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Chapter 12

Innovating Compensation for Medical Liability in the Netherlands



Berber Laarman and Arno Akkermans

Abstract In the Netherlands, concerns about the negative experiences of patients with legal procedures following adverse medical events have led to potentially profound changes in the field of procedural complaint- and compensation law. This chapter offers insight into the Dutch legal framework of compensation for damage caused by healthcare. We start by presenting the traditional framework in the paragraph on the Dutch landscape of medical liability. Having laid the groundwork, we try to explain the innovations that have recently been introduced, in the paragraph dealing with efforts for reform. We elaborate on the problems patients experience when they claim for compensation, the impact legal procedures can have on both patients and healthcare professionals, the recent changes in legislation trying to address these problems, and how these changes might entail a new reality for both healthcare and legal professionals.

The Dutch Landscape of Medical Liability

The Legal Relationship Between Healthcare Professional and the Patient

The Dutch system for compensation of damage resulting from health care is fault based. The rights of patients and the corresponding duties of healthcare professionals are laid down in the Medical Treatment Contracts Act (WGBO) which is part of the Dutch Civil Code (DCC), and the Healthcare Quality, Complaints and Disputes Act (Wkkgz). The WGBO is an act on healthcare professionals' duties concerning individual patient care, the Wkkgz sets out obligations on complaint management and quality of care, including the out of court resolution of claims for compensation.

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The relationship between the healthcare professional and the patient is a specific contract, the medical treatment contract, for which binding rules are given in the WGBO (article 7:446 Dutch Civil Code, hereinafter referred to as DCC), such as the general obligation of the health care professional to observe the standards of good care and to act in conformity with the responsibilities laid upon him by the professional standard that is applicable to him (art. 7:453 DCC). Acting in breach of the duty of providing good care is qualified as failure to fulfill a contractual duty (art. 6:74 in conjunction with art. 7:453 DCC).

In case law on the contractual¹ liability of professionals the criterion of the ‘reasonably able and reasonably acting’² professional has been developed to describe the general standard of care that is expected of all professions, i.e. not limited to the medical professions.³ This general criterion is operationalized by the applicable professional standard, depending on the profession involved. The performance of professionals is evaluated by asking what a reasonably able and reasonably acting colleague would have done in the same circumstances.

For healthcare professions, the professional standard is composed of the state of the art of medical practice, construed *inter alia* out of relevant guidelines, protocols and scientific publications. Case law is also an important source, not only of the courts, but especially of the medical disciplinary tribunals, where medical and legal experts decide on the quality of care provided by individual healthcare professionals. The professional standard is a melting pot of standards and norms of different origin, not only in regard of very different sources, but also in the sense that it contains a mixture of standards and norms from international and national origin, and it is difficult to reconstruct which norm originates from where, and to what extent. In general, the level of accepted medical knowledge (*ars medica*) will be considered from the international perspective of the applicable medical sub discipline, but the test of what a ‘reasonably able and reasonably acting’ colleague would have done in the same circumstances, naturally allows for all the circumstances of the case at hand,⁴ including circumstances that might be typical for the Netherlands. On the other side of the spectrum, there are norms that formally are of a national origin, such as norms on communication and openness on adverse events, but these as well are often inspired and/or informed by the ideas and practices in other countries. The Netherlands is a very open jurisdiction, both in practice and in theory, and the question whether a certain norm has a national or international origin is not always easy to answer and is rarely relevant.

¹The same criterion applies in tort.

²‘*Redelijk handelend en redelijk bekwaam*’.

³The norm of the ‘reasonably able and reasonably acting’ professional was first formulated by the Dutch Supreme Court in the Speeckaert/Gradener case, ECLI:NL:HR:1990:AC1103, and later laid down in article 7:453 DCC.

⁴The standard is the same for junior or new doctors, and there is some controversy on whether the kind of hospital should be allowed to make any difference (e.g. academic medical center or not).

Logically, following from the obligation to act as a good healthcare provider (and not a perfect one), the complexity of the human body, and the limitations and imperfections of health care, the medical treatment contract is considered to give rise to ‘obligations of means’ (*obligation de moyens*),⁵ although the nature of things can be such that certain obligations, such as the obligation of a surgeon to amputate the right leg and not the wrong one, will nonetheless be qualified as an ‘obligation of result’ (*obligation de résultat*).⁶ Dutch legal doctrine is not familiar with the concept of an *obligation de moyens renforcée*.⁷

Dutch law is familiar with the concept of *aléa thérapeutique* to identify adverse medical events that were not caused by errors or any other form of substandard care, but are considered risks inherent to the condition or the treatment of the patient. These are called ‘complications’ (*complicaties*) and, as Dutch medical liability is fault-based, cannot give rise to liability. There is, however, no separate normative framework for identifying ‘complications’, as they are already singled out by the applicable test of asking what a reasonably able and reasonably acting colleague would have done in the same circumstances. If the care provided was up to standard, any negative health results will be considered a ‘complication’ and will not give rise to a right to compensation.

In situations where the patient is unable to consent, no treatment contract is concluded, for instance when the patient is unconscious. In the absence of a treatment contract the basis of liability will be in tort. Dutch tort law is organized starting from a general statutory provision, article 6:162 of the Dutch Civil Code, that mentions three separate forms of unlawfulness. There is some scholarly debate

⁵In several civil law jurisdictions a doctrinal distinction is made, originating in French law, between two types of contractual obligation: an ‘obligation of result’ (in French: *obligation de résultat*) is an obligation to achieve a certain result (also known as output based obligations) is distinguished from an ‘obligation of means’ (in French: *obligation de moyens*), this is an obligation to dedicate a certain amount of resource to achieving a particular result (also known as input based obligations). If a contractual breach is committed in respect of an ‘obligation of result’, the plaintiff has only to demonstrate that the contractual result has not been achieved. The debtor is then deemed liable, except if he can prove that his obligations under the agreement were not fulfilled because of force majeure or an act or omission of the plaintiff. If a contractual breach is committed of an ‘obligation of means’, the plaintiff must prove that the debtor has acted wrongfully by not performing his obligations with the necessary degree of care and diligence. Whether an obligation is deemed to be an ‘obligation of result’ or ‘obligation of means’ will depend partly on the uncertainty of the result to be achieved and partly on the intention of the parties. For further analysis, see Alessi on the distinction between the two (Alessi 2005). In the Netherlands, the distinction is not always made nor always considered relevant, and the Courts are free to decide on issues of proof according to all the circumstances of the case at hand.

⁶A medical treatment contract can give rise to ‘obligations of result’ when the parties at the moment of entering into the contract intended the healthcare professional to guarantee a certain and explicitly described result, or that intention can be deemed to have existed based on parties’ declarations and conduct when concluding the agreement.

⁷This is a ‘strengthened’ obligation of means, sometimes called the obligation of ‘diminished’ result: it is the debtor’s duty to release himself, but the proof required is easier than that of force majeure.

on the meaning of these different forms, but in practice these theoretical differences are of no consequence, and for all practical purposes the tortious ground for medical liability can best be translated as the tort of negligence. Here exactly the same criterion applies, namely the test what a ‘reasonably able and reasonably acting’ colleague would have done in the same circumstances. As a result, the doctrinal distinction between contract and tort in medical cases is rarely relevant.

A medical professional can also be found liable for using an unsuitable or defective aid (art. 6:77 DCC), for subordinates (an assistant or trainee, art. 6:76 DCC) or an unsuitable building (art. 6:174 DCC).

The Relationship Between Healthcare Professional, Healthcare Provider and the Liability Insurance Company

First a note on relevant Dutch legal vernacular: in Dutch healthcare regulations, ‘healthcare professional’⁸ is a comprehensive term meaning doctors, such as surgeons or physicians, but also general practitioners, dentists and nurses. The ‘healthcare provider’ is the surrounding institution; the hospital, clinic or nursing home. Often the ‘healthcare professional’ and the ‘healthcare provider’ are distinct entities. An exception is when a family doctor or a dentist, or any other professionals who typically work in smaller clinics, have their own individual practice. In the terms of Dutch health care regulations, they are both ‘healthcare provider’ and ‘healthcare professional’. Most Dutch medical specialists work as self-employed entrepreneurs in hospitals. Medical specialists are usually organized in a ‘*Medisch Specialistisch Bedrijf*’ (MSB, Medical Specialist Enterprise), a partnership organized around one or more medical specialties working within a hospital on the basis of a contract with that hospital. Typically, caring and assisting personnel will be employed by the hospital.

Patients receiving treatment in a hospital will, therefore, often have to do with several legally separate contractual partners. This legal dimension of hospital healthcare will of course rarely coincide with the perceptions of patients, and could give rise to all kinds of hampering complications when patients want to exercise their legal rights or undertake other forms of action. This is why article 7:462 Dutch Civil Code provides for so called ‘central liability of the hospital’. Central liability enables patients who experience harm in a hospital⁹ to address the hospital directly in regard of all treatment received in that hospital (article 7:462 DCC). Central liability is also reflected in liability insurance arrangements, as it

⁸The Wkkgz addresses all *healthcare providers*. This means the same obligations on managing complaints and quality apply to institutions like hospitals and nursing homes, and to individually working practitioners like family doctors and dentists.

⁹‘Hospital’ here can mean a nursing home, psychiatric hospital, academic hospital, specialist clinic, etc.

logically obliges hospitals to acquire comprehensive intramural liability insurance coverage, providing coverage for all healthcare professionals working within the same hospital, whether they are employees or not (Wijne 2013).

All hospitals carry some form of agreed upon deductible excess, but the amounts vary widely, from a relatively small excess on each separate claim to an overall annual excess of several millions. Below the threshold of the deductible excess the level of involvement of the insurance company varies. Some hospitals handle claims below the agreed upon threshold independently from the insurance company. They will have an internal legal department or a complaints officer with the necessary expertise to manage (most) claims properly, and the insurance company's involvement is limited to accepting payments as part of the deductible excess—if applicable. It might also be that a healthcare provider, when confronted with a more complex claim, involves a professional loss adjuster. At the other end of the spectrum, all claims are referred to the insurance company entirely. In that case a professional claims handler of the insurance company takes over all matters pertaining to the claim, including correspondence with the patient. Between these extremes, many different arrangements and forms of cooperation occur, depending on the hospital, the policy of the insurance company, but also on the case at hand. Sometimes hospitals prefer to refer a certain claim to the insurance company because the patient is still receiving treatment and they fear that legal issues might interfere with the relationship between the patient and the healthcare professional. Conversely, the relationship with the patient may have deteriorated to the point that referring the claim to the insurance company has become the preferable option.

Open Disclosure and Apologies

The Healthcare Quality, Complaints and Disputes Act (Wkkgz) obliges healthcare providers to inform patients about the nature and circumstances of adverse events. The Act expects providers to be open and honest about 'any unintended or unexpected event that relates to the quality of the care, and has resulted, or could result, in noticeable consequences for the client' (article 10 section 3 Wkkgz). The codification of this obligation by statute was merely the crowning moment of the preceding evolution of the applicable professional standard. The careful reader will have noted that the definition of adverse events as stated in art. 10 section 3 Wkkgz does not include the so-called near misses ('could have resulted'). It is all but the near misses that have to be brought 'without delay' to the attention of the patient on the initiative of the healthcare provider (Article 10 section 3 Wkkgz).

The Dutch market for medical liability insurance is dominated by two mutual insurance societies,¹⁰ that for some time now have been actively promoting an open and proactive approach of their insured towards adverse events, including open

¹⁰These are VVAA/MediRisk (www.medirisk.nl) and Centramed (www.centramed.nl).

disclosure and the offering of apologies where appropriate. It is explained to the insured that admitting fault and apologizing must be distinguished from accepting liability, the former belonging to the responsibility of the healthcare professional, and the latter to the responsibility of the insurer or the legal department of the hospital. The prevailing view that the admission of fault and apologies as such do not constitute acceptance of liability has up till now been sustained by the very few court and disciplinary cases that explicitly address this issue.¹¹ Regretfully, it cannot be said that outside the specific domain of medical liability insurance, that is to say, in the domain of professional liability insurance in general, all insurance companies take the same enlightened approach to the issue of admitting fault and apologising by their insured. The Dutch Civil Code does however contain a provision that is relevant to this issue and applicable to all liability insurance policies:

Article 7:953 DCC: If a liability insurance prohibits the insured to make certain acknowledgements, then a violation of this prohibition will not have any effect insofar as such acknowledgement is correct. A prohibition to acknowledge facts never has any effect.¹²

This provision can be understood as being part of the general principle that parties to a civil procedure should be truthful¹³ and was explicitly introduced to protect those who correctly admit fault from being excluded from their insurance coverage (Zwart-Hink 2017). The medical liability insurers no longer entertain any prohibitions of this kind in their insurance contracts, not only out of well understood self-interest but simply because such conditions would induce their insured to act contrary to their professional standard. But a recent examination of liability insurance policies available on the internet revealed the survival outside of the medical domain of many ‘outdated’ policy provisions that article 7:953 DCC renders unenforceable and therefore can only misinform the insured about their options in regard of well-founded allegations of mistake or fault (Zwart-Hink 2017). This might help to explain that the ‘popular belief’ that liability insurance stands in the way of admission of fault and the offering of apologies is still widely spread in society and, in spite of all recent efforts, has not yet been completely eradicated among the medical professions.

¹¹This view is not without controversy (Zwart-Hink 2017).

¹²Translation by the authors. Art. 7:953 Burgerlijk Wetboek: ‘Indien een verzekering tegen aansprakelijkheid bepaalde erkenningen door de verzekerde verbiedt, heeft overtreding van dat verbod geen gevolg voor zover de erkenning juist is. Een verbod tot erkenning van feiten heeft nimmer gevolg’.

¹³Article 21 Dutch Code of Civil Procedure: The parties are obliged to provide fully and truthfully the facts relevant to the case. If this obligation is not complied with, the court can take the measures it deems appropriate (Translation by the authors).

The Current Debate on Compensation of Damage Caused by Healthcare

In the Netherlands at the moment there is no prevailing perception of a ‘medical liability crisis’ asking for measures such as limiting the number of medical litigation cases (other than by increased patient safety and the promotion of the non-adversarial resolution of claims) and diminishing the amount of financial compensation. Rather there are concerns, in both the scholarly and the political debate, that (1) inept responses to complaints and adverse events lead to unnecessary juridification,¹⁴ including the undue assertion of claims and the lodging of disciplinary complaints, both giving rise to destructive adversarial processes; that (2) this is to the detriment of both patients and health care professionals; and that (3), where there is a legitimate claim for compensation, it should be honored, but this often takes a long time and is difficult and burdensome, both financially and emotionally.

What Makes Medical Liability More Difficult?

To start with the last concern, research has revealed that, however flat the Dutch landscape may be, patients experiencing harm in healthcare may have many mountains to cross when claiming for compensation, more so than in other cases of personal injury such as traffic accidents (Smeehuijzen et al. 2013). There seem to be several reasons for this difference.

To begin with, both fault and causality are generally more difficult to establish than, for instance, in case of traffic accidents. Traffic rules are generally quite unambiguous, their violation relatively easy to determine, whereas what follows exactly from a health care provider’s professional standard in a given situation will often be much less clearly defined, allowing for different approaches and depending on different aspects of the case, often with some room for professional discretion. In many cases it may require one or more expert opinions, with all the delays and costs involved, to bring final clarity to a case. Causality, also, will often be more difficult to establish, as distinguishing between the consequences of the incident and what would have been the natural progression of the patients’ condition can be very difficult. In the fault-based Dutch system, the burden of proof lies with the patient, although case law has developed several instruments to alleviate that burden.

Three of those instruments should be mentioned here.¹⁵ The first instrument is specific to medical cases, and involves a doctrine that sets down heightened requirements to any refutations the healthcare professional might make of submissions of facts by the patient. A simple denial will never do, but will have to be substantiated,

¹⁴Phenomenon where a situation escalates into legal conflict, discussions escalate, opinions harden, parties alienate, and generally it becomes more difficult to achieve a reasonable solution.

¹⁵The number of instruments to be distinguished here is to some extent a matter of appreciation.

for instance by the provision of documentation like the patient's medical file.¹⁶ It is emphasized that this in itself does not amount to a reversal of the burden of proof, although the result may be the same. The applicable standard is whether the information provided by the healthcare professional is providing the patient sufficient clues to go on in the gathering of facts and delivering of proof to substantiate his claim.¹⁷ When the professional fails to meet this standard, the court can accept the patients' statements as insufficiently disputed or place the burden of proof upon the professional.¹⁸ Specific circumstances may give rise to approaches by the court where the distinction from the outright reversal of proof becomes rather subtle, such as when a health care professional has failed to fulfil his obligation to maintain an adequate medical file. An example of this situation is that the court might accept the patient's claim that no informed consent was given, when the medical file does not note that the required information was provided (which it should), and neither the healthcare professionals' statements nor any other documentation can convince the court that the information was provided.¹⁹

The two other doctrines alleviating the patient's burden of proof involve the requirement of causation—although the first to mention here is the doctrine of loss of chance, which in many jurisdictions will not be accepted as having anything to do with causality, only as constituting a particular form of compensable damage (Gilead et al. 2013). However that may be—scholarly debate in the Netherlands generally takes a broader view—the doctrine of loss of chance is accepted by the Dutch Supreme Court²⁰ and is widely used in medical malpractice cases. So for instance when in the absence of a timely intervention in a birth process, the new born child is suffering perinatal asphyxia, that might also have occurred if there would have been a timely intervention, the court might ask the medical expert's opinion about the chance of avoiding damage to the child's brain when the gynecologist would have acted according to his professional standard, and when that chance is sufficiently substantial, might award damages for the loss of that chance. The second doctrine,

¹⁶Dutch Supreme Court (*Hoge Raad*) 20-11-1987 ECLI:NL:HR:1987:AD0058 (*Timmer/Deutman*).

¹⁷Dutch Supreme Court (*Hoge Raad*) 20-04-2007, ECLI:NL:HR:2007:BA1093 (*Mislukte Sterilisatie*).

¹⁸Supreme Court of the Netherlands (*Hoge Raad*) 18-02-1994, NJ 1994, 368 (*Schepers/De Bruin*); Supreme Court of the Netherlands (*Hoge Raad*) 13-01-1995, ECLI:NL:HR:1994:ZC1269 (*De Heel/Korver*); Supreme Court of the Netherlands (*Hoge Raad*) 15-12-2006, ECLI:NL:HR:2006:AZ1083 (*NNEK/Mourik*).

¹⁹Since the medical file is primarily meant to serve medical purposes (good care) and not as a legal instrument, flaws in the medical file in itself do not necessarily lead to a decision in the patients' favor if the healthcare professional is able to provide the required information in another manner. This is where the distinction between the reversal of the burden of proof and heightened requirements to refutations is upheld. The healthcare professional can repair flaws in the medical file by making a statement or providing witnesses because, in the reasoning of the Dutch Supreme Court, he doesn't have to provide *proof*. Supreme Court of the Netherlands (*Hoge Raad*) 20-04-2007, ECLI:NL:HR:2007:BA1093 (*Mislukte Sterilisatie*).

²⁰Supreme Court of the Netherlands (*Hoge Raad*) 27-10-27, ECLI:NL:HR:2017:2786.

referred to as ‘the rule of reversal’, was also developed in general liability law, and allows the court to assume but-for causation (*conditio sine qua non*), unless the defendant produces proof to the contrary.²¹ This requires a close proximity between the specific protective scope of the norm that was violated (for instance: a protocol instructed in the given circumstances the use of anticoagulants, but no anticoagulants were given) and the risk that materialized (in the example: the emergence of thrombosis). In such a case, despite the possibility that the risk might also have occurred if the norm would have been obeyed (anticoagulants are not always effective), the court may assume, because of the close proximity of protective scope and risk (it is exactly for the risk of thrombosis that the protocol prescribes anticoagulants), that but for the violation, the risk would not have materialized.²² Obviously, this doctrine can only apply when the norm violated has a sufficiently specific protective scope, which is typical for all kinds of ‘safety norms’, but outside that domain hardly ever applies.²³

What also seems relevant is that financial barriers to the recovery of claims in health care are often higher than in other domains. The Dutch law of damages holds that the costs of out of court negotiations, including legal representation and expert opinions, are a compensable head of damage, provided that it was reasonable to incur these costs and that they are reasonable as to their amount.²⁴ In case of traffic accidents, where liability is easily established and remaining discussions tend to be about the extent of the damage suffered, this constitutes a substantial alleviation of the position of the plaintiff—and a strong incentive not to go to court, as other, less favorable costs arrangements will prevail there. But in case of alleged medical negligence, where it can take several years and several expert opinions before fault and therefore liability is established, the full financial burden of out of court proceedings rests upon the patient, until he might be relieved by the establishment of liability and the subsequent reimbursement of his reasonable costs—or not. Numbers vary, but over the years a rough average of around 45% of medical malpractice claims tends to be successful.²⁵

Finally, it might be, although reliable data are lacking, that adverse medical events and their aftermath are—in general—also emotionally more burdening than the average traffic accident, because they occur within a relationship of trust between the patient and the health care professionals, whereas no preexisting bond of trust

²¹See for the development of this doctrine in the case law of the Dutch Supreme Court: A.J. Akkermans.

²²Supreme Court of the Netherlands (*Hoge Raad*), 2-3-2001, ECLI:NL:HR:2001:AB0377.

²³For a comprehensive discussion of case law doctrines alleviating the burden of proof of causation, see A.J. Akkermans & Chr. H. Van Dijk (Akkermans and Van Dijk 2012).

²⁴Article 6:96 section 2 DCC.

²⁵Most Dutch hospitals are insured with either MediRisk or Centramed. For MediRisk, liability is accepted or a settlement reached in around 45% of the cases (46% in 2013, 41% in 2014, 44% in 2015, 44% in 2016) (*published online: <https://www.medirisk.nl/kennisbank-preventie/feiten-en-cijfers>*.) For Centramed this is 37% over the period of 1994–2016 (*published online: <https://centramed.nl/over-centramed/centramed-in-cijfers>*).

will be compromised between those involved in a traffic accident. What has empirically been established is that claim procedures can put severe emotional stress on patients. Patients who claim for compensation might experience secondary victimization, a new trauma caused by the nature and course of the legal procedure, as was found in research concerning victims of traffic accidents (Elbers et al. 2013). Research into claimants' experiences suggests the adversarial nature of procedures is especially stressful (Elbers et al. 2013; Smeehuijzen et al. 2013). The attitude of the healthcare provider, professional or insurance company as experienced by the patient can be hurtful. And, for all the reasons mentioned above, procedures can take years before reaching a final solution.

It's Not (Only) About the Money

It is a constant outcome of research into the motives and experiences of patients pursuing a claim in health care, that financial compensation is often not reported as their sole or even primary motive (Vincent et al. 1994; Relis 2009, 2017). In the Netherlands as well, research has revealed a variety of non-financial needs and motives, that might be prioritized above a monetary award, such as the clarification of what has happened, acknowledgement of fault, the taking of responsibility for the incident and its consequences, the offering of apologies, seeing justice done, and preventing the same incident from occurring again (Smeehuijzen et al. 2013; Lindenberg and Akkermans 2014). This is consistent with findings among the victims of personal injury in general (Akkermans and Van Wees 2007; Akkermans 2009), the only difference appears to be that non-financial concerns seem even more significant to patients than to others (Lindenberg and Akkermans 2014). These findings are problematic to traditional liability law. It is clear that the functioning of liability law in its traditional sense—the fair allocation of financial compensation—leaves room for improvement. But for those who seek fulfilment of non-financial needs as described above, the adversarial nature of the traditional civil procedure tends to lead them further astray. Discussions escalate, opinions harden, parties alienate, and generally it becomes more difficult if not impossible to achieve reconciliation. This is considered to be contrary to liability law's intrinsic restitutionary goals.

Patients' Needs, the 'Second Victim', and the Importance of 'Just Culture'

The healthcare professional has an important, if not central, role to play in responding to the needs of patients. A swift, empathic and open response of the healthcare professional can prevent escalation and unnecessary (legal) conflict.

There are, however, many barriers that can keep the healthcare professional from the appropriate response.²⁶ On the organizational level, the prevalence of a ‘blame culture’ can obstruct openness for fear of being held personally responsible and the possibility of negative (legal) consequences (Pinto et al. 2013). A strong sense of hierarchy and a limited ability to accept or give criticism can constrain healthcare professionals to speak up about their own or their colleagues (near) mistakes (Aasland and Førde 2005) (Anonymous 2015).²⁷ On a personal level, experiencing disclosure as difficult and fear of the patients reaction can be factors negatively influencing willingness to disclose (Linthorst et al. 2011). Also, the assumption that disclosure is not in the patients’ best interest is mentioned as a barrier to disclosure (Harrison et al. 2014). And last, but certainly not least, healthcare professionals can suffer severely after experiencing an adverse event, a phenomenon that has given rise to the term ‘second victim’ (Wu 2000), an expression not without controversy, yet widely used to express the potential impact of an adverse event on the healthcare professionals involved (Wu et al. 2017). Symptoms vary from worrying about the patient, loss of professional confidence, shame, and worry about loss of reputation, (Schwappach and Boluarte 2009) but also symptoms of a more serious and clinical nature occur such as depression, insomnia, hyper-alertness, PTSS-like symptoms such as flashbacks (Schouten et al. 2018) and suicidal ideation (Shanafelt et al. 2011). It is probably safe to assume this can negatively impact on the ability of professionals to properly disclose. Supporting health care professionals after a medical incident helps to relieve this impact (Seys et al. 2013; Van Gerven et al. 2016) and probably aids in disclosure.

Concerns about preventable harm in healthcare have led to a growing attention for ‘culture’ and how culture affects patient safety. Psychology professor James Reason introduced the ‘Swiss Cheese Model’ to visualize the interaction of systemic context and individual acts in the occurrence of errors, (Reason 2000) inciting a lively debate about the sense and nonsense of allocating the responsibility for adverse medical events to individual healthcare professionals.²⁸ The desirable

²⁶Many barriers, personal, professional, organizational and cultural barriers towards being open have been discussed in literature. For an extensive review of the available literature concerning open disclosure and its impeding factors: Birks et al. (2014). Kaldjian *et al* provide a clear taxonomy of factors impeding disclosure (Kaldjian et al. 2006) More recently, Carrillo et al. analyzed the relationship between factors that contribute to healthcare professionals informing patients and apologizing after an avoidable adverse event. Their research points towards the significance of an organizational culture that favors disclosure, positive example by colleagues, and positive experiences (or the lack of negative experiences) with disclosure as factors that positively impact the attitude towards disclosure (Carrillo et al. 2017).

²⁷‘Waardeer de frisse blik van de co: afhankelijkheid bij coassistenten nog altijd sta-in-de-weg’, *Medisch Contact*, 24 September 2015. Article in the magazine published by the Royal Dutch Medical Association. The article elaborates on the barriers medical students and residents experience in criticizing unsafe behavior by supervisors. Published, fittingly, anonymously by a professor and student of medicine.

²⁸Debate is mostly centered around finding the balance between ‘no-blame’ and personal accountability. Amongst others: M. Walton, (Walton 2004; Wachter and Pronovost 2009) and the concept of ‘just culture’ as the road in between (Dekker 2007).

alternative to a blame culture is a ‘just culture’. In a just culture, it is recognized that competent and dedicated professionals may make mistakes, and the often important role of the organisational context in making mistakes is acknowledged, while at the same time a clear line is drawn between acceptable and unacceptable behaviour (Dekker and Laursen 2007; Wachter and Pronovost 2009; Dekker et al. 2009; Dekker and Laursen 2010). In a just culture, adverse events are investigated in order to learn from them without putting the healthcare professional on trial.²⁹ A just culture allows openness to play its pivotal role in both patient safety and the better resolution of adverse events.

Support and guidance for ‘second victims’ is an essential part of a just culture. In several Dutch hospitals, peer support systems are being set up to that purpose (Laarman et al. 2016). Talking to peers, learning from the incident, talking to and apologizing to the patient, and adjusting practices to prevent the same from happening again, are among mechanisms that help ‘second victims’ to cope and recover (Plews-Ogan et al. 2016; Coughlan et al. 2017). We lack specific (Dutch) data on whether and how compensation procedures influence the recovery of ‘second victims’. What we do know is that complaint- and disciplinary procedures are often taxing (Laarman et al. 2018; Bruers et al. 2016; Verhoef et al. 2015; Alhafaji et al. 2009).³⁰ Blame, implicit or explicit, is prevalent in legal procedures in healthcare, either as an inherent element of the procedure itself, as is the case in disciplinary law—notwithstanding the fact that disciplinary law in the Netherlands is formally aimed at maintaining quality of care and not punishment—or it seems to inadvertently creep in because of the way procedures are carried out: formal, adversarial and mostly in writing.

The good news is that the mechanisms that benefit the recovery of ‘second victims’ correspond directly to patient’s needs after adverse events and facilitate improving patient safety by learning. Supporting ‘second victims’ and helping them to engage in dialogue with the patient, facilitates the recovery of both patient and healthcare professional. This in turn prevents harmful and unnecessary juridification. Supporting healthcare professionals in coping with adverse events is directly linked to both patient safety and to responding to patient’s individual needs.

²⁹‘Just culture’, what it takes to be ‘just’, and its importance for patient safety is far more complex than the global description we can offer here but the literature by Dekker referred to here can provide a good starting point for those who are interested.

³⁰The report by Friele *et al* is a report on a qualitative study considering the impact on the professional functioning and private lives of publishing disciplinary measures on healthcare professionals. English manuscript accepted for publication in *BMJ*: Laarman *et al*, How do doctors in the Netherlands perceive the impact of disciplinary procedures and disclosure of disciplinary measures on their professional practice, health, and career opportunities? A questionnaire among medical doctors who received a disciplinary measure?

Efforts for Reform

The Healthcare Quality, Complaints and Disputes Act (Wkkgz)

Concerns about the position of patients led to the aforementioned Healthcare Quality, Complaints and Disputes Act (Wkkgz) which came into force in 2016. The Wkkgz is a legislative attempt to achieve a fundamental change in the way complaints and claims are handled in healthcare, emphasizing an open, informal and proactive response to both claims and complaints. Relevant new statutory provisions are: (1) claims for compensation are considered to be ‘complaints’ in the meaning of healthcare complaints law (see explanation below) and have to be resolved accordingly; (2) an independent complaints officer must be available to patients; (3) a short timeframe for handling complaints/claims applies; and (4) if unsatisfied with the healthcare provider’s response to their complaint/claim, patients can resort to an independent healthcare disputes tribunal that can take binding decisions, including binding awards of damages up to € 25,000. These new statutory provisions seek to improve the patients’ position by providing informal, inexpensive, and quick avenues for the resolution of both claims and complaints.

Healthcare Complaints Law as a Non-adversarial Alternative to Liability Law

Since the 1990s, hospitals have had the statutory duty to receive, investigate and resolve any complaints of patients concerning the provided care. What might be called ‘healthcare complaints law’ provides for an internal procedure and is aimed at remedying the patient’s issue. While the procedure before a medical disciplinary tribunal is also triggered by a ‘complaint’,³¹ this procedure is quite different in both nature and end. The disciplinary procedure is aimed at maintaining quality of care. The procedure is formal, the patients’ complaint serves only as a ‘signal’, the procedure does not seek to provide personal satisfaction, either financially or emotionally, and usually leaves little room for reconciliation.³²

³¹Both nationally as internationally, what exactly is meant with the word ‘complaint’ depends on the context. In Dutch healthcare alone, four different legal procedures can be distinguished that are all triggered by a ‘complaint’ (*klacht*). A complaint can be an issue about healthcare, either big (‘my operation was done wrong’) or small (‘the doctor was impolite’); can be informal (delivered orally and resolved by the healthcare professional himself or a complaints officer) or formal (filed in writing and to be followed up by an official written response of the healthcare provider). As mentioned, a ‘complaint’ can also be lodged at a medical disciplinary tribunal, and, lastly, ‘complaints’ can be made to the National health care contact point (*Landelijk Meldpunt Zorg*, translation by authors) of the Health Care Inspectorate. The National health care contact point offers advice on how to solve the complaint, but does not investigate complaints itself.

³²Therefore, the medical disputes tribunals make increasing efforts to solve the complaint in a meeting (‘*mondeling vooronderzoek*’) with the patient and the healthcare professional, prior to the procedure.

The ‘complaints law’ referred to here is all together something different. Both in the Netherlands and internationally, the origins of complaints law lie in situations characterized by inequalities of power. The classic example is the relation between governmental agencies and citizens, but power inequalities can also be found between citizens and non-governmental institutions, large commercial companies and consumers, insurance companies and their insured, and so on. In the Netherlands all sorts and shapes of instruments can be found that are employed to effectuate the right to complain, such as ombudsmen, complaints committees and—officers, organized by institutions internally, externally or somewhere in between, and whether or not in collaboration with consumer—citizen—or patient organizations. What all these institutions have in common is that they seek to empower plaintiffs by ensuring that their complaints are received and properly investigated (Laarman and Akkermans 2017).

‘Healthcare complaints law’ is a part of complaints law that is more extensively regulated by the legislator than most others. The Wkkgz has added to the hospital’s existing statutory duties in regard of complaints, extended them to all health care providers, and has included claims into its definition of complaints. Potentially, this has far reaching consequences. While the substantive rights of claimants to compensation remain determined by the general law of torts and damages, the resolution of claims is to be governed, not by reactive and adversarial civil procedure, but by the proactive and solution focused procedures of healthcare complaints law. In theory this is a fundamental difference.

Traditional civil procedure departs from the presumption of the equality of the parties. The facts are established in a process of submission and refutation in which both the initiative and the burden of proof lie with the patient. If a patient does not present sufficient facts to support his claim, or fails to present sufficient proof, it will be rejected. Healthcare complaints law by contrast, departs not from equality, but from its inherent objective of redressing inequality. It requires the health care provider to actively investigate the complaint, take the initiative in the discovery of facts, and to complement or even correct in good faith the presentations made by the patient.

It remains to be seen, however, to what extent the healthcare providers will succeed in effecting the paradigm shift in the resolution of claims aspired by the Wkkgz. To begin with, the large majority of claims in the Netherlands are resolved in (sometimes long-drawn-out) out of court negotiations, a context where procedural regimes are of course far less compelling than in a procedure before the court. The Wkkgz now requires healthcare providers to integrate these negotiations into their complaints resolution procedures—or perhaps one might better say, to *replace* these negotiations, at least initially, by complaints resolution procedure. Clear as the statutory requirements may be, any supervision of compliance can only happen afterwards, if settlement according to complaints procedure has failed and parties have resorted either to court or to an independent healthcare disputes tribunal (see explanation below). At that moment in time effective remedies will be scarce.

Secondly, the hospital staff that are involved in the resolution of complaints are traditionally quite separate from those who are involved in the handling of claims.

The former may be accustomed to the demands of a proactive and solution focused approach in resolving issues, but the latter generally are not. As described above, although some hospitals have an internal legal department that handles claims—all claims, or only those below a certain threshold—many hospitals refer claims to their liability insurer. Most professionals involved, mainly lawyers, both those at the hospitals and at the insurance companies, will have reached their professional maturity within the bounds of conventional adversarial tradition. It will take more than the legislature waving its magic wand to make them change the way they go about their affairs. This is why efforts from the bottom up, such as the Code of conduct on medical incidents and the OPEN learning network of hospitals that are described below, are so important.

The most promising developments are to be found among the growing group of hospitals that have taken claims handling into their own hands. In some of these hospitals the conviction has taken root that a claim for compensation is not an exclusively legal issue but concerns the institution as a whole. On the operational level, this means that claims handlers work in a close partnership with complaint officers, quality and safety officers, the healthcare professional in question, and where necessary, the board of directors, to investigate and address not only the claim but also other motives behind it than its ostensible purpose, whether made explicit or not. As mentioned above, financial compensation is often just one of the patient's issues. And it is a truism that complaints procedure is, in principle, an excellent setting for a more comprehensive approach—so much can be granted to the legislator.

An Independent Complaints Officer or ‘Patient Contact Person’

Prior to the adoption of the Wkkgz, nearly every hospital in the Netherlands retained a ‘complaints officer’ (Friele et al. 1999). In 2014, the Association of Health Care Complaints Officers published a professional profile, detailing the goals, tasks, position and competences of complaints officers in hospitals.³³ According to this profile, the complaints officer is to contribute to a more equal relationship between patients and health care professionals, mediate conflicts and contribute to a better quality of care by signaling repetitive complaints. The complaints officer acts independently from the board of directors, with respect for the privacy of those involved, and much of his work is confidential. For patients and health care professionals, the complaints officer is easily accessible, and he takes a proactive role, while respecting the professional's own responsibilities. Core activities are providing ‘first emotional aid’, information, advice and assistance, mediating conflicts, process guidance and monitoring (for example during root cause analysis or claim procedures).³⁴

³³Currently under revision.

³⁴VKIG Professional Profile (*Beroepsprofiel*), downloaded from: https://www.vkig.nl/wp-content/uploads/2017/04/2014_vkig_beroepsprofiel-versie-1_okt-novweb.pdf.

In reality, the majority of complaints officers have up till now played a much more marginal role than this, and the envisioned proactive role rarely materialized in practice. Several explanations have been put forward, such as the difference in educational level between healthcare professionals and complaints officer, the (resulting?) difference in social status, the lack of professionals' familiarity with complaints procedures, and the negative association with the word 'complaint' resulting in professionals not wanting to have anything to do with complaints officers—or all of the above. However this may be, the Wkkgz now obliges all healthcare providers (so not only hospitals) to have an independent 'person' available who can 'offer assistance when patients have a complaint' and help them find their way (art. 15 Wkkgz). Combined with the far going ambitions of the Wkkgz in regard of the proactive, informal, inexpensive, and quick resolution of both claims and complaints, this seems to imply a more prominent role for complaints officers (van Dijk et al. 2015). In particular, the emphasis of the Wkkgz on *proactive* complaints management, that effectively seeks to *prevent* the filing of complaints by solving issues at the earliest opportunity in an informal manner, assigns this 'person' a central and active role as a point of contact for patients. Even the label 'complaints officer' has become unsuitable, as the focus is on solving issues before they develop into a 'complaint', which may explain why these officials are increasingly called 'patient contact person', 'patients' confidential advisor' or other varieties of this sort.

Short Timeframe for Handling Claims and Complaints

Earlier research into the experiences of patients in complaint procedures showed that hospitals often took a long time to respond to complaints—and sometimes no response was given at all (Kruikemeier et al. 2009). The Wkkgz sets a six-week-timeframe for the assessment of both claims and complaints, with the possibility to extend with 4 weeks (10 weeks in total). If the health care provider does not succeed in providing a satisfactory response—the Wkkgz requires a written 'conclusion' (*oordeel*)—within this timeframe, the patient can refer his complaint to an independent healthcare disputes tribunal (see below). According to the parliamentary history of the Act there is, however, some room for manoeuvre, as this written 'conclusion' does not necessarily amount to a final judgment; if circumstances so require, it can suffice to explain that more time is needed and to indicate the steps that will be taken to reach a final conclusion.³⁵ The timeframe of 6 weeks serves to ensure that healthcare providers do respond to complaints.

This short timeframe, taken together with the goal of informal and quick resolution of claims and complaints, seems to lead to a growing tendency to offer patients the option of a so called 'leniency payment'³⁶: a short route to limited

³⁵Kamerstukken I 2015/16, 32,402, 2, item 8.

³⁶'*Coulancebetalingen*' (translation by the authors).

compensation (perhaps comparable to the ‘limited imbursement programs’ in the US) (Mello et al. 2014), without a full-blown investigation in the provided standard of care, and without requiring a final discharge.³⁷

Independent Healthcare Disputes Tribunal

The last but—potentially—not the least of innovations of the Wkkgz to be discussed here, is the creation of a low cost and low-threshold alternative to court proceedings by obliging healthcare providers to set up, in collaboration with representative organizations of patients, independent healthcare disputes tribunals. These tribunals are to be officially acknowledged by the Ministry of Health, and can take binding decisions, including binding awards of damages up to € 25,000, and have to do so within 6 months. As mentioned above, patients can resort to a tribunal as soon as the health care provider does not provide a satisfactory response to a complaint within the timeframe of 6, or 10, weeks. The Wkkgz contains only general requirements for the tribunals, the operational details were left to the health care sector to decide upon. This resulted in a list of requirements being drawn up by a national group of representatives of healthcare institutions, patients’ organizations and medical liability insurers (de Groot 2016), on the basis of which requirements 31 different tribunals were established, divided over different sectors of health care.

The national list of requirements demands claims for compensation to be assessed according to general liability law. The president of the tribunal will be a lawyer—often a judge or an otherwise experienced adjudicator—and the members have to be nominated by either healthcare providers or patients’ organizations. The composition of the tribunal can further depend on the given case, as at least one of the members is assumed to have sufficient expertise in the medical discipline involved in the dispute.

The costs of the procedure differ. No government funding is provided. For patients the costs are low, certainly compared to court proceedings. No representation is required, and in case of a claim a fee of € 50 applies. Consequently, the operational costs of the tribunals have to be born one way or another by the healthcare providers. Details of costs arrangements vary; healthcare providers can pay a fee of € 1.500 up to € 2.300 for every dispute that is brought before the tribunal. The tribunal can require the healthcare provider to reimburse the patient’s fee, but conversely, no costs order can be made against the patient, save for the, probably exceptional, situation that the tribunal is of the opinion that the costs were ‘needlessly caused’.

The independent healthcare disputes tribunals of the Wkkgz have drawn a lot of attention, but it remains to be seen whether they will become a success. The dispute tribunals have been in operation since January 2017, and until the fall of 2017, only 242 complaints were filed, of which 69 led to a binding advice, of which an unknown

³⁷MediRisk (2017) Toelichting ‘Procesflow: Partnership in klachten- en claimopvang’.

number involved a request for monetary compensation of one sort or another (Bouwman et al. 2017). Given the annual amount of health care claims and complaints, this can only be considered a marginal number.³⁸ There are no available data on why cases are or are not brought before the tribunals, but a combination of factors gives rise to the fear that it might turn out that they will not play more than a marginal role in resolving claims, and that only a limited number of low value and/or weak cases will be brought before them. We cannot elaborate on all issues relevant to this assumption here, but the main concern lies in the combination of the fact that the tribunals do not award legal fees—whereas, as mentioned above, in the context of out of court negotiations, the costs of legal representation and expert opinions are a compensable head of damage—and the fact that a decision of a tribunal cannot be appealed.

The motives to exclude the award of legal fees probably involve the desire to prevent unnecessary juridification of relatively ‘small’ cases (that is, up to € 25,000) and the perception (or hope) that lawyer assistance will not be necessary. Understandable as these considerations might be—yet not necessarily correct³⁹—it is difficult to see why a legal counsel or anyone else providing legal support, would ever advise a patient to bring his case before a tribunal, where even if he prevails he will have to bear all his costs; unless the value of the claim and/or the chances of succeeding are estimated as so low, that the lawyer in question is hesitant to take on the case, and prefers the client (patient) to go to the tribunal unrepresented. In any strong case, continuation of out of court negotiations seems to be the preferable alternative, and even if one ultimately has to go to court, if the court finds for the plaintiff it can make a costs order against the defendant (which will not suffice to cover all costs, but still will be significant).

It is—in our opinion, regretfully—not an option for the patient to try his case before the tribunal unrepresented, and consider any alternatives later. The decisions of the tribunals are to be binding and cannot be appealed. That is, unless fundamental principles of civil procedure have not been met, such as independence and impartiality, equality of arms,⁴⁰ and a proper reasoning by the tribunal of its decision. This has to do with the fact that the authority of the tribunal to resolve the issue between the parties is considered to be based on the (implicit) agreement between the parties

³⁸In 2016, the LMZ received 6.455 complaints; medical liability insurer MediRisk received 785 claims; medical liability insurer Centramed received 870 claims; the Medical Disciplinary Tribunal received 1.646 complaints (Bouwman et al. 2017). It has to be noted that these numbers represent only a fraction of the total amount of complaints, as many complaints are not registered but resolved informally by complaints officers or the healthcare professionals themselves.

³⁹In our view, the providers of legal support have a crucial role to play in the realization of many aspirations of the Wkkgz, not the least in the success or failure of the tribunals. We cannot elaborate on this here. Even in the no-fault system of New Zealand, research has shown that the assistance of lawyers is highly appreciated by patients and can strongly contribute to reconciliation (Moore and Mello 2017).

⁴⁰The principle of equality of arms has been developed by the European Court of Human Rights in the context of the right to a fair trial (Article 6 ECHR). Equality of arms requires that there be a fair balance between the opportunities afforded the parties involved in litigation.

to accept its decision. This doctrinal categorization is not unproblematic in regard of the healthcare provider, who is obliged by statute to accept the tribunal's jurisdiction as soon as the patient files his issue there. For this reason, it has even been submitted that this is in violation of article 6 of the European Convention on Human Rights (ECHR) (Dute and Van de Laar 2014). However that may be,⁴¹ decisions of the tribunals normally cannot be appealed, and a patient who would appreciate legal support may better think twice before he puts his case to a tribunal.

Efforts from the Bottom-Up

As mentioned above, the Healthcare Quality, Complaints and Disputes Act (Wkkgz) aims to achieve a fundamental change in the way complaints and claims are handled in healthcare. However, such a change cannot be achieved by legislation alone, as it requires a change in 'culture' among all professionals involved, away from conventional adversarial tradition and towards solution focused, restorative and reconciliatory approaches, that can be considered an integral part of an even wider ranging necessary change in healthcare as a whole, from 'blame culture' to 'just culture'. The Wkkgz was, however, not adopted in a vacuum, but must be understood as the legislator's response to ongoing developments in the healthcare sector and in society at large. There have been and still are several initiatives 'from the bottom up', that in one way or another try to contribute to the comprehensive change that is meant here. We will limit ourselves to discussing two of these, the Code of conduct on medical incidents and the OPEN learning network of hospitals.

Code of Conduct on Medical Incidents (GOMA)

In 2010, stakeholders in medical liability (insurance companies, hospitals' associations, the Royal Dutch Medical Association (KNMG), patient's attorneys) collaborated in drafting the Code of conduct on open communication after medical incidents and better resolution of medical malpractice claims (*Gedragcode Openheid na medische incidenten; betere afwikkeling Medische Aansprakelijkheid, GOMA*). The GOMA contains a total of nineteen principles; ten of which are relevant to healthcare professionals and/or providers, urging the swift and proactive investigation of incidents, and a swift, open and proactive response to claims (part A), and nine principles aim to promote the just and expeditious resolution of claims by articulating rules of conduct of patient's lawyers and insurance companies' claims

⁴¹This obviously depends on the guarantees, both substantive and procedural, which are in place. See European Court of Human Rights, Guide on Article 6 of the Convention—Right to a fair trial (civil limb), Chapter III, Institutional requirements, available at https://www.echr.coe.int/Documents/Guide_Art_6_ENG.pdf.

handlers (part B).⁴² Although the GOMA is a form of private regulation, its binding force should not be underestimated. Most parties are directly bound to the GOMA as they—or organizations representing them—have formally declared that they will act in accordance with it. Only the patient’s attorneys have made no such declaration, on the basis of the reasoning that they are not free to bind their future clients in any way. They are nonetheless bound indirectly, as the principles of the GOMA are widely accepted and confirmed by both the courts and disciplinary tribunals as a part of the professional standard of all professionals involved (Legemaate et al. 2015).

The GOMA is currently under revision. The coming into force of the Healthcare Quality, Complaints and Disputes Act (Wkkgz), which has transferred the handling of medical claims from civil procedure to healthcare complaints law and initiated all the other changes referred to above, requires the elaboration of many operational details. The process of redrafting the GOMA involves numerous expert meetings and other forms of consultation, creating ample opportunity for the exchange of ideas between the different professions and organizations about how best to go forward in the present climate of change. All key activities, such as the consultation and involving of relevant organizations and individuals, the preparation and chairing of expert meetings, the editing and publication of proceedings, and the editing of the consecutive drafts of the Code, are in the hands of academics (your authors among them). Phrased in terms of research methodology, the drafting process is inspired by the principles of participatory action research (PAR).⁴³ The participation of all relevant professions and organizations, the repetitive publication of intermediates, and the involvement of both academics and practitioners, is not only expected to benefit the quality of the outcomes, but also the support the new Code of conduct will need to be successful.

The OPEN Learning Network of Hospitals

A second ‘bottom-up’ initiative to be mentioned here, is the OPEN learning network of hospitals. OPEN too, is a collaboration of academics—a multidisciplinary group of social scientists, lawyers (your authors among them) and practitioners, that is inspired by the principles of participatory action research (PAR). The heart of OPEN

⁴²Phenomenon where a situation escalates into legal conflict, opinions harden and it is increasingly difficult to come to a reasonable solution.

⁴³Both the redrafting process of the GOMA and the OPEN learning network (to be discussed below) are inspired by the principles of participatory action research (PAR). It is, given its dynamic and context-dependent nature, difficult to find a sole, concise definition of what PAR is. Houh and Kalsem (2015) provide a definition that closely resembles the dynamics of both the redrafting of the GOMA and the OPEN network, when they state: ‘PAR is research that concerns itself with action – making a difference, moving toward solutions – but only when those differences to be made or solutions have been agreed on and determined in community. The *research* and the *action* must be *participatory*, with those who will be affected by the actions – the stakeholders – involved at all stages of the research and decision-making process’ (Houh and Kalsem 2015).

is the learning network of, at the time of writing, 24 hospitals that are keen to achieve progress in the follow-up of patient safety incidents. The participating hospitals are willing to share the problems they encounter and the solutions they have found with the other hospitals and the researchers. Important activities are not only network meetings, but also the sharing of information in separate interviews, and the drafting and revising of so called ‘knowledge documents’: documents in several forms (leaflets, folders, handouts, but also journal articles) that summarize research findings for practice, are published on the website of OPEN,⁴⁴ and updated when needed. Key activities, such the preparation and chairing of network meetings, and the drafting and publishing of ‘knowledge documents’, belong to the responsibilities of the researchers. Adverse medical events are a sensitive subject, and building the trust required for a learning network devoted to this issue takes considerable effort and time. But it has been proven to be possible and very much worthwhile. At the network meetings, members feel safe to share dilemmas, fears and barriers to being open. The number of participating hospitals is gradually growing. OPEN has been operational since 2015 and has yielded a significant outcome. The learning network is operating in a climate of change, and there remain more than enough issues to tackle for some years to come.

Conclusion

The Netherlands experiences all problems inherent to the compensation of damage caused by healthcare that are common to many jurisdictions. Traditional procedures respond to claims and complaints in an inadequate and unsatisfactory way, to the detriment of both patients and health care professionals. The good news is that there is a clear momentum for change shared by all relevant organizations and institutions. This, however, is not easily achieved. What is required is no less than a change in ‘culture’, away from conventional adversarial tradition and towards solution focused, restorative and reconciliatory approaches, that is to be part of a wider ranging change in healthcare, from ‘blame culture’ to ‘just culture’. This is going to take time. The Healthcare Quality, Complaints and Disputes Act (Wkkgz) has given substantial incentives for such change, but can only succeed to the extent that healthcare providers and relevant others will successfully implement the reforms initiated by the legislator. We have tried to give a concise overview of the present state of affairs. It seems too early to draw any conclusions about the scope and success of the current reform efforts. We do what we can and hope for the best.

⁴⁴www.openindezorg.nl, unfortunately, except for some explanation of OPEN, entirely in Dutch.

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