The Principles of European Law on Service Contracts: the Rules on Medical Treatment in a Future Europe Compared to the Rules in the Netherlands

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1. Introducing the topic

The *Principles of European Law on Service Contracts* (hence: PEL SC) came to light in January 2007 after some six years of pan-European research.[1] These principles are only a (small) part of a far more elaborate scheme of provisions that could – and maybe should[2] – lead (in the more distant future) to a European Civil Code. This scheme has been set up by Prof. Dr. Chr. von Bar as the director of the Study Group on a European Civil Code (SGECC).[3] A so-called 'Working Team' located in Tilburg, the Netherlands, prepared the PEL SC. Since this team was closely connected to and worked with another Dutch team that has been dealing with Sales Law, a group of Utrecht based researchers lead by Ewoud Hondius, Ewoud has had a professional interest in the development of these principles on services.

Moreover, the topic of the PEL SC, service contracts, has been at the center of Ewoud's attention for many years, especially as regards the principles on (medical) treatment, which form a part of the PEL SC. In the Netherlands, Ewoud Hondius has been one of the inspiring forces behind the so-called 'Wet op de Geneeskundige Behandelingsovereenkomst' (WGBO), the Law on Medical Treatment Contracts that has been incorporated in the Dutch Civil Code (hence: CC) in 1995. This medical treatment contract is of course only part of Ewoud's much broader agenda as regards consumer protection issues.

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1 *Maurits Barendrecht, Chris Jansen, Marco Loos, Andrea Pinna, Rui Cascão, Stéphanie van Gulijk*, Principles of European Law on Service Contracts (PEL SC), Munich; Sellier 2007 (hence: PEL SC).

2 Interesting as the debate is, we will not deal with the desirability of a European Civil Code here since the European Commission seems to be moving away from that idea. Instead, a consumer law code seems to be at the center of attention. See *M.W. Hesselink*, Naar een (Europees) Wetboek van Consumentenrecht, NJB 2007, p. 850 ff. Of course, Ewoud Hondius will appreciate this renewal of attention for consumer law.

3 See www.sgecc.net.

K. Boele-Woelki, F.W. Grosheide (eds.), *The Future of European Contract Law, Liber Amicorum E.H. Hondius*, p. 169-182

The question we have asked ourselves and which we propose to answer hereafter is how the rather young Dutch rules as laid down in the WGBO relate to the even newer European 'rules' on medical treatment as laid down in the PEL SC. Do they coincide, and if so, to what extend? Are they related, in some more or less strong sense? Are there any notable differences in (policy) choices made, either in form or substance? In short, how 'innovative' or 'conservative' (we are after all talking about a European compromise) are the PEL SC if contrasted with the Dutch rules?[4]

Our contribution starts with a short overview of the Dutch rules on medical treatment, the rules of the WGBO (para. 2). In paragraph 3 we offer a bird's eye view over the PEL SC, focusing on the principles on medical services. Paragraph 4 proposes to work out some differences and similarities between the two sets of rules. In 4.3 we offer a somewhat more detailed account of one major difference, the central liability clause in Art. 7:111 PEL SC. A conclusion ties up some loose ends (para. 5).

2. Overview of the Dutch WGBO

The 'Wet op de geneeskundige behandelingsovereenkomst', WGBO, is a separate law, in force since April, 1st 1995, which has been incorporated in Book 7 of the Dutch Civil Code, the part that deals with several specific contracts, such as Sales, Rent, Employment, Insurance et cetera.

The contract of medical treatment is dealt with in articles 7:446-468 CC.[5] The basis of this WGBO is formed by the principle of self-determination (patient autonomy) and – as a part of that – the right to physical integrity, together with the awareness of the dependence of the patient who needs medical treatment. These ideas are concretized in several patient rights. Usually four are distinguished: the right to information (Article 7:448 CC), the requirement of consent for every/any medical treatment (Article 7:450 CC; together they form the requirement of 'informed consent'), the right to inspect the medical records (Articles 7:454 and 456 CC) and the protection of 'privacy' (Articles 7:457-459 CC). Of course, there is also a provision dealing with the duty of care a doctor has to live up to (acting as a reasonable doctor would) when performing the medical treatment contract (Article 7:453 CC). The use of this duty of care is one possible way to sanction the patient rights mentioned.

Furthermore the WGBO contains inter alia rules on representation of minors and of persons that are physically incompetent to give their consent. Also a minor of 16 of 17

4 Hondius himself has mentioned in the Dutch law review he founded years ago (*NTBR*) that initially (when they were still 'under construction') there were some concerns that the PEL SC would be *too innovative* to receive approval. The end result is less revolutionary, says Hondius, as was expected, see *E.H. Hondius*, Kroniek Algemeen, NTBR 2007/3, p. 130.

5 Articles 7:400-413 CC also apply, since these contain general rules on the 'overeenkomst van opdracht' (service contract). See for an introduction to the WGBO of recent date *B. Sluijters, M.C.I.H. Biesaart*, De geneeskundige behandelingsovereenkomst, Deventer; Kluwer 2005.

years old is considered to be capable of concluding a contract of medical treatment for him- or herself, contrary to the normal rules on minority.

An important element of the WGBO is the so-called central liability of the hospital. Article 7:462 paragraph 1 CC provides for the following: When a medical treatment contract is executed in a hospital and the hospital is not a party to this contract, it is nevertheless liable in case of non-performance as if it is party to the contract. The treatment provider remains liable also. The idea behind this is not to create liability in a larger number of cases, but to provide for a central address for the patient to claim damages.[6] Because of this provision miscommunication between persons working at the hospital will not lead to a situation where the patient will have to find out who did something wrong. And also it is no longer relevant on what legal basis a treatment provider was active at the hospital.

Finally, we mention that the WGBO also contains duties for the patient. First, the patient is – obviously – obliged to pay a price for the service provided. Second, the patient must inform the treatment provider according to his ability and he must co-operate as far as is necessary for carrying out the treatment (Article 7:452 CC). Failure to comply with these obligations may lead to the result that the treatment provider is not liable when a treatment turns out to be not adequate. In case of serious breach of this duty there might be reason to cancel the contract.

3. Overview of the PEL SC

3.1. Origins

As mentioned in the introduction, the Principles of European Law on Service Contracts form (a vast 900 pages, but yet small) part of the much wider project on the creation of principles or rules for what could be or become a European Civil Code.[7] In order to be able to build such a code several topics needed to be worked out and put into concrete rules or principles, among which of course principles on torts, on benevolent intervention in affairs of another and unjust enrichment. The general rules on contract law for this project are those that already had been developed by the Lando-Commission, *i.e.* the Principles on European Contract Law (hence: PECL). These have become part of the SGECC project.

Not surprisingly, it was felt that some principles on specific contracts were needed as well. The main stimulus behind this was probably the fact that the law on sales needed

6 See TK 1989/1990, nr. 21 561, nr. 3 (memorie van toelichting), p. 23; *C.J.J.M. Stolker*, WGBO en aansprakelijkheid, in: De WGBO: van tekst naar toepassing, Houten/Diegem; Bohn Stafleu Van Loghum 1995, p. 114.

7 In his foreword in the PEL SC, at p. VII, *Von Bar* now speaks of aspiring as an ultimate goal 'a consolidated composite text'.

to be put into writing (although the Study Group could also have chosen to incorporate the rules of the Vienna Sales Convention). After the Study Group on a European Civil Code had thus initiated a Dutch Working Team to deal with Specific Contracts in 2000, this Working Team was split in three sub-sections, dealing with Sales (Utrecht, lead by Hondius), Long-Term Contracts (Amsterdam, lead by Hesselink)[8] and Service Contracts (Tilburg, lead by Barendrecht) respectively.

In the following years the Tilburg Team developed the PEL SC as they have come to light early 2007. Why some specific contracts were chosen to be included and why other specific contracts were not, is explained in the Preface of the current volume. The starting point for the team was to identify the most common types of services that tend to cause legal conflicts. Six categories were so identified and thus analyzed while other types of service contracts were left out, sometimes also due to practical constraints.[9] Next to those deliberations, part of the decision probably also had to do with the political feasibility of generating rules on other types of 'service' contracts. One can imagine, for instance, that working on rules for employment contracts is a totally different, because politically highly explosive, matter.[10]

3.2. General structure

As stated, six topics were selected but the PEL SC volume contains seven chapters. This is because the first (general) chapter states several general rules applicable to all service contracts that are dealt with thereafter. The provisions listed there are provisions that, in the process of finding specific rules, turned out to be relevant for all types of service contracts analyzed.[11] After that first general chapter, six specific service contracts (i.e. Construction, Processing, Storage, Design, Information and Treatment) are dealt with.

However, the description of the system that has been set up is not entirely complete yet since the general part of the PEL SC is as such again 'predetermined' by the PECL, which have become, as mentioned above, an integral part of the SGECC project. Where the PECL rules provide the general rules on for instance formation of contracts and remedies, the general and the more specific parts of the PEL SC consist mainly of rules that were needed in addition to these PECL (see for instance Article 1:104 and Article 1:112 PEL SC). As such, this very general set up is also highly important for the principles regarding treatment because the PECL are as such applicable to that contract type as well.[12]

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8 *Martijn Hesselink, Jacobien W. Rutgers, Odavia Bueno Díaz, Manola Scotton, Muriel Veldmann*, Commercial Agency, Franchise and Distribution Contracts. Principles of European Law, Munich; Sellier 2006.

9 PEL SC, Preface, p. XIII, by *Barendrecht*.

10 Article 1:101 excludes employment contracts, just as contracts for transport, insurance, guarantee or supplying financial products or services, see paras. (5) and (4).

11 PEL SC, Preface (Barendrecht), p. XIV.

12 PEL SC, Chapter VII. Gen. Introduction, F, at p. 786.

Thus, the decision to combine the general applicable rules in a first chapter has had consequences for the general structure of the PEL SC. From this it follows that the system for dealing with services included herein is built up from several general rules applicable to all types of services, followed by specific rules for the specific contract in question. These general rules include decisions on, for instance, the scope of application (Article 1:101), the price (Article 1:102), pre-contractual duties to warn (Article 1:103), the duty to co-operate for the receiver of the service (Article 1:104, which is an elaboration of Article 1:202 PECL and thus a telling example of the intertwining that has taken place between the PECL and the newer parts of the PEL), and on the general standard of care for services (Article 1:107) which is that of the 'reasonable service provider'. Of course, there are also provisions on variation of the contract (Article 1:111), remedies for breach of a duty (Article 1:112, steering towards the PECL again), and on limitation of liability (Article 1:114), which is not allowed for damage relating to death or personal injury and, outside that scope, only if the limitation is fair and reasonable. The list ends with a rule on cancellation of the contract (Article 1:115).

3.3. Treatment

The specific rules or principles on treatment laid down in chapter VII[13] of the PEL SC are thus secondary to the general rules on services in the sense that several of those general rules apply directly to treatment contracts as well. For instance, for the price of the treatment, the general rule of Article 1:102 PEL SC applies. Similarly, the pre-contractual duty to warn and the duty to co-operate as laid down in Articles 1:103 and 1:104 are applicable also in cases of treatment. Other rules are however 'particularized' for treatment contracts. See for example Article 1:110 in relation to Article 7:105 on the duty of the service provider to warn,[14] and Article 7:104 that points back to Article 1:107.[15]

Much like the Dutch Civil Code, the PEL SC thus follow a structure in several layers, with rules starting out on quite a general footing and becoming more specific along the way. This is of course enforced by the fact that not only the general rules of the PEL SC but also the treatment rules are sometimes 'predetermined' by the principles laid down in the PECL, putting the specific rules of chapters 2 to 6 of the PEL SC on a third 'layer' of rules.

Now, turning to chapter VII on treatment in particular, we encounter rules on the scope of application ('contracts whereby one party, the treatment provider, is to provide

13 On the topic of treatment (in preparation of the PEL SC), see also *Rui M.P.P. Cascão,* Prevention and Compensation of Treatment Injury: A Roadmap for Reform, Ph.D. Thesis Tilburg University 2005.

14 PEL SC, Chapter VII. Gen. Introduction, P, at p. 790.

15 For more information on the relationship between the general chapter and chapter VII on treatment, see PEL SC, Chapter VII. Gen. Introduction, I-T, at p. 787-792.

medical treatment to another party, the client'[16]), and rules on the duty of care, duty to inform and duty to obtain consent (Articles 7:104, 105–107 and 108). Also, there is a rule pertaining to the duty of the treatment provider to create and hold records of the treatment. As regards remedies for non-performance, one is re-routed to the PECL, but with some modifications specific for treatment contracts (Article 7:110). A rule on central liability ends the chapter (Article 7:111). We will deal with that particular rule below (para. 4.3).

4. Similar yet different

4.1. Similar

Comparing the WGBO with the PEL SC on treatment one can not escape the thought that a lot is rather similar. The topics dealt with and the way those topics are dealt with tend to go in similar directions, give and take a few deviations here and there. Most notably, the rules on providing information and on consent are rather similar.

The similarities also extend to the mandatory character of the rules on treatment. The Dutch WGBO contains one explicit provision on this, Article 7:468 CC. The PEL SC lacks such a provision, but the mandatory character is clearly stipulated in the Comments. Most Articles are characterized as mandatory,[17] only a few are 'to some extend' default rules. An example of the latter is Article 7:105 PEL SC, which contains the obligation of the treatment provider to inform the patient on e.g. the patient's health status, the nature of the proposed treatment and the risks of the proposed treatment.[18] There are however (very limited) exceptions to the duty to inform, for example when the patient has expressly stated that he wishes not to be informed (Article 7:107 (1) PEL SC). Rightly so, the Comments call this a default rule 'to some extend' since 'the issue cannot be regarded from a negotiation point of view due to considerations of 'ordre public': the treatment provider is not allowed to exert his influence to make the patient waive his right to be informed'.[19] Dutch law is highly comparable, if not identical, with this (Cf. Articles 7:448 and 7:449 CC). We will leave this and other similarities as they are and focus hereafter on two rather intriguing differences.

16 See Article 7:101. For specifics on terminology, see PEL SC, Chapter VII. Gen. Introduction, D, at p. 785.

17 Cf. PEL SC, Chapter VII, p. 797, 812, 820, 841, 861, 870, 881, 893 and 897.

18 The duty to inform is, like in the Netherlands, based on the idea that the patient must have a free choice regarding treatment.

19 PEL SC, Chapter VII, Article 7: 105, Comments F, at p. 841.

4.2. Burden of proof

A first difference relates to the burden of proof regarding some of the issues dealt with. While under Dutch law, the division of the burden or proof is left to the Law on Civil Procedure (hence: Rv), most notably the very general ('one rule fits all') art. 150 Rv, and to case law to fill in the blanks, the PEL SC have taken up a few provisions dealing specifically with this for some specific topics,[20] although the burden as regards the breach of the duty of care in general (which is on the patient) is as such not dealt with in Article 7:104 PEL SC but only in the Comparative notes.[21]

For instance, Article 7:109 forces treatment providers to keep adequate records of the patients' treatment, including for instance information on the consent of the patient. The patient must also be given access to the records and questions relating to the interpretation of the records must be answered by the treatment provider, see Article 7:109 (2) and (3). So far, all this is to a certain extent familiar, but then surprisingly paragraph (4) explicitly states that if there is a failure to comply with paragraphs (2) and/or (3), the breach of duty under Article 7:104 (the duty of care) and causation are presumed, thus introducing a marked shift as regards the burden of proof. This presumption will not be easy to rebut, so this rule will change the procedural position of the patient dramatically, and to his or her advantage.

Under Dutch law, the burden of proof will generally be on the plaintiff, the patient, as regards the issues of breach of a duty and causation. However, since breach of the standard of care is usually hard to prove for a patient, the courts tend to 'lessen' the burden of proof a bit, give it a different content, when duties of care are supposedly breached. It comes down to this: the professional is charged by the case law with a duty to *substantiate his claim* that he has given the care or the information to which the patient was entitled. He has to do so by supplying information on all the factual aspects of the claim. Ever since this rule was introduced, it has become easier for the plaintiff to prove his claim.[22] A genuine reversal of the burden of proof is not accepted, nor is a presumption envisaged, but what is accepted here however is the use of a procedural device (based on art. 149 Rv) that the Dutch call a 'aanvullende stelplicht' or 'gemotiveerde

20 One can already add to the following that the Comments and Notes deal to quite a large extend with the topic of burden of proof.

21 PEL SC, Chapter VII. Article 7:104, Comparative Notes, 4, at p. 822.

22 See *I. Giesen*, Bewijslastverdeling bij beroepsaansprakelijkheid, Zwolle: Tjeenk Willink 1999, p. 21-24. Especially in medical cases, this is standing case law since HR 20 November 1987, NJ 1988, 500 with note WLH (Timmer/Deutman). See also HR 18 February 1994, NJ 1994, 368 (Schepers/De Bruijn); HR 13 January 1997, NJ 1997, 175 (De Heel/Korver); HR 7 September 2001, NJ 2001, 615 (Anesthesie); HR 23 November 2001, NJ 2002, 386 (Ingenhut) and very recently HR 15 December 2006, *RvdW* 2007, 1 (NoordNederlands Effektenkantoor/Mourik), as well as HR 20 April 2007, LJN: BA1093 (X./Slotervaartziekenhuis).

betwisting'. If the treatment provider does not comply, several sanctions seem to be possible, one of which is in fact a reversal of the burden of proof.[23]

As regards causation, a specific rule on the (reversal of the) burden of proof gained momentum in the Netherlands a few years ago. This rule basically states that whenever a wrongful act creates or increases a certain risk of damage and that specific risk actually materializes, the causal link has been established, unless the wrongdoer can prove that taking preventive measures would not have prevented the damage from occurring.[24] The scope of this rule was broad enough to encompass the medical field. In fact, it has been applied in cases of services liability.[25] However, in recent times the Dutch Supreme Court has taken back a lot on this issue, declaring amongst other that this presumption (and not reversal) as regards causation could not be applied if the duty broken was a general duty in the sense of art. 7:453 CC, the Dutch rule on the duty of care of a treatment provider.[26] If a duty to inform is breached by a treatment provider, the same applies.[27] Now, it is widely held that the ambit of this rule is reduced so considerably that it will only apply if traffic rules or specific safety rules are being breached. In medical treatment cases, its place is lost.

This gist of this all is not so much that the outcome differs as between the Dutch rules and the PEL SC, although they do differ to some extent, at least as regards causation. Our main point here is that while in the Netherlands the case law is struggling with these burden of proof issues (trying to find suitable, but not too general rules and trying to work out the right sanctions to apply), and having to go without any guidance from the legislator (art. 150 Rv does not really help a lot in these cases), the European front of 'academic codification' is taking up these issues and arranging them within the substantive legal rules regarding the issue at stake itself, thus giving guidance from the start and making choices.

This trend is to be applauded, most notably because of the positive influence this will have on legal certainty, which has been lacking in the Netherlands on this issue. Especially the sudden rise and somewhat hidden fall of the reversal of the burden of proof with regard to causation, is exemplary of the lack of certainty in this respect. Also, this way of handling the proof issues brings out far better the very close relationship there is

23 See HR 15 December 2006, RvdW 2007, 1 (NoordNederlands Effektenkantoor/Mourik) which leaves the answer to the question' what sanction to apply?' open and thus for the discretion of the lower judge.

24 This so-called 'omkeringsregel' was first used in the mid 1970's in cases of traffic accident and accidents at workplaces, and was widened in its scope of application in the *Dicky Trading II*-case (HR 26 January 1996, NJ 1996, 607 with note WMK). See e.g. *I. Giesen*, Bewijs en aansprakelijkheid, Den Haag: BJu 2001, p. 116 ff.

25 See the *Dicky Trading II*-case (HR 26 January 1996, NJ 1996, 607 with note WMK), a case on the liability of a notary, and, critically, *Giesen* (2001), p. 116-119; *Giesen* (1999), p. 66 ff.

26 See especially HR 19 March 2004, NJ 2004, 307 with note DA (B./J.).

27 See HR 23 November 2001, NJ 2002, 386 (Ingenhut).

between issues of proof and the substantive rules involved.[28] Luckily, two other examples of this tendency can be found. First, there is the presumption laid down in Article 7:105 (2) regarding the (notoriously difficult to proof) causation requirement in relation to the breach of an information duty, and second (outside the chapter on treatment) there is Article 6:109 dealing with causation and information issues in general through the use of a presumption.[29]

4.3. Central liability

As has been pointed out in paragraph 2 above, Dutch law contains a specific provision dealing with the central liability of a hospital. Central liability in this context means that 'if in the process of performance of the treatment contract activities take place in a hospital that is not a party to the contract, the hospital is jointly and severally liable for a failure in the performance of the contract as if the hospital were a party to the contract'.[30] This is one of the most modern legal rules in the civil code,[31] which of course makes it interesting to see whether it has been followed or not. So as to leave no doubt, we add that the central liability only refers to claims for damages, and not to the exercise of other patient rights such as the right to be informed and the right to inspect medical records.

In the PEL SC a somewhat similar provision as the above mentioned central liability clause can be found. That is to say, Article 7:111 PEL SC is introduced as one on central liability of the treatment providing organization, but as it turns out to be hardly identical. Art. 7:111 reads:

(1) If, in the process of performance of the treatment contract, activities take place in a hospital or on the premises of another treatment-providing organisation, and the hospital or that other treatment-providing organisation is not party to the treatment contract, it must make clear to the patient that it is not the contracting party.
(2) Where the treatment provider cannot be identified, the hospital or treatment-providing organisation in which the treatment took place shall be treated as the

28 See *Giesen* (2001), p. 465-467.

29 See PEL SC, Chapter VI, Article 6:109, p. 772 ff, especially National Notes, on p. 776-780. Chapter VI PEL SC deals with information (and thus advice), on which (in preparation of the PEL SC) *A. Pinna*, The Obligations to Inform and to Advice, Ph.D. Thesis Tilburg University 2003.

30 See for this translation of Article 7:462 CC: PEL SC, Chapter VII, Article 7: 111, Comp notes 1, p. 900.

31 Although it has been argued that the practical implications of the central liability should not be overestimated, Sluijters and Biesaart state that Article 7:462 CC is 'not revolutionary' for reasons of insurance and of protection of the trust on the part of the patient that the hospital is a party to the contract. Cf. *B. Sluijters, M.C.I.H. Biesaart*, De geneeskundige behandelingsovereenkomst, Deventer; Kluwer 2005, p. 130-131.

> treatment provider unless the hospital or treatment-providing organisation informs the patient, within a reasonable time, of the identity of the treatment provider.

We have cited the whole Article since first reading it without comments has puzzled us to quite some extent. The general idea behind this rule is, according to the Comments, that a hospital 'will be held liable if a treatment provider acted within the framework of that hospital (…), even if the hospital itself was not a contractual party'.[32] To be honest, we did not read this broad statement into the Article and knowing that it might be read in the Article, we still are not able to do so.

We read the Article as follows. The Article wants to make sure that a liable party can always be found by a patient who is being 'mistreated', which is of course a worthy cause. The Articles tries to do so as follows. Either the hospital[33] itself is a party to the treatment contract, and the patient knows this, in which case it can be held liable under the previous rules of the PEL SC, most notably Article 7:104, or the hospital is not a party to the contract (and it is therefore not liable) but then it must clearly state so in order to indeed avoid contractual liability (see para. (1)). The consequences if the hospital does not speak up when it is not a contracting party, are not specified in para. (1) as far as we can tell. Probably the hospital will then be considered to be party to the contract anyway, by way of (rebuttable?) presumption, since the first paragraph of the article seems to be framed in these terms ('if you are not accountable, speak up; if you don't, we'll act as if you are accountable'). Now, this would indeed be stretching things to some extend, since becoming a contractual party by presumption is not (and nowhere, we believe) the general rule but it would indeed for us be the only logical way to read the Article.[34]

Furthermore, in order complete the system so created, and to avoid that the patient still has no known person to turn to, the hospital (which can escape its own liability by mentioning that it is not a contracting party), is obliged by para. (2) to name the treatment provider in question if he or she cannot be identified and the hospital itself is not the treatment provider.[35] By mentioning the doctor in question, the patient has someone to turn to for damages, and if no name is given, the hospital itself is (again) considered responsible.

Now, the comment quoted above mentioned a far-reaching variation on this. But where in the Principles does it say *the hospital* is liable if it was not a party? It doesn't, as far as we are concerned. What is wrong or at least less clear here is the Comment. It

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32 PEL SC, Chapter VII, Article 7: 111, Comments A, at p. 895 (repeated on p. 896).

33 With hospital we mean to include other treatment-providing organizations.

34 Unless the sanction to para. (1) is (also) to be found in para. (2), which would then be that not stating that the hospital is not a party to the contract is considered to be equivalent to not stating the name of the responsible doctor, which then turns the hospital itself into the treatment provider, making it thus liable. This seems far-fetched however.

35 Our version of how to read the Article is supported, we feel, by Comment D on p. 896-897 (where it is stated that central liability is not desirable).

plainly goes overboard, we think, in stating that the hospital 'will be held liable' even if the hospital 'was not a contracting party'. It seems as if the Comment is defending another option in explaining the general idea behind Article 7:111 PEL SC, namely the Dutch rule of always being able to turn to the hospital for damages. Later the Comment correctly states that Article 7:111 PEL SC really is about the patients' right to assistance from the treatment providing organization to bring his claim against the party that is liable for non-performance.[36]

However, the Comment should (at the most) have read that the hospital *might* be held liable even it was not a party to the contract, namely in those cases in which either it does not mention it is not a party (which all hospitals will no doubt do if needed by way of a general clause) or in those cases in which it cannot (or will not) mention who actually performed the treatment that went wrong. Of course, a hospital not being the employer of the mistaken doctor in question has no reason whatsoever not to name the person on first demand, which is good for the patient but does not warrant the conclusion that the hospital 'will be held liable'.

What the comment also could have said is that there will always be some responsible party, either the treatment provider in person (being known or being named by the hospital on the basis of para. (2)), or the hospital itself as the contracting party (para. (1)) or as the provider if it does not name the doctor in question (para. (2)). This is as such quite an achievement. Overstating the working of the rule in the comments was thus not at all necessary. The result is does reach is fine enough, we feel. The reason behind the justified need for such a provision is of course related to the complexity of the situation a patient finds himself in once he steps into a hospital with some doctors being employed, some working there on their own account, etc. A patient might easily get lost when dealing with a hospital, nurses, doctors, specialists, etc.

Given the explanation of Article 7:111 we have come to, a more technical point needs to be stressed. One can conclude that according to Dutch law it is for the patient of no importance whatsoever with whom the medical treatment contract is concluded: he can always claim damages from the hospital. In the PEL SC, to the contrary, the question who is the contracting party is the central issue.

This being the case, Article 7:111 PEL SC might be seen as a disappointment from a Dutch perspective. While it does make sure that there is always someone to hold responsible if a patient suffers damage from medical treatment in a hospital, it does not take the next step. It could have made the plaintiffs' position even better by just directing all claims towards the hospital, leaving the issue of recourse from the responsible doctor to that hospital. In doing so, the possible insolvency of the doctor would also be circum-

36 PEL SC, Chapter VII, Article 7: 111, Comments D, at p. 897. One could also view the rule so specified as a more detailed duty of care provision in the sense that the treatment provider must be able to state who is actually treating patients within its walls. If it isn't willing or able to do so, the 'punishment' is set at being liable itself instead of the actual treatment provider. If this view holds under the PEL SC, is uncertain however.

vented to the advantage of the mistreated patient. However, the economic consequences of proclaiming such a rule, especially for smaller hospitals, would have been too big.[37] Of course, there seems to be some logic in that but on the other hand, we are not sure whether that would have really been the case. Empirical data seem to lacking here (they are not mentioned) but what could have been and maybe should have been learned by the drafters and the Study Group is that no hospital in the Netherlands has gone bankrupt after the introduction of precisely this rule in the Netherlands (in 1995) due to lack of resources in relation to that rule. So for now, the evidence is against the PEL SC framers, we think.

Having said that, and talking a broader look, that is to say a European view, one must notice that this Article is already going beyond what is being done in most parts of Europe, at least as far as our understanding goes.[38] So, in that sense, we can only commemorate the drafters for taking this step.[39] Our educated guess would be that the provision would not have come about as it has, had the Working Team been located anywhere but in the Netherlands.

5. Concluding remarks

How innovative are the PEL SC? Within the confines of this contribution we could not analyze all or even the majority of the rules on service contracts. What we have analyzed however shows that there has indeed been a team working on these principles that has had the guts and drive to try and be as modern as possible (within the context they had to work in). The choice of the specific topics dealt with, the whole structure that has been developed, starting of with a general part, as well as some of the substantive solutions chosen show a progressive nature. They show a team of drafters not just willing and able to state the law as it is, roughly, in about (then) 15 (and now 27) countries, but also willing to go a (small) step further in developing rules that might not be common but might well be 'better' for all of us in the long run. Some of the rules on burden of proof mentioned above are examples on this; the rule on central liability is also worth

37 PEL SC, Chapter VII. Article 7:111, D, at p. 896.

38 Our understanding is of course largely based on the PEL SC, which are actually not covering most legal systems in Europe. And, to add a note of criticisms, the materials gathered from systems we do know seem to suggest that these materials are rather outdated already. For instance, the 'omkeringsregel' with regard to causation dealt with in par. 4.3 above has been almost abolished in the years after 2002 (in 2003 and 2004 most notably) but that has not reached the (National) Notes on Dutch law. Of course, projects like these tend to age fast as they proceed, but a pity it remains because the somewhat informed reader is no longer confident in the materials on other systems once he or she finds out about a lack of accuracy in one of the systems dealt with.

39 The drafters are also to be applauded for working with a very broad notion of treatment providing organizations here, something Ewoud Hondius has also defended in the past, see *E.H. Hondius*, Ontwikkelingen in de civielrechtelijke aansprakelijkheid van arts en ziekenhuis, in: *J.H. Hubben* (red.), De geneeskundige behandelingsovereenkomst, 1990, p. 65.

mentioning, although in our opinion going one step further in that respect would have been manageable as well. The authors are thus to be applauded for their strive for progressiveness in this part of a future European contract law, a mental state of mind we wish upon all unifiers and harmonizers of European contract law, just as we wish to applaud Ewoud Hondius for his no doubt influential role in getting this project to the Netherlands where it could be taken up just the way it has been taken up.