96	Moderate	36.25	Low
17	62.51	High	58.68	Moderate	58.12	Moderate
18	41.45	Moderate	30.12	Low	32.62	Low
19	81.70	Extremely High	72.60	High	60.00	Moderate
20	84.96	Extremely High	84.00	Extremely High	80.00	High
21	12.29	Not at all	9.68	Not at all	0.00	Not at all
22	71.35	High	47.00	Moderate	40.12	Moderate
23	52.90	Moderate	50.00	Moderate	52.50	Moderate
24	84.54	Extremely High	78.20	High	85.62	Extremely High
25	45.54	Moderate	39.80	Moderate	32.50	Low
26	80.48	High	72.60	High	56.87	Moderate
27	48.87	Moderate	36.40	Low	18.87	Not at all

From the aforementioned results, it is found that the determination of the Significance Level of the criteria under examination presents several similarities among the participants in the sample, with some criteria being considered primary for the adjudication of a medical negligence case by everyone without exception, while others do not contribute at all to the judicial outcome formed and to the amount of compensation awarded, such as, for example, the sex of the patient.

However, there were differences in some criteria, which varied depending on the professional capacity of the participants, the total number of cases in which they had participated, and the type of court before which each case was adjudicated.

Nevertheless, these differences were very marginal, which means that, at first sight, it cannot be clearly determined to what extent the importance of the criteria differs from participant to participant or from court to court.

For this reason, the effect of factors such as the participants' profession on the assessment of the criteria under examination is studied econometrically, through correlation and regression analysis.

Initially, variables are created that depict the different characteristics of the participants in the sample and are used to study the effect of these characteristics on the values of each criterion. The variables that arise in this way are the following:

Y: The years of experience of each participant in his or her profession.

Case: The years of experience participating in judicial cases of medical negligence.

J: Dummy variable taking the value 1 if the participant is a judge.

L: Dummy variable taking the value 1 if the participant is a lawyer.

D: Dummy variable taking the value 1 if the participant is a physician, as an expert.

Civ: Dummy variable taking the value 1 for participation in a civil court.

Adm: Dummy variable taking the value 1 for participation in an administrative court.

Mil: Dummy variable taking the value 1 for participation in a military court.

S20: Dummy variable taking the value 1 for participation in fewer than 20 adjudicated medical negligence cases.

A50: Dummy variable taking the value 1 for participation in more than 50 adjudicated medical negligence cases.

Subsequently, the relationships between each criterion and the above variables are determined by calculating correlation coefficients, with appropriate adjustments for dummy variables. The calculation formula is derived from the Pearson product-moment correlation coefficient as follows:

$$r_i = \frac{\bar{x}_1 - \bar{x}_0}{s_n} \sqrt{\frac{n_1 n_0}{n^2}} \quad (1)$$

where $\bar{x}_1$ and $\bar{x}_0$ are the means of the subgroups in which the dummy variable took the values 1 and 0, respectively; s_n is the standard deviation of the values of each criterion for the whole sample; n_1 and n_0 are the number of cases for the different values of the dummy variable; and n is the total number of observations in the sample.

The results from the calculation of the correlation coefficients are presented in *Appendix Table 1*, where it is observed that, in the majority of cases, the values of the coefficients were very small and close to zero, a fact which indicates a very weak correlation between the values of the criteria and the different characteristics of the participants in the survey.

However, certain exceptions were observed, where the correlation was relatively strong. For example, the assessment values of several criteria showed a negative correlation with the values of the dummy variable depicting participation by those who took part in a military

court — Mil — a fact which indicates that those who participated in the adjudication of medical error cases before this type of court assessed the criteria as being of lower importance than the average.

In general, the near-zero correlation coefficients show that participants assessed the criteria' importance similarly, without being significantly affected by each participant's background.

A strong correlation coefficient confirms the direction and strength of the linear relationship but does not quantify the magnitude of change in criterion importance. Even in cases of high correlation, a criterion's importance may shift without crossing the 20-point threshold that separates importance categories.

Therefore, the effect of participants' characteristics on the assessment of criterion importance is studied through regression analysis using ordinary least squares (OLS). In this way, the following multiple linear model is estimated:

$$\text{Criterion}_i = \beta_0 + \beta_1 Y_i + \beta_2 \text{Case}_i + \beta_3 J_i + \beta_4 L_i + \beta_5 D_i + \beta_6 \text{Civ}_i + \beta_7 \text{Adm}_i + \beta_8 \text{Mil}_i + \beta_9 \text{S20}_i + \beta_{10} \text{A50}_i + \varepsilon_i \quad (2)$$

in which the basic assumptions of the least squares method apply and $\varepsilon_i \sim \text{iid}(0, \sigma^2)$.

The results from the estimation of model (2) for each criterion are recorded in detail in *Table 7*.

The regression models exhibit limited explanatory power ($R^2 = 7\text{--}35\%$), indicating that

participant characteristics do not substantially account for variation in criterion importance. Most coefficients are statistically non-significant at the 5% level, confirming broad cross-group consensus on criterion rankings.

However, there were isolated cases where the coefficients were statistically significant and

substantially influenced the final assessment. For example, in the case of the variable recording the years of experience of participants in judicial cases of medical error — Case — the statistically significant values ranged between -1.38 and 1.36. This indicates that, for specific criteria, the more participants' experience in adjudicating medical negligence cases, the more the assessed importance of each criterion increased or decreased, by about 1.3% per year.

In addition, only two cases of significant influence on the assessment of the criteria were recorded with regard to the type of profession of the survey participants.

More specifically, one concerned Criterion 2 — type, severity and extent of the harm suffered by the patient/injured party — in which it is observed that judges and lawyers considered this criterion to be of higher importance for the judicial decision reached than did the remaining participants, assessing its importance by 26.27% and 19.59% more than the average, respectively.

The second case concerned Criterion 11 — the contribution of the injured party himself or herself to the damage suffered — which participants did not consider important for adjudicating the cases, recording a 43.05% decrease in the final assessment of importance.

Participants' participation in military courts also significantly affected the assessment of the criteria, since the estimated values of this variable were negative. Indeed, for several criteria, the statistically significant values ranged from -22.4% to as much as -41.33%, a fact which, indicating that these criteria were assessed up to two levels of importance lower than inthermore, the estimated values of the constant were statistically significant in 23 of the 27 estimations of model (2), showing the expected degree of assessment of each criterion if the values of all variables were simultaneously zero.

The regression intercepts should not be interpreted as baseline criterion importance scores. In several models, the constant exceeded the 100-point scale (e.g., Criteria 13 and 24: intercepts of 102.26 and 113.94) or contradicted participants' actual ratings (Criteria 11, 13, and 16 returned intercepts of 94.75, 102.26, and 91.41, respectively, despite being rated moderate to low importance).

Finally, it is worth noting that the validity of the regression results was examined with regard to multicollinearity, heteroscedasticity and autocorrelation, and none of these problems was found to exist.

Table 7. Regression Results

Crite rion	Con	Y	Case	J		L	D	Civ	Adm	Mil	S20	A50	R ²
1	75.97*	0.60	-1.38*	3.47		6.92	11.43	2.07	-7.28	21.25	-3.51	11.13	0.24
2	72.99*	-0.23	0.37	26.27*		19.59*	15.67	1.75	-12.71*	-22.24*	0.904	13.92	0.24
3	17.62	-0.15	0.22	-8.22		-7.33	-17.66	-3.58	-10.43	-10.17	4.49	-5.31	0.15
4	59.76*	0.90	-0.28	16.40		24.23	36.25	-8.67	-5.41	-12.86	-6.40	-11.70	0.13
5	96.14*	-0.05	0.21	-9.20		-10.18	-16.28	-4.59	-11.94	-17.12	5.99	-1.02	0.16
6	99.19*	-0.06	0.00	-5.71		-1.46	-3.43	-1.72	-5.42	-17.55*	-3.68	-8.63	0.28
7	86.19*	-0.38	0.75	7.17		5.15	-4.94	-13.20	-13.31	-41.51*	-4.63	-1.07	0.18
8	63.74*	0.43	0.75	-0.14		2.57	-0.01	-6.48	-17.41	-37.16*	-3.32	-27.41	0.26
9	70.93*	0.49	0.03	7.46		4.98	2.01	2.06	-5.60	-32.87*	-9.57	10.46	0.26
10	67.92*	0.77*	-0.79*	12.09		1.19	6.89	5.09	-5.56	-13.29	-5.23	19.53	0.17

11	94.75*	-0.63	0.46	-	38.88	-	31.59	43.05*	9.06	22.82	-4.17	-	12.69	-3.15	0.24
12	64.93*	-0.31	0.12	-	12.23	-	-8.85	17.49	-	30.06*	-	26.87	13.58	0.94	0.22
13	102.26*	0.67	-1.14	-	40.03	-	54.43	33.77	-2.18	-	15.50	13.83	-	12.23	29.29
14	47.85	0.79	-1.22*	18.55		14.10	28.77	-	19.66	21.14	33.29	-3.54	1.68		0.23
15	92.30*	0.27	0.28	-5.41		-	19.67	-0.21	-7.95	-8.36	-	24.91	-3.64	-1.21	0.12
16	91.41*	-0.15	0.56	-	12.42	-	10.11	2.73	-	26.80*	-	46.71	-	16.52	21.54
17	90.25*	-0.57	0.33	4.42		5.40	-5.19	-	19.90	25.43	-	29.93	0.08	20.65	0.14
18	47.35	-0.99	0.84	-1.18		11.83	-	12.94	19.87	6.20	-2.20	-	12.75	-2.94	0.11
19	86.54*	-0.43	0.18	10.91		6.44	-5.38	-0.21	-	14.88	29.55*	-	-0.24	4.51	0.20
20	78.51*	-0.18	0.25	12.49		10.11	8.78	8.36	0.47	-	10.61	-	-9.42	2.65	0.07
21	14.30	-0.88*	1.36*	21.82		28.77	14.67	-	16.47	20.25	41.33*	-	1.21	-9.50	0.23
22	46.36*	1.18*	-0.88	24.56		-0.69	-5.75	9.98	-0.52	2.58	1.95	10.02			0.35
23	58.09	-0.43	-0.30	24.31		30.12	14.16	-	24.95	23.98	17.42	7.36	53.93*		0.17
24	113.94*	-0.23	-0.29	-6.04		-7.09	-	10.83	-0.20	-	10.79	-4.07	-	14.52	20.35
25	84.72*	-0.30	0.90	-	29.10	-	19.72	26.46	17.10	19.28	33.22	0.88	-	18.93	0.15
26	88.49*	-0.04	0.04	-1.65		-0.02	-	10.80	-6.24	-	14.36	27.75	2.22	-	18.35
27	84.26*	-0.59	0.33	-	13.39	-	10.15	22.60	-0.30	-	16.94	41.42	-	10.94	2.49

Note: * indicates statistical significance at the 5% level.

In any case, the above findings confirm the corresponding correlation coefficients, showing that participants largely agreed on the Significance Level attached to each criterion.

There were, of course, isolated exceptions where they did not fully agree on the assessment of the criteria.

The most characteristic case was that of those who participated in military courts, since they scored several criteria significantly lower than the others, showing that in those specific courts comparatively less weight is given to criteria such as the necessity of addressing the injured party's state of health, the certainty of the occurrence of future damage to him or her, and

the correspondence between monetary satisfaction and the damage he or she suffered.

Nevertheless, the most important of the criteria examined concerned the seriousness of the physician's fault and negligence, how serious the harm suffered by the injured party was, the actions that the physician should have taken and the care that he or she should have exercised in accordance with the rules of medical science, whether or not special scientific knowledge is provided before the court when considered necessary, and the extent to which the medical error is due to an act or negligence of the physician.

Subsequently, the criteria concerning the type and consequences of the disability suffered by the injured party, his or her possible incapacity for work, compliance with proportionality between the compensation and monetary satisfaction awarded and the damage suffered by the injured party, as well as the evidence made available to the court by the parties, are considered.

DISCUSSION

Through the processing of a significant number of judicial decisions from various types and levels of courts, as well as through the bibliographic and empirical review carried out, the extremely significant clinical, economic and broader social consequences of medical error are demonstrated, both for the patient/injured party himself or herself and his or her family, and for the liable physician — nurse, etc. — as well as for the healthcare bodies involved, the insurance system and the economy in general (Coetzee & Carstens, 2011; Stauch, 2011).

In Greece, judicial decisions concerning medical negligence cases, whether they concern public hospitals or private clinics and medical centres, as well as private physicians, show a continuously increasing trend, while the average amount of the sums awarded differs appreciably depending on whether they are awarded mainly by administrative or civil courts, and to a lesser extent by military courts (Panagiotou, 2016; Kampra & Vozikis, 2026)

Through judicial judgment as reflected in case law, it is obvious that every unfortunate outcome of a medical incident does not also constitute an unlawful act or omission of the physician, as is often attempted to be presented with the aim of securing excessive amounts of compensation or monetary satisfaction, since a decisive criterion of judicial judgment is whether the physician acted in accordance with the rules and teachings of medical science.

Prevention of medical errors also emerges and is assessed as an important factor, through the improvement of the conditions under which the medical function is exercised, both in public hospitals and in private clinics and private centres (Lungu, 2023; Clancy, 2009).

The patient's ability, whether correct or incorrect, to obtain medical information through the internet; the rapid increase in new technologies relating to medical science; the

operation of healthcare units — for example, staff shortages; the insufficient development of primary healthcare; and the financial magnitudes at stake for those involved in medical error — physicians, injured parties, relatives, lawyers, the healthcare system, etc. — lead patients, much more in the modern era, to claim compensation and to pursue criminal proceedings against the physician — nurse, etc. (Ng, 2024; Uznadze, 2025).

The increase in individual as well as group insurance contracts, by which physicians seek to shield themselves in the event that they face issues involving actions against them for compensation and monetary satisfaction due to medical error, has increased rapidly over the last decade both in Greece and in other European countries (Glassman, 2004).

Of particular interest is the fact that most cases of medical errors concern omissions rather than actions by physicians (Levin, 2017).

Great emphasis in the formation of judicial judgment is also placed on the individual qualities and abilities of the physician during the performance of the act or omission, which play an important role in establishing his or her negligent conduct, as well as on the specific circumstances each time, such as whether the case was urgent or chronic, whether it required experience and what kind, whether the physician was a specialist or resident physician, etc.

Indeed, according to Article 12 para. 3 of the Code of Medical Ethics, the physician is obliged to proceed immediately to perform the necessary medical act to avert the danger threatening the patient's life or health, without the patient's agreement, which is not possible under these conditions, or that of his or her relatives.

It is also worth noting that the amount of compensation awarded by the courts has decreased compared with the past, especially in civil courts compared with administrative courts (Glassman, 2004).

Differences are also observed in the courts' treatment of damage of the same intensity and extent as a consequence of medical errors, resulting in a lack of uniformity in the amounts awarded.

The causal link between medical error and the damage that occurred is elevated to a fundamental prerequisite for the existence of a tort and of the consequent obligation to compensate the injured patient, beyond the

proven damage and fault of the physician (Kachalia et al., 2008; Edozien, 2001).

According to the case law of our country, no causal link exists and, consequently, no medical liability exists, and the accused physician receives an acquittal judgment even in cases of death of the injured party, if it is proven that death would have occurred almost with certainty even if the physician had acted in accordance with the duty imposed by medical science.

In medical error and in the medical liability arising therefrom, the concept of the average social person is identified with the average scientifically trained physician.

A highly important criterion is the negligence of the physician, who, in the performance of his or her duties, did not demonstrate the care and diligence required according to an objective assessment, which any moderately prudent and conscientious person within his or her professional circle could and should have exercised under the same factual circumstances (Edozien, 2001; Samanta et al., 2006).

It is also demonstrated that equal protection must be ensured both for patients against medical errors and for physicians against unjust civil, criminal or disciplinary proceedings (Giesen, 1988).

In forming their judicial judgment, the above courts deal with important and difficult issues concerning the review of the correct or incorrect performance of medical acts, touching upon the supreme good of human life, whether this concerns harm to health or even death

The foundation of the claim for compensation from unlawful acts or omissions during the performance of medical acts consists of the provisions of Articles 105 and 106 of the Introductory Law to the Civil Code, in conjunction with the provisions of Articles 13 and 24 of Compulsory Law 1565/1939 “On the Code for the Practice of the Medical Profession”.

Also in the case of compensation under Articles 105 and 106 of the Introductory Law to the Civil Code, it is provided that: “If the person who suffered damage contributed by his or her own fault to the damage or to its extent, the court may not award compensation or may reduce the amount thereof”.

Exceptionally, and for reasons of urgency and criticality of the situation, the consent of one parent is sufficient pursuant to Article 1516 of

the Civil Code — for example, first aid in the event of injury (Uznadze, 2025; Gharthey, 2023).

In medical criminal liability, negligence constitutes the form of fault, since the physician cannot have acted intentionally; that is, cannot have pursued or accepted the punishable outcome; rather, that outcome is due to the lack of due care on his or her part or to his or her indifference (Samanta et al., 2006).

Informing the patient is a medical act and must therefore be carried out only by a person who has medical status. Otherwise, it constitutes medical error and, at the same time, defective fulfilment of the duty to inform (Uznadze, 2025).

This has led to an increasing tendency toward defensive medicine and a more suspicious or cautious stance among healthcare professionals (Panagiotou, 2016; Clancy, 2009).

From an SDG 3 perspective, the accountability function of medical-negligence adjudication is inseparable from the broader architecture of healthcare quality. Research shows that high-quality health systems require robust accountability infrastructure — clear professional standards, transparent oversight, and credible enforcement — and that deficiencies in any of these pillars directly undermine patient safety and population health outcomes (Kruk et al., 2018). Quality of care has been identified as a neglected yet decisive driver of improved health outcomes, one that depends in part on whether accountability mechanisms send clear and consistent signals to the medical profession about expected standards of conduct (Akachi & Kruk, 2017). In this light, courts function as a form of institutional accountability: the clarity and consistency of their judgments contribute directly to, or detract from, the achievement of SDG 3 objectives at the systemic level.

From a health economics perspective, adjudication inconsistency in medical negligence cases generates measurable inefficiencies across three interconnected domains: insurance markets, aggregate healthcare expenditure, and the clinical behaviour of individual physicians. The global market for medical malpractice liability insurance has grown to tens of billions of dollars in annual premiums, and unpredictable judicial benchmarks drive premium volatility, reserve uncertainty, and the withdrawal of affordable coverage (Segal & Sacopulos, 2009). Defensive medicine — the ordering of otherwise unnecessary tests, procedures, or referrals

primarily to generate a documented evidentiary record and reduce litigation exposure — represents one of the most economically significant by-products of an uncertain liability environment, with cost-burden estimates ranging from 5% to over 34% of total healthcare expenditure in affected systems (Harris, 1987; Studdert et al., 2010). The financial resilience of healthcare institutions and the insurance mechanisms that sustain them is therefore directly conditioned by the quality, predictability, and coherence of judicial adjudication (Vainieri et al., 2024; Colivicchi et al., 2024; Antoci et al., 2019).

This study's findings have direct implications for SDG 16 objectives. The cross-court inconsistencies in the weighting and application of adjudication criteria reflect a deficit of institutional coherence — precisely the fragmentation that SDG 16 calls on states to address by promoting the rule of law and building accountable, effective institutions (T. Campbell, 2023; Malito et al., 2020). The frequency with which meritorious actions are dismissed on procedural grounds of vagueness, rather than on the substantive merits of the alleged medical act or omission, signals an access-to-justice deficit that is inconsistent with SDG 16's imperative to ensure equal and meaningful access to justice for all (Yamin & Lander, 2015). Achieving the judicial and institutional reforms proposed in this study would thus constitute a concrete contribution to SDG 16 implementation within the Greek legal context.

With regard to SDG 3, the fragmentation of adjudication criteria documented in this study weakens the accountability infrastructure on which high-quality health systems depend. When courts apply variable standards, the signalling function of liability adjudication — communicating to the medical profession the conduct standards the legal order enforces — is degraded, undermining the incentive structures necessary for continuous improvement in care quality (Kruk et al., 2018; Akachi & Kruk, 2017). The National Health System staff shortages that multiple judgments identify as a contextual factor in negligence cases compound this institutional failure: accountability mechanisms cannot substitute for adequate resources, and the interaction between an under-resourced system and unclear legal standards creates a compounded risk for patient safety and health outcomes.

The economic costs of adjudication fragmentation are substantial and operate at multiple levels. At the clinical level, physicians operating under uncertain liability standards are incentivised to engage in defensive medicine — ordering diagnostics and procedures primarily to generate a documented evidentiary record rather than for direct clinical benefit — thereby driving up healthcare costs and potentially increasing patient exposure to iatrogenic risk (Harris, 1987; Studdert et al., 2010). The reputational mechanism through which liability law is theorised to discipline medical conduct is further distorted when judicial criteria are unclear, because practitioners cannot rationally calibrate their behaviour to an unpredictable adjudicatory standard. Evolutionary modelling of liability systems confirms that uncertainty over judicial benchmarks amplifies the prevalence and cost of defensive medicine in ways that are difficult to reverse without structural institutional reform (Antoci et al., 2019).

The financial resilience of healthcare providers is directly affected by the dynamics documented in this study. Institutions must allocate reserves for potential liability exposure; when that exposure is hard to estimate because judicial outcomes are inconsistent, reserve planning becomes distorted, with conservative provisioning diverting resources from clinical investment and insufficient provisioning creating acute financial shocks after large awards (Vainieri et al., 2024). The Italian National Health Service experience, in which risk-retention strategies have been adopted partly in response to the volatility of liability outcomes, illustrates a pattern that Greek public healthcare institutions may increasingly confront absent judicial reform (Colivicchi et al., 2024). Evidence from the United States further documents how hospitals adjust service portfolios, staffing levels, and facility decisions in response to tort-system conditions, with adverse consequences for access to care in the most litigation-exposed specialties (Mello et al., 2003). Structured institutional risk management that integrates legal exposure monitoring with quality-improvement processes has been shown to enhance care quality and reduce financial liability exposure (Quinlan et al., 1986).

Taken together, these findings generate a clear reform agenda spanning the judicial, systemic, and institutional levels. At the judicial level, the harmonisation of adjudication criteria through binding or quasi-binding guidelines

would directly advance SDG 16 by strengthening the rule-of-law credentials of the liability system and reducing access-to-justice disparities (T. Campbell, 2023). At the system level, consideration of no-fault and hybrid liability models -- which decouple compensation from proof of individual wrongdoing -- offers a pathway to reducing defensive-medicine incentives while improving the timeliness and equity of victim redress (Segal & Sacopulos, 2009); enterprise insurance and risk-pooling approaches would allow more efficient resource allocation across the healthcare system while moderating individual-provider exposure (Fenn et al., 2010; Chen, 2010). At the institutional level, the integration of liability risk management with clinical governance frameworks -- linking claims data to quality-improvement cycles -- represents the most direct route to aligning financial resilience objectives with SDG 3's vision of high-quality, accountable, and sustainable health systems (Quinlan et al., 1986; Akachi & Kruk, 2017; Kruk et al., 2018).

Limitations and Future Research

This study carries several limitations that should inform the interpretation of its findings. The sample of 71 professionals was drawn using a convenience sampling strategy, which may not fully represent the broader population of judges, lawyers, and medical experts engaged in medical negligence litigation in Greece. The single-country focus restricts the generalisability of findings to jurisdictions with different legal traditions, healthcare systems, or adjudication procedures. Data are self-reported and therefore subject to recall bias and social-desirability effects. Finally, the regression models have limited explanatory power ($R^2 = 7\text{--}35\%$), indicating that the participant characteristics measured in this study — profession, court type, and years of experience — do not fully capture the sources of variance in criterion importance ratings.

These limitations suggest several directions for future research. Multi-country comparative studies could examine whether the criterion rankings identified here hold across different legal systems and healthcare contexts, enabling cross-national evidence syntheses relevant to international health-governance frameworks. Probability-based sampling and larger sample sizes would enhance representativeness and statistical power. Qualitative methods — such as structured

judicial interviews or deliberative exercises— could illuminate the informal reasoning processes underlying criterion weighting that quantitative instruments alone cannot capture. Longitudinal designs tracking changes in adjudication patterns over time would allow researchers to evaluate the impact of policy reforms, including the harmonised guidelines and no-fault compensation mechanism proposed in this study.

CONCLUSIONS AND PROPOSALS

The empirical picture and the doctrinal analysis converge. The most frequent categories in the sample are those where the risk is high, time pressure is intense and proof is complex. Surgery and obstetrics are not merely numerically dominant. They are the categories in which the key problems of medical liability are condensed: information, technical performance, monitoring, timely response, expert assessment and causal link.

The distinction between public and private bodies shows that liability also has an organisational dimension. The court examines not only the physician as an isolated person, but also the environment in which the medical act was performed. The distinction between consequences shows that the severity of the harm affects not only the amount, but also the intensity of judicial review. The more serious the outcome, the greater the need for full, persuasive and specific reasoning.

The development of legal standards for improving the reasoning of judicial decisions in medical negligence must focus on the following fundamental points, as arising from the study and analysis of the judicial decisions included in the dissertation:

Strict and clear reasoning of the causal relationship

The decisions — for example, Areios Pagos 1269/2013, Areios Pagos 1419/2016 and Areios Pagos 1380/2019 — underline the need for detailed and unimpeachable reasoning of the link between negligence and the damaging outcome. It is proposed that an obligation be established for a full description of the factual circumstances, the medical acts and omissions, as well as the scientific documentation supporting the cause-and-effect relationship. The absence of clear reasoning leads to annulment of decisions or repeated trials,

undermining justice and the effectiveness of judicial proceedings.

Determination of objective criteria for negligence

Legal standards must clearly distinguish between conscious and unconscious negligence — for example, Areios Pagos 1220/2008 and Areios Pagos 45/2013 — precisely defining the elements constituting each type. Clear formulation of negligence criteria facilitates judicial assessment and reduces contradictory reasoning (Ferrara et al., 2013; O'Connell & Pohl, 1997–1998).

Strengthening of documentation based on medical opinions

The standards must require express and critical assessment of medical opinions, as noted in decisions — for example, Areios Pagos 1419/2016 and Council of State 2376/2017. Insufficient assessment or omission of reference to the opinions creates ambiguity and doubt about the validity of the decision.

Determination of criteria for the amount of compensation

The principle of proportionality must be incorporated into legal standards that determine the criteria for calculating compensation—for example, Areios Pagos 823/2024 and Council of State 1140/2017. The criteria must take into account the severity of the harm, the financial and social situation of the parties, as well as the degree of fault, ensuring fair and reasonable compensation (Knowles, 2022).

Separation of liability of physicians and legal persons

The standards must clarify the liability of individual physicians vis-à-vis hospitals/clinics, especially regarding the employment relationship and the concept of vicarious liability—for example, Kos Court of First Instance 824/2011 and Council of State 1140/2017. A clear distinction prevents legal ambiguities and facilitates the administration of justice (Crisp, 2017).

Emphasis on transparency and full recording of medical acts

The standards must incorporate the obligation to fully and accurately record medical acts and omissions, and to document them properly.

Full recording strengthens the reliability of the evidence and supports the reasoning of judicial decisions (CQuIPS, 2024).

Implementation of No-fault compensation schemes for medical injury

A no-fault compensation scheme for clinical negligence claims against the Greek NHS could be simpler than the existing litigation system and could support the development of a mutual NHS, as well as a positive feedback and learning culture. Several specific elements should be considered, including the advantages and disadvantages of no-fault schemes; choice of model; equality of coverage; cost and affordability; access to justice; and linkages to patient complaints processes, professional accountability and patient safety. With this in mind, the government must consider that such a scheme is the favoured way forward for the NHS in Greece. (Farrell, Devaney, Dar, 2010; Owusu-Dapaa, 2014; Pace, Golinelli, & Zakaras, L. 2004; Williams, 2007; World Bank, 2003).

Strengthening of procedures to avoid ambiguity

It is proposed that procedures be established to ensure that courts do not accept decisions with contradictory or insufficient reasoning. Provision must be made for the possibility of re-examination or cassation when such weaknesses are identified—for example, Areios Pagos 1269/2013 and Areios Pagos 1419/2016 (Queudot & Meurs, 2018).

Training of judges and medical experts

Improving reasoning requires training judges and medical experts in the legal and medical criteria for medical negligence. Such training will support the proper and consistent application of the standards and help avoid ambiguity and contradictions (Bornstein, 2004; Chodos, 2015).

Adopting these legal standards will enhance the quality and transparency of judicial decisions, reduce uncertainty and judicial disputes, and ensure the fair and effective administration of justice in medical negligence (Bismark, M., & Dauer, 2006).

Through a Greek and European review of cases involving the administration of justice for medical negligence, we identify common criteria used to determine compensation, as well as differences in how medical negligence is approached and treated (Watson & Kottenhagen, 2017).

The extent of the damage, medical expenses, loss of income, the patient's age, whether or not the harm is permanent and the effects of the medical error on the patient's subsequent life, court case law and the amounts

awarded in analogous cases, the evidentiary material of the specific case, the medical speciality, and the financial and social situation of the parties — patient/relatives, physician, etc. — are criteria that shape the amount of compensation awarded both in Greece and in the majority of European countries.

Author Contributions

Conceptualisation, A. K. and A.V.; methodology, A.K. and A.V.; formal analysis, A. K. and A. V.; resources, A.K. and A.V.; data curation, A.K. and A.V.; writing—original draft preparation, A.K. and A.V.; writing — review and editing, A.K. and A.V.; supervision, A.V. All authors have read and agreed to the published version of the manuscript.

Ethics Statement

As the study holds the following characteristics:

- The research sample participated anonymously as expert stakeholders and via a web-based questionnaire based on their professional and institutional capacities.
- No patients, vulnerable populations, biological material, or clinical interventions were involved,
- It is a non-invasive and non-interventional qualitative study based on

a web-based questionnaire.

- Questionnaire topics did not involve the collection of health-related information, sensitive personal data, or information concerning participants' private lives,
- All participants were fully informed about the content and the process of the study and their informed consent was obtained from all participants (see Web-based Questionnaire link: https://docs.google.com/forms/d/1Sd_hhbEalxHO7pwF7uBOoZqiNgLwPwI_KS6m9Z7M_aCro/edit)
- The study received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors

The above-mentioned research does not fall under the provisions of Article 279, par. 2a of Greek Law 4957/2022 and is therefore exempt from mandatory ethics review and approval.

Conflict of interest

The authors declare no conflicts of interest.

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Table of Greek Court Decisions

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