

Medical University of Plovdiv
Faculty of Public Health
Department of Social Medicine and Public Health



**Mediation as an Approach to Conflict Resolution in
Medical Practice**

Kostadin Yordanov Dimitrov, MD

ABSTRACT

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Scientific Supervisor:

Assoc. Prof. Tsonka Miteva-Katranjieva, DD, PhD

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Scientific Jury

Chair: Prof. Dr. Rumen Stefanov, MD

Members:

Prof. Dr. Boryana Parashkeva, MD

Prof. Dr. Boyko Kostov Bonev, MD

Assoc. Prof. Dr. Natalia Usheva, MD

Prof. Dr. Maria Anastasova Semerdzhieva, MD

Prof. Dr. Rumen Stefanov, MD

Alternate Members:

Assoc. Prof. Dr. Petar Bozhinov, MD

Assoc. Prof. Dr. Eleonora Hristova-Atanasova, MD

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All materials related to the defense are available at the Scientific Department of Medical University – Plovdiv and have also been published on the university's official website.

Note: The numbering of figures and tables in this abstract does not correspond to that in the dissertation.

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LIST OF ABBREVIATIONS AND SYMBOLS

A. General Abbreviations

- **CME** – Continuing Medical Education
- **MoH** – Ministry of Health
- **MoJ** – Ministry of Justice
- **NCPHA** – National Center for Public Health and Analyses
- **BMA** – Bulgarian Medical Association
- **NHIF** – National Health Insurance Fund

B. Statistical Tests and Metrics

- **SP** – standard error of the proportion
- **ANOVA** – Analysis of Variance
- **ANOVA Tukey post-hoc** – Tukey post-hoc test for pairwise comparisons following ANOVA
- **χ^2 (Chi-square)** – Chi-square test
- **df** – Degrees of freedom
- **U** – Mann–Whitney U test statistic
- **Z** – Z-score
- **r** – Pearson’s correlation coefficient
- **ρ** – Spearman’s rank correlation coefficient
- **τ -b** – Kendall’s tau-b coefficient
- **Exp(B)** – Exponentiated coefficient in logistic regression
- **B** – Coefficient of independent variable in regression model
- **Nagelkerke R²** – Pseudo R-squared in logistic regression
- **R²** – Coefficient of determination (explained variance)

- **Wald** – Wald test for significance of regression coefficients
- **Kolmogorov–Smirnov test** – Test for normality or distribution comparison
- **Cramer’s V** – Measure of association between categorical variables
- **Somers’ d** – Measure of ordinal association
- **Phi coefficient (Φ)** – Measure of association for 2×2 categorical tables
- **Wilcoxon signed-rank test** – Non-parametric test for related samples
- **Mann–Whitney U test** – Non-parametric test for two independent samples
- **Kruskal–Wallis H test** – Non-parametric test for more than two independent samples

INTRODUCTION

Conflicts between patients and physicians are an unavoidable aspect of medical practice, significantly affecting the quality of care, public trust, and the overall functioning of the healthcare system. Their consequences are often manifested in a decline in trust in medical professionals, the adoption of defensive medicine, and a loss of motivation among physicians, while for patients they result in emotional distress and refusal or delay in seeking timely medical care.

Traditional judicial mechanisms for dispute resolution are often perceived as slow, costly, and insufficiently effective. In this context, mediation emerges as a promising alternative, offering a faster, more accessible, and relationship-preserving approach to conflict resolution. International experience demonstrates that the introduction of mediation in the healthcare sector can reduce tension, facilitate dialogue between the parties, and improve the quality of healthcare services.

In Bulgaria, there is a lack of systematic research that simultaneously examines the attitudes of patients, physicians, and mediators. It is therefore necessary to assess the extent to which these groups are informed about the nature and potential of mediation, how they perceive its effectiveness, and which factors influence their willingness to participate in such a process. The resulting analyses will contribute to the development of practical guidelines for the institutionalization of mediation within the Bulgarian healthcare system, the design of a training model for medical professionals, and the establishment of a sustainable national model for the application of mediation in healthcare.

AIM

The aim of this PhD thesis is to analyze the applicability of mediation as an alternative method for resolving conflicts between patients and physicians in the Bulgarian healthcare system, by examining the attitudes, experiences, and perceptions of the three main parties involved in the process – patients, physicians, and mediators.

OBJECTIVES OF THE PHD THESIS

1. To explore patients' attitudes and expectations regarding the use of mediation as a method for resolving conflicts with physicians.

2. To investigate mediators' perceptions, experiences, and attitudes concerning the effectiveness of mediation in resolving conflicts between patients and physicians.
3. To examine physicians' attitudes and expectations regarding the applicability of mediation in managing conflicts with patients.
4. To develop a training course model for physicians, focusing on communication skills and the practical implementation of mediation in clinical practice.
5. To design an integrated model for institutionalizing mediation within the Bulgarian healthcare system.

MATERIALS AND METHODS

1. Object of Study

The object of this study is mediation as an alternative resolution method for resolving conflicts between physicians and patients within the healthcare system.

2. Units of Observation

- Technical units of observation include healthcare facilities providing both inpatient and outpatient care, the Unified Register of Mediators maintained by the Ministry of Justice, and patient organizations.
- Logical units of observation comprise physicians, patients, and certified mediators.

3. Observation Variables

The survey included a total of 48 variables:

Factorial variables encompass age, gender, educational level, place of residence, work experience, medical specialty, type of healthcare institution, workload (average number of patients per day), presence of chronic or rare diseases, among others.

Outcome variables reflect perceptions regarding the impact of communication on the quality of medical care, the frequency and causes of conflicts, methods of conflict resolution, and their effects on health, trust, and system evaluation. Additionally, the study examines experiences and attitudes toward the judicial system, awareness of and experience with mediation, perceived principles, advantages, and limitations of mediation, its applicability in physician - patient conflicts, barriers to its implementation, the need for mediator profiling in healthcare, willingness to use mediation services, and attitudes toward the institutional provision of mediation. Among physicians, indicators of defensive medicine and self-

assessment of communication and conflict management skills were also included, while mediators' perceptions of the specificity of mediation in healthcare compared to other sectors were assessed.

In parallel with the survey, a qualitative Delphi study was conducted with a focus group of physicians and mediators, aimed at developing a training course on mediation in healthcare.

4. Study Setting

This PhD thesis is based on three national web-based survey studies conducted in Bulgaria. In the second phase of the research, a qualitative Delphi focus group study was conducted remotely via email, involving medical professionals and certified mediators, with the aim of achieving expert consensus on the development of a mediation training program in healthcare.

5. Study Period

The survey studies were conducted between December 2022 and December 2024. The Delphi focus group study was carried out between May and September 2025.

6. Conducting Bodies

The research was carried out under the direct supervision and oversight of the PhD candidate, with guidance from the scientific supervisor.

7. Methods

7.1. Sociological Methods

7.1.1 Survey Method

Three parallel, web-based, anonymous national surveys were conducted among physicians, patients, and professional mediators. Publicly available contacts were obtained from healthcare institutions' websites, medical universities, professional and patient organizations, social media platforms, thematic health forums, and the Unified Register of Mediators maintained by the Ministry of Justice. Participation was voluntary and anonymous.

The three survey instruments were developed based on an extensive review of the literature and regulatory frameworks regarding physician - patient communication, healthcare conflicts, defensive medicine, and mediation as an alternative dispute resolution method. Their design involved a multidisciplinary expertise combining medical and mediator expertise, allowing integration of clinical, communicational, and legal perspectives. Prior to the main study, the

surveys were pilot - tested on small target subsamples (physicians, patients, and certified mediators).

7.1.2. Delphi Focus Group Study

A qualitative study was conducted using the Delphi method. Five experts (medical professionals and certified mediators) were selected based on professional experience in communication and conflict resolution. The study was carried out in two rounds through individually completed online questionnaires under guaranteed anonymity. An 80% agreement threshold was set to achieve expert consensus on individual indicators.

The Delphi questionnaire included 22 questions organized into five panels: the need for training, content and structure of training, training methodology, practical application (barriers and incentives), and the long-term impact of mediation as a professional and educational tool.

7.2. Specific Indicators

Specific indicators were formulated to assess:

- The frequency and causes of physician - patient conflicts, associated communication barriers, and their impact on health, trust, and quality of healthcare.
- Awareness, attitudes, and willingness to participate in mediation, including preferred settings for the procedure and opinions on funding.
- The need for training and specialization of mediators and physicians in mediation, as well as key competencies for effective communication and conflict resolution.
- The content, structure, methodology, and format of a healthcare mediation training course, including the balance between theory and practice, preferred training methods (case studies, role plays, simulations, supervision), and the optimal stage in medical education for its introduction.

7.3. Statistical Methods

The organization, processing, and analysis of primary data were carried out using **IBM SPSS Statistics v.22**. A significance level of $\alpha = 0.05$ was adopted for all statistical analyses.

The following statistical methods were applied:

- **Descriptive analysis**

- **Parametric tests** – applied under conditions of normal distribution: Student’s *t*-test for comparing two independent samples and analysis of variance (ANOVA) for comparisons among more than two groups, with Tukey’s post-hoc test.
- **Non-parametric tests** – applied in the absence of normal distribution and when analyzing categorical data, including Pearson’s χ^2 test for analyzing associations between categorical variables; the Linear-by-Linear Association test for examining linear trends in ordinal variables; the Mann–Whitney U test for comparing two independent groups; the Wilcoxon signed-rank test for comparing two related samples; and the Kruskal–Wallis H test for comparisons among more than two independent groups.
- **Measures of association** – Cramer’s V, Somers’ *d*, the Phi coefficient, and coefficients of linear association were used to assess the strength and direction of relationships.
- **Regression and correlation analysis** – Pearson’s (*r*), Spearman’s (ρ), and Kendall’s τ -b coefficients were applied to identify relationships between variables, as well as binary logistic regression (with indicators such as Nagelkerke R^2 , Exp(B), and Wald statistics).
- **Kolmogorov–Smirnov test** – used to assess the normality of distributions and to compare distributions between groups, including the evaluation of differences in attitudes and perceptions.
- **Qualitative analysis** – thematic analysis of open-ended questions, with the identification of categories, arguments, and recurring interpretative patterns.
- **Graphical analysis**

RESULTS AND DISCUSSION

1. PHYSICIANS

1.1. Conflicts in Healthcare

1.1.3 Previous Experience of Conflict with a Patient

A total of 245 respondents (79.80%; Sp = 2.31%) reported having experienced a conflict with a patient in the past, whereas 62 respondents (20.20%; Sp = 2.31%) indicated that they had not had such an experience. The high proportion of physicians reporting prior conflicts with patients remains consistent regardless of socio-professional characteristics. The findings indicate that conflicts with patients are a widespread phenomenon in medical practice. The absence of statistically significant associations with gender, length of professional experience, medical specialty, or type of healthcare institution suggests that this issue has a universal character, affecting diverse groups of medical professionals. This underscores the need for interventions aimed at improving communication and conflict management across all professional settings, rather than targeting only specific specialties or type of healthcare institution.

1.1.4 Causes of Conflict Between Patients and Physicians

Physicians who reported having experienced a conflict with a patient were given the opportunity to indicate the main reasons for its occurrence. The most frequently cited factors were distrust in the healthcare system (65.23%) and rude behavior on the part of the patient (63.28%) (**Table 1**). These findings suggest that, from the physicians' perspective, conflicts with patients arise primarily from interpersonal and structural factors rather than from disagreement with their professional competence.

Table 1. Causes of Conflict as Reported by Physicians (*The total percentage exceeds 100%, as respondents were allowed to select more than one answer.*)

Cause	n	%	Sp
Distrust in the healthcare system	167	65.23%	2.98%
Rude behavior on the part of the patient	162	63.28%	3.01%
Lack of cooperation	161	62.89%	3.02%
Misunderstanding of the information provided	134	52.34%	3.12%
Disagreement with the proposed treatment	83	32.42%	2.93%
Challenging the diagnosis	48	18.75%	2.44%
Other reason	16	6.25%	1.51%

1.1.5 Impact of Physician-Patient Conflicts on Healthcare

The analysis of physicians' perceptions regarding the effects of conflicts with patients encompasses three main dimensions: patient health, public trust, and the quality of medical care. Nearly 90% of respondents (n = 271; Sp = ±1.84%) believe that conflicts lead to a loss of trust in physicians, while 56.03% (n = 172; Sp = ±2.83%) consider that they negatively affect the patient's health status. A small proportion of respondents (5.86%; n = 18; Sp = ±1.34%) reported no perceived impact.

An almost unanimous consensus is observed with regard to public trust, with 97.72% of respondents (n = 300; Sp = ±0.54%) indicating that it declines as a result of physician-patient conflicts.

With respect to the quality of medical care, 85.67% of physicians (n = 263; Sp = ±2.00%) reported that conflicts lead to its deterioration, 8.79% (n = 27; Sp = ±1.62%) perceived no change, and 5.54% (n = 17; Sp = ±1.30%) reported a potential improvement (Table 2).

Overall, the findings demonstrate a stable consensus that conflicts undermine trust, irrespective of the characteristics examined. The prevailing view is that such conflicts exert an adverse impact, with no substantial differences according to the socio-professional profile of respondents. The results further confirm that the quality of physician-patient communication represents a key determinant of patient-centered outcomes, including satisfaction, treatment adherence, psycho-emotional well-being, and the perceived sense of control over one's own health.

Table 2. Perceived Impact of Conflicts as Reported by Physicians
(The total percentage exceeds 100%, as respondents were allowed to select more than one answer.)

Aspect of Impact	Response	n	%	Sp
Impact on patient health	Loss of trust in physicians	271	88.27%	±1.84%
	Deterioration of health	172	56.03%	±2.83%
	No effect	18	5.86%	±1.34%
Public trust	Decreases	300	97.72%	±0.54%
	No effect	7	2.28%	±0.54%
Quality of medical care	Deteriorates	263	85.67%	±2.00%
	Does not change	27	8.79%	±1.62%
	Improves	17	5.54%	±1.30%

Effective, informative, and empathetic communication facilitates patient engagement in the therapeutic process, strengthens trust, and is associated with better clinical outcomes, a lower risk of medical errors, and fewer unnecessary interventions. In this regard, patient satisfaction and trust emerge as indirect yet essential indicators of the quality and safety of care.

Within the framework of the present study, physicians perceive conflicts as a phenomenon that undermines public trust, deteriorates the quality of medical care, and, in a considerable number of cases, adversely affects patients' health status. The observed consensus highlights that effective, patient-centered communication represents a key instrument for mitigating these negative effects and for strengthening the resilience of the healthcare system.

1.2. Defensive Medicine

Defensive medicine is the practice of performing medical actions - including tests, investigations, and procedures - primarily to avoid legal liability, rather than in response to genuine diagnostic or therapeutic needs of the patient.

More than half of the respondents reported engaging in defensive practices: 40.72% (n = 125; Sp = ±2.80%) indicated that they do so occasionally, while 12.38% (n = 38; Sp = ±1.84%) reported doing so frequently, and 46.91% (n = 144; Sp = ±2.84%) stated that they do not employ such an approach. The prevalence of defensive medicine among Bulgarian physicians is further supported by the finding that 73.62% (n = 226; Sp = 2.49%) reported having colleagues who practice defensively. Over half of the physicians (51.47%, n = 158; Sp = 2.85%) expressed personal concerns about potential legal claims, whereas only 21.82% (n = 67; Sp = 2.36%) reported no such fears.

The type of healthcare institution was significantly associated with defensive practices ($\chi^2 = 14.920$; df = 4; p = 0.005; Cramer's V = 0.220), with physicians working in hospital settings reporting them more frequently.

These findings on the high prevalence of defensive medicine among Bulgarian physicians are consistent with international studies, which show that such behavior is widespread across various health systems and specialties and reflects a response to legal uncertainty, fear of liability, and lack of institutional support. Defensive practices have substantial economic and clinical consequences: they increase healthcare costs, prolong the diagnostic and treatment process, elevate the risk of unnecessary interventions and iatrogenic harm, and ultimately undermine trust in the medical profession.

1.3. Legal System and Healthcare

1.3.1 Physicians' Perceptions of the Effectiveness of the Legal System

Only $7.49\% \pm 1.50\%$ ($n = 23$) of respondents rated the legal system as an effective instrument for resolving conflicts between physicians and patients. Full data are presented in **Figure 1**.

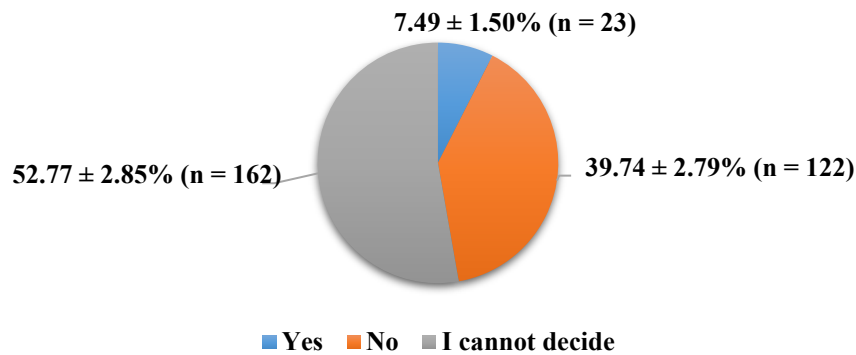


Figure 1. Perceived Effectiveness of the Legal System According to Physicians

Statistically significant results were observed for three factors. Gender showed a marginal association ($\chi^2 = 5.390$; $df = 2$; $p = 0.068$), which was confirmed by linear association analysis ($p = 0.024$) and Somers' $d = 0.128$ ($p = 0.020$). Women were more likely to respond “**I cannot decide,**” whereas men were more likely to express categorical disagreement.

The strongest association was observed in relation to the practice of defensive medicine ($\chi^2 = 20.474$; $df = 4$; $p < 0.001$; Cramer's $V = 0.183$; Somers' $d = -0.158$; $p = 0.002$), where a high frequency of unnecessary treatment was associated with lower evaluations of the effectiveness of the judicial system. A significant relationship was also found with concern over potential legal claims ($\chi^2 = 14.774$; $df = 4$; $p = 0.005$; Cramer's $V = 0.155$): among physicians without such concerns, positive evaluations of the judicial system were significantly more frequent (17.9% vs. 5.1%).

International studies report a similar pattern: physicians often experience legal proceedings as traumatic, unpredictable, and frequently unjust, particularly in contexts characterized by limited specialized expertise and structural bias favoring the patient.

1.4. Mediation in Healthcare

1.4.1 Physicians' Awareness of Mediation as a Conflict Resolution Method and Its Legal Framework

The results indicate a limited level of familiarity with mediation as a procedure and with the Mediation Act among physicians who were surveyed. The data are presented in **Table 3**.

Table 3. Physicians' Awareness of Mediation and Its Legal Framework

Question	Response	n	%	Sp (%)
Familiar with mediation and its application	Yes	199	64.82	±2.73
	No	108	35.18	±2.73
Familiar with the Mediation Act	Yes	59	19.22	±2.25
	No	248	80.78	±2.25

The analysis shows that among all factors examined, only professional experience demonstrated a statistically significant association with awareness of mediation ($\chi^2 = 7.404$; $df = 3$; $p = 0.060$; Linear-by-Linear Association = 6.996; $p = 0.008$; Somers' $d = -0.111$; $p = 0.012$), with younger physicians being more informed on the topic. Gender showed marginal significance ($\chi^2 = 3.390$; $df = 1$; $p = 0.066$; Somers' $d = 0.104$; $p = 0.060$), but the effect was weak and does not allow for definitive conclusions.

The lack of sufficient awareness regarding the nature, objectives, and accessibility of mediation constitutes one of the main barriers to its practical implementation in medical practice. In this context, the results underscore the need for targeted training, institutional support, and the integration of mediation into the policies and communication strategies of healthcare institutions as a sustainable tool for conflict management in healthcare.

1.4.2 Physicians' Participation in Mediation Procedures

Only 23 participants (7.49%; $Sp = \pm 1.50\%$) reported prior personal experience in a mediation procedure, whereas the vast majority—284 respondents (92.51%; $Sp = \pm 1.50\%$)—had no such practical experience. The proportion of physicians who had participated in mediation related to a conflict with a patient was even lower, with only 20 individuals (6.51%; $Sp = \pm 1.41\%$) reporting such experience, compared to 287 respondents (93.49%; $Sp = \pm 1.41\%$) who had not.

Physicians' participation in mediation procedures demonstrated statistically significant associations with professional experience, type of healthcare facility, and prior experience with patient conflicts. For general mediation, the highest proportion of participants consisted of physicians with more than 15 years of professional experience (65.2% of all "yes" responses; $\chi^2 = 4.159$; $df = 3$; $p = 0.245$; Somers' $d = -0.048$; $p = 0.028$), whereas in mediation related to patient conflicts, this proportion reached 75% ($\chi^2 = 6.181$; $df = 3$; $p = 0.103$; Somers' $d = -0.055$; $p = 0.009$). Participation was also more frequent among those working in complex healthcare structures combining hospital and outpatient services (general mediation: $\chi^2 = 4.027$; $df = 2$; $p = 0.134$; Somers' $d = -0.050$; $p = 0.043$; patient conflict mediation: $\chi^2 = 11.621$; $df = 2$; $p = 0.003$; Somers' $d = -0.075$; $p = 0.003$). The presence of a prior conflict also increased the likelihood of participation in mediation procedures - this association was clearly observed for general mediation ($\chi^2 = 6.292$; $df = 1$; $p = 0.012$; Cramer's $V = 0.143$) and was marginal but notable for mediation related to patient conflicts ($\chi^2 = 3.065$; $df = 1$; $p = 0.080$; Somers' $d = 0.061$; $p = 0.010$).

The low frequency of actual participation in mediation - 7.49% overall and 6.51% in the context of patient conflicts - raises questions about the recognition and integration of mediation as a practice within the Bulgarian clinical environment. The absence of significant associations with gender, specialty, communication difficulties, or fear of litigation further suggests that engagement in mediation is determined less by individual physician characteristics and more by institutional and systemic factors.

A similar pattern has been observed in international studies, where actual participation in mediation remains low despite a high declared willingness to undergo training and utilize the procedure. The gap between attitudes and practice is primarily attributable to institutional barriers, including the lack of structured mechanisms, limited legal and professional culture, and the absence of clear referral protocols for mediation.

1.4.3 Effectiveness of Mediation in Conflict Resolution According to Physicians' Experience

Only 9.45% of participants ($n = 29$) responded to the question regarding whether the mediation procedure had been successful. Among these, 62.07% of cases ($n = 18$) were successfully resolved, while in the remaining 37.93% ($n = 11$) no agreement was reached. Despite the low frequency of participation, the high proportion of successfully concluded cases

highlights the potential of mediation as an effective tool for resolving medical conflicts. Complete data are presented in **Figure 2**.

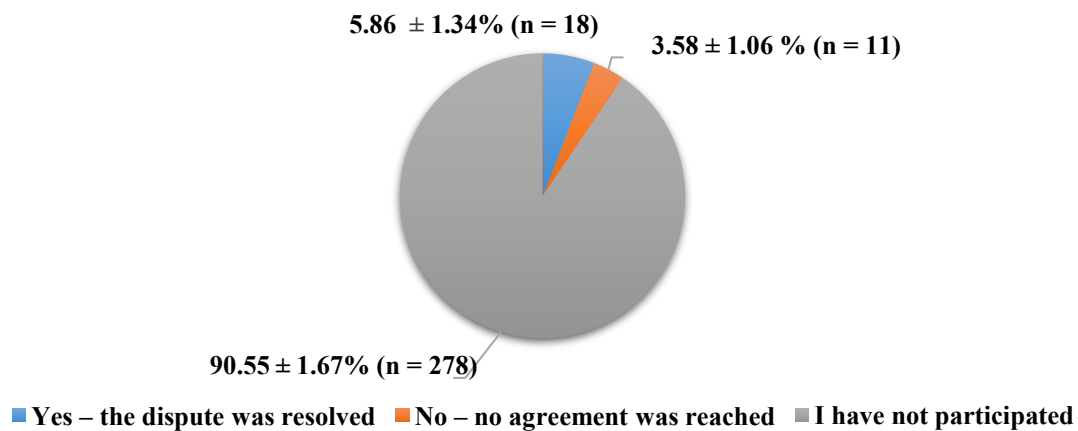


Figure 2. Success Rate of Mediation in Conflict Resolution According to Physicians' Experience

Participants with actual mediation experience had the opportunity to share their impressions via an open-ended question. Mediation was consistently evaluated as an effective and practical instrument, enabling rapid and cost-efficient conflict resolution and preventing escalation. Emphasis was placed on improved communication, with the method being perceived as a means to restore dialogue and satisfy the parties involved. A clearly positive attitude towards the future development of this mechanism was evident, along with recognition of the need for its wider implementation and inclusion in the professional training of healthcare practitioners.

The proportion of successfully resolved cases (62.07%) demonstrates that the mechanism possesses tangible potential for addressing medical conflicts.

1.4.4 Applicability of Mediation in Conflicts between Physicians and Patients

To assess physicians' attitudes toward the use of mediation in conflicts with patients, participants were asked to express their opinions regarding its applicability in such a context. The most frequently selected response was "Applicable to a limited extent" – 118 respondents (38.44%; Sp = ±2.78%), followed by "Widely applicable" – 103 participants (33.55%; Sp = ±2.69%). A notable proportion of the surveyed physicians (72 individuals; 23.45%; Sp = ±2.42%) indicated that they could not evaluate its applicability, whereas only 14 respondents (4.56%; Sp = ±1.19%) completely rejected the use of mediation in a medical context.

The results indicate that more than two-thirds of physicians (72.00%) perceive mediation as applicable to varying degrees in physician–patient conflicts, reflecting relatively high support for its implementation as an alternative dispute resolution method.

Additional analyses conducted using the Mann–Whitney U test revealed that legal awareness regarding the Mediation Act has a statistically significant effect on the perceived applicability of this mechanism in conflicts with patients ($U = 6164.0$; $Z = -1.990$; $p = 0.047$).

Furthermore, the influence of prior awareness of the procedure was also found to be statistically significant ($U = 9086.0$; $Z = -2.366$; $p = 0.018$). Interestingly, respondents who were previously unaware of the procedure exhibited a higher mean rank ($M = 169.37$ vs. $M = 145.66$), indicating a higher perceived applicability of mediation within this group. The Kolmogorov–Smirnov test confirmed the difference between the two distributions ($Z = 1.753$; $p = 0.004$).

Internationally, mediation has become a widely recognized mechanism for resolving medical disputes, owing to its advantages in terms of expediency, lower cost, confidentiality, and the preservation of professional relationships. These benefits are consistent with the perceptions of Bulgarian physicians in the present study, who identified speed, effectiveness of communication, and emotional security as the principal advantages of mediation.

1.4.5 The Need for Specialization of Mediators in Healthcare: Physicians’

Perspective

The results reveal strong support among physicians for the specialization of mediators in healthcare, with 69.06% of respondents ($n = 212$; $Sp = \pm 2.64\%$) considering it necessary. A markedly smaller proportion – only 3.91% ($n = 12$; $Sp = \pm 1.11\%$) – saw no need for such specialization, while 27.04% ($n = 83$; $Sp = \pm 2.53\%$) were unable to provide an opinion. These results suggest that, from the perspective of medical professionals, effective mediation requires not only general conflict management skills but also targeted training tailored specifically to the healthcare context. Overall, the data indicate that physicians view medical expertise as a critical prerequisite for both the effectiveness and legitimacy of mediation within clinical practice.

1.4.6 Commitment of the Medical Establishment to Providing a Mediator for Physician - Patient Conflicts: Physicians’ Perspective

Participants were asked to express their opinions on whether the provision of a mediator by the medical establishment would facilitate the resolution of conflicts between physicians

and patients. Overall, 81.43% of physicians supported this idea. Detailed results are presented in **Table 4**.

Table 4. Physicians’ attitudes toward the provision of a mediator by the medical establishment

Response	n	%	Sp(%)
Yes, this would facilitate the process	117	38.11	±2.77
Yes, definitely	79	25.73	±2.50
Maybe	54	17.59	±2.17
No, mediation should be conducted outside the medical establishment	21	6.84	±1.44
No, mediation is not suitable for resolving physician - patient conflicts	4	1.30	±0.65
I cannot decide	32	10.42	±1.73

A significant association was observed with personal experience of conflicts with patients ($\chi^2 = 13.041$; $df = 5$; $p = 0.023$), indicating that physicians who had encountered such situations were more likely to support the provision of a mediator by the medical establishment.

International evidence confirms the benefits of institutionalized mediation within healthcare settings. Internal mediation units, multidisciplinary teams, and hybrid models involving both internal and external mediators are associated with earlier access to mediation, reduced costs, fewer legal claims, and enhanced trust. At the same time, the literature emphasizes that trust in mediation depends not only on its formal implementation but also on the mediator’s impartiality and professional competence. In open-ended comments, Bulgarian physicians similarly highlighted that support from the medical establishment must be accompanied by clear professional delineation and high standards of mediator training to prevent doubts regarding neutrality and to establish mediation as a genuinely reliable mechanism for conflict resolution in healthcare.

1.4.7 Coverage of Mediation Costs: Physicians’ Perspective

This question aimed to investigate medical professionals’ attitudes regarding the most appropriate model for financing the mediation procedure in physician–patient conflicts. All 307 respondents provided valid answers, ensuring complete data coverage (100.00%).

The largest group of participants – 71 respondents (23.13%; $Sp = \pm 2.44\%$) – indicated that the costs should be covered by the state. A nearly identical proportion – 70 participants (22.80%; $Sp = \pm 2.43\%$) – considered that financing should be shared between the parties. Third

in frequency was the view that the medical establishment itself should bear the responsibility – 48 respondents (15.64%; Sp = ±2.05%), while 42 participants (13.68%; Sp = ±1.94%) identified the National Health Insurance Fund as the appropriate source of funding. Support for individual coverage was minimal: only 14 participants (4.56%; Sp = ±1.19%) considered that the patient should pay for the procedure, and just one respondent (0.33%; Sp = ±0.33%) indicated that the physician should bear the cost. A considerable proportion of participants were unable to decide – 61 respondents (19.87%; Sp = ±2.26%).

Institutional coverage of mediation costs not only ensures sustainability but also maintains equal access to the procedure, regardless of the economic status of the parties involved.

1.4.8 The Need to Raise Awareness of Mediation among Physicians and Patients: Physicians' Perspective

A primary barrier to the implementation of mediation was identified as a lack of information, leading to corresponding distrust. Regarding the need to raise awareness among physicians, 91.86% of respondents (n = 282; Sp = ±1.56%) indicated that such a need exists, 0.98% (n = 3; Sp = ±0.56%) disagreed, and 7.17% (n = 22; Sp = ±1.47%) were unable to decide. A similar distribution was observed with respect to patients: 90.55% (n = 278; Sp = ±1.62%) supported the need to increase patient awareness, 1.63% (n = 5; Sp = ±0.72%) did not, and 7.82% (n = 24; Sp = ±1.52%) were uncertain (**Figure 3**).

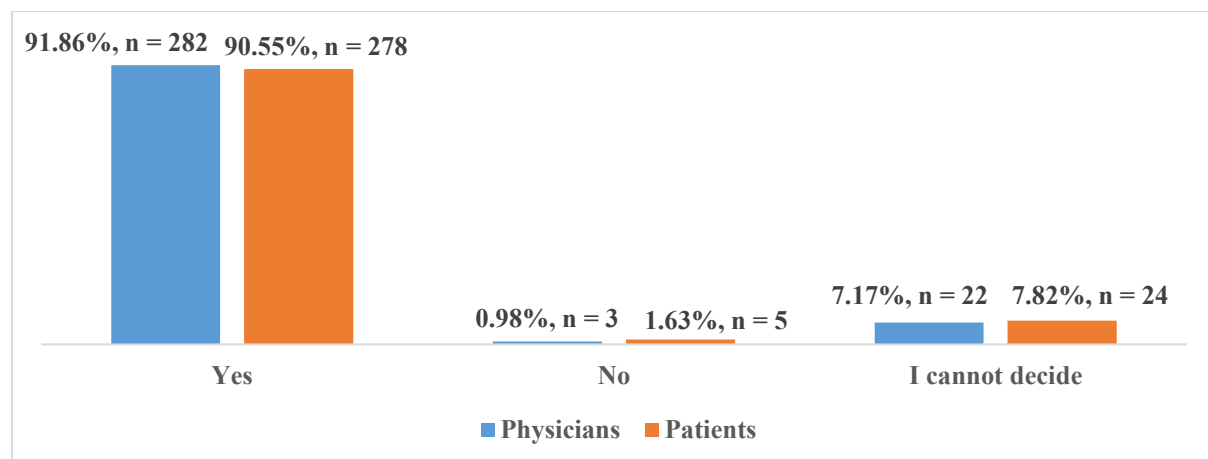


Figure 3. Physicians' Opinions on the Need to Raise Awareness of Mediation among Physicians and Patients

The development of multi-channel and well-organized information strategies is a crucial prerequisite for enhancing trust and promoting the wider use of mediation as a method for resolving conflicts in healthcare. In this context, adapting and implementing such approaches

within the Bulgarian healthcare system could help address current information deficits and foster the integration of mediation as an effective and accessible mechanism for resolving disputes between patients and physicians.

1.4.9 Usefulness of Brief Mediation Training

To examine physicians' attitudes toward brief mediation training, participants were asked to assess its usefulness in professional practice. Nearly 80% of respondents evaluated it positively (Figure 4).

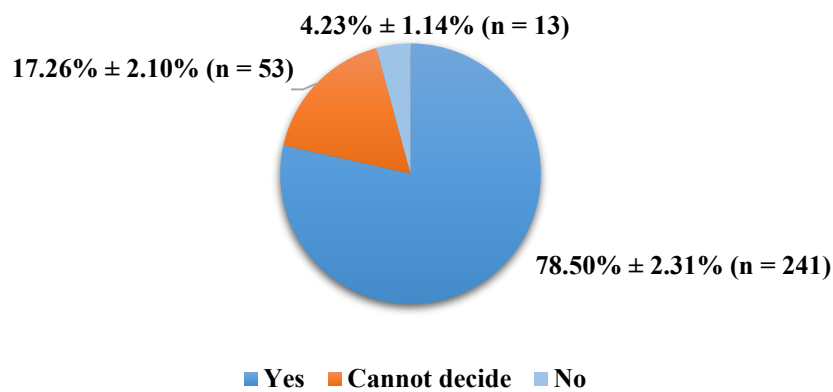


Figure 4. Physicians' Assessment of the Usefulness of Brief Mediation Training

1.4.10 Willingness to Participate in Mediation Training

Building on the previous question, respondents were asked whether they would actually participate in mediation training. Nearly 85% of physicians expressed willingness to participate, while only 15% responded negatively (Figure 5).

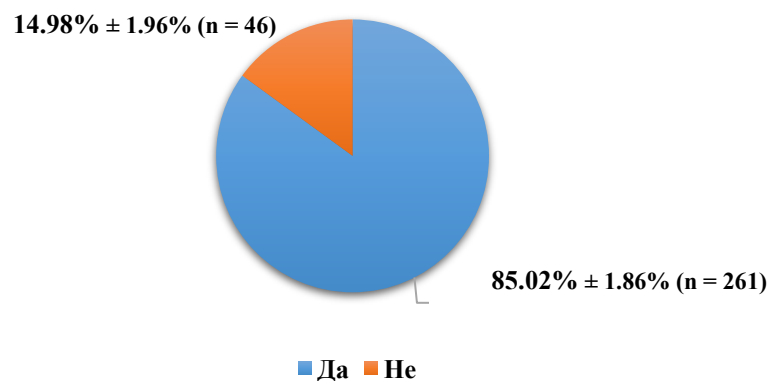


Figure 5. Physicians' Willingness to Participate in Mediation Training

Results from χ^2 tests of independence and the calculated measures of association indicate a statistically significant relationship between physicians' professional experience and their

willingness to participate in training. The data show that physicians with shorter professional tenure are more likely to demonstrate a higher readiness to engage in such training. A further significant association was observed between willingness to participate and the level of concern regarding potential legal claims ($\chi^2 = 6.425$; $df = 2$; $p = 0.040$; Cramer's $V = 0.145$), suggesting that physicians who experience greater anxiety about possible litigation are more inclined to seek structured preparation through mediation training.

1.4.11 Mediation in Medical Education

Physicians' attitudes toward the inclusion of mediation in medical education were examined. The results indicate a clear majority support (80.78%) for integrating the topic into training programs for future physicians (Figure 6).

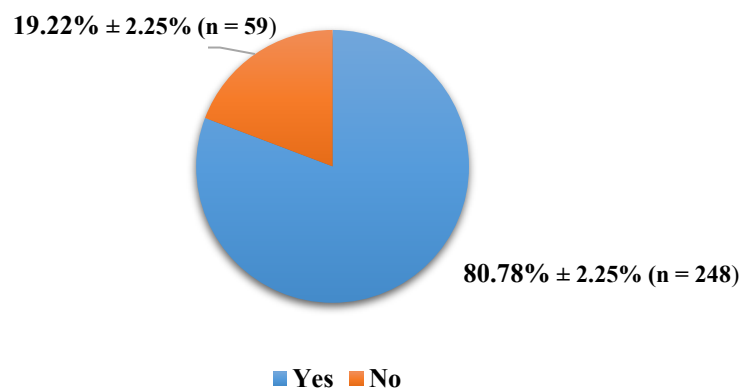


Figure 6. Physicians' Opinions on Whether Mediation Should Be Included in Medical Education

To identify factors influencing this opinion, χ^2 analyses were conducted in relation to key socio-professional characteristics of the participants. The results reveal two statistically significant associations. First, the perceived need for mediation training is linked to concern about potential legal claims ($\chi^2 = 6.346$; $p = 0.042$), with higher approval among physicians who fear legal consequences. The calculated Somers' d value (0.129; $p = 0.014$) indicates a weak-to-moderate effect size. Second, a significant association was found with personal experience of conflicts with patients ($\chi^2 = 4.820$; $p = 0.028$), with greater support for training among physicians who have experienced challenging communication situations. Overall, support for incorporating mediation into medical education is relatively homogeneous but is reinforced in contexts of real professional risk and tension.

These findings align with the broader understanding of healthcare as a conflict-prone environment, where conflict management represents a core professional competency. International studies show that structured training in mediation and conflict management enhances physicians' confidence, empathy, and effectiveness, facilitates early de-escalation of tension, and improves organizational culture. The potential of practice-oriented methods - such as role-playing, simulations, and standardized patients - is emphasized, as they bridge the gap between theory and clinical practice.

In this context, the attitudes of Bulgarian physicians toward integrating mediation into medical education reflect a global trend toward modernizing the training of healthcare professionals. They outline a strategic direction for future educational and institutional reforms aimed at strengthening communication, reducing conflicts, and enhancing the quality and safety of medical care.

2. PATIENTS

2.1. Conflicts in Healthcare

2.1.1 Previous Experience of Conflict with Physicians

A total of 147 participants (32.24%; Sp = 2.19%) reported having experienced a conflict with a physician, while 309 participants (67.76%; Sp = 2.19%) had not. A statistically significant association was observed between having experienced a conflict and the presence of a chronic condition ($\chi^2 = 4.217$; $df = 1$; $p = 0.040$; Cramer's $V = 0.096$), with patients with chronic conditions more frequently reporting tensions in communication with physicians. The strongest association was found with the frequency of medical visits ($\chi^2 = 12.955$; $df = 2$; $p = 0.002$; Cramer's $V = 0.169$); patients with 5–10 visits per year reported conflicts more often.

Almost one-third of patients have experienced a conflict with a physician, indicating that such situations are not isolated but relatively common in clinical practice. The presence of a chronic condition and the frequency of seeking medical care emerged as significant factors, which may be explained by prolonged contact with the healthcare system and the accumulation of communication difficulties over time. These findings confirm that more frequent interactions with physicians increase the likelihood of tension, particularly when communication and trust are not adequately established and maintained.

2.1.2 Causes of Conflicts between Patients and Physicians

Patients who reported having experienced a conflict with a healthcare professional were asked to indicate the primary reasons for its occurrence. The most frequently reported causes

were rude behavior and lack of adequate communication skills on the part of the physician (Table 5).

Table 5. Causes of Conflicts According to Patients

Cause	n	%	Sp
Rude behavior of the physician	120	62.50%	3.49%
Lack of communication skills of the physician	101	52.60%	3.60%
Physician incompetence	55	28.65%	3.26%
Patient's misunderstanding of information	44	22.92%	3.03%
Disagreement with the prescribed treatment	24	12.50%	2.38%
Disagreement with the diagnosis	11	5.73%	1.68%
Other reasons	5	2.60%	1.15%

The results indicate that the main cause of conflicts between physicians and patients is not medical errors or lack of knowledge, but rather breakdowns in communication and rude or dismissive behavior - findings that are consistent with the literature. Open-ended responses reveal accumulated tension, which often does not escalate into an overt conflict due to fear, uncertainty, or a perceived subordinate position relative to the physician. This underscores that unresolved conflicts have the potential to escalate and erode trust in the clinical process, particularly in the absence of an effective mechanism for resolution.

2.1.3 Impact of Physician-Patient Conflicts on Healthcare

The analysis of patients' perceptions regarding the effects of conflicts with physicians focused on three key aspects: patient health, public trust, and the quality of medical care.

Patients who had experienced a conflict with a physician were asked to indicate how it affected their own health. Among 174 valid responses, 47.70% (n = 83; Sp = ±3.79%) reported no impact, 12.64% (n = 22; Sp = ±2.52%) reported a deterioration in health, and 39.66% (n = 69; Sp = ±3.71%) stated that the experience led to a loss of trust in physicians.

Regarding the broader impact on trust in the healthcare system, almost unanimous agreement was observed among all 456 participants: 95.61% (n = 436; Sp = ±0.96%) believed that conflicts reduce trust, while only 4.39% (n = 20; Sp = ±0.96%) reported no such effect.

With respect to the perceived quality of medical care, 76.10% (n = 347; Sp = ±2.00%) believed that conflicts worsen it, 16.01% (n = 73; Sp = ±1.72%) expected no change, and 7.89% (n = 36; Sp = ±1.26%) reported a potential improvement (Table 6).

Table 6. Patients' Perceived Impact of Conflicts

Aspect	Response	n	%	Sp
Impact on patient health	No effect	83	47.70%	±3.79%
	Deterioration in health	22	12.64%	±2.52%
	Loss of trust in physicians	69	39.66%	±3.71%
Public trust	Decreases	436	95.61%	±0.96%
	No effect	20	4.39%	±0.96%
Quality of medical care	Deteriorates	347	76.10%	±2.00%
	Does not change	73	16.01%	±1.72%
	Improves	36	7.89%	±1.26%

Education was found to have a statistically significant association with changes in patient trust ($\chi^2 = 15.378$; $df = 4$; $p = 0.004$; Cramer's $V = 0.210$). Participants with only primary education more frequently reported deteriorated health, whereas those with secondary or higher education were more likely to interpret the conflict as a moral or relational violation, leading to a loss of trust without direct health consequences. This suggests that education influences how patients perceive the outcomes of conflicts - either as physical or socio-psychological effects.

These findings align with international evidence indicating that conflicts and impaired communication between physicians and patients undermine trust, reduce treatment adherence, and may negatively affect health outcomes. Meta-analyses confirm that patient-centered communication and high trust in the treating physician are associated with better self-management, improved adherence to prescriptions, higher satisfaction, and better clinical outcomes. In this context, conflicts between patients and physicians affect not only immediate interactions but also perceived quality and safety of care, highlighting the need for targeted strategies to improve communication and restore trust.

2.2. Legal System and Healthcare

2.2.1 Patients' Perceptions of the Effectiveness of the Legal System

Only 7.24% ($\pm 1.21\%$; $n = 33$) of respondents considered the legal system to be an effective mechanism for resolving conflicts between patients and physicians. Complete data are presented in **Figure 7**.

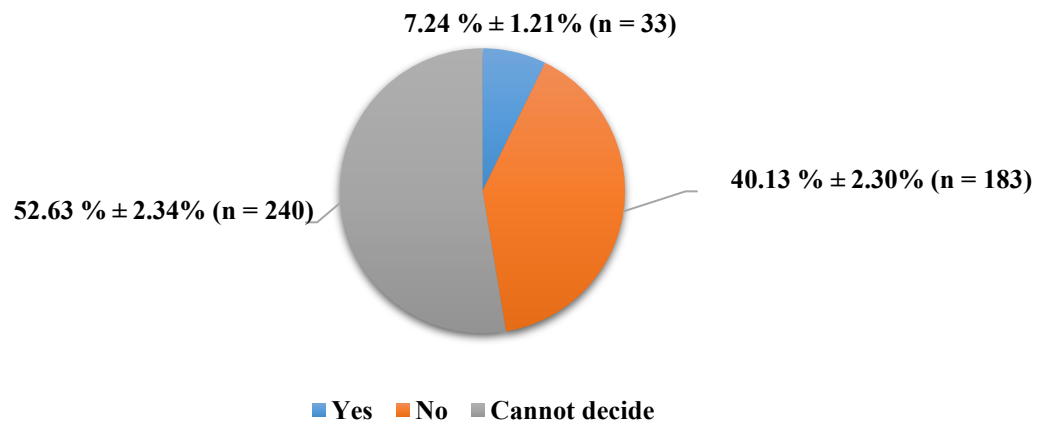


Figure 7. Patients' Assessment of the Effectiveness of the Legal System

A statistically significant association was observed with the frequency of medical visits ($\chi^2 = 12.315$; $df = 4$; $p = 0.015$), supported by a linear trend analysis ($p = 0.001$) and Somers' d analysis ($d = 0.165$; $p < 0.001$). Patients with more frequent medical contacts were more likely to perceive the legal system as ineffective in resolving conflicts with physicians.

Judicial mechanisms for holding medical professionals accountable are often slow, costly, procedurally complex, and dependent on expert testimony, with outcomes that are unpredictable for both patients and physicians. High administrative costs, prolonged procedures, and discrepancies between actual errors and awarded compensation undermine the perceived fairness and effectiveness of the system and encourage defensive medical practices. In this context, the lack of confidence in the legal system observed in the present study appears not as an isolated phenomenon, but as part of a broader structural crisis of legitimacy in using courts as a mechanism for resolving medical conflicts.

2.3. Mediation in Healthcare

2.3.1 Patients' Awareness of Mediation as a Method for Conflict Resolution and Its Legal Framework

The results indicate a limited level of awareness among patients regarding mediation as a procedure and the Mediation Act. The data are presented in **Table 7**.

Awareness of mediation showed statistically significant associations with gender, education, and patients' health status. Women were more frequently informed than men ($\chi^2 = 5.423$; $p = 0.020$; Somers' $d = -0.111$; Cramer's $V = 0.109$). Awareness increased with higher educational attainment ($\chi^2 = 19.998$; $p < 0.001$; Somers' $d = -0.208$; Cramer's $V = 0.209$), and patients with chronic conditions were more informed than others ($\chi^2 = 7.368$; $p = 0.007$; Somers' $d = 0.133$).

Table 7. Patients' Awareness of Mediation and Its Legal Framework

Question	Response	n	%	Sp (%)
Familiar with mediation and its application	Yes	198	43.42	± 2.32
	No	258	56.58	± 2.32
Familiar with the Mediation Act	Yes	50	10.96	± 2.92
	No	406	89.04	± 2.92

A significant association was found between awareness of the law and educational level ($\chi^2 = 6.925$; $df = 2$; $p = 0.031$). Knowledge of the Act was highest among participants with higher education (13.71%), compared to 5.96% with secondary education and 0% with primary education. Somers' $d = -0.079$ ($p = 0.003$) indicates a weak but statistically significant negative association. A significant relationship was also observed between knowledge of the law and the presence of chronic disease ($\chi^2 = 5.258$; $p = 0.022$), with patients with chronic conditions demonstrating higher awareness than others (Cramer's $V = 0.107$; Somers' $d = 0.071$; $p = 0.034$).

International data confirm that low awareness of mediation is a widespread issue. The findings also highlight a characteristic gap between formally reported knowledge of institutions and actual understanding of their function - a pattern observed in Bulgaria, where the Mediation Act has existed for years but remains practically "invisible" to patients. Bulgarian patients' awareness of mediation is limited, and their knowledge of its legal framework is minimal. The absence of targeted educational and communication strategies significantly constrains the potential of mediation to function as a tangible, recognized, and accessible alternative for resolving medical conflicts.

2.3.2 Patients' Participation in Mediation Procedures

Only 17 participants (3.73%; Sp = ±0.89%) reported having previous personal experience with a mediation procedure, while the overwhelming majority - 439 respondents (96.27%; Sp = ±0.89%) - had never participated in mediation. An even smaller proportion of patients reported experience with mediation specifically in relation to a conflict with a physician: only 4 individuals (0.88%; Sp = ±0.44%), compared to 452 respondents (99.12%; Sp = ±0.44%) who reported no such experience.

Personal experience of conflict with a physician was found to be statistically significantly associated with participation in mediation ($\chi^2 = 5.714$; $df = 1$; $p = 0.017$). Among respondents who had experienced a conflict, 6.80% reported participation in mediation, compared to 2.27% among those without such experience. The direction and significance of this relationship were further confirmed by Somers' $d = 0.045$ ($p = 0.044$) and $\Phi = 0.112$, indicating a weak but statistically significant association.

The limited practical use of mediation does not appear to be attributable to individual characteristics, but rather reflects systemic deficiencies, including low levels of awareness, restricted access to mediation services, and insufficient institutional support.

2.3.3 Perceived Effectiveness of Mediation in Conflict Resolution Based on Patients' Experience

A very small proportion of participants - 3.29% ($n = 15$) - provided a response to the question regarding whether the mediation procedure had been successful. Among these respondents, 73.33% ($n = 11$) reported that the dispute had been successfully resolved, while the remaining 26.67% ($n = 4$) indicated that no agreement had been reached.

Despite the low frequency of participation in mediation, the high proportion of successfully resolved cases underscores the potential of mediation as an effective mechanism for resolving medical conflicts. The complete data are presented in **Figure 8**.

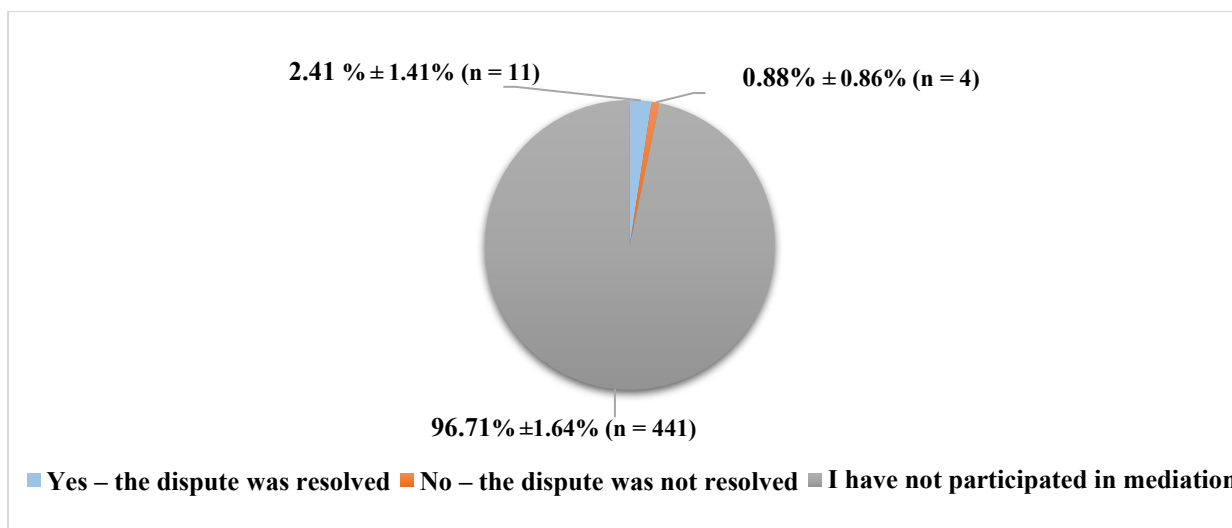


Figure 8. Effectiveness of Mediation in Conflict Resolution Based on Patients' Experience

The empirical evidence accumulated in the present study indicates a high level of effectiveness of mediation when applied in practice. Of the 15 mediation cases reported, 73.33% concluded with the achievement of an agreement between the parties. These results suggest that, although mediation remains infrequently used in the Bulgarian healthcare context, it demonstrates substantial potential as an effective, timely, and cost-efficient mechanism for resolving disputes in healthcare.

2.3.4 Applicability of Mediation in Conflicts Between Physicians and Patients

In order to assess patients' attitudes toward the use of mediation in conflicts with physicians, participants were asked to express their views on its applicability in such contexts. The most frequently selected response was "*I cannot decide*", reported by 200 participants (43.86%; Sp = ±2.32%), indicating a lack of a clearly formed position among a substantial proportion of respondents. At the same time, 132 individuals (28.95%; Sp = ±2.12%) assessed mediation as applicable to a limited extent, while 98 respondents (21.49%; Sp = ±1.92%) considered it to be widely applicable. A negative stance was expressed by only 26 participants (5.70%; Sp = ±1.09%).

A statistically significant association was identified with educational level ($\chi^2 = 13.861$; df = 6; p = 0.031), with higher education correlating with more positive attitudes toward the applicability of mediation (Somers' d = -0.139; p = 0.008). A significant association was also observed with the degree of communication difficulties experienced by patients (Somers' d = -0.089; p = 0.037), indicating that individuals who more frequently encounter communication

challenges in interactions with physicians are more likely to perceive mediation as an applicable mechanism. Although the corresponding χ^2 test did not reach statistical significance ($\chi^2 = 11.912$; $df = 9$; $p = 0.218$), the linear relationship was supported by the applied association measure.

Characteristics such as voluntariness, participation, cooperation, flexibility, and a focus on well-being render mediation particularly suitable for the healthcare context, where the preservation of trust is critically important. The expressed openness of approximately half of the patients reflects a need for procedures that combine dispute resolution with emotional and relational support. The high proportion of respondents who reported that they “cannot decide” on the applicability of mediation appears to reflect limited awareness rather than rejection of the process. This finding highlights the need for targeted informational and educational initiatives presenting mediation as a viable alternative to litigation and supporting informed patient choice in conflicts within the healthcare system.

2.3.5 Need for Specialization of Mediators in Healthcare: Patients’ Perspective

To assess attitudes toward specialized training of mediators in the healthcare sector, participants were asked about the necessity of mediator specialization when dealing with medical conflicts. The results reveal a clear predominance of positive evaluations: 285 participants (62.50%; $Sp = \pm 2.27\%$) supported the idea of specialization, while 154 respondents (33.77%; $Sp = \pm 2.21\%$) reported that they could not decide. Only 17 individuals (3.73%; $Sp = \pm 0.89\%$) expressed a negative position, confirming that the need for mediator specialization is perceived as appropriate by the majority of patients.

Patients perceive the specialization of mediators in healthcare as a necessary condition for the effective implementation of mediation procedures. The prevailing support for specialization aligns with international trends, whereby healthcare mediation is increasingly developing as a distinct subdiscipline, with a strong emphasis on empathy, fairness, and adaptation to the clinical environment. In this respect, the attitudes of patients in Bulgaria are consistent with broader international practice, which recognizes specialization as a key prerequisite for the legitimacy, trustworthiness, and high effectiveness of mediation in the healthcare sector.

2.3.6 Commitment of the Medical Establishment to Providing a Mediator for Physician–Patient Conflicts: Patients’ Perspective

To assess patients’ views on whether medical establishments should provide a mediator in the event of a conflict with a physician, participants were asked if they believed such provision would facilitate conflict resolution. Overall, 73.25% ± 2.07% (n = 334) of respondents supported the idea. Detailed results are presented in **Table 8**.

Table 8. Patients’ attitudes toward the provision of a mediator by the medical establishment

Response	n	%	Sp (%)
Yes, this would facilitate the process	158	34.65	±2.23
Yes, definitely	98	21.49	±1.92
Maybe	78	17.11	±1.76
No, mediation should be conducted outside the medical establishment	44	9.65	±1.38
No, mediation is not suitable for resolving conflicts between physician and patient	10	2.19	±0.69
Cannot decide	68	14.91	±1.67

A statistically significant association was observed with gender ($\chi^2 = 11.813$; $df = 5$; $p = 0.037$; Cramer's $V = 0.161$), with female respondents more frequently supporting the provision of a mediator, whereas male respondents tended to express neutral or reserved positions. A significant relationship was also identified with education ($\chi^2 = 22.390$; $df = 10$; $p = 0.013$; Cramer's $V = 0.157$), as participants with higher education more often expressed firm support, while those with secondary or primary education exhibited hesitation or uncertainty.

The majority of patients endorse the commitment of medical establishments to provide a mediator, perceiving it as an important mechanism for facilitating dialogue and preventing conflict escalation. International experience confirms that institutionalized mediation serves as an effective tool for restoring trust and enhancing the quality of clinical interactions.

2.3.7 Coverage of Mediation Costs: Patients’ Perspective

This question aimed to examine patients’ attitudes regarding the most appropriate model for financing mediation procedures in physician–patient conflicts. All 456 respondents provided valid answers, ensuring complete data coverage (100.00%).

The distribution of responses indicates a clear preference for institutional financing, with three options emerging as most frequently selected. The highest proportion of participants, 119 individuals (26.10%; Sp = $\pm 2.06\%$), identified the National Health Insurance Fund (NHIF) as the preferred source of funding. A nearly identical share, 116 respondents (25.44%; Sp = $\pm 2.04\%$), believed that the state should cover the costs. The third most common view was that the medical establishment itself should bear the expenses, cited by 55 participants (12.06%; Sp = $\pm 1.53\%$).

Support for individual coverage of mediation costs was minimal: only six participants (1.32%; Sp = $\pm 0.53\%$) considered that patients should pay for the procedure, and just four respondents (0.88%; Sp = $\pm 0.44\%$) identified the physician as responsible. A significant proportion of participants, 93 individuals (20.39%; Sp = $\pm 1.89\%$), were unable to decide.

These findings reflect a broader European trend toward institutional funding of mediation, recognized as a mechanism to ensure equitable access and enhance procedural effectiveness. The attitudes observed in this study align with these international patterns and emphasize the need for sustainable financing, particularly given the sensitivity of conflicts in the healthcare context.

2.3.8 The Need to Raise Awareness of Mediation among Physicians and Patients: Patients' Perspective

The results regarding perceived barriers clearly indicate that the lack of adequate information, and the resulting mistrust, represent among the most significant obstacles to the implementation of mediation in healthcare. This naturally draws attention to the need to raise awareness as a key prerequisite for its broader acceptance and effectiveness. Concerning the need to raise awareness among physicians, 80.04% of patients (n = 365; Sp = $\pm 1.87\%$) considered it necessary, 2.19% (n = 10; Sp = $\pm 0.69\%$) disagreed, and 17.76% (n = 81; Sp = $\pm 1.79\%$) were undecided. Patients' views regarding their own awareness were even more pronounced: 86.84% (n = 396; Sp = $\pm 1.58\%$) supported the need to increase their own understanding, 2.19% (n = 10; Sp = $\pm 0.69\%$) disagreed, and 10.96% (n = 50; Sp = $\pm 1.46\%$) were uncertain (**Figure 9**).

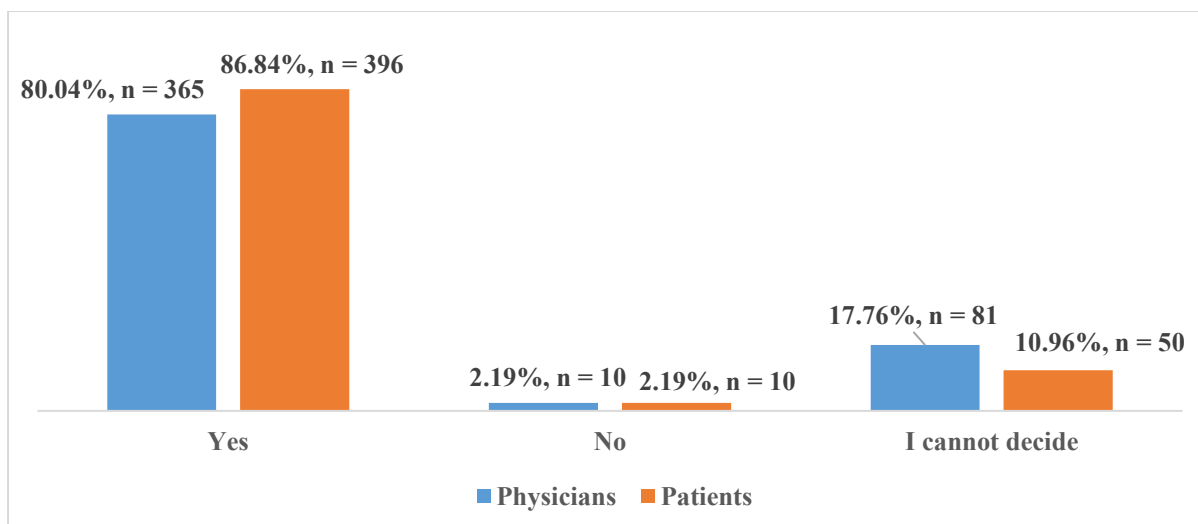


Figure 9. Patients' opinions on the need to raise awareness of mediation among physicians and patients

Regarding the need to raise awareness among patients themselves, two significant associations were identified. Patients with a previous conflict with a physician were more likely to support additional awareness-raising ($\chi^2 = 8.644$; $df = 2$; $p = 0.013$; Somers' $d = 0.096$; $p = 0.001$). A significant linear association was also observed with communication difficulties (Somers' $d = -0.059$; $p = 0.027$), although the χ^2 test did not reach significance ($\chi^2 = 1.906$; $p = 0.386$). Gender ($\chi^2 = 0.352$; $p = 0.838$), education ($\chi^2 = 2.214$; $p = 0.696$), and chronic disease status ($\chi^2 = 2.401$; $p = 0.301$) showed no significant association with this variable.

The results of the present study confirm the need for a strategic approach to awareness-raising through educational initiatives, public campaigns, and targeted communication with vulnerable groups. Such efforts could not only increase knowledge of the procedure but also foster cultural acceptance and trust in mediation as a legitimate tool for resolving conflicts in healthcare.

3. MEDIATORS

3.1. Conflicts in Healthcare

3.1.1 Causes of Conflicts between Physicians and Patients

The mediators who participated in the study were asked to identify the main factors they consider responsible for conflicts between physicians and patients. The most frequently cited causes were insufficient communication skills of the physician (78.71%) and the patient's

misunderstanding of the information provided (72.24%), followed by rude or dismissive behavior by the physician (66.54%) (Table 9).

Table 9. Causes of Conflicts between Physicians and Patients According to Mediators

Cause	n	%	Sp
Insufficient communication skills of the physician	207	78.71%	2.52%
Patient's misunderstanding of information	190	72.24%	2.76%
Rude behavior of the physician	175	66.54%	2.91%
Physician incompetence	62	23.57%	2.62%
Disagreement with the proposed treatment	47	17.87%	2.36%
Other (open-ended responses)	36	13.69%	2.12%

These findings are consistent with international studies, which emphasize that conflicts between physicians and patients primarily arise from communication breakdowns, inadequate or unclear information, and eroded trust, rather than from a lack of professional competence. Within this context, the physician's communication style and the quality of interpersonal relationships emerge as key predictors for both the initiation and escalation of conflicts in healthcare settings.

3.1.2 Impact of Physician - Patient Conflicts on Healthcare

The analysis of mediators' perceptions regarding the effects of conflicts between physicians and patients focused on three primary dimensions: individual health, public trust, and quality of medical care.

In the first item, multiple responses were permitted. Out of 263 valid cases, 92.78% (n = 244; Sp = ±1.62%) indicated that conflicts lead to a loss of trust in physicians, 51.71% (n = 136; Sp = ±3.09%) considered that they negatively affect patients' health, and only 3.04% (n = 8; Sp = ±1.06%) reported no impact.

Regarding the broader impact on public trust, near-unanimous agreement was observed among respondents - 98.86% (n = 260; Sp = ±0.71%) stated that trust decreases, while only 1.14% (n = 3; Sp = ±0.71%) reported no effect.

With respect to the perceived quality of medical care, 82.51% (n = 217; Sp = ±2.35%) considered that conflicts diminish it, 10.65% (n = 28; Sp = ±1.90%) observed no change, and 6.84% (n = 18; Sp = ±1.56%) noted potential improvement. These results indicate a clear trend:

according to mediators, conflicts negatively influence individual health, trust in the system, and the quality of care (**Table 10**).

A statistically significant association was found between gender and perceived reduction of trust in the system, with female respondents more frequently reporting a negative impact ($\chi^2 = 4.207$; $df = 1$; $p = 0.040$; Cramer's $V = 0.126$).

Table 10. Perceived Impact of Conflicts According to Mediators

Impact Aspect	Response	n	%	Sp
Health Impact	Loss of trust in physicians	244	92.78%	±1.63%
	Deterioration in health	136	51.71%	±3.09%
	No effect	8	3.04%	±1.05%
Public Trust	Decreases	260	98.86%	±0.71%
	No effect	3	1.14%	±0.71%
Quality of Medical Care	Deteriorates	217	82.51%	±2.32%
	Does not change	28	10.65%	±1.88%
	Improves	18	6.84%	±1.54%

Gender was also significantly associated with perceived impact on the quality of care ($\chi^2 = 7.655$; $df = 2$; $p = 0.022$; Cramer's $V = 0.171$). Female mediators were more likely to evaluate conflicts as reducing care quality, while male mediators tended to offer neutral or positive assessments. A linear trend was also noted ($p = 0.011$). In contrast, professional experience showed no significant association ($\chi^2 = 5.729$; $df = 6$; $p = 0.454$; Cramer's $V = 0.104$), indicating that negative perceptions were consistent across experience levels.

These findings, in which 92.78% of mediators identify conflicts as eroding trust toward physicians, align with international studies. Trust appears highly vulnerable in the absence of effective communication, clear and understandable information, and perceived empathy from healthcare providers. Even a single negative encounter can reduce patients' willingness to seek future care, whereas respectful behavior, attentive listening, and clear explanations foster patients' sense of safety and confidence. Communication skills emerge as an independent predictor of trust, while deficiencies correlate with increased anxiety, perceived loss of control, and higher risk of conflict.

At a systemic level, trust in healthcare functions as a critical determinant of health behavior: higher levels of trust are associated with better treatment adherence, greater

participation in preventive screenings, and higher engagement with vaccination programs. Poor communication and unresolved conflicts not only compromise trust in individual physicians but also erode public confidence, which may negatively affect long-term clinical outcomes and the effectiveness of public health policies. Consequently, trust should be regarded not merely as an emotional factor but as a strategic resource, maintained through empathetic, transparent, and consistent communication, while physician-patient conflicts represent a significant risk to its preservation.

3.2. Legal System and Healthcare

3.2.1 Perceived Effectiveness of the Legal System According to Mediators

Only 7.22% ± 1.60% (n = 19) of respondents rated the legal system as an effective mechanism for resolving medical conflicts. Complete data are presented in **Figure 10**.

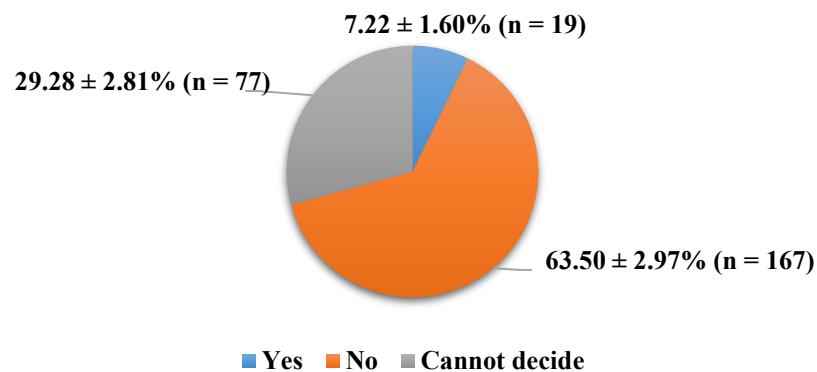


Figure 10. Perceived Effectiveness of the Legal System According to Mediators

Analysis revealed a statistically significant association between legal education and the evaluation of the legal system ($\chi^2 = 25.521$; $df = 2$; $p < 0.001$). All 19 respondents who rated the legal system as effective (representing 11.59% of mediators with legal training) held formal legal qualifications. Nonetheless, negative assessments predominated even within this group: 68.29% considered the system ineffective, while 20.12% were unable to assess. Among mediators without legal education, no positive ratings were recorded; 55.56% deemed the system ineffective, and 44.44% were undecided. The strength of the association was moderate (Cramer's $V = 0.312$), and the Somers' d statistic ($d = 0.308$; $p < 0.001$) confirmed a significant relationship, indicating that legal training increases the likelihood of a more favorable assessment, although critical views remain prevalent even among legally trained mediators.

Mediators who perceive the legal system as ineffective highlighted several recurring concerns: the slow pace and procedural formalism of court processes, doubts regarding

impartiality and competence of expert witnesses, insufficient medical expertise, the inability of legal proceedings to address the emotional and relational dimensions of conflicts, high financial costs, and the absence of tangible improvements in clinical practice.

3.3. Mediation in Healthcare

3.3.1 Success Rate in Achieving Agreements in Healthcare-Related Mediations

All 263 participants were invited to estimate the percentage of successfully concluded agreements in healthcare-related mediation cases. The majority of respondents (n = 204; 81.93% of valid responses, 77.57% of the total sample) reported that they had not participated in such mediations. Among the 45 participants who indicated a specific success rate, the largest proportion (n = 19; 42.22% of the experienced subgroup) reported a success rate below 70%. Notably, 14 participants (31.11%) reported success rates above 91%, and another 8 (17.78%) reported rates between 71% and 80%. Only 4 participants (8.89%) indicated success rates in the 81–90% range (Table 11).

Table 11. Distribution of Success Rates in Healthcare Mediations

Success Rate Category	Absolute Frequency (n)	Share of All Respondents (%)	Share of Valid Responses (%)	Share of Experienced Mediators ¹ (%)
Below 70%	19	7.22 ± 1.60	7.63 ± 1.67	42.22 ± 7.36
71–80%	8	3.04 ± 1.05	3.21 ± 1.11	17.78 ± 5.87
81–90%	4	1.52 ± 0.75	1.61 ± 0.80	8.89 ± 4.22
Above 91%	14	5.32 ± 1.37	5.62 ± 1.46	31.11 ± 6.83
Have no experience in healthcare mediations	204	77.57 ± 2.59	81.93 ± 2.47	—

¹ “Experienced mediators” refers to respondents (n = 45) who provided a specific percentage for the success of mediation (categories 1–4), i.e., they have participated in at least one healthcare mediation.

Analysis of the frequency of mediations conducted on a weekly basis revealed a statistically significant association with perceived success rates ($\chi^2 = 34.130$; $df = 8$; $p < 0.001$), with a Cramer's V value of 0.262, indicating a moderate effect. These results suggest that a higher frequency of participation in mediations does not correspond to greater perceived effectiveness. This likely reflects the specific characteristics of healthcare conflicts, including high emotional intensity, asymmetry between the parties, and limitations arising from the lack of institutional support.

The results of this study underscore the need for more active promotion of mediation within the Bulgarian healthcare system, through increased awareness and institutional support for its early implementation.

3.3.2 Applicability of Mediation in Conflicts Between Physicians and Patients

To assess mediators' attitudes toward the use of mediation in conflicts between physicians and patients, participants were asked to express their opinion regarding its applicability in this context. The most frequently selected response was "Widely applicable" - 138 respondents (52.47%; Sp = $\pm 3.08\%$), followed by "Applicable to a limited extent" - 101 participants (38.40%; Sp = $\pm 2.98\%$). A notable proportion of mediators (21 individuals; 7.98%; Sp = $\pm 1.67\%$) reported that they could not assess its applicability, while only 3 respondents (1.14%; Sp = $\pm 0.65\%$) completely rejected the use of mediation in the medical context.

Mediation has been demonstrated to be a highly applicable and particularly suitable method for resolving conflicts between physicians and patients, as it is faster, less expensive, and less confrontational than judicial procedures. International experience indicates high success rates and substantial economic and social benefits, including the restoration of trust and improvement in communication. In this sense, mediation emerges as a sustainable and effective mechanism for conflict management in healthcare.

3.3.3 Need for Additional Training of Mediators in the Healthcare Sector

To assess mediators' perspectives on the need for additional training in resolving conflicts between physicians and patients, participants were asked to indicate their position. The findings reveal strong support, with 76.43% of respondents in favor (**Figure 11**).

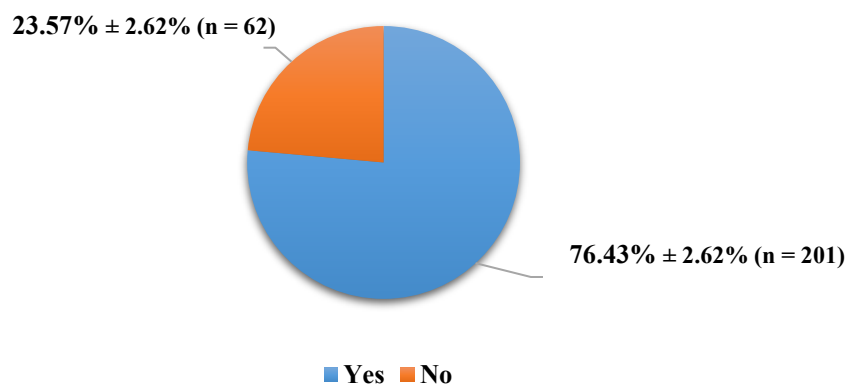


Figure 11. Mediators' Opinions on the Need for Additional Training in Healthcare

To determine whether the socio-professional characteristics of mediators influence their attitudes toward additional training in the healthcare sector, a logistic regression analysis was conducted. The model was statistically significant ($\chi^2 = 23.830$; df = 9; p = 0.005), with moderate explanatory power (Nagelkerke $R^2 = 0.125$) and a slightly improved predictive

accuracy (77.2% compared to 76.4% in the null model). Significant predictors included legal education ($B = 0.783$; Wald = 5.107; $p = 0.024$; $\text{Exp}(B) = 2.187$) and the frequency of weekly mediations ($\text{Exp}(B) = 0.035$; $p = 0.025$; $\text{Exp}(B) = 0.011$; $p = 0.014$), with the former increasing and the latter decreasing the likelihood of supporting additional training.

Supplementary χ^2 tests confirmed these results. A significant association was found with legal education ($\chi^2 = 6.251$; $df = 1$; $p = 0.012$; Cramer's $V = 0.154$; Somers' $d = -0.135$), with legally trained mediators supporting additional training less frequently (71.3% versus 84.8%). A significant relationship was also observed with the size of the locality ($\chi^2 = 9.558$; $df = 3$; $p = 0.023$; Cramer's $V = 0.191$), with the lowest support reported by mediators in medium-sized towns (60.6%). Furthermore, frequency of mediations was significantly associated with attitudes ($\chi^2 = 7.157$; $df = 2$; $p = 0.028$; Cramer's $V = 0.165$), where support dropped to 25.0% among those conducting more than 10 mediations per week. In contrast, overall mediator experience did not have a statistically significant effect ($\chi^2 = 1.680$; $df = 3$; $p = 0.641$). Notably, one-factor χ^2 analysis suggested that legal education may reduce support for additional training (71.3% versus 84.8%).

Mediators were additionally asked about the necessity of specialization in healthcare mediation. The results indicate strong support: more than half of the participants (60.08%; $n = 158$; $Sp = \pm 3.02\%$) considered it necessary. A substantially smaller proportion (14.45%; $n = 38$; $Sp = \pm 2.17\%$) did not perceive a need for specialization, while 25.48% ($n = 67$; $Sp = \pm 2.69\%$) were undecided.

Respondents supporting specialization emphasized the specificity of healthcare mediation and the need for foundational knowledge in medical terminology, regulatory frameworks, and healthcare system structures. According to them, such expertise facilitates understanding of disputes, mitigates the asymmetry between physicians and patients, and enhances trust in the mediation process. Specialization was also viewed as a factor for higher effectiveness and improved adaptation to patient needs, including through a multidisciplinary approach (e.g., joint mediation with medical experts or consultation with specialists) and additional psychological preparation, considering the high emotional intensity of healthcare conflicts. There was consensus that the sustainable implementation of healthcare mediation requires interdisciplinary, collaborative programs for mediators and healthcare professionals, aimed at developing a shared professional vocabulary and standardized procedures for conflict resolution.

3.3.4 Commitment of the Medical Establishment to Provide Mediators for Physician–Patient Conflicts, According to Mediators

Participants were asked to express their opinion on whether the commitment of healthcare institutions to provide a mediator would facilitate the resolution of conflicts between physicians and patients. Overall, 81.37% of mediators supported this notion, with the majority selecting “Yes, this would facilitate the process” or “Yes, definitely.” Full results are presented in **Table 12**. These findings indicate strong endorsement of institutionalized mediation within the medical establishment, irrespective of the mediators’ socio-professional characteristics.

Table 12. Mediators’ Attitudes Toward the Provision of Mediators by Healthcare Institutions

Response	n	%	Sp (%)
Yes, this would facilitate the process	113	42.97	±3.05
Yes, definitely	87	33.08	±2.90
Maybe	14	5.32	±1.38
No, mediation should take place outside the healthcare facility	47	17.87	±2.36
No, mediation is not appropriate for resolving physician–patient conflicts	1	0.38	±0.38
Cannot decide	1	0.38	±0.38

3.3.5 Coverage of Mediation Costs – Mediators’ Perspectives

The study explored mediators’ views regarding who should bear the financial costs associated with conducting mediation in conflicts between physicians and patients. All 263 participants provided valid responses, ensuring full sample representativeness (100.00%).

The most frequently selected option was “Costs should be shared between the involved parties,” chosen by 97 respondents (36.88%; Sp = ±2.98%). The second most common opinion was that the healthcare institution should cover the costs, indicated by 60 participants (22.81%; Sp = ±2.59%). Options involving public funding also received notable support, with the National Health Insurance Fund (n = 45; 17.11%; Sp = ±2.32%) and the state (n = 35; 13.31%; Sp = ±2.09%) being suggested as potential sources. In total, 140 participants (53.23%) expressed a preference for institutionalized forms of financing mediation. In contrast, only two respondents (0.76%; Sp = ±0.54%) considered that the costs should be borne entirely by the patient or the physician, indicating very low support for individualizing the financial burden. The response “Cannot decide” was chosen by 24 participants (9.13%; Sp = ±1.78%), reflecting some uncertainty on the topic.

Overall, more than half of the respondents (53.61%) expressed a preference for institutional funding - through the healthcare institution (22.81%), the National Health Insurance Fund (17.11%), or the state (13.31%) - while support for full coverage by the patient or physician was minimal (0.76%).

Consistent with international practices, mediators' attitudes reveal a clear preference for institutionalized models of financing mediation. This underscores the understanding that mediation should be an accessible service with guaranteed financial support, where costs are regarded not as a personal responsibility of the parties involved, but as a societal and institutional commitment.

3.3.6 Need to Increase Awareness of Mediation Among Physicians and Patients – Mediators' Perspectives

Previous findings highlighted that lack of information is the most frequently cited obstacle, undermining trust and perceptions of the procedure's applicability. In this context, respondents were asked to express their opinion on whether systematic awareness-raising could contribute to broader acceptance of mediation in healthcare. Regarding the need to increase awareness among physicians, 97.34% (n = 256; Sp = ±0.99%) of respondents affirmed that such a need exists, 0.38% (n = 1; Sp = ±0.38%) denied it, and 2.28% (n = 6; Sp = ±0.92%) were undecided. A similar distribution was observed with respect to patients: 97.34% (n = 256; Sp = ±0.99%) supported the need to improve patient awareness, 0.76% (n = 2; Sp = ±0.54%) did not, and 1.90% (n = 5; Sp = ±0.84%) were uncertain (**Figure 12**).

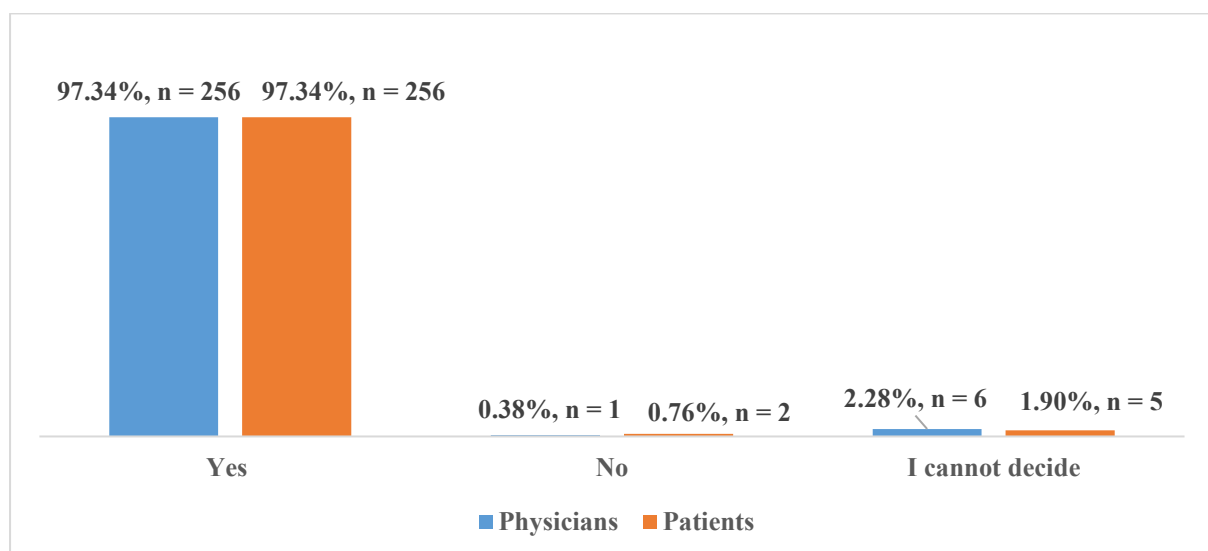


Figure 12. Mediators' Perspectives on the Need to Increase Awareness of Mediation Among Physicians and Patients

The results indicate near-unanimous agreement among mediators that systematic awareness-raising is a key prerequisite for the successful implementation of mediation in healthcare. This reflects the understanding that awareness is the primary tool for building trust and overcoming the socio-psychological barriers identified in the previous analyses.

4. DELPHI FOCUS GROUP STUDY

4.1. Content and Structure of the Training

4.1.1 Topics to Be Included in the Mediation Training Course

In the first round, full consensus (100%) was reached that the core modules in healthcare mediation training should include communication techniques, conflict management, and the psychological aspects of conflict. Strong consensus (80%) was achieved regarding the need to address ethical issues, fundamental ethical principles, and medical errors, while the principles of mediation, moral aspects of doctor-patient relationships, and care for vulnerable groups received moderate support (60%), and legal and deontological topics received lower support (40%).

Experts emphasized the need for an interdisciplinary and practice-oriented approach, cultural and ethical sensitivity, and addressing gaps in traditional medical education. Mediation training should integrate theoretical, communicative, legal, and psychological knowledge applied to real clinical cases, with a focus on ethical preparation, empathy, and the development of communication and emotional competencies.

The full consensus on communication techniques, conflict management, and psychological aspects demonstrates that mediation is viewed as a practical professional skill, not merely a legal procedure.

4.1.2 Role of Role-Playing and Simulations in Mediation Training

In the first round, strong consensus was reached regarding the importance of role-playing and simulations in healthcare mediation training: 80% of experts rated them as critically important, while the remaining 20% considered them useful but not mandatory; no respondents deemed them unnecessary.

In open-ended responses, role-playing and simulations were identified as the most effective experiential learning method, enabling theoretical knowledge to be translated into practical skills. Their role in developing empathy, active listening, emotional regulation, and understanding multiple perspectives in conflict was particularly emphasized, especially when

conducted in realistic settings involving actual medical professionals or patients. This approach provides a safe space to practice key behaviors such as de-escalation, emotional regulation, and constructive conflict resolution, encourages reflection and self-awareness, and supports the development of confidence and adaptability in managing challenging clinical situations.

4.1.3 Time Balance Between Theoretical and Practical Components of Training

In the first round, no consensus was reached regarding the proportion of theoretical versus practical components in healthcare mediation training: 60% supported a balanced model, 40% preferred predominantly practical training, and 20% each favored a primarily theoretical approach or a three-sector model. After reassessment in the second round, strong consensus (80%) emerged in favor of a balanced integration of theory and practice, with only 20% continuing to prefer mainly practical training, and the other options eliminated.

In open-ended responses, experts highlighted the advantages of a balanced model, in which theory provides the conceptual, legal, and ethical framework, while practical exercises - including simulations and role-playing - develop real-world communication and conflict resolution skills. Some participants emphasized a stronger practical focus, while others proposed a three-sector structure (theoretical, simulation, and practical modules). However, the general understanding was that, without a solid theoretical foundation, practice remains fragmented, and without sufficient practice, theory is difficult to apply. Integrating theoretical preparation with exercises, simulations, and role-playing is therefore regarded as essential for long-term mastery of mediation skills and for the development of adaptive expertise, active listening, reframing, emotional management, and confident conflict resolution.

4.1.4 Practical Conflict Resolution Methods to Be Included in Training

In the first round of the study, full consensus was reached that healthcare mediation training should include strategies for managing aggressive behavior, identified by all participants (100%) as a key competency for effective conflict management. Strong consensus (80%) was also achieved regarding techniques for de-escalating tension, analyzing conflicts, and guiding conversations toward resolution, while negotiation principles and trust-building methods received lower, non-consensus support (60%).

Aggression management strategies and de-escalation techniques are regarded as directly applicable in clinical practice, facilitating constructive dialogue, preventing escalation, and building trust through emotional resilience and appropriate nonverbal communication. De-escalation methods, conflict analysis, and solution-focused guidance enable early recognition

of tension, steer communication toward constructive resolution, and reduce the risk of escalation and legal disputes. Simultaneously, these approaches contribute to clinical safety, enhance patient and staff satisfaction, and lower organizational costs associated with conflicts and aggression.

4.2. Training Methodology

4.2.1 Most Effective Training Format

In the first round of the study, no consensus was reached regarding the most effective format for healthcare mediation training. In-person training received 60.00% support, self-directed learning with materials and manuals 40.00%, while online modules, a hybrid model, and a combined format were each indicated by 20.00% of participants, without a clearly dominant preference. After re-evaluation in the second round, full consensus (100.00%) was achieved in favor of a hybrid model combining online and in-person components. All experts considered this approach the most flexible and best suited to the practical realities of medical practice, with in-person training regarded only as a complementary option.

In open-ended responses, experts emphasized that in-person modules are indispensable for developing real mediation skills, providing direct interaction, role-playing, simulations, supervision, and immediate feedback. The online environment is seen as a valuable tool for theoretical preparation and flexibility, allowing asynchronous learning and self-directed study for busy professionals. The hybrid model is regarded as the optimal combination of these advantages, ensuring balanced acquisition of theoretical knowledge and practical skills while facilitating participation even under high clinical workload.

4.2.2 Duration of Healthcare Mediation Training

In the first round of the study, no consensus was reached regarding the optimal duration of mediation training in healthcare. A 3–5 day format received 40.00% support, while options such as “more than one week,” “2–3 weeks of six hours per day,” and “a two-week module on medical ethics” each received 20.00% support and were otherwise rejected. Training lasting 1–2 days was rejected by all participants. After re-evaluation in the second round, a strong consensus (80.00%) emerged in favor of a 3–5 day training program, while 20.00% supported an extended format of two to three weeks.

In open-ended responses, experts agreed that mediation training should be short, intensive, and practically oriented, with the 3–5 day format considered the most appropriate. This duration allows for effective acquisition of core communication and mediation skills without

imposing a significant burden on participants' professional schedules. Longer courses (1–3 weeks) are viewed as suitable for advanced or supplementary training, while overly brief formats are considered ineffective.

4.2.3 Form of Mediation Training

In the first round of the study, no consensus was reached regarding the most appropriate form of mediation training in healthcare. The option “mandatory component of the university curriculum” received the highest support (60.00%) but remained below the consensus threshold (80.00%). The options “as part of regular semester-based courses” and “within the framework of the state internship after graduation” each received 40.00% support and were similarly classified as lacking consensus, while the remaining proposals (20.00%) were rejected. After re-evaluation in the second round, a strong consensus (80.00%) emerged in favor of “within the framework of the state internship after graduation,” identified as the most appropriate format for mediation training, while the other forms did not receive significant support.

Open-ended responses emphasized that mediation should be integrated into mandatory medical education as part of communication skills and professional ethics, with opportunities for further development at various stages - during undergraduate studies, the state internship, and postgraduate training. The state internship period was highlighted as particularly suitable, as it combines a previously acquired theoretical foundation with intensive contact with patients and clinical teams in real-world settings. At this transitional stage, motivation for improving communication and conflict management skills is high, and repeated exposure to practical situations supports reflection, adaptation of communication style, and the formation of professional identity, while preserving the mediator's professional independence and neutrality.

4.3. Practical Application of the Training

4.3.1 Encouraging Physicians to Participate in Mediation Training

Experts were asked how physicians could be encouraged to participate in mediation training in healthcare. The thematic analysis identified five main motivational directions.

The first concerns institutional incentives and financial mechanisms, including involvement of professional associations such as the Bulgarian Medical Association, integration into national and European programs, and provision of training directly within healthcare facilities to facilitate access and reduce costs.

The second direction emphasizes practical benefits: improving communication with patients, reducing conflicts and complaints, mitigating legal risks, and enhancing team dynamics through demonstrable, real-world outcomes.

Third, experts highlighted the importance of integrating mediation courses into the continuing medical education system (CME) and linking them to accredited credits and official certificates recognized by professional organizations, thereby increasing professional legitimacy.

The fourth direction is critical of relying on practicing physicians as mediators due to potential risks to neutrality, recommending that mediation be conducted by external specialists, such as former physicians, lawyers, or healthcare law experts.

Fifth, communication and behavioral strategies were outlined, including the use of personal exemplars, empirical data demonstrating the impact of conflicts, engagement of respected professional authorities, and clearly articulating the benefits for everyday clinical practice.

According to the experts, the most effective approach to sustainably encouraging physicians to participate in mediation training combines institutional support, financial accessibility, integration into CME, and convincingly demonstrated practical benefits for clinical work.

MODEL FOR TRAINING PHYSICIANS IN HEALTHCARE MEDIATION

The developed practical model for mediation training is adapted to the actual conditions of the Bulgarian healthcare system and is based on the expert consensus achieved through the Delphi method (Figure 13).

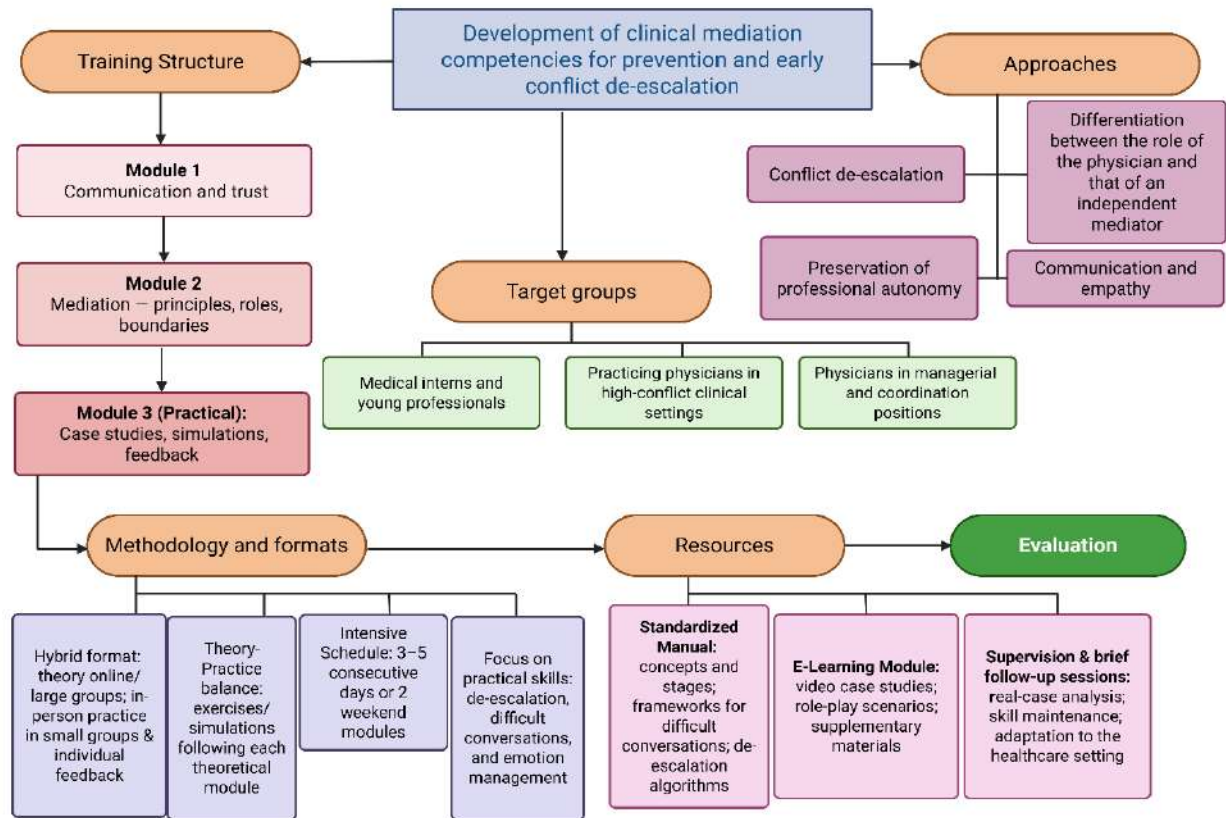


Figure 13. Model for Training Physicians in Healthcare Mediation

1. Purpose and Positioning of the Model

The primary objective of the model is to develop physicians' practical competencies for the prevention and early management of tension in interactions with patients and their relatives through the application of mediation techniques and professional communication skills.

3. Target Groups and Training Sequence

The proposed model follows a phased approach and is structured according to three authentic professional contexts within medical practice:

Level One – Medical internship and early years of professional practice.

Level Two – Practicing physicians working in settings with a high potential for conflict.

Level Three – Physicians in managerial and coordination roles.

This stratification corresponds to the sequence outlined in the expert opinions, which emphasize the early introduction of mediation and communication skills during the internship period, followed by their progressive development within the framework of continuing medical education (CME). At later stages, the training content may be tailored according to clinical risk exposure and managerial responsibilities.

3. Structure of the Training Program

The proposed model comprises three interrelated modules, which may be delivered either in an intensive format (3–5 consecutive days) or as modular components within the continuing medical education system.

Module 1. *Communication and Trust in Medical Practice* (foundational)

Module 2. *Healthcare Mediation – Principles, Roles, and Boundaries* (specialized)

Module 3. *Case Studies – Simulations – Feedback* (practical)

4. Training Methodology and Format

The methodological organization of the training follows the parameters defined during the expert discussions and aims both to ensure pedagogical effectiveness and to remain compatible with the actual professional workload of physicians. The training is delivered in a hybrid format: conceptual, ethical, and legal elements, as well as introductory topics on communication and mediation, can be completed online or in larger in-person groups, whereas all activities requiring behavioral engagement - exercises, simulations, role-plays, and facilitated mini-mediations - must be conducted in person. This arrangement allows for optimal use of trainees' time and focuses in-person sessions on the development of practical skills. This allocation enables optimal use of participants' time and allows in-person sessions to focus on the development of practical skills. Theoretical modules may be delivered to larger audiences or online in order to optimize resources and ensure standardized content, whereas practical sessions are organized in small groups of 8–10 participants. With regard to the temporal format, an intensive structure is recommended, either over 3–5 consecutive training days or across two consecutive weekend modules.

5. Training Resources

To ensure a unified standard and provide opportunities for knowledge refreshment, the model incorporates three types of resources:

1. a standardized *Healthcare Mediation Handbook*;

2. an online module including video-based cases, role-play scenarios, and concise refresher materials;
3. optionally, follow-up practical sessions or supervision focused on real cases from the respective healthcare institution.

6. Institutional Framework and Incentives

The effectiveness of the model depends not only on its content and methodology but also on the extent to which it is recognized and supported institutionally. The study identified three main barriers to physicians' participation: insufficient awareness of the benefits, lack of institutional incentives, and the perception of mediation as a "non-medical" topic. For this reason, the training should be embedded within established professional and organizational frameworks rather than remaining an individual initiative.

Several key steps are required:

- recognition of the course as a form of continuing medical education (CME) with accredited credits;
- partial or full funding by employers, the Bulgarian Medical Association, or other professional bodies, with a clear symbolic effect underscoring the importance of mediation;
- inclusion of mediation and communication competencies among the criteria for appraisal and appointment to managerial and coordination positions;
- a targeted information campaign highlighting concrete benefits (e.g., fewer complaints, earlier de-escalation of tensions, improved team climate, and more effective communication in cases of adverse outcomes).

7. Assessment

The purpose of the assessment is to determine whether participants are able to apply mediation and communication techniques in realistic situations, rather than merely demonstrating theoretical knowledge, given the predominantly practical and situational nature of these skills. The primary assessment tool is structured observation during simulations and role-play exercises, focusing on key indicators such as active listening, empathetic recognition and addressing of emotions, use of de-escalation techniques, ability to structure and conduct difficult conversations, and judgment regarding when referral to an external mediator is appropriate.

In addition, participants complete a brief written analysis of a clinical conflict, assessing their ability to identify the causes of escalation, propose an appropriate mediation or de-escalation approach, and justify it within the relevant ethical and legal framework.

8. Scope and Delimitations

The proposed model introduces a functional distinction between training physicians in the application of mediation techniques and the legally regulated training of professional mediators, in order to avoid role confusion and potential conflicts of interest. It is important to emphasize that the model is not intended to lead to mediator certification as defined by the Mediation Act and its secondary legislation. Its purpose is to equip physicians with practical tools for managing tension and improving communication within clinical practice.

ALGORITHM FOR MEDIATION IN PHYSICIAN–PATIENT CONFLICTS WITHIN THE HEALTHCARE SYSTEM

Empirical data from the three target groups - patients, physicians, and mediators - indicate that most conflicts in healthcare arise not from disagreement with diagnostic or therapeutic decisions, but from deficits in communication and access to information. All three groups express a willingness to engage in mediation, provided that it is offered in an institutionalized, accessible, and neutral manner. This finding underscores the need for a unified, institutionally compatible, and organizationally flexible algorithm for mediating conflicts between physicians and patients, which:

1. acknowledges the asymmetry between the parties and compensates for it through expert support;
2. allows for two access pathways - internal (within the healthcare institution) and external (through a specialized mediation center) - with the possibility of referral between them;
3. guarantees neutrality through the selection of the mediator and the right to challenge or recuse the mediator;
4. is financially sustainable through public or shared institutional funding mechanisms;
5. incorporates a mandatory initial triage to exclude cases that, due to legal, ethical, or emotional considerations, are unsuitable for mediation (e.g., severe adverse outcomes,

indications of criminal conduct, or situations requiring mandatory judicial proceedings)
(Figure 14).

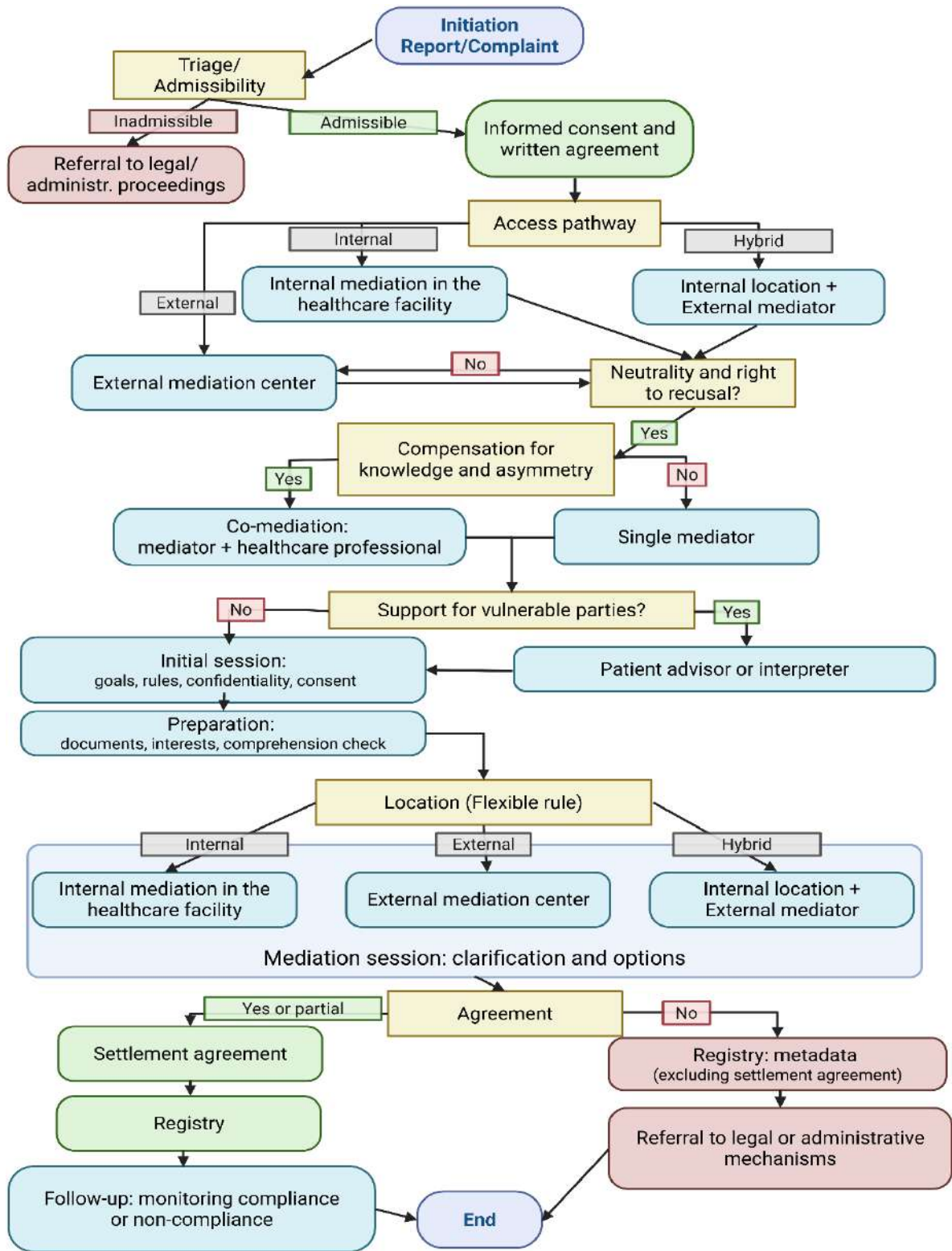


Figure 14. Algorithm for Mediation in Physician-Patient Conflicts within the Healthcare System

1. Purpose and Positioning of the Algorithm

The primary purpose of the algorithm is to establish a standardized, voluntary, and easily accessible procedure for resolving conflicts between physicians/healthcare institutions and patients/their relatives. Its aim is to facilitate dispute resolution at an early stage, reduce escalation toward judicial and regulatory procedures, and support the restoration of trust in healthcare delivery.

2. Principles of the Algorithm

2.1. Legal Compatibility and Voluntariness

The procedure is implemented solely on the basis of the parties' explicit, informed, and written consent, while preserving their right to withdraw at any stage without incurring adverse consequences within the healthcare institution. Admissibility is determined in accordance with the Mediation Act and the applicable healthcare and civil legal framework.

2.2. Compensation for Power Imbalance

The empirical data demonstrate a persistent sensitivity among patients to informational and professional asymmetry in relation to physicians, which mediators also identify as one of the structural barriers in healthcare conflict resolution. Accordingly, the algorithm provides for, by default, the possibility of co-mediation, involving a certified mediator alongside a second mediator with a medical background or specialized training in healthcare mediation.

2.3. Informed Choice and Right of Recusal

Rather than imposing a fixed formula, the algorithm provides the parties with a structured choice along three dimensions:

1. **Location** – within the healthcare institution, at an external specialized center, or a hybrid arrangement (institutional premises with an external mediator);
2. **Composition** – a single mediator or co-mediation;
3. **Access pathway** – initiation through an internal procedure with the option of referral to an external mediator if either party questions neutrality. To prevent perceptions of institutional dependence, the parties are granted an unconditional right of recusal -

without the need to provide justification - both with regard to the mediator and the venue.

2.4. Early Intervention

The algorithm is oriented toward the earliest phase of emerging tension. At this stage, communication can be restored without compromising professional reputation or clinical decision-making, a consideration of particular importance for physicians.

2.5. Public and Institutional Accessibility

The algorithm is based on primary institutional or public funding (by the healthcare institution, the national insurance mechanism, or state/project-based resources), supplemented where necessary by symbolic co-financing by the parties. Exemptions are provided for vulnerable groups.

3. Access Pathways with the Right to Referral

3.1. Internal Pathway (Institutional Mediation)

The internal access pathway provides a rapid, accessible, and formalized mechanism for the early management of emerging tensions within the healthcare institution. In cases of perceived bias or upon the explicit request of either party, an option is activated for the involvement of an external mediator or co-mediator, without interruption of the mediation process.

3.2. External Pathway (Specialized Center)

The parties have the right to directly refer the case to an accredited healthcare mediation center. The healthcare institution may also direct cases to the external pathway in situations involving heightened public interest, risk to institutional reputation, allegations of serious professional misconduct, or where the neutrality of the internal mediator is called into question. This access pathway ensures a high degree of perceived independence while maintaining coordination with the healthcare institution on organizational matters.

3.3. Right to Change the Selected Pathway

Until a settlement agreement is signed, the parties are entitled to a one-time, unconditional right to request transfer between access pathways (internal ↔ external), without such a request being interpreted as a refusal to participate in mediation. This safeguard protects trust in the

procedure and reduces the risk of premature withdrawal due to perceived dependence or insufficient neutrality.

4. Team Composition and Competencies

4.1. Basic Configuration

The minimum team composition includes a certified mediator, as defined under the applicable legislation, who may have completed a specialized module in healthcare mediation. Training should encompass: fundamental medical concepts and documentation (e.g., diagnoses, discharge summaries, informed consent), the structure and governance of the healthcare system, roles and responsibilities within healthcare institutions, financing mechanisms, and key regulatory sources.

4.2. Co-mediation

Co-mediation is applied in cases characterized by pronounced expert asymmetry, disputes requiring interpretation of medical documentation, or high emotional intensity (e.g., pediatrics, oncology, adverse outcomes). The additional team member may be:

- a healthcare professional who has completed mediation training; or
- a certified professional mediator whose basic education is in a healthcare-related field.

5. Location and the “Flexible Rule”

Empirical findings indicate a preference for external specialized centers, although this may increase the time required to initiate the procedure. Simultaneously, stakeholders are willing to accept an internal location if clear guarantees of impartiality are provided. Based on these insights, a “flexible rule” is introduced, balancing accessibility, neutrality, and procedural security:

5.1 Default – Internal within the Healthcare Institution: Applied in cases of low to moderate escalation, absence of suspected bias, and availability of a dedicated, protected space. An option for an external co-mediator must be offered upon request.

5.2 Mandatory External Location: Required in cases of suspected serious professional misconduct, significantly eroded trust, heightened media sensitivity, or when either party explicitly requests an external venue.

5.3 Hybrid Option: Conducted on the premises of the healthcare institution with participation of an external mediator/co-mediator registered with an accredited healthcare mediation center. This arrangement combines organizational proximity with perceived independence.

Regardless of the chosen location, an informed consent form is signed, specifying: the venue, team composition (including co-mediation if applicable), selected access pathway (internal/external/hybrid), rules of confidentiality, and the right to recusal. The form also includes a brief description of the objectives and limits of the procedure, a mechanism to verify comprehension, and criteria for transferring to an alternative access pathway if circumstances change.

6. Triage and Admissibility

Before scheduling a meeting, a brief triage is conducted to ensure legal compliance and procedural appropriateness. A checklist is applied: (a) Evidence of criminal activity, violence, or fraud; (b) Occurrence of a fatal outcome or severe irreversible consequences requiring forensic examination; (c) Lack of capacity or absence of informed, voluntary consent to participate; (d) Existence of a legally mandated judicial or administrative procedure. A positive response to any criterion leads to a reasoned referral to the competent procedure, with the parties provided written notification explaining the reasons and available alternatives. If deemed admissible, the coordinator proposes a location according to the “flexible rule” and schedules initial meetings.

7. Funding

The findings indicate a clear preference for mediation to be institutionally and/or publicly funded, without imposing financial burden on the parties. Such a framework aligns with the objectives of the algorithm: early intervention, high accessibility, and neutrality. Funding should minimize administrative, temporal, and emotional costs, remain predictable for healthcare institutions, and be transparent for participants.

8. Risk Management and Trust

This section ensures procedural security, perceived neutrality, and protection of vulnerable participants - prerequisites for effective, voluntary, and fair mediation.

8.1 Guarantees of Independence and Impartiality

To prevent both actual and perceived dependencies, the mediator/co-mediator signs a written declaration of independence and absence of conflict of interest prior to the commencement of the procedure, which is updated if new circumstances arise. In internal cases, mediator assignment follows a rotational or random principle to limit institutional influence.

8.2. Equality and Support for Vulnerable Participants

To counteract asymmetries in knowledge and resources, the presence of a participant-supporting person is permitted (e.g., patient advisor/advocate, guardian/custodian). Language interpretation and communication adaptations are provided for participants with hearing or visual impairments. All explanations are delivered using materials adapted to the participant's level of health literacy, accompanied by a mandatory comprehension check.

8.3. Procedural Safety and Clarity of Escalation

A protocol is prepared in accordance with legal requirements to manage risks to safety (verbal/physical aggression, self-harm), including the mediator's authority to suspend the session and refer participants to appropriate institutions. If, during the procedure, circumstances arise that require legal intervention (e.g., evidence of criminal conduct), mediation is immediately terminated, and the relevant judicial or administrative process is activated, with the rationale documented.

8.4. Transparency and Informed Participation

Before the procedure begins, parties receive a brief written guide clearly outlining the objectives, stages, rights (including the right to an external mediator and recusal), funding sources, and data protection measures. This reduces uncertainty, lowers conflict potential, and strengthens trust in the mediation process.

9. Centralized Healthcare Mediation Registry

The registry is an integral component of the algorithm, providing reliable, comparable, and non-confidential data on the scope, process, and outcomes of mediation. Data are collected at the primary level within healthcare institutions and accredited healthcare mediation centers

using standardized forms, and are submitted to a centralized platform. The objectives of the registry are: monitoring access and timeliness; evaluating effectiveness (outcomes and implementation of agreements); internal quality control and continuous improvement; and providing an evidence base for funding, training, and competency profiling.

9.1 Minimum Data Set

The standardized form collects the following data: a unique case identifier; registration date and access pathway used (internal/external/hybrid); location of the mediation; team composition (including co-mediation and/or external mediator); supporting resources utilized (language interpreter, patient advisor); key process milestones (orientation meeting, number of sessions, total duration); and outcome of the procedure (full/partial/no agreement).

Exclusions: Medical facts, diagnoses, and negotiation content are not recorded. The registry captures only outcome metadata necessary for monitoring access, quality, and effectiveness.

GENERAL CONCLUSIONS

1. Awareness of mediation among patient representatives and healthcare professionals is uneven, indicating a need for a targeted, clearly structured, and legally oriented information policy.
2. There is broad support for increasing awareness among both physicians and patients through a dual-focused, practice-oriented approach: clear informational materials for patients and operational protocols for physicians specifying when and how to use mediation.
3. The key advantages of mediation are recognized as impartiality, neutrality, equality of the parties, and confidentiality.
4. Emphasis is placed on the added value of the procedure: speed, low formalization, open dialogue, preservation of therapeutic relationships, and the restorative function (reduction of tension, opportunity for apology, and creation of a framework for future collaboration).
5. Dominant barriers include lack of information and distrust. The main barrier to using mediation concerns access and referral mechanisms—there is no established institutional pathway, early recommendation, or rapid connection to a mediator.
6. Attitudes toward applicability are predominantly positive; higher education levels and prior experience with communication difficulties increase the likelihood that mediation will be preferred.
7. The likelihood of participating in healthcare mediation is higher among mediators with legal training and greater overall practical experience. The primary reason for declining cases is uncertainty regarding one's own medical competence, compounded by perceived institutional limitations.
8. The general consensus is that mediation is appropriate for the majority of physician–patient conflicts, with reasonable exceptions including cases involving severe harm or legally significant consequences, evidence of criminal activity, lack of voluntariness or capacity, and situations requiring expert judicial assessment.

9. There is strong support for co-mediation involving a healthcare professional and for specialized training in healthcare mediation as a means to address expert asymmetry and enhance trust in the process.
10. To balance expertise and trust, targeted, interdisciplinary, and practice-oriented training for healthcare mediators is endorsed.
11. Regarding the organizational model, a hybrid approach is most rational: an internal “first line” for early intervention and de-escalation, with the option to refer complex cases to an external, accredited mediator.
12. Expectations for funding are directed toward institutional mechanisms (public or hospital-based) rather than individual payment.
13. In the educational domain, there is strong support for integrating mediation into both medical education and continuing professional development.
14. A competency-based, two-stage training model is justified, positioning mediation as an internal professional competence of the physician (prevention, de-escalation, structuring difficult conversations, early referral to external mediation) rather than as an external, separate procedure.
15. The model should be implemented early (during the medical internship) and further developed through continuing medical education in a hybrid format: theoretical and legal components delivered in a scalable format, and behavioral skills delivered in-person in small groups through simulations, role-plays, and structured feedback.

RECOMMENDATIONS

1. To the Ministry of Health (MoH) and Ministry of Justice (MoJ)

1.1. Introduce, via sub-legislative act or methodological guidelines, a model for early healthcare mediation with two access pathways (internal within the healthcare institution and external at a specialized center) and the right for parties to transfer between pathways.

1.2. Regulate triage and exclusions (e.g., evidence of criminal activity, mandatory judicial procedures, severe fatal or disabling outcomes, lack of voluntariness or capacity).

1.3. Establish a minimum standardized documentation package: initiation form, informed consent, triage checklist, session protocol, agreement template, follow-up protocol.

1.4. Create a voluntary profile/accreditation module “Healthcare Mediation” in the mediator registry covering medical terminology and documentation, ethics and confidentiality, medical law, and de-escalation techniques.

1.5. Integrate into accreditation criteria for healthcare institutions: internal mediation procedures, mediation coordinator, protected space, timelines, and reporting obligations.

2. To Public Payers

2.1. Ensure financial coverage for external (or hybrid) mediation through contracts with accredited centers and indicative tariffs.

2.2. Implement a pilot early mediation program for priority indications (emergency care, pediatrics, oncology, intensive care), tracking outcomes (time to resolution, reduced complaints, satisfaction).

2.3. Require professional liability insurers to cover early mediation as a risk-reduction mechanism.

3. To the National Center for Public Health and Analyses (NCPHA)

3.1. Administer a centralized healthcare mediation registry (metadata only, no medical facts): selected pathway, location, team composition (including co-mediation), process stages, number of sessions, outcome (full/partial/no agreement), compliance with clauses.

3.2. Publish an annual report with aggregated indicators and recommendations for improvement.

4. To Medical Establishments

4.1. Introduce an internal access pathway for mediation.

4.2. Apply the “flexible rule” for location: default internal for low/moderate escalation; mandatory external if trust is eroded, public interest is high, or bias is suspected; hybrid with external mediator when independence and organizational proximity are required.

4.3. Ensure availability of co-mediation (for expert asymmetry or high emotional load), protected space, and patient-adapted materials (with comprehension checks).

5. To Medical Universities and the Ministry of Education (MoE)

5.1. Integrate a mediation approach into clinical communication during the medical internship (basic module) and in continuing medical education (advanced module with OSCE-type assessment).

5.2. Organize interprofessional trainings for mediators and clinicians to establish a shared vocabulary and procedural algorithms.

6. To the Bulgarian Medical Association (BMA) and Professional Organizations

6.1. Recognize mediation courses as CME-accredited and support internal, on-site training.

6.2. Facilitate an informational campaign on mediation and the physician's role in early referral.

7. To Professional Mediator Organizations

7.1. Develop a "Healthcare Mediation" profile, rotational lists for internal cases, and a code of independence/conflict of interest.

7.2. Maintain joint seminars with healthcare institutions.

8. To Patient Organizations

8.1. Establish a network of patient advisors or equivalent facilitators to support participants in mediation.

8.2. Collaborate on informational materials (right of recusal, access pathways, session procedures).

9. To the Media and Civil Society

9.1. Promote mediation in a neutral and factual manner as an early, voluntary, and confidential alternative to judicial escalation, avoiding sensationalism in cases of medical incidents.

CONTRIBUTIONS

Original Contributions

1. The first national analysis of mediation in healthcare has been conducted, based on a study involving three independent groups of participants: patients, physicians, and practicing mediators.
2. A conceptual framework for the “physician’s mediation approach” as an internal professional competence has been developed and empirically validated.
3. An original mediation training model for physicians has been designed (phased, stratified by conflict risk and professional role), suitable for implementation during state residency training and within the system of continuing medical education.
4. An algorithm for the early recognition and de-escalation of physician–patient conflicts has been proposed.
5. Through recommendations addressed to the responsible institutions, the groundwork has been laid for the development of a comprehensive institutional algorithm for integrating mediation into healthcare organizations.

Theoretical Contributions

1. The boundaries and roles within the triad “physician – co-mediator – independent mediator” have been clarified, with principles formulated for the ethical and legal compatibility of the mediation approach within clinical practice.
2. An analytical model of the emergence and escalation of conflicts in healthcare has been proposed, linking communication deficits, a compromised trust framework, and institutional factors.

Contributions Enriching Existing Knowledge

1. A comparative overview of convergences and divergences among patients, physicians, and mediators has been provided with regard to the applicability, effectiveness, and limits of mediation in the Bulgarian healthcare system.
2. Persistent communication determinants of conflict (limited time, unclear or overly technical information, hierarchical communication style, and deficits in empathy) have been identified, and pathways for prevention in clinical practice have been demonstrated.

3. The role of the organizational context (policies, incentives, and internal complaint-handling procedures) has been empirically substantiated.

Theoretical-Practical Contributions

1. A three-module educational model for training physicians in mediation has been developed.
2. Concrete mechanisms for institutionalization have been proposed, including recognition within continuing medical education with credit allocation, on-site internal training, financial incentives from employers or professional organizations, and the inclusion of mediation competencies in appraisal procedures for leadership positions.
3. A comprehensive algorithm for mediation in physician–patient conflicts has been elaborated, covering early identification of escalation signals and primary de-escalation in the clinical setting, selection of the appropriate approach (internal facilitation or referral to an independent mediator), and finalization, documentation, and subsequent prevention.
4. A set of organizational indicators for assessing the effectiveness of mediation in healthcare has been proposed (early containment of tension, frequency of escalation to external judicial bodies, and indicators of team climate), enabling the introduction of a quality improvement cycle.
5. An integrated algorithm for introducing mediation into healthcare organizations has been formulated, combining training, internal regulations, and impact measurement.
6. Guidelines have been proposed for national and professional bodies to coordinate training, develop standard protocols for complaint management, and introduce participation incentives that are mutually compatible.

LIST OF SCIENTIFIC PUBLICATIONS AND CONFERENCE PARTICIPATION RELATED TO THE PHD THESIS

1. Journal Publications

- 1.1 Dimitrov, K.Y.; Miteva-Katrandzhieva, T. Exploring Patient Awareness and the Feasibility of Mediation in Healthcare: A Pilot Study in Bulgaria. *Healthcare* 2025, 13, 629. <https://doi.org/10.3390/healthcare13060629>
- 1.2 Dimitrov K, Miteva-Katrandzhieva T. Mediation in Healthcare: Enhancing Conflict Resolution Between Patients and Physicians Beyond the Courtroom. *Cureus*. 2024 Dec 10;16(12):e75487. doi: 10.7759/cureus.75487.
- 1.3 Dimitrov K, Miteva-Katrandzhieva T, Alternative Dispute Resolution in Healthcare – Historical Overview., *Science and Youth. Scientific Reports.*, 2023, pp. 7–12, asclepius.bg/cnm/wp-content/uploads/2023/09/NM-2023-full-16-aug.pdf.

2. Conference Presentations

- 2.1 Димитров К., Митева-Катранджиева Ц., Комуникационни бариери и разрешаване на конфликти между лекари и пациенти с редки заболявания: необходимост от алтернативен подход. (*Communication Barriers and Conflict Resolution Between Physicians and Patients with Rare Diseases: The Need for an Alternative Approach*). 16th National Conference on Rare Diseases and Orphan Drugs, Plovdiv, Bulgaria, 12–13 September 2025.
- 2.2 Димитров К, Митева-Катранджиева Ц, Медиацията като инструмент за разрешаване на конфликти между лекари и пациенти. Наука и младост, Пловдив, 09 – 11 май 2025 г. (*Mediation as a Tool for Resolving Conflicts Between Physicians and Patients*). Science and Youth Conference, Plovdiv, Bulgaria, 09–11 May 2025.
- 2.3 Димитров К, Митева-Катранджиева Ц, Пилотно проучване сред пациенти относно приложимостта на медиацията в българското здравеопазване като възможност за разрешаване на конфликти между лекари и пациенти (*Pilot Survey Among Patients on the Applicability of Mediation in Bulgarian Healthcare as a Means for Resolving Physician–Patient Conflicts*). 7th Scientific Conference with International Participation “Public Health: A Look into the Future,” Plovdiv, Bulgaria, 27–28 September 2024.

- 2.4 Димитров К, Митева-Катранджиева Ц, Медиация при разрешаване на конфликти в здравеопазването: Приложимост и въздействие върху конфликти при редки заболявания. (*Mediation in Healthcare Conflict Resolution: Applicability and Impact on Conflicts in Rare Diseases*). 15th National Conference on Rare Diseases and Orphan Drugs, Plovdiv, Bulgaria, 13–14 September 2024.
- 2.5 Dimitrov K, Miteva-Katrandzhieva T, Hristova-Atanasova E, Iskrov G. Mediation in healthcare conflict resolution: a paradigm shift from traditional legal processes. Xth International Conference of Young Scientists – Plovdiv 2024, 20-23 юни 2024 г., Пловдив.
- 2.6 Димитров К, Митева-Катранджиева Ц, Медиацията – метод за разрешаване на конфликт между лекар и пациент с рядко заболяване. (*Mediation as a Method for Resolving Physician–Patient Conflicts in Rare Diseases*). 14th National Conference on Rare Diseases and Orphan Drugs, Plovdiv, Bulgaria, 29–30 September 2023.
- 2.7 Димитров К, Митева-Катранджиева Ц, Методи за алтернативно разрешаване на конфликт в здравеопазването - исторически преглед. (*Methods for Alternative Conflict Resolution in Healthcare – A Historical Overview*). Science and Youth Conference, Plovdiv, Bulgaria, 21–23 April 2023.

3. Completed training

- 3.1 Certification Training in Mediation, Academy of Agreements, 2023.